



Development of the AAS Statement on “Suicide” and “Physician Aid in Dying”

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In August 2017, the American Association of Suicidology board passed a statement titled “Suicide” is not the same as “Physician aid in dying,” which was developed partly in response to the fact that aid in dying is now legal in a number of jurisdictions. In Phase 1, eight members of the AAS who had indicated interest in this issue were asked to independently draft such a statement; the convener consolidated these drafts and comments into an initial statement. In Phase 2, five additional experts who might be expected to object were asked for their independent input; the convener consolidated these with the previous draft. No one objected to the statement altogether; extensive copyediting and rewording suggestions focused primarily on issues of overlap between “suicide” and “physician aid in dying.” The resulting document represents an effort to try to accommodate the basic concerns of all participants. The document does not speak for or against legalization of this practice, but it may have bearing on whether suicide prevention professionals have an obligation to try to prevent such deaths and whether they may serve as consultants for psychological or psychiatric evaluations as sometimes required under US state law.

In August 2017, the American Association of Suicidology (AAS) board passed a statement titled “*Suicide is not the same as Physician aid in dying*” and embarked on an effort to distribute it to professional organizations, media outlets, health care organizations, end-of-life organizations (both pro and con), legal organizations, religious organizations, and a variety of popular and professional journals. This statement responds to issues for clinicians and others involved in

suicide prevention, and while it does not speak to whether aid in dying should or should not be legal, it does have bearing on whether a clinician or other party dedicated to suicide prevention also has a professional or ethical obligation to intervene to prevent, or contribute to psychological or psychiatric assessments in end-of-life decision making about aid in dying.

This note describes the working procedure for the development of this statement.

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The members of both phases of the workgroup, the initial drafting by those favoring such a statement and the subsequent critical review by those likely to be opposed, are listed alphabetically here to avoid implications about any individual's views or support of or concerns about the resulting document. Margaret Battin, Craig

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WORKING PROCEDURE

- (1) An initial working group was formed by a group of eight members of the AAS, including two former presidents and the current president. These were all individuals who had indicated interest in this issue, most of them at the business meeting of the AAS in 2017. Communicating mostly by email, each member of the group was asked to *independently* draft such a statement, without yet consulting others. The draft was ideally to be just a page or so in length, just an initial position statement. It was to be succinct but also to state the principal reasons for which this person thinks there is a difference between suicide and death-with-dignity, aid in dying practices; it was also to state the reasons for which they think there is not a difference.
- (2) The statements and remarks that were received were consolidated into a single draft statement that attempted to include the *independent* insights of each member of the group.
- (3) The consolidated draft was then distributed for discussion. The earlier independent drafts were also made available for discussion (anonymously), although no member of the group requested to see them. The draft was circulated for review within the group numerous times. Up until this point, the group included primarily people interested in having AAS make such a statement.
- (4) The draft document was then presented via PowerPoint slides at a session at the meetings of the International Association for Suicide Prevention (IASP) in Kuching, Malaysia, July 19, 2017. The audience (approximately 20–30 people) was invited to submit anonymous comments, and several people did. These were also taken into account.
- (5) At these meetings and beyond, input was solicited from AAS members who might object. Five additional experts, a convenience group formed partly of AAS members attending the IASP meetings, were given copies of the initial draft and asked for critical comment, suggestions, objections, etc. In this second phase of the project, respondents were also asked for their *independent* input.
- (6) The editor of the AAS's principal journal was included as an additional expert because of this position's special standing in the AAS.
- (7) During the second phase of the draft composition, of the experts from whom potentially negative responses might be expected, no one objected to the statement altogether. All (except one nonreply) submitted extensive copyediting and rewording suggestions, most of which focused on issues of overlap between suicides as conventionally understood and physician-assisted deaths. These comments were also incorporated into the document. It should be noted that not all editorial comments were compatible; some suggestions canceled each other out; the resulting document represents an effort to try to accommodate the basic concerns of all participants in this process but eliminate superficial differences.
- (8) The completed draft was then delivered to the AAS Board for its consideration. A folder containing all the TrackChanges-edited versions made by the various individuals involved in the first and second phases was also supplied to the Board, together with an account of the procedure followed in constructing the document.

The final document accepted by the AAS Board is the product of an effort to try to resolve the tension, evident within the AAS over a period of many years, between commitment to suicide prevention and the recognition that medical aid in dying is now legal in multiple jurisdictions, primarily in the developed world. The participants in this construction of this document were not asked whether aid in dying should or should not be legal; they addressed rather whether “suicide” in the conventional sense and aid in dying can be distinguished. Thus, the AAS statement is not a “consensus” policy document in the usual sense; rather, it makes the conceptual point that suicide in the conventional sense and aid in dying are different in the clear cases, but that there are areas of overlap that remain open for further research and discussion. The policy implications of the document, although not made explicit, would seem to be that the suicide prevention clinician or worker does not have a professional obligation to try to prevent clear, legal cases of aid in dying and that in the clear cases, there would be no professional objection to serving as a consultant in providing an assessment of the mental status of a terminally ill patient requesting aid in dying, as may be legally required if there is concern on the part of the attending or consulting physicians, although no psychologist or psychiatrist is required under any of the US laws to do so. Neither of these implications has direct bearing on whether the practice should or should not be legal.

As the product of both supporters and possible opponents, the AAS statement incor-

porates the views of a baker’s dozen suicide prevention experts initially working independently, and the resulting document is the product of the convener’s effort to consolidate both their agreement on some issues and disagreement about others. (This is most evident in the “overlap” section.) Although none of the parties involved objected to the construction of the document during phase 1 or phase 2, some of those involved in this process have pointed out that they do not support the resulting document fully. It was suggested during the discussions by the Board that a dissenting opinion or minority report be drafted, although this has not yet occurred.

Finally, it should be noted that the experts involved in the construction of the AAS statement work primarily in western, developed countries, where advanced mental health care, health care, and end-of-life palliative and hospice care are widely available; where causes of death primarily involve late-life degenerative diseases with characteristically long down-hill courses; and where discussion of end-of-life issues is often open. However, this cultural context represents only a small minority of the annual deaths worldwide. Thus, the AAS statement, developed as it has been in a largely western context, can be understood as an invitation for many sorts of future research, including “overlap” issues, cross-cultural issues, and many more.

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