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My name is Christopher A. Riddle, PhD, and I am a Professor and Chair of Philosophy at Utica University in New York, USA. I have dedicated my life to promoting the rights of people with disabilities and have written books on disability and justice, as well as the promoting of human rights for people with disabilities. I very strongly support Assisted Dying and have published in some of the most prestigious academic venues detailing my defense of it. The following is an excerpt from a forthcoming publication detailing what can be learned from those jurisdictions that permit aid in dying. I argue that despite criticism from some disability rights organizations, their concerns are neither justified, nor representative of all people with disabilities. This book chapter will appear as:

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Concerns about person affecting harm permeate almost all disability rights organizations' objections to aid in dying. The question at hand is the following: Is there any evidence in jurisdictions where aid in dying is legal that suggests harm befalls people with disabilities or other vulnerable populations to a greater extent than other states without legalized aid in dying?

The short answer is that no harm appears to have befallen people with disabilities or others as a result of permitting aid in dying.

Consider first, jurisdictions outside of America prior to moving to American ones. There exist more complexities with systems in most European jurisdictions than American ones, but nonetheless, these complexities do not give way to abuse.

In the Netherlands, for example, there is no evidence that people with disabilities or other vulnerable groups are experiencing harm as a result of medical aid in dying. There is some well-documented concern over under-reporting within the Netherlands, but Govert den Hartogh (2012) attributes this under-reporting to what he calls "a relic of prelegalization practice" (366), and not as a result of the legalizing of euthanasia.

Opponents suggest that doctors and other medical professionals might be inclined to hasten the death experience against the wishes of a patient. Disability Rights Organizations suggest that this practice is more likely employed against people with disabilities who might be perceived to have a life not worth living. Disability Rights objectors cite concerns that the most likely manner in which lives might be ended without request would be for those outside of the terminal window to be killed (Hartogh 2012, 365). The concern emerges from the claim that with normalizing the taking of lives, compassion might be thought to extend outside of the legal restrictions placed on aid in dying practices. Medical professionals might view suffering to be so bad that they hasten the death experience, even without death being immanent, as defined by the law. Perhaps obviously, given the ablest attitudes of many in society, disability rights organizations suggest this notion of suffering and a life not worth living might be more likely to be applied to people with disabilities. The concern here then, is that an under-reporting of the use of some drugs, such as morphine, might result in the use of it in large doses to kill those who have not expressed desire to die, and who have not navigated the legal process and the safeguards within. Opponents do not attribute malicious intent to medical professionals in all instances, but instead, can suggest such actions could emerge from a misbegotten effort to spare the disabled from lives perceived to be so dominated by suffering that they are not worth living.

That said, there appears to be no evidence of this in the Netherlands that cannot be explained by a more general underreporting of morphine use (Hartogh 2012, 366). In short, “no evidence for this causal nexus has ever been offered” (Hartogh 2012, 365). In other words, while under-reporting of terminal sedative drugs exists, although decreasing in frequency (Onwuteaka-Philipsen 2012, 127), there is no evidence to suggest that this under-reporting constitutes an instance of abuse against disabled people or other vulnerable populations (Battin et al. 2007, 597).

Similar conclusions can be drawn in Belgium. Indeed, little or no opposition exists to Belgian laws from Belgian disability rights organizations or people with disabilities. Concern about abuse is not

present in Belgium and there appears to have been little or no opposition to the legalizing of euthanasia from disabled people (Fitzpatrick and Jones 2017, 147). There is no evidence to suggest abuse of any kind, and indeed, there remains to be no organized disability-rights-based opposition to even a mere hypothetical risk of harm, let alone any attempt to suggest actual harm exists (Fitzpatrick and Jones 2017, 149).

In Canada, where aid in dying has been legal since 2016, and where 2 percent of all accounted deaths were attributed to the practice in 2019, there is no evidence of person affecting harm emerging from either abuse of the system, or the system itself (Martin 2021, 137). Indeed, recent data from Canada, the Netherlands, and Belgium are consistent with the claim that there is “no indication that individuals who *may* be vulnerable to undue influence are accessing assistance in dying” (Martin 2021, 142).

