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ARTÍCULO DE REVISIÓN

A view of thanatology from the perspective of social bioethics and epistemic justice

Visión de la tanatología desde la bioética social y la justicia epistémica

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Abstract

Contemporary thanatology faces the challenge of moving beyond viewing death as a medical failure in order to understand it as a comprehensive human process. The predominance of a biological and technological model has shifted attention away from patient well-being towards the mere prolongation of vital signs, giving rise to phenomena such as dysthanasia or therapeutic obstinacy. This article examines the underlying assumptions of medicalised death and the model of individualistic autonomy, contrasting them with the need for relational autonomy, which is more consistent with Global South contexts. It identifies blind spots in traditional principlist bioethics, which often overlooks intersectional dimensions of gender, race, and class that deepen vulnerability at the end of life. It also highlights the role of health institutions in the expropriation of patients' autonomy through depersonalised protocols. It is necessary to integrate literature and philosophy into bioethical analysis in order to recover the patient's subjectivity and truth. The transition towards orthothanasia and the recognition of the epistemic justice of those who suffer illness are fundamental steps towards humanising dying and guaranteeing an environment that preserves moral integrity until the very last moment.

Keywords: Thanatology; Bioethics; Justice; Epistemology.

Resumen

La tanatología contemporánea enfrenta el desafío de trascender la visión de la muerte como un fracaso médico para entenderla como un proceso humano integral. El predominio de un modelo biológico y tecnológico ha desplazado la atención del bienestar del paciente hacia la mera prolongación de constantes vitales, generando fenómenos como la distanasia o encarnizamiento terapéutico. En este artículo, se examinan los supuestos subyacentes de la muerte medicalizada y el modelo de autonomía individualista, contrastándolos con la necesidad de una autonomía relacional más acorde a contextos del Sur Global. Se identifican puntos ciegos en la bioética principialista tradicional, la cual suele ignorar dimensiones interseccionales de género, raza y clase que profundizan la vulnerabilidad al final de la vida. Asimismo, se destaca el papel de las instituciones sanitarias en la expropiación de la autonomía de los pacientes mediante protocolos despersonalizados. Resulta necesario integrar la literatura y la filosofía en el análisis bioético para recuperar la subjetividad y la verdad del paciente. La transición hacia la ortotanasia y el reconocimiento de la justicia epistémica de quienes padecen la enfermedad son pasos fundamentales para humanizar el morir y garantizar un entorno que preserve la integridad moral hasta el último instante.

Palabras clave: Tanatología; Bioética; Justicia; Epistemología.

Introduction

Contemporary thanatology has evolved beyond its original psychological focus to become a field of fundamental ethical intersection within healthcare. This discipline, now understood as bioethical thanatology, is devoted to the critical analysis of the values, rights, and duties that arise during the end-of-life process, acting as a mediator between technological progress and human dignity. Its work goes beyond the study of death as a mere biological phenomenon to question the power structures and ontological assumptions that underlie contemporary clinical practice.

The urgency of this reflection stems from three fundamental crises afflicting modern medicine: the medicalisation of dying, which has established a paradigm in which death is perceived as a medical failure rather than a natural process; institutional dehumanisation, which has transformed a biographical and ritual act into a depersonalised technical procedure; and the troubling justice gap in the Global South, where predominant bioethical models —grounded in an individualistic, Anglo-Saxon notion of autonomy— prove insufficient for contexts marked by social vulnerability and relational family structures.

Against this backdrop, this paper aims to conduct a critical review of the limitations of principlist bioethics and to argue for the integration of philosophical and literary perspectives that, by recognising the patient's testimony, can ensure support that preserves their moral integrity until the very last moment.

Underlying Assumptions

Contemporary bioethics has set itself the task of dismantling the assumptions that structure the experience of death in healthcare settings. One of the most deeply rooted is the paradigm that equates death with medical failure. Traditional training, by instilling the preservation of biological life as the ultimate end, turns mortality into an enemy to be fought, thereby shifting attention away from the patient's well-being towards the mere prolongation of vital signs. Works such as Gawande's, reviewed by Honrubia (2017), challenge this axiom by reminding us that medicine often ignores mortality as a natural reality. In the same vein, González (2025) understand death not as an uncomfortable topic, but as an integral human process, while Rodríguez (2009) underscores the importance of ontological values and intrinsic dignity over mere technical functionality.

