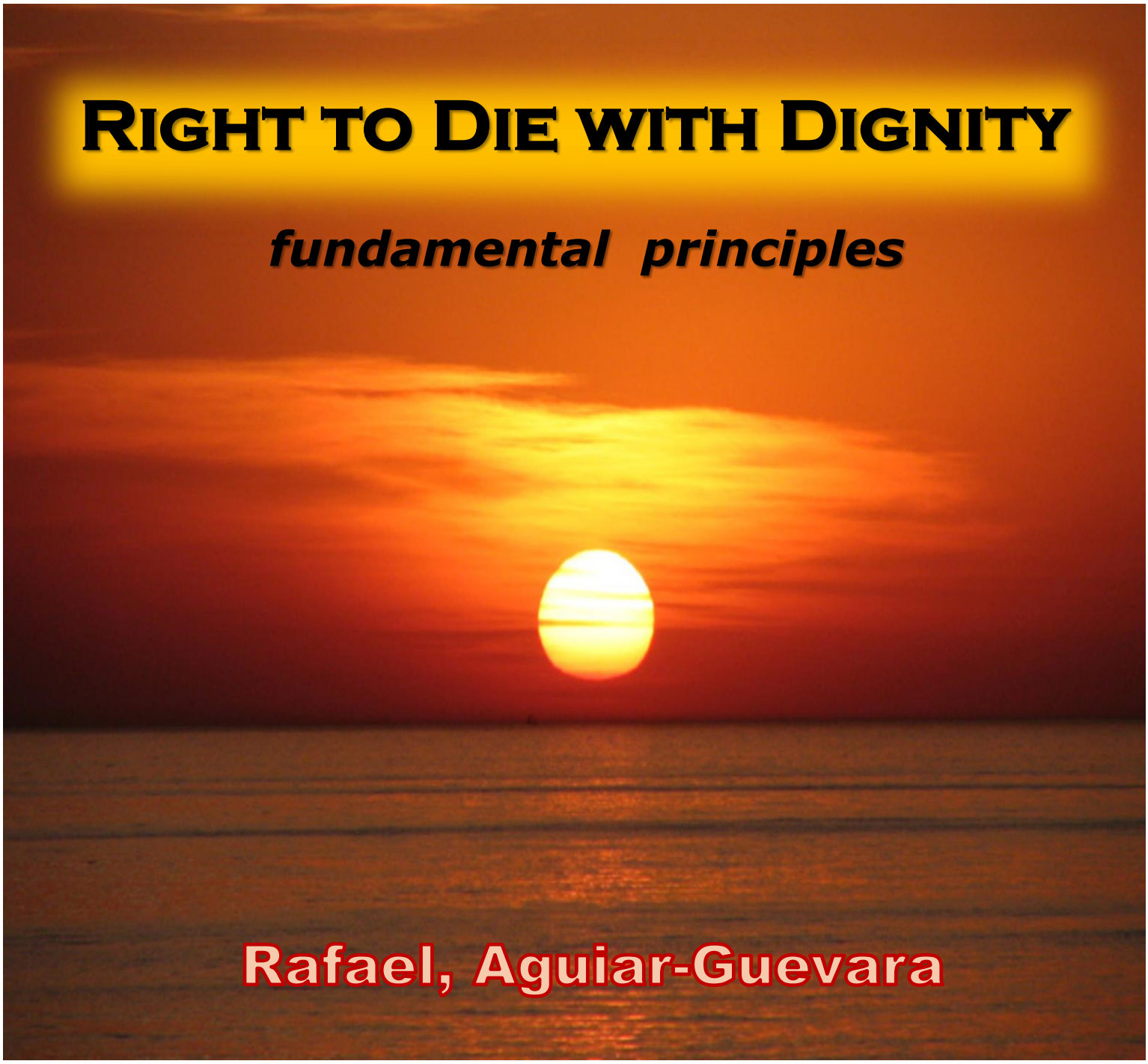
RIGHT TO DIE WITH DIGNITY
fundamental principles
Rafael, Aguiar-Guevara

RIGHT TO DIE WITH DIGNITY:

FUNDAMENTAL PRINCIPLES

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Right To Die With Dignity: fundamental principles

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To my dear friend Dr. Rob Jonquiere (MD), former President of NVVE, Nederlandse Vereniging voor Vrijwillige Euthanasie (Duth Association for Volunary Euthanasia) and actual Executive Director of the World Federation of Right to Die Societies (WFRtDS) to whom I feel profound gratitude and affection, ever since we met, for first time, at the NVVS office in Amsterdam , in 2002, and kindly dedicated some of his busy time to teach me and guide my steps in this marvelous world of the euthanasia principles. During these 16 years he has always being there, to advise me, to listen, and encourage me within my activities regarding euthanasia and only because of him I felt greatly motivated and I dared to convert the original Spanish version of my recent book: *Derecho a Morir con Dignidad: principios fundamentales* into this English version *Right to Die with Dignity: fundamental principles*, which I really wish may well serve its purposes beyond frontiers.

Caracas-Venezuela, July-2018

Rafael, Aguiar-Guevara

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Foreword

Since 2003, the date on which my predecessor book: "*Euthanasia:: Myths and Realities*" was published, many have been the conceptual, doctrinal, jurisprudential and legislative changes that have taken place; subject to those changes in personal value judgments that strengthen the need for the presentation of this new text and whose name obeys, in my personal conviction, a contemporary reality that goes beyond of the simple name of euthanasia to establish our right to a dignified death, in the way in which I will present the foundations of what, this new meaning, entails and translates into each of the most varied situations.

As always, I propose to describe, in plain and simple form, all the points of view of a plurality of thoughts; and perhaps, more than feelings, that teach us to respect the way of thinking that, personally, each individual may have on the subject and with the conviction that, in defending this deep topic, I do it from the particularity of the need of a mere legislative alternative so that those convinced of it can have the opportunity, according to their convictions, to put their rights into practice without their being limited by the beliefs of those who, precisely, do not share it but who intend to impose, under the strict adherence of their thoughts, unjustified restrictions on those who defend that dying with dignity is, definitely, a fundamental, personal right, and this will be evident in the following pages of this book.

The central theme, beyond Law and Medicine, of Deontology and Bioethics, enters and shares the same criteria of Functional Contemporary Ethics, and imposes a radical change in the way in which, on the one hand, we have been taught that paternalistic, protectionist, taxation of the motivations and beliefs of a doctor in a vocational exercise corresponding to an overdue vertical doctor-patient relationship, with an immeasurable cult, alone and exclusively, to life, whatever its quality, without realizing that our actuality teaches us that our model currently belongs to a horizontal relationship in which the patient, the subject and not the object of that relationship, must also face, in his(her) own way and decision, that other phase of life itself which is dying, and dying with dignity, without the need to suffer opprobrious conditions at the expense of beliefs of third parties alien to their will and personal relationship.
The present reflections are directed not only to the professionals of Law and Medicine, who have abrogated the exclusivity of the decision of the patient about life itself, but it is oriented to all general public that could get in the present reflections a help to their own and autonomous decisions, which, in times of difficulties, personal or neighboring, may need to know their rights and the presentation of an alternative in their life-health project that can help them make their own and voluntary decisions.

To paraphrase my predecessor's exposition on this subject, a change of attitude and participation on the part of the medical professional is imposed, to whom the traditional educational culture of life prevents him from seeing death, or, rather, the end of the unique process of life itself, as an element that is part of the relationship with his(her) patient. Convinced I am that it is time for the doctor to take care to know, without fear, but with reverence, everything necessary to continue his role of assistance to his patient when the

patient faces a special phase of his life, considered from the perspective of the patient and not of the doctor, when the quality of life does not offer a worthy alternative (according to the patient believe and not to the opinion of the doctor) and that, undoubtedly, free, without coercion or urgency, request from medical doctor a human and professional assistance. Change of paradigm that is not easy, but that, convinced I am, the moment has arrived for the restructuring of thought and professional formation.

Change of paradigm that is not exclusive of the health professional but that also corresponds to the legal professional, and to those who are precisely in charge of legislating and interpreting, conceptually, human rights, and who try to show himself as a stranger to this subject leaving his analysis and discussion exclusively to the medical doctor, for being this, the one in charge, for his teachings and traditions, of the patient's life. The lawyer, doctrinaire and jurist, whatever role he plays, must understand that it has been wrong to think and assume that the discussion of euthanasia corresponds only to a teleological dissertation of the philosophy of Law for classrooms or merely academic environments, discussions that they are performed, in their generality, in such an abstract and generic way that they prevent them from seeing, appreciating, feeling, the feelings of anguish and fear of a patient who needs free alternatives; and a medical professional who, wishing to help, is impeded by reformable legal rules that are imposed, arbitrarily, from cenacles constituted by obtuse thoughts of legislative committees that never approach, with sincerity and altruism, the reality of being, and where it matters most the total expiration of one or another thesis corresponding to the doctrinal philosophy of the Law that to the very right of the persons that, under the rigor of those theses, must be submitted unrestrictedly.

But, I insist, this change of paradigm does not only involve health and legal professionals, it involves us all, as people, because we are, ultimately, the beneficiaries of this right to a dignified death, in the personal sense that each one, well, consider it. I propose, as usual, to face the great myths that have been erected about euthanasia, revealing the great mysteries and taboos that have been built, intentionally or maliciously, on the subject, but that in the same way they had achieved their objective: to exclude the topic of conversation from their properties and natural areas; excluding, *ad libitum*, all those people to whom the right of this reading really corresponds: the patient.

Exclusive restrictive myths have been imposed, I have said it many times, on very personalistic beliefs that try to make everyone live, regardless of the opprobrious conditions of their existence. However, since 2003, with the publication of my first book on euthanasia, it has been possible to see a general, positive change, from Law, Medicine, the general culture of the peoples, which has made possible the existence of positive legislations, worldwide, on the Right to Die with Dignity, and as always, countries that have not yet done so, nevertheless show positive figures in their surveys in favor of the subject.

Personally, I see very positive changes. We no longer speak, merely, of euthanasia. We refer to the subject as the Right to Die with Dignity. We no longer talk about assisted suicide, because of the pejorative tax (intentional?) name of "suicide". We simply refer to assisted death or medical assisted death, whatever the case may be.

But I see with concern that another unreal concept is also developing. Perhaps, due to not being able to face the Right to Die with Dignity, the concept of palliative care or of Palliative Medicine has been developed, in a substitute way. Another great myth to collapse, especially

when the World Health Organization itself (http://www.who.int/mediacentre/factsheets/fs402/es/) establishes that globally more than 40,000,000 terminal patients would need This Palliative Medicine and only 86% of these patients worldwide, that who would need these "palliative care", never reaches them, precisely, among other reasons, due to the high costs and, on the other hand, due to the lack of professional training in this special type of Medicine; and whose figures, in other countries, such as Spain, which considers itself a leader in this field, confesses its President of the Deontological Commission of the Collegial Medical Organization, Marcos Gómez, in publication of July 3, 2014, (https: // www. .elconfidencial.com / alma-corazon-vida / 2014-07-03 / sedacion-paliativa-el-derecho-a-la-muerte-worthy-que-solo-llega-al-50-de-los-espanoles_154887 /) , that in Spain, half (50%) of terminal patients do not receive palliative care; criteria ratified in the JANO publication of October 7, 2016 (http://jano.es/noticia-el-50-de-los-pacientes-no-24955) by Dr. Álvaro Ganda, President of SECPAL (Spanish Society of Palliative Care) and in which it ratifies the previous criterion; with the exception of other countries, such as Mexico, where 90% of patients who need palliative medicine do not manage to reach it. We will also deal with this subject later in this work.

Reiterating criteria expressed in my predecessor work, I repeat and insist: I am convinced that the path must be conciliatory, integrating, in a field of dissertation full of respect for the beliefs, fundamentally family and religious, of each one and that allows us an alternative that, being discreetly there, it can allow, in due course, the proposal of viable alternatives within a free social system that respects the rights of people, and that obeys, consequently, the general principles in which we believe, and that we seem to defend in some cases yes but in others not, breaking with the defined structures of constant monitoring of a set of values and principles that are sometimes easy to proclaim but that are made of very complex, locked, and complicated execution at the crucial moment of the taking of decisions on the path of life itself.

With the progressive development of human rights we are tried, in the same way, to make believe that there also seems to be a so-called right to clinical research and the full scientific development that would allow the doctor to impose, in some cases, an exaggerated behavior towards his patient, which leads him to incur in true therapeutic cruelty (dysthanasia), most of the time in flagrant violation of the rights of the patient who, in his agony and suffering, becomes unable to ask if, for him, there are no better alternatives than the imposition of extraordinary life procedures that, far from thinking about the cost of them, we think about the unnecessary of them specially facing the scientific evidence that, in each case in particular, must be taken into account with the competent patient, or in his case, with the closest relatives who, through him, can raise a voice in search of an adequate and wise advice that, without major limitations, it must offer, in terms of alleviating human suffering, that doctor considered as the strong of a doctor-patient relationship who, surely, is unaware that this model of vertical imposition does not exist anymore and that now it is due to a dynamic and participatory relationship in which, the opinion, beliefs, wills, of the patient must be attended, listened to, perceived, as far as possible attended, without major limitations that respect for the right of third parties that appears as exclusive limitation, in what we consider the principle limitation of the damage, which we will discuss in due course.

The criterion imposed in this analysis will not be, *ab initio*, the search for an affirmative consensus of the procedure of euthanasia. Could not be farther from the truth. I propose to study and discuss the myths and realities in order to think about the possibility of establishing logical alternatives that, through the necessary opinion of the community in which we live, can it, the same society, impose its criteria and possibilities, by establishing, without odious restrictions, and another's believing, the alternate ways that can, at a given moment and without forcing anyone else who does not want it, to be able to select, because they exist in essence, a response to their quality of life, either because his will developed at the time or thoughtfully enough in advance, a decision that must be respected by scientists, lawyers, and those who are definitely the owner of making their own decisions: the person.

The most important thing, I am convinced, is to leave the indifference and propose a broad and necessary debate, in each region, in each country, and that it is they, the patients, the citizens, who really decide on whether to exercise, or not, their Right to Die with Dignity.

CHAPTER I
THE MEDICAL TRUE AND THE JURIDICAL TRUE

Without wanting to enter in a sterile discussion and trying to avoid some philosophical position on what is or should be the truth, a truth, or simply truth, which is not the object of this analysis, I always try to present, figuratively speaking, what I have called the medical truth and the legal (juridical) truth. It does not correspond to the strict definition of what is - true - but rather to the diverse and alternative approaches, disjunctive, alternative, that can be presented on the same reality. Conceptual difference between truth, reality and actuality that we must point out to understand, from tolerance, that none of us possesses, in an unequivocal and irrevocable way -the truth-; on the contrary, each one of us understands a reality from different perspectives and approaches; corresponding, consequently, to a deductive process of inference that we achieve from conceptions that, having been wrong since its inception, we have traditionally accepted as true.

But we also add the situation of the fact that, presented in our cognitive sphere, we accept as reality when otherwise, by the fact of not having perceived, or known, we tend to distort as not true or not existing. If at this moment of reading these lines I could tell you, dear reader, that a few meters away from you a thundering lightning bolt fell and that you, because of your deep concentration in reading these lines, did not listen, you will not be able to deny how true that such a thunderbolt, in fact, fell and perhaps caused some damage in the neighbor's car. For not having perceived the thunderous thunderbolt, you cannot deny the existence of it. From there we conclude that, its actuality, of some determined fact, does not change the reality of it. The same happens with the consideration of the presentation of these two truths that, over time, I have defined as medical truth and legal truth, and that figuratively I always express that they go together but do not shake hands, and it seems to be always confronted, especially on the judicial bench.

I like to point out the following example that, especially for the subject at hand, seems pertinent to me. A patient suffers from a terminal illness, and, in addition, he is in the terminal phase (that is, we expect his imminent death, perhaps maximum a few months); perhaps the patient suffers from a terminal cancer, with unbearable pain, or is in the final phase of any disease, or perhaps a patient with severe renal terminal insufficiency, whose dialysis processes no longer offer an opportunity for greater expectation of prolongation of life; patients that as a common factor, and among other manifestations, could present intense (intense and severe), incapacitating, inhuman, almost continuous pain (physical and emotional) that no longer yields with morphine or similar; whose artificial life support makes life itself disgraceful, with a clear serious decrease in their quality of life, and who, confirmed the irreversibility of his disease, occurs before a doctor begging for the administration of a lethal substance to achieve, not only the relief of his evils misfortune, but also, in the exercise of his self-determination and autonomy of will, to come to face with dignity his final life process.

Medical truth teaches us that the main objective of the doctor is to relieve unnecessary human suffering; This is what the Oath of Luis Razetti stipulates, and thus, perhaps he would consider, as many of us could have considered it at some time, to proceed with the administration of such lethal substance and help the terminal patient, in terminal phase, to finish, once and for all, with so much unnecessary suffering. However, if the doctor dares to take care of his patient's request and the judicial mechanism of the State is at stake, the Public Prosecutor's Office would not delay ordering the opening of a criminal investigation against the physician, charging him with the commission of intentional homicide; finally sanctioning him in the conclusion of the process with the penalty indicated for the crime of homicide, subject to the qualifications and aggravating circumstances that could be added; in conclusion: euthanasia, homicide, induction to suicide, assisted suicide. Our patient, then, desperate for his ailment, obfuscated by the refusal of attention, resentful against a society that has not helped him in his morbid process, which on the contrary has excluded and discriminated against him, in frank depression, takes a vehicle and, to put an end to his unworthy suffering, in flagrant manifestation of competent will, and before the felt injustice of his ailment, he attacks his vehicle, at high speed, against a shopping center, to end his life, managing, unfortunately, to cut off the life of some innocent citizens, but leaving him, paradoxically, alive. Let us suppose, just for a moment, that this fact, as happens in those American States in which the commission of a crime that admits the death penalty, is judged by a Tribunal, after a peremptory judicial process, to face the death penalty that must be fulfilled by the administration of a lethal substance, the same as the patient requested the doctor to whom he visited primarily. Suppose also, that the doctor who worked in the shift from 7 am to 1 pm in the local Public Hospital, works in the afternoon shift (1 pm to 7 pm) in the prison regime, and it is that same doctor who has to administer to the patient, now the convicted prisoner, same patient in terminal phase who saw in his hospital consultation, the same lethal substance that was voluntarily requested by his patient, with the same final objective: to end his life. Finally fulfilling the order of the Judge administers it and the patient dies. In this case the doctor, administering the same lethal solution, and ending the life of the patient, is not prosecuted, is not imprisoned, is completely free: there is no illegality, there is (as called in Legal Doctrine) a cause for justification.

The same medical truth, before two different legal truths. There is the conflict. Medical truth teaches us that we are in the presence of an act, for some, at odds with professional ethics and the fundamental principles of Medicine. The legal truth for its part does not show any sanction neither against the Judge who dictates the measure nor against the medical executioner who executes it or that he presence and authorizes.

Truth, according to DRAE (Spanish Royal Academy Dictionary) (Latin verîtas-âtis) is a concept that includes several meanings. According to the school of Greek scholastic philosophy and realism, it means a conformity of the thought with the thing or of the things with the concept that of them forms the mind; there is always an adaptation, an adequation, of what is said with what one feels or thinks. In pure modern idealism, the concept of truth entails a systematic coherence, a conformity of thought with its laws. If we touch the physical laws we could say that it correlates with the property that has a thing of always staying the same without any mutation. Logic, on the other hand, defines truth as one of the possible

values of any proposition since the concepts are not true or false, but exemplified or not. It could be a judgment or proposition that cannot be denied rationally.
With it, it is intended to ensure the certainty or reality of a thing. But if this assurance is understood within a judicial process, especially civil, but does not exclude the criminal, we are then presented with the verification of the facts and allegations through probation, and we are led to think about the existence of a true truth and a procedural truth, despite the fact that one of the guiding principles of the judicial process is that judges must have the truth as his north and final objective.

Finally, we come to the *busilis* of the question we raise. The existence of these truths or different ways of dealing with the search for truth does not prevent us from presenting the dual approach of the same reality or what figuratively speaking, which caricature, I present as the confrontation of these two truths that interest us: the medical truth and legal (juridical) truth. Hence the relevance that is configured to deal with the issue of the Right to Die with Dignity because, as I will explain later, we are presented with different approaches to the same reality, and it is not the same to treat the issue of euthanasia from the medical point of view than from the legal criterion; nor will it ever be the same to present it from the prism of the scientific-juridical doctrines to the reality and actuality that the patient must face in the loneliness of his illness.

In this way we understand that there are two truths to consider within the professional medical practice, and social, human, in general, and in this issue of euthanasia in particular: medical truth and legal truth, not always being possible their coexistence, such as we recognize that not always what is fair is legal, nor what is legal has always to be just.

This confrontation of the medical truth and the legal truth that I have presented from the simple alternative of a behavior assumed by a patient and materialized in the death of the same medical form with two (2) different legal solutions are aggravated when we consider that in the discussion not only ethical or deontological factors or principles of the professional practice of Medicine intervene, together with the juridical criteria, that within the orthodox and /or contemporary currents of the Penal Law, can be appreciated, but also necessarily appear in the analysis and consideration of the subject treated a series of criteria and beliefs of philosophical, moral, religious, behavioral, which, corresponding immanently to each person in particular, aggravate the complex situation in the consideration of the legal good protected by the State, which is life and health, and that inexorably make more complex the situation at the time of achieving reconciliation of all these different positions in the achievement of an alternative solution for who ultimately must make their own decision: the patient.

I am fully convinced that the natural law must be developed from its ethical foundation towards a positive law, under the ideals of freedom, love, understanding, tolerance, which allows us, outside of all interests, to be materialist, to reconcile the rights of people in general, and of the terminal patient, not necessarily in terminal phase in particular, with the rights and obligations of those who, initially inspired by principles of justice and assurance of life, can finally understand that, above all, their obligation of reverence for life by attending terminally

ill patients will not be able to collide with their fundamental obligation to alleviate human suffering.

On the other hand, in obedience to the fundamental principle of beneficence, which has been erroneously imposed on us in a mythological way, as the first thing is to do well when the health professional is primarily called to help, and with this it could not be excluded to help the patient in his terminal life process.

Thus, medical truth and legal truth become complicated in their existence before the myths that, for hundreds of years, have existed for the training of health personnel who have tried to hide that the conscientious objection, before a certain procedure diagnostic or therapeutic, appears as a frontal clash against the concept of a modern state that proclaims itself neutral from the moral point of view and that must renounce all external inspiration by accepting to mold its legal system at the beginning of a universally accepted ethics. But what seems to be a truth of the State for this universality, could not be totally true for the other universality, peaceful and orderly society, which considers as necessary, legitimate and justified for it (society), the alternative possibility of its objection of conscience before the alleged neutrality of the State, thus finally imposing the recognition of the proper value of the dignity and quality of life itself and that must prevail over the very personal motivations of doctrinal, religious and moral order, of those who, from the strength of its position, merely conjunctural in the legislative commissions, pretend to bow to supposed duties of protecting particular interest, thus violating another of the fundamental principles of human being, as it is the dignity, the autonomy and free will, as the free development of the personality , freedom of religion and cults, also subject to the obligation of the State to protect who, even in a minority and vulnerable manner, belong to groups of agnostics or non-religious.

Evoking the master Louis Pasteur: "*Medicine, obeying the laws of humanity will always work in the enlargement of the frontiers of life*". That is why regardless of what is relevant to the law, the protection and compliance with a certain legal duty regarding the protection of life, Medicine cannot easily determine if that imperative of protection derives from an act of faith or from a personal conception of life. The myth of the existence of frontiers in the professional exercise of health must be destroyed and therefore also be destroyed the myth that the limiting principles obey to supposedly moral, deontological, or religious concepts of those who, precisely, are not the direct beneficiaries of the exercise of the right that pretend to be limited.

Medical truth and legal truth, as dual points of contradiction, in the manifestation of value -being to be- must be materialized in its expression of -being- in a third point that evidently is constituted by all those values that, without being conceived our right to object, they constitute the foundations of the existence of the one who requests the benefit and the protection of the doctor and the lawyer and who is not more than the patient, who, without disrespectful restrictions and other ethical or religious beliefs, seeks the exercise, when facing an determined undignified situation, exercise their autonomy of will, self-determination, conscientious objection, personal integrity, free development of the personality, unequivocal right to a maximum expression of health, *ergo*, to a fully developed quality of life.

These truths should help us to understand that human life, as a good legally protected and supervised by the State, cannot be understood, exclusively, from only one of the aspects of Law itself applied by the State through positive norms of a -*ius puniendi*- that bends the goodness of life itself when trying, from criteria, always feasibly to reform, and of exaggeratedly particular criteria to try to disrupt the axiological primacy that, indisputably, must be established as the fundamental pillar of the consecration of the patient's rights.

I understand and accept that, *ab initio*, the State must protect the legal rights of individuals, including health and life; but in the understanding that, currently and for us in the country according to article 83 of the Constitution of the Bolivarian Republic of Venezuela, health is constituted as a fundamental social right and that the State must guarantee it as part of the right (immanent, inherent) of life itself; therefore, *ad pédem litterae*, I understand that, from our constitutional point of view, the right to life can no longer be separated from the right to health in the acceptance that these protected legal rights are now inexpugnably linked, so that every patient in terminal phase, and every person in general, have the right to life, translated, therefore, as the right to a quality and dignity of life, and that cannot be restricted or limited by very particular interests of those who, without updated foundation, they intend to limit legislatively the right of people to express themselves in this regard.

As I will explain, later in this essay, there is a clear contradiction, public and notorious, between the values expressed by individuals belonging to a particularly defined social group (community of secular apostolic religious) apparently prone to the acceptance of positive legislation in euthanasia when they are individually considered as compared to the negative reality when the opinion of the Church as an institution is asked. In the same way, we will demonstrate that in many countries the general criterion of individuals that is prone to the premise discussed is contradicted and suffocated by the opinion of the leaders of the public administration in that State who genuflect before political interests or pressures of the religious institutions believe otherwise to the universality of their administrated abolishing, illegitimately and unjustly, the feeling of the majority that expresses its particular adherence to the legislative amendment towards a positive criterion that allows, at least, the possibility of choosing between one and the other alternatives, in the full exercise of its competence and development of autonomy of will and self-determination.

The Biomedical Sciences defined as Medicine, Biology and other related sciences that have as object of study the life and the health of the human being, as much as they allow to explain, the first, in its origin and in its end as they affect in any phase of the natural process of both, they should project their development in the expansion in the application of the advances that allow the professionals of the Medicine to be able to act within scientific and restrictive criteria as much in the processes of beginning of the life as in the final process of the same and remembering that denying, as I deny, the existence of any right to scientific research and clinical practice, and even less accept that such a pretended right may prevail over the individual right of life and health of people, especially in the so-called therapeutic cruelty (dysthanasia), it must be ensured that the law operates under favorable conditions to offer legitimately adequate responses to the realities and actualities that present themselves to us in contemporary life and in the face of the progressive progressivity of human rights.

I will explain, later, that the constitutional right of life is presented to us as a guarantee principle of the State for the purposes that, even though I depart from the norm of expected behavior of society and commit a crime, I might be sanctioned with any penalty to exception of any penalty that is imposed on life itself, (death penalty) and not as it was intended to be built as a myth that, in this analysis we also destroy, the right to life would hypothetically translate into an obligation to live, regardless of the quality and dignity of life itself as it has been tried to believe until now. To all effect and event, I adhere to the constitutional principle that stipulates that the enunciation of the rights and guarantees contained in the current constitution and in the international instruments on Human Rights should not be interpreted as denial of others that, being inherent to the person, do not appear expressly in them (article 22 of the Constitution of Bolivarian Republic of Venezuela)

This principle of progressiveness in the protection of some Human Rights not expressly stated in our Constitution, in correspondence with international conventions in this matter, introduces us to the true path of what I expressed as a fundamental premise in previous paragraphs when expressing that the right to life it can no longer be treated in an isolated and independent way to the right to health and, on the contrary, the progressive criterion of acceptance is imposed that these legal rights supervised and protected by the State include, as an immanent factor and the essence itself of them, the right to quality of life and human dignity as inseparable components of the preliminary mentioned rights that give rise to it.

