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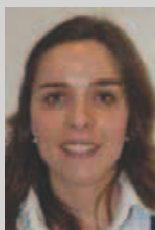
Responsibility and technology: the issue of dysthanasia

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Abstract

This article reflects on dysthanasia, as consequence of scientific-technological development that led to instrumentalization of Medicine and medicalization of death. It presents aspects of medical training, which imply that death is seen not as part of life but rather as synonym of physician's failure. It argues that scientific progress allows healing the disease but not death, which becomes necessary to reflect on systematic and uncritical use of technology at the end of life. The analysis bases in the Han Jonas' principle of responsibility, taken as major philosophical tool to understand the context. It seeks to assess the causes and underlining bioethical principles to dysthanasia and the relationship technological development-responsibility, within the scope of clinical practice at the terminal stage. Still, one will try to show the necessity to change the paradigm on treating the sick, mostly at the chronic or terminal stage, as corollary for this responsibility.

Key words: Medical futility. Technology. Palliative care. Social responsibility.



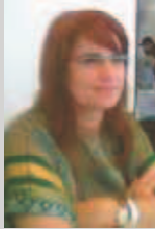
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Dysthanasia: what is it?

Although less disseminated than euthanasia, dysthanasia is, albeit unconsciously, most practiced. Although opposite, both are ethically condemned for Archer¹ because, *roughly speaking*, one anticipates the death of a person still alive and the other extends the life of a person already dead. Despite the difference, as affirmed by Pessini², they cause death *unexpectedly*.

The concept of dysthanasia, proposed initially by Morache in the book "Naissance et mort", is etymologically derived from the Greek and it results from the prefix *dis*, *distance*, *wrongly done*, and the substantive *thanatus*, *death*. Dysthanasia, therefore, refers to digression of death, the botched death, a difficult death or, more precisely, under Brito and Rijo's perspective³, extending a patient's life beyond his natural period.

Such definition apparently simple raises complex questions on what life is and on quality of life.



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Accordingly, Machado ⁴ says that dysthanasia is the *non criterion prolongation of any kind of life at any cost*, reason why the process is true cruelty therapy. In Cabral's perspective ⁵, the individual does not survive, but rather *under-lives*, which means that he remains in a state of *simulacrum* of life ⁶. Gafo ⁷ is in line with these authors' perspectives, by saying that the dysthanasia is the *exaggerated elongation of a patient's death*, or Pessini's ⁸, when asserting that the issue is the prolonging of the dying process and not life itself, given that this beam of prolonged life is precarious and painful⁴.

In dysthanasia one resorts to totally excessive care in view of the benefits that may be obtained. A care or treatment may be considered unreasonable or disproportionate to the extent that it does not supplant the benefit and, here, respecting the ill-person's autonomy, he shall decide about the continuity of his treatment. But the proportionality of a treatment must always be contextualized according to the ill-person, his wellbeing, dignity, and his death in peace, and not on factors external to him. As stated by Lima ⁹, *treatments are not futile by themselves, but futile in relation to an objective*.

Basically, all alternatives are used to the life of a human being's life, even if healing is not possible (yet) and suffering and anguish become unbearable. For such reasons, dysthanasia is also known as *therapeutic intensification*, *therapeutic obstinacy* or *therapeutic fierceness* (on European culture), or even by *futility therapy* or *medical futility* (*medical futility* in North-American culture). Although representing the same, the underlying principle is different.

Medicine suffered strong changes in its passage from pre-modernity, when it was considered an art or craft in which doctors watched and listened carefully and

silently its patients, to modernity, in which the area is regarded as science and technique ¹⁰: the scientific and technological paradigm. This is the paradigm that considers health as the absence of disease, which makes absolute the value of life and which left the pride of healing becoming arrogance, converting death into a foe to be defeated ^{2,11} and creating the conditions for the birth of dysthanasia. This idolatry for techno-science is underlined in the dysthanasia practices linked to European culture itself.

The increased use of state-of-the-art technology, often lying between the experimental and consolidated treatment, caused that medicine to be increasingly less a philanthropic and public activity and becoming a more commercial and private one. As a result, dysthanasia also grew with the enterprise-business model, in which the therapeutic development continues while the patient does not die or while he still has resources (purchasing power). In this model, very connected to capitalist values, dysthanasia is the company's profit engine, although it is disguised by the human life's great value advocacy ^{2,11}. It seems to us, therefore, that this is the model more connected to the concepts of therapy futility, i.e. dysthanasia practices in North American culture.

