

Module 5

## Case 5.2: Physician Assisted Suicide and Euthanasia— Mrs. Scott's Plan for the Future

### Case Presentation

After following the appropriate procedural steps, including consultation with the hospital's ethics committee, the physician's judgment is confirmed: Mrs. Scott is requesting futile care. Dr. Lee recommends that she see a medical oncologist (not a surgeon) for a full assessment and treatment alternatives, and he offers her information about hospice care. Not surprisingly, Mrs. Scott requests a referral to a different surgical oncologist, hoping she will find one who disagrees with Dr. Pandihar's judgment. Dr. Lee provides her with this referral, also.

Several weeks later, Dr. Lee notices that Mrs. Scott has an appointment that afternoon. Dr. Lee doubts she found a surgeon willing to perform the surgery, and he guesses she's back for another referral. He gets Mrs. Scott's chart and heads to exam room 2.

As he enters, he gives his usual greeting, "Hello, Mrs. Scott, and how are you doing today?"

"Not too well."

"The nurse said you didn't explain exactly why you're here today."

"I didn't want to get her involved. You see, Dr. Lee, no one will do the surgery. They all tell me that I only have 6 months to live. I'm sorry I blew up at you and Dr. Parihar, but I..." she trails off.

Dr. Lee speaks comfortingly, "As much as I would have preferred it didn't happen, it's an understandable reaction to such grave news. Did you meet with the medical oncologist, and were you able to get in touch with the hospice care facilities I recommended?"

"I met with the medical oncologist and he confirmed that I have a few months to live. He also gave me some information about some hospice places." She pauses. "Dr. Lee, I want you to give me a prescription for barbiturates. I don't want to spend the last few months of my life in agonizing pain. I watched my father die a painful, slow death, and I don't want any part of that. I want some control over how I die. I know this could put you in a compromising position, so I should also tell you that I've had some pain that regular strength pain killers do not alleviate. Please, Dr. Lee, just give me the prescription."

### What should Dr. Lee do? (select an option)

- A. [Prescribe the barbiturates and inform Mrs. Scott of the proper dosing levels for pain treatment and the amount that would result in an "overdose."](#)
- B. [Inform Mrs. Scott that he will not prescribe barbiturates for the reasons she has suggested, but that he will prescribe appropriate pain control.](#)
- C. [Inform Mrs. Scott that she will have to ask another physician for assistance in ending her life and give her contact](#)

[information for several other physicians.](#)

D. [Recommend Mrs. Scott see a counselor, either pastoral or otherwise, or undergo a psychological evaluation.](#)

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### Option Assessment

- Prescribing the barbiturates and informing Mrs. Scott of the appropriate dosing levels potentially makes Dr. Lee an accessory to Mrs. Scott's suicide and, so, should be **avoided**; it also violates the *Code* in Opinion 2.211, "Physician-Assisted Suicide": "Physician-assisted suicide is fundamentally incompatible with the physician's role as healer."
- Informing Mrs. Scott that he will not prescribe barbiturates for the reasons she has suggested—he will not take part in physician-assisted suicide—is supported by the *Code* in Opinion 2.211, "Physician-Assisted Suicide": "Physician-assisted suicide is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks." Further, offering to prescribe analgesics or opioids to alleviate her pain and suffering is **preferable** and is also supported in Opinion 2.211, "Physician-Assisted Suicide": "physicians must aggressively respond to the needs of patients at the end of life...Patients near the end of life must continue to receive emotional support, comfort care, adequate pain control, respect for patient autonomy, and good communication."
- Informing Mrs. Scott that she will have to ask another physician for assistance in ending her life and referring her to other physicians should be **avoided** and is not supported by the *Code*. Opinion 2.211, "Physician-Assisted Suicide" states: "physicians must aggressively respond to the needs of patients at the end of life...Patients near the end of life must continue to receive emotional support, comfort care, adequate pain control, respect for patient autonomy, and good communication."
- Recommending Mrs. Scott see a counselor, either pastoral or otherwise, or undergo a psychological evaluation is **acceptable** and is supported by the *Code* in Opinion 2.211, "Physician-Assisted Suicide": "Multidisciplinary interventions should be sought, including specialty consultation, hospice care, pastoral support, family counseling, and other modalities." This course of action, however, may not be warranted at this point.