It is evident that the conscientious objection gradually extends as a guideline of behavior that makes necessary an effort of coexistence of rights in order to find the balanced term. I understand and accept, of course, that the interest of the State in preserving the life and health of its citizens must correspond to the interest of maintaining the ethical integrity of the professional practice of health, whose purpose is to procure the health of those who entrust themselves to their watch out; but in the same way I understand and accept that the jurisprudential *praxis* and the development of the principle of conscientious objection to medical treatments is not only feasible for the patient who rejects treatment in the presence of a terminal illness, or the right of the order of not resuscitation, or the legitimate objection of conscience to receive blood transfusions in religious groups that do not accept it but, by extension, I must also understand and accept the right of people who, in full use of their competence and autonomy of will and self-determination, choose the path of a final life process that they consider worthy and humanly acceptable.

We realize then that there are indisputable principles that make our medical truth and legal truth an extremely complex field that needs deep reflection and analysis, but that at no time could we accept that such considerations could be affected by ethical, deontological, scientific criteria, legal, religious, private universes that do not always correspond to the universality of citizens who, even dispersed throughout the countries of the world, are closely linked in bonds commonly determined by their acceptance of a life and health project whose axiological principles of valuation it corresponds to them exclusively because they could not be affected or restricted by the particular interests of the former.

The medical truth and the legal truth are still faced in the judicial stages and, what seems even more complex, these truths unfold in turn in the actualities and realities of the people and professionals who exercise the different points of interpretation of the mentioned truths.

CAPÍTULO II

DIGNITY

Ramón Sampedro Cameán (January 5, 1943 - January 12, 1998), quadriplegic from the age of 25, incapacitated, paralyzed from his neck down, permanently in a bed, after many attempts and judicial denials in his just struggle, he asked, to the Judges, political and religious authorities: "What is dignity for you?"

The question of Ramón Sampedro, who had remained tetraplegic for about 29 years, 4 months, and some days, is constituted, in the central foundation of this debate, taking into consideration the dignity, ontological, from the conception (from the Latin: dignitas) as a quality of worthy, valuable, excellence, merit, honor, respect for itself, and makes, precisely, reference to that inherent, immanent, value of the human being, not for having earned it or quality that has been granted for others, but simply for the fact of being human.
Human dignity is a value and right immanent to the human being based on the respect and honor that a person has over himself, and of which he is worthy. That dignity is nothing more than the quality of being worthy, deserving, valuable. It is not about how dignified, or how much honor I deserve according to other people or how other people consider me; it is an immaterial quality of the human being, as a fundamental right, innate, inviolable, intangible, and inalienable, simply, among other things, by its rationality and creative power. It is an intrinsic value that does not depend on external factors.
This immanent value of the human being is, without any doubt, a fundamental, intangible, inalienable, non-negotiable, non-conditioned and non-limiting human right; because it is the human being a rational being endowed with freedom and creative power. It is ultimately an ontological dignity with which all humans are born.
And that dignity must be respected, so much so that, despite its long history, it has already been recognized, since the Second World War with the Universal Declaration of Human Rights, approved in 1948, and of which two articles forcefully call us to reflection: Article 1 stipulates that *all human beings are born free and equal in dignity* ... (*omissis*); and Article 5 (of human dignity): *No one shall be subjected to torture, or to cruel, inhuman or degrading treatment or punishment*. And within these cruel, inhuman and degrading treatment must be included, precisely, to force a person to live, under the beliefs of others, regardless of the opprobrious conditions of their existence. The right to life cannot be reduced to mere subsistence but implies living adequately in conditions of dignity.

Nothing so cruel as to force a person to subsist in the midst of shameful suffering, in the name of beliefs of others, so an immense majority of the population deems them intangible. I will talk about this later.

Rights that are repeated in other International Agreements, and from which the State's duty to protect life is deduced and, consequently, must be compatible with respect for human dignity and the free development of personality.

Thus, it is easy to infer that from this human dignity, as Fundamental Right, and considering the human being as a rational and creative being, that there is an elemental triad of his being: rationality, free will, and autonomy of will.

The paradigm of the new doctor-patient relationship, desired for this millennium, which is built on the fundamental pillars of the reformist and progressive bases of human rights, allows us, in the same way, to advance in the understanding of a fundamental fact: the collapse of one of the major myths, which is the abhorrent, detestable, unwanted model addressed as a vertical model of the doctor-patient relationship, paternalistic, protectionist, limiting, from which the health professional have acted (¿and keeps acting?), over-insurance of his actions and decisions and without caring, with full conviction, which is the patient's thought and decision because this model of relationship works from the decision making on the part of the doctor who thinks that he is the owner of the right of selection of what to him, in his opinion, considers the best and most appropriate diagnostic and / or therapeutic, palliative or curative procedure, for his patient and no matters how important, in reality this doctor should be, ultimately, the one who make their vocation of service, with the most sacred of the commitments, that is the relief of the human suffering, as it remembers the Oath of Luis Razzetti when being established, of this form, in the immanent principles of the Code of Medical Deontology (Venezuela) that in its initial paragraphs obliges us: "*My reverence for life alongside patients will not collide with the fundamental obligation to alleviate human suffering*," . and without that we should understand, exclusively, physical suffering, as the only objective, not always fulfilled, of palliative medicine, because we know that analgesics, whichever they might be, could, at some point, not always, palliate (cover-disguise) the suffering or physical pain more would never alleviate the inner suffering in the dignity of the human person.

The human dignity contains subjective elements, which correspond to the conviction that the particular conditions of life allow to achieve happiness and objective elements, linked to the living conditions that the person has to obtain it. This being the case, Human Dignity was determined as a fundamental human right. Fundamental rights are those inherent to the human being, which belong to every person because of their dignity, *ergo*, are inalienable, intangible, non-negotiable.

Human dignity is within each person's being; I said earlier that it is an inherent, immanent quality of the human being that allows the free development of his personality. In this triad of rationality, free will, and autonomy of will, other elements that strengthen this fundamental right are combined: the free development of their personality, the objection of conscience, which reveal that creative power and rationality that is proper to being human.

But this fundamental value, that honor, merit, fundamental human right, must not be isolated and constitutes an expression of the utmost respect and value that must be granted to the human being by virtue of his human condition that stands as a principle of the values of autonomy, security, equality and freedom. I could base, without fear of being mistaken, that

human dignity is the fundamental primary value from which the other values of the human being are raised. It is an attribute of a rational being, with creative power, and autonomy of will, denoting, thus, an end and not merely a means. Thus, it is the human dignity from which the other values and rights of the human being are built and born.

This dignity of the human being is recognized to all persons and constitutes a primary and fundamental obligation of each State to protect it. Hence, without going into detail of comparative legislation, we can affirm that most of Constitutions of countries declare human dignity as the primary function of the State and that it not only declares it, but is its main defender.
As expressed this way by the Sentence C-239 of May of 1997 of the Constitutional Court of Colombia, and criterion reiterated more recently in the Constitution of the City of Mexico (February 5, 2017), the fundamental right to live in a dignified manner implies, then, the right to die with dignity, because to condemn a person to prolong for a time, even scarce, their existence, when they do not want it and suffer deep afflictions, is equivalent not only to a cruel, inhuman and degrading treatment, but to an annulment of his dignity and his autonomy as a moral subject. The person would be reduced to an instrument for the preservation of life as an abstract value.
Exemplary the new Constitution of Mexico City (promulgated February 5, 2017) by including, in its article 3 that: "*Human dignity is the supreme governing principle and support of human rights* ... (*omissis*)", and then, specifically recognizes, in its article 6-A-1 and 2: 1. "*Everyone has the right to self-determination and the free development of a personality*. 2. *This fundamental human right must enable all people to fully exercise their abilities to live with dignity.* ***The dignified life contains implicitly the right to a dignified death*** ". (bold and underlined by the Author).

However, I must clarify, very contrary to the international trend during the last 17 years, that dignity of living, as a fundamental, original, human right, is autonomous, not dependent, without being able to be conditioned in any way because it would lose, then, all its essence. And so, I express it because the general belief is to affirm that I must be in a terminal illness, in terminal phase, under opprobrious, unworthy, unbearable sufferings, so that I may be allowed, then, to declare my will to a dignified death. Already, that person, in those conditions, has lost its essence of value, of deserving, of honor, of dignity. It seems to be understood that this fundamental right, immanent of the human being, would be respected only if there was some external element that modified it: a terminal illness and unworthy suffering.

I avoid commenting on real, historical, specific cases, because in doing so I could, involuntarily, fail to mention any of those that have already happened. And for me, everyone is important and exemplary. However, and I will comment later in this Work, some emblematic cases that, due to their characteristics, are worth referring to.

This Chapter begins with Ramón Sampedro's question regarding dignity. There is a great example: more than 29 years of unworthy life, according to his personal criteria, reasoning, autonomous, seeking the dignified death that, only after so much suffering, he managed to achieve. Or perhaps the case of Dianne Pretty, who suffered from amyotrophic lateral

sclerosis, paralyzing neurological disease that would make her face an unworthy death by suffocation in a conscious state, by paralysis of the respiratory muscles, made her look in all possible Courts, including the one of Human Rights in Europe, so that her husband, when the time came, and not before, could help her to ingest the solution that would put an end to her life whenever she, paralyzed, could not do it by herself, needing the help of her husband but who did not wish, for his help, that the State sanctioned him for homicide or induction to suicide. Regrettably, what she wanted to avoid could not be and she had to face, not only an unworthy life, but also an unworthy death, barely two weeks after the last negative sentence of the Strasbourg Human Rights Tribunal, facing, a death by asphyxia, by respiratory paralysis, still being conscious.

Convinced I am, and so I defend it, that, if the right to a dignified life implies the right to a dignified death, I do not have to wait to suffer from unworthy and disgraceful terminal conditions, with unbearable pains, and other so many unmentionable ailments, but that could, with dignity, in use of that reasoning, of that creative power, of that autonomy of will, of that inherent dignity immanent to my being, power, precisely, to anticipate the predictable facts and decide how long I could live, with dignity. Case example of Brittany Maynard, who suffered from brain cancer (astrocytoma grade II) and who had already undergone surgery and received all kinds of treatment. However, the tumor continued to progress, becoming an astrocytoma IV, practically a Glioblastoma, and with enough information, timely, truthful, impartial, clear and precise of its doctors about the irreversibility of their conditions, she decided, before entering in undesirable neurological conditions expected and unworthy, end her life. She made a detailed list of things to do before her death, which she fulfilled in the company of her husband, her parents, and finally, on November 1, 2014, at the age of 29, she voluntarily put an end to her life, without waiting for the appearance of those terrible conditions that our society requires us to present in order to qualify for a dignified death.
With simplicity, she expressed in her last message on Facebook: "*Goodbye to all my dear friends and family who love me, today is the day I have chosen to die with dignity in view of my terminal illness, this terrible brain cancer that has taken a lot from me ... but that would have taken a lot more* "
And dignity, precisely, is about that: to live with dignity and die with dignity, according to one's own conviction. Nothing so cruel as to force a person to subsist in the midst of shameful suffering, in the name of beliefs of others, so an immense majority of the population deems them intangible.

Express masterfully Günther Jakobs, in his work “Suicide, Euthanasia and Criminal Law” (Tirant lo Blanchu, Alternativa Collection, 1st Edition, Valencia, 1999): "*the main value is not life itself as a biological phenomenon but its quality…*"

And it is precisely that quality of life, as understood by oneself, personally, and not based on the beliefs of others, which allow me to decide and make my own decision. This was stated by the Constitutional Court of Colombia in its ruling C-239 of 1997, when it held that even though life is necessary for the enjoyment of other rights, the same applies to human dignity. Without it, without dignity, life is hardly guaranteed because, says the Constitutional Court: "***life can not be reduced to mere subsistence, but implies living properly in conditions of dignity***"(bold and underlined by the Author).

In the understanding of our current horizontal model of doctor-patient relationship, in which two subjects of rights, protected and under tutelage by law, put into play the most beautiful and sacred gift, or condition, inherent, immanent, of the human being , which is the autonomy of will and self-determination, cannot accept another mention or particularity that I am, as a patient, as a person, as a human being, who must, according to my determinations, and based on the whole, timely, truthful, fair, impartial information that the doctor must offer me, who must make decisions at a particular time in which, according to my own convictions, and knowing that there is no longer dignity in living, power then, with the help of the professional of the health, following the modern technique, use of drugs and medicines (thesis that I defend) or by third parties, who can help me in the supply of these drugs, end the process of life, and understanding that any of them is not helping me **to** die but helping **in** dying.

It is alleged, contrary to the Right to Dignified Death, that the right to life is absolute, and supersedes any other right. Absolutist thesis that I really do not share and is enough, a mere analysis, to demonstrate the lack of certainty of such an assertion.

On the one hand, I refer to the universal criterion contained in Article 4, numeral 1, of the American Convention on Human Rights, approved in San José de Costa Rica and in force since November 1969, and which states, with precision, that: "*Everyone has the right to have their life respected. This right will be protected by law and, in general, from the moment of conception. No one can be deprived of life arbitrarily*."

In accordance with the general principles of Law, the legal norm should be interpreted and understood by attributing to it the evident meaning of the proper significance of words, according to the connection between them, and especially, taking into account the intention of the legislator.
Based on this principle could easily, contradict, the absolutist character that is intended to give the right to life. If the intention of the legislator had been so absolutist and radical in defending the right to life, simply would have written and declaring the right to life, and then, there, putting a final point and moving to the next article. But it has not been that way.

The above mentioned Human Rights Convention uses only a numeral, the first one, of that article 4, to defend the right to life, but immediately after, it devotes from numeral 2 and up to 6 (inclusive), that is, five numerals, in which it accepts, validates and conditions the death penalty.
If the intention of the "representatives" of Human Rights had wished to consider the absolutist thesis of the right to life, they would never have spent five numerals in accepting and validating the death penalty. Simply put all people have the right to life and point (and separate).
In the same way, the right to life is not absolutist nor superior to other rights. Frequently, a true sophism is alleged, that if life does not exist, other rights would not exist. The Constitutional Court of Colombia, in Judgment T-970/142 of December 15, 2014, and ratifying judgment C-239 of May 20, 1997, stated, with clear clarity: "*The Constitution not only protects life but also other rights. That's why none of them is absolute. Each constitutional guarantee must be seen in concrete because depending on the particular circumstances of the cases, its restriction will be greater or lesser**. In the case of life, for***

example, the Court, from its inception, considered that it is possible to limit it to safeguard other rights, especially the free development of personality and personal autonomy. " (bold and underlined by the Author). Criteria that, personally, I share fully.

That is why I have always maintained that, although it is true in most of the Constitutions of States, it is consecrated (relatively as I explained) that the right to life is inviolable and understood as a guarantee that the State owes me. As a matter of fact, the constitutional right of life is presented to us as a guarantee principle of the State for the purposes that, even when I depart from the norm of expected behavior of the society and commit an offense, I am sanctioned with any penalty except for no penalty imposed on life itself, (death penalty) and not as it was intended to build as a myth that, in this analysis we also destroy, the right to life would, hypothetically, translate into an obligation to live, without import the quality and dignity of life itself as it has been tried to believe until now.

To all effect and event, I adhere to our constitutional principle (Article 22) which stipulates that the enunciation of rights and guarantees contained in the current constitution and international instruments on Human Rights should not be understood as a denial of others that, being inherent in the person, do not appear expressly in them.
That is why, the constitutional principle of the right to life should be understood as a guarantee of the State, not being able to impose the death penalty despite incurring in crime.

But, from there to think, or admit by erroneous or manipulated interpretation, that another person, outside of me, can exercise in my name, against my will, without faculty, mandate or power, a right that is not theirs and force me to live, in whatever the conditions of the moment, is legally and humanly unacceptable. The right to live cannot be translated into the obligation to live, and less because of beliefs or beliefs outside of me.

In this way we can understand, finally, that in life, what matters is its quality, and in that quality and circumstance becomes the honor, merit, esteem, consideration, of each person; that is to say, its dignity, and on top of it, no other criteria can be imposed to force another to "live", to endure, insufferable, and disgraceful conditions. Life is necessary for the enjoyment of other rights, the same happens with human dignity. Without it, life is hardly guaranteed because life cannot be reduced to mere subsistence but implies living adequately in conditions of dignity.

Understood dignity as a fundamental element of this subject, being a condition, fundamental human right of the human being, inherent and immanent to it, remains, only for the moment, to notice a conceptual deviation, general, on this important issue.
Perhaps, by the time of its enactment, the countries that originally enacted permissive laws of euthanasia, and perhaps, by facilitating such legal enactment, imposed the condition, exclusive, that only those persons with terminal illness, terminally ill, and with undoubted and unbearable suffering, they could opt for euthanasia as an exercise of their right to die with dignity. I understand that this position has been like that and I am glad that, at least, that type of patients described there could then, more than 15 years ago, opt, legally, for something that, until that moment, could never be possible.

However, currently, in those same countries, as in others, the right of other people to opt for a dignified death at an opportune time in their lives is due. And I refer to two types of people different from that terminal patient, terminally ill, with unbearable suffering. To be brief, it is enough, only, to refer to the exemplary case of Brittany Maynard. With a terminal illness, cancer in the brain, surgically treated and properly treated, the disease progressed enough to make her understand that, at any moment her life would change, and that, inevitably, she would enter the phase of uncontrollable, unworthy, disgraceful suffering, and perhaps with loss of mental faculties that prevented her from rejecting extraordinary measures of artificial maintenance of life, and that, consequently, in exercise of her right, she could then, with dignity, put an end to her life process and avoid everything of which we have been talking.

And, this being the case, it is prudent and necessary to remember what happened when in Colombia, after the referred sentence of 2014, the doctors wanted to express their opinion and decide, according to their conviction, that the moment of great suffering of the patient who opted for euthanasia had not still arrived, and as a result they would not apply euthanasia to the patient who requested it. The patient had to appeal again to the Court and the opinion, sentence, was clear and forceful:

> *"The requirement that the illness cause intense suffering to the patient* ***should not be limited to a medical criterion****, since this would clash" with the very idea of autonomy and freedom of the people "; and thus, "it will be* ***the patient's will that determines how unworthy the suffering is***." (bold and underlined by the Author).

It is easy to understand, especially for doctors, and specifically for those who work in intensive care units, that in these terminal patients is born, in them, in health professionals, an altruistic feeling that leads them to share that suffering and leads them, then, to try to help avoid, without verifiable results, the opprobrious conditions of those patients, and especially those referred to pain, which, as I expressed earlier, could, perhaps, avoid or diminish physical pain, but never the suffering from the collapse of the personal dignity of the patient whom they are trying to help. That compassion moves them to try, with drugs and medicines, not only to try to diminish the physical pain, but also to silence, cover or palliate, the human suffering through the elimination of conscience, with drugs and sedatives, to avoid manifestation of the patient regarding his right to a dignified death. And that will be my criticism of the radical defense that attempts to make of palliative medicine that, even with its approved reasoning of being, and its humanistic origin and objective, and without denying the help that, in some cases, can be obtained, are not nevertheless the answer for those who wish to die with dignity but that, in their moment and locality there is no other legal possibility that allows them to finish dying and to avoid those unbearable sufferings of which I have been talking. Very well, palliative medicine for those who do not believe in the Right to Die with Dignity. I respect the belief of each one. But what about those who believe in dignified death and the full exercise of autonomy of will and self-determination?

But beyond the terminal patient, in the terminal phase, with unbearable suffering, who lives in opprobrious conditions; and beyond the patient who, for personal reasons, of any kind and always respectable, does not believe or share our reasoning in a dignified death and prefers, if he can choose to live those conditions and those sufferings and accept, perhaps, even for lack of information and perhaps without a legitimately declared consent, in the use of

sedatives that prevent it from manifesting and even the use and progressive increase of powerful analgesics knowing that the final result is, precisely, the shortening of the life period, beyond In these cases, I ask: What happens to those who, when they reach a point in their lives, perhaps of a long age, who simply survive every day, and whom one can see in those hospices, or geriatric, or home, or in their homes, and see their bodily attitude and facial expression, and talk to them (if at all possible) and listen to their fatigue and a life without reason ?. People who, because of their age or condition, and who have already fulfilled their achievements and goals, have developed their families, and descendants, but they become a problem for their relatives and they, there, waiting for each day to come, by itself, the final outcome. What happens to them?

I can think of people of advanced age, almost totally disabled by their own old age, in need of help to eat, for their personal hygiene (frequent for their incontinence), to change clothes, to wander, sitting there, lonely, with a look vague and sad, with nothing to do, and perhaps hear in their own words the disenchantment and unhappiness of being there "vegetating" and waiting for that desired, but unspeakable, outcome. The same face, facial expression and body that I have seen in nursing homes where, as a deposit of disposable items, people bring their family members who, personally, cannot give the care they need and those who only wait for the end of the process lifetime. How many years of unworthy life could be avoided if doctors, jurists, bioethicists, politicians, people in general, could understand the need to pass enough legislation to be able to offer an alternative that, without forcing anyone, could offer an alternative for those who do? We believe in the dignity of life and in our right to autonomy of will and self-determination and who, in our beliefs, could decide our final moment and not have to endure disgraceful, undesirable conditions, unworthy of the beliefs of third parties, alien to our will?

Clearly and forcefully it was exposed by the Constitutional Court of Colombia in its judgment 239 of 1997 and ratified in sentence 970 of 2014,: "***The right to die with dignity is a fundamental right***". This is what the Court said in Judgment C-239 of 1997, when it stated that "***the fundamental right to live in a dignified manner implies the right to die with dignity***, *since it condemns a person to prolong his existence for a short time, when he does not desire and suffers deep afflictions, it is not only a cruel and inhuman treatment, prohibited by the Charter (CP Article 12), but also an* ***annulment of his dignity and autonomy as a moral subject*** ". *This guarantee consists of two basic aspects: on the one hand,* ***human dignity and, on the other, individual autonomy***. *In effect,* ***human dignity is the essential presupposition of the human being that allows him to reason about what is right or not, but it is also essential for the enjoyment of the right to life***. "(Bold and underlined by the Author).

Same criterion expressed and stipulated in the new Constitution of Mexico City (promulgated February 5, 2017) by including, in its article 3 that Human dignity is the supreme governing principle and support of human rights ... (omissis), and then, specifically recognizes, in its articles 6-A-1 and 2: 1. Everyone has the right to self-determination and the free development of a personality. 2. This fundamental human right must enable all people to fully exercise their abilities to live with dignity. The dignified life implicitly contains the right to a dignified death. (bold and underlined by the Author).

In this way, we can not only affirm today that the Right to Die with Dignity is a fundamental human right and that the dignity of the human being is an autonomous right, as I explained in this Chapter, it is an immanent value of the human being for the simple fact of being, endowed with freedom, rationality of being, and autonomy of will or free will.

These rights accompany the human being from its formation, and through all its development; because nowhere is it required that to have dignity one must have certain age. Dignity is a fundamental human right, inalienable, irreducible, inalienable, and valued at all times, and I insist at this time on these particularities because all those inherent characteristics of the being of which I have been mentioning belong equally to children and adolescents. Hence, we have countries such as the Netherlands that, since it passed its law, included all ages; and that the same modifications, with subtle variations but equal considerations approved in Belgium for Infant Euthanasia in 2014 and recently (2018) in Colombia, Today this consideration is taken into account and quite explanatory is the case of the girl Hanna Jones, of thirteen years, and of which I will comment in a later chapter, and which has awakened the need to be able to graduate the degree of discernment of these children and adolescents; to guarantee that the child is able to form a judgment of his own, to exercise his right to express his opinion in all matters that affect him taking into account his maturity.

CHAPTER III
AUTONOMY OF WILL

As a complement to the right of life, and the dignity of the human being, immanent quality of the human being, endowed with rationality, free will and autonomy of will, we must consider some correlative principles, many of them embodied in various constitutions of countries; as also in most of comparative legislation, and which are complementary support of the right to live a dignified and full life. The fundamental pillar of this described model of doctor-patient relationship, of a horizontal, dynamic, participatory nature, stands on the principle of self-determination and autonomy of will. Each person must be able to make their own decisions, regarding their health and life project; but for that, it needs the health professional to comply with his constitutional obligation to inform his patient, fully, timely and truthfully.

The autonomy of the person, of the patient in particular, as a legally protected good, arises, naturally, from the recognition of their dignity as a human being, and all that dignity entails, including reasoning, free will and autonomy of will. From there, ontologically, it is easy to understand that the autonomy of will, along with that free will, belong as qualities of the dignity of the human being and which was overshadowed, for a long time, by that aberrant vertical model of the medical relationship -patient, in which, the doctor (quasi god) took for himself, what, in his opinion, he considered to be his best decisions, for his patient. Unheard part and regardless of the opinion of his patient. (Still, today, we see examples of this undesirable vertical model of doctor-patient relationship)

This aberrant model should not exist anymore, we do not want it anymore, and nowadays we are putting into practice a horizontal model of doctor-patient relationship through which two subjects of rights, protected and under tutelage by Law, put into play the most beautiful of the human being since it arrives and that is the principle of autonomy of will and self-determination. It is the patient who must decide on his life project, his health project. And this capacity for self-determination imposes the extension of the obligation of the doctor, and of the health personnel, to inform, in a timely manner, fully, truthfully, impartially, in terms understandable to their development, in order that the patient may, in their free will, essential component of their dignity, make their own decisions.

This horizontal model should be the prevailing one today, with more human characteristics than the previous deceased vertical, patronizing and protectionist model. And although, that capacity for decision is born from the ontological and the dignity of the human being, today we see it translated into a series of legal norms that are imposed in the different legislations recognizing that right to be informed of the patient so that it is him, the patient, and not the doctor, who makes the necessary decisions in his existence.

Obviously, to fully develop this exercise of self-determination and autonomy of will, the professional of medicine and health, in general, must comply with its constitutional

obligation to inform, in a timely, truthful and impartial manner (Article 58 of the Constitution of the Bolivarian Republic of Venezuela) to his patient so that, this, the patient, can make the most favorable decisions for the achievement of his life project, attending, as we explained previously, to the quality of life and the dignity of the very existence.

Legally, and without this being the subject of this Work, the legal nature of the doctor-patient relationship is generally recognized as a contractual obligation, called the Medical Assistance Contract, and obeys positive substantive rules of law, in terms of the civil and the general character of the obligations. Precisely, a contractual obligation is nothing more than a convention, a consent, between two people to constitute, modify, regulate, transmit, extinguish between them a legal link through which, if in our bilateral case, both parties commit themselves to the performance of giving, doing or not doing. Then the other rules related to the contractual obligations applied to this Medical Assistance Contract are explained, in the legal aspect, that we will not deal with here because of the very nature of the central theme, but that, obviously, they are recognized at international level with all their responsibilities and consequences.

However, we cannot fail to mention that, universally, these principles have been recognized at the constitutional level. Hence, in comparative universal legislation we find the common determinant factor of recognizing, to the human being, the person, some rights in relation to the autonomy of will and self-determination.

