

## End-of-life Decision-making: Ethical Conundrums in light of the Sanctity of Life

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### Abstract

Ethical issues in end-of-life care, specifically the complex decision-making process involving medical professionals, patients, and families regarding treatment alternatives have been challenging. The context underlines the importance of social and health systems serving terminally ill patients' physical, emotional, social, and spiritual needs. It acknowledges the impact of modern medicine on mortality rates, patients' wish to die with dignity, and the importance of recognizing bereavement after death among primary carers. Advanced medical interventions to extend the lifespan of terminally ill patients raise questions about who should make such a decision and whether it is ethical. The aim of this study is to ascertain the ethical challenges and study the principles of biomedical ethics implicated in end-of-life care decisions among physicians, patients, and caregivers. A literature review of library-based resources using descriptive and explanatory methods is employed in this study. Patients' autonomy, beneficence, non-maleficence, and justice should be considered while making end-of-life care decisions in dilemmas arising from treatment withdrawal and withholding, medical futility, physician-assisted suicide, and the doctrine of double effect. End-of-life care decision-making is challenging, but the application of bioethical principles to guide such decisions among key stakeholders is fundamental. Future research on other possible solutions for end-of-life care is recommended.

**Keywords:** End-of-life care, biomedical ethics, terminally ill, advanced medicine, primary carers

### 1. Introduction

The sanctity of life, which is at the basis of bioethics itself, is the explicit ethical dilemma in end-of-life decisions.<sup>264</sup> End-of-life care is the term used to describe the social and health system necessary to meet the physical, emotional, social, and spiritual requirements of patients who have life-threatening conditions, fatal diseases, or are nearing the end of their lives.<sup>265</sup> The clinical assessment of a terminally ill patient at this point should take into consideration the aspects pertaining to the patient's mental wellbeing, including personal beliefs, customs, and values that could be impacted by his or her spirituality and religious practice.<sup>266</sup> In light of this, making decisions concerning end-of-life care can be tricky.

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<sup>264</sup> Steve Clarke, 'The sanctity of life as a sacred value' (2022) 37 (1) *Bioethics* 32 <<https://doi.org/10.1111/bioe.13094>> accessed 8 July 2023.

<sup>265</sup> Mohsin Choudry, Aishah Latif and Katharine G Warburton, 'An overview of the spiritual importances of end-of-life care among the five major faiths of the United Kingdom' (2018) 18 (1) *Clin Med (Lond)* 23 <<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6330909/>> accessed 8 July 2023.

<sup>266</sup> *ibid* 23-31.

Modern medicine and technological advancement have increased life expectancy and altered the natural patterns of death. Supportive medical interventions like artificial medical nutrition therapy and oxygen therapy comprising the invasive or non-invasive ventilatory support in the intensive care unit can lengthen a patient's life by providing secondary assistance, despite the fact that many contemporary therapies and technologies do not heal chronic conditions.<sup>267</sup> Modern medicine has prioritized end-of-life care. This process starts with the diagnosis of a terminal illness and includes the patient's wish to die with dignity and the grieving period after death. Many people suffer hardships when their loved ones die. Families, informal caregivers, or close acquaintances of the patients are often required to deal with a wide spectrum of emotional difficulties and are required to make decisions for their loved ones — the patients, when providing therapy for them at the terminal stage of life, which includes preceding, throughout, and even after death.<sup>268</sup>

Family members, most if not all, are the patient's primary caregivers. The family of dying patients frequently goes through a time of intense stress after knowing the patient has been pronounced to have a grave diagnosis at a critical stage, which can lead to rage, despair, interpersonal conflict, and psychological issues.<sup>269</sup> When they are unable to alleviate the pain of a family member who is terminally ill, they may experience hopelessness, frustration, guilt, and futility.<sup>270</sup>

## 2. Methodology

This doctrinal research employs a descriptive-explanatory study methodology involving a qualitative analysis to examine nationwide literature pertaining to ethical considerations in deciding treatment or comfort care for dying patients. The sources of research encompass local legislation, such as the Malaysian Penal Code (Act 574), and global policies, as well as books, journals, and online articles regarding ethical issues in end-of-life care. A comprehensive search was conducted across various academic databases, including LexisNexis, PubMed, National Institute of Health (NIH), SAGE Journals, ScienceDirect, and Google Scholar, using the keywords "end-of-life" OR "palliative care" AND "ethical consideration." This search is aimed at identifying relevant articles or publications addressing end-of-life issues. A thorough examination of all articles was conducted in this literature review, from which a subset of 21 was carefully chosen to elucidate the author's perspective most effectively.

