The slippery slope of assisted suicide

Proponents of physician-assisted suicide tell us that there is no danger of a slippery slope, that in Oregon the cases are “not that numerous” and are “carefully monitored.” I hope that reasonable people will question these claims and reflect further on whether a law with insufficient safeguards is what we want in the commonwealth.

Slippery slope arguments involve small decisions that lead to undesirable outcomes that never would have been supported at the outset. Often, it is impossible to prove that one small step will have significant negative effects, but common sense allows reasonable people to judge the likelihood that a sequence of events that have happened in one place are likely to happen in another place in a similar way.

Question 2 proposes to allow physician-assisted suicide for those diagnosed with a terminal illness with six months or less to live. Many groups are concerned that, if passed, it not only would be harmful in itself, but could lead to unintended tragic outcomes. (1) Elder advocates are concerned that it could become a new form of elder abuse. (2) Advocates for the disabled are concerned it could lead to “quality of life” standards in our society, where those with a lower perceived quality of life receive fewer benefits or protections. (3) Doctors and nurses are concerned it could lead to a lower “quality of care” for those at the end of life. (4) Doctors are also concerned that it could undermine the doctor-patient relationship. (5) Ethicists are concerned that it could lead to a devaluing of human life. (6) Suicide-prevention organizations are concerned that the state legally allowing suicide for one group (those with terminal diagnoses of fewer than six months to live) could lead to increased suicide rates for the rest of the population. (7) Those who have studied the evolution of this matter in the Netherlands are concerned that assisted suicide could lead, first to voluntary euthanasia (requesting direct help to end one’s life), and then to involuntary euthanasia (where those with a lower perceived quality of life become their executioners). (8) The Dutch patients’ organization, NPV, strongly criticizes the current application of the law, saying the practice of euthanasia has been extended to include patients with dementia and other conditions who may not, by definition, be competent to request help in dying, including children. Elise Van Hock-Burgerhart, a spokeswoman for NPV, told the New York Times reporter that the idea of mobile euthanasia teams was a matter of concern because there was no way for the mobile team doctors to get to know the patients. Moreover, she stated that research in the Netherlands indicated that requests for euthanasia from the elderly would be substantially reduced if palliative care were better in their country and that the country should be working toward improving palliative care, not increasing euthanasia. She also indicated that the law in the Netherlands required review committees to sign off on every reported case of euthanasia, but that 469 cases from 2010 had still not been reviewed; 2010 is the latest year for which data is available. That year 3,136 notifications of termination of life on request were reported, indicating that it was not clear how well doctors were adhering to the official guidelines. Anyone that believes that a “slippery slope” doesn’t exist with assisted suicide and euthanasia only has to look at its “evolution” in the Netherlands.

In the United States we are still a long way from the Dutch situation; however, this is not because the laws in the two states that allow PAS are well written or because of careful oversight. What has put the brakes on the growth of physician-assisted suicide in the U.S. is that more than 20 states have rejected proposed legislation and ballot initiatives.

Now it is our turn in Massachusetts to stop this bad idea and bad law from going into effect. Please join me to stop assisted suicide by voting “No on Question 2” on Election Day.