#### [Compare these options](#)

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### **Option Comparison**

Because physician-assisted suicide is not supported by the AMA's *Code of Medical Ethics*, prescribing barbiturates for Mrs. Scott as in option A should be avoided. Nonetheless, Mrs. Scott is suffering and in need of medical care, so, in the absence of independent reasons, referring her to another physician, option C, should also be avoided.

There is still a great deal that medicine can do for Mrs. Scott. Hence, Dr. Lee should not abandon this patient and should attempt to treat her pain effectively, as stated in option B. Option D—recommending that Mrs. Scott see a counselor—is acceptable, but the need for this action will be clearer after her pain is under better control and Dr. Lee learns more about her illness and state of mind.

Preferable: Option B

Acceptable: Option D

Avoid: Options A and C

#### [Additional discussion and information](#)

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### Additional Information

The physician's role is healing disease, preserving life, and relieving suffering. In end-of-life care, the duties to relieve suffering and preserve life can come into conflict. Although as much as possible should be done to relieve suffering, the physician's duty to preserve life is overriding. Even though physician-assisted suicide is now legal in Oregon, it remains the position of the AMA that physician-assisted suicide violates the traditional prohibition against using the tools of medicine to cause a patient's death. Physician-assisted suicide also carries societal risks, including the potential for coercive pressures on patients to choose suicide.

#### Opinion 2.211, "Physician-Assisted Suicide"

Physician-assisted suicide occurs when a physician facilitates a patient's death by providing the necessary means and/or information to enable the patient to perform the life-ending act (eg, the physician provides sleeping pills and information about the lethal dose...

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, allowing physicians to participate in assisted suicide would cause more harm than good. Physician-assisted suicide is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks.

Instead of participating in assisted suicide, physicians must aggressively respond to the needs of patients at the end of life. Patients should not be abandoned once it is determined that cure is impossible...

While in some difficult cases physician-assisted suicide may seem appropriate, the medical profession does not condone the practice due to the likelihood of grave harm. Physicians instead must strive to identify the concerns behind patients' requests for assisted suicide, and make concerted efforts at finding ways to address these concerns short of assisting suicide, including providing more aggressive comfort care. At the present, many physicians are not adequately informed about the modalities of pain control for patients with severe chronic pain. The success of the hospice movement illustrates the extent to which aggressive pain control and close attention to patient comfort and dignity can ease the transition to death.

#### [Related topic: Euthanasia](#)

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### Related topic: Euthanasia

Euthanasia, a cousin to physician-assisted suicide, is also prohibited by the *Code*.

#### Opinion 2.21, "Euthanasia"

Euthanasia is the administration of a lethal agent by another person to a patient for the purpose of relieving the patient's intolerable and incurable suffering. 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.

...The physician who performs euthanasia assumes unique responsibility for the act of ending the patient's life...Instead of engaging in euthanasia, physicians must aggressively respond to the needs of patients at the end of life. Patients should not be abandoned once it is determined that cure is impossible. Patients near the end of life must continue to receive emotional support, comfort care, adequate pain control, respect for patient autonomy, and good communication.

There may be cases where a patient's pain and suffering are not reduced to tolerable levels and the patient requests a physician's help to die. If a physician cannot ease the pain and suffering of a patient by means short of death, using medical expertise to aid an "easy" death may seem to be the humane and appropriate treatment for the patient. But the prohibition against medically killing patients is a strong and lasting tradition in medical ethics that is based upon a professional commitment to healing.

Weakening the prohibition against euthanasia, even in the most compelling situations, has troubling implications. Though the magnitude of such risks are impossible to predict accurately, the medical profession and society as a whole must not consider these risks lightly. Condoning euthanasia by physicians might undermine public trust in medicine's dedication to preserving the life and health of patients. Moreover, in a society that condones euthanasia, some patients may fear the prospect of involuntary or nonvoluntary euthanasia if they think their lives are no longer deemed valuable by others.

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