

The origins of “Legal physician-assisted dying in Oregon and the Netherlands: Evidence concerning the impact on patients in ‘vulnerable’ groups”

Authors of study: Margaret P. Battin, Agnes van der Heide, Linda Ganzini, Gerrit van der Wal, Bregje D. Onwuteaka-Philipsen, *Journal of Medical Ethics* 2007;33:591-597

Claims about the slippery slope (1994-2005)

- “... no matter how carefully any guidelines are framed, assisted suicide and euthanasia will be practiced through the prism of social inequality and bias that characterizes the delivery of services in all segments of our society, including health care. The practices will pose the greatest risks to those who are poor, elderly, members of a minority group, or without access to good medical care.”

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- “... the State has an interest in protecting vulnerable groups—including the poor, the elderly, and disabled persons—from abuse, neglect, and mistakes. The Court of Appeals [Ninth Circuit] dismissed the State’s concern that disadvantaged persons might be pressured into physician assisted suicide as ludicrous on its face....We have recognized, however, the real risk of subtle coercion and undue influence in end of life situations ...”
- US Supreme Court, joint opinion in *Washington v Glucksberg* (1997) and *Vacco v Quill* (1997)

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- “Both society in general and the medical profession in particular have important duties to safeguard the value of human life. This duty applies especially to the most vulnerable members of society—the sick, the elderly, the poor, ethnic minorities, and other vulnerable persons. In the long run, such persons might come to be further discounted by society, or even to view themselves as unproductive and burdensome, and on that basis, “appropriate” candidates for assistance with suicide.”
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- “In the BMA’s view, legalizing euthanasia or physician-assisted suicide would have a profound and detrimental effect on the doctor– patient relationship. It would be unacceptable to put vulnerable people in the position of feeling they had to consider precipitating the end of their lives...The BMA acknowledges that there are some patients for whom palliative care will not meet their needs and wishes, but considers that the risks of significant harm to a large number of people are too great to accommodate the needs of very few.”

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Evidence of heightened risk in physician-assisted dying in Oregon and the Netherlands? Groups examined:

- *Findings based on robust data*
 - The elderly
 - Women
 - Uninsured people
 - People with AIDS
- *Partly direct, partly inferential data*
 - People with low educational status
 - The poor: people with low socioeconomic status
 - Racial and ethnic minorities
 - People with chronic physical or mental disabilities or chronic non-terminal illnesses
 - Minors
- *Inferential or partly contested data*
 - People with psychiatric illness, including depression and Alzheimer disease

The results: **No evidence of heightened risk in any groups except**

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Group with heightened risk

(most data from years before development of highly active antiretroviral drugs)

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Conclusion of the study:

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New Assisted Suicide Study No More Than Pro-Euthanasia Propaganda

Alex Schadenberg, September 28, 2007

- “No effective conclusions concerning whether or not a ‘slippery slope’ exists can be ascertained by studying the annual reports from the Oregon Department of Human Services because these reports do not include information that would allow the study to get into the actual decision making bias of a person. These reports are compiled from the information from reports sent in from physicians who prescribed the assisted suicide concoction. It is unlikely that a person prescribing assisted suicide would self-report information that may be considered outside of the law.”

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- The reality is that it is difficult to prove a slippery slope does not exist through information that is devised to support a social regime of assisted suicide or euthanasia. ... The reality is that a significant level of social bias exists within our culture that views certain types of disability and physical conditions as connected to intolerable suffering. Many people have accepted this social bias as normal and thus when they experience certain diseases or types of disabilities they consider their lives as not worth living. Within a structure of social bias, it is impossible to determine the slippery slope without analyzing the personal and relation attitudes that lead to a decision of assisted suicide.

Our reply to a similar critique, from I.G. Finlay and R. George

- ...we examined 10 groups variously identified here and in inequality studies generally as “vulnerable.” We explicitly refrained from assuming that people in these groups are actually vulnerable and that people not in these groups are not, and we did not assert that issues about vulnerability could not be examined in other ways—as Finlay and George have undertaken to do.
- We certainly do not claim that people not in the 10 groups identified as vulnerable might not seek physician assistance in dying for the “wrong” reasons—disturbed emotional states, reactions to loss, personality types, and other factors Finlay and George mention. That is not the focus of our paper. Finlay and George provide as it were a supplemental look at the same issue, but with an entirely different focus. However, our paper does indirectly address some of their concerns. Not only do we examine rates of assisted dying in depression (rates of depression are elevated in people seeking assistance in dying, but may not be elevated in people receiving it), but in conditions like physical disability, stigmatized illnesses such as AIDS, chronic nonterminal illness, and psychiatric illness (all conditions in which physician-assisted suicide and euthanasia may be legal in the Netherlands). All may all be associated with distressed emotional states and loss, but, with the exception of AIDS (largely prior, it can be noted, to the development of highly active antiretroviral therapy), in none of these conditions are rates of assisted dying elevated.

