

# Medical Student as Professional: Responding to a Dying Patient's Request for Assisted Suicide

**Rachel Biber, B.A.**  
*University of Missouri*

**David Fleming, M.D.**  
*University of Missouri*

While bioethics is a growing and expanding field, its boundaries do not automatically extend into the world of medical students, as there has been little discussion about how we should handle the unique ethical dilemmas that we encounter. As aspiring physicians caring for patients, we face frequent challenges compounded by the daily struggle to balance learning, interaction with patients and colleagues, and performing procedures. Facing a request for assisted death is a distinct possibility in the lives of medical students and we must know and understand how to react. Being a professional from the first day we walk into class as a first-year medical student gives us an influential role on the health care team and compels us to confront such challenges as a patient's appeal for assistance in death.

Key words: physician-assisted suicide, euthanasia, professionalism, medical student

As a medical student, I am not immune to facing ethical battles just because I am not a physician. Being a student does not alleviate my obligations in the care of patients because, as a medical student, I am also a medical professional. With that in mind, consider the following situation in which the inevitability of death cannot be escaped. Betty Rollin knew her mother's death from ovarian cancer would come soon. She records a conversation with her mother in *Last Wish*:<sup>1</sup>

"Her eyes were too much for me. I looked down, but when I looked up they were still there. I think that's when I knew she was really asking me.

'I've had a wonderful life, but now it's over, or it should be,' says Rollin's mother. 'I'm not afraid to die but I am afraid of this illness, what it's doing to me. I'm not better. I'm worse. There's never any relief from it now. Nothing but nausea and pain. The pain – it never stops ... So what happens to me now? I know what happens. I'll die slowly.' She paused, she coughed, but kept her eyes on me. 'I don't want that. I wouldn't mind if it killed me fast. Fast I wouldn't mind. Slow I mind ... There's no point in a slow death, none. I've never liked doing things with no point. I've got to end this.'"

Grappling with pain, suffering, and the reality of death, Betty's mother is implicitly asking to die – for help to die now, not later. Placing myself as a medical student at the bedside, I ask, "How do I respond, what should I do?" After a swirl of emotion and shock, I would probably sit dumbfounded and afraid due to the gravity of the request. As a student, I have no formal power in making treatment decisions, yet I have still promised to do my best to serve the needs of patients,

both present and future. A request for assistance to die from such a patient introduces a host of ethical challenges to be surveyed by one whose familiarity with end-of-life issues stems only from personal experience and beliefs that precede my role as a professional. This conflict is underscored by the fact that I chose to pursue the profession of medicine in order to heal patients and to extend life, not to end life when suffering becomes overpowering.

It is clear that a physician should be skilled and knowledgeable about how to respond to such a request, along with being well versed in the controversy surrounding physician-assisted suicide (PAS) and euthanasia; medical students should be equipped with the same knowledge. Being challenged with a patient like Betty's mother demands that a medical student recognize the historical, ethical, societal, professional, and personal constructs that frame the debate about PAS and euthanasia in order to unravel the controversy and piece together a personal decision when strong competing ethical viewpoints exist.

## A Historical Background of Physician-assisted Suicide and Euthanasia

A glance at the historical debate about the divisive issue of PAS and euthanasia reveals a timeless tension within the medical realm of society, as physicians in all eras have struggled to find common ground. In this context, euthanasia is taken strictly to mean the active termination of the life of a terminally ill patient by a second party (e.g., the physician administers a lethal injection), while PAS is a passive act whereby a physician assists the patient in taking his or her own life (e.g., the physician prescribes a lethal dose of medication). Opponents of PAS and euthanasia espouse the ancient Hippocratic Oath and frequently quote the portion of the pledge that reads, "I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect."<sup>2</sup> Others mention that

---

**Rachel Biber, B.A.**, *University of Missouri, SOM, MA213, Mailbox 324, Columbia, MO 65212;*  
E-mail: [rabtf7@mizzou.edu](mailto:rabtf7@mizzou.edu)

while the Oath has grounded medical ethics for centuries, it “has turned out to be a limited and generally unreliable basis for medical ethics.”<sup>3</sup>

