

Between illness and death: “Euthanasia”

Entre la enfermedad y la muerte: “eutanasia”

María del Carmen Dubón-Peniche^{1*} and Luis E. Bustamante-Leija²

¹Medical Directorate, Hospital General de México Dr. Eduardo Liceaga; ²Arbitration Directorate General, Comisión Nacional de Arbitraje Médico. Mexico City, Mexico

Abstract

The arguments for and against euthanasia present a complex picture that will need to be discussed and decided in Mexico. This article addresses some relevant aspects such as the legal determination of death, the field of bioethics intervention, terminology related to euthanasia, its classifications, and international instruments promoting human rights, as well as reflections on the importance of palliative care and the patient's right to be in a terminal situation to act in accordance with their goals, expectations, and beliefs, in the context of their family and social relationships.

Keywords: Palliative care. Euthanasia. Death. Assisted suicide.

Resumen

Los argumentos a favor y en contra de la eutanasia exponen un panorama complejo, que será necesario discutir y decidir en México. En este artículo se abordan algunos aspectos relevantes, como la determinación legal de la muerte, el campo de intervención de la bioética, la terminología relacionada con la eutanasia, sus clasificaciones, los instrumentos internacionales promotores de los derechos humanos, y reflexiones sobre la importancia de los cuidados paliativos y el derecho que tiene el paciente en situación terminal para actuar conforme a sus objetivos, expectativas y creencias, en el contexto de sus relaciones familiares y sociales.

Palabras Clave: Cuidados paliativos. Eutanasia. Muerte. Suicidio asistido.

*“Death is a punishment to some, to others a gift,
and to many a favor.”*

Seneca

Introducción

To approach the issue of euthanasia, it is inevitable to talk about death; the term comes from Latin *mors-mortis*, which means cessation. From the biological

point of view, it involves the cessation of a living being's organic functions, beyond which its revivification is not possible. In the law, a person's death extinguishes his personality in legal relationships, while in legal medicine, clinical diagnosis of death is based on a definitive, irreversible, and permanent abolition of the body's vital functions.

In this sense, the first problem that arises is legal determination of the moment of death, its causes, and

Correspondence:

*María del Carmen Dubón-Peniche

E-mail: maria.dubon@salud.gob.mx

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the way to certify the decease, since these are matters not only of public order, but also of General Public Health of the Republic.

The General Statute of Health, in its Title IV “Loss of Life”, provides as criteria for legal determination of death the following¹:

Article 343. For the purposes of this Title, loss of life occurs when brain death or irreversible cardiac arrest occurs.

Brain death is determined when the following signs are verified:

- *Complete and permanent absence of consciousness*
- *Permanent absence of spontaneous breathing, and*
- *Absence of brainstem reflexes, manifested by pupillary areflexia, absence of eye movements in vestibular tests, and absence of nociceptive stimuli.*

It should be ruled out that these signs are the result of acute intoxication by narcotics, sedatives, barbiturates, or neurotropic substances.

Article 344. Clinical signs of brain death must be corroborated by any of the following tests:

- *Electroencephalogram demonstrating total absence of electrical activity, corroborated by a specialist physician*
- *Any other imaging study that documentary demonstrates a permanent absence of arterial brain flow.*

Death is one of the most transcendent events, as it means the end of a living body, and while for some people, it represents the end of their existence, for others, it is the beginning of eternal life². It is a fact that is inherent to all living beings, and in particular, in people, its approach is complex and involves the circumstances of time, form, and place in which it occurs³. One way to classify death is by its cause (illness, accident, suicide, homicide, etc.), which determines the possibilities of medical intervention.

To sum up, people die from different causes, in various circumstances and cultural settings, with different levels of consciousness and different perceptions of what a good death constitutes.

The relationship each one of us establishes with death is woven in the most intimate plane, through personal consciousness, nuanced by the era, beliefs and knowledge, and based on that, each one looks back to seek for a meaning of his own death⁴.

