GLOBAL HEALTH LAW JOURNAL

GLOBAL HEALTH LAW JOURNAL

VOLUME 3 - Nº 02 - 2025

GLOBAL HEALTH LAW JOURNAL

Health Law, International Health Law, Comparative
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Global Health Law Journal

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VOLUME 3 - Nº 02 – 2025

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Maria Cristina Pontes de Oliveira

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[1] **How to cite:**
QUEIROZ E SOUZA, Eduardo Leandro de; KHAMIS, Renato Braz Mehanna. Orthotanasia in the dimension of the fundamental right to health. **Global Health Law Journal**, Santos-Brazil, v. 03, n. 02, p. 157-188, 2025, available at: https://ojs.unisanta.br/index.php/GHL/index

[2] **Eduardo Leandro de Queiroz e Souza**:
Graduate degree in Law from Centro Universitário das Faculdades Metropolitanas Unidas, Master's student in Health Law at the PPG of the Universidade Santa Cecília, Santos/SP. Lawyer and partner-owner of the law firm Queiroz Advogados. http://lattes.cnpq.br/0631501617557269; https://orcid.org/0009-0001-7180-604X

[3] **Renato Braz Mehanna Khamis**
Graduate degree in Law from Pontifícia Universidade Católica of São Paulo.
Master in State Law from the Pontifícia Universidade Católica of São Paulo.
PhD in State Law from the Pontifícia Universidade Católica of São Paulo.
Professor of the Specialization Course in Constitutional Law at PUC-SP (2008/present).
Professor of the Specialization Course in Constitutional Law at the Escola Superior da Advocacia do Mato Grosso do Sul - ESA/MS (2008/2009).
Guest Professor of the Specialization Course in Human Rights at UNITINS (2009). Professor of the Undergraduate Law Course at Universidade Católica de Santos (2012/2016).
Professor of the Undergraduate Law Course at Universidade Santa Cecília (2012/present).
Professor of the Stricto-Sensu Graduate Program, Master's in Health Law, at Universidade Santa Cecília (2016/present).
Visiting Professor at Nicolaus Copernicus University, Poland (2017). http://lattes.cnpq.br/5597839038397259; https://orcid.org/0000-0001-8306-9174

DOI: https://doi.org/10.5281/zenodo.17029274

Abstract

The article addresses the right to orthothanasia in the context of the fundamental right to health and human dignity, as provided for in the Federal Constitution. The central issue examined is whether orthothanasia can be considered a fundamental right to die with dignity for the terminally ill patient who chooses to refuse disproportionate medical treatments. The aim of the study is to analyze the practice of orthothanasia and integrative palliative care as possible rights inherent to human dignity and health, and to examine how the legal protection of dignity relates to the right to life in these cases. The methodology used is deductive, based on the analysis of national and international legislation, doctrine, and jurisprudence. The results indicate that orthothanasia can be legitimized as a practice of respecting the autonomy of terminally ill patients by avoiding the artificial prolongation of life with futile treatments. It is concluded that, by ensuring the right to orthothanasia, human dignity is respected, providing the patient with a dignified and humane death, in accordance with constitutional and ethical principles. The study demonstrates the intersection between constitutional and infraconstitutional norms, as well as alignment with international treaties, reinforcing that orthothanasia is an extension of the right to health and dignity.

Keywords: Integrative palliative care, Terminally Ill, Right to die, Patients´ rights**.**

Introduction[4]

Orthothanasia, derived from the Greek "ortho" (correct) and "thanatos" (death), refers to the idea of allowing death to occur at the right time, without the intervention of disproportionate medical treatments that prolong the suffering of terminally ill patients. It is a practice that aims to free the human being from

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[4] Original Text in Portuguese Published by CIDS/UNISANTA 2024

suffering, avoiding futile procedures that do not promote healing, but only extend the agony. Given this lexical context, we intend to analyze whether orthothanasia is part of the understanding of the Fundamental Right to Health and the Fundamental Right to a dignified life, constituting a true fundamental right to a good death, a dignified death through the assurance of lawful medical interventions at the end of life, with the suspension or abstention from disproportionate medical treatments.

