

2024



Multidimensional Study of the Attitudes Towards Euthanasia of Older Adults with Mixed Anxiety- Depressive Disorder

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TESE DE DOUTORAMENTO APRESENTADA

À FACULDADE DE MEDICINA DA UNIVERSIDADE DO PORTO EM
Bioética

Faculty of Medicine, University of Porto, Porto, Portugal

Dissertation application to Doctoral Degree (Ph.D.)

**Multidimensional Study of the Attitudes Towards Euthanasia of Older
Adults with Mixed Anxiety-Depressive Disorder**

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September 2024

This work was done under the supervision of Professor Rui Nunes (Faculty of Medicine, University of Porto) and the co-supervision of Professor Guilhermina Rêgo (Faculty of Medicine, University of Porto).

Acknowledgements

Thank you to Professor Rui Nunes and Professor Guilhermina Rêgo for their help, openness, availability, kindness, and precious advice.

To my parents, thank you for the gift of life, love and opportunities.

To my sister for her love.

To my friends and family for caring.

To my wife for her tolerance, support and affection.

To my daughter and son, my lighthouses and reasons to be, for the teachings and for making me a better person.

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LIST OF ACRONYMS

CPR – Constitution of the Portuguese Republic

DALY – Disability-adjusted Life Year

DSM – Diagnostic and Statistical Manual of Mental Disorders

FMUP – Faculty of Medicine, University of Porto

ICD – International Classification of Diseases

IPCs – International Psychiatric Classification Systems

MADD – Mixed Anxiety and Depressive Disorders

OECD – Organization for Economic Cooperation and Development

PAD - Physician-assisted Death

PAS – Physician-assisted Suicide

PBA – Portuguese Bioethics Association

PCU – Psychogeriatrics and Cognitive Disorders Unit

PD – Psychiatry Department

PR – President of the Republic

SOH – Senhora da Oliveira Hospital

UNESCO – United Nations Educational, Scientific and Cultural Organization

WHO – World Health Organization

ABSTRACT

Introduction: Euthanasia is an ancient theme that, especially since individual autonomy became the healthcare paradigm in contemporary societies, has sparked profound reflections and declared dissensions between different socio-ideological quadrants. The experience of the countries where it is decriminalised shows a tendency to broaden the clinical, age and legal assumptions for its access. People in mental distress due to a psychiatric illness are now able to request physician-assisted death in some jurisdictions. Now, given the impossibility of identifying an incurable or irreversible injury through ancillary diagnostic tests and the fact that psychiatric disorders demand complex and holistic treatments (not always available), where psycho, social and familial approaches not always available assume particular and decisive relevance, it is difficult to determine that a disease is incurable and provokes unbearable suffering. Older adults with psychiatric disease, a clinically and socially idiosyncratic group, where physiological weaknesses and social losses accumulate, and the chronological proximity to death becomes progressively more self-aware, these shortcomings assume particular relevance. Our research aimed to highlight the problem of the low literacy levels in this age group, reflect on the Constitutional feasibility of Euthanasia in Portugal, make available a validated psychometric instrument to assess attitudes towards euthanasia and do a multidimensional study of the attitudes towards euthanasia of older adult patients with mixed anxiety-depressive disorder.

Materials and Methods: The field research study applied a paper questionnaire composed of a sociodemographic section and a battery of scales (to assess depression, anxiety, cognitive performance, suicide risk, therapeutic adhesion, functionality, loneliness, attitude towards euthanasia, decision pattern, personality, empathy and health status) in the Psychogeriatric Unity of Senhora da Oliveira Hospital in Portugal. The sample was collected by convenience. One hundred fourteen patients were included in the cross-cultural adaptation and validation of Faria's Attitude about Euthanasia scale. A pre-final scale version was tested in a small group with good results. The validity of the internal structure was analysed using exploratory factorial analysis. The multidimensional study included 114 patients and 25 controls of the same age. Six months later, a reassessment was conducted. Patients and controls were compared using descriptive statistics and a multiple-regression model.

Results: There is a severe problem with the low literacy levels of older Portuguese adults, particularly those with depressive and anxiety symptoms, which interfere with their decision-making capacity for well-informed and free decisions in healthcare. The Constitution of the Portuguese Republic does not prohibit physician-assisted death. The internal consistency study verified the reliability and significant correlations in the construct validity of the adapted Faria's attitude about the euthanasia scale. It showed good internal consistency. One factor was retained in the principal component analysis. The results support the scale's usefulness and validity.

Regarding the multidimensional analysis, eighty-one point six per cent of patients had four or fewer years of schooling. Contrary to controls, they presented mild depressive and anxiety symptoms, loneliness feelings, worse cognitive performance, a more fragile personality, higher personal distress and a poorer health state. No statistically significant differences were found between controls and patients regarding their attitudes towards euthanasia. Patients more favourable to euthanasia had higher empathic concern, conscientiousness and fantasy and lower personal distress.

Conclusion: When addressing euthanasia in older adult patients with mixed anxiety and depressive disorder, it is crucial to ensure they are fully self-determinate and that all the necessary treatment and support are available. It may not be the case when the educational level is low and mild disease persists, significantly affecting their well-being and cognitive performance.

Keywords: anxiety, depression, euthanasia, older adults

INTRODUCTION

Death and the fear of dying

Death has been a troublesome and fascinating theme to humankind for millennia. As far as it is known, humans have struggled to understand the phenomenon and tackle its fear as the only living beings fully aware of their mortality. The fear of death seems universal and innate, driving human actions and endeavours and being one of the most important mainstays of human social organisation (Moore & Williamson, 2012). Cultures address the issue in several manners to preserve social cohesion. In the absence of such cultural responses (e.g. religion, philosophy, political systems based on rules), fear of death would be a potentially disintegrating force and a source of chaos and disorganisation. Several religious systems, which are, in essence, a form of authority of humans over other humans (Weber, 1963), implemented the concept of purification as a fundamental need to expiate the fear of death. This is quite interesting because it fights the fear of death with the fear of not living a virtuous life to attain a peaceful afterlife and possibly immortality of the soul.

Although fear of death has been present since the dawn of humankind, the way it was approached varied according to the epoch to which we refer. Classical Greek societies, influenced by philosophers like Democritus or Epicurus, addressed the theme rationally, trying to overcome the fear of death. Democritus argued that accepting death naturally as part of life was fundamental, and Epicurus focused on maximising pleasure as the path to achieving peace. On the other hand, during the Middle Ages, the influence of the Catholic Church dogmas led to an obsessive fear of death. However, classical ideas re-emerged in the Renaissance with the belief that people owned their lives and destiny and that death gave value to life. Philosophical approaches to the fear of death are, in essence, based on the duality of mind/body and in two possible notions: either one does not need to fear death because it represents simply the detachment of the soul from the body or the total annihilation which prevents any suffering or punishments for the being (Moore & Williamson, 2012). However, quite notably, considering the theistic ruling visions and the prevailing religious explanations of the natural world, some philosophers addressed the fear of death quite differently in ancient times. It was the case of Lucretius (99 – 55 BC), who, in Book III of *De Rerum Natura*, tries to convince the readers that death should not be feared by presenting two main arguments: the symmetry argument

and the no subject of harm argument (O'Keefe, 2003). In the first, Lucretius states that the infinite stretch of post-mortem non-existence is equal to the infinite stretch of pre-natal non-existence; if we do not feel anguish with the latter, by parity of reasoning, we cannot fear the previous. In the no subject of harm argument, Lucretius says that death cannot be harmful to the person who died because the person no longer exists. *De Rerum Natura* is considered one of the first philosophical works about atheism. It shows that the discussion on death is millennial and embraced by several different beliefs and worldviews.

In modern and current days, with the sanitisation of societies and the fast development of technology and medicine, death and dying have been away from the public eye and acquired a kind of aseptic significance. Death is given to us filtered by the media and the rule today is to die in a hospital, allegedly without or with minimum pain and anguish (Fulton, 1977). The notion of a peaceful and painless death can give the idea that the discussion on themes like euthanasia is unnecessary. Death is being medicalised and ignored by a culture obsessed with anti-ageing, which leads to death-denying societies and prevents a healthy and fruitful discussion on mortality and ageing well. Death and dying are certainties and should be addressed early in the life course to reduce fears and augment individuals' literacy to engage in healthy ageing strategies and make well-informed decisions about their end-of-life (Otto et al., 2023). Canada already implemented a program of advanced care planning in the high school curriculum (Canadian Hospice Palliative Care Association, 2020).

At the same time, modern societies have faced death in a magnitude never seen before. The 20th-century World Wars and the genocides which still happen throughout the world reveal humanity's darkest facet. The threat of a nuclear war and extinction is very well alive and present in the thoughts and concerns of many. To fight the fear of death and the associated anxiety, modern societies, especially in the West, make available a wide array of distractions to keep individuals' minds away from the horror (Moore & Williamson, 2012). Contemporary occidental societies seem to nurture a predisposition towards an excessively idyllic vision of the world and the human being.

On the one hand, *H. Sapiens* is unrealistically seen as a species innately endowed with pure goodness and, on the other hand, subsists a primacy of the beautiful over the ugly (in the aesthetic and moral sense of life), camouflaging aversive conditions such as violence or cruelty. There is also a tendency for both the "psychiatrisation" of emotions,

such as sadness or anxiety, and personality traits, such as malice. However, negative emotions, such as sadness [that induces crucial internal and/or external changes to cope appropriately with a distressing event], have important phylo and ontogenetic functions. Their role in the species' survival and a person's harmonious development is unquestionable.

The somewhat candid vision of the human being, the hiding of aversive realities and the sanitisation of death and dying may nowadays contribute to making subjects such as euthanasia a taboo and undermine serious, open, thoughtful and pondered debates on the matter which are crucial for ethics' consensus and proper and tailored legislation. Moreover, as Lucretius' *De Rerum Natura* evokes, mainly because it presented ideas that put the prevailing beliefs at stake, the discussion on such a complex and quite intriguing matter should not be held hostage by any worldview whatsoever. In a mature democracy, everyone must be respected, and minorities who think differently are duly protected. Fighting the fear of death by restraining individual legitimate and non-aligned beliefs to preserve social cohesion is not admissible in any circumstance.

One last and brief word about the concept so many times elicited of "natural death". Natural death is commonly defined as dying of natural causes without external interferences (Lamb, 2020). This concept alludes to a somewhat aseptic world where individuals are not, since their conception, under the influence of several biological and environmental factors. To be completely accurate, humans are influenced by others' decisions (external factors) even before conception. When a future mother and father, for example, abuse drugs, live in locations with high levels of pollution, stay in very stressful jobs or have bad eating habits, they are already influencing future offspring, augmenting the probability of some weakness or disability and potentially diminishing the life span of the yet unborn.

Furthermore, when someone gets sick with a severe disease, the implementation of medications and other non-pharmacological measures also disturb the so-called "natural" course of the disease. Therefore, should we not act and let the disease take its "natural" course, even if patients want to receive treatment and its absence means great suffering for them? If natural, on the other hand, refers, for the believers, to the will of a superior entity (God), who can honestly and objectively say that respecting the wish of a patient to die by euthanasia is not "natural" and the will of that entity?

Euthanasia throughout history

Euthanasia derives from the junction of two Greek words: "Eu", which means good and "Thanatos", which means death. Thus, etymologically, euthanasia is a "good death". However, euthanasia has been debated for millennia, and its meaning and ethical interpretation have varied according to the epochs, cultures and individual beliefs. It is, at its basis, intimately related to the fear of death, which may fuel several positions regarding euthanasia acceptance or prohibition. For example, when someone deeply fears death and believes life, even under great suffering, is the supreme gift of humankind, they will undoubtedly have difficulty accepting that someone else wants to die, inclusively if suffering from a non-curable disease. On the other hand, people will face death fearless (or with much less fear) if they see it as the ultimate palliative treatment for the relief of their suffering. Of course, the central position of societies regarding euthanasia throughout time has been highly influenced by the predominant rulers and currents of thought and how a dignified life was interpreted. To demonstrate this, we will refer briefly to the epochs: Ancient Greece, the Middle Ages, the Renaissance and the 20th Century.

In Ancient Greece, the use of euthanasia was widely practised and accepted. Socrates and Plato were in favour of the termination of life whenever a severe illness which promoted long agony and suffering was present. Also, Plato, in his book "The Republic", condemned those who defended the prolongation of life by overuse of ineffective treatments, a practice currently known as *distanasia* (Picón-Jaimes et al., 2022). Of course, dissonant voices were raised against this broad practice even then. The most known example is Hippocrates, who wrote the oath that was the basis of the ethical-deontological regulation of the medical profession (Bont et al., 2007). The generally known idea is that Hippocrates was firmly against euthanasia. However, some translators of Hippocrates' text suggest that his main concern was to avoid a doctor being instrumentalised as a vehicle to murder someone by using his privileged relationship of trust with a patient, as in ancient Greece, murders by poisoning were commonplace (Van Hooff, 2004).

During the Middle Ages, Catholicism was the dominant current of thought, taking over the sciences, arts and medicine. Based on St. Thomas Aquinas and St. Augustin's ideas, self-induced death and administration of a lethal substance to someone with a

terminal illness were forbidden, and consequences existed for those who did it. People who committed suicide could not be buried and have a proper funeral service, and those who injected lethal substances into terminally ill patients were excommunicated and judicially sentenced. Curiously, it was allowed to kill during the Crusades for religious expansion and conversion and on the battlefield (Bont et al., 2007), a short dagger could be used to kill seriously wounded enemies ("mercy killing").

In the Renaissance, science and philosophy became the thrusters of political and social organisation. It was during that time that, through the contribution of thinkers like Thomas More and Francis Bacon, the euthanasia concept developed into its current meaning and began to be defined as a means for seriously ill persons, with their permission, to achieve a dignified death (Emanuel et al., 2016). Of course, opposing positions continued to exist, advocating the right and need for the incurably ill to continue living, even when suffering a lot and against their will.

The discussion on euthanasia in the 20th century was mainly influenced by the crimes committed by the Nazis during the Third Reich. Hitler's euthanasia program was a form of eugenics where individuals of ethnicities were considered inferior, and physical and mental disability were considered unworthy of living and killed. This included newborns, as the hospitals were forced to dispose of all of those who were born with a disability (Von Engelhardt, 2002). These atrocities were the main responsible for the shift of the medical paternalistic approach, which prevailed until then, to the patients' full autonomy and self-determination in health decisions of the current modern days (O'Sullivan et al., 2020). The relatively consensual worldwide recognition, at least in the West, of patients' total autonomy and legitimacy to decide freely about the treatments they want or not to receive is at the basis of the progressive increase of countries and states that decriminalise euthanasia and physician-assisted suicide. The focus is on respect for the patient's sovereignty regarding their personal beliefs and the concept of dignity in the face of death.

CHAPTER 1 – Euthanasia nowadays worldwide

Euthanasia, defined here as the act of deliberately ending patients' lives at their request when they suffer from an incurable disease that causes great and unbearable suffering, has been progressively discussed and implemented in several countries (Mroz et al., 2021). The notion that death is an indissociable part of life and that patients should be sovereign in deciding the process of dying is gaining strength, particularly in the West. Also, secularity, which is at the basis of Democratic States of Law, is becoming increasingly apparent in citizens' minds, fuelling the respect for individual beliefs and decisions as one of the most important mainstays of social cohesion. In matters of individual conscience and personal beliefs, a growing number of people are refusing to be held hostage by third-party religious, political and philosophical worldviews. Thus, deciding about one's death, either by an advance directive or by an active decision when facing an incurable disease, is becoming more and more perceived as natural.

Nevertheless, euthanasia is far from being a consensual theme, and much confusion and disinformation promoted by both sides (those in favour and those against it) still exist. That is why it is of the utmost importance that science leans over the matter and studies the phenomenon in detail in several cultures and populations and its most diverse related areas of knowledge (e.g. ethics, law, neuroscience, general medicine, palliative care). Only by doing so euthanasia and assisted suicide can be deeply understood in each culture and tailored and realistic legislation implemented, if necessary.

Euthanasia can be active when someone ends a patient's life by administering a drug or passive (orthothanasia) by interrupting ineffective treatments, which leads to death. Around the world, some form of either euthanasia, assisted suicide or both is legalised in the following countries (British Medical Association, 2024; Desk, 2024; Eutanásia e Suicídio Assistido - Legislação Comparada, 2016; Maxim Institute, 2021; Mroz et al., 2021).

- Europe: Netherlands, Austria, Belgium, Luxembourg, Switzerland, Portugal, Italy, Germany, Spain, Sweden;
- North America: Canada; the US states of Oregon, Montana, Washington, Vermont, California, Colorado, Hawaii, New Jersey, Maine, and the District of Columbia;
- Oceania: New Zealand; Tasmania; the Australian states of Victoria and Western Australia;

- South America: Colombia, Ecuador, Chile;
- Central America: Mexico;
- Asia: India.

Active euthanasia is allowed in Canada, Spain, Belgium, Netherlands, Luxemburg, Portugal, Spain, New Zealand, Tasmania, and the Australian states of Victoria and Western Australia. At the moment, six countries offer assisted dying to psychiatric patients (Netherlands, Belgium, Luxemburg, Spain, Canada, and Switzerland). Finally, Belgium, Netherlands, and Luxemburg allow minors to appeal to assisted dying.

A summary of the differences between countries can be seen in Table 2.

TABLE 2. EUTHANASIA AND PHYSICIAN-ASSISTED SUICIDE WORLDWIDE

<i>Continent</i>	<i>Country / State</i>	<i>Year of first law</i>	<i>Physical Diseases</i>				<i>Psychiatric Diseases</i>			
			<i>AE</i>	<i>PE</i>	<i>PAS</i>	<i>Minors</i>	<i>AE</i>	<i>PE</i>	<i>PAS</i>	<i>Minors</i>
<i>Europe</i>	Austria	2021			X					
	Belgium	2002	x		X	x ^a	x		x	x ^b
	Finland			x ^g						
	Germany	2020	x		X					
	Italy	2019			x ^c					
	Luxemburg	2009	x		X		x		x	x ^e
	Netherlands	2001	x		X	x ^d	x		x	x ^f
	Norway			x ^g						
	Portugal	2023	x		X					
	Spain	2021	x		X		x		x	
	Switzerland	2009			X				x	
	Sweden		x ^g	x ^g						
<i>North America</i>	Canada	2016	x		X		x		x	
	Oregon, USA	1994			X					
	Montana, USA	2009			X					
	Washington, USA	2008			X					
	Vermont, USA	2013			X					
	California, USA	2015			X					
	Colorado, USA	2016			X					
	Hawaii, USA	2019			X					
	New Jersey, USA	2019			X					
	Maine, USA	2019			X					
	District of Columbia, USA	2017			X					
	New Mexico, USA	2021			X					

TABLE 2. EUTHANASIA AND PHYSICIAN-ASSISTED SUICIDE WORLDWIDE

Continent	Country / State	Year of first law	Physical Diseases				Psychiatric Diseases			
			AE	PE	PAS	Minors	AE	PE	PAS	Minors
Oceania	New Zealand	2021	x		X					
	Tasmania	2021	x		X					
	Victoria, Australia	2017	x		X					
	Western Australia	2021	x		X					
South America	Columbia	1997	x		X					
	Ecuador	2024	x		X					
	Argentina	2012		x						
	Chile	2012		x						
Asia	India	2023		x						
Central America	Mexico	2008		x						

Abbreviations: AE – Active euthanasia; PE – Passive euthanasia; PAS – Physician-assisted suicide; USA – United States of America; ^a allowed to a minor emancipated by a court order or a minor competent and conscious at the time of his or her request; ^b allowed to emancipated minors; ^c In 2019, the Italian Constitutional Court ruled that it is not always a crime to assist terminally ill patients experiencing ‘intolerable suffering’ to die. Work is ongoing in Italy to explore what this ruling means for the law more generally; ^d between the ages of 12 and 16 years old; ^e allowed to children aged 16 to 18 and parental or legal guardian consent is needed; ^f the minor must be at least 12 years old and parent's consent is required; ^g allow euthanasia under strict circumstances.

The first laws, which decriminalised some form of euthanasia (Netherlands, 2001) or physician-assisted suicide (PAS) (Oregon, 1994), were not written and approved after thorough and robustly diverse scientific studies on several domains (bioethics, medicine, Law) related to the issue. Compassion and several known cases where such practices already had occurred were at the basis of the legalisation processes and laws (Mroz et al., 2021). Ultimately, particularly in the Netherlands, the legislator did little more than provide a legal basis for an already existing practice. In fact, well before the euthanasia law took effect, Dutch criminal courts had already considered euthanasia not punishable in certain conditions (Buijsen, 2022). The accumulated and learned experience from previous social and legal practices led the legislators to write the first laws allowing euthanasia and PAS, and quickly, other states and countries followed. Over the years, the criteria to access assisted dying have been becoming larger, raising several ethical and legal concerns (Gallego et al., 2022). Initially limited to adults and physical diseases, many laws allow nowadays minors, psychiatric patients and older adults advocating being tired of life to be granted assisted dying. In this respect, psychiatric disease, particularly

of the most fragile, like older adults, is of special concern for several reasons that we will address in the following sections.

Ageing

The world's population is becoming older. By 2050, the number of people aged 60 and older will double, and the number of persons aged 80 years or older is expected to triple. In the European Union (E.U.), older people (aged 65 or over) are around 21.3 % of the total population, with Portugal (24 %) and Italy (24 %) being the most aged countries (Eurostat, 2024). Portugal is a country that is ageing faster and already has around 25% of older people over 75 living alone (Eurostat, 2024).

Recent data reveal that demographic ageing in Portugal continues to increase. In 2023, the ageing index, which compares the population aged 65 and over (older population) with those aged 0 to 14 (young population), reached the value of 188.1 older people for every 100 young people. In 2012, for every 100 young people, 131.4 older people were living in Portugal. Likewise, the total dependency index, which corresponds to the number of young people and older people for every 100 people aged 15 to 64, continues to increase, accentuating the demographic pressure on the working-age population (Statistics Portugal, 2024)

According to a central projection scenario, the ageing rate in Portugal will almost double between 2018 and 2080, from 159 to 300 older adults for every 100 young people (Statistics Portugal, 2020).

Ageing is a process of progressive biological, social, and functional loss whose final destination is death. It is associated with progressive homeostatic/hemodynamic dysregulation, making an organism less and, eventually, non-resilient (Fulop et al., 2010). It can be more or less pronounced and debilitating depending on the individual's genetic characteristics and exposure to harmful extrinsic factors throughout life (e.g., unhealthy habits, radiation, stressful environments, loneliness). The ageing rate is, therefore, variable and dependent on the interplay of intrinsic and extrinsic factors. As ageing becomes more prominent, related diseases and social and personal losses will rise, and the associated age burden and suffering will be potentially more significant. These factors make older adults particularly prone to psychiatric disorders and highly susceptible to requesting assisted dying. In addition, several studies refer to the low levels of health

literacy (Kutner et al., 2006; Sørensen et al., 2015) of many older adults in developed countries. Literacy, in general, is known to decrease with ageing (Barrett & Riddell, 2019). Low health literacy is particularly troublesome as older adults, due to the high prevalence of chronic diseases, are in greater need of information and making decisions. Low health literacy is related to poorer self-rated health (Toci et al., 2014), higher mortality (Bostock & Steptoe, 2012) and suboptimal Decision-Making in Old Age (Boyle et al., 2022), age-related cognitive decline (Brito et al., 2023) and lower educational level (Kutner et al., 2006).

Depression and Anxiety in Older People

The most common mental health conditions for older adults are depression and anxiety (World Health Organization: WHO, 2023). Consequently, as ageing becomes more prominent, more older adults will suffer from these disorders, which are not only currently among the top ten leading causes of global burden, as this is expected to increase. In Portugal, Alzheimer's and other dementias, depression and anxiety disorders appear in the fifth, sixth and ninth position, respectively, of the ten top causes of disability-adjusted life year (DALY) (Global Health Estimates: Leading Causes of DALYs, n.d.). The estimated prevalence of anxiety among Portuguese older adults is 9.6%, and depression is 11.8% (De Sousa et al., 2017).

Older adults are particularly prone to depression and anxiety. In fact, there are several risk factors strongly associated with this age group, such as chronic medical conditions, polypharmacy, cumulative losses, physical and cognitive functional decline as part of physiological ageing and social isolation (Cahoon, 2012; Wolitzky-Taylor et al., 2010). Depression and anxiety disorders are often unperceived and undertreated in older adults. They worsen older adults' physical health, decrease daily activity performance capacity, and deteriorate their well-being and isolation (Cahoon, 2012; Wolitzky-Taylor et al., 2010). The assessment and diagnosis of late-life depression and anxiety are incredibly challenging because symptoms are often interpreted as part of the normal ageing process or of physical illnesses (Cahoon, 2012; Lenze & Wetherell, 2008). Weight loss, memory problems, pain, muscle tension, hypervigilance or trouble sleeping are some of those symptoms. On the other hand, physical conditions such as cardiovascular, respiratory and thyroid disease can involve depressive and anxiety

symptoms, making it even harder to make a timely and proper diagnosis (Alwahhabi, 2003; Kogan et al., 2000). The importance of identifying precociously depressive and anxiety disorders is related to the fact that there is copious evidence that they are treatable in a high percentage of cases (Cahoon, 2012; Lenze & Wetherell, 2011).

The International Psychiatric Classification Systems (IPCs), the Diagnostic and Statistical Manual of Mental Disorders (DSM), and the International Classification of Diseases (ICD) attempt to standardise diagnoses, classifying psychiatric disorders in a categorical way. The constant evolution and reformulation of the diagnostics systems occur, on the one hand, in parallel with the evolution of scientific knowledge, particularly neurosciences, and, on the other hand, with globalisation that established multiculturalism as the norm and promoted changes in the social and cultural paradigm understanding of what is a mental illness. Homosexuality, for example, was once classified as paraphilia and is currently not included in any psychiatric diagnostic manual.

However, this laudable attempt to "refine" psychiatric diagnoses could compartmentalise them in such a way that, in a discipline in which illnesses are often longitudinally chameleon-like and transversally mixed, it is not uncommon to have some difficulties in "fitting" the syndromes observed in clinical practice into the IPCs "diagnostic boxes". DSM diagnosis criteria are slightly more distant from clinical practice than ICD (Stein et al., 2022; Tyrer, 2014). The elimination of mixed anxiety depressive disorder from DSM-V but not from ICD-11 is a good example of this. The well-known frequent overlap between Depressive and Anxiety Disorders in older adults (Preisig et al., 2001; Schoevers et al., 2003; Cairney et al., 2008; Beekman et al., 2000) is highly consistent with the diagnosis of Mixed Anxiety and Depression Disorder (MADD) whose prevalence is significant, as reported by several studies (Cassidy et al., 2005). Curiously, this diagnosis has been commonly underdiagnosed, probably because it is not so well known by psychiatrists and is overshadowed by another more propagated diagnosis, such as, for example, Major Depressive Disorder. Nevertheless, supporting even further MADD relevance as a diagnosis intimately related to clinical practice are studies suggesting that in older people, a dimensional classification is more appropriate than a categorical classification of depression and anxiety (Schoevers et al., 2003).

MADD is characterised by a combination of symptoms of anxiety and depression severe enough to justify a psychiatric diagnosis, neither of which are predominant and, when considered separately, do not meet the full diagnostic criteria of either syndromic

anxiety or depressive disorder (ICD-10; ICD-11). Women are the most affected gender. It is essential to recognise MADD promptly as comorbid anxiety and depressive symptoms are more resistant to treatment, have a greater risk of suicide and have been associated with severe psychological, physical, social and workplace impairment than either condition alone (Möller et al., 2016). In addition, depression and anxiety disease are related to premature or advanced biological ageing and consequently adversely impact somatic health, particularly in older people (Milligen et al., 2019).

Treatment of MADD should be tailored to each patient and involve all the necessary means to fully or frankly remit symptoms, allowing the patient to live a meaningful life with a high sense of satisfaction. Consequently, biological treatments (e.g. psychopharmacology) and non-biological therapies (e.g. psychotherapy and social interventions) must be widely available. Studies found that comorbid anxiety and depression negatively affect patients' treatment responses, putting them at a higher risk of suicide. Evidence also shows that these patients are more likely to prematurely stop treatment in comparison to patients with either a depressive or an anxiety disorder alone (Cassidy et al., 2005). Thus, having the diagnosis in mind is the first step to guarantee it is promptly diagnosed, augmenting the chances of being effectively treated.

Euthanasia in Psychiatry

Physical diseases have been the central motif for patients to request euthanasia. However, in countries where it is legal, euthanasia requests due to psychiatric diseases have been increasing. A recent study revealed that worldwide cancer in a terminal phase (45,4%), dementias (19,8%), treatment-resistant mood disorders (12,2%) and advanced cardiovascular disorders (12,2%) are the most common grounds for euthanasia requests (Rahimian et al., 2024). Overall, chronic and physically debilitating diseases are still essentially the main reasons for requesting assisted dying. Nevertheless, requests due to psychiatric illnesses advocating incurability and unbearable mental suffering are substantial, and the types of disorders behind those requests are as varied as dementia, depression, personality disorders, generalised anxiety disorder or schizophrenia (Rahimian et al., 2024). This variability and the related difficulties in establishing unbearable mental suffering and incurability reveal an absence of consensual eligibility criteria for psychiatric patients. In fact, the requirement of unbearable mental suffering

for granting euthanasia is frequently reported and experienced by psychiatric patients at suicidal risk and with suicidal ideation (Ducasse et al., 2018). In addition, there is no scientific support (Doherty et al., 2022) for the argument that introducing assisted dying reduces rates of non-assisted suicide, as defended by some (Nicolini et al., 2020). The high percentage of patients who no longer wish to die and drop out of their euthanasia request shows the complexity and the possible transitory nature of unbearable mental suffering in many cases (Caceda et al., 2017). Some patients report that they have been suffering more from a chronically harsh personal context than from a concrete mental disorder (Verhofstadt et al., 2021). It may, in fact, seem a paradox that unbearable psychological suffering is, at the same time, both a target for suicide prevention strategies and a required criterion for euthanasia. The lack of ancillary tools (Bohman, 2023) not only to make clear-cut diagnoses but to classify illnesses' severity, the heterogeneity of psychiatric assessments and disorders' presentations that lead psychiatrists to assess the gravity of disease differently (Newson et al., 2020; Saito et al., 2022), the fact that even mild psychiatric disease can lead to worse quality of life as compared to healthy controls (Calcedo-Barba et al., 2020), and the inconsistency related to the definition of treatment-resistant psychiatric disorders (Howes et al., 2021) are some of the handicaps that difficult a concise determination of refractory disease and unbearable suffering in mental health. Also, can it be said that a disease is resistant to treatment and incurable when many patients refuse treatment? (Calati et al., 2021). Could not intense mental suffering secondary to serious psychopathology limit patients' capacity to consider feasible treatments? Can an inadequate response to at least two antidepressant trials, generally accepted to consider Depression refractory,¹³ in the absence of a pharmacokinetic profile and without knowing if the drugs used reached the appropriate plasmatic dose for a therapeutic effect guarantee that the antidepressants chosen were, without doubt, the most suitable?

Complex and very heterogeneous diseases, such as Personality Disorders, have been identified as being the diagnosis of a large proportion of those who requested and received assisted death (Mehlum et al., 2020). However, what are the specific criteria to define refractory disease and unbearable suffering in disorders characterised by a rapidly fluctuating course, as happens, for example, in Borderline Personality? There is robust evidence that with proper strategies, like structured psychotherapies, suicidal tendencies and disruptive behaviour can be effectively treated in these patients. However, surveys of

Dutch psychiatrists show that the percentage of psychiatric patients with personality disorders who request euthanasia goes as high as 64%, and most refuse several treatment options (Evenblij et al., 2019; Calati et al., 2021).

Regarding older adults, it has been identified that patients with mood disorders who requested euthanasia were generally (65%) older than 60 years of age (Dierickx et al., 2017), which suggests the specific vulnerability of this age group where, curiously, older women are more likely to die by euthanasia or assisted suicide than older men (Canetto & McIntosh, 2022; Steck et al., 2016), whose rates of non-assisted suicide are higher. Empowerment, fears of being a burden, not being as valued as men in social, occupational and economic areas, and the higher incidence of affective illnesses are all suggested reasons for this gender difference concerning euthanasia (Doherty et al., 2022). Thus, it is generally accepted that mental disorders are much more common among older people than in the young and middle-aged population (Petrova & Khvostikova, 2021). Neuropsychiatric diseases are estimated to cause 6.6% of total disability in people of this age group (Ageing & Health, 2015). If psychiatric disorders were effectively treated in older adults, some studies estimate that the suicide rate would be reduced as high as 74% (Beautrais, 2002). Overall, when asked what could have prevented their euthanasia request, adult patients refer to the need to increase the accessibility, quality and efficiency of mental healthcare resources (Mistiaen et al., 2019). In fact, most countries are still far from the percentage of the total healthcare budget recommended by the Organization for Economic Cooperation and Development (OECD) to be invested in mental health (Verhofstadt et al., 2021).

All of this data indicates the need to study deeply the phenomenon of euthanasia in psychiatric patients, especially older adults, where the rates of non-assisted suicide and euthanasia are higher in men and women, respectively.

Euthanasia in Portugal

On May 25, 2023, the decriminalisation of euthanasia was published in the Portuguese Republic Diary no. 101/2023, Series 1 (Assembleia da República, 2023). The law establishes the conditions under which physician-assisted death (PAD) is not punishable and amends the Penal Code. However, it will only be in effect thirty days after its regulation is set and approved, which has not happened yet. The regulation will focus

on several practical matters, such as the clinical registration model of the requests or the content that the final medical report must include.

The theme has been broadly and deeply discussed socially and politically for many years. In 1995, the National Ethics Council for Life Sciences issued a document encouraging a discussion on the topic (Conselho Nacional de Ética para as Ciências da Vida, 1995), that is, seven years before the Netherlands, the first European country to decriminalise euthanasia and assisted suicide in 2002. In 2010, the Portuguese Bioethics Association (PBA) appealed to the Parliament to legalise the living will (Associação Portuguesa de Bioética, 2010), which would happen two years later. Anticipating the uproar that would create the addition of euthanasia to the discussion of the living will, Rui Nunes, the PBA president, defended that the debate on the theme should be reserved for "a next phase". In 2012, five proposals were then presented regarding the living will. The aim was to guarantee self-determination regarding the health care an individual would or would not want to undergo during a disabling illness. Legalizing the living will was a decisive milestone for the Assembly of the Republic discussion on PAD, which would occur in the following years (Assembleia da República, 2014).

In 2016, the Assembly of the Republic published comparative legislation, contributing to informing the general population about specific terms, like active and passive euthanasia or orthothanasia, and the terms of access to the procedure in several countries where it was legal (Assembleia da República, 2016). In the same year, the civic movement "Right to Die with Dignity" presented a manifesto signed by several public figures defending the urgency of decriminalising and regulating PAD (Movimento Cívico "Direito a Morrer com Dignidade", 2016). In this regard, a civil petition gathered more than eight thousand signatures, and in the following years, many more followed, both for and against euthanasia. On May 29, 2018, proposals on the decriminalisation of PAD presented by four political parties (Left Block, Socialist Party, People-Animals-Nature and Green Party) were rejected by the parliament. Among those, the Socialist Party bill was nearly approved, with 110 votes in favour and 115 against. A year and a half later, the same four parties (left-wing parties), plus the Liberal Initiative (a right-wing party), presented five legislative initiatives on euthanasia, which the parliament approved. The final global vote took place at the end of January 2021 and culminated with the approval of a euthanasia law. The President of the Republic (PR) would veto it, advocating "insufficient normative density". On November 5, 2021, the decree was approved again

by Parliament. However, it was also vetoed again by the PR, who pointed to alleged contradictions in the diploma regarding certain concepts such as "serious illness", "incurable illness", and "fatal illness". During 2022, several definitions and conceptualisations were reformulated, and the law would then be approved and published in its final version in 2023 (Assembleia da República, 2023).

Since its beginning, the debate on euthanasia has been based on the experiences of other countries and individuals' political and religious beliefs, self-conscience and ethical principles and worldviews. During those years, no scientific studies were done to better assess the phenomenon in Portuguese society, enriching the discussion and enlightening policymakers' decisions. With a law already approved, it remains of the utmost importance to study several issues related to euthanasia in several disciplines (e.g. ethics, medicine, law), allowing for comparative studies between states and populations. Although oriented to physical illnesses, the current legislation (table 3) does not tacitly and explicitly exclude the possibility of a person requesting euthanasia on the grounds of unbearable mental suffering due to a psychiatric illness. It states, "Physician-assisted death occurs by the will and decision of the person who is in one of the following situations: a) Permanent injury of extreme severity (a severe, definitive and largely disabling injury that places the person in a situation of dependence on third parties or technological support to carry out elementary activities of daily life, with the certainty or very high probability that such limitations will persist over time without the possibility of cure or significant improvement); b) Serious and incurable disease (the disease that threatens life, in an advanced and progressive phase, incurable and irreversible, which causes suffering of great intensity). Furthermore, the law also does not refer to previously expressed wishes of euthanasia of a patient in an advance directive (despite the possibility being expressly discussed by PBA in preliminary parliamentary hearings). This is very important as there are conditions in which the patient, although fully conscient and cognitively competent, may not be capable of communicating by any means and, as such, cannot express the wish to die (as the Locked-in syndrome) and several other situations where the patient suddenly becomes cognitively incompetent (e.g. massive stroke) and may have expressed the wish to be euthanised if in those circumstances.

Thus, it is essential to study deeply the issue in psychiatric patients, particularly those most vulnerable like older adults, to gather detailed and extensive data on the several demands, limitations and concerns related to these diseases. Only with objective

data on the matter will we be able to assist and inform the legislator, who can then reflect on the necessity of producing tailored legislation adapted to the specific necessities of several cultures and populations (e.g. young and older adults, psychiatric patients).

TABLE 3. Law No. 22/2023, May 25 - Regulates the conditions under which physician-assisted death (PAD) is not punishable and amends the Penal Code

The Assembly of the Republic decrees, by paragraph c) of article 161 of the Constitution, the following:

CHAPTER I

General Provisions

Article 1

Object

This law regulates the conditions under which PAD is not punishable and amends the Penal Code.

Article 2

Definitions

For this law, it is considered:

- a) «PAD», a death that occurs by decision of the person himself, in the exercise of his fundamental right to self-determination and free development of personality, when practised or assisted by health professionals;
- b) “Medically assisted suicide”, the self-administration of lethal drugs by the patient himself, under medical supervision;
- c) “Euthanasia”, the administration of lethal drugs by a doctor or health professional duly qualified for this purpose;
- d) «Serious and incurable disease», a disease that threatens life, in an advanced and progressive phase, incurable and irreversible, which causes great suffering;
- e) «Definite injury of extreme severity» means a serious, definitive and largely disabling injury that places the person in a situation of dependence on third parties or technological support to carry out elementary activities of daily life, with certainty or a very high probability that such limitations persist over time without the possibility of cure or significant improvement;
- f) «Great intensity suffering» means suffering resulting from a serious and incurable illness or definitive injury of extreme severity, with great intensity, persistent, continued or permanent and considered intolerable by the person;
- g) «Advising doctor», the doctor indicated by the patient who is responsible for coordinating all information and assistance to the patient, being the patient's main interlocutor throughout the entire care process, without prejudice to other obligations that may fall to other professionals;
- h) «Specialist doctor» means the doctor who specialises in the pathology affecting the patient and who does not belong to the same team as the supervising doctor.

Article 3

Non-punishable PAD

1 - Non-punishable PAD is considered to occur by decision of the person himself, an adult, whose will is current and reiterated, serious, free and informed, in a situation of great intensity suffering, with definitive injury of extreme severity or illness severe and incurable, when practised or assisted by health professionals.

2 - For this law, only requests for PAD presented by national citizens or legal residents in national territory are considered legitimate.

TABLE 3. Law No. 22/2023, May 25 - Regulates the conditions under which physician-assisted death (PAD) is not punishable and amends the Penal Code

3 - PAD occurs by the will and decision of the person who is in one of the following situations:

- a) Permanent injury of extreme severity;
- b) Serious and incurable disease.

4 - PAD can occur due to:

- a) Medically assisted suicide;
- b) Euthanasia.

5 - PAD can only occur by euthanasia when medically assisted suicide is impossible due to the patient's physical incapacity.

6 - The request underlying the decision provided for in paragraph 1 follows a clinical and legal procedure, following the provisions of this law.

7 - The request may be freely revoked at any time under Article 12.

CHAPTER II

Procedure

Article 4

Opening of the clinical procedure

1 - The request to open the PAD clinical procedure is made by a person who meets the requirements set out in the previous article, from now on referred to as the patient in a written document, dated and signed by the patient, or by the person designated by him/her under the terms of paragraph 2 of article 11, to be integrated into a special clinical register (RCE) created for this purpose.

2 - The request is addressed to the doctor chosen by the patient as the guiding doctor.

3—The supervising physician must have access to the patient's clinical history and consider it an essential element of his opinion, issued under Article 5.

4—Requests from patients subject to judicial proceedings for the application of the accompanied adult regime are not accepted while the same is pending. The PAD procedure is immediately suspended when the judicial proceedings are initiated after the submission of the request and while the same occurs, regardless of the stage in which the PAD procedure is at.

5 - Without prejudice to the provisions of this chapter regarding deadlines, PAD cannot take place without a period of two months having elapsed from the date of the request to initiate the procedure.

6 - The patient is always guaranteed, if they want, access to palliative care.

7 - The patient is guaranteed access to monitoring by a specialist in clinical psychology throughout the entire procedure.

8 - For the purposes of the provisions of the previous paragraph, within ten working days from the start of the procedure, the patient has access to a clinical psychology consultation, the scheduling of which is the responsibility of the supervising physician, in order to ensure complete understanding of their decisions, about themselves and those around them, but also the clarification of relationships and communication between the patient and their family members, as well as between the patient and the health professionals who accompany them, in order to minimise the possibility of undue influence on the decision.

9—Monitoring by a specialist in clinical psychology, as referred to in the previous paragraphs, is mandatory unless the patient expressly rejects it.

TABLE 3. Law No. 22/2023, May 25 - Regulates the conditions under which physician-assisted death (PAD) is not punishable and amends the Penal Code

Article 5

Opinion of the supervising physician

1 - The supervising physician issues, within 20 working days from the opening of the procedure, a reasoned opinion on whether the patient meets all the requirements referred to in Article 3 and provides all information and clarification on the clinical situation that affects it, the applicable, viable and available treatments, particularly in the area of palliative care, and the respective prognosis, after which it checks whether the patient maintains and reiterates their wishes, and the patient's decision must be recorded in writing, dated and signed by himself or by the person designated by him under paragraph 2 of article 11.

2 - The information and opinion provided by the doctor and the patient's statement, signed by both, form part of the RCE.

3—If the supervising physician's opinion does not favour the patient's PAD, the ongoing procedure is cancelled and closed. The supervising physician informs the patient of this decision and its reasons. The procedure may be restarted with a new request for opening under Article 4.

Article 6

Confirmation by a specialist doctor

1 - After the favourable opinion of the supervising doctor, he proceeds to consult another doctor, a specialist in the pathology affecting the patient, whose opinion confirms or not that the conditions referred to in the previous article are met, the diagnosis and prognosis of the clinical situation and the profound and incurable nature of the disease or the definitive and severe condition of the injury.

2—The specialist doctor's reasoned opinion is prepared within 15 working days, in writing, dated, and signed by the specialist, and forms part of the RCE.

3—If the specialist doctor's opinion is not favourable to the patient's PAD, the ongoing procedure is cancelled and closed. The supervising doctor informs the patient of this decision and its reasons. The procedure may be restarted with a new request for opening under Article 4.

4 - In the case of a favourable opinion from the specialist doctor, the supervising doctor informs the patient of the content of that opinion, after which he checks again whether the patient maintains and reiterates his wishes. The patient's decision must be recorded in writing, dated and signed by himself or by the person designated by him under the terms of paragraph 2 of article 11 and, together with the opinion or alternative opinions issued by the specialist doctor or doctors, form part of the RCE.

5—If the patient suffers from more than one definitive injury of extreme severity or severe and incurable illness, the supervising doctor decides which medical speciality to consult.

Article 7

Confirmation by a psychiatric specialist

1 - The opinion of a doctor specialised in psychiatry is mandatory whenever one of the following situations occurs:

a) The advising doctor and/or the specialist doctor have doubts about the person's capacity to request PAD, revealing a serious, free and informed desire;

TABLE 3. Law No. 22/2023, May 25 - Regulates the conditions under which physician-assisted death (PAD) is not punishable and amends the Penal Code

b) The advising doctor and/or the specialist doctor admit that the person has a psychological disorder or medical condition that affects their ability to make decisions.

2 - If the psychiatric doctor confirms any of the situations referred to in the previous paragraph, the ongoing procedure is cancelled, the patient is informed of this decision and its reasons, and the procedure may be restarted with a new request for opening, under the terms of the article 4

3 - The opinion of the specialist in psychiatry is prepared within 15 working days, in writing, dated and signed by the doctor himself, and forms part of the RCE.

4 - The assessment necessary to prepare the opinion referred to in paragraph 1 involves, whenever the specific condition of the patient so requires, collaboration with a clinical psychology specialist.