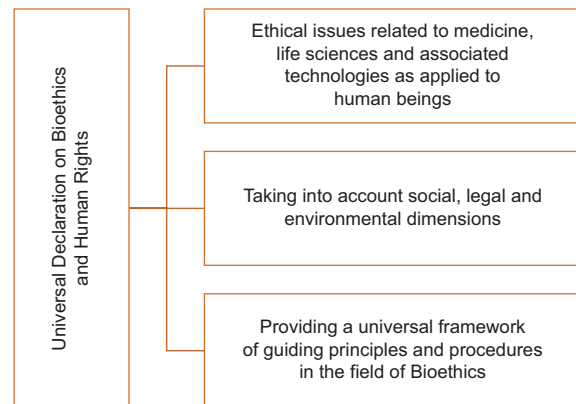


Figure 1. Universal Declaration on Bioethics and Human Rights (adapted from: United Nations Educational, Scientific and Cultural Organization⁵).

The rapid advances of science and its technological applications in medicine have given rise to different ethical approaches related to euthanasia, which deserve to be explored, considering not only respect for the dignity of the person, but also universal respect and observance of human rights and fundamental freedoms.

Life is a universal right recognized in the political constitutions and regulations of different countries, as well as in international instruments, among which the Universal Declaration of Human Rights, the Universal Declaration on Bioethics and Human Rights, the Charter of Fundamental Rights of the European Union, and the American Convention on Human Rights stand out. In this context, it is evident that international law acts as one of the main promoters of human rights (Fig. 1)⁵.

There are different perspectives to position the analysis of euthanasia, which invariably must recognize its consequences on positive law. The field of bioethics intervention is broad, since it supports its reflection with philosophy, medicine, law, and sociology, among other disciplines. Given the complexity of its object, it connects and integrates different kinds of knowledge to give answers to different arguments and positions that continuously arise with scientific and technological advances, which in medical sciences have represented the possibility of transforming the health-disease process in people, generating higher expectations regarding the prolongation of life, and especially in patients in serious, critical, or terminal condition.

In this sense, although it is true that the development of science and technology implies ethical

reasoning in its applications, it is also true that not everything that is scientifically and technically possible can be justifiable from an ethical and legal point of view.

Bioethics demand from society the need to deliberate on problems related to the environment, people's lives, and bodies, as well as responsibility with the future generations, among other aspects⁶.

Historically, the doctor-patient relationship has been the central element of medical ethics, since it is from this relationship that the processes of medical care acquire meaning. In this regard, it is necessary to reflect on such a controversial issue when focusing our attention: knowing how to notice the demarcation line that allows us to distinguish what is permissible from that which is not⁷. Indeed, the decision regarding the indication, performance, or suspension of diagnostic-therapeutic procedures in patients with terminal illness is not easy, and in this field, the support of Hospital Bioethics Committees arises, whose objectives include advising health personnel and users with regard to the problems and bioethical dilemmas that arise in the provision of medical care services and health teaching, from a secular and scientific perspective⁸.

Achieving conceptual clarity is essential to have the possibility of addressing the moral paradigms that arise in the management of patients and their diseases by medical care service providers, who every day are faced with decision-making in which conflicts of values come into play.

Euthanasia: the concept and related terms

The World Health Organization refers that the definitions of euthanasia are not accurate and may vary from one person to another, but have some elements in common. Most pundits limit their description to direct or active euthanasia, which can be divided into three categories: (1) intentional homicide of those who have expressed their competent and free desire; (2) professionally assisted suicide; and (3) intentional homicide of newborns who have congenital anomalies that may or may not be life-threatening, often due to food retention. The term passive euthanasia is misleading and inaccurate; it refers to practices in dying patients, such as withdrawal of a treatment that has been shown to be of no benefit, or failure to initiate a treatment that is considered of no benefit, and vigorous application of treatment for pain, although this may possibly shorten life. Since these decisions can

be made near the end of life, death can follow soon, but not invariably, and these practices have been labeled as euthanasia⁹.

For the World Medical Association, euthanasia is considered as the intentional and knowledgeable performance of an act with clear intentions of ending the life of another person, provided the person is competent, informed about the incurable state of his disease, and has voluntarily requested to terminate his life¹⁰.

Euthanasia is defined by the Royal Spanish Academy as an "Action or omission that, to avoid suffering for terminally ill patients, hastens their death with or without their consent" and as "Death without physical suffering"¹¹.

Etymologically, "euthanasia" is a word that derives from its Greek roots, *eu* (good) and *thanatos* (death), and means good death or to die well. The opposite of euthanasia is dysthanasia (therapeutic obstinacy or therapeutic cruelty), for its Greek roots *dis* (wrong, something wrongly done) and *thanatos* (death), and consists of delaying the event of death as much as possible even if there is no hope of cure at all, without taking into account the quality of life of the patient; that is, it is the prolongation of the agony, suffering, and death of a patient¹². Therapeutic obstinacy is nothing more than the adoption of disproportionate or useless measures with the purpose to prolong life in a situation of agony¹³.

