

# Palliative care: an anthropological and bioethical reflection

## Cuidados paliativos: una reflexión antropológica y bioética

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### Abstract

Palliative care is a form of integral care of the patient, considering his anthropological and ontological character, as a biopsychosocial and spiritual being, where death and suffering are characteristics that define him and separate him from other species. Bioethical principles give us an approach to understand why it is important to care for the patient in all areas, beyond the curative intention. It allows us to visualize the true goal of palliative care.

*Key words:* anthropology, palliative care, bioethics, interdisciplinarity.

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## 1. Introduction

Death has accompanied the human being for as long as he has existed. It is part of an intrinsic process of man, which must be treated in an interdisciplinary way for the simple fact that the human being is a person and is not just a body, but a biopsychosocial and spiritual being that transcends corporeality and has a value, an ontological value and a dignity that make it an object of rights, respect, and freedom. It is capable of feeling, deciding, acting, thinking, suffering, and enjoying (1).

In medicine we speak of palliative care, a branch responsible for preventing and alleviating suffering, as well as providing the best possible quality of life to patients suffering from a serious illness that compromises their life, both for their well-being and that of their family. Providing comprehensive palliative care must include both the bioethics that governs medical behavior and the clinical practices that protect and guarantee the well-being of the patient and the fulfillment of orthothanasia with the full dignity that the human being deserves.

In this paper, by means of analytical methodology, we will seek to approach palliative care and death from an anthropological and bioethical point of view in the light of the principles, seeking to reach a conclusion on the importance of palliative care in the integrity of the person.

## 2. Medical practice since the hippocratic oath

When a physician enters or leaves medical school, he/she takes an oath that has been recorded since before the era of Christ, known as the Hippocratic Oath, which reads as follows:

I swear by Apollo the Healer, by Asclepius and Hygieia, by Panacea by all the gods and goddesses, taking them as my witnesses,

that I will carry out, according to my ability and judgment to fulfill the following oath and pledge:

To consider my master of medicine as if he were my father; to share with him my goods and, if it comes to it, to help him in his needs, to have his children as my brothers and sisters and to teach them this Art, if they want to learn it, without gratification or compromise; to make my children partakers of the precepts, teachings and other doctrines, as well as those of my master and the disciples committed and who have taken the oath according to the medical law, but to no one else.

I will direct the diet with an eye to the recovery of the patients, to the best of my strength and judgment, and I will spare them all evil and harm.

I will not administer to anyone a deadly drug, even if he asks me to do so, nor will I take the initiative of such a suggestion. Likewise, I will not prescribe to a woman a passive abortifacient; on the contrary, I will live and practice my art in a holy and pure manner.

I will not operate with a knife even on patients suffering from calculus but will leave them in the hands of those who are engaged in these practices (2).

I solemnly promise to dedicate my life to the service of humanity To watch over the health and well-being of my patient above all To respect the autonomy and dignity of my patient, to watch over human life with the utmost respect... (3).

As the time in which we live changes, there are also transformations in medical practice, so the oath was also modified, having nowadays the last recognized international version which is the Declaration of Geneva of 2017. From thousands of years ago until today there are issues that prevail, one of them is the respect for human life and its dignity. This does not mean that the physician must ensure the maintenance of life in all circumstances, but that, regardless of these, the physician must take care of the person in a comprehensive manner and accompany him/her in the dying process with palliative care and

a humane and bioethical approach. Palliative care allows us to provide this to the patient during the end of his or her life, and bioethics provides us with the study of the principles and values that should govern practice in the biological sciences.

### **3. Palliative care**

Let us explore the expanded definition of the World Health Organization (WHO) which tells us the following:

Palliative care is an approach that improves the quality of life of patients (adults and children) and their families facing problems associated with life-threatening illness. It prevents and relieves suffering through early identification, correct assessment and treatment of pain and other problems, whether physical, psychosocial, or spiritual (4).

First, palliative care affirms life and considers death as a normal process. Second, it does not seek to hasten or postpone death. Palliative care values life, its quality and time with family and community; it is not about medical aid in dying or euthanasia. As mentioned by the WHO, it OFFERS a support system to help patients live as actively as possible until death.

This type of medical and non-medical care, such as that offered by nurses, social workers, paramedics, pharmacists, physiotherapists, psychologists, thanatologists, and volunteers, is applicable at the onset of the disease, along with other therapies aimed at improving life, such as chemotherapy, radiotherapy and care including the management of distressing clinical complications. There is now increasing evidence that palliative care provided earlier in the course of the disease can not only improve a person's quality of life but can also increase survival. When you feel better, your ability to cope with the disease increases, even when it is not curable. That is why it is vital to provide palliative care and to bring more physicians into this area of healthcare.

