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DEATH WITH DIGNITY: AN ANALYSIS IN ADULTS AND CHILDREN

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A common buzzword used in medical ethics is the word “dignity,” which becomes especially relevant when dealing with oftentimes controversial end of life issues which can include advance directives, physician-assisted suicide, and euthanasia. However, dignity is often used as a broad umbrella-term, meant to encompass a host of other concepts, yet the notions included are ambiguous and variable. Due to its relatively nebulous definition and ubiquitous usage, some call for the complete elimination of the term. Bioethicist Ruth Macklin argues that the word dignity should be completely eliminated from medical ethics and be replaced with the phrases “respect for persons” and “respect for autonomy,” phrases that she suggests have more concrete definitions, making them more practical.1

While the exact definition of dignity may be a tricky concept to pin down, the phrase and its strong emotional and religious connotations have sculpted a hearty niche in modern society. Documents of national and international significance, such as the works put out by the President’s Council on Bioethics and by the United Nations, focus on dignity as a central talking point.2-4 For instance, in the preamble, the Universal Declaration of Human Rights goes so far as to assert that “recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in this world.” Whatever concepts are encompassed in the term dignity carry significant weight, as evidenced by their prominence in these globally recognized documents.

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As something so heavily ingrained in modern society, the concept of dignity, even if one accepts Macklin’s view that it is ill-defined, can be quite influential. In a cross-sectional study examining terminally ill patients and their perceptions of dignity, Chochinov et al. reported that patients who felt their dignity was intact reported a better quality of life, had lower rates of depression, and a higher will to live.6 Survival rates were not significantly different between patients with an undamaged sense of dignity and those with a broken sense of dignity.7 However, the psychological benefits patients receive via the perceived preservation of their dignity is enough to persuade many medical professionals to make efforts towards maintaining a patient’s dignity.

This analysis aims to further explore the role of dignity in modern medicine, specifically the concept of “death with dignity” and how it relates to end-of-life decisions in both adults and children. Special emphasis will be placed on the differences between the measures in place for preserving an adult’s dignity and those for preserving a child’s. The analysis will explore several different methods for considering end-of-life scenarios in adults including advance directives, physician-assisted suicide, and euthanasia. The focus will then shift towards death with dignity in children, focusing on how age and maturity can impact a minor’s ability to express his opinions, as well as how a child’s dignity can be respected when a child is unable to make his wishes known. Together, these topics aim to provide a greater understanding of the complexities surrounding dignity and end-of-life situations.

DEATH WITH DIGNITY IN ADULTS

According to the Merriam-Webster dictionary, dignity is “the quality or state of being worthy, honored, or esteemed.”8 Many view treating someone with dignity as honoring (or respecting) their wishes. For those with a terminal illness, this extends to people respecting the healthcare decisions of these individuals as well as their wishes after death. Advance directives are legal documents used in medicine that help protect the rights of individuals surrounding their end-of-life decisions.9 People can specify whether they would like to receive medical intervention to sustain their lives, decline these life-sustaining treatments, or stipulate these measures be terminated under certain scenarios.10 Through an advance directive, an individual can also designate a healthcare
A legal standpoint, a terminal condition is one which must follow the guidelines set forth in an advance directive. 

Ensure one’s requests are followed should a catastrophic scenario when a person is unaware of the environment and himself and this state of unawareness cannot be reversed. Permanent and severe harm, incompetency and physical dependency, as well as ineffective treatment options characterize end-stage conditions. In order to ensure one’s requests are followed should a catastrophic event or illness occur, people can use advance directives to clearly outline their desires. Within reason, physicians must follow the guidelines set forth in an advance directive, and if, for some reason, they are unable or unwilling to do so, must transfer the patient to another physician who will carry out the advance directive to the best of his ability. By allowing the opportunity for pre-emptive planning, advance directives help reduce some of the emotional stress surrounding end-of-life decisions and give an individual peace of mind that their requests will be honored. One’s death, or to an extent, that their dignity will be upheld.