I must support myself in Venezuelan legislation and from there it will be easy for anyone to seek equivalence in their own laws.
Such precepts are conjugated of the agreement of the constitutional principles of physical integrity (article 46, numeral 3 of the Constitution of the Bolivarian Republic of Venezuela), by means of which *nobody will be able to be subjected to clinical or biological examinations without his consent*; so I must understand that if to achieve a diagnosis, *ergo*, an appropriate treatment, I must practice clinical and paraclinical test and these (examinations) cannot be practiced without the express consent of the person, no one can indicate medical treatments to any person who has not obtained legitimate declared consent.

For its part, the right to free development of personality (article 20, ejusdem), and the right to timely, truthful and impartial information (article 58, ejusdem), which are fully informed by the doctor's obligation, are enshrined. respect the will of the patient when he decides to refuse medical, diagnostic or therapeutic procedures (article 25, number 2 of the Law on the Exercise of Medicine), in accordance with articles 72, numeral 3, 4 and 8 of the Code of Medical Ethics, with regard to information, informed consent and the right to exercise autonomy of will and self-determination; of the Organic Law of Health, in its article 69; and other substantive laws,
Special and general legal norms, which are not relevant at this time comment, are, however, suitable to validate the principles discussed above.

In such a way that there is no doubt as to the existence of constitutional and legal foundations that validate the patient's autonomy of will and self-determination. Legal Right that only gets a limitation on the so-called principle of damage, by which, this right, of autonomy of will and self-determination, cannot be abrogated by society except when it comes to safeguard

public order or health. But, in this sense, it is essential to explain now that, in the jurisprudence of our Supreme Court of Justice, this limitation of public health does not influence in any way the particular, individual decision that a patient makes in relation to his / her own health, when this decision does not affect the interests of third parties, in the sense that it does not correspond to an illness or decision that can be limited by means of the protection of collective or diffuse interests.

That is, society can abrogate the right of autonomy of will and self-determination of a person, only, when it comes to diseases of mandatory reporting, epidemic, contagious, in which the State imposes the protection of the legal interest of third parties, collective or diffuse form, to protect the legally under tutelage good of its particulars: health and life. But in the case of a particular decision in a disease that does not affect the collective, does not even affect the health of the family environment, or of the health professionals who attend it, this limitation could not be invoked to the exercise of autonomy of will and self-determination. That is why, in analyzing the situation, it seems that the only limitation that attempts to impose on self-determination is based on values or moral or religious principles, which, again, I must insist, are relative, not being able to accept that the moral criterion, that belongs to the internal forum of each human being, can prevail over the interest of a community that thinks and feels that such moral or ethical value cannot be detrimental to the full exercise of its own self-determination.

But, in greater abundance, these defined principles are intertwined with many other principles that are legitimately invoked by believers in euthanasia. From our Constitution, as well as from many international conventions on the rights of people, other rights are inferred that, real and unequivocally, must be understood in the general context of the problem that concerns us. Only through the collective and interrelated interpretation of all these principles can we reach convincing conclusions.

The criterion of conscientious objection is imposed on us, as a fundamental principle. Objection of conscience manifested, in its moment, by the person that defends its right to a dignified life and to dispose, according to its own autonomy, the moment in which, under the restrictive rigor of the norm, having to continue exercising that right or not to a dignified and integral life. But conscientious objection also expressed at the time by the health professional who does not agree with the ideas of his patient and has the full right to decline their care and continue their relationship with the patient, without this meaning a statement of status of abandonment, also sanctioned by the special law.

Similarly, health rights, quality of life, comprehensive medical care, access to services, freedom of religion and religion, protection of privacy, honor, privacy, confidentiality and reputation, work, respect to human dignity, the equalization of opportunities are informed, in extenso, in special substantive norms that contemplate with more specificity other rights and values.

From some of them we can give an account of the right of people, as stipulated in Article 69 of the current Organic Law of Health (Venezuela):

a) respect for their dignity,
b) without being discriminated against for any reason,

c) to receive an explanation in understandable terms, regarding your health and treatment of your illness, so that you can give your informed consent;
d) refuse extraordinary measures to extend his life, when he finds himself in irrecoverable vital conditions duly verified in the light of current medical science knowledge.

With greater specificity, in article 82 of the Code of Medical Ethics (Venezuela): "*the terminally ill patient should not be subjected to the application of vital support measures derived from technology, which will only serve to prolong the agony and not for the preservation of life.* " The neglect of this desire can be considered as a violation of the rights of the patient to die in peace.

The patient with a terminal illness has the right to be informed of his condition (Article 77, ejusdem) and being mentally competent has the right to participate in decisions concerning his condition, being able to refuse any diagnostic or therapeutic procedure and its determination must be respected by the doctor, although it collides with what is considered to be the best (article 78, ejusdem).

When I have participated as an exhibitor in this topic, I always highlight the double standard with which some professionals, especially health professionals, debate. They say they do not accept the Right to Die with Dignity; that is, they do not agree with euthanasia. However, they accept, validate and are bound by Article 83 of the Code of Medical Ethics, (mandatory compliance), whose clear mandate of the rule we appreciate: "*When a terminally ill patient suffers pain* (I wonder: Which do not present it?) *the doctor* ***must*** (bold and underlined by the Author: it does not say "may" but "must", so an obligation imposed on the doctor is inferred) *sponsor the use of analgesics in sufficient doses in order to alleviate human suffering. On occasions when it is feared that with the progressive increase of powerful analgesics* (morphine type, remifentanil, or similar) *the vital process can be shortened by the depression of the nerve centers that regulate respiration, it should proceed giving priority to the objective of analgesia as the primary effect sought, over the eventual undesirable effect*. (end of quotation)"

In other words, they say they do not accept euthanasia, but they seem to induce it through the use of potent analgesics, with the excuse, or hidden behind the mantle of impunity, from the principle of beneficence and non-maleficence of bioethicists, and I ask: (although I do not agree with the terms) is this not an involuntary euthanasia? Is not this an indirect euthanasia? Are we not in clear euthanasia? Here, it seems, do not care about the dignity, the autonomy of the will, of the human being, patient, whom they should treat. However, saying that they do not agree with the right to die with dignity, or with euthanasia, they send it to practice, in terms used in general, with the use of drugs and analgesics whose "secondary" characteristics are severe cardiovascular depression. they produce, and send them to use these analgesics and opioids, although they shorten the vital period. And worse yet. With awareness of this, also supported by the use of large sedatives that are, synergistically, cardio-respiratory depressants. But here they say they are protected because they use these drugs only because of their primary analgesic effect for the patient and not because of their (final and safe) effect

of producing death in them, used, as is required in the norm: in progressively more powerful doses.

Given the capacity of the person, emerges, therefore, the duty of the doctor to respect this decision, not trying any maneuver of resuscitation even in case of cardiac, respiratory or cerebral arrest, not being able to impute to the resuscitating doctor any legal or civil responsibility, or criminal, for the behavior assumed in respect of the patient's full will. Which leads us to the consideration of another of the fundamental principles and rights of people, which is the refusal to resuscitation maneuvers, in those cases in which the competent patient, before a terminal illness, can request the medical body that in the event of a cardiorespiratory arrest, resuscitation maneuvers should not be carried out. This order is the known DNR or no resuscitation order (Do Not Resuscitate).

However, understanding and accepting the non-resuscitation order (DNR) for verifiably terminal cases, and hospitalized patients, is less complicated than when the same guideline comes from an ordinary human being, not ill at that time and who, thinking in advance and considering the figures regarding the likelihood of brain recovery *ad integrum*, you want that in the event of a cardiorespiratory arrest you do not practice the resuscitation maneuvers.

In many countries there are a series of legal norms that regulate the so-called advanced guidelines, including the DNR (Do Not Resuscitate) order; they must be fulfilled within a series of limitations and requirements such as: written policies and rules of procedure in case of advanced guidelines, complete and written information on patient's rights that must be given to the patient upon admission to the hospital, inclusion of the document content of the guideline in the patient's medical history and the assurance that treatment and hospital care will not depend on the inclusion or not of such guidelines.

All these guidelines allow the patient to exercise their rights as regards life and death, be duly informed and grant their valid consent when they are still competent and legally able to do so; allows medical planning in advance, also allows to die with dignity exercising the right to death of each human person, limiting the resuscitation maneuvers in the understanding that they are not applicable in all cases, knowing that, even with immediate assistance, statistical percentages of adequate brain recovery are against the patient.

From all the above we can infer that the current trend of the legislator in health matters is to act in coordination with the parameters established in international legislations and to recognize, not declaring or granting, people's rights, specifically related to the principle of self-determination and autonomy of will.

There is a clear and obvious dissociation between the modernity intentions of health legislation and those contained in the positive criminal legislation, which remains excessively restrictive in this area.

In extension of these principles we recognize the existence of the right of people to establish advanced manifestations of will, which in the same way are accepted legitimate, lawful and legally valid, for purposes such as the generic donation of organs in the matter of transplants,

disposition of body by cremation; and others, must also be legitimately valid for the purpose of deciding to exercise the right of self-determination and autonomy of will embodied in a document that contains advanced orders that include: the non-resuscitation, the non-application of extraordinary measures of artificial life support, especially in cases of proven and evident irreversibility of unfavorable conditions. And there are even advanced manifestations of will for the unlimited administration of opioid analgesics, even if it means death; as well as widely accepted manifestations for interruption of automatic ventilation equipment in cases of decerebration. We think that in the same way it will be time to accept valid, legitimate and legally viable, the possibility of manifesting, in advance, the acceptance of euthanasia procedures in those cases in which there is evidence of irreversibility of brain damage and the patient remains, because of illness or accident, deprived of his mental competence to freely make such a decision.

This manifestation of will, as the right of the people, is known as LIVING WILL, or Advance Manifestation of Will, legislated in some countries, and is not more than a document that authorizes not to keep a person depending on Medical devices without which I would soon die. It is a document in which a person, physically and legally competent, declares that, in the event of suffering irreparable damage to their health, they want it not to be kept artificially alive.

We have then, by concept, that a manifestation of will of this type includes, in its nature:
a) A manifestation of will
b) From a person demonstrably capable, physically and legally.
c) That it contains a desire or mandate that, at the moment when that person cannot decide for himself, the right to die with dignity is respected, that there is no so-called therapeutic cruelty, and that he does not continue to administer drugs or medication or you are kept alive with ventilatory equipment or similar.
d) It must be documented.
e) The document so that it is valid *erga omnes* must be authenticated.
f) Must include witnesses.
g) It is directed, fundamentally but not exclusively, to doctors, because any relative or other third party who comes to know of its existence, can assert it.
h) Sometimes an executor can be appointed to be entrusted with enforcing it.
i) It must be known to be effective. Therefore, the person must give a certified copy to at least the executor, a family member or a trusted doctor.

As a manifestation of the will of a competent person, in the exercise of their autonomy of will and self-determination, they must be respected. However, being a right of the person, it may be that the doctor in question does not agree, in which case you must notify immediately to the family members, who can arrange for another doctor to attend and decide accordingly.

In my opinion, the difference between accepting euthanasia and living will is very close. I have previously stated that I do not share and consider sterile that subtle differentiation between active and passive euthanasia, direct and indirect, voluntary and involuntary, because, ultimately, it is about accepting, deep inside, without pettiness, without hypocrisy, that every person at birth if something has been won is his right to die, and die well, with

dignity, without anyone can impose a therapeutic cruelty and force him to live even against his will, regardless of the conditions in which he is.

Then the "living will", or advance manifestation of will in life for my death, is a valid document that must be respected. There is included, fundamentally and generally, the disposition to not be administered drugs, medicines, or mechanical support that keep me alive when its non-use means death; but it must, in my opinion, equally respect the right that I have to say that, in case of suffering a terminally, irreversibly, and that means for me great suffering, physical or moral agony, I will be given analgesics and sedatives in sufficient doses that allow me to surrender myself to my Creator in peace, without pain, with dignity.

But in the same way as we defend the right of people to the exercise of their autonomy of will and self-determination, we must also be clear that, in the exercise of their rights, any doctor or nurse, like any other person, has the constitutional right to manifest their conscientious objection; that is why, freely, any doctor, nurse, or similar could refuse to comply with this manifestation of will; without this being detrimental to the observation of the patient, who should be sought, if possible, a substitute professional who understands the advanced manifestation of will. Norvie Lay, a law professor at the University of Louisville, Kentucky, explains that any doctor, nurse, staff member, employee of any public or private hospital or any health care institution, declares in writing to the hospital any objection to comply with the terms of advanced orders because of moral, religious or professional reasons will not be required to comply with the terms of that agreement or living will. No one shall be legally responsible for such refusal, provided that it proves that it has complied with the requirements regarding the notification and transfer of the patient.

In the United States of America, the State protects both sides of the Living Will or the advance manifestation of will; nor can it be held responsible, nor take legal, disciplinary, labor or administrative actions to health personnel who do not wish to comply with the directive, as long as it complies with the requirements of notification to the patient (if possible), relatives and authorities hospitable nor may they suffer any type of sanction or criminal prosecution, criminal sanction or civil claim, those doctors or auxiliary personnel who, in obedience to the mandate of the living will or the order of advance, suspend some medical treatment or do not provide mechanical support for artificially maintain the life of the patient.

We understand then that the right to life implies a concept of living, which in turn translates into the principle of the right to a quality of life that involves a holistic concept of health (environmental, family, personal, labor, biodiversity, etc.). .) that cannot, in turn, be separated from the right to life by establishing the constitutional principle, that health is a fundamental social right that the State must guarantee as an integral part of the right to life, and from which it is inferred a series of fundamental principles (integrity, free development of the personality, conscientious objection, privacy, honor, quality of life, etc.) that shape a new paradigm in the doctor-patient relationship. This reality obliges us to review the myths, until now extended in an exaggerated and exclusive cult of life, in abstract, without considering the full rights of people and establishing new realities that we need to discuss openly, without restrictions or imposed limitations by particular minorities who, for their reasons, always

respected, try to impose an insurmountable barrier to the right to express opinions and decide on their own lives.

Everything explained above is not only valid when dealing with adult patients. Children and adolescents have also been recognized subjects of rights. Since the appearance of the Convention on the Rights of the Child, signed in the OEA (Organización de Estados Americanos), in 1990, the States Parties are ordered to legislate on this special subject. Thus, in our country, and other countries of the continent, the ORGANIC LAW FOR THE PROTECTION OF CHILDREN AND ADOLESCENTS appears, and in them we find the same principles of which we have been commenting.

That is, Article 8 establishes the "best interests of children and adolescents" and this principle seeks to ensure the integral development and protection and full and effective enjoyment of their rights and guarantees. One of them is precisely the right of children and adolescents to receive information about their state of health in terms understandable to their development (Article 43), and in frank conjunction with their right to be heard, to express their opinions, that they must be taken into account in accordance with their development; and all this complemented (Article 32) with the right to personal, physical, psychological, moral integrity, not being able, in principle, to be forced to diagnostic or therapeutic procedures that could be interpreted as cruel, inhuman or degrading treatment.

All of the above leads us to the consideration of what is currently taking place at the international level and is the measurement of the "capacity of discernment" of that child, in terms of medical treatment.

The typical case is that of the girl Hanna Jones, of British origin, 13 years old, (2008) and who has suffered from a leukemia disease since she was 5 years old. To stop the cancer, she underwent an extensive and intense chemotherapy cure and later ended up causing a hole in the heart. Last year they implanted a pacemaker, but his heart cannot stand it anymore. The only solution was to undergo a heart transplant. The intervention did not guarantee her life. Within 10 years, motivated to its growth, it would have to be transplanted again and, meanwhile, the medicines that would have to supply it to avoid a rejection of the new organ threaten to rekindle the leukemia.
Hannah had stated that she did not want the heart transplant. She preferred to risk continuing as she was then and resign herself to dying at home, in Marden, in the west of England, surrounded by her family, until the time comes. Her parents supported her and assure that they have hardly influenced her decision. The girl has shown an extraordinary maturity and temper and has been resisting the pressure of doctors for months. Forced treatments are not exceptional. They are carried out, for example, when the parents of a child object to it for religious reasons. But in this case, it is the patient herself who opposes, and not for religious reasons but appealing to her own dignity. The case was brought to court. A court social worker interviewed Hannah Jones alone and concluded that the girl was fully informed of the consequences of her decision and that she had sufficient maturity and insight to decide for herself. The obligation was fulfilled to guarantee that the child was able to form her own judgment, the right to express her opinion in all the matters that affect him, taking into account her age and maturity. She made her decision not to have surgery. Finally, at age 14, she reversed her decision and consented to the operation, from which it was possible to affirm

that, initially everything came out, "apparently good"; but it is very strange that no more new information has appeared in all these years that confirm this.
But, the important thing to note is that, even a girl of 13 years, exercised their right to information, to be taken into account, cataloged their ability to discern the court accepted their decision. At all times his dignity was above any interest or desire of others or third parties. And that has been the important thing.

For our part, and returning to the double standard, although it is true our Code of Medical Ethics does not approve euthanasia in adults, the opinion is different in children and stipulates Article 62 of the Code in mention: "*If the child's condition is To such an extent that the treatment will cause precarious prolongation of the life of a being with profound mental or physical deterioration, the parents must be informed of their* ***authority to suppress the consent for the treatment and of their authority to demand the doctor's suspension of the has started****".* (bold and underlined by the Author).

CHAPTER IV

CORRELATIVE PRINCIPLES

I have maintained, since the beginning of this Work, that the guiding principle of this theme is based on the dignity of the human being; ontological consideration, from the conception (of the Latin: dignitas) as a quality of worthy, valuable, excellence, merit, honor, respect for itself, and makes, precisely, reference to that inherent, immanent value of the human being, not because of it earned or quality that has been granted, but simply for the fact of being human. It is, consequently, an immanent, inherent right, a quality that is given to him by being human without expecting anyone to grant him, give him, this condition and obey, according to his translation, and origin, honor, merit, value.
Human dignity is a value and right immanent to the human being based on the respect and honor that a person has over himself, and of which he is worthy.
This immanent value of the human being is, without any doubt, a fundamental, intangible, inalienable, non-negotiable, non-limiting and non-limiting human right; because it is the human being a rational being endowed with freedom and creative power. It is ultimately an ontological dignity with which all humans are born.

Then we propose the Principle of Autonomy of Will and self-determination. Value, condition and right that accompanies in the fundamental triad: dignity, reason (creative power) and autonomy of will. Right, otherwise determinant, of our current horizontal model of the doctor-patient relationship, which, as I explained, is no more than a convention or consent between two people: doctor (health professional in general) and patient for the purposes to constitute, train, regulate, including a legal link. That is why, today, it would be impossible to deny the legal nature of the doctor-patient relationship as a merely contractual obligation, defined and regulated by positive rules of law contained in the Civil Code, of any country, and to whom, the professor Arturo Ricardo Yungano, due to its complexity, its own nuances, special and essential characteristics, certain contents, he proposed a name, in the International Medical Congress, in Buenos Aires, 1979, as a Medical Assistance Contract. We are not interested in entering into the legal nature of this doctor-patient relationship as a contractual obligation, but I must make it perfectly clear that our current horizontal model works, mainly, because of that double characteristic: for a prate the doctor's obligation (health personnel) to inform about the diagnostic and/or therapeutic procedures to be performed, so that the patient can be the one who can, according to their own beliefs, convictions, determinations, according to their health project, make their own decisions; that is, exercise their right to autonomy of will and self-determination, with limited exceptions, as was already mentioned, such as in the case of public health matters.

But it is important to understand that, although these principles are fundamental pillars on which rests the Right to Die with Dignity, it is no less true that, according to International Conventions, and regulations of the Law, in each country, there are other regulatory correlative principles that reinforce the first two and sustain, among all of them, that decision that would correspond, personally, to each one, with respect to the life process, its quality

and, especially, its finalization; within, of course, limiting factors that each country that has been approving for euthanasia, and that can impose for the purpose of its realization.

It is important to note, at this time, that, unlike other constitutions, ours in its article 22 expressly mentions: "*the enunciation of the rights and guarantees contained in this Constitution and in the international instruments on human rights should not be understood as denial of others that, being inherent to the human person, do not appear expressly in it"*. The lack of statutory law of these rights does not impair the exercise of them. That is, considering the Right to Die with Dignity as a fundamental human right, and based on the progressiveness of human rights, it should not necessarily be written in it so that, being inherent in the human person, and in the absence of regulatory law, can be denied or impaired its exercise.

I will mention, fundamentally, the guiding principles of our Constitution of the Bolivarian Republic of Venezuela, and from there it will be easy for each reader, to look for the equivalents in their own regulations.

The principle of physical, mental and moral integrity is reported from the Universal Declaration of Human Rights (UN) in its articles 3 and 5, through articles 4, numeral 1, and article 5, numerals 1 and 2, of the Convention American Human Rights Organization (OEA), where we find what has been explained about the right to life, human dignity, and the prohibition, as a result, of cruel, inhuman or demeaning treatment. In our Constitution, we not only achieve as a principle the right to life (Article 43) and the dignity and prohibition of cruel, inhuman or degrading treatment, (article 46, enunciation and numeral 1) but also, in an innovation way, perhaps not seen in other constitutions, article 83 (ejusdem) stipulates that health is a fundamental right that will be guaranteed as an integral part of the right to life.
That is, we could not speak, in an exclusive way, of the right to life, because the Constitution enshrines the right to health as a fundamental right inherent in the right to life, which is why it can easily be understood, as we already know, as raised an earlier chapter, that life is not enough as a biological phenomenon in itself, but its quality. And this right to health, inherent, immanent to the right to life, is not a mere good state of wellbeing in the physical, but also in the mental, biological, social, work, family, environment, family, peace, wellness, etc.

We are interested in considering these correlative principles and we could advance criteria on a particularly important one, which is freedom of religion and freedom of worship (article 59). Having this freedom or constitutional right to freedom of worship and religion is why no one can force me to live under the religious beliefs of others; regardless of the opprobrious conditions and suffering that the person is presenting.
That is why, for example, I accept and validate it is the manifestation of the will of religious groups that do not accept blood transfusions based on their interpretation and belief, faith, and biblical principles. I have always said that, for a person to leave their house and entertainment on a Saturday and go door to door, regardless of the disrespectful treatment they usually receive, to bring you a spiritual message, and to be able to die based on their religious beliefs, it is a fact that, in particular, I respect a lot.

The principle of the free development of the personality (article 20), fundamental right of the human being that confers the possibility of him, autonomously, to plan his project of life. Therefore, the right to the free development of the personality is located in the fundamental rights whose object has the particularity of protecting a vital sphere of the individual, that is, the construction of his plan or vital project, and intimately related to the fundamental right of human dignity. The essential core of this right protects the general freedom of action, closely linked to the principle of human dignity. It is the person himself who defines, without interference from others, the meaning of his own existence and the meaning he attributes to life and the universe, because such determinations are the very basis of what it means to be a human person, and hence his intimate relationship with human dignity.

If we consider that the right to the free development of personality provides the necessary substrate for each subject to display their individuality, their unique characteristics, having as a limit the right that others have to do the same, we would not be if not insisting on the principle of Kant's universal freedom: "*works externally in such a way that the free use of your will can coexist with the freedom of each according to a universal law*".
We live, convinced I am, within the universal principle of Kant. According to this, I have a power of reason, creative power, faculty, freedom, autonomy of will and decision, which I can exercise fully, as long as it does not affect the discretion or the rights of others: it is the principle of universal freedom; and in accordance with this I can conclude that I have the right, the discretion, to die with dignity, according to my own convictions and beliefs, since my discretion, my capacity for decision, my autonomy, can, in fact, coexist with the discretion of others.
In other words, in the free development of the personality, the autonomy of will, I could exercise my customs and rights as long as it does not affect the rights of others. "*An action is in accordance with law when it allows, or whose maximum allows, the freedom of the discretion of each one to coexist with the freedom of all according to a universal law*".
This would imply that if there is a resistance to my freedom it generates a grievance to me, because such resistance could not constitute a maxim according to a universal law. This means that I cannot adopt as a maxim of my action that resistance that inhibits the freedom of others, the essential thing is that it does not harm the freedom of others with my external action.

But our correlative principles do not end there. We find, functionally coherent, the principle of conscientious objection, by which we all have the right to freedom of conscience and to manifest it. (Article 60, ejusdem).
Here I must make a reservation. It has been argued that I can raise conscientious objection (in this case, state the end of my life) as long as it does not prevent others from exercising their rights. This is what the Constitution says. But there comes the wrong, sophistical interpretation. It is argued that the fact of posing, in my conditions, the end of my life "would prevent" the exercise of the right of the doctor to "save" lives.
There is no such right. If perhaps we study the Code of Medical Deontology (of obligatory fulfillment for every doctor) in its article 67 it stipulates that the doctor can exercise the right of free choice of his patients, except in the case of emergency or urgency, or when one of his patient call to his care, or that there is no other doctor in the locality. Precisely, if I ask the doctor that, as a terminal patient, he does not use extraordinary measures of life, I am not

preventing his right; On the contrary, I place it in the opportunity to decide, freely, not to attend to me. I do not prevent the exercise of your rights.

For its part, the Law on the Exercise of Medicine (article 28) gives the doctor the opportunity not to be obliged to use extraordinary measures of life when dealing with terminally ill patients. And it is imposed even the obligation of the doctor to respect this principle and legal norm. Thus, I do believe that there is an extensive interpretation, beyond what the legislator wanted, when trying to argue that my decision as a patient not to stay alive "prevents" the doctor "exercise their rights."
We are granted the criterion of conscientious objection as a fundamental principle. Objection of conscience manifested, in its moment, by the person that defends its right to a dignified life and to dispose, according to its own autonomy, the moment in which, under the restrictive rigor of the norm, having to continue exercising that right or not to a dignified and integral life. But conscientious objection also expressed at the time by the health professional who does not agree with the ideas of his patient and has the full right to decline their care and continue their relationship with the patient, without this meaning a statement of status of abandonment, also sanctioned by the special law. In fact, we already notice the civilian character that the doctor-patient relationship is a contractual obligation that is based, by definition, on consensus, on the conformity of wills. Similarly, health rights, quality of life, comprehensive medical care, access to services, freedom of religion and worship, protection of privacy, honor, privacy, confidentiality and reputation, work, respect to human dignity, the equalization of opportunities, they are informed, *in extenso*, in special substantive norms that contemplate with more specificity other rights and values.

From some of them we can give an account about the right of people, as stipulated in article 69 of the current Organic Health Law:
a) respect for their dignity,
b) without being discriminated against for any reason,
c) the right to receive explanations in understandable terms regarding their health and treatment of their illness, so that they can give their informed consent;
d) the right to refuse extraordinary measures to prolong his life when he finds himself in irrecoverable vital conditions duly verified in the light of current medical science knowledge.

Even, Article 78 of the Code of Medical Ethics recognizes the right to patients, in terminal conditions, to be able to refuse any diagnostic and/or therapeutic procedure and its determination must be respected by the doctor, although it collides with what he considers the best. Supplementary articles 79 and 82 (*ejusdem*) to establish the obligation of the doctor to help your patient to face death with dignity without submitting to the application of life support measures that would only serve to prolong their agony and not for the preservation of the lifetime.

We already mentioned the principle of physical, mental and moral integrity, contained in Article 5, paragraph 1 of the American Convention on Human Rights, but we insist on paragraph 2 of that same Convention when it prohibits cruel, inhuman and degrading treatment, in concordance with article 5 of the Universal Declaration of Human Rights. Reference that only helps me describe the right of the dying patient, terminal patient in terminal phase, who is in special conditions and that under no circumstances may the doctor

impose inhuman, cruel or degrading treatment with the excuse of fulfilling his "right" to save his life

So things, I understand a complexity of values, principles, fundamental rights, inherent in my person or each of them, immanent human being, emerging from the very dignity of being, simply for that reason, for being, that make me analyze, think, meditate, and consequently accept that, being all of them my fundamental rights as a human being, no one can, or should, abrogate those rights and make me live, under disgraceful conditions, by other people's beliefs, and force myself to go through undesirable suffering, not only physical but also spiritual, instead of accepting a legislative alternative that allows us, to those who so desire, to exercise our Right to Die with Dignity, at the moment in which, according to our own convictions, we decide it.

