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Systemic euthanasia

The escalating economic and social cost of supporting the aged beyond natural lifecycles leads to wider acceptance of assisted suicide.

Given the certainty of imbalanced population growth and the increasingly ageing population, some claim that there are people born today who, if they wish, could live for over 200 years. With the current record at 120 and a host of people already living past 115, there is little doubt that, with technology advancing as quickly as it is, physically adding another 80 years or so is looking possible. Whether or not mental capacity can be sustained for that long may be a greater challenge, but the world will certainly get used to more and more centenarians. In the UK alone there are over 9,000 of them today.

While this may be all well and good at an individual level, many see that, from a societal perspective, the ageing population is presenting us with a major financial burden, especially given that current pensions were not really designed for people living much beyond 75. With increasing dependency ratios in many nations and escalating healthcare costs across the board, some people have been asking the rather difficult questions around whether we can continue to cope with this level of mass long-term ageing.

An increasing number of healthcare professionals see that life-sustaining treatment is frequently not cost-effective. In the US, acute hospital care accounts for over half (55%) of the spending for Medicare beneficiaries in the last two years of life. In many other countries, the high costs of surgery, intensive care and life-extending drugs used towards the end of a patient's life adds up to nearly 80% of total healthcare costs. A recent study in Brazil confirmed that over 70% of total healthcare costs occur in the twelve months before death. And a story on Bloomberg a couple of years ago highlighted the case of one US resident whose healthcare costs totalled $618,616, almost two-thirds of it for the final twenty-four months and, according to his wife, 'much of it for treatments that no one can say for sure helped extend his life'.

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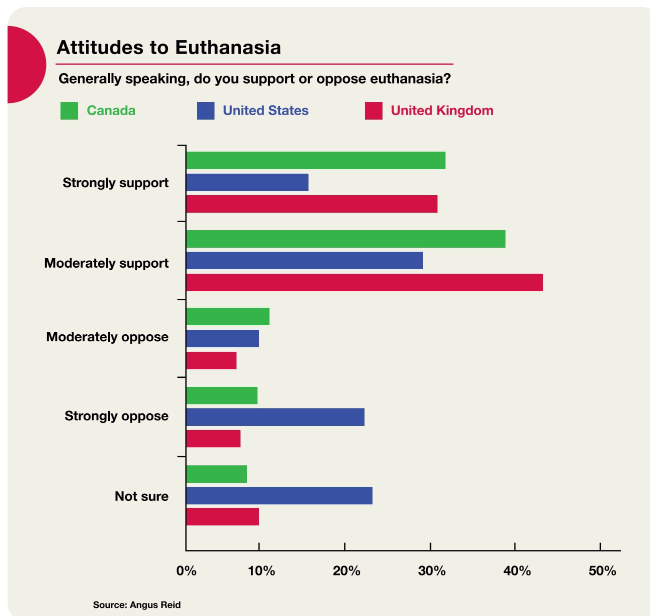
Given such predictable trends, a question increasingly being raised in governments and medical policy groups is whether we should continue to put in all these resources and effort, in many cases only to delay the inevitable by a few months. In a US future of health workshop, the question was asked: 'When will the US adopt the Do Not Resuscitate policy used by the National Health Service in the UK?' A DNR order on a patient's file means that a doctor is not required to resuscitate a patient if his or her heart stops and is designed to prevent unnecessary suffering. This is used when a patient is in hospital and



When will the US adopt the Do Not Resuscitate policy used by the National Health Service in the UK?

the benefits of treatment are seen to be outweighed by the burdens of future quality of life. Some regard this as a form of passive euthanasia. At the workshop it was argued that 'if the US were to adopt the same policy, the savings to the healthcare budget would be enormous and unnecessary suffering of patients who had little hope of long-term recovery would be avoided'. However, this is just one step and others are proposing even more significant changes.

Over the past few years, euthanasia and physician-assisted suicide for the terminally ill have become prominent medical and social issues. There are legal and ethical constraints on euthanasia in many countries, but not in all. Physician-assisted suicide and euthanasia are legal in, for example, Colombia, Belgium and the Netherlands (in 1990, 9% of all deaths in the Netherlands were as a result of physician-assisted suicide or euthanasia). However, in most countries, despite a number of legal challenges, assisted suicide for the terminally ill remains illegal – albeit rarely prosecuted. Acceptance of the concept is not widespread and some workshops, most noticeably in South Africa, rejected the concept for religious reasons. Nevertheless, recent attention in the Western press has specifically been focused on the growing popularity of clinics such as those run by Dignitas and EXIT in Switzerland. Since its foundation in 1998, Dignitas has assisted around 1,000 people to die, 60% of them from Germany and 10% from the UK.

In markets such as the US, where the healthcare system is largely focused on keeping people alive for as long as possible, assisted suicide and DNR are highly controversial topics. Even with increasingly public debate, such as the plea from author Terry Pratchett, who has called for tribunals to give sufferers from incurable diseases the right to medical help to end their lives, wider acceptance of euthanasia is still in the minority. But it is growing.

In ten years, many think that more and more people will start to see that life doesn't need to go on for ever, especially since the option to live for longer in reasonable comfort is really only a luxury for wealthier nations where the healthcare systems, insurance policies and private wealth enable increased levels of support. The argument is that systemic euthanasia

should be introduced. Moreover, this should not be limited just to those who have a proven terminal illness but should be an option available to all.

With the economic burdens evident and the trends clear, the rational side of the case is increasingly accepted, but in many influential circles the ethical, emotional and political perspectives are also shifting. Some see that opening the door for euthanasia beyond those with terminal illness is a slippery slope leading to a point where individuals who would not otherwise consider it may be pressurised into asking for assisted suicide by interested parties; others see that the option to proactively check out of life when enough is enough is a sign of a more balanced society. No doubt the debate will continue, and pick up pace as more countries make assisted suicide legal, and, for those that don't, the numbers travelling across borders for the service may well increase.

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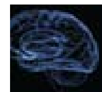
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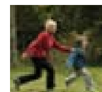
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