Testimony of Douglas W Heinrichs M.D.
Support for SB 845 and HB 933
In support of the End-of-Life Option Act

I am Dr. Doug Heinrichs, a psychiatrist who has been practicing in Maryland for over 40 years. I am a member of the Maryland Psychiatric Society (MPS) legislative committee, but I am here as a private individual, not representing the MPS. I strongly support this bill and wish to make three points from the perspective of a psychiatrist.

First, a recent poll of the MPS membership showed 57% support medical aid in dying or MAID for the terminally ill, in keeping with polls of psychiatrists nationally and US physicians in general. The official opposition of the MPS is out of step with its membership.

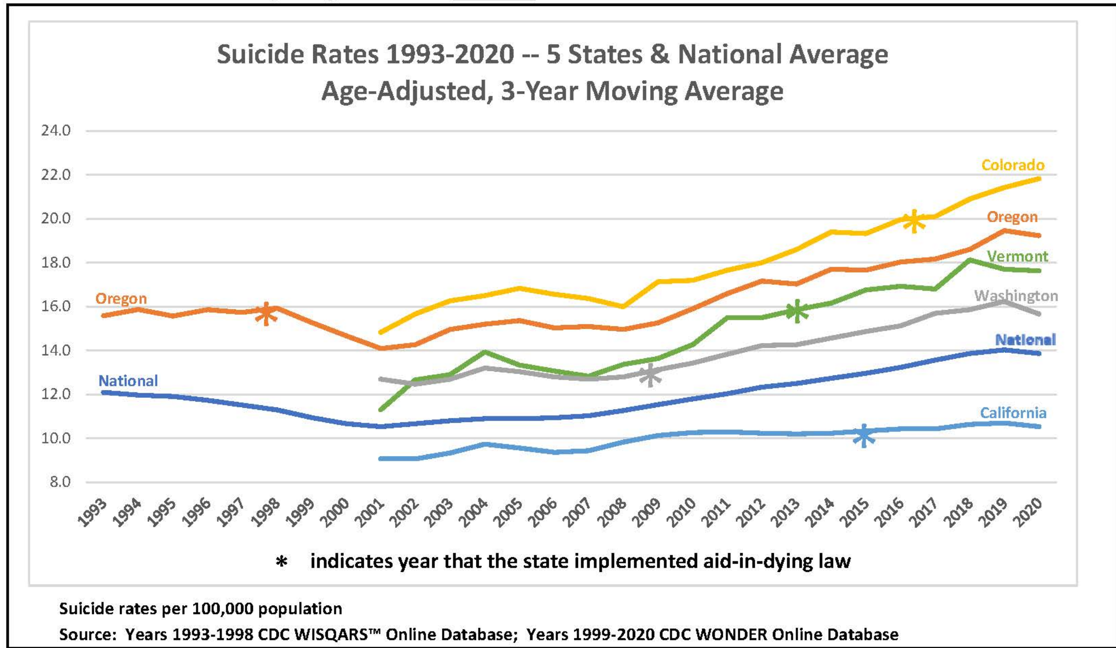
Second, the objection that there should be a mandatory psychiatric evaluation of anyone seeking MAID is unreasonable. The University of California San Francisco chose to require such an evaluation for everyone in its system. A five year review recommended the policy be dropped because "… zero patients in our sample were found to lack capacity due to having a current psychiatric condition that impaired decision-making." (Bell BK, *et al*. 2022) Data from Oregon and Washington State also argue against the need

for such a requirement. (Ganzini L, 2014) Furthermore, requiring such a mandatory assessment when mental health resources are so severely stretched is counterproductive, and the inevitable delay would be an extreme burden for those seeking to use this option.

Third, the objection that allowing MAID would lead to increases in copycat suicides is not supported by data from states where it is available. No changes in the pattern of suicide rates are seen that correspond to the introduction of medical aid in dying legislation. (CDC WISQARS Online Database) This should be no surprise. Suicides involve people who want to end their life. People seeking MAID would love to keep living. It is their disease that is determining that they will be dying imminently. They are only seeking control over how they die, to minimize the distress for themselves and their loved ones.

