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Orthothanasia in medical training: taboos and unveilings

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Abstract

Orthothanasia is the suspension of artificial methods that prolong the life of a patient with no prospects of cure. Such concept is a complex issue, since many health care professionals consider death to be a failure, highlighting the need for its inclusion in academia. Consequently, this study sought to understand how medical professors view orthothanasia. To this end, we conducted a qualitative-quantitative research between May and July 2019, via online questionnaire, with medical professors from a federal university in Northern Brazil. Results show that this issue is poorly addressed in medical education, and a more consistent pedagogical approach to orthothanasia in academia is essential.

Keywords: Education, medical. Terminal care. Death. Medicine.

Resumo

Ortotanásia na formação médica: tabus e desvelamentos

A ortotanásia refere-se à suspensão de métodos artificiais que prolongam a vida de um paciente sem perspectivas de cura. Trata-se de uma questão complexa, já que para muitos profissionais da saúde a morte é considerada um fracasso, de modo que é necessário abordar a temática em meio acadêmico. Diante disso, este trabalho visa entender a perspectiva de docentes de medicina sobre a ortotanásia. Para tanto, o estudo traz uma investigação qualiquantitativa realizada entre maio e julho de 2019 com docentes do curso de medicina de uma universidade federal do Norte do país, por meio de questionário on-line. Os resultados mostram que o tema não é bem abordado na formação médica, sendo essencial uma didática mais consistente sobre ortotanásia em meio acadêmico.

Palavras-chave: Educação médica. Assistência terminal. Morte. Medicina.

Resumen

La ortotanasia en la formación médica: tabúes y desvelos

Ortotanasia se refiere a la suspensión de métodos artificiales que prolongan la vida de un paciente sin posibilidad de cura. Sin embargo, practicarlo no es tan simple, ya que, para muchos profesionales de la salud, la muerte se considera un fracaso. Por lo tanto, es necesario acercarse a la muerte en un entorno académico. Por lo tanto, el objetivo era comprender la perspectiva de enseñanza adoptada por los profesores de medicina en una universidad federal en el norte del país sobre la ortotanasia. Con este fin, el estudio trae una investigación cualitativa y cuantitativa de mayo a julio de 2019 con profesores del Curso de Medicina, a través de un cuestionario en línea. Entre los resultados obtenidos, se pudo notar que aún existen vacíos en el énfasis del tema en la educación médica, y es fundamental su inserción didáctica más consistente en el ámbito académico.

Palabras-clave: Educación médica. Cuidado terminal. Muerte. Medicina.

Research

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In Ancient Greece, physicians were considered deities with the power to cure diseases and provide longevity and even immortality. In Modern Age, when science and rationality took place, physicians went from "demigods" to ordinary and flawed professionals. Currently, medicine is linked to technology in several areas, especially diagnosis, surgery, anesthesiology, and resuscitation, to promote life maintenance and disease control, thus progressively postponing natural death [1].

Health has been significantly developed regarding basic sanitation, quality of life, and increased longevity, among others. Nevertheless, many procedures are invasive, expensive, painful, and ultimately inefficient, since they cannot achieve the main goal: to prevent death at all costs [1]. This contrasting scenario can, therefore, artificially prolong life, disrespecting human dignity [2] and even the characteristics and differences between male and female patients [3].

The concept of orthothanasia, which means "correct death" and derives from the Greek *orthós* (right) and *thánatos* (death) [4], emerges in this context. Its practice means to suspend artificial acts and methods that prolong the life of a patient with no prospects of cure, thus avoiding unnecessary suffering and offering a dignified death [2]. Much of this proposal is included in palliative care, an approach that cares for patients who have life-threatening diseases respecting their social, spiritual, physical, and psychological demands until they pass away, with dignity.

To do so, the patient or – if they cannot decide by themselves – their family may decide on orthothanasia [4]. According to research published by *NeoReviews*, patients can be under palliative care since the neonatal period, especially children born prematurely or with congenital anomalies. To delay this care is to miss opportunities to build relationships, establish family bonds, and to consider the family's spirituality and psychosocial health [5].

In Brazil, orthothanasia finds legislation support in Bill 6,715/2009, included in the new Code of Medical Ethics in 2010. Consequently, if the family of a patient unable to undergo therapy requests the suspension of medical procedures, orthothanasia is legitimized. But the practice still arouses insecurity in medical practice, since Brazil lacks any specific laws for it.

In other countries, such as Norway, terminal patients can stay home, receiving visits from general practitioners, to pass away with dignity next to their loved ones [6]. Practicing orthothanasia, however, requires a complex decision. The patient, their family, and the medical team face a dilemma regarding the choice of death, since it is still related to failure, shame, and helplessness.

