

The need for education about death in medical practice

La necesidad de educación en muerte para la práctica médica

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OPEN ACCESS

Citation: Palacios GM, Torres VYY. **The need for education about death in medical practice.** Colomb Méd (Cali), 2022; 53(4):e1005510
<http://doi.org/10.25100/cm.v53i4.5510>

Received: 10 Mar 2022
Revised: 12 Sep 2022
Accepted: 18 Nov 2022
Published: 30 Dic 2022

Keywords:

Death; education; euthanasia; lethality

Palabras clave:

Muerte; educación; eutanasia; letalidad

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Colombia is one of the leading countries in the world regarding regulations and rights at the end of life. Currently, there is legislation on access to palliative care, limitation of therapeutic effort, euthanasia, euthanasia in children and adolescents, conscientious objection for doctors, and medically assisted suicide is decriminalized. Meanwhile, the remaining Latin American countries are just beginning the discussion about dignified death. Among many reasons for this delay, one of them is that it begins with the most controversial of issues, euthanasia, instead of focusing on humanizing the end of life.

Although, etymologically, euthanasia means “good death,” a good death does not mean euthanasia. The definition of a good death is complicated because it corresponds to an individual notion affected by culture, religion, society, and medical science¹. Due to the lack of definition, the tools available to estimate the quality of death and end-of-life care are still unreliable². One of the most recognized criteria to define a good death is the preference of the place to die of the patient, but this depends on factors of the individual, their family environment, the disease, the logistical possibilities of the health system, and the health team that accompanies the process³. Some of these determinants can be modified, but not others. Health team care is the one with the greatest potential and, possibly, requires the most investment in education and organization.

For physicians, death is transforming from being a natural part of the human experience into a crisis of patient health from which they must be rescued⁴. In addition, technology-based clinical training ensures that they are well qualified to prolong life and poorly prepared to confront death or discuss it with their patients. The problem is bigger than it seems because the conviction about reliance on hospital-based, technologized medicine at the end of life is applicable to them. Research in Canada found that physicians died more in intensive care units and used more palliative care than the general population, but there was no difference in the possibility of dying at home⁵.

Bioethicist Howard Brody proposes that the problem of doctors when facing death has two parts: first, the overestimation of their capacities to save lives that he calls “the rescue fantasy”; and second, that doctors can also err by underestimating what medicine can do to relieve patients’ distressing symptoms, and helping them until they die⁴.

Death is well defined, unequivocal and irreversible. It is one of the variables of epidemiology; and some health quantifiers have been derived from it, such as «mortality», «lethality», «excess deaths», or «avoidable deaths», which measure the quality of a system or strategy of health. With these indicators, important investments in research are justified to overcome death; paradoxically, the resources allocated to research and training in the acceptance of death (palliative care and the teaching of thanatology in medical schools) lag behind compared to other medical disciplines. Death attracts more research funds than suffering ⁶.

Due to fear, unpreparedness, or discomfort in that situation, physicians prefer not to engage in difficult end-of-life conversations with their patients, limiting themselves to instructions about resuscitation ⁷. As a result, it is established a false contract because the patients and their relatives believe that doctors have greater powers than they really have; and doctors, who are aware of their limitations, opt for trying unsuccessful, costly, and painful measures, clinging to the slim chances of providing more life ⁶.

Medical intervention protocols, which are useful tools in health systems, are more questionable at the end of life because the rational and standardized approach may end up being inappropriate, wasteful, and useless ⁸. For example, even the guidelines implemented in the United Kingdom for the care of dying patients have not shown better results than not using them ⁹. On the contrary, more personalized attention, with the support of the family and the community, can reduce the costs of attention during the last year of life, and especially during the last month ^{10,11}.

Medical education in palliative care and end-of-life care is becoming increasingly necessary ¹². It gives balance to the training of the physicians because it requires enhancing the autonomy of the patients; it requires communication skills that are also useful in other areas of medicine; it humanizes and brings the physicians closer to the patient and the family; and it is a good investment for health systems because it is profitable. For Colombia, it is urgent because the leadership of the discussion of the end of life of society, as well as the regulations achieved, will demand appropriate medical attention. For other Latin American countries, it may be the prologue to an obliged, essential, and unavoidable debate on dignified death.

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