Chapter 16
Legalization of Euthanasia

16.1 Introduction

The Oxford English Dictionary (2nd edition, 1989; online version June 2011) provides the following definitions of euthanasia:

> A gentle and easy death… The means of bringing about a gentle and easy death… In recent use: The action of inducing a gentle and easy death. Used esp. with reference to a proposal that the law should sanction the putting painlessly to death of those suffering from incurable and extremely painful diseases.

According to ProCon.org (http://euthanasia.procon.org/): "Proponents of euthanasia and physician-assisted suicide (PAS) contend, that terminally ill people should have the right to end their suffering with a quick, dignified, and compassionate death. They argue that the right to die is protected by the same constitutional safeguards that guarantee such rights as marriage, procreation, and the refusal or termination of life-saving medical treatment. Opponents of euthanasia and physician-assisted suicide contend that doctors have a moral responsibility to keep their patients alive as reflected by the Hippocratic Oath. They argue there may be a "slippery slope" from euthanasia to murder, and that legalizing euthanasia will unfairly target the poor and disabled and create incentives for insurance companies to terminate lives in order to save money."

The controversy over the legalization of euthanasia is being debated nationally, from the halls of Congress to hospital corridors. The ramifications of possible legalization have many groups scrambling to either enforce it or stop it. Although the media has not given euthanasia much air time, the issue is still in the forefront of the minds of the populous. Several states have proposed legislation to legalize assisted suicide. The state of Oregon put this on a ballot and the voters passed the bill in 1996. Soon thereafter, an injunction was filed by a right to life organization questioning the constitutionality of the bill. In 2006 the United States Supreme Court upheld a lower court ruling that found that Oregon's Death With Dignity Act protected assisted

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suicide as a legitimate medical practice. The differentiation between passive and active euthanasia and assisted suicide is a very important one. Passive euthanasia is what is currently being practiced in most states. If a patient no longer wishes to receive medical care, then doctors abide by his or her wishes by foregoing medication, withholding hydration and nutrition, or "pulling the plug" on a breathing apparatus. The patient may legally express these wishes in a living will or advance directive. Assisted suicide refers to doctors possibly prescribing medication to end patient's lives, but the medication would be administered by the patient. Active euthanasia entails the doctors taking an active role by actually injecting a lethal solution into the patient's bloodstream. Many people believe the latter to be murder, but are more tolerant toward the former alternatives. Dr. Jack Kevorkian tested the legality of assisted suicide many times, and was brought to trial on several occasions. He spent eight years in prison after being convicted of second-degree murder in the death of the last of about 130 ailing patients whose lives he had helped end, beginning in 1990. The people whose lives he assisted in ending were all terminally ill, and requested his help. Dr. Kevorkian's rationalization for assisted suicide is that if the patients request to die, who are "we" to deny them? He and other advocates of euthanasia and assisted suicide believe it to be an issue of individual rights and patient autonomy, and also wish to exempt physicians who participate in this activity from potential criminal prosecution. The medical community is divided on this issue because many physicians believe it violates the Hippocratic Oath: "I will give no deadly medicine to anyone if asked, nor suggest any such counsel" [1]. However, they do not wish to prolong suffering if the patient is terminally ill and wishes to die. Some doctors currently perform a version of assisted suicide, prescribing increasing doses of morphine to terminally ill patients—effectively sedating them to death [2]—while others refuse to break their promise to uphold life at any cost. The possible legal ramifications of legalizing euthanasia are far-reaching. Many foes of assisted suicide believe that there would be a great potential for abuse on the part of physicians. This would probably necessitate the formation of a new government agency which would monitor physicians—a costly endeavor. Many people in the religious community have contested the reasoning of patient autonomy by stating that patients may not be in rational state of minds when making the decision to end their lives [3]. Another issue is the objective measurement of suffering. Who is to make the distinction between the suffering of a terminally ill cancer patient and a depressed teenager? If the latter is protected from assisted suicide, why not the former? Right to life advocates also list the improvements that may be gained from therapy, counseling, analgesia, and pastoral practice as conceivable alternatives to taking one's life.

As of 2011, there is no specific federal law regarding either euthanasia or assisted suicide. All 50 states and the District of Columbia prohibit euthanasia under general homicide laws. Assisted suicide laws are handled at the state level: Of the 50 states: 36 states have specific laws prohibiting all assisted suicides; seven states prohibit all assisted suicides under common law; four states (and the District of Columbia) have no specific laws regarding assisted suicide, and do not recognize common law in regard to assisted suicide; and only three states, Oregon, Washington, and Montana, have legalized physician-assisted suicide.