Alongside this paradigm, the notion of a peaceful natural death has been idealised, set against medicalised death. Bioethics shows that this romantic construction overlooks suffering and the lack of palliative care in past eras, while also acknowledging that medicalisation, though problematic, has made it possible to relieve pain, a moral good that should not be dismissed.

Another central assumption under review is the model of autonomy understood as a rational and solitary decision. Predominant bioethical approaches, especially those rooted in the Anglo-Saxon tradition, have positioned individual autonomy as an unquestionable pillar. However, recent systematic reviews show that, in Global South contexts, decision-making is mediated by family relationships, religious norms, and community structures, which compels us to think in terms of forms of relational autonomy more consistent with patients' lived experience in the face of finitude (Akhtar et al., 2024). Likewise, the concept of best interests appears insufficiently developed, oriented mainly towards avoiding harm, but without establishing what constitutes a valuable life or a good death (Birchley, 2021).

This notion of relational autonomy is strengthened when it is articulated with the personalist principles of Freedom-Responsibility and Sociality-Subsidiarity, according

to which the patient's freedom is not exercised in isolation, but within a framework of community ties that sustain it and make it accountable to others. Dying, in this sense, is not merely an individual act, but an eminently communal and relational event in which the family and the social environment legitimately participate in the decision-making process (Akhtar et al., 2024).

Finally, it has been assumed that language describes moral reality in a neutral way. Clapp et al. (2024) show that how we speak about decision-making, consent, or treatment shapes the options that can be imagined and legitimises certain end-of-life trajectories. Metaphors of control, liberation, or burden not only represent but also mould the lived experience of dying. To address these complexities, it is essential to broaden the bioethical framework beyond the health sciences. Rivas-Sucari et al. (2024) propose that literature and philosophy are essential for understanding the truth of the subject and thereby integrating a humanistic perspective that transcends technical analysis.

Historical and social contexts

Death is a historical and social phenomenon, not merely a biological event. The way it is experienced has been transformed by modernity: from being a public, ritualised event in the home, it has become a technical process managed in the hospital. Rodríguez (2009) situates this shift by noting that bioethics emerged in the post-war period in response to the medicalisation of life and to an individualistic, secularised society. González (2025) frames thanatology as the discipline that responds to the historical need to humanise these processes in technified societies.

The current social context is characterised by the denial of death. In a culture oriented towards production and consumption, dying becomes a taboo and a failure. Honrubia (2017) analyses how the modern social structure —the shift from the extended family to the nuclear family and the rise of residential care facilities— has altered the care of older adults, displacing death from the family sphere to the institutional one. This context of denial leads people to avoid planning for the end of life and causes healthcare professionals to experience death as a defeat. Moreover, the recent historical context confronts us with prolonged death. Technological advances make it possible to extend biological life beyond natural limits, raising unprecedented ethical dilemmas about therapeutic obstinacy. Bioethics has had to develop concepts such as therapeutic obstinacy to address this new reality.

The intersectional turn in bioethics underscores how gender, race, class, and coloniality intersect in producing vulnerability at the end of life. Brünig et al. (2024) show that, in palliative care, barriers to access affect racialised people and Indigenous peoples in different ways. Mithani et al. (2020) emphasize incorporating colonial pasts and structural violence as the ethical backdrop to illness, challenging narratives that reduce thanatology to an individual psychology of grief.

This perspective calls for moving from bioethics centred on abstract conflicts to a critical praxis oriented towards social justice in health. Rivas-Sucari et al. (2024) draw on the literature of authors such as García Márquez to understand the social and cultural construction of death in Latin America, and they reveal how literary narratives incorporate intergenerational traumas and structural inequalities that traditional clinical bioethics often renders invisible.

Power relations

The process of dying constitutes a scenario in which multiple power relations converge, shaping the experience of the end of life. The most evident of these manifests itself in the clinical relationship, where power has traditionally resided with the healthcare

professional. This imbalance, heightened by the vulnerability of the terminally ill patient, allows the physician to decide which treatments to offer, what information to provide, and when to cease therapeutic efforts. Honrubia (2017) analyses how institutions and technology have stripped older adults of autonomy, delegating decisions about their death to depersonalised medical systems.

Healthcare institutions exercise structural power through protocols, routines, and organisational priorities, such as bed management or resource efficiency. A patient may wish to die at home, but the lack of in-home support or difficult access to palliative care pushes them towards an institutionalised death. González (2025) highlights the need to reclaim human dignity in the face of these hospital structures that marginalise the will of terminally ill patients. The family sphere also exerts pressure —sometimes out of love, sometimes out of guilt— for treatments to be prolonged, perceived as a means of "not abandoning" the person.

