Disability and Health Journal 3 (2010) 56–70

Disability and Health Journal

www.disabilityandhealthjnl.com

Public health, populations, and lethal ingestion

Kirk C. Allison, Ph.D., M.S.

Program in Human Rights and Health, University of Minnesota School of Public Health, Minneapolis, MN 55455, USA

Abstract

Background: In 2008 the American Public Health Association endorsed lethal ingestion as a public health policy as part of "Patients' Rights to Self-Determination at the End of Life." Although rhetoric framing physician-assisted suicide (PAS) invokes individual autonomy, public health's focus is populations. Even regarding treatment refusal, its logic and coercive power (e.g., quarantine) subordinate autonomy to population interests. Research indicates health practitioners and disciplines that are closer to persons with terminal conditions oppose more PAS than those having little contact: specifically, public health associations are more willing to authorize life-ending means than disciplines directly caring for the dying. Why is that the case and with what consequences for populations and public health?

Methods: Contextual analysis of semantics; policy submissions; standards; statutory and regulatory documents; related economic, equity, and demographic discourses is employed; and, finally, scenarios offered of the future.

Results: Notwithstanding rhetoric invoking autonomy, public health's population orientation is reflected in population health measures (e.g., aggregated DALYs, QALYs) that intimate why public health might endorse availing life-ending means. Current associated statutes, regulations, terminology, and data practices compromise public health and semantic integrity (e.g., the falsification of death certificates) and inadequately address population vulnerabilities. In recent policy processes, evidence of patient and system vulnerabilities has not been given due weight while future-oriented scenarios suggest autonomy-based rationales will increasingly yield to population-driven rationales, increasing risk of private and public forms of domination and vulnerabilities at life's end.

Conclusion: Public health should address institutionalized violations of data integrity and patient vulnerabilities, while rescinding policy supporting the institutionalization of lethal means.

Keywords: Public health policy; Physician-assisted suicide; Population perspectives; Practice standards; American Public Health Association

In 2008, the American Public Health Association (APHA) endorsed lethal ingestion as a generalizable public health policy under the rubric "Patients' Rights to Self-Determination at the End of Life" [1], invoking the Oregon Death With Dignity Act (ODWDA) [2].

While rhetoric framing physician-assisted suicide (PAS) often invokes individual autonomy, public health's focus is on populations. Even regarding refusal of treatment, its logic and coercive power prioritize populations (e.g., quarantine, compulsory vaccination [3], compulsory sterilization [4]).

Research indicates health practitioners and disciplines working closely with persons having terminal conditions more oppose PAS than those having little contact [5]. Of major health disciplines, public health, through its population logic, has the greatest distance to individual patients, yet shows itself more willing than proximate disciplines to authorize life-ending means.

This article examines intersections between public health and assisted suicide semantics, policy process, population perspectives, and impact of related regulations on public health practice standards. Finally several population arguments "of the future" are discussed indicating autonomy discourses may become an increasingly limited consideration, increasing vulnerabilities at life's end.

Hypotheses

1. Population perspectives will increase in import in framing lethal means at life's end.

Financial disclosure: This research was supported by the Program in Human Rights and Health, University of Minnesota School of Public Health. I have no conflicts of interest to declare. One may consider a potential conflict of interest to be that I am an American Public Health Association member and was a participant in policy discussions on the topic, including hearings at the 2007 and 2008 APHA annual meetings. In that regard I presented in opposition to the draft policy resolutions and encouraged APHA to not support physician-assisted suicide as public health policy. (I make mention of presenting in opposition in the body of the article.)

Corresponding author: 420 Delaware Street SE, MMC 164. Fax: (612) 626–3908.

E-mail address: alli0001@umn.edu (K.C. Allison).

1936-6574/10/$ – see front matter © 2010 Elsevier Inc. All rights reserved.
doi:10.1016/j.dhjo.2009.09.005

2. Current associated statutes and practices diminish public health integrity.
3. The semantics of ‘‘dignity’’ and ‘‘compassion’’ are inappropriately reduced (demeaned).
4. While framed in terms of autonomy, structural features supervene on the individual and population context increasing vulnerabilities at life’s end.

Methods

Discursive analysis of

- Semantics
- APHA submissions, policy proposals (2007–2008), and policies; Washington State Public Health Association’s (WSPHA) Measure I-1000 endorsement; policy processes
- Statutory and regulatory sources (Oregon, Washington State), implementations, and practice standards
- Economic, equity, and demographic discourse influencing individual and population decisions

Introduction

Public health’s purpose is to advance population health. When a policy is adopted in its name, it is reasonable to query links between policy and population perspectives. This applies also to the APHA’s 2008 endorsement of physicians writing lethal prescriptions to qualified patients as a general public health policy [1].