16.2 The Analytic Hierarchy Model

The legalization of euthanasia is a highly charged political issue. Like many other political issues, its fate is determined by key players—politicians, the general public, and strong lobbying groups—and their view of the major issues within the dilemma. The model used to answer the question of whether or not euthanasia should be legalized is the benefit—cost analytic hierarchy. The risks associated with the legalization of euthanasia are incorporated in the cost hierarchy because, in a life-critical situation, all risks inevitably become costs. Because we are not at liberty to gamble with human life, we must assume the worst case scenario and take all risks to be costs. The key players surrounding this issue are the criteria and the key issues they face are the subcriteria, followed by the alternatives.

16.2.1 Key Players

Politicians—Politicians play a critical role in that members of congress would be the ones to pass the legislation necessary to legalize euthanasia or assisted suicide. The decision not to divide this criterion into Republican and Democrat subcategories is due to the fact that euthanasia is not a bipartisan issue.

General Population—The population at large plays the most important role in this model because they influence all of the other key players in that they elect politicians or they can boycott certain hospitals who refuse to perform the procedure and those who do perform the procedure. This criterion was divided along racial lines because different ethnic groups react and feel differently about this subject.

Religious Groups—A third group that bears a powerful political voice and has expressed strong views on the subject of euthanasia is religious groups. There is a strong Catholic influence in the U.S., and we felt that this group's opinions would have a significant influence on the outcome. The stance of the Catholic Church is adamantly opposed to both assisted suicide and euthanasia. However, passive euthanasia is not condemned [4]. The second subgroup which has become quite a strong political force is the Religious Right. In the past few years, their number has grown tremendously and their influence is being felt on the political level. We understand that the majority of the US population belongs to Protestant, Jewish, and other faiths, but their voices on the issue of euthanasia have not been strongly heard. Because their influence on the decision was minute, we have excluded them from the hierarchy.

American Medical Association—The AMA is at the center of this issue because doctors would play a major role in the decision to terminate life. In the past, the AMA has vehemently opposed assisted suicide and active euthanasia [5] because they directly contradict the Hippocratic Oath. More recently, however, the AMA has moderated its position in response to the increasing number of physicians who

support the measures. The AMA is a powerful political lobbyist, and therefore placed third in overall ranking of key players.

Hemlock Society—In our model, the Hemlock Society represents all right-to-die groups. The Hemlock Society has been in existence for over twenty years and its members are very vocal in support of all forms of euthanasia. Although the group placed last in the rankings, its influence should not be ignored. An organization like the Hemlock Society placed the assisted suicide bill on the ballot in Oregon in 1996.

16.2.2 Kev Issues

16.2.2.1 Benefits Hierarchy

Economic—Medical costs incurred by patients for hospitalization and terminal care would be significantly reduced, and the limited resources available to fund such care would not be as strained. Approximately 80% of a patient's lifetime medical expenses are incurred in the last three weeks of life—mostly because of the high costs of life support and intensive care [6]. Economic issues are considered by all of the key players with the exception of Religious groups and the Hemlock Society.

Moral/Ethical—The moral benefits of euthanasia refer to the people's perception of euthanasia as mercy killing, and the ethical nature of obeying a terminal patient's last wishes. Under the benefits hierarchy, the moral priority would be to relieve terminally ill patients from suffering a long and painful death.

Legal—It has been argued that the constitutional guarantee of individual liberty includes the right to seek aid in dying [7]. The decision to end one's own life is one of the most intimate and personal choices a person may make in a lifetime. These choices, central to an individual's autonomy and personal dignity, are central to the liberty protected in the 14th Amendment [8]. The legalization of assisted suicide and active euthanasia will guarantee the freedom to exercise this right.

Patient Concerns—This subcriterion encompasses the personal dignity, autonomy, and self-determination which follows through the course of an individual‘s life, and should accompany death. Some believe that the legalization of assisted suicide or active euthanasia will improve compassionate care at the end of life [9]. Doctors feel helpless in the face of terminal illness, and the dying patient perceives this helplessness as abandonment. Euthanasia would increase the patient's autonomy and control, reduce pain, and a1low for the proper termination of life under a physician's guidance.