5 - In the case of a favourable opinion from the specialist in psychiatry, he, accompanied by the supervising doctor, must inform the patient of the content of that opinion, after which he checks again whether the patient maintains and reiterates his wishes, with the conscious and express decision of this being recorded in a written document, dated and signed by the person or by the person designated by them under paragraph 2 of article 11, which forms part of the RCE.

Article 8

Opinion of the Verification and Evaluation Committee

1 - In cases where favourable opinions are presented under the terms of the previous articles, once the patient's wishes have been reconfirmed, the supervising physician sends a copy of the RCE to the Commission for Verification and Evaluation of Clinical Procedures for PAD (CVA), provided for in article 24, requesting an opinion on compliance with the requirements and previous phases of the procedure, which is prepared within five working days.

2 - When the CVA has doubts about whether the conditions set out in this law for the practice of PAD are met, it must summon the doctors involved in the procedure to provide statements. It may also request the sending of additional documents it deems necessary.

3 - In case of an unfavourable opinion from the CVA, the ongoing procedure is cancelled and may be restarted with a new opening request under Article 4.

4—In the case of a favourable opinion from the CVA, the supervising doctor must inform the patient of the content of that opinion, after which he checks again whether he maintains and reiterates his wishes. His conscious and express decision must be recorded in a written, dated document and signed by himself or by the person designated by him under paragraph 2 of Article 11, which forms part of the RCE.

Article 9

Implementation of the patient's decision

1 - Upon favourable opinion from the CVA, the supervising physician, under the patient's wishes, agrees on the day, time, place and method to be used for the practice of PAD.

2 - The supervising physician informs and clarifies the patient about the methods available to practice PAD, namely the self-administration of lethal drugs by the patient himself or administration by a doctor or health professional duly qualified for the purpose, but under medical supervision when the patient is physically incapable of self-administering lethal drugs.

TABLE 3. Law No. 22/2023, May 25 - Regulates the conditions under which physician-assisted death (PAD) is not punishable and amends the Penal Code

3 - The decision referred to in the previous paragraph must be recorded in writing, dated and signed by the patient, or by the person designated by them under paragraph 2 of article 11, and integrated into the RCE, without prejudice to the provisions of paragraph 7 of article 3

4 - After making the decision, the supervising doctor sends a copy of the respective RCE to the General Inspection of Health Activities (IGAS), which can monitor the procedure for implementing the patient's decision in person.

5 - If the patient becomes unconscious before the date set for the PAD procedure to be carried out, it is interrupted. Unless the patient regains consciousness and maintains his decision, it will not be carried out.

Article 10

Administration of lethal drugs

1 - In addition to the supervising physician and another health professional, who are obligatorily present during the administration of lethal drugs, other health professionals may be present as indicated by the supervising physician, as well as people indicated by the patient, as long as the supervising physician considers that there are adequate clinical and comfort conditions.

2 - Immediately before starting the administration or self-administration of lethal drugs, the supervising physician must confirm whether the patient remains willing to request PAD in the presence of one or more witnesses duly identified in the RCE.

3—If the patient does not expressly confirm their desire to request assisted death, namely, if they express any doubts, the ongoing procedure is cancelled and considered closed. This is recorded in a written document, dated and signed by the supervising doctor, integrating the RCE. The procedure may be restarted with a new request for opening under Article 4.

4 - In the case provided for in the previous paragraph, the respective RCE must be delivered to the patient, with a copy attached to their clinical file and another sent to the CVA with the respective Final Report from the supervising physician, under article 17.

Article 11

Personal and non-delegable decision

1 - The patient's decision at any stage of the PAD clinical procedure is strictly personal and non-delegable.

2 - Without prejudice to the provisions of the previous paragraph, if the patient requesting PAD does not know or is physically unable to write and sign, he or she may, at all stages of the procedure in which it is requested, be replaced by a person from his/her trust, designated by him/her solely for this purpose, applying the rules for signature recognition upon request in the presence of a legally competent professional. The signature must be made in the presence of the supervising physician, with express reference to this circumstance, and in the presence of one or more witnesses.

3 - The person designated by the patient to replace him/her under the terms of the previous paragraph cannot obtain a direct or indirect benefit from the death of the patient, namely a patrimonial advantage, nor have any inheritance interest.

Article 12

Revocation

TABLE 3. Law No. 22/2023, May 25 - Regulates the conditions under which physician-assisted death (PAD) is not punishable and amends the Penal Code

1 - The revocation of the request for PAD cancels the ongoing clinical procedure, and the decision must be entered in the RCE by the supervising physician.

2 - Upon revocation of the request, the respective CER is delivered to the patient, and a copy must be attached to their clinical file with the final report from the supervising physician.

Article 13

Authorised locations

1 - The choice of the location for PAD is up to the patient.

2 - The PAD procedure can be practised in health establishments of the National Health Service and in the private and social sectors that are duly licensed and authorised to practice health care, have hospitalisation and have an adequate place with access reserved.

3 - If the patient's choice falls on a location other than those referred to in the previous paragraph, the supervising physician must certify that the patient has adequate clinical and comfort conditions for this purpose.

Article 14

Follow-up

For the purposes set out in paragraph 2 of article 10, people indicated by the patient may also be present in addition to the supervising physician and other health professionals involved in the PAD procedure.

Article 15

Verification of death and certification of death

Verification of death and certification of death comply with current legislation, and the respective copies must be filed with the RCE.

Article 16

Special clinical record

1 - The RCE begins with the request for PAD written by the patient or by the person designated by them under the terms of paragraph 2 of article 11 and must include the following elements:

- a) All clinical information relating to the ongoing procedure;
- b) Opinions and reports presented by doctors and other health professionals involved in the process;
- c) The opinion of the CVA;
- d) The patient's decisions regarding the continuation of the procedure or the revocation of the request;
- e) The patient's decision on the method of PAD;
- f) Other occurrences considered relevant.

2 - Once the procedure has been completed or cancelled due to revocation of the patient's request, medical decision or following the CVA's opinion, the RCE is attached to the final report, and a copy must be attached to the patient's clinical file.

3 - The supervising physician is responsible for the RCE, including the documents referred to in paragraph 1.

TABLE 3. Law No. 22/2023, May 25 - Regulates the conditions under which physician-assisted death (PAD) is not punishable and amends the Penal Code

4 - The patient has access to the RCE whenever he requests it from the supervising doctor.

5 - The CER model is established in regulations to be approved by the Government.

Article 17

Final report

1 - Within 15 working days after the death, the supervising physician prepares the final report, to which the RCE is attached and sent to the CVA and IGAS.

2 - The obligation to present the final report remains in cases where the procedure is closed without the PAD of the patient has occurred, whether due to a medical decision, an unfavourable opinion from the CVA or revocation.

3 - The final report must include, among others, the following elements:

- a) Identification of the patient and the doctors and other professionals involved in the process, including those who performed or assisted in PAD, and the people consulted during the procedure;
- b) The elements that confirm compliance with the requirements required by this law for PAD;
- c) Information on the clinical status, namely on the diagnosis and prognosis, with an explanation of the serious and incurable nature of the disease or the definitive condition and extreme severity of the injury and the characteristics and predictable intensity of the suffering;
- d) The method and lethal drugs used;
- e) The date, time and place where the PAD procedure took place and the identification of those present;
- f) The grounds for closing the procedure.

4 - The final report model is established in regulations to be approved by the Government.

CHAPTER III

Rights and duties of healthcare professionals

Article 18

Qualified healthcare professionals

1 - Health professionals registered with the Order of Doctors or the Order of Nurses may practice or assist in the PAD procedure, excluding those who may obtain any direct or indirect benefit from the patient's death, namely patrimonial advantage.

2 - For the purposes of carrying out the act of PAD, the health professionals referred to in the previous paragraph must previously verify the existence of a prescription for the necessary drugs carried out under the applicable legal terms.

3 - Health professionals involved in the PAD procedure are provided with psychological support whenever requested.

Article 19.º

Duties of healthcare professionals

During the PAD clinical procedure, doctors and other health professionals involved in it must respect the following duties:

- a) Inform the patient in an objective, understandable, rigorous, complete and truthful manner about the diagnosis, applicable, viable and available treatments, predictable results, prognosis and life expectancy of their clinical condition;
 - b) Inform the patient of their right to revoke their decision to request PAD at any time;
-

TABLE 3. Law No. 22/2023, May 25 - Regulates the conditions under which physician-assisted death (PAD) is not punishable and amends the Penal Code

- c) Inform the patient about the methods of administration or self-administration of lethal drugs, so that they can choose and decide in an informed and conscious way;
- d) Ensure that the patient's decision is free, clear and informed;
- e) Listen regularly and frequently to the patient's wishes;
- f) Dialogue with the health professionals who provide care to the patient and, if authorised by the patient, with their family and friends;
- g) Dialogue with the health care proxy, if appointed and if authorised by the patient;
- h) Ensure the conditions so that the patient can contact the people with whom he wishes to do so;
 - i) Ensure psychological support for the patient.

Article 20

Professional secrecy and confidentiality of information

- 1 - All professionals who, directly or indirectly, participate in the PAD procedure are obliged to observe professional secrecy about all acts, facts or information of which they become aware in the exercise of their functions in that context, respecting the confidentiality of the information to which they have had access, under current legislation.
- 2 - Access, protection and processing of information related to the PAD procedure are processed under current legislation.

Article 21

Conscientious objection

- 1 - No health professional may be obliged to practice or assist in the act of PAD of a patient if, for clinical, ethical or any other reasons, they believe it is not their duty to do so, with the right to conscientious objection being guaranteed. All who call upon him.
- 2 - The professional's refusal must be communicated to the patient within 24 hours. It must specify the nature of the reasons that motivate it without prejudice to the provisions of the following paragraphs.
- 3 - The conscientious objection is expressed in a document signed by the objector, addressed to the person responsible for the health establishment where the patient is being cared for and where the objector provides services, if applicable, and with a copy to the respective professional association.
- 4 - Conscientious objection is valid and applies in all health establishments and workplaces where the objector exercises his profession.
- 5 - Conscientious objection can be invoked at any time and does not require justification.

Article 22

Disciplinary responsibility

Health professionals cannot be subject to disciplinary liability for participating in the PAD clinical procedure as long as they comply with all the conditions and duties established in this law.

CHAPTER IV

Inspection and evaluation

TABLE 3. Law No. 22/2023, May 25 - Regulates the conditions under which physician-assisted death (PAD) is not punishable and amends the Penal Code

Article 23

Oversight

1 - IGAS supervises clinical procedures for PAD under this law.

2 - In case of non-compliance with this law, IGAS may determine, based on reasons, the suspension or cancellation of the ongoing procedure.

Article 24

Commission for Verification and Evaluation of Clinical Procedures for PAD

The Commission for Verification and Evaluation of Clinical Procedures for PAD was created to comply with the provisions of Article 8, paragraph 1, and evaluate the application of this law.

Article 25

Composition and functioning of the committee

1 - The CVA is made up of five members of recognised merit who guarantee special qualifications in the areas of knowledge related to the application of this law:

a) A jurist appointed by the Superior Council of the Judiciary;

b) A jurist appointed by the Superior Council of the Public Ministry;

c) A doctor designated by the Medical Association;

d) A nurse designated by the Order of Nurses;

e) A bioethics specialist designated by the National Ethics Council for Life Sciences.

2 - Health professionals, referred to in paragraphs c) and d) of the previous paragraph, who have expressed conscientious objection under the terms of article 21 cannot join the CVA.

3 - The term of office of CVA members is five years, renewable once.

4 - The appointment of CVA members must be carried out within 20 working days of the entry into force of this law.

5 - The CVA draws up and approves its internal regulations and elects a president from among its members.

6 - The CVA works alongside the Assembly of the Republic, which covers its operating costs and the necessary technical and administrative support.

7 - CVA members are not remunerated for carrying out their duties. They are entitled to attendance vouchers for each meeting in which they participate, in an amount to be defined by order of the President of the Assembly of the Republic, to cost allowances and transport requests under general law.

Article 26

Verification

1 - The CVA assesses the compliance of the PAD clinical procedure through a prior opinion, under the terms of article 8, and through an evaluation report under the terms of the following number.

2—Once the final report of the PAD process, which includes the respective RCE, has been received, the CVA examines its content and evaluates, within five working days after receipt, the terms under which the conditions and procedures established in this law have been complied with.

TABLE 3. Law No. 22/2023, May 25 - Regulates the conditions under which physician-assisted death (PAD) is not punishable and amends the Penal Code

3 - In cases where the assessment provided for in the previous paragraph is non-compliant with the requirements established by this law, the CVA sends the report to the Public Prosecutor's Office, and to the respective professional orders of those involved for possible disciplinary proceedings.

Article 27

Assessment

1 - The CVA annually presents an evaluation report on applying this law to the Assembly of the Republic, with detailed statistical information on all relevant elements of PAD processes and possible recommendations.

2 - To prepare the report, the final reports and respective RCE sent to the CVA by the supervising doctors are evaluated, with guaranteed anonymity and confidentiality, who must provide any additional clarifications requested by them.

3 - IGAS provides the CVA with the requested information on the inspection procedures concerning compliance with this law.

CHAPTER V

Legislative change

Article 28

Amendment to the Penal Code

Articles 134, 135 and 139 of the Penal Code are now worded as follows:

«Article 134.^o

[...]

1 - [...]

two - [...]

3 - Conduct is not punishable when carried out in compliance with the conditions established in Law No. 22/2023.

Article 135

[...]

1 - [...]

two - [...]

3 - Conduct is not punishable when carried out in compliance with the conditions established in Law No. 22/2023.

Article 139.^o

[...]

1 - (Current body of the article.)

2 - A doctor or nurse who, without inciting or advertising, merely provides information, at the express request of another person, about medically assisted suicide, under paragraph 3 of article 135, shall not be punished."

CHAPTER VI

TABLE 3. Law No. 22/2023, May 25 - Regulates the conditions under which physician-assisted death (PAD) is not punishable and amends the Penal Code

Final and transitional provisions

Article 29

Life insurance

1 – PAD is not an exclusion factor for the life insurance contract.

2 - Health professionals who participate, in any capacity, in the clinical procedure of PAD of an insured person lose the right to any contractual benefits.

3 - For the purposes of defining the cause of death of the insured person, the death certificate must indicate that a PAD procedure was carried out.

4 - Once the PAD clinical procedure has begun, the insured person cannot change the beneficiary designation clauses.

Article 30

Dissemination of information on the Internet

The Directorate-General for Health provides, on its website, an area dedicated to information on non-punishable PAD, with the following fields:

- a) Information about clinical procedures;
- b) Standardised forms and documents;
- c) Applicable legislation.

Article 31

Regulation

The government approves the respective regulations within 90 days after the publication of this law.

Article 32

Deadlines

The deadlines provided for in this law are calculated according to the provisions of Article 87 of the Code of Administrative Procedure.

Article 33

Transitional provision

In the first two years of this law's validity, the CVA presents the evaluation report referred to in paragraph 1 of article 27 to the Assembly of the Republic every six months.

Article 34

Implementation

This law comes into force 30 days after the publication of the respective regulations.

Approved on March 31, 2023.

The President of the Assembly of the Republic, Augusto Santos Silva.

TABLE 3. Law No. 22/2023, May 25 - Regulates the conditions under which physician-assisted death (PAD) is not punishable and amends the Penal Code

Enacted on May 16, 2023.

Get published.

The President of the Republic, Marcelo Rebelo de Sousa.

Countersigned on May 18, 2023.

The Prime Minister, António Luís Santos da Costa.

CHAPTER 2 – Research Objectives and Method

The scarce studies on euthanasia in older psychiatric patients, mainly using objective assessments, and the lack of a multidimensional approach, which considers the idiosyncrasies associated with ageing previously described and takes into account the several domains that may affect humans' decisions regarding health care, was the fuel of our research. In Portugal, the most aged European country, where older adults present low levels of education and literacy (PORDATA, 2024), the prevalence of depressive and anxiety symptoms is significant (De Sousa et al., 2017) and many live alone (PORDATA, 2021) with scant social and familial support, it is mandatory to assess the euthanasia phenomenon in this age group properly. Several psychosocial factors put older adults at risk of developing psychiatric disease and suicide. For example, loneliness has been associated with an increased risk of developing dementia (Sundström et al., 2019; Donovan et al., 2016)] and anankastic and anxious personality traits have been associated with an increased risk of suicide (Harwood et al., 2001).

In the Psychogeriatrics/Cognitive Disorders Unit (PCU) of the Psychiatry Department (PD) of Senhora da Oliveira Hospital (SOH) in Guimarães, Portugal, reported international data has also been seen. In 2013, older adults (age ≥ 65) comprised 18% of the total number (4544) of adult patients (age ≥ 18) who were assisted in the PD, a figure that increased to 27% of a total of 6354 in 2023. In both 2013 and 2023, around 40% of older adult patients had depressive and anxiety disorders, the average education level was low (3 years) and the burn-out of several caregivers due to the lack of appropriate social and institutional support was evident several times. Regarding loneliness, most patients live with at least one person but have little or no social interaction or occupational activities. The low level of education is particularly troublesome as it significantly decreases the decision-making capacity for well-informed and free decisions about health care. Many, for example, when subjected to simple cognitive assessments such as the mini-mental-state test, do not perform appropriately, not because they have a cognitive deficit resulting from a psychiatric disease but because of their poor level of academic instruction. For example, most commonly, they do not answer correctly when asked about the country, the season, or the district because they do not know, and never did, the meaning of such words.

Thus, the objectives of this work were to:

- Alert to the problem of Portuguese older adults' low literacy levels and poor decision-making capacity;
- Reflect on whether there is a right to euthanasia according to the Constitution of the Portuguese Republic;
- Make available a Portuguese-validated psychometric instrument to assess the overall opinion (in favour or against) of samples regarding euthanasia, allowing for comparative studies;
- Perform a Multidimensional study on the attitudes towards euthanasia of Portuguese older patients with psychiatric disease, particularly MADD, according to the design below (Figure 1.).

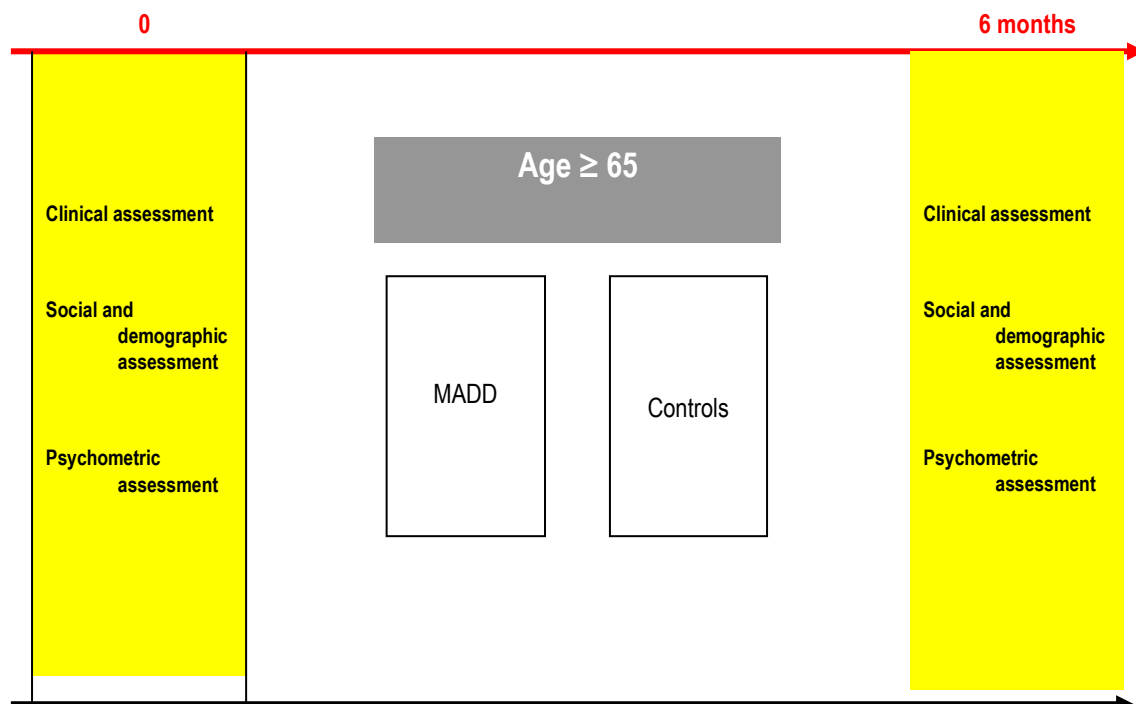


Figure 1. Study design

The methodology, sociodemographic questionnaire and scales (Annex B6) used for each objective are detailed in the following sections, where the published articles are fully available. All the psychometric instruments were used with permission (Annex B7). The participants in the study signed an informed consent (Annex B8). The Ethics Committee of SOH approved the study on September 18, 2020 (ref. 70/2020) (Annex B9).

Table 4 shows the articles published in the PhD program.

TABLE 4. PUBLISHED ARTICLES

Articles related to the thesis theme

- Fonseca L, Monteleone F, Gonçalves A, Rego G, Nunes R. **Decision-Making Capacity of Elderly Patients with Mixed Depression-Anxiety Disorder.** *Acta Médica Portuguesa*. Published online April 12, 2023. doi:10.20344/amp.19682
 - Fonseca L, Gonçalves A, Couto B, Monteleone F, Machado E, Rêgo F, Rêgo G, Nunes R. **Empathy: The Core of Morality.** *Journal of Humanities & Social Sciences*. Accepted for publication (ANNEX B1).
 - Fonseca L, Rêgo G, Nunes R. **The empathic genesis of the Right to Euthanasia.** *Revista Jurídica Portucalense*. Published online December 29, 2023. doi:10.34625/issn.2183-2705(34)2023.ic-06
 - Fonseca L, Castro L, Gonçalves A, Monteleone F, Rêgo G, Nunes R. **Cross-Cultural Adaptation and Validation of an Attitude about Euthanasia Scale in Portuguese Older Adults with Mixed Anxiety-Depressive Disorder.** *Healthcare* (Basel). 2024;12(12):1221. Published 2024 Jun 19. doi:10.3390/healthcare12121221
 - Fonseca L, Castro L, Rêgo G, Nunes R. **Multidimensional Study of the Attitude towards Euthanasia of Older Adults with Mixed Anxiety-Depressive Disorder.** *Healthcare* (Basel). 2024;12(11):1078. Published 2024 May 24. doi:10.3390/healthcare12111078
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Article not related to the thesis theme

- Fonseca, L, Rêgo G, Nunes R. **Anthropo-Symbiotic Ethics: A Path to The Sustainability of Life.** *Eubios Journal of Asian & International Bioethics*. Sep2022, Vol. 32 Issue 5, p126-130. 5p
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CHAPTER 3 – Articles

Decision-Making Capacity of Elderly Patients With Mixed Depression-Anxiety Disorder

Acta Medica Portuguesa - Scientific Journal Rankings (SJR): Quartile 4 (2023)

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Citation: Fonseca L, Monteleone F, Gonçalves A, Rego G, Nunes R. Decision-Making Capacity of Elderly Patients with Mixed Depression-Anxiety Disorder. *Acta Médica Portuguesa*. Published online April 12, 2023. doi:10.20344/amp.19682

Literacy admittedly promotes healthy ageing,¹ by being associated with a decreased risk of dementia.² Even though literacy goes beyond the level of formal education, the latter is an important objective indicator of one's cognitive skills.

After the proper approval by the hospital Ethics Committee, we collected a sample of 51 elderly patients with mixed depressive-anxiety disorder (ICD-10), obtained randomly from the psychogeriatrics clinic, and analyzed the association between their education level and cognitive test performance. The association is used here for a brief ethical discussion about elderly decision-making competence for health-informed consent.

The correlation between schooling and cognitive tests was significant, that is, a higher education level was associated with better cognitive performance [Corr schooling, MMS = 0.467; p -value < 0.001; Corr schooling, CDT = 0.533; p -value < 0.001 (Pearson coefficient, IBM SPSS Statistics)].

The resident Portuguese population is 10 298 252 people (Statistics Portugal, 2021). Of these, 22.3% are 65 years old or older, with 1 186 700 having between one and four years of education and 387 500 having zero years, which means that 69% of the elderly population has four years of schooling or less.

In addition, as observed in clinical practice, many elderly patients who have four years of schooling or less often have very limited reading or writing skills, with some only knowing how to sign their name and many not being able to perform 'simple' digital tasks (e.g., handling a smartphone or texting). Therefore, there are cognitive limitations that may not be the result of any disease, but of a poor socio-cultural and academic background. These limitations could, of course, also result from depressive and/or

anxious symptoms.³ However, this is highly unlikely in our sample as participants had mild symptoms, normal performance on cognitive tests, excellent therapeutic compliance and good overall autonomy (Table 1).

Table 1 – Psychometric and cognitive assessment

n = 51		Age	Schooling	HDRS	HARS	MMS	CDT	BI	TAS
	Mean	72	4	11.54	13.40	26.22	7.72	97.19	7.78

HDRS: Hamilton depression rating scale⁶; HARS: Hamilton anxiety rating scale⁷; MMS: Mini Mental State scoring⁸; CDT: clock drawing test⁹; BI: Barthel index¹⁰; TAS: therapeutic adhesion scale¹¹

Note: all patients medicated with antidepressants.

Within the scope of a truly free and informed consent,⁴ it is essential for the patient to be an active agent. However, in a globalized world, where new technologies occupy an increasingly prominent place, cognitive limitations can limit the understanding and access to relevant information.

Despite full autonomy for instrumental and daily life activities, many patients may not be entirely competent to make informed healthcare decisions. In addition, if other interferences are present, such as a poor doctor-patient relationship, inadequate communication or excessive paternalism, pitfalls can be more serious. The problem may worsen with the reduction of literacy levels with age.⁵

This analysis had some limitations. First, although the findings seem to affect a vast majority of the Portuguese elderly population, our sample is very small and, therefore, may not be generalizable. Moreover, the cognitive tests used present limited diagnostic accuracy and the depression and anxiety scales are not elderly-specific.

In such a frail population, coming up with a solution may be difficult. However, some measures can mitigate these shortcomings, such as:

- Informed consent should take into account cognitive baseline differences rather than being generalizable;
- The competence and decision-making capacity of elderly individuals should be assessed properly and in due time;
- The cognition level of older people should be periodically and routinely assessed in primary care;

- A person of an elderly individual's trust should be nominated to participate in decision-making, and paternalistic approaches in decision-making should be discouraged;

- There should be a focus on public policies regarding disease prevention and health and literacy promotion and on the undergraduate training of healthcare professionals.

AUTHOR CONTRIBUTIONS

LF: Research and writing of the manuscript. FM, AG: Research.

GR, RN: Research and critical review of the manuscript.

PROTECTION OF HUMANS AND ANIMALS

The authors declare that the procedures were followed according to the regulations established by the Clinical Research and Ethics Committee and to the Helsinki Declaration of the World Medical Association, updated in 2013.

DATA CONFIDENTIALITY

The authors declare having followed the protocols in use at their working center regarding patients' data publication.

COMPETING INTERESTS

The authors have declared that no competing interests exist.

FUNDING SOURCES

This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors.

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Empathy: The Core of Morality

Journal of Humanities & Social Sciences (JHSS), ISSN: 2690-0688 | DOI: 10.33140/JHSS, Accepted for publication (ANNEX B1).

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ABSTRACT

Studies and opinion articles present unequal conclusions concerning empathy and morality, mainly because a somewhat heterogeneous and foggy conceptual approach prevails.

This scoping review aims to analyse the relationship between empathy and morality and to present a novel conceptual model of empathy applied to moral decisions.

A search in PsycINFO, Scopus and PubMed identified articles addressing the relationship between empathy and morality.

Thirty-two articles were included. We find an absence of a consensual definition of empathy. It is commonly defined as a predominant emotional process and a factor of bias and prejudice in moral decisions.

According to our conceptual model, empathy is a distinct, complex human neuropsychological capacity that mobilises and is dependent on the proper functioning of several brain areas and balances the scales on which are Emotion and Reason, enabling the most thoughtful moral decisions possible in diverse circumstances and contexts.

Keywords: empathy, morality, cognition, emotion.

1. Introduction

The term empathy comes from Edward Titchener's (1904) translation of the German word "Einfühlung" (Ganczarek et al., 2018). The concept of "Einfühlung" emerged in the late 19th/early 20th century in German philosophical aesthetics to refer to the act of an individual projecting himself onto another body or environment (including inanimate objects) to understand what is like to be in the outer space of the Self (Ganczarek et al., 2018). In the artistic world, considering that works of art are human artefacts and, therefore, translate thoughts, emotions and ideologies of humankind, there is a parallel between aesthetic and interpersonal empathy. Both present the fundamental role of the ability to take perspective, incorporate an alien situation and integrate the resulting affective effects. There is an important dimension of understanding, which, as Jaspers (2000) said, "is the way to access the mental states of others". We use what is subjectively available to us and spontaneously reinterpret it, realising what it is like to be in someone else's shoes. According to Jaspers (2000), this so-called "phenomenological observation" is not provided by the senses or by logical reasoning but comes from a direct and immediate understanding of what the other presents to us. Thus, we can affirm that considering its origin, empathy might be conceptually broader than it is commonly defined in several articles, where, often, it is limited to an exclusively emotional and interpersonal dimension (Churcher, 2016; Cuff et al., 2014; Isern-Mas and Gomila, 2019; Kauppinen, 2017; Pascal, 2017) or divided into several subtypes (Decety and Cowell, 2014; Decety, 2010; Decety and Cowell, 2014b; Schoeps et al., 2020; Simmons, 2013). This creates conceptual and methodological difficulties for an adequate clarification of its meaning and importance for general human behaviour and morality.

It is important to present our understanding of morality to clarify the relation we intend to approach and defend here. Derived from the Latin "*moràlia*", which means habits, customs or traditions, we will refer to morality as an expression of the judgments that classify decisions and the resulting behaviours as good/correct or bad/wrong (Ugazio et al., 2014). Normative and descriptive ethics seek to establish the best way to reach the most morally correct decision and untie the knot of several difficult-to-resolve dilemmas (Beauchamp and Childress, 2019). Here, we will not detail any theories that try to answer this herculean mission. Assuming that it is impossible on several occasions to attain a morally perfect response, that is, a decision deprived of any doubt or moral and existential anguish, we will propose that empathy, as we conceptualise it, is undoubtedly the core of morality.

The role of empathy in morality has been quite debated. The absence of a consensus (Coplan, 2011; Engelen and Röttger-Rössler, 2012; De Vignemont and Singer, 2006) on this relation has been due to several factors. First, the definition of empathy is disparate, which leads to different interpretations and conclusions about its importance for morality, in the distinction between good and evil or between the most and the least admissible when one faces ethical dilemmas. Second, the widespread understanding of empathy as an emotion or a predominantly emotional process alludes to subjectivity and the inability to determine what is morally acceptable. Third, the vagueness of its definition makes it difficult to accept that it is an exclusively human capacity. Fourth, the central role of empathy is often overshadowed by a dominant Kantian conception of morality as an absolute and objective value derived solely from Reason.

The complexity of humans' affective phenomena does not result from a brain area associated explicitly with emotions but from an intricate and harmonious relation of neuronal networks responsible for the most diverse emotional, behavioural, sensory, motor and cognitive functions (Sporns, 2013). Each person has a specific behavioural and emotional pattern resulting from the inter-influence between biology and the environment (Allen, 2015). These different patterns are part of the human affective spectrum, which can be more or less dynamic over time and whose intensity derives from the balance between Reason and Emotion.

Based on a literature analysis of the relationship between empathy and morality, we will present our conceptual model of empathy to justify its indispensability for moral judgments and decisions.

To simplify concepts, we will refer to emotions, feelings, and affects as Emotion or affective phenomena and to higher cognitive functions as Reason.

2. Objective

This scoping review aims to analyse the relationship between empathy and morality and propose a conceptual model of empathy to respond appropriately to the most diverse circumstances in which a moral decision is pending.

3. Methodology

A scoping review was performed based on the PRISMA guidelines (Liberati et al., 2009; Shamseer et al., 2015).

Table 1. Search strategy

Date	Databases	Search strategy	Number of results
17th June 2023	APA PsycINFO	Search terms: empathy and morality	65
		Search options	
		Expanders - Apply equivalent subjects	
		Restrict by Subject: - empathy	
		Restrict by Subject: - morality	
		Search Modes - Boolean/Phrase	
	SCOPUS	ALL (“empathy and morality”) AND (LIMIT-TO (EXACT KEYWORD, “Empathy”) OR LIMIT-TO (EXACT KEYWORD, “Morality”))	119
	PUBMED	“empathy” and “morality”	210
Total			394

a) Selection criteria

Articles published in any language addressing the relationship between empathy and morality were included. Clinical cases, editorials, guidelines and news were excluded. No articles were excluded based on publication date.

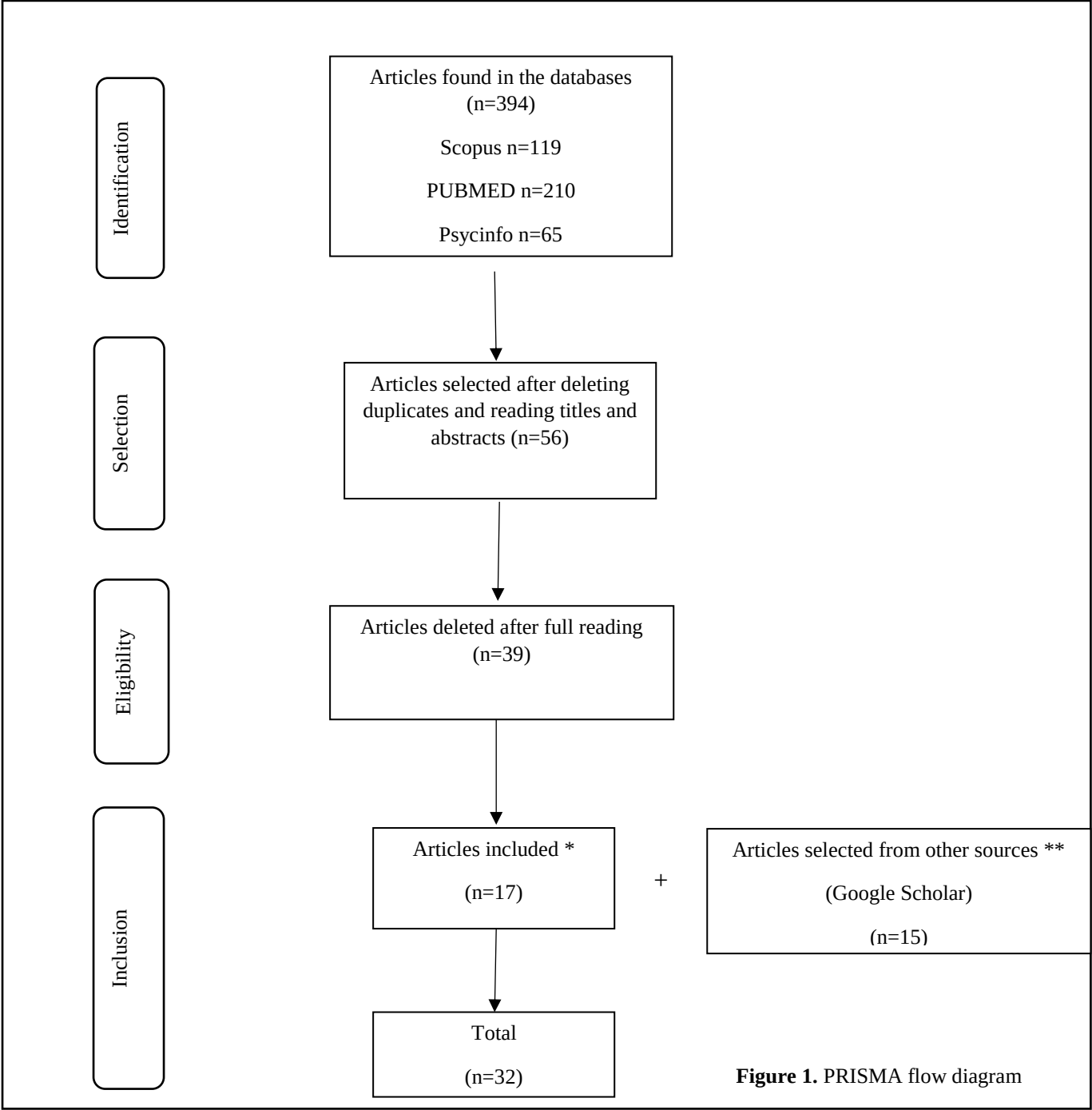
b) Data collection and analysis

Eight researchers participated in the search and analysis of the quality and eligibility of the articles. The results were subjected to a joint critical review. Differing opinions were solved through a consensus among the investigators. The evaluation of the quality and level of evidence of the articles included were also discussed and decided by consensus.

After excluding duplicate articles and carefully reading the titles and abstracts, 56 works were included. Of these, 39 were eliminated. Considering the conceptual and

philosophical dimension of the topic addressed, 15 articles selected from other sources were also considered in this selection.

Figure 1 shows the PRISMA flow diagram (Liberati et al., 2009; Shamseer et al., 2015). Table 2 presents the articles assessed in this review, and the most significant conclusions for the topic studied.



4. Results

Table 2. Selected articles [*- articles included (figure 1.); ** - articles selected from other sources (figure 1.)]

Article	Article type	Conclusions
Altuna, B. (2018b). Empatía y moralidad. Dimensiones psicológicas y filosóficas de una relación compleja. <i>Revista De Filosofía</i> , 43(2). https://doi.org/10.5209/resf.62029 *	Narrative review	"From empathy do not derive ethical principles related to impartiality or equity".
Babcock, S. E., Li, Y., Sinclair, V. M., Thomson, C., & Campbell, L. (2017c). Two replications of an investigation on empathy and utilitarian judgement across socioeconomic status. <i>Scientific Data</i> , 4(1). https://doi.org/10.1038/sdata.2016.129 **	Study replication + Meta-analysis	"Individuals with high socioeconomic status tend to make utilitarian decisions partly due to a lack of empathy".
Bloom, P. (2017c). Empathy and its discontents. <i>Trends in Cognitive Sciences</i> , 21(1), 24–31. https://doi.org/10.1016/j.tics.2016.11.004 *	Opinion article	Empathy is an "experience of feeling what we think others are feeling". "Individuals with low empathy are more rational and less biased moral decision-makers". "There are reasons to believe that when it comes to making the world better, we are better off without empathy".
Cameron, C. D., Conway, P., & Scheffer, J. A. (2022b). Empathy regulation, prosociality, and moral judgment. <i>Current Opinion in Psychology</i> , 44, 188–195. https://doi.org/10.1016/j.copsyc.2021.09.011 *	Comprehensive review	Elements other than empathy are necessary for a moral decision. Motivation and inter-relational empathic subjectivity modulate moral judgment.
Churcher, M. (2016c). Can empathy be a moral resource? A Smithean reply to Jesse Prinz. <i>Dialogue</i> , 55(3), 429–447. https://doi.org/10.1017/s0012217316000688 *	Opinion article	Adam Smith's concept of the impartial spectator supports the importance of empathy in morality.
Cuff, B. M. P., Brown, S., Taylor, L. K., & Howat, D. (2014d). Empathy: A review of the concept. <i>Emotion Review</i> , 8(2), 144–153. https://doi.org/10.1177/1754073914558466 **	Narrative revision	Empathy is an emotional (affective) response dependent on the interaction between trait capabilities and state influences. The resulting emotion derives from the perception of the other's state and its understanding, with the recognition that the origin of the emotion is outside the Self.
Decety, J., & Cowell, J. M. (2015c). Empathy, justice, and moral behaviour. <i>Ajob Neuroscience</i> , 6(3), 3–14. https://doi.org/10.1080/21507740.2015.1047055 *	Narrative revision	"Empathy produces social preferences that may conflict with justice and equity".
Decety, J., & Cowell, J. M. (2014c). The complex relation between morality and empathy. <i>Trends in Cognitive Sciences</i> , 18(7), 337–339. https://doi.org/10.1016/j.tics.2014.04.008 *	Opinion article	To better characterise the relation with morality, it is essential to "abandon the term empathy" and use more "precise" concepts, such as "emotional sharing, empathic concern and taking an affective perspective."

Table 2. Selected articles [*- articles included (figure 1.); ** - articles selected from other sources (figure 1.)]

Article	Article type	Conclusions
Decety, J. (2010c). The neurodevelopment of empathy in humans. <i>Developmental Neuroscience</i> , 32(4), 257–267. https://doi.org/10.1159/000317771 *	Revision article	Empathy must be decomposed into sub-components related to specific brain areas to understand human development better.
Decety, J., & Cowell, J. M. (2018b). The Social Neuroscience of Empathy and its Relationship to Moral Behavior. <i>The Wiley Blackwell Handbook of Forensic Neuroscience</i> , 145–169. https://doi.org/10.1002/9781118650868.ch7 *	Book article	Empathy can lead to bias in moral judgments and decisions. In evolutionary terms, empathy is vital in caring for offspring and facilitating group life.
Decety, J., & Cowell, J. M. (2014f). Friends or Foes. <i>Perspectives on Psychological Science</i> , 9(5), 525–537. https://doi.org/10.1177/1745691614545130 *	Opinion article	"While there is a relation between empathy and morality, it is not as linear as it might seem. In addition, distinguishing between the different facets of empathy is of the utmost importance, as each uniquely influences moral cognition, predicting differential moral behaviour".
Duan, C., & Sager, K. (2018c). Understanding Empathy. <i>Oxford University Press</i> . https://doi.org/10.1093/oxfordhb/9780199396511.013.62 *	Book article	Empathy is multidisciplinary, and it is not easy to define conceptually.
Ferrari, P. F. (2014b). The neuroscience of social relations. A comparative-based approach to empathy and the capacity to evaluate others' action value. <i>Behaviour</i> , 151(2–3), 297–313. https://doi.org/10.1163/1568539x-00003152 *	Research article	Multiple cognitive and emotional brain networks are essential for empathy and decision-making.
Fowler, Z., Law, K. W., & Gaesser, B. (2021). Against empathy bias: the moral value of equitable empathy. <i>Psychological Science</i> , 32(5), 766–779. https://doi.org/10.1177/0956797620979965 *	Research article	"Participants in two studies thought it was morally correct to empathise with socially closer people, although they felt it was morally more appropriate to show similar empathy and independent of social distance".
Isern-Mas, C., & Sureda, A. (2019b). Why does empathy matter for morality? <i>Análisis filosófico</i> . https://doi.org/10.36446/af.2019.310 *	Opinion article	"Morality is not reduced to rational judgment, but necessarily presupposes prosocial preferences, motivation, and sensitivity to intersubjective demands".
Johanson, M., Vaurio, O., Tiihonen, J., & Batalla, A. (2020). A systematic literature review of neuroimaging of psychopathic traits. <i>Frontiers in Psychiatry</i> , 10. https://doi.org/10.3389/fpsy.2019.01027 **	Systematic revision	"Psychopathy has been associated with a dysfunction of the default mode network that has been linked to poor moral judgments". "Empathy-related brain regions were active in psychopaths when imagining themselves in pain, but inactive when imagining others in pain".
Kauppinen, A. (2017b). Empathy as the moral sense? <i>Philosophia</i> . https://doi.org/10.1007/s11406-017-9816-1 *	Opinion article	A comprehensive, empathic process is a potential source of moral knowledge.

Table 2. Selected articles [*- articles included (figure 1.); ** - articles selected from other sources (figure 1.)]

Article	Article type	Conclusions
Lambe, L. J., Della Cioppa, V., Hong, I. K., & Craig, W. M. (2019). Standing up to bullying: a social-ecological review of peer defending in offline and online contexts. <i>Aggression and Violent Behavior</i> , 45, 51–74. https://doi.org/10.1016/j.avb.2018.05.007 **	Systematic revision	In the context of bullying, "defenders tend to have more empathy and less moral detachment".
Lenzen, L. M., Donges, M. R., Eickhoff, S. B., & Poeppel, T. B. (2021). Exploring the neural correlates of (altered) moral cognition in psychopaths. <i>Behavioral Sciences & the Law</i> , 39(6), 731–740. https://doi.org/10.1002/bsl.2539 **	Meta-analysis	"The antisocial behaviour of psychopaths is due, at least in part, to structural brain dysfunctions of regions associated with moral cognition and emotion"; "Psychopaths have reduced activity in the dorsomedial prefrontal cortex (dmPFC) that has been implicated in social cognitions, which include empathy, morality, and theory of mind".
Markowitz, A. J., Ryan, R., & Marsh, A. A. (2014). Neighbourhood income and the expression of callous–unemotional traits. <i>European Child & Adolescent Psychiatry</i> , 24(9), 1103–1118. https://doi.org/10.1007/s00787-014-0663-3 **	Cohort study	The environment and experience shape behaviour and reward-seeking, leading to the development of more or less adaptive traits and strategies. Insensitive non-emotional traits, including poor empathy, represent a robust hereditary pattern of socio-emotional response associated with an increased risk of persistent delinquent behaviour.
Masto, M. (2015). Empathy and Its Role in Morality. <i>The Southern Journal of Philosophy</i> , 53(1), 74–96. https://doi.org/10.1111/sjp.12097 **	Opinion article	"Empathy is indispensable to our moral lives".
Maxwell, B., & Racine, E. (2010). Should empathic development be a priority in biomedical ethics teaching? A critical perspective. <i>Cambridge Quarterly of Healthcare Ethics</i> . https://doi.org/10.1017/s0963180110000320 **	Narrative revision	Compassionate empathy is a strong motivator of ethical behaviour, but empathic reactions often fall short of appropriate standards of moral judgment because they are so susceptible to familiarity bias.
Pascal, E. A. (2017b). Being similar while judging right and wrong: The effects of personal and situational similarity on moral judgements. <i>International Journal of Psychology</i> . https://doi.org/10.1002/ijop.12448 **	Cohort study	Moral judgment depends on perceived personal and situational familiarity due to two mechanisms: motivational (where the goal is to avoid blame and harm) and non-motivational (through Empathy and Sympathy).
Passos-Ferreira, C. (2015). In defence of empathy: A response to Prinz. <i>Abstracta</i> , 8(2), 31–51. **	Opinion article	"Empathy is a crucial element in morality and, in certain circumstances, is our best guide".
Persson, I., & Savulescu, J. (2017b). The moral importance of reflective empathy. <i>Neuroethics</i> , 11(2), 183–193. https://doi.org/10.1007/s12152-017-9350-7 *	Opinion article	"Empathy can play an essential role in moral motivation, but it needs to be severely disciplined by other factors – in particular, Reason".
Prinz, J. J. (2011). Is Empathy Necessary for Morality? <i>Oxford University Press eBooks</i> , 211–229. https://doi.org/10.1093/acprof:oso/9780199539956.003.0014 **	Opinion article	"Empathy is not necessary for the capabilities that are part of basic moral competence".
Redford, L., & Ratliff, K. A. (2017). Empathy and humanitarianism predict preferential moral responsiveness to in-groups and out-groups.	Research article	Empathy favours a preferential morality.

