PHYSICIAN-ASSISTED DYING AND THE SLIPPERY SLOPE: THE CHALLENGE OF EMPIRICAL EVIDENCE

MARGARET P. BATTIN*

Direct physician-assisted dying, typically called physician-assisted suicide by opponents and aid in dying by proponents, is of increasing salience for at least two reasons: legal evolution and changing demographics. As of this writing, physician-assisted dying has been legal in Oregon for a decade. Known as Measure 16 at the ballot box, the Death with Dignity Act (ODDA, or, in Oregon, DWDA) passed in 1994 and came into effect in 1997.[1] Under the Act, it is legal for a physician to provide a lethal drug prescription to a terminally ill Oregon resident who voluntarily requests it, if that resident is a legally competent adult.

Non-physician assisted suicide, under specific conditions, is legal in Switzerland, and

---

* D un0Uguishd sProfessor of Philosophyand

Box 1: *The Argument Concerning Physician-Assisted Dying*

The argument for physician-assisted dying	*The argument against physician-assisted dying*
Autonomy	Wrongness of killing
Mercy	Possibility of abuse

The two principal arguments asserted by proponents of assisted dying are phrased in terms of autonomy and mercy.[14] Proponents argue that these ethical principles must govern the very end of life. Under the principle of autonomy or self-determination, people are entitled to be the architects of the very end of their lives; this liberty-right includes dying in a way that is in accord with one's own values and interests—provided, of course, that the harm principle is satisfied and that this does not constitute a serious harm to others.[15] In addition, any indirect expression of preferences that a presently incompetent person had made prior to incapacity are also to be honored under the principle of autonomy—here, advance directives or surrogate decision-makers may be brought into play.[16] Yet the principle of autonomy itself is clear enough: a person is entitled to decide, as far as possible, how the end of his or her life shall go, provided it does not harm others, and provided he or she has the capacity to do so.

The principle of mercy is typically less clearly phrased, but plays an equally important role. It holds that pain and suffering are to be

---

[14] For further elucidation of the discussion in this section, see generally Margaret P. Battin, *Euthanasia*, *in* HEALTH CARE ETHICS 58 (Donald VanDeVeer & Tom Regan eds., 1987) [hereinafter Battin, *Euthanasia*]; Margaret P. Battin, *Euthanasia and Physician-Assisted Suicide*, *in* THE OXFORD HANDBOOK OF PRACTICAL ETHICS 673 (Hugh LaFollette ed., 2003) [hereinafter Battin, *Euthanasia and Physician Assisted Suicide*]; Margaret P. Battin, *Terminal Sedation: Pulling the Sheet Over Our Eyes*, HASTINGS CTR. REP., Sept.–Oct. 2008, at 27–28 [hereinafter Battin, *Terminal Sedation*].

[15] *E.g.*, Battin, *Euthanasia*, *supra* note 14, at 67. For a brief definitions of terms, see also Timothy E. Quill & Jane Greenlaw, *Physician Assisted Death*, *in* FROM BIRTH TO DEATH AND BENCH TO CLINIC: THE HASTINGS CENTER BIOETHICS BRIEFING BOOK FOR JOURNALISTS, POLICYMAKERS, AND CAMPAIGNS 137 (2008), *available at* www.thehastings center.org/Publications/Bri

relieved to the extent possible, provided taking such action does not serve some further purpose in the treatment of disease, play a role in religious or other value-commitments of the person, or worsen the state of affairs for an individual.[17]

In my view, these two principles of autonomy and mercy "operate in tandem to underwrite physician-assisted dying: physician assistance in bringing about death is to be provided just when the person voluntarily seeks it and just when it serves to avoid pain and suffering or the prospect of them."[18] Both of these requirements must be met. Because these principles do not operate independently, it cannot be claimed that permitting physician-assisted dying on the basis of the principle of autonomy would require providing it for lovesick teenagers who want to die but are not terminally ill; likewise, it cannot be claimed that permitting physician-assisted dying on the basis of the principle of mercy would require involuntary euthanasia for someone in pain who nevertheless wants to stay alive. *Both* principles must be in play; but when they are in play, they jointly provide a powerful basis for permitting and respecting physician aid in dying.

