

After the Slippery Slope: Dutch Experiences on Regulating Active Euthanasia

Theo A. Boer

Abstract

“When a country legalizes active euthanasia, it puts itself on a slippery slope from where it may well go further downward.” If true, this is a forceful argument in the battle of those who try to prevent euthanasia from becoming legal. The force of any slippery-slope argument, however, is by definition limited by its reference to future developments which cannot empirically be sustained. Experience in the Netherlands—where a law regulating active euthanasia was accepted in April 2001—may shed light on the strengths as well as the weaknesses of the slippery slope argument in the context of the euthanasia debate. This paper consists of three parts. First, it clarifies the Dutch legislation on euthanasia and explains the cultural context in which it originated. Second, it looks at the argument of the slippery slope. A logical and an empirical version are distinguished, and the latter, though philosophically less interesting, proves to be most relevant in the discussion on euthanasia. Thirdly, it addresses the question whether Dutch experiences in the process of legalizing euthanasia justify the fear for a slippery slope. The conclusion is: Dutch experiences justify some caution.

Despite the fact that we live in a global village, and despite the fact that values and norms are widely exchanged within the Western culture, some differences have in the past decades become larger instead of smaller. The discussions on euthanasia and assisted suicide are an example. In this paper, I intend to contribute to the discussion from an inside perspective, i.e., as a participant in a political

culture in which active euthanasia is considered more or less accepted, having worked in medical ethics in a clinical setting for most of my career, and being part of a family of practicing physicians and nurses. The paper will concentrate upon one of the arguments used in the current euthanasia debate worldwide: the contention that any form of legalization of voluntary euthanasia will inevitably go from bad to worse, from euthanasia in the case of terminal diseases to assisted suicide under much broader conditions,¹ to more requests, to misuse, to nonvoluntary or even involuntary euthanasia and, eventually, to an erosion of the roots of our public morale. I will concentrate on developments in Holland.² It should be noted from the onset, however, that other countries, which have not or not yet legalized euthanasia, may be worse off than the Netherlands.³ In this paper, I will first clarify the Dutch legislation on euthanasia and comment on the cultural context from which it stems. Second, I will look at the argument of the slippery slope: What does it mean to use the argument? What function does it have in ethics? Thirdly, I will combine the two and look whether Dutch experiences since the legalization process of euthanasia give ground to the fear for a slippery slope.

The Dutch Euthanasia Law

In April, 2001, the Dutch Senate passed a law concerning active euthanasia and physician assisted suicide. This makes the Netherlands the first country in the world which has legalized euthanasia.⁴ Although assisted suicide and euthanasia remain part of the Criminal Code, the law itself contains a special ground for exemption from criminal liability. This ground means that doctors who terminate life on request or assist in a patient's suicide can no longer be prosecuted, provided they satisfy the statutory due care criteria and notify death by non-natural causes to the appropriate regional euthanasia review committee.

When dealing with a patient's request for euthanasia, doctors must observe six due care criteria. They must:

1. be convinced that the patient's request is voluntary and well-considered;
2. be convinced that the patient's suffering is unbearable and that there is no prospect of improvement;
3. inform the patient of his or her situation and further prognosis;
4. discuss the situation with the patient and come to the joint conclusion that there is no other reasonable solution;
5. consult at least one other physician with no connection to the case, who must then see the patient and state in writing that the attending physician has satisfied the due care criteria listed in the four points above;
6. exercise due medical care and attention in terminating the patient's life or assisting in his or her suicide.

An important, basic principle established in case law is the existence of a close doctor-patient relationship. A doctor may only perform euthanasia on a patient in her care. She must know the patient well enough to be able to assess whether the request for euthanasia is both voluntary and well-considered, and whether his suffering is unbearable and without prospect of improvement.

The five regional review committees mentioned in the Act had already been established under earlier legislation on November 1, 1998. Their task is to assess whether doctors satisfy the criteria of due care.⁵ A commission consists of an odd number of members, among which at least one lawyer, who at the same time is the chairperson, one physician, and one ethicist. In contrast with earlier legislation, the new law which came into force in April, 2002, holds that a review committee will only notify the Public Prosecution Service if there are indications that a physician has not acted in accordance with the due care criteria. The committees have some discretion in deciding whether or not a doctor has satisfied the criteria. If there are no such indications, euthanasia will not be reported to the prosecutor. The regional review committees are also responsible for keeping record of the reported cases of euthanasia and assisted suicide. Keeping record is also useful as an instrument for later evaluation.