This article analyzed the scope and dimension of orthotanasia in the context of fundamental rights to a dignified life and health, with a focus on the autonomy of the terminally ill patient. The study also addresses the legal and ethical implications related to the patient's ability to decide about their own life, especially when they are of legal age and in full possession of their mental faculties. Integrative palliative care, which seeks to ensure a dignified death by avoiding unnecessary treatments, is also discussed. The right to choose is therefore considered, either directly through the patient's voice or through a living will, with orders not to resuscitate. We sought to analyze the depth of human dignity as a potential supporter of the right to a dignified death, which can be considered a corollary of the right to choose not to undergo treatment. To this end, it is essential to consider whether the person is of legal age and capable, that is, whether they are in full possession of their mental faculties. In other words, if the chances of a cure are minimal, one must consider whether the protection of human dignity takes precedence over the right to life.

It is important to highlight that the dignity of the human person was the foundation of the Democratic Rule of Law, according to article 1, paragraph III, of the Federal Constitution. Therefore, just as individuals have the right to live with dignity, they also have the right to die with dignity, without suffering or unnecessarily prolonging their lives. Thus, the term "dignified death" should be understood as the possibility for a patient suffering from a terminal or irreversible illness to have their right to choose respected regarding the way they wish to die. This was supported by articles 1, item III (human dignity), and 5 (right to life) of the Federal Constitution.

From reading and understanding the constitutional norms, notably articles 5, 6 and 196 of the Federal Constitution, it was found that health protection included not only the right to treatment, but also the right to refuse interventions that do not contribute to improving the patient's quality of life. The dignity of the human person, a fundamental principle enshrined in article

1, III, reinforced the need to consider the patient's will and their right to choose a dignified death, without the imposition of disproportionate therapeutic measures.

The article also examines the rules of the Federal Council of Medicine and international standards, such as the Pact of San José of Costa Rica and the Universal Declaration of Human Rights. Regarding the resolutions of the Federal Council of Medicine, such as Resolution No. 1.805/2006, it corroborates the legitimacy of orthotanasia by allowing doctors to suspend or limit treatments that only prolong life artificially, respecting the will of the patient or their legal representative. These standards highlighted the importance of offering palliative care that alleviated suffering and provided physical, psychological, social and spiritual comfort.

At the international level, treaties and conventions, such as the Pact of San José of Costa Rica and the Universal Declaration of Human Rights, ensured the right to life and personal integrity, reinforcing the need for dignified and humane treatment for terminally ill patients. The case study of Maria Teresa Benito Orihuela, diagnosed with Amyotrophic Lateral Sclerosis (ALS) in Peru, illustrated the relevance of the patient's right to choose a dignified death, highlighting autonomy and human dignity as central elements in the decision to cease invasive and futile treatments.

Philosophical and ethical reflections, based on theorists such as Norberto Bobbio and Kant, argue that the dignity of the human person must be preserved until the end of life. Patient autonomy and respect for their decisions are ethical imperatives that guide medical practice, avoiding the instrumentalization of human beings and promoting a dignified death as a corollary of a dignified life. Just as humanized childbirth was discussed, with all its contours and protection, a good death must also be discussed and humanized. This topic must be brought to light, dispelling the belief that talking about death attracts it. After all, death is an inevitable part of life.

The objectives of this study include the analysis of orthotanasia and palliative care as possible fundamental rights to human dignity and health, verifying how the legal protection of dignity relates to the right to life. The hypothesis is raised that orthotanasia is recognized as a fundamental right inherent to the dignity of the human person, allowing terminally ill patients to refuse disproportionate medical treatments in order to ensure a dignified death. It assesses whether Brazilian legislation and ethical and medical standards support this practice as an extension of the right to health and dignity.

The method adopted is deductive, using the analysis of national and international legislation, doctrines and jurisprudence. The methodology involves documentary research, based on legal, philosophical and scientific sources, allowing the practice to be replicated by other researchers interested in the relationship between orthotanasia, dignity and the right to health. Thus, the methodology used will be deductive, with its application through consultations of bibliographies, using law, legal articles and the Federal Constitution itself as research sources.