In fact, it has been shown that people who receive palliative care at the end of life have a longer life expectancy and less desire for assisted suicide or active euthanasia. Palliative care can help people live well so that they do not want to end their lives early. Integrating the psychological and spiritual aspects of patient care provides a support system to enable patients to live as actively as possible until death. It also provides a support system for primary caregivers and family members to cope with the patient's illness and their own grief. Let us remember that grief is a psychological process that everyone can go through when faced with a loss. Loss does not only speak of death, but of anything or any expression that we had and that leaves our lives. In this case, we can talk about the loss of health or the impairment of activities of both the patient and the loved ones with the patient. This affirms for us the integrative definition of palliative care, which requires a vision of all spheres and considering the patient's loved ones as part of the subjects requiring care. It uses an interdisciplinary team approach to address the needs of patients and their family caregivers, including bereavement support and counseling. These are all important goals of palliative care (5).

#### **4. Pain and suffering**

Palliative care addresses pain and multiple non-pain symptoms. Pain is usually the initial treatment, but it does not stop there. Palliative care cannot be only medical, it is important to have psychological, spiritual, family, and multidisciplinary support. The patient must be able to live as actively as possible before death and the family must know how to manage this process before, during and after death.

Pain must be distinguished from suffering. Pain is organic, physical, or bodily, which any animal being can experience, while suffering is rooted in human nature, of psychosocial-spiritual origin, associated with our condition as thinking beings. We must also be able to differentiate the multiple varieties of suffering that we can encounter

social, emotional, spiritual, and physical. The physician usually focuses on physical suffering, sometimes only on the aggravation of that suffering, but may fall short of comprehensive care. The bioethicist will be able to give us a comprehensive overview of the patient as a human being, considering him or her a being with dignity, as an end and place the values and principles of their area around the patient's death and their grief (6).

## **5. Suffering at the end of life**

The human being behaves as a complex individual, this creature, defined by Boethius as an individual substance of rational nature, has the capacity to think, feel and act, but also to suffer. This suffering is not limited to physical discomfort, but is made up of social, cultural, psychological, religious, and spiritual phenomena that accompany the patient and his or her support network, which is why palliative care plays a fundamental role in understanding the whole person in the face of the uncertainty that comes with the end of life.

It is important to mention that palliative medicine is not limited to the somatic management of the individual; on the contrary, it provides physical, psychosocial, and spiritual support.

Terminal illness is an irreversible phenomenon that results in the death of the person, which is accompanied by suffering, not only for the person suffering from the disease, but also affects the people around him or her. Death cannot exist without life, just as life cannot exist without death. Death, seen as the ultimate outcome of life, represents one of the most sublime manifestations of life itself. By finding meaning in death, patients and their families can face illness and death with less suffering.

The role of palliative care at the end of life takes on special importance when starting from the idea of dying with dignity, according to Brena, the way of dying reflects the way of living; for life to have meaning, death must also have meant (7). Palliative care not

only accompanies the patient during the dying process, but also helps the person to reach his or her own transcendence, finding meaning in life and in death, thus reducing suffering.

The suffering that an individual experiences at the end of life is complex, on the one hand, the organic deterioration is accompanied by symptoms that afflict the patient, which can diminish their quality of life at the end of it, on the other hand, since human nature exceeds their own corporeality, commonly the end of life is accompanied by fear, uncertainty, and other manifestations of psychological, spiritual, and social suffering.

Spirituality forms a substantial part of the human being, who, in search of his own transcendence, crosses the limits of his existence. Spiritual accompaniment at the end of life through palliative care improves the quality of life and death (8).

## **6. Death, transcendence, and palliative care**

The finitude of the human being is often one of the sufferings that can be encountered at the end of life. It is intrinsic to human beings to seek transcendence prior to death. This is presented in many ways: in our loved ones, actions, profession, objects, even in the people who accompany us in our death. Living in society conditions us to leave something of ourselves on the earthly plane in life, as well as in death. It can be something positive or detrimental, but our human actions tend to rationalize our actions. This is what defines part of anthropology, that study of the human being both historical and present. Anthropology includes death as a fact of the humanization of the first men. The presence of rites such as burial tells us of an advance even more representative than the use of tools or fire. This loss was accompanied by mourning and a social process that leads us to a suffering seen today that requires its own mention and treatment (9).

