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End of life: bioethical reflection on medical education

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Abstract

This qualitative study used the collective subject discourse method to identify the meanings, feelings and perception of medical students about death and terminally ill patients. In total, 60 students from a medical school in southern Minas Gerais were interviewed. For the meanings about end of life, the most common idea was "closure of life." When the topic addressed was the feeling about terminal patients, the central ideas were "insecurity," "impotence," "frustration" and "anguish." Regarding the preparation to deal with death and dying, "unpreparedness" was the most common. When considering how these themes are approached during training, "superficial approach," "not very frequent" and "not addressed" emerged as ideas. We can thus conclude that the inexorability of death is not part of medical training, removing the possibility of rethinking care as a therapeutic form.

Keywords: Bioethics. Death. Medical education. Empathy.

Resumo

Terminalidade da vida: reflexão bioética sobre a formação médica

Nesta pesquisa qualitativa, utilizou-se o método do discurso do sujeito coletivo para conhecer os significados, sentimentos e percepções de estudantes de medicina sobre o tema morte e pacientes terminais. Foram entrevistados 60 alunos de uma universidade do Sul de Minas Gerais. Para os significados sobre terminalidade da vida, a ideia central mais frequente foi "fechamento da vida". Quando o tema abordado foi o sentimento a respeito do paciente terminal, emergiram as ideias centrais "insegurança", "impotência", "frustração" e "angústia". Quanto ao preparo para lidar com a morte e o morrer, prevaleceu a ideia "não estou preparado". Já com relação à presença desses temas na formação, surgiram as ideias "abordagem superficial", "deveriam ser abordados com mais frequência" e "não abordados". Conclui-se que a formação médica não trata da inexorabilidade da morte, o que afasta a possibilidade de repensar o cuidado como forma terapêutica.

Palavras-chave: Bioética. Morte. Educação médica. Empatia.

Resumen

Terminalidad de la vida: reflexión bioética sobre la formación médica

En esta investigación cualitativa se utilizó el método del discurso del sujeto colectivo para conocer los significados, sentimientos y percepciones de los estudiantes de medicina sobre el tema muerte y pacientes terminales. Se entrevistó a 60 alumnos de una universidad del sur del estado de Minas Gerais, Brasil. En lo que respecta a los significados sobre la terminalidad de la vida, la idea central más frecuente fue "cierre de la vida". Cuando se abordó el sentimiento respecto al paciente terminal, surgieron como ideas centrales: "inseguridad", "impotencia", "frustración" y "angustia". En cuanto a la preparación para enfrentarse a la muerte y al morir, prevaleció la idea "no estoy preparado". A su vez, respecto a la presencia de estos temas durante la formación, surgieron las ideas "enfoque superficial", "deberían abordarse con más frecuencia", y "no abordados". Se concluye que la formación médica no aborda la inexorabilidad de la muerte, lo que aparta la posibilidad de repensar el cuidado como forma terapéutica.

Palabras clave: Bioética. Muerte. Educación médica. Empatia.

The authors declare no conflict of interest.

Research

For millennia, humanity's stance on mortality has been that of resignation. Excepting wars or hunting, looting or territory conquest expeditions, death occurred in a family context: patients died in their homes, surrounded by family and friends. Since the nineteenth century, however, medical advances have increased life expectancy and the reversibility of many contagious diseases [1]. In this way, biological knowledge and technological advances have made death more problematic, a source of ethical dilemmas and difficult choices, generating anguish and uncertainty. In the twentieth century, bioethics emerges thus as a field of knowledge that helps professionals rethink their fundamental role in health [2].

Since the first years of undergraduate studies, medical students are induced to value the technical-scientific foundations of the profession, overshadowing the holistic conception of the human being and life [3]. Thus, feelings of anxiety or anguish at the inevitability of death, if they eventually arise, are superseded in favor of training [4]. Medical training follows the general crisis in education, increasingly focused on the technicality of the postmodern world, eager for human beings endowed with specialized and utilitarian knowledge [5]. In this type of teaching, dimensions of human existence – such as the aesthetic, emotional, and physiological – are all supplanted by the market domain.