1. Concept and philosophical, legal and medical dimensions of orthotanasia

Orthothanasia, originating from the Greek *orthos* (correct) and *thanos* (death) (Dicionário Aurélio, 2018, p. 45), can be defined as death in due time, that is, one that is not anticipated or even postponed. It can be inferred from this that, through the practice of orthotanasia, death is not being caused - euthanasia - nor is its occurrence being indefinitely postponed – dysthanasia. What is sought is that the inevitable death occurs, but preserving all basic care for the patient's health. (Villas-Boas, 2005, p. 73).

Before continuing to understand the distinctive aspects between orthothanasia, dysthanasia and euthanasia, it is still necessary to preliminarily conceptualize "palliative care" as an essential element in understanding orthothanasia and its dimensions discussed in this work. The World Health Organization defines palliative care as a set of actions that aim to improve the quality of life not only of patients, but also of their families, when involved with issues related to life-threatening illnesses (WHO, 2010).

According to the 2nd edition of the Global Atlas on Palliative Care, published in October 2020 by the Worldwide Palliative Care Alliance (WPCA) in partnership with the World Health Organization (WHO), palliative care is defined as a multidisciplinary approach aimed at improving the quality of life of patients, whether adults or children, who face life-threatening illnesses. Furthermore, this approach also extends to supporting patients' families, aiming to prevent and alleviate suffering through early identification, correct assessment and appropriate treatment of pain and other problems, whether physical, psychosocial or spiritual in nature. The main objectives of palliative care include: providing relief from pain and distressing symptoms; affirming life and treating death as a natural process, without hastening or postponing its course;

integrating psychological and spiritual aspects into patient care; offering support to families in dealing with illness and bereavement; use a collaborative approach, involving a multidisciplinary team to meet the needs of both patients and their families, including bereavement counseling when necessary; and improve quality of life by positively influencing the course of the disease (Dadalto, 2001, p. 3).

In palliative care, there is a move away from modern medical techniques and the obsessive search for a cure, making room for the idea of providing good care, accepting that life is a chronological sequence that begins with fecundation, goes through all the stages of life and ends with death. The main concern is with the sick person, not the disease (Pessini, 2004).

Godinho, mentioning Klaschik, teaches that medicine should prioritize not what is technically possible, but what is ethically justifiable, considering the patient's physical, spiritual and psychological problems, respecting their dignity and autonomy (Godinho, 2017).

Pessini describes five fundamental ethical principles in palliative care: truthfulness, which underpins trust between doctors and patients, requiring doctors to provide information necessary for patients to make decisions about their care;

therapeutic proportionality, which requires the implementation of therapeutic measures that are useful for the patient, taking into account their health, alternative courses of action, prognoses of risks and benefits, and the costs involved; the principle of double effect, allowing measures that can shorten the patient's life, as long as the purpose is to relieve the pain and symptoms of the disease, and not to cause death; prevention, which requires that medical choices, even palliative ones, come with prognoses that avoid complications and advise the patient and their relatives about future actions; and non-abandonment, which imposes on the doctor the duty to care for the patient until death, even if they disagree with the patient's choices. Pessini teaches, in Godinho's view, that this principle distinguishes orthotanasia, where care is maintained until natural death, from euthanasia, where death is induced (Godinho, 2017).

In view of this, there are some considerations between palliative care and orthothanasia: what is sought with orthothanasia is not death, but the humanization of the dying process, without abuse in its prolongation or even provoking death, since it is the result of the illness the person suffers from, but on the contrary, it is accepted as the natural end of life. (Blanco, 1997, p. 31-32). The consideration refers specifically to orthotanasia, which seeks to humanize the process of dying by not artificially prolonging life, but also by not causing death, accepting it as a natural result of the disease. However, when dealing with palliative care, it is important to highlight that the main objective is not to accelerate or postpone death, but rather to alleviate suffering and improve quality of life. Palliative care focuses on the patient's physical, emotional, social and spiritual well-being, providing a comprehensive approach that involves both the patient and their family. They offer ongoing support during illness and after death, in the grieving process, as a way of ensuring that the end of life occurs in a dignified manner, without unnecessary suffering, respecting the patient's wishes and promoting a natural and peaceful death. Thus, palliative care and orthotanasia complement each other in promoting a dignified death: while the former care for the patient in a holistic way and alleviate suffering until the end, orthotanasia ensures that invasive and disproportionate treatments that unnecessarily prolong the dying process are not used.