## 3. Who Decides End-of-life Care?

From an ethical perspective, the patient should be the main decision-maker to choose if the doctors were to limit care that does not heal but does prolong life momentarily. The patient's family, the delegate, or the doctor must make a decision regarding the patient's care if the patient is no longer capable of doing so.<sup>271</sup> Family members who are under deep stress,

<sup>267</sup> Sameera Karnik and Amar Kanekar, 'Ethical Issues Surrounding End-of-Life Care: A Narrative Review' (2016) 4 (2) *Healthcare* 24 <<https://doi.org/10.3390/healthcare4020024>> accessed 21 Nov 2022.

<sup>268</sup> PDQ® Supportive and Palliative Care Editorial Board, 'Grief, Bereavement, and Coping With Loss' (*National Cancer Institute*, 18 October 2022) <<https://www.cancer.gov/about-cancer/advanced-cancer/caregivers/planning/bereavement-hp-pdq>> accessed 5 August 2023.

<sup>269</sup> Susan H. McDaniel and others, *Family-Oriented Primary Care* (2nd edn, Springer New York 2005) 261-284.

<sup>270</sup> Melahat Akdeniz, Bülent Yardımcı and Ethem Kavukcu, 'Ethical considerations at the end-of-life care' (2021) 9 *SAGE Open Medicine* <<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7958189/>> accessed 8 July 2023.

<sup>271</sup> *ibid.*

depressed, and fearful will struggle to make decisions when their loved one is terminally ill. They are uncertain if they will make the right decision for the patient when they are uncertain of their loved one's wishes for terminal care.<sup>272</sup> Some relatives may choose different care. This will add to the challenges faced by doctors when making end-of-life decisions for their patients. Some are very reluctant to choose when to stop the treatment and may prefer the doctors to decide for them,<sup>273</sup> whereas some family members express a clear and unwavering desire that they want "everything" to be done to keep their loved one alive, which implies active resuscitation management involving cardiopulmonary resuscitation, invasive intubation for ventilatory support, and defibrillation in the event of a cardiopulmonary arrest.<sup>274</sup> The doctors, on the other hand, encounter ethical dilemmas in such circumstances when being pressured by family members who differ in their preferences of a patient's end-of-life treatment choice.<sup>275</sup>

Terminally ill patients should receive treatment that reduces pain, improves quality of life, and offers comfort in dying. However, achieving these objectives may be difficult. End-of-life care is ethically challenging because doctors, patients, and families must consider several treatment alternatives, including their indications, advantages, and risks, and decide whether to use medical technology to extend life or delay the natural death of the terminally ill patient.<sup>276</sup> Medical personnel, patients, and their main carers need to understand the fundamentals of biomedical ethics to address issues with regard to end-of-life care.<sup>277</sup>

## 4. Medical Ethics

### 4.1 Autonomy

Autonomy is the right of a patient to decide for himself or herself. Everyone has the right to choose the kind of care they want and have that decision honored. One of the key principles in medical ethics is respect for a patient's autonomy.<sup>278</sup> In order for there to be autonomy, the patient must have the capacity to make their own decisions. This concept mandates that medical professionals uphold a patient's self-determination rights even in cases where the patient suffers a cognitive impairment or lacks the mental capacity to decide for himself. Advance directive can be used to achieve preservation of a patient's autonomy in deciding his or her desired end-of-life treatment.<sup>279</sup> Generally, the treating doctors look for the authorized caretakers to make decisions in place of the patient who has been mentally incapacitated, and the discussion with the caretakers can be difficult when addressing end-of-life concerns

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<sup>272</sup> McDaniel (n 269) 261-84.

<sup>273</sup> Timothy M. Smith, 'When patients, families disagree on treatment: 6 ways forwards' (*AMA*, 20 December 2018) <<https://www.ama-assn.org/delivering-care/ethics/when-patients-families-disagree-treatment-6-ways-forward>> accessed 8 July 2023.