Education is a process of human formation, and the human person is a central theme of bioethics. Therefore, besides enabling technical knowledge, medical education should also help future professionals establish more humanized and affective relationships with their patients. In view of the scarcity of reflections on the terminality of life in the medical academic context, this research analyzes students' speeches to access their experiences and perceptions about death and understand to what extent they are familiar with the topic.

Method

This is a qualitative, descriptive, cross-sectional, uncontrolled study, with intentional sampling. By using the collective subject discourse (CSD) method, we aimed to give the group researched a voice, proposing that such speech expresses a collective thought. The verbal tense is that of the one who speaks, the "I," since the social representation expressed by the CSD aggregates different subjects and narratives, although semantically similar [6].

Target population and sample

The study population included students from the first to the sixth year of the medical undergraduate course at Universidade do Vale do Sapucaí (Univás), in Pouso Alegre, Minas Gerais. The intentional sampling disregarded gender or age, using only the list of students enrolled in each year. Ten students from each year were selected, totaling 60 individuals – a significant sample, corresponding to 12.5% of the total of students.

Research tools

A sociodemographic questionnaire (with the variables *course year*, *gender*, *age* and *religion*) and a semi-structured questionnaire with four questions on the topic of terminality of life, formulated based on the theory of social representations, were used as a research instrument. This theory, founded on a socially elaborated and shared knowledge, associates the mental activity of individuals and groups to determine the subjects' stance regarding situations and events that concern them. The four questions in the questionnaire were: 1) "For you, what does terminality of life mean?"; 2) "How would you feel if you had to deal with a terminal patient at this moment?"; 3) "If someone asked if you feel prepared to deal with death and the process of dying, what would you say?"; and 4) "If someone asked you about the approach to the topic of death and terminally ill patients in medical education, what would you say?"

Data analysis

The sociodemographic data underwent descriptive analysis. To analyze the data obtained by the semi-structured instrument, we used CSD, written in the singular first-person point of view and composed of key expressions that presented the same central ideas and basis.

Ethical procedures

The present study followed the ethical precepts established by the Resolution of the National Health Council 466/2012 [7], which defines the ethical procedures for research involving human beings. Participants were informed of their right to withdraw from the study, if they so wished, at any time during the research. They all signed an informed consent form, thus autonomously expressing their agreement to participate in the work.

Results

Interviewee profile

The sample of this study comprised 60 medical students from Univás, of both genders, aged between 18 and 31 years old, and attending the first to the sixth year of undergraduate studies (10 students from each year). Regarding the experience with terminality of life, 50 (83%) stated having already had some contact with issues related to the topic, as well as with bioethics, in undergraduate disciplines. The participants pointed out, however, a great gap between the theoretical classes on euthanasia, dysthanasia and orthothanasia (taught in the first year of the course) and the practice.

From the third year, students report practical experiences with death, in the discipline of semiology, when they are faced with the divergence between the subject studied and the reality of the doctor-patient relationship. In the fourth year, practical experiences with death expand in semiology classes and internships, but without major reflections, almost trivialized. In the fifth year, medical residency presents this experience routinely, but the only theoretical apparatus to face the situations are the few bioethics classes of the first year. In the sixth year, the experiences with the topic intensify, but, despite the greater maturity and experience, students still refer to the classes they have taken in the first year, when they did not understand well the issues raised.

Based on the responses to the semi-structured instrument, central ideas were identified and organized in a synthesis speech, written in the singular first-person. We present below the most frequent of these central ideas, with their respective synthesis-speeches.

For you, what does terminality of life mean?

In the answers to this question, the central ideas that emerged were "closure/end of life," "transition from physical to spiritual body," "brain death," "body-mind-spirit separation" and "multiple factors." The most frequent were "closure/end of life" and "transition from physical to spiritual body."

- ***Closure/end of life***

  "I think it is a natural process, a part of life like any other, as if it were the conclusion of a cycle. Life ending is the end of that cycle. It would be the interruption of physiological functions, heartbeat and other important organs, when there is no more to be done about any disease, comorbidity, a health problem in general" (frequency: 34).

- ***Transition from physical to spiritual body***

  "It is an evolutionary stage, a moment of transition from physical to spiritual body, when the part of life here on Earth ends (and it continues on some other plane, for example)*"* (frequency: 15).

