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## The Role of a Physician in End-of-Life Stages of Their Patients

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## **“The Role of a Physician in End-of-Life Stages of Their Patients,” by David Anson**

### **Instructor’s Note**

It can be risky to select a hot button topic such as capital punishment, gun control, or abortion because one cannot generally join such a wide and vast written conversation with any kind of authority in such a limited number of pages as a typical essay. Yet in this persuasive essay, David Anson is able to tackle the vast topic of euthanasia because he narrows it and focuses only on the physician’s role. What do you think about David’s choice to begin his essay with a hypothetical story? What do you think works well in his conclusion? How could his conclusion be improved upon?

### **Writer’s Biography**

David Anson is a freshman Biology major from southern Illinois. His love for learning and writing was instilled by his parents. Outside of his studies, David enjoys sports, playing piano, and spending time with friends and family.

### **The Role of a Physician in End-of-Life Stages of Their Patients**

Imagine sitting in a hospital room with your 79-year-old father. Your father was diagnosed with Alzheimer’s disease about 3 years ago, and the condition has advanced to the point that he no longer recognizes you. He has recently stopped eating, so the nursing staff inserts a feeding tube. Unfortunately, your father vigorously pulls on the tube, causing it to become dislodged. Nurses are forced to physically restrain him, and he consequently moans and thrashes against the restraints. Aware that your father’s quality of life has diminished rapidly, you know that he is suffering in his current state. With deep sadness, you realize that your father is no longer mentally capable of

making difficult end-of-life decisions, and several questions race through your mind. What should you do in this situation? Should you allow your father's condition to continue to progress further and further until he passes away, or would it be better to end the suffering he is experiencing?

Families face situations like these with their loved ones every day. For this reason, it is vital for physicians to be able to interact with families regarding end-of-life options which would allow patients to live their final days in peace. The role of a physician in these situations has become a topic of great debate in recent years, as physicians attempt to find a balance between their own moral and ethical convictions, sustaining life and relieving suffering, and fulfilling the wishes of patients and their families. Terms like "physician-assisted suicide" and "euthanasia" frequently come up in these discussions as advocates of both sides rise up to attack the views of the other. Unfortunately, the terms of these discussions have not been clearly defined, causing a great deal of confusion among those who seek to understand the debate. The terms must be clearly defined, and the chief arguments of both sides should be carefully examined and analyzed. I believe strictly "passive euthanasia" should be the only involvement physicians perform during the end-of-life stages of their patients because it is the most ethical and moral of the three types of involvement.

All areas of physician involvement in the death of patients fall into one of three categories. The first and most conservative of the three categories is passive euthanasia. In this type of involvement, which is often known as "pulling the plug," the physician allows the patient to die by withholding or removing life-sustaining interventions, such as kidney dialysis, mechanical ventilation, or chemotherapy, in accordance with the wishes of the patient. According to Timothy Murphy, Professor of Philosophy in the Biomedical Sciences at the University of Illinois College of Medicine at Chicago, "Medical ethics have traditionally accepted [passive euthanasia] as moral on the

grounds that it is disease and not the physician who is doing the killing” (Murphy, 2013).

The reason this type of intervention is defined as “medically ethical” is that it allows the patient’s body to follow its natural course. Because of this, physicians are not considered morally or ethically at fault as long as patients are competent when making decisions regarding their care. Physicians are also legally protected from malpractice lawsuits according to the 1990 ruling from the U.S. Supreme Court case *Cruzan v. Director, Missouri Department of Health*. After nearly seven months of discussion, the Supreme Court ruled 5-4 that competent patients have the ability to exercise their constitutional right to refuse medical treatment under the Due Process Clause (The Sullivan Group, 2013).

The American Medical Association’s Code of Medical Ethics provides physicians with various guidelines to assist in this process. In order for a physician to withhold or remove life-sustaining interventions, the patient must be a competent adult and provide valid consent or provide an advance directive of their wishes in the event that they are incompetent and unable to make decisions due to an illness. In addition, the patient may also designate a proxy through the advance directive who has the authority to make decisions on behalf of the patient if necessary. If no proxy is designated and patients are not capable of making their own decisions, the patients’ families become the surrogate decision-makers. In certain circumstances, interventions in the decision-making process or judicial review by ethics committees or courts are required. These include situations when no surrogate decision-maker is available, the family disputes the decision regarding the patient, the family’s decision is clearly not what the patient would have wanted, or the family’s decision is not in the patient’s best interest (American Medical Association, 1996).