Contemporary bioethics recognises its own embeddedness in broader power structures. Mithani et al. (2020) argue that if the discipline does not attend to racial hierarchies and hegemonic discourses, it ends up reinforcing narratives that render the suffering of marginalised groups invisible and legitimise health inequalities. Stramondo (2023) contends that the field excludes people with disabilities, devaluing their experience and entrenching an epistemic asymmetry: those who suffer most from the effects of policies on palliative care and dying with dignity have the least voice in their design and evaluation.

This power dimension compels us to ask who narrates death, which deaths are deemed worthy, and which remain at the margins. Nelson et al. (2022) show that the testimony of those living with terminal illness provides specific moral insights, but it faces suspicions of partiality and bias. Rodríguez (2009) proposes moving beyond a principlist approach and attending to the Latin American sociocultural context, where economic power dictates who gains access to dignified healthcare and a dignified death. Rivas-Sucari et al. (2024) complement this view by integrating philosophical and literary perspectives that recover the subject's truth, underscoring that bioethics cannot be confined to the health sciences if it aspires to understand the human experience of dying.

Implications and consequences

Bioethical decisions surrounding death generate profound consequences that transcend the clinical sphere. The application of principles such as autonomy or justice determines the quality of dying: Honrubia (2017) assesses how doing too much leads to a solitary, medicalised death in the intensive care unit (ICU), rather than a peaceful transition accompanied by loved ones. When the institutional response prioritizes the technical management of the end of life, avoidable suffering, loss of dignity, and trauma for family members ensue.

These decisions also affect the distribution of healthcare resources. High-technology intensive care consumes extraordinary resources; keeping a terminal patient on life support may deprive others with prospects of recovery of care. Rodríguez (2009) analyses the implications of Hans Jonas's imperative: humanity must act in such a way that authentic life is sustainable for future generations, which requires assessing economic consequences from the principle of distributive justice.

The debate on euthanasia and assisted suicide illustrates the legal and social implications. Borges et al. (2024) warn that interpreting the wish to die either as a pure expression of autonomy or as a symptom to be treated has consequences for the organisation of services and for the symbolic construction of certain lives as "less worthy." Birchley (2021) notes that an emphasis on negative autonomy can reinforce a neoliberal logic that prioritizes the withdrawal of interventions over the creation of social conditions for an

accompanied death.

The language used is not neutral either. Clapp et al. (2024) show that framing medically managed death as a "technical" solution to existential problems obscures collective responsibilities regarding poverty, loneliness, or discrimination. Mithani et al. (2020) and Brünig et al. (2024) warn that ignoring these contexts reproduces injustices and legitimises policies that, under the rhetoric of choice, entrench structural inequalities.

González (2025) discusses the therapeutic consequences of multidisciplinary care that addresses total pain —physical, emotional, and spiritual— as an alternative to dehumanization. Rivas-Sucari et al. (2024) warn that scientific bioethics, without a humanistic perspective, deepens social justice gaps. The way we approach death thus shapes the social conception of old age and illness: if the dominant response is technical management, it reinforces the view of older people as problems to be solved, with the consequent isolation.

Medicalisation and dehumanization of death

Contemporary medicine faces a fundamental ethical challenge when it turns dying into a strictly biological and technological event. This trend towards medicalisation displaces the human essence of the process, since academic training often focuses on repairing organs while neglecting the management of mortality and affective accompaniment (González, 2025; Honrubia, 2017). Under this paradigm, a systemic rejection of therapeutic obstinacy or dysthanasia emerges, understood as the futile prolongation of agony through the excessive use of technology (Honrubia, 2017). By contrast, orthothanasia is presented as the ideal model, as it respects the natural course of life's decline and allows for a transition consistent with the human condition (González, 2025).

Within this framework, the shift towards orthothanasia requires the development of proportionate palliative care that addresses suffering in a comprehensive manner. This entails appropriate control of physical pain through ethically permissible palliative sedation when clinically indicated, as well as psychological support and the patient's spiritual and religious accompaniment, recognised as a basic requirement of justice for those undergoing the transcendent dimension of dying (González, 2025).

The ethical validity of any clinical intervention rests on the primacy of patient autonomy and dignity. Respect for dignity constitutes an intrinsic and unconditional value that sets clear limits on technical domination over the individual (Rodríguez, 2009). Therefore, it is imperative that the patient retain the ability to direct their illness process in the face of institutional impositions. Regaining control over privacy and life goals restores to older adults and terminally ill patients their role as active subjects of their own existence (Honrubia, 2017; Rivas-Sucari et al., 2024).