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*Suggestion for another research
project?*

from

DRAFT STATEMENT FOR THE AMERICAN ASSOCIATION OF SUICIDOLOGY
THAT SUICIDE IS NOT THE SAME AS PHYSICIAN-ASSISTED “SUICIDE” OR
MEDICAL AID-IN-DYING

• (approved August 2017)

• Physician aid in dying (PAD) is called by a number of different names, including “physician-assisted suicide” (PAS), “physician-assisted dying” (PAD), “Death with Dignity” (DwD), “medical aid in dying” (MAiD) and more, all of which are used in the medical and sociological literature.

• The American Association of Suicidology (AAS) recognizes that the practice of physician aid in dying is distinct from the behavior that has been traditionally and ordinarily described as “suicide,” the tragic event our organization works so hard to prevent. This recognition does not assume that there cannot be “overlap” cases, but only that the two practices can in principle be conceptually distinguished.

Point of difference between “suicide” and physician aid-in-dying (PAD) (#1 of 15)

- Under US law, the patient requesting aid in dying must be diagnosed by two independent physicians as terminally ill, defined as death expected within six months. In suicide, a life that could have continued indefinitely is cut short. PAD is not a matter of life or death; it is a matter of a foreseeable death occurring a little sooner but in an easier way, in accord with the patient’s wishes and values, vs. death later in a potentially more painful and protracted manner.

Point of difference between “suicide” and physician aid-in-dying (PAD)

- The term “suicide” may seem to imply “self-destruction,” and the act may be cast that way in some cultural and religious traditions. Ending one’s life with the assistance of a physician and with the understanding of one’s family is often viewed more as “self-preservation” than “self-destruction,” acting to die while one still retains a sense of self and personal dignity, before sedation for pain or the disease itself takes away the possibility of meaningful interaction with those around one.

Point of difference between “suicide” and physician aid-in-dying (PAD)

The conventionally suicidal person may be unable to assess his or her situation clearly or objectively; the person considering PAD is typically able to balance the choice of an earlier death against the loss of control and increased medicalization they may experience as they enter the end-stages of a terminal illness.

Point of difference between “suicide” and physician aid-in-dying (PAD)

- Research methods and findings that have frequently been used in the attempt to decrease the incidence of suicide as traditionally defined do not apply well to PAD. For example, risk factors considered significant in some strategies of suicide prevention, like childhood trauma, addiction, recent divorce, access to firearms, or other factors that may contribute to emotional pain or capability of suicide, do not typically apply to those choosing PAD. Attention to “warning signs” is not relevant; PAD deaths that meet the legal criteria are typically planned in consultation with a physician and within a family that knows what to expect.

The possibility of “overlap” between
suicide and medical aid-in-dying

For further research?

- The finding that physician aid in dying is not suicide does not mean that some requests for PAD by people with terminal illnesses could not be closer to conventional suicides in character. All US statutes require that if either of the two independent physicians suspect that that depression or other mental illness is playing a distorting role in the decision, a psychological or psychiatric consult is to be called. Where factors compromising the capacity for decision-making are found, such cases are to be screened out from access to PAD. In these cases, traditional suicide prevention services and treatment for depression may well play a role.

For further research?

- Nor does the fact that suicide and PAD are not the same indicate that some cases identified as suicides may not be deaths that have a great deal in common with PAD. especially those in which poor health is a precipitating factor. Although such cases are typically labeled 'suicide' if the person initiated the causal process leading to death, medical conditions associated with suicide risk in potentially terminal illness—including (among the best studied) cancer, cardiovascular disease, COPD, Huntington's, HIV/AIDS, multiple sclerosis, ALS, Parkinson's, renal disease, and Alzheimer's—may arise from the motivation to avoid a protracted, debilitating, and potentially painful bad death. While many forms of end-of-life care may be helpful, a patient's choice of PAD that satisfies legal criteria is not an appropriate target for prevention.

In conclusion:

- “Vulnerability” goes both ways.
 - Will some people be pushed into PAD? (no evidence for this)
 - Will some people be pushed away from PAD when they might want it by “suicide prevention” and other social pressures?

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the interesting question:

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 - Will some people be pushed away from PAD when they might want it by “suicide prevention” and other social pressures?