[I am attaching data on longitudinal patterns of suicide before and after the introduction of MAID in 5 states and three recent articles that I have written for the Psychiatric Times that address these and related issues from a psychiatric perspective in more detail. (https://www.psychiatrictimes.com/view/the-case-for-medical-aid-in-dying-part-1; https://www.psychiatrictimes.com/view/the-case-for-medical-aid-in-dying-part-2; https://www.psychiatrictimes.com/view/the-case-for-medical-aid-in-dying-part-3.)]

Aid in Dying Does NOT Increase the Suicide Rate



Suicide rates per 100,000 population

Source: Years 1993-1998 CDC WISQARS™ Online Database; Years 1999-2020 CDC WONDER Online Database

The Case for Medical Aid in Dying: Part 1

Aug 23, 2022

Douglas W. Heinrichs, MD

As more states consider legislation permitting medical aid in dying (MAID), the controversy around this practice within our profession continues to swirl. Articles in opposition have appeared frequently in this publication.[1-14] As someone in support of MAID as a reasonable and merciful option for some patients, I have struggled to make sense of the basis for opposition.

In this culture, which highly values individual freedom, we generally hold that persons should be free to choose how they want to live their lives, unless they violate the rights of others. Choosing how to die in the face of a terminal illness is certainly an important life choice—one increasingly supported by the majority of our citizens.[15] Thus, the burden is on opponents to show why this option should be prohibited.

Arguments are of 2 general types: arguments from fundamental principles held categorically by opponents, and arguments that undesirable practical consequences are likely to follow—or have followed—MAID implementation. In this and 2 subsequent articles, I will challenge these arguments as unconvincing. Here I examine arguments from fundamental principles. In subsequent articles, I will consider arguments based on consequentialist concerns.

The Primary Principles of the Opposition

Two primary principles are involved: (P1) It is categorically wrong to take one's own life under any circumstances, and (P2) it is categorically wrong for a physician to help anyone take their own life.[10] Such allegedly self-evident first principles typically derive from religious or other transcendent beliefs, cultural traditions, or appeals to the universal dictates of reason in the spirit of Immanuel Kant. The last is suspect, as rational individuals clearly do not come to the same conclusions about what reason dictates. Transcendent beliefs are only compelling to those who accept that religious or metaphysical system. Even respected traditions may become less relevant or rejected as circumstances and other cultural values change. In short, appealing to principles does not in itself clinch the argument.

For (P1), there is typically an appeal to transcendent beliefs, directly or indirectly religious, hence there is not much room for logical arguments that might persuade someone who operates from different premises. Weekly churchgoers are the only group where the majority do not support MAID.[15] The question is whether one's personal ethical intuitions, religiously derived or not, should be imposed on everyone else. Our cultural tradition and legal system have generally said no to that.

The Hippocratic Oath

The argument that MAID intrinsically does violence to the physician's role (P2) appears to have 2 components. The first is that it violates the Hippocratic Oath and the tradition surrounding it, with its commitment to respect the value of life.[3,5] In its original form, the Hippocratic Oath explicitly forbids the administration of lethal medicine for the purpose of killing the patient. It should also be noted that the original Hippocratic Oath involves swearing in front of Apollo as well as the promise to take care of our teachers and their children as if they were our own.

Traditions are not fixed in time but evolve as the needs and values of society changes. Due to its many anachronisms, the oath has largely been replaced in medical schools around the country by alternative oaths thought to better reflect modern realities and values. It is noteworthy that in a content analysis of medical school oaths administered in 2000, only 6 of the 122 allopathic medical schools surveyed had oaths that contained a stipulation against MAID or euthanasia.[16] We still embrace our commitment as physicians for the valuing of life. But should this reflect the quality or the quantity of life? For many of us, respecting the life of the patient has as much or more to do with supporting their dignity, autonomy, and relief of suffering as it does with simply maximizing the number of days they keep breathing.

