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Handling End-of-Life Care in Medical Decision Making: On a Bioethical View

Maribel Bont-Paredes, Carmen Malpica-Gracian and Carlos Rojas-Malpica
Universidad de Carabobo
Venezuela

1. Introduction

1.1 Life awareness

The world of life, is a world that precedes human existence, therefore it constitutes and projects us as human being, beyond men reflection allows to take it. Life itself was not men made, as a creative phenomenon it originated and per suited humanity. It is in its core substantially coated with dignity and respect, as well as that of the biological *materia*; in other words, body and soul are indeed equally precious (Cely, 2001, 2005; Gherardi, 2007)

Human life is one of the best emergencies of life itself, and holds within all its multifactorial harmonious complexity. So complex that it has become in abstraction of its own realization, in its auto-recognition thinking process. From life's fundamental nature emerged the spiritual essence of materiality and the profound giving of consciousness than allows the binomial energy-*materia* to appropriate of the existing reality. It corresponds to human kind the responsibility of humanizing life from our own cultures, by favoring thoughtfully reflexive processes with transcendental meanings on all forms of living existence (Cely, 2001, 2004, 2005; Gherardi, 2007)

Life could be defined as a sequence of moments that create the existence of a person, whose moral and cognitive development and evolution have been influenced by different socio-cultural factors that characterize the configuration and structuring of attitudes and personality, as being part of a society. Common sense implies the acceptance of dogmas that although could be interpreted in various individual ways, however are accepted and followed by most member of a community; as epitomized by experiencing birth and death (Cely, 2001; Gherardi, 2007).

Every human action is necessarily associated and related. This means that no one lives totally on its own; to enable the existence of each individual it must be articulated by needs and deliberation to other human beings and the natural surrounding environment, in a complex network of interactions. These connections respond to *Ecological* and *Ethological* links of reciprocity in manifold directions with chaotic and eventful energy exchanges of growing complexity that increases a higher new emergency in the *ethos vital* (Cely, 2001, 2005; Gherardi, 2007).

Nowadays *Bioethics* as a branch of applied ethics, new and required by the *society of knowledge of the third millennium*, proposes to take as a very serious matter all data that different sciences subsequently contribute with, from the beginning of life until its end, to distinguish this information with wisdom to all existence, doing so in the perspective of a

scientific humanism which can attain responsibility for making moral consensus and prescribing binding actions to carry out this complex purposes (Cely, 2001, 2004; Albuquerque 2008).

The two dilemmas at the endpoint of life have represented enigmas that men have sought to penetrate along human history. Conception and acceptance of pain and suffering seems to be inexorably linked to the beginning and end of human lifecycle, since they distinct not only the peaks of biophysical life; but perhaps, also the advent of a new spiritual dimension, yet to be explored, comprehended and known (Gherardi, 2007; Cely, 2004).

Decision making for handling death and medical intervention has led civilizations to adopt different behaviors and cultural patterns at end-of-life, which have evolved over time, seeking to alleviate pain or suffering in cases where the patient's ill condition has taken to boundaries of where, may not be a health recovery.

With no doubt biomedical scientific and technological progress, has led medicine to participate and to intervene in this biotechnical development, using utensils and medical apparatus that enable the maintenance of life even in artificial ways.

The *principles of bioethics and medical ethics* arise to guide medical decision making and action taking, in a harmonious and concord approach, as a result of the agreement by consent between all members of a group or even among several groups. Behold, as occurs in *doctor-patient's interaction, coming out as result of this relationship reciprocally exerted in an affective and effective interaction deriving to a medical care technically desirable, in the management of those who are in a terminal stage disease* (Cely, 2001, 2004; Gherardi, 2007; Albuquerque 2008; León 1996; CENABI, 1999).

These dissertations about biomedical sciences and technology's contributions at *End of the Life Decision Making (ELDM)*, demonstrates the need for a bioethical prosecution in the quest for these resolutions, under the scope that its complexities exceeds the competence of the medical profession, requiring the successful assembling of different disciplines; consequently there is an urgent need for consensus between medical doctors, ethicists, secular, lawyers, humanists and priests of various clergy, along with the whole society (Cely, 2001, 2004; Gherardi, 2007; Albuquerque 2008; León 1996; CENABI, 1999).

The different aspects related to the approach of life's end decision making, have to be analyzed from its various dimensions and in recognition of its integrations into a dynamical socio-cultural framework, as is life itself; having diverse perspectives involved within each other. This new complex approach allows a closer look to the reality in the process of dying, in which the convergence of all aspects of the phenomenon and their mutual relations, will allow to come closer to the multidimensional true existence (Cely, 2001; CENABI, 1999).

Bioethics brings a plural-dimensional view on reality concepts, creates an interwoven reciprocal and reflective connection that allows an altogether vision of dilemmas, re-evaluating humanity at its whole, to place it as a cardinal axis of dignity and into a higher purpose of human being. Emphasizing that all things that can be scientifically man made possible are not ethical or bioethical acceptable to accomplished (Cely, 2001; CENABI, 1999).

Death, once easy to identify by the cessation of breathing and heartbeat can be in our days, somehow more difficult to establish, as a result of the implementation of new technologies and procedures brought by biomedical sciences. The cease of organic functions, today only determines a state of “perceptible” death, as it may be resolved by resources of respiratory and/or hemodynamic support. Not even the irreversible damage of the neuroregulatory centers are enough to establish with accurate precision the time of death, when even under such circumstances, it is possible to maintain the visceral process unscathed.

As a result of this biomedical and biotechnology intervention, establishing the advent of death, nowadays appeals to a neurological refined approach, as in: *brain death*. This indeed is of complex concern especially in developing countries; therefore sanctioning death by this mean only, could become a decision mediated by increasingly sophisticated biomedical devices. Interestingly, it would be the sensitivity and appropriate management of this equipment which could authorize end of life decisions. In recent past, with a more human clinical approach and the help of few instruments, this pronouncement could be easily taken behold a closer interaction among the physicians as principal care takers, the patients and their families (Aguiar, 2003; Cely, 2005; Castillo, 2006).

However, the fear of ethical, bioethical and legal implications, actually frequently become a limiting condition upon therapeutic measures in patients who need end-of-life care; all of these immersed in a framework surrounded by social, economic and cultural contexts distinctive of each moment in time, which restrict, stipulates and determines the most appropriate approach through the course of action, being as well responsible for caring of life in the planet and of human survival (Aguiar, 1997; Cely, 2001, 2004;).

Different aspects of patients medical mediated death, have already engaged for decades scientific literature, with the emergence of new terminologies to distinguish the most frequent situations being discussed within the confines of human life. Declarations rights of the terminally ill patients have been bound-for to avoid any type of discrimination or abuse that could prejudice the patient's sense of individual dignity and self-respect (Gherardi, 2007).

Clearly, the circumstances of medical mediated death have provided legitimacy to the claims for a "*good death*", leading the way to a movement that aims to create a forum for discussion of the various aspects that should be considered regarding the ethical-bioethical problems at the finale of human lifecycle, as well known as "*Omega Dilemma*" (CENABI, 1999; Gherardi, 2007;).

Terminally ill patients going through the process of dying need to be appreciated in their own conditions and therefore rights. Which can be summarized as follows: right to the relief of pain and other symptoms; right to remain vigilant; right to be informed truthfully; right to exercise its decision-making capacity; right to maintain affective human contact; right to be respected in their religious beliefs; right to "die in due course"; in other words, to be marginalized of excessive medical practices aimed to keep them alive (Cely, 2001, 2004; Gherardi, 2007).

Nowadays new concepts as *Euthanasia*, *Criphanasia*, *Dysthanasia*, *Orthothanasia*, *Tachythanasia* and *Assisted Suicide* are added to the terminologies used to refer end-of-life decision making within the terminally ill patient, brought by these novel spectrum of discussions being done by the reciprocal intervention of family members, legal representatives of patients, health care-takers and religious councils.

Currently in some Nations such as Venezuela, there are actually undergoing a legal reform of laws known as *Anteproyecto de Reforma del Código Penal Venezolano-New Project of the Venezuelan's Penal Code*, in which just few lawyers, members of the National Assembly have reviewed discussion, adoption and implementation of some of existing biotechnical interventions in medical-mediated death; which is described on text as the intentional physician's delivered purpose of ending a terminally ill patient's life, patient's or family's written consent and life testament; being both *active and passive voluntary euthanasia*, the two forms of execution.