Under such economic perspective, as referred by Mota ¹², based on studies undertaken in the United States (USA), a socio-economic gap can be generated in which economically profitable individuals risk to

suffer from excess of useless and unprofitable treatments, suffering from the absence of useful treatments, in a clear attack to the principle of social justice. It may also be stressed that we are not defending that dysthanasia practices cannot exist based on trading-business model in Europe. It is only considered that the U.S. health policies provide for profit practices.

The concept of therapeutic obstinacy (*lacharnement tharapeutique*) was introduced into medical language by Frenchman Jean-Robert Debray in the 1950s. In the words of Nunes, Amaral e Gonçalves ¹³ its sole objective is to *prolong survival, without quality of life*. However, for Santos ¹⁴, the English expression 'life sustaining treatment' *defines with far more property, removing from it the derogatory burden for care providers contained in terms 'obstinacy' and 'futility'*.

Regardless of terminology to be used, dysthanasia requires reflection. According to Pinto ¹⁵, one of the causes of therapeutic obstinacy is related to the so-called *defensive medicine*, that is, a practice that is based on the physician's intent to protect himself from possible accusation of malpractice. In this case, it is a positive defensive medicine, since to defend himself against such accusations, the doctor uses unnecessary procedures. Monteiro ¹⁶ agrees with this author's position, adding even the relative probability of medical knowledge and the fragmentation of knowledge, as well as the

fragmentation of competences as factors for dysthanasia.

Santos ¹⁴, however, points out other causes for these practices: a) the medical teams' anxiety before the therapeutic failures and the resistance to accept the patients' death; b) ignorance or non-attention to patient's rights, his representatives and/or his family to be able to reject the medical treatments that will prolong his suffering; c) the lack of proper communication between medical staff and patients, their representatives and/or caregivers. In order to patients, their representatives or caregivers would not insist on therapeutic obstinacy *they must feel included in the decision-making process, namely the importance of preventing the extension of the death, receive clear explanations about their role, receive help to reach consensus, receive information of quality in good amounts and in the appropriate time* ¹⁵.

Despite these differences, both Santos ¹⁴ and Monteiro ¹⁶ also point out as cause of therapeutic obstinacy the belief that human life is an asset for which one must fight to the limit, even over the capabilities of ill-person's autonomy and desire. According to Pessini ⁸, this conviction is so uncritically internalized that is accepted by some as an ethical principle. In this respect, Cabral ⁵ states that many are in favor of dysthanasia because, for them, letting die is killing and, as it unlawful to kill, one cannot let die.

Thus, the question is whether letting to die

will be the same as killing. According to this author, we usually forget that *not doing* is often a positive act much more important from the ethical and moral point of view than *doing* (which is difficult for the medical profession, whose teachings are directed to *doing*). This way, associating the *not doing* something recurrently negative is an error that it should be avoided. In parallel, this *letting die* is very concrete and refers only to stop using disproportionate means - which refers to the area of euthanasia (passive) or omission of help. This fact, indeed, would be equivalent to killing.

It may be easily concluded that the balance between not killing and not postponing death is fragile and that dysthanasia and passive euthanasia have been often confused. Moreover, the ethical principles that underpin dysthanasia practices or its negation are very interwoven: dysthanasia underlines the ethical principle of beneficence that can be *understood as the self-respect transposed to third parties* ¹⁷ and *that defines good and determines that it be accomplished* ¹⁸, what underlies a medical commitment to engage all feasible efforts and technical means to keep the patient alive. The denial of dysthanasia has the principle of non-maleficance underlined, related to the *primum non nocere* maxim, as part of the principle that any therapeutic intensification only prolongs or increases the ill-person's suffering. In addition, there is the underlining principle of human dignity, in a lineage of Kantian ethics or the virtues of the 20th century.

In Portugal, the non performance of dysthanasia practices is enshrined in several documents. The Constitution of the Portuguese Republic ¹⁹ sets forth in its Article 25 that *no one shall be subjected to ruthless, inhuman or degrading treatments. This enunciate derives from Article 5th of the 1948 Universal Declaration of Human Rights* ²⁰, rectified by Portugal thirty years ago.

