



DEATH AND THE RIGHT TO DIE: A PHILOSOPHICAL REFLECTION IN THE LIGHT OF CONTEMPORARY HERMENEUTICS

*¹Janielle Ferreira de Brito Lima, ²Helder Machado Passos, ³Santana de Maria Alves de Sousa, ⁴Isaura Letícia Tavares Palmeira Rolim and ⁵Eremilta Silva Barros

¹Master student in Nursing at the Federal University of Maranhão, Nephrologist Nurse at the Renal Unit of the Presidente Dutra University Hospital - HUUFMA. São Luís, Maranhão, Brazil

²PhD of Philosophy. Professor of the Department of Philosophy, Federal University of Maranhão, São Luís, Maranhão, Brazil

³PhD in Social Sciences. Anthropology. Professor of Department of Nursing, Federal University of Maranhão, São Luís, Maranhão, Brazil

⁴PhD in Nursing. Professor of Department of Nursing, Federal University of Maranhão, São Luís, Maranhão, Brazil

⁵ Nephrologist Nurse at the Renal Unit of the Presidente Dutra University Hospital – HUUFMA São Luís, Maranhão, Brazil

ARTICLE INFO

Article History:

Received 14th December, 2017
Received in revised form
26th January, 2018
Accepted 11th February, 2018
Published online 30th March, 2018

Key Words:

Death, Right to die,
Philosophy in Nursing.

ABSTRACT

The present philosophical essay aims to reflect on questions related to the prolongation of the biological life of the individual beyond its autonomy, under Gadamer's Philosophical Hermeneutics. The dying process takes on different meanings for people of different cultures. For some people, it means the end of everything, for others, it is a passage to a better or worse life. Health professionals have the arduous task of dealing directly with pain and suffering, and have the responsibility for determining prognoses and treatments. With the advancement of technology to maintain life, numerous interventions are carried out to avoid death, using a variety of resources to keep people alive. In this endeavor, death ceases to be a natural process, and there is a risk of prolonging the suffering implied by the dying process. Thus, the work of those who deal with the limits of life and death every day raises permanent questions. Reflections on the anxieties related to the death of the other, as a preparation for dealing with a terminal patient, are necessary to offer a more sensitive approach.

Copyright © 2018, Janielle Ferreira de Brito Lima et al. This is an open access article distributed under the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly cited.

Citation: Janielle Ferreira de Brito Lima, Helder Machado Passos, Santana de Maria Alves de Sousa, Isaura Letícia Tavares Palmeira Rolim and Eremilta Silva Barros, 2018. "Death and the right to die: a philosophical reflection in the light of contemporary Hermeneutics", *International Journal of Development Research*, 8, (03), 19613-19616.

INTRODUCTION

The German philosopher Hans-Georg Gadamer is considered the father of contemporary hermeneutics. In his work "The Hidden Character of Health", he reflects on issues related to health and science with the contextualization of current aspects and relates medicine and philosophy to the resumption of concepts of thinkers such as Plato, Socrates, Kant, Heidegger, among others.

***Corresponding author: Janielle Ferreira de Brito Lima,**
Master student in Nursing at the Federal University of Maranhão, Nephrologist Nurse at the Renal Unit of the Presidente Dutra University Hospital - HUUFMA. São Luís, Maranhão, Brazil.

When reflecting on coping with a disease, Gadamer says that the illness removes the individual from the outside, making him turn to the inside. This detachment from oneself when falling ill is considered by the philosopher as an intelligent attitude (GADAMER, 2006). The patient seeks a balance produced through an imbalance, and for this he often resorts to an avoiding-to-see the disease, since the disease would mean, for the subject, exclusion from life, closeness to death (KÜBLER-ROSS, 2008). Although we deal daily with the certainty of a finite body, historically man fears death and sees it as an enemy. Gadamer (2006) puts the restraint of death as a will to live and affirms that someone has a future until he knows he has no future.

