DEATH AND DYING IN THE ERA OF NEW MEDICAL TECHNOLOGIES

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Many of the problems under consideration are generated by scientific and technological progress in the field of biomedicine. So, traditionally, death was determined by criteria such as irreversible respiratory and circulatory arrest. However, the rapid scientific and technological progress of biomedicine in the XX century (first of all, the successes of resuscitation and anesthesiology) has led to the fact that it is now possible to support the processes of respiration and blood circulation, as well as to supply the body with food and water, with the help of artificial means of life support, such, say, as heart-lung machines and artificial ventilation (VENTILATOR).

Thus, it became possible to save the lives of many patients who were previously doomed. It was precisely this highly noble and morally worthy motive - to push the fatal line of death as far as possible - that guided scientists and doctors working in this field. However, these same scientific and technical achievements have led to the emergence of moral and ethical difficulties, as well as legal ones. Indeed, if respiration and blood circulation can be maintained with the help of artificial means, then we can no longer consider the natural cessation of both as a clear and unambiguous criterion of death.

Therefore, the concept of "clinical death" is introduced when there are no visible signs of life, such as cardiac activity and respiration, and the functions of the central nervous system fade away, but metabolic processes in tissues persist. Unlike "biological death", with the onset of which the restoration of vital functions is impossible, clinical death is not irreversible. Thus, a situation arises when not only the appearance of signs, but also the onset of death (clinical) is not yet a signal for the cessation of the doctors' struggle for the patient's life.

When, however, doctors had the opportunity to prolong the life of the human body for a very, very long time with the help of the same ventilator systems, they faced a completely new question: how long should we fight for life extension? This is, in fact, the question of what the definition of death should be and the criteria of death corresponding to it, with the onset of which condition doctors have the right to stop this struggle, that is, they are allowed to suspend efforts to maintain life. This, by the way, was the meaning of the appeal of anesthesiologists to Pope Pius XII, which we have already talked about. The indicated situation, however, has another side - the desired criterion of death determines the moment when doctors are obliged to state its occurrence, which means that they must end life-sustaining treatment.

The fact is that, on the one hand, as soon as death is pronounced, it is thereby recognized that further treatment is useless. As a result, it becomes possible to release the personnel who conduct it - and these are, as a rule, very highly qualified personnel, and the

drugs and equipment used are very expensive and usually scarce, such that other patients can be returned to a full life.

On the other hand, the criterion of death is also important from the point of view of what F. says. Aries, - it is designed to limit the efforts of physicians and thereby prevent situations when delaying the hour of death turns into an end in itself. And this is quite possible, and the motive for this may be either the research interest of physicians studying the process of dying of the human body and the possibility of its suspension or even reversal, or - if the treatment is paid for by the patient's relatives or the insurance company - the interest is purely commercial.

Of course, even in situations where relatives do not bear the costs of paying for life-sustaining treatment, it can be immensely difficult for them to see a patient in a hopeless and helpless state. There are many cases described when relatives asked and even demanded (including through the court) to stop life-sustaining treatment and allow a loved one to die. So, we see that in modern medicine there is a situation when, due to completely objective reasons, and not someone's intent or bad faith, the commandment "To fight for the patient's life until the last breath" loses its universal applicability.

The moral, ethical and legal aspects of the issues arising in connection with the definition and criteria of death can be summarized as follows. The criterion should be:

1. justified from a scientific and medical point of view, that is, allowing reliably and with high accuracy to distinguish someone who can no longer be saved from someone whose life can still be fought for;

2. accessible from a practical point of view - in the sense that in each specific case, its use should not require the extraordinary efforts of many specialists and too much time. After all, a medical statement of a person's death is, alas, a very common procedure in modern society;

3. objective, that is, one that will be equally understood and applied by any sufficiently qualified specialist, as well as the correctness of the application of which in each specific case can be verified. This condition is necessary in order for the criterion to be considered acceptable from a legal point of view;

4. acceptable from the point of view of cultural and ethical norms prevailing not only among doctors or lawyers, but also in society as a whole. The fact is that, as we have already noted, the death of a person is a phenomenon filled with the deepest cultural and moral meaning, and therefore society must somehow sanction the criterion of death used by specialists.

