

Doctors as End-Of-Life Patients

APRIL 8, 2019 / RISHIKA / 25 COMMENTS

You know the saying “doctors make the worst patients.” Although, when it comes to the end-of-life care, they may be more different than they are difficult. Like most people, doctors want to die in a painless and peaceful way. [1] Although doctors want to die in the same manner as most people, do they die any differently than those who are not physicians?

The cultural perspective of this blog post will investigate why doctors seem to die differently than those not in the medical field. A pivotal essay by Ken Murray, a doctor himself, provided the first insight into why doctors typically deny aggressive, and even futile, end-of-life care. He shares that doctors witness their patients go through aggressive and futile measures to stay alive, only to see them suffer further.¹ Murray is not the only doctor who has come forward about these intense treatments. Dr. Kendra Fleagle Gorlitsky accounts times when she performed cardiopulmonary resuscitation [CPR] on an elderly woman. She recounted that CPR generally results in broken ribs, which can leave people in more pain at the end of their lives. Dr. Gorlitsky knew the attempt was in vain. This event may have influenced Dr. Gorlitsky to have a Do Not Resuscitate [DNR] at the end of her life. [2] A Stanford study exemplified that many doctors concurred with the opinions of Murray and Gorlitsky. The study showed that 88.3% of doctors surveyed in 2013 indicated that they would choose to

have a DNR. [3] Doctors choose limited measures at the end of their lives because they understand that is not the way to a peaceful end.

On the other hand, there is no proof that doctors have a better end-of-life experience. Although, according to an article in *The New York Times*, there are no statistics to support the fact that doctors have a better end-of-life experience, there is proof that suggests that doctors are more likely to have advanced directives and living wills. This may be because doctors are typically closer to death than the general population. [4] As aforementioned, doctors see the aggressive treatment their patients go through, and advanced directives and living wills may indicate to the proxy decision-maker that the doctor does not want the same treatment. A retrospective study also concurs with this statement. According to the study, doctors are more likely to have completed advanced directives than those who are not doctors. [5] Even though doctors are more likely to opt out of aggressive treatment, this retrospective study found that those who are and are not doctors are about as likely to use intensive end-of-life care.⁵ This study was of those who already died between 2008 and 2010, so more research would need to be done in order to determine if there is a current correlation between being a doctor and having intense end-of-life care.⁵

Doctors see the aggressive treatment that their patients endure daily. They know that these efforts are in vain and typically end in discomfort and pain. Because of this recognition, doctors are less likely to accept aggressive treatment, and are more likely to have an advance directive and living wills. Doctors are well-

aware of the prognosis and their chances of survival. They are also cognizant of the limits to modern technology, and this contributes to the little treatment they seek.¹

ADVANCE DIRECTIVE FOR A NATURAL DEATH ("LIVING WILL")

NOTE: YOU SHOULD USE THIS DOCUMENT TO GIVE YOUR HEALTH CARE PROVIDERS INSTRUCTIONS TO WITHHOLD OR WITHDRAW LIFE-PROLONGING MEASURES IN CERTAIN SITUATIONS. THERE IS NO LEGAL REQUIREMENT THAT ANYONE EXECUTE A LIVING WILL.

GENERAL INSTRUCTIONS: You can use this Advance Directive ("Living Will") form to give instructions for the future if you ever need your health care providers to withhold or withdraw life-prolonging measures in certain situations. You should talk to your doctor about what these terms mean. The Living Will states what choices you would have made for yourself if you were able to communicate. Talk to your family members, friends, and others you trust about your choices. Also, it is a good idea to talk with professionals such as your doctor, chiropractor, and lawyer before you complete and sign this Living Will.

You do not have to sign this form to give these instructions, but if you prefer your own Advance Directive, you need to be very careful to ensure that it is consistent with North Carolina law.

This Living Will form is intended to be valid in any jurisdiction in which it is presented, but please note that North Carolina may impose requirements that this form does not cover.

If you want to use this form, you must complete it, sign it, and have your signature witnessed by two qualified witnesses and notarized by a Notary Public. Follow the instructions about which choices you can make and carry out your wishes. You may also make other advance directives in another jurisdiction and sign it. You then should consider giving a copy to your primary physician and/or a trusted relative and should consider filing it with the Advanced Health Care Directive Registry maintained by the North Carolina Secretary of State: <http://www.ncdchealth.org/ahcr/>

My Desire for a Natural Death

I, [REDACTED] being of sound mind, desire that, as specified below, my life not be prolonged by life-prolonging measures.