Current and future health care professionals, patients, families, and the society must thus discuss, study, and understand the different scenarios involving orthothanasia so they can cope with terminality while favoring ethical and humanized care [7].

Since they undergo a technical-scientific training that disregards emotional, spiritual, and social matters, health professionals have a hard time dealing with death both culturally and spiritually. Considered taboo, death causes uneasiness and strangeness [8]. As a result, professionals view death as failure and weakness [9].

Death and orthothanasia must then be emphasized in academia to better prepare future health professionals for these hostile and difficult issues. Moreover, the death process should be humanized, collaborating to improve care for the patient and their family [10].

Method

This study conducted a qualitative-quantitative investigation between May and July 2019, with medical professors from a university in Northern Brazil who met the following participation criteria: work at the university's medical school, define the years of service, inform the respective educational field, and agree to freely participate in the survey. Fifteen professors participated in our study.

First, the university's Research Ethics Committee had to accept and authorize the study, according to the guidelines and requirements of the National Health Council. All participants were informed of its purpose and agreed to participate after reading the informed consent form (ICF). Since their identities were protected, no signatures were needed.

To facilitate data collection data and provide time, confidentiality and comfort to the interviewees, an online questionnaire was made available via Google Forms, whose link was sent to each

professor's email and individual WhatsApp account. It consisted of 14 questions, mostly multiple choice, with alternatives having only words or numbers and short sentences. Estimated time to answer was five minutes.

The interview emphasized each professional's educational background, field of work, and length of work experience; what orthothanasia means to them; the method and frequency in which this topic is mentioned in classes; degree of comfort to discuss orthothanasia and the need to do so in medical education, considering field experience.

Data analysis was facilitated by the questionnaire program, which provided raw answer quantity and percentage graphs for each alternative, allowing us to analyze the participants' answers quantitatively, and their knowledge and comprehension degrees qualitatively. To understand the themes unveiled, we used Gadamer's hermeneutic circle, that is, when reading a text, the context of tradition interacts with the interpreter' movement. The encounter between the familiarity and the strangeness of the text would thus be a fusion of horizons [11].

Besides this existential openness movement, the literature helped us build dialogue between found themes and consolidated scientific knowledge to achieve our main goal: to understand the teaching perspective adopted by medical professors from a federal university in Northern Brazil on orthothanasia.

Results and discussion

Results were first con-validated with a 100% rate (n=15) of positive answers regarding research participation, which was individually and freely decided on. This data possibly shows disinterest in answering a survey on death, since the medical school of the researched university has 62 professors and only 24.19% answered the questionnaire.

This leads us to the first question: "What year do you teach?" We chose this question because, throughout medical school, students are expected to become more accustomed to hospital environments, medical treatments, and death as a possible consequence of illness, and the professor's teaching methodology should correspond to the student's growth [12].

As some of the professors teach several years, the obtained percentages exceeded 100%. Results showed that 40% (6) were first year professors; 53.3% (8) were second year; 40% (6) were third year; 6.7% (1) were fourth year; 20% (3) were fifth year; and 26.7% (4) were sixth year.

The prevalence of professors from the first three undergraduate years allows us to infer on their greater openness to discuss human finitude and orthothanasia than those who teach later years, more focused on medical treatment and intervention. If professors receive training regarding awareness about orthothanasia, those who teach later years must be prioritized [13].

Terminal patients and health professionals are also affected by uncertainties in the field of pharmaceuticals. Clinical trials on medications that can postpone death are still incipient, which generates great tension and indecision in individuals about whether to participate on such research or to undergo palliative care right away [14].

This relates to the next question, about the interviewees' different areas of expertise. Respondents were specialized in biomedicine (3), pharmacy (1), physical therapy (1), medicine (7), dentistry (1), and psychology (2). Medical professors included those specialized in urology, clinical medicine, cardiovascular surgery, and child neurology.

Length of professional activity, starting from graduation, varied from six and a half to 30 years, making up a diversified sample. The arithmetic mean was 14.53 years, and the median followed closely with 14 years. Means were 9, 12, and 15 years, with two respondents each.

Although most respondents (66%) seemed to understand the concept of orthothanasia, 26.7% confused it with euthanasia, that is, to cause the death of a patient who is deeply suffering and has no prospects of improvement. On the other hand, 6.67% believed orthothanasia was an artificial prolongation of death by life support and medical equipment.