Table 2. Selected articles [*- articles included (figure 1.); ** - articles selected from other sources (figure 1.)]

Article	Article type	Conclusions
<i>Journal of Social Psychology.</i> https://doi.org/10.1080/00224545.2017.1412933 *		
Schoeps, K., Mónaco, E., Cotoí, A., & Montoya-Castilla, I. (2020b). The impact of peer attachment on prosocial behaviour, emotional difficulties and conduct problems in adolescence: The mediating role of empathy. <i>PLOS ONE</i> , 15(1), e0227627. https://doi.org/10.1371/journal.pone.0227627 **	Cohort study	Emotional and cognitive empathy are two subtypes of empathy. Greater empathic capacity is associated with prosocial and altruistic behaviour and healthy socio-emotional functioning.
Simmons, A. T. (2013b). In defense of the moral significance of empathy. <i>Ethical Theory and Moral Practice</i> , 17(1), 97–111. https://doi.org/10.1007/s10677-013-9417-4 **	Opinion article	"Empathy is necessary and sufficient for morality as long as the individual possesses it in its two dimensions, cognitive and affective".
Slote, M. (2010). The mandate of empathy. <i>Dao-a Journal of Comparative Philosophy</i> , 9(3), 303–307. https://doi.org/10.1007/s11712-010-9170-5 **	Opinion article	"Empathy is central to the moral life".
Slote, M. (2016). The many faces of empathy. <i>Philosophia</i> , 45(3), 843–855. https://doi.org/10.1007/s11406-016-9703-1 **	Opinion article	"Empathy is a way of perceiving the moral virtues and vices of the people around us".
Zucchelli, M. M., & Ugazio, G. (2019). Cognitive-emotional and inhibitory deficits as a window to moral decision-making difficulties related to exposure to violence. <i>Frontiers in Psychology</i> , 10. https://doi.org/10.3389/fpsyg.2019.01427 *	Narrative revision	"Empathic ability plays a vital role in the development of morality". "Exposure to violence substantially increases the dysfunction of necessary mechanisms (such as empathy) for morally sound decision making".

a) Summary of the results

- 1) Empathy is commonly presented as an exclusively or predominantly emotional process;
- 2) Empathy is frequently divided into subtypes;
- 3) Empathy is associated with certain specific brain areas;
- 4) Empathy is referred to as a source of bias in moral decisions;
- 5) It is stated that to be empathetic, one must feel what the other is feeling;
- 6) The partiality of empathy is presented as an evolutionary advantage.

5. Discussion

a) We are Brain

The *Homo Sapiens* brain allows complex and exclusive functions, including abstract, reflective and philosophical thinking, as well as the potential for the development of a unique personality in close and continuous relation with the external environment (Sherwood et al., 2008; Tost et al., 2015). However, due to Cartesian dualism (Thibaut, 2018), which still significantly hovers over civil and medical-scientific societies, there continues to be a resistance to attributing an organic substrate to personality, behaviours and emotions.

Deep down, there is a generalised misunderstanding and refusal to tacitly assume that human beings are (in the sense of Being, of Existing) brains. Our personality and, therefore, the way we act, react and get emotional is the result of the functioning of this organ. This does not mean that external factors do not influence us. What makes the brain idiosyncratically complex and distinct is that its development is affected by social experiences (Riccelli et al., 2017). For example, a hepatocyte will not be directly compromised if children experience frequent and violent arguments between their parents throughout their growth. However, depending on the individual's greater or lesser genetic resilience, neuronal development may be more or less affected, conditioning the development of a personality with greater or lesser weaknesses (Fairchild et al., 2016). That is why a healthy social and family environment is so crucial for the balanced growth of a human being, minimising the probability of suffering from a psychiatric illness (Wille et al., 2008). We die when the brain dies precisely because our personality (our Self) disappears forever. This misunderstanding of the brain as the substrate of our Being and of our ability to, through reflective thinking, extrapolate the most diverse theories and ethical-philosophical, esoteric and mystical considerations can make it difficult to understand that there is no appreciation of what is morally acceptable outside the inner space of the person. Morality is an internal ethical judgment that stems from the individual's relation with everything and everyone around them and seeks to guide human action towards harmony within diversity. Empathy, in turn, according to the conceptual model that we will present next, is an essential process for determining this morality.

b) Conceptual model of empathy and its relation with morality

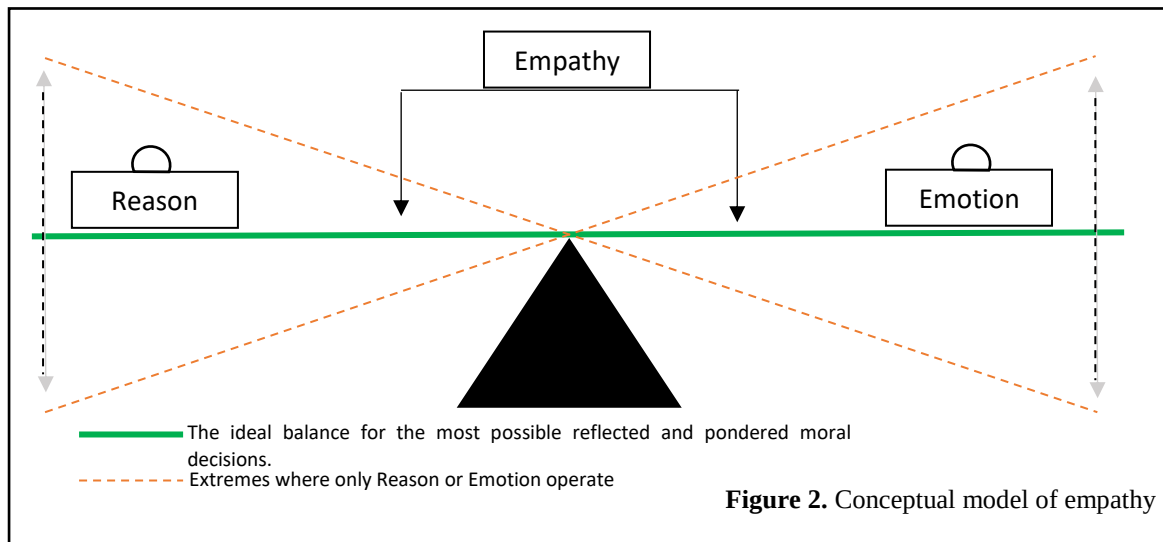
The core problem in approaching empathy is often understanding it as an exclusively or predominantly emotional process, subjective and unable, at least in some

circumstances, to contribute to the best possible moral decision. In the clinical context of the therapeutic alliance between a doctor and a patient, Jaspers (2000) alludes to empathy as putting ourselves in others' shoes and understanding their experiences through a comparison with ours. According to this notion, empathy is a process that simultaneously uses emotional and cognitive competencies in the relational context. Thus, the potential uniqueness of empathy arises from a parallel, synchronous and harmonious interaction between superior cognitive aptitudes and a unique and complex affective ability. A dog, for example, may feel and react to the owner's sadness (sympathy $\neq$ empathy), but it will not be able to put itself in the owner's shoes, understand the reasons for his sadness and conclude that if it were going through the same, it would feel the same way. A psychopath with total affective coldness, on the other hand, may retain the ability to put himself in someone else's shoes, but he will not feel or value the other emotional state.

Given the integrative and networked functioning of the human brain, the classic division between Reason and Emotion is artificial, particularly when we consider the concept of empathy, where the presence and integrity of both (and the systems that regulate them) seem necessary. Emotion without Reason is a primary and potentially instinctive affective expression. Reason without Emotion is a superior cognitive aptitude devoid of the ability to feel and value other people's emotional states. In these two situations, it may not be possible to establish a balanced moral judgment, such as determining whether killing an innocent person to satisfy a basic need such as hunger (in the circumstances of a total absence of other food resources) will be morally acceptable. Without the ability of Reason, food deprivation will induce discomfort and despair of such intensity that it will inevitably incite to kill. On the other hand, without the affective-emotional capacity, Reason will prevail over Emotion, and logic will determine that one kills the other to survive.

Therefore, we understand empathy has been wrongly defined as an exclusively or predominantly emotional mechanism or artificially divided into subtypes (e.g., emotional, cognitive). These conceptualisations have generated great confusion about determining its relevance to morality. Hence, we propose a concept of empathy to clarify its importance for moral decisions. We affirm that empathy is neither an emotion nor a cognition, nor is it divided into subtypes. There is no support in the brain studies analysed for this subdivision, nor can it be said that a brain area is related explicitly to empathy (Decety, 2010; Yoder and Decety, 2017; Ferrari, 2014). Consequently, we define

empathy as a unique and distinct human neuropsychological capacity dependent on the proper functioning of several brain areas, which balances the scales of Emotion and Reason, allowing moral decisions to be as reflected and pondered as possible in the most diverse circumstances and contexts. (Figure 2.).



There is an ideal stage where empathy promotes a perfect balance between Reason and Emotion, giving rise to the most thoughtful and pondered moral decision possible (green line in Figure 2.) and the extremes (red dashed in Figure 2.) where no empathy occurs. A dramatic oscillation between Reason and Emotion instigates an absolute domination of one over the other and a volatile and uncertain moral judgment and decision. In these extremes, the individual's specific situation and personality determine the predominance of one dimension (Reason or Emotion) over the other. Thereby, for example, a psychopath completely lacking in empathy makes overly rational or emotional moral decisions depending on the circumstance. He may have the brutal coldness of premeditated and planned murder of a group of individuals for his financial gain or the impulsiveness of being suddenly violent with someone in his sphere that insults his "honour". Between the ideal (green line in Figure 2.) and the extremes (dashed red lines in Figure 2), there is a whole empathic spectrum (dashed blue arrows in Figure 2.) that contributes to more or less thoughtful moral decisions. It is important to emphasise that the ideal does not mean immaculate moral answers that do not leave doubts or ethical anxiety, but the empathic ability to balance Reason and Emotion as best as possible to reach a moral solution to the concrete problem with which one is faced. There are many potentially irresolvable ethical dilemmas, that is, without unquestionable and universal

moral answers. Therefore, any decision can include morally acceptable and unacceptable aspects.

In one of the final scenes of the 1993 film “The Good Son”, a mother (Susan) is faced with the dilemma of having to choose between saving the life of her 12-year-old firstborn son Henry (who she knows has been responsible for the death of her youngest son) and that of her nephew Mark of the same age. Susan chooses to save her nephew. This situation perfectly illustrates how an answer to a dilemma can leave residual ethical anguish and permanent questioning from then on about its lawfulness. Would the mother make the same decision if she could go back? Here, we argue that Susan's decision (despite being far from perfect and unquestionable) resulted from a process of balance between Reason and Emotion promoted by empathy. Under the domination of the extremes of Figure 2, it would be expected that Reason would lead her to choose her nephew (an innocent child of good character) and Emotion her son (a merciless murderer). This film also raises another important issue. Although more and more, especially in the Western world, a primacy of the beautiful over the ugly is being nurtured (hiding aversive realities such as cruelty), the truth is that human nature is dichotomous. That is, it oscillates between innate evil and goodness. Without disregarding the noticeable positive and negative effects that the environment can have on the development of our character, the truth is that genetics can overcome the environment. The tender and stable environment where Henry grew up failed to model his mischievous temper. Mark, on the other hand, despite dealing with difficult times (like the death of his mother), had a docile and harmonious personality with excellent coping resources.

Our model responds to moral judgments in interpersonal relations and includes a solution to the dimension of the concept of “Einfühlung”, from which the word empathy emerged (Ganczarek et al., 2018). In other words, empathy is also essential for moral decisions where non-humans are involved. Before a lost inanimate object (e.g., a painting, a watch) or a pet, if endowed with empathy, an individual will be able to assess whether stealing it is morally lawful. Empathy's induced balance between Reason and Emotion will evaluate whether the action is morally wrong in itself (e.g., even if no negative consequences are apparent, perhaps it would be better, in such a circumstance, to take the watch to a lost and found and only keep it if no one claims it) or because it will undoubtedly damage (emotionally or financially) someone else. At the extremes (without

empathy), once again, the decision will be volatile and may not be the most appropriate. We are entirely left to the chance of the moment.

In summary, our model defines Empathy as a distinct human neuropsychological capacity that seeks to balance Reason and Emotion to allow the most thoughtful and pondered moral decisions possible. At the same time, it recognises that, in many circumstances, immaculate moral judgments do not exist. As with any other domain, we are born with an empathic potential that can be more or less developed in a close and continuous inter-influence between genetics and the environment.

Empathy allows us to calibrate our judgements and decisions in clinical contexts (e.g., palliative care), making them as secular as possible, scientifically centred and adapted to the patient's needs. It promotes respect for others' beliefs and choices. Before a dying patient, for example, a doctor with high empathic skills can put personal beliefs aside and act according to the patient and family's wishes and autonomy.

c) Critical reflection

Analysing the articles selected for this scoping review allowed us to verify that the approach to the relation between empathy and morality has had several limitations.

First, there is always a significant variability of the concept, which undermines, from the outset, the clairvoyance of the discussion between the defenders and opponents of empathy as a fundamental element of morality. One side's arguments are debated and refuted by the other with personally biased notions, often with overlapping ideas or poor differential delimitation. This debate could contribute to an eventual progressive refinement of the concept. However, the discussion is already ancient, so it would be expected that a consensus on what empathy is already existed. When one decides to test whether a variable exerts a relevant influence on another, it is convenient that, from the outset, there is a clear conceptualisation of the variables involved. Even those endowed with subjectivity are often conceptually well-defined. For example, no one doubts what sadness is, although we can interpret its intensity and, ultimately, its putative presence in another person with variable degrees. Thus, when we seek to determine whether or not empathy is relevant to morality and to compare arguments and studies, it would be helpful to have a consensus on its definition first.

Second, although several selected studies and opinion articles consider empathy a vital element of morality, none assumes it is necessary in all circumstances. In addition, they approach it only from a relational perspective between human beings, not considering objects, animals or nature.

Third, the allusion that empathy does not serve morality because it biases moral decisions based on personal proximity (Pascal, 2017; Martineau et al., 2019; Decety and Cowell, 2015; Fowler et al., 2021; Redford and Ratliff, 2017) is fallacious and results from its improper definition and confusion with the concept of sympathy. Understandably, we are more sympathetic to the people with whom we share our personal lives. However, this does not mean that, despite the possible latent pressure to favour these people when making moral decisions, we will do so. As we presented, empathy will precisely seek to mitigate or eliminate this bias, promoting a balance between Reason and Emotion to allow the most thoughtful and pondered moral judgment possible. We sympathise more with our peers, but we can morally consider, through empathy, strangers and loved ones alike.

Finally, despite the topographical conceptualisation that helps us clinically and allows us to understand which areas are most associated with specific functions, the human brain works in an integrated and networked way. Unlike other cells in the body, neurons that perform a specific function can replace neighbouring neurons destroyed, for example, by ischemia that performed a different task. (Wang et al. 2021). Furthermore, the impairment of a particular activity generally attributed to a specific brain area may result from a dysfunction or injury in another brain area (Young, 2014). Therefore, the identification of a specific brain area (such as the ventromedial prefrontal cortex or the dorsomedial prefrontal cortex) as the centre of morality or empathy (Ferrari, 2014b) is reductive, even more so when we consider functions whose complexity necessarily requires the involvement of other areas, such as the limbic, sensory and motor systems. Thus, studies that seek to relate certain brain regions to morality and empathy, mainly using functional neuroimaging assessment of psychopaths, have several conceptual, methodological and phenomenological limitations (Lenzen et al., 2021; Blair, 2007).

6. Conclusion

Empathy is an ancient topic whose definition and procedural conceptualisation have yet to reach a clear-cut consensus. Thus, studying its importance to morality has been challenging, giving rise to various divergent and confused opinions and conclusions. This scoping review revealed that empathy is commonly presented as an exclusively or predominantly emotional process, often conceptually divided into subtypes, associated with certain specific brain areas and referred to as a source of bias in moral decisions. These are artificial findings with poor argumentative and scientific support. Our operational model of empathy responds to several of these limitations.

Empathy is the cross-cultural mainstay of morality. We recognise, for example, that empathy is evolutionarily advantageous for the human species, but not because it allows for partiality in the defense of specific groups or individuals with whom we have closer relations (confusion with sympathy, love, attachment). On the contrary, it contributes to the most impartial and righteous moral decisions possible between various groups and individuals, whether they are more or less close.

Research limitations

Considering the scope and complexity of the subject addressed, some relevant papers may still need to be identified and included. However, we tried to significantly minimise this potential bias with the number of participants in the research, the criteria used, the careful analysis of the texts and the reading of the complementary bibliography.

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The Empathic Genesis of the Right to Euthanasia

Revista Jurídica Portucalense - Scientific Journal Rankings (SJR): Quartile 3 (2023)

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Citation: Fonseca L, Rêgo G, Nunes R. The empathic genesis of the Right to Euthanasia. *Revista Jurídica Portucalense*. Published online December 29, 2023. doi:10.34625/issn.2183-2705(34)2023.ic-06

ABSTRACT: Euthanasia is an ancient theme that, especially since individual autonomy became the health paradigm in contemporary societies, has aroused deep reflections and declared dissensions between socio-ideological quadrants. The relationship between Empathy and Morality has been addressed several times over recent centuries. Studies and opinion articles present disparate conclusions regarding this relation, mainly because a heterogeneous, nebulous and somewhat maladjusted conceptual approach to human nature has prevailed. In this article, we argue that considering diversity as the fundamental axiological axis of a democratic rule of Law, Empathy is essential to respond appropriately to the most diverse circumstances in which an ethical-legal decision is pending, as in Euthanasia.

KEYWORDS: Constitution, empathy, ethics, euthanasia, Law, morality.

RESUMO: A eutanásia é um tema milenar que, sobretudo a partir do momento em que a autonomia individual se tornou o paradigma em saúde nas sociedades contemporâneas, tem despertado reflexões profundas e dissensões declaradas entre diversos quadrantes socioideológicos. Por sua vez, a relação entre a empatia e a moralidade tem sido abordada inúmeras vezes ao longo dos séculos recentes. Os estudos e os artigos de opinião apresentam conclusões díspares relativamente a esta temática, sobretudo porque tem prevalecido uma abordagem conceptual heterogénea, nebulosa e algo desajustada da natureza humana. Neste trabalho defendemos que, no seio do respeito pela diversidade como o eixo axiológico fundamental dos Estados de Direito democráticos, o modelo de empatia apresentado é fundamental para responder de forma adequada às mais diversas circunstâncias em que uma decisão ético-jurídica está pendente, como na eutanásia.

PALAVRAS-CHAVE: Constituição, empatia, ética, eutanásia, Direito, moralidade.

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Introduction

The avoidance that the subject of Death commonly arouses is rather curious. Being the only certainty in Life from which no one can escape, it would be expected that Death would be widely discussed in an open and uncomplicated way in its most diverse aspects and areas of interest, as in Euthanasia. However, more or less strangely, and to a greater or lesser extent, depending on the culture we refer to, it is still a taboo subject about which one tries to talk as little as possible. It is also interesting that the degree of consensus on Death varies according to the context and nature of the discussion. For example, the abolition of the death penalty in Portugal (1867)⁴ enjoyed broad parliamentary agreement and multiple national and international reactions of praise. It was understood that the purpose of a sentence should be to correct the guilty party and not to avenge the victim. Undeniably, penal codes have two primary goals: to prevent misconduct, deter wrongdoing, and punish the offender. However, we must always bear in mind that human nature is dichotomous.

The pure evil of a human being exists; that is, there are "normal" people (without any psychiatric disorder and with comfortable socio-economic conditions) who derive genuine pleasure from gratuitously inflicting suffering on others. On the other hand, the avid and happy perpetrators of criminal atrocities are not all "recoverable". Humanity's history, personal experiences and various professional activities (such as psychiatry, the judiciary or the police) repeatedly reveal some sinister facets. Thus, subjects such as the death penalty or life imprisonment should be thoughtfully and realistically discussed without taboos, with an awareness of the dichotomy of human nature, the irreversibility of the lives taken (and the suffering of loved ones) and the imperiousness of determining the appropriate legal proportionality of a sentence for someone who, without any remorse whatsoever, murders innocent people (once or repeatedly and indiscriminately). Although we do not defend the death penalty (if only because the condemned may be innocent), we mention it in order, on the one hand, to allude to the somewhat outdated justification of dichotomous human nature that was at the basis of its abolition [the "moral correction of the guilty subject"⁵], and, on the other hand, to point out some differences in the way in which Death is interpreted when discussing Euthanasia. Although this is a very different situation, where Death is not a penal consequence but

⁴ FERNANDES, R. (1971), *A Pena de Morte em Portugal*, Lisboa, Ordem dos Advogados.

⁵ GOUVEIA, A. (1863), *Eliminação do salário do carrasco*, Lisboa, Assembleia da República.

is requested by the individual because he suffers from a terminal illness or finds himself in humanly unbearable living conditions, there is no consensus on Euthanasia. Opponents define the practice as a step backwards in civilisation. Amidst primitive and demagogic discussions, confusion has increased over what is really at stake: Is there a right, based on personal ideological or metaphysical beliefs, to force another person, physically incapable of ending their Existence, of living against their will? What will the role of the Law be regarding this?

Empathy: the heart of morality

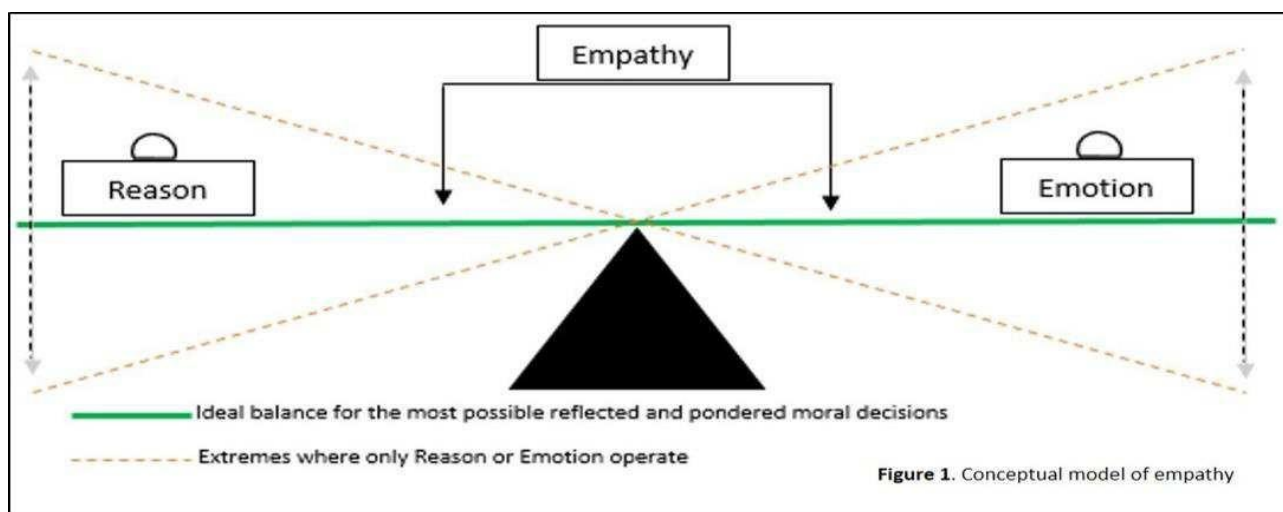
Empathy comes from Edward Titchener's translation (1904) of the German word "Einfühlung".⁶ The concept of "Einfühlung" was developed in German philosophical aesthetics in the late 19th / early 20th century. It refers to individuals projecting onto another body or environment (including inanimate objects) to understand what it is like to be outside of themselves. In the artistic field, considering that works are human artefacts and translate human thoughts, emotions and ideologies, there is a parallel between this "aesthetic" and interpersonal Empathy. In fact, in both, there is the fundamental role of the capacity to take perspective, incorporate the situation of others and integrate their affective effects. There is here an essential dimension of understanding, which, as Jaspers stated, is the way to access the mental states of others.⁷ Through it, we subjectively use what is made available to us and spontaneously reinterpret it, thus perceiving what it is like to be in another one's shoes. According to Jaspers, this so-called "phenomenological observing" is not provided to us by the senses or logical reasoning but instead comes from a direct and immediate understanding of the other's state of mind. Empathy may be more embracing than it is too many times defined. It is commonly limited to an exclusively emotional and interpersonal dimension and divided into various subtypes, thus creating a conceptual and methodological difficulty for an adequate clarification of its meaning and importance for human behaviour in general and for morality in particular. Hence, we consider Empathy erroneously defined as an exclusively or predominantly emotional mechanism and artificially divided into subtypes that seek to identify its alleged components (e.g. emotional, cognitive). We

⁶ GANCZAREK, J., et al. From "Einfühlung" to Empathy: exploring the relationship between aesthetic and interpersonal experience. *Cogn Process*. 2018 May;19(2):141-145.

⁷ JASPERS, K. (1913). *General Psychopathology*. Johns Hopkins. University Press.

argue that it is not an emotion or divided into subtypes.

Moreover, we do not find support for empathy's subtypes in cerebral studies, nor can it be stated that a specific brain area is associated with Empathy.⁸ Therefore, we define Empathy as a neuropsychological capacity that balances the scales on the plates of which are Emotion and Reason, enabling moral decisions to be as reflected and pondered as possible in the most diverse circumstances and contexts (Figure 1).



There is an ideal where Empathy promotes a perfect balance between Reason and Emotion, originating a moral decision that is as reflected and pondered as possible (green line in Figure 1), and the extremes (red dashed line in Figure 1) where without Empathy there is a dramatic oscillation between Reason and Emotion that instigates an absolute dominance of one over the other and a judgment and a decision that is volatile and uncertain as to its morality. In these extremes, what determines the predominance of one dimension over the other is the specific situation individuals are faced with, as well as their personality. So, for example, a psychopath utterly devoid of Empathy makes excessively rational or emotional moral decisions, depending on the circumstance. He may have the brutal coldness to premeditatedly, and in a planned manner, murder several individuals for his financial gain or the impulsiveness to be suddenly violent with someone in his sphere of personal relations who insults his 'honour' [determined by his idiosyncratic moral code]. Between the ideal (green line in Figure 1.) and the extremes

⁸ DECETY, J., COWELL, JM. The complex relation between morality and empathy. Trends Cogn Sci. 2014 Jul; 18(7): 337-9. doi: 10.1016/j.tics.2014.04.008.

(red dashed lines in Figure 1.), there is a whole empathetic spectrum (blue dashed arrows in Figure 1.) that contributes to more or less thoughtful and reflected moral decisions. The ideal does not mean immaculate answers with no ethical doubts or distress but the empathic ability to balance Reason and Emotion as best as possible to arrive at a moral solution to an individual's concrete problem.

There are many potentially irresolvable ethical dilemmas, that is, without unquestionable and universal moral answers. That is why any moral decision may simultaneously include acceptable and unacceptable aspects.

This model of Empathy is not limited to responding to moral judgements within the scope of interpersonal relationships but includes a solution for the dimension of the concept of "Einfühlung" derived from the word Empathy.⁹ Empathy is also essential for moral decisions involving non-humans. Given an inanimate object (e.g. a painting, a watch), if endowed with the Empathy we advocate, an individual will be able, to a greater or lesser degree, to assess whether destroying or stealing it is morally licit. The balance between Reason and Emotion fostered by Empathy will enable one to determine if the action is morally wrong in itself (e.g. even if there are no severe consequences for anyone, perhaps it will be better to take a found object to a lost and found and keep it only if no one claims it) or because it will indeed represent harm (emotional, financial or otherwise) to someone. In the extremes (without Empathy), the decision will be volatile (and may not be the most appropriate - we are left entirely to the moment's chance) as it will be based on excessive rationality or emotionality.

In short, our model understands Empathy as a neuropsychological capacity that seeks to balance Reason and Emotion to make a moral decision as reflected and pondered as possible, recognising that, in many circumstances, there are no immaculate moral judgements. On the other hand, the subject of an ethical decision may be a person, an object, an animal or nature itself. Like any other ability, we are born with an empathic potential, which may be more or less developed in a close and continuous inter-influence between genetics and the environment.

⁹ GANCZAREK, J., et al. From "Einfühlung" to Empathy: exploring the relationship between aesthetic and interpersonal experience. *Cogn Process*. 2018 May;19(2):141-145.

The internal origin of morality

The human brain enables complex and unique functions, including abstract, reflective and philosophical thinking. In addition, it endows humans with the potential to develop a singular personality in a continuous close relation with the external environment.¹⁰

However, due to Cartesian dualism, which still hangs significantly over civil and medical-scientific societies, there is still a specific resistance to attributing an organic substratum to personality, behaviour and emotions.

At the bottom, there is a general lack of understanding and refusal to tacitly assume that human beings are (in the sense of Being, of existing) brains. Our personality and, therefore, the way we act, react and get emotional is a result of the functioning of this organ. This does not mean that social experiences do not influence us. What makes the brain idiosyncratically complex and distinct is that its development is affected by life events.¹¹ For example, a hepatocyte will not see its function or development directly compromised if a child witnesses frequent and violent arguments between parents during their growth. Nevertheless, depending on the individual's genetic resilience, neuronal development may be more or less affected, conditioning the construction of a personality with more or less fragility.¹² That is why a healthy socio-familiar environment during infancy and adolescence is so crucial for later in life, a person to be mentally capable of dealing with the hardships of Life, minimising the probability of the emergence of a psychiatric illness.¹³ We die when there is brain death precisely because it is only then that our personality (our "self") definitively disappears.

The lack of understanding of the brain as the substratum of our Being and our capacity, through reflective thought, to extrapolate the most diverse ethical-philosophical, esoteric and mystical theories and considerations may make it difficult to understand

¹⁰ TOST, H., CHAMPAGNE, F., MEYSER-LINDENGERG, A. Environmental influence in the brain, human welfare and mental health. *Nat Neurosci* 18, 1421–1431 (2015).

¹¹ RICCELLI, R., et al. Surface-based morphometry reveals the neuroanatomical basis of the five- factor model. *Social Cognitive and Affective Neuroscience*; 25 Jan 2016

¹² FAIRCHILD, G., et al. Mapping the brain's structural organisation in conduct disorder: replication of findings in two independent samples. *Journal of Child Psychology and Psychiatry*; 16 June 2016.

¹³ WILLE, N., et al. Risk and protective factors for children's and adolescents' mental health: results of the BELLA study. *Eur Child Adolesc Psychiatry* 17, 133–147 (2008).

that there is no evaluation of what is morally acceptable outside the internal space of the human person. Morality is an internal ethical judgement that stems from the individual's relations with everyone and everything around them, whose ultimate goal is to guide human action toward harmony within diversity. Empathy, in turn, according to the conceptual model previously presented, is an essential process for the determination of this morality.

The Empathy of Justice

Human beings write laws with a regulatory purpose.

They are, in essence, rules with two essential goals: (1) to promote the proper and harmonious functioning of civilisations through a punitive act proportional to the misconduct in question and (2) to prevent (by seeking to deter the individual) behaviour that destabilises the healthy community balance.

The punishments are gradual, that is, hierarchical according to the gravity of the illicit behaviours and based on concepts rooted in the human condition. In this way, acts with more serious consequences are subject to more severe penalties. At the top of the vilification is homicide, the crime usually punished most severely by the penal codes of democratic states.

The objectivity and the proportionality of laws are derived from the human idiosyncrasy of the empathic process, which properly balances Reason and Emotion. The application of faithful Justice is inseparable from the need for the presence of Empathy, which is the basis of the blindness of Justice concerning races, ethnicities, genders, sexual orientations or socio-economic classes.

Recognising Empathy as a fundamental element of judicial reflections is necessary for the courts to refrain from establishing themselves as mere places to ensure compliance with the Law instead of centres for the application of faithful Justice.

The Constitutional View of Euthanasia

Portugal is a State of Law, constitutionally consecrated as secular. This secularity goes beyond the mere spiritual domain. It translates the principle of respect for diversity as the fundamental axiological axis of a democratic society, inclusive and open to the

most varied worldviews. One of the noblest objectives of Democracy is the protection of the most disadvantaged and safeguarding minorities' rights. Therefore, articles 13 and 41 of the Constitution of the Portuguese Republic (CPR)¹⁴ establish that freedom of religion and conscience must be respected in all circumstances, and no one may be subjected to a decision determined by the religious beliefs of others, just as no one may be forced to commit or be subjected to certain acts that conflict with their ethical, moral and religious conscience. On the other hand, no constitutional principle overrides the others, so there may be circumstances in which dilemmas result from the confrontation between two or more articles of the CPR and situations that require an adequate and complex ethical assessment in addition to legal interpretation.

For example, Article 24 of the CPR states that Life is unbreakable. However, should an individual be convicted for killing in self-defence or a war? Or should individuals be forced to stay alive under any circumstances and against their will?

In March 2021, the Constitutional Court¹⁵ declared unconstitutional the draft law of the Assembly of the Republic that proposed to legalise Euthanasia because it violated the principle of determinability. However, it concluded that Article 24 of the Constitution "does not constitute an insurmountable obstacle," and the President of the Court declared that "the right to life cannot be transformed into a duty to live under any circumstances". Now, this pronouncement follows from the analysis arising from the unique empathic capacity of the human being. Without it, article, 24 would be interpreted literally and unanimously, closing the door to Euthanasia in all circumstances.

Later, in November of the same year, the President of the Republic vetoed the reformulated Law.¹⁶ The reasons invoked were formal (related to incomprehensible poor drafting by the deputies!) and practical. Regarding the latter, it can be read in item 12: "For the decision I took, I did not consider any personal religious, ethical, moral, philosophical or political position...but only...the judgement I make about what I consider to be the dominant evaluative feeling in Portuguese society". Firstly, it is complicated, if not impossible, to approach Euthanasia without ethical, moral or philosophical

¹⁴ DECRETO de 10 de abril de 1976. 8ª versão (Lei 1/2005, de 08/12). Constituição da República Portuguesa.

¹⁵ ACÓRDÃO nº 123/2021. Processo nº 173/2021. Tribunal Constitucional Português.

¹⁶ CARTA enviada ao Presidente da Assembleia da República: "Palácio de Belém, 29 de novembro de 2021. https://www.presidencia.pt/media/uhjckew3/carta_ar_20211129.pdf

judgements. That would be to contradict and deny the evaluative demand that the nature of the problem evokes since there are no judgements of this nature dissociated from Empathy and the internal, intimate morality of each human being. Secondly, if, on the one hand, without a referendum, we are not sure that the position against Euthanasia is the evaluative feeling of Portuguese society, on the other hand, even if it was, a majority position on matters of individual conscience and self-determination should not, in a democracy, be imposed on minorities who legitimately think otherwise. Consequently, when a specific incurable clinical condition, whose suffering cannot be mitigated by science, itself violates Article 24 of the CPR and gives rise to an insidious and painful process of Death, irreversibly desecrating the moral and physical integrity of the individual (no. 1 of article 25 of the CPR) and subjecting them to a kind of permanent torture (no. 2 of article 25 of the CPR), what should we (Society/State) do?

When a person in these conditions, lucid, conscious and unable to "take matters into his/her own hands", calls for someone to do so, what should the response be? Should we comfort them with words that do not comfort them? To beckon them with a non-existent or unattainable purpose? To ignore them?

The right of self-determined individuals to decide about themselves is constitutionally enshrined. The Law allows a patient to refuse treatment with curative potential, guaranteeing that the right of access to all available and appropriate palliative treatment, if so desired by the patient, is not jeopardised. It also ensures the right to choose not to be subjected to resuscitation manoeuvres or that legal representatives turn off the life support machines of family members in certain clinical conditions.

Articles 13 and 41 of the CPR state that freedom of religion and conscience must be respected in all circumstances, and therefore, no one can be subjected to a decision determined by the religious beliefs of others, just as no one can be forced to commit or be subjected to certain acts that conflict with their ethical, moral and religious conscience.

Article 64 of the CPR states that "everyone has the right to the protection of health and the duty to defend and promote it". However, an incurable disease can irreparably debilitate individuals to such an extent that it becomes impossible to defend or protect their health, leaving only (and this is no small thing, on the contrary) to try to safeguard their human dignity.

Finally, who is and what is the State's duty? Is the State a merely abstract entity, or are they real people? Firstly, it is important to mention that States under the Rule of Law are not watertight. They show a constant dynamism arising from cultures and temporal epochs, reflecting them. Secondly, it seems unequivocal that the State is the people, represented in the functions that fall to each one, in bodies such as the Assembly of the Republic, the Government or the Presidency of the Republic.

Within the democratic rules, we all must assume the reality and give a response to the people in the extreme situations described here. Ignoring the irreversibility of suffering and the resulting despoliation of human dignity will never be a solution. Of course, the complexity and seriousness of the subject require that the discussion is not held hostage to dogmatic worldviews of any kind and be socially broadened, varied, enlightened and mature. Everyone has the duty and the right to express their opinion. However, even after all the debate, there will still be a reality to which an explicit solution must be given.

Assuming the impossibility of immortality and the curative and palliative limits of science, should a law not be made available to citizens which, while respecting constitutional principles and the human rights of all, gives a concrete answer to the problem, avoiding undue and arbitrary practices? Euthanasia (a Greek word made up of "I" (good) and "*Thanatos*" (Death)), in the conditions described here, is a barbarity or the ultimate act of Humanity?

Finally, it is of the utmost importance to emphasize that under no circumstances should the investment in palliative care be neglected. Several countries (e.g. Belgium and the Netherlands) where Euthanasia is decriminalised have the most developed palliative care in the world.¹⁷

Locked-in syndrome: Empathy and self-determination

Locked-in syndrome¹⁸ meets particular conditions for the debate on the legitimacy of Euthanasia. It is a rare neurological disorder in which there is paralysis of all voluntary muscles. There are three forms: pure, in which the patient loses control of

¹⁷ WOITHA, K., et al. "Ranking of Palliative Care Development in the Countries of the European Union." *Journal of pain and symptom management* vol. 52,3 (2016): 370-7.

¹⁸ SAHOO, S., PEARL, PL. *Locked-In Syndrome*. NORD Guide to Rare Disorders. Lippincott Williams & Wilkins. Philadelphia, PA. 2003:554

all body movements, except blinking; incomplete when movements other than blinking are preserved; and total, where there is a complete loss of motor function. Patients with this disease are bedridden and utterly dependent on others. However, their cognitive function is unaffected, so they are alert and aware of everything around them. They hear, see, have a preserved sleep-wake cycle and understand the people who speak to them. This condition is often described in the literature as "the closest thing to being buried alive". The prognosis depends on the cause and form of the disease, as well as the degree of support and care patients receive. Recent studies show that some patients report living a happy and meaningful life, especially when they have appropriate social services and technology to improve their adaptability to their circumstances. They can live, with proper care, for 10 to 20 years.

The question that Locked-in Syndrome raises within the discussion on Euthanasia is the following: Is it ethically and legally legitimate to oblige someone in these circumstances, without the possibility of ending their own Life, to remain alive when they request Euthanasia (or if this is not possible, have expressed this wish in an advance directive)?

The Health Professional as Euthanasia "Performer"

It is argued that the participation of health professionals in Euthanasia is not admissible because, for example, in the case of doctors, it contravenes the Hippocrates' ethical code of the profession. In this regard, three points seem essential for reflection.

Firstly, the historical context in which Hippocrates drew up the oath as the basis for Western medical ethics was extraordinary. In ancient Greece, murders by poisoning were commonplace, and the practice of Euthanasia was generally well accepted by doctors and society. Thus, several translators of Hippocrates' text seem to agree that what he intended to avoid was that a doctor could be instrumentalised as a vehicle to murder someone by using his privileged relationship of trust with a patient.¹⁹

Second, there are no immaculate and temporally and culturally static ethical judgments. Ethics, as a science, must accompany the inevitable human evolution in all fields (e.g. technological, social, scientific) and contribute to an adequate and secular

¹⁹ VAN HOOFF, A. "Ancient euthanasia: 'good death' and the doctor in the graeco-Roman world." *Social science & medicine* (1982) vol. 58,5 (2004): 975-85.

moral reflection. An excellent example is the shift from medical paternalism to complete patients' autonomy in the post-World War II period.

Finally, ethical-deontological orientations should consider Empathy as a fundamental instrument of moral deliberation, assume morality as an internal human judgement and consider the profound scientific and social transformations that occur continuously and the cultural plurality of contemporary societies. Making room for various worldviews and respecting the individuals' self-determination should be the axiological framework of a secular and reliable ethics.

Gonçalves found that 37% of oncology physicians would be willing to practice Euthanasia.²⁰ This clearly shows that this issue deals with deeply personal reflections and convictions and is averse to any unanimity, even in the universe of the medical class.

Conclusion

Ethics and Law do not always go "hand in hand" and sometimes present strange dissonances. Nonetheless, the decision of the Portuguese Constitutional Court to admit, within the scope of the evaluation of the euthanasia bill, that article 24 of the CPR, which consecrates the inviolability of human Life, is not an insurmountable obstacle, alludes to an essential premise that should be transversal to both disciplines. There are no absolute principles or norms. That is why, in Law too, Empathy, as we have presented it here, is fundamental for legislative drafting congruent with the vicissitudes of human nature and a contextually sober, serious and ethical application of the laws. Justice is incompatible with judgements based on feelings, prejudices or conflicts of interest arising from undue proximity to the accused or the magistrate's sympathies with similar situations that they have experienced.

However, without the lucidity and secularity of Empathy, it is impossible, in matters such as Euthanasia, to legislate or judge properly. If the inviolability of Life were interpreted literally and took precedence over other constitutional norms and ethical principles, not even someone who had killed in self-defence could be judicially acquitted. Respect for diversity is the fundamental moral aggregating axis of Law in the constitutional protection of liberties that, in a democracy, the discipline must confer secularly on every citizen.

²⁰ GONÇALVES, F. Attitudes toward assisted Death amongst Portuguese oncologists. *Support Care Cancer*, v. 18, p. 359-366, 2010.

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Cross-Cultural Adaptation and Validation of An Attitude About Euthanasia Scale in Portuguese Older Adults with Mixed Anxiety-Depressive Disorder

Healthcare: Journal Citation Report (JCR): Quartile 2 (2022)

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Citation: Fonseca L, Castro L, Gonçalves A, Monteleone F, Rêgo G, Nunes R. Cross-Cultural Adaptation and Validation of an Attitude about Euthanasia Scale in Portuguese Older Adults with Mixed Anxiety-Depressive Disorder. *Healthcare* (Basel). 2024;12(12):1221. Published 2024 Jun 19. doi:10.3390/healthcare12121221

Abstract: On May 25, 2023, the Portuguese parliament approved the decriminalisation of euthanasia for incurable illnesses. As the experiences of other countries show us, it will be a matter of time before mental disorders are addressed. Studying the phenomenon, particularly in vulnerable groups, in advance is essential for proper law drafting. Therefore, instruments which allow an objective assessment and comparison between groups must be available. This study aims to explore the validation of Faria's Attitude about Euthanasia scale in Portuguese older adults with mixed anxiety-depressive disorder. A sample of 114 older adults with mixed anxiety-depressive disorder collected by convenience in the Psychiatry Department of Senhora da Oliveira Hospital in Portugal was included. The pre-final version of the scale was tested in a small group with good results. The validity of the internal structure was analysed using exploratory factorial analysis. The internal consistency study verified reliability. For construct validity, we assessed the correlation with other validated scales measuring attitudes toward euthanasia, cognitive performance, personality and empathy. The attitude about euthanasia scale showed good internal consistency. One factor was retained in the principal component analysis. Significant correlations verified construct validity. The results support the scale's usefulness and validity. This study makes available a unique instrument to assess the overall tendency of the attitudes towards euthanasia in European-Portuguese, which can be used, for example, to compare Portuguese with Brazilian older adults suffering from the same disorder. Furthermore, the adapted scale paves the way for other cross-cultural translations, adaptations, validations, and comparative analyses.