1. When My Directives Apply

My directions about prolonging my life shall apply if my attending physician determines that I lack capacity to make or communicate health care decisions and:

NOTE: YOU MAY INITIAL ANY OR ALL OF THESE CHOICES

[Initial]	I have an incurable or irreversible condition that will result in my death within a relatively short period of time.
[Initial]	I become unconscious and my health care providers determine that, to a high degree of medical certainty, I will never regain my consciousness.
[Initial]	I suffer from advanced dementia or any other condition which results in the substantial loss of my cognitive ability and my health care providers determine that, to a high degree of medical certainty, this loss is not reversible.

This is a sample of an advanced directive, or living will, in the state of North Carolina.

<http://livingwillforms.org/nc/north-carolina-living-will-advance-directive/>

This is a sample DNR in North Carolina, and it outlines the patient's wishes in terms of extensive end-of-life measures.

<https://k-sit.com/12-things-you-wont-miss-out-if-you-attend-free-do-not-resuscitate-form-nc-free-do-not-resuscitate-form-nc/45538/free-north-carolina-do-not-resuscitate-dnr-order-form-pdf/>

The rejection of aggressive, end-of-life care options by physicians may not only be rooted in cultural perceptions, but also in the minimal, if any, improvements in quality life or increases in life span after administering these extensive measures (see *The Legal and Ethics of Prognosing the Terminally Ill*). The experience afforded to physicians working with patients at the end-of-life offers insight into how patients suffer in the hopes of prolonging life. Various methods of end-of-life care exist as options for terminally-ill patients, or those in critical care. Perhaps one of the most overused resources involve extended stays in the

Intensive Care Unit [ICU], which may entail placement of feeding tubes, insertion of catheters, placement on artificial ventilators, and chemotherapy for cancer patients.

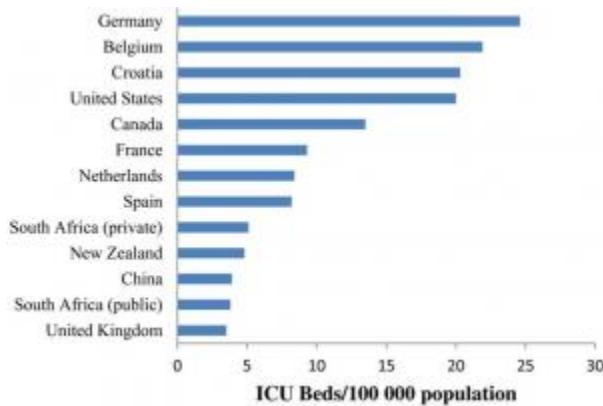


This photo displays a typical scene in ICU rooms across the country with an abundance of wires, tubes, and equipment that the patient is often hooked up to.

<https://www.statnews.com/2016/09/07/hospital-icu-modernize/>

To provide a frame of reference for the usage of these resources, approximately 38.3% of deaths reported in six states across eastern United States since 1993 occurred in a hospital, 22.4% of which occurred following admission into the ICU. [6] It is understandable that doctors are more hesitant to offer, and use for themselves, extended ICU support for the critically ill when approximately 1 in 5 Americans die even after being admitted to the ICU. The United States, in particular, has a disproportionately higher number of extended ICU stays when compared to a majority of developed nations. For instance, only 31.5% of medical deaths and 61% of surgical deaths in patients over the age of 85

involved ICU use in the United States, which far surpasses the respective rates 1.9% and the 8.5% in England.⁷



This figure displays the global variation in ICU beds per 100,000 people in each of these countries. <https://ccforum.biomedcentral.com/articles/10.1186/cc11140>

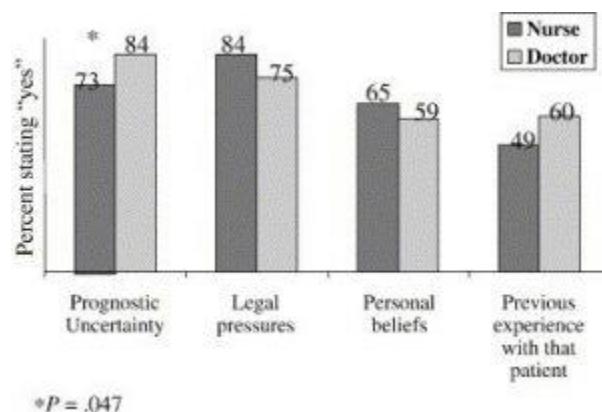
The medicalization of dying has popularized the notion of these aggressive, end-of-life care treatments, such as extended ICU use, as viable options to the public. However, a general consensus against these invasive options, as referenced earlier, seems to be forming amongst physicians, leading to the growing popularity of options such as hospice and palliative care (see *The Differences Between Hospice and Palliative Care*). The term “medically futile” has become a controversial and highly-debated topic in bioethics. Technically speaking, quantitative, or physiological, futility refers to the situation in which the chance of the treatment producing the desired effect is low or poor, referring to a success rate of less than 1% in some cases.⁸ One study of 1,900 subjects found that the chances of a poor neurologic outcome during or after the stay, including severe cerebral disability, coma, or persistent vegetative state, was