16.2.2.2 Costs Hierarchy

Economic—As with any medical procedure, assisted suicide and active euthanasia will involve some financial costs. These may include the cost of a prescribed drug overdose for assisted suicide or fees paid to the attending physician for active euthanasia. The increase in medical malpractice liability should also be considered, and although current malpractice insurance is likely to cover euthanasia suits [10], it is also likely that the legalization of euthanasia will drive up the cost of malpractice insurance to doctors and hospitals.

Moral—Refers to the notion of whether it is morally right to take one's own life and for someone else to assist this endeavor. This criterion weighted heavily with the general population and with religious groups.

Legal—This subcriterion looks at the possible lawsuits that medical profession could face for potential abuses of the system, and for an unwillingness to participate in assisted suicide. In addition, physicians may face liability in cases of assisted suicide where the drug overdose did not cause the patient to die. As many as a quarter of those who try to kill themselves with a prescribed overdose could linger for hours or days before they died [11]. The legal costs also refer to an increase in legal activity in the government due to necessary legislation to pass this bill and regulate its use.

Patient Concerns—The major cost in patient concerns in assisted suicide is the risk of failed procedure. Because doctors are not trained in terminating life, their "fatal" prescriptions come with no guarantees. Patients who take an insufficient dose could suffer increased pain and incapacitation. In addition, there is the risk that the patient is not mentally fit to make the decision to seek assisted suicide or active euthanasia. Many people who seek to commit suicide are motivated by depression, mental illness, or emotional distress, rather than by a rational evaluation of the situation and subsequent logical decision. A final cost is the families' potential difficulties in accepting this decision.

16.2.2.3 Alternatives

Status Quo—The current acceptable practice is passive euthanasia where a physician may withhold medical services at the patient's request.

Assisted Suicide—This alternative would allow physicians to prescribe medication which patients would self-administer.

Active Euthanasia—This is the extreme of all of the alternatives where a doctor would lethally inject a terminally ill patient.

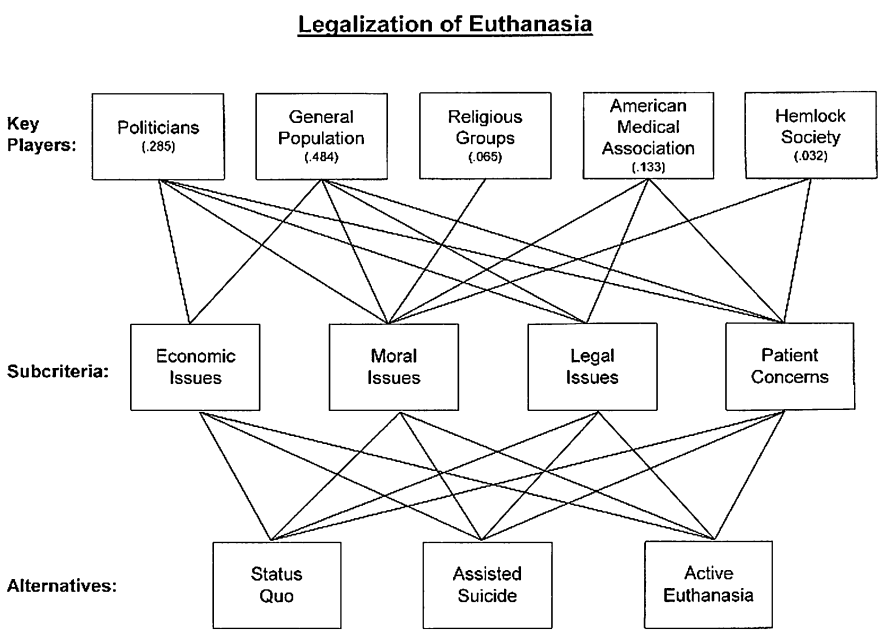


Fig. 16.1 Legalization of euthanasia hierarchy

16.2.2.4 Model Assumptions

Prior to evaluating the criteria, we made several assumptions:

1. This is a political issue in that without proper legislation, none of these alternatives would be legal, and therefore would be deemed impossible.
2. All of the key players are essentially lobbyists who must attempt to convince congress to act appropriately depending on each group's stance.
3. Terminally ill patients and their families are represented in the general population as well as the other groups. We did not list them as a key player because they are not a unified, politically active entity. In addition, if we had divided the general population into subsets of people in favor Of euthanasia and people against euthanasia, our end result would not be as objective.
4. The only subcriterion that religious groups are concerned with is the moral issue. These groups are not affected by possible economic or legal ramifications, and they do not have a substantial voice on patient concerns. Therefore, we deleted all subcriteria within the religious groups except for the moral/ethical issue.