Within the United States, and Oregon in particular, the jurisdiction with the oldest assisted dying laws in America, there is no evidence of vulnerable populations of any kind experiencing person affecting harm. No Oregonians with disabilities have, since 1997, experienced person affecting harm from aid in dying. No people without a terminal diagnosis confirmed by two physicians have died in Oregon (Battin et al. 2007, 594). More pointedly, “no one received such assistance for disability alone” (Battin et al. 2007, 594). Robert Lindsay has concluded that a “decade after implementation of the ODWDA [Oregon Death with Dignity Act], the weight of evidence suggests that these predictions of dire consequences were incorrect” (Lindsay 2009, 19). Indeed, a good deal of data points to rejecting many people who requested aid in dying, who were not deemed capable of consenting to such action. Almost 20 percent of requests for aid in dying came from patients deemed to be experiencing depression, and exactly none of them progressed to medical aid in dying (Battin et al. 2007, 596). More generally, no people availing themselves of aid in dying were concluded to have a mental illness influencing their decision (Battin et al. 2007, 596).¹ Indeed, not only has no disparate impact on those perceived to be

vulnerable been detected, but there has been no slippery slope, and there has been, more generally, the effective prevention of abuse (Lindsay 2009, 22–23). Indeed, some strong opponents to medical aid in dying have publicly expressed that the concerns they previously stated have not materialized (Coombs Lee 2014, 97–98). In short, there is no evidence of abuse or coercion, and there is no evidence to suggest the misuse of the carefully crafted policies supporting aid in dying (Coombs Lee 2014, 99).

To support this point further, consider that 87.8 percent of individuals availing themselves of medical aid in dying were in a hospice setting (Al Rabadi et al. 2019, 5). If patients were typically placed in a hospice care setting prior to initiating medical aid in dying requests, there is an additional layer of protection to confirm terminal diagnosis, and to thus, avoid or mitigate the potential for the sort of abuse opponents suggest is present.² That said, data “supports the overall safety and reliability of the lethal medications used in MAID [medical aid in dying]” (Al Rabadi et al. 2019, 5).

But, in the absence of evidence of person affecting harm, is there still cause to be concerned about this possibility as a matter of principle? I suggest there is not.

Arguments concerned about person affecting harm ought not to be regarded as justifying a prohibition on aid in dying for at least the following two reasons. First, disability rights organizations that suggest person affecting harm constitutes a sufficient threat to prohibit medical aid in dying are guilty of moral inconsistency. Second, these arguments also fail because of moral disproportionality.

Some forms of the argument suggest that there is an illusion of free choice when seeking medical aid in dying, and thus, people with disabilities will be harmed because they will be forced or coerced to avail themselves of it. The claim is that for some vulnerable populations, it is not a free choice, but instead, a forced one (Scoccia 2010, 481). It is suggested that when choices are made in the context of pervasive inequality, or under a structure of oppression, free choices cannot exist (Scoccia

¹ It is relevant to note that this study has received critical appraisal (Finlay and George 2011). That said, the critical remarks focused on the study’s perceived failure to identify all possible forms of vulnerability, and thus, do not undermine the claims pertaining to any potential person affecting harm to people with disabilities.

² Indeed, palliative care, has appeared to have improved in jurisdictions permitting aid in dying (Lindsay 2009, 19).

2010, 481). Indeed, actions taken by people with disabilities to seek aid in dying might be thought to be suitably likened to those taken by others when under duress (Feinberg 1989, 98–219).

Additionally, not only is the concern that people with disabilities might avail themselves of aid in dying due to social pressures, but that they themselves might be viewed as preferential subjects or objects of euthanasia and be killed against their will (Somerville 2001, 263). In short people with disabilities might not only be pressured to invoke the legal process for aid in dying, but they might be killed, against their will, in spite of safeguards or laws designed to protect them.

Some suggest the only method to ensure the prevention of person affecting harm as a result of aid in dying is its prohibition:

‘[S]afeguards cannot be established to prevent abuses resulting in the wrongful death of death of numerous disabled persons, old and young.’ Indeed, the only true safeguards against abuse ‘is that assisted suicide remain illegal and socially condemned for all citizens equally’ (Bickenbach 1998, 125).

Sumner (2018, 105) calls arguments of this variety, ‘arguments from abuse’, and suggests the common thread is a concern over safeguards being inadequately established, or monitored and enforced. Similarly, but more generally, I have previously called these arguments, ‘avoidance of harm’ arguments (Riddle 2019, 188–90).

