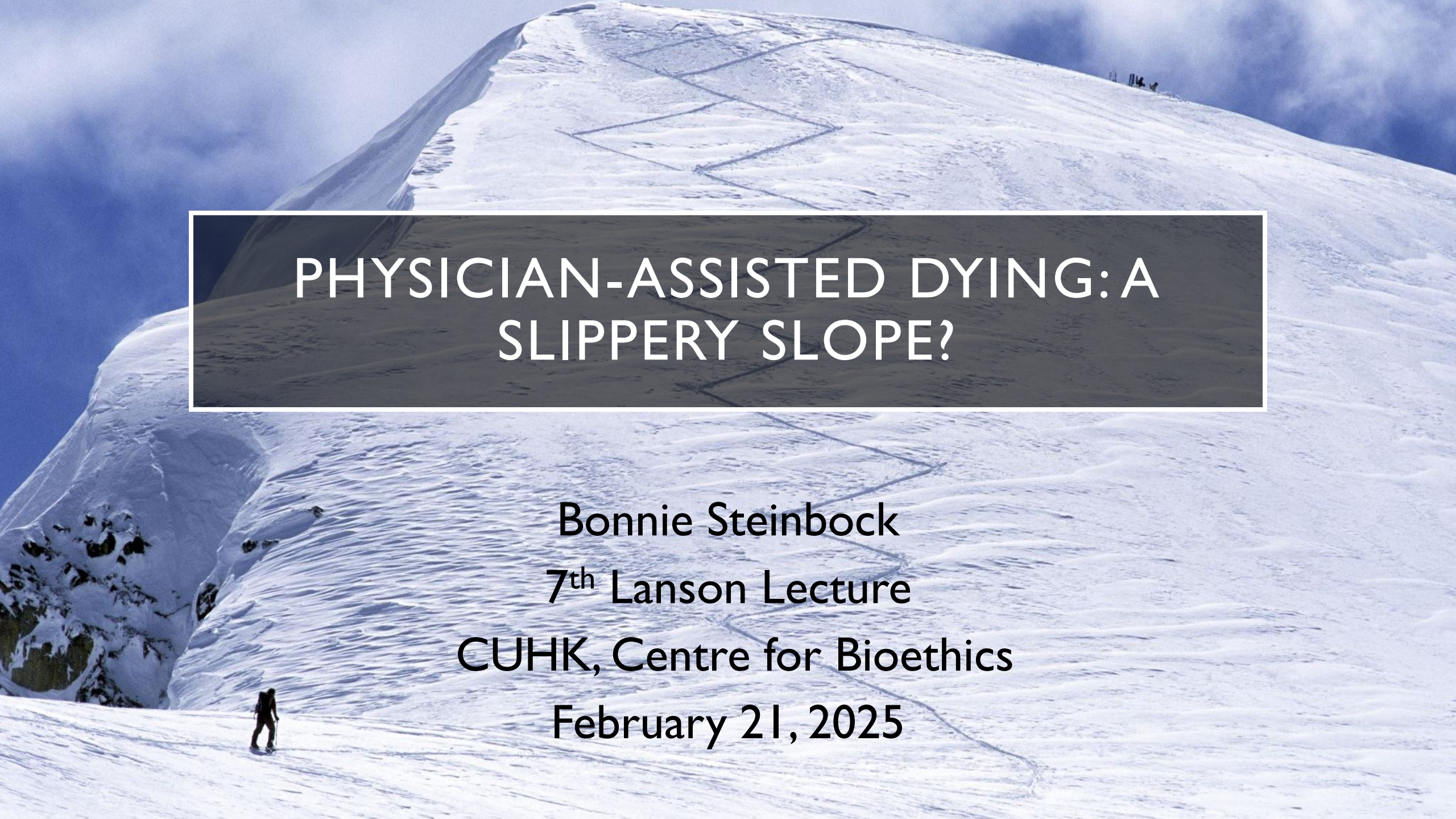

PHYSICIAN-ASSISTED DYING: A SLIPPERY SLOPE?

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7th Lanson Lecture

CUHK, Centre for Bioethics

February 21, 2025

INTRODUCTION

- PAD: a voluntary and intentional choice to receive medical assistance in causing or hastening dying
  - PAD, PAS, VAD, MAID, death with dignity
- Worldwide, legal in small, but growing number of countries
- In US, legal in 10 states and D.C.
- A controversial topic
  - Some opponents make arguments of principle.
  - A different objection: a slippery slope

AIMS OF TODAY'S TALK

- Explain and assess slippery slope arguments.
- Has MAID led to a slippery slope in Canada?
- Is psychiatric MAID an example of a slippery slope?