The Deontological Code of the Portuguese Physicians Order ²¹ contains several articles which highlight postures opposing dysthanasia. The Article 32 points out that *the physician has freedom of choice of diagnostic and therapeutic means, but shall refrain from prescribing unnecessarily costly examination or treatment or perform unnecessary medical acts.* Article 57 establishes that *the physician is prohibited to assist in suicide, euthanasia and dysthanasia* and Article 58 sets that *in situations of advanced and progressive diseases whose treatments do not allow reversing its natural evolution, the physician should direct its attention to patients' wellbeing, avoiding the use of futile diagnosis and therapeutic means that can, by themselves, lead to more suffering, without deriving any benefit.* It is important to remember that Article 59 recommends that *the use of extraordinary means of maintaining life must be stopped in unrecoverable cases of fatal and close prognostic, when the continuation of such therapies shall not result in benefit for the patient.*

However, the Deontological Code of the Portuguese Physicians Order seems to contain some contradictions.

Article 5 admits that all practices unjustified in patient's interest are reprehensible and Article 51 states that *the physician must respect patient's religious, philosophical or ideological options and his legitimate interests.* In light of the above, several issues may be raised: what will the physician do if, by respecting autonomy and ideology of the ill person, is he in favor of dysthanasia? What will the physician do if the patient finds that the dysthanasia is the practice that most suits his interests? What decision may or must make the physician? Decisions that he can take are effectively the decisions that he must make?

In turn, the Deontological Code of Nursing ²² seems not to raise this kind of ambivalence. Article 82 clarifies that *nurse, in respect of the person's right to life throughout the life cycle, assumes the duty of respecting the individual's biopsychosocial, cultural and spiritual integrity,* and Article 87 states that *the nurse should monitor the patient in the different stages of the terminal stage.*

The idea of life extension as the aim of medicine first appeared in the work by Francis Bacon, in the transition between the 16th and 17th centuries, who claimed *to be a clear mission of the physician not only to restore health, but also alleviate the pains and torments of illnesses; and not only when such mitigation of pain, as of a dangerous symptom, helps and leads to recovery, but also when all hope of recovery has ceased it helps only to make a fairer, and easy passage of life (...) the third part of medicine that I defined and that which relates to the prolongation of*

life, which is new and deficient, and is the noblest of all⁸. However, the prolongation of life at all costs is historically recent and only became possible after mid-20th century, as a result of the extraordinary scientific-technological progress. Progress, by the way, that allowed redefining the very concept of death, taken today as a process and not as time. As stated by Lima: *dysthanasia and the technological sophistication go side by side*⁹.

Terminality of life in medical formation

Modern society came to recognize the individual patient as autonomous, with values and beliefs, fading the paternalistic character of Hippocratic medicine. Then, it is a matter of questioning why, as stated by¹⁴, often medical teams remain distracted to the sick's wishes and rights in not been subjected to intensification. Perhaps this might be explained if we consider that physicians have been trained in a biomedical or biomechanical model, based on Cartesian mold of man-machine²³, mind-body separation, in which the disease is envisioned in a linear causality. In the vision of Oliveira¹⁰, medicine became the investigation of physical-chemical processes and components that result in diseases.

In essence, physicians have been trained to become *higher officers of science and managers of biotechnology complex*²⁴.

For this reason, they face the patient more as a therapeutic opportunity or a clinical challenge and less as a person full of rights¹². Thus, they use and abuse of technology on the vain attempt to defeat their big opponent, death. When they realize that they cannot achieve their intent, they conclude the mission, forgetting that it is also their competence to assist the sick during this important phase of life.

This situation is perfectly explicit in Article 41 of the Code of Deontological Code of the Portuguese Physicians Order: *the inability to control the disease does not justify abandoning the patient*²¹. As stated by Lima, *the discomfort that most professionals feel in face of death is transferred to their relationship with the patient, which is virtually abandoned, leading personal contact to a minimum*⁹. This discomfort that leads to the abandonment of the ill person, Mota¹² calls *frustration*. But for the author is the fear of showing weakness that makes the health professional to take dysthanasia practices. Studies such as the *Archives of Internal Medicine*, of 1995, reveal a lack of medical teachings about the purpose of life²⁵.

