## Ward Ethics: "What Do I Do Now?

# *"Help Me Die"*

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Ward Ethics: "What Do I Do Now?" is a section created in response to our growing awareness that, despite the ever-expanding bioethics literature and curricula, medical trainees are not being adequately prepared for the daily struggles they face in becoming physicians. This challenge, posed by our own students, prompted us to undertake an ongoing project of interviewing medical students and doctors-in-training from around the world as to the specific dilemmas they face in trying to balance learning medicine, performing procedures, and interacting with patients and colleagues. The initial collection of real-life dilemmas are compiled in *Ward Ethics* (Cambridge University Press, 2001), some of which will appear in this section.

Beginning in this issue, trainees pose, in their own voices, the questions they find most troublesome, but which are all too often surrounded in silence. Interdisciplinary commentary follows from noted bioethicists.

We invite students, past as well as present, to submit their own dilemmas for possible presentation and discussion. In all cases, scenarios are presented anonymously to prevent identification of individuals and institutions involved. Send manuscripts to Thomasine Kushner, 104 Bulkeley Ave., #4, Sausalito, CA 94965.

As a medical student doing a rotation, I was feeling positive as we knocked on the door of an elderly lady who I'd seen just 2 days earlier. Even though seriously ill for many months, this patient had always lived life in her own way, refusing to go to a nursing home. It was clear that her condition had deteriorated rapidly, and the nurse informed me privately that she was dying, sooner rather than later.

Although her body was falling apart, her mind was as sharp as ever. Hardly able to talk or move, she could still communicate. The physical and mental pain she was going through seemed unbearable. The final straw was the indignity of permanent care.

Alone with the patient, I asked if there was anything I could do for her. She motioned to her medication and uttered three words that will stay with me, "Help me die." Nothing had prepared me for this situation. My first thought was to comply. She was a competent woman in terrible pain who was going to die anyway. Much of her medication was analgesic and, with my help, her

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death would be painless. Then fear took over, both because of what she was asking me to do and what it could mean for my future.

Sweating and heart racing, I heard my voice explain, as if on autopilot, that I was only a medical student and was there anything else I could do to make her more comfortable? As I babbled away, a sad smile formed on her lips. I hope she knew that I was genuinely sorry. I was aware at the time that the argument could be made that I was interested in pain relief only, but I knew that this wasn't the case.

Did I do the right thing? I still feel incredibly ashamed that I allowed thoughts of my future to enter my head and affect my clinical judgment. But is this a fair way to treat myself? If I had helped her die, 4 and a half years of medical training would be wasted and my hopes of helping and treating scores of future patients would be ruined.

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## Commentary
## Courtney S. Campbell

The moral and professional anguish experienced by the medical student in response to the request "Help me die" is a fundamental sentiment that needs to be retained within the ethos of the medical community. Especially as laws on professional assistance in dying undergo increasing liberalization, society should not want its physicians (or its prospective physicians) to either be so callous, so lacking in compassion that they would dismiss such a patient request out-of-hand, or to be so cavalierly accustomed to acquiescing in such requests that it simply becomes a routine pattern. Either approach on its own betrays the moral integrity of medicine. We instead want those professionals who are present to us in our dying to express both care and respect, to display both compassion and dignity for the dying person, even when, as in this circumstance, these core values come into conflict. In such a situation, moral anguish protects both the professional and the patient, not to mention society, from callous paternalism and/or callous indifference.

The moral anguish of the physician-to-be leads to a question of conscience, "Did I do the right thing?" This question reflects an important ethical dimension of the situation, an ethic of duty focused on right action. There are other complementary ethical questions that might be asked: "What kind of person ought I to be to do the right thing?" or "Did my actions appropriately express caring?" or "Did I respect the rights of the patient?" or "Did the outcome bring about the greatest benefit or minimize the harm?" How we resolve professional ethical conflicts in medicine will depend on the kinds of questions we pose, and so clarifying the *right question* is a necessary first step in moral awareness. It is important, nonetheless, to understand the conflict from the perspective of the agent, and so in this commentary, I will focus on the agent's concern of "doing the right thing," and its subtext, "for the right reason."