No incident has sparked national debate on the topic of passive euthanasia quite as much as the medical and legal battle for the treatment of Terri Schiavo. At the age of 26, Schiavo collapsed for an unknown reason, causing

cardio-respiratory arrest and blocking the flow of oxygen to her brain, resulting in substantial brain damage. After consulting numerous physicians, neurologists diagnosed her with an irreversible persistent vegetative state (PVS). She was on a ventilator for several weeks but was taken off mechanical ventilation shortly thereafter. Although she was able to breathe on her own, she was given a feeding tube to provide her with fluids and adequate nutrition. Schiavo's husband Michael was given legal guardianship over her, and proceeded to take legal action to take her off of the feeding tube, claiming that she would not have wanted to live. After over a decade of legal suits by Schiavo's parents and interventions from President George W. Bush, Governor of Florida Jeb Bush, and Congress to continue life-sustaining treatment, Schiavo was removed from the feeding tube and passed away March 31, 2005 (Terri Schiavo Life & Hope Network).

The Terri Schiavo case is a prime example of the difficult decisions that must be addressed regarding passive euthanasia. To this day, many Americans are still outraged that Schiavo was removed from her feeding tube and allowed to die. According to Schiavo's family, she was able to respond to stimuli, tried to communicate, and performed other limited cognitive functions. In addition, fourteen medical professionals including six neurologists assessed her and gave statements or testimonies that she was not in a persistent vegetative state (Terri Schiavo Life & Hope Network). Based on evidence from her family, medical professionals, and the fact that Schiavo showed no signs that she was suffering, there was no reason for her to be removed from the feeding tube and allowed to die. Our response to this horrific tragedy should be to do everything in our power to ensure that a similar situation will never happen again. Physicians need to take full responsibility for the care of their patients by making sure that they are being treated effectively to reduce suffering and that all medical decisions made by the family are in the best interests of the patient.

The second category of physician involvement is active euthanasia. According to Dr. Michael Manning in

his book *Euthanasia and Physician-Assisted Suicide: Killing or Caring?*, active euthanasia is defined as, “A physician providing medications or other means to a patient with the understanding that the patient intends to use them to commit suicide.” Active euthanasia is currently only legal in the Netherlands, Belgium, and Luxembourg. The American Medical Association’s Code of Medical Ethics gives a unique insight into the role of a physician in regards to euthanasia:

It is understandable, though tragic, that some patients in extreme duress – such as those suffering from a terminal, painful, debilitating illness – may come to decide that death is preferable to life. However, permitting physicians to engage in euthanasia would ultimately cause more harm than good. Euthanasia is fundamentally incompatible with the physician’s role as healer, would be difficult or impossible to control, and would pose serious societal risks. (American Medical Association, 1996)

The responsibility of physicians in regards to end-of-life treatment ultimately comes down to one question, “What is the purpose of a physician?” If it is to aid in the healing process of patients as the American Medical Association suggests, then allowing a patient to die, whether requested or not, goes against that purpose.

The third type of physician involvement, which is a relatively new idea that has gained increasing popularity, is physician-assisted suicide. According to Dr. Timothy Quill (2012), Professor of Medicine, Psychiatry, and Medical Humanities at the University of Rochester School of Medicine and Dentistry in an article published in *The Journal of Law, Medicine, & Ethics*, physician-assisted suicide is defined as involvement in which “the physician provides the means for a patient to potentially end their life (usually a prescription for barbiturates) that patients must take by their own hand if they choose to end their life [sic]” (Quill, 2012).

Physician-assisted suicide gained national attention during the late 1980’s with the medical practices of Dr. Jack Kevorkian, also known as “Dr. Death.” Dr. Kevorkian was a medical pathologist from Michigan and a

strong advocate for physician-assisted suicide. He believed that it was an ethical and moral practice, in that it gave patients the opportunity to end their unbearable suffering through providing them a quick and painless death. After his assistance in the 1989 suicide of 54-year-old Alzheimer's patient Janet Adkins, Dr. Kevorkian faced a series of legal allegations. Although the State of Michigan revoked his medical license, he continued to practice physician-assisted suicide for nearly 10 years, using his "suicide machine" on over 130 patients. However, in 1998, he released a videotape during an interview on CBS's *60 Minutes*. The tape depicted Dr. Kevorkian administering a lethal injection to Thomas Youk, who was suffering from the final stages of Lou Gehrig's disease. Days after the incident, Dr. Kevorkian was charged with second-degree murder and sentenced to 10-25 years in prison. After 8 years, he was released on parole, and passed away June 3, 2011, at age 83 (Hosseini, 2012).

Incidents such as those involving Terri Schiavo and Dr. Jack Kevorkian affirm the need for an analysis and discussion of both sides of the argument regarding the ethical and moral dilemma of these issues. Physician-assisted suicide and active euthanasia are often argued together against passive euthanasia, as the only difference in physician-assisted suicide is that the physician does not directly intervene, but provides the resources and allows the patient to have control over the administration. With this understanding and for the purposes of the discussion, they will be argued together against passive euthanasia.

Proponents of active euthanasia often center on several ideas: patient suffering, "death with dignity," and patient autonomy. The arguments of patient suffering and "death with dignity" are closely linked. The premise of the argument is that patients with terminal or debilitating diseases are experiencing excruciating pain and suffering. Instead of giving them a quick, painless, and dignified death through active euthanasia, we are forcing them to continue living in overwhelming agony and suffering. Patients are being kept alive by machines and die slowly, leading to an "undignified" death. The responsibility of

physicians is to relieve the suffering of their patients, and when all other medical avenues are exhausted, physicians have a duty to their patients to end the suffering they are experiencing through the least painful method possible.