This shows a possible spread of misinformation, since to teach about orthothanasia, facilitators must be familiar with its concept and applicability. They must learn and be trained to fully understand its content and scope, to later share this knowledge

with students. Otherwise, they are more likely to disseminate misinformation, damaging the already fragile education on the topic [13].

Regarding frequency of class discussions, only 6.67% of professors discussed orthothanasia more than three times in their classes, while 26.7% contemplated it twice, and 33.3% discussed it only once or never. These percentages are low and insufficient for building up knowledge.

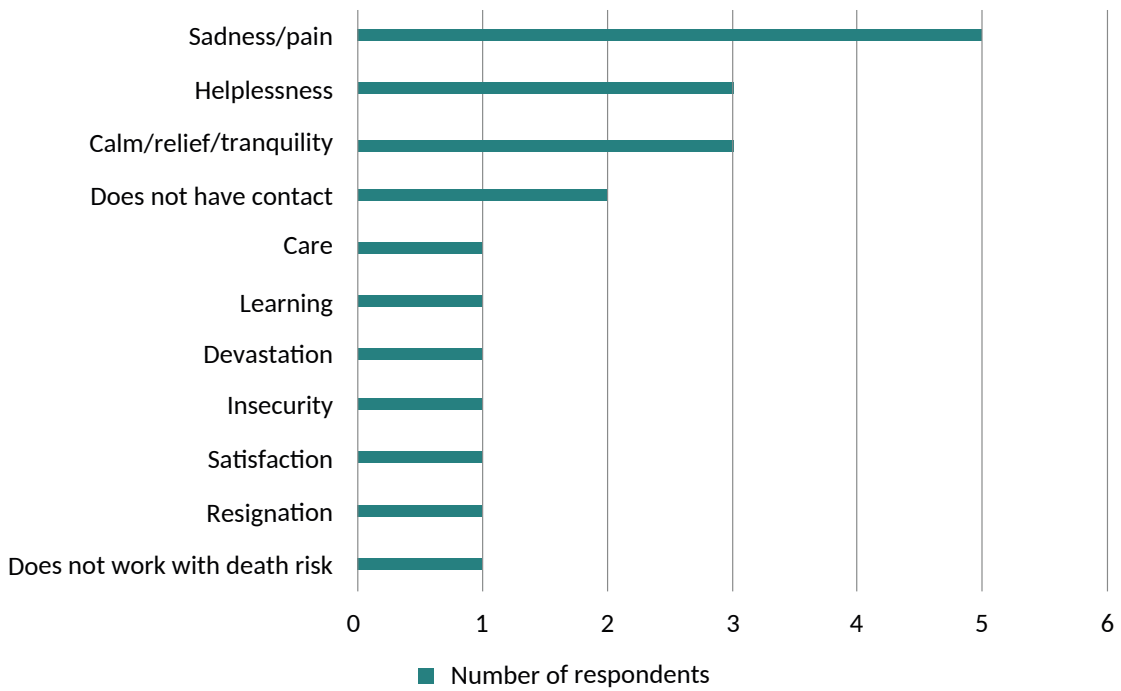
Most common approaches were clinical cases (25%) and others (16.7%), including mentions, with 8.3% each, of lectures, debates/films, tutorials, clinical discussions, and feedback activities. Conferences, simulations, and dynamics were never used. Results show that the teaching-learning process can be improved by methods other than the classic methodologies of problem-based learning (PBL), the pedagogy often used in undergraduate medical school [15].

Physicians usually discuss their *in situ* experiences in class, which helps students prepare for everyday medical situations. Health professionals apparently do not come across orthothanasia at all in their daily routine, since 10 professors (66.7%) reported never having practiced it during their work routine. Another 13.3% stated they practiced it three times, while 20% said they experienced it on four occasions.

These data makes us wonder whether health professionals do not usually practice orthothanasia in their routines, or if they do not know or do not understand what it is. One cannot recognize the application of something one does not know, reiterating the importance of teacher training on the topic. What we see in medical school is the prevalence of undergraduate specific theoretical and practical subjects, to the detriment of curricular subjects such as orthothanasia [16].

Regarding the feeling of professional accomplishment/frustration after a patient's death, in an open-ended question, five professors (22.72%) reported pain/sadness, three (13.63%) declared helplessness, three (13.63%) said calm/relief/tranquility, while two (9.9%) related having no contact with patient death, and two (9.9%) stated they never experienced it (Graph 1). Having pain/helplessness as the most frequent answers shows that professionals are still poorly instructed to deal with death. Such unpreparedness stems from the emphasis given to life, thus fostering the feeling of failure before a patient's death [17].

Graph 1. Answers to the question "What feeling do you associate with the process of a patient's death?"