77%. Along with this, mechanical ventilation increased the likelihood of a patient exhibiting symptoms of delirium three-fold. Absent pupil or corneal response after just twenty-four hours in the ICU would increase the likelihood of poor neurological outcome ten-fold, emphasizing quality of life as a significant cost for those weighing their options with regard to sustaining or prolonging life. [9]

In addition to psychological complications, mechanical ventilation often results in increased inflammation and fluid in the lungs, eventually leading to multi-organ failure, a common cause of death associated with longer stays in the ICU. [10] Clearly, the weight of futility has increased in providers' perceptions of death and logically impacted their decision to pursue invasive options. When considering constraints on resources in hospitals, decreases in the quality of life of the patients, and the limited increases in their lifespans, the decision of most doctors to reject these aggressive measures, that they so often see fail, seems justified. However, when faced with making that decision for someone else's life, this may not be the case.

The stark difference between the way that doctor's choose to approach their end-of-life care juxtaposed to what they generally prescribe to their patients raises many questions and ethical concerns. The biggest question being: if doctors do not see this care as holistically the best way to approach a terminal disease, why do they influence others to take this route? In fact, in many scenarios, it is pressure from the healthcare system itself rather than patient

interests that direct one's end of life experience. [11] This can be attributed to many different things. For one, the entire enterprise of medicine is focused on the extension of life, and often prioritizes quantity over quality. Furthermore, treatment can be very subjective and thus variable to an individual doctor's opinion or practice style. Since there are not always set procedures—especially in the case of terminal illnesses—the doctor's own opinion often reigns supreme. When identifying why physicians may pressure futile care, “prognostic uncertainty,” “legal pressures,” “personal beliefs,” and “previous experience with that patient” all ranked highly. [12]



This figure displays reasons for physician-driven futile care. The interlocking and sometimes overlapping points can make a strenuous decision that much more complex.

<https://www.sciencedirect.com/science/article/pii/S088394410500050X>

Finally, doctors often prescribe the most aggressive forms of end of life care in order to avoid legal conflicts. [12] As doctors work in a field that confronts

death often, they may be suspected of not doing “everything they can” to save a life, prompting the family or other healthcare providers to attempt to press charges. For example, in the article How Doctors Die, Ken Murray describes a situation in which his friend Jack had asked not to be placed on life support at the end of his life, but his wishes were ignored. When Murray unplugged the machine, which inevitably caused Jack’s death, one of the nurses attempted to report the instance to local police as a possible homicide. [1] The fear of impending legal charges is one that a doctor must constantly consider, contributing to part of the reason they may exclude the most reasonable form of end-of-life care as an option.

This idea in itself raises a moral conflict as a doctor must juggle whether to be aligned with the law or what is in his or her patient’s best interest. In one case presented in Stephanie O’ Neil’s article, Nora Zamichow expresses that she wished doctors had been more transparent when it came to her late husband’s end-of-life care. After reading Ken Murray’s article, she felt dismayed at the fact that she had not been presented “the full range of options”. [2]

So why don’t doctors give nontreatment as a treatment option, or limit treatment to reasonable treatment rather than “futile care”? For some doctors it comes largely from the discomfort associated with the subject of death itself. In Western countries, like America, death is a taboo subject, which is portrayed in the ways we refer to death: “passing away,” “didn’t make it,” “at peace,” “eternal rest,” etc. All of these roundabout ways of describing death

simultaneously symbolize the American instinct to avoid death. As one doctor puts “I think it’s sometimes easier to give hope than to give reality.”² This is then only exacerbated by subtle pressure from the family to continue doing “everything” one can to save their loved one. In fact, in a survey explicated in the article written by Palda et al., “family request” was cited as the number one reason for providing futile care. [12] Unfortunately, the family’s desire to extend their loved one’s life may be the unintentional cause of their loved one’s extended suffering.