This approach calls for a transition towards a relationship in which the healthcare professional acts as a facilitator of the subject's will. Literature and philosophy provide a necessary perspective here for understanding that death does not represent a mechanical failure, but rather the final stage of a biography that requires protection and respect (Rivas-Sucari et al., 2024). Thus, justice in the healthcare context entails not only access to treatments, but also the guarantee of an environment that preserves moral integrity and freedom of decision-making up to the very last moment (González, 2025; Rodríguez, 2009).

It is acknowledged that this ideal of facilitating the subject's will faces an unavoidable tension with the realities of care. In the agonizing or terminal phases, the patient's cognitive deterioration (secondary to the disease itself, to palliative sedation, or to extreme exhaustion) restricts their ability to express or reaffirm decisions at the very moment when those decisions are most consequential, posing a genuine ethical challenge

regarding how to proceed in relation to their will. This limit does not invalidate the ideal of subject-centred orthothanasia, but it does require shifting the axis of autonomy from an isolated moment of decision to a process that is anticipated and sustained over time. Advance care planning and wishes expressed early on, when cognitive capacity still permits, thus become the instrument that preserves freedom of decision-making, provided that the healthcare team and the family environment act as faithful stewards of that previously expressed will (Birchley, 2021). This is consistent with the model of relational autonomy described for the Global South, in which the family and community do not replace the patient but rather support and extend the patient's voice when they can no longer articulate it on their own (Akhtar et al., 2024). In this way, the challenge posed by the loss of decision-making capacity in the final phase is addressed by recognizing that autonomy at the end of life is also a relational and temporal construction, whose validity is extended through testimony and the subject's biographical memory (Nelson et al., 2022).

The role of the family and the community in this process is to extend and safeguard that will, rather than replace it with their own criteria. When the patient loses decision-making capacity and there are no clear advance directives, or when uncertainty or disagreements arise among family members regarding what the patient would have wanted, it is appropriate to have recourse, on a subsidiary basis, to the criterion of the patient's best interests and, if disagreement persists, to deliberative bodies such as clinical ethics committees, rather than relying solely on family or institutional will. Kim et al. (2024) document that this uncertainty constitutes a considerable source of emotional burden for family members who assume responsibility for the decision, which underscores the need to support them through shared decision-making protocols rather than leaving them to resolve such matters informally.

Biases and limitations

The bioethical approach to death faces various biases and limitations that shape how we understand and accompany the end of life. Hofmann (2023) systematises these biases as cognitive, affective, and moral —including framing, moral-theory, and decision biases— which operate in debates on euthanasia, palliative sedation, and the appropriateness of therapeutic effort. In these debates, the privileging of arguments aligned with the author's prior position (myside bias) and the use of "moral fictions" to uphold established positions in the face of practices that challenge them are common.

A relevant cognitive bias is the "black box fallacy", whereby healthcare professionals equate the cessation of organic functions with the total absence of subjective experience. This limitation impoverishes the support offered to patients in minimally conscious states or in the palliative phase. Honrubia (2017) also identifies an intervention bias that leads physicians and families to prefer aggressive treatments out of fear or uncertainty, even though these interventions reduce quality of life. Cultural bias constitutes another significant limitation.

Bioethics of Anglo-Saxon origin, with its emphasis on individual autonomy and procedural justice, is not always applicable to contexts where decision-making is communal or where family hierarchy determines the course. Rodríguez (2009) points out the limitations of U.S. principlism when applied in contexts of poverty, where individual autonomy becomes secondary to the lack of basic resources. González (2025) also highlights educational bias in medical schools, where thanatology has been relegated to oblivion or treated only tangentially in curricula.

Another limitation stems from the medicalization bias: bioethics tends to focus on technical decisions in the final moments, neglecting how prior living conditions — loneliness, existential fears, poverty— shape the quality of death. Borges et al. (2024) show, in their review of the desire to hasten death, that the empirical literature rarely

makes its ethical principles explicit, instead merely inferring notions of autonomy or dignity without subjecting them to critical analysis.

Finally, Rivas-Sucari et al. (2024) criticize the limitation of a scientific bioethics that ignores the emotional and subjective dimension present in literary narrative. Integrating philosophical and literary perspectives would make it possible to overcome these biases and recover the complexity of the human experience of dying.