Palliative care addresses this uncertainty with a complete and comprehensive approach to the subject. It is determined by the

patient's daily context, his or her personal and cultural history, his or her place of origin and place of death. It has as many facets as the person's life itself and influences both young and old. This intrinsic and exclusive quality of death intertwined with the transcendence of the human being is considered in ethics as part of human nature. Thanatology, theology, psychology, and spirituality are tools that accompany the patient in the process of transcendence at death so that he/she can find that meaning in his/her life, even if he/she lacks religious beliefs that accompany the ideal of life after death (10).

## **7. Orthothanasia and euthanasia**

These two definitions are often confused. It will be important to determine the difference between each of them: orthothanasia, a concept used in the law, distinguishes between curing and caring, without actively, directly or indirectly causing death, avoiding the application of any obstinate, disproportionate or useless medical act, always seeking the dignity of the terminally ill patient, providing palliative care, minimal ordinary measures (hydration, hygiene, oxygenation, nutrition and/or cures) and comprehensive care that includes psychological care and spiritual assistance. Euthanasia, according to its etiology, is defined as "good death", but most commentators define it as "deliberate act of putting an end to life, at the request of the family or self", even the Catholic Church determines it as "an action or omission that, by its nature, or in intention, causes death, with the purpose of eliminating any pain" (11).

## **8. Bioethics and palliative care**

The development of palliative care, as we have seen throughout this essay, arises from the need to attend to death. But death cannot be attended to without consideration for life, and this is where the vital importance of using ethics and bioethics to understand how to ap-

proach comprehensive palliative care is founded. We will use some of the personalist principles, as well as the principles of medical practice, which are: beneficence, non-maleficence, autonomy, justice, totality or therapeutic and inviolability of human life and the duty to respect life and death.

The latter must precede all the others due to its axiological hierarchy and was even reflected in the Hippocratic oath mentioned at the beginning. Life is the most essential thing we have, to which the physician is attached and fights to save, but also to exalt. In people there is a certain intuition that leads us to understand that the person has value, something that gives the person a category of greater importance than other species or objects. This value, exclusive to the human being, is what we call dignity. Dignity, mentioned above, is the most important value and precedes all others. Within the study of ethics, we find the categorical imperative, which reminds us that the person should never be used as a means, but always as an end in themselves (12).

Beneficence will always seek the good for the sick person. We must know that the good is not always the search for a cure, or the treatment of an illness; the good must be understood as the best that the patient requires for his condition, his possibilities, and his desires.

Non-maleficence is a fundamental medical duty that will be ensured in the principle *primum non nocere*, first is to do no harm. It is strongly related to the proportionality of the act. We must know that there is collateral damage in providing a greater good, but we must never fall into harming the patient without an end greater than the harm done. Let us also remember that the patient's wishes here are important and therapeutic proportionality helps to follow this important principle.

Justice promotes equality in the allocation of health resources, not only to the individual patient, but also to the general population or to a group of patients, a group such as terminally ill patients. The physician has responsibility for the care he/she provides, and it would be unethical to refuse treatment to a patient, even if he/she is

close to death. The treatment and the care he or she receive must be the same.

The principle of totality or therapeutics recognizes how a being must be considered in all its spheres and how the damage or improvement of one of these influences the patient's total. It is evident that if an organic disease has no cure, it will have repercussions in all the patient's spheres and we must treat each one of them to ensure an improvement in the general and integral state of the patient.

Autonomy, a recently added principle, boasts the independence of each patient. It affirms the right of each patient who is competent and informed to actively participate in the medical process, including the refusal of certain measures. This breaks completely with the old paternalistic model of medicine and gives both rights and responsibilities to the patient to be the protagonist of his or her own health care. This is especially important in end-of-life care. Each person, each patient, will have the freedom to choose how he/she wants to manage and mitigate this process, we must respect him/her and give him/her the best tools to make a conscious and informed decision.

## **9. Conclusion**

Finally, palliative care will be able to improve the quality of life and can also positively influence the course of the disease by increasing survival and decreasing physical, social, psychological, and spiritual symptomatology and discomfort. Palliative care represents a powerful tool to address the suffering of patients suffering from incurable diseases, since its approach is not limited to the relief of symptoms from the person's corporeality but recognizes the person as a biopsychosocial and spiritual being who deserves and deserves to be accompanied until the last moment of his or her life, however short or long it may be. This will only be possible if palliative care is provided ethically and focused on the patient's well-being. We cannot ignore the need to care for the dying and this is something we must continue

to promote in modern medicine with all the bioethical guidelines that govern every medical act. The patient remains a patient even in death and it is not a matter of curing each disease, but of ensuring that the life we can offer is one that the patient wants to live.

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