The hyper specialization of medicine and the great technological development have seduced society and, of course, the medical class. In the background, as says Jonas^{6,26}, the *Homo sapiens* was swallowed by what

he became: the *Homo faber*, since man won the total domain about things and about himself or, as affirmed by Camello²⁷, This technological evolution, which changed the physician-patient relationship, replaces the word¹⁶, creating the listening without hearing²⁸. It removed the patient's leading role and made auxiliary examinations essential, transforming the physician into a performer, like a mechanic of programmed engine. It was reversed, therefore, the principles that govern medical practice and the mission of been at the of patients' service²⁹.

In parallel, also in the opinion of Oliveira³⁰, the formation of physicians, of a molecular nature, devalues the suffering as normal process of human existence and as a potentiality of *autopoeietica* reconstruction. According to these authors, this formation reinforces often the importance of the physician not to falter between patient's pain and suffering, which contradicts the Hippocrates' oath. In the Hippocratic medicine, it is the physician's responsibility to reduce suffering, what assumes a consoling and comforting patient-physician relationship..

Accordingly, says Machado⁴: *together with a serious scientific ability the physician should possess a profound human formation*, under the risk of reducing medicine to an inhumane and dehumanizing 'technicality'. The same author reiterates that values, virtues, attitudes and behaviors are also needed: awareness of the dignity and

vulnerability of the ill person and the physician's responsibility as caretaker, domain of verbal and non verbal language and understanding of the complexity of the ill person. As advocated in Portugal by the National Council of Ethics for the Life Sciences (CNECV)³¹, in the medical decisions is not the physician, in the position of a technician, who should decide, but the physician while a person.

Alluding to Jonas, Zirbel³² states that responsibility stems from the power and Siqueira³³ reiterates that the one to whom is entrusted the guardianship of something perishable considers himself responsible, feels effectively responsible. Thus, *the physician has obligations to the patient and nobody else (...) Only the patient matters when he is under the physician' care (...) it is manifest that rules exist of a more sublime order than the contract one. We may talk of a sacred loyalty*⁶. Accordingly, *the patient should be perfectly sure that his physician shall not become his executioner: the last moments of the patient must be taken care with compassion and free of exploration*⁶.

Technology and responsibility

The question of departure, such as that formulated by Jonas⁶, is to know *how the modern technique affects our actions*, i.e., *the human difference of modern technique compared to the one that preceded it* since, as the author states, *man never felt deprived of technique*. Regarding the biological and medical technologies

we can say, like Archer ¹, that they emerged and developed more in 25 years than in 25 centuries and caused unprecedented decisions and inter-rogations: at what point the technologically possible is ethically acceptable? According to Jonas ⁶, after opening Pandora's Box of technology, it currently assumes an *ethical importance as a result of the central position that it now occupies in human projects* ³⁴.

The modern society that created the technological paraphernalia, *infinite drive of species* ⁶, also created the utopia of progress, the false hope of omnipotence and immortality and mistook curing the mortal being with curing mortality, forgetting that the incorporation of technology in the area of health is not mandatorily a synonym for therapeutic success and that no technological advance will enable us to escape from death. For Jonas ⁶ *man is the creator of his life as a human life. He molds the circumstances to his will and needs and he is never disoriented, except when he is facing death* ³⁵.

Considering the extreme fascination that any power represents, for man, which is given to him to possess and its expansion converted him into an agent of that power, making him, proportionately, liable, the question is: will the dysthanasia be a form of man trying to prove (to himself) his power and its supremacy, eluding himself when trying to win that single unbeatable dimension? Jonas ⁶ states that *no matter the number of diseases man arranges a way to heal, the mortal condition does not bend to his wit.*

Under this aspect, we cannot neglect that *the human control is small and its permanent nature remains.*

The society that created technology is the same that idolizes the body, vitality, youth, beauty and progress. And society that requires healing, survival, use of expensive technology, not always adjusted to the clinical situation. This is the society that broke with the traditional physician-patient relationship and that, therefore, demands, claims, and accuses. However, it is also the society that overlooks the care in end of life ⁹, which makes *the past, even close, a territory of little value* and that respects the elderly by Decree, as long as they are not a social and economical burden²⁵.

Caring in this society. is dethroned by the curing, which is to say, by technology, that the individuals at the end of the line of life constitute the main threat to the main function in which the hospital institutions have become since the *technolatr* ⁸. Therefore, the more technologically equipped is the institution or society, more drastic may be the dysthanasia practices.