The best way to avoid this dismal pitfall is to improve family-physician communication. In a survey described in the article written by Sibbald et al., there seemed to be a general consensus that medical professionals educating the public about “futile care” was necessary in limiting it. In this sense, both doctors and the common person must make an adjustment. Medical professionals need to present all of the information in regards to a case without fear of legal prosecution, and patients—as well as family members of patients—must be receptive to this reality in order to prevent prolonged suffering associated with futile care. [13]

By delving into the scientific, cultural, and ethical considerations that doctors must take into account when faced with death, the wide gap between end-of-life options that doctors offer to patients and those they choose for themselves can be better understood. Medical professionals witness the limitations of modern technology and the significant costs associated with aggressive end-of-life

options more frequently than most of the general public. Although the chances of survival or recovery of patients choosing these options are low, this sliver of hope is often enough for family members to hang on as they watch their loved ones slip away from them. Forcing doctors to consider relationships and family dynamics places them in difficult positions when discussing treatment options and further complicates their suggestions. The research discussed above can better inform the modification of current patient-provider interactions to ensure that doctors provide reasonable end-of-life care options to patients, while not prolonging the suffering of both the patients and their loved ones.

By: Naomi Glidden, Emily Miller, Rishika Reddy

¹ Ken Murray, “How Doctors Die,” 30 November 2011,
<https://www.zocalopublicsquare.org/2011/11/30/how-doctors-die/ideas/nexus/>.

² Stephanie O’Neill, “Knowing How Doctors Die Can Change End-Of-Life Discussions,” 6 July 2015, <https://www.npr.org/sections/health-shots/2015/07/06/413691959/knowing-how-doctors-die-can-change-end-of-life-discussions>.

³ Tracie White, “Most physicians would forgo aggressive treatment for themselves at the end of life, study finds,” <http://med.stanford.edu/news/all>

[news/2014/05/most-physicians-would-forgo-aggressive-treatment-for-themselves-.html.](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1751001/)

4 Dan Gorenstein, “How Doctors Die: In Coming to Grips With Their Own Mortality, They Are Showing the Way for Others,” *The New York Times*, November 20, 2013, page F1.

5 Daniel D. Matlock et al., “How U.S. Doctors Die: A Cohort Study of Healthcare Use at the End of Life,” May 16, 2016, <https://doi.org/10.1111/jgs.14112>, 1061.

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7 Niederman, Michael S., and Jeffrey T. Berger. “The Delivery of Futile Care Is Harmful to Other Patients.” *Critical Care Medicine* (March 2010). <https://ovid-com.libproxy.lib.unc.edu/article/00003246-201010001-00003/HTML>.

8 Aghabary, Maryam, and Nahid Dehghan Nayeri. “Medical Futility and Its Challenges: A Review Study.” *Journal of Medical Ethics and History of Medicine*, October 20, 2016.

9 Meyer, Nuala J., and Jesse B. Hall. “Bench-to-bedside Review: Brain Dysfunction in Critically Ill Patients – the Intensive Care Unit and beyond.” *Critical Care Medicine*, July 24, 2006.
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1751001/>.

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https://www.hopkinsmedicine.org/news/media/releases/longer_stay_in_hospital_icu_has_lasting_impact_on_quality_of_life.

11 Periyakoil, Vyjeyanthi S., Eric Neri, Ann Fong, and Helena Kraemer. 2014. “Do Unto Others: Doctors Personal End-of-Life Resuscitation Preferences and Their Attitudes toward Advance Directives.” *PLoS ONE* 9 (5).

<https://doi.org/10.1371/journal.pone.0098246>.

12 Palda, Valerie A., Kerry W. Bowman, Richard F. Mclean, and Martin G. Chapman. 2005. “‘Futile’ Care: Do We Provide It? Why? A Semistructured, Canada-Wide Survey of Intensive Care Unit Doctors and Nurses.” *Journal of Critical Care* 20 (3): 207–13. <https://doi.org/10.1016/j.jcrc.2005.05.006>.

13 Sibbald, Robert, James Downar, and Laura Hawryluck. 2007. “Perceptions of ‘Futile Care’ among Caregivers in Intensive Care Units.” *CMAJ*, November, 1201–8. <https://doi.org/https://doi.org/10.1503/cmaj.070144>.