As one would expect, in medical practice it is viable to identify different situations vulnerable of questioning and moral deliberation, in which are not always easy to complement the will of the patient, among the different treatment alternatives brought by the healthcare team, and at the same time, in the course of actions to be adjusted to the existing constitutional framework in every contextual location. In addition occasionally, some family members of the patients are those who inquire medical doctors to alleviate pain at all cost or in some way to bring to an end the suffering of their loved ones, regardless of the unwanted side effects.

However, *what is put into bioethical consideration are the possibilities of medical intervention and the legitimate moral behavior that will be decided during the process of dying*, a succession of events which would have its point of departure at the time of diagnosing an incurable disease and envisage of death, and its finishing point in the clinical representation of the “apparent death” (Castillo, 2006). How to confront suffering, pain or a disease which could inexorably bring to death, are subjective and absolutely auto-determined decisions by patients, among their family group.

Bearing agony and closure of lifecycle supported by medical conventional or palliative care is the reality that many of our Venezuelan’s patients either alone or with the company of their families face every day; in a heroic attempt to keep alive, not letting feelings of discouragement overcome their hopes by the added hardships of poor public health care services. There are not enough well medical equipped health care centers for patients in need, or in most locations where not only the access to public facilities are complicated, but yet to obtain medical disposable material and equipment is not feasible either.

This scenery brings a more detail conflict into the bioethical discussion, reaching out-far the existing gap between developed and underdeveloped countries, which makes it impossible to mimic context of medical or legal situations; furthermore, embraces each national and regional context of its own proper deliberations. This is what makes bioethical dilemmas so significant and of a unique type, by considering in the consensuses of medical decision making a contextual reflection of a single kind. There are no “golden rules” to it, so all life human forces of every community parties need to be taken into account, within the introspection of their socials and cultural backgrounds (Bont, 2007; Castillo, 2006; León, 1981, 1996).

From an *spiritual dimension*, the topic of death can be tackled from the traditional dominant “*dualism*” of the west world, which sees the human being composed of two different reality matters, *body and soul*, irreducible one to the other, perishable the first and immortal the second. This anthropology, of Hellenistic and Christian origin, in which the majority of Venezuelans have been educated, currently receives deep questioning from sciences and contemporary humanities (Bont, 2007; Cely, 2004; Castillo, 2006).

In the other hand, the modern theological hermeneutics reinterprets the sources of revelation, to make them understandable to men and women of our days. Another view of this spiritual dimension would be the “*monist*”, in which man is not divided between a body and a soul, but it sees as a “*substantive unit*”, a single vital substance, as conceive by *Parmenides, Spinoza, Plotinus, Schelling, Hegel and Freud*, among others philosophers. For whom reality is the unity of the essence and existence. The essence is not behind or beyond the phenomenon, but for this same reason the essence exists, the essence is specified in the phenomenon; realizing that the phenomenon is life itself, life turned-as energy emerged from the Cosmos in the infinity of *ethos vital* (Bont, 2007; Cely, 2004; Castillo, 2006).

Being understood as well, men would be a very complex structure of embodied vital energy, forming part of the biota as a whole, coming through an intimate relationship and reciprocity with the abiotic. Being Humanity an inside-out of creation as nature's turned into the awareness of life, which means that we have become the consciousness of natures by itself (Cely, 2001, 2004).

The two anthropologies have their strengths and their weaknesses. With either of two anthropologies, *monist* or *dualist*, men will reach the same goal: *life after death*, in theological propositions that provide wisdom to human reasoning to grant ourselves with dignity inside an *ethos vital* that nourish our hope for a spiritual life without suffering anymore pain or perennial death, by the promise of a supra-dimension of eternal life.

Although different faiths believe also provide sense of binomial life and death. Religions, as part of the human spiritual dimension, are an attempt of civilized man to give an explanation to the emerge of life and its needed link relations, through enclosure devotion in a supreme being, endowed with all the wisdom, always eternal power, in its different forms of reflections, the only way to reach-out for salvation and allegory hope, beyond this earthly mortal abode (Cely, 2004).

The *Roman Catholic Church*, representing the predominant religion in Venezuela, raises the permissibility of not using extreme biomedical measures to sustain life and expressively supports the relief of pain in terminally ill patients, justifying the fact that when you cannot be cured, the therapeutic goal is to relieve symptoms and improve as possible, the quality of life of the patient. For that reason it sustains, that *palliative care* can be considered an extension of medical practice that, given the impossibility of doctors to cure any given disease, they must promote and uphold patients leading one's life based on faith, which is above all gifted with dignity by itself (John Paul II, 2004; Del Prete, 2008).

Christian Catholic anthropology interpretation supports respect for human life from its very conception known by the binding of the ovules and spermatozoids, through the fusion of gametes to produce a new organism, until life it-self with no extreme biomedical technology intervention comes to an end. In light of what the Scriptures say about the kind of care God wills that we provide to those who suffer and are facing death, rejecting such claims for active euthanasia and assisted suicide as neither compassionate nor caring (Bont, 2010; Cely, 2004; León, 1981).

Enlighten two major Biblical Principles to oppose euthanasia. The first is the *sanctity of human life*: Being a fault to voluntarily terminate a life, killing incurable physically or mentally ill patients, or commit assisted suicide, do to that life is taken only by God-given powers. The Christian faith cannot accept the argument that in such circumstances life has no value, so it must be finished (León, 1981; John Paul II, 2004).

The second principle attaches meaning to suffering. "God is omnipotent; when there is suffering on earth it is intended that this happens. God has an intellect greater than man, so it is sometimes impossible to the human understanding to fully comprehend God's purpose". To sum up Catholic Church, standardizes medical mediated forms of ending human life by the patient's voluntary decision, including passive euthanasia, with murder; considering them as a mortal sin. The reasons for this are based on the inviolability of human life and in human redemption suffering purposes, which lead men to Christ and heaven (Bont, 2010; León, 1981; John Paul II, 2004).

To what Paul VI express: "medicine is required to fight overcoming of death with all available resources, but when the battle is unavoidably to be lost, there is not necessity to

use extreme resuscitation techniques. It is a useless torturing to maintain a person in a vegetative condition”. **Euthanasia**, in its proper sense, is a synonym for **mercy killing**, which involves suicide and/or murder. It is, therefore, contrary to God’s Law.

When the God-given powers of the body to sustain its own life can no longer function and doctors in their professional judgment conclude that there is no real hope for recovery even with life support instruments, a Christian may in good conscience “let nature take its course” (Bont, 2010; León, 1981; John Paul II, 2004).

Being Christian Roman Catholic, the dominant religious believe in Venezuela’s social context, discussions over medical handling and management of life’s end decisions, need yet a long way to go, especially if taken into consideration the constants disputes and confrontations undergoing between Government officials and cleric headquarters; leading this delicate topic to be devilish among general population, somehow as an intent of Government’s legislators to overlook and contravene Human Rights principles. Never the less, what is indeed most preoccupying is the lack of interest of official congresspersons to come out in the open and let all community living forces to give their opinions and promote participation, in a clear effort for consensus over this essential dilemma of life; letting people know about de currently discussions that are held regarding the intension of lawmakers to reform the *Venezuela’s New Project of the Legal Code* (Bont, 2010; Anteproyecto de Código Penal-República Bolivariana de Venezuela, 2000).

National lawmakers have not done up-to date proper researches or open discussions about arguments to sustain these modifications and to include for the first time in the country’s history a new ruling, as in Article N° 217 *Dar muerte por piedad- Giving death by mercy*. Do to the novelty of the topic in our socio-cultural framework, its new applications and implications especially for terminally ill patients and physicians; this important matter has to be debate within a broad participation of Venezuelan’s community members.

Foreign experiences as the ones quoted at current text project, are far from our socio-economic, cultural or religious reality, most of all if considering government’s poor coverage of adequate medical services wide across the nation, particularly of intensive care units. Furthermore, there is a considerable gap between those who living in the same geographic region, but with different economic holding, have access to a barely satisfactory health service. There are many issues to bring about before lawmaking over this delicate topic. Lawyer who favor article support arguments on current changes in developed countries like Spain, Netherlands, Germany and the United States, this point of view lacks of profound academic knowledge or empirical practices to be properly sustained (Anteproyecto de Código Penal-República Bolivariana de Venezuela, 2000).