The Oath's faulty foundation is argued to lack timelessness and to be unable to stand as an absolute standard of medical conduct. Edmund Pellegrino calls for “more explicit guidelines than traditional codes can afford,” stating that the Hippocratic Oath is “insufficient for the complexities of today's problems.”<sup>4</sup> Paradoxically, contemporaries of the writers of the Hippocratic Oath in ancient Greece 2500 years ago commonly offered a poisonous solution at the request of a dying patient. Indeed, the Oath itself most likely originated through the efforts of a religious group, the Pythagoreans, representing a minority of Greek opinion. For centuries, ancient physicians, in opposition to the demands made by the Oath, directly supplied poison to patients intending to commit suicide.<sup>2</sup> Those in support of assisted death disdain a literalist reading of the Oath and interpret its expectations as being broad principles. Francis Dominic claims that a broader analysis of the Hippocratic tradition cannot support the definitive rejection of physician-assisted suicide any more than it can support the prohibition of surgery and abortion, both of which are also forbidden by the Oath.<sup>6</sup> Still, the controversy persists, and remains one of the perennial ethical debates in medicine, evolving thousands of years before the term “bioethics” was even coined.

The legal history of assisted suicide is one of liberty rights and begins at the turn of the 20<sup>th</sup> century with the first euthanasia bill being introduced in Ohio. It has culminated in more recent action, including the U.S. Supreme Court rulings in 1997 that upheld Washington and New York state laws banning assisted suicide. In the Washington ruling (*Washington v. Glucksberg*), Chief Justice William Rehnquist writes, “we are confronted with a consistent and almost universal tradition that has long rejected the asserted right [of PAS] ... To hold for respondents, we would have to reverse centuries of legal doctrine and practice, and strike down the considered policy choice of almost every State ...”

State attempts to legalize PAS have steadily occurred across the nation, including failed referenda in California in 1992 and Michigan in 1998. However, in 1997, when Oregon voters refused to repeal the Oregon Death with Dignity Act for the second time, the state became the first to permit PAS under limited circumstances. On March 24, 1998, the first terminally ill patient committed assisted suicide under the conditions outlined by state law. Section 2.01 of the Death with Dignity Act reads:

“An adult who is capable, is a resident of Oregon, and has been determined by the attending physician and consulting physician to be suffering from a terminal disease, and who has voluntarily expressed his or her wish to die, may make a

written request for medication for the purpose of ending his or her life in a humane and dignified manner in accordance with this Act.”<sup>7</sup>

As demonstrated by the fact that the controversy surrounding PAS and euthanasia is firmly entrenched throughout history, its place in medical school curricula should not be ignored amongst the novel ethical questions forced upon us because of innovative medical technology. Why debate the age-old question of euthanasia when flashy issues like stem cell research or gene therapy can be discussed? Because as medical students we will all become physicians, and physicians must face every aspect of death and dying. Approximately 60% of formal ethics curricula in American medical schools address the issue of PAS and euthanasia, while more than one third of students are left to explore the issue on their own or be stunned when confronted with a request for assistance in death.<sup>3</sup> The expansion of ethics curricula in medical schools must continue.

### The Ethical Debate

From a student's vantage point, the competing arguments concerning assisted suicide and euthanasia are equally compelling and convincing, but the physician cannot plead neutrality. Obligated by our profession and the relationship we have with our patients, we must listen and try to understand the issues on both sides. Central to the debate are the opposing notions of personal autonomy and professional values. In identifying the “good consequences” of permitting euthanasia, philosopher Dan Brock remarks that “if euthanasia were permitted it would be possible to respect the self-determination of competent patients who want it, but cannot get it because of its illegality.”<sup>9</sup> Opponents, however, are quick to strike down the autonomy argument. Daniel Callahan contends that “the self-determination in [PAS and euthanasia] can only be effected by the moral and physical assistance of another,” making the practice “no longer a matter of only self-determination, but of a mutual, social decision between two people, the one to be killed and the other to do the killing.”<sup>10</sup> Another argument against self-determination as an ethically valid basis for assisted suicide is rooted in Kantian ethics, dictating that it is irrational to remove the singular element necessary for autonomy, which is one's life.