Doctors and Death

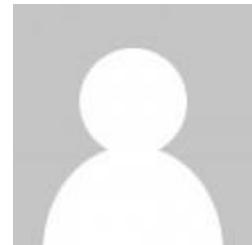
PREVIOUS POST

The Unidentified Dead in America

NEXT POST

How Photography Impacted the Civil War and Vice Versa

25 Comments



1.

liz29271

APRIL 20, 2019 AT 12:41 PM

I found this article fascinating in that explores the paradoxical inevitability that doctors, who spend their lives trying to prevent others from dying, must ultimately themselves face death in the same way their patients do. In taking this unique perspective, the article artfully examines how physicians' increased proximity to and knowledge regarding death and the processes of dying influences their personal end of life experiences. One point you made that I found especially interesting was how, although the suffering doctors witness makes them less likely to extend their own end of life care, it does not have a significant impact on whether or not they encourage patients to pursue such treatments. Your further stipulation that such conflicting attitudes of doctors towards their own deaths and the deaths of others is largely influenced by American social taboos surrounding death that prevent healthy patient-doctor communication regarding end of life options highlights how the dysfunctionality present in modern American attitudes towards death impacts more than just the emotional wellbeing of the population. Indeed, the fact that, as you point out, the amount of information the average person receives regarding death is far below that of what physicians receive highlights our society's reluctance to discuss death openly outside of clinical and higher educational settings prevents the majority of patients from making the best, most well informed decisions about end of life care possible and also prevents doctors from encouraging such decisions for fear of possible legal repercussions from distraught, poorly informed family members. Thus overall, I think

you post and its exploration of how medical professionals differ from the general population in their end of life decisions is very eye opening as to why the efforts of individuals like Caitlin Doughty, who aim to encourage more healthy discussions of death ,are so necessary for the improvement of end-of-life experiences in the U.S.

[LOG IN TO REPLY](#)



2.

karan97

APRIL 21, 2019 AT 12:12 PM

Great post! It discusses a perspective on end of life measures that I never really considered. Near the end of the post you stated that “Medical professionals need to present all of the the information in regards to a case without fear of legal prosecution”. Since legal prosecution seems to be a serious issues, how can physicians successfully circumvent this obstacle. Have other solutions been proposed? In my opinion improving physician-family communication does not seem like it would be enough to make a patient totally aware of certain consequences.

[LOG IN TO REPLY](#)



3.

hmelkins

APRIL 22, 2019 AT 2:21 PM

Beginning the article with the quote that doctors “may be more different [patients] than they are difficult” is a good introduction and statement to think about. It is not easy to understand and go through a process which will end you life in the first place. To add to that fact that, the doctor is more than likely familiar with the detrimental and harsh realities associated with terminal illnesses. Doctors also may be closer to death, as they study, practice, understand, and deal with death much more often than the regular civilian. Which type of doctors were specified in the research? Did the statistics account for nurses, medical assistants, or other staff members at healthcare facilities? Are there any differences in the opinions of end-of-life care between these professions? I think that if there was research on this subject, it would have been beneficial to include this as it would enhance the discrepancies between doctors, patients, and those practicing in the healthcare industry. I found the section of the article which discussed the difference in how doctors treat their patients at end of life care versus their own prescribed end of life care to be especially interesting. I think an insight which can be drawn from this statement is that doctors may want to take every measure possible to save or support their patients, in order to be able to explain to the family that they did everything they could to save them.

LOG IN TO REPLY

4.



wesyano

APRIL 22, 2019 AT 7:42 PM

I found that this post had many parallels between my topic which was the effect of patient death on doctors themselves. As this post examines how doctors react to patient death in the handling of their own end-of-life care. Particularly, the ethical portion of this article interested me. These physicians tend to avoid the methods of care that they often prescribe patients in near-death scenarios. This brings up the issue of whether these doctors should be administering types of

treatment to patients if they would not want to receive it themselves. A parallel that I was able to find between my own work and this article was the effect of patient care on doctors being mostly negative. In this post patient care resulted in physicians being hesitant with their own healthcare choices. Similarly, in my palliative care of harsh patient death often resulted in professional burnout.

[LOG IN TO REPLY](#)



5.

alexiren

APRIL 22, 2019 AT 7:52 PM

I think this topic takes a very interesting perspective as we often times view doctors as those that always give treatment as compared to receiving it. I appreciated that reasoning was provided regarding why doctors sometimes refuse treatment, such as with the CPR example, often because they understand the harsh realities medicine can sometimes present. I do wonder, however, how the views of doctors towards their personal end of life care change over the course of their professional career as well as if they would recommend different treatment or lack of treatment options to their patients had they considered what they would have preferred for care. Is it possible that another reason doctors tend to refuse treatment is because they understand the financial burdens that extensive care can require or that they feel they would be a burden to their families if life-sustaining treatment is required? You mention that doctors shouldn't fear the possibilities of legal consequences if they take actions that are in the best interest of the patient as well as having better communication between families and doctors, but how does this interpret doctors as end of life patients? Is it possible that the active doctors of a physician as a patient don't communicate options as clearly to them because they are under the belief that they already understand all of their options?