One of the developments over time that has changed the balance, certainly from the time of Hippocrates, is that we have largely eliminated bacterial aid in dying (BAID). I think it can be argued that with the discovery and development of antibiotics—overall a tremendously wonderful thing—there has come 1 harmful and unintended consequence: The frequency and duration for which individuals had to face protracted deterioration with extensive suffering and dignity-reducing loss of function before dying was greatly lower in pre-antibiotic times. Patients with such conditions would typically rather quickly contract life-ending infections, such as pneumonia. Having curtailed nature's most common way of alleviating such suffering, I would suggest the least we can do is to provide some merciful alternative.

The Valuable Role of Physicians

A second component of this argument put forward by opponents of MAID is that if an individual wants to die, why involve the physician?[10] This strikes me as a profoundly insensitive attitude. If any of you, like me, has had and loved multiple pets, you have undoubtedly had the difficult experience of being present as one was euthanized by a veterinarian. Beyond the unavoidable sadness of losing a beloved member of the family, I have always found this a peaceful and comforting process made possible by the supportive presence of the veterinarian who cared for my animal over many years, or if that is not possible, by another caring veterinarian. How should I have felt if the veterinarian had said, "As a doctor to animals, I am here to preserve and value their lives, not to end them. Besides, you can do this yourself or ask someone else to help you. If you do not have a gun, a sledgehammer will work"? I would argue that we have a valuable role to play, as physicians, in providing not simply technical assistance but emotional support and understanding to patients if they have reached the difficult decision to end their life.

The example of the veterinarian raises an interesting question. I have never heard anyone say that a veterinarian is violating their professional integrity by euthanizing their patients—rather, it is looked upon as a kind and humane option. It seems to me that the burden is on those who oppose MAID to demonstrate why we should be less kind and humane to our fellow humans than we are to the nonhuman members of our families. It seems to me that once one removes any theological or metaphysical beliefs that humans are categorically different by virtue of our soul or some special plan God has for us, the basic principles of kindness in the face of suffering should apply to humans as well. Besides, humans—unlike our beloved pets—can tell us what they want.

Opponents to MAID argue that it is a whimsical jettisoning of a 2500-year tradition of how physicians should act based on a brief contemporary moment in which autonomy is excessively valued over the other cornerstones of medical ethics—beneficence, non-malfeasance, and justice—as an expression of a consumer-based culture in which physicians have become mere providers.[1,11] Although I agree that long-standing traditions should not be abandoned thoughtlessly, there are times when the tradition needs to be modified in light of changes in conditions or the evolution of other values in society. Slavery is a tradition with a much longer history and more universal acceptance than the Hippocratic tradition, and it is only relatively recently that modern societies have rejected it—yet I doubt any of us would argue that the

rejection was unwarranted. Aspects of a tradition need to be judged on their own merits after careful consideration as to whether we should continue, modify, or abandon them.

In the same spirit, opponents of MAID accuse supporters of simply following public opinion based on polls showing that the majority of the public support MAID, as if they engage in less thoughtful ethical reflection than opponents.6 It is true that no one, including physicians, should blindly or reflexively change their position based on the latest poll. However, when our own guild becomes seriously out of step with the values of the larger culture, it may be time for a serious self-examination as to whether we have become ossified and out of touch.

"Noble" Deaths

Opponents of MAID frequently cite in heroic terms cases of individuals bravely facing their gradual deterioration and death, and even fighting it until the end, with courage and dignity.[7,8] And it is certainly fine for individuals to do so, if that is how they choose to end their life. However, there is the implication that this is a nobler way to die than MAID. I see no reason why an individual cannot approach MAID with courage and dignity as well. Just as there is more than one good way to live, there is more than one good way to die.

The flip side of this rhetorical maneuver is to describe the empathic and spiritually edifying experience for the doctor and loved ones of being there and sharing the dying experience with the patient. I suspect that this experience is often more satisfying for the participants other than the suffering patient. Furthermore, it has been a long time since physicians typically spent much time at the deathbed communing with the dying person. That role, if it occurs at all, has long since been abdicated to other health care professionals. But most basically, I see no reason why the same empathy and caring cannot be provided in the context of MAID as well as, if not better than, with a protracted unaided death.