Supporters contend that PAS honors a patient's right of self-determination and that, with procedural safeguards, it can be controlled and should be legalized. However, those against the practice envision disastrous consequences if the legalization of PAS and euthanasia were to become commonplace, fearing that a “slippery slope” phenomenon of acceptability would lead to abuse. One concern is that relaxation of the law to accommodate difficult cases would inevitably result in its extension to incompetent patients or those who may not be suffering unbearably. Opponents cite grave practical dif-

facilities in framing and enforcing safeguards to thwart abuse from taking place, and that public apprehension regarding involuntary euthanasia does exist.<sup>11</sup>

In fact, clinical problems have been cited in regards to the performance of euthanasia and PAS in the Netherlands, where both practices are now legal.<sup>12</sup> The incidence of euthanasia has increased since 1990, and there is also some evidence of the occurrence of involuntary euthanasia being performed by physicians.<sup>13</sup> This “slippery slope” to abuse can even be characterized as psychological. That is, an attitude of acceptability regarding killing could occur if assisted suicide were to become commonplace. Edmund Pellegrino argues that if “enough moral agents in a society have wrong intentions about killing in the medical context, the attitudes of the whole profession and society will be affected with a disvaluation of human life itself.”<sup>14</sup> But defenders of PAS and euthanasia reject the concern about a “slippery slope” and see its supposed threat as purely speculative. In examining the Dutch health care system in which euthanasia has been legalized, Dr. Pieter Admiraal does not accept that there is a slippage to abuse. He says that a “clear and moral boundary can be drawn around the notion of consent,” and that “no patient – no matter how ill – will have his or her life cut short, unless there is an explicit request.”<sup>15</sup>

Supporters also claim that hastening a terminally ill patient’s death is founded in the notion that the practice fulfills the duty of medicine to relieve suffering. In pointing to the principle of beneficence, supporters argue that, in some cases, suffering simply cannot be relieved while awaiting a natural death, and in such cases ending a painful life will actually be of greater benefit to the patient. Physicians have a “moral obligation to use medical means to relieve their patients’ suffering.”<sup>16</sup> In contrast, opponents contend that this “moral obligation” lies in providing optimal palliation of physical distress, modeled by a growing number of hospice and palliative care programs. But defenders believe that “not all patients can receive adequate relief of pain or suffering even under conditions of optimal palliative care.”<sup>17</sup> Those not favoring PAS and euthanasia argue that better pain management needs to be enforced for dying patients and that the resources and opportunity to improve on end-of-life care definitely exist. Contesting the assumption that there is some pain that cannot be alleviated in dying patients, Ira Byock states that it “is undeniably true that physical suffering is not always adequately controlled even in current hospice settings,” but that it is “illogical to use the existence of a problem to argue against the possibility of a solution.” Care is not “optimal” if severe pain is allowed to persist without relief.<sup>18</sup>

Supporters also maintain the permissibility of PAS and euthanasia by rejecting the notion that there is a difference of intention between the practices of withholding or withdrawing life-sustaining treatments (i.e., “letting someone die”

or “passive euthanasia”) and actively assisting them to die. Refuting this “difference thesis,” James Rachels’ pivotal 1975 article in the *New England Journal of Medicine* claims that the “conventional doctrine,” stating that killing and letting die can be differentiated, can be challenged because “the doctrine rests on a distinction between killing and letting die that itself has no moral importance.”<sup>19</sup> Rachels is claiming that the intention of promoting death in a suffering and dying patient is inherent in both acts and, therefore, the difference is obscured. Opponents deny Rachels’ claim and outline the difference between killing and letting die on the same basis of intentionality. The intention, according to opponents, of withholding treatment is to save a patient from the hopeless manipulations of medical technology, which is morally distinct from the deliberate and calculated aspect of killing.

The goals of medicine and the role of the physician are additional rallying points in the PAS and euthanasia debate. Some believe assisting in suicide is abusive to the truths of medicine and takes it outside of its proper boundaries. In its code of ethics, the American Medical Association declares that PAS is “fundamentally incompatible with the physician’s role as healer, would be difficult or impossible to control, and would pose serious societal risks.”<sup>20</sup> But, as proponents claim, promoting and defending the values of autonomy and beneficence are at the moral center of medicine and it is the commitment to these obligations that guides the physician as healer and supports allowing patients suffering at the end of life to choose assisted death.<sup>21</sup> The core arguments of autonomy and beneficence appear to highlight both sides of the moral debate.