Some jurists consider that the whole writing of the article needs to be fully supervised anew, do to the insufficient clarification of the terminology implicit in it; which could lead to regretting misunderstandings on behalf of the medical care takers or even patients themselves. On the other hand, the Venezuelan Constitution as our maximum legal framework does contravene this proposal, as so does the *Law of Medical Practice* and the *Deontology Medical Venezuelan Code* followed by medical doctors. Never the less administering pain-killing medications is permissible, even at the risk of shortening life, since this does not entail the choice of death as either a means or an end (Piva & Pinto, 2003; Ley del Ejercicio de la Medicina en Venezuela, 1982; Código de Deontología Médica de Venezuela, 2003).

What is evident is the distance from general agreement that according to this matter we are about-of, for mediated medical end of life decision-making to be legally established, needing a meticulous debate yet to be done. Before, Government must guarantee all society members the benefits of being capable to receive appropriate, contemporary medical attention, distributed with justice and equitability in every nation's state, regardless of any social-economic or religious faith barrier.

Complex thought and paradigm projected on the phenomenon of human care in dying, allows integrating different methods for relating scientific knowledge in problem-solving, which is based on dialogue and consensus of diverse perspectives to view in and out the dilemma, considering *Social and Clinical Bioethics* and the *Bioethical Principles* of autonomy-respect for person, non-maleficence, beneficence and justice; on the common understanding by all parties involved, that is indispensable the adequate relief of pain, the emotional support on suffering, winding the patient's and family's anguish with affective and spiritual accompaniment.

1.2 Methodological framework: A new comprehension

Based on complex thought proposed by *Edgar Morin*, which serves as groundwork to the investigative episteme, researcher finds support in the *paradigm of complexity* from postmodernism, seeking to embrace and comprehend reality of patients and medical doctors at end of life decision management. On complex view the main purpose is to dialog in an interactive reciprocal relation among subjects participating in the phenomenon of study, rather than just determine or measure what happens under those circumstances. The investigators deepens on terminally ill patient's death as a phenomenon of interest within a creative, genuine and holistic intention, in which might emerge novel theoretical constructs, than through reflexive thought and into practice permits a better medical management at end-of-life (Morin, 2003, 2004; Orcajo, 2000).

The research is constructed considering postmodern anti-method, and method is structured on its way, to end-up on the conjunction of two investigative momentous, one of qualitative expression and a second one in quantitative terms. Guided by complex thought researcher adapts the method as a strategy resulting from the interaction between reality and its comprehension with the paradigm; in which each decision and procedure regenerates the method, not being applied as a pre-determined rigorous and unequivocal pathway to follow; allowing researcher to create new interpretative understanding and innovate strategies, relying on singular analytical and reflective investigative momentous connecting knowing, comprehension, and medical practice intended for intellectual enrichment and proper management of end-of-life decision making among *doctor-patient's interaction* (Leal-G, 2005; Morin, 1999, 2003).

In postmodern comprehension the enormous fullness that surrounds us, encompass and challenges our capacity of knowledge, which can't be established on a single rigid pathway method; perhaps, is the innovative result of such an effort, the only thing that truly appeals the attempt of learning new things by applying novel methodologies (Martín-F, 2006).

Researcher's view on a complex paradigm, is allowed to open to intuition and *amusement* (which is about freedom of thought and imagination), as the *muse* (from Latin *Mūsa*) or a source of inspiration that guides the meaning and essence of the exploration, using logical thinking in the investigation procedure, as well as letting passion inspire reasoning at the pursuit of learning the best way to come closer in reality's interpretation; this gnosis allows

researcher to be an active participant subject in the development of the entire investigative process. This challenges the valuable sense of investigators, in the approximation of the living-dying phenomenon in a genuine, warm, imperative and provisional nature as is life itself. Giving this model its uniqueness, exhibiting its particular way, this is also fundamental in the generation of new overcoming knowledge (Leal-G, 2005, Martín-F, 2006).

Complex thought is a style of thinking and approaching reality. In that sense the complex thought generates its own strategy, indivisible of inventive participation of those who develop the research. Rationality is not the only mental process that guides the search and construction of an emerging understanding (Martín-F, 2006).

It is also necessary to take into account that method and paradigm are inseparable. All methodical activity is based on a paradigm that directs a cognitive practice. Since the complex thought proposes a paradigm that interacts, articulates and understands, at the same time that can develop its self-criticism (Leal-G, 2005; Martín-F, 2006; Morin, 1999, 2003).

In a primary stage of research, the author recognizes the need to provide an original scientifically valid construct in close relation to the contents of the Venezuelan socio-cultural and economic contexts; into the different manifestations of faith and spirituality as part of our life experience. Taking into account the current review carried out by the *Asamblea Nacional de la República Bolivariana de Venezuela-National Assembly of Venezuela's Bolivarian Republic*, about the *Código Penal- Legal Code* (Anteproyecto de Código Penal Venezuela, 2000).

The *first quantitative language momentous* approaches the phenomenon focused on an empirical-analytical basis research method, according logical positivism as the epistemological cornerstone, methodology research design is exploratory, transect of not-experimental, with the main object of exposing the importance of the medical practice decision making et end of life based on the opinion, degree of information and training of doctors working in areas of Surgery, Internal Medicine, Intensive-Care Units, Oncology and Anesthesiology of the *Servicio Autónomo Hospital Central de Maracay-Autonomous Central Hospital Service of Maracay*, in Aragua's State and the *Hospital Central de Valencia-Carabobo "Dr. Enrique Tejera"- Central Hospital Service "Dr. Enrique Tejera" of Valencia-Carabobo* (CHET); representing the 2 biggest middle states Medical Centers in Venezuela (Bont, 2007; Hurtado & Toro, 1997; Hernandez & Fernandez 1991).

From primarily empiric process of data, the population of study from which our sample is drawn was represented by 185 doctors, to whom were applied an anonymous questionnaire, of not probabilistic selection sampling (opinatic and volunteer sample), being finally constituted by 123 subjects, who agreed to freely participate in research throughout written informed consent. Obtained data was tabulated and coded in Excel in comparative tables, which subsequently formed sectorial diagrams (pie charts) in the same program, for statistical analyzing. The collected data then was triangulated to become innovative figures representations of reality in terminally ill patient life decision making.

Depth perception of phenomenon led investigation to a *second qualitative language momentous*, within an inductive method, to come close and reconstructs the significance that terminally ill patients as subjects of study had regarded to the conscious decision making and action taking at the end of their own existence, which was accomplished through profound interviews by means of an intentional 5 patient's sample.

Throughout qualitative language in which *herméia and phenomenology* recreates, actions are intervened in order to understand them, the author strives to give a general sense in the interaction of parties to get a proximate vision if it all. Hermeneutics in its desire of interpretation causes a constant return and sway from whole meaningful sense to each element interacting, as a perfect complement of *complex thought* (Martinez-Miguélez, 2004; Spiegelberg, 1975; Morin, 2000).

Researcher's strategy seeks for an interpretative perspective, mainstreaming as is *phenomenology and hermeneutics*, in which the purpose is to embrace what patients are going in the course of a comprehensive and explicative perspective of events, *finally* inserting this experience into learning about the caring in terminally ill patients. Allowing when necessary, emotional assistance from religious or spiritual leaders of patients' creed.

Textual data analysis theoretical considerations obtained from the primer quantitative investigation, as result of the medical experience in decision making at the end of human life, is also integrated as part of the second qualitative textual document evaluation. Being able to concatenate the product of the first momentous as an initial element in the second momentous of comprehension and redefinition of terminally ill patient's reality.

Under this intention researcher conducts in-depth interviews with no limit of time and in several meeting moments (when necessary), with each patient selected as a *key-informant* with a clinical diagnosis of malignant neoplasm (cancer); afterward all informants' data collected is transcribed into a handwritten designed history profile, which is later transcribed in digital computerized *Word* format, to finally make a digital format makeover to a *primary document*, in the *Atlas/ti* textual data analyzing software (Muñoz, 2003; Glaser, 1992).

In the means of the study, the *process of dying* is understood to begin from the moment a person losses health condition associated with a medical adequate diagnosis of incurable illness, that subsequently evolves on dying within days or weeks, which imminently entails patient's envisage of death.