Physician-Assisted Suicide

Opponents of MAID prefer the label of physician-assisted suicide (PAS). Although I think MAID is a less emotionally biasing term, I do not see this as an important argument. What I do think is important is their stress that there should be no fundamental distinction between this practice and any other kind of suicide.[15] Killing oneself is killing oneself. They then go on to argue that MAID should not be allowed because of the devastating effects that suicide

has on surviving family, citing either anecdotes or data supporting this.[13] But there is little reason to think that reactions to an unexpected self-inflicted death by a troubled individual would resemble reactions to a planned death in the context of MAID, whether we call that suicide or not. I believe there is quite a difference in these 2 kinds of suicide. If I am taking a family history of a depressed patient and the patient tells me that their parents committed suicide in midlife while depressed, it has very different implications than if the patient tells me that their parents with terminal illnesses chose to end their lives rather than continue to suffer.

Voluntary Stopping of Eating and Drinking

Opponents of MAID insist on making a fundamental distinction where I believe there is none—namely between electing MAID or hastening one's death by other means, such as refusing further treatment or the voluntary stopping of eating and drinking (VSED).[6,7] The latter is viewed as a totally acceptable and even admirable removal of the impediments to death, while the former is ethically wrong. Frankly, this seems like a hairsplitting distinction based on a bit of medieval casuistry. If VSED is acceptable because it is simply refusing essential nutrients rather than actively consuming a lethal substance, I would assume that opponents of MAID have no problem with a person sealing themselves in a small, airtight box and dying of suffocation. After all, they are simply depriving themselves of oxygen rather than actively consuming a lethal substance. I would argue that this is a distinction with no ethical or moral importance—a difference of means, not of ends. If there is no difference between MAID and any other suicide, is there a difference between VSED in the context of a terminal illness and dying from severe anorexia nervosa? Starving to death is starving to death. Whether or not this distinction exists or is significant has important implications for many of the consequentialist arguments that will be addressed in subsequent articles.

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The opinions expressed are those of the author and do not necessarily reflect the opinions of Psychiatric Times™.

What are your thoughts on MAID? Share your questions, concerns, and potential solutions via PTEditor@mmhgroup.com.

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The Case for Medical Aid in Dying: Part 2

Aug 30, 2022

Douglas W. Heinrichs, MD

In part 1 of this series,[1] I argued that in our society, in valuing an individual's right to choose how to live their life unless violating the rights of others, the onus is on opponents of medical aid in dying (MAID) to demonstrate why individuals with terminal illness should be deprived of the option of asking a physician to provide a means to end their life.

I considered arguments derived from fundamental principles held by opponents and maintained that they were not compelling. But opponents further argue that MAID should be rejected because of unacceptable consequences that may follow it. We are moving from arguments based on principles and ethical rules (deontological) to ones based on effects (utilitarian). The question is whether undesirable consequences are likely to be of such a magnitude and/or beyond remediation that they outweigh the positive impact of MAID. Such arguments are of 3 types: 1) safeguards to protect the individual from abuse and misuse of MAID will be inadequate, 2) MAID will undermine other important public policy priorities, and 3) permitting MAID puts us on a slippery slope that will inevitably lead to other unacceptable practices. I will consider the first 2 here and the last in the final article of this series.

Safeguards

Some safeguards are certainly important. Individuals choosing MAID should be competent and not subject to excessive external pressure by those who might benefit from their death. They should understand that the prognosis as to how long they have to live is a fallible medical judgment. They should be aware of other available treatments that they have not yet tried that may alter their life expectancy or quality of life. Palliative care options should be discussed. If there is concern that their judgment is impaired by

an episode of psychiatric illness, a psychiatric assessment may be indicated. Such safeguards already apply in other situations in which individuals make important decisions about the closing phase of their life—for example, advanced directives and living wills, do not resuscitate orders, naming medical power of attorney, stopping life-sustaining treatments, voluntarily stopping eating and drinking (VSED) to hastens one's death, and making a will. Although at times abuses undoubtedly occur in these situations, we generally feel that our existing safeguards are adequate to minimize such instances.