Figures 16.1, 16.2, 16.3, 16.4, 16.5, 16.6, 16.7, 16.8, 16.9, 16.10, 16.11 show the benefits and costs hierarchies as well as the priorities assigned to the criteria and the priorities of the alternatives under each criterion.

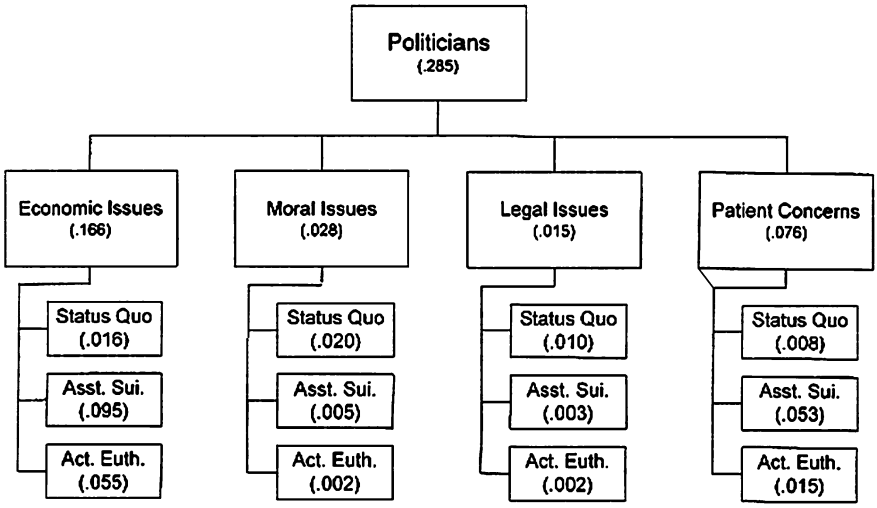


Fig. 16.2 Politicians' benefits hierarchy

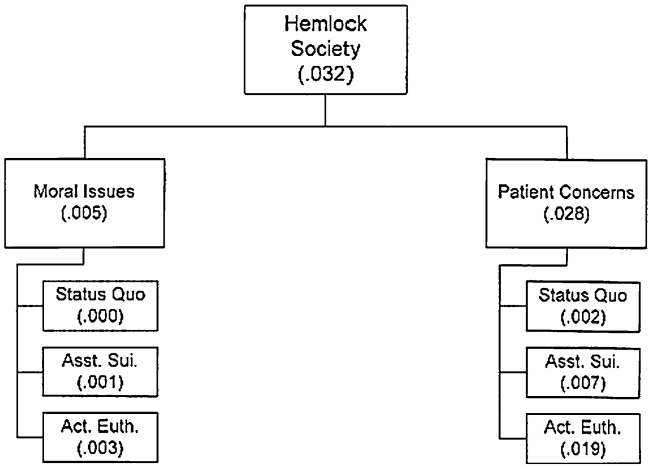


Fig. 16.3 Hemlock society's benefits Hierarchy

16.3 Results

Table 16.1 summarizes the points of view of the different constituencies. Note that Politicians, the general population and the AMA think that *Assisted Suicide* has the most benefits while religious groups and the Hemlock society find themselves at opposite extremes. In terms of costs, everybody but the Hemlock society think that active euthanasia is most costly