Theoretical approaches to health care ethics have evolved in response to societal changes; evolution of health care can be traced from the "Hippocratic ethic" with emphasis on duty, virtue, and gentlemanly conduct, which emerged from relatively homogenous societies where beliefs were similar and the majority of societal members shared common values; through the "principlism" and into the current "antiprinciplism" movement. The theoretical model proposed in this research brings into reflection from a bioethical perspective an intercurrency of facts and the participant's role at end of life decision making in medical death intervention, as the third millennium of humanity unfolds into biotechnological advances and challenges. Not rejecting principles but choosing to frame the use of values as standards to make them useful in a bioethical discussion. To construct this model, the author relies on broad and different referents theorists, who have sustained its investigative activity during the past years.

Principles are too far removed from the concrete particularities of everyday human existence; therefore principles do not represent a theoretical approach. The anti-principlism movement has risen with the expansive technological changes and the tremendous burst in ethical issues accompanying these changes.

1.3 Interaction of the research perspectives: Theoretical bioethical model

As to the profile of physicians whom participated by consent agreement and filled out the questionnaires in this research were of 123 out of 185 medical doctors. Sample's data

analysis demonstrated that majority correspond to *females of 35 years old, with 15 years on average of graduated as medical doctors in Venezuelan Universities*. All working at the moment of consultation in Public Community Healthcare Centers, in the fields of *Surgery, Internal Medicine, Critical Care Medicine, Oncology and Anesthesiology* of the *Servicio Autónomo Hospital Central de Maracay-SAHCM in Aragua’s State (Autonomous Central Service Hospital of Maracay)* and of *Ciudad Hospitalaria “Dr. Enrique Tejera” of Carabobo’s State-CHET (Central Hospital Service “Dr. Enrique Tejera”)*, representing the 2 biggest and most important public medical centers of the middle region in the country.

When asked about the knowledge of the content of **Article N° 217** *Dar muerte por piedad-Giving death by mercy* of the preliminary draft partial reform of *Venezuela’s New Project of the Legal Code*, 90% of the surveyed doctors claimed to ignore it; 8% knew the undergoing reform and 2% did not response. As shown in this study most physicians surveyed had an important deficit of information or knowledge about the advance intention of Venezuelan Government on adding a new paragraph to our *Legal Code: article entitled “Giving death by mercy”*. Discussions are currently carried out in the *Asamblea Nacional de la República de Venezuela-Republic’s National Assembly*, which has a transcend impacts on medical decision-making and action-taking at end-of-life (*Anteproyecto de Código Penal de Venezuela, 2000*). On this discussion about *active and passive voluntary euthanasia* legal forms, the most significant disagreement among the entire medical community is whether if the Government is also supporting all forms of medical suicide participation, including the executive ones.

At the same time it was unclosed the insufficient information physician surveyed (74%) had about the improvement done in 2003 to the *Código de Deontología Médica de Venezuela-Deontology Medical Venezuelan Code*, which included new definitions on medical concepts, supporting medical guidance in handling end-of-life care for terminally ill patients. The result of this research is undoubtedly preoccupying taking into consideration that the medical staffs participating are working directly in areas such as *Surgery, Internal medicine, Intensive Care Units, Oncology and Anesthesiology*, having to deal day by day with medical mediated death.

On the other hand, 85% of physicians manifested to have cognitive theory *criteria for terminally ill patients*. And when they were asked about the behavior willingness to apply euthanasia to terminally patients 48% surveyed doctors responded affirmatively, the same number responded negatively while 4% decided not to respond. Also 54% of surveyed physicians claimed to theoretically know all different *types of euthanasia* that could be applied in terminally ill patients, while 41% thought they had lack of information; 5% did not provide their answers. Out of the data qualitative analysis it was shown that 69% of doctors declared to know the definition of *assisted suicide*, whereas 31% were not familiar with this concept.

This poor groundwork of theoretic approach has a direct negative impact on their knowledge and skills in medical practice; also established when taking into consideration the lack of interest expressed by medical doctors to know about our *national legal regulations*; possibly leading to the default in concepts and performance related to medical decision making at end-of-life, as demonstrated in this study; compromising the ethical and medical judgment and actions when managing patients in terminally ill stage disease. On the other hand, based on the results of this study, doctor’s surveyed have a considerable level of acceptance regarding the accomplishment of *direct active voluntary euthanasia*, while a broad

number of participants were favorable to *facilitate death without pain to the terminal patients*, being this another form of *active voluntary euthanasia*, but since there is no intention to cause death is *indirect*.

The above shows the importance for the subjects of study to relief pain in dying patient, what resembles the *Hippocratic Oath* and the Oath's evoking *Dr. Luis Razetti*, distinguished founder of Venezuelan Medical School and author of the *Código de Deontología Médica de Venezuela-Deontology Medical Venezuelan Code*. These Oaths are adopted as a solemn commitment in medical practice by physicians graduated at all Universities in Venezuela. There for *with regards to the relief of pain and caring of the terminally ill patient known as Orthothanasia* is favored by the majority (Aguiar, 2003; Castillo, 2006)

In relation to the *abolition of lives that doctors considered as a burden on society (Criphanasia)*, the vast majority disapproved its application; from what we could deduct that medical participants in this research have highly appreciation for patients as persons and the dignity of the human life. This attest that surveyed physicians have the theoretical knowledge under which they cannot presuppose that upon medical reputation doctors have the moral or legal authorities to determine the value of a life worth living, thus taking into their own hands the action of killing another human being (León, 1975, 1981).

Concerning the possible practice of physicians in *Assisted Suicide*, a high percentage of respondents were in disagreement; But it should not be underestimate that 25% accept to facilitate the means and resources available to patients in terminal stage to help them die.

It is worth to highlight that these numerical results extracted from the quantitative phase of research about physician's cognitive and practice skills, are consistent with those related to theoretical bibliographic background that they acknowledged to possess; bringing out the importance between *gnosis* and *behavior/noemata* and *noesis* in decision's skill management, especially in medical assertive perform among life's end.

This amalgam between the theoretical constructs and humanistic principles within a reflexive attitude by physicians, leads to an *assertive medical practice*, impregnated with the value of humanist thought and the fondness for life, which comes evident in the *discernment and performing* of the health care team as a whole, especially for physicians who work at critical medical areas, where they have to deal with the process of perilously decision making, stating that train should be restrictively preceded by an adequate and followed theory learning process; assuring that when practitioners need to, they can relay-on a strong body of knowledge to guide them throughout the empirical experience.

These integrated complex way of approaching end of life decision making in terminally ill patients is of special significance, highlighting the expected linkage between the *awareness of self-been of a persons* within their reflection on values and principles, that become as projections connecting *noema* and *noesis* for a *right-doing*. There is a higher level of consciousness lead by the analysis of theoretic construct which puts into context the fact of doing something with a superior humanistic purpose favoring the wellbeing of others, respecting Human Rights and the sense of spirituality on human conduct; favoring the *knowing how-to do* expressed as a proper approach on professional behavior.

From de interrelation of the 2 investigative quantitative-qualitative perspectives accomplished throughout the research emerges an innovative approach of the *physician-patients-family auto-organizational systematic interaction*.

2. Universe of cosmic dimensions, sub-dimensions and their emerging elements

Out of this *retroactive-recursive integrated universe*, there are 3 main **macro-dimensions** to be discerned:

1. One related to the *patient*, with a macrocosm and microcosm patients related sub-dimension.
2. A second **macro-environmental dimension**, in which 2 sub-dimensions intervene as well, represented by the **patient’s family and friends** and those who also work as part of the **healthcare team of support**, represented by nursery staff, lab personal, technicians and other hospital attendants who share the healthcare of patients.
3. A third one related to the *physician*, as the leader of the healthcare team; relating their macrocosm and microcosm.

Discourse and dialogue analysis of interviewed subjects allowed recognition of 2 sub-dimensions: *patient’s microcosm and macrocosm dimensions*, in the spectrum of terminally ill patients. *Patient’s microcosmic dimension* reflects their interpretation of new reality, referring to the inner world of patients as a gravely ill subject, facing the odds constrained by health deterioration, forcing the consciousness of life’s end, which in turn has an impact in patient’s *quality of life*.