Everywhere there is fear in the face of the mystery of death, as if it were the other side of its restraint in the consciousness of the living individual, the trembling before its sacred character, the frightening that causes silence, the definitive disappearance of someone who just was still alive (GADAMER, 2006, p.73). The medical sciences have as their paradigm the struggle to preserve the life of the patient, and have historically given physicians a superhuman knowledge to such an extent that death, in some spheres of social life, is no longer represented as an integral part of life, but the finding of an error or failure by the processes of evolution. This change of perspective has transformed the experience of death in the lives of human beings (Gadamer, 2006). Discussions about death and the performance of the multi professional team in this stage of life are frequent and have gone beyond the limits of health services. An outstanding technological advance in health care is well known. Every day new treatments and equipment that can be used to prolong life appear (Aredes; Modesto, 2016). Here we come across another question posed by Gadamer: the right to die.

Health professionals routinely deal with life and death, and they are prepared to seek the preservation of life, often at all costs. To do so, they use all available technological resources to try to postpone death. In their training process, these professionals are taught to perform complex procedures, monitor vital signs, handle different equipment items, act with readiness, but they are not prepared to deal with death and dying issues, or to meet the needs of the patient and the family when there is nothing else to be done (Costa and Lima, 2005; Medeiros And Lustosa, 2011). We come therefore to a preponderant question: To which extent should biological life of individuals be prolonged by the use of technological resources? Linked to this problem, there are other questions: To which extent should therapies and technology be used to keep a person alive? From what perspective can one evaluate the benefits of survival provided by the use of medications and equipment that "replace" vital functions? In view of these concerns directly related to the activity of health professionals and in the light of Gadamer's thought, this essay proposes a reflection on questions related to the extension of biological life of individuals beyond their autonomy.

A perspective of death

From ancient times man abhors, challenges and tries to conquer death, taking it as an enemy. Death has assumed over history a negative representation, as something obscure, something that engenders fear and dread for human kind. Today, contemporary society, in general, does not know how to deal with the death and dying process or does not accept this idea as something natural. The experience of death, in Gadamer's view, occupies a central position in the history of mankind. He even states that the understanding of the living body as something finite is the core of becoming human (Gadamer, 2006). According to Heidegger, the human being exists finitely; he is not prior to finitude, nor is there any possibility that finitude will not affect him (Arantes, 2016). For Kübler-Ross, however, man unconsciously does not understand his condition of finitude. At this level of consciousness, death is impossible, and its occurrence would always be caused by something evil that can not be controlled. Thus, according to the author, the unconscious does not admit death as part of the life cycle. For it, there is no possibility of reaching the end of life due to natural causes; an individual can

only be killed (Kübler-ross, 2008). In line with Gadamer's thought, Kovács (2011) defends the idea that human beings are mortal, and that the consciousness of their finitude is the main characteristic that differentiates them from other animals. Talking about death is a great challenge because this is a little known stage of life. We do not have information of someone who has gone through death and who could share the experience with other people, because this is a path with no return. It is unknown when and where death will occur. However, this moment cannot be ignored as part of human existence. All living beings will reach death (PEREIRA, 2013). For Heidegger (2006), death is certain and at the same time indeterminate as to when it will occur: it can occur unexpectedly and at any time. Thus, "the risk is constant, since it is neither possible to control nor calculate the possibility of the absolute impossibility of existence, although, on a daily basis, a movement prevails in order to avoid meeting with this event" (Leite, 2011). Interestingly, the representation of death is influenced by cultural, historical, ethical, religious and psychological factors, and the interaction between these factors contributes to the difficulty of any attempt to reflect and understand the subject (Cantu; Mariuzzo; Rondina, 2005). Pereira (2013) believes that the idea of death assumes different meanings for people of different cultures. For some people, it means the end of everything, for others, it is a passage to a better or worse life. It can also mean joy, sadness or relief. Like Pereira, Kovács (1992) states that each individual brings a representation of death in himself and is aware of his finitude. Nevertheless, man has always sought ways to prolong life, to become immortal, to challenge and to try to defeat death.