### **Societal Expectations Regarding Assisted Death at the End of Life**

If history is any indication of contemporary opinion concerning life and death issues, then the divisive split over PAS and euthanasia in all sectors of society should not be surprising. Countless polls have been conducted to assess the attitudes of physicians, all of which reaffirm the lack of a united outlook. In a 2002 study by *Medical Economics*, 51% of physicians agreed that there were “circumstances under which physician-assisted suicide should be permitted,” while the remaining 49% responded negatively.<sup>22</sup> Despite the near even split in opinion among physicians, agreement surfaces about the need to treat pain better. In disclosing its stance on PAS, the American College of Physicians echoes this sentiment and states, “Patients often fear the prospect of unrelieved pain. Many patients with terminal illness are in fact under medicated ... When patients select palliation as their highest goal, physicians should make relief of suffering the highest priority.”<sup>23</sup>

Similar to the disagreement amongst physicians, discordant public opinion also exists. Innumerable surveys have been done among the American public, showing a wide variation in support of assisted death depending on the type of situa-

tion presented. In general, roughly one third of the American public supports assisted death regardless of the circumstances, while one third opposes it in any circumstance. The remaining one third of Americans support PAS or euthanasia in some circumstances, usually when patients are experiencing extreme pain, but oppose it when other reasons, such as patient depression or feelings of being a burden, are at issue.<sup>24</sup> Important sociodemographic characteristics of both patients and physicians should also be considered. Catholics, and others with a religious affiliation, are significantly more likely to oppose both practices, as are the elderly and African-Americans. Additional surveys suggest that women are more likely to oppose PAS or euthanasia.<sup>24</sup> Nonetheless, it seems doctors are more conservative than the public-at-large, as evidenced by a Harris Interactive poll conducted in 2001, in which 65% of the public expressed support for PAS.<sup>22</sup>

However, public opinion does not necessarily correlate with patients' decisions. In a 2000 *Journal of the American Medical Association* study examining terminally ill patients and their care givers, a total of 60.2% of patients supported euthanasia or PAS in a hypothetical situation, while only 10.6% would seriously consider it for themselves. Ironically, the same study indicated that the crucial components that generated interest in PAS and euthanasia were not physical symptoms, but rather psychological stress and care needs. This study suggests that there exists "a tension between attitudes and practices, between the reason people find euthanasia and PAS acceptable – predominantly pain – and the main factor motivating interest in euthanasia or PAS – patient depression."<sup>25</sup> The results of these surveys suggest that the focus of surveying public opinion rests on probing the appropriateness of PAS and euthanasia based on experiencing "severe pain," or "distress," rather than specifically inquiring about the suitability of assisted death when depression, rather than physical suffering, is a motivating factor.<sup>26</sup>

There is an unavoidable public and professional divergence over the issue of PAS and euthanasia, underscored by a constant tension surrounding the acceptability of death. This controversy cannot be avoided by those entering the medical profession. Medical students need to be aware of both public and professional attitudes regarding end-of-life issues and how these impact the way in which physicians think and react to the events surrounding death. Awareness of the issues and the debate over assisted suicide is crucial to the ability to communicate effectively about end-of-life issues with both patients and other health care professionals.

### The Professional's Role

Betty Rollin's mother is suffering and asking for help to die. I find myself, as a medical student, helplessly standing at the bedside. When asked about the certainty of her decision, Betty's mother replies, "Of course I want to die. Next to the

happiness of my children, I want to die more than anything in the world."<sup>1</sup> Upon hearing this, I may feel a powerlessness that relegates me to simply nodding my head and offering emotional support, but wearing a short white coat does not leave me incapable of influencing my patients' care. When students begin their journey through medical school they are not outside of the medical realm, but rather placed squarely inside of it. As a medical student, I have already promised to be bound by the professional duties of physician even without bearing the title of MD. The reality is that I, as a student, am also a professional. Learning institutions, such as mine, that recognize the student *qua* professional seek to "provide a professional environment that fosters and develops the values and professional traits of a competent and compassionate physician," while medical students are "expected to act in a professional manner."<sup>27</sup> As a professional, the guiding principle that influences my actions is pursuing the best interest of the patient. Discussing and identifying that "best interest" will always be the challenge.