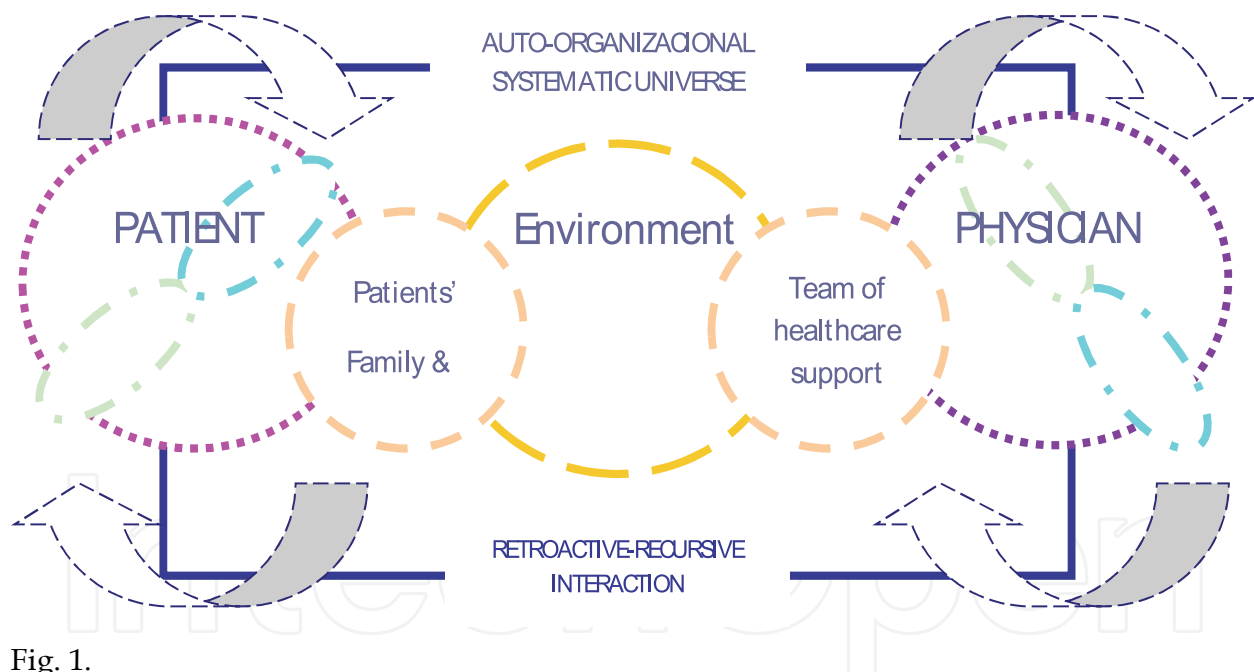


Fig. 1.

This sub-dimensional recognition proposes an inner reciprocal interaction about one self’s thinking regarding *the health of the body-the health of the soul*. In this personal way of insight patients will re-elaborate a new adjusted project of life, expressed in actions and re-construction of their *lifestyle*.

Through the understanding of the contents of the patient’s human consciousness, known as *noema*, researchers can achieve a better understanding of a person’s way of thinking and actions, which are projected as *noesis*. The contents and their projections are do to the dynamics of life and individual development. Therefore, by this approach it is possible to establish a relationship between a patient’s cognition and what will later be their behavior in

the process of adjusting life to a burst dynamic of changes in a survival environment. This deep cognitive reflection cannot be done in everyday life conditions, the notion of death, loneliness and departure are otherwise rejected, out of one's thoughts.

PATIENT'S COSMIC INTEGRATION

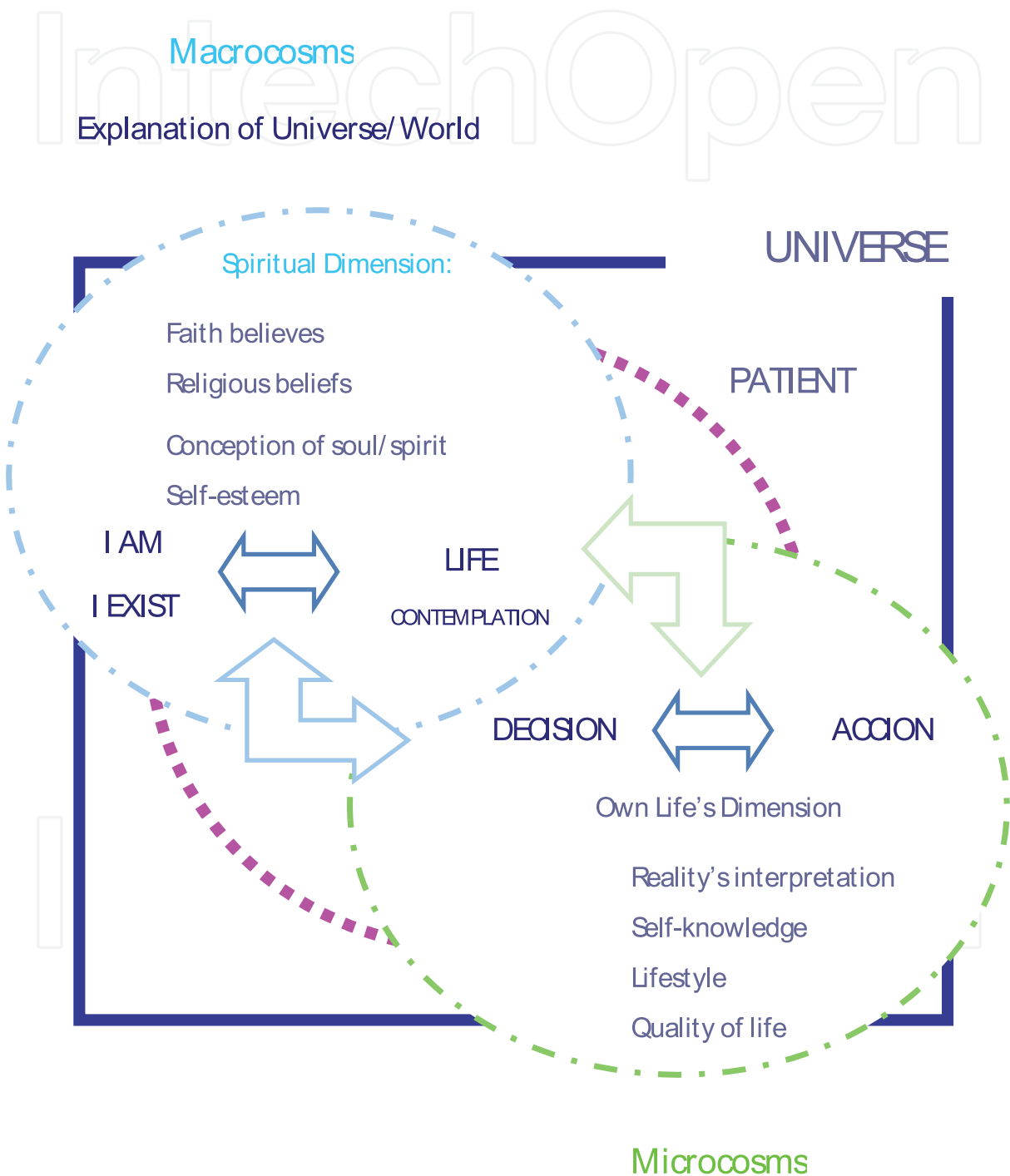


Fig. 2.

Upon this *self-knowledge*, subsequently patients may materialize their modes of action, to establish behavior to confront life’s threaten circumstances re-balancing vital energy’s state of mind-soul-body, aimed to re-establish their health conditions and quality of life as possible; or instead, successfully adapt to a new circumstance for survival.

In this sub-dimension were identified as emerging elements *fear, repentance, guilt, depression and denial* as negative elements, to the conscience of the incurable disease, the diagnosis of cancer or death’s despair.

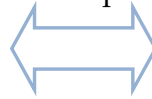
This is a process in spiral that changes permanently, which is given by a continuous, unfinished course of multiple interactions between the patient, his own capacity of internalization/learning, surrounding environment, self-spiritual and existence development and growth, with the main objective of achieving their personal fulfillment based on the moral values that the person possesses.

All these recurrences allow the creation of a network of intimate exchange and multidirectional (*retroactive-recursive*), complementary between the *microcosm* of the patient and the *macrocosm* (such as an *auto-eco-organizational process*), with their *eidetic* content (from the Greek *eidetic*: *eidētikos*, which means “relating to or subject to such imagery”), eminently contemplative that define the spiritual world of the subject.