Orthothanasia refers to allowing death to occur at the right time, "when it has to occur", and health professionals are trained to provide the patient with all the care and treatments to reduce suffering without altering the course of disease or, therefore, the course of death. There is also the limitation of therapeutic effort, which consists in withdrawing or not initiating therapeutic measures because health professionals consider that, in the specific situation of the patient, they are useless, since they would only achieve prolonging his life without the possibility of providing a functional recovery with a minimum quality of life. The omission or withdrawal of extraordinary means has also been called adysthanasia¹⁴.

On the other hand, suicide refers to the act by means of which a person voluntarily deprives himself from life, and assisted suicide refers to a third party providing some effective means to the patient for him to bring about his death by himself.

As for its classification, euthanasia has been catalogued according to its type, with a variety of categories thus emerging, with the following standing out¹⁵⁻¹⁸:

- By its purpose
 - Eugenic: death to deformed or sick people, for not to degenerate the race
 - Economic: elimination of incurable, disabled, or elderly subjects, to relieve society from useless people who entail high economic and health-care costs
 - Pious: due to a feeling of compassion toward the person who is enduring serious suffering, with no hope of survival
 - Solidary: painless death to terminally ill people to use their organs or tissues for therapeutic purposes
- By action modality
 - Active: requested by the terminal patient himself and caused by a positive action of a doctor or health personnel
 - Passive: death of a patient by omission of a necessary therapeutic treatment, therapy discontinuation for not to prolong the suffering of a patient at the end of life.

This distinction between active and passive euthanasia tends to disappear when the terminology of “passive euthanasia” is replaced by that of “therapeutic effort limitation”, and it is generally accepted that uselessly prolonging the suffering of the patient is not justified.

- By intention
 - Direct: immediate and deliberate inducement of death with accurate means
 - Indirect or lenitive: action or omission that indirectly (as a side effect) causes death
- By volitional content
 - Voluntary: it is carried out at patient request with his informed, express, and conscious consent
 - Non-voluntary, which contemplates two arguments:
 - Death of the patient who is not able to understand the choice between life and death
 - It is imposed to a patient against his will, in contravention of his own wishes.

The non-voluntary modality is a subject of debate, since it is understood as being an imposition, and, therefore, one would speak about homicide.

- By authorship
 - Heteronomous: one or more third parties intervene
 - Autonomous: the patient acts by himself. In this modality, it would constitute suicide.

Regardless of the different classifications, the purpose is the same: to terminate a person's life.

Palliative medicine

At present, palliative care, including the psychology of the dying person and grief, occupies a prominent place; it is an approach to improving the quality of life of patients and families facing problems associated with life-threatening diseases, through the prevention and relief of suffering by early identification and correct evaluation and treatment of pain, as well as other physical, social, and spiritual problems. It is especially important in underdeveloped countries, where cases diagnosed at advanced stages of disease occur with high frequency, when cure is no longer possible, but help can be provided to reduce suffering through affordable interventions.

In our country, on January 5, 2009, a Decree was published in the Official Journal of the Federation, which amended the General Statute of Health, making additions in palliative care matters. Said Law provides that any person of legal age, in full use of his mental faculties, may, at any time and regardless of his health status, express his wishes in writing, before two witnesses, on whether or not to receive any treatment, in the event of suffering a disease and being terminally ill and unable to express such wishes.

Palliative care consists of active and total care of those diseases that do not respond to curative treatment: control of pain and other symptoms, as well as care of psychological, social, and spiritual aspects.

A patient susceptible to receiving palliative care is that who has an advanced, chronic, incurable disease, or situation, which may include infectious, traumatic, metabolic, degenerative or oncological disorders, and among others, regardless of survival time prognosis¹⁹. However, palliative care should not be reserved only for the last stage of life, but should be applied together with treatments that attempt to modify the disease and increase as the patient approaches the end of life. Palliative care should also be extensive to the family, even after the patient's death²⁰.