CHAPTER V
TERMINAL PATIENT? TIRED OF LIVING?

It becomes easier for us to understand this topic when we consider, and that is the image that each one has in his mind when reading these lines, of a hospitalized patient, with a terminal, incurable disease, who is in terminal phase, irreversible, and perhaps, in some Intensive Care Unit, full of tubes: respiratory for ventilation, venoclysis, parenteral feeding, central lines, dialysis, etc., prostrate in a bed, practically immobile, who must be mobilized every so often to avoid eschar, doing his cleaning and cleaning the patient every time it is necessary, and the thought is inevitable: Until when?
Here, it seems that there is not so much problem and the feeling of empathy, towards that patient, is present there, in an active way, called "compassion", which leads us, dynamically, to feel pain, and pain from others, and forces us to think. In what way could we help? We pray for patience, because it is the only thing that we would not accept another alternative, except that of "palliate", cover, silence, mask, drugs and medicines, and again: wait!

Reasoning, *in extenso*, this principle of dignity, and prohibition of cruel, inhuman or degrading treatment, should also include, precisely, the right, based on all the correlatives enunciated in the previous Chapter, of the patient who, knowing that he has an illness terminal, not yet in terminal phase, does not wish, precisely, to enter into opprobrious, unworthy conditions of suffering, and wishes to take, his free decision, and anticipate that cruel and inhuman moment of suffering.

I consider it unfair to impose an obligation to live under the premise of the right to life when the objective and subjective conditions of this right are frankly depleted, to the detriment, and in the irreversible phase of loss; and therefore I think it is wrong when we say that the place of the debate on euthanasia is the legal one, par excellence or exclusivity, when at stake are other factors of a human nature that are extremely important and where Medical Law, as such, is much more pragmatic, without wearing out in endless and sterile doctrinal semantic discussions, hermeneutics, teleological, on the factors to be considered and discussed from the prism of the study of crime.

I stated earlier that I avoid using names of particular cases because it seems unfair that, with so many cases known or not, worldwide, one can select one and involuntarily let others, in silence, and they are also so important because, ultimately, all have been participants in the same experiences. But not for that reason I can omit, voluntarily, some of them who can here serve me as an example.

Diane Pretty, (November 15, 1958-11 May 2002) to whom I dedicated my previous book EUTHANASIA: MYTHS AND REALITIES (2003) suffered from Amyotrophic Lateral Sclerosis, which gradually paralyzed her. She was not that she wanted to die at that initial moment of her illness, but she knew and feared that the day would come, in which her respiratory

muscles would be paralyzed, and she would have to face an opprobrious death by asphyxia but aware of it. She always fought, first in the British courts so that, when the time came, her husband could give her what she needed to die at once. She needed him because she was paralyzed and alone could not do it. Evidently, under the prevailing laws, her husband would be imprisoned. And even the Human Rights Courts in Strasbourg went to stop with her case. Fifteen days after hearing the refusal of the court she had to face what she feared so much. A death by suffocation but with a conscious condition. I wonder: Could it be that she could not have avoided the indignity and suffering of that horrible moment? Will the judges have awareness and conscience that, again and again, denied Dianne the possibility of a dignified death? How would they feel now? Would they feel something of thinking about it?
Brian, her husband, said: *Dianne must have suffered what she most feared death by suffocation and nothing I could do to help her*. She finally died in an English sanatorium, two days after entering a coma, as a result of respiratory problems and with intense pain. The scene of death seems to clear up any doubt about the possible intervention of the husband, who had always declared himself willing to fulfill his wife's wish. She was an extraordinary woman who was surprised by her humanity and courage in the face of the adversity of unbearable suffering.

But ... I must stop for a moment ... Obviously, until now, we have kept in mind the photograph, the image, of the terminal patient, in terminal phase, full of tubes, artificial support of life, pain, etc. At this moment, perhaps, and only perhaps, it is more reasonable to think on what it has failed with the dignified death that the patient could have had, and perhaps, some might justify, the fearsome "therapeutic cruelty" and accept that this patient the doctors and their science give everything that they learned in their medical practice.

But what about the terminal patient, who has not yet reached the terminal stage? What happens with that patient, with a terminal illness, not yet in terminal phase, that is, does not comply with the legislation in the matter, but hopes that, at any moment, he loses his abilities, and /or initiates what science expected from him: suffering? What happened in the case of Dianne Pretty? And many other cases ...!
Is it possible that we cannot prevent and respect that dignity and its correlatives that we have discussed and take, in time, decisions that, after all, are not ours, but the patient who exercises their autonomy of will and self-determination?

Compare the case of Pretty with that of Brittany Maynard (November 19, 1984 - November 1, 2014). This young woman suffered from brain cancer. Astrocytoma II. Very evil because of its location and evolution. She, a lover of life, had all the treatments that medical science recommended, including a surgical intervention (partial craniotomy and a partial resection of her temporal lobe).
However, the cancer progressed to Astrocytoma IV, practically a Glioblastoma, and the doctors gave very short survival time. Brittany, after meditating a lot, thought about her right to die with dignity and did not wait for the moment in which, because of her brain conditions, nothing could be done and then the unwanted “Via Crucis” would begin. She was already symptomatic. She decided, then, her final day. She completed a series of things with her husband and parents, before her farewell and on November 1, 2014, as she had announced

earlier, she wrote on Facebook: "*Goodbye to all my dear friends and family who love me. Today is the day I have chosen to die with dignity in view of my terminal illness, this terrible brain cancer that has taken a lot from me ... but that would have taken much more* "

As the two previous cases, there are many others. The common denominator factor, except for cases like Brittany's, is that she was able to make her own decision and carry it out without waiting for a life of very poor quality, unworthy, full of suffering, and in which, nobody, nor palliative medicine, would have offered her a better alternative. Her dignity would have been lost by the time brain cancer began to make its way. There and the, she could have done nothing. However, she could, unlike many others, make her own decision, in time, and prevent all unworthy suffering.
Despite everything, the decision was not easy. She had to move to a State within the USA that would allow her to do what she planned. See with doctors. Obtain certifications Invest money and buy pills.
Any of those who have read so many books, from so many authors, experienced and knowledgeable in the matter, if anything we have is the fear that these pills or the patient fail during the course of the process and is not achieved with the planned objective or at least, not in the easy way that was planned. Or that during the process to reach the final day the inevitable happens and all the effort made is lost and the indignity of life begins.

Medical science, and it is not up to me to detach it here, has the ways and how to make it a simple, painless, fast and effective procedure.

But ... I stop again ... and another thought comes to me ... ..as it has reached so many others worldwide.

So far, I have talked about the terminal patient, in the terminal phase, and then only talk about the terminal patient. However, and it is already happening in other countries, what to do with these people, that I mentioned in the previous chapter, of advanced age, almost totally disabled by their own old age, that are left alone because even the couple of their whole life have lost it , needing help for everything: food, constant toilet for their incontinence, change of clothes, ambulation, etc., who cannot do anything else but sit in a chair for long hours, with a vague, distant look, feeling that their life was full, and that he had already realized all his goals and obligations, but now, disabled, old, lonely, with nothing to do, not even his personal hygiene, and thinking that each new day is one more day of his agonizing wait for the inevitable death that, at any moment, would arrive?

From there, I cannot but, being sincere, objective, to fulfill the purpose of this work: to inform. I wonder: Is it worth living this way of life, if you want to call it, without any other perspective in your life? Or on the contrary: Would it not be more dignified to be able to exercise his immanent fundamental right as a human being, his autonomy of will, when his reasoning is told: now! It's all right, I do not want anything else! And then exercise your Right to Die with Dignity rather than please third parties in their beliefs and continue to "live" the indignity and pain, not physical, but also spiritual, human? Many times, almost always, turned into mere burden for family members?
Now, at the time of writing, we know about the case of David Goodall, an Australian scientist, botanist, ecologist, with three doctorates, who has traveled to Switzerland, at 104 years of

age, to put an end to long and satisfactory life but whose current conditions are no longer the same. In his own words expresses: "*... my quality of life has deteriorated ... I want to finish with respect and dignity ... no longer scared that someone turns 80 or 90 years old, what worries is the quality of life that these elders should carry ... To what extent can society intervene in imposing values of the quality of life of an individual? ...* "
Today (May 10, 2018) his definitive death was announced in Switzerland, when, at his will, the lethal substance that the doctors prescribed was administered, and thus put an end to his life, and surprised the world with some comments before his death: "*... At my age, I wake up in the morning. I eat the breakfast. And then I sit down until lunchtime. Then I have a little lunch and I just sit down. What is the purpose of that? ... Until the age of 90 years I was enjoying life, but not now. Life has passed me by and I've done the best I can with that ... At my age, or less than my age, one wants to be free to choose death when death is an appropriate time ... I do not think anyone's choice is involved ... It's my own choice to end my life and I look forward to that ...* " (https://www.univision.com/noticias/suicidio-asistido/cual-es-el-proposito-de-vivir-asi-muere -in-Switzerland-the-scientist-of-104-years-that-opto-for-the-suicide-assisted).

The debate has already been opened, for some time, in the Netherlands. Holland, again, takes the baton in this issue. I must warn, as I will present later, that the statistics of this type of mental cases that go to the euthanasia are a very small percentage in relation to the majority as the cases of cancer. But anyway, we present the issue for the reader's consideration because it is no secret to anyone the existence of these painful cases without anyone paying attention, until now, when the debate opens, the discussion begins, and society should then take the reins to be able to decide whether or not to support this new situation that is currently considered.

A Dutch deputy, Frans Jozef van der Heijden, was 78 years old. He had more than 50 years with his wife, a lifetime, when she was diagnosed with a terminal illness. He, a very Catholic Dutch deputy, promised her before God to be with her in health and illness. And he kept his word. The disease progressed, and she decided to resort to euthanasia. Then, her husband decided to accompany her also on that last trip.
Before dying, they left a public letter explaining to all their decision to die together, despite having always been Catholics and very devout, according to the local press. "*The debate on a chosen life is still very much dominated by religious minorities, who benefit from the country's political weakness, one must be able to decide for himself when he wants to end his life*," the couple said in that letter.
In the letter, the couple also had a few words to talk about euthanasia and the Dutch health system. In his words they defend the freedom to choose to die when "people discover that their life has no meaning". They defend the right not to suffer so much if you are sick or healthy. (Taken from https://www.lainformacion.com/mundo/diputado-holandes-suicida-junto-terminal_0_966503770.html Published on October 27, 2016)

CHAPTER VI
OPPOSING MYTHOLOGY

In the analysis of two articles published in a newspaper in the capital city, dated January 24, 2001 and April 3, 2003, the sowing of a serious opinion matrix regarding the issue of euthanasia began. The first of the articles reported an interview with a former Minister of Health and Social Development, motivated by the delivery of the Reform Project of the Organic Health Law of the Presidential sub commission for the reform of the law and was delivered to the Health Subcommittee of the National Assembly. Within the 34 (one more, one less) articles discussed in relation to the reform project, the journalist took one that served as a major headline, in large letters, I think in red, and that said: "Euthanasia approved! "
The headline was placed in such a way by the journalist that it really provoked chills. Of all the articles that the former minister could have commented on the draft of new health law, each with its degree of importance, the only thing that seemed relevant, for her and/or for the environment in which she worked, was that great holder; media manipulation because no euthanasia was approved; it was only a draft of a new Organic Health Law, and only one of its articles certainly referred to euthanasia but the wording would have to be read to understand that what was intended (as I later learned) to create a negative matrix of opinion.
The following day two interviews were opened, one to a well-known Orthodox criminalist lawyer, a professor from the country, and the other to an orthodox doctor from the country. Both opined against the project, and their arguments are presented later in this same section, so I do not stop at this moment.
What is important to note is that in the following days was held in a well-known University of our capital an International Bioethics Seminar and the foreign guests interviewed who could say, to the same journalist, in favor of euthanasia, was not published (as to the two previous ones that were against that they left in front page to complete page), except for a couple of them that left in inner pages and exaggeratedly small squares. When I asked her personally to the social communicator, in the lobby of the Hotel Intercontinental del Lago, where I happened to meet her because of a Congress and be able to say hello, and in response to my question regarding the titles on the private journal she worked for, the answer was simple, short and blunt: she obeys the editorial line imposed!

Later, on the second date mentioned above, and in the same private newspaper, the same journalist, another striking headline was displayed: "Venezuelan doctors and lawyers divided on the issue of euthanasia." Another media manipulation as only three or four people were interviewed, all medical doctors except me as a lawyer, so talking about the division of Venezuelan professionals in relation to a topic, implying an overpopulated survey, was totally false.
However, this comment is propitious because it helps us to define what the different points of view in relation to this issue have been offered and those that are constituted, as I will demonstrate with figures later, as true myths that have been raised as an insurmountable barrier.

Let's see, then, which would be the main ones, although not only, derogatory allegations of euthanasia, and that are used against the acceptance of the Right to Die with Dignity, without the order of priority of their exposure having to do with the relevance or importance of the argument but, in the end, serve as guidance.

a) Legal Rule: prohibition of the law.

The orthodox criminal professor was of the opinion that euthanasia was totally unacceptable because the legal norm (Penal Code) prohibited it. Argument, *quid divinum*, which denies any possibility of debating the issue because, plainly and simply, the legal norm forbids it. In my opinion, and unlike other countries, our Penal Code, of 1964 (with some very specific subsequent reforms in 2005) does not contain any rule in which the crime of Euthanasia, (wrongly called) Pietist Homicide, or similar, is typified, unless that it is desired to include within the qualified homicides (for futile reasons, or with treachery), induction to the suicide, or it is tried to place them in some other place. Existing yes, the type of homicide there will be taken into account for the sanction of the doctor and/or person who, in the current circumstances, causes the death of another person. The law was somewhat contradictory; reduced the penalty in cases of abortion when the mobile was the guard of the honor or the honor of wife, mother, descendant, sister or adopted daughter (repealed by special law in 2007); In the same way, the penalty was reduced (before repeal of the sanction in 2006, by the Constitutional Chamber of the Supreme Court of Justice) in cases of homicide in cases of adultery, but, nevertheless, homicide is aggravated when it is carried out for reasons futile, ignoble or using poison, when what is at issue is to avoid the suffering of a serious and irreversibly sick person when this one consents or requests it; and subject to the type of crime as induction to suicide.

Anyway, the argument is not entirely valid if we remember that the legal norm is not more than a norm of conduct, expressed in a logical grammatical order, that gathers the opinion of the necessity of a form of conduct, imposed on a community under its jurisdiction and for a period of time, also specific and determined. The legal norm stems from the *opinio neccesitatis* of that community and will change as many times as necessary to reform it considering the advances of the dynamic science and the equally changing criterion of the community that from that norm will be used as an expected model of behavior. Proof of this are the endless reforms of constitutions, laws, codes, resolutions, etc. Recall that our Criminal Code already belongs to the last century, having been born, originally, since 1863, its subsequent reforms, and final adoption of the Code of 2005, which lasts until today, subject to very specific reforms at the beginning of this century XXI .

That is to say: the argument that the law forbids it, as this "professor" argues, is vain and unfounded because, although it is true, there could currently be the type of the crime (which really does not exist) and its penalty, a mere reform of the Penal Code may decriminalize it, or another special law may repeals provisions contrary to it and solved the legal or juridical problem.

One of the most important aspects of these reforms, especially that which our National Constitution presents to us, is the inclusion of the defense of human rights, not only those of the first, second and third line or generation, but also those that, not yet expressly defined in the Constitution, whether they are understood as immanent rights of the human being, from its birth and even before its conception (Article 22).

The Constitution of the Bolivarian Republic of Venezuela expresses in its article 43 that the right to life is inviolable, and it will not be possible to impose the death penalty, nor any authority to apply it. We must analyze that a right, according to the legal thought of Kant, is the set of conditions by which the discretion of each can coexist with the discretion of others, according to the "universal law of freedom." According to this, as a human being, I have the discretion, faculty, freedom, autonomy of decision, to accept a resolution in preference to another. It is my right, then, to life. It is not, in the constitutional norm, another right but mine, my right to life; Of course, in the understanding that I must also respect the right of others to their decision or not to live; That is your right. What does, indeed, impose the constitutional rule is the restriction that no authority imposes a penalty, understood as punishment or punishment for unlawful conduct, to death; The State must guarantee, as a citizen, that no one can violate my right to life, and if I have departed from the norm of conduct expected by the legislator, I will be subject to any penalty, except death. That is the guarantee right imposed by the constitutional norm.

But from there, to think or admit, by erroneous or manipulated interpretation, that another person, third party outside of me, can exercise in my name, against my will, without faculty, mandate or power, a right that is not theirs and to force myself to live, in whatever the conditions of the moment, is legally and humanly unacceptable.

Lawyers who are still trying to interpret, wrongly, Medical Law, from the point of view of orthodox criminal law exclusively, maintain that euthanasia, as a legal norm contained in the draft Organic Health Law, is illegal because the Penal Code sanctions homicide and the induction to suicide. But, I ask myself, why not think, if perhaps the norm becomes necessary and is accepted by a community? The Health Law is the Organic Health Law and can easily repeal any specific provision related to it as it would be if the crime of euthanasia were to exist, complying with the general principle of Law: *Lex posterior derogat legi priori* (later law repeals previous law) .
The international legal community is prone, although fearful of this type of impositions, of favoring a right to a dignified, dignified and timely death. Well the solution is easy, and it is already announced. If perhaps the sanitary norm collides with the criminal one, because the penal norm is reformed, the euthanasia is decriminalized, and problem solved.

Then, the orthodox ethical of Medicine, who have not realized the evolution of it and that ethics, of other times, have given way to a new form of philosophy of thought that is bioethics and Functional Contemporary Ethics. They allege that the Code of Medical Ethics in its Article 84 establishes that it is not possible, under any circumstance, to deliberately cause the death of the patient even when he or his relatives request it.

Timely to remember that legally, strictly, this Code, even mandatory for doctors, is not a law product of a National Assembly as a collegial body, as mandated by the Constitution in the formation of laws, so that It could never be above the Organic Law of Health or any other special law that regulates euthanasia. But it should be noted, that the same Code that prohibits the euthanasia of adults seems to favor and allow the euthanasia of children, when in the light of Article 62 states that if the child's condition is such, that the treatment will cause the precarious prolongation of life, parents must be informed of the authority to suppress consent for treatment and require the doctor to suspend the already initiated. If euthanasia is active or passive, it is not the issue. Different semantics for the same problem.

However, it is worth mentioning that in 2004 the Code of Medical Ethics was reformed and now, they accept its euphemistic and badly called "indirect euthanasia". In its article 83, and in relation to the terminally ill, physicians are forced to resort to the use of potent analgesics (morphine type), in progressively higher doses, although this shortens the patient's life span.
The rule obliges. It does not say that the doctor "can" or “may” use potent analgesics. It says clearly: (quote) "*the doctor" **must** "sponsor the use of such potent analgesics in progressive increase even if it means shortening the vital process by the depression of the nerve centers that regulate breathing*" (end of quote, bold and highlighted by the Author); and they continue to maintain their criteria in favor of child euthanasia because Article 62 (previously 64, already commented) stipulates that (I quote): "*If the child's condition is such that the treatment will cause precarious prolongation of the life of a being with deep mental or physical deterioration, the **parents must be informed of their authority to suppress the consent for the treatment and its authority, to demand from the doctor the suspension of the one that has begun*** "(end of quotation.(bold and highlighted by the Author)

In such a way that an open consultation is forced, without restrictions, at a national level, on this subject; debates, workshops, discussions, and if, finally, the community is won over to the idea of modifying the penal norm and decriminalizing euthanasia, as has already happened in other countries, because it is she, the community, which exercises its right without that isolated orthodox writers try to inhibit the right to exercise it.
Man has that right based on his autonomous power to dispose of himself and that the liberal State of law must enable its exercise through legislation and jurisprudence.

b) Religion:

The other opposing myth is raised from the foundations of religious convictions. And I express, with precision, that it is a true theological-dogmatic myth that, fundamentally, from the "institutions", rather than from the individualities, it leads to the rule, more than to the belief, of going against euthanasia. Basically Catholicism, Judaism, and even Islamism, and any other considered born of the same common trunk of Christianity, obey the commandment delivered "you will not kill."

Without excluding those other religions that, without being faithful followers of Christ, are also based on the biblical teachings. Here, we find another sophism when that biblical mandate of "you will not kill" has, in religions, its own exceptions as the concept, already criticized and commented on, of the right to life established in Article 4, numeral 1 of the American Convention of Human Rights of the OEA when the same article 4 in its numerals 2 to 5, both inclusive, agrees, accepts and conditions the death penalty. Something similar happens here when we contemplate biblical examples that the biblical injunction to "not kill" is bad if it is someone from the group itself, while the death of someone from another group is accepted, and especially if it is considered an enemy.

However, it is necessary to clarify the difference of opinion existing between the official or institutional opinion, of the ecclesiastical hierarchy, to the opinion of the parishioner of those religions taken individually. Studies have already been carried out, and even in countries as Spain, where the so-called "Catholic Monarchs" reside, or the Vatican, where the Pope himself resides, the majority, more than 60%, of those who identified themselves as Catholics, showed themselves, individually, to favor of euthanasia, in open contradiction with the official position of the ecclesiastical hierarchy. In fact, actual news shows us the Spain is just about to approve euthanasia legislation; or at least, it is going to be discussed for approval in the Senate.

It is known that even Pope John Paul II himself, who was terminally ill, in the terminal phase, finally rejected the support and extraordinary measures of life support. After starting with his illness, including laryngeal-tracheitis, kidney failure, septic shock, circulatory collapse, without forgetting Parkinson's disease, he even received parenteral nutrition through the nasogastric tube, he expressed those words of "*Let me go to the Father's house*", and it is known that, upon request, he refused the Germelli Polyclinic in Rome to remain in his apartment in the Vatican. With this I can never claim that he approved euthanasia; it is evident that no and there are his pronouncements about it. But I do call attention to its manifestation and exercise of the principle of autonomy of will and self-determination.

I must not concentrate or deepen in the religious theme for not being the objective of this Work; nevertheless, I must clarify that I will be referring, in this aside, fundamentally to the catholic religion. This depends on two main reasons. Our country is fundamentally Catholic, and it is precisely the Catholic religion that I know most. Respecting the freedom of religion and worship could not include all religions in these concepts, although I recognize that the applicability of the concepts issued now encompass the clear majority of them. All the arguments seem to be good and sufficient, as long as we all belong to the same religion; but I do not think it prudent or conducive to try to apply a restrictive measure to an entire population based on religious foundations that are not shared by all that population, especially when the Constitution in Article 59 guarantees freedom of religion and worship.
The main arguments used are:

1. ***Principle of the sacredness of life***: only God has given life and only He can take it away.

2. ***Principle of transcendentality***: if doctors and scientists in general, could start life, by artificial assisted reproduction, manipulate the genes, clone, as currently practiced and done, and now they could also remove it, surpass the work and transcendence of the Creator's own, and for that reason it is conceptually unacceptable, inconceivable;

3. Principle of redemption: a more radical criterion of a sector of the church (O.D.), through which the Creator should be thanked and accept the pain and unworthy and disgraceful conditions that accompany illness and death; and the patient must be grateful for all the suffering and disgraceful conditions in which he finds himself because by doing so he participates in the passion of his son Christ and is a spiritual union with the sacrifice of the Redeemer, which he has offered in gratitude to the Father's will and his mission to redeem us by dying for us in suffering is evident. Suffering has, for them, a mystical and even expiatory meaning.

Respect for the person, the belief and whoever believes it. But, the harsh reality is that, these principles would work for those fervent practitioners and true believers of religious doctrine; But what happens to those who are not religious? If a patient is of another religion that thinks differently, or if the patient does not have any religion? If the patient is agnostic, atheist? Do we not have, by constitutional principle, a freedom of religion and worship?
Then a religious principle cannot be applied to impose an obligation, a restrictive measure, on those who are not religious or practice a different religion or worship.
The other big problem with the religious foundation is that there is no choice: either you are a believer, or you are not; you are in religion or you are not; and from the moment you are in that religion you can no longer go in favor of euthanasia; that is a restriction on the free development of personality that greatly affects the opinion of those belonging to religious groups.

b. Slippery slope

This myth has been created and sustained, specially, by those dedicated to ethics and bioethics. They maintain that, if euthanasia is approved, it would enter a kind of slippery slope that would make the proper execution of euthanasia uncontrollable and would include a series of cases that, by the same applicable regulations, would not otherwise be candidates for it. They have even come to say that, arriving on the slippery slope, after the approval of euthanasia, uncontrolled killings of elderly people, disabled people, by racial type, and minority or vulnerable groups, and even those depressed because the bride left them, Therefore, they do not recommend approving any regulation in this regard. Well, the truth happened in other countries, especially Holland, after the time they take with the legal approval of euthanasia (remember that they had been practicing it for 27 years) has shown that the famous slippery slope is nothing more than a myth; and this is demonstrated by official evaluations carried out and officially published.

• The official figures published by Regionale Toetsingscommissies Euthanasie Jaarverslag, in the year 2017 (I clarify that these official figures are published, officially, every 5 years, although annual reports are made and published), and the official page of the Report is perfectly reviewable. portal: https://www.euthanasiecommissie.nl/de-toetsingscommisies/uitspraken/jaarverslagen/2017/mei/17/jaaverslag-2017, corresponding to the report published on May 17, 2018, and evidencing, for 2017, a total of 6,585 cases of euthanasia, compared to 3,136 in 2010. But these results cannot be taken into account in an absolutely form, as they try to do, but relative; that is, there is a discreet global increase but that must be contrasted with the increase of the population on the one hand, and on the other, the figures of the general mortality, resulting in the year 2010 that 3,136 cases of euthanasia that were presented corresponded 2.13% of the total mortality of the population in general. The figures, obviously, are increasing slightly each year. For the year 2012, for example, there were 4,188 cases of euthanasia with a correspondence of 2.98% of the general mortality. By the year 2017, they show that there were 6,585 cases of euthanasia, which although they reveal a slight increase, when compared with the general mortality figures and that of euthanasia were 4.44% for that year, it represents, barely, an increase of 2.31% in 7 years.

Even more significant is to compare the 2.4% of euthanasia of the total mortality of 1995, with that 4.4% of the year 2017, which would reveal that, in 22 years, the numbers of euthanasia in the Netherlands have increased, just, in 2%; that is, insignificant enough to be able to defend the thesis of the slippery slope. For this, we must also consider that, being official and proceeding according to law, there is a greater number of requests, greater acceptance of the general population; and yet the 22-year increase of just 2% destroys the myth of the famous slippery slope.

- For the avid reader, I can refer you to independent studies published in internationally indexed medical journals such as Lancet in: Onwuteaka-Philipsen BD, Brinkman-Stoppelenburg A, Penning C, Jong-Krul GJF, van Delden JJM, van der Heide A. Trends in end-of life practices before and after the enactment of the euthanasia law in the Netherlands from 1990 to 2010: a repeated cross-sectional survey. Lancet Vol. 380: 9845, september 2012; or in another previously published study: Two Decades of Research on Euthanasia from the Netherlands. What Have We Learned and What Questions Remain? J Bioeth Inq. 2009 Sep; 6 (3): 271-283.
- Only 27% of the euthanasia requests finally arrive to be approved and to be fulfilled.
- The official notification that doctors must make to the Governing Body has increased, so the process has become official without fear.
- The figures of morbidity requesting euthanasia are kept in extreme figures, the vast majority of cases correspond to patients with terminal cancer, with unbearable pain, and added problems, which make it unworthy to continue trying to survive and where palliative medicine no longer offers any alternative human
- Definitely, there is no evidence of the demonstration of the famous slippery slope.