Population perspectives are generally not emphasized in controversial issues such as induced death or abortion (excepting aggregate maternal health, eugenics, population control), while advocacy accounts often frame issues through personal narrative invoking autonomy [6]. While not insensitive to individual sagas, public health examines specific cases primarily to illuminate population implications. Its ethics frequently subordinate individual autonomy to population interest. What population-health interests are implied by availing life-ending means to specific populations? Are there externalities for other population segments or impacts on public health practice standards? Will population discourse increasingly shape such issues?

Terms

Naming is power. Terminology concerning induced death is contested. ‘‘Assisted suicide’’ has been interrogated regarding whether it is logically coherent as a term and for medicine as a practice [7]. In Switzerland since 1937 assisted suicide need not be mediated through medical personnel to avoid prosecution; anyone unmotivated by ‘‘selfish interest’’ may facilitate (Swiss Penal Code, SR 311, Article 110, *Vorsätzliche Tötung, Intentional Killing*) [8,9].

‘‘Assisted suicide’’ yet predominates a recent PubMed search of related terms[1] notwithstanding that ‘‘assisted suicide’’ and ‘‘physician-assisted suicide’’ have been statutorily, if not logically, defined out of existence in Oregon and Washington [‘‘Actions taken in accordance with ORS 127.800 to 127.897 shall not, for any purpose, constitute suicide, assisted suicide, mercy killing or homicide, under the law,’’ Oregon Revised Statutes (ORS) 127.880 §3.14; similarly Revised Code of Washington (RCW) 70.245.180] [10]. Oregon’s Public Health Division continued using the term over a decade until prevailed upon by the proponent organization Compassion and Choices in 2006. Precision of scope and etymology notwithstanding, market research indicated the term did not inspire public support of the policy [11,12]. Garrow notes the presence or absence of ‘‘suicide’’ or ‘‘assisted suicide’’ can generate a 15% to 20% difference in poll responses [13].

Instead of direct references to life-ending acts, the Oregon Public Health Division now uses ‘‘death with dignity.’’ Hemlock Society co-founder Derek Humphreys objected: ‘‘The department’s cop-out choice of words, ‘death with dignity,’ is wildly ambiguous and means anything you want. Let’s stick to the English language and in this matter call a spade a spade’’ [14]. Still, ‘‘PAS’’ remains embedded like a palimpsest in the Death With Dignity Act’s URL (egov.oregon.gov/DHS/ph/pas/index.shtml).

Excepting death certificates, Washington’s Measure I-1000 (codified as RCW 70.245) prescribes relatively clear descriptive language for ingesting a prescribed, lethal *pharmakon*[2] [15]: ‘‘state reports shall refer to practice under this chapter as obtaining and self-administering life-ending medication’’ [16].

‘‘Physician-assisted Death’’ (PAD) is used by the American Academy of Hospice and Palliative Medicine (AAHPM) ‘‘with the belief that it captures the essence of the process in a more accurately descriptive fashion than the more emotionally charged designation physician-assisted suicide’’ [17], while its URL references suicide (www.aahpm.org/positions/suicide.html). ‘‘Physician-assisted death,’’ however, semantically shifts focus to the physician as (if sole) agent. Less focused than ‘‘physician-assisted suicide,’’ it would cover direct euthanasia, voluntary or nonvoluntary, without revision.

‘‘Death with dignity’’ has been promoted by proponents to embed lethal ingestion into vaguer semantic and broader value fields. ODWDA reifies it to a *terminus technicus* [2]. Persons dying under it are ‘‘persons who use the Death with Dignity Act’’ [12].

---

[1] Title/Abstract National Library of Medicine PubMed searches (excluding Medical Subject Headings) returned: ‘‘assisted suicide’’ (2074), ‘‘physician assisted suicide’’ (1150), ‘‘physician assisted death’’ (116), ‘‘physician aided death’’ / ‘‘…dying’’ / ‘‘…aid in dying’’ (2, 0, 16), ‘‘death with dignity’’ (356;122 re ODWDA) [12]. (Results for last 2 years: ‘‘assisted suicide’’ (116), ‘‘physician assisted suicide’’ (51), ‘‘ physician assisted death’’ (14), ‘‘physician aided death / …dying / …aid in dying’’ (0, 0, 1), and ‘‘death with dignity’’ (16;11 re ODWDA). July 1, 2009.

[2] Greek *pharmakon*: a potent agent (healing, noxious, or lethal) [15].