The new law concerns only termination of life on request. A written directive counts as a well-considered request for euthanasia, but its existence can never discharge the doctor from his duty to reach his own decision on the request in the light of the statutory due care criteria. As with any written directive, the doctor must give serious consideration to the patient's written request. The only exception is where he has reason to believe that the patient was not competent to make a reasonable appraisal of his own interests at the time when he signed the request. In that case, the directive will not constitute a request for euthanasia within the meaning of the Act. It is important that the doctor and the patient discuss the terms of the directive, if at all possible. The statutory provision for written directives makes it possible for patients to indicate in advance that they wish their lives to be terminated if they eventually find themselves in unbearable suffering with no prospect of improvement, in circumstances which render them incapable of expressing their wishes personally. Since the law applies only to termination of life on request, it follows that it is not applicable to patients who have made no advanced directive and are unable to decide or express their wishes. Whether the new government will make additional statutory provision for this category of patients, remains unclear (see below).

Please note the Dutch definition of "euthanasia": intentional termination of life by a doctor at the request of a patient. When there is no request, e.g., because the patient is in a coma, use of the term "euthanasia" is not common; instead, the term "termination of life without request," or less popular, "non-voluntary euthanasia" is used. Termination of life against the will of the patient, "involuntary euthanasia," sometimes called "mercy-killing," is and remains murder and will be sentenced accordingly.⁶ Moreover, withdrawing or

withholding life sustaining treatment is not considered to be “passive euthanasia,” because the term “euthanasia” always refers to what most Americans classify as “active euthanasia.”⁷

The new law is the result of a compromise between those who wanted euthanasia to be taken out of the Criminal Code altogether, and those who were against any form of a legal arrangement. Some of the opponents got convinced that legislation seemed the only way to regain control over a practice which had grown more or less out of hand. A survey published in 1991, which was based on anonymous polls, showed that of a total of 129,000 deaths about 2,200 (1.7 percent) were the result of euthanasia; moreover, one thousand (0.8 percent) were the result of nonvoluntary euthanasia, i.e., the doctor performed euthanasia without a request.⁸ Five years later, a similar study was done. This study, which was published in 1996, shows an increase of the cases of euthanasia. Of an estimated 136,000 deaths in the Netherlands about 3,300, or 2.4 percent, were cases of voluntary euthanasia whereas 238, or 0.3 percent, were cases of assisted suicide. The number of euthanasia without request, however, had gone down to an estimated 900 (0.7 percent).⁹ During the 1990s, the number of cases reported by physicians went up, both in absolute and in relative figures. In 1990, 18 percent of the cases were reported, in 1995, 41 percent, and in 1998, an estimated 50 percent of the cases. These figures were obtained by combining the number of cases reported to the review committees, and estimates of the real number of euthanasia cases based on polls.

After 1998, the year when the review committees took over most of the work of the public prosecutor, we see something worth notifying. One of the reasons for establishing review committees had been the expectation that physicians are more apt to report euthanasia if they no longer have to turn themselves in at the office of the public prosecutor. Research had shown that doctors were more likely to report cases of euthanasia if their own peers had a hand in the initial review. The Health Department repeatedly expressed the hope that the preparedness to report would go up, or have to go up, from 50 percent to an estimated 60, 70, or 80 percent. However, instead of going up, the number of reported cases went down since 1999. Why this is so, remains disputed among experts. One of the explanations is that the presence of one or two physicians in the review committees is not at all so appealing as some had suggested; to be assessed by a medical colleague may be confronting rather than reassuring. Many doctors have found that the way in which they performed the euthanasia was critically scrutinized by the committees. Although a doctor is only rarely reported to the prosecutor—the “threat” is really modest—a considerable number of files are sent back to the physician with comments such as, “Why did you not offer alternatives?” and “Could you not have provided more adequate pain treatment?”

Besides reluctance to report to a committee which does its job thoroughly, there is another explanation which deserves consideration: the possibility that the absolute number of euthanasia cases has gone down. We will return to this later.

The Dutch Act on Euthanasia and Assisted Suicide should be understood against its own cultural background. Ever since the foundation of the Union of Utrecht in the year 1648, the Netherlands has considered itself to be a tolerant nation. Over the many waterways—rivers and oceans—many people and influences came which were “different.” There was extensive trade with many countries; Jews came from Portugal, Huguenots from France. Although officially a Calvinist country, a large Catholic minority was tolerated and was allowed to have its own places of worship and to keep its own lifestyle. At the end of the nineteenth century, the concept of “limited cultural sovereignty” was developed, according to which every social group was allowed its own standards; pluralism and freedom were important values already then. In the past decades, large groups from former colonies have immigrated to the Netherlands and contributed to further cultural pluralization. More than many European countries, Holland has a tradition of tolerance. The new euthanasia law fits well into this pattern. When someone requests euthanasia, this is first and foremost his or her own choice. The right to die at your own discretion is the ultimate freedom. No patient may ever be forced to undergo euthanasia, nor can a doctor be forced to perform it. The Dutch health care system is accessible to all and guarantees full insurance coverage for terminal and palliative care. Insurance companies are obliged to provide full palliative care without comparing the costs to the alternative—euthanasia. All this information is vital to understanding the Dutch way.¹⁰