All patients without curative expectations should have access to a basic level of palliative care. A terminal patient is considered as that who has an advanced, progressive, and incurable disease, with intense, multiple, multifactorial symptoms, without the possibility of positively reacting to a curative treatment, with broad possibilities of death occurring in the medium- or short-term due to this condition. The

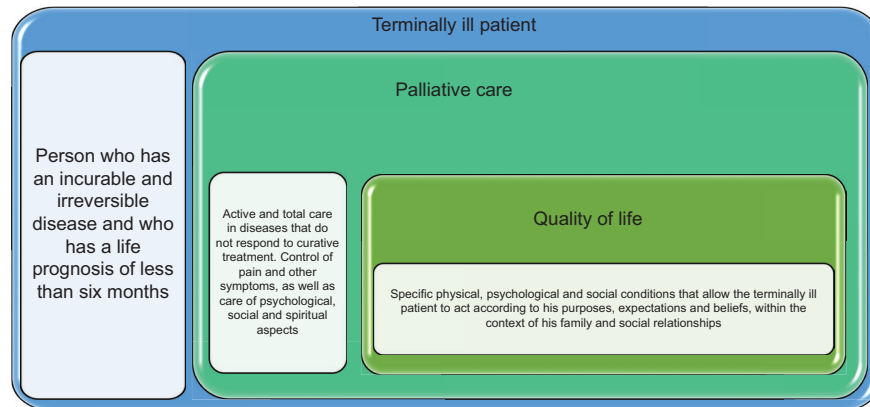


Figure 2. Terminally ill patient (adapted from: Official Mexican Standard NOM-011-SSA3-201419).

terminally ill patient has the right to receive comprehensive medical care, as well as to choose to receive palliative care at home. Indeed, autonomy is a fundamental principle of bioethics and refers to the ability to knowingly perform acts, with sufficient information and without internal or external coercion; that is, autonomy recognizes that the patient has the right to freely decide, after having received appropriate information, between available clinical options, and also recognizes the right to refuse treatment¹⁹.

The physician should initiate palliative care at the time, the terminal status is diagnosed and the patient has been informed about the options, respecting his decision and requesting his written informed consent. In this regard, article 166 bis of the General Statute Health provides the following²¹:

- I. *The dignity of terminally ill patients should be safeguarded to guarantee a life of quality through the care and medical attention necessary for this purpose*
- II. *Natural death in dignified conditions should be guaranteed to terminally ill patients*
- III. *The rights of the terminally ill patient in relation to their treatment should be established and guaranteed*
- IV. *The limits between curative and palliative treatment must be informed to the patient*
- V. *Treatments ordinary and extraordinary means should be determined; and*
- VI. *The boundaries between the terminally ill patient's life defense and therapeutic obstinacy must be established.*

It should be noted that quality of life refers to the specific physical, psychological, and social conditions that allow the terminally ill patient to act in accordance

with his objectives, expectations, and beliefs, within the context of his family and social relationships¹³ (Fig. 2).

When talking about palliative care, the distinction between ordinary and extraordinary measures should be specified. Ordinary measures are those provided to patient conditions, such as accompaniment, communication, hydration, feeding, position changes, hygiene, and wound dressing, as well as procedures and medications administered to mitigate pain or suppress unpleasant symptoms such as nausea, vomiting, dizziness, and insomnia, all this to decrease suffering, whereby more comfort and a better quality of life for the patient are intended. Measures that are extraordinary or disproportionate to patient conditions are not indicated in those in whom, due to the advanced stage of their disease, serious complications, and lack of treatment response, prognosis is fatal in the short- or medium-term; these measures include respiratory support, invasive diagnostic procedures, surgery, antibiotics, parenteral nutrition and vasoactive drugs, and the same goes for chemotherapy and radiotherapy, which give rise to discomfort and undesirable effects. In this train of thought, there is no doubt that, to those scientific and technological advances that have saved many lives and cured many diseases, palliative medicine has been added, which is not opposed to these advances, but strives for their proper use, with a humanist sense in which respect for the patient will and autonomy prevails. The palliative medicine team intervenes and accompanies the patient from the initial moment, throughout the evolution of the disease and the diagnostic and therapeutic process, a time during which the doctor relationship with the patient and the family is strengthened²².

Euthanasia in different countries

Euthanasia has essentially been addressed from the point of view of two philosophical currents founded on science and religion, based on socially-developed knowledge and beliefs, invoking human dignity both to defend and to reject it. For its advocates, patient human dignity consists of the right to freely choose the moment of his death. For its detractors, human dignity is opposing to this right for considering it to be an arbitrariness vis-a-vis an issue that is exclusively of divine order for some, or of scientific-legal nature for others²³.