Opponents of MAID, however, argue that this level of safeguard is woefully inadequate.[2,3] For instance, they cite the relatively small percentage of cases applying for MAID that get psychiatric evaluations.[2] But what portion of patients get psychiatric assessments before we honor their living wills, advanced directives, decisions to end life-sustaining treatment, or to opt for VSED? Opponents argue that there are insufficient protections against other interested parties encouraging an individual to seek MAID. But those same interested parties could also encourage an individual to terminate life-sustaining treatment or to engage in VSED. Opponents point out that individuals often seek MAID not because they are in excruciating pain, but because they want to avoid future suffering and/or deterioration that they feel deprives them of dignity.[4] But the same motives can lie behind the decision to stop treatment or engage in VSED, and we do not generally view them as inappropriate. Opponents have gone so far as to argue that an individual seeking MAID may be subtly influenced by their own inner fantasies and fears about death, and thus cannot exercise true autonomy in making the decision. Such unconscious factors require not a basic competency assessment, but detailed psychiatric exploration.[5] Are opponents arguing for the universal need for psychoanalysis before electing MAID?And besides, unconscious fantasies and fears are as likely to make one fight death to the bitter end as they are to make one opt for MAID.

I believe there is something disingenuous about these arguments. They set up a standard for safeguards that could not ever be achieved in practice, and at the same time, they do not apply this standard to other decisions that hasten death. In my experience, individuals making these arguments also oppose MAID based on their fundamental ethical principles, as discussed in part 1 of this series. Is demanding impossible safeguards just a way to persuade those of us who do not share those fundamental principles?

Opponents argue that MAID is so fundamentally different that different standards for MAID are appropriate. Opponents stress that MAID is simply suicide—preferring the term physician assisted suicide (PAS)—and not fundamentally different from other suicides.[6] Furthermore, suicide is a subset of killing. Hence, it is appropriate to it treat it quite differently than other strategies to hasten death. I argue that whereas there are important practical and ethical differences between MAID and other forms of suicide, there is in fact little ethically relevant difference between MAID and other techniques that hasten death. I see making such a distinction as a bit of medieval casuistry.

Hastening one's death is hastening one's death—the same factors and risk for undue influence come into play in both cases. Should it not be the individual's choice?

This is not to say that every effort should not be made, both in formulating MAID legislation and fine-tuning it once it is enacted, to optimize safeguards that are effective as well as practical. But such safeguards will never be perfect. All laws about anything result in some instances in which the outcome is other than what the law intends. Any law could be attacked on these grounds. Should we never imprison anyone because sometimes an innocent person goes to jail? Should the police not be allowed to carry weapons since they sometimes do egregious things with them? Should no one get disability benefits because some people cheat and get them undeservingly? It seems to me the logical response is not to oppose every law that could be misused, but to work in an ongoing way to fine-tune regulations and controls to minimize the undesirable outcomes.

This is an evolving process over time, as it takes experience with any law to see which regulations work and which need improvement. But it could be argued that in the meantime, some individuals may experience significant harm. That is true, but it must be weighed against the individuals who will be harmed by having to endure protracted pain, suffering, or lack of dignity by not having the option of MAID in place. This weighing of benefit versus harm involves a quantitative judgment that is difficult to make with any precision before significant accumulated experience occurs. Just as in assessing the risks and benefits of a new treatment in medicine, we must be careful not to be unduly swayed by striking anecdotes on either side.

Models designed to project risk and harm can be useful to consider, but they are notoriously unreliable, given that they always involve a host of assumptions that are only approximately true in the real world. As fallible human beings, the best we are likely to do is to make reasonable attempts to provide sensible safeguards and be prepared to fine-tune over time as experience accumulates. This is the equivalent of post-marketing reports of adverse effects with a new therapeutic agent.