Opponents of physician-assisted dying base their objections on two central concerns. One is the principle of the wrongness of killing, variously called the principle of the sanctity of life, of respect for life, of the wrongness of suicide, or of the wrongness of murder.[19] The second objection, the possibility of abuse, is often identified in two ways. First, opponents are concerned with the possibility of undercutting the integrity of the medical profession; second, and closely related, they are concerned with the possibility of the "slippery slope," the prediction that domestic, institutional, or social pressures will make people victims of assisted dying when that is not their choice.[20]

Both the wrongness-of-killing objection and the possibility-of-abuse objection are fears of those who oppose the legalization of physician aid in dying. However, these objections operate independently, and one could be opposed to euthanasia or assisted suicide on, say, religious grounds concerning the sanctity of life even without fearing the "slippery slope." Alternatively, one could fear the

---

[17] *See, e.g.*, Battin, *Euthanasia*, *supra* note 14, at 58–59.

[18] Battin, *Terminal Sedation*, *supra* note 14, at 27.

[19] *See* Battin, *Euthanasia and Physician-Assisted Suicide*, *supra* note 14, at 678.

[20] *See* Battin, *Euthanasia and Physician-Assisted Suicide*, *supra* note 14, at 681–82.

corruption of physicians even though one has no principle-based or religious-principle-based objections.

In short, it is autonomy and mercy on the one side, and sanctity of life and/or the possibility of abuse on the other. That is the standoff, argued in a kaleidoscope of ways that vary around these central themes.

These debates have been ongoing over the past several decades among many countries around the globe with advanced industrial economies. These highly developed economies support elaborate health-care systems in which people typically die, at comparatively advanced ages, of degenerative diseases (heart disease, cancer, organ failure) with characteristic downhill slopes.[21] Moral, legal, and religious arguments are all typically addressed under these headings, but it is specifically the empirical arguments about the possibility of abuse that I wish to address in this article.

"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."

". . . the ramifications [of legalization] are too disturbing for the . . . value our society places on life, especially on the lives of disabled, incompetent, and vulnerable persons."

American College of Physicians—American Society of
Internal Medicine (ACP-ASIM), 2001[26]

". . . the College concluded that making physician-assisted suicide legal raised serious ethical, clinical, and social concerns and that the practice might undermine patient trust and distract from reform in end of life care. The College was also concerned with the risks that legalization posed to vulnerable populations, including poor persons, patients with dementia, disabled persons, those from minority groups that have experienced discrimination, those confronting costly chronic illnesses, or very young children."

American College of Physicians, 2005[27]

". . . allowing physicians to participate in assisted suicide would cause more harm than good. Physician-assisted suicide is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks . . ."

"Euthanasia could also readily be extended to incompetent patients and other vulnerable populations . . ."

The American Medical Association, 1996,[28] 2005

Journal.[32] Because this article has been a principal target of much of the criticism to be explored in my discussion here and because it is, as far as I know, the first empirical attempt to address the issue of abuse of groups identified as vulnerable, I take it as a focus for my discussion here. I hasten to stress that this discussion reflects my views alone, not necessarily those of all five authors of the target article.

The target article uses data from both Oregon and the Netherlands—the two jurisdictions where physician assistance in dying is legal and where data is available over an extended period of time—to consider whether there is evidence of disparate impact on people in vulnerable groups in either of these jurisdictions. Sources for the Oregon data included the "nine annual reports issued by the Department of Human Services [which] cover the period since the Oregon Death with Dignity Act (ODDA) took effect in 1997,"[33] plus three surveys of Oregon physicians and hospice professionals.[34] The Oregon data used in the target study are from the Oregon Department of Human Services 2006 report (which includes cumulative data).[35] Since the target study was published, the Oregon data has been updated with another year's report, but there are no significant changes from the patterns reported in the 2006 report. From the Netherlands, the target article used primary data from the "four nationwide studies (the first of which is known as the Remmelink report) commissioned by the Dutch government . . . [concerning] end-of-life decision making in the years 1990, 1995, 2001, and 2005,"[36] as

---

[32] Timothy E. Quill, *Physician Assisted Death in Vulnerable Populations*, 335 BRIT. MED. J. 625 (2007).

[33] *Target Article*, *supra* note 22, at 592 (citing OR

well as several smaller, focused Dutch studies.[37] "[T]he Dutch data are from the 2005 nationwide study unless otherwise mentioned."[38] In effect, the target study covers all the primary data available in Oregon over a nearly ten-year period and in the Netherlands over a period of slightly more than twenty years.