The distinction between the concepts of euthanasia, dysthanasia and orthothanasia must be carefully understood, especially with regard to orthothanasia and passive euthanasia. While passive euthanasia involves the omission of proportionate treatments or care that, if administered, could maintain the patient's life, orthothanasia consists of avoiding futile and disproportionate treatments, which would not bring any benefit to the patient and would only prolong the process of death. In passive euthanasia, the medical conduct that interrupts essential treatments establishes a direct causal link with the death of the patient, who does not die as a result of the disease, but rather due to the withdrawal of measures that could keep the patient alive. In contrast, in orthotanasia, death is a natural result of the patient's terminal condition, without interventions that would postpone or anticipate this process, accepting death as an inevitable consequence of the progression of the disease. (Godinho, 2017, p 135-136).

Orthothanasia can be seen as a middle ground between euthanasia and dysthanasia, where euthanasia would "speed up" death, while dysthanasia would "delay" death. In this middle ground, orthotanasia would imply that the patient would have a dignified death, avoiding unnecessary suffering.

We now move on to some reflections on the philosophical-legal context of the topic. First, the most obvious assertion: death is part of life. As Matilde Zavala de Gonzalez lectures, “*la muerta própria y a la ajena son parte de la vida, en tanto la limitam, como em um camino que llega hasta determinando ponto; y esse conocimiento sobre la inexoble mortalidade* *impregna de sentido los momentos vividos"* (Gonzalez, 2010, p. 3). To illustrate the issue, Maria Helena Diniz questions how a dignified death can be guaranteed if there are no conditions for a dignified life. She suggests that human dignity requires the absence of inhumane and violent treatment, and criticizes the incoherence of a society that offers technology to help people die well, but often fails to offer adequate means to live with dignity. (Diniz, 2006, p. 481).

Jorge Miranda (2010, p. 166) states that the Brazilian Constitution is based on the dignity of the human person, giving a unity of meaning, value and practical agreement to the system of fundamental rights, based on the concept that the person is the foundation and the purpose of society and the State. Thus, it can be seen that the individual is the center of the legal system. Dignity in dying must be pursued by legal practitioners and interpreters, just as dignity is sought in birth and in life. Although there is no specific legal provision on euthanasia and assisted suicide, the Brazilian legal system allows the defense of a dignified death as a fundamental right. From this perspective, the State should not hinder the way the individual chooses to achieve this right (Dadalto, 2019, p. 8-9).

In this way, the right to life seems to bring a dimension of a dignified life, from birth to the struggle to continue living, even respecting dignity in the right to die. The principle of human dignity protects the human being as a legal person, that is, as the holder of legal personality. The dignity of the human person is a spiritual and moral value inherent to each individual, manifesting itself in the conscious and responsible self-determination of one's own life, and demands respect from others. This principle constitutes an invulnerable minimum that the legal system must ensure (Melo, 2017, apud Morais). Roberto Adorno complements this idea, stating that, for Kant, human dignity is above any price and cannot be reduced to a simple exchange of interests. A person's dignity is an absolute value, which cannot be measured in terms of cost-benefit. This Kantian concept requires that people should never be treated as means to achieve other people's goals, which is especially relevant in bioethical contexts. This implies that one should not subject an individual to scientific experiments without their consent, even if the results could benefit society, nor should one force people in extreme poverty to sell organs to meet basic needs. The instrumentalization of human beings, in these cases, would be a direct violation of their dignity, something unacceptable from any ethical perspective (Adorno, 2012, p. 72).