Now, the problem with the slippery slope is that the followers to it also come to use in their favor the so-called involuntary euthanasia; that is, that practiced without the consent of the patient (which really is not euthanasia), either for lack of manifestation or for incompetence that prevents collecting an informed consent. The results in the published Third Remmenlink Report demonstrated the falsity of this argument since involuntary euthanasia, pillar of this erectile of the slippery slope, is 4-5 times higher in countries that, like Australia, still had not passed legislation against the figures of the Netherlands that remain, in this line, stable in barely 0.7% of the total cases and has not increased.
As Dr. Luis Montes Mieza, doctor, anesthesiologist, Head of the Severo Ochoa Hospital Reanimation Service, Madrid, and President Association Right to Dignify Dignitarily of Spain, explains: "euthanasia reduces suffering does not increase the number of deaths"

c. Indiscriminate deaths:

A great fear turned into myth. It is tried to argue that, to approve the euthanasia, an uncontrolled chain of unjustified deaths would begin. That any person, for any reason, would request and apply euthanasia procedures. There is no worse lie than this one. The Dutch experience, and already the Belgian that is beginning to be known, as well as in other countries or States, have demonstrated the rigorous scientific-juridical control for the application of the euthanasia procedure.

Many are the requirements that must be fulfilled:

- Patient with terminal illness demonstrated, undoubtedly and reliably, and with certification from the attending physician.
- Patient who, in addition to having a terminal illness, is in the terminal phase; that is, his imminent death is expected in hours or in a period not exceeding three months. The irreversibility of the process must be evidenced medically and that in fact there are no viable scientific alternatives.
- In addition to the disease in terminal phase, and to be in terminal phase, the patient must present unbearable pain or other serious complications that Medicine, in any of its forms, including palliative, cannot offer any alternative of relief and that imply continue living with dignity.
- The above criteria must be ratified by the so-called independent physician; that is, corroborated by a doctor other than the patient who initiates new consultations to verify compliance with the conditions described above.
- There must be an expressly informed consent granted by a (physically and legally) competent patient. Consent that must be obtained on at least two different occasions with some time (month) of difference between one and the other. Consent that, at any time, can be reviewed and revoked by the same patient.

- There must be a notification to the Euthanasia Committee, composed of a lawyer, who presides, a doctor and a bioethicist, (at least) who review all the information, before proceeding with the authorization.
- Practiced euthanasia the doctor is obliged to inform, report the procedure to a Special Commission that reviews each and every one of the steps. If irregularities have been committed or if the procedure is not approved, the Commission itself passes the file to the Public Prosecutor's Office for the purpose of initiating the judicial prosecution of the medical professional who has incurred criminal penalties.
- It should be clarified that, according to the same figures reported by the Dutch Society of Euthanasia, the total absolute number of notifications made by physicians to the Special Commission have increased, which denotes seriousness and confidence in compliance with the requirements and the decreased fear of doctors to be persecuted unjustly.

The ethical problem also argued against euthanasia is solved with the demonstration, legal and statistical, that only with the informed consent and legitimately declared of the patient can resort to the procedure. So, what remains is the fear of doctors to lose power instead of thinking, according to the new paradigm of the doctor-patient relationship, in granting, recognizing and defending the rights of people and the patient.
Official studies show this: 64,3% of patients correspond to diseases with cancer; 17.50 to cardiovascular, neurological, and pulmonary diseases; only 3.7% correspond to patients with dementia and psychiatric disorders, and then comes another conditions no listed before.

d. Isolated statistics in Intensive Care Units

Some doctors have opted to the contrary to euthanasia alleging that, in his long career in the Intensive Care Units, there had seen as a case, which, considered irrecoverable or irreversible, has suddenly reacted after month(s) and come back to life. Without discussing whether the initial diagnosis was well-founded and accepting the reality of recovering very isolated and counted cases within the total, universal ICU experience, a restrictive criterion to euthanasia cannot be imposed simply because one case of each million has recovered after a diagnosis of irrecoverability. You cannot deprive the feeling of one against the law an obviously greater percentage.

e. Image of the physician. Myth of the Hippocratic Oath

Another one of the great unfounded myths is that the image of the doctor would be deteriorated because his mission in medical practice is to save lives and not to kill

people. Recall, we have already considered in previous section of this same essay, that our Medicine Schools have become accustomed to the exaggerated absolutist cult of life and are afraid of having to face death because part of it is considered a failure of the physician. We have discussed how Hospices, unlike Hospitals, face the process of death naturally and doctors, as true professionals, are dedicated to the fulfillment of two of the fundamental pillars of bioethics: helping, and doing good; managing to mitigate human pain and suffering with true respect for life and the dignity of people. That is why this argument becomes a myth that we have already unveiled.

Many have been the myths that have been constructed about the professional exercise of health, serving in many cases, in a guilty way sort of speak, of interference with the advances of the medical sciences, and euthanasia has been another of those fields. But the mythification and mystification of Medicine has been increased in a relative manner that serve to particular interests. We tear our clothes every time we try to talk, debate, analyze important issues such as euthanasia and unnecessary suffering; but nothing is said, on the part of the same groups of scientific, legal, political, and religious detractors, when every day we see opprobrious discriminations; every day countless embryos (which are also considered life) are discarded in the trash basket because they are not used in the reimplantation processes; manufacture of babies " à la carte"; manufacture of donor babies, such as the case of the United Kingdom that manufactures an embryo, genetically manipulated, with the sole intention of serving as a donor to the existing brother; nothing is said about the violation of human rights and lack of medical attention in vulnerable population groups (elderly patients abandoned in asylums, prison population, HIV / AIDS patients), human cloning; scientific experimentation against the will; medical attention by telephone or by Internet portals without seeing, even less examining, the patient; execution of procedures of very high economic costs for implantation of a pacemaker, in a Public Hospital, for Parkinson's disease (Bs. 100,000,000) that favored a single patient while, in the same hospital, patients and doctors went on strike, at that same moment, for lack of basic supplies in the emergency (case Hospital Pérez Carreño, late 70's); artificial insemination in lesbian couples; surrogacy or belly rent ", etc.

It has been one of my purposes, both in the lectures given and in my previous works as well as in the classes taught, to reveal the great myths that exist in relation to doctors and professional practice, while presenting the realities that in their essence constitute the issue raised. It is essential, necessary, fundamental, to humanize the doctor in his daily practice; with this I mean, bring the doctor closer to the human figure that really is and move them away from that mythification that elevates him into deity and covers him with a sacred mantle of protection that does not really correspond to him in nature, not particularly at the turn of the century XXI, at least.

It is true that the doctor is due to his art and science, just as he owes a special vocation, almost priestly, to his patients and to the civil society in which he works. Equal respect to his colleagues or teachers and duty of teaching has always had to his students or apprentices. But, despite the fact that we believe in the rescue of the ethical values of the medical profession, I firmly believe that we must, once and for all, humanize, approach the human, the medical professional and understand that he, like other professionals, you have the right to feel, love, suffer, get tired, be happy, enjoy, sadden, eat, dress, play sports, recreate, laugh, cry, win, lose, increase your income,

save, etc. like any human being on this planet. Imagine, for a moment only, HIPÓCRATES in a bathing suit playing racket on the shore of a beach, or GALENO trotting through the streets of the city, or CELSO serenades some girlfriend, or locally the beatified JOSÉ GREGORIO HERNÁNDEZ with a suit of baseball player playing in the play-off of the national baseball league; I think the image is a bit uncomfortable, right? That's what it is, we need to humanize the image of the doctor and understand it, in spite of the special ones of his exercise, like any other human being.

In the same way that this humanization of the doctor is sought within the exercise of his science, I am also convinced that the paradigms and dogmas that have traditionally been taught in medical schools must adjust to the changes and dynamism of today's society. There is a society, or part of it, that has particular values, many of them based on beliefs and religious convictions, that need attention and medical care but cannot achieve it because of the fears, dogmas, myths and paradigms that have been established almost institutionally.

Hence the need to reform these Hippocratic teachings of past centuries that must adjust to modernity. Sometimes I wonder: what would Hippocrates have done at the request of a Jehovah's Witness who, because of his firm and undeniable religious conviction, refused to accept a blood transfusion? What would Esculapio have done to an HIV / AIDS patient who does not have millions of dollars a month to get his monthly medical treatment, who cannot work because of the discrimination that society imposes on him, who is in the terminal phase, and cannot stand it anymore? the suffering that drowns before the indignity of one's life that the same State that must guarantee the right to health does not take care of it? What would be the attitude of the doctors of the Alexandrian era like Herófilo y Erasístrato in the presence of a Prosecutor of the Public Prosecutor's Office with a court order depriving them of liberty for practicing "autopsies" (if they can be called that) in criminals of the Real prison while they were still alive? Not even Celso failed the idea at the time.

Anyone who spends a little time reading the History of Medicine will get many examples of what it should not be, what it is not today but what it was, and practiced methods and procedures that are at odds with the morals were still accepted by royalty and by the Church. They were the conveniences of the moment and what in reality could, after all, have allowed the development of medical science.

That is why our paradigms must change. Accustomed to an absolutist cult of life, we lose the image of the help that a doctor can provide to his patient at the time of his death. But accustomed to a hypocritical, vertical, protectionist, paternalistic practice, it is impossible for us to realize that our relationship is now horizontal, dynamic, participatory, and that the doctor can no longer make decisions that he considers convenient for his patient; not without listening at least to the feelings and wishes of his patient.

An extremely controversial aspect in Medicine, closely correlated with the ethical or ethical aspect of medical practice is the belief, both of society in general and of the doctor in particular, that the doctor is obliged to attend to all patient, at all times, in all circumstances because the medical professional has so solemnly sworn at the time of graduation and proffer before his colleagues, university authorities, teachers and the general public the well-known Oath of Hippocrates.

The legal truth emerges here again when teaching us that, above all ethics, morals or philosophical or deontological principles, doctors (at least at the Central University

of Venezuela and since 1984) do not take any oath of Hippocrates upon graduation, but rather, on the contrary, they commit themselves through the Oath of LUIS RAZETTI, adopted by the Council of the Faculty of Medicine of the Central University of Venezuela on February 14, 1984.

One of the great myths that is always imposed on the doctor is his pretended and famous Hippocratic oath. But let's analyze for a moment. An oath to have a certain degree of credibility must be done about something, or for something, in which one truly believes; something or someone that one respects. How else could an oath be based on certainty and credibility if it is done on something that the oath-holder does not believe or care about? Our country proclaims itself religious, fundamentally Catholic, but almost exclusively, if not totally monotheistic; So what credibility can an oath have, such as that of Hippocrates that is made before Apollo, Asclepius, Higinia, Panacea, and all those other Gods of the Olympus?

There is no absolute certainty that this -juration- was written by Hippocrates, and it was not until the fourth century that it finally became a mandatory requirement for the doctor to take the oath upon graduation, establishing, then, the first behavioral parameters markers of the general guidelines of the doctor-patient relationship and other ideals of professional confraternity of the doctor.

Certainly, in that oath any type of euthanasia was prohibited: "*Do not administer to anyone a deadly drug, even if you ask me, or take the initiative of a suggestion of this kind. Also, do not prescribe a woman an abortive pessary; but, on the contrary, to live and practice my art in a pure and holy way* "

But in the same way, if we thought that there is some validity of this oath, doctors could not perform operations of vesicular lithiasis, or other surgeries: The Oath says: "*Do not operate even patients who are ill with stones, but leave them in the hands of those who deal with these practices* "

That is why the Hippocratic Oath has become a great myth. What would Hippocrates have said, or who wrote such an oath (History does not confirm with certainty the originality of Hippocrates as author of it) before the new procedures of laparoscopic surgery? With intrauterine fetal surgery? Before the telesurgery? The transplants? Assisted reproduction?

That is why given the religious conditions in our country, considering that as a Catholic, monotheistic country, the doctor could not be swearing before the gods of Olympus or similar. In an attempt to update the Hippocrates Oath and adapt it to the modern circumstances of at the time, the Faculty Council of the Faculty of Medicine of the Central University of Venezuela, adopted on February 14, 1984, the Oath of Luis RAZETTI, which is a modification made on the basis of the one described and until then in force. Oath of Hippocrates

Within the framework of his evocations we appreciate:

My reverence for life in attending terminally ill patients will not collide with my fundamental obligation to alleviate human suffering.

I will not allow the intellectual satisfaction derived from my ability to identify and treat diseases and contribute to the progress of medical science make me forget the humanitarian principles that govern our profession and the priority consideration of the patient as a person.

I understand that the doctor must have as a priority to understand and accept his patient as a person, subject of rights and obligations, and that his capacity derived from his science cannot be imposed on the humanitarian principles that should govern the doctor-patient relationship and should be always reverent for life and accept as a fundamental obligation the relief of human suffering. Who could rule out the validity of relief from human suffering in the terminal phases of life? Because not even those who say otherwise to euthanasia but who do accept the use of potent analgesics even if it means shortening the life cycle could deny that this is the doctor's obligation: to help, alleviate suffering, do good, and without all this can cure, well better; But if you are faced with a terminal patient, declared irreversible, why not fulfill your obligation to help alleviate human suffering, even if it means shortening the period of life? There is another of the great myths that we need to analyze and convert.
Following the great Hippocratic myth, we have made over time an exaggerated culture of life, no matter its quality. Proof of this was the news of the case of Argentina where doctors, regardless of the quality of life, maintained the gestation of a product that was known impossible of viability: some Siamese that completely joined, two skulls, share a single heart and other organs, with deformities in upper limbs, and of those who have been certified there is no surgical possibility of separation. Is there ethics in that procedure? Have doctors who kept such a pregnancy with unfounded hopes for mother and father been Hippocratic? Now how to decide the sacrifice? Who to sacrifice? I think that, with another way of thinking, these are the cases that by exclusivity, with restrictive scientific, legal and bioethical criteria must be treated in a totally different way to how this case has been handled.

We understand then that, if we analyze the Pledge of Hippocrates, as well as the other known oaths or codes of ethics, we will realize the cold and harsh reality in that there is no oath anywhere that compromises or establishes the obligation unconditional doctor to attend to any patient, as the doctors themselves believe in their majority and as repeatedly demanded by society in general through the press, radio or television, every time an information or opinion program is made through these means.

Great Hippocratic myth of Medicine that needs revision in light of the doctrine, jurisprudence, and legislation, and the need to adapt our exaggerated cult to life by a model that allows us to live with death without it meaning an attack to the false pride of the doctor who feels that each death means his professional failure before life. This paradigm must change. The doctor can exercise a beautiful professional and more human role before his terminal patient, and there must be oriented the new functional contemporary ethics.

f. Obligatory nature of the practice of euthanasia

Finally, the major myth. The opponents to euthanasia claim that if the euthanasia is approved, it means that every patient must submit to it and every doctor will be obliged to practice it. False. I have already explained that it is a legislative alternative.

> What exists is the legal possibility of accepting an alternative that, as a fundamental alternative that is, it can be chosen or not by it; in such a way that neither the patients who object to it are obliged to request it nor the doctors who object to it are obliged to practice it. The fundamental basis, as explained in this Work, is the manifestation of self-determination and autonomy of will based upon consensus. There is not such a thing as involuntary (no willing) euthanasia nor exist an obliged euthanasia.

So, we think that we live in a modern society, advanced, that we need to update and modernize, not only in terms of legal standards, but criteria and ways of thinking, and we must once and for all, stop tearing our clothes and learn to respect that the right of a person does not mean an obligation for me to accept and execute it. We live in a free, democratic society and each one must be able to select, within certain limits already indicated, their own decisions. Let's stop fighting and restricting the advances of the dynamic science of Medicine, and let human rights be imposed, in the way that, as we express, the fact of establishing the legality of euthanasia does not mean, in any way, that no person can be imposed if he does not want it, and no doctor can be forced to act within these criteria.

The exercise of my right to die, to die with dignity, does not harm, benefit or harm any third party, does not obligate any doctor or person to assist me, nor do I eliminate the possibility of any use to the State whenever I am in terminal phase; *ergo*, nobody can abrogate me or limit me the sacred right of my own self-determination and autonomy of will.

We are preachers of the principle of autonomy of will and self-determination of the patient; and if we really believe in these principles we must accept that it is the patient's right who decides their own self-determination; and we, consistent with our ideas, we must, we are obliged, at least to encourage the due treatment and discussion of these issues, together with the people and patients, so that there is a real active participation of the most important of this discussion, the patient, and to be able to listen to them, with certainty, tolerance, understanding, in the understanding that the right to life means for us, in the light of modern doctrine, something more than merely living, necessarily means a life project that matters, not only living, that it also matters the quality of life itself, and respect for the integrity and development of one's personality, which ultimately becomes the legally protected good as a consequence of this right of self-determination and autonomy of will.
As well expressed in a Colombian Constitutional Court, sentence on the decriminalization of euthanasia: *Nothing so cruel as to force a person to subsist in the midst of shameful suffering, in the name of beliefs of others. The right to life cannot be reduced to mere subsistence but implies living adequately in conditions of dignity.*

CHAPTER VII

THE GREAT SOPHISM: PALLIATIVE MEDICINE

At the beginning of this debate, the two positions were clear and defined: for or against euthanasia. It was defended or not the Right to Die with Dignity, and of course, understanding the latter by the right of every person not to suffer cruel, inhuman or degrading treatment; not go through the therapeutic cruelty; not have to live or endure life ailments in any condition that the patient was; in short, to take your determinations well in advance to avoid having to go through that indignity and suffering.

But over time things have changed. Especially in recent years some are trying to defend at all costs what has been called Palliative Medicine. And it is presented as the great miracle of God, which guides us to follow the Hippocratic principles and the beliefs of a Bioethics, manipulated in its fundamental principles, and we are trying to convince ourselves that the solution is neither euthanasia, nor suffering, and that the path of a dignified death is through substances, drugs and medicines that "relieve" the suffering "until" (I repeat, I insist: until) that the moment of death arrives, without being able to specify when that moment will come, and without thinking or mentioning the high costs that this means.

The Palliative Medicine was born in London, 1970, with an intense objective and humanistic content, of great sympathy with the suffering of others, and which would try, in its own way, to contribute to the decrease of the pain of others, especially in its terminal phase or agonizing. The World Health Organization defines Palliative Care as *a way to address advanced and incurable disease that aims to improve the quality of life of both patients who face an illness and their families, by preventing and alleviating suffering through of an early diagnosis, an adequate evaluation and the opportune treatment of pain and other physical, psychosocial and spiritual problems*. (underlined by the Author)

Its basic objectives were:

- Management of symptoms that put the patient **and / or family members** in a situation of suffering, especially controlling pain and other symptoms.
- Personalized and comprehensive patient assistance.
- Support and psychosocial support **of the family**.
- Support of the healthcare team itself.
- Improve the quality of life, **not only of the patient, but also of their relatives** and / or caregivers.

(bold and underlined by the Author).

However, the reading, analysis, observation, study and participation in matters related to Palliative Medicine, has led me to unmask the great fallacy of this Palliative Medicine, and through the recognition of its errors, to achieve the growth of its humanistic content.

I always liked to start, as it should, in the beginning. And the first thing I must do is define, clearly, what is meant by Palliative Medicine, and then see what is really being understood as Palliative Medicine, but for that, and clarifying the name of this chapter, I must clarify some preliminary concepts.

According to the Dictionary of the Royal Academy (DRAE) "sophism", of the Latin *sophisma*, and this in turn of the Greek *Saphism*, has a single meaning: ***reason or false argument with the appearance of truth***. (Author's bold letters)

Can Palliative Medicine be a false reason or argument with the appearance of truth?

A sophism consists of any argument, adulterated, that is used to defend a fallacy, an erroneous argument, or invalid. This confuses the adversary in the dialogue or discussion. Argument, ratiocination, is used with a single objective: to induce the adversary in an error. Through a sophistry in the argument that could well start from true premises, but conclude in false arguments that do not follow the initial premise.

And it is precisely what I describe what I feel when, in most of the time, I hear about Palliative Medicine.

We are told that Palliative Medicine is the art of caring, with technical and humanistic competence, for the patient, and their families, in the face of finitude. And here the first fundamental trick. Because the patient is not cared for, and in our subject of the Right (individual, personal) to Die with Dignity, the family members do not really become important people to whom some care is due, subject to compassion, solidarity, etc.
We will analyze why, really, the patient is not taken care of, as originally thought, and second, the central objective of our topic is the patient and not the relatives.

What does "palliate" mean? According to the Dictionary of the Royal Academy (DRAE) palliate (paliar), of the Latin *palliare*, and this of the Latin *pallium*: mantle; that is to say: it means nothing more than covering up, conceal, hide, placing a cloak over it to hide.
In no way can we understand the premise as useful to care for the patient and their families as they want to understand Palliative Medicine.

According to the SECPAL (Spanish Society of Palliative Care) of the Medical Association of Spain, when they are presented, in a terminal patient, in terminal phase, and I must understand in the Intensive Care Unit, (In your room?) symptoms-signs such as: pain, intense suffering, unbearable refractory symptoms, delirium reactive, anxiety, panic, dyspnea, vomiting, then it **must**, with the use of certain drugs and medications (midazolam, chlorpromazine, levomepromazine, haloperidol, phenobarbital, propofol, and they are combined with potent morphine-type analgesics, or opioids such as remifentanil), it must be **palliated, covered, hidden**, **concealed**, these symptoms and / or signs, and sedated, the patient immobilized, perhaps in a certain degree of unconsciousness, that in no way can complain; then, the conclusive premise, the patient, and his relatives, who no longer listen to the patient's complaints, are facing his design with "dignity".

Basic teaching of Palliative Medicine: ***When the cause cannot be cured <u>the symptoms are covered or covered</u>, with specific treatments such as sedatives and analgesics*** (Manual of Palliative Ethics, School of Medicine, Pontifical University of Chile)

The European Association of Palliative Care clearly defines it: "*Therapeutic Sedation (or Palliative), in the context of Palliative Care, is the controlled use of medications with the purpose of <u>inducing a state of diminished or absent consciousness</u> (loss of consciousness). and in order to <u>alleviate the burden of intractable suffering</u>, in a way that is ethically acceptable to the patient, <u>family and professionals</u>* "(bold and underlined by the Author)

And they insist that relief from the burden of intractable suffering is in an ethically acceptable way for patients. The Right to Die with Dignity is an express act of will, of the patient. It was explained our current model of doctor-patient relationship, between two subjects of rights, protected by law, in which they put into play the most beautiful and sacred gift of the human being: the autonomy of will and determination. The patient's right to decide, according to his personal criteria, extends and places the limits of the physician's obligation to inform. To them corresponds such decision. Of course, as long as we understand a patient, physically and legally, capable. Whether the relatives suffer or not with the decisions of the patient is not a matter that may correspond to the Palliative Medicine. But, it is appreciated, in all the consulted sources that always the medical decisions of treatment are to alleviate the moan of the patient for relief of the relatives and this should not work in this way.

The central objective, according to the SECPAL (Spanish Society of Palliative Care) is to eliminate consciousness.

From the Bioethics is justified, by the principle of beneficence, and interpreting the double effect: the action of the use of sedatives and analgesics to alleviate is good, the intention of the doctor is also good, there is a ratio between the good (desired) and the bad (tolerated), and finally the good effect should not be caused by the bad. (Terminal Sedation Protocol, University Hospital of Donostia, San Sebastián, Spain).

That is why, in the beginning, I defined the sophism of this Palliative Medicine. It is about arguing, already in the last years of a patient's life, when he has already been in his indignity for a long time, to justify the use of certain drugs and medicines, simply to alleviate, cover up, conceal, the patient's pain and suffering and let's not forget, also objective of these palliative care: of their relatives.

We cannot fail to recognize that a true palliative medicine has a high humanistic content and will look for ways to alleviate those symptoms-signs of the patient that, evidently, cause suffering. But from there to promote that this is the solution between euthanasia and to do nothing is a real sophism.

I mentioned earlier, for necessity, the case of Brittany Maynard. She, with her diagnosis and treatment performed, could not do anything else. It is there where palliative medicine fails in its foundations. According to its principles: Should we expect a fatal neurological outcome, alarming, with refractory symptoms, justifying the doctor to simply palliate them, to, through sedation and analgesia, cover the disease? Was it not worth the decided solution,

voluntarily by Brittany? She exercised his right to a dignified death before having to reach symptom-signs such as: intense suffering, unbearable refractory symptoms, reactive delirium, anxiety, panic, pain, dyspnea, vomiting, paralysis, etc. to wait for a doctor to come, perhaps depending on the family, to alleviate, cover, the incurable, and who knows, for how long and what cost.

Thus, it is important to point out that, in spite of its great humanistic content, Palliative Medicine only serves, exclusively applies, to that terminal patient, already in terminal phase, and evidently pre-agonic, generally already hospitalized, and when it complies with certain symptoms and signs according to the Manual that the doctor is following, and based on a treatment exclusively consisting of sedatives and potent analgesics, and whose sole purpose is to alleviate (cover, hide, conceal) the "physical" suffering of the patient and to calm their relatives.
But, respecting for its humanistic content the Palliative Medicine, and the compassion that the doctors who follow it can definitely feel, is not in my opinion the ideal answer to the problem, since the patient is already in degrading, opprobrious conditions , who knows for how long, and that is precisely the attack on the dignity of the human being that we wish to avoid, preventively, with the exercise of the Right to Die with Dignity; being the patient, and not the doctor and / or family members who decide when it is appropriate to alleviate or not the final symptoms of the patient before dying.

I already explained that, according to the World Health Organization itself, more than 40.000.000 patients in the world need Palliative Medicine and only 14% of them can achieve it. (http://www.who.int/mediacentre/factsheets/fs402/es/). In Spain, which claims to be a leader in this area, more than 50% of patients who require Palliative Medicine do not achieve it either. Mexico reports figures as high as 90% of patients needing Palliative Medicine than may not have it.

Then, the need arose to encourage debate, sincere, professional and social, and seek, as I have proposed, a legislative alternative that allows, those who believe in it, to exercise their right to die with dignity, and not have to get to go through, undesirable sufferings and shameful conditions at the cost of beliefs of third parties alien to their will. Being a legislative alternative, it simply does not obligate anyone. Neither the patients to opt for euthanasia, nor the doctors and / or third parties to perform it.

I have often seen that the central objective, ¿the only one? of the intensivist doctor who treats these terminal agonists, or terminal patients, is the administration of sedatives. Eliminating consciousness becomes the first objective. Then, also, powerful analgesics can be added that, in their form and part, also help sedation as a side effect of it. Hence, we insist on mentioning: palliating, covering up, concealing, hiding ...
With the patient calm, sedated, unconscious, and their analgesics What can concern the eschar, the psychological inner pain of the patient that, although it cannot show it is not evidenced its disappearance, the need for cleaning and corporal hygiene due to the lack of controllability of your sphincters, etc.? The question: Could all this have been avoided? Or unnecessarily wait for suffering to receive palliative medicine?

The patient is still, sedated, quiet, calm, the family member, then, it's okay. But if somehow the patient complains, shouts, moves with despair, etc. the familiar or relative will not delay in claiming the doctor: Dr. There is nothing that can be done?