Keywords: euthanasia; depression; anxiety; psychometrics; scale; older adults

1. Introduction

Euthanasia has been widely discussed and progressively implemented in many countries.^{1,2} Self-determination, which became the health paradigm in Western societies after World War II, is the basis for increasing acceptance.^{3,4,5} Nowadays, the right of an individual to decide whether to do ancillary diagnostic tests or treatments proposed by a doctor supersedes medical authority in almost every circumstance. One of the most known exceptions to this patient's full autonomy occurs in psychiatry when, due to a severe mental disorder, the individual's capacity to make informed decisions and give proper consent is compromised.⁶ However, even here, the possibility of a person refusing treatment through an advanced healthcare directive is debated.⁷ Inclusively, this has been recently considered by the Portuguese parliament in the proposal for the reform of the Mental Health Law currently in effect.⁸

Regarding mental health, euthanasia is not only about whether a patient can make such a request. Many are certainly mentally competent to do so.⁹ However, the quantification of "unbearable" mental suffering is much more complicated than "unbearable" physical suffering^{10,11,12} and too many times, non-pharmacological treatments are not available.¹³ In fact, psychopharmacology is only one of a vast array of psychiatric therapies.¹⁴ However, a psychiatric illness is often considered refractory to treatment after only psychotropic drugs were used.¹⁵ This narrow interpretation of refractory illness is particularly alarming in older adults, who accumulate psychosocial needs and ageing-related health problems.¹⁶ One systematic review of older adults' attitudes towards euthanasia and physician-assisted suicide (PAS) found associations with some psycho and socioeconomic variables. However, it stressed that findings were complex to compare across studies because of the variety of sample characteristics and outcome measures.¹⁷ Hence, as far as euthanasia is concerned, it is imperative to do exhaustive comparative studies involving older adults with the most various psychiatric disorders to evaluate their opinion regarding euthanasia, the main reasons behind it, and the differences (if any) between this population and both healthy and physically sick individuals of other ages. Furthermore, it is essential to conduct timely and thorough evaluations of the mental capacity of older adults when considering decisions related to euthanasia. Finally, assessing whether factors other than poor medication response contribute to a reduced quality of life, lower satisfaction with health, and a specific attitude towards euthanasia must be a priority.

For this extensive and critical research, instruments that allow an objective assessment and comparison between different groups must be available. However, the existing attitude towards euthanasia scales^{18,19,20} present a significant limitation. They focus on specific domains and situations (active vs passive; doctor vs patient decision) and, by not providing an overall opinion of a specific group of individuals about euthanasia, difficult cross-cultural comparisons.²¹

The primary strength of the Attitude About Euthanasia scale (AAEs) developed by Faria²² is to assess the overall tendency of a group of individuals regarding euthanasia and to allow intra and intercultural comparisons. This is why its validation is essential, specifically for vulnerable groups like older adults with mental disorders. In fact, despite several articles addressing euthanasia both in older adults and mental disorders in general^{23,24,25}, a more objective and concise comparative analysis is lacking to fully understand the phenomenon and add information to legalisation processes, which are currently at the centre of the discussion in a growing number of countries.

This study aims to validate AAEs in European-Portuguese older adults with mixed anxiety-depressive disorder (ICD-10).

2. Material and Methods

The AAEs was initially developed for Brazilian-Portuguese speakers.²² This study's cross-cultural adaptation of the original instrument was performed to validate the scale for European-Portuguese speakers. Then, the validation of the adapted version of the scale was pursued using exploratory factor analysis to assess the internal structure; Cronbach's alpha, inter-item correlations and corrected item-total correlations for internal consistency; and correlation with related constructs to address construct validity.

a) Cross-cultural adaptation

Brazilian-Portuguese native speakers developed the AAEs.²² Some guidelines establish recommendations for the cross-cultural adaptation process²⁶, detailing the necessary steps for an adequate translation. However, Portuguese and Brazilian speaking and writing are similar, so no translation was necessary for AAEs. Nevertheless, subtle lexicon and semantic differences exist between Brazilian-Portuguese and European-Portuguese. Thus, the questionnaire was analysed in detail by an expert committee (composed of the authors of this article, all highly proficient in European and Brazilian Portuguese writing and speaking) to assess if some adaptation was needed for application

to Portuguese native speakers. Overall, it was concluded that the Portuguese language of the original scale was closely related to European-Portuguese writing and no significant changes were needed. Slight differences in the verb tenses and lexicon of ten items (Table 1.) were subjected to minor adjustments for an adequate reading and interpretation of the Portuguese population (Table 1.). The expert committee (composed of the authors of this article, specialists in medicine, geriatric psychiatry, bioethics, statistics and economics) reached a consensus about the pre-final version of the scale (see supplementary material, table S1.), which was submitted to a pre-test in 20 older adults (age ≥ 65) selected by convenience. The pre-test revealed an excellent interpretation of all the items. No doubts or objections were raised.

Table 1. ITEMS ADJUSTED TO EUROPEAN-PORTUGUESE WRITING.

Item number	Original items of AAEs	Adjusted items of aAAEs
1	É um absurdo manter uma pessoa com vida vegetativa através de aparelhagem artificial. (<i>It is absurd to maintain a person in a vegetative life through artificial devices.</i>)	É um absurdo manter uma pessoa em vida vegetativa através de aparelhos artificiais. (<i>It is absurd to maintain a person in a vegetative life through artificial devices.</i>)
2	Se existe condição de manter vivo um doente com recursos artificiais, mesmo por tempo indefinido, não se deve praticar a eutanásia. (<i>If there are conditions to keep a patient alive with artificial resources, even for an indefinite time, euthanasia should not be practiced.</i>)	Se existem condições para manter vivo um doente com recursos artificiais, mesmo que por tempo indefinido, não se deve praticar a eutanásia. (<i>If there are conditions to keep a patient alive with artificial resources, even for an indefinite time, euthanasia should not be practiced.</i>)
3	Não hesitaria em abreviar, sem dor ou sofrimento, a vida de um doente reconhecidamente condenado. (<i>I would not hesitate to abbreviate, without pain or suffering, the life of an admittedly condemned patient.</i>)	Não hesitaria em abreviar, sem dor nem sofrimento, a vida de um doente reconhecidamente condenado. (<i>I would not hesitate to abbreviate, without pain or suffering, the life of an admittedly condemned patient.</i>)
7	Não me sentiria culpado permitindo a eutanásia em um de meus familiares que estivesse desenganado e sofrendo terrivelmente. (<i>I would not feel guilty allowing the euthanasia of one of my family members with hopeless and terrible suffering.</i>)	Não me sentiria culpado permitindo a eutanásia de um dos meus familiares que estivesse desenganado e a sofrer terrivelmente. (<i>I would not feel guilty allowing the euthanasia of one of my family members with hopeless and terrible suffering.</i>)
10	Deve-se manter o doente incurável, o tempo necessário, apenas com paliativos em vez de apressar-lhe a morte. (<i>The incurable patient</i>	Deve-se manter o doente incurável, o tempo que for preciso, apenas com paliativos em vez de lhe abreviar a morte. (<i>The incurable patient should be</i>

Table 1. ITEMS ADJUSTED TO EUROPEAN-PORTUGUESE WRITING.

Item number	Original items of AAEs	Adjusted items of aAAEs
	<i>should be maintained, for as long as necessary, only with palliative care instead of abbreviating their death.)</i>	<i>maintained, for as long as necessary, only with palliative care instead of abbreviating their death.)</i>
14	Aquele que pensa saber a hora certa para alguém deixar de viver se julga Todo-Poderoso. <i>(Those who think knowing the right time for someone to stop living think they are Almighty.)</i>	Aquele que pensa saber a hora certa para alguém deixar de viver julga-se Todo-Poderoso. <i>(Those who think knowing the right time for someone to stop living think they are Almighty.)</i>
17	Há certas circunstâncias em que a pessoa tem todo o direito de decidir se quer ou não continuar esperando a morte. <i>(There are certain circumstances in which a person has every right to decide whether to continue waiting for death.)</i>	Há certas circunstâncias em que a pessoa tem todo o direito de decidir se quer ou não continuar à espera da morte. <i>(There are certain circumstances in which a person has every right to decide whether to continue waiting for death.)</i>
24	Quem autoriza a morte de um parente, na verdade, está querendo aliviar sua própria dor. <i>(Those who authorize the death of a relative truly want to alleviate their own pain.)</i>	Quem autoriza a morte de um parente, na verdade, quer aliviar a sua própria dor. <i>(Those who authorize the death of a relative truly want to alleviate their own pain.)</i>
25	Se o desligamento da aparelhagem artificial não resolver, deve ser aplicada uma injeção que adiante a morte do condenado. <i>(If turning off the artificial life support machines does not solve the problem, an injection must be applied to anticipate the death of the condemned patient.)</i>	Se desligar as máquinas de suporte artificial à vida não resolver, deve ser aplicada uma injeção que adiante a morte do condenado. <i>(If turning off the artificial life support machines does not solve the problem, an injection must be applied to anticipate the death of the condemned patient.)</i>
26	O sofrimento do doente incurável faz parte de sua missão na Terra, por isso a eutanásia não deve ser praticada. <i>(The suffering of the incurably ill is part of their mission on Earth, so euthanasia should not be practiced.)</i>	O sofrimento do doente incurável faz parte da sua missão na Terra, por isso a eutanásia não deve ser praticada. <i>(The suffering of the incurably ill is part of their mission on Earth, so euthanasia should not be practiced.)</i>

AAEs: attitude about euthanasia scale; aAAEs: adapted attitude about euthanasia scale.

b) Study design and participants

A questionnaire with a sociodemographic section and a battery of scales was applied to older adults (aged ≥ 65) with mixed anxiety-depression disorder (International Classification of Diseases, 10th Revision) with stable co-morbidities (if present). All patients were medicated with psychotropic drugs, respecting international prescribing guidelines (13th Edition of the Maudsley Prescribing Guidelines in Psychiatry ²⁷).

Patients with depressive and anxiety symptoms secondary to non-psychiatric illness, chronic pain and dementia were omitted.

The study was approved by the Ethics Committee of the Senhora da Oliveira Hospital (SOH), Guimarães, Portugal (ref. 70/2020). The sample was collected in the Psychogeriatric Unit of the Psychiatry Department (PD) between May 7, 2021, and November 30, 2022. Patients who met the inclusion criteria were asked to participate voluntarily and signed an informed consent. In compliance with Portuguese law, the researchers guaranteed the participant's data confidentiality and the right to refuse participation without any consequences.

The PD of SOH has an area of influence of 350,000 inhabitants²⁸ and includes the following services: Outpatient care, Inpatient care, Emergency Service, Daycare Hospital, Liaison Psychiatry, Community Psychiatry, and Psychogeriatric.

The number of patients included (114) aligns with the minimum reported in the literature to ensure the stability of the variance-covariance matrix in factor analysis.²⁹

c) Instruments

Wasserman et al.²⁰ developed a 10-item scale (wATEs) to measure attitudes towards euthanasia, considering six contexts: severe pain, non-recovery, patient's wish, physician's authority, active euthanasia, and passive euthanasia. Participants answer using the Likert scale response categories of 1) strongly disagree, 2) disagree, 3) undecided, 4) agree, and 5) strongly agree. It delineates active and passive euthanasia, no chance for recovery and severe pain, and the patient's autonomy and doctor's authority. Higher scores indicate a more favourable attitude towards euthanasia in the respective domain. The Cronbach's Alpha of the original study was .87.²⁰ The Portuguese version presented good overall internal consistency (Cronbach's Alpha = .90),²⁹ including in two separate domains, "Decision/Will of the Patient" ($\alpha = .94$) and "Decision/Evaluation of the Physician" ($\alpha = .85$) revealing a high internal consistency with values of .94 and .85 respectively.³⁰

The interpersonal reactivity index (IRI) measures empathy and includes four sub-scales: perspective taking, which reflects the tendency to adopt the other's points of view; empathic concern, which measures the ability to experience feelings of compassion and concern for the other; personal discomfort, which assesses feelings of anxiety, apprehension, and discomfort in tense interpersonal contexts; and fantasy which assesses

the person's propensity to place themselves in fictional situations.³¹ Responses to each statement/item of the IRI are given by using a 5-level scale ("Does not describe me well" = 0; "Describes me very well" = 4; 1, 2, 3 for intermediate answers) and the overall quotation results from the average of adding the values of each sub-scale. Higher scores indicate a higher capacity, use or intensity of the respective dimension of empathy. The Cronbach's' alpha of the Portuguese version (perspective taking = .74; empathic concern = .77; personal discomfort = .81; fantasy = .83) was similar to those found with the other versions of IRI.³²

NEO Five-Factor Inventory (NEO-FFI) measures five personality factors (Neuroticism, Extraversion, Openness, Agreeableness, and Conscientiousness), with 12 items for each factor.³³ Each of the items is measured on a Likert-based scale ranging from 0 ("Strongly Disagree") to 4 ("Strongly Agree"). Higher scores in each domain indicate a higher impact of that particular personality trait. The Portuguese version of NEO-FFI revealed good reliability with Cronbach's Alpha values (Conscientiousness=.81, Neuroticism = .81, Extraversion = .75, Agreeableness = .72, and Openness = .71) related to those reported for the original NEO-FFI.³⁴

Mini-mental-state (MMS)^{35,36} and clock-drawing test (CDT)^{37,38} evaluate one's cognitive ability, which is closely related to education level.^{39, 40} In the MMS,^{35,36} Portuguese scores are as follows: possible cognitive decline if MMS ≤ 22 for subjects from 1 to 11 years of education, ≤ 27 for those with 11 years of education, and ≤ 15 for illiterate. The CDT uses a 10-point quantitative system encompassing three major clock components (circle picturing, numbers writing and clock hands drawing). In our study, ten past eleven (11:10) was used as a reference, as recommended by several authors^{41,42} Scores ≤ 6 were considered abnormal.^{37,38,40}

d) Statistical analysis

Analyses were performed using the statistical software SPSS (IBM SPSS Inc.). The categorical variables were described by absolute and relative frequencies, n (%). The quantitative variables presented deviations from the normal distribution and were described by median and interquartile interval, Med [1stQ, 3rdQ]. The normality of quantitative variables was evaluated by visual inspection of the respective histograms. Correlations were calculated using the Spearman correlation coefficient, *r*. Values of *p* ≤ 0.05 were considered significant.

Internal structure, reliability, and construct validity were analysed to validate the aAAEs for Portuguese older adults.

An exploratory factor analysis was performed to assess the scale's internal structure, following the procedure adopted in the original article.²² First, and to assess the suitability of the sample for use in the analysis, both the Keiser-Meyer-Olkin (KMO) measurement and Bartlett's sphericity test were conducted. Then, factor extraction was performed using the principal component analysis method with Varimax (orthogonal) rotation. Kaiser's method (keep factors with eigenvalues greater than 1), the percentage of explained variance higher than 5%, and the interpretation of the scree plot flattening point were considered to decide the number of factors to retain. The results are reported regarding factor loadings for each item and item communalities, the latter describing the proportion of the item's variance explained by the factor(s) retained.⁴³

The scale's reliability was studied through internal consistency, measured by Cronbach's alpha (α),⁴⁴ and McDonald's Omega (ω) coefficients. Cronbach's alpha measures the interrelation between items of a one-dimensional scale or subscale, and values between .7 and .9 are acceptable.^{45,46} Cronbach's alpha relies on a measurement model that assumes that the indicators are essentially tau-equivalent; that is, the relationship between items and the measured construct is assumed to be constant across the items (among other conditions). However, this is often not the case. In fact, it is more of an exception than a rule. Research indicates that alpha tends to estimate reliability less accurately than omega when tau-equivalence is not met. Hence, MacDonalDs' omega has emerged as a recommended alternative and, in this article, both were computed. The mean of the correlations between items should be between .15 and .5 to ensure they assess the same construct and are not redundant (Clark & Watson, 1995). Each item must correlate with the total of the construct (item-total corrected correlation) with values between .3 and .7.⁴⁵ Effects of 'ceiling' or 'floor' are present when more than 15% of respondents reach the theoretical maximum or minimum of the scale, respectively. Therefore, these effects limit the scale's validity and should be verified.⁴⁷

Several studies found a more favourable attitude towards euthanasia in individuals with better empathic skills,^{48,49} higher educational levels^{50,51} and some personality traits,^{17,50,52} like openness to experience and agreeableness. Thus, to test these hypotheses in our sample and to verify the construct validity⁵³ of the aAAEs, correlations were calculated between aAAEs and the IRI,^{31,32} which measures empathy, the NEO-FFI,^{33,34} which assesses the emotional, behavioural and cognitive tendencies of the individuals in

five significant categories of personality traits, and MMS^{35,36} and CDT^{37,38} to evaluate education-related cognitive performance.^{39,40} Furthermore, the correlation with wATEs,²⁰ already validated for the Portuguese population,³⁰ was also tested to verify the equivalence of measures.

Hospital Anxiety and Depression Scale (HADS),^{54,55} MARS Therapy Adherence Scale (TAS)^{56,57} and Barthel index (BI)^{58,59} were also used to assess depression and anxiety, therapeutic adherence and level of independence for daily life activities, respectively.

3. Results

One hundred fourteen patients medicated with antidepressants participated in the study (Table 2). The group consisted mainly of women (76.3%), and the mean age was 73 (average $\pm$ SD, min-max: 73.01 $\pm$ 5.32, 65-91) years old. Most were married (60.5%), and 76.3% of the household included two or more people. 81.6% had four years of schooling or less. Most were catholic (97.4%) and retired (98.2%). Psychometric assessment (Table 3) revealed that most patients presented mild depressive and anxiety symptoms (HADS), normal cognitive performance (as shown by MMS and CDT scores), good therapeutic adherence (MARS) and were fully independent for daily life activities (BI).

All the scales used presented high internal consistency:

- wATEs - $\alpha = .98$, $\omega = .97$; “Patient's Decision/Will”: $\alpha = .97$, $\omega = .97$; “Doctor's Decision/Evaluation”: $\alpha = .98$, $\omega = .98$.
- IRI - perspective taking $\alpha = .94$, $\omega = .94$; empathic concern: $\alpha = .84$, $\omega = .85$; personal discomfort: $\alpha = .92$, $\omega = .91$; fantasy: $\alpha = .89$, $\omega = .90$.
- NEO-FFI - Conscientiousness: $\alpha = .84$, $\omega = .84$; Neuroticism: $\alpha = .93$, $\omega = .93$; Extraversion: $\alpha = .86$, $\omega = .87$; Agreeableness: $\alpha = .62$, $\omega = .64$; Openness: $\alpha = .86$, $\omega = .88$.

Significant and positive correlations were found between Schooling/ MMS and Schooling/ CDT [Schooling/MMS: $r(112) = .48$ ($p < 0.001$); Schooling/CDT: $r(112) = .56$ ($p < 0.001$)], which is in line with previous findings that cognitive abilities are closely related to educational level.

Table 2. SOCIODEMOGRAPHIC DESCRIPTIVE ANALYSIS (N=114).

Variable	Descriptive	
Gender, n (%)	Woman	87 (76.3)
	Man	27 (23.7)
Age(years), average $\pm$ SD, min-max		73.01 $\pm$ 5.32, 65-91
Schooling years, n (%)	0	7 (6.1)
	1	2 (1.8)
	2	1 (0.9)
	3	13 (11.4)
	4	70 (61.4)
	6	5 (4.4)
	7	1 (0.9)
	8	1 (0.9)
	9	3 (2.6)
	11	2 (1.8)
	12	4 (3.5)
	15	2 (1.8)
	16	1 (0.9)
	17	2 (1.8)
Grouped schooling (for MMS), n(%)	illiterate (0 years)	7 (6.1)
	1 to 11 years	98 (86)
	>11 years	9 (7.9)
Civil status, n (%)	Married	69 (60.5)
	Divorced	12 (10.5)
	Single	7 (6.1)
	Widow	26 (22.8)
Religion, n (%)	Catholic	111 (97.4)
	Jehovah witness	2 (1.8)
	Agnostic	1 (0.9)
Profession, n (%)	Self-employed	1 (0.9)
	Manager	1 (0.9)
	Retired	112 (98.2)
Household size, n (%)	1	27 (23.7)
	2	51 (44.7)
	3	25 (21.9)
	4	7 (6.1)
	5	2 (1.8)
	6	1 (0.9)
	11	1 (0.9)

MMS: mini-mental-state.

Table 3. DESCRIPTIVE ANALYSIS of the SCALES (N=114).

Scales and subscales	Descriptive
HADS Depression, med (IQI), min-max	9 (6; 10), 0 -15
HADS Depression, n(%)	
0 a 7 - asymptomatic	34 (29.8)
8 a 10 – mild depression	67 (58.8)
11 a 14 – moderate depression	11 (9.6)
15 a 21 – severe depression	2 (1.8)
HADS anxiety, med (IQI), min-max	8 (5; 10), 1 -19
HADS anxiety, n(%)	
0 a 7 - asymptomatic	35 (30.7)
8 a 10 – mild anxiety	54 (47.4)
11 a 14 – moderate anxiety	22 (19.3)
15 a 21 – severe anxiety	3 (2.6)
MMS, med (IQI), min-max	28 (26; 29), 11 -30
MMS (without cognitive deficit), n(%)	109 (95.6)
MMS (with cognitive deficit:), n(%)	
illiterate ≤ 15	1 (0.9)
1 to 11 years of schooling ≤ 22	4 (3.5)
Schooling years higher than 11 ≤ 27	0 (0)
CDT, med (IQI), min-max	9 (7; 9.5), 1 -10
CDT, n(%)	
Normal (>6)	89 (78.1)
Cognitive deficit (≤6)	25 (21.9)
MARS, med (IQI), min-max	9 (7; 9), 0 -10
MARS, n(%)	
No adherence: < 4	1 (0.9)
Partial adherence: 4 a 7	28 (24.6)
Good adherence: > 7	85 (74.6)
BI, med (IQI), min-max	100 (100; 100), 70 -
BI, n(%)	100
0-20: total dependence	0 (0)
21-60: severe dependence	0 (0)
61-90: moderate dependence	6 (5.3)
91-99: very mild dependence	10 (8.8)
100: full independence	98 (86)

SD-standard deviation; min-minimum; max-maximum; med-median; IQI – interquartile interval [1stQ; 3rdQ]; HADS: hospital anxiety and depression scale; MMS: mini-mental-state; CDT: clock drawing test; MARS: medication adherence rating scale; BI: Barthel index.

4. Validation of aAAEs

a) Validation of the internal structure

Data revealed good adequacy to a factorial analysis through the measure KMO=0.96, having rejected the hypothesis of correlation matrix equal to identity by Bartlett's test of sphericity (df=325; p<.001).

After extracting the factors, it was found that only two resulted in an eigenvalue greater than 1. The first factor alone explains about 72% of the total data variability, and the second explains 4.5%. Since the second factor accounted for less than 5% of the explained variance, retaining only the first factor is appropriate. The visual analysis of the scree plot corroborates this. As two of the three criteria support the retention of only one factor, we propose this factorisation (Table 4). The commonalities for the 26 observed variables ranged from .47 to .89, with a mean value of .72. The variable with the highest commonality was Item 19 (.89), which suggests it is a strong indicator of the construct being measured. The variable with the lowest communality was Item 1 (.48), which may suggest that it is less strongly related to the underlying factor. However, all commonalities were within an acceptable range and provided evidence of good measurement quality for the observed variables.

Table 4. FACTOR LOADINGS of the 26 ITEMS of the ADAPTED ATTITUDE ABOUT EUTHANASIA SCALE (aAAEs) in the ONE-FACTOR SOLUTION EXTRACTED by the PRINCIPAL COMPONENTS' METHOD (N=114).

aAAEs Item	Factor Loading
1. É um absurdo manter uma pessoa em vida vegetativa através de aparelhos artificiais. (<i>It is absurd to maintain a person in a vegetative life through artificial devices.</i>)	.69
2. Se existem condições para manter vivo um doente com recursos artificiais, mesmo que por tempo indefinido, não se deve praticar a eutanásia. (<i>If there are conditions to keep a patient alive with artificial resources, even for an indefinite time, euthanasia should not be practiced.</i>)	.85
3. Não hesitaria em abreviar, sem dor nem sofrimento, a vida de um doente reconhecidamente condenado. (<i>I would not hesitate to abbreviate, without pain or suffering, the life of an admittedly condemned patient.</i>)	.73
4. A prática da eutanásia é uma violência camuflada. (<i>The practice of euthanasia is a camouflaged violence.</i>)	.85
5. A eutanásia é um direito do Homem. (<i>Euthanasia is a right of Humankind.</i>)	.88

Table 4. FACTOR LOADINGS of the 26 ITEMS of the ADAPTED ATTITUDE ABOUT EUTHANASIA SCALE (aAAEs) in the ONE-FACTOR SOLUTION EXTRACTED by the PRINCIPAL COMPONENTS' METHOD (N=114).

aAAEs Item	Factor Loading
6. O Homem não deve ter o direito de abreviar a vida de outro, nem para poupá-lo de sofrimentos maiores que o levarão irremediavelmente à morte. <i>(Humankind should not have the right to abbreviate the life of another, not even to spare them from greater suffering that will irremediably lead to death.)</i>	.81
7. Não me sentiria culpado permitindo a eutanásia de um dos meus familiares que estivesse desenganado e a sofrer terrivelmente. <i>(I would not feel guilty allowing the euthanasia of one of my family members with hopeless and terrible suffering.)</i>	.80
8. É cobardia optar pela eutanásia. <i>(It is cowardice to choose euthanasia.)</i>	.80
9. A eutanásia deve ser praticada em situações definidas, simplesmente, por razões humanitárias. <i>(Euthanasia should be practiced in defined situations, simply for humanitarian reasons.)</i>	.86
10. Deve-se manter o doente incurável, o tempo que for preciso, apenas com paliativos em vez de lhe abreviar a morte. <i>(The incurable patient should be maintained, for as long as necessary, only with palliative care instead of abbreviating their death.)</i>	.88
11. Abreviar com a morte os sofrimentos de alguém que se ama é, antes de tudo, um ato de humanidade. <i>(Abbreviating the suffering of someone you love with death is, above all, an act of humanity.)</i>	.93
12. A família que realmente ama o doente nunca autoriza a eutanásia. <i>(The family that really loves the patient never authorizes euthanasia.)</i>	.82
13. Uma legislação especial permitindo a prática a eutanásia seria uma conquista da humanidade. <i>(A special legislation allowing the practice of euthanasia would be an achievement of humanity.)</i>	.90
14. Aquele que pensa saber a hora certa para alguém deixar de viver julga-se Todo-Poderoso. <i>(Those who think knowing the right time for someone to stop living think they are Almighty.)</i>	.82
15. Se o doente não está mais lúcido e a família assumir a decisão, a eutanásia deve ser praticada. <i>(If the patient is no longer lucid and the family assumes the decision, euthanasia should be practiced.)</i>	.84
16. Por motivos vários não deve haver uma legislação especial permitindo a prática da eutanásia. <i>(For various reasons, there should be no special legislation allowing the practice of euthanasia.)</i>	.86

Table 4. FACTOR LOADINGS of the 26 ITEMS of the ADAPTED ATTITUDE ABOUT EUTHANASIA SCALE (aAAEs) in the ONE-FACTOR SOLUTION EXTRACTED by the PRINCIPAL COMPONENTS' METHOD (N=114).

aAAEs Item	Factor Loading
17. Há certas circunstâncias em que a pessoa tem todo o direito de decidir se quer ou não continuar à espera da morte. <i>(There are certain circumstances in which a person has every right to decide whether to continue waiting for death.)</i>	.84
18. O direito de vida e o direito de morte escapam, sob qualquer circunstância, ao âmbito de decisão do Ser Humano. <i>(The right to life and the right to death escape, under any circumstances, the scope of decision of the Human Being.)</i>	.89
19. Ter direito à eutanásia é ter direito a uma morte digna. <i>(Having the right to euthanasia is having the right to a dignified death.)</i>	.94
20. Praticar a eutanásia é matar por amor, mas não deixa de ser assassinato. <i>(Practicing euthanasia is killing for love, but it is still murder.)</i>	.89
21. É um crime manter um ser humano em vida puramente vegetativa. <i>(Keeping a human being in a purely vegetative life is a crime.)</i>	.74
22. A eutanásia não se aplica a nenhum caso, pois cada doente reage de forma diferente a uma mesma doença. <i>(Euthanasia does not apply to any case, as each patient reacts differently to the same disease.)</i>	.90
23. Uma legislação especial permitindo a prática da eutanásia deveria ser ampla, abrangendo o maior número de casos incuráveis e fatais. <i>(Special legislation allowing the practice of euthanasia should be broad, covering the greatest number of incurable and fatal cases.)</i>	.91
24. Quem autoriza a morte de um parente, na verdade, quer aliviar a sua própria dor. <i>(Whoever authorize the death of a relative truly want to alleviate their own pain.)</i>	.75
25. Se desligar as máquinas de suporte artificial à vida não resolver, deve ser aplicada uma injeção que adiante a morte do condenado. <i>(If turning off the artificial life support machines does not solve the problem, an injection must be applied to anticipate the death of the condemned patient.)</i>	.89
26. O sofrimento do doente incurável faz parte da sua missão na Terra, por isso a eutanásia não deve ser praticada. <i>(The suffering of the incurably ill is part of their mission on Earth, so euthanasia should not be practiced.)</i>	.90

Data indicated adequate internal consistency of the aAAEs total scale: a Cronbach's alpha of .98, a MacDonald's omega of 0.98, a mean item-item correlation of

2.7 (ranging from 1.91 to 3.15); corrected item-total correlations between .67 and .94 and no “floor” or “ceiling” effects.

b) Construct validity

The original studies of AAEs focused only on the association between the attitude toward euthanasia and religious beliefs or the attitude towards euthanasia of certain professional groups, specifically doctors and lawyers.⁶⁰ Later studies have found relations between empathic skills,^{48,49} personality^{17,50,52} and educational level^{50,51} and the individuals' attitude towards euthanasia.

In this study, significant positive correlations of aAAEs were found with both dimensions of wATEs - “Patient's Decision/Will” [$r(112) = 0.90$; $p < .001$] and “Doctor's Decision/Evaluation” [$r(112) = .83$; $p < .001$]; the IRI perspective taking [$r(112) = .76$; $p < .001$], empathic concern [$r(112) = .32$; $p < .001$] and fantasy [$r(112) = .38$; $p < .001$] domains, the MMS [$r(112) = .29$; $p = .002$] and CDT [$r(112) = .25$; $p = .007$] and with the NEO-FFI openness to experience [$r(112) = .23$; $p = .013$], agreeableness [$r(112) = .22$; $p = .017$] and conscientiousness [$r(112) = .29$; $p = .002$] domains. Likewise, a significant negative correlation of AAEs was found with the IRI personal discomfort [$r(112) = -.20$; $p = .033$] domain.

These results indicate the instrument's construct validity in this group of patients.

5. Discussion

On May 25, 2023, the Portuguese parliament decriminalised euthanasia.⁶¹ Self-determined adults can request it in a situation of great suffering and with definitive injury of extreme severity or incurable illness (“life-threatening disease”). Furthermore, medically assisted death can only occur by euthanasia when medically assisted suicide is impossible due to the patient's physical incapacity. The law neither lists any diseases nor explicitly excludes psychiatric disorders from euthanasia. Nevertheless, as mentioned earlier, mental disorders present specific problems related to the subjectivity of unbearable suffering and the daily clinical consideration of refractory disease. This is particularly troublesome in older adults, where ageing-related issues, illiteracy and psychosocial frailties are prominent. Several Portuguese older adults with four years of schooling or less have minimal reading or writing skills, with some only knowing how to

sign their name and many unable to perform 'simple' digital tasks like handling a smartphone or texting.⁶² In addition, people lose much of their autonomy when they grow old and fragile, being increasingly inclined or forced to leave decisions to others,⁶³ which may compromise free and informed decisions. Thus, research addressing potential circumstances and factors that might influence attitudes towards euthanasia is of the utmost importance, particularly in older adults. In Portugal, depressive and anxiety disorders appear in the sixth and ninth position, respectively, of the ten top causes of disability-adjusted life years⁶⁴ and the estimated prevalence of anxiety among older adults is 9.6% and depression is 11.8%.⁶⁵ Therefore, we prioritise addressing these disorders, especially when Portugal faces a dramatic demographic winter.⁶⁶ Several studies have been trying to understand how empathy,^{48,49} personality traits,^{17,50,52} education,^{50,51} or loneliness^{51,67,68} affect one's judgment of unbearable suffering and attitudes toward euthanasia. However, the variety of the methodology used and the absence of similar measure' tools hinder the comparison between studies and compromise a better understanding of the phenomenon. AAEs,²² which objectively assesses a group of individuals' opinions regarding euthanasia and allows cross-cultural comparisons, is a psychometric tool that can aid in overcoming those limitations. Its use in comparative analysis will help to clarify differences regarding the attitudes towards euthanasia, allowing for tailored legislation and health and public policies to be implemented. Also, understanding how the overall attitude towards euthanasia relates to psychiatric disorders severity, suicidal ideation, psychosocial factors, personality traits, educational level, and ageing-related issues will contribute to targeted prevention and treatment strategies, enhancing people's autonomy, well-being and quality of life.

The complete form of the original AAEs was validated with eight samples and used in research^{22,69} with highly satisfactory results. In our study, aAAEs proved to be a valid and reliable instrument for evaluating the attitude toward euthanasia in older adults with mixed anxiety-depressive disorder, with a good representation of all items by the single extracted factor (in the unifactorial solution, the commonality varied between 0.47 and 0.89).

Regarding construct validity, statistically significant correlations were found between aAAEs and IRI, some NEO-FFI domains, MMS and CDT, indicating that a more favourable tendency towards euthanasia is associated with higher perspective taking, empathic concern and fantasy capacities, lower personal discomfort, personality traits of openness to experience, agreeableness and conscientiousness and higher education. These

results align with several findings from other studies where the same variables (empathy,^{48,49} personality^{17,50,52} and education^{50,51}) were considered. Furthermore, the significant positive correlation between aAAEs and both dimensions of wATEs, that is, between two different scales that measure the same variable, adds value to construct validity and suggests equivalence of measures.^{43,70}

Our research not only makes cross-culturally adapted and validated AAEs available, allowing for immediate comparisons between Brazilian and Portuguese older adults with a mixed anxiety-depressive disorder, but it also contributes to characterising its factor structure.

Some limitations should be noticed in our study. Firstly, because the participants were selected by convenience (older adult patients of the Psychogeriatric Department), obeying the inclusion criteria, the sample may not be representative of the elderly Portuguese population. Secondly, although the number of participants followed the recommended minimum for such studies,⁷¹ large samples are advised for reducing measurement errors and producing generalisable results for the population. Finally, the consistency of AAEs across time (test-retest reliability) still needs to be explored. This can be particularly interesting in clinical practice when following up with patients. Thus, future works should address its temporal consistency.

Novel strategies, such as Complex Dynamic Systems Theory (CDST), an emerging research approach, can be considered in future studies. It provides formulas for examining non-linear, multifaceted elements, behaviours or phenomena (e.g., euthanasia) and allows the identification of factors that influence them.⁷² In fact, the CDST framework has proven to be appropriate for analysing factors which may be in a state of flux and change with even subtle variations of contexts, as can happen in the attitude towards euthanasia.

6. Conclusions

The AAEs presented good internal consistency and construct validity, and the exploratory factor analysis proposes a one-factor structure of the instrument. Hence, its use in research should be extended to several age groups and diseases. Furthermore, additional transcultural validations should be encouraged. A better understanding of the attitude towards euthanasia in several settings and cultures will allow the implementation of tailored legislation and health strategies.

Table S1. **Supplementary Material: complete pre-final version of Attitude about Euthanasia Scale (Table S1.). ITEMS ADJUSTED to EUROPEAN-PORTUGUESE WRITING**

Item number	Original items of AAEs	Adjusted and final items of the aAAEs
1	É um absurdo manter uma pessoa com vida vegetativa através de aparelhagem artificial. <i>(It is absurd to maintain a person in a vegetative life through artificial devices.)</i>	É um absurdo manter uma pessoa em vida vegetativa através de aparelhos artificiais. <i>(It is absurd to maintain a person in a vegetative life through artificial devices.)</i>
2	Se existe condição de manter vivo um doente com recursos artificiais, mesmo por tempo indefinido, não se deve praticar a eutanásia. <i>(If there are conditions to keep a patient alive with artificial resources, even for an indefinite time, euthanasia should not be practiced.)</i>	Se existem condições para manter vivo um doente com recursos artificiais, mesmo que por tempo indefinido, não se deve praticar a eutanásia. <i>(If there are conditions to keep a patient alive with artificial resources, even for an indefinite time, euthanasia should not be practiced.)</i>
3	Não hesitaria em abreviar, sem dor ou sofrimento, a vida de um doente reconhecidamente condenado. <i>(I would not hesitate to abbreviate, without pain or suffering, the life of an admittedly condemned patient.)</i>	Não hesitaria em abreviar, sem dor nem sofrimento, a vida de um doente reconhecidamente condenado. <i>(I would not hesitate to abbreviate, without pain or suffering, the life of an admittedly condemned patient.)</i>
4	A prática da eutanásia é uma violência camuflada. <i>(The practice of euthanasia is a camouflaged violence.)</i>	A prática da eutanásia é uma violência camuflada. <i>(The practice of euthanasia is a camouflaged violence.)</i>
5	A eutanásia é um direito do Homem. <i>(Euthanasia is a right of Humankind.)</i>	A eutanásia é um direito do Homem. <i>(Euthanasia is a right of Humankind.)</i>
6	O Homem não deve ter o direito de abreviar a vida de outro, nem para poupá-lo de sofrimentos maiores que o levarão irremediavelmente à morte. <i>(Humankind should not have the right to abbreviate the life of another, not even to spare them from greater suffering that will irremediably lead to death.)</i>	O Homem não deve ter o direito de abreviar a vida de outro, nem para poupá-lo de sofrimentos maiores que o levarão irremediavelmente à morte. <i>(Humankind should not have the right to abbreviate the life of another, not even to spare them from greater suffering that will irremediably lead to death.)</i>
7	Não me sentiria culpado permitindo a eutanásia em um de meus familiares que estivesse desenganado e sofrendo terrivelmente. <i>(I would not feel guilty allowing the euthanasia of one of my family members with hopeless and terrible suffering.)</i>	Não me sentiria culpado permitindo a eutanásia de um dos meus familiares que estivesse desenganado e a sofrer terrivelmente. <i>(I would not feel guilty allowing the euthanasia of one of my family members with hopeless and terrible suffering.)</i>
8	É cobardia optar pela eutanásia. <i>(It is cowardice to choose euthanasia.)</i>	É cobardia optar pela eutanásia. <i>(It is cowardice to choose euthanasia.)</i>

Table S1. *Supplementary Material: complete pre-final version of Attitude about Euthanasia Scale (Table S1.). ITEMS ADJUSTED to EUROPEAN-PORTUGUESE WRITING*

Item number	Original items of AAEs	Adjusted and final items of the aAAEs
9	A eutanásia deve ser praticada em situações definidas, simplesmente, por razões humanitárias. (<i>Euthanasia should be practiced in defined situations, simply for humanitarian reasons.</i>)	A eutanásia deve ser praticada em situações definidas, simplesmente, por razões humanitárias. (<i>Euthanasia should be practiced in defined situations, simply for humanitarian reasons.</i>)
10	Deve-se manter o doente incurável, o tempo necessário, apenas com paliativos em vez de apressar-lhe a morte. (<i>The incurable patient should be maintained for as long as necessary, only with palliative care instead of abbreviating their death.</i>)	Deve-se manter o doente incurável, o tempo que for preciso, apenas com paliativos em vez de lhe abreviar a morte. (<i>The incurable patient should be maintained, for as long as necessary, only with palliative care instead of abbreviating their death.</i>)
11	Abreviar com a morte os sofrimentos de alguém que se ama é, antes de tudo, um ato de humanidade. (<i>Abbreviating the suffering of someone you love with death is, above all, an act of humanity.</i>)	Abreviar com a morte os sofrimentos de alguém que se ama é, antes de tudo, um ato de humanidade. (<i>Abbreviating the suffering of someone you love with death is, above all, an act of humanity.</i>)
12	A família que realmente ama o doente nunca autoriza a eutanásia. (<i>The family that really loves the patient never authorizes euthanasia.</i>)	A família que realmente ama o doente nunca autoriza a eutanásia. (<i>The family that really loves the patient never authorizes euthanasia.</i>)
13	Uma legislação especial permitindo a prática a eutanásia seria uma conquista da humanidade. (<i>A special legislation allowing the practice of euthanasia would be an achievement of humanity.</i>)	Uma legislação especial permitindo a prática a eutanásia seria uma conquista da humanidade. (<i>A special legislation allowing the practice of euthanasia would be an achievement of humanity.</i>)
14	Aquele que pensa saber a hora certa para alguém deixar de viver se julga Todo-Poderoso. (<i>Those who think knowing the right time for someone to stop living think they are Almighty.</i>)	Aquele que pensa saber a hora certa para alguém deixar de viver julga-se Todo-Poderoso. (<i>Those who think knowing the right time for someone to stop living think they are Almighty.</i>)
15	Se o doente não está mais lúcido e a família assumir a decisão, a eutanásia deve ser praticada. (<i>If the patient is no longer lucid and the family assumes the decision, euthanasia should be practiced.</i>)	Se o doente não está mais lúcido e a família assumir a decisão, a eutanásia deve ser praticada. (<i>If the patient is no longer lucid and the family assumes the decision, euthanasia should be practiced.</i>)
16	Por motivos vários não deve haver uma legislação especial permitindo a prática da eutanásia. (<i>For various reasons, there should be no special legislation allowing the practice of euthanasia.</i>)	Por motivos vários não deve haver uma legislação especial permitindo a prática da eutanásia. (<i>For various reasons, there should be no special legislation allowing the practice of euthanasia.</i>)
17	Há certas circunstâncias em que a pessoa tem todo o direito de decidir se quer ou não continuar	Há certas circunstâncias em que a pessoa tem todo o direito de decidir se quer ou não continuar à

Table S1. *Supplementary Material: complete pre-final version of Attitude about Euthanasia Scale (Table S1.). ITEMS ADJUSTED to EUROPEAN-PORTUGUESE WRITING*

Item number	Original items of AAEs	Adjusted and final items of the aAAEs
	esperando a morte. <i>(There are certain circumstances in which a person has every right to decide whether to continue waiting for death.)</i>	espera da morte. <i>(There are certain circumstances in which a person has every right to decide whether to continue waiting for death.)</i>
18	O direito de vida e o direito de morte escapam, sob qualquer circunstância, ao âmbito de decisão do Ser Humano. <i>(The right to life and the right to death escape, under any circumstances, the scope of decision of the Human Being.)</i>	O direito de vida e o direito de morte escapam, sob qualquer circunstância, ao âmbito de decisão do Ser Humano. <i>(The right to life and the right to death escape, under any circumstances, the scope of decision of the Human Being.)</i>
19	Ter direito à eutanásia é ter direito a uma morte digna. <i>(Having the right to euthanasia is having the right to a dignified death.)</i>	Ter direito à eutanásia é ter direito a uma morte digna. <i>(Having the right to euthanasia is having the right to a dignified death.)</i>
20	Praticar a eutanásia é matar por amor, mas não deixa de ser assassinato. <i>(Practicing euthanasia is killing for love, but it is still murder.)</i>	Praticar a eutanásia é matar por amor, mas não deixa de ser assassinato. <i>(Practicing euthanasia is killing for love, but it is still murder.)</i>
21	É um crime manter um ser humano em vida puramente vegetativa. <i>(Keeping a human being in a purely vegetative life is a crime.)</i>	É um crime manter um ser humano em vida puramente vegetativa. <i>(Keeping a human being in a purely vegetative life is a crime.)</i>
22	A eutanásia não se aplica a nenhum caso, pois cada doente reage de forma diferente a uma mesma doença. <i>(Euthanasia does not apply to any case, as each patient reacts differently to the same disease.)</i>	A eutanásia não se aplica a nenhum caso, pois cada doente reage de forma diferente a uma mesma doença. <i>(Euthanasia does not apply to any case, as each patient reacts differently to the same disease.)</i>
23	Uma legislação especial permitindo a prática da eutanásia deveria ser ampla, abrangendo o maior número de casos incuráveis e fatais. <i>(Special legislation allowing the practice of euthanasia should be broad, covering the greatest number of incurable and fatal cases.)</i>	Uma legislação especial permitindo a prática da eutanásia deveria ser ampla, abrangendo o maior número de casos incuráveis e fatais. <i>(Special legislation allowing the practice of euthanasia should be broad, covering the greatest number of incurable and fatal cases.)</i>
24	Quem autoriza a morte de um parente, na verdade, está querendo aliviar sua própria dor. <i>(Whoever authorizes the death of a relative truly want to alleviate their own pain.)</i>	Quem autoriza a morte de um parente, na verdade, quer aliviar a sua própria dor. <i>(Whoever authorize the death of a relative truly want to alleviate their own pain.)</i>
25	Se o desligamento da aparelhagem artificial não resolver, deve ser aplicada uma injeção que adiante a morte do condenado. <i>(If turning off the artificial equipment does not solve the problem, an injection</i>	Se desligar as máquinas de suporte artificial à vida não resolver, deve ser aplicada uma injeção que adiante a morte do condenado. <i>(If turning off the artificial life support machines does not solve the</i>

Table S1. *Supplementary Material: complete pre-final version of Attitude about Euthanasia Scale (Table S1.). ITEMS ADJUSTED to EUROPEAN-PORTUGUESE WRITING*

Item number	Original items of AAEs	Adjusted and final items of the aAAEs
	<i>must be applied to anticipate the death of the condemned patient.)</i>	<i>problem, an injection must be applied to anticipate the death of the condemned patient.)</i>
26	O sofrimento do doente incurável faz parte de sua missão na Terra, por isso a eutanásia não deve ser praticada. <i>(The suffering of the incurable patient is part of their mission on Earth, so euthanasia should not be practiced.)</i>	O sofrimento do doente incurável faz parte da sua missão na Terra, por isso a eutanásia não deve ser praticada. <i>(The suffering of the incurably ill is part of their mission on Earth, so euthanasia should not be practiced.)</i>

AAEs: attitude about euthanasia scale; aAAEs: adapted attitude about euthanasia scale

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Multidimensional Study of The Attitude Towards Euthanasia of Older Adults with Mixed Anxiety-Depressive Disorder

Healthcare: Journal Citation Report (JCR): Quartile 2 (2022)

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Citation: Fonseca L, Castro L, Rêgo G, Nunes R. Multidimensional Study of the Attitude towards Euthanasia of Older Adults with Mixed Anxiety-Depressive Disorder. *Healthcare (Basel)*. 2024;12(11):1078. Published 2024 May 24. doi:10.3390/healthcare12111078

Abstract: Introduction: This study aims to verify if elderly patients with mixed anxiety-depressive disorder are more prone to euthanasia and identify factors that interfere with their satisfaction with health and capacity for well-informed decisions. Material and Methods: The study applied a paper questionnaire composed of a sociodemographic section and a battery of scales (to assess depression, anxiety, cognitive performance, suicide risk, therapeutic adhesion, functionality, loneliness, attitude towards euthanasia, decision pattern, personality, empathy and health status) in the Psychogeriatric Unity of Senhora da Oliveira Hospital in Portugal. The sample was collected by convenience to include patients and controls of the same age. Six months later, a reassessment was done. Patients and controls were compared using descriptive statistics and a multiple-regression model. Results: A total of 114 patients and 25 controls were included. Eighty-one point six per cent of patients had four or fewer years of schooling. Contrary to controls, they presented mild depressive and anxiety symptoms, loneliness feelings, worse cognitive performance, a more fragile personality, higher personal distress and a poorer health state. No statistically significant differences were found between controls and patients regarding their attitudes towards euthanasia. Patients more favourable to euthanasia had higher empathic concern, conscientiousness and fantasy and lower personal distress. Discussion and Conclusion: When addressing euthanasia in these patients, it is crucial to ensure they are fully self-determinate and that all the necessary treatment and support are available. It may not be the case when the educational level is low and mild disease persists, significantly affecting their well-being and cognitive performance.