The potential benefits of advance directive planning make it essential for the modern medical world; however, its implementation is still limited. The Patient Self-Determination Act of 1990 requires healthcare providers to tell all of their adult patients that they have the right to accept or refuse medical treatment and to create an advance directive. This information needs to be repeated to a client each time he enters a medical facility, and if a patient is too ill to comprehend these details, the information must be conveyed to a family member or surrogate. Patients who play an active role in their care generally have better outcomes, so the educational aspect of this law proves to be an important facet.

However, even though the Patient Self-Determination Act requires healthcare providers to discuss these topics with patients, this does not always mean patients have a full understanding of the issues or choose to follow those suggestions. According to a 2012 study by McCannon and Temel, only 15% of people with advanced stage cancer have advance directives in place. Death is a sparsely discussed, uncomfortable topic for many people, so this probably plays a role in the limited implementation of advance directives.

Another, more controversial, avenue in the discussion of death, dignity, and what dying with dignity entails, is the concept of physician-assisted suicide. While the terms are often used interchangeably, physician-assisted suicide is not to be confused with euthanasia. Euthanasia is when the physician physically injects the patient with a lethal drug, whereas physician-assisted suicide is when the doctor prescribes the medication, but the patient is the one who gives it. The physician-assisted suicide is legal in four states: California, Oregon, Vermont, and Montana. In these states currently have death with dignity laws in the legislative process, so this number could increase in the near future. Oregon was the first state to introduce its Death with Dignity Act in 1997, and the bills, which exist in other states, are modeled after Oregon’s law.

Under Oregon’s Death with Dignity Act, physicians can prescribe lethal doses of medication (usually barbiturates) to terminally ill patients; however, the patients are the ones who must administer the medication. The law recognizes the right of physicians to refuse to participate, so only medical professionals who are comfortable with the practice will prescribe the medications. To qualify for this act, someone must be at least eighteen years of age, live in the state, and be mentally competent to understand his own healthcare decisions, and be diagnosed with a terminal illness that will cause death within six months. Obtaining a prescription is an involved process. The individual seeking the medication must first make two oral requests to their physician for the medication fifteen days apart. The prescription must be signed by the client with witnesses present (at least one of whom is not related to the patient) is also a necessity. The attending physician and an additional consulting doctor must concur on the diagnosis and outlook for the patient’s illness, determine whether the patient has the mental faculties to make these decisions on his own, and request that the patient tell a relative about his their request for the prescription. If there are any doubts about the individual’s mental state, a psychiatrist should be consulted. Finally, family members are not able to request this path for a relative in the case of a coma or other forms of mental incapacitation. The patient needs to request the prescription on his own. Supporters of physician-assisted suicide argue that being able to choose the timing and circumstances surrounding one’s death, as well as relieving suffering caused by a terminal illness, are benefits to the practice and methods for maintaining one’s dignity at the end of life. They believe it is a patient’s autonomy to refuse treatment with no hope for recovery and choose another form of care. The practice is legal in several states. In Oregon and Montana, the patient must sign a living will that allows for the physician to administer the medication. The patient is then able to serve as their own proxy, and must administer the medication, putting it to their own mouth. In these states, the proxy must administer the medication, and the patient must sign the prescription. If a patient chooses to use another method, the physician must administer the medication. In Oregon and Montana, the patient must sign a living will that allows for the physician to administer the medication. The patient is then able to serve as their own proxy, and must administer the medication, putting it to their own mouth. In these states, the proxy must administer the medication, and the patient must sign the prescription. If a patient chooses to use another method, the physician must administer the medication.

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Advocate for physician-assisted suicide generally cite reduced suffering and respect for an individual’s autonomy as the major factors in shaping their decision. However, even though the Patient Self-Determination Act requires healthcare providers to discuss these topics with patients, this does not always mean patients have a full understanding of the issues or choose to follow those suggestions. According to a 2012 study by McCannon and Temel, only 15% of people with advanced stage cancer have advance directives in place. Death is a sparsely discussed, uncomfortable topic for many people, so this probably plays a role in the limited implementation of advance directives.