Uses of the Slippery Slope Argument

In a double sense, Holland has become a guiding country: on the one hand setting the example for those advocating legalization of euthanasia and assisted suicide, on the other hand a haunting perspective for those opposing euthanasia. Interestingly enough, both those strongly for, and those strongly against, the Dutch law tend to see the Dutch euthanasia practice as a point on a road or, if you will, a slope. That is to say: the current practice is not, or not only, judged by virtue of its present features, but by what is feared or hoped for. I take this to be one of the major characteristics of the slippery slope. Despite the sometimes unarticulated use of the slippery slope argument, the argument generally means that a practice or a viewpoint A will, for some reason, with great probability lead to practice and viewpoint B (and C, etc.) which is not originally intended and sometimes not even foreseen.¹¹

The slippery slope argument is often used as a forceful argument to deter people from an alleged wicked path. A classical example of this is found in Leo Alexander:

Whatever proportions [Nazi] crimes finally assumed, it became evident to all who investigated them that they had started from small beginnings. The beginnings at first were merely a subtle shift in the basic attitude of physicians.

It started with the acceptance of the attitude, basis in the euthanasia movement, that there is such a thing as a life not worthy to be lived. Gradually the sphere of those to be included in this category was enlarged to encompass ... all non-Germans.¹²

Slopes on themselves are not necessarily an evil. Despite the dangers, many people visit the mountains. Of course, a mountain climber will take a number of precautions in order not to slide down and be hurt or killed. For a skier, sliding down a mountain is his main objective, but even in this case, sliding down has to take place under controlled circumstances. Some of those who have promoted the present euthanasia law consider the law as a strategic move on the road to complete legalization of every conceivable form of dying on request. For most, however, the slippery slope argument comes with negative associations.

In most literature, two versions of the slippery slope argument are distinguished: the logical (or conceptual) and the empirical (or factual, or psychological) version.¹³

The Logical Slippery Slope

The logical version of the argument holds that we logically have to accept B once we accept A; rejecting B when we accept A implies logically contradicting ourselves. For this to be true, A and B must be identical in one or more of their relevant characteristics, and the justification for A must also apply for B.¹⁴

The cogency and credibility of the logical slippery slope argument depend upon what exactly establishes this conceptual identity and this identity of justification. Let us take as an example the alleged slippery slope between euthanasia on terminally ill patients, and assisted suicide on patients who are "tired of living," but who can otherwise be called healthy.¹⁵ When I say that it is right to perform euthanasia in situation A, the conclusion that it must also be right to grant assisted suicide in situation B is based on either or both of two possibilities: shared characteristics of A and B—e.g., "the man in B is suffering as much as the woman in A" and "both persons ask for euthanasia"—and a shared argumentation for this option, such as, "suffering human beings have a *prima facie* right to voluntary euthanasia." Whether the latter is right if the former is right, depends on whether we agree that there are no essential differences between A and B. However, when there is disagreement about what establishes identity, or about the justification of norms, the argument that there is a slippery slope is disputed and it consequently loses much of its rhetoric effectiveness.

The logical slippery slope is thus only compelling insofar as there is some agreement on the identity of situations and justifications; this makes the argument rather circular. The director of the Dutch Association for Voluntary Euthanasia once stated that "[n]ow that euthanasia has become legal, it is a logical step to proceed to assisted suicide."¹⁶ To him, euthanasia on terminally ill patients is

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essentially the same as assisted suicide. His adversaries may reply that this rests on a wrong observation of the two situations (for example, in one case there is a physical illness, in the other there is not), and that killing on request can only be justified when there is a terminal physical illness. As with Kant's categorical imperative, we can always find a way to describe a universal moral law in terms which, although universalisable in principle, only apply to a limited number of cases in practice.

Whilst the logical version will hardly be convincing to those who disagree on the essentials, there is some perspective when there is agreement on the essentials (description of the situation and appliance of justificatory reasons). In such a discussion, standpoints can go two ways. First, one can conclude that the slippery slope argument actually is appropriate here, and be frightened, since one did not anticipate that A would logically imply B; or be amazed or even happy about the newly discovered continuity between one's confirmed position and the consequences following from one's position. If this logical implication is conceived to be morally negative, one can consider a change in one's normative position: since A leads to B, one no longer supports A. After euthanasia became legal, the Dutch discussion moved on to questions regarding medically assisted suicide—which is something else than saying that assisted suicide became accepted. Some physicians have withdrawn their initial approval of euthanasia once they discovered that their position implied approval of assisted suicide as well.