It is precisely at this moment when we are presented with an area or time that, like a limbo, allow the fundamental principles of euthanasia to merge with those correlative of (so-called) orthotanasia, and that is where very subtle and suspiciously hide some detractors of the euthanasia that confesses prone to the use of these potent opioid analgesics even if it means shortening or ending life and it is there, where rigorously, we reveal at this moment this other great myth as to try to hide behind the inexistence of a primary animus of a result of death, but knowingly and with the representation that the powerful analgesic will produce possible, probable, and surely the shortening of life as a side effect is no more than another trick to accept, in disguise, what with courage, transparency and honesty is not able to accept: euthanasia!

It seems a vulgar fallacy, or a great deception to his listeners or students, the teaching of the one who expresses in public his total rejection of euthanasia but nevertheless keeps in his pocket an authenticated document where he not only asks, but demands, that in certain conditions they are administered sufficient quantities of potent opioid analgesics (morphine, and the like), together with powerful sedatives, even if it means, and so the applicant knows, that the final and inevitable result of the application of these analgesics is the advent of death due to the inevitable cardio-respiratory depression that, secondary, but surely, is going to occur causing (the desired) the end of the patient's life. Therefore, we assimilate this position with that of the judge who must sentence in a case if the accused committed wrongful death, in a fault with representation or on the contrary must qualify the intentional homicide in the evidence of the eventual fraud. The subtle separation or limit between the fault with representation and the eventual misconduct and the difficulty for its precise and undoubted statement is the one that by analogy and semblance we narrate in the differentiating context between accepting euthanasia by applying large amounts of morphine to shorten it definitely life and cause the death of one who says he does not accept euthanasia but accepts the administration of the same amounts of the same morphine to mitigate his pain and knowing that this (morphine), will inevitably cause the death of the patient.

Doctrine in Criminal Law who have studied in depth the criminal position regarding euthanasia describe this dual situation and like others try to justify the non-commission of crime, and therefore the non-acceptance of euthanasia in patients who tolerate the application of large amounts of opiates to defend the thesis that the applicant does not want death in the first place but to mitigate the pain, but who accepts, as any patient would accept a side effect of any other treatment, the shortening of life as a result of the administration of such analgesics

I have the doubt and uncertainty, as it would be for any judge, to know if we are in the presence of a fault with representation or an eventual misconduct whenever the applicant, and the doctor, who prescribes and administers the potent analgesic can be doing with the internal animus to achieve shortening of life in case of a terminal illness and shortage in the condition and externally manifest that is against euthanasia and only requires analgesics to mitigate the pain although this in a "secondary" produce the death expected by the patient.

When a terminally ill patient in the terminal phase, palliative measures are applied to mitigate the pain of the patient based, especially but not exclusively, with the administration of potent analgesics we are in the presence, according to some authors, of an indirect form of euthanasia. Many courts opposed to euthanasia accept, however, therefore do not condemn, the use of these large or repeated doses of potent analgesics, in doses of progressive increase. In the dying, the attenuation of suffering can be placed in the foreground, so that a possible but inevitable shortening of life can be accepted. The (so-called) indirect euthanasia achieved by the administration of these doses of analgesics is no more than a manifestation of medical impunity, and legal, whose primary actor, or active is the patient himself who, surely knowing the collateral or consequential effects of this application, the final result of death is forced in a short time. There is, no doubt, at least an eventual fraud, but attempts to justify through atypicality.

Quoting Claus Roxin: *If indirect euthanasia is unpunished, this is due to the fact that, along with the will of the patient oriented to a concrete result, the consideration is added that, given the case, the duty to lengthen the preservation of life gives way to the obligation to mitigate suffering. A somewhat shorter life without serious pain can be more valuable than another not much longer accompanied by a barely bearable suffering*. It is decisive that the patient can still express his will. Another one of the great myths that are presented and must be demolished.

But the theses that some authors maintain get the limitations to their own inventions; One of them is the opportunity in which these analgesics can be used. A terminal patient, with a lung cancer, would not be a candidate for direct euthanasia, but could he achieve a shortening of his life through the (so-called) indirect euthanasia? We know that the application of effective means against pain should be able to be delivered to these patients, even when they carry a certain risk of acceleration of death and the patient is satisfied with it. From there also has tried to interpret extensively the application of these powerful analgesics, not only to the function of mitigating pain but also in other parallel situations that, knowing the double effect of these analgesics (pain and sedation) is they try to be used when other situations that generate indignity of life in these terminal patients can also be used; but they insist, although they shorten the period of life, they do not consider it euthanasia. fallacy?

I defend the Right to Die with Dignity in all its conceptual amplitude. The right to life can no longer be separated from the right to health, which is an immanent part of the first, and which means not only and simply living, but also having a sufficient quality of life. It is not about keeping a patient in a bed palliating, concealing, covering, hiding his pain, and his indignity to make him live in opprobrious conditions, whatever they may be, through the administration of drugs, and subject to a large sum of money (for doctor and for the Institution) that involves such medications, equipment and care. It is, precisely, to prevent, avoid, that the patient, who already knows terminal, irreversible, does not have to go through these sufferings, and these conditions unworthy, inhuman, when it could, very well, opt for a legislative alternative that allows him to die with dignity now that he (she), patient, and not his doctor or relatives, can decide.
Timely recall the figures of the World Health Organization: more than 40,000,000 patients need palliative medicine and only 14% of them can achieve it.

CAPÍTULO VIII

A CONCEPTUAL MYTH. SEMANTIC PROBLEM.

In relation to the definition of euthanasia I have always maintained the thesis of the existence of a great conceptual myth that originates, only, purely academic material and that varies from author to author; but in the end, in my opinion, they only translate the same procedure, the same value, the same philosophy based on the principles that I have been presenting throughout this essay. The difficulty is also expressed in specifying a definition that has many edges and whose grammatical expression will depend a lot on who defines it from the medical, legal, bioethical, social point of view, and of course, it will have different connotations and adjectives according to who the definition is in favor or against it. That is why I define this aside as the conceptual myth of euthanasia, and I will try to conclude that all the variation of terminology and its divisions are not things beyond the semantics that have been constructed on this subject.

However, to help the reader somewhat who has not been familiar with these concepts, and for purely academic purposes, I will try to cover the most generally accepted concepts without it being understood that I accept, *nemine discrepante* (without debating), the artificial concepts and divisions universally understood.

From the general point of view euthanasia is a term of Greek origin, *eu* that means good, well, and *tannatos*: death, conception referred to "good death" that is defined as:

1. Death without physical suffering.
2. Voluntary shortening of the life of those who suffer an incurable disease to end their suffering.

General words are also accepted as: action to induce a quiet death; act of producing a painless death; death caused without suffering by means of appropriate agents.

In some criminal substantive norms, and from the juridical point of view it has been equated to “homicide for piety” or “pious homicide”, terms that, legally and medically, I do not accept; precisely because it is not homicide, in the literal legal sense of the word, in terms of its aims, intentions, motives, etc., nor is it pietistic because it is not done out of pity, piety, mercy, misericord. Juridically, euthanasia would include a homicide characterized by a motive presumably inspired by a humanitarian sentiment in order to avoid or continue with prolonged suffering due to pain or other symptoms or complications in patients whose illness is reputed to be incurable. Some consider it equal to a simple homicide, others as a crime of suicide aid and finally, others consider it as a great cause of attenuation of responsibility and come to call it the pious homicide par excellence.

It is compared to homicide because given the circumstances that any person (active subject) could, intentionally, kill another (passive subject) for reasons of mercy (mitigating sanction or penalty). However, we differ from this criterion, which I do totally reject, because not every person should be the active subject in this relationship; it must be, in my opinion, a "qualified" active subject: the medical doctor; who through his knowledge, and with the use of known medicines could complete the express desire of the patient and help him to die with dignity, in an active way. Then we should differentiate the *animus* with which we proceed, because in the simple homicide intentionality is directly and expressly referred to the disappearance of the person with which you would always get a benefit: kill for revenge, for passion, for stealing, etc. In this sense, the health professional would be very distant from achieving a benefit with the death of the passive subject: the patient. In simple homicide, the passive subject on whom the action relapses is generally healthy, free of any disease, or even when ill, his death is not sought for a relief from it; in euthanasia the patient (passive subject) is also a qualified subject; that is, he must suffer from a terminal illness, be terminally ill, with unbearable pain or other conditions that make it unworthy to endure more suffering, that his condition of irreversibility has been certified, etc. and who voluntarily seeks the physician to help him in a process of ending his life that, already, a disease (cause legitimately insurmountable by either of the two) has begun; and it is only a matter of shortening a process already initiated by the nosological entity itself, and that it occurs without pain.

The relief of the suffering involved in the need to end life are mostly related to the pain, generally intolerable, that occurs in certain terminal diseases. Today, such a foundation lacks, according to some authors, a valid scientific criterion since medical activity currently has adequate and effective means to alleviate the pain in the last days of any incurable patient. But other inhuman, degrading, and disgraceful conditions in which the patient may be found should be considered and they would need this medical intervention to help him complete the process.

The debate has increased greatly and is aggravated for the anesthesiologist who, today, is the one who deals mostly with pain therapy and intensive care. It is believed that aggressive palliative care combined with modern techniques for pain control, reinforced with true social programs for terminal patients will reduce calls for euthanasia and assisted suicide.

Euthanasia can also be understood as the help given to a person, seriously ill, because of their desire, or at least attention to his alleged willingness to enable him a humanly dignified death in accordance with their own convictions.

This concept leaves me with many lacunae because not all the nuances that relate to the subject are contemplated. Currently, and in accordance with the various legislations, not every seriously ill person is a natural candidate for euthanasia, and the will may never be presumed. I do not believe it is the person's desire to die; the patient does not want to die, but he has no alternative in the light of science. What is certain is that he goes voluntarily and does so to eliminate the factor that makes it unworthy to continue to endure an irreversible disease and that makes suffering unworthy. As in other subjects, consent must be express, and here, in euthanasia, consent would even be required on at least two occasions; and that is why, I decided, some time ago, to speak better about exercising the Right to Die with Dignity.

However, only for the clearly didactic purpose, I must clarify to the reader, the terminology used in this important focus of the Right to Die with Dignity; thus, there will be no doubts when you can, in other works, get these different denominations.

The motivation to the end of life due to suffering in unrecoverable patients can be presented in different modalities:

1*) Euthanasia*: administration, which in my opinion must be medical, of a lethal agent with the purpose of preventing and / or alleviating the intolerable and incurable suffering of a patient. The doctor performs the immediate action that ends the life.
2) *Voluntary active euthanasia*: A form of euthanasia that is provided at the request of a patient, (physically and legally) competent. To me it is absurd to speak about "voluntary" euthanasia because the concept of euthanasia is always volunteer, desired for the patient who must show his written agreement and desire or will for self-determination.
3) *Involuntary active euthanasia*: It does not exist, in principle. Euthanasia is an expression of will and it has already been explained that one of the correlative principles is the principle of autonomy of will and self-determination. However, the use of this terminology will be achieved by referring to that form of euthanasia made without the consent of a competent person. Applicable only to the incompetent patient (in a coma) without an advance manifestation of will. It usually occurs in cases of patients who become brainless and are the family or the judicial system who make the decision. In these cases, you cannot talk about euthanasia, and what should be is an authorization (judicial) of the relatives that the law (of each country) are called to supply this "authorization". Otherwise, unfortunately, we cannot even talk about euthanasia, even less exercise it. Attempts are made, to stigmatize the procedure, to mention the "collective euthanasia" executed in the Nazi concentration camps. That, simply, can never be considered euthanasia, and much less involuntary, because none of the deceased was, actively, requesting, to be eliminated.
4) *Passive euthanasia*: It does not exist either. The characteristic of euthanasia is that a person (doctor or not) applies, provides, "actively" a lethal substance for the patient to achieve his goal: death. Otherwise, it is other people who help and supply the lethal agent to the person. *Ergo,* cannot be passive, and, perhaps, we would be talking about assisted death.
5) *Direct euthanasia*: directly and expressly helps the patient in dying. The administration of lethal drugs or substances is done for that purpose.
6) *Indirect euthanasia*: it is achieved through the administration of drugs, usually potent opioid-type analgesics, used in progressive doses, which mitigate pain and as a side effect, collateral (not originally desired?) death ensues. We already define it as one of the great fallacies and it is the favorite argument of those who, being willing to die and shorten their life in case of serious, irreversible, and disgraceful suffering, do not dare to say it with sincerity that they directly accept euthanasia , and generally belong to Catholic religious groups. Some sentences summarize: a medication intended to alleviate pain, issued by a doctor, in correspondence with the declared or presumed will of a patient, is not inadmissible in a dying but, unintentionally, that assumes as inevitable consequence of compliance with the acceleration of the deadly process.

7) *Autonomous euthanasia*: We would be considering a patient, prepared and technically competent, who could achieve the acquisition of lethal substance and he himself apply, administer, ingest, without help from anyone else. Or perhaps reach the same end through other existing, known procedures. It is not common. We should talk about assisted death.

8) *Heteronymous euthanasia*: Concept derived from the original and unique euthanasia term where it means that the doctor, or third person, administers a lethal substance for the purpose of preventing, alleviating and ending the suffering of the terminal unrecoverable patient. There is an active subject who simply perform or put into action the necessary measures, to let the patient finally die. Euthanasia, in itself,, will always be heteronymous.

9) *Euthanasia by omission*: It is one of the common ethical and legal problems since it is not always easy to define what is lawful and what is not lawful. By not administering any substance, although it is true that he lets the patient die when the moment comes, he does not actively administer any substance that relieves him while that moment arrives; so that passive euthanasia cannot be correctly described, since euthanasia implies an action consisting in the administration of a special agent. An operation or an intensive treatment that would have allowed the patient a longer period of life is renounced. For the purposes of legal treatment, possibilities must be differentiated: omission of measures that lengthen life, which can happen with or without agreement of will with the patient; and the third case is one in which the patient is already in a situation in which he cannot express himself. This form called passive is the most frequent to be observed because it only requires omission in the paralysis of treatments that, having been initiated, could prolong the life of the dying patient for a longer period of time. The biggest problem arises when discussing the paralysis of a fan, mechanical ventilator for breathing, for example. In finalist interpretation is simply to interrupt a treatment, to omit the treatment, it would be euthanasia by omission, but in clear and frank interpretation the switch to the OFF or disconnection position is executing a very positive and direct action, so, although it is true the primary intention is to omit to continue a treatment already installed, it is no less true that it corresponds to a positive and dynamic action that when interrupting the ventilator is known, and it is certain, that the death of the patient will come: active euthanasia!

10) *Resolutive euthanasia*: Strictly adhering to the terminology, euthanasia will always be resolutive as long as it is known, it is known with certainty that, in a very short time, the desired effect happens: death. From that point of view, it will always be decisive. There is an active conduct to shorten life.

11) *Solutive euthanasia:* It would be, more adequately, the conjunction of two terms because in this case, and remembering the so-called indirect euthanasia, the doctor uses potent analgesics and other drugs, in function ¿primary? to help mitigate the pain even if you know that, finally, you will achieve the death of the patient. The issue is that you do not know when it will appear. From this point of view, we would speak of a solutive action because knowing that these potent analgesics could help or cause the shortening of the vital period, and "supposedly" not done with this intention, it is unknown, completely if it will happen, and much less when it will happen.

12) *Natural or provoked euthanasia*: No explanation needed. Being an expression of the patient's will, and needing another person to exercise it, euthanasia will always be provoked.
13) *Assisted suicide (assisted death):* Provision, help, to a patient of the necessary means and / or information that enables a patient to perform a finalizing act of life. The expression of will always corresponds to the patient, but the preparation of the lethal solution, if at all ingested, will always be assisted by a third person since the patient would be incapacitated by himself to administer it: the afore mentioned case of Ramón Sampedro. I clarified that the term of assisted suicide is no longer used, preferring to speak of assisted death.
14) *Medical-assisted suicide* (death assisted by a doctor): Facilitation of the death of a patient when he or she is a doctor who provides the necessary means and / or information to enable a patient to perform a life-ending act. I also clarified that the term medical assisted suicide is no longer used, preferring to talk about physician-assisted death.

I must make it clear that, in order to avoid the stigmatization of euthanasia and its forms, at the international level, there is no longer talk of assisted suicide or doctor-assisted suicide, preferring the term aid in dying, or (medical) help in dying . In this way we try to fight against the stigmatization of euthanasia to which pejorative concepts are placed looking, in their purpose, to place the Right to Die with Dignity, in an unfavorable and even monstrous way. Actually, the word "suicide" although grammatically well applied, because it is a person voluntarily takes his life, does not explain the whole humanistic, philosophical, dignity, by which action is motivated. Hence, it is preferred, now, of the above mentioned semantic changes.
It should be understood that in euthanasia the medical help is always provided when the death process has already begun. The disease is in the terminal phase and its fatal outcome is expected and it has been confirmed that there is nothing else that medical science can achieve.

There have been great debates around the world regarding euthanasia and its new forms such as physician-assisted suicide, called PAS by Physician Assisted Suicide, today Medical Aid in Dying. Generally, large and deep religious, moral and even scientific convictions have prevented a faster advance of such practices. However, over time, a growing number of cases reach the courts seeking protection of the State in the sense of allowing a person capable, seriously ill, irreversibly, to end their agony in what affects not only his mental, physical, social capacity but also patrimonial. This last topic might seem a bit crude but let us think about those relatives of patients who have had to support very large sums of expenses of the Intensive Therapy Units to perhaps please in the moral relief the doctors who have tried, in vain, to keep at all cost the life of a person who already knew himself terminal and irreversible.

The criteria used against assisted suicide are mostly of a religious nature. Life is considered sacred. There is a large majority of non-religious people, but even in those of certain religions, not all are achieved against this issue, which seem to consider human life as sacred, decline their beliefs to the possibility of a life sufficiently attacked with the unbearable pain of a terminal and irreversible condition.

Other scientific aspects are considered; it is speculated that the approval of assisted suicide may induce the wrong diagnosis, the denial of the discovery of treatments that would allow the survival or recovery of these patients, and ultimately favor the disincentive in the scientific and clinical research that such assisted suicide could engender. But it is demonstrated that before a request for help in dying the collegiate diagnosis, of at least two other doctors, would eliminate the risk of medical error in the initial diagnosis; and on the other hand, the search for efficient therapies against pain would be favored or stimulated. In any case, the same argument of abuse in the aid in dying, , we face with that one of high-risk surgery decisions presented in seriously ill patients and those who are warned, as well as their relatives: ... *we will simply do our best but all the statistics are against* ..., is not this a form of therapeutic cruelty or dysthanasia? Would not it be better to respect the will of the patient and before the unequivocal and inevitable death help him to die with dignity?

The fundamental thing in all our discussion, on this and other related topics, is to be consistent with our ideas; we believe in informed consent (or as I proposed in World Association for Medical Law Congress in 2000, Helsinki: *legitimately declared consent*), but not in euthanasia; we ask ourselves: deep down we do not deal with the same aspect: self-determination and autonomy of will?

Of course, from the moral point of view that it is not a matter of any futile reason I go to the doctor to ask for injection of a lethal substance; it is about meeting certain conditions and before the opportunity of a precarious life, in agony, in suffering, by proven irreversible illness, can I, in the exercise of my right to self-determination, leave the struggle for life and seek help for a dignified death, without suffering; and there the doctor has, in advanced, to think that also before death his action of avoiding pain and suffering is his obligation. But I have maintained the criterion that the right to life and to die with dignity of the patient cannot mean an obligation for the doctor, who, convinced I am, has his right to express his conscientious objection. All the purposes of legalization of doctor-assisted suicide declare this justification: the doctor can choose to help but is not obliged to do so.

That is why when I started this section with the purpose of conceptualizing euthanasia, I clarified that it was nothing more than a matter of semantics. Whatever the name that is intended to be given to the behavior of action or omission, primary or secondary finalist, will always lead to the result of death; otherwise, what is sought is consolation, protection and social approval in ways that, seen *prima facie* as partial, are basically euthanasia, and it is precisely the group of people who declare themselves to be opponents, the first to keep in their pockets an advanced manifestation of will where they accept shortening of their life period in conditions such as those discussed in this essay.

Whatever the position taken, we can accept that euthanasia is nothing more than the procedure by which the reduction of the life span of a person suffering from a terminal illness, undoubtedly irreversible, in the light of the prevailing scientific criterion, is achieved, and who palliative medicine no longer offers the alternative of living with dignity, and that the doctor accepts to assist in the expressly shaped request of the patient, who, for purely humanitarian reasons, helps to end their suffering, in the assurance that If there is no such action or procedure, the patient will die in the same way but suffering unbearable pain or other opprobrious conditions that violate his personal integrity as a whole. It is understood that the deadly process has already begun, and the doctor is faced with legitimate and insurmountable causes that he himself has not provoked.

CHAPTER IX
HOLISTIC HIERARCHY

In abuse of the juridical figure of Hans Kelsen regarding the hierarchical supremacy of the laws and by way of analogical application in the interpretation of the laws, is that I have created what I have called the pyramid of the holistic hierarchy of life. If in the hierarchical supremacy of the laws we use a pyramidal system of interpretation of a supreme law and that teaches us which law to use in case of double regulation of the same matter (fact that for the reader who is a lawyer is easy to understand), in the same way we will use a pyramidal system that will teach us what is the true supreme essence in the matter that concerns us.

On the one hand, we must clarify that I adhere to the new concept of health that, by extension and development of the constitutional concept of Article 83 of the Constitution of the Bolivarian Republic of Venezuela, and modern conceptualization, was established, it is accepted and inferred that Health is:

a) A fundamental social right
b) That must be guaranteed by the State
c) **That is part of the right to life**
d) That all people have the right to a high level of quality of life
e) Every person is obliged, by a principle of co-responsibility, to participate in the promotion of the quality of life
f) **That health being a fundamental social right is defined from an integral holistic concept that encompasses an optimal state of social, psychological, cultural, biological well-being**
g) That it is the result of a collective process of integral interaction
h) **That health, as an immanent element of the right to life, is inseparably associated with a style and quality of life**, working conditions, habitat, recreation, environment, and health services.

In such a way that we can understand that in a pyramidal system we could place the right to life at its apex; below the right to health; and below, successively, each, and every one, of the elements that we have already mentioned.
When a person, during his life, achieves a terminal illness, which reaches its terminal phase, it is evident that already, from the point of view of our pyramidal system, begins to descend; which means a detriment to the quality of life as the fundamental apex of the right to life, and that, as a legal right that must be protected, protected by the State, it is achieved outside the protection of that fundamental premise. Absence of health, in terminal phase, and especially if we aggravate the situation with the failure or lack of medical-care services that can give me the opportunity to successfully overcome the nosological problem posed. Imagine for a moment that this type of disease is one of those that, too much, correspond to so-called stigmatizing diseases, and for which reason there is segregation, discrimination, which even decreases the workforce to get an adequate treatment.

How to understand, from the integral holistic point of view of health and the right to life, that a person suffering from terminal chronic renal failure can satisfactorily face, with a true and adequate quality of life, the uncertain process of his disease. Not to mention that the costs of dialysis are very high, and despite the existence of many dialysis centers in the country, and in which doctors work with true vocation, nevertheless must have suffered the shortage of a relative attended in these centers to account for the indignity of life itself when these patients must "endure" or patiently endure any kind of treatment, not only from the Institution and its staff, but for all the hardships that their suffer when taken to these centers means, for the ailments and sufferings that the same dialysis process itself means during the first hours after the treatment is installed; and that procedure repeated once and again and again, three or four times a week, without the right to rest and knowingly, consciously, that the so-called "point-of-no-return" has been reached. The patient is taken to his dialysis. From there he leaves with high ailments because the dialysis itself causes a painful detriment to his health. He spends a day recovering and when he begins to feel better, he is taken back to his inter-day dialysis shift, and penury begins again. Any of us who could have been close to a case like these could understand that it would not take long to get an affirmative answer if we dared to converse with these patients and ask them if they wished there were some other alternative that they could freely choose.

I have always commented that it is very easy to play soldiers, and from an office, with air conditioning, full of food and beverage services, move the chips representing soldiers and war machines, being general of three stars and exclaim: soldier! You cannot suffer from trench panic! It is very easy to say it; I would have to be in the trench listening to the deafening noise of the artillery, inspiring the suffocating smell of gunpowder mixed with the strange smell of blood (fresh, burnt, parched), feeling the trembling of the bombs falling near the trench, bursting the eardrums with the scream of pain of the trench companions, some of them already dismembered, alone and abandoned, to be able to say: why should not I suffer trench panic? Who says it? Who, oblivious to me at this moment, can force me not to suffer trench panic?

Thus, it is very easy, returning to our theme, from an air-conditioned office, full of wealth or well-being, full of health and excellence in quality of life, philosophizing about law, justice, reason, medical science and the example of professional with his starched white coat, and, still, conclude in a legislative office: every patient must live, regardless of their quality of life. Who am I to impose a model of life on another? What does it do to me above the pain and suffering of others and say: every person, regardless of their will, must live, no matter what their quality of life is, and what is most important, regardless of what their temporary expectation of lifetime?

The integral holistic concept of health, and considered as an immanent element, inseparable from the right to life, leads me to consider the possibility that perhaps we can coexist, live, under the universal criterion of freedom, of free will, and without continuing with the fallacy of a misunderstood purity of life, to offer an alternative for those who, from their own existence, can reasonably and under the rigor of scientific and legal criteria, choose for an alternative that, present, can be carried out without it mean to me a fear, a failure, a utopia.

The time of conscience and deep thinking has arrived. The concept of health and the right to life has, universally, changed. We cannot continue analyzing this problem from the prism of orthodox law, nor with restricted religious criteria, much less with rigid criteria of an ethics that has disappeared over time. The criterion of a right to live, and to live with quality of life, at least one opportunity to achieve an adequate quality of life, which allows us, reasonably and rationally, to face the risk of the path taken is imposed. I can analyze the alternatives that each patient brings, but the doctor must offer information and be prepared to help, assist, orient him in the solution of his problem. He cannot and should not simply reject him.
It is like the patient who approaches the doctor and asks for an abortion. Let's think, for a moment, that it's about saving the life of the woman in labor. Permitted, decriminalized in our article 435 of the Penal Code. However, the doctor consulted is a doctor of extreme religious conviction, who follows, *ad pedem litterae*, (verbatim) each and every one of his religious precepts, without exception and therefore, opposes to practice an abortion that, from the medical point of view is justified, and from the legal point of view is decriminalized, so there is nothing, except his sin to reject the request of the patient. However, the doctor cannot be required to conduct other behavior, cannot be forced to perform an abortion; he simply does not accept it and therefore cannot practice it; but not for that reason, he is in the position of leaving the patient without solving his problem, being obliged, at least, to offer guidance. However, I would like to know what happens to this doctor if, as consequence of his decision, does not save the woman and she dies (as foreseen) and, in consequence, he is taken to court for homicide.

The patient finally chooses her alternative and is seen by another doctor who does accept this type of abortion, and to save her life he accepts it. But let us imagine, beyond that, the patient seeks a eugenic abortion, given that the fetus she brings within herself, and through medical studies carried out, has a deformity incompatible with life. The first doctor surely rejects it; it's obvious; but the second one could accept it or could justify saying: in the first case, science and the law authorized me; in this second case I do not agree; Your life is not in danger and what God has commanded you I cannot help it. In which case the patient or choose the alternative to complete their pregnancy and perhaps lead a wrong life (we already know the legal actions by Wrongful Life and Wrongful Birth) or choose the alternative of going to the consultation of another doctor who, within its scientific and human criteria, understand that the product of pregnancy will not be viable (an anencephalic, for example) and resort to the procedure of abortion, which will not be criminally sanctioned in the countries in which it is allowed, and even in this, I think that there would be many justice workers who turned a blind eye to get to know the eventuality.
Where I want to go is: in any of the cases discussed, regardless of our reasoning and particular belief, there existed both for the patient and for doctors viable alternatives and adjusted to their personal convictions; and that no one, even if the alternatives are established there, could force them at any given moment to comply with any of them; however, whatever the decision of the patient or of any of the doctors we could not make a value judgment, from the outside, from the air conditioning office, and to say that is a reprehensible behavior, it is unlawful, it must be sanctioned.

