

Unit 7 project part 3: opposing sides



My initial position Euthanasia is wrong and should never be legalized. Laws against euthanasia and assisted suicide are in place to prevent abuse and to protect people from unscrupulous doctors and others. They are not, and never have been, intended to make anyone suffer. Activists often claim that laws against euthanasia and assisted suicide are government mandated suffering. This claim would be similar to saying that laws against selling contaminated food are government mandated starvation.

In a society as obsessed with the costs of health care and the principle of utility, the dangers of the slippery slope are far from fantasy. Assisted suicide is like a half-way house, or a stop on the way to other forms of direct euthanasia. If terminating life is a benefit, the reasoning goes, why should euthanasia be limited only to those who can give consent? Why do we need to ask for consent? In cases like Schiavo's touch on basic constitutional rights, such as the right to live and the right to due process, and consequently there could very well be a legitimate role for the federal government to play.

There's a precedent as a result of the highly publicized deaths of infants with disabilities in the 1980s. The federal government enacted 'Baby Doe Legislation, which would withhold federal funds from hospitals that kept lifesaving treatment from newborns based on the expectation of disability. The medical community has to have restrictions on what it may do to people with disabilities. What would happen if some members of that community are willing to do anything when no restrictions are in place?

Savings to governments could become a consideration. Drugs for assisted suicide cost about \$35 to \$45, making them far less expensive than

providing medical care. This could fill the void from cutbacks for treatment and care with the treatment of death. It must be recognized that assisted suicide and euthanasia will be practiced through the prism of social inequality and prejudice that characterizes the delivery of services in all segments of society, including health care.

Those who will be most vulnerable to abuse, error, or indifference are the poor, minorities, and those who are least educated and least empowered. This risk does not reflect a judgment that physicians are more prejudiced or influenced by race and class than the rest of society. Also, they are not exempt from the prejudices manifest in other areas of our collective life. While our society aspires to eradicate discrimination and the most punishing effects of poverty in employment practices, housing, education, and law enforcement, we consistently fall short of our goals.

The costs of this failure with assisted suicide and euthanasia would be extreme. Nor is there any reason to believe that the practices, whatever safeguards are erected, will be unaffected by the broader social and medical context in which they will be operating. Opposing Position A state's categorical ban on physician assistance to suicide as applied to terminally ill patients who wish to avoid unendurable pain and hasten inevitable death substantially interferes with this protected liberty interest and cannot be sustained.

The right of a competent, terminally ill person to avoid excruciating pain and embrace a timely and dignified death bears the sanction of history and is implicit in the concept of ordered liberty. The exercise of this right is as central to personal autonomy and bodily integrity as rights safeguarded by

this Court's decisions relating to marriage, family relationships, procreation, contraception, child rearing and the refusal or termination of life-saving medical treatment.

In particular, this Court's recent decisions concerning the right to refuse medical treatment and the right to abortion instruct that a mentally competent, terminally ill person has a protected liberty interest in choosing to end intolerable suffering by bringing about his or her own death. The mere possibility that such consequences might occur does not constitute such evidence. We need the evidence that shows that horrible slope consequences are likely to occur.

Especially with regard to taking life, slippery slope arguments have long been a feature of the ethical landscape, used to question the moral permissibility of all kinds of acts. The situation is not unlike that of a doomsday cult that predicts time and again the end of the world, only for followers to discover the next day that things are pretty much as they were. These intensely personal and socially expensive decisions should not be left to governments, judges or legislators better attuned to highway funding.

We'll all die, but in an age of increased longevity and medical advances, death can be suspended, sometimes indefinitely, and no longer slips in according to its own immutable timetable. Real decisions are demanded for both patients and their loved ones. When do we stop doing all that we can do? When do we withhold which therapies and allow nature to take its course? When are we, through our own indecision and fears of mortality, allowing wondrous medical methods to perversely prolong the dying rather than the living?

One concern has been that disadvantaged populations would be disproportionately represented among patients who chose assisted suicide. Experience in Oregon suggests this has not been the case. In the United States, socially disadvantaged groups have variably included ethnic minorities, the poor, women, and the elderly. Assisting death in no way precludes giving the best palliative care possible but rather integrates compassionate care and respect for the patient's autonomy and ultimately makes death with dignity a real option.