1. First dimension: Terminally ill patient’s dimension

a. **Microcosm:** dimension on their own health-disease process.

- Interpretation of reality
- Management of emotions
- Self-knowledge
- Quality of life in terminally ill patients
- Patient’s Lifestyle



INTEGRAL BIOETHICS
PATIENTS’ RIGHTS

b. **Macrocosm:** patient’s individual spiritual dimension of life.

- Faith believe
- Religious beliefs
- Patient’s own conception of soul/spirit
- Patient’s self-esteem

Microcosm of patients’ interview is based on their own perception on health-illness process, sustained on emotions management, self-understanding of reality, self-knowledge and expectancy of lifestyle and quality. In which *negative self-patterns as guilt, depression, fear to die, pain/suffering and self-meaning of cancer will contrast forces with positive conduct elements as acceptance and peacefulness*.

The *macrocosm* patient’s sub-dimension emerges from the way in which patients from their own moral and ethics principles seek an explanation of the universe at whole, and of Cosmo’s creation, constructing a frame of reference in the concepts and dogmas of their spiritual world.

In their own ways as individuals decipher and seek to understand the meaning of life, insofar as it relates to an immensurable-inexplicable and infinite supreme order, which is expressed through beliefs and convictions of faith, giving it the properties of divinity and Holiness to his own life and life-extended forms in other creatures that accompany men on planet and into the fullness of the universe.

Since this auto-perception of the macrocosm individuals creates their contemplative eidetic content, which they will have to pay worship and veneration; in view of these imaginaries

intellect constructs patients are to be founded in a superior belief, leading to the contemplation of the universe's creation, which gives the appraisal of their own existence in the world and their mission in life, consequently influencing their *self-esteem*.

Throughout this reflective process patients look for an explanation to their existence and all that is provided in their about, although still not understandable in some circumstances. But that in turn, allows the person to project itself beyond its biological and organic existence, becoming integrated to infinity, be no more death, in an always eternal supra-dimension.

In this sub-dimension the patient sustains *faith believes*, which consequently have an impact on *his lifestyle and quality of life*, to reinforce the interdependencies between the conceptions of the microcosm and the macrocosm of the human systemic universe, auto-organizational and dialogic, of complex associations in necessary instances, obligatory combined in human existence, required in the development and process of the phenomenon of life and its terminal process in death.

"I am, I exist and feel, I am undividable linked with what is, exists and feels to my around and also belongs to an eternal dimension", is a statement expressed in the context of the interviews conducted in the research, in which the terminal patient seeks to find a greater meaning than of finite biophysical worlds, provided within a non-perishable sensorial and existential dimension. Every intentional act has noetic content (or a noesis - from the Greek nous, "mind"). This noetic content, to which the noema corresponds, is that which gives meaning or sense to an intentional act.

Discourse analysis of interviewed patients allowed recognition of sub-dimensions in the spectrum of terminally ill patient, given by microcosm-macrocosmic patient's dimensions and understanding of reality based on their own perception of the health-illness process, sustained self-board of sentiment, self-understanding of reality, self-knowledge and expectancy of life; in which positive and negative self-patterns emerge as contrasting emotions and feelings to conduct their actions in the process of dying.

There were defined as elements of *microcosmic patient's dimension* in which interact the patients' faith conviction, religious upbringing, personal conception of soul and self-esteem, to balance patients' willingness to collaborate with treatment, to have confidence and relay on healthcare team work.

2. Second dimension: Interactional environmental dimension

- a. Trans-disciplinary Healthcare team: *retroactive-recursive system*
- Justice and equity in health services for all patients in need
 - Effective Social Security
 - Intergenerational Social Security Plans for terminally ill patients
 - Suitable treatment
 - Care for patients with human kindness.

↔ SOCIAL BIOETHICS

In this categorization of items, this dimension refers to the care and treatment given to patients with a terminal illness by the healthcare team, led by physicians, but involving nurses, bioanalysts, lab and technical assistants; even including administration, maintenance and protection of safety personnel, of Healthcare Centers.

The *reification of the individual* is considered by the patient, as the impersonal behavior, cold and distant towards them and their family. Not conceiving the idea that a patient could be treated as an object or a damaged "thing". The terminally ill patients interviewed referred be treated and of feeling like an artifact, like if their sickened body was interpreted by the caregivers as a damaged machine with an irreparable injury.

The terminal patient referred to feel *discriminated* upon doctors and nurses misbehavior. As well, they expressed to suffer financial fragileness and vulnerability *without an effective or reliable social security service*, with a sense of *hopelessness* do to the lack of economic resources to fill the needs of their treatment expenses. This increases the sacrifices that they have to do, to pay for procedures and treatments required.

One of the emerging elements in this sub-dimension also was the *accompaniment*, which is why each person who has contact and handles the terminally ill, are perceived by the patient as *companions* in their process of dying.

Fear is a predominant element in speeches, as a result of the feeling of death and separation from their loved ones, which is intensified if the patient does not dare to ask doubts to doctors, therefore to evade reality or because he does not feel confidence and empathy with caregivers.

In addition, patients recognize as important the following elements: 1. - simple and loving communication 2. - manage of symptoms and adjuvant treatment 3. - pain treatment and sedation 5.-accompaniment and a human warmth attitude related not only to the company of family members, in this case is extremely important to understand that the *doctors along with the healthcare team, are a group of affective and emotional support for the patient and their loved ones. Unable to cure, the health-team can accompany and support the patient and their family group.*

b. Family and Friends Group of Support for Terminally Ill Patients

- Economic livelihood
- Care and affection
- Solidarity
- Travels and other needs for transportation

This sub-dimension emerges in relation to the support of family members and friends of the critically ill persons, in which sickened patient's finds *support and solidarity* in order to understand the decline of lifetime; in them they'll seek for harbor to their feelings and the comfort to manage the emergency situation.

They will be inclined to look for the family member that offer a sense of security and trust under such circumstances, and even will go to those who he thinks might offer *financial support*, to the huge costs of their disease. In some cases it was referred by patients with low incomes and no social security uphold end-up selling their few belongings in order to find required money to pay for expensive treatments; demonstrating the devastating economic consequences of life threatening sickness in those who are out of the social security system, needing to provide themselves even with the most simples dispensable medical materials such as disposable syringes and cotton.

Patients refer *nostalgia*, sense of loneliness and loss. They felt sadness because they were far from home country/home town, or dear somewhere, their house, family and friends. Speaking about their sentiment of melancholy, which came along with the memories of old times or people to whom they once felt linked emotionally, but that are not in present days, and perhaps the imaginary possibility or hope to be reunited again at a unknown dimension.

As patients get closer to an end, some of family member who accompanied them, tend to retrieve exhausted by suffering and sense of *impotency*. Loved ones need to deal with sentiments of regrets and helplessness, as they watch their relative die.