Blind spots

The bioethical analysis of death reveals blind spots that call for conceptual and methodological alternatives. A first blind spot lies in the deductive application of principlist ethics, which often reduces dilemmas to algorithms and overlooks the uniqueness of each person. The alternative involves reclaiming narrative and virtue ethics: not only asking which principle applies, but what kind of accompaniment is required by the story of the life that is ending. Honrubia (2017) proposes "difficult conversations" as a tool to align medical treatment with the patient's personal goals. Methodological individualism constitutes another blind spot.

Traditional bioethics analyses the physician–patient dyad in isolation, overlooking the affective and community network. Brünig et al. (2024) propose intersectionality as a critical praxis for making inequalities visible and designing policies that are sensitive to multiple axes of oppression. Parker (2024) suggests models of adversarial cooperation that treat moral disagreement as a resource, integrating antagonistic voices into deliberation on the end of life.

The focus on the agonising moment of death —euthanasia and withdrawal of life-sustaining treatment— has shifted attention away from the ongoing process of dying. González (2025) presents an integrative perspective and orthothanasia as alternatives to therapeutic obstinacy. Roest et al. (2021) highlight the value of narrative methods for preserving the complexity of experiences, attending to metaphors, silences, and shifts in perspective in the accounts of patients and families.

The technological bias also requires reassessment. Rodríguez (2009) proposes a bioethics of responsibility and social justice as an alternative to the liberal model, incorporating Hans Jonas's principle: act in such a way that authentic human life remains sustainable for future generations. Hantel et al. (2024) and Jecker et al. (2024) broaden the focus to ecological and social dimensions —climate change, war, and incarceration— that shape trajectories of dying.

Finally, Rivas-Sucari et al. (2024) identify the blind spot of scientism and propose literature as a means of exploring the existential dimension that medicine cannot measure. In the case of Nelson et al. (2022) and Stramondo (2023), advocate for epistemic justice: recognising the authority of those who live with illness without idealising or dismissing their experience. Davies et al. (2015) and Ives et al. (2018) emphasise the need to make explicit the ethical and epistemological assumptions underlying empirical research on categories such as dignity or intolerable suffering. As summarised in Table 1, the shortcomings of principlism —abstract individual autonomy, a deductive method, and decontextualised universalism— find a counterpoint in approaches such as narrative ethics, intersectionality, and the valuing of patient testimony.

This commitment to epistemic justice entails listening with empathy to the patient's subjective experience of pain and suffering, without this implying any relativisation of ethical judgment regarding medical actions. The rejection of euthanasia and dysthanasia must remain anchored in the objective truth of the person's integral good, such that validating the patient's testimony and providing an ethical foundation for clinical decisions constitute complementary planes, not interchangeable ones (Nelson et al.,

2022; Stramondo, 2023).

Table 1

Limitations of traditional principlism compared to the proposed alternatives

Dimension	Traditional principlist approac	Alternatives
Autonomy	Individual, rational, decontextualised	Relational autonomy
Justice	Distributive	Epistemic justice + intersectionality
Method	Deductive	Narrative, deliberative, and virtue Ethics
Subject of analysis	Doctor–patient dyad	Affective, family, and community network
Language	Neutral	Performative, reality-shaping
Context	Abstract, liberal-Anglo-Saxon	Global South, coloniality, structural vulnerability

Note. Comparison between the main limitations of the traditional principlist approach —centred on individual autonomy, abstract universality, and the deductive method— and the alternatives proposed by social bioethics, relational autonomy, and epistemic justice, as developed in the manuscript. The table summarises the transition towards a more contextual, narrative framework that is attentive to power asymmetries.

Towards an Intersectional Thanatology in the Global South

The understanding of death cannot be reduced to an isolated biological event; rather, it must be analysed as a phenomenon profoundly shaped by historical and social structures. In this sense, the intersectional turn in contemporary bioethics is indispensable for making visible how categories such as gender, race, class, and coloniality intersect, producing specific forms of vulnerability at the end of life.