To reiterate, death is an integral part of life. The act of dying is the final act of each human being's personal biography and cannot be seen as something distinct from it. The right to a dignified human life must not be interrupted by an undignified death. Therefore, the legal system must implement and protect the ideal of a dignified death (Mold, 2010, p. 1). Furthermore, the so-called "Human Rights of Patients", according to Aline Albuquerque’s doctrine, are international human rights regulations applicable to patients (Dadalto, 2021, p. 14). According to Albuquerque, the patient's mental and physical suffering can be aggravated by the action or omission of the state and health professionals, characterizing a violation of the right not to be subjected to torture, cruel, inhuman or degrading treatment or punishment. In palliative care, the absence of specific policies and the lack of availability and access to adequate medications to relieve pain can subject the patient to avoidable suffering, resulting in treatment that is incompatible with human rights standards (Albuquerque, 2016, p. 30).

Continuing with the philosophical reflection, religious overtones inevitably arise. In 2012, the president of the National Conference of Bishops of Brazil (CNBB), Dom Raymundo Damasceno Assis, in an interview with the Federal Council of Medicine, stated that: "Death is not a disease for which we must find a cure. It is necessary for people to recognize and accept their own reality and their own limits." This perspective is complemented by the view of Pope John Paul II in the Encyclical Evangelium Vitae, where he differentiates euthanasia from the decision to refuse excessive treatment. For John Paul II, when death inevitably approaches, it is possible, with due awareness, to renounce treatments that would only prolong life in a painful and poor quality way, without, however, suspending the essential and normal care due to the patient. This renunciation is not equivalent to euthanasia or suicide, but rather to the acceptance of the human condition in the face of finitude. The Church's position reinforces that dignity in the dying process lies in accepting the natural course of life, without resorting to extreme measures that would only prolong suffering, while maintaining care and respect for life until its natural end (Holy See, John Paul II. Encyclical Evangelium Vitae, 1995).

Based on what has been exposed, everything seems to indicate that a dignified death through euthanasia should be widely accepted, as it is based on principles that ensure the dignity of the human person. The defense of human dignity, the protection of life, among others, affirm that the individual has the sacrosanct right to experience their own death with dignity.

2. Normative and case-specific frameworks of orthotanasia: comparison between Brazilian and international legislation and the case of Maria Teresa Benito Orihuela (Peru)

The analysis begins with the normative frameworks that govern the issue of orthotanasia, the right to health and a dignified life, issues that are deeply rooted in the Constitution. The dignity of the human person is a central concept in this debate and, as defined by Alexandre de Morais, it is a spiritual and moral value inherent to each individual. This dignity is manifested in the capacity for conscious and responsible self-determination over one's own life, bringing with it the demand for respect from others. Morais emphasizes that this principle constitutes an inviolable core that every legal system must protect, allowing limitations on the exercise of fundamental rights only in exceptional situations, without ever compromising the necessary respect that every person deserves as a human being (Moraes, 2003, p. 16).

Tepedino and Schreiber emphasize that this is a problem of understanding, in the constitutional context, what should be considered unavailable and absolute is not life, but the dignity of the human person. Although the aforementioned authors do not recognize a normative hierarchy between constitutional provisions, they argue that human dignity, as the foundation of the Republic, has axiological superiority in relation to other interests protected by the Constitution. Therefore, the dignity of the human person, and not life, is the supreme guideline of constitutional legality (Tepedino, Schreiber, 2009).

Therefore, it is essential to reflect on the concept of a good death, which is deeply connected to the idea of a good life until the last moment. Quality of life and dignity throughout the dying process are issues that deserve to be studied, as they are part of the human experience itself. Norberto Bobbio highlights the importance of what we think, love and do, stating that our identity is directly linked to our memories and the actions we cultivate throughout our lives. Bobbio adds that we are what we remember, and that our memories are the true heritage we keep. He argues that life should be lived fully while our memories accompany us, allowing us to continue to reconnect with them, preserving the value of our trajectory (Bobbio, 1997, p. 30).

