

Death with Dignity: Redefining What It Means to Heal

Michelle Trieu

Herbert Wertheim College of Medicine, Florida International University, Miami, FL, USA

Corresponding Author: Michelle Trieu mtrie002@fiu.edu

Physicians heal. All physicians recite an oath to heal all individuals, whether children, drug addicts, or even warzone enemies. In 2014, however, when Brittany Maynard publicly announced her decision to die by medication prescribed to her by her physician rather than suffer from end-stage glioblastoma, it reignited the conversation concerning physicians' roles¹. After two surgery attempts with a recurrence of cancer, she moved to Oregon and chose the exact terms by which she would pass away, including when and where it would happen and with who she would be surrounded. Her decisions became her legacy as a right-to-die activist, garnering numerous supporters and detractors for her actions²⁻³. If she was able to do this legally, then what exactly is a physician's role in healing, and do physicians have a duty beyond curing diseases?

As of now, five states (Oregon, Vermont, Washington, California, and Colorado) have passed Death With Dignity Acts (DWDA), which allow mentally competent patients who are terminally ill with an expected lifespan of six months or less to use physician-assisted services to determine their circumstances of death⁴. This is highly controversial as it redefines the role of a physician from strictly a healer to an arbiter of life or death. The consequences of these acts are potentially damaging to the perception of physicians as healers and could undermine society's trust in physicians⁵. For patients with terminal illnesses, this law provides an alternative to available options, namely hospice care, in which quality of life and relief of debilitating symptoms are emphasized rather than aggressive treatment. While physicians have traditionally allowed patients to forego treatments or choose alternative medicine to respect patient autonomy, the DWDA laws allow physicians the unprecedented power to be proactive in these cases.

More generally speaking, the traditional role of the physician as no more than an uncompromising fighter of illnesses often clashes with respect for patient autonomy. Culture, family values, and morals often go against traditional assumptions concerning what it means to practice medicine. Appropriately, modern healthcare—as taught in medical school and beyond—has already moved past the view that “physicians are only curers of disease” towards a model of shared decision making. In this viewpoint, physicians regularly take into consideration a patient's emotional, spiritual, and psychosocial influences when guiding a patient through their diagnosis to not only cure but heal holistically. In addition,

patients already have the right to choose or refuse treatment and pursue alternative medicine. They pursue elective treatments such as cosmetic surgery, abortion, and organ donation which are traditionally outside the realm of “healing” but are essentially medical in nature. One choice many terminally ill patients are not privileged to is the right to end their lives with the help of their doctor when death is imminent. Instead, many of these patients simply trudge along, often prolonging their suffering and becoming increasingly reliant on others for support, losing any control over their quality of life. Nonetheless, to what extent should it be permissible for physicians to be involved in how patients choose to die? Here, one could argue that there is a conflict between healing and granting patients total autonomy over the terms of their lives and deaths. But is there really a conflict here?

Oregon was the first state to implement the DWDA for terminally ill patients in 1997. Benefactors of this legislature were mostly white and more likely to have graduated from college. Almost 70% were over 65 years old, 90% died at home, in contrast to the general population, and 92% were enrolled in hospice care⁶. This data implies that these patients were likely well-educated and well-informed about their treatment options beyond aggressive therapy of their terminal illness. Of the 218 people who were prescribed the medication in 2015, only 132 actually took it (57.3%)⁷. This could mean that what patients really wanted was a sense of control as the disease progressed. This data supports other studies that show that end-of-life care patients tend to prioritize dignity, autonomy, and identity near the end of their lives.

The question remains: is it the physician's job to support this desire for control? Nobody would deny that shared-decision making and informed consent are part of any medical decision. Control comes in many forms, including opting for supportive care, aggressive care, or even choosing not to be informed about one's own diagnosis. In that sense, the framework already exists to help physicians and patients choose a model of care that benefits their own personal priorities and values. DWDA simply expands on that paradigm to include another option for patients with less than six months to live. Rather than viewing the physician as a passive or proactive instigator, the physician's true role is to keep an ongoing conversation about available options while providing professional assessment towards a shared decision.

What then is a physician? A physician could choose to be someone who only reverses ongoing disease processes and prevents sick patients from getting worse. A more cynical approach would say physicians merely delay the inevitable. Perhaps the profession should not solely be about prolonging life but rather about empowering patients to choose their own paths in accordance with their personal sense of dignity. Acknowledging patients' desires to face their illness allows for a stronger physician-patient relationship and empowers both patients and physicians. A physician's role is certainly that of a healer, but perhaps the idea of healing is one that should incorporate not only treatment of disease processes, but also care of patients such as Brittany Maynard in ways that respect their own values and goals.

References

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