Because the target article is brief and succinct, this present article will reiterate some of the background, sketch the target article's methodology, and quote the full results. The focus of the present article is on the objections that have been raised to the target article, which was the first attempt to assemble comprehensive *empirical* data about the issue of abuse of the vulnerable. Such objections are of particular importance not only because they reveal many of the misunderstandings of this debate, but also because they point the way for future research.

OBJECTIONS TO THE EMPIRICAL STUDY OF ABUSE IN VULNERABLE GROUPS

Objections following the publication of the target article and coordinated editorial have been of three general kinds: to the Oregon Death with Dignity Act and its reporting system; to the Netherlands'

Concerning the End of Life, 22 HEALTH POL'Y 1 (1992) (the full English version of the first nationwide "Remmelink Report"), *summarized in* 338 THE LANCET 669 (1991); Paul J. van der Maas et al., *Euthanasia, Physician-Assisted Suicide, and Other Medical Practices Involving the End of Life in the Netherlands, 1990–1995*, 335 NEW ENG. J. MED

> the possible social consequences of legalisation. They are also concerns for proponents of legalisation who assume that the risks for vulnerable patients

Oregon and the Netherlands, but often in a selective manner and without a rigorous assessment of such data.[43]

The target article constituted an effort to provide an empirical evaluation of abuse based on a thorough analysis of all available data. As a sequel, the present article examines several responses to the target article[44] and its effort to assemble *empirical* evidence concerning the possibility of abuse.

WHAT THE TARGET STUDY SHOWS: NO EVIDENCE OF

this age category. Persons aged 18–64 years were over 3 times more likely than those over age 85 years to receive assisted dying. In the Netherlands, rates of assisted dying were lowest in the people over 80 (0.8% in 2005), next lowest in the age range 65–74 years (2.1%) and higher below age 65 (3.5%). People over 80 formed 30% of the group of patients whose requests were refused and 13% of those whose requests were granted and carried out.[46]

Women: *no evidence of heightened risk*

In Oregon, 46% of individuals receiving assisted dying were women and women were not more likely than men to use assisted suicide. In the

requires their full approval. This is known as the Groningen protocol.[52] Such cases are infrequent—22 cases have been reported to district attorneys in the Netherlands during the past 7 years, and there are an estimated 10 to 20 cases annually among the somewhat over 1000 children born in the Netherlands who die during the first year of life, about 1% of newborn deaths.

Findings based on inferential or partly contested data

Patients with psychiatric illness, including depression and Alzheimer Disease: *no evidence of heightened risk*

Approximately 20% of requests for physician assistance in dying came from depressed patients, but none progressed to PAS.[53] None of the 292 patients who died under the ODDA were determined to have a mental illness influencing their decision, though there have been three disputed cases among the 9-year total of 456 who received prescriptions.[54] Because not all patients who requested assistance were specifically evaluated by mental health professionals and because many cases of depression are missed in primary care, it is possible that some depressed patients received lethal prescriptions; it is also possible that a patient without a mental disorder at the time of receiving the prescription became depressed by the time they ingested it. There is, however, no direct evidence that depressed patients are at higher risk for receiving assistance in dying under the ODDA.

In the Netherlands, about two-thirds of explicit requests for assistance in dying are not granted. In 31% of all requests not granted in the 1995 study, the physician gave the presence of psychiatric illness as at least one reason for not complying. Physicians in the interview portion of the 1995 Dutch nationwide study mentioned depression as the predominant symptom in four times more likely to request euthanasia, but how often the request was granted is unknown.[55]

In 1994, the Dutch supreme court ruled in the *Chabot* case, in which a psychiatrist assisted with suicide for a woman with intractable depression but without concomitant physical illness, that "intolerable suffering" might consist in mental suffering alone without somatic origins and not involving the terminal phase of a disease, though the Court commented that such cases would be rare and that they require heightened scrutiny.[56] The 2001 Dutch interview study estimated that about 3% of all requests for euthanasia or PAS that physicians had received the previous year were from patients with predominantly psychiatric or psychological illnesses, but none were granted. In the Dutch 1995 nationwide substudy on end-of-life decision making in psychiatric practice, there appeared to be about 2 to 5 physician-assisted

practice was not yet fully legal but was tolerated under specific guidelines, reporting levels were extremely low; in fact, in the first nationwide study, published in 1990, just 18% of physicians reported cases of physician-assisted dying to the Ministry of Justice, as was required under the guidelines.[69] During the following years, the rate of reporting climbed: 41% in 1995, 54% in 2001, and 80% in 2005.[70] Even so, it is still the case that a sizeable number of cases go unreported.