SLIPPERY SLOPE ARGUMENTS

- If we adopt a policy that seems justifiable, it will lead to policies that are unjustifiable.
  - For some, the slippery slope is inevitable, and a decisive reason not to accept the original policy.
  - For others, the original restrictions and safeguards must be retained to avoid a slippery slope.
- My view: slippery slopes can be prevented with appropriate safeguards, which need not be the original ones.

APPLIED TO PAD

- PAD originally created to allow terminally ill adults with decision-making capacity, whose intolerable suffering cannot be adequately controlled, to receive medical assistance in dying.
- But it hasn't stopped there. It's been expanded to allow PAD to those who:
  - Are not dying
  - Are no longer competent
  - Have no physical, but only mental illness
  - Suffer from anorexia nervosa

TWO KINDS OF SLIPPERY SLOPE ARGUMENTS

- Empirical
  - **Factual** prediction: unacceptable results likely
    - Attitudes about what is acceptable will gradually change.
  - Some empirical slippery slope arguments are purely speculative.
    - Very little weight
- Logical (a consistency argument)
  - Acceptance of original policy logically requires extending it in unacceptable ways.

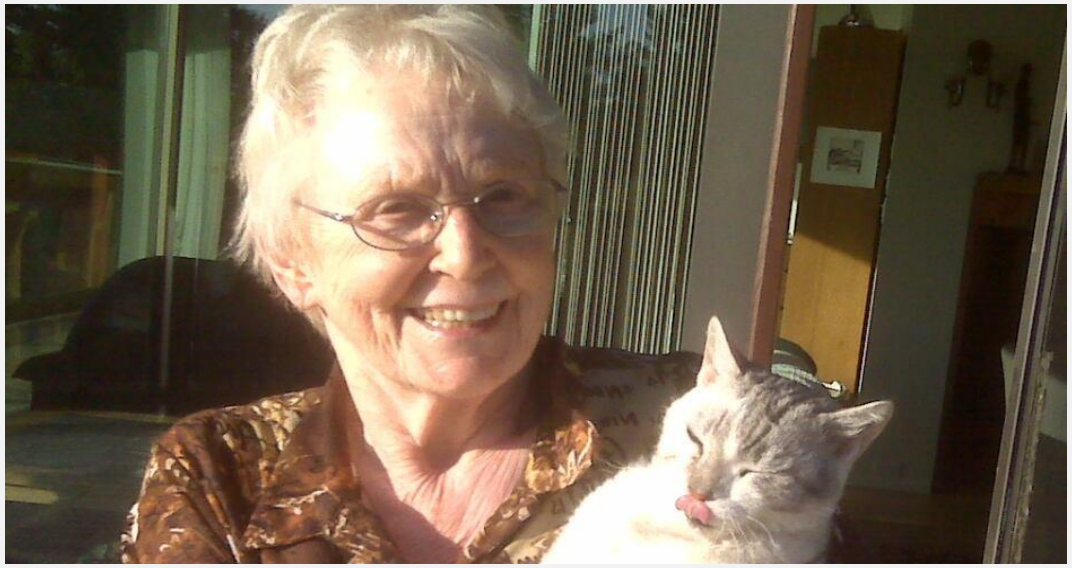
WHAT ASSUMPTION LIES BEHIND SLIPPERY SLOPE ARGUMENTS?

- That the outcome is unacceptable
  - The mere fact that the outcome differs from the original intention does not show that it's unacceptable.
- Scalia's argument for allowing states to retain sodomy statutes
  - If states can't make criminalize homosexual acts, what justification is there for mandating that marriage can only be between those of the opposite sex?
  - Response of gay rights advocates: Precisely!
- Logical slippery slope arguments must show there are morally relevant differences between original policy and expansions.

TWO ETHICAL ARGUMENTS FOR PAD

- Argument from suffering: cruel to force terminally ill or incurable patients, with decision-making capacity, to undergo unbearable, irremediable suffering.
- Argument from autonomy: adults should be able to make the most important decisions about how their lives go.
  - Ronald Dworkin: "Making someone die in a way that others approve, but he believes a horrifying contradiction of his life, is a devastating, odious form of tyranny."

GILLIAN BENNETT



"Every day I lose bits of myself, and it's obvious that I am heading toward the state that all dementia patients eventually get to: not knowing who I am and requiring full-time care. I know as I write these words that within six months, or nine months, or twelve months, I, Gillian, will no longer be here. What is to be done with my carcass? It will be physically alive, but there will be no one inside."