The potential benefits of advance directive planning make it essential for the modern medical world; however, its acceptance is still limited. Everyone has the right to end one’s life, be it by natural causes or an act of suicide. If these choosing to utilize death with dignity laws to end their lives was an avenue these patients wanted to pursue, they would most likely need a practice called voluntary active euthanasia. If these individuals live in an area where physician-assisted suicide is legal, they are unable to utilize it if their chosen form of euthanasia is legal but they have already enacted a law that states they are unable to do so. Some advocates for physician-assisted death view the improved medical technology present in modern society as a desirable alternative. By allowing individuals to exercise their autonomy as the major factors in shaping their decision.

The right of physicians to refuse to participate, so only medical professionals who are comfortable with the practice will prescribe the medications. To qualify for this act, someone must be at least eighteen years of age, live in the state of Oregon, and be mentally competent to sign his own healthcare orders, and be diagnosed with a terminal illness that will cause death within six months.24 Obtaining a prescription is an involved process. The individual seeking the medication must first make two oral requests to their physician for the medication fifteen days apart.35 Within twenty-eight days, the client’s request must be signed by the patient with two witnesses present (at least one of whom is not related to the patient) is also a necessity.36 The attending physician and an additional consulting doctor must concur on the diagnosis and outlook for the patient’s illness, determine whether the patient has the mental faculties to make these decisions on his own, and request that the patient tell a relative about his request for the prescription.37 If there are any doubts about the individual’s mental state, a psychiatrist must accept. Finally, family members are not able to request this path for a relative in the case of a coma or other forms of mental incapacitation—the patient needs to request the prescription on his own.38 Supporters of physician-assisted suicide argue that being able to choose the timing and circumstances surrounding one’s death, as well as relieving suffering caused by a terminal illness, are benefits to the practice and methods for maintaining one’s dignity at the end of life; others are also able to alter their physicians’ limitations and autonomy as the major factors in shaping their decision.
variant of euthanasia is more common in the medical field and occurs when a physician more-or-less allows the patient to die from natural causes by removing necessary life-sustaining medical treatment or by not providing these treatments in the first place. Some examples of passive euthanasia would include removing a brain-dead patient from life-support or not resuscitating a patient if he had previously signed a DNR order.22 Passive euthanasia has less taboo, and it is more openly practiced in healthcare facilities. While “death with dignity” is a ubiquitous phrase in bioethics, the meaning of the term is difficult to pinpoint, and the term can mean different things to different people. Personal views, social, and religious contexts all shape the term and determine the appropriate courses of actions during end-of-life cases. Due to the intricate nature of the concept, a variety of means are in place which adults can use in order to maintain and foster their dignity. Not everyone has access to all of these options, as the legality of some practices is under scrutiny. Advance directives allow individuals to specify their wishes unless conducted through their physician-assisted suicide requires an individual to be at least eighteen. This leaves the question: what about children? How should medical professionals and healthcare institutions treat a child’s dignity? In the United States, children generally do not have a legal means of specifying their wishes surrounding the end-of-life.52 In the majority of cases, parents act in their child’s best interests, but if the child’s interests are unknown, or if the parents and child have different interests, a complex scenario ensues, making respecting a child’s dignity an extremely tough prospect. A recent case study, that of Jahi McMath, will be used to further illustrate the intricacies surrounding the dynamic interplay of a child’s medical condition, her parent’s wishes, the role of healthcare providers, and the meaning of dignity. After complications from a surgery designed to correct sleep apnea, Jahi McMath, then thirteen years old, was declared brain dead in December 2013.12 Doctors at the California hospital that performed the procedure suggested her family take Jahi off life-support. However, her family refused to do so and eventually had Jahi transferred to UCSF Benioff Children’s Hospital Oakland.22 As an otherwise healthy thirteen-year-old, McMath and her family had few reasons to consider end-of-life