I believe arguments of this kind suffer from a moral inconsistency that renders them ineffective. First, consider how many people die as a result of aid in dying. This numbers differs significantly depending upon jurisdiction, but ranges from .05 percent of deaths, to as high as 1.7 percent of total deaths (Emanuel et al. 2016, 85). By any measure, this number represents a very low percentage of total deaths. In other words, not many people are dying from aid in dying.

In contrast, consider those who have opted to refuse or remove life sustaining treatment. Approximately 85 percent of critical care physician respondents acknowledged that they had withdrawn or withheld life support in the preceding year (Way, Back, and Curtis 2002, 1342). An American study indicated that between 1992 and 1993, over 90 percent of deaths in intensive care units resulted from a

decision to withdraw or withhold life support (Way, Back, and Curtis 2002, 1342). This is true in most countries, where most deaths in intensive care units occur as a result of a decision to stop or refuse life sustaining treatment (Way, Back, and Curtis 2002, 1342).

Importantly, all the reasons that can be invoked to support the refusal or removal of life sustaining treatment, can be applied, with equal force, to medical aid in dying. Because we value patient autonomy, and relief of suffering, we permit patients to make choices about the kind of care they receive, or do not receive, at the end of their life. These reasons are so powerful, that we permit people the autonomy to make them even when it will surely result in their death. Why then, are disability rights organizations not in favor of denying patients the right to remove or refuse treatment? I suggest that for their argument against aid in dying to be morally consistent, they must.

Surely the potential for abuse that can emerge with aid in dying is also present in current practices. People with disabilities or other vulnerable groups, such as the elderly, or even those living in poverty, might be thought to be pressured into hastening their death experience. They could just as likely be subjected to an unjust death from a medical professional exercising a wrongful notion of compassion to rid them of a life perceived to be so dominated by suffering or misery, that it is not worth living. In short, our current practices that permit people to make choices about care at the end of their life are not subject to the same scrutiny that medical aid in dying is, and many more people are forced to make choices pertaining to the refusal or removal of care, than those who will be eligible, or who will seek, aid in dying. If disability rights organizations were genuinely concerned about abuse of healthcare systems and person affecting harm against people with disabilities, they should be equally as concerned about granting *any* autonomous decision-making ability at the end of life, due to both its equal potential for abuse, and its more frequent use. They are silent on this matter however. To fail to apply their moral logic in this case constitutes a moral inconsistency that is both unjustifiable as a matter of principle, as well as inexplicable.

I argue that opposition of this kind is also morally disproportionate. By morally disproportionate, I mean to suggest something like the following: as a result of a moral wrong or harm, actions to be taken must be proportionate to that harm, and similar to analogous cases where moral wrong or harm has been done. In other words, despite the fact that no demonstrable harm emerges from permitting aid in dying, *if it could*, it would be insufficient to point to an instance or instances of harm, and suggest that on the basis of that harm, a proportionate response is its prohibition. Instead, one must demonstrate, again, counterfactually, that not only will harm emerge, but that it is of a sufficient quality and quantity that it justifies an outright refusal to permit the action leading to that harm.

To be clear, such an argument has not been made with reference to aid in dying, nor can it be. To demonstrate this, consider other actions that have risks. All medicine carries risk. For example, it is thought to be the case that as high as 10 percent of patients admitted into a hospital setting will suffer an adverse reaction, or acquire a new ailment, often as a result of medical error, by virtue of being in the hospital (Riddle 2019, 190). This number is startling, and demonstrates the risk that we endure to receive medical treatment. No one suggests we ought to prohibit hospital visits as a result of medical error and the person affecting harm that emerges as a result of it. The reason this is not suggested is because it is not morally proportionate to do so. It is neither proportionate to risk aversion strategies employed in morally similar situations, nor would it be proportionate to the actual quality and quantity of harm or risk, more generally.

We can now circle back to a discussion of the refusal or removal of life sustaining care. I argue that this represents a much greater threat to people with disabilities and other vulnerable populations than aid in dying. That said, no one has argued for a denial of autonomy at the end of a patients' life in this regard. As a result of moral proportionality, disability rights organizations cannot argue for a moral prohibition on aid in dying. At most, opponents to aid in dying can argue for safeguards to be enacted, as we do with reference to hospital visits more generally, and to end of life decisions to refuse or

remove life sustaining care. To suggest a prohibition on aid in dying is justifiable, is to make a morally disproportionate argument. In other words, opponents to aid in dying overstate the implication of their argument, and suggest a prohibition on the practice, when at best, their principled case can justify the enacting of safeguards, which have already been established, and proven to be reliable.