<sup>274</sup> Akdeniz (n 270).

<sup>275</sup> Nüket ÖRNEK BÜKEN, 'Clinical ethical decision making process and determining factors at the end of life' (2016) 2 (3) *Türkiye Klinikleri Journal of Medical Ethics-Law and History* 24 <<https://www.turkiyeklinikleri.com/article/en-yasamin-sonunda-klinik-etik-karar-verme-sureci-ve-belirleyici-faktorler-77246.html>> accessed 21 November 2023.

<sup>276</sup> Karnik (n 267) 24.

<sup>277</sup> Akdeniz (n 270).

<sup>278</sup> Carlos Gómez-Virseda, Yves de Maeseneer and Chris Gastmans, 'Relational Autonomy in End-of-Life Care Ethics: A Contextualized Approach to Real-Life Complexities' (2020) 21 *BMC Medical Ethics* 50 <<https://pubmed.ncbi.nlm.nih.gov/32605569/>> accessed 8 July 2023.

<sup>279</sup> Karnik (n 267) 24.

regarding the dying patients. If the patient is still able to make decisions but has not designated a proxy decision-maker, or if the patient is incapable of making decisions but the decision-maker was not appointed by the patient or is not aware of the patient's wishes, then this action may be against the principle of autonomy.<sup>280</sup>

Taking decisions regarding care for the dying is indeed challenging not just for the doctors, but also for the patients and their families since "decision making" itself is a sophisticated process of thought.<sup>281</sup> All individuals have the liberty to express their wills for terminal care. The Federal Patient Self-Determination Act (PSDA), which has been in place since 1991, has eased the communication between patients and their healthcare practitioners.<sup>282</sup> The PSDA imposes a set of obligations on hospitals and hospice organisations, requiring them to carry out a range of prescribed actions and verify compliance with certain predetermined conditions. In accordance with the aforementioned, patients are duly apprised of their entitlement to actively participate in the decision-making process pertaining to their medical treatment, and it is therefore crucial to inquire about the patients' advance directives (ADs) and meticulously record any preferences they may have concerning their desired or undesired care, for which the healthcare organisations must refrain from engaging in any form of discrimination against patients who assert their ADs.<sup>283</sup> The implementation of patients' ADs is required, contingent upon their legal validity and compliance with state law.<sup>284</sup>

Given the use of advanced medicines and prognostication, it is ethically necessary to respect the patients' wishes to convey their end-of-life treatment preferences. This autonomous right indeed has some restrictions, which pose an ethical conundrum. While acknowledging its limitations, the medical practitioners should respect the patient's autonomy and perform their obligations in a manner that serves the patient without causing any harm.<sup>285</sup> To add on, autonomy allows patients the freedom to direct their own care in accordance with their wishes; however, this right is frequently violated.<sup>286</sup> Their end-of-life care is not offered in line with their desires. This emphasises the ethical concern of autonomy regarding preferences for end-of-life care.

It is therefore said that ADs are drawn from the ethical principle of patient autonomy. Such ADs consist of instructions given orally or in written form apprising a patient's future direction of medical care in the event that the patient loses the ability to communicate, and the patient's judgements may be influenced for any reason.<sup>287</sup> Living wills, proxies, and "Do Not Resuscitate" (DNR) requests are examples of ADs signed by a competent patient.<sup>288</sup> A living will is written by a competent individual expressing their own wishes for end-of-life medical treatments, which include the insertion of nasogastric (NG) or percutaneous endoscopic gastrostomy (PEG) feeding tubes for continuous assisted nutrition and hydration therapy, as

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<sup>280</sup> McDaniel (n 269) 261-84.

<sup>281</sup> *ibid.*

<sup>282</sup> Patient Self-Determination Act 1991.

<sup>283</sup> Dac Teoli and Sassan Ghassemzadeh, *Patient Self-Determination Act* (StatPearls Publishing 2022).

<sup>284</sup> *ibid.*

<sup>285</sup> Basil Varkey, 'Principles of Clinical Ethics and Their Application to Practice' (2021) 30 (1) *Med Princ Pract* 17 <<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7923912/>> accessed 8 July 2023.