planning. Since Jahi could not have a legal stake in the matter, her guardians are the logical choice to make the decision regarding her end of life care. However, the highly emotional nature of this scenario is further complicated by the permanent unconsciousness of the patient. By agreeing to remove her daughter from life-support, Jahi’s mother is accepting the fact that her daughter will die. Herein lies the importance of understanding Jahi’s mother’s reluctance to adhere to the physicians’ advice and her desire to continue her daughter’s medical treatment. When family members and physicians cannot agree about the proper course of action regarding a minor, a stalemate can ensue. This is evidenced by the fact McMath remains on life support nearly three years after doctors announced she was brain-dead. While Jahi’s family and the physicians have made their positions clear, the most important person’s opinion remains a mystery. What would Jahi have really wanted regarding this situation? If respecting a person’s dignity (in terms of “death with dignity”) means honoring her wishes surrounding the circumstances of her death, for Jahi McMath to die with dignity, whatever her definition of the concept might be? As a minor, she has limited options for asserting and protecting these ideas. Since she is underage, are her opinions simply expressed through the views of her parents? What happens if a child does not agree with her parents? Another case, similar to that of Jahi McMath, is the ordeal of Israel Stinson. Doctors in a Sacramento hospital pronounced Israel Stinson brain dead in April 2016 and suggested he be removed from life support; however, his parents disagreed.44 After international travel and an extensive court case, it was decided that the hospital could not remove Israel from life support until August.44 The most salient difference between this case and McMath’s story is the age of the patient. While McMath is a teenager, old enough to have her own opinions on these types of issues and perhaps a notion of what death with dignity means to her, Stinson was only an infant. Clearly, Israel Stinson could not have had his own opinions about what constitutes a dignified death, but Jahi McMath was probably mature enough to have at least a general idea. This age discrepancy introduces a slippery slope: at what age (if at all) should a child’s wishes be taken into consideration when dealing with death with dignity? For instance, some eighteen-year-olds may not be able to reach a rational conclusion regarding end-of-life decisions, while some fourteen-year-olds could possess a strong enough set of lucid standards to make a clear, educated choice. Perhaps the incredibly complex nature of end-of-life decision-making in children is why this concept is relatively underdeveloped in the American medical system. In setting a magic number to act as an age restriction, these laws have taken a relatively fluid concept and grounded it in a more concrete principle.
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Do not medically intervene in certain cases. The death occurs through natural causes, but life is not sustained through the uses of medical technologies. Physician-assisted suicide, only legal in certain areas and only through the use of medical technologies. Physician-assisted suicide requires an individual to be at least eighteen. This leaves the question: what about children? How should medical professionals and healthcare institutions treat a child's dignity? In the United States, children generally do not have a legal means of expressing their wishes, so families must act on their behalf. However, in the majority of cases, parents act in their child's best interests, but if the child's interests are unknown, or if the parents and child have different interests, a complex scenario ensues, making respecting a child's dignity an extremely tough prospect.

A recent case study, that of Jahi McMath, is used to further illustrate the intricacies surrounding the dynamic interplay of a child's medical condition, her parent's wishes, the role of healthcare providers, and the meaning of dignity. After complications arising from a surgery designed to correct sleep apnea, Jahi McMath, then thirteen years old, was declared brain dead in December 2013.62 Doctors at the California hospital that performed the procedure suggested her family take Jahi off life-support. However, her family refused to do so and eventually had Jahi McMath transferred to UCSF Benioff Children's Hospital. At the hospital where her religious exemption law allows her to remain on life-support, Jahi's family is being involved in a lawsuit against UCSF Benioff Children's Hospital and the physician who performed Jahi's surgery.63 McMath and her family had few reasons to consider end-of-life planning. Since Jahi could not have a legal stake in the matter, the only way for the parents to make this decision was to hire attorneys to determine the child's wishes. In this case, the parents and child had different interests, a complex scenario further obfuscates the proper course of action.