The scientific and technological progress began to interfere, decisively, at the terminal stage of human life and, therefore, dysthanasia has become a first line ethical problem. Instead of improving our condition at the time of death, technology makes it a more problematic process, unpredictable, of difficult coexistence, a source of anxiety and difficult choices: *death does not emerge as a fatality of the nature of life itself, but as an unavoidable organic dysfunction or, at least, in principle treatable and postponable* ⁶.

In parallel, this technology has brought a *violent and desecrator outburst of the cosmic order*⁶, invading several branches of nature.

Jonas⁶ questions to *what extent is this desirable?* To the author, answering to this question implies to reflect on death's own meaning, the attitude in face of death and the importance of biological balance between birth and death. In one hand, death is the counterpart of life, *and one thing cannot exist without the other*³⁶; in the other hand, prolong the arrival of death raises the proportion of elderly population and slows down the replacement of generations, which reduces, therefore, the influx of new life. *Having to die does not necessarily derive from being born; mortality is not being the other side of the eternal wellspring of birth*⁶.

As stated by Siqueira³³, closeness to death increased in Jonas the concern with the life. For Jonas, death takes on two roles: one of a deeply Kantian inspiration, *our life expectancy may need a non-negotiable limit that encourages each of us to count the days and make them worthwhile*⁶; another, a renewing meaning of humanity itself.

We are not in any way disregarding the tremendous achievements in the field of health, nor adopting technophobic postures. If the intent is to assume the similarity of

Siqueira²⁸ and Gomes³⁷, the ambivalence of technique is to warn against using non complementary, but essential, technology for technolatriy; so that the legitimate effort to control death cannot constrain awareness leading to ignore that it is part of a process of life. The alert, according to Martin¹¹, is to the fact that the technological pride has transformed into arrogance. Like Jonas⁶, the intent is also to point out to the fading between natural and artificial and the imposition of this over the other.

If the technology has introduced in human actions unpredictable results, then the intent is to warn, as Jonas⁶, for the awareness about the consequences of the uncontrolled use of technology and to the fact that the dysthanasia is becoming a chronic practice. We are also signaling to the growth of an aged population dependent on intensive and prolonged care and, as affirmed by Diniz and Costa, to the fact the dysthanasia *is the practice which more directly threatens the promotion of the principle of human dignity in health care for the elderly*³⁸.

We are seeking to show also the danger of reducing the human being into a physiological being, removing from him all the other dimensions that constitute him, i.e., the risk of facing the ill person according to the Cartesian – Flexenerian model and not from a multidimensional and holistic model. This model implies not just simply instructing, but humanizing, forming true health

professionals and not merely caretakers of diseases ²⁵. *It is necessary to cultivate wisdom to integrate death on the finitude of human nature. Death is not an illness and should not be treated as such* ³⁹. Therefore, it means that the ethical duty of life must be consistent with the ethical duty of accepting death ⁴.

To affirm human rights and their importance we are placing man and his dignity in front of scientific progress, finding new place for humankind in the universe. It is precisely this aspect that we can read in the preamble of the *Universal Declaration of Human Rights* ²⁰: *the recognition of the inherent dignity of all members of the human family is the foundation of peace in the world.*

Accordingly, we must urgently reflect on global imbalances concerning the creation and use of technology: there is today, clearly, an overwhelming gap between the countries that use unreasonably technology, often offered to dysthanasia itself, and those in which the survival of human beings depends on the technology that, in those locations, does not exist. This situation is an evident attack to the principle of social justice and may even become an engine opposite to the chain of world peace.

From the technological era we live in and *homo faber* we became, Jonas ²⁶ proposes the assumption of a new ethics and a new ethical principle: *the principle of responsibility*

responsabilidade. Responsibility calls for renouncement of the utopia of progress and the careless use of technology, minimizing its negative impact. This responsibility is not limited to the subject himself, but also in his relationship with the others.