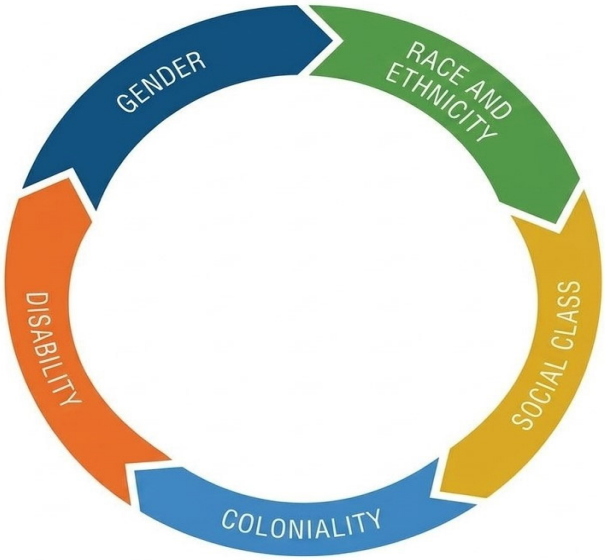
Whereas traditional principlist bioethics often operates within an individualistic and abstract model of autonomy —predominant in Anglo-Saxon contexts— the reality of the Global South reveals how these categories can determine who has access to a dignified death and who is silenced by the system. For example, barriers to accessing palliative care do not affect all individuals equally; racialised groups and Indigenous peoples face systemic obstacles that are frequently overlooked by narratives centred on individual choice.

Although such social injustices exacerbate neglect and increase the vulnerability of those approaching the terminal stage of life, the dignity of the human person constitutes an unalterable ontological absolute, grounded in the substantial unity of body and spirit that defines every human being, irrespective of historical or identity-based constructs such as gender, race, or social class (Rodríguez, 2009). This clarification makes it possible to articulate the personalist principle of safeguarding physical life alongside the denunciation of structural inequalities: the pursuit of social justice protects life against conditions that obscure or deny its inherent dignity.

As illustrated in Figure 1, thanatology must move beyond the individual psychology of grief to become a critical praxis oriented towards social justice.

Figure 1

Axes of intersectional vulnerability at the end of life



Note. This figure illustrates the convergence of social factors that shape the experience of dying. The intersection of these axes generates structural vulnerability that challenges the individualistic model of autonomy and calls for a shift towards epistemic justice and relational autonomy within the clinical setting.

Convergence between social bioethics and the ontological personalist model

It is necessary to broaden the critique of traditional principlism by confronting it with the social bioethics approach and with the ontological personalist model, for which the human person constitutes a unified totality of body and spirit whose value does not depend on historical, social, or functional circumstances. Although these two currents start from different premises —the former emphasizes the structural conditions that produce vulnerability, while the latter underscores the unalterable ontological value of the person— both converge in their firm rejection of dysthanasia as a form of violence against the natural process of dying, as well as in their critique of a radical autonomy that reduces the patient's decision to an isolated, decontextualized act (Rodríguez, 2009; Akhtar et al., 2024). This convergence strengthens the proposal of an orthothanasia that respects the subject's intrinsic dignity, understood as an ultimate ontological value and an inalienable foundation of any human accompaniment at the end of life (González, 2025; Rodríguez, 2009).

The social reference should not be interpreted as a formulation that contradicts what has been developed throughout the manuscript. The dignity of the person, as has been argued, constitutes an unalterable ontological absolute that does not depend on historical, social, or identity-related circumstances; what social bioethics contributes is the denunciation of the structural conditions that prevent its full practical recognition. Along these lines, Frantz et al. (2025) warn that when dignity is dissociated from a stable ontological foundation, it is left open to being interpreted as a contingent attribution (linked to autonomy, cognitive capacity, or social recognition), which makes it vulnerable to technocratic reduction and moral relativism in contexts of heightened vulnerability, such as the end of life.

Conclusions

Dismantling the paradigm of death as a medical failure requires an ethical transition towards orthothanasia, in which dignity is understood not as an abstract concept but as a praxis that ensures respect for the person's life story. Autonomy cannot be understood solely as a rational and individual decision; rather, it must be situated within a relational and community-based model, particularly in contexts across the Global South. By recognising the cognitive and institutional biases that promote therapeutic obstinacy, bioethics can function both as a regulatory framework and as an instrument of humanisation, recovering the patient's truth in the face of the technical management of mortality.

Looking to the future, thanatological research should explore more deeply models of epistemic justice that recognise the moral authority of the testimonies of marginalised and disabled populations. Further research is needed to examine the impact of literature and narrative approaches on the education and training of healthcare professionals, thereby enabling a move beyond blind scientism when addressing existential suffering. In this way, integrating ecological and social dimensions into debates on the end of life may contribute to the development of a bioethics of responsibility capable of promoting dignified and sustainable trajectories of dying for future generations.

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