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6.

lchua

APRIL 22, 2019 AT 11:56 PM

This is really interesting! Doctors are people too, but I'm sure that they are not often thought of with the possibility of becoming patients themselves. I can completely agree with their wishes, like signing a DNR, as they are exposed to death year-round. However, while I understand, I do agree that it seems unfair that these types of patients will know more about the healthcare system and treatment options than any other patient. While I understand the pressures doctors face, they should still present the option of no treatment to family members. Advanced directives should also be a more well-known document, like organ donation. I know your article was about doctors as patients, but I wonder if they would behave similarly if the patient was a family member; would they also be more willing to sign DNRs or refuse medically futile treatments for their loved ones?

[LOG IN TO REPLY](#)

7.

Mamoon Khan

APRIL 23, 2019 AT 7:00 PM

This article did a very good job of providing a perspective on a topic that many people including myself may overlook. I have never given much thought to the idea of my own doctor as an end-of-life patient because fundamentally when the term doctor comes to my mind, I associate it with becoming healthier. People go to the doctor when

they are sick in order to get better, however nobody thinks about what a doctor does when they know that they may not get better. A point that is brought up in your article is that doctors know about end-of-life treatments and their effect which makes them less likely to accept this treatment because they know it may only prolong their suffering. This point kind of relates to my groups article on healthcare serial killers who deal with end-of-life patients as well. These HSKs know that end-of-life patients are only prolonging the inevitable with more suffering than needed, so they take the initiative in their own hands and release the patients of their suffering. This kind of ties in to the idea of doctors refusing any aid in prolonging their own lives because they know that they may only suffer for a little longer instead of peacefully passing sooner than later. Great Job!

[LOG IN TO REPLY](#)

8.



alinalt

APRIL 23, 2019 AT 10:16 PM

I didn't realize that by seeing their own patients suffer after resuscitation attempts, doctors would choose to bypass the extension of their lives. I suppose it makes sense, though. Doctors learn from their patients as much as the patients learn from them. Essentially, through observing what their patients went through, they are able to conclude the best, most effective, least painful transition towards death. One idea that struck a curiosity in me was when the post stated how "patients suffer in hopes of prolonging life." Does this mean that doctors know that attempts to prolong their patients life is essentially prolonging their own suffering, but they cannot say anything because they took an oath to help prolong the life of people when they can? If they were to advise patients to avoid treatments that would not only prolong their life, but prolong their suffering, would it be breaking their oath because the advice to not have treatment could be considered advising early death? Overall, this was a very interesting

topic and it made me consider how I would approach my own death after knowing that some treatment would only be prolonging my suffering.

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9.

laurhut

APRIL 23, 2019 AT 11:50 PM

What an interesting choice of topic; this is a perspective on doctors that I'd never considered before! It definitely makes sense to me how doctors' experiences with aggressive end of life care might dissuade them from engaging in those practices themselves. I do wonder how this varies among different kinds of doctors and whether those professions more distanced from terminal illness have the same preferences as an oncologist, for example.

While I understand the discrepancy between the choices the doctors make for themselves and those that they outline for their patients, I feel like we can't blame doctors for offering these treatments or ascribe this as immoral. Through the medicalization of death, we as a culture perceive death as the failure of medicine and view doctors as the relentless perpetrators of life, and I feel as though we would be more upset with our doctors for designating treatments as futile and limiting our personal autonomy or our family's choices.

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10.

ssherif1

APRIL 24, 2019 AT 1:28 PM

Beginning with the saying, “Doctors make the worst patients” was a nice introductory sentence because I think everyone already understands where the rest of the post will go. The saying is so true since doctors believe they know everything and how things will unfold to the point that sometimes it may hinder their own treatment team. At first, I didn’t understand what the post meant by doctors “die differently.” However, it became clear that because doctors have seen their own patients go through more aggressive treatments, they may choose another route as to die peacefully. They have more tools and observation to know how to change their treatment based off of what their patients went through. I don’t agree with the question, “Why do they influence others to take this route?” though. The majority of physicians present the facts and options, and serve as a guide to answer any questions patients may have, but they do not infringe upon their autonomy as much as possible.