ENVIROMENT’S COSMIC INTEGRATION

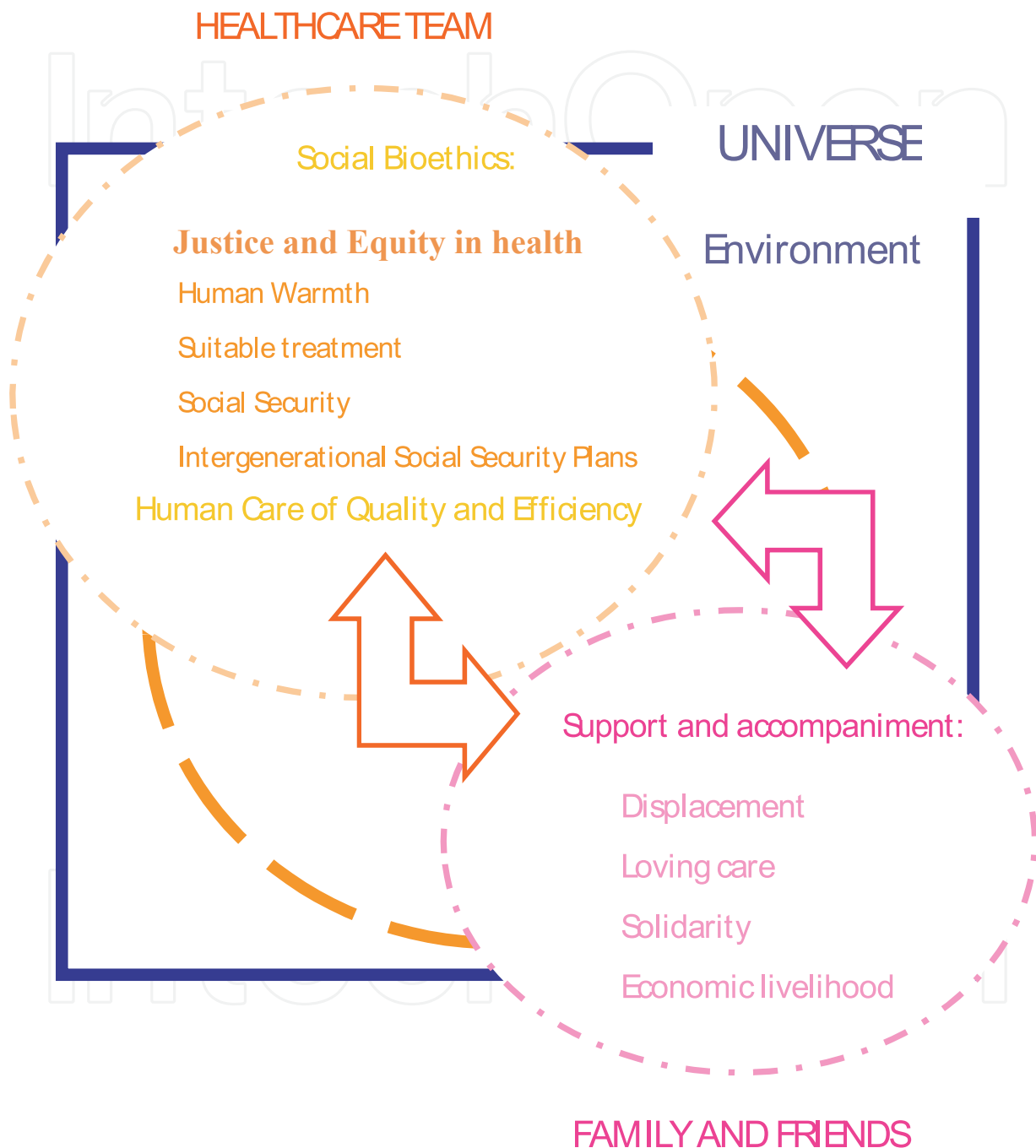


Fig. 3.

Displacement refers to the need of relocation which is undergone by the patient, at first by getting out of private home or city of residence, moved by the hope to find other medical opinions and secondly, being able to have access to better resources in health services in the infrastructure facilities of other institutions, gaining access to procedures and treatments,

which may not be able to have in own location. This place shift creates primarily a sudden change in the family and physical environment of the patient, which implies a detachment of their near loved ones, and having to get used to other home surroundings or to the development within this new community; secondly, with all the economic adaptation and unexpected modifications generated.

The heated discussion about life's end was paradoxically exempting increasingly needs and cries of the terminally ill patients. Little by little, as their lives were quenched, their voices were extinguished and silenced in stealth of their finale, as so their pain and fears. *The life support machines replaced the caretakers in the accompaniment of the dying.*

The excessive maelstrom of biotechnology's advances burst leaving behind the consideration of peoples Human Rights, principles and values, which should encourage civilized communities in the realization of a good modest life worth living for, what in consequence has a negative impact on a deserved worthy death (Universal Declaration of Human Rights-Declaración Universal de los Derechos Humanos, 1948).

In an attempt to be heard, groups of terminally ill patients across the globe and professionals dedicated to take care of them, as in palliative care, aiming to ensure the correct medical exercise concerning the terminal sickened, with the support of international organizations, proclaimed their rights: *Patient's Right*. Patients' rights vary in different countries and in different jurisdictions, often depending upon prevailing cultural and social norms; for instance WHO in Europe proclaimed a *declaration on the promotion of patients' rights in Europe*; in Latin America the Fundación pro Derecho a Morir Dignamente have declared: *Terminally ill Patient's Rights*. Specifically in Venezuela there is Fundación Hospice Venezuela-Hospice Foundation Venezuela, in which they provide guidance for terminally ill patients. (Fundación Hospice Venezuela, 2009; Fundación pro Derecho a Morir Dignamente-Derechos del Paciente Terminal, 1991; World Health Organization-Patient's Rights, 1948; WHO-European consultation on the rights of patients, 1994)

Still these rights were not enough, the medical scientific community highly mechanized imposed their dominance in the units of intensive care with new and sophisticated equipment and procedures; while this was the reality in some developed countries, not for underdeveloped ones, these new facilities just opened even more profound inequities in health care service, between these nations and those immersed in poverty.

3. Third dimension: Physicians' dimension

a. **Microcosm of physicians:** Dimension that reflects the attitude of doctors on health-disease process of terminal patients.

- Human Rights and Terminally ill Patient's Rights.
- Respect for person's Autonomy
- Beneficence
- Non-maleficence
- Justice



- Ethical and Deontological aspects of Medical Doctors' Practice.

- Approach between scientific and humanistic medical's sense.

- Attachment and self-conviction upon JURIDICAL NORM:

VENEZUELA'S BOLIVARIAN REPUBLIC CONSTITUTION

VENEZUELAN'S PENAL CODE and its amendment.

b. **Macrocosms of Physicians:** Spiritual dimension of medical specialists.

- Religious belief: dealing patients with affection and compassion.

- Conception of the Soul-Spirit
 - Confession of faith: attachment to the values and principles of own's religion
- In the **physicians' dimension** again there were acknowledged 2 sub-dimensions, one **microcosmic physician's dimension** in which the professionals' own understanding of Humans Rights, Medical Ethics, Bioethical Principles and legal framework regulations, will lead his conduct favoring respect for persons opinion, patients' autonomy, benevolence and most proper communication and using best techniques available for the right treatment of terminally ill persons, in the sense of a **Clinical Bioethical interaction** inserted in the **knowing how-to do**

Once again we see that in the way as a subject confronts the tensions that exist in the mode of conceiving his process of health-disease, in this specific case referring to the medical specialist, their position will be clearly expressed in their speech, conduct and actions (*noema-noesis*), *with which they will have to deal and resolve the conflicts of life, especially before a big dilemma, such as death, seen through his patients.*

The projection of these noema in noesis will let glimpse the conception of its principles, values and the attachment to the legal regulations, as well as, their correct medical exercise in accordance with the professional conduct and ethics. From the microcosm doctors joint their technical knowledge (*knowing*), with his technical skills *knowing-how*, this will define their biotechnical *knowing how-to do*, in their professional environment.

It is based on their own preconceptions about the *health-disease process*, as the specialist will feel motivated to enrich its values, principles and duties, supporting them on *Human Rights, Social Bioethics and the Principles of Clinical Bioethics, and Medical Ethics and Deontology.*

From *Social Bioethics* guided by the *Principles of a Clinical Bioethics and Human Rights*, they strengthen the links between the parties involved in the medical-patient interaction, and will favor consensus decisions, allowing doctors gradually abandon paternalistic behavior traditionally imposed on patients, looking forward to encourage, direct and support them in the taking of autonomous, reasoned and informed decisions, of great importance into the finitude of life.

On the other hand, *macrocosmic physician's dimension* is related also to personal religious convictions, spiritual contemplation, life divinity and on physicians' own perspective of existence, which leads to a beneficent human patient relationship submerged in kindness, solidarity and good willingness into *physician-patients-family auto-organizational systematic interaction*. It's of special significance to accent the connection expected between *self-being* with oneself values, principles and spirituality belief, which together with the theoretical consciousness content will be expressed in high quality professional's technique combined to the individual capacity of analysis, allowing a greater understanding in the *knowing how-to do*.

In this sub-dimension individuals combine the principles of faith and spirituality with which doctors contemplates the existence, in which religious beliefs will be fundamental mainstay to define actions, leading him to the *knowing-how*, as a result of the balance between knowing and doing from the humanistic point of view as in result, into a humane compassion behavior interaction, with quality and warmth inside their individual technical knowledge (*knowing*).

In their macrocosm Galen will seek for *dialogue and the emotional warmth in relationship* with patients and their family members, encouraging linkages to strengthen solidarity, trust, honesty, harmony, flexibility and interaction. Is this sub-dimension doctor's will project their personal skills using of simple, clear verbal language providing adequate information

to patients; as well as, they shall assume the importance of affective and proximate gesture language to patients and their relatives.