Undermining Public Policy Priorities

Opponents have further argued that allowing MAID could adversely impact several important public policy priorities. The concern has been raised that, once available, MAID will encourage a reduction in resources made available for palliative care and improved treatments for terminal illnesses, as well as research dollars in these areas.[3,6] It is unclear to me why this would be the case. It is unlikely that more than a small percentage of individuals with terminal illnesses will opt for MAID, and the need for better palliative care as well as definitive treatments of life-threatening illnesses will remain. There is always a battle between worthy medical projects for the limited funding available, but in comparative terms, MAID requires very little of the health care dollar and is unlikely to meaningfully reduce what is available for other purposes.

Another version of this argument is that if society made optimal palliative care available and affordable to all, there would be no need for MAID.[6] There are 2 points to be made here: (1) Even optimal palliative care cannot always prevent levels of suffering and/or loss of dignity that the individual patient may deem unacceptable to them, and (2) it is insensitive to the individual's unique predicament to say that because society should make better, affordable palliative care available but does not, the individual should be deprived of the option of MAID.

Consider the case of "Mr Smith," a man diagnosed with a terminal illness who is told that without treatment X, he is likely to die after considerable suffering in 3 to 6 months. With treatment X, he may live 1 to 2 years before succumbing to his illness. Treatment X is not covered by Mr Smith's insurance and will deplete the bulk of his modest savings on which he and his healthy spouse were counting for their retirement years. No one in his family is pressuring him on this issue, but he is not willing to leave his wife in such a financially precarious condition. I agree with those who feel it is a travesty that Mr Smith is faced with this dilemma in a society as affluent as ours, and I support the fight for more equitable and affordable health care for our citizens. But given his current reality, should Mr Smith be deprived of choosing to make this sacrifice to provide for the person he loves?

Another aspect of public policy is the concern that MAID legislation could put physicians in situations where they were compelled to play some role in it despite their ethical objections. It is important to note that no current or proposed MAID legislation requires physicians to participate in any capacity. Could they be pressured to do so by a public or private employer? It seems relatively straightforward to safeguard against this possibility, as is done in current legislation. Concerns have been also raised about indirect collaboration with MAID being required of a physician who objects on ethical grounds. For instance, hypothetically, if a psychiatrist is treating a patient who requests MAID, the psychiatrist may be asked to do a competency assessment of the patient. It seems clear that the psychiatrist could refuse to participate. In that case, however, another psychiatrist may be asked to do the evaluation, and that psychiatrist could, with the patient's permission, request treatment records from the first psychiatrist to aid his evaluation. There is a legal obligation to supply the records in such a case. Is the first psychiatrist being compelled to participate in a process they find morally objectionable?[4] I think this is a pseudo-dilemma. By law, medical records are the property of the patient held in our possession. They have a right to those records for whatever purpose they choose. It is not our place, as physicians, to judge the ethical acceptability of their purposes, and supplying records is not an endorsement of those purposes.

Concluding Thoughts

Could future MAID legislation, or court decisions interpreting such legislation, in some way compel physicians to participate in a practice they find ethically unacceptable? I think that is extraordinarily unlikely, but should that occur, that would be something worth fighting against. But because it cannot be guaranteed that such a thing could not

happen in the future, is that a basis for rejecting MAID as currently construed? To argue that it is constitutes an instance of one of the most pervasive species of argument employed by opponents of MAID: the slippery slope. Because this sort of argument is so important in this debate, it requires a careful consideration, which will be the focus of the final article in this series.

Dr Heinrichs *is a psychiatrist in Ellicott City, Maryland.*

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What are your thoughts on MAID? Share your questions, concerns, and potential solutions via PTEditor@mmhgroup.com.

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The Case for Medical Aid in Dying: Part 3

Sep 6, 2022

Douglas W. Heinrichs, MD

In parts 1 and 2 of this series,[1,2] I examined arguments by opponents of MAID based on beliefs that the practice is categorically wrong, followed by arguments asserting unacceptably harmful consequences that might follow MAID. In both cases, I maintained that these arguments are unpersuasive. In this final article, I will examine a type of argument that has played a prominent role in this debate: the slippery slope.[3-5]