That said, not all harm that can emerge from legalized aid in dying is of this kind. There is also a concern that the mere permitting of assisted dying causing emotional, attitudinal, or existential harm, to vulnerable groups by suggesting their lives are not worth living. The prejudices that exist against people with disabilities are in fact, harmful and abundant (Morin et al. 2013). Disability rights organizations suggest that by legalizing aid in dying, people with disabilities will be further devalued and harmful stereotypes will be ignited, rather than extinguished. If people with disabilities are at present, devalued, which we have sound reason to believe is true, the concern is that legalizing medical aid in dying would be even more “detrimental to the way that [the disabled] are viewed by society as a whole” (Box and Chambaere 2021, 4).

Measuring social attitudes is difficult, especially when subjects are asked about attitudes or dispositions that they know they ought not to have, or that are not socially favorable, such as discriminatory or ableist ones (LaPiere 1934, 230). Indeed, it is often thought that actions are more representative of attitudes or dispositions (LaPiere 1934, 237). The adage, ‘actions speak louder than words’ is perhaps helpful to bear in mind here. If what we aim to discover is if people with disabilities are devalued to a greater extent in states that have legally permissible aid in dying, than examining how those states *treat* people with disabilities, and not just reported attitudes, is perhaps a good starting point. In other words, if disability rights organizations suggest that disabled people are devalued by legalized aid in dying, it should be the case that support services and spending on people with disabilities is less in states with medical aid in dying than in those without. In fact, the opposite appears to be true.³

Just as with person affecting harm, let us start by examining non-American jurisdictions first. Public expenditure on disability (PED) is a measure commonly used in Europe to assess welfare programs for people with disabilities across different, and seemingly incommensurable, social welfare models. European models of disability welfare are startlingly different in their approaches and application, but have a common solidarity and commitment to both social justice more generally, as well as the provision of resources to mitigate and eliminate social exclusion, more specifically (Boeri, Borsch-Supan, and Tabellini 2001; Hemerijck 2002). People with disabilities are thought to represent approximately 17 percent of the population of Europe for people between the ages of 16 and 64 (Navarro, Rodríguez, and Santamaría 2021, 1481). Given the significance of this number, PED is an especially important measure.

The typical manner in which PED is assessed is as a percentage of total social expenditures. Thus, the higher the percentage of total social expenditure absorbed by PED, the more resources allocated to people with disabilities, and in my estimation, the greater the social value placed upon disabled people. After all, if people with disabilities were devalued, presumably the policies within those States would reflect those values, and public expenditure would at least trend in a direction that reflected those social values. Conversely, if disabled people were thought to deserve provisions necessary through the law, public expenditure would also reflect this positive disposition (or at least not a negative one) towards the disabled.

The European Union (EU) average is 7.38 percent of total social expenditure on PED. Countries that are thought to correspond to the Nordic typology, perhaps unsurprisingly, do remarkably well in this regard. Denmark, Sweden, Holland, and Finland, are all significantly higher than the other EU countries (Navarro, Rodríguez, and Santamaría 2021, 1481). That said, Belgium and the Netherlands

³ It is important to note that I am not suggesting a causal effect between aid in dying and support for people with disabilities. I am not suggesting that legalizing aid in dying increases support services for disabled people. That said, it is at least possible that in light of a concern over abuse of aid in dying, states increase support services for people with disabilities. This has not been established however.

have a PED as a total percentage of social expenditure much higher than average. Belgium's PED as a percentage of total social expenditure is just below 9 percent, and the Netherlands is just above 9 percent – significantly above the European Union average (Navarro, Rodríguez, and Santamaría 2021, 1481).

In short, if it were true that legalized aid in dying causes the further devaluing of disabled people, and if it were also true that this devaluing would manifest itself in harmful social policy and less expenditure on support for people with disabilities, then those countries that permit aid in dying should be spending less on the disabled. This is not the case.

Let us shift our focus now to American jurisdictions. In the United States, the most common measure utilized for our present purposes is disability-associated health expenditures (DAHE). In 2015, for example, DAHE were \$868 billion nationally (Khavjou et al. 2021, 441). This number accounted for 36 percent of total health care expenditure nationally, and it ranged from 29 percent to 41 percent across states (Khavjou et al. 2021, 441).