However, the four Dutch nationwide studies, which use cross-sectional analyses of interview, death-certificate, and questionnaire data, cover all deaths in the years 1990, 1995, 2001, and 2005 that involve medical decision-making. These include deaths associated with withholding or withdrawing treatment, the use of opiates in the treatment of pain, terminal sedation, physician-assisted suicide or euthanasia, and the category known as LAWER or “lit that the body of information about assisted dying in the Netherlands is more extensive than that in Oregon,[75] it does not follow that the information on Oregon is therefore comprised of "unverifiable" anonymous physician self-reports.

Objection No. 3: "Excessive Secrecy:" Data Inadequate or Missing

A more substantial concern, recently voiced by Herbert Hendin and Kathleen Foley in the *Michigan Law Review*,[76] objects to the data provided by the ODHS on the grounds that (1) the Department does not collect adequate information about the patient, and (2) that the Department collects information only from the physician who actually wrote the prescription for the life-ending drug, rather than from all of the physicians who saw the patient.[77] Hendin and Foley describe the ODHS's website statement that there is no evidence of abuse as "overreaching in the conclusions they draw from the limited information they have."[78] The ODHS, they say, "does not collect the information it would need to effectively monitor the law . . . [and fails to serve] as the protector of the welfare of terminally ill patients."[79] They also note that Oregon destroys individual information about patients who die under the ODDA, and does not make their identities public.[80]

Hendin and Foley call these policies, designed as they are to protect patient-doctor confidentiality, matters of "excessive secrecy."[81] As Marilyn Golden, a policy analyst with the anti-assisted suicide and anti-euthanasia Disability Rights Education and Defense Fund in Berkeley, California stated, "This makes it impossible for any outside researcher to avail themselves of the data. . . . The truth is, we really don't know what's happening in Oregon."[82] The International Task Force on Euthanasia and Assisted Suicide portrayed with

---

[75] 75. The study in the Netherlands covers twenty years of information, whereas the Oregon study covers ten years of information.

adequate to rebut histrionic claims that the ODDA saw "record highs"[90] in the most recent year. Even at its highest point in 2007, there were only 49 ODDA deaths altogether, or 15.6 ODDA deaths for every 10,000 deaths.[91] That is just one or two out of every thousand deaths—not out of every thousand people, but out of every thousand people who die in that year, a very small fraction of the total population. The data also provides information about (1) whether the patients in question were members of any of the groups identified as vulnerable, (2) what counties they resided in, (3) whether the physician was present when the medication was ingested, and (4) whether emergency medical services were called.[92]

How should Oregon respond to this attack on the availability of ODDA data? Publicizing patient identifiers would, of course, provide more access to family members who could then be interviewed. Such disclosure might also underwrite the inspection of homes in the interests of protecting patients, much like that done by agencies that monitor child and elder abuse. It would make searching public and commercial databases possible for matters like marriage licenses, weapons permits, criminal records, or shopping behavior. Perhaps the inquisitive might learn something about the reasons for which the patient in question elected to utilize the ODDA. But the invasion of privacy would be immense, as the drafters of the ODDA clearly recognized, and would subject family members and others to the intense and sometimes highly politicized pressures of advocacy groups. Would demonstrators picket outside the home of a recent decedent, if his or her identity were revealed? Would they harass other family members or associates of a decedent who might also be terminally ill? Bottom dredging for lurid detail has already occurred with the few patients whose identities have become known (Kate

As displayed in Box 4, Oregon's current ODDA data release policy clearly privileges patient confidentiality.

Box 4: *Oregon State Public Health Division Data Release Policy*[94]

Release of Information Regarding the Death with Dignity Act

The Death with Dignity Act requires that the Oregon Department of Human Services collect information pertaining to compliance (ORS 127.865 (2)) and to make available to the public an annual statistical report (ORS 127.865 (3)).

- The Department of Human Services's role is limited to collecting information so that we can monitor compliance and provide a report regarding the effects of this legislation.

- Confidentiality is critical and the Act specifically states that information collected is not a public record and is not available for

> To reiterate, the Department of Human Services's role in reporting on the Death with Dignity Act is similar to other public health data we collect. The data are population-based and our charge is to maintain surveillance of the overall effect of the Act. The data are to be presented in an annual report, but the information collected is required to be confidential. Therefore, case-by-case information will not be provided, and specificity of data released will depend on having adequate numbers to ensure that confidentiality will be maintained.

