

NEW WSPA POLICY ON VALUE-NEUTRAL LANGUAGE REGARDING END-OF-LIFE CHOICES

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On January 8, 2007, by unanimous vote of the Executive Board, WSPA adopted a policy on the use of value-neutral terminology, submitted by the End-of-Life Committee, regarding requests by mentally competent terminally ill individuals for physician aid-in-dying that distinguishes such choices from suicide. The policy neither endorses nor opposes the legalization of physician aid-in-dying, but supports efforts to refine current terminology in a way that respects and supports quality care for terminally ill individuals, and continues the scientific contributions to end-of-life care that psychology is so well suited to provide.

WASHINGTON STATE PSYCHOLOGICAL ASSOCIATION POLICY ON VALUE-NEUTRAL LANGUAGE REGARDING END-OF-LIFE CHOICES

WSPA recognizes that the term “suicide” implies psychiatric illness or other emotional distress that impairs judgment and decision-making capacity, and thus may not be an accurate or appropriate term for a terminally ill, mentally competent individual choosing to control the time and manner of his or her death. Therefore WSPA supports value-neutral terminology such as aid-in-dying, patient-directed dying, physician aid-in-dying, physician-assisted dying, or a terminally ill individual’s choice to bring about a peaceful and dignified death.

The new policy reflects awareness of the power of language to shape and affect human experience. At issue is the quality of end-of-life experience, both for dying individuals and those who love them. Profound psychological differences distinguish suicide from patient-directed dying. The term suicide is traditionally used to refer to medically well individuals who wish to end their lives because of severe emotional suffering and/or psychiatric disorders. Typically they do not consult with or have the support of others, acting alone, often choosing violent means, and causing suffering to those they leave behind. Mentally competent, terminally ill individuals who wish for a humane and dignified death that is patient-directed, supported by the patient’s family and physician, in a situation in which death is inevitable, differ from suicidal medically well individuals. A person with a terminal illness is going to die even with, or despite, the best medical treatment available. The designation of suicide is disrespectful to individuals with terminal illness who wish to have choice regarding death with dignity, and can be distressing and problematic emotionally, socially, psychologically, and financially, for family members and loved ones of dying individuals.

WSPA has been a leader among state psychological associations and other mental health organizations including APA for 10 years in providing expertise in the national debate on the question of whether a terminally ill person expressing a desire for a humane

hastened death can be rational and competent to make such a decision, and whether mental health professionals have adequate diagnostic tools to assess the mental competency of a terminally ill person making such a request. WSPA has commented in amicus curiae briefs submitted to the U.S. Supreme Court in 1996 and several state district courts since then that (1) If a terminally ill person wishes to die, it does not necessarily mean that the person is depressed. Even if a terminally ill individual has some symptoms of depression, this does not necessarily mean the person has lost decision-making capacity regarding health care. (2) Diagnostic tools and guidelines are available to identify factors in a terminally ill patient's wish to hasten death, determine the patient's mental capacity, examine whether clinical depression is a motivating factor, and evaluate for impaired judgment.

A number of other health care agencies and associations have recently adopted similar policies regarding value-neutral terminology.

1. The Oregon Department of Human Services, which is vested with responsibility to report on the Oregon Death With Dignity Act (ODWDA), adopted a policy in October 2006 that it will no longer use the terms “assisted suicide” or “physician-assisted suicide.” This is consistent with the wording of the Oregon law: "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." (<http://www.oregon.gov/DHS> <<http://www.oregon.gov/DHS>>; <http://www.ama-assn.org/amednews/2006/11/06/prsc1106.htm>)

2. The American Public Health Association adopted a policy in November 2006 that terms such as “aid in dying” or “patient-directed dying” rather than “suicide” or “physician-assisted suicide” be used to describe the choice of mentally competent, terminally ill persons to “self-administer medication to allow them to control the time, place, and manner of their own impending death.” (<http://www.apha.org/legislative/policy/policysearch/index.cfm>)

3. The American Academy of Hospice and Palliative Medicine approved a position statement on “physician-assisted death” in February 2007, acknowledging that in cases of intolerable suffering persisting even when such state-of-the-art palliative care is delivered, a patient may request physician assistance for self-administered lethal medication. “The term [physician assisted death] is utilized...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... AAHPM takes a position of ‘studied neutrality’ on the subject of whether PAD should be legally regulated or prohibited, believing its members should instead continue to strive to find the proper response to those patients whose suffering becomes intolerable despite the best possible palliative care.” (<http://www.aahpm.org/positions/suicide.html>)

4. Support for value-neutral language was approved by the Executive Board of the Oregon Psychological Association in March 2007.

All of these policy changes are congruent with the 2000 report of the APA Working Group on Assisted Suicide and End-of-Life Decisions which stated: "It is important to remember that the reasoning on which a terminally ill person [whose judgments are not impaired by mental disorders] bases a decision to end his or her life is fundamentally different from the reasoning a clinically depressed person uses to justify

suicide." See Working Group on Assisted Suicide and End of Life Decisions. (2000).
Report to the Board of Directors. Washington, DC: American Psychological Association:
<http://www.apa.org/pi/aseolf.html>
<http://www.apa.org/ppo/issues/asresolu.html>