Oregon spent 40 percent of total health expenditures on DAHE (Khavjou et al. 2021, 444). This number is bested only by two other states. Washington, which has the second oldest aid in dying laws in the country, also has a DAHE that is above the national average (Khavjou et al. 2021, 444). Vermont, the next state to legalize medical aid in dying, is on par with the national average (Khavjou et al. 2021, 444). California, although aid in dying was legalized the same year as the data was gathered, has a DAHE two points above the national average. Indeed, no state that had legalized aid in dying had a DAHE as a percentage of total health expenditures less than the national average at the time the data was collected. More pointedly, the data in the United States suggests that states with legalized aid in dying have a DAHE as a percentage of their total expenditure of health services, that is equal, or greater than, the national average. States that permit aid in dying are not devaluing people with disabilities or underfunding support services to any greater extent than states that do not permit medical aid in dying. Just

as in Belgium and the Netherlands, there appears to be a correlation between those states with aid in dying, and a higher DAHE as a percentage of total health expenditure.

Indeed, between 2003 and 2015, DAHE per capita spending increased well above the national average in Oregon. While nationally, the increase represented a 28 percent change, in Oregon it was 64 percent (Khavjou et al. 2021, 448). In other words, Oregon appears to be increasing its DAHE as a percentage of total health expenditure at a rate much faster than other states. Presumably, if aid in dying caused the devaluing of disabled people, this would result in DAHE per capita spending decreasing, or at least increasing slower than national trends, and not much faster. Again, every state with legalized aid in dying at the time these data were collected is above the national average with respect to increased spending on DAHE between 2003 and 2015 (Khavjou et al. 2021, 448).

In short, there appears to be no factual evidence to support the claim that legalizing aid in dying causes the greater devaluing of people with disabilities. More pointedly, harm of this second kind does not emerge as a result of aid in dying. It is simply inaccurate to suggest it does.

However, do arguments pertaining to this kind of harm have any principled merit? I argue that they do not. I argue that respect for people with disabilities and their autonomy demands access to aid in dying, and not its denial or prevention.

Arguments of this kind share a common sentiment: permitting aid in dying devalues the lives of people with disabilities. A primary concern is that harmful stereotypes become further ingrained into society when we suggest some lives are not worth living (Gill 2010, 35). More strongly, opponents can suggest that even if medical aid in dying provided a benefit to everyone, including people with disabilities, and did not introduce person affecting harm into their lives, that it would still be impermissible because the very practice harms people with disabilities as a group, or class (Scoccia 2010, 480). An analogy can be drawn between arguments of this sort, and arguments against something

like sex work, for example, that suggest even if it were not harmful to sex workers themselves, the very practice harms women, more generally (Scoccia 2010, 480).

Arguments of this kind are such that even without harm actually befalling people with disabilities, there is a greater social harm being done in the perpetuating of harmful attitudes or demeaning stereotypes against the disabled. These arguments suggest that an already marginalized or oppressed group is only bound to have those harmful attitudes magnified if aid in dying is encouraged or allowed. Given that many of us tend to think we have even stronger obligations to avoid *further* harming already disadvantaged populations, it only stands to reason, they might suggest, that the argumentative force behind a denial of access to aid in dying is even stronger when couched as being a matter of importance for disabled people.

Opponents to aid in dying suggest that it results in an affront to the dignity of disabled people that manifests itself through social policy and laws. As a result of this vulnerability, disability rights organizations argue that aid in dying ought not to be permissible.

To the contrary, I suggest that respect for people with disabilities demands the guaranteeing of autonomy and the recognition that people with disabilities, like people without disabilities, are best suited to make decisions about their own life and their own medical care. To suggest that people with disabilities ought to be denied the ability to control what happens with their own bodies at the end of their lives is an overly paternalistic attitude that cannot be justified, and that itself, does harm.

Indeed, respect for patient autonomy and compassion for patient suffering are claimed to provide powerful *pro tanto* reasons for permitting aid in dying (Sumner 2018, 103). The very manner in which these arguments are constructed demonstrates a lack of respect for the autonomy of people with disabilities. People with disabilities are individuals, and not an amorphous group of insignificant parts. Instead, rightly regarded, disabled people are capable of making important decisions on their own (Nelson 2003, 3).