The conflict is evidenced by the fact McMath's mother's opinion remains a mystery. What would Jahi really have wanted for herself in this situation? If respecting a person's dignity (in terms of "death with dignity") means honoring her wishes, then the circumstances of Jahi's life for Jami to die with dignity, whatever her definition of the concept might be? As a minor, she has limited options for asserting and protecting these ideas. Since she is underage, are her opinions simply expressed through the views of her parents? What happens if a child does not agree with her parents? Another case, similar to that of Jahi McMath, is the ordeal of Israel Stinson. Doctors in a Sacramento hospital pronounced Israel Stinson brain dead in April 2016 and suggested he be removed from life support; however, his parents disagreed.64 After international travel and an extensive court case, it was decided that the hospital could remove the life support; on August 1, 2016, he passed away with no legal means of expressing her wishes.65

While "death with dignity" is a ubiquitous phrase in bioethics, the exact meaning is difficult to pinpoint, and the term can mean different things to different people. Personal views, social, and religious contexts all shape the meaning of the term. The role of the medical provider is also difficult to pinpoint, and the term can mean different things to different people. 

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"Perhaps the incredibly complex nature of end-of-life decision-making in children is why this concept is relatively underdeveloped in the American medical system."

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One possible solution to the slippery slope of including age restrictions is to craft advance directives and request physician-assisted suicide to be eliminated them altogether. Legalizing euthanasia in 2002, Belgium has been on the pioneering edge of the death with dignity movement.64 Expanding on the law in 2014, Belgium completely eliminated age restrictions for people requesting euthanasia.65 Additional conditions must be met, however, when a minor is requesting this option. Firstly, the child needs to be deemed able to comprehend the meaning of euthanasia and possess full rational capacities.66 The child needs to be terminally ill and be in the last stage of that illness.67-68 Two doctors, one of which is a psychiatrist, and the child’s parents must also approve the idea before the case can continue.69

The potential for abuse of the policy exists so long as the “capacity for discernment” remains relatively vague. Some series of universal standards should be put into place in order to allow this concept to be employed more effectively. This could be done by creating objective standards for making objective and subjective measurements, which the medical community with respect to the proper treatment, the outcome of said treatment should allow the child to maintain a relatively high quality of life, the child will die without this treatment, and the parent will not consent to the treatment doctors suggest.70 If the situation satisfies all of these criteria, the state or hospital is able to take control of the child’s medical treatments for a specified period of time, ensuring the child receives the treatment necessary to allow him to survive and have a better quality of life. Moreover, parents who are found to withhold medical care from their children can face severe legal penalties, including loss of custody, or being charged with child abuse, child neglect, or assault.85

The situation where a child’s parents and physicians disagree regarding treatment options becomes a difficult scenario. For example, parents who are practicing Jehovah’s Witness and refuse blood transfusions, even when lifesaving, on the basis of religious, moral, or ethical reasons, or other reasons.86 However, this right does not extend to adults making decisions for their children.87 For example, parents who are practicing Jehovah’s Witness members may not allow their child to receive a blood transfusion. In the United States, there are only limited cases when minors can agree to receive medical treatment without parental consent, and these vary by state.88 Minors who are able to make these decisions without parental agreement and consent are termed medically emancipated.73 While the conditions to qualify for medical emancipation vary from state to state, these minors generally include people who are married, parents themselves or pregnant, armed service members, or people who are financially independent of their parents.74-75 The minors must also be deemed “mature” and fit the criteria of the “mature minor doctrine”, which also varies by state.76 This is another subjective measurement which can be interpreted to possess a rather arbitrary quality. The criteria for becoming a medically emancipated minor are severely limiting, making this option unrealistic for the majority of individuals under the legal age.