<sup>286</sup> Muneerah Lbugami and Usamah El Alem, 'Patient autonomy' (2021) 9 (1) *International Journal of Medicine* 58 <[https://www.researchgate.net/publication/354416462\\_Patient\\_autonomy](https://www.researchgate.net/publication/354416462_Patient_autonomy)> accessed 8 July 2023.

<sup>287</sup> Eileen E. Morrison (ed), *Health care ethics: critical issues for the 21st century* (2nd edn, Jones & Bartlett Publishers 2009).

<sup>288</sup> Akdeniz (n 270).

well as how they should be handled in terms of terminal care, cardiopulmonary resuscitation (CPR), assisted ventilation, withholding or withdrawal of treatment, physician-assisted suicide, and euthanasia.<sup>289</sup> Malaysia lacks advanced decision-making laws and judicial judgements, but ADs assist patients in receiving their preferred treatment and support their families in making decisions. Additionally, ADs reduce costly, intrusive, and unnecessary care that patients have not sought. ADs also enhance the standard of terminal care and alleviate burden without impacting mortality.<sup>290</sup>

A patient's legal guardians or parents typically act as their proxies until they reach 18 years old. Individuals are permitted to elect a health care proxy once they reach the age of 18. One or more individuals, including members of the family and close friends, may serve as proxies. The patient has priority when making end-of-life decisions in terms of care. If the patient loses his or her ability to decide, all choices about medical care, including the withdrawal or continuation of life support, are left to the proxies<sup>291</sup> who are autonomously selected by the patient at a time when he was deemed lucid and was able to make a clear judgement. At a critical stage, when a patient becomes mentally impaired, the proxies' duty is to execute according to the patient's wish even though their personal preferences may conflict with those of the patient.<sup>292</sup> In the circumstance whereby the proxies refuse to make any decision, the healthcare providers are responsible for making the decision for which they find it optimal for the patient.

#### 4.2 Beneficence & Non-maleficence

Beneficence demands that medical practitioners plead for the best medical intervention for their patients' best interest. In many cases, the patients' preferences in the direction of their end-of-life care support are not communicated via ADs, and their medical professionals, family members, or caregivers are not informed of their desires.<sup>293</sup> If a patient is unable to make decisions or has not explicitly expressed his or her wishes in the event of a terminal illness, the terminal care decision is made by the patient's medical practitioners after confronting the patients families, or their authorised representatives.<sup>294</sup> The medical professional's duty in the treatment of the terminally ill patient is to ensure the provision of the optimum and appropriate treatment at the patient's end of life.<sup>295</sup> In an effort to do what the medical doctor believes is in the patient's best interest, the doctor must be careful not to violate the patient's autonomy. Even if the doctor believes the patient's choice is not in their best interest, the patient's right to make that decision should be respected. Paternalism should therefore give way to patient autonomy.

The ethical principle of non-maleficence denotes that harm should never be intentionally inflicted. The doctor should not purposefully cause harm, pursuant to this principle. *Primum non nocere* is a fundamental rule of good medical conduct, and it is addressed in this principle

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<sup>289</sup> *ibid.*

<sup>290</sup> Cristina Sadini and others, 'Advance care planning and advance directives: an overview of the main critical issues' (2022) 34 (2) *Aging Clin Exp Res* 325 <<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8847241/>> accessed 8 July 2023.

<sup>291</sup> Akdeniz (n 270).

<sup>292</sup> Gómez-Vírseda (n 278) 21.

<sup>293</sup> Varkey (n 285) 17-28.

<sup>294</sup> BÜKEN (n 275) 24-33.

<sup>295</sup> McDaniel (n 269) 261-84.

(i.e., do no harm).<sup>296</sup> Non-maleficence is the moral justification for why suffering is induced, even when some medical therapies may cause discomfort or other detrimental consequences. When the benefit from the medical intervention to one patient outweighs the patient's risk of harm and the treatment is not given to cause a detrimental insult to the patient, the damage caused may be justified; however, many medical professionals believe that taking part in physician-assisted suicide violates this rule.<sup>297</sup> This stance is mirrored in the Osteopathic Oath, which is a requirement for all osteopathic medical school graduates, and it declares, "I will deliver no medicament for lethal purposes to any individual, despite what may be asked of me."