I have previously argued that denying “people with disabilities the right to exercise autonomy over their own life and death says powerfully damaging things about the disabled, their abilities, and their need to be protected” (Riddle 2017, 487). The late Anita Silvers (1998) has forcefully stated that “characterizing people with disabilities as incompetent, easily coerced, and inclined to end their lives places them in the roles to which they have been confined by disability discrimination” (133). The attitude that people with disabilities need protecting from themselves is in itself, demeaning and patronizing.

Thus, if disability rights organizations want to promote the dignity and rights of people with disabilities, denying medical aid in dying is not the proper means of doing so. The patronizing and paternalistic attitudes displayed by opponents to aid in dying *cause* personhood affecting harm, rather than prevent it. By acknowledging that people with disabilities do not need protecting from themselves and that they are capable of making choices about their own care, even if pressured from ableist social attitudes, we can begin to undo the negative stereotypes that have followed disabled people even after the enacting of human rights provisions such as the Americans with Disabilities Act, or the UN Convention on the Rights of Persons with Disabilities. If true regard or care is to be given to endorsing actions that promote accurate, positive dispositions towards people with disabilities, disabled people need to stop being painted as helpless, pitiable individuals, requiring the care and protection of others. Such a disposition plays in to ableist preconceptions of disability and further entrenches attitudes of disability as a state of suboptimal or inferior functioning.

Importantly, the general practice of aid in dying, or the particular laws surrounding its implementation, make no judgments about what kinds of life are worth living. The only inherent values in the practice of medical aid in dying are ones concerning compassion for suffering, and perhaps most importantly, respect for autonomy. Neither the practice nor the laws force anyone to seek aid in dying and to suggest that people with disabilities are especially vulnerable to social nudging is to perpetuate

the myth that people with disabilities cannot make decisions of their own and need to be protected from themselves. Similarly, these laws offer no guidance as to who ought to consider such a practice, aside from those with terminal conditions. Negative valuations about people with disabilities are not perpetuated or brought to the forefront through legalized medical aid in dying. Denying its practice as a result of the perceived vulnerability of disabled people, however, does.

References

- Battin, Margaret P., Agnes van der Heide, Linda Ganzini, Gerrit van der Wal, and Bregje D Onwuteaka-Philipsen. 2007. "Legal Physician-Assisted Dying in Oregon and the Netherlands: Evidence Concerning the Impact on Patients in 'Vulnerable' Groups." *Journal of Medical Ethics* 33 (10): 59–597.
- Bickenbach, Jerome E. 1998. "Disability and Life-Ending Decisions." In *Physician Assisted Suicide: Expanding the Debate*, edited by Margaret P. Battin, Rosamond Rhodes, and Anita Silvers, 123–32. New York: Routledge.
- Boeri, T., A. Borsch-Supan, and G. Tabellini. 2001. "Would You Like to Shrink the Welfare State? A Survey of European Citizens." *Economic Policy* 32: 9–50.
- Box, Graham, and Kenneth Chambaere. 2021. "Views of Disability Rights Organizations on Assisted Dying Legislation in England, Wales and Scotland: An Analysis of Position Statements." *Journal of Medical Ethics* 47 (12): e64.
- Coombs Lee, Barbara. 2014. "Oregon's Experience with Aid in Dying: Findings from the Death with Dignity Laboratory." *Annals of the New York Academy of Sciences* 1330 (1): 94–100.
- Emanuel, Ezekiel J., Bregje D. Onwuteaka-Philipsen, John W. Urwin, and Joachim Cohen. 2016. "Attitudes and Practices of Euthanasia and Physician-Assisted Suicide in the United States, Canada, and Europe." *Journal of the American Medical Association* 316 (1): 79–90.
- Feinberg, Joel. 1989. *Harm to Self*. Oxford: Oxford University Press.
- Finlay, Ilora, and Rob George. 2011. "Legal Physician-Assisted Suicide in Oregon and The Netherlands: Evidence Concerning The Impact on Patients in Vulnerable Groups - Another Perspective on Oregon's Data." *Journal of Medical Ethics* 37 (3): 171–74.
- Fitzpatrick, Kevin, and David Albert Jones. 2017. "A Life Worth Living? Disabled People and Euthanasia in Belgium." In *Euthanasia an Assisted Suicide: Lessons From Belgium*, edited by David Albert Jones, Chris Gastmans, and Calum MacKellar, 133–49. New York: Cambridge University Press.
- Gill, Carol J. 2010. "No, We Don't Think Our Doctors Are Out to Get Us: Responding to the Straw Man Distortions of Disability Rights Arguments Against Assisted Suicide." *Disability and Health Journal* 3

(1): 31–38.