For the most part, parents want to act in their child’s best interests, but what happens if the parents’ desires are not the best course of action for a child? Are there measures in place to protect a child’s dignity in that case? In the United States, there are only limited cases when minors can agree to receive medical treatment without parental consent, and these vary by state.88 Minors who are able to make these decisions without parental agreement and consent are termed medically emancipated.73 While the conditions to qualify for medical emancipation vary from state to state, these minors generally include people who are married, parents themselves or pregnant, armed service members, or people who are financially independent of their parents.74-75 The minors must also be deemed “mature” and fit the criteria of the “mature minor doctrine”, which also varies by state.76 This is another subjective measurement which can be interpreted to possess a rather arbitrary quality. The criteria for becoming a medically emancipated minor are severely limiting, making this option unrealistic for the majority of individuals under the legal age.

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One possible solution to the slippery slope of including age restrictions on practices like creating advance directives and requesting physician-assisted suicide would be to eliminate them altogether. Legalizing euthanasia in 2002, Belgium has been on the pioneering edge of the death with dignity movement.64 Expanding on the law in 2014, Belgium completely eliminated age restrictions for people requesting euthanasia.65 Additional conditions must be met, however, when a minor is requesting this option. Firstly, the child needs to be terminally ill and be in the last stage of that illness.66 Two doctors, one of which is a psychiatrist, and the child's parents must also approve the idea before the case can continue.67

Eradicating age restrictions entirely seems to be the simplest solution; however, what about the situation where a child becomes mature enough to be able to make these complex medical decisions? In order to use the law, a child has to understand the meaning of life, death, illness, and medical treatment.68 The translation of the law describes this child as possessing the “capacity of discernment.”69

What exactly is the “capacity of discernment”? Can this capability be measured objectively through highly subjective and emotional topic, something which would be very difficult to accurately accomplish.

Furthermore, the Belgian law for minors still hinges upon the idea of parental consent. In cases where the child and parents are in agreement about the best course of action, this does open up a new avenue of treatment. An important consideration is how this decision happens when the child and his parents do not agree? If a child wishes to seek out euthanasia as a treatment, but his parents do not support this decision, the child cannot use the Belgian policy. This effort to allow the child to die with dignity falls short, as his death remains linked to his parents’ wishes. While allowing children to make these decisions completely autonomously does not seem the best course of action, from a dignity-related standpoint, maintaining the necessity of parental consent little to protect a child’s dignity under the law. Abolishing the age restrictions entirely may have been a relatively straightforward method of eliminating the ambiguity associated with maturity levels; however, the other issues this suggestion introduces make it nearly as complicated, if not more so, than the eighteen-year-old limitation originally in place.

A second possible solution could be to reduce the age requirement instead of eliminating it entirely. This would allow for situations where some of the above mentioned standards in place to protect a child’s dignity under the law. Abolishing the age restrictions entirely may have been a relatively straightforward method of eliminating the ambiguity associated with maturity levels; however, the other issues this suggestion introduces make it nearly as complicated, if not more so, than the eighteen-year-old limitation originally in place.

The potential for abuse of the policy exists so long as the “capacity for discernment” remains relatively vague. Some series of universal standards should be put into place in order to allow this concept to be employed more effectively. This would alleviate the current reliance on highly subjective and emotional topic, something which would be very difficult to accurately accomplish.