How would you feel if you had to deal with a terminal patient at this moment?

In the answers given, the central ideas "insecurity," "solidarity," "sadness, anxiety and impotence," "inconstancy," "anguish, compassion, frustration and failure" and "dread" emerged. The three most common ideas are highlighted below.

- ***Insecurity***

  "I don't know what I would do, I don't know how to react to these situations yet (...). *I don't think I would be prepared. Today, I would not be able to do that [deal with a terminal patient], speaking of both theoretical and emotional background. Neither college nor* (...) *life teaches us how to deal with losses"* (frequency: 21).

- ***Solidarity***

  "I would try to do everything for the patients' well-being, I would try my best to support and see what would be better to ease their suffering, their pain, so that they can go through this period in the best possible way" (frequency: 15).

- ***Sadness, anxiety and impotence***

  "At first, I would be a little emotionally shaken, a little anxious, sad, because of the feeling of helplessness, of not being able to do anything else for the person" (frequency: 9).

If someone asked if you feel prepared to deal with death and the process of dying, what would you say?

The central ideas that emerged in the answers were "I am not prepared," "I am prepared," "one is never prepared," "more or less prepared," "it depends on the bond" and "I don't know." The three most frequent ideas, with their synthesis-speeches, are highlighted below.

- ***I am not prepared***

  "I am not prepared, I have not yet been prepared for it, neither in life nor in college" (frequency: 25).

- ***I am prepared***

  "I am prepared because it is something natural, life and experiences teach us" (frequency: 10).

- ***One is never prepared***

  "I will never be fully prepared, no one is prepared to die or see the other dying" (frequency: 10).

If someone asked you about the approach to the topic of death and terminally ill patients in medical education, what would you say?

The central ideas that emerged in the answers to this question were "superficial approach," "it should be addressed more frequently," "topic not addressed," "important to be addressed" and "there is no preparation." The most frequent ideas were "superficial approach" and "it should be addressed more frequently."

- ***Superficial approach***

  "Very unsatisfactory approach, there is no discussion about it: how to deal with it, feelings that arouse" (frequency: 35).

- ***It should be addressed more frequently***

  "I think it is very important, especially when it comes to medicine; 99% of our workload is about life, with all areas dealing with the loss process, and we have no support" (frequency: 14).

Discussion

Among the central ideas related to the meaning of terminality of life, the most prevalent notion was "closure/end of life," considered as a natural biological process, end of an organic cycle. Medical schools prepare students to become senior science officers and managers of complex biotechnologies, bypassing teaching about the true art of being a doctor [8]. Much is invested in teaching biological aspects, but to the detriment of the patient's psychosocial and spiritual aspects.

Life goes far beyond the physical body, and considering the patient's biography is essential to understand that each person leaves a legacy when death arrives. We are neither sick nor victims of death: we are pilgrims in existence, and that is healthy. When biological life is absolutized, one begins to seek the cure for death, postponing the inevitable [9]. In students' speeches, we observe a reduction of the human being to the biological dimension: "(...) *when there is no more to be done about any disease, comorbidity, a health problem in general*." The statement reinforces the dichotomy between the disease and the sick person: instead of caring for the person, treating the disease is privileged.

Another central idea, part of this reductionism, refers to the notion of terminality of life as brain death. Living is not the same as being alive; living involves all the elements that make up the human being, while being alive refers only to the biological element [10]. Medicine maintains the principle of life as the end of its activities,

and as a result the biomedical sciences deal more directly with the issue of technical ethics. Thus, assuming the idea of responsibility for the future and fear of putting human life at risk, the proposal is an ethics of responsibility that guides the technical action of medicine and does not consider the patient as an object. Medical science can only pull away from the "objectifying" paradigm if it starts from the first response criterion developed by Hans Jonas [11], which is the imperative of motivated and conscious will.

The relation between the right to live and the right to die must guide medical art, its rights and duties. This art consists of inflicting the least possible pain and degradation, avoiding the unwanted and degrading prolongation of the process of extinction of life. When medicine does not accept the right to die, the doctor stops being a servant concerned with the patient's well-being and becomes a tyrannical master [11].