In connection with this last condition, it must be borne in mind that such authorization by society presupposes a certain, rather high level of its literacy in terms of the substance of the proposed criterion of death. In other words, the consent of the society must be informed. Obviously, both in Russia and in all other countries, this condition is currently not being properly fulfilled.

A new criterion for death was developed in 1968 at Harvard (USA). For this purpose, a commission of specialists was created, which proposed a criterion of death based on the irreversible cessation of the activity of the brain, not the heart and lungs. When brain death is detected, the cessation of all functions of the hemispheres and the brain stem is recorded; persistent lack of consciousness; lack of natural breathing; absence of all movements – both spontaneous and in response to strong stimuli; lack of reaction of the pupils to bright light; immobility of the eyeballs fixed in the middle position, etc. The decisive sign of brain death is the death of the trunk, where the respiratory center is located. In addition, when the diagnosis of "brain death" is established, the absence of electrical activity of the brain is tested with the help of EEG and the cessation of cerebral circulation is tested with the help of angiography.

The first reason for the need for a new criterion was formulated by the Harvard commission as follows: Improvements in the means of reviving and maintaining Life gave rise to numerous attempts to save people with hopeless injuries. Sometimes these attempts lead only to partial success, so that as a result the individual's heart continues to beat, but the brain is irreversibly destroyed. A heavy burden falls on patients who lose their minds forever, on their families and on those who need hospital beds already occupied by these comatose patients."

Subsequently, this new criterion of death was legalized in the United States, based on the conclusions of the Presidential Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research. In 1981, this commission proposed the formulation of the so-called "total brain death". Two criteria of death were specified:

1) irreversible cessation of circulatory and respiratory functions;

2) irreversible termination of all functions of the brain as a whole, including the brain stem. The first of these criteria is obviously traditional, the second is new. Subsequently, this new criterion of brain death was legalized in most countries of the world. It should be borne in mind that the diagnosis of brain death is made only in special cases by a team of highly qualified specialists. Under normal conditions, the same criterion continues to be used.

However, the discussions around the new criterion of death with the approval of this criterion are by no means over - it is being criticized from two opposite positions. One of them can be called traditional, the other radical. What is the essence of these positions?

From the traditional point of view, the new criterion is rejected on the basis of religious and socio-psychological considerations. One of the arguments used in this case in a number of religions is that the human heart has a special role. For example, from the point of view of the outstanding Russian surgeon and clergyman V.F.Voino-Yasenetsky (Bishop Luke), the heart is an organ of higher - not sensual and not rational, but beyond rational, spiritual - cognition. Based on this, it is difficult to recognize as dead a person whose heart continues to beat.

Conclusion

Thus it is possible to summarize the basic principles of communication with a dying person:

- Be always ready to help.
- Be patient.
- Give an opportunity to speak out.
- Say a few comforting words, explain to the patient that the feelings he is experiencing are completely normal.
- Be calm about his anger.
- Avoid misplaced optimism.

A dying patient wants to feel protected. He wants to be calmed down, told that he will not suffer at the moment of dying. We need to talk to him about his fears and help him cope with them. It is impossible to avoid this topic in silence on the grounds that you cannot offer the patient to become healthy. Ask, listen and try to understand what the patient feels. To help him finish his earthly affairs. To promise to fulfill his last will, if he himself did not have time to do something. It is important for the patient to feel that everything possible is being done for him. The patient should not feel isolated, should not feel that something is being withheld from him. You cannot use false promises of recovery as a way not to talk to the patient about difficult topics. The worst thing for a patient is to refuse him medical care. The main assistance to the patient consists in constant communication with him, in living together the last period of his earthly life. By itself, the presence of a doctor at the bedside of a seriously ill and dying person can have a calming effect. The patient should be sure that he will be helped to relieve pain and other painful sensations at the time of death. A trusting relationship should be established with the patient. The patient should know that at the moment of death he will not be left alone, and that someone will help him to live through this period.

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