### 4.3 Justice & Fidelity

The moral principle of justice requires fairness in the delivery of healthcare services and seeks to ensure the equitable distribution of health resources.<sup>298</sup> Owing to the scarcity of medical resources, they should be allocated evenly and fairly. To avoid wasting scarce resources, the need to assess how advanced medical therapies are distributed will be crucial. The doctors have a moral obligation to advocate for the appropriate and fair treatment of terminally ill patients.

Another ethical rule, fidelity, calls on the medical professionals to be trustworthy and dependable for the dying patients. When medically necessary, practitioners should keep their patients updated on their condition. Additionally, the medical practitioners must be faithful in upholding the patient's preferences and decisions even when the patient is unable to speak for themselves and must be truthful in matters like diagnosis and prognosis. Naturally, this defence presupposes that the patient's request does not conflict with the treating doctor's own moral principles or code of medical ethics.<sup>299</sup>

## 5. Ethical Dilemmas in End-of-Life Care

### 5.1 Withholding and Withdrawal of Treatment

In the management of patients who are approaching the final stage of life, it may be ethically and medically appropriate to stop providing life-sustaining care. First, some therapies may merely be medically ineffective, in which case there is no moral, legal, or medical obligation to deliver treatment that is ineffective. Second, if the patient or his proxy does not want the therapy, it is permissible to withdraw and withhold it. It can be challenging for the doctors to stop interventions once they have already started. Nevertheless, an intervention should be stopped if it can no longer accomplish its intended purpose or if the patient no longer desires it. Hence, from an ethical viewpoint, refusing to receive therapy and withdrawing from it are morally equal.<sup>300</sup> The doctor is the sole member of the medical team with the authority to write orders indicating treatments that are to be withheld or discontinued, even though end-of-life care requires a team approach. Therefore, it is critical that doctors understand the fundamentals of withdrawing and withholding interventions when providing care for patients

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<sup>296</sup> Akdeniz (n 270).

<sup>297</sup> *ibid.*

<sup>298</sup> *ibid.*

<sup>299</sup> Karnik (n 267) 24.

<sup>300</sup> Akdeniz (n 270).

who are getting close to the end of their lives. Sadly, a recent study discovered that most patients in intensive care units passed away without having their requests for life-sustaining care fulfilled.<sup>301</sup> Invasive medical procedures are commonly performed on these people against their wills.<sup>302</sup>

When caring for patients who are approaching death in life, decisions on whether to discontinue or suspend CPR, endotracheal intubation for assisted ventilation, and ANH are often considered. However, additional treatments, including antibiotics or other medications, operations, dialysis, diagnostic tests, or admissions to acute care facilities, might be discontinued or withheld.<sup>303</sup> A medical intervention's potential to achieve a goal set by the doctor, the patient, and the authorised decision-maker will determine whether it should be withheld or discontinued. The objective must be realistically attainable from a medical standpoint. It is appropriate to consent to a specific, time-limited intervention and to revoke that intervention if the objective is not attained within the allotted time frame. For instance, if the benefits of mechanical ventilation could not be recognised within a given timeframe, a time-limited usage of the technology might be suitable.<sup>304</sup>

It can be challenging for the doctor, the patient, or a legalised decision-maker to cease ventilator care during decision making. Withdrawing ventilator support when the aim of artificial breathing cannot be met is ethically acceptable if it is in conformity with the patient's preferences.<sup>305</sup> For the comfort of the patient after extubation, approaches for quick extubation or terminal weaning have been established, and management of discomfort with narcotic analgesics and tranquillisers is crucial. When a patient is nearing death, it's critical to determine their do-not-resuscitate (DNR) status in order to prevent futile and unethical cardiac resuscitation. The patient and the carers should be reassured that all other interventions for comfort care at the terminal stage will still be carried out.<sup>306</sup>

