The New York Times

The Opinion Pages

Four Myths About Doctor-Assisted Suicide

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October 27, 2012, 2:45 pm

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IN a little more than a week, voters in Massachusetts will decide whether to allow doctors to "prescribe medication, at the request of a terminally ill patient meeting certain conditions, to end that person's life." A similar bill is being debated in New Jersey. Unfortunately, like so many health care questions, the debate about physician-assisted suicide is confused, characterized by four major falsehoods.

PAIN The fundamental claim behind arguments for physician-assisted suicide is that most patients who desire it are experiencing excruciating physical pain. The 1996 decision of the United States Court of Appeals for the Ninth Circuit supporting a constitutional right to physician-assisted suicide in Washington State summarized the conventional wisdom: "Americans are living longer, and when they finally succumb to illness, lingering longer, either in great pain or in astuporous, semi-comatose condition that results from the infusion of vast amounts of painkilling medications."

But this view is false. A multitude of studies based on interviews of patients with cancer, AIDS, Lou Gehrig's disease and other conditions have demonstrated that patients who desire euthanasia (in which a doctor administers a lethal drug) or physician-assisted suicide (in which the patient himself takes the lethal drug prescribed by the physician) tend not to be motivated by pain. Only 22 percent of patients who died between 1998 and 2009 by assisted suicide in Oregon— one of

three states, along with Washington and Montana, where it is legal — were in pain or afraid of being in pain, according to their doctors. Among the seven patients who received euthanasia in Australia in the brief time it was legal in the ’90s, three reported no pain, and the pain of the other four was adequately controlled by medications.

Patients themselves say that the primary motive is not to escape physical pain but psychological distress; the main drivers are depression, hopelessness and fear of loss of autonomy and control. Dutch researchers, for a report published in 2005, followed 138 terminally ill cancer patients and found that depressed patients were four times more likely to request euthanasia or physician-assisted suicide. Nearly half of those who requested euthanasia were depressed.

In this light, physician-assisted suicide looks less like a good death in the face of unremitting pain and more like plain old suicide. Typically, our response to suicidal feelings associated with depression and hopelessness is not to give people the means to end their lives but to offer them counseling and caring.

ADVANCED TECHNOLOGY A second misconception about assisted suicide is that it is the inevitable result of a high-tech medical culture that can sustain life even when people have become debilitated, incontinent, incoherent and bound to a machine. It is the “inevitable consequence of changes in the causes of death, advances in medical science, and the development of new technologies,” as the appeals court put it.

But the ancient Greeks and Romans advocated euthanasia. In modern times, debate about legalizing euthanasia and assisted suicide was revived with intensity in England in the late 19th century, after a famous debate at the Birmingham Speculative Club. The first such bill introduced in the United States was in 1905, before the discovery of antibiotics and dialysis, much less respirators and feeding tubes. If interest in legalizing euthanasia is tied to any trend in history, it is the rise of individualistic strains of thought that glorify personal choice, not the advances of high-tech medicine.

MASS APPEAL A third misconception about assisted suicide is that it will improve the end of life for everyone. After all, death afflicts everyone, and legalized

assisted suicide would allow any individual to avoid an excruciatingly painful death. But the fact is that, even in places where physician-assisted suicide is legal, very few people take advantage of it. In Oregon, between 1998 and 2011, 596 patients used physician-assisted suicide — about 0.2 percent of dying patients in the state. In the Netherlands, where euthanasia and physician-assisted suicide have been permitted for more than three decades, fewer than 3 percent of people die by these means. And even if we add all the dying patients who even vaguely express an interest in assisted suicide, it amounts to much less than 10 percent. For the vast majority of dying patients, it will have no impact on improving the ends of their lives.

Whom does legalizing assisted suicide really benefit? Well-off, well-educated people, typically suffering from cancer, who are used to controlling everything in their lives — the top 0.2 percent. And who are the people most likely to be abused if assisted suicide is legalized? The poor, poorly educated, dying patients who pose a burden to their relatives.

A GOOD DEATH The last misconception about assisted suicide is that it is a quick, painless and guaranteed way to die. But nothing in medicine — not even simple blood draws — is without complications. It turns out that many things can go wrong during an assisted suicide. Patients vomit up the pills they take. They don't take enough pills. They wake up instead of dying. Patients in the Dutch study vomited up their medications in 7 percent of cases; in 15 percent of cases, patients either did not die or took a very long time to die — hours, even days; in 18 percent, doctors had to intervene to administer a lethal medication themselves, converting a physician-assisted suicide into euthanasia. (In the states where assisted suicide is legal, and under the proposed Massachusetts law, this intervention would be illegal.)

Instead of attempting to legalize physician-assisted suicide, we should focus our energies on what really matters: improving care for the dying — ensuring that all patients can openly talk with their physicians and families about their wishes and have access to high-quality palliative or hospice care before they suffer needless medical procedures. The appeal of physician-assisted suicide is based on a fantasy. The real goal should be a good death for all dying patients.