The current concept of the right to life and its correlative right to health, focused from the holistic, integral point of view, with all its elements and immanent principles presents a reality that seeks to tear down myths rooted almost dogmatically, and often by custom,

perhaps without justification or sound criticism. The current concept of life project is immersed in the broad horizon of an opportunity to a quality of life and reaches far beyond mere physical or biological subsistence.

I already commented, in previous chapter, my opinion against that absolutist concept of life, much less if there is no quality of life that is the most important thing. I insist, in the same way, the right to life is not absolutist or superior to other rights. Frequently, a true sophism is alleged, that if life does not exist, other rights would not exist. The Constitutional Court of Colombia, in Judgment T-970/142 of December 15, 2014, and ratifying judgment C-239 of May 20, 1997, stated, with clear clarity: "*The Constitution not only protects life but also other rights. That's why* ***none is absolute****. Each constitutional guarantee must be seen in concrete because depending on the particular circumstances of the cases, its restriction will be greater or lesser.* ***In the case of life, for example, the Court, from its inception, considered that it is possible to limit it to safeguard other rights, especially the free development of personality and personal autonomy***. " (bold and underlined by the Author). Criteria that, personally, I fully share.

With the passage of time and the increase, sometimes exaggerated, in the interpretation of human rights, some rights have been giving rise to other rights, or it has happened that some principle that supposedly originated another right has been misunderstood.

It is debated whether the right to life gives women the subjective right to procreation. To accept this thesis, not far from getting many adherents to it, we could logically think of the acceptance of other subjective rights that would arise from that right.

If we accept as valid the criterion of the right to life as a generator of other rights that depend on that originating, we could infer that the right to procreation would be a subjective element, inherent in the right to life. Perhaps therefore we see how this "right" is taken care of in assisted reproduction clinics and unlimited scientific help is offered to the woman who comes in search of the assisted reproduction procedure. Of course, we know that for whom the doctors will first ask is for the father, the couple. But without going into deep philosophical considerations, we have reason to think that the feeling of motherhood is higher than its correlative in man. The woman without offspring, without gestation, without a child looks incomplete, feels unrealized as a woman and it seems that the structure and configuration of being a woman leads her to think about the right to procreation. Do not think many times, altruistically, I will complete the mission that God, my creator has entrusted to me: grow and multiply! It does not create or procreate a woman only for the external reason to bring a human being more to this planet; it is spoken in possessiveness: I bring my son to life; and maybe even, someday, I will demand: I have brought you to life ...! Well, we think if this right to life entails, inherent in itself, the right to procreation; and to accept it, it would be understood that having the right to life may have the right to procreation to the limit that each person, each woman, each couple wishes to exercise that right to procreation, and may limit it using traditional contraceptive methods such as also resort to abortion if necessary.

I have always commented that this misunderstanding right of procreation seems to bring another right attached to the originator: the right of information and publicity. The reader will agree with me to remember that the first thing one can observe when entering an assisted

reproduction clinic is a large billboard where doctors and nurses usually place the photographs, names and dates of birth of each of the children that, artificially, they have brought to life. Pride grows, both from the mother and the doctor, as well as from the institution in general. I wonder: Have realized these parents, doctors and nurses that they have violated the sacred right of the child to confidentiality, privacy, honor, reputation? It seems that the right to life obeys a supreme interest; and the derivative right to procreation has a supremacy over the rights of the minor, which, even protected by the Organic Law for the Protection of Children and Adolescents, and the American Convention on the Rights of Minors, is impaired, unprotected, subordinated to the rights of the mother, the father, and even the doctor.
To accept, that in fact I do not accept, the existence of this subjective right of procreation, at least in the sense that it has been tried to grant, we would be facing the conjunctural problem, or perhaps structural background, of thinking that then we should accept accordingly a subjective right to non-procreation, in which case we would be opening a dangerous gateway to indiscriminate abortion, to irresponsible motherhood.

In fact, it is happening. Nuances and varieties that could, *prima facie*, deceive us with subtle appearances of legitimacy that reveal the veil of the exercise of this pseudo right. The woman is subjected to hyperstimulation processes, a very variable number of embryos are achieved, two or three are implanted, and the rest are discarded without mercy and without consideration, or they are kept in extreme cold temperatures (cryopreservation) up to a variable period of time, according to the techniques and the country, but which varies from two to five years, after which the embryo must be discarded if it has not been replanted before.

Right to life that leads to the right to procreation, together with the right to propaganda and now, therefore, to the right to non-procreation.

All of which leads us to think about the activity of the doctor, of the biologist, who works in these assisted reproduction and / or fertility clinics. Because next to these alleged rights we are imposed another, very dangerous to consider, and that is where I intend to conclude. Behind this beautiful and heartfelt motherhood and the right to procreation is the very personal interest of the scientist behind the procedure. A scientist who studies, researches, experiments, and seeks the greatest number of achievements, which in turn inevitably lead to greater consideration in the world of science, the reputation and good treatment of his colleagues, and why not? increase in patients that help them to a better quality of life. Scientist who can sometimes try to surpass the informed consent of the patient, offering guaranteed treatments, which can then fail, offering innovative procedures, coming to think that over and above all these rights, there is also a right to scientific research, a right to clinical practice, who knows if we finally get to convince ourselves of a right to the professional exercise of health, and return to the rejected vertical model of the doctor-patient relationship. Shielded from the barrier of collective and / or diffuse interests, as the case may be, and the probable benefit of medical research, the very personal right of the doctor who tries to overcome the interests and rights of the patient is concealed in the understanding that it is the doctor, the strong one of that contractual obligational legal relationship that exists between him and his patient.

There are no major limitations to scientific research; and those that exist, as in fact we know multiple declarations and international agreements of ethics in the investigation, of bioethics in the experimentation and in all of them, in spite of those limitations, many of the times they are disrespected or crossed with contrived arguments, until making us to come to think about the violations that, in the field of genetic engineering, cloning, genetic manipulation and other scientific investigations, have surpassed the limits imposed by such declarations and agreements made.

All of the above to conclude that we already confuse the rights of people who are not sure of what is the good and/or the legally protected interest that the State is obliged to protect and care under tutelage. Because of accepting the sequence that I have pointed out there would be no lack of who could argue that, on the right to life of a person suffering from a terminal illness, who is in the terminal phase, with an evident criterion of irreversibility, not necessarily in a coma or in an intensive care unit, with deep pain, and a clear decrease in their quality of life, who faces a truly unworthy life, perhaps even discriminated against because of the origin of their illness, someone who could say that, as a doctor, and in its right to medical practice and research, and in compliance with its duty to defend life, as the sole purpose or objective of their professional training, can and in fact be considered with the right to practice the disgraceful and rejected practice of the dysthanasia or also called therapeutic cruelty.

I perceive a loss in the scale of values that leads us wrongly along an uncertain path in flagrant violation of the rights of people in general, and of patients in particular. You cannot take the flag of the defense of the principle of self-determination and autonomy of will partially and without being consistent with the principles and ideas that are proclaimed. If we defend the right of people to self-determination, autonomy of will, the right to information, the free development of personality, integrity, informed consent, the patient's right to be informed as well as to respect their right to not be informed and as we defend their right to refuse to undergo diagnostic or therapeutic procedures without their consent, as reflected in our national constitution, we must then be prepared to the debate on euthanasia from its beginning.

What must be completely clear, far away from any reasonable doubt, is that there is no such right of the doctor to impose behaviors on his patient, at all costs, and in any condition, protected by the duty or the alleged obligation that his mission in life is to save all patients and initiate an indiscriminate and unacceptable struggle without meaning by subjecting their patients to unworthy and immoral conditions knowing the irreversibility of the patient and / or their conditions, knowing that the only representation that, eventually, in short term can be done is the expected death of your patient; and especially knowing the patient's right to take a free decision that can go from the simple rejection of medical treatment, to its maximum expression, in the countries where it is allowed, to opt for the euthanasia procedure.

The juridical norm is not more than a set of words that, expressed in a logical grammatical order, gathers the opinion of the necessity of a form of conduct, that establishes a determined community, for itself, and so that it has validity in a space geographic and at a specific and determined time.

The legal norm stems from the *opinio iuris neccesitatis* of that community, and will change, therefore, as many times as necessary to reform it in the light of the advances of dynamic science and the equally changing criterion of the community that will use that norm. as an expected model of behavior. Proof of this are the endless reforms of constitutions, laws, codes, resolutions, etc.

One of the most important aspects in these reforms, especially the one that our Constitution presents, is the inclusion of the defense of human rights, not only the so-called first, second and third line or generation, but also those that, not yet expressly defined in the Constitution, are understood as immanent rights of the human being, from its birth and even before its conception (article 22).

The Constitution of the Bolivarian Republic of Venezuela expresses in its article 43 that the right to life is inviolable, and it will not be possible to impose the death penalty, nor any authority to apply it. As we explained earlier, this right to life is closely linked and inseparable to the right to health, contained in Article 83 (ejusdem), and that should be understood as the quality of life immanent to the right to life.

We must analyze that a right, according to the legal thought of Kant, is the set of conditions by which the discretion of each can coexist with the discretion of others, according to the "universal law of freedom." According to this, as a human being, I have the discretion, faculty, freedom, autonomy of decision, to accept a resolution with preference to another. It is my right, then, to life. It is not, in the constitutional norm, the right of another, of a third party, but of mine, my right to life. Of course, in the understanding that I must also respect the right of others to their decision to live or not to live. That is your right. What yes, certainly, imposes the constitutional norm is a conduct of abstention on the part of the State and of the individuals, to the restriction of which no authority imposes a punishment to me, understood like sanction or punishment by an unlawful conduct, to the death; must the state guarantee me, as a citizen, that no one may violate my right to life, and if I have departed from the norm of conduct expected by the legislator, and commits a crime, I will be imposed any penalty, deprivation of liberty or accessory, any other, except death. That is the guarantee right imposed by the constitutional norm.
The State must guarantee that right to life; a *motus proprio*, through institutional care and the prohibition of the imposition of any death penalty; and the abstention of individuals to cut off my right to life through the ius puniendi and by the guarantees principles of *lex certa* and prior that should lead to the imposition of criminal sanctions when violating, without just cause, my right to life.

I understand that the consecrated constitutional right, derived from the same form of precepts contained in the universal declarations of the rights of man and international agreements, is no more than a principle of guarantee for my life to be respected even when it incurs a crime; so much so that, in the generality of the declarations, the right to life does not come in isolation but on the contrary, it is always accompanied by the precept of non-condemnation to the death penalty.

But from there, to think or admit, by erroneous or manipulated interpretation, that another person, third party outside of me, can exercise in my name, against my will, without faculty, mandate or power, a right that is not theirs and to force myself to live, in whatever the conditions of the moment, is legally and humanly unacceptable.

Lawyers who are still trying to interpret, wrongly, Medical Law from the point of view of orthodox criminal law exclusively, maintain that euthanasia, as a legal norm that was intended to be included in the draft Organic Law of Health is illegal because the Penal Code sanctions the homicide and the induction to suicide. But, I wonder, why not think if the approving norm of euthanasia would be considered necessary and accepted by a community?

The international legal community is prone, although fearful of this type of impositions, of favoring a right to a dignified, decorous, honorable and timely death. Well the solution is easy, and it is already announced. If perhaps the sanitary norm collides with the criminal one, then the penal norm shall be reformed, the euthanasia is decriminalized, and problem would be solved. We are answering to understand that every norm is reformable; even those who have publicly opined that euthanasia is illegal because it is prohibited in the criminal substantive law, are the same ones that are reforming the same criminal law to include new crimes or decriminalize situations that modernity has demanded in its dynamic development; and even eliminate others that, being classified as crimes, already in the light of current situations would not be considered as such. The problem is and always has been to try to stay behind in a Penal Code whose specific reforms of reforms take us to past centuries, due to the erroneous position that the norm is already imposed and therefore a variant of it would not be acceptable.

Then, the traditional orthodox ethics of Medicine, who, like the Orthodox criminalists, have not realized the evolution of it and that ethics, from other times, have given way to a new form of philosophy of thought within the so-called biomedical sciences and expressed through Bioethics, or the most modern currents of Functional Contemporary Ethics.

These orthodox argue that the image of the physician would not be in accordance with the position of euthanasia; that the physician is formed only for life, and to it the modern criteria of the autonomy of will and self-determination of the patient must still be disrespected. They also add that the Code of Medical Ethics in its Article 84 establishes that it is not possible, under any circumstance, to deliberately cause the death of the patient even when he requests it. But it should be noted that the same Code that prohibits the euthanasia of adults seems to favor and allow infant euthanasia, when, in the light of Article 62, it states that if the child's condition is such that the treatment will cause the precarious prolongation of life, parents must be informed of the authority to suppress consent for treatment and require the doctor to suspend the already initiated. If euthanasia is active or passive, it is not the issue. Different semantics for the same problem.

We are confronted with a terminally ill, terminally ill patient, from whom an imminent death is expected, with a humanly unbearable suffering, unworthy of being taken away, shameful and ruthless. It is the terminal patient himself who, in his free will, faculty or right, physically and legally capable, brings into play the most beautiful and sacred right of the human being: self-determination and autonomy of will. Right otherwise enshrined in Article 72 of the Code

of Medical Ethics and that cannot be abrogated by society unless they were in danger or interest public order or health. But here we repeat that, in the opinion of the Supreme Court of Justice, this reservation of public order and health cannot be misunderstood, in the understanding that an individual decision of this type would never affect collective or diffuse interests, and that the limiting notion of damage that could subrogate the right to self-determination would be those cases of notifiable diseases, reportable, due to its epidemic nature, infectious contagious, etc.

But let us be clear on this matter. The fact of accepting euthanasia as a right of the human being does not impose on you, as a human being, the obligation to accept and ask for it; nor does it impose on any doctor the obligation to execute it. It remains the right of everyone, according to their own conviction to accept it and request it or not. Some examples of daily life illustrate us. Cremation is accepted, but that does not mean that you are obliged to accept it. Experimentation in humans is allowed, but this does not mean that you are obliged to accept experimental treatments. The right of free movement is accepted throughout the national territory, but this does not impose on you the obligation to circulate, and you prefer to stay at home resting. You exercise your right or not. What nobody can do is impose the absolute restriction of not circulating. Legislation is given, the opportunity is offered to those who wish to do so, from an alternate solution to the conflict of a deplorable, unworthy life, laden with suffering, when it is known that there is no solution. That is my right. Nobody, alien to me, can impose his will on me to live according to his principles, beliefs or convictions; After all, who should continue to live in pain is me and not that outsider who tries to decide for me. Hence the difference of the right to life against the obligation to live.

Of course, favoring the criterion of euthanasia, assisted suicide, the so-called pious, pietistic homicide, or whatever you want to call it, does not mean that any person can make use of it. The afore mentioned project norm, in a similar way as expressed in other legislations, announced a special law or regulation. As in other countries, some requirements should be met; and it occurs to me that, for example, the criterion of terminal illness must be supported by a private doctor, family doctor, in turn corroborated by an independent doctor; and / or a Qualifying Board of not less than three members, certifying the existence of the patient's irretrievability; that there is also an institutional Bioethics Committee that gives its opinion, and certifies that it is a patient, physically and legally, competent that can freely impose its self-determination and autonomy of will, that has expressed its informed consent, legitimately declared, at least on two different occasions; that such decision is documented, perhaps in an authentic manner, and that the requesting patient has been fully informed of the consequences of his decision, that there are no alternate palliative methods, in short, any other reasons or arguments that wish to be included.

So, we think that we live in a modern society, advanced, that we need to update and modernize, not only in terms of legal standards, but criteria and ways of thinking, and we must once and for all, stop tearing our clothes and learn to respect that the right of a person does not mean an obligation for others to accept and execute it. We live in a free, democratic society and each one must be able to select, within certain limits already indicated, their own decisions.

Let's stop fighting and restricting the advances of the dynamic science of Medicine, and let human rights be imposed, in the way that, as we express, the fact of establishing the legality of euthanasia does not mean, in any way, that no person can be imposed if he does not want it; nor can any doctor be required to perform an obligatory action that is outside their criteria and values.

In this sense, it is appropriate to point out that, on the contrary, as some authors have opined, a patient suffering from a terminal illness, terminally ill, disabled by the disease itself, with unbearable pain, and other conditions of the disease that make the life an unworthy martyrdom, is no longer of any benefit to the State, so that the decision of that person to achieve peace and dignity in its terminal phase of life, does not deprive the State of any benefit for what could be misunderstood a negative of the State to the same procedure for the argument of an occasional or eventual benefit that would lose acceptance of the departure of this citizen.

The exercise of my right to die, to die with dignity, does not harm any third party, does not oblige any doctor or person to assist me, nor do I eliminate the possibility of any use to the State whenever I am in the terminal phase; *ergo*, nobody can abrogate or limit me the sacred right of my own self-determination and autonomy of will; concluding that the right to live could not and should never be understood as an obligation imposed by third parties to live, regardless of the quality of life that makes me suffer unnecessary.

CHAPTER X
HISTORICAL EVOLUTION

In another order of ideas, and figures obtained from other studies, we can account for the following facts:

In 1605 Francis Bacon introduces for the first time, the current conception of euthanasia: "*the action of the doctor on the patient including the possibility of hastening death*".

David Hume, (1711 to 1776) justifies euthanasia when he says "*if the disposition of human life were something reserved exclusively for the almighty, and it were to infringe the divine right that men had their own lives, so criminal would be that a man will act to preserve life, as the one who decided to destroy it* "

In the **Netherlands (Holland)** euthanasia was practiced, even illegally, and it took more than thirty years of debates and numerous court rulings that ended in 2002 in the so-called LAW OF TERMINATION OF LIFE AT OWN REQUEST AND FROM AIDS TO SUICIDE. First in the world in its kind. Of just 24 articles and passed in the Senate in 2001 was really in 2002 when it came into force. The law not only contemplated its own regulations but also modified articles of the current Penal Code. There euthanasia was allowed in adults, under certain characteristics: it required medical confirmation that the patient presented and had arrived at the conviction that the request was voluntary and well thought out. The terminal illness, terminal patient, terminal phase, was presented with unbearable conditions and without hope of improvement, there being no other solution.

There were some interesting variants. In patients over 16 years of age it was required that there be a reasonable record of their requirement with written writing of their request. Otherwise, the request was heard and to maintain a good degree of discernment it was necessary that the parents, representatives or guardians had participated in the decision. Otherwise, it was measured if he was in a position to make a reasonable assessment of his interests and it was also necessary to listen to the opinion of the parents. And between 12 and 16 years the patient was listened to, their degree of discernment was valued, but needed the authorization of the parents, representatives or tutor.

In the afore mentioned law, other essential requirements were detailed so that the procedure could be carried out.

In **Belgium**, two laws followed. A first one in 2002: LAW RELATING TO EUTHANASIA. The law maintains principles similar to the Dutch but did not mention the practice of assisted suicide. It required the age of the patient, and even older than 16 years of age but emancipated, and maintained the patient's willingness and reflection, and there may be

evidence in a document of anticipated wills but no more than 5 years. Certainly, it was maintained that the patient suffered constant or insurmountable physical or psychic suffering caused by a serious and incurable pathological condition.

Evidently, the law contemplates other details related to the procedure and that it should, strictly speaking, be complied with.

But in 2014 a new law was approved in Belgium that amended the previous one and in this new law euthanasia was allowed in children and adolescents, as long as there was constant, or insurmountable physical or psychic suffering caused by a serious pathological condition. incurable, the consent of the parents and a psychiatric report certifying the degree of discernment of the minor.

In **Luxembourg**, in 2006 appears the LEGISLATION THAT REGULATES EUTHANASIA AND ASSISTANCE TO SUICIDE, with parliamentary decision in 2008 and came into force in 2009. The patient was required: 1) the patient is of legal age, trained and aware at the time of your demand; 2) the demand is formulated voluntarily, reflected and, where appropriate, repeated, and that is not the result of external pressure; 3) the patient is in a medical situation without solution and his condition is of a physical or psychic suffering constant and unbearable without perspective of improvement, resulting from an accidental or pathological ailment; 4) the patient's demand to resort to euthanasia or suicide assistance must be recorded in writing. In the following articles appear the medical and accessory requirements.

In **Colombia**, although there is no real legislation, euthanasia is approved by decision of the Constitutional Court C-239 of May 20, 1997, and the criterion is ratified, totally, with decision of the Constitutional Court itself T 970 of December 15 of 2014 and subsequent recourse exercised in the face of medical refusal, through which three clear fundamental principles remain:
1. The right to die with dignity is a fundamental human right.
2. It is the patient who decides how unbearable his pain is. The requirement that the disease cause intense suffering to the patient should not be limited to a medical criterion, since this would clash "with the very idea of autonomy and freedom of the people"; and thus, "it will be the patient's will that determines how unworthy is the suffering caused.
3. The right to life is not absolute. It can be regulated and limited to protect other rights such as the free development of personality and autonomy of will.

Recently, (March-2018) it was approved to extend, by Resolution 825 of the Ministry of Health, following the Sentence T-544 of the Constitutional Court of Colombia the procedure for children and adolescents after 12 years of age, considering that, between 12 years and 14 years, although the autonomy of the child is required, also the authorized concurrence of the parents is required. Between 14 years and 17 years, parental authorization is not required; while in the group of 6 years to 12 years, the conditions are stricter and more rigorous, including that the child psychiatrist who knows the case must identify an exceptional neurocognitive and psychological development.

Quebec: year 2015. Discussed and controversial Law for the RIGHT TO DIE WITH DIGNITY was finally approved in the autonomous province of Quebec. It is the first such legislation in that region, and that allows, only in Quebec, the application of the Law whenever the Federal Government of Canada does not agree. The Deputies approved the law with 92 votes in favor and 22 against. To avoid federal laws, the Quebec authorities have declared that their bill is a sanitary issue, which in Canada is an exclusive competence of the provinces. The so-called "Law 52" provides the conditions for granting palliative care, as well as the parameters for a doctor to prescribe the necessary treatment to end the life of a patient if he or she has an incurable disease or is suffering too much. Law 52 distances itself from laws passed in other jurisdictions in the United States (Washington, Montana, Oregon, Vermont) that are more oriented towards assisted suicide; and it is closer to the laws of the Netherlands and Belgium, where they are really referring to euthanasia. It would be doctors who would apply drugs to patients with terminal illness, with unbearable suffering and proven no possibility of regression to life, as long as there is still enough mental capacity to request the procedure.

To request euthanasia, the patient must be of legal age, have an incurable disease, and prove that he or she is going through unbearable physical or psychological suffering. The request must be submitted by the patient, must be in writing and two doctors must certify compliance. Then it was decided by Canada, as a country, 2016. After a few years since the decision of the Supreme Court of Justice, finally the parliament approved positive legislation in Canada, effective from June 2016. The legislation includes medical-assisted death and also the law itself. euthanasia. As in other legislations, requirements are imposed such as: presence and ratification of a terminal illness, in terminal phase, which is in intolerable suffering, and whose manifestation of will belongs to a competent (mentally) adult. The doctor, for his part, is not bound by the procedure.

The **Australian State of Victoria** approved, November 29, 2017, but effective as of June 2019, legalize euthanasia. Better, we should consider the true option of saying assisted death because the patient should be the one who ingests the solution and only in those cases in which the patient is not willing or does not have enough strength to do it by himself, he can request the assistance of a doctor who facilitates the work (death assisted by a doctor). This fact makes this jurisdiction the first in the oceanic country to recognize the right of the terminally ill to request assisted death that will allow terminal patients to request the dispensation of a drug that ends their lives. The changes include a reduction of time (from 12 to 6 months) that eligible patients will have to access the program, and exemptions for patients with neuronal palsy or multiple sclerosis with a life expectancy of 12 months. According to the law, patients will receive within ten days the drug they may request after overcoming two independent medical check-ups and must administer it themselves except in some special cases.

Taiwan: The Taiwanese Parliament passed a law, on December 18, 2015 they passed a law, which will be effective in 2019, but what it does is approve the interruption of medical treatment and the use of extraordinary life support devices. Approval made only for specific and specific medical conditions: irreversible coma, terminal diseases, extreme dementia, vegetative states and incurable diseases. All this must be fulfilled under the conditions established by law: two doctors specialized in the area of illness must certify the condition.

The patient, beforehand, or after consulting with the doctors, can reject the care, when it is in one of the five conditions stipulated in the law. I wonder, how could patients with severe dementia, or in a coma or in a vegetative state, express their rejection of medical treatment? I clarify that I do not mention Taiwan especially, because what it has done is to recognize the patient's right to refuse medical treatment, which is the most common and accepted in most countries in the world. It is not true euthanasia.

Now, the reader will ask about other countries or States. We leave them to finish with them because they have not had positive legislation regarding euthanasia, although they have approved assisted death and / or doctor-assisted death. We shall see.

1. **Switzerland**: one of the majority defenders of assisted death, and has, with at least three very recognized institutions in which, under certain conditions, assistance in death can be achieved. Assisted suicide has been practiced since the 40s in the Alpine country, but legally since 2006. The law supports it and the Swiss Federal Court of 2006 established that every person in use of their mental capacities (without taking into account they were terminally ill or not) has the right to decide about their own death. Important characteristic to mention, under certain conditions, not difficult to fulfill, accepts non-nationals, but residents; that is, foreigners.
2. In the **USA**, several states have already approved it, and I am talking about assisted death.

    1. The first was **Oregon**, in 1997, and medical-assisted death is approved. The Oregon Dignified Death Act (DWDA) allows a person of legal age, terminally ill, with a life expectancy of no more than six months, to request a doctor to prescribe a lethal drug. Other requirements are imposed, such as the following: the petition must also be signed by two witnesses; the patient must be advised by a psychologist and a specialist doctor; a period of reflection of fifteen days must be respected. It was precisely in Oregon that Brittany Maynard had to travel, because being a resident of Florida, but not approved in that State, she moved to Oregon to fulfill her final decision.

    2. **Washington**, was the second State, in 2009. Washington's Law is similar to Oregon's. Evidence is requested, life expectancy is less than 6 months, and the person must be at least 18 years of age.

    3. **Montana**. 2010. The requirements are the same as in the previous states, although it does not specify the minimum age to be able to access the process.

    4. **Vermont** 2013. After final approval, Vermont became the fourth State along with Oregon, Washington and Montana to have this legislation, and the first on the East Coast to allow doctors to administer lethal drugs to the terminally ill. It is the first time that a State has granted legislative approval to a regulation of this type. Oregon and Washington managed to legalize dignified death by referendum and a court ruling was made in Montana.

    7. **California**. 2015. The Legislative Assembly of that State (California) approved assisted suicide in September and allowed physicians to make indications and offer medications to patients to comply with assisted suicide, thus exercising the right of autonomy of will and self-determination.

    Now, the Governor signed the legislation and allows doctors to prescribe lethal doses of drugs for terminally ill patients who want to end their lives. The legislation applies only to mentally competent people and that doctors certify a prognosis of

life span of no more than six months. The resolution of the California Legislative Assembly, based in Oregon, requires physicians, fully aware of their patients, to have a terminal illness, and have a prognosis of less than six months of life.

The approval of the Governor was lacking, because of his religious conditions (Jesuit seminarian in his youth) is very prudent and reserved in moral matters such as that approved by the legislature. However, he thought that he thought about the need for a valid alternative for all people and that he would not be able to see these people in suffering. He himself suffers from skin and prostate cancer.