This responsibility derives from a duty towards the human essence, which is equivalent to an ethics of care. A caring that goes well beyond palliative practices and which should be the basis for all medical acts, which assumes accepting every human being as a non-repeatable unit, at the same time that exists with the others, for the others and in the others, as affirmed by Mounier in *Le personalisme*. As strengthened by the CNECV ³¹, every human being is an end in himself, not an instrumental value or a medium that *has the same dignity of existing and belonging to the world as I belong and enjoy it* ³⁷. Moreover, Zancanaro ⁴⁰, when interpreting the Jonas' work, asserts that this end in itself is life, understood not as mere living, but how to live with dignity.

Jonas' ethics ²⁶ is based on a categorical imperative of Kantian inspiration: *it acts so that the effects of your action are compatible with the permanence of an authentic human life on Earth* and, although it is not confined to a space-time, nor is anthropocentric, it does not neglect the relationship between human beings. Jonas ^{6,26} refers to the duty of being of the present to ensure the future being or, put in another way, it is not licit to *be* in the

present risking not *being* on the near or distant future, which means that assuring to *be* in the future is a *must be* in the present’.

From this it is possible to say that the physician cannot commit therapeutic obstinacy in the development of his *being* (a being with the technological power), risking the *not being* of the ill person, while an end in himself, full of dignity. Jonas’s responsibility moves from a *must do* to a *must be: if I am, then I must*. And this duty, inherent to the human existence itself, makes the universal duty and the grounds of Jonas’ collective ethics. Thus, the responsibility is founded on respect for the dignity, taken as a universal value, in the development of what is humanly desirable and humanly possible.

Then, the question that arises is to realize up to what extent, even though it is possible to use modern technology to postpone death, is this humanly desirable. In parallel, it also matters to realize that, under Jonas’ perspective, the use of technology gives greater power to the physician and, consequently, greater responsibility, which implies respect for human life and dignity, as it can be read in the preamble of the Deontological Code of Portuguese Physicians ²¹.

In situations in which healing became impossible, the physician should have the predictive ability regarding the increase of suffering that any of his performances can inflict on the sick person. Thus,

according to Jonas ⁶, what we should avoid is decided by what we should preserve in this case, the suffering and dignity, respectively.

Responsibility entails, therefore, knowledge, wisdom and humbleness. On this subject, Jonas ³⁵ stresses that knowledge is not used today for the understanding and contemplation of timeless phenomena, but as an attempt to control these phenomena. We can, therefore, truly say that dysthanasia is just the putting into practice knowledge that seeks, albeit on an unreachable way, to control and postpone the death process.

Final considerations

Healing, typical of technoscience, ignores that suffering, while it may be accompanied by pain, is a much more complex category. Despising this perspective is reducing human life to the physiological dimension; and allowing therapeutic intensification in deep conviction that relieving pain is relieving the suffering of those who live.

When the imminence of death is approaching, begins a new stage in the sick people’s lives, in which healing must be replaced by caring, that cannot be faced, however, as a consolation prize when everything else fails ^{15,41}. In caring, human life does not equate or reduces the physiological life, and *there is more concern with the ill person than with the person’s disease* ⁸, by which the individual

is seen as a whole and health seen as a overall wellbeing ⁴¹. In this sense, the physician is not at the service of the sick organs or body, but of the ill person ⁴, and his greatest concern is with the quality (personal, untransferable and difficult concept to measure by science and technology), and not with the amount of life..

Under this milestone, death is not felt as a gap of medical ability or failure, but rather as condition of human existence itself, an integral part of life, as natural as being born, as clarified by Hegel in *Phenomenology of the spirit*. Dying is, therefore, the other side of living. And this condition inherent to the human being, the inevitability of death, which Horta ⁴² refers to as being indiscriminately democratic. However, the author caveat also the profoundly democratic character, which cannot be understood in the light of mortality or average life expectancy at peripheral and central countries or, within the same country, the individuals' socioeconomic condition, in an allusion to the principle of social justice

Although, according to Jonas ⁶, death gives meaning to life, it is its inevitability, associated with its unpredictability, that makes it frightening even more so when the therapeutic obstinacy not only does not mitigate pain and suffering but further enhances and prolongs them. In caring there is not place, therefore, for therapeutic obstinacy, because the intention is a dignified death and without suffering ¹⁵.

Therefore, there is an appeal to (re) emerge of a template that places human being as the central value. A humanist model that

reconciles with care, to face the human being in its multidimensionality, which values living and dying with dignity and which combines with the orthotanasia. Etymologically, from Greek, the orthotanasia refers to a death in a given time, *without disproportionate abbreviation or prolongation* ⁴¹ or, as advocated by Martin ¹¹, the art of dying well or a healthy way to die. Resisting to the use of disproportionate resources in time at which the mortal human being is inevitable, is to be consistent with a dignified death.