Apparently, based on orthotanasia, the fundamental principle of article 1, III of the Federal Constitution, the principle of human dignity, would be reaffirmed in the sense that the human being, in the most difficult moment of his life, when his existence comes to an end, must be treated with dignity. In this sense, it seems that the legal system should be interpreted in such a way as to guarantee that the patient is offered all the medical, emotional and psychological support, along with comfort and peace, in order to achieve a dignified death, according to their choice not to undergo medical treatment that prolongs their life unnecessarily in the face of an incurable disease. It seems that this idea is in line with article 5 of the Federal Constitution, when it exhorts the right to life as a fundamental right. And it is proposed that, with orthothanasia, the principle set out in article 5, item III of the Federal Constitution would be fully complied with, as it establishes that "no one shall be subjected to torture or inhuman or degrading treatment". In the same sense, arts. 6 and 196 of the Federal Constitution also proclaim health as a right and duty of all people.

It is worth mentioning that these guidelines are not only enshrined in the Federal Constitution. Valério Mazzuoli states that the expression human rights is associated with public international law and refers to the rights guaranteed by international standards, such as declarations or treaties concluded between States with the purpose of protecting the civil, political, economic, social and cultural rights of people under their jurisdiction[5] (Mazzuoli, 2018, p. 13).

The right to health has double protection: it can be classified as a fundamental right, when protected internally by the Constitution, and as a human right, when protection occurs through international treaties. With regard to international treaties related to the protection of life, in all its aspects, the Pact of San José of Costa Rica – American Convention on Human Rights – and the International Covenant on Economic, Social and Cultural Rights (ICESCR), of which Brazil is a signatory, stand out. The Pact of San José of Costa Rica, in its Article 4, states that every person has the right to have their life respected, and that this right must be protected by law, generally from the moment of conception. Article 5 guarantees the right to physical, mental and moral integrity, prohibiting torture, cruel, inhuman or degrading punishment or treatment,

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[5] Mazzuoli explains that these protective standards can exist both at a global level, within the scope of the United Nations, and at a regional level, such as in the inter-American, European or African systems of human rights protection. When a rule is established by a State or nation, it is about protecting the rights of a citizen, called "fundamental rights". On the other hand, when the norm is of external origin, that is, from international society, and protects the same right on a global scale, it is a human right. These rights are essential for a dignified life and establish a level of protection that all States must respect, under penalty of international responsibility. Thus, human rights guarantee people the means to claim their rights in international protection bodies, in addition to the domestic level (Dadalto, 2021; Mazzuoli, 2018).

and ensuring dignified treatment for all persons deprived of liberty. The ICESCR, in its Article 12, recognizes the right of everyone to enjoy the highest attainable standard of physical and mental health. To ensure the full exercise of this right, Member States shall adopt measures that include the reduction of infant and stillbirth mortality, the improvement of hygiene conditions at work and in the environment, the prevention and treatment of epidemic, endemic, occupational and other diseases, and the creation of conditions that guarantee medical care and medical services in case of illness.

In the same sense, the right to life is considered a universal right, especially after its proclamation in articles 3 and 5 of the Universal Declaration of Human Rights (UN) of 1948. Article 3 states that everyone has the right to life, liberty and personal safety, while Article 5 prohibits subjection to torture and cruel, inhuman or degrading treatment or punishment. The Universal Declaration of Human Rights is based on ethical content that guarantees the intangibility of human dignity, equality between people, the search for effective freedom, the achievement of justice and the construction of a conscience that fully preserves these principles (Nunes, 2004, p. 361).

In addition to the aforementioned guidelines, which can be interpreted as an indirect basis for the right to a dignified death for terminally ill patients, the 2013 Prague Charter reinforced this right, calling on governments to guarantee access to palliative care and relief from suffering. The Charter highlighted that access to palliative care is a legal obligation, recognized by United Nations conventions and defended as a human right by several international associations. It highlighted that for patients in severe pain, the lack of palliative care by governments could be considered a form of cruel, inhuman or degrading treatment. Palliative care, in addition to being effective in alleviating suffering, could be applied at a relatively low cost, preventing even more harm to the patient (United Nations, 2013, no page).