IS CANADA ON A SLIPPERY SLOPE?

- There are too many deaths.
- Euthanasia is allowed.
- MAID is allowed for those not yet at the end of their natural lives.
- Soon, psychiatric MAID will be available in Canada.

ARE THE NUMBERS TOO HIGH?

- By 2023, Canada had 15,300 deaths from MAID, more than any other country.
- In CA, PAD is less than 1% of all deaths; in Canada, with roughly same population, it's 5%.
- Whether this is evidence of a slippery slope depends on what the number should be.
- Maybe the number in the US is too low.

ALLOWING EUTHANASIA

- In most countries, patients can choose doctor-administered death (euthanasia) or self-administered death.
  - In the US, euthanasia illegal everywhere.
- Why the objection to euthanasia?
  - Linked with Nazism
  - Can be performed involuntarily
  - Doesn't allow patients to change their minds
- Each of these objections can be met.

PROBLEMS WITH SELF-ADMINISTRATION

- Makes the ability to swallow an eligibility condition
  - Arbitrary and irrational
  - If feeding tubes and anal catheters are "ingesting, any real difference from doctor-administered?
- Self-administration considerably more cumbersome
  - Swallowing thickened liquid takes practice.
  - Nausea can occur.
  - Giving meds by IV, simpler, faster, less likely to result in bad outcomes.
- Why not give patients an easier and more reliable option?

EXPANSION TO NON-TERMINAL ILLNESS

- In US, only patients with terminal illness eligible
- Canada never required terminal illness. Original law restricted MAID to those with a "reasonably foreseeable natural death" (RFND)
- Reasons against limiting PAD to those whose deaths are reasonably foreseeable:
  - As much (or more) suffering with incurable, progressive illnesses where death is not imminent or reasonably foreseeable
  - As much a violation of autonomy to force someone to go on living when that contradicts their deepest values (Gillian Bennett)

PSYCHIATRIC MAID (PM)

- Argument from suffering: Those who don't have a physical illness but have capacity and severe mental illness that causes unbearable and irremediable suffering, should be able to access PAD.
  - Patients with severe, treatment-resistant depression
- Illogical, even discriminatory, to deny PAD to those whose suffering is due to psychiatric illness.
- In Canada, MAID was supposed to be available to those with psychiatric illnesses as of March 17, 2024.
  - Implementation now delayed until March 17, 2027.

OBJECTIONS TO PM

- Psychiatrists accept that severe depression can cause unbearable suffering.
- Two doubts
  - Can severely depressed persons give genuinely voluntary consent to MAID?
  - Can a reliable prognosis of incurable disease be made for severe depression?

THE RIGHT OF COMPETENT ADULTS TO MAKE MEDICAL DECISIONS

- Fundamental tenet of contemporary medical ethics
  - Wasn't always the case; until mid-twentieth century medical paternalism held sway
  - Today, physicians may seek to persuade patients, but at the end of the day, the choice belongs to the patient.
- In the case of competent patients, autonomy trumps well-being.
- Raises a further question: how should decision-making capacity in patients with severe mental illness be determined?

WIDELY ACCEPTED FRAMEWORK FOR DECISION-MAKING CAPACITY

- Patients have decision-making capacity if they can:
  - Understand the information given to them
  - Appreciate that the information applies to their situation
  - Reason about the information to weigh options and to decide about treatment
- Patients with mild to moderate depression, and even some with severe depression, may have these capacities.
- Are cognitive capacities sufficient in the case of severe depression?

THE EFFECTS OF SEVERE DEPRESSION ON DECISION-MAKING

- Even when patients *understand* the information, their attitude toward it is skewed by their disease.
- To severely depressed, world appears bleak.
  - Cannot imagine that recovery or relief is possible
  - Cannot imagine a future in which they are not miserable
- Feelings of guilt and worthlessness common in severe depression
  - Many feel they deserve to suffer and die; that they have no right to exist
    - Red flag for distorted thinking, not carefully considered rational request for PAD

THE PROBLEM POSED BY SEVERELY DEPRESSED PATIENTS

- Jennifer Hawkins: "Not only is it a terrible thing to remove choice from someone who wants it and could exercise it appropriately, it is equally terrible to leave choice in the hands of someone who cannot exercise it appropriately."
- Focus on cognitive capacities alone unlikely to give enough weight to protecting patients who cannot exercise choice appropriately

THE RIGHT TO REFUSE TREATMENT AND A RIGHT TO PAD

- If persons with severe depression have the right to refuse treatment, shouldn't they also have the right to request and receive PAD?
- Two reasons why more restrictive capacity requirements for PAD than for treatment refusal are justified:
  - Only PAD requires participation of health care professionals.
    - If they're going to help people to die, it's reasonable that they regard the requests as voluntary and well-considered, not "the disease talking."
  - Forcing medical treatment violates that person's bodily integrity; disqualifying for PAD does not.