Life and health are fundamental goods, but not absolute; death cannot be avoided. It is fundamental to rehabilitate the place of death as a natural occurrence and humanize this process, remembering that behind each ill person there is a face and a name, often overlooked, and also with a history of life ^{2,11}. As stated by Siqueira ²⁵, it is necessary to heal but it is also necessary to care, restore, compensate, alleviate, comfort, monitor, settling down and recognize human finitude and the limitations of the very medicine, balancing the use of modern technologies.

That should be the future of clinical practice, based on an holistic vision in which the medicine is able to accept the human being as a complex unit ²⁹, abolishing the mutilated notion of man in which the hyper specialization of the

medicine itself transformed it³³ and facing the human being as a complex and multidimensional being, in an approximation to what Gaillard called *Homo systemus*⁴³.

For this author, the human being is the fruit of his own life history, i.e., his actions, choices and relations he established with the environment and with other human beings. Thus, as affirmed by Gaillard⁴³, the human being cannot be described as the set of several systems that compose him. In this perspective, health and disease result from the simultaneous interaction of various dimensions that constitute the human being, such as the affective, emotive, rational, ethical, spiritual, social, ecological, or community; therefore, health and diseases cannot be regarded in a linear causality.

That medicine is *a form of scientific progress*³⁵ is unquestionable. We should not, however, look to medicine as an opportunity to prolong life beyond sustainable limits, an act as ethically wrong as the negligent medical practice. Physicians, caregivers, patients and their representatives (all of us) must be educated to the fact that the lawfulness of refusing disproportionate or extraordinary means, this not being a synonym for suicide nor irresponsible omission of assistance. As a Jonas³⁵ points out, the human being does

not express himself in the parts which constitute him, but in a whole which is physically materialized in a body and that goes beyond that matter, reason why it is important to know when giving up postpones the death process⁶.

Resumo

Este artigo reflete acerca da distanásia, como consequência do desenvolvimento científico-tecnológico que conduziu a instrumentalização da medicina e medicalização da morte. Apresenta aspectos da formação médica que implicam que a morte seja vista não como parte da vida, mas sinônimo de fracasso médico. Argumenta que o avanço tecnológico permite curar a doença, mas não a morte, o que torna necessário refletir sobre a utilização sistemática e acrítica de tecnologia no final da vida. A análise baseia-se no princípio da responsabilidade de Hans Jonas, tomado como ferramenta filosófica importante para compreender o contexto. Busca-se levantar as causas e os princípios bioéticos subjacentes a distanásia e a relação desenvolvimento tecnológico-responsabilidade, no âmbito da prática clínica na fase terminal. Tentar-se-á ainda mostrar a necessidade de mudar o paradigma de tratamento da pessoa doente, sobretudo terminal ou crônica, como corolário dessa responsabilidade.

Palavras-chave: Distanásia. Tecnologia. Cuidados paliativos. Responsabilidade social.

Resumen

Responsabilidad y tecnología: la cuestión de la distanasia

Este artículo reflexiona acerca de la distanasia, como consecuencia del desarrollo científico-tecnológico que condujo a la instrumentalización de la medicina y medicalización de la muerte. Presenta aspectos de la formación médica que implican que la muerte sea vista no como parte de la vida, sino como sinónimo de fracaso médico. Argumenta que el avance tecnológico permite curar la enfermedad, pero no la muerte, lo que torna necesario reflexionar sobre la utilización sistemática y acrítica de tecnología en el final de la vida. El análisis se basa en el principio de la responsabilidad de Hans Jonas, tomado como herramienta filosófica importante para comprender el contexto. Se busca analizar las causas y los principios bioéticos subyacentes a la distanasia y la relación desarrollo tecnológico-responsabilidad, en el ámbito de la práctica clínica en la fase terminal. Se ha de intentar asimismo mostrar la necesidad de mudar el paradigma de tratamiento de la persona enferma, sobretodo terminal o crónica, como corolario de esa responsabilidad.

Palabras-clave: Distanasia. Tecnología. Cuidados paliativos. Responsabilidad social.

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