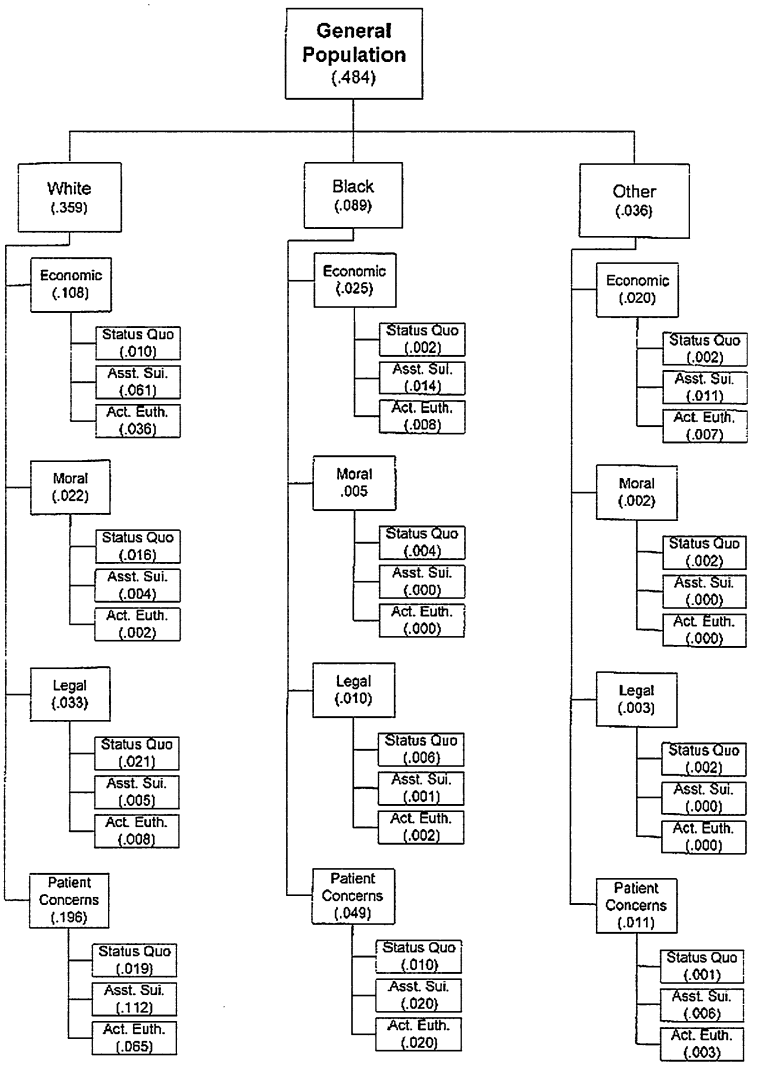


Fig. 16.4 General population's benefits hierarchy

The final result is to keep the status quo, although assisted suicide was a close second and active euthanasia finished a distant third. The final decision is not surprising and reflects people's unwillingness "to rock the boat". Most people would rather avoid making such a choice because of the delicacy of the issue. No one really wants to face death and no one wants to play God. We believe the moral/ethical issue played the biggest role of all the subcriteria in the final decision because it is the most ambiguous. Costs and benefits values can easily be measured