However, the physician also has a responsibility to minimize the harm the patient encounters in the process of dying.80 In cases where the parents wish to stop medical treatment for a child when physicians deem medical intervention important for the patient’s survival, a difficult dilemma appears as the principles of respect for autonomy and nonmaleficence conflict with each other.81

In cases when a child’s parents are pursuing a course of action that they may violate the child’s dignity by placing him in danger, the state can act as a vessel to intervene and protect said child.82 For the most part, states let parents make decisions regarding the medical treatment of their children; however, if the life of a child is in danger, courts will allow the state to intervene and make the medical decisions for the child instead of the child’s parents. Several conditions must be met in order for this to occur: there must be a clear course of action in the eyes of the medical community with respect to the proper treatment, the outcome of said treatment should allow the child to maintain a relatively high quality of life, the child will die without this treatment, and the parent will not consent to the treatment doctors suggest.83 If the situation satisfies all of these criteria, the state or hospital is able to take control of the child’s medical treatment for a specified period of time, ensuring the child receives the treatment necessary to allow him to survive and have a better quality of life.84 Moreover, physicians are able to treat and provide medical care from their children can face severe legal penalties, including loss of custody, or being charged with child abuse, child neglect.

A common reason why people would refuse certain medical treatments is their religious beliefs. Adults are allowed to exercise their autonomy and refuse medical treatments; however, this right does not extend to children.85 For example, parents who are practicing Jehovah’s Witness may refuse blood transfusions for their child, and the physicians will not force the procedure. However, this right does not extend to adults making decisions for their children.86 For the most part, parents make decisions regarding the medical treatment of their children; however, if the life of a child is in danger, courts will allow the state to intervene and make the medical decisions for the child instead of the child’s parents. Several conditions must be met in order for this to occur: there must be a clear course of action in the eyes of the medical community with respect to the proper treatment, the outcome of said treatment should allow the child to maintain a relatively high quality of life, the child will die without this treatment, and the parent will not consent to the treatment doctors suggest.87 If the situation satisfies all of these criteria, the state or hospital is able to take control of the child’s medical treatment for a specified period of time, ensuring the child receives the treatment necessary to allow him to survive and have a better quality of life.88 Moreover, physicians are able to treat and provide medical care from their children can face severe legal penalties, including loss of custody, or being charged with child abuse, child neglect.

For the most part, parents want to act in their child’s best interests, but what happens if the parents’ desires are not the best course of action for a child? Are there measures in place to protect a child’s dignity in that case? In the United States, previous court cases long have acknowledged a child’s dignity in these cases. In the United States, previous court cases long have upheld the parents’ right to dictate the medical treatment of their child. However, this right does not extend to adults making decisions for their children.

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transfusion, or parents who are Christian Scientists will not give insulin to a diabetic child based on their religious views surrounding medical interventions. Both of these scenarios could have fatal consequences for the child, depending on the situation. In these instances, the state can legally, temporarily take custody of the child and allow the blood transfusion or insulin administration to occur, since withholding treatment has been ruled to be not in the best interests of the child.96 For determining when the state allows parents to dictate medical decisions and when it chooses to intervene, the amount of harm the parents’ option causes the child appears to be the deciding factor. By intervening to allow a potentially life-saving treatment, the state works as a vessel to maintain the dignity of a child.

A physician has means of mediating in a child’s medical treatment if he feels a certain course of action is in the child’s best interests. In other words, doctors can also act as means for protecting the dignity of a minor. One such ethically complex example is a physician’s use of a technique called a slow code, which is a modified version of the full code or code blue protocol used to resuscitate patients.97 In a regular code, an entire team of doctors and nurses appears to care for a patient.98 The arrival time is very rapid and the team will execute all procedures possible in hopes of saving that person’s life.99 In a slow code, the medical team still attempts to save the patient’s life, but will perform everything more slowly.100 The responding medical team might not get to the patient as quickly as they would during a regular code and also may forego the most drastic treatments.101 Though never explicitly stated, a slow code is essentially a method some medical professionals use to facilitate the death of a highly afflicted individual.102 In a sense, it could be considered a form of passive euthanasia. The medical professional does not actively end the patient’s life (this individual died from his ailments), but he also does not do everything in his power to save it.