Any bioethical debate is rooted in the fact of illness and the act of healing, which requires responding in accordance with the best interest of the patient. "Acting for the good of the patient is the most ancient and universally acknowledged principle in medical ethics," writes Edmund Pellegrino. "It grounds ethical theories and shapes the way their principles are applied in particular cases. It is the ultimate court of appeals for the morality of medical acts."<sup>28</sup> For that reason, comprehension of the ethical debate surrounding PAS and euthanasia is crucial in promoting the good of the patient. But how does one delineate the "good of the patient" in this seemingly irreconcilable controversy? This is an impending question in medical ethics, a question without a unanimous answer, yet this does not leave medical students without a response. Rather it compels us to explore, form opinions, and ultimately respond with a rational ethical argument as to how one should act.

There is a central obligation of the medical student *qua* professional – an obligation inherent in the definition of student, but an obligation that should not subside once the title of student is replaced by that of doctor. Indeed, the role of physician brings with it the responsibility of life-long learning, as the world of medicine is ever changing, challenging health care professionals to soak up the flood of new knowledge like a sponge. As a medical student, this stands as the most fundamental commitment. In the context of ethics, students are obliged to develop a framework of argument derived initially from their own values and moral agency. We must identify and apply our beliefs and values in a knowledgeable manner, learn the limits of our profession, and reflect skillfully on the situations that confront us. The ability to excel as a student also requires us to listen and ask for greater clarification when encountering difficult circumstances, especially when there is no "right answer."

A medical student's commitment to exploring the ethical realm of medicine and acquiring new knowledge does not disappear when challenged with a situation like standing at the bedside of Betty Rollin's mother. Moreover, the task of learning and reflecting must be balanced with good communication skills, which means listening to patients and attempting to discuss what is in their best interest. In reality, the lasting component of a medical student's ethical education and developing moral agency takes place at the bedside, as each patient encounter strengthens those that will follow. Indeed, as professionals we come full circle. The central obligation of the student *qua* professional to learn, listen, and reflect is grounded in the best interest of the patient and promoted by the healing relationship that forms between physician and patient or medical student and patient. Within this construct, "healing" does not take place strictly in the medical sense, but requires the patient to be treated spiritually and holistically as "person." Eric Cassell identifies our duty to treat patients as persons and writes, "The health of the person is a wider goal than the health of the body and reaches into all dimensions of life."<sup>29</sup>

### Conclusion

When faced with a request by a patient for assistance in dying, a medical student may feel incredibly challenged, but an incredible opportunity also presents itself. It is an opportunity to learn, contemplate, communicate, explore, and infuse humanism into one's medical education and mold it into an environment allowing for a lasting impact. Students often comment about the "dehumanizing" routine of tests and scientific fact shaping medical school curricula. Nonetheless, being at the bedside of a dying patient who pleads for an end to suffering and pain should not leave medical students with a sense of powerlessness, as a medical student is a professional and, as such, is an integral part of the health care team. Requests for assisted death can be a harrowing experience. At such times, however, medical students must fulfill their obligation to learn and understand. With compassion, they must place the best interest of the patient squarely in the center of their educational experience while still caring for the patient in a professional manner, even when there is no "right answer" to be given.

### Acknowledgements

We would like to thank the Office of Medical Research at the University of Missouri School of Medicine, especially Dr. William Folk, for making the opportunity to explore this pressing issue possible.