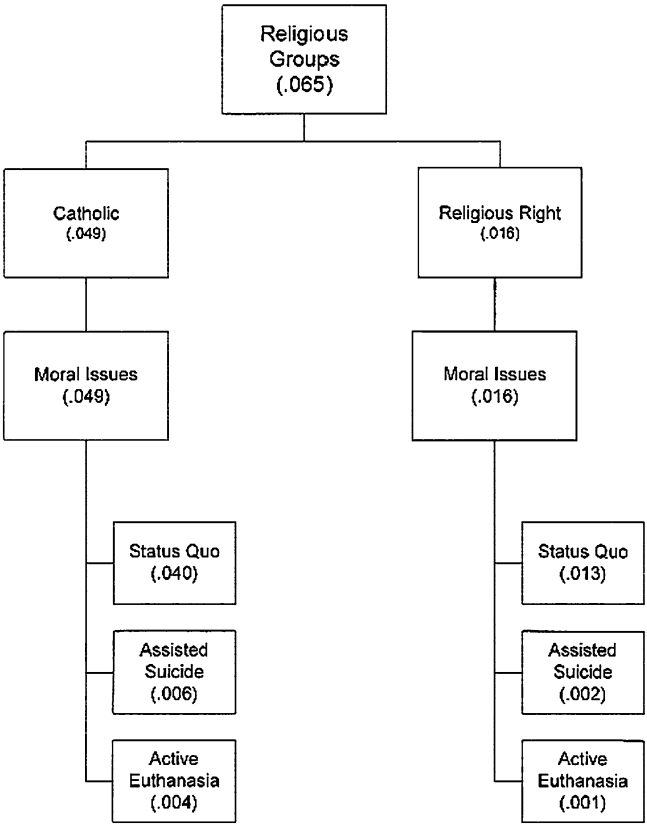


Fig. 16.5 Religious groups' benefits hierarchy

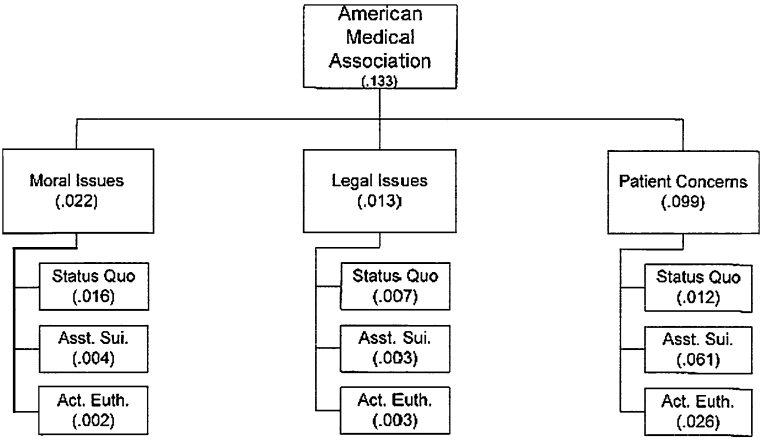


Fig. 16.6 AMA's benefits hierarchy

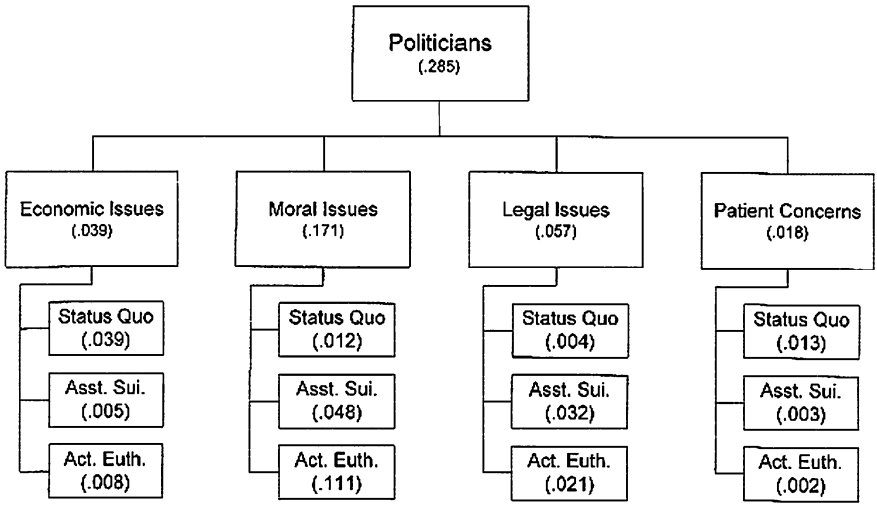
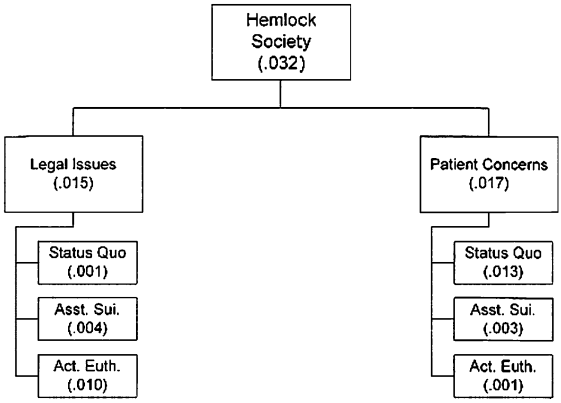


Fig. 16.7 Politicians' costs hierarchy

Fig. 16.8 Hemlock society's costs hierarchy



for economic and legal issues, while in the cases of moral/ethical and patient concerns, value is very much subjective. Finally, the country seems to be heading in conservative direction, and maintaining the status quo confirms that trend.

16.4 Sensitivity Analysis

To determine the strength and resilience of our model, we must conduct sensitivity tests. Although this is an issue of national importance, we expect that different regions within the U.S. would impose varying degrees of latitude on euthanasia. In our sensitivity analysis, we looked at Western states, Southern states, and the Pittsburgh area. Our results are given in Table 16.2, 16.3 and 16.4.