While at first glance this may seem a horrific practice, further analysis reveals the intentions behind the procedure are not as maleficent as they appear. Consider a scenario when a child is suffering a profound disability and will not have a long or high quality life (for instance, consider an infant born with severe, fatal birth defects). If the child is dying, instead of calling for a regular code, the doctor performs a slow code, and the child is spared an aggressive, violent resuscitation treatment which would ultimately prove futile.103 Furthermore, by enacting a slow code, the physician also eliminates an emotional burden on the parents’ part, as the child’s parents are not forced to choose to terminate their child’s treatment.104 Instead of doing nothing and letting nature take its course, the physician will still have performed some life-saving measures on his patient, giving him the sense that he at least attempted to help this patient.105 Considering the same argument used to support physician-assisted suicide and/or euthanasia, instead of prolonging the suffering of an individual whose prognosis is bleak, performing a slow code could act as a way to reduce the aggregate amount of dignity by minimizing suffering from the condition and from the intervening medical treatments.

The ethics of the practice itself come into question, however. While the doctor never explicitly lies to the parents of the child, a slow code could be considered analogous to a lie by omission. In general, parents of children who receive slow codes are not informed that their child received this type of treatment.106 If instead, this idea harms the trust between a physician and his clients.107 Furthermore, in advocating a slow code, the physician is violating the parents’ autonomy over the care of their child. In certain cases, when the life or dignity of the child is in danger, this can be viewed as permissible, but a fine line exists between a doctor acting beneficently and overstepping his boundaries. Perhaps the practice of a slow code is not dignified in itself, but it allows someone to die in a more dignified fashion.

Overall, the difficulties in defining and working with the concept of dignity in adults are compounded greatly when they are expanded to children. Due to the vastly different maturity levels of children, strict age limits which restrict access to certain medical treatments appear an incomplete solution. Transferring the decision-making powers to the child’s parents can be a useful option, however, this is only true when the parents, child, and medical professionals agree on the course of action. If any of the parties dissent, it becomes exceedingly difficult to balance the conflicting views of everyone involved. In certain instances, the child’s parents may not be the best options for making choices which respect the child’s dignity, and when this occurs, the state or physician may need to intervene. Due to the complex nature of death with dignity in minors, and its relatively rare occurrence, the best course of action appears to be a case-by-case analysis. If the specifics of each situation to be fully examined before decisions are made.

CONCLUSIONS

Dignity, and the notion of death with dignity, is a concept which means different things to different people. A general conception of the term involves respecting a person’s wishes and, by doing so, acting in his best interests; however, a more concrete meaning is challenging to succinctly state. Irrespective of its nebulous definition, dignity is a powerful term with universally strong emotional connotations, so imbuing an individual with a sense of dignity at all stages of his life remains a desirable goal for the healthcare industry.
transfusion, or parents who are Christian Scientists will not give insulin to a diabetic child based on their religious beliefs. Both of these scenarios could have fatal consequences for the child, depending on the situation. In these instances, the state allows parents to dictate medical decisions and, in a sense, it could be considered an aggressive, violent resuscitation treatment which will ultimately prove futile.90

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Instead of doing nothing and letting nature take its course, the physician will still have performed some life-saving measures on his patient, giving him the sense that he at least attempted to help this patient.92 Considering the same argument used to support physician-assisted suicide and/or euthanasia, instead of prolonging the suffering of an individual whose prognosis is bleak, performing a slow code could be seen as restoring a greater amount of dignity by minimizing suffering from the condition and from the intervening medical treatments. The ethics of the practice itself come into question, however. While the doctor never explicitly lies to the parents of the patient, a slow code may be considered analogous to a lie by omission. In general, parents of children who receive slow codes are not informed that their child received this type of treatment.93 If discovered, this idea harms the trust between a physician and his patients.94 Further, in advocating a slow code, the physician is violating the parents’ autonomy over the care of their child. In certain cases, when the life or dignity of the child is in danger, this can be viewed as permissible, but a fine line exists between a doctor acting beneficently and overstepping his boundaries. Perhaps the practice of a slow code is not dignified in itself, but it allows someone to die in a more dignified fashion.

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