We experience situations of escape from death and denial of its possibility: "Someday, at last, one also dies, but not immediately hit by death" (Heidegger, 2006, p.329). Still according to the author, what is sought is actually the pleasures of eternal youth, its beauty and strength. In this way the individual enters into a battle for the escape of old age with all the inherent losses and pains. Throughout history man has maintained different relationships and ways of dealing with death. Kovács (2012) discusses the relationship of man with death within Western history, based on the works of Philippe Ariès. The author shares the idea of Gadamer and Ariès, stating that people recognize their finitude and the existence of death, and explains that this knowledge is collective, public and everyone lives in it. In the Middle Age, time was necessary to detect the death of a person, and when death was found, it was announced through rituals. They believed that the dead were somehow present among the living on some occasions, and when people were near death they could perceive them, and there was no clear distinction between the natural and the supernatural. This belief persisted for a long time, and exists until today in the popular imagination (Kovács, 2012; Nunes, 2017).

Contrary to what is now believed, that a sudden and painless death is a "good" one, according to the above-mentioned authors, a quick death was considered a bad thing at that time, regarded as shameful, ugly, dishonorable, and monstrous, as deaths caused by accidents and murders. Clandestine deaths, without witnesses or ceremonies, were also not well seen. It was believed that when death occurred quickly, there was no time for repentance, so in these situations it was forbidden to perform Christian funerary rituals. Historically there is a desire to dominate death and control it.

Kovács (2012) emphasizes two characteristics in the way of experiencing the process of death in the past: the simplicity of the ceremonies and their realization in public. At the imminence of death, it was common to perform acts on patient's bedside that indicated a familiarity and acceptance of the event, such as the meeting of relatives around the patient to say goodbye. Generally, the relatives were around the dying person, because what they feared most was the possibility of dying alone. At that time death was considered a natural event of life, not an adverse event. The author comments that over the years, death started to be transferred to hospitals, where it would take place in an isolated and often unnoticed and silent manner. Rituals of death and farewell started to gradually disappear, and the representation of death in society started to fade away. Discrete attitudes, almost as a denial of pain, was sought, and this interfered with the expression of mourning. What is perceived nowadays is a movement contrary to the rites that involved the journey to the death of our ancestors. In the constant search for delaying the dreaded end, technological advances have made it possible to prolong the dying process. Thus, it has become increasingly common for sick people to leave their routine and stay in treatment, hospitalized, away from family and loved ones, in their last moments of life. Death, in this context, ceases to be a natural process and depends on the decision of doctors and family members.

Palliative care and the right to die

An illness can have a major impact on the life of a person and his family, especially in the terminal phase, when there is no possibility of recovery. The diagnosis of a terminal illness usually leads to disorganization in the family and to many changes, requiring members to adapt and acknowledge that, most of the time, they are unprepared. Health professionals have the difficult task of dealing directly with pain and suffering, considering their responsibility for determining prognoses and treatments (Aredes; Modesto, 2015). In terminal cases, ethical issues arise between professionals and family members, causing consistent discussions. Usually, the outcome of many such cases is a death preceded by physical and psychological suffering. Furthermore, many health professionals are not prepared to deal with their own emotions, as well as with those of the patient and their relatives, at the moment of providing care in conditions when death is imminent (Cantu; Mariuzzo; Rondina, 2005). Carvalho (2011) calls attention to the fact that these professionals need to reflect on their anguish before the death of others as a preparation to deal with terminal patients and to offer a more sensitive approach.

The majority of Brazilian hospitals do not have guidelines on care for terminally ill patients and there is also no systematized information about how these last moments are experienced. Given this problem, Palliative Care represents a form of care different from curative medicine by focusing on integral care, through prevention and control of symptoms and promotion of comfort for patients facing serious diseases (Matsumoto, 2012). Palliative Care is the approach that promotes the quality of life of patients and families who are facing diseases that threaten the continuity of life, by means of prevention and relief of suffering. It requires the early identification, evaluation and impeccable treatment of pain and other physical, psychosocial and spiritual problems (WHO, 2002). This form of care is based on the humanization of care and respect for patients as human beings, and require the