The patient's request, "Help me die," suggests the medical student had already been doing many right things to establish a context of trust and candor within which the patient felt comfortable rather than intimidated about even raising her request. Trust and



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honesty are necessary elements of any caring relationship, but especially so in the care of the dying, when the professional's power is heightened because the patient is so vulnerable.

The request nonetheless reveals the student's *own vulnerability*: a sense of inadequacy owing to lack of preparation (in general, and with this particular patient) for such a discussion; an inclination of "compliance," language that implies a reversal of roles so that the position of power has now been assumed by the patient; and then fear that pushes in the direction of moral paralysis, such that the student responds "as if on autopilot." These are hard lessons in personal and professional vulnerability; they nonetheless are one way, to borrow a phrase from Elisabeth Kübler-Ross, that the dying *teach* the living. The (aspiring) healthcare professional in the context of dying needs always to be open to the invitation to learn that care for the dying offers.

The student's moral anguish culminates in a babbled "autopilot" reply about the implied limited knowledge and responsibilities of a medical student and an inquiry about comfort. Under the circumstances, what alternatives might have been open to the student that could be designated "the right thing?" The student might have replied to the patient's request with a dismissive, "There, there, you're not ready to die yet," but that kind of condescending communication would have betrayed the trust, care, and honesty at the basis of the relationship's integrity. Moreover, substantial empirical evidence indicates that the vast majority of patient requests for medical assistance in dying decline when the patient's pain is alleviated. It would have been callous and indifferent to not have inquired about the patient's level of comfort, given the case description of the patient's "unbearable" pain and indignities. Alternatively, the student might have replied, "We'll see what we can do. Tell me more about why you want to die now," and used the request to initiate a conversation that explored the patient's wishes more fully. Although such a conversation between the patient and a professional caregiver seems necessary, it falls outside the role, expertise, and responsibilities of a medical student to conduct such an exploration, and particularly a medical student who is self-described as not at all "prepared" for such a situation. There are other professionals and mentors with the training and "practice" to explore the patient's request for death in a caring, compassionate, and respectful manner, and it would be appropriate for the student to communicate this request to the patient's attending physician.

Had this situation taken place in the U.S. state of Oregon, it is possible that the patient's request might have ultimately led to utilization of the Oregon Death with Dignity Act (ODDA), which permits licensed physicians to prescribe a lethal dose of medication to a qualified terminally ill patient with the intent to end the patient's life in a "humane and dignified manner." I use the language of "possible" and "might" advisedly here, because the ODDA requires the patient to initiate the request for lethal medication to their attending physician; the request cannot be conveyed by a student or a family member. Moreover, the physician who prescribes the medication must be licensed to practice, a certification the student currently lacks.

However, if the (crucial) details of this case are changed slightly, so that the patient does in fact initiate a request for a lethal dose of medication to her attending physician, then a set of procedures is set in motion to ensure the patient is dying with care, respect, and dignity. These include:



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- determination by two physicians that:
  1) the patient has a terminal illness;
  2) the patient is capable of making a choice about treatment options; and
  3) the specific request to die is made voluntarily.
- an informed consent process by which the attending physician discloses to the patient:
  1) the diagnosis and anticipated prognosis;
  2) alternatives to the prescription, such as comfort care and hospice;
  3) the risks and the likely result of taking the medication;
  4) the patient's option to notify their next of kin of their decision; and
  5) the opportunity to rescind their request at any time.

