About Benefits and Costs

Euthanasia and Assisted Suicide

by Peter Terry

Euthanasia and assisted suicide are enjoying a renaissance. Public opinion polls demonstrate a shift in favor of these practices over the past four decades, to the point where two thirds of Americans recently polled favor both alternatives. Legislation legalizing these practices has been introduced in three states, with Oregon enacting a law permitting assisted suicide.

Explanations for this growing interest include the promotion of a century-old trend recognizing individual rights, increased mistrust of medical technology, fear that illness will deplete family resources, and perceived insensitivities to patients' wishes at the end of life.

Arguments for euthanasia and assisted suicide are both philosophical and practical. As noted, some believe that legalization is a logical extension of the carefully nurtured liberty rights movement. Others argue that dying patients have the right to determine what care is in their best interest. Further, they maintain that extending this element of control to end of life circumstances gives the dying patient a needed sense of assurance and security.

Practically, end of life care represents major expenditure, which could be alleviated by premature termination of life. The Remmelink report from the Netherlands cited "burden to others" as one of the primary reasons why the Dutch request euthanasia.

Arguments against these practices have paradoxically included a loss of trust in physicians, slippery slope predictions, fear of a subtle but pervasive loss of societal respect for human life, and concern that research to find more effective pain alleviation strategies for the terminally ill would decrease.

Most of these arguments are what moral philosophers call a utilitarian form of a consequentialist argument. This philosophical school holds that ethically appropriate actions are those that maximize good consequences while minimizing harmful ones.

The leading rival to this school, the deontologic philosophy of Kant and others, holds that right and wrong are dependent on elements other than consequences. The universal principle that it is wrong to enslave others reflects this philosophy, and deontology adds that it is wrong even if good consequences outweigh bad ones. Deontologic points against euthanasia include the principle that it is wrong to kill innocent human beings and that physicians are obligated to maintain the integrity of their profession, one which historically has promoted life.

Philosophy aside, our only practical experience in modern times comes from the Netherlands, where euthanasia is permitted if specific criteria are met. More than 70% of Dutch favor euthanasia. Approximately 5% of deaths in which Dutch physicians are involved in end of life decisions are euthanasia related. It is unclear what effect these deaths have on society and on health care savings. It is clear that those who argue against euthanasia have found empiric evidence on their side, based upon the Dutch experience.

The Remmelink report on a sample of more than 400 Dutch physicians given legal immunity from prosecution demonstrated that over 25% of patients euthanized had not met the criteria for euthanasia required by the government. The observation has been made that the majority of patients requesting euthanasia do so not because of physical pain, but because of psychological distress.

It would be hazardous to extrapolate the Dutch experience to the United States. The Dutch are a relatively homogeneous society with a universal health care system. The United States, a pluralistic society, is moving towards a variety of managed care systems that may provide physicians with incentives to reduce health care costs. Because costs for end of life care represent a significant portion of overall costs, physicians or third parties may consciously or unconsciously promote discussions with patients that lead to a request for euthanasia. It is unlikely that the poor will have the same end of life care plans as the financially advantaged, and therefore their terminal care may be associated with more psychological and physical distress and lead to more requests for euthanasia.

Societal acceptance of euthanasia does not guarantee physician acceptance. Recent polls suggest that less than 30% of physicians are willing to participate. Many medical organizations have unequivocally stated that it is wrong for physicians to participate in euthanasia.

The euthanasia and assisted suicide question is likely to equal or surpass the abortion debate in intensity and interest. It is also likely to be just as insoluble and divisive.

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