The Slippery Slope

The basic form of the argument is that even if A is not so bad, if allowed, it will inexorably lead to B, which is even worse, then to C, which is worse still, and on to some catastrophic state of affairs. How should we look at these kinds of arguments? Bernard Williams, widely regarded as one of the most astute and nuanced ethicists and philosophers of the late 20th century, wrote an insightful article entitled "Which slopes are slippery?"[6] In it, he points out that there are 2 assumptions behind a slippery slope argument. The first is that what is at the bottom of the slope is something we all see as horrible, even if the first step may seem acceptable and even positive to at least some of us. He points out that frequently, the advocates of this sort of argument actually think the first step is wrong as well, but are not sure they can persuade others. If I think A is wrong but you do not, I may get you to agree to oppose A if I can convince you that it inevitably leads to B, then C, and so forth, until we reach some point that we all agree is wrong.

The second assumption is that the slide down the slope, once begun, is unstoppable. This sometimes involves the notion that the advocates for A will then advocate for B, then for C, and so on. But if we believe A and B are desirable, but C and D are not, is it not logical to support A and B but oppose C and D? The usual response here is that each step is so incremental and essentially indistinguishable from the immediately prior step that drawing a line at any point on the continuum is simply arbitrary and hence hard to defend. One could argue, for instance, that wherever one draws the line of

eligibility for MAID procedures, those just outside that line can understandably argue that it is unfair that they are being excluded. Why those with a prognosis limited to 6 months? Why not 7 months or 8 months? In cases of protracted suffering, why not extend MAID to those whose deaths are not imminent? If it is acceptable for age 18, why not 17, 16, and children? If MAID is legal, why not permit euthanasia for those who cannot self-administer a lethal drug? Surely the incompetent suffer as much as the competent, so why not allow a competent person to leave instructions to authorize euthanasia once they reach some future condition that they feel is unacceptable to them at a time they are no longer judged competent? And on and on.

Williams makes the point that this is not a valid type of argument, noting that "indistinguishable from is not a transitive relationship: from the fact that A is indistinguishable from B, and that B is indistinguishable from C, it does not follow that A is indistinguishable from C." Around most matters, even if it is difficult to draw a precise line between acceptable and unacceptable, it is likely that agreement can be had as to a large portion of the behaviors at issue that some are not acceptable and others are.

In matters of public policy, we nonetheless need to draw some explicit line in the sand between acceptable and unacceptable at a practical level. Williams argues that in such cases, it is a long-established societal practice to draw an arbitrary line as a reasonable and practical approximation to our sense of what is the conceptual breakpoint between acceptable and unacceptable. We draw arbitrary lines all the time, and these can be pragmatic solutions that work quite well even if we cannot logically defend why the line is drawn precisely where it is as opposed to somewhere else. Speed limits on roads are an example. If the speed limit is 55, we cannot logically defend that 54 is categorically safer than driving at 56. The age for consent to marriage, the age at which one may buy alcohol, the blood-alcohol level that defines intoxication, and the age at which we are deemed mature enough to vote are other examples. As a society, we are free to draw arbitrary demarcations in the continuum of behaviors when they have practical utility. We are not doomed to keep sliding down the slope.

Pushing the Agenda

But what about the concern that advocates of MAID do not want to stop at A? Their agenda is to push for more and more permissive laws expanding the pool of individuals who are eligible as well as easing access to the process. Opponents cite changes that have in fact occurred in other states and countries that have permitted MAID. It is indeed true that some advocates

believe in much broader applications than imminent terminal illnesses and/or support euthanasia as well. But just because there is a push in this direction does not automatically make it a bad thing. We must judge the merits of each step and decide whether we find it acceptable.

Frankly, I personally find a lot of the subsequent developments cited as if they are obviously horrific to be positive. I think it is totally reasonable to allow MAID for intractable suffering even in the absence of imminently terminal illness. It seems to me quite reasonable to allow a competent individual to state in advance that they wish to be euthanized once they reach a defined level of physical or mental deterioration, even if they are not judged competent at that later point. To me, one of the greatest tragedies of not allowing euthanasia in such circumstances is that an individual who has an illness that is likely to reach a point at which they are no longer physically and/or mentally capable of ending their own life must make and implement the decision to terminate their life while they are still able, when by their own standards some period of satisfying life remains. I am not suggesting that everyone should agree with me around each of these issues. I am only saying that the pressure to move to a next step is not automatically a bad thing. The case needs to be made for each new change as to whether it is desirable or undesirable. The fact that there is pressure to move in and of itself is morally neutral.