integration of knowledge from various specialties, with the aim of alleviating pain and suffering in the terminal or persistent vegetative state, or in case of a chronic illness (Basilio, 2013). In a Palliative Care unit, where the death process is routinely monitored, it is important that the team recognizes the limits of pursuing healing, but this does not necessarily imply a restriction of care. In this perspective, Resolution 1,805/2006 of the Federal Council of Medicine determines that: The patient will continue to receive all the necessary care to alleviate the symptoms that cause suffering, ensuring integral assistance and physical, psychic, social and spiritual comfort, including assuring the patient the right to go home (CFM, 2006). When there is no possibility of healing, it is important not to lose sight of the idea of a "good" death, one with dignity and without interference so as not to accelerate or delay the moment of death. The central issue here is to shift the problem from the field of failure to that of personal experience, by taking death not as a scientific but as an existential issue. Thus, it is necessary to mobilize and strengthen the subjective resources of the sick person, in the search for a proper knowledge to deal with the imminence of death. In addition to interventions to patients at that particular moment, the work should also involve family members (AranteS, 2016). Conditions of pain and suffering accompanied by physical and psychic degenerations often generate ambivalent feelings in the patients and their families, say Pereira and Dias (2007). The desire for death may occur at this moment, on the part of the subject or the family, glimpsing the relief of suffering. We now come to one of the most complex points of working with people in the terminal stage: the management of the individual who does not want to live any longer. Healthcare professionals are often led to reflect on the limits of their care in cases of terminality, and to what extent the patients' wishes must be met. They are divided by their ethical and professional duties to preserve the life and the strength of the individual to decide on his own life. In this context, it is necessary to observe that health professionals do not act in their own favor, but rather in favor of the patients, being therefore subordinated to their interests.

Therefore, the challenge of health professionals is to work with individuals who have different perceptions and needs and at the same time provide a comprehensive and individualized assistance. Some anxieties permeate the autonomy of professionals and reach other spheres, since all action must be governed by norms and care is no different. For example, until which point should care be provided to an individual? Who determines this? Which "voice" speaks louder? There are many questions that professionals find it difficult to solve, making it necessary for other instances to intervene and support the performance of the categories. The rights of terminally ill patients to a dignified death and the guarantee of respect for their autonomy have been the subject of discussion today and are dealt with in the Advance Directives of Will (ADW). According to the resolution n° 1,995/2012 of the Federal Council of Medicine, the ADW are the set of wishes previously and openly expressed by the patient about care and treatment that he wants or not to receive when unable to express, freely and autonomously, his will (CMF, 2012). According to Penalva (2009), these guidelines make it easier for family members and health care staff to make decisions about the patient's treatment when he or she is unable to do so, as they allow the participants to know their wishes when there is no possibility of expressing them. The ADW can contribute to the patients' autonomy to be respected, guaranteeing a better

quality of life in the process of dying, as well as preserving their dignity.

Final Considerations

The experience of death, in Gadamer's view, occupies a central position in the history of mankind and the understanding of the living body as finite is the core of becoming human. Death is perceived as having different meanings for each individual and its representation is influenced by cultural, historical, ethical, religious and psychological factors. Throughout history, man has modified the way of dealing with this moment and today, what was considered a "good death" is the one experienced without pain and suffering. With the advancement of technology to maintain life, numerous interventions are carried out to avoid death, resorting to a variety of resources to keep people alive. In this endeavor, death ceases to be a natural process and there is a risk of prolonging the suffering implied by the dying process. The work of those who deal with the limits of life and death every day is surrounded by permanent questionings. In terminal cases, the outcome is often a death preceded by physical and psychic suffering and this produces consistent discussions about ethical issues among professionals and families.

A mobilization in favor of life is observed in health services in which professional ethics, biomedical models and scientific techniques dominate the dynamics of an institution. However, sensibility and affectivity also mediate the performance of professionals. To act at such times, practitioners need to reflect on their anguish towards the death of another person as a preparation to deal with terminal patients and offer them a more sensitive approach. In this context, movements of humanization arise as a search for the opportunity of a quiet and smooth death, shared with relatives and close friends. Moreover, in the final stage of life, many patients are unable to make decisions. To promote respect for their autonomy and ensuring that their wills are respected, early will directives are a useful tool for guiding the conducts during Palliative Care. It is worth emphasizing that in these situations care should be directed towards the patients and their families, aiming at minimizing suffering and offering support to cope with the death and dying process, given the importance of the participation and support of loved ones in this stage of life.