If either of the two physicians suspect the patient's request may be a result of "impaired judgment," the patient must be referred for counseling. However, if the physicians concur in their determination that the patient is terminal and the request to die by lethal medication is an authentic choice of the patient, and the necessary information is disclosed, then a "waiting period" must transpire that helps to ensure the continuity of the patient's request over time. In particular, after the initial oral request to the physician for lethal medication, and prior to receiving the prescription, the patient:

1) must write out their request;
2) must reiterate their oral request no sooner than 15 days after their initial request;
3) must be informed again of their right to rescind their request;
4) must wait at least 48 hours after submitting their written request before the prescription will be written.

In the 3 years since the ODDA has been law, 70 terminally ill patients have made use of these provisions to end their life. Perhaps the patient in the case study would have chosen this option had it been available to her. Her attending physician would not be required to participate in this process but would also be immune from any legal liability or professional discipline for participation, which is an understandable concern of the medical student. However, no legal safeguards, no bureaucratized process of dying, can answer the profound question of moral conscience and professional integrity, "Did I do the right thing?"

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## Commentary

### Gerrit Kimsma

This case is both an excellent as well as a sad illustration of the complexities, intensities, and foibles of the issue of "helping" sick people to die. Although the reaction expressed here is that of a student, it is also, sadly, the reaction of many an experienced physician in being emotional, irrational, and hasty. The description is a perfect example of the student's dilemma: "I would like to help but I can't because to do so would threaten my position"—altruism versus egocentric motivation.

In most instances, I am happy to say that Dutch medical students are able to approach their teachers and share their similar euthanasia experiences in a climate of open discussion. As faculty, in teaching students to respond profes-



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sionally to these challenges, we begin first of all by realizing how deeply students are disturbed by these questions. Students are scared—as they should be. Second, responding professionally means understanding that the patient's disturbing question needs to be dealt with in the calm, caring, and compassionate manner expected of a physician. And third, there must be a clear understanding of what constitutes a student's medical responsibility and what exceeds that boundary.

Surely, helping patients to die is never a student's responsibility. However, students do have a responsibility to respond appropriately to this question. The student's reaction should be sensitively responsive and open-minded in acknowledging the patient's distress. As soon as possible, he or she should relay the information to the physician in charge. A sequence of events might then unfold, in which the physician recognizes the student's discomfort in a reassuring manner. The physician would then interview the patient, exploring the facts and the feelings prompting the request. It is incumbent on the physician to give sufficient time and focus, along with a calm attitude to demonstrate that the patient's request has been taken seriously. Next, a responsible physician analyzes and assesses the patient's individual situation, with special attention for the person's suffering. Being taken seriously and provided with possible means for lessening the patient's suffering through alternative palliative measures may be enough to comfort the patient. Thus far, the approach I describe may be shared by Dutch and non-Dutch physicians alike.

What might happen next in the Netherlands concerns the duty of physicians to take a request for euthanasia or assisted suicide seriously with an aim to determine whether or not certain criteria have been met. The physician begins with an in-depth assessment of the patient's circumstances, covering such issues as: Is the patient's request to die voluntary? Repeated? Well considered? Is the patient's suffering durable? Unbearable and irreversible? If, and only if, the answers to these questions are positive along with the fact that the patient does have a serious disease for which there are no acceptable alternatives and no hope for improvement, then a procedure to end the life of the patient may be initiated. This procedure involves the physician's legal duty to ask for a collegial consultation to determine whether there has been compliance with all legal conditions. This consultative step functions both as a support for the physician as well as a double-check to prevent acts of physician-assisted death without due care. If in the end a decision is made to end the patient's life, the act takes place in a calm atmosphere, usually at the patient's home, with effective medication. The event is followed by the physician's report to a local coroner who sets the process of legal evaluation in action by sending the necessary report to a regional Euthanasia Evaluation Committee, which will decide on the medical, ethical, and legal acceptability of the act of physician-assisted death. The Committee's decision must be made within 6 weeks after reporting.

Questions like these are scary business for students: if the scare is not shared and discussed, it will remain scary. And scared students often become scary physicians.

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