[LOG IN TO REPLY](#)

11.



yymerino

APRIL 24, 2019 AT 1:45 PM

A statistic that stood out to me was the 88.3% of doctors who decided to have a DNR. I had never thought about how the experiences in the hospital could affect how doctors take their death on. The decisions that doctors make while in an emergency setting are difficult, especially when they revolve around potential death. How is this different in other cultures? What about those doctors who want to be resuscitated? Why? Your post opened up several questions to me and informed very well at the beginning with the statistics compared across the world.

[LOG IN TO REPLY](#)



12.

meganmn

APRIL 24, 2019 AT 3:15 PM

This is a very interesting perspective, in terms of flipping the spotlight of “patient” back on the doctor themselves and it begs the question of whether or not ignorance is bliss. Though one person said she would have rather had a full range of options for her husband, there are many family members who would react very strongly to the option of ending futile treatment because, like the doctor says, it can be easier to give a family hope rather than reality. Unfortunately, this also then puts all that pressure on doctors and nurses to continue end-of-life care that they know will not help. It’s no wonder that doctors themselves make the decision to have things like advanced directives and DNRs, because family cannot always be trusted to make the best decisions on their loved ones’ behalf.

[LOG IN TO REPLY](#)



13.

Parian Covington

APRIL 24, 2019 AT 4:46 PM

This article was really interesting to read! It’s cool to know how doctor’s think, and how seeing what their patients experience may influence how they want their own lives to end. I guess this can be related to anything in life as far as learning from another persons journey and understanding that is not a path you want to take. I also know it probably takes a huge toll on doctors to see their patients

suffering or not being able to help them because they do not want to be helped or for whatever other reason.

[LOG IN TO REPLY](#)



14.

Madison Bencini

APRIL 24, 2019 AT 6:52 PM

I think this post brought up an insightful perspective as to the medicalization of dying. The statistic that 88.3% of doctors would sign a DNR speaks highly of how futile end-of-life care actually is. Also, this shows just how much medicine is a business first and foremost. As technology progresses, I feel that we have begun to depend on doctors to tell us when the end is near instead of accepting illness.

You read inspiration articles about people who are trying to fight diseases using extraordinary measures. However, is this actually increasing quality of life? Doctors are encouraged to use extreme measures in order to avoid legal repercussions, but wouldn't it leave them vulnerable to human cruelty suits?

[LOG IN TO REPLY](#)



15.

Brianna Ramgeet

APRIL 24, 2019 AT 7:21 PM

While reading this I was thinking that all of your research goes against what people assume doctors would do to care for themselves. From personal experience and witnessing the end of life care of a doctor, I know that most doctors do not want to make themselves suffer longer than they must. The main question that I had that was left unanswered, that also connects to my topic, was so doctors often choose physician assisted death when they have a terminal illness, or has there been any research done concerning that?

[LOG IN TO REPLY](#)



16.

ismael

APRIL 24, 2019 AT 10:05 PM

I was exposed to new perspectives on medicalization of death and dying. Considering how doctors choose to use methods of prolonging life that actually cause more suffering than if the doctors just allowed the patients to die is an idea I never considered. I particularly noted the statistics on how certain treatments produced low rates of the desired effects that were intended. Some cases resulting in less than 1% success rates were shocking to me. Considering suffering of a patient as unnecessary is something many people do not think of when trying every method to prolong life.

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17.

yingke

APRIL 24, 2019 AT 10:09 PM

ICU is actually terrifying to most of people around me. I remember one time when my mother went to visit one of her friends in the ICU room. She said placing tubes all over the body extremely seems extremely uncomfortable and made up her mind that she would never use that when she has been extremely ill in the future. It is glad to see that the scientific proof in the article supports her decision.

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18.

jasonls

APRIL 24, 2019 AT 10:29 PM

This post had an interesting perspective to me. I had never thought about how doctors want to avoid end of life treatment because they often see how pointless it is in causing the person less pain or a prolonged life. The Murray essay you cited was interesting in discussing the ethical dilemmas many doctors face when they encounter situations where there is no clear right or wrong. I certainly agree that doctors must have a better communicative structure and there should be more legal framework to the end of life discussion because it is so ethically gray. Either way, great job on the post.