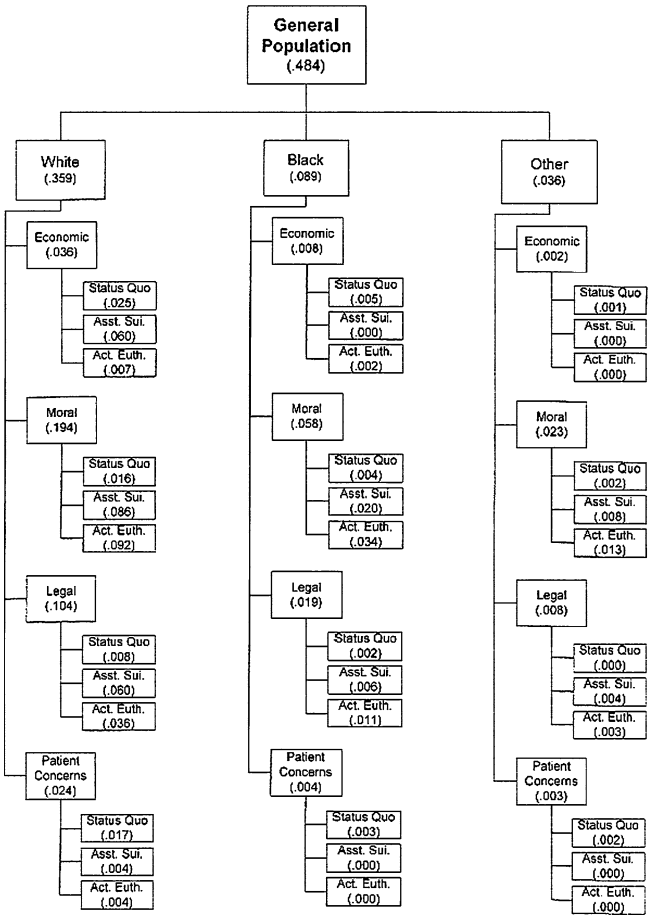


Fig. 16.9 General population's costs hierarchy

In our analysis for the West, we incorporated the growing sentiments against the government and in favor of individual rights among the citizens by decreasing the influence of politicians from 28.50 to 18.9%, and increasing the influence for the Hemlock Society by nine percentage points. Consequently, assisted suicide won by a very slight margin. We found this to be strongly supported by the situation in Oregon, where the bill legalizing assisted suicide was passed by a 51–49% vote.

Citizens in the South are very religious and are more conservative than the rest of the population. Therefore, we increased the percentage for the religious groups from 6.50 to 23.9%, This confirmed our initial results in that the status quo received a higher ratio then assisted suicide and active euthanasia. The major difference is that people in the south consider assisted suicide to be worse than active euthanasia.