When approved, California becomes the fifth state that has already approved this subject in the United States (Washington, Montana, Oregon, Vermont).

8. **Washington DC**. 2017. The US capital legalizes assisted death. It allows doctors to prescribe to patients with terminal illness medications that end their lives. This new law, defined by its supporters as a "dignified death," establishes that only those terminally ill patients residing in Washington D.C. who wish to die.
9. **Hawaii**: 2018. Hawaii has become the most recent state of the USA, with a liberal tendency, in legalizing physician-assisted death, which allows doctors to attend to the requests of terminally ill patients to prescribe medications that can put an end to to his life; that is, assisted medical death or doctor-assisted death. The law was written to ensure that the patient has total control and provides only one option available for end-of-life care, knowing that assisted suicide is not for everyone. For this purpose, the doctor must confirm the diagnosis, prognosis and mental health of the patient. In addition, you will have to make sure that it is an application made at will and that it is witnessed by two people, one of whom can not belong to the sick person's family.

WORLD DAY OF THE RIGHT TO DIE WITH DIGNITY.

As a final corollary, I must mention that On November 2, 2010, the Dying with Dignity day is celebrated worldwide, better known as the day for the Right to Die with Dignity.

We sympathize with the announcement by the Board of Directors of the World Federation of Societies Right to Die with Dignity and honored us with uniting, from Venezuela, with the dignity of that day.

It began, this celebration for the first time, on November 2, 2008; day in which significant events were held in the city of Paris. The World Federation of Associations Right to Die with Dignity (World Federation of Right to Die Societies), of which the Venezuelan Association Right to Die with Dignity had been a member, declared November 2 as the World Day of the Right to Die with Dignity. The first commemorative act was held in Paris, France on Sunday, November 2, 2008; in the vicinity of Le Mur pour la Paix (Wall of Peace) which is a fairly recent monument that is located in the Champ de Mars park in Paris since the year 2000. At the event members of the various world associations met, including the Venezuelan, under the direction and coordination of the directors of the World Federation of Right to Die Societies, and within the framework of the 17th World Congress of the Federation. It was thus declared on November 2 as the World Day of the Right to Die with Dignity.

All of us, in this globalized world, are united by our belief in the autonomy of will and self-determination and in the possibility of being able to determine the moment worthy of completion of our life process, when the critical moment has arrived. There are many ways and procedures that are part of our belief, from the will guidelines for a palliative medicine, the refusal of medical treatment, to the determination to go through a procedure of euthanasia, when life, due to unnecessary suffering, is done disgraceful to us.

It has been, ever since, an extraordinary day and from then I, personally, take care to celebrate the day by any sort of event, conference, symposium, etc. and thus, join the World Federation of Right to Die Societies.

CHAPTER XI
NATIONAL LEGISLATION. LEGISLATIVE PROPOSAL.

Since its inception, this Work has presented the fundamental pillars on which the Right to Die with Dignity is based. However, for the didactic purposes of the presentation of a legislative proposal we will make some approaches, which, although sometimes repeated, are necessary in our discussion.

The first reference of this term and the behavior assumed by the legislator in this situation is found in the Hippocratic Oath when in its fourth paragraph the doctor commits to:

> DO NOT ADMINISTER ANY DEADLY DRUG, EVEN IF YOU ASK ME, OR TAKE THE INITIATIVE OF A SUGGESTION OF THIS TYPE. Also, do not prescribe a woman an abortive pessary; but on the contrary, live and practice my art in a pure and holy way (Capitals mine)

The position of the Hippocratic oath against euthanasia is clear, express, decisive and prohibitive. However, in the considerations made previously in this essay (chapter 6) we present the argument that invalidates the validity of this Oath and there we refer the kind reader, in order to avoid repetition.

The second reference was obtained in the Oath of Luis RAZETTI, adopted by the Council of the Faculty of Medicine of the Central University of Venezuela, from February 1984; on the one hand, it is not clearly expressed against euthanasia, but rather tacitly opens a door to authorize the doctor to practice it when, in its seventh aside, it says:

> 7. *My reverence for life in attending terminally ill patients will not collide with my fundamental obligation to alleviate human suffering*. [...]

Let us understand then that it is more important to alleviate human suffering, the terminal patient's pain than life itself and that in the face of the eventual situation of imminent death the doctor, even his reverence for life, should administer agents that alleviate suffering and allow the "good to die" of the patient.

This obligation of the Oath of Luis Razzetti is correlated and complements with the stipulated in the article 1 of the Code of Medical Deontology that, with clarity, expresses:

> *Respect for the life, dignity and integrity of the human being constitute in all circumstances the primary duty of the doctor*.

Strictly attached to the fundamental principles that I explained in the initial chapters and that we now see, diaphanously, in the deontological norm. The dignity and integrity of life as

fundamental aspects of the doctor.

These ethical principles to which he (the doctor) commits compliance are nothing more than those contained in the Code of Medical Ethics itself, declared standards mandatory acceptance for any physician who practices within Venezuelan territory, and where Article 84 itself It is very clear and decisive when prohibiting euthanasia: *It is the doctor's fundamental obligation to relieve human suffering. It can not, under any circumstances, deliberately cause the death of the patient even if he or his family members request it*.

However, it is worth analyzing the contradiction that occurs between the said article and the content of Article 62 (ejusdem) that contrary to the alleged prohibition of euthanasia adult, when dealing with matters of infants seem to leave open door for euthanasia; thus: if the child's condition is of such a degree that the treatment will cause the precarious prolongation of the life of a being with profound mental and physical deterioration, the parents must be informed of their authority to suppress the consent for the treatment and of their authority. to demand from the doctor the suspension of the one that has begun.

The third reference is to the Law Practice of Medicine which Article 25, paragraph 2, clearly states that: *professionals who practice medicine are obliged to respect the will of the patient or their representatives expressed in writing, when he decides not to undergo the treatment and hospitalization that would have been indicated. This circumstance leaves the doctor's responsibility safe*. (omissis)

In extension, in Article 28 clearly authorizes: *The doctor who cares for irrecoverable patients is not obliged to use extraordinary measures of artificial maintenance of life*. [...]

In Venezuela there is still the commitment of some professionals, who from different points of view and action, try to regulate this issue in some way. Still in one of the last drafts of the Organic Health Law Project appeared as the right of the patient:

> *The patient has the right to die with dignity and to request to his treating doctor the application of an adequate treatment or advice in this sense, provided that he is in a terminal state of his life or presents a serious chronic illness with suffering. This right will be subject to regulation by the Ministry of Health and Social Development*.

A few comments against went publicized in the national press and this article was deleted from the project. One of the lawyers who attacked the regulation of this right retains, however, in his portfolio a Living Will (Declaration of will) where he clearly manifests his desire and approval of some form of euthanasia for the time he is in terminally ill and provides that all treatment be eliminated and that it signifies the end of his life; that is, he does not approve euthanasia but asks for it.

For its part, our Criminal Code does not expressly classify euthanasia as a crime; neither does it decriminalize it; so any situation raised will have to be settled under the protection of the articles corresponding to crimes against persons, specifically homicide, articles 405 (homicide), 414 (induction to suicide), fundamental but not exclusively.

On the other hand, it is worth mentioning that, at the level of the Supreme Court of Justice, there was a Commission that drafted the Reform of the Penal Code and there was within the Commission the idea of decriminalizing both euthanasia and abortion; clear that within certain limitations and regulations and in special cases. That is, the discussion is still standing and at the time of writing these lines, and for its printing, there is still nothing definitive about it. In any case, there have been several, our participation, both in the National Assembly and in the Supreme Court of Justice.

Günther Jakobs said: *There has been a delay in the self-consciousness of society ..... it is a diffuse fear of not being able to assume such behavior through rational argument. In addition, Jakobs comments in this regard (Günter Jakobs, Criminal Law Studies, Civitas Editorial, Spain, 1997) that at this time the State is no longer the institution that administers objectivity, truth and morality, but rather, at the best In these cases, the State is the guarantor of the external conditions for this: protection, provision and State benefits that not only guarantee survival, but also the* ***quality of life****.*

The Criminal Code Reform Project, presented by Judge DR. ALEJANDRO ANGULO FONTIVEROS, and collaborators, and published then, 2004, (Edition of the Supreme Court of Justice) means an exhaustive work that, although it could have some contradictory aspects among diverse, honest and serious, doctrinal of the Law, contains relevant aspects of advanced that are well worth considering for the purposes of the perfectibility that the same project means. That is why I propose to try to present a focus on the most important points that I think should be discussed, understood, perhaps improved, articles that, by their content, have a direct relationship with Medical and Health Law, as a special branch of law (Tulio, A. Legal Medical Dictionary, Buenos Aires, Argentina, Abeledo Perrot, 1999), in the understanding of the concept issued by this author as: *set of legal rules and ethical-moral precepts, Public and Private, that regulate the activity of the doctor on the occasion of his professional practice, the doctor-patient relationship and the consequences that derive from it, thus establishing the fundamental principles of medical legal responsibility*. (Aguiar-Guevara, Rafael, Medical Law in Venezuela, Livrosca, Caracas, Venezuela, 1996).

Integral holistic concept of the project and quality of life that taken individually must be defended by preventing, by merely restrictive, disgraceful criteria, based on beliefs of others, the society, collectively or diffuse, try to limit these individual and personal rights and abrogate the they impose punitively a limitation that prevents the individual to fully exercise their individual rights.
It is then this quality of life, informed by the conjunction of our constitutional principles contained in articles 83 and 43, which has led to advance, in the Draft Reform of the Criminal Code, an alternative, viable, always optional not mandatory, for that those who do not get any objection of conscience, may have the possibility of adapting them within their normal bond of performance in this society, call the patient in terminal phase, call the health professional who must watch over his patient, as a person, as the subject of a legal relationship, from its inception and until its completion.

In due consideration of the legal rights faced, we must examine the realization of the specific actions required of a person who, in the face of any illness (irreversible terminal illness and

imminent death), or for refusing medical treatment as a blood transfusion in the case of those religious groups that do not accept it) is necessary for the satisfaction of the good to which a preponderant value has been recognized. It is unquestionable that the weighting judgment carried out, in what is now strictly of interest, confronts not merely the right to life of the person insofar as it matters as the right to a quality of life expressed in the terms that our Constitutional Chamber has indicated in various opportunities Life cannot continue to be understood exclusively, in an abstract way, as a superior value of the constitutional legal system, but also, it is appropriate to point out that the decision to face one's own death, by denying medical treatment, is not only a fundamental right but also a manifestation of the general principle of freedom that informs our constitutional text; integrating itself in the notion that the concepts of public order and health, as limiting exclusive damage (principle limiting harm as a way of exception to the exercise of autonomy of will and self-determination), do not become applicable in these cases of rejection to medical treatment, when by prevailing a right to an acceptable and dignified quality of life, the person freely chooses to reject medical treatment, without it being understood that there is an affectation of the public order or health, as long as there are no risks to safety or collective health in general. The decision, by reiterated constitutional jurisprudence, even international, is very personal, and does not affect interests neither of the State nor of the collective, and much less of its individuals.

So things, we can, *prima facie*, delve into the field of the right of people in the area of health, and how this Draft Reform of the Criminal Code, introduces avant-garde concepts, fully supported by international doctrine and jurisprudence, that, far from sterile and archaic dogmas and egocentric myths, will allow the medical professional to be able to respect the human being as such, and to accept that, beyond a cult at all costs of life, the physician must also be prepared to serve and to accompany his patient, with courage and professionalism, when he decides to refuse any medical treatment, as in the case mentioned above, or as in so debated issue of euthanasia to which we will also have some considerations.

Article 217 of the Draft Reform of the Penal Code, *in comment*, contemplates, for the first time in Venezuela, that *does not commit a crime who, in the alternative forms described in the article, causes the death of someone, who suffers from terminal or incurable disease*. The content of the article of the mentioned project is developed in the following way:

> ARTICLE 217.- GIVE DEATH FOR PIETY. *It does not commit a crime that to avoid or alleviate the unbearable pain or suffering of a terminal or incurable disease, stop medical treatment knowing that death could happen or even that it will happen. Nor does anyone commit a crime who administers the patient such a tranquilizer in massive doses that can mitigate their pain or suffering. In all these cases the consent of the patient will be required and given in a conscious, express and unequivocal way. If you are unable to give your consent, it may be supplemented by a living will or authentic document in which you have expressed your wish about the medical treatments you wish to receive or not receive if you suffer from a terminal or irreversible illness, when the latter it prevented him from expressing himself in a loud voice or directly from such an eventuality. The testament mentioned must be evaluated by a Commission composed of a relative of the patient; a doctor and a lawyer, appointed by the State. A doctor and a lawyer appointed by the family may*

be added to this Commission if there is disagreement between the members of the Commission, they must immediately send the will to a criminal court which will have the final decision on the case. If in spite of there being no such consent or that authentic document or testament, some person will kill another, and it will be proven that mercy reasons were mediated, this action will be considered a homicide but the penalty of imprisonment will be one to five years and a fine from one hundred to five hundred tax units.

Author's Comments:
FIRST: The first observation to the proposed article is its own title: it is expressed: to give death for mercy, homicide for mercy.

When homicide is considered, as reprehensible behavior, which harms an immanent right of man, which is considered a protected legal interest or protected by the State, the active subject of the crime carries it out, in the case of intentional homicide, with an *animus necandi* perfectly defined: a) achieve death, in itself, by: revenge, retaliation, sicariato (payed crime), political motive, passion, reward; or b) as a means to achieve impunity or assurance in the commission of another crime.

In our case in particular, the health professional, the only one who should be considered an active subject in this situation, does not have a special animus to destroy the patient's life; the doctor will act, under restrictive and supervised conditions, in response to the patient's declaration of will, without this being able to accept that he is in a positive state of mind, of satisfaction, of realization, of the activity performed. It can be likened to that situation of animus in which there is a head and neck surgeon who, before a certain cancer, must, by obligation, carry out a "command" type operation which mutilates and is deforming, but which, in spite of the internal animus of the physician, it must, nevertheless, be carried out according to the life of the patient. Equal consideration when deciding an amputation.

That is why I am deeply convinced that the title of this article that defines the criminal offense under the name of "homicide" should never be accepted, especially when other characteristics of the homicide, such as the illegitimacy of the action, the unjust act, and the violence with which it is achieved, are not in competition in euthanasia.

On the other hand, the action performed by the doctor is not motivated or justified by piety, mercy, grief, commiseration, by the patient who suffers a terminal illness. No such qualifier can be accepted. Euthanasia cannot be considered as a work of charity.

It is the legitimate respect and obedience that the health professional owes to his patient who, as a person, subject of the doctor-patient relationship, has his full right to dignity, autonomy of will and self-determination, discernment, reasoning, except the exceptional limitation of damage to third parties, and who expresses clearly, expressly, undoubtedly, their own will to end their life cycle when, under restrictive conditions determined by special law, and in function of not maintaining an improper quality of life, disgraceful, unworthy, decides, freely, to request the doctor to assist him, according to which he, the doctor, is precisely the professional who by his knowledge, is in a better position to help his patient, and that, as the well-known sentence of the Constitutional Court of Colombia (Judgment C-239-97; File D-

1490; Plaintiff JE Parra Parra, unconstitutionality claim of Article 326 of Decree 100 of 19880 l Penal Code; Santa Fe de Bogotá, May 20, 1997), it is not about helping the patient "to" die, but helping him "in" dying.

It is for this reason that the epithet of pietistic, or for mercy, cannot be sustained as a title of the article that we are now analyzing. It is not about pity or mercy; and much less of an act of the doctor; it is a complete and full exercise of an active right of the people; it is about the external manifestation of the will of the patient, who decides, on his own account, and before a terminal illness, to put an end to his cycle of life, through a methodology, rigor, and scientific respect, that allow him to die with dignity.

I believe the title of this article should be referred, without fear, or reservations, to euthanasia, or if it is preferred, in a more conservative, assertive and reasonable way, to name it: the right to die with dignity.

SECOND: the articulate description of: "... DO NOT COMMIT CRIME WHO ..." (*omissis*) should not be accepted. Do not decriminalize generically to: "... who ..." since the active subject of this legal relationship should only be the medical professional, the doctor.

The type and penalty should be left for any other person than the health professional. Only the doctor, under a scientific criterion, with the proper verification of the diagnosis, previous clinical and paraclinical examinations, and with the corroboration of another(s) physician(s) may not be punishable when he / she respects the patient's will and proceeds to the euthanasia, either directly or actively administering the lethal substance to the patient or prescribing what is necessary.

In this sense, acting consistently, and in accordance with principles, not only should be any doctor, in the special law that necessarily accompany this article should be preferred to the family doctor, usual treatment doctor, perhaps the oncologist doctor who is controlling it in the treatment of his cancer, who is the professional who truly knows his patient, who has talked extensively with him, knows his family environment, his personality, his projects and is the one who is most legitimate at the time of accompanying the decision of his patient. It constitutes its true guarantor.

The image of this family doctor is not a utopia for us. In the country there have already been graduates specialists in the field of family medicine; at all levels there is always a doctor who could be called "patient´s head doctors", even in public health institutions, and especially in the primary networks of medical care.

THIRD: "It will not be a crime for someone who out of pity and directly causes death to mitigate their pain or suffering"
I insist: you cannot accept the word for: "piety" as we explained above, since it is not an act of mercy, or piety. Euthanasia should not be seen as a medical failure, nor as an act of pain, beyond the feeling of each person for the end of the life of a family member. Generally, this type of patient has thought about his decision, has meditated, surely talked with family and / or friends; and when making the final decision, it is done from the will, from the clarification of thought and feelings, and never from grief. Perhaps, Brittany Maynard case was not at that

time in pain, but her disease was clear, determined, and she wanted to prevent the indignity of their existence.

FOURTH: Always, in any of the accepted modalities (active, passive, indirect, etc.), must state the manifestation of will on the part of the patient, clearly, expressly, undoubtedly, written, to accept and request the procedure. Without rigor or greater formalism; perhaps simply in your medical record, if you have not had the opportunity to do it authentically before a competent authority. That is, there must always be evidence of an informed consent, legitimately declared, which, like any act of will, can always be revocable by the patient at any time he wishes. But the article speaks of an authentic document and I wonder: Does the Civil Code say or not that the Authentic Instrument, granted, of course before a competent authority, does it fully test itself? So, why so much Commission to study the document? It would be a form of restriction, of making the procedure more difficult, burdensome and complicated. The constancy of the patient's will, in writing and the corroboration of the doctors should be sufficient.
The experience of countries that have accepted the procedure always requires that such consent be ratified, at least, in an opportunity after the original manifestation. This manifestation of will, in accordance with the constitutional principles, should avoid complexity and formality. It may be simply conferred on the patient's medical history. Subscribed by doctors and patient, in addition to other witnesses who may be called to sign such a declaration of will. In any case, there will always be the legitimate possibility of achieving, by means of an authentic document, an advanced manifestation of will, "living will", by means of which the will of the patient is clearly specified so that, after a moment of not being able to express his will A loud voice, due to physical disability, you can know your will and decision and power according to it proceed to euthanasia, if that is the case.

FIFTH: CONDITIONS
It is necessary to understand that the presence of a terminal illness, by itself, would not be enough criterion to opt for euthanasia. For example: a middle-aged patient, virtually asymptomatic, and in some medical evaluation, annual, preoperative, or motivated to another condition, is diagnosed with cancer, in some organ or system, and has a vital prognosis of a few years ahead. A diabetic patient, who, advanced his disease, begins a renal failure, but still susceptible to medical treatment. They are types of patients who, under the restrictive criterion imposed in other countries, still do not reach the classification of terminally ill terminally ill patients. There is a conceptual difference between the terminal illness, which is known to be irreversible, in the light of current medical knowledge, but from whom, still, an imminent result of death is not expected, in the time from hours to months (terminal phase).

In the same example above, the patient with cancer already metastasizes, invades other organs or systems; or the diabetic patient, who already enters severe renal failure and who needs dialysis (hemodialysis or peritoneal dialysis). This criterion of terminal illness, in terminal phase, allows to limit the number of possible cases and allows a useful time to try palliative medical treatments.

It is required, in the norm, usually, that these patients present medically uncontrollable pain, or some other type of physical or psychic suffering, or some other type of suffering, that

makes life disgraceful, and in whom traditional, or complementary, medicine they have not produced more beneficial effects. I wonder: And is not that what you want to avoid? Living without quality, in disgraceful conditions? There are people willing to accept euthanasia and those who claim their right to not even have to suffer from these sufferings.

LEGISLATIVE PROPOSAL:

I could break down each term in that proposal, but I think that the reasons, up to now, are enough to make us understand how it should be, or not be, the type of standard sought, written and typified.

Convinced I am that, simply typifying a decriminalization in the Penal Code would not be enough. The decriminalization would be tied to any reform that must be made of the Penal Code for reasons of this single article.

That is why my proposal would legislate a special law, short but sufficient, which in turn repeal the criminalization of the action of the Penal Code, and there could be placed the conditions under which operate both euthanasia and assisted death by doctor, in those cases in which the direct administration, by doctor, of lethal substance would not be necessary, but the prescription of the necessary medication to fulfill the objective sought but it is the own person who, already acquired the medicine by the medical prescription, can then, on their own and willingly, ingest them.

In this way, advancing the criteria of society, as has happened in recent years, could be reformed, from the special law, those items or elements that are thought to be, or are no longer necessary to be included in the own law.

PROPOSAL:

> *"The doctor who, having complied with the requirements and conditions set forth in the SPECIAL LAW ON TERMINATION OF LIFE AT OWN REQUEST, intentionally terminates the life of who, for his own will and self-determination, of his own accord, has by any form, verifiable, expressly requested. Nor will the doctor be punishable if, complying with the requirements and conditions of the afore mentioned law, prescribe and / or provide drugs or medicines to people who have, in the same way expressed their will, for these people to take it by their own account*"

COMMENTS:

a. A unique, single and simple article is proposed that allows the alternative or option so that people can, according to their criteria and will, opt for a procedure that helps them to end their life cycle.
b. The special law expressly repeals any provision to the contrary in the Criminal Code.
c. The regulations, conditions and requirements must be left to the SPECIAL LAW ON TERMINATION OF LIFE AT OWN REQUEST, which must also be brief (about 20

articles), and which is the one that establishes the parameters and conditions under which it can proceed to euthanasia. This law would include, among other aspects:

1. Provenance requirements: types of illness or patient conditions.
2. b. Ratification of the medical criterion by another independent physician.
3. Types of eligible people. I must insist that it should not be restricted only for those terminally ill people with physical or mental suffering. It is precisely this suffering that the patient wishes to avoid.
4. Legitimately Declared Consent, Living Will, Living Will, or Authentic Instrument in which, undoubtedly, the will of the patient is expressed, physically and legally capable.
5. Creation of the National Special Commission: integration, operation, attributions, obligations.
6. Obligations: a) of the doctor to inform this National Commission that the procedure, once completed, is reviewed; and b) the obligation of the Commission to inform the Public Ministry to initiate the criminal action against the doctor or person who has not complied with the requirements of the special law at the time of euthanasia.
7. Any other that the legislative body considers convenient.
8. It is suggested to read the Law of the Netherlands or Belgium and / or other countries or States.
9. I consider it prudent that the community in general, as well as the professional (Medicine and Law preferably) in special, and the student and school, specifically, as a final expression of the article, both in the reform of the Criminal Code and the special law suggested, it should be noted the obligatory nature of teaching and educational treatment that this special subject must mean for the community in general. A good educative campaign, informative, would allow us, in immediate and medium-term future, a guarantee of acceptance, permanence and good compliance with the modified norm.

CHAPTER XII
WHY DO I DEFEND EUTHANASIA?

Fundamentally, because it is a volitional action, maximum expression of will, of the human person, full of dignity in its essence, with its intrinsic, immanent and inherent value, merit, honor, quality of worthy, valuable, excellence, respect towards itself, as a value and immanent inalienable right of the human being; and does, precisely, reference to that inherent, immanent value of the human being with the ability to reason, and who exercises the free expression of the most sacred and beautiful gift (right) that the human being has since arriving in this life: autonomy of will and self-determination. I am free to decide, according to my free will, in accordance with my own convictions, until and as long as the exercise of my right does not limit, aggress, obstruct the exercise of the rights of other people. I am free to decide whether I wish to suffer or not; If I want to die with dignity or if, on the contrary, I must, through interposition of arguments alien to my reality, conviction and quality of life, suffer unjustly in the sublime moment of facing the final process of life, in opprobrious conditions, and considering at the same time that this immanent value of the human being is, without any doubt, a fundamental, intangible, inalienable, non-negotiable, non-conditional or limitable human right; because it is the human being a rational being endowed with freedom and creative power. It is ultimately an ontological dignity with which all humans are born.

This immanent value of the human being is, without any doubt, a fundamental, intangible, inalienable, non-negotiable, non-conditional or limitable human right; because it is the human being a rational being endowed with freedom and creative power. It is ultimately an ontological dignity with which all humans are born.

I accept and respect the right to life of every person, but from there, to think or admit, by wrong or manipulated interpretation, that another person, a third party, can exercise in my name, against my will, without faculty, mandate or power, a right that is not yours and force me to live, in whatever the opprobrious conditions of the moment, present or already known to come, is legally and humanly unacceptable.

In the beginning, dignity has been recognized as the fundamental right of the human being, inherent and immanent to his person. It has also been recognized that the right to a dignified life implies the right to a death dignity. In its end, the Fundamental Human Right to Die with Dignity has also been recognized.

The simplicity of the response leads to deep considerations that, for limit of space and time, I cannot offer; but, my free decision of will is manifested, also based on other correlative principles, already explained; human rights and constitutional principles such as: the free development of personality; the right to conscientious objection; freedom of religion and religion, the principle of physical integrity through which no one can be subjected to diagnostic or therapeutic procedures without their consent; the right of the person not to suffer inhuman, cruel or degrading treatment; the right to refuse and medical treatment and, last but not least, for the sacred right to life which, in the light of our constitution, can no

longer be called the right to life in the abstract; but on the contrary, the right to a quality of life if we consider that the right to health, as a fundamental social right, is immanent to the right to life.

Therefore, my life must be full, from the point of holistic interpretation, of my life and health project; that is, not merely the greatest state of physical and mental well-being of an individual but rather the integrality of factors that have to do with my life project: well-being and physical, mental, social, biodiversity, family, work, etc., under the conviction that the development of my life is carried out within the values of my dignity.

But, on the other hand, and within the principle of the universal freedom of Kant, the Right to Die with Dignity is, simply, the acceptance and existence of a legislative alternative that allows me, to exercise my right of will for a dignified death and that at no time means any obligation for any third party to accept it, or even the doctor, to accept or practice it. We live within the universal principle of freedom. As I have always defended and explained that the right to life, contained in the constitutional principle, does not mean an obligation to live.

The Right to Die with Dignity offers me, personally, in the individuality of each one, an opportunity to exercise that reason and free will, exercise my principle of autonomy of will and self-determination, according to my beliefs and convictions, and with the which each human being is born, within the rationality and creative power and without constraining anyone to get involved.

But ... I could say, is it that God has not given us the opportunity to advance scientifically and technically to avoid the suffering and indignity of a life already in its final stages?

Can there be something more beautiful and human than a doctor helping me to alleviate my suffering and help me find my Deep Peace when, due to terminal illness, my life is irreversible, it is unworthy to continue it, it is disgraceful to suffer it and / or I have become the irremediable suffered and vexatious burden of my relatives and / or friends?
I paraphrase the words of Ramón Sampedro when making his decision:

What is dignity for you?