REFERENCES

- Arantes, J.C. 2016. Os feitos não morrem: psicanálise e cuidados ao fim da vida. *Ágora*, 19(3).
- Aredes, J.S. and Modesto A.L. 2016. "Entre vidas e mortes, entre máscaras e fugas": um estudo sobre a prática médica hospitalar. *Physis Revista de Saúde Coletiva*, 26 (2).
- Basilio, R.M.C.S. 2013. A vigência das diretivas antecipadas de vontade em relação à vida e à morte digna. Dissertação [Mestrado]. Universidade de Fortaleza – UNIFOR. Fortaleza, Ceará, Brasil.
- Cantu, F., Mariuzzo, T. and Rondina, R.C. 2005. A percepção da iminência da morte em pacientes terminais: dilemas, conflitos e angústias. *Rev. Científica Eletrônica de Psicologia*, 04.
- Carvalho, V.A. 2011. A vida que há na morte. In: *Vida e Morte: Laços da Existência*. 2ª Edição. Casa do Psicólogo: São Paulo, Brasil.
- Conselho Federal de Medicina. 2006. Resolução 1.805/2006. Diário Oficial da União, Brasília, 28 nov. 2006. Seção I, p.169. Disponível em: <http://www.portalmedico.org.br/resolucoes/cfm/2007/111_2007.htm>.
- Conselho Federal de Medicina, 2012. Resolução CFM no 1.995, de 31 de agosto de 2012. Dispõe sobre as diretivas antecipadas de vontade dos pacientes. [Internet]. Disponível:http://www.portalmedico.org.br/resolucoes/CFM/2012/1995_2012.pdf.
- Costa, J.C. and Lima. R.A.G. 2005. Luto da equipe: revelações dos profissionais de enfermagem sobre o cuidado à criança / adolescente no processo de morte e morrer. *Rev. Latino - Am. Enfermagem*, 13(2).
- Gadamer, H-G. 2006. O caráter oculto da saúde. Vozes: Petrópolis, Rio de Janeiro, Brasil.
- Heidegger, M. 2006 *Ser e tempo*. Vozes: Petrópolis, Rio de Janeiro, Brasil.
- Leite, F. 2011. O ser-para-a-morte a partir e depois de Ser e Tempo. Ítaca, 16.
- Kóvacs, M.J. (Org.). 1992. *Morte e desenvolvimento humano*. Casa do Psicólogo: São Paulo, Brasil.
- Kovács, M.J. 2011. A morte em vida. In: *Vida e Morte: Laços da Existência*. 2ª Edição. Casa do Psicólogo: São Paulo, Brasil.
- Kovács, M.J. 2012. *Educação para a Morte Temas e Reflexões*. 2ª Edição. Casa do Psicólogo: São Paulo, Brasil.
- Kübler-Ross E. (2008) *Sobre a Morte e o Morrer*. 9ª Edição. WMF Editora Martins Fontes: São Paulo, Brasil.
- Matsumoto, D.Y. 2012. Cuidados Paliativos: conceito, fundamentos e princípios. In: Carvalho R.T., Parsons H.A. (Org.) *Manual de Cuidados Paliativos*. Academia Nacional de Cuidados Paliativos (ANCP): São Paulo, Brasil.
- Medeiros, L.A. and Lustosa, M.A. 2011. A difícil tarefa de falar sobre morte no hospital. *Rev.Sociedade Brasileira de Psicologia Hospitalar*, 14(02).
- Nunes, C.T.S. 2017. Reflexões sobre pacientes terminais: um olhar para a família. Monografia [Aprimoramento Profissional]. Secretaria Estadual de Saúde de São Paulo-SP. São Paulo, Brasil.
- Ortega, F. 2012. O estatuto da medicalização e as interpretações de Ivan Illich e Michel Foucault como ferramentas conceituais para o estudo da desmedicalização. *Interface*, 16(40):21-34.
- Pereira, L.L., Dias A.C.G. 2007. O familiar cuidador do paciente terminal: o processo de despedida no contexto hospitalar. *PSICO*, 38(1).
- Pereira, Z.P. 2013. Eutanásia e distanásia: Bioética e ação médica. *Revista Húmus*, 3(7).
- WHO. 2002 Definition of Palliative Care. World health Organization. Disponível em: <<http://www.who.int/cancer/palliative/definition/en/>>.