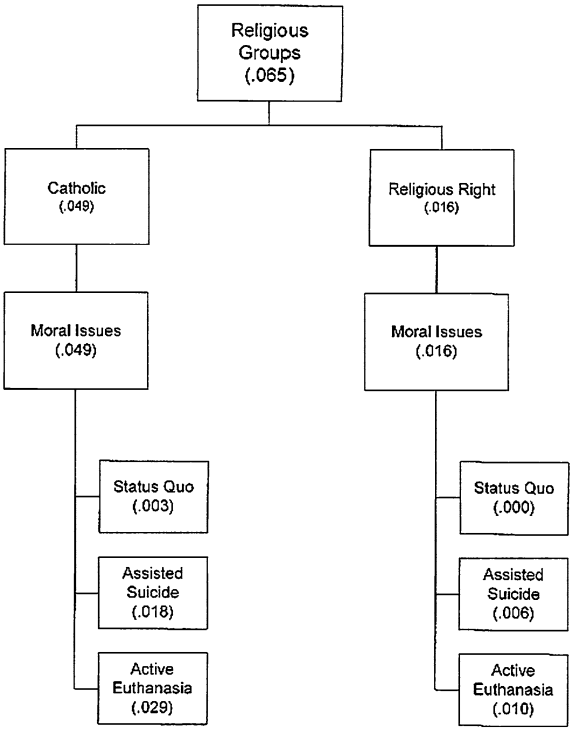


Fig. 16.10 Religious groups' costs hierarchy

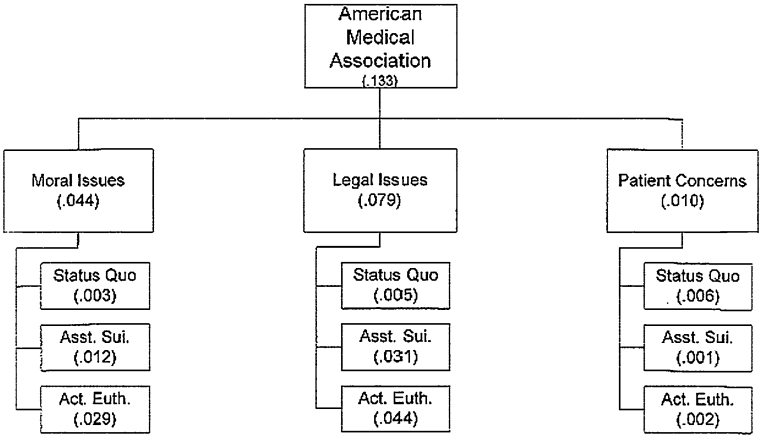


Fig. 16.11 AMA's costs hierarchy

Table 16.1 Priorities and B/C ratios of the alternatives

	Politicians	General Population	Religious Groups	AMA	Hemlock Society		
	0.285	0.484	0.066	0.133	0.032		
Benefits						TOTAL	B/C Ratio
Status Quo	0.055	0.095	0.053	0.035	0.002	0.240	1.404
Assisted Suicide	0.156	0.234	0.008	0.067	0.008	0.473	1.318
Active Euthanasia	0.074	0.155	0.005	0.031	0.022	0.287	0.611
Costs						TOTAL	
Status Quo	0.055	0.085	0.003	0.014	0.014	0.171	
Assisted Suicide	0.088	0.196	0.024	0.044	0.007	0.359	
Active Euthanasia	0.142	0.203	0.039	0.075	0.011	0.470	

Table 16.2 Priorities for the west

West	Benefits	Costs	B/C Ratio
Status Quo	0.232	0.196	1.184
Assisted suicide	0.451	0.350	1.289
Active Euthanasia	0.317	0.454	0.698

Table 16.3 Priorities for the south

South	Benefits	Costs	B/C Ratio
Status Quo	0.348	0.151	2.305
Assisted suicide	0.412	0.357	1.154
Active Euthanasia	0.329	0.491	0.670

Table 16.4 Priorities for pittsburgh

Pittsburgh	Benefits	Costs	B/C Ratio
Status Quo	0.314	0.155	1.184
Assisted suicide	0.437	0.356	1.228
Active Euthanasia	0.249	0.489	0.509

Pittsburgh has a large catholic population and is renowned for its medical facilities. As a result, we increased the religious factor to 17% and increased the AMA's influence to 17% as well. This led to a final decision to keep the status quo by a large margin. This is not too surprising seeing that the religious groups are categorically against assisted suicide and active euthanasia.

In all three cases, active euthanasia was never a consideration because most citizens, regardless of geographic location, do not look favorably on a physician taking life instead of sustaining it.

16.5 Conclusions

The analysis done using the AHP, suggests that the *Status Quo* should be maintained. The *Status Quo* states that if a patient requests to discontinue medical services, then a doctor must abide by his or her wishes. The sensitivity analysis confirmed this decision except in the West, where legalization of euthanasia has advanced much further than any other region. The end results confirm a conservative trend which has been sweeping the country, and also indicates people's unwillingness to take life into their own hands. The issue of assisted suicide and euthanasia will not be resolved overnight, and will continue to divide people along geographic, racial, and ethical lines.

Bibliography

1. Drinan RF (1994) The law and assisted suicide. America. 4 June 1994, p 7
2. Medicine's Position is Both Pivotal and Precarious in Assisted-Suicide Debate," JAMA. February i, 1995, p 363
3. lbid
4. Life (1995) Death, and the Pope, Newsweek. April 10, 1995, p 59
5. States Weigh Assisted Suicide (1995) American Medical News. February 27, 1995, p 24
6. Pallone Nathaniel J (1992) Costs and benefits of medicide. Societv July/August 1992, p 34
7. Medicine's Position is Both Pivotal and Precarious in Assisted-suicide Debate, JAMA. February 1, 1995, p 364
8. Drinan, Robert F. "The Law and Assisted Suicide," America. June 4, 1994, p 6
9. Oregon Doctors Fear Fallout From Assisted Suicide, American Medical News. January 23, 1995, p 21
10. Ibid
11. Ibid, p 26