CAN PSYCHIATRISTS KNOW WHEN DEPRESSION IS REALLY TREATMENT-RESISTANT?

- Psychiatrists differ on:
  - How prevalent TRD is
  - The reliability of individual prognoses
- Is prognosis in psychiatry different from the rest of medicine?
  - Most serious physical illnesses have underlying etiology; not so for mental illness
  - "In the case of an individual patient, it remains extremely difficult to predict whether therapy will produce an early response, a delayed response or no response… These uncertainties are far more pronounced in psychiatric practice…, to the extent that it is essentially impossible to describe any psychiatric illness as incurable…"

THE PARADOX IN SEVERE DEPRESSION

- The more severe the depression, the greater the suffering imposed and therefore, the more justifiable the PAD request.
- At the same time, the more severe the depressive disorder, the greater the likelihood that decision-making capacity is impaired and the less justifiable it is to provide PAD.
- Likely to be very few patients with severe depression who are both competent to make decisions about ending their own lives, but who have no prospect for relief of their suffering.

THE FRAMEWORK FOR PAD

- If access to PAD is seen as a matter of justice, the numbers do not matter.
  - If even one patient with decision-making capacity is denied access, it's an intolerable injustice.
- A justice framework may not achieve the right balance between respecting autonomy and protecting vulnerable patients.
- Possible that viewing MAID as a fundamental human right is responsible for the rapid expansion
- The problem is the framework, not a slippery slope.

DIDN'T CANADA'S SUPREME COURT PROCLAIM MAID TO BE A FUNDAMENTAL RIGHT?

- *Carter v. Canada* (2015)
  - Supreme Court ruled that an absolute Criminal Code prohibition violated Canadian Charter of Rights and Freedoms; directed government to create an assisted dying scheme
  - Bill C-14 legalized MAID for adults with a serious disease, illness or disability, with an RFND, an irreversible decline of capability, and intolerable physical or psychological suffering.
- *Truchon v. Attorney General of Canada* (2019)
  - Restricting PAD to those with an RFND is unconstitutional.
    - Bill C-7 (2021) created 2 tracks: those with RFND, those without

DID THE GOVERNMENT HAVE TO DROP THE RFND IN LIGHT OF *TRUCHON*?

- Probably not
- *Truchon* was a trial court not binding on higher courts or outside Quebec.
  - Federal government could have appealed but decided not to.
- It remains unclear how expansive *Carter* requires MAID to be.
- *Carter* did not establish an unrestricted constitutional right to MAID
  - There can be reasonable restrictions

MANY MAID ADVOCATES IN CANADA DO REGARD IT AS A BASIC HUMAN RIGHT

- Dr. Ellen Wiebe: legal restrictions just mean we'll be back in court
  - Regards as irrelevant that severe depression can distort decision-making
  - Maintains that all that matters is whether the patient *understands* the information and the consequences of the decision
  - When asked if the MAID Assessors gave sufficient weight to his mother's depression in deeming her eligible, Dr. Wiebe replied, "Your mother had rights."

THE DIFFERENT APPROACH OF THE DUTCH

- PAD not framed as a fundamental right of patients
  - Rather, a way to resolve dilemma of conflicting duties of doctors: to prolong life and reduce suffering
- Dutch physicians play a greater role in determining suffering to be unbearable and irremediable.
  - In Canada, suffering ultimately seen as subjective and therefore only the patient can say when it's unbearable
  - Only the patient can decide when further treatment is unacceptable.
- Dutch regard PAD as the result of a joint decision between patient and doctor that there is no other reasonable solution.

REVISITING SLIPPERY SLOPE ARGUMENTS

- Weakness of the logical version is the *assumption* that departure from the original intent/restrictions must be unacceptable.
  - What's needed is an argument to show that the outcome is bad.
- Empirical version depends on strength of the evidence.
  - Some evidence that PAD is becoming normalized in Canada, which is worrisome.
- PAD should always be considered a last resort when there is no other reasonable way to prevent unbearable and unmitigable suffering, or to respect patients' autonomy and protect their fundamental values.