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19.

annafior

APRIL 24, 2019 AT 11:17 PM

“Medically futile” is the term that immediately jumps out to me in this post, and seems to be the reason the majority of doctors die differently than non-medical professionals. The recognition that sometimes inaction is better than intense medical intervention seems a difficult concept to grasp for those of us not in the medical field. Your post seems to present the troubling implication that “normal people” die worse deaths than medical professionals simply because they are not as well informed as doctors. I appreciate the suggestion toward the end of the post that greater information and awareness can bridge this gap and potentially improve the deaths of non-medical professionals.

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20.



Tierra Faulkner

APRIL 25, 2019 AT 12:03 AM

I chose to read your post because the title sounded interesting and I was not disappointed. As medical professionals, doctors come into contact with numerous end of life patients. Having a deep interest in philosophy and ethics, I found the fact that doctors often don't choose the same things they suggest or prescribe to their patients very interesting. While we expect doctors to be willing to accept whatever treatment they prescribe, I am at least interested in hearing their reasoning or studying if this misalignment is something that develops over a doctor's career. In total, this was a very interesting topic and an extremely well written paper!

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21.

memcd

APRIL 25, 2019 AT 12:13 AM

This topic is really fascinating to consider, because it involves a total role reversal of doctor and patient. It's difficult for doctors because they have their entire careers worked to solve medical difficulties for patients and treat them for the purpose of extending life, but at the end of their life, they have to hand that responsibility over to someone else. This can be difficult, as noted, when they know the ins and outs of treatment and their own diagnoses and treatment ideas might differ from their doctor. This post was very well written and approached the topic well from all angles. I wonder how the same ideas would apply to other medical caretaking positions such as nurses or therapists whose professions involve different approaches to end of life care.

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22.

isabel17

APRIL 25, 2019 AT 12:19 AM

I found this article really interesting — I've never really thought of what doctors are like as dying patients. It makes sense that they provide medical advice that differs from their own beliefs to protect themselves from legal issues. I'm interested to know how this research would change if the setting were another country, where the medical field looks different than that of America. Do doctors give

the same advice that they themselves would take? Are legal bindings a worry of theirs?

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23.

Miyah Lockhart

APRIL 25, 2019 AT 1:37 AM

I thoroughly enjoyed reading this post and all that you all had to say about how doctors act as patients in their last stages of life. I found it interesting to see different perspectives on how doctors treat other doctors when their life circumstances change and instead of treating people, they are being treated. I realize it must be very difficult trying to balance legal guidelines and the patient's best interest. This only gets harder and more tedious if you have a personal relationship with the patient. I didn't consider many of the factors discussed before reading this post. Logistics of end of life care, especially dealing with another doctor as your patient, must be extremely difficult. Thank you for educating me and thank you for sharing!

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24.

mwzheng

APRIL 25, 2019 AT 5:19 AM

Interesting hook with a good transition to the topic. I would like to know other examples of aggressive treatments that doctors opt out of

besides CPR and their statistics. I am also curious what the difference is between aggressive treatment and intensive end-of-life care is, and why doctors opt to do intensive end-of-life care as much as patients (i.e. how is aggressive treatment and intensive end-of-life care different in their eyes so that they choose end-of-life care as often as patients). I am also curious about how many of the ICU stays and deaths are from patients who are critically ill, since the article seems to draw a causal relationship between the terminal patient care and ICU deaths and stay time. The sections about doctor's own morals and the pressure of the healthcare industry and society to do "everything they can" reminds me of the articles "Neomorts and the Sociocultural Implications of Modern Life Extending Technologies" and "The Unexpected Killers in Healthcare." I was reminded of the neomorts article with the story about Murray and his friend Jack. The debate between the living status of the brain dead discussed in the neomort article was relevant to this case because the nurse's want to report him for homicide despite the patient's wishes are due to a belief that the brain-dead are alive. The homicide allegation reminded me of the healthcare serial killers article because there were doctors who also "killed" patients who were going to die either way, although the ones in the HSK article have more murky motives than Murray's, who is clearly stated to be following his friend's will. I wonder how the statistics would alter if doctors were able to suggest the options they think were best without fear of backlash.

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25.

milansak

APRIL 25, 2019 AT 7:51 AM

I enjoyed reading this article ! It makes me think of myself because I know I want to become a doctor, but it will be difficult having to handle assisted aid in dying situations. It must take a lot to see these patients suffer and them deciding the best way to put an end to their

suffering. I realize how it can be hard on both the doctor and family members to make the best decision of what to do when they have a patient who is dying. I would like to know the difficulty of this issue in other countries and what laws they might have to approach this problem. It is important that doctors do what is ethically right and also keep the family members in mind despite the added on stress from possibly not being able to make the decision they rather woul