### References

1. Rollin R. *Last Wish*. New York:Linden Press/Simon & Schuster;1985,149-50.
2. Edelstein L. The Hippocratic Oath: Text, translation, and interpretation. In: Veatch RM (ed). *Cross Cultural Perspectives in Medical Ethics*. Boston, MA:Jones and Bartlett Publishers;2000, 3-21.
3. Beauchamp TL, Childress JF. *Principles of Biomedical Ethics*, 5th ed. New York:Oxford University Press;2001,400.
4. Pellegrino E. Toward an expanded medical ethics: The Hippocratic ethic revisited. In: Veatch RM (ed). *Cross Cultural Perspectives in Medical Ethics*. Boston, MA: Jones and Bartlett Publishers;2000, 41-53.
5. Weir R (ed). *Physician Assisted Suicide*. Bloomington, IN: Indiana University Press;1997.
6. Degnin FD. Levinas and the Hippocratic Oath: A discussion of physician-assisted suicide. *J Med Phil* 1997;166:402-6.
7. Zucker MB (ed). *The Right to Die Debate: A Documentary History*. Westport, CT:Greenwood Press;1999,275.
8. DuBois JM, Burkemper J. Ethics education in US medical schools: A study of syllabi. *J Acad Med* 2002;77: 432-8.
9. Brock DW. Voluntary active euthanasia. *Hastings Center Report* 1992;March/April:11-2, 14-7, 19-21.
10. Callahan D. When self-determination runs amok. *Hastings Center Report* 1992;March/April:52-5.
11. Keown J. *Euthanasia, Ethics and Public Policy*. Cambridge, UK:Cambridge University Press;2002, 80.
12. Groenewoud J, van der Heide A, Onwuteaka-Philipsen B, Willems D, van der Mass P, van der Wal G. Clinical problems with the performance of euthanasia and physician-assisted suicide in the Netherlands. *New Eng J Med* 2000;342:551-6.
13. Van der Maas PJ, van der Wal G, Haverkate I, de Graaff CL, Kester JG, Onwuteaka-Philipsen BD, van der Heide A, Bosma JM, Willems DL. Euthanasia, physician-assisted suicide, and other medical practices involving the end-of-life in the Netherlands, 1990-1995. *New Eng J Med* 1996;335:1699-1705.
14. Pellegrino E. The Place of intention in the moral assessment of assisted suicide and active euthanasia. In: Beauchamp T (ed). *Intending Death: The Ethics of Assisted Suicide and Euthanasia*. Englewood Cliffs, NJ:Prentice Hall;1996, 163-83.
15. Kuhse H (ed). *Willing to Listen, Wanting to Die*. Ringwood, Victoria:Penguin Books;1994, 230-45.
16. Brody H. Assisting in patient suicides is an acceptable practice for physicians. In Weir R (ed). *Physician Assisted Suicide*. Bloomington, IN:Indiana University Press;1997, 136-51.
17. Miller FG, Brody H. Professional integrity and physician-assisted death. *Hastings Center Report* 1995;May-June: 8-17.
18. Byock IR. Physician-assisted suicide is *not* an acceptable practice for physicians. In: Weir R (ed). *Physician Assisted Suicide*. Bloomington, IN:Indiana University Press;1997, 107-35.
19. Rachels J. Active and passive euthanasia. *New Eng J Med* 1975;292:78-80.

20. AMA Code of Ethics. URL: <<http://www.ama-assn.org/ama/pub/category/2416.html>>
21. Brock DW. Physician assisted suicide is sometimes morally justified. In: Weir R (ed). *Physician Assisted Suicide*. Bloomington, IN:Indiana University Press;1997,86-103.
22. Guglielmo W. Assisted suicide? Pain control? Where's the line? *Med Econ* 2002;19:48.
23. Snyder L, Sulmasy D (on behalf of the Ethics and Human Rights Committee, American College of Physicians-American Society of Internal Medicine). Physician-assisted suicide. *Ann Intern Med* 2001;135:209-16.
24. Emanuel E. Euthanasia and physician assisted suicide. UpToDate Online 11.2.
25. Emanuel E, Fairclough D, Emanuel L. Attitudes and desires related to euthanasia and physician-assisted suicide among terminally ill patients and their caregivers. *JAMA* 2000; 284:2460-8.
26. "National Polling on Physician Assisted Dying." Death with Dignity National Center. URL: <<http://www.deathwithdignity.org/resources/polls.htm>>
27. University of Missouri School of Medicine Student Handbook. URL: <<http://www.muhealth.org/~medicine/studenthandbook/>>
28. Pellegrino E, Thomasma D. *For the Patient's Good*. New York:Oxford University Press;1988,73.
29. Cassell E. Pain, suffering, and the goals of medicine. In: Hanson W, Callahan D (eds). *The Goals of Medicine*. Washington D.C.:Georgetown University Press;1999, 101-7.