The issues with this argument stem from the premise that must be assumed to be true for the argument to logically follow. The fundamental claim is that patients with terminal and otherwise debilitating diseases live in excruciating pain and agony. A 2001 study of pain experienced by terminally ill patients found that only 29% requested additional pain treatment while 71% felt that their pain treatment was well-managed or could be reduced or stopped entirely (Weiss, Emanuel, Fairclough, & Emanuel, 2001). Terminally ill patients undoubtedly experience moderate or severe pain in the final stages of their lives, but not to the degree this claim would suggest. Although improvements in pain management could be made, the study suggests that the majority of patients are happy with the pain treatment they are receiving, invalidating the claim made by proponents of active euthanasia.

Patient autonomy is also cited as a strong argument for active euthanasia. The claim of this argument is that patients have the fundamental authority and right to decide whether they receive treatment, even if it is a matter of life or death. When patients wish to end their lives due to suffering or low quality of life and physicians refuse to administer lethal doses of drugs that the patients want, the physicians are violating their autonomy. According to the American Civil Liberties Union's amicus brief presented during the Supreme Court case *Vacco v. Quill*, "The right of a competent, terminally ill person to avoid excruciating pain and embrace a timely and dignified death bears the sanction of history and is implicit in the concept of ordered liberty" (American Civil Liberties Union, 1996). While patients should have the authority to decide on their own treatment, or lack of treatment, I don't believe it can be carried over to assisted suicide by the physician. Even if patients have a right to kill themselves if they desire, the physician's job is not to obey the patient's every whim, but

to provide the most effective treatment that will be in the best interests of the patient. From a physician's perspective, killing patients would clearly not be in their best interest. Although there are flaws in the arguments for active euthanasia, proponents still present strong evidence and highlight the need for further analysis and discussion.

Arguments against active euthanasia include the violation of the Hippocratic Oath, the "slippery slope" to legalized murder, and advancements in palliative care (ProCon.org, 2012). The most common argument made against active euthanasia is that it violates a section of the Hippocratic Oath. The Hippocratic Oath is often taken by students graduating from medical school as they receive their medical degree. The portion of the oath used in support of the argument states, "I will do no harm or injustice...I will not give a lethal drug to anyone if I am asked, nor will I advise such a plan" (North, 2002). Although this may appear like strong evidence against active euthanasia, the Hippocratic Oath was believed to have been written in the 5<sup>th</sup> century B.C., and is not practically applicable to our modern age. For instance, another section of the oath forbids physicians from performing surgery, stating, "I will not use the knife, even upon those suffering from stones, but I will leave this to those who are trained in this craft." Because of this, the Hippocratic Oath is often viewed as outdated and not a strong argument against active euthanasia.

Another argument against active euthanasia is that it is a "slippery slope" which will eventually lead to legalized murder. The argument makes the assumption that active euthanasia will inevitably lead to a system where the government and health care professionals would legally euthanize individuals without their consent. In order for this to be the case, definitive proof would have to be found, showing that dire consequences were likely to occur if the first step of legalizing active euthanasia was taken. Since the argument is based on pure speculation, it is not a convincing argument against active euthanasia.

The final and strongest argument against active euthanasia is advances in palliative care. Palliative care,

also referred to as hospice, is end-of-life treatment that is aimed at preventing and relieving suffering through assessment and effective pain management. Palliative care is an excellent alternative to active euthanasia because it relieves the suffering experienced by patients with serious or terminal diseases without forcing them to end their lives. In this way, palliative care has the potential to be a win-win scenario for both sides of the discussion, as patients would not be suffering and therefore would not need to consider active euthanasia. Dr. Edmund Pellegrino describes the positive results of effective palliative care in his book, *Regulating How We Die*:

Patients treated this way [palliative care] usually do not ask for termination of their lives; when they do ask for it, they tend to change their minds later. It is an injustice to offer these patients assisted suicide or euthanasia as options when so much more can be offered in the way of sophisticated treatment. (Pellegrino, 1998)

Emphasis on palliative care is vital to patients who are at the final stages of their lives. Further advancements in palliative care and treatment will allow patients to receive more access to pain relief and relieve suffering. It will also prevent the need for active euthanasia entirely, since patients will no longer feel like it is their only option to relieve their pain.

The role of physicians and their involvement in the end-of-life stages of their patients has been increasingly controversial over the past several years. After defining the terms of the discussion and analyzing the supporting and opposing arguments, passive euthanasia is the most ethical and moral as physicians are not forced to compromise their beliefs and convictions. At the same time, the patient's pain and suffering are relieved due to effective palliative care, eliminating the need for active euthanasia. By reducing involvement to passive euthanasia, physicians can ensure that their actions are moral and ethical, while still looking out for the best interests of their patients.

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