The other central ideas related to the meaning of the terminality of life – "transition from physical to spiritual body," "body-mind-spirit separation" and "multiple factors" – relate to the spiritual dimension, in addition to the biological body. The *Universal Declaration on Bioethics and Human Rights* [12] is based on the integral vision of the human being, in the biological, psychological, social, cultural and spiritual dimensions. The human being is much more than biological materiality, and therefore health professionals must be sensitive, aware of a new model – the biopsychosocial paradigm – that is concerned with all human dimensions.

The spiritual dimension is a factor of well-being, comfort, hope and health [13]. Therefore, one should consider not only physical pain, since terminality also brings the pain of existence. It means taking care of the vulnerable being, burdened by the pain and disease suffering and the end of life, so a dignified death can be provided, which helps re-signify life in the face of finitude [13].

Regarding feelings when dealing with terminally ill patients, the central ideas "insecurity" and "inconstancy" show that students experience conflicts in the face of suffering. The predominance of technical aspects of disease management in training, without reflecting on the emotions involved, causes affective overload [13]. Faced with terminality of life, students can experience feelings such as insecurity and fear, revealed by the statement: "*Today, I would not be able to do that, speaking of both theoretical and emotional background.*"

At the beginning of training, medical students have their first encounter with death during anatomy classes, through a devitalized and dismembered body [14], devoid of biography. This first depersonalized contact initiates a process of expropriation of feelings and denial of existential and symbolic aspects of death and dying [15].

Due to technical training, students feel insecure when dealing with the inexorability of death. But medicine cannot keep death at bay indefinitely, as it is a condition of human existence. When it is no longer possible to preserve life, the obstinate search for a cure becomes futile. We could not wish for an endless physical life without any quality of life. Since death is inevitable, let it be dignified [16].

The purpose of medicine is not just healing, but restoring the health of the body, including psychological and social. Restoring the patients' health implies not only curing the disease, but also making them resume their normal life with autonomy, which is often lost in the disease process [17].

The central idea "security" was cited by only three students, reaffirming that training linked to the biomedical model is incapable of supporting future professionals emotionally. In view of the content overload during academic life and the dilemma of lack of time, many doctors experience profound shock, fear, insecurity and depression when facing death, and then ignore it as a form of self-protection [18].

The central ideas "solidarity" and "compassion" refer to very different human feelings. "Compassion" can mean virtuous acts and represent a moral weakness, if understood as the patients' exclusion and medication based on the idea that physicians know their needs and demands even before they have the possibility to verbalize their real desires. Solidarity, as a principle, refers to actions that benefit the patients based on their recognition as autonomous subjects, capable of making choices [19]. Many medical professionals in conflict with these feelings disrespect the patient's autonomy and desire.

The central ideas "sadness," "anxiety," "impotence," "anguish," "frustration and failure" and "dread" show the fragility of the medical student in the face of the complexity of life. To defend oneself, the future professional develops two strategies: depersonalization of the patient (the doctor denies to be dealing with a person and sees only the pathology) and "omnipotence" (developed when one begins to believe in the fantasy that it is possible to dominate life and death). With omnipotence, physicians end up isolating themselves from the team and even from the patient and may develop disorders when confrontation with reality generates frustrations [20]. The health professional deals with situations of suffering and pain, and the presence of death is constant. Failure to avoid it and possibility of only alleviating suffering lead professionals to the awareness of their own finitude [21].

Regarding the meaning of death and dying, "I am not prepared" and "one is never prepared" are the central ideas that stood out the most. In this theme, reflections on scientific advances, related to fear and denial of death are relevant [22].

To deepen the bioethical issues related to death, the so-called "bioethical trinity" was used: the principles of autonomy, beneficence, and justice [23]. Autonomy defends a symmetrical relationship between health professional and patient, in which patients are masters of their life and, aware of their conditions, make their own decisions. However, it is common for the opposite to occur: the paternalistic relationship, in which the health professional, taking the place of knowledge, uses the principle of beneficence (doing good and avoiding suffering) to act unilaterally, determining *what* to do with the patient, *how* and *when*. In this type of relationship, the professional uses a mechanical and depersonalized approach as a defense mechanism, which represses anxiety and rejects imminent death, avoiding exposing flaws, limitations and their own mortality [22]. The principle of justice refers to the quality of life, considering the singularities and needs of each person. What is fundamental is not the extension of life, but its quality.

