Matters of Life and Death

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Assisted suicide as a medical treatment fails to respect patients' rights and dignity

by Jason Negri

We live in an age that values people solely for what they can do, rather than who they are. While problematic, this attitude is particularly dangerous when it marginalizes the elderly or people with disabilities and results in bold cries demanding that assisted suicide and euthanasia be considered medical treatments.

What starts today as an individual choice can rapidly become an expectation. A new standard is set, which affects insurance coverage, hospital policies, public attitude and the practice of medicine itself.

First, some definitions may be helpful. Euthanasia is when someone other than the patient performs the last act that intentionally causes that person's death. For example, administering a lethal injection would be considered euthanasia. In some European countries, such as the Netherlands and Belgium, euthanasia

by lethal injection — even involuntary euthanasia — is an established practice, and doctors in the Netherlands sometimes refer to it as "life-terminating treatment."

By contrast, in the case of assisted suicide, the person who dies performs the last act. In most cases, this involves a person receiving assistance from a doctor to end his or her life, usually by a prescription for poison. In countries such as Canada, New Zealand and the United States, advocates of doctor-prescribed suicide are waging campaigns to achieve their goal of death on demand.

THE RIGHT TO DIE?

Much of the news about end-of-life controversies employs the phrase "the right to die," a sound bite crafted by supporters to gain support for their position. But when it comes down to it, every human being has this right already: Anyone can legitimately refuse medical treatment, and if a doctor ignores a patient's wishes and provides medical treatment anyway, that doctor can be sued for battery.

Current discussions, however, are not about an individual's right to die. There are many who instead want assisted suicide to be a legitimate option that can be chosen by anyone of sound mind. But what starts today as an individual choice can rapidly become an expectation. A new standard is set, which affects insurance coverage, hospital policies, public attitude and the practice of medicine itself.

In the Netherlands, where euthanasia was formally legalized in 2002, citizens have seen fewer hospices, an increase in involuntary euthanasia, the euthanizing of disabled infants, and seniors who carry "do not euthanize" wallet cards. In a 2009 interview, Dr. Els Borst, the former health minister and deputy prime minister who guided the euthanasia law through the Dutch parliament, acknowledged that medical care for the terminally ill had declined since the law came into effect. The remarks were published in a book about the history of euthanasia by Dr. Anne-Marie The. Dr. The also contends that a number of Dutch seniors request euthanasia out of fear, because of an absence of adequate palliative care. And this only stands to reason: Where euthanasia is an accepted medical solution to patients' pain and suffering, there is less incentive to develop programs which provide modern, effective pain control for patients.

In Oregon and Washington, where assisted suicide is considered a medical treatment, patients have received letters from their health insurance providers refusing to cover the cost of life-saving medication but offering to cover a prescription for suicide. Certainly, not every desired treatment will be covered by insurance, but the insensitive offer to pay for assisted suicide is but one of the unforeseen consequences of establishing it as a right.

The effort to transform the practice of assisted suicide from a crime into a legitimate medical treatment is currently underway in both Vermont and Massachusetts. Vermont's governor has publically declared that the legalization of assisted suicide is a priority. Supporters have since raised a bill and have poured hundreds of thousands of dollars into promoting public acceptance of what they call "death with dignity."

In Massachusetts, supporters of assisted suicide have filed a petition to put a measure called the Massachusetts "Death With Dignity Act" on the 2012 ballot. The proposal mirrors the Oregon and Washington laws by the same name.

A HIGH PRICE TO PAY

Once legalized, assisted suicide may be offered as simply one more form of treatment, but there is one

big difference: It is the least expensive option. Many nations are discussing the rising costs of health care, particularly the cost of treatment at the end of life. Under these circumstances, assisted suicide may quickly become the new standard of care.

Leaders in the movement to legalize prescribed death have been saying for years that economics, not the quest for broadened individual liberties, will drive assisted suicide to the plateau of acceptable practice. It is time for Americans to ask themselves whether they are prepared to let this happen.

A person battling severe illness or pain is already vulnerable to suggestion and pressure. In addition to his pain, uncertainty and fear, he may also worry about becoming a burden — financially and otherwise — to those he loves. Acting out of love, he might be tempted to choose assisted suicide to alleviate that burden, when in fact he may well recover or enjoy more good years with his family.

As more governments allow assisted suicide and euthanasia, everyone over the age of 18 should have a well-drafted durable power of attorney for health care, which designates someone to make medical decisions on his or her behalf if they become unable to make those decisions on their own, either temporarily or permanently. This is different from a living will, which is a potentially harmful document, as it is subject to interpretation by others who might not share your values or have your best interests in mind.

Sometimes, when people imagine what it would be like if they were unable to do the simple things they now enjoy or even perform basic functions like walking or bathing, they tend to think, “I wouldn’t want to live like that.” Moreover, they speak as if there is a societal consensus about what kind of life is no longer worth living. They assume that because they wouldn’t want to live like that, no one would. But this doesn’t account for the reality that people’s understanding of the value of life changes over time. It’s common for people who swore that they would rather die than no longer be able to live in a certain way to fiercely want to live when actually faced with a disability.

Instead of offering assisted suicide as an easy out, we need to offer proper medical responses and comfort care to those in need. Pain alleviation has made tremendous strides in the past few decades, such that no one should have to live with intractable pain.

Members of the Knights of Columbus have always been steadfast in their commitment to life and to service. We don’t alleviate suffering by killing those who suffer. Let us meet the needs of the suffering, protect the vulnerable, comfort the afflicted and continue to make a stand for life.

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