- Hartogh, Govert den. 2012. "The Regulation of Euthanasia: How Successful Is the Dutch System." In *Physician-Assisted Death in Perspective: Assessing the Dutch Experience*, edited by Stuart J. Youngner and Gerrit K. Kimsma, 351–91. New York: Cambridge University Press.
- Hemerijck, A. 2002. "The Self-Transformation of the European Social Model." *Internationale Politik Und Gesellschaft* 4: 39–66.
- Khavjou, Olga A., Wayne L. Anderson, Amanda A. Honeycutt, Lurel G. Bates, NaTash D. Hollis, Scott D. Grosse, and Hilda Razzaghi. 2021. "State-Level Health Care Expenditures Associated With Disability." *Public Health Reports* 136 (4): 441–50.
- LaPiere, Richard T. 1934. "Attitudes Vs. Actions." *Social Forces* 13 (2): 230–37.
- Lindsay, Ronald A. 2009. "Oregon's Experience: Evaluating the Record." *The American Journal of Bioethics* 9 (3): 19–27.
- Martin, Stevie. 2021. *Assisted Suicide and The European Convention on Human Rights*. London: Routledge.
- Morin, D., M. Rivard, A. G. Crocker, C. P. Boursier, and J. Caron. 2013. "Public Attitudes Towards Intellectual Disability: A Multidimensional Perspective." *Journal of Intellectual Disability Research* 57 (3): 279–92.
- Navarro, Maria José Portillo, Gabriela Lagos Rodríguez, and Maria Leticia Meseguer Santamaría. 2021. "Public Expenditure on Disability (PED) in Europe: An Efficiency Analysis." *Regional Science Policy & Practice* 13 (4): 1479–95.
- Nelson, Lawrence J. 2003. "Respect for the Developmentally Disabled and Forgoing Life-Sustaining Treatment." *Mental Retardation and Developmental Disabilities Research Reviews* 9 (1): 3–9.
- Onwuteaka-Philipsen, Bregje D. 2012. "The Unreported Cases." In *Physician-Assisted Death in Perspective: Assessing the Dutch Experience 2*, edited by Stuart J. Youngner and Gerrit K. Kimsma, 123–36. New York: Cambridge University Press.
- Rabadi, Luai Al, Michael Leblanc, Taylor Bucy, Lee M. Ellis, Dawn L. Hershman, Frank L. Meyskens, Lynne Taylor, and Charles D. Blanke. 2019. "Trends in Medical Aid in Dying in Oregon and Washington." *JAMA Network Open* 2 (8): e198648.
- Riddle, Christopher A. 2017. "Assisted Dying & Disability." *Bioethics* 31 (6): 484–89.
- . 2019. "Assisted Dying, Disability Rights, and Medical Error." *International Journal of Applied Philosophy* 32 (2): 187–96.
- Scoccia, Danny. 2010. "Physician-Assisted Suicide, Disability, and Paternalism." *Social Theory and Practice* 36 (3): 479–98.
- Silvers, Anita. 1998. "Protecting the Innocent from Physician-Assisted Suicide." In *Physician Assisted*

Suicide: Expanding the Debate, edited by Margaret P. Battin, Rosamond Rhodes, and Anita Silvers, 133–48. New York: Routledge.

Somerville, Margaret. 2001. *Death Talk: The Case Against Euthanasia and Physician-Assisted Suicide*. Montreal: McGill-Queen's University Press.

Sumner, L. W. 2018. "Disability, Death, and Self-Determination." In *From Disability Theory to Practice: Essays in Honor of Jerome E. Bickenbach*, edited by Christopher A. Riddle, 101–20. New York: Lexington Books/Rowman & Littlefield.

Way, Jenny, Anthony L Back, and J Randall Curtis. 2002. "Withdrawing Life Support and Resolution of Conflict with Families." *British Medical Journal* 325 (7376): 1342–45.

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