Thus, Hendin and Foley's objection alleging excessive secrecy cloaks a controversial assumption that the ODHS does not collect the information necessary to effectively monitor the ODDA and thus fails to serve as the protector of the welfare of terminally ill patients. Yet, protecting confidentiality is also protecting the welfare of terminally ill patients. The ODHS is not a police organization. The kind of continuous and intrusive surveillance that Hendin and Foley appear to have in mind as necessary to protect the welfare of terminally ill patients is by no means part of the ODHS's charge. Rather, the charge of the Department, as the policy puts it, is "population-based," statistical in character, concerned with monitoring patterns of utilization of the ODDA, but not intended to ferret out abuse.[95] Hendin and Foley insist that "[e]nsuring adequate care for patients is the aim of monitoring,"[96] and in a general sense, they are correct; but this is not to warrant intrusive surveillance in every area of medical practice. The ODHS does investigate cases in which the physician's report appears to have deficiencies or does not correlate with the death certificate or other information, and further, the ODHS does report cases involving inadequate reporting or unexpected side effects to the Board of Medical Examiners or the Board of Pharmacy respectively.[97] But this reporting, in turn, does not make the Department responsible for the day-to-day operations of the law.

---

[95] EIGHTH ANNUAL REPORT ON ODDA, *supra* note 59.

[96] Hendin & Foley, *supra* note 65, at 1627.

[97] EIGHTH ANNUAL REPORT ON ODDA, *supra* note 59, at 13.

> During 2005, four cases were referred to the Oregon Board of Medical Examiners, one involving witnessing of signatures and three others for failure to file required documentation in a timely manner. One case, in which a patient awakened after ingesting the prescribed medication, was referred to the Board of Pharmacy.

Id.

Objection No. 4: Flaws in Study Design or Scope

A rather varied set of objections points to what are seen as flaws

nutrition or hydration may be utilized—no more than two weeks.[118] The rationale for this limit is that it is not medically sound to sedate someone in this way for longer than two weeks (this applies only to continuous deep sedation), since "If the patient's life expectancy exceeds one to two weeks, continuous deep sedation would affect the time of death, which would be hastened by dehydration"[119]—that is, continuous deep sedation without nutrition or hydration would kill the patient. If the guideline's two-week limit is followed, sedation is normal medical practice and therefore does not have to be reported. Euthanasia and assisted suicide, in contrast, are never normal medical practice and are always required to be reported. Thus, the two-week limit on terminal sedation, in effect, ensures doctors do not use terminal sedation as a form of silent euthanasia in a way that eludes the reporting requirement.[120]

The Dutch nationwide studies identify the number of cases casod(Eutha-)3gw[(ThebkTryi.9c numbers is the result of a difference so intrinsic as to what counts as assisted dying, that it challenges the feasibility of rigorous research at all. Further, it questions the possibility of settling on the scope of the phenomenon being studied, even at the broadest level.

Objection No. 6: Data Cannot Get at Cases of Depression

The assertion that the background data in Oregon and the Netherlands, and hence the target article, cannot reach cases of depression is one of the more prevalent objections to the empirical work so far. For example, Alex Schadenberg argues, indeed correctly, that the Oregon data does not make it possible to analyze the decision-making processes of patients.[123] Madelyn Hicks laments the absence of a standardized depression-screening tool.[124] Linda Ganzini, one of the authors of the target article, is quoted by the International Task Force on Euthanasia and Assisted Suicide as saying that it is "risky how low the rate of mental health evaluation is."[125] The International Task Force also complains that patients are never interviewed prior to their deaths.[126]

Overall, it is fair to say that parties both favoring physician-assisted dying and those in opposition agree that the rates of euthanasia and assisted suicide ought to be minimized in mental disorders.[127] It is probably also fair to say that all parties acknowledge that depression may be a partial factor in some cases. Lastly, all parties must acknowledge that depression is a frequent factor in *requests* for assisted dying. As estimated in Oregon, about 20% of requests for physician-assisted death under the ODDA are from people who are depressed, though none of these cases

---

[123] Alex Schadenberg, *Assisted Suicide in Oregon: Lessons Learned and Unanswered Questions*, May 20, 2004, http://www.lifenews.com/bio276.html.