Withdrawing and withholding ANH needs specific attention. Doctors have long considered feeding and hydration, even for the dying, as standard care. Ethically, ANH is considered a medical intervention. As a symbol of care, nutrition and hydration can be difficult to withdraw or withhold, especially for families. The patient or proxy can stop ANH when they no longer meet care goals. In this situation, the doctor must comfort, counsel, and educate the patient and proxy. Families must recognise that symptoms like dry mouth may be handled and that fluids may worsen other end-of-life symptoms, including breathlessness and edema-induced pain.<sup>307</sup>

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<sup>301</sup> Seema Rajesh Rao and others, 'Palliative and end-of-life care in intensive care units in low- and middle-income countries: A systematically constructed scoping review' (2022) 71 *Journal of Critical Care* 154115 <<https://www.sciencedirect.com/science/article/pii/S0883944122001447#bb0120>> accessed 8 July 2023.

<sup>302</sup> Lbugami (n 286) 58.

<sup>303</sup> Angela Luna-Meza and others, 'Decision making in the end-of-life care of patients who are terminally ill with cancer – a qualitative descriptive study with a phenomenological approach from the experience of healthcare workers' (2021) 20 (76) *BMC Palliat Care* <<https://doi.org/10.1186/s12904-021-00768-5>> accessed 8 July 2023.

<sup>304</sup> Varkey (n 285) 17-28.

<sup>305</sup> Akdeniz (n 270).

<sup>306</sup> Rao (n 301).

<sup>307</sup> Varkey (n 285) 17-28.

## 5.2 Medical Futility

In medical ethics, medical futility can complicate end-of-life treatment. The term "medically futile" is used to describe an intervention; however, there is no precise definition and few clinical instances in which all parties agree.<sup>308</sup> Most agree that brain-dead patients should not receive cardiac resuscitation. However, artificial feeding and hydration for a prolonged vegetative patient would not be universally considered medically futile. Depending on one's concept of medical futility, either intervention may be medically ineffective.<sup>309</sup> A more practical definition of medical futility is a treatment that will not achieve its intended purpose. Thus, in this latter description of medical futility, a therapy is futile if it does not follow the patient's needs or an advance directive if the patient has lost decision-making capacity.<sup>310</sup> When a dying patient's proxy makes an end-of-life care decision, futility conflicts may arise. The proxy decision-maker's misinterpretation of the prognosis, values, or distrust in the healthcare system may trigger conflicts. Education, defining the patient's goals, and fostering a team approach to decision-making after religious involvement can often settle problems. The institutional ethics committee may help resolve conflicts. Transferring services may be necessary if a conflict cannot be resolved. Advance care planning usually prevents medical futility conflicts.<sup>311</sup>

## 5.3 Physician-assisted Suicide

Physician-assisted suicide includes a doctor prescribing a lethal sedative-hypnotic upon the patient's self-request at end of life. In contrast, euthanasia entails the physician conducting the intervention that terminates the patient's life.<sup>312</sup> Only Oregon in the United States allows physician-assisted suicide. Physician-assisted suicide is immoral and violates the patient-physician relationship, according to most medical bodies such as the American Osteopathic Association, American Geriatrics Society, and the American Medical Association.<sup>313</sup> Many argue that the legalisation of physician-assisted suicide will nullify a societal commitment to palliative or hospice care. Similarly, many imply that maltreatment of vulnerable groups like the disabled and elderly may ensue.<sup>314</sup>

Intractable pain, sadness, fear of burdening family, or loss of dignity may prompt patients to desire physician-assisted suicide.<sup>315</sup> The doctor should confront patients' pains and fears that may lead to physician-assisted suicide. When necessary, involve the psychologists, psychiatrists, and priests in managing depression. Having a preacher on the healthcare team may help with spiritual issues revolving around abandonment, remorse, and hopelessness. Communication with multi-disciplinary teams to address several grounds for patients' request for physician-assisted suicide is important. The doctors should reassure their dying patients

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<sup>308</sup> Akdeniz (n 270).

<sup>309</sup> Karnik (n 267) 24.

<sup>310</sup> Akdeniz (n 270).

<sup>311</sup> *ibid.*

<sup>312</sup> Ewan C. Goligher and others, 'Physician-Assisted Suicide and Euthanasia in the ICU: A Dialogue on Core Ethical Issues' (2017) 45 (2) *Crit Care Med* 149 <<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5245170/>> accessed 8 July 2023.

