Executive summary

The American Association of Suicidology recognizes that the practice of physician aid in dying, also called physician assisted suicide, Death with Dignity, and medical aid in dying, is distinct from the behavior that has been traditionally and ordinarily described as "suicide," the tragic event our organization works so hard to prevent. Although there may be overlap between the two categories, legal physician assisted deaths should not be considered to be cases of suicide and are therefore a matter outside the central focus of the AAS.

STATEMENT OF THE AMERICAN ASSOCIATION OF SUICIDOLOGY:

"SUICIDE" IS NOT THE SAME AS "PHYSICIAN AID IN DYING"

Approved October 30, 2017

Beginning in the mid-1980s with legal tolerance in the Netherlands and in 1997 with the effective date of the Oregon Death with Dignity Act, physician aid in dying has become legal by statute or court decision in a number of US states and international jurisdictions. Although legal requirements vary from one jurisdiction to another, all require well-documented choice by the patient and a serious medical reason for such a choice, either terminal illness, intolerable or unbearable and irremediable suffering, or both. In the US, self-administration of the lethal medication is seen as a safeguard against abuse and is required by law; in most European jurisdictions and in Canada, physician administration of the lethal medication is also permitted and is the predominant practice. In all jurisdictions, the physician is protected by law provided the legal requirements and/or practice guidelines are followed, including reporting the case to the designated authorities. Physician aid in dying (PAD) is called by a number of different names, including "physician assisted suicide" (PAS), "physician assisted dying" (PAD), "Death with Dignity" (DwD), "medical aid in dying" (MAiD) and more, all of which are used in the medical and sociological literature.

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

Points of difference between suicide and physician aid in dying include the following:

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

2) In PAD, the person with a terminal illness does not necessarily want to die; he or she typically wants desperately to live but cannot do so; the disease will take its course. Suicide, by contrast, even when marked by ambivalence, typically stems from seemingly unrelenting psychological pain and despair; the person cannot enjoy life or see that things may change in the future.

3) In PAD, the individual who is already facing death often experiences intensified emotional bonds with loved ones and a sense of deepened meaning as life is coming to an end; in suicide, by contrast, the individual typically suffers from a sense of isolation, loneliness, and loss of meaning.

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

5) Suicide in the conventional sense often involves physical self-violence, as in gunshot wounding, self-hanging, jumping, self-cutting, self-drowning, and the ingestion of substances or compounds that may cause painful death. PAD in contrast is intended to provide the physically easiest, least violent, least disfiguring, most peaceful form of death an already dying person could face.

6) While suicide in the conventional sense may involve sustained suicidal thinking and prior planning, during periods of acute stress suicide decisions-to-act are sometimes reached shortly before the fatal act. All US statutes legalizing PAD include safeguards against impulsivity: all require two oral requests, separated by a 15-day waiting period, plus a written request signed in the presence of two witnesses.

7) In suicide, the person often "sees no way out" of their desperate situation. Under the PAD statutes in the US, the physician is required to inform the patient of all feasible alternatives for relieving their situation, including comfort care, palliative care, hospice care, and pain control.

8) Suicide in the ordinary, traditional sense is much more common among those with mental illness, where it may be a complex byproduct influenced by anhedonia, impaired thinking, cognitive distortion and constriction, impaired problem-solving, anxiety, perseveration, agitation, personality disorders, and/or helplessness and hopelessness. Under the PAD statutes, in contrast, mental illness that would affect the rationality of decision-making is screened out, and where, as in some European jurisdictions, PAD is legal in cases of unbearable suffering in intractable mental illness, heightened scrutiny is required. Evidence of depression and other mental illness is, by statute in the US, subject to evaluation by a psychiatrist or psychologist and, if it is determined to be influencing the decision, the patient is not qualified under the law.

9) The conventionally suicidal person may be unable to assess his or her situation clearly or objectively; the person considering PAD is typically able to balance the choice of an earlier death against the loss of control and increased medicalization they may experience as they enter the end-stages of a terminal illness. According to studies from the Netherlands, the patient who dies with physician assistance forgoes on average about 3.3 weeks of life.

10) The legal status and consequences of the two acts are different. In the United States, the statutes in those states with "Death with Dignity" or "End of Life Options" laws assert that such a death "shall not, for any purpose, constitute suicide, assisted suicide, mercy killing, or homicide under the law." Deaths under these laws are not reported as suicide on death certificates, but as death from the underlying terminal condition.

11) Studies from Oregon and the Netherlands show that the impact of PAD on bereavement in family members tends to be less severe than in other deaths. In contrast, those bereaved by suicide deaths have higher rates of complicated grief and PTSD, and may be at higher risk for suicide themselves.

12) Death by suicide is often associated with substantial social stigma, often a considerable burden for bereaved families or other persons involved, including, for example, treating physicians and psychotherapists. Where it is legal, PAD is typically well accepted within the community and society at large.

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

14) PAD deaths do not incur the sometimes substantial forensic and other costs that suicides do, especially suicides by school-age children and adolescents. They do not invite dilemmas of publicity. In PAD, after-the-fact efforts to determine the reasons for the death are not necessary; the process is well-documented by the physician.

15) Unlike most cases of suicide, the person who has requested and receives aid in dying does not typically die alone and in despair, but, most frequently, where they wish, at home, with the comfort of his or her family.

The possibility of overlap between suicide and physician aid in dying:

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

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

Conclusion

In general, suicide and physician aid in dying are conceptually, medically, and legally different phenomena, with an undetermined amount of overlap between these two categories. The American Association of Suicidology is dedicated to preventing suicide, but this has no bearing on the reflective, anticipated death a physician may legally help a dying patient facilitate, whether called physician-assisted suicide, Death with Dignity, physician-assisted dying, or medical aid in dying. In fact, we believe that the term "physician-assisted *suicide*" in itself constitutes a critical reason why these distinct death categories are so often conflated, and should be deleted from use. Such deaths should not be considered to be cases of suicide and are therefore a matter outside the central focus of the AAS.

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