Some acts that hasten death can be the result of the loneliness of professionals, who feel unsupported when caring for suffering patients [21]. This loneliness can occur even in busy hospitals (loneliness in the crowd). People do not see each other or know what happens in the other room or bed. In several hospitals, end of life is full of suffering, with terrible pain, dehumanized. Therefore, society seeks to hide death, delegating it to the doctor and the hospital, making it medicalized, institutionalized, rationalized, and usual [24].

The doctor became largely responsible for fighting and overcoming death. The insecurity felt by the professional and the awareness of not feeling prepared contrast with this image of a great savior, institutionalized since the beginning of medicine, but increasingly present with the advent of scientific medicine. The speech excerpt selected to illustrate the issue reveals the anguish of feeling lonely in the face of the inexorability of death: "(...) I have not yet been prepared for it, neither in life nor in college."

The central ideas "I am prepared" and "more or less prepared" show that experiences, maturity and contact with the terminality of life contribute to the formation of the future doctor. We are all subject to pain and illness, and we all fear death, but this experience is lived in many different ways, over which we have the right and the obligation to reflect [19]. As interesting, exciting and stimulating as things in the world seem, they do not become human until the moment when we can discuss them with our peers [5].

Everything that is not an object of dialogue can be sublime, horrible or mysterious. We humanize what happens in the world and in us when we dialogue and, with that dialogue, we learn to be human. Only from the encounter we can overcome the barrier of insecurity and feel prepared before the prospect of death.

The central idea "it depends on the bond" denotes that creating bonds destabilizes the strategies used to face death. Health professionals create bonds with some patients and, when they die, they undergo an unrecognized, unauthorized grieving process [25]. This creates a conflict between escaping death or learning about its process with patients. The medical profession is the exercise of an art based on scientific medicine and, as such, has as its object the human body, but what really matters is the subject. The doctor must first treat the patient [11].

The statement "*I think everything depends on the degree of relationship we have*" represents precisely the existence of affection, which humanizes care. The doctor-patient relationship is, above all, a relationship between subjects, and care arises when someone's existence truly matters. The doctor then dedicates himself/herself to the patient and participates in their destiny, in their life [26].

The central idea "*I don't know*" shows the distance from reflection and discussion about death in medical school. As long as health professionals do not understand finitude, they will not be able to really be present in a care situation [27]. Medical art requires, in addition to precious scientific knowledge, the ability to listen and understand the vulnerability of those who suffer. In care, doctors use all their knowledge and experience, even though they do not know whether or not they will be able to cure [28].

Regarding the approach to the topic of death and terminally ill patients in medical education, the main central ideas were "superficial approach" and "it should be addressed more frequently," stressing the need to emphasize the discussion and reflection on death during medical undergraduate studies.

From what can be seen from the analysis, death is presented to the medical student in a reductionist manner, privileging the biological and anatomical over psychological, symbolic and subjective aspects, ignoring the biography of the terminally ill patient. Since the beginning of training, the student has learned that, to understand a disease, one must divide the object of the study, following the scientific method proposed by Descartes [29], for whom the search for scientific knowledge came from the knowledge of the parts.

The statement "*there is no discussion about it: how to deal with it, feelings that arouse*" denounces the scarcity of reflection on finitude and distance in relation to the student's existential conflicts, also vulnerable, due to their own human condition. In the excerpt "*99% of our workload is about life, with all areas dealing with the loss process, and we have no support*," the need to deepen the discussion on death is evident. For this, however, it is necessary to reflect on life, as it is through the acceptance of the being-for-death that the true meaning emerges. One who transits poetically through existence, discovering some meaning, will probably come to the end in a smoother and more peaceful manner. Through the awareness of finitude, the human being is driven to life.

In medical training, human beings are often described simply by their mechanisms: respiratory, circulatory, digestive, etc. Life is taught in almost the entire workload, but the biological focus reduces human beings, fragmenting them and ignoring psychological, social and spiritual dimensions. Death is not understood as a natural process of life.