In the Brazilian context, the Federal Council of Medicine, in 2006, issued Resolution No. 1.805, establishing that doctors are allowed to limit or suspend procedures that prolong the lives of patients in the terminal phase of serious and incurable illnesses, as long as the wishes of the patient or their legal representative are respected. The Resolution also requires that the physician explain the therapeutic options to the patient or their representative, record the decision in the medical record and ensure the right to a second opinion. Furthermore, it determines that the patient continues to receive all necessary care to alleviate symptoms, ensuring their physical, psychological, social and spiritual comfort, including the right to hospital discharge, if desired (Brazil. Federal Council of Medicine. 2006, no page).

From a simple reading of the Resolution, it can be inferred that the practice of euthanasia was not covered by the rule, not even passive euthanasia, and furthermore, that there is the possibility of suspending futile treatments, since their suppression will not shorten the patient's life. There is also clear permission for procedures that would constitute dysthanasia, that is, that useless prolongation of the life of a terminally ill patient, imposing the duty on the doctor to inform all possible alternatives or therapies. And continuing the analysis of the Resolution in plan, article 2 enshrines the philosophy of palliative care, which must be carried out aiming at the physical, psychological, social and spiritual comfort of the patient, even if it is outside the hospital environment.

Despite the existence of this Resolution, it is clear that the doctor's duty is to prevent the patient's death, when this becomes possible, but when this is not possible, the patient will have the secular duty to comfort the terminally ill patient until their death, reducing, if possible, their pain and suffering.

Orthotanasia and palliative care are also duly covered by the Code of Medical Ethics. Article 41 of the Code explicitly prohibits doctors from shortening a patient's life, even at the request of the patient or their legal representative, but, in its sole paragraph, establishes that, in cases of incurable and terminal illnesses, the doctor must offer all available palliative care, avoiding diagnostic or therapeutic actions that are useless or obstinate, always respecting the expressed will of the patient or, if this is not possible, the will of their legal representative. (Brazil. Federal Council of Medicine, 2019, p. 28).

This device prohibits the practice of euthanasia, but, on the other hand, recommends orthotanasia as an appropriate medical measure for terminally ill patients, prioritizing comfort and relief of suffering through palliative care, without imposing unnecessary treatments. The Code of Medical Ethics reinforces this guideline in item XXII, determining that, in irreversible and terminal clinical situations, the physician must avoid unnecessary procedures and guarantee the patient all appropriate palliative care. This reflects the ethical commitment to the dignity and well-being of the patient during the final process of their life. (Brazil. Federal Council of Medicine, 2019, p. 17).

Finally, a brief note is also in order in the context of Brazilian infra-constitutional law. The patient's right to choose medical treatment is guaranteed by both the Federal Constitution and the Civil Code. The Constitution, as already mentioned, in its articles 1, III and 5, caput, ensures the inviolability of the right to life, liberty and dignity of the human person, while the Civil Code (law 10.406/02), in its articles 15 and 16, provides for the informed consent of the patient for the performance of any medical procedure. In addition to this right to choose, instruments such as the living will and the do-not-resuscitate (DNR) order allow patients to express their wishes in advance regarding medical treatments, ensuring that their decisions are respected, especially in situations where they cannot express their wishes at the time of care. These instruments are fundamental to ensuring patient autonomy and respect for human dignity at critical moments in their lives.

We will now analyze the recent case concerning the life of Maria Teresa Benito Orihuela. To demonstrate the importance of the patient's right to choose a dignified death, the case of Maria Teresa Benito Orihuela, diagnosed with Amyotrophic Lateral Sclerosis (ALS), in Peru, must be brought to light (Superior Court of Justice of Lima, Third Constitutional Chamber Exp. 04988-2023-0-1801-JR-DC-11 Subject: Protection process Page 1 of 80 FILE: 004988-2023-0-1801-JR-DC-11). The patient underwent medical interventions, including a tracheostomy, and was dependent on a mechanical ventilator due to an episode of asphyxia. Initially, the patient administratively requested *EsSalud* to cease the invasive treatments that were keeping her alive artificially. However, the health system denied the patient's request. The patient expressed the desire to stop these treatments, arguing that they only increased her suffering without offering any prospect of cure or significant improvement, fully understanding her condition and seeking a dignified death.