The Netherlands was the first country to allow euthanasia with the approval of the Law on Termination of Life on Request and Assisted Suicide, which stipulates the conditions of the procedure that must be followed for it to be carried out²⁴. In turn, Belgium approved the Law on Dignified Death and Euthanasia, which stipulates that the patient must meet several requirements in his request, since it has to be voluntary, thoughtful, and reiterated with certification of several doctors, who must obtain approval of a Federal Medical Commission. Subsequently, Luxembourg adopted the Law on the Right to Die with Dignity.

In the United States of America, active euthanasia is legal in Oregon under the Death with Dignity Act, which establishes the requirements to request medication that ends a life in a humane and dignified way; it is a decriminalization that is far from Belgian and Dutch legislations.

In Latin America, Colombia is the only country where euthanasia is decriminalized for terminally ill patients who express their free will to end their lives, leaving the doctors who assist them exempt from legal liability.

Euthanasia in Mexico is penalized. The Federal Penal Code contemplates the crime of assisting or inducing suicide, and although it is considered as pious homicide, since aid to the terminally ill patient is provided with the purpose to relief his suffering and on request of the patient himself, it is prosecuted ex officio, and in the case of a minor or mentally ill person, the penalty is aggravated and the crime is considered to be first-degree murder.

Article 312.- Anyone who assists or induces another to commit suicide will be punished with a penalty of 1-5 years in prison; if assistance is lent by someone to the point of bringing about death by himself, the prison term will be from 4 to 12 years

Article 313.- If the deceased or suicidal person is a minor or suffers any form of mental derangement, the murderer or instigator will be applied the sanctions indicated for first-degree murder or first-degree injuries²⁵.

On January 7, 2008, the Advance Directives Law for the Federal District (now Mexico City) was enacted, with the purpose to establish and regulate the norms, requirements, and forms of carrying out the will of any person with the capacity to exercise it with regard to the refusal to being subjected to means, treatments, or medical procedures that seek to unnecessarily prolong his life, protecting at all times the dignity of the person, when for medical, fortuitous, or force majeure reasons naturally maintaining his life is impossible. The provisions established by this law are related to the medical practice applied to the terminally ill patient, consisting of the provision of palliative care treatment, protecting his dignity at all times.

Following Mexico City, other states have laws that regulate advance directives, including Aguascalientes, Chihuahua, Coahuila, Colima, State of Mexico, Guanajuato, Guerrero, Hidalgo, Michoacán, Nayarit, and San Luis Potosí.

Among the arguments of those who oppose euthanasia, one of the strongest is that legalizing euthanasia would inevitably lead to abuses in the sense of ending the lives of patients without their request, either by decision of the doctor, the family, or both²⁶.

There are also positions that refer that the moral right of the patient to respect for his integrity and autonomy is not absolute, and when that right is in conflict with the right to integrity of other people, several limitations arise. One of them is the right of the doctor, since the patient cannot transgress the integrity of the doctor as a person when he opposes euthanasia on moral grounds.

Final thoughts

The arguments for and against euthanasia exhibit a complex outlook, which will have to be discussed and decided in Mexico, and while the experience in other countries is highly useful, solutions must be found that answer to the particularities of our culture.

The issue is highly sensitive and transcendent and should raise a broad debate, both in ethical and legal aspects, which should involve not only the scientific community, but also express the feeling of society, both nationally and internationally, with fundamental

arguments, referring to the defense of human dignity and concern for medical practice to maintain the humanist sense that has characterized it.

Within their daily activities, medical care service providers are faced with the phenomenon of death, for which they must be able to carry out a critical analysis and choose the best option for the patient and his family, clearly distinguishing between prolonging life and prolonging death.

To achieve this, it is considered essential that health institutions should promote bioethics training, as well as continuous medical updating in bioethical and legal aspects.

Conflicts of interest

The authors declare that there are no conflicts of interest.

Ethical disclosures

Protection of human and animal subjects. The authors declare that no experiments were performed on humans or animals for this study.

Confidentiality of data. The authors declare that no patient data appear in this article.

Right to privacy and informed consent. The authors declare that no patient data appear in this article.

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