[124] Madelyn H. Hicks, Rapid Response to Timothy Quill Editorial, *Mentally Ill Given Short Shrift*, BRIT. MED. J., Oct. 10, 2007, http://www.bmj.com/cgi/eletters/335/7621/625#177848.

[125] Int'l Task Force on Euthanasia and Assisted Suicide, *10 Years Under Oregon's Assisted-Suicide Law*, *supra* note 84 (citing Tim Christie, *Assisted-Suicide Law Passes 10-Year Mark*, THE REGISTER-GUARD, March 19, 2008, at C15).

[126] *Id.*

[127] JOHN GRIFFITHS ET AL., EUTHAN R REU38.578.52 203.52 1834(R)Tj4

The case of Kate Cheney, an 85-year-old widow terminally ill with stomach cancer who requested an assisted death, is often put

Objection No. 7: Misconstrual of "Vulnerable" Patients

This objection takes a variety of forms: that not just those in "vulnerable" groups are to be considered vulnerable, but "all people facing such serious concerns and conditions are vulnerable" (Grogan);[142] that people "are made vulnerable by their situation" (Thorns);[143] and that "vulnerability applies to the majority of the population at any one time" (O'Neill).[144]

The claim that the notion of vulnerability is inappropriately applied, to a certain extent, rings true. However, any one of these

> health status in violation of the Americans with Disabilities Act. Current trends in managed care and health care rationing have already reduced and threaten to further diminish the availability of health care and related services needed by people with disabilities.[146]

Similarly, Schadenberg argues that within our society exists a significant level of social bias that connects certain types of disabilities and physical conditions to intolerable suffering.[147]

These authors are surely correct about the levels of social bias in our society toward people with disabilities. However, while these concerns are of paramount importance, they may be used to reach an unjust conclusion if they result in a requirement of heightened scrutiny for access to assistance in dying for people in certain groups, effectively preventing a disabled individual from making an end-of-life decision that an able-bodied person would be permitted to make. In any event, these concerns underscore the difficulties of defining terminal illness in the first place. For many people with long-term chronic disabilities, life expectancy is not shortened, but for some, the line between living with a disability and living with terminal illness is less clear.

Objection No. 8: Author Bias

Among the objections to empirical research on the practice of physician-assisted dying in Oregon and the Netherlands in general and to the target article in particular are those alleging that such research and/or its authors are biased. Accusations of bias are found in many writings on end-of-life issues (by both sides in the argument), and it is no doubt true that the various authors on all sides of this issue each have an antecedent point of view. As for the target article, for example, Schadenberg calls it “propaganda.”[148] “Dr. Peter Saunders, suicide advocate" and says that my views on physician-assisted suicide are well known.[150] Goodenough also claims that Wesley Smith says that I am an "ardent euthanasia and assisted suicide legalization activist—[who] supports PAS for categories of people way beyond the terminally ill."[151] Stephen Drake alleges that I use "research for political purposes."

repeated claims that I "failed to disclose" that I am a member of the Advisory Board of the pro-legalization Death With Dignity National Center by pointing out that journals require disclosure of *financial* conflicts of interest.[157] Well, I have no such conflicts.

More importantly, those pursuing this line of *ad hominem* objections fail to recognize that the target article has five authors, not just one.[158] Three are well-known epidemiological researchers in the Netherlands with varying views about the ethical issues in assisted dying, but who do not take public stands on them; one is a distinguished physician in Oregon, associated with the Oregon Health and Science University. Whatever "biases" one author might have had in seeking to examine empirical data about the issue of abuse has been rigorously—I repeat, rigorously—deleted by the others, all of them empiricists by training.

Even more importantly, this line of *ad hominem* argument seems to assume that people who hold individual views about a particular social issue are thereby disqualified from engaging in objective research on it. It is a safe guess that with a highly controversial social issue like physician-assisted dying, most people who are at all familiar with the issue have a view about it (whether for or against, or sometimes moving back and forth as they reflect on the issue). If the *ad hominem* argument were right in holding that people with antecedent views about an issue cannot be objective, then virtually no one, on either side, would be able to conduct such research. What is far more desirable, as I have argued elsewhere, is the practice of "oppositional collaboration," where researchers on opposite sides of an issue collaborate in assembling their data: they visit the same locations at the same times; read the same articles and pore through the same books; design protocols together, and interview the same people at the same times, always in the room together so that each hears what the other one hears.[159]