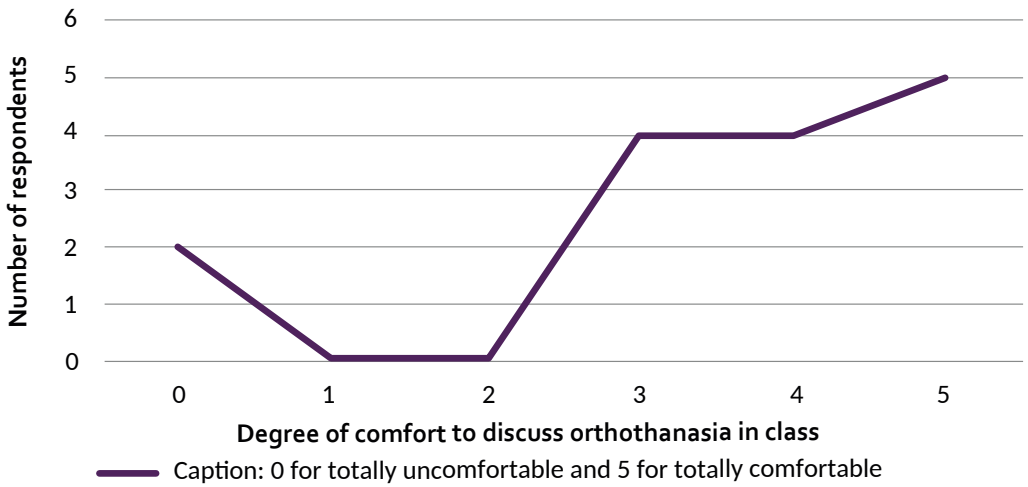
Additionally, all the following answers obtained frequency 1 (4.54%): learning, devastation, insecurity, satisfaction, resignation, and does not work with death risk. A health professional who does not, in any case, work with death risks is hard to consider, since even a stable patient could deteriorate and die from complications of the health-disease process. Importantly, most answers in this sector were associated with negative aspects of death. Despite being part of the natural life cycle, many professionals view death as something to be avoided at all costs. Such perspective, however, may be associated with the healing paradigm, in which the desire to prolong life using methods and technology enables the adoption of an uncritical stance on therapy [18].

The conditions in which the patient died should also be considered, including age group and acute or chronic health conditions, which could cause different sensations regarding the same fact – death. But the same results do not imply the same process, which is exactly why death should be approached globally, not only as a categoric imperative to be familiarized with, but to be discussed in different cases.

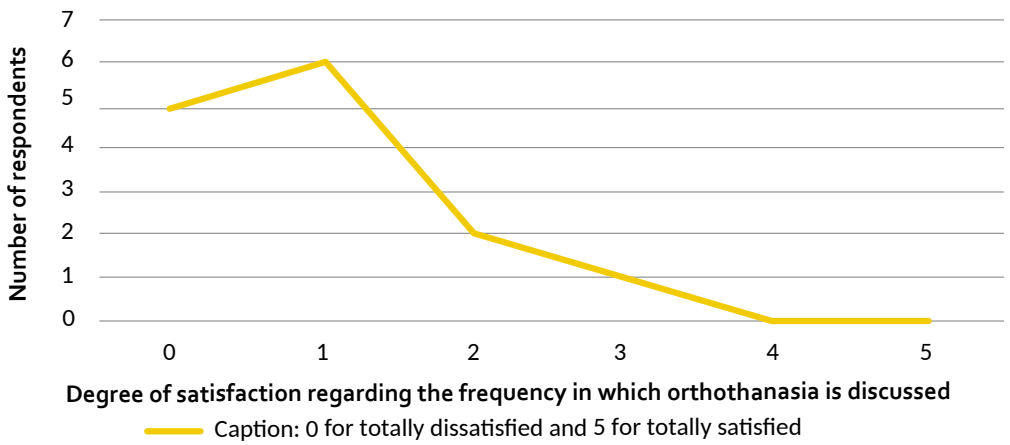
Most respondents said they felt comfortable enough to discuss death in class. On a scale of 0 to 5 to indicate the degree of comfort with the topic, 5 being the most comfortable/safest, 26.7% answered 3; 26.7%, 4; and 33.3%, 5 (Graph 2). These data show that orthothanasia is not a taboo, but a subject that causes no major inconveniences to those who face it.

On the other hand, most professors were dissatisfied with the frequency in which orthothanasia is discussed in academia. On a scale of 0 to 5, 0 being completely dissatisfied, the only answers marked were 0 (35.7%), 1 (42.9%), 2 (14.3%), and 3 (7.1%) (Graph 3).