Never the less, throughout the investigation patients perceived that *physician-patient relation* was classic and *paternalistic*, with a lack of effective and efficient communication between both parties. From physicians' conduct towards critically ill patient, it's manifest that based on their own knowledge of *medical ethics, deontology and principles of Clinical Bioethics*, the specialist who works in areas such as *Surgery, Internal Medicine, Critical Care Units, Oncology and Anesthesiology*, will feel motivated to enrich their moral values and principles to encourage the adequate conduct behavior and technical approach in proficient healthcare (Hernandez, 2001; Malpica, 2008).

There was documented by the hermeneutic-phenomenological interpretation of facts, that terminal patients' awareness of incurable disease, as negative-depressant conduct behavior can be more bearable when *patient's family and close friends* support them by companionship, economic uphold and solidarity throughout these crucial circumstances. As well as the *team of healthcare* based on *Social Bioethics and an Integral Bioethics* ensure that each person in need will receive an optimal adequate treatment for their illness, with dignity, without discrimination of social status, age or gender.

By systematic triangulation of all data information gathered the author proposes to reconstruct an approximation theory which enunciates that, in the process of decision making and action taking at end-of-life in terminally ill patients, physicians should take into consideration with each person first of all Human Rights, patients' own values and believes, respecting their opinion as well as that of their families or surrogate representative, according to preserve everyone's right to a dignified moment of death, being offered and receiving technically countable efficient resources in a caring and comfortable environment. Furthermore, doctors working in critical areas using life-support measures should make a constant update of the concepts and emerging procedures involved in the application of vital support effort; at the same time as taking awareness of changes done or yet close to come in the legal framework on our underdeveloped Latin-American countries, to provide patient appropriate and timely media in the process of dying.

It is in this multiple humanistic movement towards life, in the reflection of *Human Rights*, through the caring of life and all its living components over the world, in which is validated an upcoming concept of *Integral Bioethics*. Without losing a specific perspective to be applied in every contextualized circumstance, as we have to deal in Venezuela. In view of the fact that *Bioethics* exhorts and promotes inclusion, solidarity, of profound depth in social, tolerance and respect, is that we can assume the center of attention in the use of new biotechnologies advantages, guiding their profits towards a vital preservation of the environment, heartfelt admiration for biodiversity, protection of life and living (Lolas, 2008; Sass Hans, 2008).

3. Conclusion

Systematic generation of a theoretic approach from triangulating data as conducting research, follows construction of theory, enunciating that at end-of-life ethical and bioethical decision-making health care givers, led by physicians, must consider and respect the values and personal opinions of patients and family members to shelter terminally ill patients into the lifecycle dying process; therefore, medical doctors working in critical areas practicing life support measures should make a continuous update of theoretical concepts and emerging

technical procedures involved in the appliance or not of vital support, considering the current ethical, socio-economical and legal framework in Venezuela and present-days changes, preserving in mind the *maxima* moral cognition and behavior to offer patients opportune-adequate means in the process of dying.

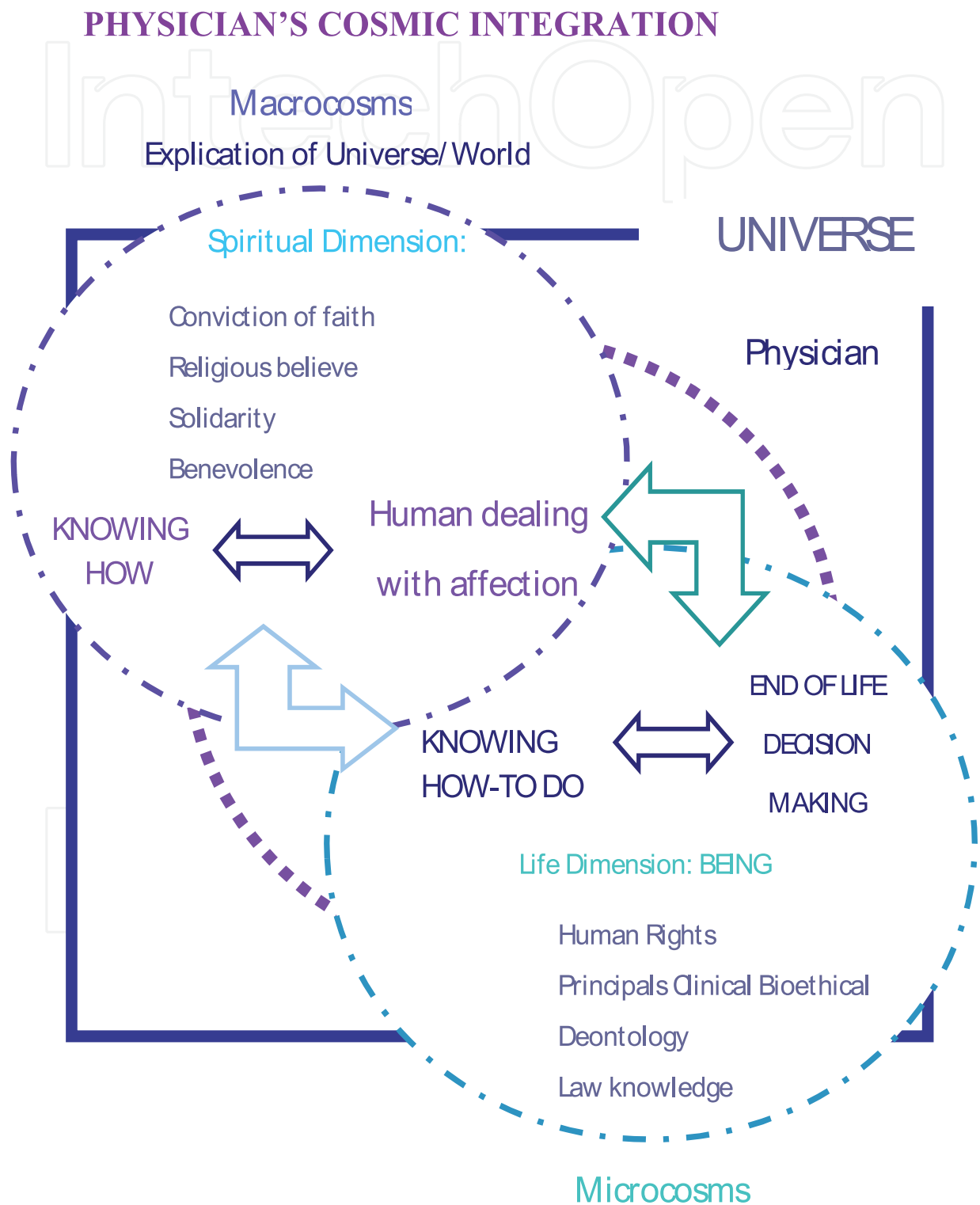


Fig. 4.

Model offers insight into how medical doctors think about the dilemma omega as care givers of terminally ill patients, provides a way to assort, real situation decision-making, by recognizing that adult development is linked to educational and work experiences and it is not just a reflection of socioeconomic status or degree of theory academic knowledge of physicians; by extent, working experience and degree of education may provide the stimulus for further moral development in health care gives. Highlighting the importance of the interaction between cognition-as how individuals think about moral dilemmas and behavior-what they would actually do in a particular decision situation. It emerges from this new complex and holistic thinking that given the impossibility of curing, might the ending be “caring” as an assemblage of coordinated actions of the health care team members, led by medical doctors, in a transdisciplinarity effort accompanied by the nursing and bioanalysis staff.

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No one really wants to die, or do they? From classical times to our post-modern era of medical high tech, societies have struggled with the thorny issue of euthanasia, and what it entails. Who shall be entitled to a "good death" and in what form shall it arrive? This book provides the reader with insight and enlightenment on the medical, philosophical, social, cultural and existential aspects of "good death" amid our digitized, individualized and ageing society, hampered by rising health care costs but unchained from one standardized level of care.

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Slavka Krautzeka 83/A
51000 Rijeka, Croatia
Phone: +385 (51) 770 447
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InTech China

Unit 405, Office Block, Hotel Equatorial Shanghai
No.65, Yan An Road (West), Shanghai, 200040, China
中国上海市延安西路65号上海国际贵都大饭店办公楼405单元
Phone: +86-21-62489820
Fax: +86-21-62489821

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