Keywords: depression; anxiety; elderly; euthanasia.

Introduction

Demographic winter is a reality worldwide. By 2050, the number of people aged 60 and older will double, and the number of persons aged 80 years or older is expected to triple.¹ In the European Union (E.U.), according to data from January 2022, older people (aged 65 or over) were around 21.1 % of the total population, with Italy (23.8 %), Portugal (23.7 %), Finland (23.1 %), Greece (22.7 %) and Croatia (22.5 %) being the most aged countries.²

Between 2018 and 2080, according to a central projection scenario, the ageing rate in Portugal will almost double, from 159 to 300 older adults for every 100 young people.³

The demographic turnover will have a tremendous impact on several areas of our societies,⁴ including mental health, as it is known that advanced age represents a risk factor for depression and anxiety in midlife and older adults.⁵ Thereby, it cannot be surprising that mental illness, particularly depressive and anxiety disorders, are not only currently among the top ten leading causes of global burden,⁶ as this is expected to increase. The burden of a disease is calculated using the disability-adjusted life year (DALY). In Portugal, Alzheimer's and other dementias, Depression and Anxiety disorders appear in the fifth, sixth and ninth position, respectively, of the ten top causes of DALY.⁷ The estimated prevalence of anxiety among Portuguese older adults is 9.6%, and depression is 11.8%.⁸ The most common mental health conditions for older adults are depression and anxiety.⁹ Consequently, as ageing becomes more prominent, more older adults will suffer from these disorders.

In addition, the Portuguese elderly present specific frailties that will add to the problem, namely a low educational and literacy level¹⁰ (some only know how to sign their name and many are not able to perform 'simple' digital tasks, like handling a smart-phone or texting) and loneliness. Sixty-eight point five per cent of people aged 65 or over have between 0 and 4 years of schooling¹¹ and the number of people living alone has been increasing, with the number of single-person families consisting of an older adult representing the majority of these families.¹² Low education and illiteracy have been correlated with anxiety and depressive symptoms⁸ and a higher risk of dementia,^{13,14} mainly when years of education reflect cognitive capacity.¹⁵ Also, loneliness has been linked with an increased risk of developing depression,¹⁶ anxiety¹⁷ and dementia.¹⁸ One

study even associated a higher cortical amount of amyloid with loneliness in cognitively normal elderly individuals.¹⁹

Several risk factors for anxiety and depression in older adults have been identified (e.g. personality traits, poor self-perceived health), augmenting the complexity of the demanded treatments.²⁰ Furthermore, there are also specific regional-related differences that increase the probability of suffering from depression and anxiety. Southern European countries (e.g. Portugal, Spain) have more socioeconomic inequality and more late-life depression than Northern European countries (e.g. Denmark, Sweden), and this relationship was not mitigated by more significant individual income.²¹

Thus, considering the negative impact of the demographic winter on the elderly mental health, it is of the utmost importance to discuss and study in advance euthanasia (the act of deliberately ending patients' lives at their explicit request to relieve suffering) in this population, particularly when a growing number of countries are legalising it.²²⁻²⁴ In May 2023, the Portuguese parliament decriminalised euthanasia for people with a fatal disease and unbearable suffering.²⁵

Several studies found that numerous factors relate to attitude towards euthanasia, such as religion,²⁶ empathic skills,^{27,28} personality,^{29,30,31} disease type and severity,^{32,33} loneliness³⁴ and educational level and other psycho and socioeconomic variables.²⁹ Also, suicide risk and euthanasia have been approached, but no relation was found between the two phenomena.³⁵ However, all these findings have been complex to compare across studies because of the variety of sample characteristics and outcome measures.^{29,30} Humans are complex, and several determinants affect their beliefs and decision-making.^{36,37} As such, it is of the utmost importance to do exhaustive comparative studies involving older adults with psychiatric disorders that include objective assessments of several of those determinants, mimicking the best as possible, the complexity of humans' beliefs and decision-making processes when euthanasia is considered.

Herein, we present a multidimensional study of the attitude towards euthanasia of Portuguese elderly with mixed depression and anxiety disorder, a commonly underdiagnosed disease which meets particular characteristics to assess the most frequent psychopathological domains that often coexist in older adults, depression and anxiety³⁸ The aim is to verify if these patients are more prone to euthanasia and identify specific needs and weaknesses that may interfere with their satisfaction with health and capacity for well-informed decisions. If studied and discussed beforehand, tailored euthanasia legislation can be elaborated and targeted prevention and treatment strategies

implemented to increase the well-being and the decision-making capacity of older adults with mental health disorders.

Material and Methods

Inclusion and exclusion criteria

After the proper approval by the Ethics Committee of the SOH (ref. 70/2020), the sample was collected in the consultation of the PU between May 7th, 2021, and November 30th, 2022, to include older patients (aged ≥ 65) diagnosed with mixed anxiety-depression disorder (ICD-10) by the assistant psychiatrist, stable co-morbidities (if present) and medicated in accordance to the presented symptoms and international guidelines (13th Edition of the Maudsley Prescribing Guidelines in Psychiatry). Patients with depressive and anxiety symptoms secondary to non-psychiatric illness, chronic pain and dementia were omitted. Also, mentally healthy controls of the same age with stable co-morbidities (if present) and without any psychopharmacological medication were collected by convenience from the consultation of the PU (where healthy companions of the patients were asked to participate voluntarily) and the community. Six months later, a reassessment using the same instruments was done. During this time, patients continued to be followed as usual in the PU consultation, which is based on a psychopharmacological and psychoeducational approach. Patients and controls were compared using descriptive statistics and a multiple-regression model.

Instruments

This study involved applying a paper questionnaire both in the community and in the Psychogeriatric Unit (PU) of the Psychiatry Department (PD) of Senhora da Oliveira Hospital (SOH) in Portugal. The questionnaire comprised a sociodemographic section and a battery of scales validated for Portuguese. The participants always filled out the questionnaire with a researcher available. If any doubts occurred, they were promptly clarified.

The purpose of the use of the several following instruments was to analyse which of the factors or combination of them most influence the attitudes towards euthanasia of the

participants, given the various determinants that operate in humans' personal beliefs and decision-making processes, as stated previously.

The hospital anxiety and depression scale (HADS) comprises seven questions for anxiety and seven questions for depression, and cut-off scores are available for quantification (8 – 10: mild symptoms; 11 – 14: moderate symptoms; 15 – 21: severe symptoms). Instrument ³⁹ was validated for Portuguese (α : anxiety = .76, depression = .81) ⁴⁰ and revealed a Cronbach's Alpha in our sample of .889 for anxiety and .847 for depression.

UCLA loneliness scale (UCLAs) is a 16-item scale designed to measure one's subjective feelings of loneliness. Participants rate each item as either "I often feel this way", "I sometimes feel this way", "I rarely feel this way", or "I never feel this way". Scores > 32 indicate feelings of loneliness. UCLAs ⁴¹ were validated for Portuguese (α = .905) ⁴². Our sample presents a Cronbach's Alpha of .953.

Treatment adherence was assessed using the Measure Treatment Adherence (MTA) scale. This scale is an instrument composed of seven items that assess an individual's behaviour about the everyday use of medicines. The answers are obtained by an ordinal six-point scale ranging from 'always' (1 point) to 'never' (6 points). The values obtained from the responses to the seven items are added and divided by the number of items. Higher values mean higher levels of adherence. The scale is validated for Portuguese (α = .74) ⁴³ and the Cronbach's Alpha in our sample was .831.

Barthel index (B.I.) is an ordinal scale that measures functional independence in personal care and mobility. ⁴⁴ The 10-item version is the most used. The scoring method considers whether the person receives help while doing each task. The scores for each of the items [0, 5), (0, 5, 10) or (0, 5, 10, 15) depending on the item] are summed to create a total score, with higher scores indicating higher levels of independence. It is validated for Portuguese (α = .622) ⁴⁵. The Cronbach's Alpha in our sample was .622.

Yara's attitude towards euthanasia scale (YATEs) was validated with eight samples and applied in research studies with highly satisfactory results. ⁴⁶⁻⁴⁸ It assesses the overall tendency of a specific group regarding euthanasia and allows comparisons between groups. Scores range from 0 to 104. Higher scores indicate a more favourable attitude towards euthanasia. The sample median divides those with a more favourable attitude from those with a less favourable attitude. It was recently validated for Portuguese (α = .934) ⁴⁹. The Cronbach's Alpha in our sample was .983.

Wasserman's (2005) attitude towards euthanasia scale (WATEs) is a 10-item scale which measures attitudes towards euthanasia, considering different dimensions: severe pain, the impossibility of recovery, patient's request, physician's authority, active euthanasia, and passive euthanasia. The subjects answer to each one using the Likert scale response categories of 1) strongly disagree, 2) disagree, 3) undecided, 4) agree, and 5) strongly agree. The scale's internal consistency in the original study was measured by a Cronbach's Alpha of .87.⁵⁰ The internal consistency of the Portuguese version was good (Cronbach's Alpha = .90).⁵¹ Cronbach's Alpha was also analysed for two dimensions, "Decision/Will of the Patient" and "Decision/Evaluation of the Physician", revealing a high internal consistency with values of .94 and .85, respectively.⁵¹ In our sample, wATEs presented high internal consistency for both the total scale ($\alpha = .98$) and its two dimensions ("Patient's Decision/Will": $\alpha = .97$, and "Doctor's Decision/Evaluation": $\alpha = .98$)

The Melbourne Decision-Making Questionnaire [(MDMQ) was designed to assess how individuals approach decision situations.⁵² It includes five subscales to which the respondent checks "True for me" (score 2), "Sometimes true" (score 1) or "Not true for me" (score 0). Each scale ranges from zero to 10 (procrastination and hypervigilance) or 12 (vigilance, self-esteem and buck-passing). It is validated for Portuguese [α (self-esteem) = .76; α (vigilance) = .747, α (buck passing) = .859, α (hypervigilance) = .782, α (procrastination) = .793]⁵³. In our sample, Cronbach's alpha was .838 for self-esteem, .911 for vigilance, .936 for buck passing, .833 for procrastination and .812 for hypervigilance.

The NEO Five-Factor Inventory (NEO-FFI) concisely measures five personality factors (Neuroticism, Extraversion, Openness, Agreeableness, and Conscientiousness), with 12 items for each factor.⁵⁴ Each of the items is measured on a Likert-based scale ranging from 0 ("Strongly Disagree") to 4 ("Strongly Agree"). Higher scores in each domain indicate a higher impact of that particular personality trait. The Portuguese version of NEO-FFI revealed good reliability with Cronbach's Alpha values (Conscientiousness=.81, Neuroticism = .81, Extraversion = .75, Agreeableness = .72, and Openness = .71) related to the ones reported for the original NEO-FFI in the USA.⁵⁵ In our sample, the Portuguese NEO-FFI also presented high internal consistency in four of its five dimensions: Conscientiousness=.848, Neuroticism = .934, Extraversion = .859, Agreeableness = .618, and Openness = .862.

The interpersonal reactivity index (IRI) is based on a multidimensional view of empathy and comprises four sub-scales: perspective taking, empathic concern, personal discomfort and fantasy.⁵⁶ For each statement/item of the IRI, a person is asked to indicate to what extent that statement applies to self, using a 5-level scale (between "Does not describe me well" and "Describes me very well" using the numbers 0 and 4, respectively, and 1, 2, 3 for intermediate evaluations). The quotation is made by adding these values by sub-scale and averaging them. Higher scores indicate a higher capacity, use, or intensity of the respective component of empathy. The Cronbach's' alpha of the IRI scale in the Portuguese version (perspective taking = .74; empathic concern = .77; personal discomfort = .81; fantasy = .83) was moderate and similar to those found with the other versions of IRI.⁵⁷ In our sample, IRI presented the following Cronbach's' alpha: perspective taking = .936; empathic concern = .838; personal discomfort = .919; fantasy = .870.

Short Form 36 Health Survey Version 2 (SF36v2) is a patient-reported outcome assessment designed to measure patients' quality of life, functional health and well-being across various conditions. It covers eight health domains: physical function, physical role, pain, general health, vitality, social function, emotional role and mental health.⁵⁸ It was validated for Portuguese^{59,60} presenting the following Cronbach's' alpha: α (physical function) = .8731; α (physical role) = .7511; α (pain) = .8441; α (general health) = .8745; α (vitality) = .8264; α (social function) = .6031; α (emotional role) = 0.7104; α (mental health) = 0.6446. In our sample, Cronbach's' alpha were: α (physical function) = .920; α (physical role) = .964; α (pain) = .833; α (general health) = .821; α (vitality) = .859; α (social function) = .844; α (emotional role) = 0.945; α (mental health) = 0.937.

Tool for assessment of suicide risk (TASR) has been designed to be used by clinicians to document a summary of their assessment of a patient who may be suicidal. The TASR is divided into three sections: individual profile, symptom profile and interview profile. The TASR is a 'bedside' tool that helps the clinician determine the 'burden of risk' for suicide.⁶¹ Points are used to provide the clinician with a section weighing suicide risk. Section 1 is assigned a weighing of one point for each item, section 2, two points, and section 3, three points. The greater the number of points, the greater the level of suicide risk. The tool's developers provided no psychometric properties or indication of its validity in assessing suicide risk. Nevertheless, we decided to use it here to have a concrete and brief measure of the suicide risk and to verify if it relates to a specific attitude towards euthanasia.

Mini-mental-state ^{62,63} and clock-drawing test ^{64,65} are two brief tests that assess an individual's cognitive performance and are closely related to one's education level. ⁶³⁶⁶. In our patient's sample, the correlations between Schooling/ Mini-mental-state (MMS) and Schooling/ clock-drawing test (CDT) were significant and positive [Schooling/MMS: $r(112) = .48$ ($p < 0.001$); Schooling/CDT: $r(112) = .56$ ($p < 0.001$)], showing that even slight differences in the years of education can have a significant impact on one's cognitive abilities. In the MMS, Portuguese normative values considered were: possible cognitive decline if MMS ≤ 22 for subjects from 1 to 11 years of education, ≤ 27 for those with 11 years of education, and ≤ 15 for illiterate. The CDT used a 10-point quantitative system encompassing three major clock components. The selected time setting was "11:10", as recommended by several authors. ^{67,68} Scores ≤ 6 were considered abnormal.

Statistical analysis

Analyses were performed using the statistical software package SPSS Statistics (v. 28.0; SPSS ® Inc., Chicago, Illinois, United States) and Jamovi 1.1.9.0 (datalab. CC, Sydney, Australia). The categorical variables were described by absolute and relative frequencies, n (%). The normality of quantitative variables was evaluated by visual inspection of the respective histograms and by the Kolmogorov-Smirnov test. The quantitative variables presented deviations from the normal distribution and were described by median and interquartile interval, Med [1stQ, 3rdQ]. The Chi-Square test was used to compare categorical variables between cases and controls, the Fisher-Freeman-Halton test was employed for categorical variables with more than 2 categories and small expected counts, and the Mann-Whitney U test was utilized to compare non-normally distributed quantitative or ordinal variables between the two groups. Correlations were calculated using the Spearman correlation coefficient, r . Values of $p \leq 0.05$ were considered statistically significant.

A multiple regression analysis was performed in the patient's sample to verify which variables were associated with the attitude towards euthanasia (outcome). First, all the relevant variables were tested in simple linear regression models for the outcome. Then, all variables significant at the $p < 0.2$ level in the simple models were included in an initial multiple model. The final model was obtained by successively eliminating the independent variables with the highest p -value until only variables significant at the 0.05 level remained. The results of linear regressions are presented with non-standardised

coefficient values (B), 95% confidence intervals (95% CI), and p-values. Multiple models were evaluated using the F statistics, p-values, and coefficients of determination (R²). All final models complied with the adequate assumptions: normally distributed residuals (assessed by the Kolmogorov-Smirnov test), no multicollinearity (variance inflation factors <2) and homoscedasticity (absence of patterns in the scatter plot of residuals versus unstandardized predicted values, with a consistent spread along the fitted values).

RESULTS

Descriptive analysis

One hundred and fourteen (114) patients and 25 controls participated in the study at baseline, and ninety patients and seventeen controls six months later. Dropouts were voluntary and for no other reason than not wanting to participate further.

At baseline, patients (P) and controls (C) were of the same age (P-median=72; C-median=7) and most were married (P-60.5%; C-84%), catholic (P-97.4%; C-92%), retired (P-98.2%; C-100%), with a median household of two (P-44.7%; C-68%) and controls had more years of schooling (P-median=4; C-median=6). Seventy-six per cent of patients were female, and 56% of controls were male (Table 1.). Psychometric assessment (Table 2.) showed that both patients and controls had good therapeutic adherence (MAT: patients – med = 5.86; controls – med = 6; p=1) and were independent for daily life activities (BI: patients – med=100; controls -med=100; p=1). In addition, several statistically significant differences between controls and patients were found. Patients revealed mild depressive and anxiety symptoms (HADS - p<0.001), loneliness feelings (UCLALs – p=0.001), worse cognitive performance (MMS/CDT - p<0.001), a more fragile and dysfunctional personality [more neurotic (p<0.001) and less extroverted (p<0.001), open (p<0.008) and conscientious (p=0.017) on NEO-FFI], higher personal distress (IRI personal distress=p<0.001) and worse health state [(worse physical functioning (p<0.001), physical role (p<0.001), general health (p<0.001), vitality (p<0.001), social function (p<0.001), emotional role (p<0.001) and mental health (p<0.001) on SF36-v2]. Patients' reassessment six months later (Table 3.) revealed an improvement in depressive and anxiety symptoms (HADS - p<0.001), better cognitive performance (MMS/CDT - p<0.001), fewer loneliness feelings (UCLALs - p<0.001) and a better physical role (p=0.010), social function (p=0.007), emotional role (p=0.001) and

mental health ($p < 0.001$). However, the differences between controls and patients remained the same, except for conscientiousness (Table 2.).

TABLE 1 CHARACTERISATION OF THE SAMPLE OF PATIENTS (N=114) AND CONTROLS (N=25)

	Patients (n=114)	Controls (n=25)	p-value
Gender, n (%)			0.001^X
Female	87 (76.3)	11 (44)	
Male	27 (23.7)	14 (56)	
Age (years), med [1stQ; 3rdQ], min-max	72 [68.8; 76.3], 65-91	71 [69.5; 75], 66-78	0.520 ^M
Years of school, med [1stQ; 3rdQ], min-max	4 [4; 4], 0-17	6 [4; 13.5], 3-17	<0.001^M
Civil status, n (%)			0.214 ^F
Married	69 (60.5)	21 (84)	
Divorced	12 (10.5)	1 (4)	
Single	7 (6.1)	0 (0)	
Widow	26 (22.8)	3 (12)	
Religion, n (%)			0.112 ^F
Catholic	111 (97.4)	23 (92)	
Jehovah witness	2 (1.8)	0 (0)	
Agnostic	1 (0.9)	2 (8)	
Profession, n (%)			1 ^F
Self-employed	1 (0.9)	0 (0)	
Manager	1 (0.9)	0 (0)	
Retired	112 (98.2)	25 (100)	
Household, med [1stQ; 3rdQ], min-max	2 [2; 3], 1-11	2 [2; 2], 1-5	0.912 ^M
Abbreviations			
med: median; 1 st Q and 3 rd Q: first and third quartile; p-value ^M : Mann-Whitney test's p-value; p-value ^X : Chi-square test's p-value; p-value ^F : Fisher-Freeman-Halton test's p-value; bold: statistically significant p-values ($p < 0.05$).			

TABLE 2. SCALES DESCRIPTIVES OF PATIENTS (N=114) AND CONTROLS (N=25)

Scales	Baseline Patients (n=114)	Controls (n=25)	Mann- Whitney's p-value with Bonferroni correction for multiple testing (33 tests)*	Six months later Patients (n=90)	Controls (n=17)	Mann- Whitney's p-value with Bonferroni correction for multiple testing (33 tests)*
	med (IIQ), min-max	med (IIQ), min-max		med (IIQ), min-max	med (IIQ), min-max	
HADS Depression (8 – 10: mild symptoms)	9 (6; 10), 0 -15	1 (0; 2), 0 -5	<0.001	8 (3; 9), 0 -14	1 (0.5; 2), 0 -3	<0.001
HADS Anxiety (8 – 10: mild symptoms)	8 (5; 10), 1 -19	1 (0.5; 2), 0 -4	<0.001	7 (3; 9), 2 -14	1 (0; 2), 0 -2	<0.001
MMS	28 (26; 29), 11 -30	30 (29; 30), 25 -30	<0.001	28,5 (27; 30), 15 -30	30 (30;30), 28 -30	0.001
CDT	9 (7; 9.5), 1 - 10	10 (9.5; 10), 5 -10	<0.001	9,25 (7,9; 9,5), 1 -10	10 (9,5; 10), 9 -10	0.002
UCLAs	36.5 (20; 46), 16 -64	22 (17; 27.5), 16 -31	0.001	33 (20; 41,3), 16 -60	19 (16.5; 22.5), 16 -25	0.007
MAT	5.86 (5.25; 6), 3.71-6	6 (5.4; 6), 5-6	1	5.86 (5.43; 6), 3.71-6	5.86 (5.57; 6), 5.29-6	1
BI	100 (100; 100), 70 -100	100 (100; 100), 100 -100	1	100 (100; 100), 75 -100	100 (100; 100), 100 -100	1
YATEs	83.5 (51.5; 95.25), 3 -104	52 (30; 80.5), 2 -103	0.288	86 (41; 97,5), 3 -104	55 (23,5; 80,5), 0 -103	0.590
WATEs (patient's decision)	4 (2.75; 4.75), 1 -5	3.25 (2.25; 4), 1 -5	1	4 (2,4; 4,5), 1 - 5	4 (2; 4), 1 -5	1
WATEs (Doctor's decision)	2.75 (1.5; 3.875), 1 -5	2 (1.5; 2.5), 1 - 4	0.612	2,33 (1,7; 3,6), 1 -5	2 (2; 2), 1 -3	1
MDMQ						
Self-esteem (max = 12)	8 (5; 10), 1-12	10 (8; 11), 6- 12	<0.001	8 (5,8; 10), 1 - 12	11 (8;11,5), 6 - 12	0.315
Vigilance (max = 12)	10 (6; 12), 0- 12	12 (10; 12), 2 - 12	1	11 (8; 12), 0 - 12	12 (10; 12), 3 - 12	1
Buck Passing (max = 12)	6 (2; 11), 0-12	3 (1.5; 6), 0 - 12	0.514	5 (2; 10), 0 -12	4 (1; 7), 0 -9	1
Procrastination (max = 10)	3 (1; 6.25), 0- 10	3 (1; 4), 0 -9	1	3 (1; 6), 0 -10	3 (1; 4,5), 0 -9	1
Hypervigilance (max = 10)	6 (3.75; 8), 0- 10	4 (2; 5), 0 -10	0.144	5,5 (3; 8), 0 - 10	4 (3; 5,5), 0 -7	1
NEO-FFI						
Neuroticism	31 (20; 36.25); 2-47	16 (12; 19.5), 4 -28	<0.001	28,5 (18; 34), 4 -41	14 (13; 20), 11 -25	<0.001
Extraversion	19.5 (16; 25.25), 8-44	31 (26; 33), 17 -36	<0.001	20,5 (17; 26), 9 -39	29 (26,5; 33), 20 -36	<0.001
Openness	12 (7; 19), 3- 39	23 (18,5; 27.5), 6 -33	<0.001	14 (10; 19), 3 - 35	23 (18,5; 26,5), 14 -35	<0.001
Agreeableness	33 (30; 35), 18-41	33 (29,5; 36,5), 20 -41	1	32,5 (30; 34), 19 -38	33 (30; 34,5), 24 -36	1
Conscientiousness	33.5 (31; 36), 4-46	36 (34; 39,5), 31 -45	0.016	34 (31; 36), 12 -39	36 (35; 37,5), 28 -41	0.064
IRI						
Perspective Taking	3.17 (2; 3.67), 0,5-4	2.5 (1.5; 3,3), 1 -4	1	3,17 (1,7; 3,8), 0 -4	1,67 (1,17;3,34), 1 - 3,83	1
Empathic Concern	3.33 (2.63; 3.83), 1.3-4	3.2 (2.4; 3.6), 1.5 -4	1	3,42 (2,8; 3,8), 1,7 -4	2,83 (2,50;3,25), 1,67 - 3,83	1
Personal Distress	2.83 (1.83; 3.33), 0-4.2	1.7 (0.8; 2,3), 0 -3	<0.001	2,75 (2; 3,3), 0,5 -4	1,5 (1;2,09), 0,33 - 2,67	<0.001

TABLE 2. SCALES DESCRIPTIVES OF PATIENTS (N=114) AND CONTROLS (N=25)

Scales	Baseline Patients (n=114)	Controls (n=25)	<i>Mann-Whitney's p-value with Bonferroni correction for multiple testing (33 tests)*</i>	Six months later Patients (n=90)	Controls (n=17)	<i>Mann-Whitney's p-value with Bonferroni correction for multiple testing (33 tests)*</i>
	med (IIQ), min-max	med (IIQ), min-max		med (IIQ), min-max	med (IIQ), min-max	
Fantasy	1.5 (0.67; 2.33), 0-3.7	1.7 (1.2; 2.3), 0.3 -3.3	1	1,5 (0,5; 2,2), 0 -3,7	1,5 (1,09;1,67), 0,50 – 3,33	1
SF36v2						
physical functioning	90 (65; 95), 10-100	95 (92.5; 100), 60 -100	<0.001	90 (70; 90), 10 -95	95 (90; 95), 50 -100	0.005
physical role	93.75 (62.5; 100), 12.5-100	100 (100; 100), 75 -100	0.012	100 (75; 100), 6,3 -100	100 (100; 100), 100 -100	0.026
pain	74 (62; 84), 0- 100	84 (62; 100), 51 -100	1	84 (62; 100), 12 -100	84 (74; 100), 62 -100	1
general health	38.5 (30; 50), 15-95	67 (51; 73.5), 35 -100	<0.001	37,5 (28,8; 52), 10 -87	67 (56; 74,5), 30 -95	<0.001
vitality	37.5 (25; 62.5), 6.25- 93.75	75 (71.9; 81.3), 56.25 - 93.75	<0.001	43,75 (31,3; 56,3), 0 -87,5	75 (69; 81), 69 -100	<0.001
social function	50 (25; 87.5), 0-100	100 (81.3; 100), 62.5 - 100	<0.001	62,5 (25; 90,6), 0 -100	100 (100; 100), 75 -100	<0.001
emotional role	75 (50; 100), 0-100	100 (100; 100), 83.33 - 100	<0.001	91,67 (58,3; 100), 25 -100	100 (100; 100), 100 -100	0.003
mental health	50 (35; 70), 5- 100	90 (80; 90), 65 -100	<0.001	67,5 (50; 85), 15 -95	90 (85; 90), 55 -100	0.003
TARS	7 (4; 10), 2-18	3 (2; 3), 2-8	<0.001	5,5 (3; 7), 3 - 16	3 (2; 3), 2 -3	<0.001

Abbreviations

min-minimum; max-maximum; med-median; IIQ – interquartile range [1^oQ;3^oQ]; * Mann-Whitney test bilateral p-value; bold: statistically significant p-values (p<0.05).

HADS: hospital anxiety and depression scale; MMS: mini-mental-state; CDT: clock drawing test; UCLA: UCLA loneliness scale; MARS: medication adherence rating scale; B.I.: Barthel index; YATES: Yara attitude towards euthanasia scale; WATES: Wasserman attitude towards euthanasia scale; MDMQ: Melbourne decision-making questionnaire; NEO-FFI: NEO five-factor inventory; SF36-v2: short-form health survey - version 2; IRI: interpersonal reactivity index; TARS – tool for assessment of suicide risk.

TABLE 3. DESCRIPTIVES AND SCALES COMPARISON OF PATIENTS BETWEEN THE BASELINE (N=114) AND SIX MONTHS LATER (N=90)

Scales	baseline, med (IIQ), min-max	Six months later, med (IIQ), min-max	<i>Wilcoxon's p-value with Bonferroni correction for multiple testing (14 tests)</i>
HADS Depression	9 (6; 10), 0 -15	8 (3; 9), 0 -14	<0.001
HADS Anxiety	8 (5,8; 10), 1 -19	7 (3; 9), 2 -14	<0.001
MMS	28 (26; 29), 11 -30	28,5 (27; 30), 15 -30	<0.001
CDT	9 (6,9; 9,5), 1 -10	9,25 (7,9; 9,5), 1 -10	1
UCLA loneliness scale	36 (20; 45), 16 -62	33 (20; 41,3), 16 -60	<0.001

TABLE 3. DESCRIPTIVES AND SCALES COMPARISON OF PATIENTS BETWEEN THE BASELINE (N=114) AND SIX MONTHS LATER (N=90)

Scales	baseline, med (IIQ), min-max	Six months later, med (IIQ), min-max	<i>Wilcoxon's p-value with Bonferroni correction for multiple testing (14 tests)</i>
MAT	5.86 (5.25; 6), 3.71-6	5.86 (5.43; 6), 3.71-6	1
SF36v2 Physical functioning	90 (65; 95), 10 -100	90 (70; 90), 10 -95	1
SF36v2 Physical role	100 (67,2; 100), 12,5 -100	100 (75; 100), 6,3 -100	0.010
SF36v2 Pain	74 (62; 91), 0 -100	84 (62; 100), 12 -100	0.238
SF36v2 General health	38,5 (25; 50,5), 15 -87	37,5 (28,8; 52), 10 -87	1
SF36v2 Vitality	37,5 (25; 62,5), 6,25 -93,75	43,75 (31,3; 56,3), 0 -87,5	1
SF36v2 Social function	56,2 (25; 87,5), 0 -100	62,5 (25; 90,6), 0 -100	0.007
SF36v2 Emotional role	75 (50; 100), 0 -100	91,67 (58,3; 100), 25 -100	0.001
SF36v2 Mental health	50 (35; 70), 5 -100	67,5 (50; 85), 15 -95	<0.001
Abbreviations			
med-median; IIQ – interquartile range [1°Q;3°Q]; min-minimum; max-maximum; bold: statistically significant p-values (p<0.05). HADS: hospital anxiety and depression scale; MMS: mini-mental-state; CDT: clock drawing test; UCLALs: UCLA loneliness scale; MARS: medication adherence rating scale; B.I.; SF36-v2: short-form health survey - version 2.			

No differences were found between controls and patients regarding the attitudes towards euthanasia, as measured by euthanasia YATEs and WATEs.

Patients tendentially more favourable to euthanasia presented higher perspective-taking capacity, empathic concern, fantasy, openness, agreeableness, conscientiousness, and vigilance and lower personal distress, buck-passing, procrastination, and hypervigilance (Table 4). Controls more favourable to euthanasia presented higher perspective-taking capacity, empathic concern, and lower procrastination (Table 4).

TABLE 4. SPEARMAN CORRELATIONS OF YATES WITH UCLALS, HADS, IRI, NEO-FFI, MDMQ, SF36-V2 AND TASR IN BOTH PATIENTS' (N=114) AND CONTROLS' (N=25) SAMPLE

Scales and Subscales	Correlation with YATEs	
	Patients	Controls
UCLA	-0.181	0.159
HADS Depression	-0.100	0.280
HADS Anxiety	-0.084	0.297
IRI Perspective taking	0.758**	0.803**
IRI Empathic concern	0.325**	0.668**
IRI Personal distress	-0.200*	-0.128
IRI Fantasy	0.378**	0.368

TABLE 4. SPEARMAN CORRELATIONS OF YATES WITH UCLALS, HADS, IRI, NEO-FFI, MDMQ, SF36-V2 AND TASR IN BOTH PATIENTS' (N=114) AND CONTROLS' (N=25) SAMPLE

Scales and Subscales	Correlation with YATEs	
	Patients	Controls
NEO-FFI Neuroticism	-0.167	0.021
NEO-FFI Extroversion	0.101	0.011
NEO-FFI Openness	0.232*	0.012
NEO-FFI Agreeableness	0.223*	0.188
NEO-FFI Conscientiousness	0.293**	-0.114
MDMQ Self-esteem	0.302**	0.260
MDMQ Vigilance	0.276**	0.179
MDMQ Buck passing	-0.280**	-0.384
MDMQ Procrastination	-0.371**	-0.415*
MDMQ Hypervigilance	-0.344**	-0.375
SF36v2 Physical functioning	0.163	-0.227
SF36v2 Physical role	0.086	0.180
SF36v2 Pain	0.007	-0.329
SF36v2 General health	-0.060	-0.177
SF36v2 Vitality	0.116	-0.132
SF36v2 Social function	0.128	-0.050
SF36v2 Emotional role	0.089	0.172
SF36v2 Mental health	0.087	-0.149
TASR	-0.124	-0.146
Abbreviations		
bold: statistically significant p-values (*p < 0.05; **p < 0.01)		
HADS: hospital anxiety and depression scale; MMS: mini-mental-state; CDT: clock drawing test; UCLALs: UCLA loneliness scale; MARS: medication adherence rating scale; B.I.: Barthel index; YATEs: Yara attitude towards euthanasia scale; WATEs: Wasserman attitude towards euthanasia scale; MDMQ: Melbourne decision-making questionnaire; NEO-FFI: NEO five-factor inventory; SF36-v2: short-form health survey - version 2; IRI: interpersonal reactivity index; TASR – tool for assessment of suicide risk.		

Multiple regression analysis of the patient's sample

All the variables with $p < 0.2$ in the simple model (table 4) were included in the initial multiple regression model (table 5).

TABLE 5. NON-STANDARDISED REGRESSION COEFFICIENTS (WITH CONFIDENCE INTERVAL AND P VALUE) OF MULTIPLE LINEAR REGRESSION HAVING YATES AS THE DEPENDENT VARIABLE FOR PATIENTS' SAMPLE (N=114).

Independent variables	Simple Linear Regression Model		Initial Multiple Model		Final Multiple Model	
			R ² =0.362 F(16,97)=3.44, p < 0.001		R ² =0.325 F(4,109)=13.1, p<0.001	
	B [I.C. a 95%]	p-value	B [I.C. a 95%]	p-value	B [I.C. a 95%]	p-value
Age	-1.21 [-2.34; -0.08]	0.035	-0.33 [-1.56; 0.90]	0.598		

TABLE 5. NON-STANDARDISED REGRESSION COEFFICIENTS (WITH CONFIDENCE INTERVAL AND P VALUE) OF MULTIPLE LINEAR REGRESSION HAVING YATES AS THE DEPENDENT VARIABLE FOR PATIENTS' SAMPLE (N=114).

Independent variables	Simple Linear Regression Model		Initial Multiple Model		Final Multiple Model	
	B [I.C. a 95%]	p-value	B [I.C. a 95%]	p-value	B [I.C. a 95%]	p-value
Gender						
Female	Reference					
Male	7.32 [-6.93; 21.6]	0.311				
Schooling (in years)	1.62 [-0.17; 3.42]	0.076	0.13 [-2.03; 2.29]	0.904		
HADS Depression	-0.54 [-3.45; 0.38]	0.114	-1.19 [-3.93; 1.55]	0.390		
HADS Anxiety	-0.83 [-2.47; 0.81]	0.318				
MDMQ Self-esteem	3.98 [1.97; 6.00]	<0.001				
MDMQ Vigilance	2.47 [0.80; 4.13]	0.004	0.57 [-1.59; 2.73]	0.601		
MDMQ Buck passing	-2.14 [-3.48; -0.80]	0.002	-0.18 [-2.13; 1.77]	0.857		
MDMQ	-3.90 [-5.69; -2.10]	<0.001				
Procrastination						
MDMQ	-4.22 [-6.32; -2.13]	<0.001				
Hypervigilance						
NEO-FFI Neuroticism	-0.54 [-1.14; 0.06]	0.079	0.29 [-0.87; 1.46]	0.618		
NEO-FFI	0.48 [-0.39; 1.35]	0.276				
Extraversion						
NEO-FFI Openness	0.90 [0.14; 1.66]	0.020	0.15 [-0.82; 1.12]	0.762		
NEO-FFI	1.60 [0.20; 2.99]	0.025	-0.35 [-1.87; 1.17]	0.652		
Agreeableness						
NEO-FFI	2.15 [1.22; 3.09]	<0.001	1.65 [0.50; 2.81]	0.005	1.65 [0.77; 2.54]	<0.001
Conscientiousness						
IRI Perspective taking	25.92 [22.3; 29.51]	<0.001				
IRI Empathic concern	15.7 [7.26; 24.2]	<0.001	15.79 [6.46; 25.13]	0.001	14.32 [6.19; 22.46]	<0.001
IRI Personal distress	-6.89 [-13.1; -0.67]	0.030	-3.21 [-11.16; 4.74]	0.425	-6.01 [-11.78; -0.25]	0.041
IRI Fantasy	11.3 [5.62; 16.9]	<0.001	5.54 [-1.41; 12.48]	0.117	6.51 [1.15; 11.86]	0.018
UCLA	-0.37 [-0.80; 0.06]	0.089	-0.47 [-1.09; 0.16]	0.145		
SF36v2 Physical functioning	0.25 [-0.02; 0.52]	0.069	0.11 [-0.41; 0.57]	0.748		
SF36v2 Physical role	0.10 [-0.13; 0.33]	0.406				
SF36v2 Pain	0.09 [-0.19; 0.38]	0.515				
SF36v2 General health	-0.08 [-0.44; 0.28]	0.645				
SF36v2 Vitality	0.20 [-0.08; 0.47]	0.159	0.08 [-0.41; 0.57]	0.748		
SF36v2 Social function	0.15 [-0.04; 0.34]	0.122	-0.25 [-0.57; 0.08]	0.133		
SF36v2 Emotional role	0.13 [-0.09; 0.36]	0.234				
SF36v2 Mental health	0.11 [-0.12; 0.38]	0.296				

Abbreviations

bold: statistically significant p-values (p<0.05)

HADS: hospital anxiety and depression scale; UCLALs: UCLA loneliness scale; YATES: Yara attitude towards euthanasia scale; MDMQ: Melbourne decision-making questionnaire; NEO-FFI: NEO five-factor inventory; SF36-v2: short-form health survey - version 2; IRI: interpersonal reactivity index.

Since some independent variables were highly correlated [corr (self-esteem; vigilance) = 0.803, corr (self-esteem; buck-passing) = - 0.754, corr (procrastination; buck-passing) = 0.757, corr (buck-passing; hypervigilance) = 0.781 and corr (procrastination; hypervigilance) = 0.824], three were eliminated (self-esteem, procrastination and hypervigilance). Thus, only vigilance and buck-passing were included in the multiple model.

The multiple model was obtained progressively, eliminating the non-significant ($p < 0.05$) variables. The only significant variable in the final model was perspective-taking, which alone explained around 65.7% of the variability of YATEs. For each point of the sub-scale perspective-taking, YATEs increased an average of twenty-six points. This happened because perspective-taking was highly correlated with the outcome (YATEs, $r = 83\%$). A decision was then made to exclude this variable from the final model.

In the end, the significant associations with a favourable attitude towards euthanasia in the patients' sample were higher conscientiousness, empathic concern and fantasy and lower personal distress (Table 5.).

Discussion

Portugal recently legalised euthanasia for competent (as determined by a judge) people with a fatal disease and unbearable suffering.²⁵ It will be a matter of time before the subject will be addressed for psychiatric disorders. Therefore, it is of the utmost importance to discuss and understand several issues surrounding mental illnesses of the most vulnerable segments of the Portuguese population, like older adults.

Euthanasia of psychiatric patients is not only about whether they are legally competent and self-determined to make such a request. Many are undoubtedly able to do so.^{69,70} In our study, patients have shown to be independent in daily life activities [B.I. mean, controls/patients (baseline and six months later) = 100; $p = 1$]. However, they had worse cognitive performance, more neuroticism, and less extraversion and openness at baseline and six months later (see MMS, CDT and NEO-FFI in Table 2.). In addition, people lose much of their autonomy when they grow old and fragile, being increasingly inclined or forced to leave decisions to others.⁷¹ Decision-making capacity is linked to several individual characteristics, such as personality^{72,73} and individual cognitive abilities⁷⁴ and mild cognitive impairment is associated with poorer decision-making.⁷⁵ Thus, it is doubtful whether, under certain conditions, older adults retain their total decision-making capacity (the ability to make a medical decision within a given situation)

for free and informed consent in health. Several Portuguese elderly who have 4 years of schooling or less (in our study, 81.6% of patients and 44% of controls had 4 or fewer years of education) have minimal reading or writing skills, with some only knowing how to sign their name and many not being able to perform 'simple' digital tasks (e.g., handling a smart-phone or texting). Therefore, there are cognitive limitations that may not be only the result of a mental illness but also of a poor socio-cultural and academic background.⁷⁶ This adds to the problem of the negative influence of depressive and anxiety symptoms on cognitive performance.

As shown in Table 2, the presence of mild mental illness (HADS scores) is sufficient to determine feelings of loneliness (despite most patients – 76,3% - living in a household of two or more people), lower self-esteem, worse cognitive performance, personal distress and health satisfaction and higher suicide risk. Now, in countries where euthanasia is available for psychiatric patients claiming unbearable mental suffering, the legalisation was based on the assumption that there is no clinical or legal argument to consider physical suffering worse than mental suffering.^{77,78} Hence, if intolerable mental anguish is advocated, the proper and legally established assessment for euthanasia can be initiated. However, two significant problems arise here. First, the quantification of "unbearable" mental suffering poses more incredible difficulty in comparison to "unbearable" physical suffering,⁷⁹⁻⁸¹ leaving more space for subjectivity in the assessment and potentiating some arbitrariness regarding which cases are allowed or not. Imagine that a patient from our study, suffering from mild depression and anxiety, claimed unbearable suffering. Would euthanasia be admissible? Despite psychiatrists being well-trained doctors, there is a heterogeneity in mental health assessment⁸² that can lead two psychiatrists to classify differently the severity of the same patient's disorder. Secondly, in many cases, patients may not be offered or subjected to all the necessary treatments.⁸³ In Mental Health, therapies are holistic and go far beyond biological treatments.^{84,85} Nevertheless, in daily clinical practice, and despite the recommendations of several official guidelines, the failure to respond to biological therapies is too often the only criterion to consider a psychiatric disorder refractory to treatment.⁸⁶ This is particularly important in older people, where psychosocial issues and ageing-related problems arise, increasing the need for non-pharmacological approaches.^{70,87} In our study, six months after the first evaluation, upon psychiatric follow-up, there was an improvement in depressive and anxiety symptoms, leading to better cognitive performance, social function, and mental health and fewer feelings of loneliness (Table

4). However, this follow-up, with a medical-centered approach (psychopharmacology and brief counselling), was insufficient for a full recovery as the differences between patients and controls remained the same (Table 2.).