The goal of health care is not just to reach a diagnosis, test a hypothesis or evaluate the effectiveness of a treatment; the clinical decision must be the most correct for the patient [30]. The doctor who, aware of the impossibility of a cure, subjects patients to techniques to prolong life, objectifies them, violating their nature. It is necessary to understand that, after a certain moment, the doctor stops being the person who heals to become the one who helps the patient to die in the least painful manner possible [31]. Thus, each patient must be respected, providing fewer doses of technological cure and more human care.

About the central idea "topic not addressed," the following statement emerged: "*This topic is not addressed specifically in class. The sooner we have this approach, the sooner we will be able to think about it and accept the process.*" Once again, the fragility of medical training is revealed. Before talking about life and death in a philosophical sense, the student is inserted in the anatomy room, in which there are dismembered bodies, the smell of death, and a whole scenario of decomposition of the human body.

This lack of reflection on death can form a technically impeccable professional, capable of mastering high technology and prolonging life, but unskilled in the art of relating to human beings and dealing with their vulnerability in the face of finitude. The doctor-patient relationship must be a moment of encounter between human beings, with all their weaknesses. Hence, in addition to technology, it is necessary to be able to consider the patient's needs and listen to their suffering, helping them to live or die, but without uselessly prolonging a vegetative, inhuman life [22].

The central idea "important to be addressed" confirms the need, felt by the students, to reflect on the theme of death. We would have great progress in the art of medicine if it were possible to teach students human care in addition to the value of science and technology [22].

The statement "*during training, I think it is necessary to humanize, learn to privilege the patient over the illness*" shows the preponderance of the biomedical model when training future professionals. But the doctor, in addition to mastering science and technique, is a caregiver [32]. Those who care and let themselves be touched by the suffering of the other become humanized and have a precious chance to grow in wisdom [33]. Therefore, a humanistic, critical and reflective professional training, based on ethical, legal and bioethical principles [34] is paramount. Humanized practices in the health field, due to their dialogical nature, cannot be taught or learned technically. They are inserted in a cultural, ethical and aesthetic context [35] and are based on the relationships between individuals and groups.

The central idea "there is no preparation" was pointed out by a single student, through the following statement: "*We deal with and will deal with death in the profession (...) You end up learning in practice how you should act.*" This refers to the idea that humanistic values are not amenable to learning, echoing a certain disbelief in the transformative potential of the educational process.

To substantiate the importance of education, it is worth remembering the idea that it is better a well-made than a well-filled head [36]. A well-filled head accumulates knowledge without criteria and without meaning. For the well-made head, it is not enough to just accumulate knowledge; the most relevant is that knowledge leads to appropriate decisions. Education humanizes the professional future, contributing to the formation of the individual [37].

Final considerations

Among all human concerns, death is the most exciting and causes the greatest fear. Not so much for the end in itself, but for the process of dying, the fear of the unknown. Death is enveloped in different meanings and subjective emotions. Today, it occurs in hospitals, and health professionals, especially the doctor, accompany it. Therefore, it is expected that these professionals are prepared for this experience.

Although the doctor's commitment is to life, regardless of their technical competence and ethical conduct, finitude will always be present. In a culture that idealizes the doctor as being able to guarantee the cure and, consequently, the immortality of people, when death happens, feelings of failure and guilt arise. The patient's death puts the professional's credibility at risk, which intensifies their feeling of helplessness in the face of the inevitability of the end.

Upon entering college, the medical student is faced with a technical training, almost always guided by the obsessive search for a cure. Rare are the moments of dialogue and reflection on subjective aspects of the professional-patient relationship, which allow the student to express their feelings and anxieties about death. However, for the formation of the future doctor, ethical skills and competences are essential, which the hegemonic biomedical model is not capable of teaching.

Since death is inevitable, let it be dignified. To this end, it is necessary to promote ethical care, which avoids suffering, strengthens autonomy and guarantees equity. Through this care, the true meaning of the Greek terms *therapéuo* ("I care") and *klinos* (reverence to human suffering manifested by bowing over the patient's body) is recovered [33]. Care is one of the prerequisites for guaranteeing human dignity, in life and in death.