Graph 2. Number of professors according to degree of comfort to discuss orthothanasia in class



Graph 3. Number of professors according to degree of satisfaction of orthothanasia discussions in class



Research

Respondents were then asked if orthothanasia should be broached more often, and ten (66.7%) professors answered it was essential, while five (33.3%) said it might be needed. These answers contradict the professors' confidence to discuss this matter, considering that, were they really well prepared, they would discuss it.

When asked if they had been well instructed on orthothanasia as undergraduates, all professors stated that they were poorly instructed and that their education endorsed death as a symbol of failure, implying professional frustration. Today, however, they recognize how important this issue is, and how its symbolism could change if orthothanasia were discussed more frequently and positively, as a useful therapeutic possibility. This is confirmed by the students' insecurity to discuss orthothanasia due to little approach during medical school, perpetuating unpreparedness to face death [8].

The field of orthothanasia and palliative care also includes end-of-life experiences (ELEs) or deathbed visions (DBVs), phenomena that occurs hours, days or weeks before an individual's death. In these cases, patients usually describe meeting with deceased friends or relatives [19]. These events are psychologically and existentially significant, since they can provide comfort, encourage patients to discuss waking life concerns, and decrease fear of death.

The literature distinguishes these occurrences from neurological disorders, dementia, or delirium. Which is significant, because these cognitive dysfunctions are historically classified as the cause of such phenomena, causing fear and shame in both patients, when telling their experiences, and physicians, when underreporting the cases, for fear of judgement [20]. Orthothanasia and death are thus poorly studied, taught, and understood due to several causes.

The following question, also open-ended, asked what death meant for each professor. Oh the 18 references made, five (27.78%) considered it as a crossing/transition; four (22.22%) as the beginning or ending of a cycle, in which one said beginning and three said ending; four (22.22%) as the end, mentioning no other noun; two (11.11%) as part of the life cycle; and one (5.56%) as a mystery, the fulfillment of a mission, and eternal life, respectively.

Only 11.11% of health professionals view death as part of the biological life cycle, showing that even they consider death to be mysterious and uncertain. One must, then, understand death as a natural process, to assure the patient dignity in completing their life cycle and ease the agony felt in their final moments of life [21]. Moreover, research published by the *Palliative Medicine* journal asserts that spirituality is a significant support to several non-religious theistic families [22].

Finally, professors were asked to freely give suggestions on how to discuss orthothanasia in the medical school at the university in question. Of the 21 references made, the most cited, with three mentions (14.29%) each, were multidisciplinary team approach and tutorials/conferences/lectures. A multidisciplinary team shares the guilt by deciding on orthothanasia together, not individually, allowing for a less negative feeling of responsibility at the individual level. They are thus essential to mediate obstacles set by professionals who individually wish to prolong life at any cost, even at the expense of ethical principles of care [23].

Other possible approaches mentioned were workshops/conversation circles (9.52%), cinema/theater/other non-conventional methods (9.52%) and clinical cases (9.52%). Respondents also mentioned contact with professionals trained in a specific discipline with team-based learning (TBL) at the university hospital (4.76%), in simulations (4.76%), and in internships (4.76%).

To create a course on orthothanasia that reflects on a dignified death is a great challenge in Brazil, but such a course would be a milestone in changing how medical schools face this issue. Not least because the literature on dignified death is incipient, especially from a medical standpoint, which makes it even more important [24].

Final considerations

Based on our results and discussions, we found that medicine cannot be changed without considering the way it is taught. New methods and topics considered relevant for facing death need to be better explored, since common sense cannot continue to permeate the practice of orthothanasia, to the detriment of scientific advances and the legislation that addresses it.

Since the professors underwent an unsatisfactory medical education, specialized training must be offered so they can be prepared to discuss orthothanasia more clearly and didactically, dissociating it from professional frustration. According to our results, they believe orthothanasia to be essential, but to turn this acknowledgement into change, they must take the first step and come out of their comfort zone.

The concept of a "demigod" physician needs to be overcome not only formally, but also in practice. Recognizing that human knowledge is limited in dealing with the various outcomes of the health-disease process seems to be the first step to include orthothanasia as a real possibility of treatment, reinstalling the patient as the end of the therapeutic process, and not the medical knowledge *per se*.

Patients will thus have clearer models of medical treatment and cure, removing false hopes of improvement that are known to be impossible. Besides, physicians will handle better the responsibility over someone's life and will have, in the multidisciplinary team, the necessary support to face moral dilemmas. These changes would encourage doctor-patient-family relationships based on care and presence, and most of all, human dignity.

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