Unlike other medical disciplines, where it is easier to establish analytical criteria for evaluation, diagnosis and intervention, psychiatry is a grey area. That is, diseases (for which there are no biological markers), from a longitudinal perspective, are often dynamic in their nature and intensity.⁸⁸⁸ Furthermore, there is significant individual variability about diseases' aetiology and perpetuating factors and the needs of each patient include complex and tailored bio-psycho-social interventions. In older adults, a clinically and socially idiosyncratic age group, physiological weaknesses and social losses accumulate, and the chronological proximity to death becomes progressively more self-aware. In addition, can it be said that patients who refuse evidence-based treatments (56% of Dutch patients who received PAD due to psychiatric suffering did refuse some therapy) suffer irremediably?⁸⁹ Older adults are particularly prone to the tiredness of life argument for requesting euthanasia without sufficient medical grounds for their suffering to be legally granted.⁹⁰ However, data show that the willingness to die without severe disease is often ambiguous and does not necessarily represent a genuine wish to die.⁹¹ As the experience of the countries where euthanasia is available for people with mental illness shows us, psychiatric patients are increasingly seeking access to euthanasia.⁹² Curiously, several patients do not complete the process, indicating that the formal request for medically assisted death is a way of getting attention and help.⁹³

Moreover, the stigma that hangs over mental illness can alienate patients, particularly older adults, depriving them of adequate support. This is congruent with our data, where no significant difference was found between patients and controls regarding their attitude towards euthanasia (table 2.). Despite the higher suicide risk, the disease does not determine a specific attitude towards euthanasia in these elderly patients, even when time passes and mild symptoms prevail. However, this persistent symptomatology, along with loneliness feelings and health dissatisfaction [as opposed to controls (table 2.)], may lead patients who may not have had access to the necessary holistic treatment to ask for euthanasia.

Finally, despite depressive and anxiety symptoms and loneliness feelings not appearing to determine a specific tendency towards euthanasia (Table. 2), several factors are more related to a favourable attitude. Patients with higher perspective-taking, empathic concern, fantasy, openness, agreeableness, consciousness, self-esteem and

vigilance and lower personal distress, buck-passing, procrastination and hypervigilance tend to be more favourable to euthanasia (Table. 3). In controls, only higher perspective-taking, empathic concern and lower procrastination correlated significantly with YATEs (Table. 3). This is congruent with some studies where some of these variables, more or less consistently, have been associated with the same tendency [e.g. empathy ^{27,28} and personality traits ^{29,30}]. However, none of these studies either analysed attitudes towards euthanasia in elderly patients with mixed anxiety-depression disorder nor did it objectively use several psychometric instruments, trying to mimic humans' complexity. Because human beings are multidimensional and several traits, health conditions, and social factors influence their thoughts, opinions and actions, a regression model was done in our study and higher conscientiousness, empathic concern and fantasy and lower personal distress were identified as the variables that better explained a favourable patients' attitude towards euthanasia. This might mean that patients with persistent depressive and anxiety symptoms, feelings of loneliness, precarious health status and higher suicide risk as compared to controls when endowed with higher conscientiousness (which is related to enhanced cognitive abilities ⁹⁵), empathic concern and fantasy (that measures an individual's tendency to imagine themselves in fictional situations and is associated with empathic accuracy ⁹⁶) and lower distress are more aware of their precarious situation and more inclined to consider euthanasia as a viable way out. Stimulating older people's literacy and cognitive abilities is crucial, augmenting their autonomy and informed decision capacity. However, one must remember that it is crucial to put all the necessary support (clinical, psychosocial, and economic) at their disposal to correspond to those higher demands. Otherwise, a sense of dissatisfaction could be nurtured, and euthanasia perceived as a fast, unique and painless solution.

Some limitations should be noticed in our study. First, large samples are advised to reduce measurement errors and produce generalisable results for the same population. Second, the participants' low literacy levels might have difficulty accurately interpreting the statements and questions of the psychometric instruments used, producing results bias. Third, longitudinal assessment should be interpreted cautiously as the number of participants, particularly controls, decreased, diminishing the power of the statistical analysis. Thus, this study should be replicated with larger samples. A comparative analysis of elderly patients with severe disease and younger patients should be done to confirm our results and measure the impact of the severity of the illness and age, respectively, on the attitudes towards euthanasia of those age groups.

Some important considerations can be retrieved from our analysis. First, even mild depressive and anxiety symptoms negatively impact patients' well-being, being related to loneliness feelings, worse cognitive performance, personal distress and poorer health status. Second, the factors that most influenced a favourable attitude towards euthanasia of patients were related to personality traits, cognitive abilities and empathic capacity (higher conscientiousness, empathic concern and fantasy) and lower personal distress (Table. 5) rather than depressive and anxiety symptoms (suggesting that, at least for this severity level, the disease does not determine a specific attitude). Finally, the low educational level, together with depressive and anxiety symptoms, might harm patients' clairvoyance, determine poorer literacy, make access to information and health services harder and interfere with their capacity to make well-informed and free decisions, favouring a paternalistic approach.

Conclusion

The challenge when addressing euthanasia in elderly patients with mixed anxiety-depressive disorder is not only whether they are fully self-determinate to request euthanasia but also if a timely and proper diagnosis, treatment and support were at their disposal and implemented. Enhancing these patients' sense of satisfaction and usefulness in a production-oriented society that tends to devalue and alienate them is essential. Suppose non-fatal disabilities whose unbearable suffering is either questionable and/or derived from the absence of proper psychiatric, psychosocial and economic support become a generally accepted criterion for granting euthanasia. In that case, human rights can be put at stake.

The authors have no conflicts of interest to disclose.

Authors' roles: Luís Fonseca (research, statistics, writing, and revision), Luísa Castro (research, statistics, and revision), Guilhermina Rêgo (research and revision), and Rui Nunes (research and revision).

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CONCLUSION

The United Nations Educational, Scientific and Cultural Organization (UNESCO) defines literacy as a means of identification, understanding, interpretation, creation and communication in an increasingly digital, text-mediated, information-rich and fast-changing world (UNESCO, 2024). Literacy is a continuum of learning and proficiency in reading, writing and using numbers throughout life. It is part of a more extensive set of skills, including digital skills, media literacy, education for sustainable development and global citizenship, and job-specific skills. Although significant progress has been made, with most recent data showing that currently, 86% of the world's population know how to read and write compared to 68% in 1979, there are at least 765 million adults worldwide who cannot read and write and 250 million children to fail to acquire basic literacy skills (UNESCO, 2024). Therefore, we may say that illiteracy is a "disease". Low educational levels are proven to condition several deficiencies in an individual. It promotes fragile coping mechanisms, augments the dependency on others and affects the decision-making capacity to make well-informed and free decisions (Cui et al., 2019; Zajacova & Lawrence, 2018). Especially in a world where technology is increasingly dominant and access to information is readily available and just a click away, three major problems arise for people with little or no education. Firstly, the lack of proactivity in the search for information to make sustained decisions increases the probability and risk of others deciding in their place. Secondly, people with low literacy struggle to access information using technological devices, which they have great difficulty handling. Thirdly, the critical ability to distinguish relevant information from the large amount available is compromised. All these difficulties are heightened when older people are involved (Schroeder et al., 2023). The decreased literacy during physiological ageing (Barrett & Riddell, 2019) further diminishes the empowerment of people with low literacy levels about their autonomy and ability to make informed decisions.

Furthermore, an individual's low cognitive reserve also increases the risk of developing dementia and dependence on others (Rentería et al., 2019). The proportion of older Portuguese people with poor literacy, particularly in health, is still significant (Costa et al., 2023), and the experience and data from the PCU align with this fact. In PCU, older patients have low levels of education and literacy that interfere with the understanding of their disease, the adherence to treatment and the adoption of non-pharmacological strategies. In PCU consultations, it is relatively common, for example, to find patients

taking two medicines from different pharmaceutical companies with the same active ingredient, thinking that they are different drugs. Not having, nor ever having had, recreational and occupational habits and showing characteristic traits of rigidity, older patients spend their days practically inactive, alone at home, without any cognitive stimulation, worsening their dependence on others. The ease with which they delegate essential decisions regarding their health care to others is worrying. It is common, for example, to see them signing documents "blindly" without reading them, trusting entirely in the judgement of a doctor, a family member or a friend. As far as living wills, euthanasia and medically assisted suicide are concerned, the darkness is total. They are unaware of the concepts, the law and the terms under which these procedures can be requested and completed. Thus, illiteracy in older Portuguese people, particularly in those with psychiatric illness, is an everyday reality that is important to keep always in mind. The probability that they make misinformed decisions is high. The fulfilment of the criteria of intolerable suffering is easily attainable in this age group, allowing easier access to PAD, a severe and irreversible consequence.

Thus, as proposed in our article “Decision-Making Capacity of Elderly Patients with Mixed Depression-Anxiety Disorder”, it would be essential to take several measures immediately to deal with the problem, such as:

- Informed consent should take into account cognitive baseline differences rather than being generalisable;
- The competence and decision-making capacity of elderly individuals should be assessed correctly and in due time;
- The cognition level of older people should be periodically and routinely assessed in primary care;
- A person of an elderly individual's trust should be nominated (durable power of attorney, according to the Portuguese law) to participate in decision-making, and paternalistic approaches in decision-making should be discouraged;
- There should be a focus on public policies regarding disease prevention, health and literacy promotion, and the undergraduate training of healthcare professionals.

In our article "The Empathetic Genesis of the Right to Euthanasia", we reflect on whether there is a right to PAD, particularly euthanasia, alluding to the concept of Empathy, Locked-in Syndrome and the Constitution of the Portuguese Republic. Firstly, it seemed essential to try to clarify the concept of empathy. We presented a model that defines it not as an emotion, as it is usually considered, but as a complex neuropsychological capacity that makes it possible, in the decision-making field, to make the best possible decisions by balancing Emotion and Reason. This is a fundamental issue, especially in matters of conscience such as euthanasia, in order to nullify or minimise the interference of personal beliefs in the decisions of others. Empathy is an aggregating element of societies that enables peaceful coexistence between different cultures and respect for individuals' personal worldviews. It differs from sympathy, a concept with which it is often confused and promotes biased and potentially unfair decisions. Secondly, conditions such as Locked-in Syndrome have particular and important characteristics for the discussion of euthanasia. In fact, there are diseases that suddenly deprive individuals of the possibility of a self-determined life (for example, a massive ischemic stroke), making them totally dependent on others, and there is Locked-in Syndrome, where an individual is "buried alive", that is, conscious, cognitively intact, self-determined but potentially incapable of any communication. In the first case, unless the patient has previously expressed in an advance directive the desire to be euthanised, the procedure cannot be requested by oneself as the patient is incapable of making such decisions. In the second case, the patient can decide but may not be able to communicate if suffering from the most severe form of the disease. If the patient had previously expressed freely in an advance directive the desire to be euthanised in such a circumstance, the decision on how to proceed may be clear. However, what should be done if the patient has not done it and cannot communicate? Keep him/her alive with artificial means of life support (knowing that a person in these conditions with appropriate care can remain alive for around 20 years)? Moving forward with a PAD procedure, either by passive or active euthanasia? The dilemma can be big and distressing. It may be impossible to know if the patient is in great suffering and wants to die or if, on the contrary, despite the severity of the disease wants to stay alive. The notions of quality and meaning of life are very subjective, and third parties must respect every conscious and free decision. However, is it legitimate to deny to a patient with a Locked-in syndrome, capable of communicating, a PAD procedure (active or passive)? Thereby, the real issue and focus of concern may not be if there is a Right to PAD but under which circumstances. In any case, it cannot be

stressed enough that high-quality and universal health care must always be available, particularly palliative care.

The Constitution of the Portuguese Republic (CPR), as stated by the President of the Constitutional Court, by not determining an inalienable duty to live under any circumstances (Tribunal Constitucional Português, 2021), does not prevent the decriminalisation of PAD. There are no absolute legal or ethical principles. Otherwise, it would be impossible for the Law to fulfil its fundamental purpose: to allow societies to live peacefully in cultural diversity, guarantee freedom of consciousness and secularly protect every citizen's constitutional rights. Nevertheless, even though the CPR do not prohibit euthanasia, it doesn't mean PAD is a discretionary right. The conditions under which the procedure may be elicited must be well determined and defined, and the entire process must be under rigorous ethical, clinical, and legal control from the beginning. Legislation must, therefore, be based not only on the data of countries with wider experience on the matter but also on national and international scientific studies to better adapt it to the cultural and clinical idiosyncrasies of the Portuguese population. An important and rarely addressed issue is the well-accepted fact that the PAD procedure in countries where euthanasia is decriminalised is not determined by a judge. Also, legal scrutiny is carried out afterwards, that is, when the death of the patient already happened. In other words, only when and if the respective Commission for the Control and Assessment of PAD (constituted by doctors and legal experts) suspects that some illegality has occurred are criminal proceedings initiated in the public prosecutor's office. In Portuguese law (Assembleia da República, 2023), there seems to be some concern in providing the Commission with members appointed by central bodies of the Rule of Law, such as the Superior Council of the Judiciary and the Superior Council of the Public Prosecutor's Office (in addition to doctors, nurses and a bioethics specialist). However, the final authorisation for PAD still does not depend on a decision by a Court judge, as happens, for example, in the case of involuntary treatments. On the other hand, the Portuguese euthanasia law is silent regarding advance directives, which are essential in the case of a patient who, due to a sudden serious illness (for example, locked-in syndrome), is not self-determinate and does not tacitly exclude psychiatric patients from accessing the procedure. There are already precedents of decisions by higher courts, such as the European Court of Human Rights, which considered psychiatric patients' access to PAD to be legitimate (De Hert et al., 2022). However, it is no less true that there are still

serious problems related to clinical assessment, the capability to make free and informed decisions and the determination of incurable disease and unbearable suffering in patients suffering from mental disorders (De Hert, Loos, Sterckx, et al., 2022; Nicolini et al., 2022).

According to some authors, access to PAD appears to be becoming a right for patients to request suicide, with doctors providing them with the means to carry it out (García-Sánchez, 2019). In this regard, some pro-euthanasia movements advocate a Right to Die. However, is dying a right or an inevitability? A right presupposes a choice, which death is not. It will come sooner or later. So, in the context of the discussion on euthanasia, it may be more appropriate philosophically and conceptually to talk about the Right to Live, which includes a choice regarding how each and every person wants to live. There is a difference between living and staying/being alive. Any living being, including a plant, is alive but does not live with the sense of purpose that each human being gives idiosyncratically to his or her own life.

Psychiatry is a complex speciality. Multiple factors (biological and environmental) contribute to the emergence of mental disorders, which are diagnosed exclusively through clinical assessments (Craddock & Mynors-Wallis, 2014). In fact, there are no complementary diagnostic tests or biological markers that decisively help identify a disorder or clarify differential diagnoses. On the other hand, the treatment of psychiatric disorders is multidimensional. It often demands pharmacological and non-pharmacological approaches, such as psychotherapies, psychoeducation, social and family interventions, professional reintegration programs, rehabilitation, skills training or cognitive stimulation (De Pinho et al., 2024; Elkrog et al., 2022). Older adults are particularly vulnerable to suffering from depressive-anxiety disorders (World Health Organization, 2023). These cause significant physical and mental suffering. It is well known that depressive and anxious symptoms, on the one hand, have a negative impact on physical illnesses, worsening their symptoms and prognosis, and, on the other hand, cause significant psychological suffering and a worse quality of life (Brenes, 2007). Thus, older adults may be especially prone to see PAD as a route to alleviating suffering. Furthermore, when their levels of education and literacy are low, they are more dependent on others and frequently delegate important decisions to third parties. In the context of euthanasia, they may be more vulnerable to external pressures and influences who, for example, may benefit from their death. To better identify the shortcomings, it is of the

utmost importance to carry out studies on older psychiatric patients in order to clarify the influence of the disease on their attitude towards euthanasia and identify factors associated with their greater frailty. This will help policymakers legislate properly.

In countries with experience in PAD in psychiatric patients, such as the Netherlands and Belgium, several studies have consistently reported that the diagnoses most commonly associated with the requests are depression and personality disorders (Calati et al., 2021). Several limitations have been highlighted at different stages of the process, particularly in the clinical assessment of patients, the establishment of incurable disease and intolerable suffering and the evaluation (or lack thereof) of patients' decision-making capacity (Calati et al., 2021). It is also reported that some who received PAD had complex and chronic psychiatric, medical and social disorders, and others presented highly dubious ability to consent, such as autistic patients with intellectual disability (Gallego et al., 2022). Although problems and doubts are varied and complex, they seem to be of little interest, given that the procedures continue under the same premises and circumstances. Can it be said that a psychiatric disorder is incurable when it is known that around 49% of patients do not adhere to psychotropic medication (Ramamurthy et al., 2023)? In decades of experience in Belgium and Netherlands, the law has expanded the criteria for euthanasia to somewhat unexpected limits: people without a survival mean time (such as medically treatable mental disorders), sick children or people fed up with living (Gallego et al., 2022). Death is inevitable; it is a fact. However, does it mean that the dominant thinking should be permissive to the point that, regardless of the reasons, there should be unlimited access to PAD? In the face of alleged unbearable suffering, PAD appears to begin to be made available as anticipation (albeit decades) of the inevitable death, disclaiming Society and the State of their obligation to guarantee the social, economic and clinical conditions for everyone to have a meaningful life.

Concerned about the tolerance increase regarding the criteria for euthanasia in countries where it is long practised, we studied a highly vulnerable age group (older people with psychiatric illness), trying to understand their specific weaknesses and attitudes towards euthanasia. The aim is to enable a serious reflection and debate on the matter in advance to allow appropriate legislation to be written. First, given the absence of an instrument validated for European-Portuguese to assess attitudes towards euthanasia in specific groups, a cross-cultural validation of Yara's attitude about euthanasia scale was done. The scale will allow several analyses and comparative studies to better

understand the phenomenon in Portuguese society. Next, a detailed multidimensional analysis of older patients with depressive-anxiety disorder using several psychometric instruments was done. It is not usual to conduct studies on the topic using objective assessments. Research has been based mainly on opinion surveys, making it difficult to reproduce results and make comparisons between groups. Through our analysis, several important conclusions were reached, such as:

- Patients had a statistically significant lower level of education compared to controls, which aligns with the knowledge that low literacy is a risk to mental health (Hunn et al., 2023);
- Depressive and anxiety symptoms, even when mild, have a significant impact on the patient's well-being and quality of life, being related to feelings of loneliness, worse cognitive performance, personal distress and worse overall health;
- The factors that most influenced a favourable attitude towards euthanasia of patients were related to personality traits, cognitive abilities and empathic capacity (higher conscientiousness, empathic concern and fantasy) and lower personal distress (Table. 5) rather than depressive and anxiety symptoms (suggesting that, at least for this severity level, the disease does not determine a specific attitude);
- The low educational level and the existence of depressive and anxiety symptoms, even if mild, interfere with patients' decision-making capacity.

Psychiatric older patients with mixed anxiety and depressive disorder are both physically and psychologically vulnerable and present statistically significant poorer health status as compared to age-related controls, even when only mild symptoms are present. This is of great concern, especially when their educational level is low, and loneliness feelings prevail, harming their clairvoyance, making it difficult to access information and health services and interfering with their capacity to make well-informed and free decisions. This could promote paternalistic approaches, which might ignore the specific handicaps and needs of the age group and promote a sense of uselessness in the patients, favouring medically assisted dying as a painless and viable way out. Therefore, it is of the utmost importance to act upstream, with concrete actions based on public policies of prevention and promotion of mental health and literacy enrichment strategies, empowering older adults.

Even though mild symptoms do not appear to favour any particular tendency regarding euthanasia, the fact is that the law is not in effect yet. When it is, supply will most certainly generate demand, particularly for those with age-related frailties, alienated and in mental distress. It is a candid illusion to believe that a euthanasia law, how well written and regulated it may be, will by itself safeguard the high vulnerability of older psychiatric patients (Pereira, 2011). The PAD of psychiatric patients in dubious conditions is already a reality nowadays, and the "tired of living" argument has been accepted for euthanasia.

Portugal must learn not only from the examples of the countries where euthanasia for psychiatric patients is long in effect but also from regional and nationwide studies addressing the issue in order to solve several insufficiencies related to the health system and implement tailored legislation and control mechanisms.

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ANNEX A

1. Biographical and Professional Note

Luís Fonseca, M.D.

Birthdate: January 24, 1978

- Psychiatry Consultant at the Psychiatry Department, Senhora da Oliveira Hospital, Guimarães, Portugal;
- Head of Psychogeriatrics/Cognitive Disorders Unit, Psychiatry Department, Senhora da Oliveira Hospital, Guimarães, Portugal.
- Supervisor and Clinical Tutor of the School of Medicine of the University of Minho.

2. Doctoral Program in Bioethics 2021-2024

The PhD in Bioethics at Faculty of Medicine of University of Porto (FMUP) offers advanced education and training in the area of Bioethics. It lasts six semesters and has 180 ECTS.

The Program consists of a curricular component, which is carried out through the successful completion of ten modules (General Bioethics; Philosophy and Bioethics; Professional Ethics; Ethics in Early Life; Ethics in End-of-Life and Palliative Care; Ethics in Health Priorities; Environment, Biodiversity, and Biopolitics; Biolaw; Seminars; and Individual Projects), and a research component for the elaboration of an original thesis.

Table 1 presents the classifications obtained by the candidate so far in the several curricular units.

TABLE 1. DOCTORAL PROGRAM IN BIOETHICS, FACULTY OF MEDICINE, UNIVERSITY OF PORTO – CLASSIFICATIONS

ACADEMIC YEAR	Curricular Unit	Final Classification
2021/2022	General Bioethics	18
	Philosophy and Bioethics	17
	Professional Ethics	16
	Ethics in the end of life and palliative care	19
	Ethics at the beginning of Life	19
	Environment, Biodiversity and Biopolitics	18
	Biolaw	19
	Seminars	18
	Ethics in Health Priorities	18
2022/23	Seminar in Biolaw	18
	Seminar in General Bioethics	18
	Seminar in Ethics and Research in Human Beings	18
	Seminar in Thesis Project	18
	Research work leading to the thesis	18
2023/24	Research work leading to the thesis	-

The monography “Anthropo-symbiotic ethics: a path to the sustainability of life” (Annex A3), written in the Curricular Unit of Environment, Biodiversity and Biopolitics, was published in the Eubios Journal of Asian & International Bioethics (Eubios Journal of Asian & International Bioethics. Sep2022, Vol. 32 Issue 5, p126-130. 5p.).

3. Anthropo-Symbiotic Ethics: A Path To The Sustainability Of Life

Eubios Journal of Asian & International Bioethics. Sep2022, Vol. 32 Issue 5, p126-130. 5p

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Eubios Journal of Asian & International Bioethics. Sep2022, Vol. 32 Issue 5, p126-130. 5p.

Abstract:

The moral status of Humans, Animals and Nature has been widely debated. Several theories have been trying to answer the ethical challenges that arise in the relationship between these three entities. However, although there are models with conciliatory views, none have been sufficient to reach a broad consensus on the moral hierarchical positioning of human beings, animals and the environment. Here, we propose a conceptual framework of anthropo-symbiotic ethics to respond, most realistically and thoughtfully possible, to the moral obstacles often placed in the context of the Human-nature-animals interaction.

Keywords: ethics; anthropo-symbiotic; animals; environment; mankind; morality

1- Introduction

Earth is about 4.5 billion years old [1], and *H. Sapiens* evolved from other human species that inhabited Africa 200.000 years ago [2]. Therefore, the disparity between humans and the planet's age is substantial. Along its journey, the latter was affected by several catastrophes but always regenerated with viable conditions for Life. Thus, the common rhetoric that Earth needs salvation is, in fact, a fallacy. Humans are the ones

who are at risk of extinction due to climate change. If humanity persists in attacking it, Earth will most likely continue to exist, renewing itself as it has been doing for billions of years.

After its birth 200.000 years ago, *H. Sapiens* spread throughout the world. They lived an animalistic existence until the Neolithic revolution and the emergence of the first civilizations in Mesopotamia, Egypt, India, Pakistan and China. At this time, about 10 to 12.000 years ago, the species' culture changed profoundly. Its nomadic way of life, based mostly on hunting groups to facilitate survival, gave place to a sedentary model with agriculture and villages as its pillars. This was the beginning of organized social, economic, political and religious systems that led to significant population growth. This increase continued until today and has been responsible for the scarcity of natural resources, the destruction of habitats, deforestation, environmental pollution and the questionable exploitation of various animals. [2] Humans have thus evolved from an animalistic past to become the most intelligent, dominant and populous species that ever inhabited Earth. However, notwithstanding its unique cognitive evolution, several of its most biological primal instincts subsist.

The current environmental imbalance promoted by humanity is a serious threat to life's sustainability and requires an urgent response. We believe that symbiotic ethics, in which mankind is at the top of the moral hierarchy, can make a decisive contribution to the problem.

2- The Concept of Humanity

In contemporary occidental societies, there is a general predisposition towards an excessively idyllic vision of the world and human beings. On the one hand, *H. Sapiens* is

unrealistically seen as a species innately endowed with pure goodness and, on the other hand, subsists a primacy of the beautiful over the ugly (in the aesthetic and moral sense of life), camouflaging aversive conditions such as violence or cruelty.

There's also a tendency for both the "psychiatrization" of emotions, such as sadness or anxiety, and personality traits, such as malice. However, negative emotions, such as sadness [that induces crucial internal and/or external changes to cope properly with a distressing event], have important phylo and ontogenetic functions. Their role in the species' survival and a person's harmonious development is unquestionable. Also, evil is not exclusive to any psychiatric disorder. It is an independent personality trait, such as being funny, kind or introverted. There is a recurrent difficulty and resistance in accepting that certain atrocities are cruel acts without any underlying disease. People often show surprise regarding the monstrosity of specific human behaviours, asking themselves, "How was it possible?" and stating that the perpetrator "could not be right in the head to have done something so grotesque and impious", insinuating a psychiatric illness as a causal factor. This frequent, automatic and unconscious need to consider these perfidious pathological actions may serve the purpose of preserving the person's sanity through a mechanism of denial, which obliterates the awareness that a human being (the person herself) is capable of such barbaric behaviours. We often define an altruistic demeanour as great humanity and a malicious action as pathological and/or shocking inhumanity. However, what to think of monsters like Hitler or the cinematic serial killer Hannibal Lecter? Are they not simply the embodiment of pure Human Evil (part of humanity's eternal dichotomous nature)? Otherwise, what does the Devil symbolize? Evil (character) or Psychopathy (disease)?

The ordinary recognition of the word humanity as a synonym of benevolence distorts its true meaning. Human nature is dichotomous and gravitates between two

extremes: evil and goodness. Thus, being human includes the whole package—everything we have, good and bad.

Therefore, it would be of great importance for Humanity to recognize its true nature without subterfuges of any kind. Otherwise, unrealistic solutions for several issues will continue to be presented, and the disagreements between human, animal, and environmental ethics will remain unresolved.

3- Aggression and Violence: Man vs. Animals

The similarity (in varying percentages) between human and other animals' genomes [3,4], as well as the shared, to a greater or lesser extent, brain structures (e.g., brain stem, cerebellum or limbic system) with other species (even with some phylogenetically distant) [5], supports Darwin's theory of evolution. Therefore, the assumption that humankind and animals share common characteristics, including specific behavioural patterns, cannot sound strange. Darwin, in "The Descent of Man and Selection in Relation to Sex", defended that "the difference of mind between humans and the higher animals, however great, is certainly one of degree and not of species". Thus, if, on the one hand, certain animals can, after all, be endowed with some degree of rationality (usually assumed to be an exclusively human capacity), on the other hand, it will also be no less true that certain more primary behaviours (such as aggression), usually negatively connoted as animalists, are an inalienable part of humans' nature.

According to a study published in Nature [6], humans have a phylogenetic propensity for violence and species (*H. Sapiens* included) with territoriality and social behaviour traits are more aggressive. Also, the level of lethal violence became progressively higher as humans evolved from their ancestral trunks. Nevertheless,

humanity's political and social organization appear to have diminished this aggressiveness, which suggests that culture can shape the inherited inclination towards violence. In turn, its apparently high evolutionary benefit may justify the aggressive phylogenetic trend over time [7].

The lower degree of violence and conflict in contemporary societies is due not only to a greater capacity of containing such instincts by social systems based on rules, and from which collective and individual advantages arise but, above all, to the generalization of democracies as regimens that give space for freedom, autonomy, diversity and individual merit. History teaches us that autocracies, sooner or later, by cornering and stifling individual's freedom and legitimate aspirations end up imploding.

Regarding animals, it is important to emphasize that they also exhibit gratuitous violence (evil) and deviant behaviour [8,9,10]. For example, 10% and 17% of deaths in groups of yellow mongooses and certain lemur species, respectively, result from lethal violence not related to any imperative of survival [11]. Thus, it's not true that animals are exclusively candid and innocent, and all their aggressiveness stems only from the need for survival. In the film "Dawn of the Planet of the Apes", Caesar, the leader of the simians, after having known that an ape had maliciously incited the war, said to the human: "I always thought we were better than humans, but now I see how much alike we really are." Furthermore, George Orwell, in his dystopian book "The Triumph of Pigs", describes a gradual intellectual and behavioural transformation of an elite of animals into the humans they so abhorred. These artistic works allude to the possibility that acquiring complex and unique cognitive abilities by any other species would likely result in a human-like way of being and acting. Indeed, considering the theory according to which the difference between *H. Sapiens* and other animals is more of degree than of quality, a dichotomous nature (endowed with a behavioural spectrum between two extremes, evil

and goodness) seems to be common to both rational and irrational beings of the Animal Kingdom. Having this realistic conception is important; otherwise, a Manichean vision between humans and animals can prevail and block the opportunity to create a judicious ground for a consensus on ethical matters involving the environment and humans. The power of *H. Sapiens* gives him great responsibility in preserving the balance that makes Life possible. However, it can be difficult to resist the latent biological pressure for violence that, throughout evolution, has been an advantage for the dominant species. Only by facing the world as it really is, without taboos, prejudices and utopian ideals, can we accomplish meaningful changes.

4- Dystopia of perfection

The incessant and unrealistic demand for an alleged perfect regime by various political and social organizations grossly ignores human nature and its idiosyncrasies.

Dystopias, however well-intentioned they may be, are, in essence, despotic, so the construction of societies based on absolute control under the pretext of a supposed greater Good, such as generalized well-being, is condemned from the start as it won't respond to the vicissitudes and the diversity of human action and thought. Especially since the mid-twentieth century, when the paradigm of autonomy became dominant, most humans have not been willing to abdicate freedom. Few, if any, like to feel trapped, cornered, or forced to embed other people's ideals and ways of living that they don't share. Human history and literature have already shown us this. In their books "Brave New World" and "1984", Aldous Huxley and George Orwell, respectively, reflect brilliantly and lucidly on human nature and question control and individual freedom deprivation as proper paths to functional and peaceful societies.

Only by not smothering diversity and promoting education of fundamental human rights from an early age, underlining the importance of respecting difference, will it be possible to reach a consensual ground from which judicious ethics emerge and adequately address the problem of the sustainability of Life. Cancel cultures, or other similar prohibitionist and authoritative movements, will never be a balanced, realistic, plural, solid and temporarily tenable solution.

5- Contempt for the bottom of the iceberg

Most of the proposed solutions for environmental problems and the sustainability of the diversity of life focus on a reactive approach, ignoring the “bottom of the iceberg”, that is, the need for structural reforms to change, consequently, humans' way of thinking and acting. Taking the pollution of fossil fuels as an example, for years, it has been repeatedly emphasized that the main solution would be the replacement of diesel and gasoline vehicles by electric-powered fleets. This narrative has been adopted by various sectors of society (e.g. politicians, media) as an inevitable and miraculous solution that would decisively contribute to climate change mitigation. It was “naively” or deliberately ignored that, in fact, what was being proposed was replacing a source of pollution by another, perhaps, even more serious. Today, fortunately, public opinion is more aware that the methods for producing electricity (dams, wind turbines) [12], the exploration and acquisition of raw materials for the construction of electric vehicles (e.g., mining, such as lithium) and the impossibility of recycling various of their components (e.g., batteries) [13] are highly harmful to biodiversity [14]. The environmental degradation secondary to the exploitation of ores for the messianic "green energies" can seriously affect public health and even force the evacuation of villages from contaminated areas [15].

The obsessive focus on replacing fossil fuels with electricity, without clear environmental benefits in the way it is proposed, has masked many other problems whose negative impact on the environment is significant. The current economic model [based on valuing animals and environment-derived raw materials (e.g. skins and wood, respectively)], deforestation (e.g. promoting contact with vectors of microorganisms harmful to humans and destroying the Earth's "lungs"), irrational consumerism (which incites the unbridled, repeated and unnecessary purchase of the most diverse frivolities, such as electronic devices), overpopulation (and the inevitable pollution and resources scarcity increases) [16], unbalanced diets [stimulating the exaggerated consumption of meat or proposing an exclusively plant-based diet, which is also harmful to public health and the environment (intensive agriculture; transgenic foods)] or the focus of Medicine on treatment instead of prevention are some of the upstream problems that are never properly addressed. Several, like the need to discuss overpopulation and birth control, are taboo subjects or disregarded because they have no short-term impact. Of course, in plural societies, based on a primacy of autonomy, an imposing culture is not at all desirable. However, there are solutions that, although not immediately consequent, would certainly contribute to profound positive changes in the medium and long term, such as early and continuous education policies, promoting respect for individual freedom, cultural diversity, biodiversity and intergenerational solidarity. This is how evolved societies can be built, based on a developed literacy and a culture of transparency and demand, with clear individual and collective benefits.

6- The internal origin of morality

One of the biggest and most relevant questions in philosophical ethics is the moral status of living beings and things and their intrinsic or extrinsic value.

First, it is important to know what moral status is. According to the *Priberam* online dictionary, status refers to a "law", "rule", or "condition of a person or entity" moral derives from the Latin *moralis* and means habits, customs or traditions, and morality designates the expression of judgments that classify decisions, and the resulting behaviours, as good/correct or bad/wrong. Thus, an individual or an entity can have moral status if its relevance to society requires that its interests are always necessarily considered and safeguarded. However, it should be noted that morality is dynamic, that is, it varies over time and with cultures, so it is a Herculean task (if not even impossible) to unanimously determine a Common Moral that serves everyone and everything. Therefore, bioethics (and ethics in general) has, as a science, sought to follow the constant social, scientific, epistemological and technological transformations and to provide societies with principles, reflections and moral solutions suited to the most varied human and mundane idiosyncrasies of a world in permanent metamorphosis. There are not, and presumably never will be, perfect, unanimous, and universal moral solutions. However, it seems feasible to reach a broad consensus, albeit with room for dissension, regarding the sustaining moral foundations, at a certain point in time, of civilizational harmony within the multicultural space that is the current world. For this, it is essential to recognize morality as an ethical judgment of humanity, resulting from its capacity for reflective and philosophical thinking and, therefore, non-existent outside its internal space. So far, there is no evidence that any other species is endowed with human beings' ethical-philosophical and critical thinking. Thus, the intrinsic or extrinsic value of living beings and things will be what humanity gives them. In all ethical theories dedicated to the subject, the moral value of the environment, humans and/or animals results solely and exclusively from the attribution and moral connotation of the proponents of those theories. In these circumstances, if the positions taken by the different currents are too rigid, emasculating

the space for questioning and debate and undermining any possibility of consensus, irreconcilable worldviews and irresolvable conflicts will emerge.

7- An anthropo-symbiotic ethics

Ethical theories with a more conciliatory and balanced view of the relationship between the environment, humans and animals still have two significant limitations.

The first is considering a relationship of interdependence between the environment (or the planet, if you will) and humankind (Earth Ethics and Ecosophy). However, it is humanity who, for the moment, is dependent on Earth insofar as he cannot abdicate the preservation of viable conditions to survive. Planet Earth, incomparably older than humanity, has regenerated throughout its billions of years after several catalytic events. The illusion of immortality, which daily permeates human thought, wrongly instils the presumption of indispensability in humankind. In the future, with space exploration, humans may settle on other planets, and Earth becomes expendable, losing its inestimable value. However, for the moment, it is essential that *H. Sapiens* recognize, without subterfuge or delusional rhetoric, his insurmountable dependence on the planet. Failing to do so will maintain the current course of action towards extinction.

The second limitation of “conciliatory” theories is placing humanity at a level of moral status superimposed on other species and the environment. Now, this situation immediately poses a challenge: it needs to recognize the undeniable evolutionary supremacy of the human being. Even the most radical animalistic or environmental theories, with a pessimistic view of humanity, identifying it as the main villain of animal and environmental destruction, recognize *H. Sapiens* simultaneously as the only species capable of changing the course of events. It should be noted that the architects of these

theories are not trees or animals but humans, so the moral hierarchy they elaborate corresponds to their internal ethical judgment and not to an inalienable physical rule. Any dominant species, taking into account the evolutionary advantage of animal aggressiveness [7], would hardly accept attributing itself an equal (or inferior) moral status. Thus, a realistic solution would be to embrace anthropo-symbiotic ethics. This model recognises the indispensability of a fruitful and mutually advantageous relationship between humanity, other species, and the environment. However, humanity's superior moral status is unquestionable, and the ultimate goal of such relations is human well-being (figure 1.) Humans (as the cognitive “summity”) invest sustainably in the environment and in animals (seeking that they also benefit from the investment) in order to reap the best possible gains. In extreme situations that require a choice between the environment, animals, and humanity, the best for *H. Sapiens* should, in principle, prevail (minimizing, as far as possible, the cost to animals and the environment). It is unrealistic to think that a species with the domain and cognitive potential of human beings, which permanently challenges the limits of Existence and the Cosmos, will not always assume a superior moral status in the cycle of Life. We believe that it is only based on this assumption that a favourable ground can be built for a substantive agreement that faces environmental challenges and, at the same time, responds, in the most thoughtful and pondered way possible, to the various ethical dilemmas and conflicts that arise in the dynamics of the relation between humanity, animals and the environment. Anthro-symbiotic ethics recognizes human cognitive superiority, the dichotomous nature of humankind and animals, the evolutionary human domain and the indispensability of a long-term association between systems of different natures where, in principle, the well-being of human beings is the ultimate purpose. It also accepts that exceptional dilemmas may occur where humanity is neglected in relation to animals and nature. Imagine, for

example, that a person would have to choose between saving the life of Adolph Hitler or his faithful pet dog. What would be the most morally acceptable choice?

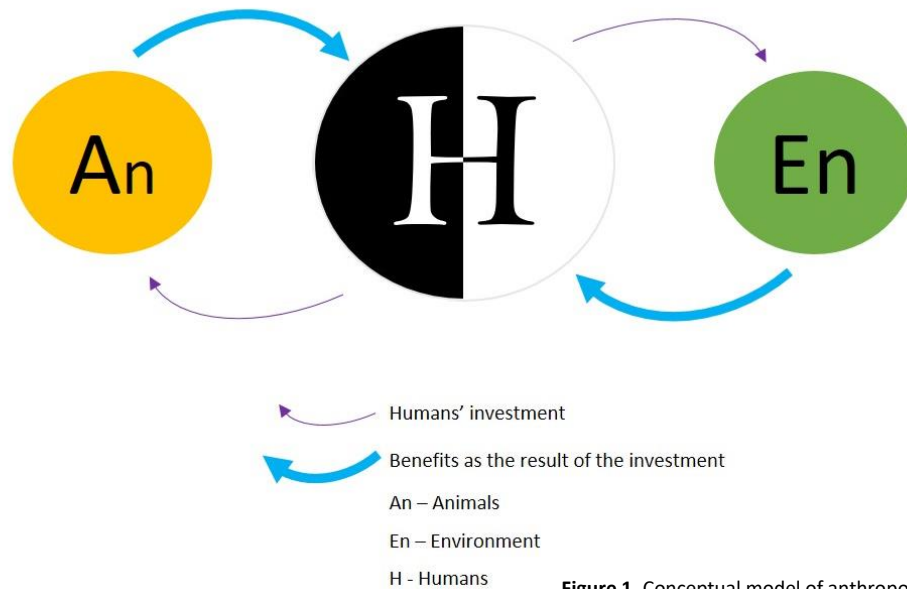


Figure 1. Conceptual model of anthropo-symbiotic ethics

8- Conclusion

The emergence of several ethics in the context of the relationship between Mankind, Nature and Animals can have a perverse effect and create an even more divisive and conflicting culture between different currents. On the other hand, the defence of similar moral plans for all is incongruous with human and animal natures, with the evolutionary dominance of some species over others and with the internal human origin of morality. Aggression and conflict are also important in maintaining the balance of ecosystems and their biodiversity. What would it be like if, for example, we attributed to animals the same intrinsic value as *H. Sapiens*, advocating that it would not be legitimate to kill them for food or interfere with their reproductive autonomy? What if, in this context, under a principle of absolute respect for animal life, human beings abolished the

consumption of meat (and fish, by the way) by all carnivores and omnivores and replaced it with other equally nutritious food? Wouldn't this unbalance ecosystems?

Moreover, if nature had an intrinsic value similar to humans, how would we solve the dilemma of destroying an entire forest to save a human being? What if we had to choose between letting our neighbour (a normal, compliant man, but with whom we have no relationship) or our pet die? Placing animals and nature on a moral plan similar to human beings would, therefore, add more confusion and arbitrariness in the face of different moral dilemmas, even assuming that, in fact, it is very unlikely that there is an entity with an intrinsic and absolute moral value under any circumstance. The inviolability of human life enshrined in the Constitution of the Portuguese Republic is a good example of this. Is it morally reprehensible to kill in a war or self-defence? On many occasions, there will never be immaculate ethical judgments. However, this does not dispense the establishment of a consensual moral hierarchical chain that, recognizing humans at the top, mitigates the whim in the field of moral decisions, making them as thoughtful and pondered as possible. Within the scope of anthropo-symbiotic ethics, there will also be room for freedom, divergence of opinion, and healthy human competitiveness. No animal, humans included, likes to feel cornered or diminished in the importance of the evolutionary domain, so it is necessary, within societies, to guarantee the right to individual autonomy and avoid, as far as possible, imposing and prohibitionist cultures. History presents us with evolution as a machine fuelled by the unique human cognitive capacity that is impossible to stop. We could even question what all the human intellectual potential would be for if one abdicated, by choice, from discovering the secrets of Life and the Cosmos (would it be acceptable to dispense animal studies and the use of raw materials from nature, giving up the discovery and the development of curative therapies for the most diverse diseases of *H. Sapiens*?)

At last, some defend, with greater or lesser vigour, that humans should refrain from interfering with the “natural order” of Life. But what is the “natural order”? If there's one thing Darwinism taught us, it is that there is no predetermined design. Moreover, for those who believe that there is, who can outright deny that humans' interference in Life is not part of that predefined purpose? The natural order will depend on the relation between the physic-chemical circumstances of the Cosmos, the interactions between the various forms of Life and the course of action of the dominant species.

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4. Attendance And Presentations in Scientific Meetings

Attendance:

- 14th World Conference on Bioethics, Medical Ethics and Health Law on March 7-10, 2022. (Annex 3)

Oral presentations:

- **Luís Fonseca**, Francesco Monteleone, Andreia Gonçalves, Gustavo Soutinho, Luís Meira-Machado, Rui Nunes. **A diferenciação cognitiva dos idosos: competência decisional no consentimento informado em saúde.** 17.º Congresso Nacional de Bioética. 26 e 27 Novembro, 2021. Faculdade de Direito da Universidade do Porto. Porto, Portugal. (Annex 4)

- **Luís Fonseca.** **Empathy as a moderator of the perception of Death.** 6th International Seminar on Palliative Care: Death, Dying and Palliative Care. June 30, 2023. Faculty of Medicine, University of Porto. Porto, Portugal. (Annex 5)

- **Luís Fonseca**, Guilhermina Rêgo, Rui Nunes. **The empathic genesis of the Right to Euthanasia.** 15th World Conference on Bioethics, Medical Ethics and Health Law. October 16 – 19. Sheraton Porto Hotel & SPA. Porto, Portugal. (Annex 6)

Panel moderator:

Session Title: End of Life Ethics II

Date and Time of the Session: Tuesday, October 17, 2023, 11:30-13:00h

15th World Conference on Bioethics, Medical Ethics and Health Law. October 16 – 19. Sheraton Porto Hotel & SPA. Porto, Portugal. (Annex 6)

ANNEX B

1. Article Acceptance Letter



Journal of Humanities and Social Sciences (ISSN: 2690-0688)

Article Acceptance Letter

Date: July 18, 2024

To

Luís Fonseca,
Bioethics Department, Faculty of Medicine, University of Porto, Porto, Portugal

It's my pleasure to inform you that, after the peer review, your paper, "**Empathy: the Core of Morality**" has been ACCEPTED to be published in Journal of Humanities and Social Sciences (ISSN: 2690-0688). Thank you for submitting your article to the Journal of Humanities and Social Sciences. I believe that our collaboration will help to accelerate the global knowledge creation and sharing one step further.