<sup>313</sup> Herbert Hendin and Kathleen Foley, 'Physician-assisted suicide in Oregon: a medical perspective' (2008) 106 (8) *Mich Law Rev* 1613 <<https://pubmed.ncbi.nlm.nih.gov/18595218/>> accessed 8 July 2023.

<sup>314</sup> Goligher (n 312) 149-55.

<sup>315</sup> Luna-Meza (n 303) 76.



that they will be cared for and should not condone the patients' request for physician-assisted suicide, as it often stems from self-doubt.<sup>316</sup> Thus, the doctor's affirmation of such an approach may perpetuate the patient's self-worthlessness. A doctor who intentionally causes or accelerates the death of a terminally ill patient and, at the patient's request, commits criminal homicide,<sup>317</sup> as stated under Section 299 of the Penal Code (Malaysia):

“Whoever causes death by executing an act with the intent of causing death, or with the motive of causing such physical injury as is likely to be fatal, or with the knowledge that such act would cause death, commits culpable homicide.”

#### 5.4 Doctrine of Double Effect

Doctors have been reluctant to administer higher doses of narcotics to terminally ill patients out of concern that central nervous system depression will kill them. Some have called this euthanasia.<sup>318</sup> Studies have revealed that this effect has been exaggerated. However, even if delivering a narcotic may accelerate the dying process in a near-death patient, it is ethical to do so if the primary intention is pain management and not hastening death. This ethical concept of “double effect” enables the unintended implication—the death acceleration—to happen.<sup>319</sup> It is believed that the patient or proxy is aware of the unintentional effects of aggressive pain management.<sup>320</sup>

#### 6. Conclusion

Most medical professionals encounter numerous ethical challenges when treating critically ill and dying patients. When treating near-death patients, doctors must consider moral dilemmas and conflict resolution. Doctors must also be decisive and communicative. Dying patients must be prioritised and respected in all decisions. Thus, end-of-life care requires advance care planning.<sup>321</sup> It is vital for doctors to comprehend the relevant ethical principles associated with medical futility, withdrawing and withholding medical interventions and other ethical and legal difficulties. Moreover, doctors should understand the ethical, legal, and professional implications of euthanasia and physician-assisted suicide, and their personal beliefs on this, and other end-of-life ethical dilemmas. Proper end-of-life care involves spiritual consideration.<sup>322</sup> The understanding of ethical concepts guides medical practitioners on how they can apply those biological ethics in caring for dying patients. An ethical obligation ingrained in the very nature of the doctor's job is to provide ideal care to terminally ill patients at the end of life. Future research on other possible solutions or alternatives regarding end-of-life care for terminally ill patients is also recommended.

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<sup>316</sup> Goligher (n 312) 149-55.

<sup>317</sup> Malaysia Penal Code (Act 574), s 299.

<sup>318</sup> Hendin (n 313) 1613-40.

<sup>319</sup> Akdeniz (n 270).

<sup>320</sup> *ibid.*

<sup>321</sup> Sedin (n 290) 325-30.

<sup>322</sup> Åsa Rejnö and Linda Berg, ‘Strategies for Handling Ethical Problems in End of Life Care: Obstacles and Possibilities’ (2015) 22 (7) *Nursing Ethics* 778 <<http://journals.sagepub.com/doi/10.1177/0969733014547972>> accessed 21 Nov 2022.

## **7. Limitations and Strengths**

One of the limitations of this research is its subjective nature, as the interpretations of the study rely on individual perspectives and analyses, which may differ among individuals. Nevertheless, these perceptions can be deemed reasonable and rational. Another limitation of this study is that doctrinal research does not address the discrepancy between observed real-world social behaviours and the behaviours required by legal norms. Despite its limitations, this research delineates the fundamental basis for enhancing understanding of the application of bioethics to resolute ethical dilemmas related to end-of-life care for critically ill patients. This is particularly relevant for key stakeholders involved in these decisions, including treating physicians, patients, and their primary carers.

## **8. Declaration of Originality and Conflicting Interests**

The author declared this article as an original work based on independent research and analysis. Any sources used in the creation of this paper have been cited to give credit to the main authors. There are no potential conflicts of interest in relation to the research, authorship, and/or publication of this article.

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