Perhaps the most important error in allegations of bias, though, lies in the assumption that an examination of abuse of people in vulnerable groups would be of interest primarily to pro-legalization

---

[157] James Coyne,

parties. To repeat what the target article points out, because this point is so important:

> These are concerns both for those who oppose physician-assisted dying on moral grounds and for those who support it but are uneasy about the possible social consequences of legalisation. They are also concerns for proponents of legalisation who assume that the risks for vulnerable patients are heightened if these practices remain underground, as well as for those who favour legalisation but fear that vulnerable patients will be denied a privilege reserved for better-situated patients and that healthcare

in a number of respects: they cover different time periods, were obtained by different methods, and are of different strengths. Neither the Oregon nor the Dutch studies were corrected throughout for considerations of whether diagnoses that may make physician-assisted dying attractive are equally distributed in vulnerable and non-vulnerable groups. Clearly, more work needs to be done.

Where they do overlap, however, the studies are largely consistent. Where the data are robust, the picture in Oregon and the Netherlands is similar: in both jurisdictions, a smaller percentage of older people received assistance in dying than of younger patients; gender ratios were slightly higher for males over time; and assistance was not more common among the uninsured. Socioeconomic data of intermediate strength, usually inferred from other, more robust data, also suggest similar pictures in the two jurisdictions: recipients of assistance in dying were likely to be of equal or higher educational status and were less likely than the background population to be poor. Data that are robust in one jurisdiction but partly inferential and hence less secure in the other did not reveal cases in either data set of assisted dying associated with physical disability alone without concomitant serious or terminal illness. The rates of physician-assisted dying among mature minors, which is legal in the Netherlands, were too low to be does not directly speak to the moral issues in physician-assisted dying; it does not argue whether physician-assisted dying would be more or less appropriate for people in some groups; and it does not show that people in vulnerable groups could not be disproportionately affected in the future or in other jurisdictions. It also does not show whether low rates of physician-assisted dying among vulnerable persons reflect a protective effect of safeguards or, rather, are evidence of unequal access to assistance. But it

Compassion and Choices that has called for the ODHS to collect data about disabilities that are independent of or that preexist a terminal illness. The anti-legalization groups have not done so, suggesting, perhaps, that they fear their concern will turn out to have no basis in fact.[162]

What, then, might be a plausible response to the target article's finding that, with the exception of people with AIDS, there is no evidence of heightened risk for any of the ten groups identified as "vulnerable"? Wouldn't the most without fear of prosecution.[163] This is what made it possible to obtain information about cases which had not been reported as required under the guidelines, and to determine their characteristics. There were no differences between reported and unreported cases in the Netherlands except that the unreported cases did not involve consultation and, obviously, were not reported. With respect to every other characteristic studied they were the same. Similar assurances would be necessary in Oregon for an adequate study; otherwise fully candid information could not be obtained.

Second, studies of the decision-making processes of dying patients who requested assistance in dying would also be appropriate, *if* it is possible to conduct them without intrusion and, *if* similar studies are conducted for other end-of-life decision-making by patients. These studies would be particularly informative if they could be targeted not just at broad decision-making processes of dying patients (e.g., "is this person methodical and deliberative, or is this person characteristically impulsive and changeable?"), but more directly focused on dying patients' decision-making processes as they make their choices about how to die. In the target article, the findings are based on the numbers of deaths in each group identified as vulnerable, not, as the International Task Force on Euthanasia and Assisted Suicide correctly pointed out, on whether those individual patients had actually experienced pressure to end their lives. The evidence available gives no reason to think either that these people have been selectively pressured, or at the very least, that if they were pressured, they were unable to resist the pressure. After all, their rates of assistance in dying are lower than those for people not in vulnerable groups.

But this does not fully answer the question about pressures on people who are making end-of-life decisions. A possible area for further research would be to try to examine pressures within domestic, clinical, and organizational settings—after all, pressures could come from overwrought or greedy family members, impatient or overworked physicians, or cost-conscious insurers or health-care systems. However, such research would be informative only if it examined patients in other medical situations as well: facing surgery or chemotherapy; seeking pain-relieving drugs; and considering whether to terminate respiratory support or quit dialysis in long-term

---

[163] See the accounts of methodology in van der Maas et al., *Euthanasia and Other Medical Decisions Concerning the End of Life*, *supra* note 36.