Thanks and Regards


Andrews
Managing Editor
Journal of Humanities and Social
Sciences (ISSN: 2690-0688)

**2. 14th World Conference on Bioethics, Medical Ethics and Health Law –
Certificate of Participation**



CERTIFICATE OF PARTICIPATION

Presented to

Luís Fonseca

for participate at the 14th World Conference on Bioethics, Medical Ethics and Health Law
on March 7-10, 2022.

3. A diferenciação cognitiva dos idosos: competência decisional no consentimento informado em saúde. 17.º Congresso Nacional de Bioética.

17.º CONGRESSO NACIONAL DE BIOÉTICA
O nosso futuro pós pandémico

RESUMOS

A DIFERENCIAÇÃO COGNITIVA DOS IDOSOS: COMPETÊNCIA DECISIONAL NO CONSENTIMENTO INFORMADO EM SAÚDE

Luís Fonseca* • Francesco Monteleone**
Andreia Gonçalves** • Gustavo Soutinho***
Luís Meira-Machado**** • Rui Nunes*****

Introdução: A literacia contribui, reconhecidamente, para um envelhecimento saudável. Embora literacia não seja, apenas, o grau de escolaridade, este parâmetro é um importante indicador objetivo da diferenciação cognitiva de um indivíduo. Os idosos, devido às alterações fisiológicas decorrentes do envelhecimento, à maior propensão para morbilidades médicas e a fatores de ordem psico-sócio-cultural, são uma faixa etária vulnerável. Neste âmbito, parece-nos pertinente abordar o impacto do grau da diferenciação cognitiva na sua competência decisional no consentimento informado em saúde.

Método: Partindo da análise de uma amostra de uma população idosa com síndrome depressivo-ansiosa, focamo-nos na correlação entre o grau de escolaridade e o desempenho em testes cognitivos simples como ponto de partida para uma reflexão sobre a sua competência para o consentimento informado em saúde.

Resultados: Correlação positiva entre o grau de escolaridade e os testes cognitivos. Funcionalidade preservada.

Discussão: Apesar de autónomos para as atividades de vida diária, e de todos os seus direitos fundamentais estarem garantidos (p. ex. o voto),

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** Serviço de Psiquiatria do Hospital da Senhora da Oliveira, Guimarães EPE

*** Instituto de Saúde Pública (ISPUP), Universidade do Porto

**** Departamento de Matemática & Centro de Matemática, Universidade do Minho

***** Faculdade de Medicina da Universidade do Porto

muitos destes doentes não apresentam a plenitude da competência e compreensão desejáveis para tomar decisões verdadeiramente informadas e esclarecidas na saúde.

Conclusão: Na prática, nestas pessoas, afigura-se difícil uma solução que garanta a competência e compreensão plenas para um consentimento informado esclarecido. Entendemos, porém, que existem mecanismos cuja aplicação poderia, pelo menos, mitigar essas deficiências, nomeadamente: o consentimento informado ter em conta a diferenciação cognitiva ao invés de ser padronizado; submeter os interessados a uma avaliação prévia do alcance da sua competência e capacidade de decisão; avaliar periódica e rotineiramente, cognitiva e psicopatologicamente, os idosos; se detetadas deficiências (não devido a doença) na sua capacidade de compreensão e competência, nomear alguém da confiança do próprio que participe da tomada de decisão. Deixamos estas propostas à consideração de uma desejável, profícua e mais aprofundada reflexão presente e futura sobre o assunto.

Palavras-chave: consentimento informado; bioética; geriatria; psiquiatria; cognições.

Introduction: Literacy is a known important promotor of healthy ageing. Although the word literacy does not refer only to academic achievement, the latter is an important objective indicator of one's cognitive skills. The elderly, due to the physiological changes of ageing, to a greater predisposition for medical morbidities and to psycho, social and culture-bound factors, are a vulnerable group. As such, it seems important to address the impact of their cognitive abilities on their decision-making competence for an informed consent in health issues.

Method: Based on the analysis of a group of elderly patients with depressive-anxiety syndrome, we focused on the correlation between their educational level and their performance on basic cognitive tests as a starting point for pondering on their competence for informed consent.

Results: A positive correlation between the educational level and the cognitive tests scores was present. The elderly functional independence was preserved.

Discussion: Despite being independent for the activities of daily living, and in possession of all their fundamental rights (e.g., voting), many of these patients do not have the full competence and understanding for a truly informed and clear decision in health.

R E S U M O S

Conclusion: Realistically it is difficult to find a solution which guarantees a full competence and understanding for an informed consent in these people. However, it is our believe that there are mechanisms that could at least mitigate these deficiencies, namely: instead of being standardized, the informed consent should take into account the cognitive skills of each person; assess patients' competence and decision-making abilities previously; periodically and routinely submit the elderly to cognitive and psychiatric evaluations; if deficiencies of competence and understanding are detected (that are not due to a disease), designate a patient's trustful person to engage in the decision-making process. We leave these proposals open to discussion hoping for a fruitful and more in-depth present and future thinking on the subject.

Keywords: informed consent; bioethics; geriatrics; psychiatry; cognitions

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4. Empathy as a moderator of the perception of Death. 6th International Seminar on Palliative Care: Death, Dying and Palliative Care

6TH INTERNATIONAL SEMINAR ON PALLIATIVE CARE

Death, Dying and Palliative Care

30th June, 2023, GMT+1

Aula Magna, Faculty of Medicine of the
University of Porto

9:15 Opening Session

Rui Nunes, *Diretor do Programa Doutoral em Cuidados Paliativos,
Faculdade de Medicina da Universidade do Porto*
Altamiro da Costa Pereira, *Diretor da Faculdade de Medicina
da Universidade do Porto*

9:30 Opening Panel "O Impacto da Eutanásia nos Cuidados Paliativos"

Ángela Ortega, *Universidad de Huelva*

Chair: Giovanni Cerullo

10:30 Coffee break and Posters

11:00 Panel "Controvérsias em Cuidados Paliativos"

- O Estado Atual da Rede Nacional de Cuidados
Paliativos

Rui Sousa Silva, *Presidente da Comissão Nacional de Cuidados
Paliativos*

- O Estatuto do Cuidador Informal

Catarina Pazes, *Presidente da Associação Nacional de
Cuidados Paliativos*

- Cuidados Paliativos Pediátricos

Cândida Cancelinha, *Vice-presidente da Associação Nacional
de Cuidados Paliativos*

- Comunidades Compassivas

Mariana Abranches Pinto, *Presidente da Associação
Compassio*

- Alimentação e Hidratação

Paula Silva, *Diretora do Serviço de Cuidados Paliativos, IPO-
Porto*

Chair: Carla Ribeiro

13:00 Lunch break

14:30 Panel "Universal Access to Palliative Care"

Stephen Connor, *Executive Director of Worldwide Hospice
Palliative Care Alliance*

Chair: Rui Nunes, *Elected President of the International
Chair in Bioethics*

15:30 Panel "Contemporary Issues in Palliative Care"

- Palliative Care and Euthanasia

Marie-Jose Gijssels, *End-of-Life Research Group Vrije
Universiteit Brussel & Universiteit Gent, Belgium*

- Teaching about palliative care

Frank Elsner, *Universitätsklinikum Aachen, Germany*

- The importance of meaning and purpose

Francisca Rego, *Head of the Palliative Care Department,
International Chair in Bioethics*

Chair: Chin An Lin and Ana Branco

16:30 Panel "Encountering Death"

- Experience of death at home by the palliative
care team

Hugo Oliveira, *Local Health Unit of Matosinhos - Hospital
Pedro Hispano, Portugal*

- Impact of death on healthcare professionals

Marina Maffoni, *Istituti Clinici Scientifici Maugeri IRCCS,
Psychology Unit of Montescano Institute, Italy*

- Empathy as a moderator of the perception of
death

Luis Fonseca, *Head of Psychogeriatrics/Cognitive Disorders
Unit S.º da Oliveira Hospital, Guimarães, Portugal*

Chair: Liliana Teixeira and Ricardo Fernandes

17:30 Award for Best Poster

Guilhermina Rego, *Faculty of Medicine of the University of
Porto*

17:45 Closing Session

João Fonseca, *Head of MEDCIDS Faculty of Medicine of the
University of Porto*



Registration:
https://upbioetica.org/6th_international_seminar_palliative_care/



5. Lecturer: The empathic genesis of the Right to Euthanasia; Panel Moderator. 15th World Conference on Bioethics, Medical Ethics and Health Law



Luis Fonseca <luisoliveirafonseca@gmail.com>

Pedido de foto atual e de alta resolução para site de Centro de Bioética

Rute Figueiredo <rmfigueiredo@med.up.pt>
Para: Luis Fonseca <luisoliveirafonseca@gmail.com>

4 de outubro de 2023 às 10:56

Caro Dr. Luis Fonseca,

após consultar o programa atualizado envio detalhe da sua participação na conferencia. Assim, será moderador na sessão em que fará a sua apresentação. Gostaria de esclarecer que a política da nossa conferência é ter dois co-moderadores em cada sessão e que o moderador pode também fazer a sua apresentação na mesma sessão de forma a agilizar o processo, permitindo dessa forma enquadrar e simplificar dois momentos preciosos por parte dos nossos palestrantes (apresentação e moderação) na mesma sessão. Além disso, ficamos felizes em informar que o Dr. Luis Fonseca também estará a moderar a sessão com o Dr. Ilan Keidar. Acreditamos que esta equipa proporcionará uma excelente experiência aos participantes.

Dia 17, às 11h30/13h

End of Life Ethics II
Co-Chairs: Ilan Keidar Luis Fonseca
012 Dead Again? Understanding the 2023 Revisions to the Definition of "Brain Death." <u>Jim Dammann</u> , USA
081 The association between cognitive biases and moral characteristics of healthcare workers and their treatment approach for patients with advanced dementia in acute care settings <u>Esther-Lee Marcus</u> , Israel
135 Palliative patients autonomous decision-making at the end of life and conditioning factors. <u>Elvira Huerta Andrés</u> , Spain
189 The empathic genesis of the Right to Euthanasia <u>Luis Fonseca</u> , Portugal
221 The Principles of Bioethics and their impact on debate surrounding the Right to Die <u>Karen Joan Sutton</u> , Ireland
225 I do not wish even my hater to end up in a nursing home": An autoethnography on the work of formal caregivers in wards for the mentally frail in Israel <u>Felix Kaplan</u> , Israel

Grata,

Atentamente,

Rute Figueiredo,

Centro de Bioética | Center of Bioethics
Faculdade de Medicina da Universidade do Porto / Faculty of Medicine of the University of Porto
Alameda Professor Hernâni Monteiro 4200-319 Porto, Portugal
rmfigueiredo@med.up.pt



6. Sociodemographic questionnaire and scales

Estudo de Psicogeriatria/Bioética

1. Processo Hospitalar

2. Iniciais do nome próprio e sobrenome

3. Número de utente (SNS)

Caracterização Sociodemográfica

4. Sexo

Marcar apenas uma oval.

☐ Masculino

☐ Feminino

5. Idade

6. Religião

7. Estado civil

Marcar apenas uma oval.

- ☐ Casado(a)
- ☐ Viúvo(a)
- ☐ Divorciado(a)
- ☐ Solteiro(a)

8. Anos de escolaridade

9. Profissão

Marcar apenas uma oval.

☐ Reformado Outra:

☐ Outra

10. Número de Pessoas no Agregado Familiar

Escala de Ansiedade e Depressão Hospitalar

Este questionário foi construído para ajudar a saber como se sente.

Pedimos-lhe que leia cada uma das perguntas e selecione a resposta que melhor descreve a forma como se tem sentido na última semana.

Não demore muito tempo a pensar nas respostas. A sua reação imediata a cada questão será provavelmente mais correta do que uma resposta muito ponderada.

11. 1. Sinto-me tenso/a ou contraído/a (A)

Marcar apenas uma oval.

- ☐ a maioria das vezes
- ☐ muitas vezes
- ☐ de vez em quando, ocasionalmente
- ☐ nunca

12. 2. Ainda tenho prazer nas mesmas coisas que anteriormente (D)

Marcar apenas uma oval.

- ☐ tanto como antes
- ☐ não tanto
- ☐ só um pouco
- ☐ de modo nenhum

13. 3. Tenho uma sensação de medo, como se algo de mau estivesse para acontecer (A)

Marcar apenas uma oval.

- ☐ nitidamente e muito forte
- ☐ sim, mas não muito forte
- ☐ um pouco, mas não me incomoda
- ☐ de modo algum

14. 4. Sou capaz de me rir e de me divertir com as coisas engraçadas (D)

Marcar apenas uma oval.

- ☐ tanto como habitualmente
- ☐ não tanto como antes
- ☐ nitidamente menos agora
- ☐ nunca

15. 5. Tenho a cabeça cheia de preocupações (A)

Marcar apenas uma oval.

- ☐ a maioria das vezes
- ☐ muitas vezes
- ☐ de vez em quando
- ☐ raramente

16. 6. Sinto-me bem disposto/a (D)

Marcar apenas uma oval.

- ☐ nunca
- ☐ poucas vezes
- ☐ muitas vezes
- ☐ quase sempre

17. 7. Sou capaz de me sentir à vontade e sentir-me relaxado/a (A)

Marcar apenas uma oval.

- ☐ sempre
- ☐ habitualmente
- ☐ algumas vezes
- ☐ nunca

18. 8. Sinto-me parado (D)

Marcar apenas uma oval.

- ☐ quase sempre
- ☐ com muita frequência
- ☐ algumas vezes
- ☐ nunca

19. 9. Fico tão assustado que até sinto um aperto no estômago (A)

Marcar apenas uma oval.

- ☐ nunca
- ☐ de vez em quando
- ☐ muitas vezes
- ☐ quase sempre

20. 10. Perdi o interesse em cuidar do meu aspecto (D)

Marcar apenas uma oval.

- ☐ com certeza
- ☐ não tenho cuidado como deveria
- ☐ talvez não tanto como dantes
- ☐ tanto como habitualmente

21. 11. Sinto-me impaciente e não consigo estar parado (A)

Marcar apenas uma oval.

- ☐ muito
☐ bastante
☐ um pouco
☐ não me sinto assim

22. 12. Penso com prazer no que tenho que fazer (D)

Marcar apenas uma oval.

- ☐ tanto como habitualmente
☐ menos que anteriormente
☐ bastante menos que anteriormente
☐ quase nunca

23. 13. De repente, tenho sensações de pânico (A)

Marcar apenas uma oval.

- ☐ com grande frequência
☐ muitas vezes
☐ algumas vezes
☐ nunca

24. 14. Sinto-me capaz de apreciar um bom livro ou um programa de rádio e TV (D)

Marcar apenas uma oval.

- ☐ frequentemente
- ☐ algumas vezes
- ☐ poucas vezes
- ☐ muito raramente

Índice de Barthel

25. Higiene pessoal

Marcar apenas uma oval.

- ☐ Necessita de ajuda com o cuidado pessoal
- ☐ Independente no barbear, dentes, rosto e cabelo (utensílios fornecidos)

26. Evacuar

Marcar apenas uma oval.

- ☐ Incontinente (ou necessita que lhe sejam aplicados clisteres)
- ☐ Episódios ocasionais de incontinência (uma vez por semana)
- ☐ Continente (não apresenta episódios de incontinência)

27. Urinar

Marcar apenas uma oval.

- ☐ Incontinente (ou necessita que lhe sejam aplicados clisteres)
- ☐ Episódios ocasionais de incontinência (uma vez por semana)
- ☐ Continente (não apresenta episódios de incontinência)

28. Ir à casa de banho (uso de sanitário)

Marcar apenas uma oval.

- ☐ Dependente
- ☐ Necessita de ajuda mas consegue fazer algumas coisas sozinho
- ☐ Independente (senta-se, levanta-se, limpa-se e veste-se sem ajuda)

29. Alimentação

Marcar apenas uma oval.

- ☐ Incapaz
- ☐ Necessita de ajuda para cortar, barrar manteiga, etc.
- ☐ Independente (a comida é providenciada)

30. Transferências (cadeira /cama)

Marcar apenas uma oval.

- ☐ Incapaz - não tem equilíbrio ao sentar-se
- ☐ Grande ajuda (uma ou duas pessoas) física, consegue sentar-se
- ☐ Pequena ajuda (verbal ou física)
- ☐ Independente (não necessita qualquer ajuda, mesmo que utilize cadeira de rodas)

31. Mobilidade (deambulação)

Marcar apenas uma oval.

- ☐ Imobilizado
- ☐ Independente na cadeira de rodas incluindo cantos, etc.
- ☐ Anda com ajuda de uma pessoa (verbal ou física)
- ☐ Independente (mas pode usar qualquer auxiliar, ex.: bengala)

32. Vestir-se

Marcar apenas uma oval.

- ☐ Dependente
- ☐ Necessita de ajuda, mas faz cerca de metade sem ajuda
- ☐ Independente (incluindo botões, fechos e atacadores)

33. Escadas

Marcar apenas uma oval.

- ☐ Incapaz
- ☐ Necessita de ajuda (verbal, física, transporte dos auxiliares de marcha) ou supervisão
- ☐ Independente (subir / descer escadas, com apoio do corrimão ou dispositivos ex.: muletas ou bengala)

34. Banho

Marcar apenas uma oval.

- ☐ Dependente
- ☐ Independente (lava-se no chuveiro/ banho de imersão/ usa a esponja por todo o corpo sem ajuda)

Escala de Solidão - UCLA

35. 1 -Sente-se infeliz por fazer muitas coisas sozinho

Marcar apenas uma oval.

- ☐ Frequentemente
- ☐ Algumas vezes
- ☐ Raramente
- ☐ Nunca

36. 2 – Sente que não tem alguém com quem falar

Marcar apenas uma oval.

- ☐ Frequentemente
- ☐ Algumas vezes
- ☐ Raramente
- ☐ Nunca

37. 3 - Sente que tem falta de companhia

Marcar apenas uma oval.

- ☐ Frequentemente
- ☐ Algumas vezes
- ☐ Raramente
- ☐ Nunca

4 - Sente-se como se realmente ninguém o compreendesse

Marcar apenas uma oval.

- ☐ Frequentemente
- ☐ Algumas vezes
- ☐ Raramente
- ☐ Nunca

38. 5 - Sente que não tem ninguém a quem possa recorrer

Marcar apenas uma oval.

- ☐ Frequentemente
- ☐ Algumas vezes
- ☐ Raramente
- ☐ Nunca

39. 6 - Não se sente intimo de qualquer pessoa

Marcar apenas uma oval.

- ☐ Frequentemente
- ☐ Algumas vezes
- ☐ Raramente
- ☐ Nunca

40. 7 - Sente que os que o rodeiam já não compartilham dos seus interesses

Marcar apenas uma oval.

- ☐ Frequentemente
- ☐ Algumas vezes
- ☐ Raramente
- ☐ Nunca

41. 8 – Sente-se abandonado

Marcar apenas uma oval.

- ☐ Frequentemente
- ☐ Algumas vezes
- ☐ Raramente
- ☐ Nunca

42. 9 – Sente-se completamente só

Marcar apenas uma oval.

- ☐ Frequentemente
- ☐ Algumas vezes
- ☐ Raramente
- ☐ Nunca

43. 10 – É incapaz de estabelecer contactos e comunicar com os que o rodeiam

Marcar apenas uma oval.

- ☐ Frequentemente
- ☐ Algumas vezes
- ☐ Raramente
- ☐ Nunca

44. 11 – As suas relações sociais são superficiais

Marcar apenas uma oval.

- ☐ Frequentemente
- ☐ Algumas vezes
- ☐ Raramente
- ☐ Nunca

45. 12 – Considera que na realidade ninguém o conhece bem

Marcar apenas uma oval.

- ☐ Frequentemente
☐ Algumas vezes
☐ Raramente
☐ Nunca

46. 13 – Sente-se isolado das outras pessoas

Marcar apenas uma oval.

- ☐ Frequentemente
☐ Algumas vezes
☐ Raramente
☐ Nunca

47. 14 – Sente-se infeliz de estar tão afastado dos outros

Marcar apenas uma oval.

- ☐ Frequentemente
☐ Algumas vezes
☐ Raramente
☐ Nunca

48. 15 – É-lhe difícil fazer amigos

Marcar apenas uma oval.

- ☐ Frequentemente
- ☐ Algumas vezes
- ☐ Raramente
- ☐ Nunca

49. 16 – Sente-se posta à margem e excluída das outras pessoas

Marcar apenas uma oval.

- ☐ Frequentemente
- ☐ Algumas vezes
- ☐ Raramente
- ☐ Nunca

INSTRUÇÕES: As questões que se seguem pedem-lhe opinião sobre a sua saúde, a forma como se sente e sobre a sua capacidade de desempenhar as atividades habituais. Pedimos que leia com atenção cada pergunta e que responda o mais honestamente possível. Se não tiver a certeza sobre a resposta a dar, dê-nos a que achar mais apropriada

Questionário do Estado de Saúde (SF-36v2)

50. 1. Em geral, diria que a sua saúde é:

Marcar apenas uma oval.

- ☐ Ótima
- ☐ Muito boa
- ☐ Boa
- ☐ Razoável
- ☐ Fraca

51. 2. Comparando com o que acontecia há um ano, como descreve o seu estado geral atual:

Marcar apenas uma oval.

- ☐ Muito melhor
- ☐ Com algumas melhorias
- ☐ Aproximadamente igual
- ☐ Um pouco pior
- ☐ Muito pior

3. As perguntas que se seguem são sobre atividades que executa no seu dia-a-dia. Será que a sua saúde o/a limita nestas atividades? Se sim, quanto?

64. a. Atividades violentas, tais como correr, levantar pesos, participar em desportos extenuantes

Marcar apenas uma oval.

- ☐ Sim, muito limitado/a
- ☐ Sim, um pouco limitado/a
- ☐ nada limitado/a

65. b. Atividades moderadas, tais como deslocar uma mesa ou aspirar a casa

Marcar apenas uma oval.

- ☐ Sim, muito limitado/a
- ☐ Sim, um pouco limitado/a
- ☐ nada limitado/a

66. c. Levantar ou pegar nas compras de mercearia

Marcar apenas uma oval.

- ☐ Sim, muito limitado/a
- ☐ Sim, um pouco limitado/a
- ☐ nada limitado/a

67. d. Subir vários lanços de escada

Marcar apenas uma oval.

- ☐ Sim, muito limitado/a
- ☐ Sim, um pouco limitado/a
- ☐ nada limitado/a

68. e. Subir um lanço de escadas

Marcar apenas uma oval.

- ☐ Sim, muito limitado/a
- ☐ Sim, um pouco limitado/a
- ☐ nada limitado/a

69. f. Inclinar-se, ajoelhar-se ou baixar-se

Marcar apenas uma oval.

- ☐ Sim, muito limitado/a
- ☐ Sim, um pouco limitado/a
- ☐ nada limitado/a

70. g. Andar mais de 1 Km

Marcar apenas uma oval.

- ☐ Sim, muito limitado/a
- ☐ Sim, um pouco limitado/a
- ☐ nada limitado/a

71. h. Andar várias centenas de metros

Marcar apenas uma oval.

- ☐ Sim, muito limitado/a
- ☐ Sim, um pouco limitado/a
- ☐ nada limitado/a

72. i. Andar uma centena de metros

Marcar apenas uma oval.

- ☐ Sim, muito limitado/a
- ☐ Sim, um pouco limitado/a
- ☐ nada limitado/a

73. j. Tomar banho ou vestir-se sozinho/a

Marcar apenas uma oval.

- ☐ Sim, muito limitado/a
- ☐ Sim, um pouco limitado/a
- ☐ nada limitado/a

4. Durante as últimas 4 semanas teve, no seu trabalho ou atividades diárias, algum dos problemas apresentados a seguir como consequência do seu estado de saúde físico? Quanto tempo, nas últimas quatro semanas...

74. a. Diminuiu o tempo gasto a trabalhar ou noutras atividades

Marcar apenas uma oval.

- ☐ Sempre
- ☐ A maior parte do tempo
- ☐ Algum tempo
- ☐ Pouco tempo
- ☐ Nunca

75. b. Fez menos do que queria?

Marcar apenas uma oval.

- ☐ Sempre
- ☐ A maior parte do tempo
- ☐ Algum tempo
- ☐ Pouco tempo
- ☐ Nunca

76. c. Sentiu-se limitado/a no tipo de trabalho ou outras atividades

Marcar apenas uma oval.

- ☐ Sempre
- ☐ A maior parte do tempo
- ☐ Algum tempo
- ☐ Pouco tempo
- ☐ Nunca

77. d. Teve dificuldade em executar o seu trabalho ou outras atividades (por exemplo, foi preciso mais esforço).

Marcar apenas uma oval.

- ☐ Sempre
- ☐ A maior parte do tempo
- ☐ Algum tempo
- ☐ Pouco tempo
- ☐ Nunca

5. Durante as últimas 4 semanas, teve com o seu trabalho ou com as suas atividades diárias, algum dos problemas apresentados a seguir devido a quaisquer problemas emocionais (tal como sentir-se deprimido/a ou ansioso/a)? Quanto tempo, nas últimas quatro semanas...

78. a. Diminuiu o tempo gasto a trabalhar ou noutras atividades

Marcar apenas uma oval.

- ☐ Sempre
- ☐ A maior parte do tempo
- ☐ Algum tempo
- ☐ Pouco tempo
- ☐ Nunca

79. b. Fez menos do que queria?

Marcar apenas uma oval.

- ☐ Sempre
- ☐ A maior parte do tempo
- ☐ Algum tempo
- ☐ Pouco tempo
- ☐ Nunca

80. c. Executou o seu trabalho ou outras atividades menos cuidadosamente do que era costume

Marcar apenas uma oval.

- ☐ Sempre
- ☐ A maior parte do tempo
- ☐ Algum tempo
- ☐ Pouco tempo
- ☐ Nunca

81. 6. Durante as últimas 4 semanas, em que medida é que a sua saúde física ou problemas emocionais interferiram no seu relacionamento social normal com a família, amigos, vizinhos ou outras pessoas?

Marcar apenas uma oval.

- ☐ Absolutamente nada
- ☐ Pouco
- ☐ Moderadamente
- ☐ Bastante
- ☐ Imenso

82. 7. Durante as últimas 4 semanas teve dores?

Marcar apenas uma oval.

- ☐ Nenhumas
- ☐ Muito fracas
- ☐ Ligeiras
- ☐ Moderadas
- ☐ Fortes
- ☐ Muito fortes

83. 8. Durante as últimas 4 semanas, de que forma é que a dor interferiu com o seu trabalho normal (tanto o trabalho fora de casa como o trabalho doméstico)?

Marcar apenas uma oval.

- ☐ Absolutamente nada
- ☐ Pouco
- ☐ Moderadamente
- ☐ Bastante
- ☐ Imenso

9. As perguntas que se seguem pretendem avaliar a forma como se sentiu e como lhe correram as coisas nas últimas quatro semanas. Para cada pergunta, selecione por favor o número que melhor descreve a forma como se sentiu. Quanto tempo, nas últimas quatro semanas...

84. a. Se sentiu cheio/a de vitalidade?

Marcar apenas uma oval.

- ☐ Sempre
- ☐ A maior parte do tempo
- ☐ Algum tempo
- ☐ Pouco tempo
- ☐ Nunca

85. b. Se sentiu muito nervoso/a?

Marcar apenas uma oval.

- ☐ Sempre
- ☐ A maior parte do tempo
- ☐ Algum tempo
- ☐ Pouco tempo
- ☐ Nunca

86. c. Se sentiu tão deprimido/a que nada o/a animava?

Marcar apenas uma oval.

- ☐ Sempre
- ☐ A maior parte do tempo
- ☐ Algum tempo
- ☐ Pouco tempo
- ☐ Nunca

87. d. Se sentiu calmo/a e tranquilo/a?

Marcar apenas uma oval.

- ☐ Sempre
- ☐ A maior parte do tempo
- ☐ Algum tempo
- ☐ Pouco tempo
- ☐ Nunca

88. e. Se sentiu com muita energia?

Marcar apenas uma oval.

- ☐ Sempre
- ☐ A maior parte do tempo
- ☐ Algum tempo
- ☐ Pouco tempo
- ☐ Nunca

89. f. Se sentiu deprimido/a?

Marcar apenas uma oval.

- ☐ Sempre
- ☐ A maior parte do tempo
- ☐ Algum tempo
- ☐ Pouco tempo
- ☐ Nunca

90. g. Se sentiu estafado/a?

Marcar apenas uma oval.

- ☐ Sempre
- ☐ A maior parte do tempo
- ☐ Algum tempo
- ☐ Pouco tempo
- ☐ Nunca

91. h. Se sentiu feliz?

Marcar apenas uma oval.

- ☐ Sempre
- ☐ A maior parte do tempo
- ☐ Algum tempo
- ☐ Pouco tempo
- ☐ Nunca

92. i. Se sentiu cansado/a?

Marcar apenas uma oval.

- ☐ Sempre
- ☐ A maior parte do tempo
- ☐ Algum tempo
- ☐ Pouco tempo
- ☐ Nunca

93. 10. Durante as últimas quatro semanas, até que ponto é que a sua saúde física ou problemas emocionais limitaram a sua atividade social (tal como visitar amigos ou familiares próximos)?

Marcar apenas uma oval.

- ☐ Sempre
- ☐ A maior parte do tempo
- ☐ Algum tempo
- ☐ Pouco tempo
- ☐ Nunca

11. Por favor, diga em que medida são verdadeiras ou falsas as seguintes afirmações.
Ponha um círculo para cada linha.

94. a. Parece que adoço mais facilmente do que os outros

Marcar apenas uma oval.

- ☐ Absolutamente verdade
- ☐ Verdade
- ☐ Não sei
- ☐ Falso
- ☐ Absolutamente falso

95. b. Sou tão saudável como qualquer outra pessoa

Marcar apenas uma oval.

- ☐ Absolutamente verdade
- ☐ Verdade
- ☐ Não sei
- ☐ Falso
- ☐ Absolutamente falso

96. c. Estou convencido/a que a minha saúde vai piorar

Marcar apenas uma oval.

- ☐ Absolutamente verdade
- ☐ Verdade
- ☐ Não sei
- ☐ Falso
- ☐ Absolutamente falso

97. d. A minha saúde é ótima

Marcar apenas uma oval.

- ☐ Absolutamente verdade
- ☐ Verdade
- ☐ Não sei
- ☐ Falso
- ☐ Absolutamente falso

**Questionário de
Melbourne de
Tomada de
Decisão**

Instruções

As pessoas diferem na forma como tomam decisões. Por favor indique como toma decisões indicando, em cada questão, a resposta que melhor representa o seu estilo habitual de decidir.

98. Sinto-me confiante em relação à minha capacidade em tomar decisões.

Marcar apenas uma oval.

- ☐ verdade em relação a mim
☐ por vezes verdade
☐ falso em relação a mim

99. Sinto-me inferior à maioria das pessoas a tomar decisões.

Marcar apenas uma oval.

- ☐ verdade em relação a mim
☐ por vezes verdade
☐ falso em relação a mim

100. Penso que sou um(a) bom(a) decisor(a).

Marcar apenas uma oval.

- ☐ verdade em relação a mim
☐ por vezes verdade
☐ falso em relação a mim

101. Sinto-me tão desmotivado(a) que desisto de tomar decisões.

Marcar apenas uma oval.

- ☐ verdade em relação a mim
- ☐ por vezes verdade
- ☐ falso em relação a mim

102. As decisões que tomo resultam bem.

Marcar apenas uma oval.

- ☐ verdade em relação a mim
- ☐ por vezes verdade
- ☐ falso em relação a mim

103. É fácil para outras pessoas convencerem-me que as suas decisões, em vez das minhas, são as melhores.

Marcar apenas uma oval.

- ☐ verdade em relação a mim
- ☐ por vezes verdade
- ☐ falso em relação a mim

104. 1. Sinto como se estivesse sobre grande pressão de tempo quando estou a tomar decisões.

Marcar apenas uma oval.

- ☐ Verdade em relação a mim
- ☐ Por vezes verdade
- ☐ Falso em relação a mim

105. 2. Gosto de considerar todas as alternativas.

Marcar apenas uma oval.

- ☐ Verdade em relação a mim
- ☐ Por vezes verdade
- ☐ Falso em relação a mim

106. 3. Prefiro deixar as decisões para outras pessoas.

Marcar apenas uma oval.

- ☐ Verdade em relação a mim
- ☐ Por vezes verdade
- ☐ Falso em relação a mim

107. 4. Tento descobrir as desvantagens de todas as alternativas.

Marcar apenas uma oval.

- ☐ Verdade em relação a mim
- ☐ Por vezes verdade
- ☐ Falso em relação a mim

108. 5. Gasto muito tempo em assuntos triviais antes de me dedicar à decisão final.

Marcar apenas uma oval.

- ☐ Verdade em relação a mim
- ☐ Por vezes verdade
- ☐ Falso em relação a mim

109. 6. Analiso a melhor forma de levar a cabo uma decisão.

Marcar apenas uma oval.

- ☐ Verdade em relação a mim
- ☐ Por vezes verdade
- ☐ Falso em relação a mim

110. 7. Mesmo depois de tomar uma decisão demoro a agir de acordo com ela.

Marcar apenas uma oval.

- ☐ Verdade em relação a mim
- ☐ Por vezes verdade
- ☐ Falso em relação a mim

111. 8. Quando tomo decisões gosto de recolher muita informação.

Marcar apenas uma oval.

- ☐ Verdade em relação a mim
 - ☐ Por vezes
 - ☐ verdade O Falso
- em relação a mim

112. 9. Evito tomar decisões.

Marcar apenas uma oval.

- ☐ Verdade em relação a mim
- ☐ Por vezes verdade
- ☐ Falso em relação a mim

113. 10. Quando tenho que tomar uma decisão espero muito tempo antes de começar a pensar no assunto.

Marcar apenas uma oval.

- ☐ Verdade em relação a mim
- ☐ Por vezes verdade
- ☐ Falso em relação a mim

114. 11. Não gosto de assumir a responsabilidade de tomar decisões.

Marcar apenas uma oval.

- ☐ Verdade em relação a mim
- ☐ Por vezes verdade
- ☐ Falso em relação a mim

115. 12. Tento ser claro(a) sobre os meus objetivos antes de escolher.

Marcar apenas uma oval.

- ☐ Verdade em relação a mim
- ☐ Por vezes verdade
- ☐ Falso em relação a mim

116. 13. A possibilidade que alguma pequena coisa possa correr mal leva-me a mudar rapidamente as minhas preferências.

Marcar apenas uma oval.

- ☐ Verdade em relação a mim
- ☐ Por vezes verdade
- ☐ Falso em relação a mim

117. 14. Se uma decisão pode ser tomada por mim ou por outra pessoa eu deixo que outra pessoa a faça.

Marcar apenas uma oval.

- ☐ Verdade em relação a mim
- ☐ Por vezes verdade
- ☐ Falso em relação a mim

118. 15. Sempre que enfrento uma decisão difícil sinto-me pessimista sobre encontrar uma boa solução. *Marcar apenas uma oval.*

- ☐ Verdade em relação a mim
- ☐ Por vezes verdade
- ☐ Falso em relação a mim

119. 16. Tomo muito cuidado antes de escolher.

Marcar apenas uma oval.

- ☐ Verdade em relação a mim
- ☐ Por vezes verdade
- ☐ Falso em relação a mim

120. 17. Não tomo decisões a não ser que tenha mesmo que ser.

Marcar apenas uma oval.

- ☐ Verdade em relação a mim
- ☐ Por vezes verdade
- ☐ Falso em relação a mim

121. 18. Adio tomar decisões até que seja demasiado tarde.

Marcar apenas uma oval.

- ☐ Verdade em relação a mim
- ☐ Por vezes verdade
- ☐ Falso em relação a mim

122. 19. Prefiro que pessoas que estão melhor informadas que decidam por mim.

Marcar apenas uma oval.

- ☐ Verdade em relação a mim
- ☐ Por vezes verdade
- ☐ Falso em relação a mim

123. 20. Depois de uma decisão ser tomada gasto muito tempo convencendo-me que era a correta.

Marcar apenas uma oval.

- ☐ Verdade em relação a mim
- ☐ Por vezes verdade
- ☐ Falso em relação a mim

124. 21. Adio ter que tomar decisões.

Marcar apenas uma oval.

- ☐ Verdade em relação a mim
- ☐ Por vezes verdade
- ☐ Falso em relação a mim

125. 22. Não consigo pensar adequadamente se tenho que decidir rapidamente.

Marcar apenas uma oval.

- ☐ Verdade em relação a mim
- ☐ Por vezes verdade
- ☐ Falso em relação a mim

Escala de atitudes perante a eutanásia (Yara et al)

Esta escala consta de 26 frases relativas à eutanásia, isto é, à prática pela qual se procura abreviar, sem dor ou sofrimento, a vida de um doente incurável.

O objetivo deste instrumento é, apenas, conhecer a opinião geral a respeito das ideias contidas nas frases. Não há respostas certas nem erradas. O importante é que não deixe de opinar sobre nenhuma das frases. Existem 5 respostas possíveis para cada frase:

Concordo totalmente - se concorda sem nenhuma dúvida

Concordo em parte - se concorda mais do que discorda

Indeciso - se não concorda nem discorda

Discordo em parte - se discorda mais do que concorda

Discordo totalmente - se discorda sem nenhuma dúvida

Escolha aquela que melhor expressa a sua opinião

126. 1. É um absurdo manter uma pessoa em vida vegetativa através de aparelhos artificiais

Marcar apenas uma oval.

- ☐ Concordo totalmente
- ☐ Concordo em parte
- ☐ Indeciso
- ☐ Discordo em parte
- ☐ Discordo totalmente

127. 2. Se existem condições para manter vivo um doente com recursos artificiais, mesmo que por tempo indefinido, não se deve praticar a eutanásia.

Marcar apenas uma oval.

- ☐ Concordo totalmente
- ☐ Concordo em parte
- ☐ Indeciso
- ☐ Discordo em parte
- ☐ Discordo totalmente

128. 3. Não hesitaria em abreviar, sem dor nem sofrimento, a vida de um doente reconhecidamente condenado.

Marcar apenas uma oval.

- ☐ Concordo totalmente
- ☐ Concordo em parte
- ☐ Indeciso
- ☐ Discordo em parte
- ☐ Discordo totalmente

129. 4. A prática da eutanásia é uma violência camuflada.

Marcar apenas uma oval.

- ☐ Concordo totalmente
- ☐ Concordo em parte
- ☐ Indeciso
- ☐ Discordo em parte
- ☐ Discordo totalmente

130. 5. A eutanásia é um direito do Homem.

Marcar apenas uma oval.

- ☐ Concordo totalmente
- ☐ Concordo em parte
- ☐ Indeciso
- ☐ Discordo em parte
- ☐ Discordo totalmente

131. 6. O Homem não deve ter o direito de abreviar a vida de outro, nem para poupá-lo de sofrimentos maiores que o levarão irremediavelmente à morte.

Marcar apenas uma oval.

- ☐ Concordo totalmente
- ☐ Concordo em parte
- ☐ Indeciso
- ☐ Discordo em parte
- ☐ Discordo totalmente

132. 7. Não me sentiria culpado permitindo a eutanásia de um dos meus familiares que estivesse desenganado e a sofrer terrivelmente.

Marcar apenas uma oval.

- ☐ Concordo totalmente
- ☐ Concordo em parte
- ☐ Indeciso
- ☐ Discordo em parte
- ☐ Discordo totalmente

133. 8. É cobardia optar pela eutanásia.

Marcar apenas uma oval.

- ☐ Concordo totalmente
- ☐ Concordo em parte
- ☐ Indeciso
- ☐ Discordo em parte
- ☐ Discordo totalmente

134. 9. A eutanásia deve ser praticada em situações definidas, simplesmente, por razões humanitárias.

Marcar apenas uma oval.

- ☐ Concordo totalmente
- ☐ Concordo em parte
- ☐ Indeciso
- ☐ Discordo em parte
- ☐ Discordo totalmente

135. 10. Deve manter-se o doente incurável, o tempo que for preciso, apenas com paliativos em vez de lhe abreviar a morte.

Marcar apenas uma oval.

- ☐ Concordo totalmente
- ☐ Concordo em parte
- ☐ Indeciso
- ☐ Discordo em parte
- ☐ Discordo totalmente

136. 11. Abreviar com a morte os sofrimentos de alguém que se ama é, antes de tudo, um acto de humanidade.

Marcar apenas uma oval.

- ☐ Concordo totalmente
- ☐ Concordo em parte
- ☐ Indeciso
- ☐ Discordo em parte
- ☐ Discordo totalmente

137. 12. A família que realmente ama o doente nunca autoriza a eutanásia.

Marcar apenas uma oval.

- ☐ Concordo totalmente
- ☐ Concordo em parte
- ☐ Indeciso
- ☐ Discordo em parte
- ☐ Discordo totalmente

138. 13. Uma legislação especial permitindo a prática a eutanásia seria uma conquista da humanidade.

Marcar apenas uma oval.

- ☐ Concordo totalmente
- ☐ Concordo em parte
- ☐ Indeciso
- ☐ Discordo em parte
- ☐ Discordo totalmente

139. 14. Aquele que pensa saber a hora certa para alguém deixar de viver julga-se Todo-Poderoso.

Marcar apenas uma oval.

- ☐ Concordo totalmente
- ☐ Concordo em parte
- ☐ Indeciso
- ☐ Discordo em parte
- ☐ Discordo totalmente

140. 15. Se o doente não está mais lúcido e a família assumir a decisão, a eutanásia deve ser praticada.

Marcar apenas uma oval.

- ☐ Concordo totalmente
- ☐ Concordo em parte
- ☐ Indeciso
- ☐ Discordo em parte
- ☐ Discordo totalmente

141. 16. Por motivos vários não deve haver uma legislação especial permitindo a prática da eutanásia.

Marcar apenas uma oval.

- ☐ Concordo totalmente
- ☐ Concordo em parte
- ☐ Indeciso
- ☐ Discordo em parte
- ☐ Discordo totalmente

142. 17. Há certas circunstâncias em que a pessoa tem todo o direito de decidir se quer ou não continuar à espera da morte.

Marcar apenas uma oval.

- ☐ Concordo totalmente
- ☐ Concordo em parte
- ☐ Indeciso
- ☐ Discordo em parte
- ☐ Discordo totalmente

143. 18. O direito de vida e o direito de morte escapam, sob qualquer circunstância, ao âmbito de decisão do Ser Humano.

Marcar apenas uma oval.

- ☐ Concordo totalmente
- ☐ Concordo em parte
- ☐ Indeciso
- ☐ Discordo em parte
- ☐ Discordo totalmente

144. 19. Ter direito à eutanásia é ter direito a uma morte digna.

Marcar apenas uma oval.

- ☐ Concordo totalmente
- ☐ Concordo em parte
- ☐ Indeciso
- ☐ Discordo em parte
- ☐ Discordo totalmente

145. 20. Praticar a eutanásia é matar por amor, mas não deixa de ser assassinato.

Marcar apenas uma oval.

- ☐ Concordo totalmente
- ☐ Concordo em parte
- ☐ Indeciso
- ☐ Discordo em parte
- ☐ Discordo totalmente

146. 21. É um crime manter um ser humano em vida puramente vegetativa.

Marcar apenas uma oval.

- ☐ Concordo totalmente
- ☐ Concordo em parte
- ☐ Indeciso
- ☐ Discordo em parte
- ☐ Discordo totalmente

147. 22. A eutanásia não se aplica a nenhum caso, pois cada doente reage de forma diferente a uma mesma doença.

Marcar apenas uma oval.

- ☐ Concordo totalmente
- ☐ Concordo em parte
- ☐ Indeciso
- ☐ Discordo em parte
- ☐ Discordo totalmente

148. 23. Uma legislação especial permitindo a prática da eutanásia deveria ser ampla, abrangendo o maior número de casos incuráveis e fatais.

Marcar apenas uma oval.

- ☐ Concordo totalmente
- ☐ Concordo em parte
- ☐ Indeciso
- ☐ Discordo em parte
- ☐ Discordo totalmente

149. 24. Quem autoriza a morte de um parente, na verdade quer aliviar a sua própria dor.

Marcar apenas uma oval.

- ☐ Concordo totalmente
- ☐ Concordo em parte
- ☐ Indeciso
- ☐ Discordo em parte
- ☐ Discordo totalmente

150. 25. Se desligar as máquinas de suporte artificial à vida não resolver, deve ser aplicada uma injeção que adiante a morte do condenado.

Marcar apenas uma oval.

- ☐ Concordo totalmente
- ☐ Concordo em parte
- ☐ Indeciso
- ☐ Discordo em parte
- ☐ Discordo totalmente

151. 26. O sofrimento do doente incurável faz parte da sua missão na Terra, por isso a eutanásia não deve ser praticada.

Marcar apenas uma oval.

- ☐ Concordo totalmente
- ☐ Concordo em parte
- ☐ Indeciso
- ☐ Discordo em parte
- ☐ Discordo totalmente

Escala de Atitudes perante a Eutanásia, Wasserman et al

152. 1. Se um paciente em dor severa o pedir, um médico deverá remover o suporte de vida e deixar o paciente morrer.

Marcar apenas uma oval.

- ☐ Discordo fortemente
☐ Discordo
☐ Indeciso
☐ Concordo
☐ Concordo fortemente

153. 2. É aceitável para um médico que já não acredita na recuperação de um paciente, administrar-lhe remédios suficientes que ponham fim à vida do paciente.