Every educational process is a living, moving process, in which teacher and student are responsible for the necessary transformations for new learning. The act of reflecting on pedagogical praxis is key to put into practice an education in living and dying. Current training is insufficient to change the model of care for terminally ill patients, since the great discussions with society regarding care in the face of death have not yet advanced enough [38]. Reflecting on the terminality of life is difficult, since the hegemony of the biomedical model, which seeks, often obsessively, to cure the disease, is not limited to health professionals, but is present throughout society.

This research sought to reflect on medical training regarding the complex theme of the education of living and, especially, dying, recognizing the dimensions that characterize students as human beings with feelings. We expect to have emphasized the need to change not only the curriculum of the medical course, but the educational institutions themselves, which must be spaces of listening governed by *ethos* (way of conducting, thinking, acting, feeling). These spaces need to promote openness to communication, awareness of feelings, listening and availability, deepening the discussion about death to reduce the fear that surrounds the topic and infusing students with the perception that they are prepared to care for patients at all times in life, including in the terminal phase.

References

1. Gomes ALZ, Othero MB. Cuidados paliativos. Estud Av [Internet]. 2016 [acesso 25 jun 2019];30(88):155-66. DOI: 10.1590/s0103-40142016.30880011
2. Pessini L. Distanásia: até quando investir sem agredir? Bioética [Internet]. 1996 [acesso 25 jun 2019];4(1):31-43. Disponível: https://bit.ly/3eLS6qx
3. Kovács MJ. Profissionais de saúde diante da morte: morte e desenvolvimento humano. São Paulo: Casa do Psicólogo; 1992.
4. Calasans CR, Sá CK, Dunningham WA, Aguiar WM, Pinho STR. Refletindo sobre a morte com acadêmicos de medicina. Rev Bras Neurol Psiq [Internet]. 2014 [acesso 25 jun 2019];18(1):34-57. Disponível: https://bit.ly/2QGjBKb
5. Arendt H. Vidas políticas. Madrid: Taurus; 1980.
6. Lefévre F. Discurso do sujeito coletivo: nossos modos de pensar nosso eu coletivo. São Paulo: Andreoli; 2017.
7. Conselho Nacional de Saúde. Resolução nº 466, de 12 de dezembro de 2012. Aprova as diretrizes e normas regulamentadoras de pesquisas envolvendo seres humanos. Diário Oficial da União [Internet]. Brasília, p. 59, 13 jun 2013 [acesso 3 maio 2021]. Seção 1. Disponível: https://bit.ly/3eTt6NR
8. Lown B. A arte perdida de curar. São Paulo: JSN; 1996.
9. Pessini L, Bertachini L, editores. Humanização e cuidados paliativos. 4ª ed. São Paulo: Centro São Camilo; 2009.
10. Almeida AJT. A ortotanásia e a lacuna legislativa. In: Azevedo AV, Ligiera WR, editores. Direitos do paciente. São Paulo: Saraiva; 2012. p. 447-87.
11. Jonas H. Técnica, medicina e ética: sobre a prática do princípio responsabilidade. São Paulo: Paulus; 2016.
12. Organização das Nações Unidas para a Educação, Ciência e Cultura. Declaração Universal sobre Bioética e Direitos Humanos [Internet]. Paris: Unesco; 2005 [acesso 27 mar 2021]. Disponível: https://bit.ly/3u5C2pR
13. Bertachini L, Pessini L. Encanto e responsabilidade no cuidado da vida: lidando com desafios éticos em situações críticas e de final da vida. São Paulo: Paulinas; 2011.
14. Vianna A, Piccelli H. O estudante, o médico e o professor de medicina perante a morte e o paciente terminal. Rev Assoc Med Bras [Internet]. 1998 [acesso 25 jun 2019];44(1):21-7. DOI: 10.1590/S0104-42301998000100005
15. Zaidhaft S. Morte e formação médica. 2ª ed. Rio de Janeiro: Francisco Alves; 1990.
16. Jonas H, Lopes WES. O fardo e a benção da mortalidade. Princípios [Internet]. 2010 [acesso 25 jun 2019];16(25):265-81. Disponível: https://bit.ly/3gWNMre
17. Pellegrino E, Thomasma D. Para o bem do paciente: a restauração da beneficência nos cuidados da saúde. São Paulo: Loyola; 2018.
18. Andrade JBC, Sampaio JJC, Farias LM, Melo LP, Sousa DP, Mendonça ALB *et al*. Contexto de formação e sofrimento psíquico de estudantes de medicina. Rev Bras Educ Med [Internet]. 2014 [acesso 25 jun 2019];38(2):231-42. DOI: 10.1590/S0100-55022014000200010
19. Caponi S. Da compaixão à solidariedade: uma genealogia da assistência médica. Rio de Janeiro: Fiocruz; 2000.