EsSalud contested the request, stating that its role was to protect the life and health of patients and that ceasing treatments would be contrary to that duty, constituting a merciful killing under Article 112 of the Peruvian Penal Code. It further argued that although ALS is incurable, it is not an imminently terminal disease, allowing many patients to live for years with an acceptable quality of life. Therefore, continuity of treatments was considered a medical and ethical obligation.

In the first instance, the lawsuit was declared inadmissible, based on the interpretation that the rights to life and health took precedence and that *EsSalud's* refusal was justified by the need to protect these rights. There was an appeal to the Third Constitutional Chamber of the Superior Court of Justice of Lima, which converted the Habeas Corpus process into a Protection process, considering that the rights to dignity and personal autonomy should be protected. The Court ordered *EsSalud* to respect Maria's informed decision to cease medical treatments, allowing terminally ill patients to make decisions about their bodies and treatments.

The Superior Court of Justice of Lima recognized the importance of respecting and protecting human dignity, in accordance with Article 1 of the Political Constitution of Peru, and ordered the cessation of invasive medical treatments against the patient's will, considering them a violation of her basic human rights (Article 2 of the Political Constitution of Peru), including the right to life, moral, psychological and physical integrity and free development and well-being.

In its reasoning, the Court reaffirmed that the right to human dignity is inherent to all human beings and must be respected, especially in contexts of terminal illnesses and palliative care, considering the patient's conditions, such as the progression of ALS and the loss of the ability to communicate.

The decision included a recommendation that *EsSalud* provide adequate palliative care to the patient, ensuring treatment for pain relief and other symptoms, providing comfort in her final days of life. The Court highlighted the importance of palliative care as a patient-centered approach that respects dignity and quality of life until the end. It recommended that *EsSalud* and other health entities implement policies to ensure that patients' decisions about medical treatments are respected, as well as ongoing monitoring to ensure compliance with the decision and the protection of patients' rights.

Finally, the Court emphasized the need for cultural change within the health system, to value and respect patients' autonomy, as well as human dignity and the patient's expressed wishes, stating that continuing treatment against the patient's will would be a violation of constitutional rights. Legal precedents were cited, such as Montgomery v. Lanarkshire Health Board in the United Kingdom (2015), which reinforced the importance of patient autonomy and the right to information about the risks of medical treatments, and the Quinlan Case (United States, 1976), in which the New Jersey Supreme Court ruled in favor of the Quinlan family to remove life support from Karen Ann Quinlan, establishing an important precedent on the right to refuse medical treatments (Baylor College of Medicine Blog Network).

Final considerations

The analysis developed in this article allowed us to conclude that orthotanasia, understood as the practice of allowing death to occur in its natural time, without the imposition of disproportionate medical treatments, is aligned with constitutional principles and with the fundamental rights to health and human dignity. Orthotanasia, by avoiding the perpetuation of useless treatments that only prolong suffering without providing a cure, guarantees the terminally ill patient a dignified death, in accordance with the inherent dignity of the human person. In response to the hypothesis raised, it can be concluded, from reading the opinions presented, that orthotanasia was recognized as a fundamental right inherent to the dignity of the human person, allowing terminally ill patients to refuse disproportionate medical treatments in order to ensure a dignified death. Brazilian legislation and ethical and medical standards support this practice as an extension of the right to health and dignity. In short, orthotanasia represents an essential dimension of the fundamental rights to health and human dignity, ensuring that patients who are terminally ill can live their last moments with respect, autonomy and without unnecessary suffering. The intersection between constitutional, infra-constitutional, international norms and philosophical reflections justified the legitimacy of orthotanasia as a fundamental right, demonstrating that human dignity must prevail in the conduct of end-of-life care.

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How to cite:

QUEIROZ E SOUZA, Eduardo Leandro de; KHAMIS, Renato Braz Mehanna. Orthotanasia in the dimension of the fundamental right to health. **Global Health Law Journal**, Santos-Brazil, v. 03, n. 02, p. 157-188, 2025, available at: https://ojs.unisanta.br/index.php/GHL/index .

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