Marcar apenas uma oval.

- ☐ Discordo fortemente
☐ Discordo
☐ Indeciso
☐ Concordo
☐ Concordo fortemente

154. 3. Se um paciente em estado de dor extrema o pedir, um médico deverá prescrever a esse paciente medicação suficiente para pôr termo à sua vida.

Marcar apenas uma oval.

- ☐ Discordo fortemente
- ☐ Discordo
- ☐ Indeciso
- ☐ Concordo
- ☐ Concordo fortemente

155. 4. É correto para um médico que já não acredita na recuperação de um paciente, retirar-lhe o suporte de vida e deixá-lo morrer.

Marcar apenas uma oval.

- ☐ Discordo fortemente
- ☐ Discordo
- ☐ Indeciso
- ☐ Concordo
- ☐ Concordo fortemente

156. 5. É aceitável para um médico administrar medicação suficiente a um paciente em sofrimento para terminar a sua vida se o médico considerar que a dor do paciente é demasiado severa.

Marcar apenas uma oval.

- ☐ Discordo fortemente
- ☐ Discordo
- ☐ Indeciso
- ☐ Concordo
- ☐ Concordo fortemente

157. 6. Mesmo que um médico não considere que um paciente vai recuperar, será errado para um o médico terminar a vida de um paciente.* *Marcar apenas uma oval.*

- ☐ Discordo fortemente
- ☐ Discordo
- ☐ Indeciso
- ☐ Concordo
- ☐ Concordo fortemente

158. 7. É aceitável para um médico remover o suporte de vida de um paciente e deixá-lo morrer se o médico considerar que a dor do paciente é demasiado severa

Marcar apenas uma oval.

- ☐ Discordo fortemente
- ☐ Discordo
- ☐ Indeciso
- ☐ Concordo
- ☐ Concordo fortemente

159. 8. Se um paciente moribundo o pedir, o médico deverá prescrever medicação suficiente para terminar a sua vida *Marcar apenas uma oval.*

- ☐ Discordo fortemente
- ☐ Discordo
- ☐ Indeciso
- ☐ Concordo
- ☐ Concordo fortemente

160. 9. Mesmo que um médico saiba que o paciente se encontra em dor severa e incontrolável, será errado para o médico terminar a vida desse paciente.*

Marcar apenas uma oval.

- ☐ Discordo fortemente
- ☐ Discordo
- ☐ Indeciso
- ☐ Concordo
- ☐ Concordo fortemente

161. 10. Se um paciente moribundo (ou em estado terminal) o pedir, um médico deve remover o seu suporte de vida e deixá-lo morrer.

Marcar apenas uma oval.

- ☐ Discordo fortemente
- ☐ Discordo
- ☐ Indeciso
- ☐ Concordo
- ☐ Concordo fortemente

Escala de Personalidade NEO-FFI

162. 1. Não sou uma pessoa preocupada *

Marcar apenas uma oval.

- ☐ Discordo fortemente
- ☐ Discordo
- ☐ Neutro
- ☐ Concordo
- ☐ Concordo fortemente

163. 2. Gosto de ter muita gente à minha volta **

Marcar apenas uma oval.

- ☐ Discordo fortemente
- ☐ Discordo
- ☐ Neutro
- ☐ Concordo
- ☐ Concordo fortemente

164. 3. Não gosto de perder tempo a sonhar acordado(a) ***

Marcar apenas uma oval.

- ☐ Discordo fortemente
- ☐ Discordo
- ☐ Neutro
- ☐ Concordo
- ☐ Concordo fortemente

165. 4. Tento ser delicado(a) com todas as pessoas que encontro****

Marcar apenas uma oval.

- ☐ Discordo fortemente
- ☐ Discordo
- ☐ Neutro
- ☐ Concordo
- ☐ Concordo fortemente

166. 5. Mantenho as minhas coisas limpas e em ordem*****

Marcar apenas uma oval.

- ☐ Discordo fortemente
- ☐ Discordo
- ☐ Neutro
- ☐ Concordo
- ☐ Concordo fortemente

167. 6. Sinto-me muitas vezes inferior às outras pessoas*

Marcar apenas uma oval.

- ☐ Discordo fortemente
- ☐ Discordo
- ☐ Neutro
- ☐ Concordo
- ☐ Concordo fortemente

168. 7. Rio facilmente**

Marcar apenas uma oval.

- ☐ Discordo fortemente
- ☐ Discordo
- ☐ Neutro
- ☐ Concordo
- ☐ Concordo fortemente

169. 8. Quando encontro uma maneira correcta de fazer qualquer coisa não mudo mais***

Marcar apenas uma oval.

- ☐ Discordo fortemente
- ☐ Discordo
- ☐ Neutro
- ☐ Concordo
- ☐ Concordo fortemente

170. 9. Frequentemente arranjo discussões com a minha família e colegas de trabalho****

Marcar apenas uma oval.

- ☐ Discordo fortemente
- ☐ Discordo
- ☐ Neutro
- ☐ Concordo
- ☐ Concordo fortemente

171. 10. Sou bastante capaz de organizar o meu tempo de maneira a fazer as coisas dentro do prazo*****

Marcar apenas uma oval.

- ☐ Discordo fortemente
- ☐ Discordo
- ☐ Neutro
- ☐ Concordo
- ☐ Concordo fortemente

172. 11. Quando estou numa grande tensão sinto-me, às vezes, como se me estivessem a fazer em pedaços*

Marcar apenas uma oval.

- ☐ Discordo fortemente
- ☐ Discordo
- ☐ Neutro
- ☐ Concordo
- ☐ Concordo fortemente

173. 12. Não me considero uma pessoa alegre**

Marcar apenas uma oval.

- ☐ Discordo fortemente
- ☐ Discordo
- ☐ Neutro
- ☐ Concordo
- ☐ Concordo fortemente

174. 13. Fico admirado(a) com os modelos que encontro na arte e na natureza***

Marcar apenas uma oval.

- ☐ Discordo fortemente
- ☐ Discordo
- ☐ Neutro
- ☐ Concordo
- ☐ Concordo fortemente

175. 14. Algumas pessoas pensam que sou invejoso(a) ou egoísta****

Marcar apenas uma oval.

- ☐ Discordo fortemente
- ☐ Discordo
- ☐ Neutro
- ☐ Concordo
- ☐ Concordo fortemente

176. 15. Não sou uma pessoa muito metódica (ordenada)*****

Marcar apenas uma oval.

- ☐ Discordo fortemente
- ☐ Discordo
- ☐ Neutro
- ☐ Concordo
- ☐ Concordo fortemente

177. 16. Raramente me sinto só ou abatido(a)*

Marcar apenas uma oval.

- ☐ Discordo fortemente
- ☐ Discordo
- ☐ Neutro
- ☐ Concordo
- ☐ Concordo fortemente

178. 17. Gosto muito de falar com as outras pessoas**

Marcar apenas uma oval.

- ☐ Discordo fortemente
- ☐ Discordo
- ☐ Neutro
- ☐ Concordo
- ☐ Concordo fortemente

179. 18. Acredito que deixar os alunos ouvir pessoas, com ideias discutíveis, só os pode confundir e desorientar***

Marcar apenas uma oval.

- ☐ Discordo fortemente
- ☐ Discordo
- ☐ Neutro
- ☐ Concordo
- ☐ Concordo fortemente

180. 19. Preferia colaborar com as outras pessoas do que competir com elas****

Marcar apenas uma oval.

- ☐ Discordo fortemente
- ☐ Discordo
- ☐ Neutro
- ☐ Concordo
- ☐ Concordo fortemente

181. 20. Tento realizar, conscienciosamente, todas as minhas obrigações*****

Marcar apenas uma oval.

- ☐ Discordo fortemente
- ☐ Discordo
- ☐ Neutro
- ☐ Concordo
- ☐ Concordo fortemente

182. 21. Muitas vezes sinto-me tenso(a) e enervado(a)*

Marcar apenas uma oval.

- ☐ Discordo fortemente
- ☐ Discordo
- ☐ Neutro
- ☐ Concordo
- ☐ Concordo fortemente

183. 22. Gosto de estar onde está a ação**

Marcar apenas uma oval.

- ☐ Discordo fortemente
- ☐ Discordo
- ☐ Neutro
- ☐ Concordo
- ☐ Concordo fortemente

184. 23. A poesia pouco ou nada me diz***

Marcar apenas uma oval.

- ☐ Discordo fortemente
- ☐ Discordo
- ☐ Neutro
- ☐ Concordo
- ☐ Concordo fortemente

185. 24. Tendo a ser descrente ou a duvidar das boas intenções dos outros****

Marcar apenas uma oval.

- ☐ Discordo fortemente
- ☐ Discordo
- ☐ Neutro
- ☐ Concordo
- ☐ Concordo fortemente

186. 25. Tenho objetivos claros e faço por atingi-los de uma forma ordenada*****

Marcar apenas uma oval.

- ☐ Discordo fortemente
- ☐ Discordo
- ☐ Neutro
- ☐ Concordo
- ☐ Concordo fortemente

187. 26. Às vezes sinto-me completamente inútil*

Marcar apenas uma oval.

- ☐ Discordo fortemente
- ☐ Discordo
- ☐ Neutro
- ☐ Concordo
- ☐ Concordo fortemente

188. 27. Normalmente prefiro fazer as coisas sozinho(a)**

Marcar apenas uma oval.

- ☐ Discordo fortemente
- ☐ Discordo
- ☐ Neutro
- ☐ Concordo
- ☐ Concordo fortemente

189. 28. Frequentemente experimento comidas novas e desconhecidas***

Marcar apenas uma oval.

- ☐ Discordo fortemente
- ☐ Discordo
- ☐ Neutro
- ☐ Concordo
- ☐ Concordo fortemente

190. 29. Penso que a maior parte das pessoas abusa de nós, se as deixar-mos****

Marcar apenas uma oval.

- ☐ Discordo fortemente
- ☐ Discordo
- ☐ Neutro
- ☐ Concordo
- ☐ Concordo fortemente

191. 30. Perco muito tempo antes de me concentrar no trabalho*****

Marcar apenas uma oval.

- ☐ Discordo fortemente
- ☐ Discordo
- ☐ Neutro
- ☐ Concordo
- ☐ Concordo fortemente

192. 31. Raramente me sinto amedrontado(a) ou ansioso(a)*

Marcar apenas uma oval.

- ☐ Discordo fortemente
- ☐ Discordo
- ☐ Neutro
- ☐ Concordo
- ☐ Concordo fortemente

193. 32. Muitas vezes sinto-me a rebentar de energia**

Marcar apenas uma oval.

- ☐ Discordo fortemente
- ☐ Discordo
- ☐ Neutro
- ☐ Concordo
- ☐ Concordo fortemente

194. 33. Poucas vezes me dou conta da influência que determinados ambientes produzem nas pessoas***

Marcar apenas uma oval.

- ☐ Discordo fortemente
- ☐ Discordo
- ☐ Neutro
- ☐ Concordo
- ☐ Concordo fortemente

195. 34. A maioria das pessoas que conheço gostam de mim****

Marcar apenas uma oval.

- ☐ Discordo fortemente
- ☐ Discordo
- ☐ Neutro
- ☐ Concordo
- ☐ Concordo fortemente

196. 35. Trabalho muito para conseguir o que quero*****

Marcar apenas uma oval.

- ☐ Discordo fortemente
- ☐ Discordo
- ☐ Neutro
- ☐ Concordo
- ☐ Concordo fortemente

197. 36. Muitas vezes aborrece-me a maneira como as pessoas me tratam*

Marcar apenas uma oval.

- ☐ Discordo fortemente
- ☐ Discordo
- ☐ Neutro
- ☐ Concordo
- ☐ Concordo fortemente

198. 37. Sou uma pessoa alegre e bem-disposta**

Marcar apenas uma oval.

- ☐ Discordo fortemente
- ☐ Discordo
- ☐ Neutro
- ☐ Concordo
- ☐ Concordo fortemente

199. 38. Acredito que devemos ter em conta a autoridade religiosa quando se trata de tomar decisões respeitantes à moral*** *Marcar apenas uma oval.*

- ☐ Discordo fortemente
- ☐ Discordo
- ☐ Neutro
- ☐ Concordo
- ☐ Concordo fortemente

200. 39. Algumas pessoas consideram-me frio(a) e calculista****

Marcar apenas uma oval.

- ☐ Discordo fortemente
- ☐ Discordo
- ☐ Neutro
- ☐ Concordo
- ☐ Concordo fortemente

201. 40. Quando assumo um compromisso podem sempre contar que eu o cumpra*****

Marcar apenas uma oval.

- ☐ Discordo fortemente
- ☐ Discordo
- ☐ Neutro
- ☐ Concordo
- ☐ Concordo fortemente

202. 41. Muitas vezes quando as coisas não me correm bem perco a coragem e tenho vontade de desistir* *Marcar apenas uma oval.*

- ☐ Discordo fortemente
- ☐ Discordo
- ☐ Neutro
- ☐ Concordo
- ☐ Concordo fortemente

203. 42. Não sou um(a) grande otimista**

Marcar apenas uma oval.

- ☐ Discordo fortemente
- ☐ Discordo
- ☐ Neutro
- ☐ Concordo
- ☐ Concordo fortemente

204. 43. Às vezes ao ler poesia e ao olhar para uma obra de arte sinto um arrepio ou uma onda de emoção*** *Marcar apenas uma oval.*

- ☐ Discordo fortemente
- ☐ Discordo
- ☐ Neutro
- ☐ Concordo
- ☐ Concordo fortemente

205. 44. Sou inflexível e duro(a) nas minhas atitudes****

Marcar apenas uma oval.

- ☐ Discordo fortemente
- ☐ Discordo
- ☐ Neutro
- ☐ Concordo
- ☐ Concordo fortemente

206. 45. Às vezes não sou tão seguro(a) ou digno(a) de confiança como deveria ser*****

Marcar apenas uma oval.

- ☐ Discordo fortemente
- ☐ Discordo
- ☐ Neutro
- ☐ Concordo
- ☐ Concordo fortemente

207. 46. Raramente estou triste ou deprimido*

Marcar apenas uma oval.

- ☐ Discordo fortemente
- ☐ Discordo
- ☐ Neutro
- ☐ Concordo
- ☐ Concordo fortemente

208. 47. A minha vida decorre a um ritmo rápido**

Marcar apenas uma oval.

- ☐ Discordo fortemente
- ☐ Discordo
- ☐ Neutro
- ☐ Concordo
- ☐ Concordo fortemente

209. 48. Gosto pouco de me pronunciar sobre a natureza do universo e da condição humana***

Marcar apenas uma oval.

- ☐ Discordo fortemente
- ☐ Discordo
- ☐ Neutro
- ☐ Concordo
- ☐ Concordo fortemente

210. 49. Geralmente procuro ser atencioso(a) e delicado(a)****

Marcar apenas uma oval.

- ☐ Discordo fortemente
- ☐ Discordo
- ☐ Neutro
- ☐ Concordo
- ☐ Concordo fortemente

211. 50. Sou uma pessoa aplicada, conseguindo realizar sempre o meu trabalho*****

Marcar apenas uma oval.

- ☐ Discordo fortemente
- ☐ Discordo
- ☐ Neutro
- ☐ Concordo
- ☐ Concordo fortemente

212. 51. Sinto-me, muitas vezes, desamparado(a), desejando que alguém resolva os meus problemas por mim* *Marcar apenas uma oval.*

- ☐ Discordo fortemente
- ☐ Discordo
- ☐ Neutro
- ☐ Concordo
- ☐ Concordo fortemente

213. 52. Sou uma pessoa muito ativa**

Marcar apenas uma oval.

- ☐ Discordo fortemente
- ☐ Discordo
- ☐ Neutro
- ☐ Concordo
- ☐ Concordo fortemente

214. 53. Tenho muita curiosidade intelectual***

Marcar apenas uma oval.

- ☐ Discordo fortemente
- ☐ Discordo
- ☐ Neutro
- ☐ Concordo
- ☐ Concordo fortemente

215. 54. Quando não gosto das pessoas faço-lhes saber****

Marcar apenas uma oval.

- ☐ Discordo fortemente
- ☐ Discordo
- ☐ Neutro
- ☐ Concordo
- ☐ Concordo fortemente

216. 55. Parece que nunca consigo ser organizado(a)*****

Marcar apenas uma oval.

- ☐ Discordo fortemente
- ☐ Discordo
- ☐ Neutro
- ☐ Concordo
- ☐ Concordo fortemente

217. 56. Já houve alturas em que fiquei tão envergonhado(a) que desejava meterme num buraco*

Marcar apenas uma oval.

- ☐ Discordo fortemente
- ☐ Discordo
- ☐ Neutro
- ☐ Concordo
- ☐ Concordo fortemente

218. 57. Prefiro tratar da minha vida a ser chefe de outras pessoas**

Marcar apenas uma oval.

- ☐ Discordo fortemente
- ☐ Discordo
- ☐ Neutro
- ☐ Concordo
- ☐ Concordo fortemente

219. 58. Muitas vezes dá-me prazer brincar com teorias e ideias abstratas***

Marcar apenas uma oval.

- ☐ Discordo fortemente
- ☐ Discordo
- ☐ Neutro
- ☐ Concordo
- ☐ Concordo fortemente

220. 59. Se for necessário não hesito em manipular as pessoas para conseguir aquilo que quero****

Marcar apenas uma oval.

- ☐ Discordo fortemente
- ☐ Discordo
- ☐ Neutro
- ☐ Concordo
- ☐ Concordo fortemente

221. 60. Esforço-me por ser excelente em tudo o que faço*****

Marcar apenas uma oval.

- ☐ Discordo fortemente
- ☐ Discordo
- ☐ Neutro
- ☐ Concordo
- ☐ Concordo fortemente

Índice de Reatividade
Interpessoal de Mark
Davis

Por favor responda assinalando a alínea que melhor corresponde à sua situação (qualquer resposta entre 0 e 4)

222. 01. Tenho muitas vezes sentimentos de ternura e preocupação pelas pessoas menos afortunadas do que eu.

Marcar apenas uma oval.

- ☐ 0 Não me descreve bem
- ☐ (1)
- ☐ (2)
- ☐ (3)
- ☐ (4) Descreve-me muito bem

223. 02. De vez em quando tenho dificuldade em ver as coisas do ponto de vista dos outros.

Marcar apenas uma oval.

- ☐ 0 Descreve-me muito bem
- ☐ (1)
- ☐ (2)
- ☐ (3)
- ☐ (4) Não me descreve bem

224. 03. Às vezes, não sinto muita pena quando as outras pessoas estão a ter problemas.

Marcar apenas uma oval.

- ☐ 0 Descreve-me muito bem
- ☐ (1)
- ☐ (2)
- ☐ (3)
- ☐

(4) Não me descreve bem

225. 04. Facilmente me deixo envolver nos sentimentos das personagens de um romance.

Marcar apenas uma oval.

- ☐ 0 Não me descreve bem
- ☐ (1)
- ☐ (2)
- ☐ (3)
- ☐ (4) Descreve-me muito bem

226. 05. Em situações de emergência, sinto-me desconfortável e apreensivo/apreensiva

Marcar apenas uma oval.

- ☐ 0 Não me descreve bem
- ☐ (1)
- ☐ (2)
- ☐ (3)
- ☐ (4) Descreve-me muito bem

227. 06. Habitualmente mantenho a objectividade ao ver um filme ou um teatro e não me deixo envolver por completo.

Marcar apenas uma oval.

- ☐ 0 Descreve-me muito bem
- ☐ (1)
- ☐ (2)
- ☐ (3)
- ☐ (4) Não me descreve bem

228. 07. Quando há desacordo, tento atender a todos os pontos de vista antes de tomar uma decisão.

Marcar apenas uma oval.

- ☐ 0 Não me descreve bem
- ☐ (1)
- ☐ (2)
- ☐ (3)
- ☐ (4) Descreve-me muito bem

229. 08. Quando vejo que se estão a aproveitar de uma pessoa, sinto vontade de a proteger.

Marcar apenas uma oval.

- ☐ 0 Não me descreve bem
- ☐ (1)
- ☐ (2)
- ☐ (3)
- ☐ (4) Descreve-me muito bem

230. 09. Por vezes tento compreender melhor os meus amigos imaginando a sua perspectiva de ver as coisas. *Marcar apenas uma oval.*

- ☐ 0 Não me descreve bem
- ☐ (1)
- ☐ (2)
- ☐ (3)
- ☐ (4) Descreve-me muito bem

231. 10. É raro ficar completamente envolvido/envolvida num bom livro ou filme.

Marcar apenas uma oval.

- ☐ 0 Descreve-me muito bem
- ☐ (1)
- ☐ (2)
- ☐ (3)
- ☐ (4) Não me descreve bem

232. 11. Quando vejo alguém ficar ferido, tendo a permanecer calmo/calma.

Marcar apenas uma oval.

- ☐ 0 Descreve-me muito bem
- ☐ (1)
- ☐ (2)
- ☐ (3)
- ☐ (4) Não me descreve bem

233. 12. As desgraças dos outros não me costumam perturbar muito.

Marcar apenas uma oval.

- ☐ 0 Descreve-me muito bem
- ☐ (1)
- ☐ (2)
- ☐ (3)
- ☐ (4) Não me descreve bem

234. 13. Depois de ver um filme ou um teatro, sinto-me como se tivesse sido uma das personagens.

Marcar apenas uma oval.

- ☐ 0 Não me descreve bem
- ☐ (1)
- ☐ (2)
- ☐ (3)
- ☐ (4) Descreve-me muito bem

235. 14. Estar numa situação emocional tensa assusta-me.

Marcar apenas uma oval.

- ☐ 0 Não me descreve bem
- ☐ (1)
- ☐ (2)
- ☐ (3)
- ☐ (4) Descreve-me muito bem

236. 15. Geralmente sou muito eficaz a lidar com emergências.

Marcar apenas uma oval.

- ☐ 0 Descreve-me muito bem
- ☐ (1)
- ☐ (2)
- ☐ (3)
- ☐ (4) Não me descreve bem

237. 16. Fico muitas vezes emocionado/emocionada com coisas que vejo acontecer.

Marcar apenas uma oval.

- ☐ 0 Não me descreve bem
- ☐ (1)
- ☐ (2)
- ☐ (3)
- ☐ (4) Descreve-me muito bem

238. 17. Acredito que uma questão tem sempre dois lados e tento olhar para ambos.

Marcar apenas uma oval.

- ☐ 0 Não me descreve bem
- ☐ (1)
- ☐ (2)
- ☐ (3)
- ☐ (4) Descreve-me muito bem

239. 18. Descrever-me-ia como uma pessoa de coração mole.

Marcar apenas uma oval.

- ☐ 0 Não me descreve bem
- ☐ (1)
- ☐ (2)
- ☐ (3)
- ☐ (4) Descreve-me muito bem

240. 19. Quando vejo um bom filme, consigo facilmente pôr-me no lugar do protagonista.

Marcar apenas uma oval.

- ☐ 0 Não me descreve bem
- ☐ (1)
- ☐ (2)
- ☐ (3)
- ☐ (4) Descreve-me muito bem

241. 20. Tendo a perder o controlo em situações de emergência.

Marcar apenas uma oval.

- ☐ 0 Não me descreve bem
- ☐ (1)
- ☐ (2)
- ☐ (3)
- ☐ (4) Descreve-me muito bem

242. 21. Quando estou aborrecido/aborrecida com alguém, geralmente tento pôr-me no seu lugar por um momento.

Marcar apenas uma oval.

- ☐ 0 Não me descreve bem
- ☐ (1)
- ☐ (2)
- ☐ (3)
- ☐ (4) Descreve-me muito bem

243. 22. Quando estou a ler uma história ou um romance interessante, imagino como me sentiria se aqueles acontecimentos se tivessem passado comigo.

Marcar apenas uma oval.

- ☐ 0 Não me descreve bem
- ☐ (1)
- ☐ (2)
- ☐ (3)
- ☐ (4) Descreve-me muito bem

244. 23. Quando vejo alguém numa emergência a precisar muito de ajuda, fico completamente perdido/perdida.

Marcar apenas uma oval.

- ☐ 0 Não me descreve bem
- ☐ (1)
- ☐ (2)
- ☐ (3)
- ☐ (4) Descreve-me bem

245. 24. Antes de criticar alguém, tento imaginar como me sentiria se estivesse no seu lugar

Marcar apenas uma oval.

- ☐ 0 Não me descreve bem
- ☐ (1)
- ☐ (2)
- ☐ (3)
- ☐ (4) Descreve-me muito bem

Mini Mental State Examination (MMSE)

246. 1. Orientação (1 ponto por cada resposta correta)

Marcar apenas uma oval.

- ☐ 0
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8
- ☐ 9
- ☐ 10

326. 2. Retenção (contar 1 ponto por cada palavra corretamente repetida)

Marcar apenas uma oval.

- ☐ 0
- ☐ 1
- ☐ 2
- ☐ 3

327. 3. Atenção e Cálculo (1 ponto por cada resposta correta. Se der uma errada, mas depois continuar a subtrair bem, consideram-se as seguintes como corretas. Parar ao fim de 5 respostas) "Agora peço-lhe que me diga quantos são 30 menos 3 e depois ao número encontrado volta a tirar 3 e repete assim até eu lhe dizer para parar".

Marcar apenas uma oval.

- ☐ 0
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5

328. 4. Evocação (1 ponto por cada resposta correta.) "Veja se consegue dizer as três palavras que pedi há pouco para decorar".

Marcar apenas uma oval.

- ☐ 0
- ☐ 1
- ☐ 2
- ☐ 3

5. Linguagem (1 ponto por cada resposta correta)

329. a. "Como se chama isto? Mostrar os objetos:

Marcar apenas uma oval.

- ☐ 0
- ☐ 1
- ☐ 2

330. b. "Repita a frase que eu vou dizer: O RATO ROEU A ROLHA"

Marcar apenas uma oval.

- ☐ 0
- ☐ 1

331. c. "Quando eu lhe der esta folha de papel, pegue nela com a mão direita, dobre-a ao meio e ponha sobre a mesa"; dar a folha segurando com as duas mãos.

Marcar apenas uma oval.

☐ 0

☐ 1

☐ 2

☐ 3

332. d. "Leia o que está neste cartão e faça o que lá diz". Mostrar um cartão com a frase bem legível, "FECHE OS OLHOS"; sendo analfabeto lê-se a frase.

Marcar apenas uma oval.

☐ 0

☐ 1

333. e. "Escreva uma frase inteira aqui". Deve ter sujeito e verbo e fazer sentido; os erros gramaticais não prejudicam a pontuação.

Marcar apenas uma oval.

☐ 0

☐ 1

6.Habilidade Construtiva (1 ponto pela cópia correta.)

334. Deve copiar um desenho. Dois pentágonos parcialmente sobrepostos; cada um deve ficar com 5 lados, dois dos quais intersectados. Não valorizar tremor ou rotação

Marcar apenas uma oval.

☐ 0

☐ 1

Teste do Relógio

335. Esfera do relógio

Marcar apenas uma oval.

- ☐ 2 pontos (Desenho normal. Esfera circular ou ovalada com pequenas distorções por tremor)
- ☐ 1 ponto (Incompleta ou com alguma distorção. Esfera muito ovalada)
- ☐ 0 pontos (Ausência ou desenho totalmente distorcido)

336. 2. Presença e sequência de números

Marcar apenas uma oval.

- ☐ 4 pontos (Todos os números presentes e na ordem correta, apenas “pequenos erros” na localização espacial em menos de 4 números (p.e. colocar o nº 8 no espaço do nº 9))
- ☐ 3,5 pontos (Quando os “pequenos erros” na localização espacial se dão em 4 ou mais números)
- ☐ 3 pontos (Todos presentes - na ordem correta - mas com erros significativos na localização espacial - p.e. colocar o nº 3 no espaço do nº 6; Alterações na sequência de números - em menos de 4 números)
- ☐ 2 pontos (Omissão ou adição de algum número mas sem grandes distorções nos restantes números; Alteração na sequência de números (em 4 ou mais números); 12 números colocados em sentido anti-horário (rotação inversa); Todos os números presentes mas com grande distorção espacial (nº fora do relógio ou desenhados a meio do círculo); Presença dos 12 números em linha vertical, horizontal ou oblíqua)
- ☐ 1 ponto (Ausência ou excesso de números com grande distorção espacial; Falta ou excesso de números colocados em linha vertical, horizontal ou oblíqua; Rotação inversa com falta ou excesso de números)
- ☐ 0 pontos (Ausência ou escassa representação de números (menos de 6 números desenhados))

337. 3. Presença e localização dos ponteiros

Marcar apenas uma oval.

- ☐ 4 pontos (Localização correta dos ponteiros e com proporções adequadas notamamanho)
- ☐ 3,5 pontos (Os ponteiros em posição correta mas de igual tamanho)
- ☐ 3 pontos (Pequenos erros na localização dos ponteiros (situar uma das agulhas no espaço destinado ao número anterior ou posterior); Agulha dos minutos mais curta do que a das horas, com marcação horária correta)
- ☐ 2 pontos (Grande distorção na localização dos ponteiros (inclusive se os ponteiros estão na posição correta para as 11 e 10, mas os números apresentam erros significativos na localização espacial; Quando os ponteiro não se juntam no centro e marcam a hora correta)
- ☐ 1 ponto (Quando os ponteiro não se juntam no centro e marcam a hora incorreta; Presença de um só ponteiro ou um esboço dos dois)
- ☐ 0 pontos (Ausência de ponteiros ou perseveração dos mesmos no desenho. Efeito em forma de “roda de carro”)

Avaliação Risco de Suicídio / TASR – Tool for Assessment of Suicide Risk

PERFIL DE RISCO INDIVIDUAL * (1)

5 Masculino

Marcar apenas uma oval.

☐ Sim

☐ Não

6 Idade 15-35

Marcar apenas uma oval.

☐ Sim

☐ Não

7 Idade > 65

Marcar apenas uma oval.

☐ Sim

☐ Não

8 História familiar de suicídio

Marcar apenas uma oval.

☐ Sim

☐ Não

9 Doença médica crónica/dor crónica

Marcar apenas uma oval.

- ☐ Sim
- ☐ Não

10 Doença psiquiátrica prévia

Marcar apenas uma oval.

- ☐ Sim
- ☐ Não

11 Fraco suporte social - isolamento social

Marcar apenas uma oval.

- ☐ Sim
- ☐ Não

12 Abuso de substâncias

Marcar apenas uma oval.

- ☐ Sim
- ☐ Não

13 Abuso físico/sexual

Marcar apenas uma oval.

- ☐ Sim
- ☐ Não

14 Sintomas depressivos

Marcar apenas uma oval.

☐ Sim

☐ Não

15 Sintomas psicóticos positivos *Marcar apenas uma oval.*

☐ Sim

☐ Não

16 Desesperança

Marcar apenas uma oval.

☐ Sim

☐ Não

17 Sentimentos de menos-valia *Marcar apenas uma oval.*

☐ Sim

☐ Não

18 Anedonia

Marcar apenas uma oval.

☐ Sim

☐ Não

19 Ansiedade/agitação

Marcar apenas uma oval.

☐ Sim

☐ Não

20 Crises de pânico

Marcar apenas uma oval.

☐ Sim

☐ Não

21 Raiva

Marcar apenas uma oval.

☐ Sim

☐ Não

22 Impulsividade

Marcar apenas uma oval.

☐ Sim

☐ Não

PERFIL DE RISCO NA ENTREVISTA *** (3)

356. Consumo recente de substâncias *Marcar apenas uma oval.*

☐ Sim

☐ Não

357. Ideação suicida

Marcar apenas uma oval.

☐ Sim

☐ Não

358. Intenção suicida

Marcar apenas uma oval.

☐ Sim

☐ Não

359. Plano suicida

Marcar apenas uma oval.

☐ Sim

☐ Não

360. Acesso a meios letais

Marcar apenas uma oval.

☐ Sim

☐ Não

361. Antecedentes de comportamentos suicidários

Marcar apenas uma oval.

☐ Sim

☐ Não

362. Problemática vivencial parece sem solução ao doente

Marcar apenas uma oval.

☐ Sim

☐ Não

363. Alucinações de comando

Marcar apenas uma oval.

☐ Sim

☐ Não

7. Psychometric instruments authorisation



Luis Fonseca <luisoliveirafonseca@gmail.com>

Fwd: Tese- Atitudes Perante a Eutanásia e Ansiedade Perante a Morte

Catarina Lemos Rosa <lemosrosacatarina@gmail.com>
Para: "luisoliveirafonseca@gmail.com" <luisoliveirafonseca@gmail.com>

27 de dezembro de 2021 às 11:03

----- Mensagem encaminhada -----

From: **Catarina Lemos Rosa** <lemosrosacatarina@gmail.com>
Data: qua., 22/12/2021 às 18:35
Assunto: Tese- Atitudes Perante a Eutanásia e Ansiedade Perante a Morte
Para: <luisoliveirafonseca@hospitalguimaraes.min-saude.pt>

Boa tarde Excelentíssimo Sr. Luís ,

Como combinado, segue em anexo a minha tese. Peço desculpa mas só agora me foi possível enviar. Espero que lhe seja útil. Caso precise de alguma informação estou disponível!

Com os melhores cumprimentos,

--

Psicóloga Clínica e da Saúde
Catarina Rosa,
Cédula n.º 21841
lemosrosacatarina@gmail.com |

--

Psicóloga Clínica e da Saúde
Catarina Rosa,
Cédula n.º 21841
lemosrosacatarina@gmail.com |

 Tese Catarina Rosa.pdf
149K

FW: Melbourne Decision-Making Questionnaire

Luis Manuel Oliveira Fonseca <luisoliveirafonseca@hospitaldeguimaraes.min-saude.pt>
Para: luis <luisoliveirafonseca@gmail.com>

1 de maio de 2023 às 14:38

De: Luis Filipe <luis.veludo.filipe@gmail.com>

Enviado: 30 de março de 2021 13:51

Para: Luis Manuel Oliveira Fonseca <luisoliveirafonseca@hospitaldeguimaraes.min-saude.pt>

Assunto: Re: Melbourne Decision-Making Questionnaire

Boa tarde,

obrigado pelos parabéns.

É com muito gosto que disponibilizo o instrumento com a cotação.

Qualquer dúvida não hesite em perguntar.

Bom trabalho!

Luis Filipe

Às 11:48 de 30/03/2021, Luis Manuel Oliveira Fonseca escreveu:

Boa tarde.

Li o artigo que publicou acerca do Melbourne Decision-Making Questionnaire. Parabéns pelo trabalho.

Gostaria de lhe pedir, se possível, a versão portuguesa do Questionário para aplicação no âmbito do acompanhamento clínico que realizo à população idosa da nossa área assistencial.

Desde já, obrigado pela sua atenção.

Escala SF36-v2

rimas@fe.uc.pt <rimas@fe.uc.pt>
Para: luisoliveirafonseca@gmail.com

2 de maio de 2023 às 10:05

Caro Luís Fonseca,

É com muito gosto que enviamos, em anexo, a versão portuguesa do SF-36 v2 para utilizar no seu projeto de investigação.

As informações sobre o processo de tradução e validação deste questionário encontram-se na plataforma RIMAS, disponível em <http://rimas.uc.pt/instrumentos/79/>.

Melhores cumprimentos.

Inês Ribeiro



Repositório de Instrumentos de Medição e Avaliação em Saúde

Centro de Estudos e Investigação em Saúde da Universidade de Coimbra

[Av. Dias da Silva, 165, 3004-512- Coimbra- Portugal](#)

[Citação ocultada]



Luis Fonseca <luisoliveirafonseca@gmail.com>

Escala HADS

José Pais Ribeiro <jlpr@fpce.up.pt>
Para: Luis Fonseca <luisoliveirafonseca@gmail.com>

2 de maio de 2023 às 10:29

Caro Colega

Autorizamos o uso da Escala de Ansiedade e Depressão Hospitalar que adaptámos para uso com a população portuguesa

Cordialmente

José Luís Pais Ribeiro
jlpr@fpce.up.pt
mobile phone: (351) 965045590
web page: <http://sites.google.com/site/jpaisribeiro/>
ORCID iD:  <http://orcid.org/0000-0003-2882-8056>
ResearchGate- https://www.researchgate.net/profile/Jose_Pais-Ribeiro/publications

<https://scholar.google.pt/citations?user=8OnOW5MAAAAJ&hl=en>

[Citação ocultada]

escala de reatividade interpessoal de Mark Davis

Teresa Limpo <tlimpo@fpce.up.pt>

2 de maio de 2023 às 14:50

Para: Luis Fonseca <luisoliveirafonseca@gmail.com>

Caro Luís,

Agradeço o contacto e sim pode utilizar o IRI. Anexo alguma documentação que poderá ser útil. Se precisar de algo mais diga pf.

Bom traabalho

Teresa

[Citação ocultada]

2 anexos

IRI_vPT.docx

95K



LimpoAlves&Castro10-LabPsi.pdf

102K

Permissão de Utilização de Obra (Escala de Eutanásia)

Biblioteca Karl A. Boedecker - FGV em São Paulo || Referência <biblioteca.sp.ref@fgv.br>

3 de maio de 2023 às 21:38

Para: Luis Fonseca <luisoliveirafonseca@gmail.com>

Cc: GVPesquisa <gvpesquisa@fgv.br>

Prezado Luís,

Boa noite. A Escala de Eutanásia foi desenvolvida por Yara Silveira Faria, no referido artigo em que você mencionou abaixo. Este artigo está disponível na Biblioteca Digital da FGV na modalidade Acesso Aberto -- logo, não há necessidade de pedir autorização para seu uso. Basta utilizar o conteúdo em seu trabalho acadêmico e citar a autora.

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Estamos à disposição em caso de dúvidas.

Atenciosamente,

Amanda Pedrosa Bibliotecária | *Librarian*Setor de referência | *Reference Section*

+55 11 3799 7728



amanda.pedrosa@fgv.br



Av. 9 de Julho, 2029 - Bela Vista

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Biblioteca Karl A.
Boedecker

NEO-FFI

Margarida Lima <mplima@fpce.uc.pt>
Para: Luis Fonseca <luisoliveirafonseca@gmail.com>

5 de maio de 2023 às 00:05

Bom dia Luís,
Muito obrigada pelo seu contacto e interesse na utilização do NEO-FFI. Da nossa parte não há qualquer inconveniente na sua utilização para fins científicos.
Remeto em anexo material de apoio à utilização do instrumento no contexto do seu trabalho.
Com os melhores cumprimentos,
Margarida

4 anexos

-  2014. Magalhães et al. Neoffi Psychometric Properties of a Short Personality.pdf
485K
-  2014. Pedroso-Lima et al. Neoffi Psicologia.pdf
610K
-  Itens e componentes_NEOFFI.docx
14K
-  NEO_FFI.pdf
109K

Índice de Barthel

Fátima Araújo <araujo@esenf.pt>
Para: Luís Fonseca <luisoliveirafonseca@gmail.com>

7 de maio de 2023 às 19:23

Boa tarde Exmo Drº Luís Fonseca

Em resposta ao solicitado, anexo a versão validada do IB numa amostra de idosos portugueses não institucionalizados, a fim de a poder utilizar no âmbito do seu percurso académico - Doutoramento de Bioética da FMP-UP, para o qual lhe desejo muito sucesso.

Informo, que neste processo de validação não foram estudados pontos de corte para discriminar os participantes em diferentes classes de dependência.

Ao dispor
Prof Fátima Araújo

A 2023-05-06 09:07, Luís Fonseca escreveu:

Exma. Professora Fátima Araújo,

Boa tarde.

Sou aluno de Doutoramento de Bioética da Faculdade de Medicina da Universidade do Porto e gostaria de lhe pedir permissão para usar o Índice de Barthel (<https://repositorio-aberto.up.pt/bitstream/10216/15740/2/84575.pdf>) para fins de investigação.

Grato pela sua atenção.

Melhores cumprimentos.

Luís Fonseca (LinkedIn) [1]
Médico Psiquiatra

Links:

[1] <https://www.linkedin.com/in/luisoliveirafonseca>

8. Informed Consent

Termo de Consentimento Informado para Estudo de Investigação

O termo de consentimento informado deve ser específico do Estudo de Investigação (o modelo deve ser adaptado ao estudo em causa, acrescentando outros dados considerados pertinentes ou eliminando partes não aplicáveis).

Compete ao Investigador Responsável ou ao(s) elemento(s) da Equipa de Investigação em que ele delegue, prestar aos Participantes do estudo as informações necessárias ao consentimento livre e esclarecido.

O sentimento de solidão percebida em doentes idosos com perturbação depressivo-ansiosa: impacto cognitivo, clínico, funcional e na atitude perante a eutanásia

Eu, abaixo-assinado _____:

Fui informado de que o Estudo de Investigação acima mencionado se destina a estudar o impacto cognitivo, clínico, funcional e na atitude perante a eutanásia da solidão percebida em doentes idosos com Perturbação Depressivo-Ansiosa (CID-10).

Sei que neste estudo está previsto o preenchimento de escalas psicométricas de avaliação de dimensões psicopatológicas, sociais e funcionais, tendo-me sido explicado em que consistem e quais os seus possíveis efeitos.

Foi-me garantido que todos os dados relativos à identificação dos Participantes neste estudo são confidenciais e que será mantido o anonimato.

Sei que posso recusar-me a participar ou interromper a qualquer momento a participação no estudo, sem nenhum tipo de penalização por este facto.

Compreendi a informação que me foi dada, tive oportunidade de fazer perguntas e as minhas dúvidas foram esclarecidas.

Aceito participar de livre vontade no estudo acima mencionado.

No âmbito deste estudo, concordo que me sejam efectuados eventuais exames e a colheita de amostras de sangue.

Também autorizo a divulgação dos resultados obtidos no meio científico, garantindo o anonimato.

Nome do Participante no estudo

Data

Assinatura

Nome do Médico Responsável

Data

Assinatura

English translation

Informed Consent Form for Research Study

The informed consent form must be specific to the Research Study (the model must be adapted to the study in question, adding other data considered relevant or eliminating inapplicable parts).

It is the responsibility of the Responsible Investigator or the member(s) of the Research Team to which he or she delegates to provide study Participants with the information necessary for free and informed consent.

The feeling of loneliness perceived in elderly patients with depressive-anxiety disorder: cognitive, clinical, functional impact and on the attitude towards euthanasia

I, the undersigned _____:

I have been informed that the aforementioned Research Study is intended to study the cognitive, clinical, functional and attitudinal impact of perceived loneliness in elderly patients with Anxiety-Depressive Disorder (ICD-10). I know that this study involves filling out psychometric scales to assess psychopathological, social, and functional dimensions, and I was explained what they consist of and their possible effects.

I was assured that all data relating to the identification of Participants in this study are confidential and that anonymity will be maintained.

I know that I can refuse to participate or stop participating in the study without any penalty for this fact.

I understood the information provided, had the opportunity to ask questions, and had my doubts clarified.

I agree to participate voluntarily in the study mentioned above.

I agree that tests and blood samples might be taken as part of this study.

I also authorize the publication of the results obtained in scientific circles, guaranteeing anonymity.

Study Participant Name

Date

Signature

Name of the Responsible Doctor

Date

Signature

9. Ethics Committee Approval



Hospital da
Senhora da Oliveira
GUIMARÃES



CENTRO
ACADÉMICO
E DE FORMAÇÃO
Hospital da Senhora da Oliveira Guimarães

PARECER DO COORDENADOR DO CENTRO ACADÉMICO

Título: "Impacto cognitivo e neurobiológico do sentimento de solidão em doentes idosos com perturbação depressivo-ansiosa crónica."

Ref: 70/2020 – Trabalho Académico de Investigação

Investigadora Principal: Dr. Luís Fonseca, Serviço de Psiquiatria do HSOG.

Avaliação da exequibilidade e de mérito científico: Estudo com interesse clínico e académico, pelo que, nada a opor ao presente projeto.

Com os melhores cumprimentos,

Prof. Doutor Pedro Guimarães Cunha
Coordenador do Centro Académico e de Formação do HSOG



PARECER DO COMISSÃO DE ÉTICA PARA A SAÚDE

Nos termos da reunião desta Comissão de Ética, dá-se o conhecimento a V. Exa. do parecer emitido em reunião extraordinária do dia 18 de Setembro de 2020:

Analisado o projeto de investigação, "Impacto cognitivo e neurobiológico do sentimento de solidão em doentes idosos com perturbação depressivo-ansiosa crónica", que tem como Investigador Principal o Dr. Luís Fonseca do Serviço de Psiquiatria do HSOG, a Comissão de Ética deixa as seguintes considerações:

Nada a opor.

Com os melhores cumprimentos,

Dr. João Lima Reis
Presidente da CES

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Hospital da
Senhora da Oliveira
GUIMARÃES

Parecer da Comissão de Ética para a Saúde

PARECER

A Comissão de Ética do HSOG, aqui representada pelo seu Presidente, Dr. João Lima Reis, reuniu no passado dia 07 de junho de 2022 e tomou conhecimento da alteração do título do trabalho de investigação:

Título anterior: *Impacto cognitivo e neurobiológico do sentimento de solidão em idosos com perturbação depressivo-ansiosa crónica.*

Título atualizado: *Análise multidimensional da atitude perante a eutanásia de idosos com síndrome depressivo-ansiosa.*

não tendo **nada a opor à alteração proposta.**

Com os melhores cumprimentos,

Dr. João Lima Reis
Presidente da CES

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