20. Silva ALP, Teixeira MAA. A angústia médica: reflexões acerca do sofrimento de quem cura. Cogitare Enferm [Internet]. 2002 [acesso 25 jun 2019];7(1):75-83. DOI: 10.5380/ce.v7i1.32560

21. Kovács MJ. Bioética nas questões da vida e da morte. Psicol USP [Internet]. 2003 [acesso 25 jun 2019];14(2):115-67. DOI: 10.1590/S0103-65642003000200008

22. Kübler-Ross E. Sobre a morte e o morrer. 10 ª ed. São Paulo: WMF Martins Fontes; 2017.

23. Pessini L, Barchifontaine CP. Problemas atuais de bioética. São Paulo: Loyola; 1994.

24. Menezes RA. Difíceis decisões: uma abordagem antropológica da prática médica em CTI. Physis [Internet]. 2000 [acesso 25 jun 2019];10(2):27-49. DOI: 10.1590/S0103-73312000000200002

25. Kovács MJ. Instituições de saúde e a morte: do interdito à comunicação. Psicol Ciênc Prof [Internet]. 2011 [acesso 25 jun 2019];31(3):482-503. DOI: 10.1590/S1414-98932011000300005

26. Boff L. Saber cuidar: ética do humano, compaixão pela terra. 10ª ed. Petrópolis: Vozes; 2004.

27. Capena LAB. Os sentimentos dos acadêmicos de medicina no seu enfrentamento com o fenômeno da morte. Porto Alegre: Pontifícia Universidade Católica; 1997.

28. Souza VCT. Bioética, espiritualidade e a arte do cuidar na relação médico-paciente: uma interação da bioética com a teologia. Curitiba: Prismas; 2015.

29. Descartes R. Discurso del método. Ciudad de México: Porrúa; 1984.

30. Pellegrino ED, Thomasma DC. A philosophical basis of medical practice: toward a philosophy and ethic of the healing professions. New York: Oxford University Press; 1981.

31. Jonas H. Le droit de mourir. Paris: Payot & Rivages; 1996.

32. Tostes MA. (Des)encontro do médico com o paciente: o que pensam os médicos? Rio de Janeiro: Rubio; 2014.

33. Pessini L, Bertachini L, editores. Bioética, cuidado e humanização: sobre o cuidado respeitoso. São Paulo: Centro Universitário São Camilo; 2014.

34. Brasil. Ministério da Educação. Resolução nº 3, de 20 de junho de 2014. Institui Diretrizes Curriculares Nacionais do Curso de Graduação em Medicina e dá outras providências. Diário Oficial da União [Internet]. Brasília: Ministério da Educação; 2014 [acesso 2 maio 2020]. Disponível: https://bit.ly/3eRJwpY

35. Silva MR, Sakamoto J, Gallian DMC. A cultura estética e a educação do gosto como caminho de formação e humanização na área da saúde. Trab Educ Saúde [Internet]. 2014 [acesso 25 jun 2019];12(1):15-28. DOI: 10.1590/S1981-77462014000100002

36. Morin E. A cabeça bem-feita: repensar a reforma, reformar o pensamento. Rio de Janeiro: Bertrand Brasil; 2001.

37. Severino AJ. A busca de sentido da formação humana: tarefa da filosofia da educação. Educ Pesqui [Internet]. 2006 [acesso 25 jun 2019];3(2):619-34. DOI: 10.1590/S1517-97022006000300013

38. Silva RCF. Cuidados paliativos oncológicos: reflexões sobre uma proposta inovadora na atenção à saúde [dissertação] [Internet]. Rio de Janeiro: Fiocruz; 2004 [acesso 25 jun 2019]. Disponível: https://bit.ly/3gUHrwn

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