The metaphor gets in the way here. If we are on a slippery descending incline and we do not want to end up at the bottom, then any movement we feel is ominous. If it is slippery enough, the only safe thing to do is not get on the slope at all. I think a much more apt analogy in these kinds of situations is a hill rather than a slope. This is in keeping with the Aristotelian notion of the golden mean—namely that the desirable position, the point of virtue, is somewhere between 2 extremes, both of which are morally bad.[7] When an advocate of a position wants to continue moving in a particular direction, the question we need to answer is whether the advocate is pushing us uphill and closer to the optimal position, or downhill toward one of the extremes.

Consider the following slippery-slope argument: “It was a mistake to give women the right to vote. After all, once they had it, they were not satisfied. Advocates then were pushing for equal employment opportunities, equal pay, protection from on-the-job sexual harassment, and increasing numbers of women in management. Where will it end? Before you know it, they will want women’s salaries to be double that of men and all supervisors to be women. This is a slippery slope indeed, and it all started with giving them the right to vote.” I suspect very few of us would find this argument compelling, because most of us see women’s rights as still on the ascending slope of the hill and

further pressure to advance them as justified. Furthermore, I suspect we all feel that the movement could and would be stopped long before it reached the projected end of a woman-dominated society. Yet the logical structure of this argument is exactly the same as the ones made regarding MAID and its alleged slippery consequences. The mere fact that there has been pressure to move the line of what is permissible is not in and of itself ominous. We need to assess each proposed step on its own merits, and then decide whether to support it or argue to draw the line there.

The Disability Community

There is one instance of the slippery-slope argument that, because of its importance, merits specific comment. Spokespersons for the disability community have raised concerns that if MAID were extended to individuals based on pain, suffering, or dignity-depriving dysfunction, it could lead to a judgment that individuals with disabilities have lives not worth living and result in pressure for those individuals to request MAID.[6] This would seem a highly unlikely consequence of MAID legislation as currently conceived, even where it has been broadened to individuals without imminently terminal illnesses. Safeguards against undue influence on the individual choosing MAID by persons who stand to benefit from hastening the individual's death have been accepted as important for everyone, not just those with disabilities. Any future attempt to unduly pressure individuals with disabilities should be vigorously opposed by us all. But it is not a reason to reject MAID as currently construed.

Spokespersons for the disability community sometimes go further to argue that even if an individual with significant functional limitations freely opts for MAID, this is an afront to all disabled individuals because it is an assertion that living with significant functional impairments is not a life worth living. I think this is an unfair conclusion. When an individual chooses MAID, they are not making a judgment as to the worth of the lives of a group of people who happen to share their medical condition or limitations. They are not even saying that their particular life is in some abstract sense not worth living. Rather, they are saying that after considering and weighing all the unique components of their situation, they are deciding that they would prefer not to go on living.

Every significant decision we make should consider all the unique circumstances of our lives in light of our own values and preferences. Such a decision should not be seen as a judgment on the lives of others who happened to share some features with our lives, or on the decisions they choose to make in light of their unique circumstances. This is true of all our

important life decisions, such as whether to marry, whether to have children, whether to divorce, what career you choose, and where to live. We should not be condemned to having every one of our choices be viewed as a judgment we are passing on others.

Concluding Thoughts

In this series of articles, I have argued that the burden is on opponents of MAID to demonstrate why we should be deprived of this particular exercise of our freedom and autonomy. I have considered in turn what I view as the primary categories of these arguments. I believe they fail to make the case. These discussions have focused on MAID for terminal illnesses, and although I personally support broader applications in cases of intractable suffering or loss of dignity, that merits fuller discussion at another time.

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What are your thoughts on MAID? Share your questions, concerns, and potential solutions via PTEditor@mmhgroup.com.

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