Secondly, discovering the truth about the slippery slope may lead one to take on a different justification. For example, some physicians whose main argument for supporting the possibility of euthanasia had been the patient's autonomy, and who after some decades of clinical experience judged the path towards assisted suicide enticing yet at the same time horrifying, instead argue on the basis of the principle of beneficence in combination with medical professional reasons. This argumentation makes it more difficult to justify euthanasia and assisted suicide in one breath. By disconnecting euthanasia and assisted suicide, they try to halt the latter from becoming clinical practice.

Since we are dealing with loose rather than strict logic in this question, the logical version has a number of weaknesses. First, it is hard to prove a clear logical continuity between any A and B; secondly, the ability to do so does not by any means guarantee a captive or easily convinced audience. As in so many political discussions, those who participate in the debate will find one way or another to "argue their way out" without having to alter their position. The logical slippery slope is more interesting to philosophers and ethicists than for doctors and politicians.

The Empirical Slippery Slope

Philosophically less interesting, but usually of great importance in the discussion concerning euthanasia and assisted suicide, is the empirical version of the argument. The empirical version holds that allowing A (or doing A) will eventually result in the acceptance of B (or doing of B), and C, etc. What status does the reference to factual developments have in critical morality? Within a utilitarian framework, reference to the empirical slippery slope is the least complex, since any consequence of an action, however irrational or unlogical it may be, has to be weighed into judgments about the rightness or wrongness of an action or policy. For a deontologist, reference to empirical data is *prima facie* more problematic. If euthanasia is considered a right originating from a patient's individual autonomy, the fact that a doctor might occasionally be tempted to force his patient towards euthanasia does not make the right to euthanasia wrong, although it may be considered circumstantial evidence against allowing euthanasia. Since most theories are mixed (i.e., they contain utilitarian elements), consequences of actions are morally relevant to some extent and will have to be weighed in. But how? Those who assume the intrinsic rightness or wrongness of certain actions can go into two directions. One is to prioritize the right to euthanasia or assisted suicide, despite the chances that this right may allow for some occasional misuse.¹⁷ The other is to stress the wrongness of the expected or feared abuse. It is fairly commonly accepted that the principle of non-maleficence outweighs other principles in the case of a clash; so a human rights adherent might argue that the chance that some may get "euthanized" against their will (murdered) once euthanasia becomes legal, suffices to overrule the rights of many. Which of the competing values is prioritized, depends on the type of deontology and is not inherent to the slippery slope metaphor.

Another way in which the empirical slippery slope may prove relevant ethically is when we assume that public intuitions have a legitimate role in determining critical morality, e.g., in Rawls' and Daniels' method of reflective equilibrium.¹⁸ Even here, it is not clear what this would imply in the euthanasia debate. On the one hand, we may take public fear for a slippery slope, however disputed logically, as an intuition ("marker of moral value") which should be taken seriously. On the other hand: should morality, as a result of a dynamic and critical moral process, not be granted the possibility of change? When someone predicts that when A is allowed to lead to B, and B to C, and C will no longer allow us to hold A, does this mean that B is wrong? When respect for patient autonomy is used as an argument for euthanasia, and a free euthanasia practice might cause those who were originally opposed to euthanasia to change their minds, is this an argument against euthanasia? In the Netherlands, a number of those who were opposed to legalizing euthanasia have become so familiar with this new phenomenon that they are no longer as critical as they were. They have become part of their own slippery slope, they know it, they admit it, and do not regret it. This may prove the accuracy of the empirical slippery slope more than anything else, but the moral question is: are we justified in blocking a road

towards a change in our own morals? Is the fear for a moral slide-down not, in the words of Hare, a “now-for-then preference” which should be met with sound suspicion?¹⁹ Should we not rather take one step at a time, and trust that at every new point in the process, we will be vigilant enough to prevent ourselves from sliding down?²⁰ I raise this question only to leave it open for now.

Like its logical counterpart, the empirical slippery slope might have a stronger and a weaker version. In the stronger version, A will inevitably lead to B, just as a stone hits the ground once it has been thrown into the air. In a weaker version, A will probably or possibly lead to B, just as it sometimes cannot be excluded that a stone hits a hiker before hitting the ground. It seems, however, that the empirical slippery slope by definition contains some degree of uncertainty. Putting a loaded rifle in the hands of a little boy is not a slippery slope: it is plain danger; but exposing a little child to too much violence on television may be a slippery slope, because the danger may or may not occur. The empirical slippery slope involves some uncertainty, or rather a chain of subsequent uncertainties, plus the expectation that this uncertainty may imply negative, normally very negative, scenarios.

The unpredictability of possible great danger is both a weakness and a strength. It may be considered a strength because language of risks and dangers has a powerful effect on any audience, no matter how high or low the odds are. The force of danger-talk lies not so much in its probability. Many people knowingly accept very different levels of risks in different contexts: they like skiing down the black diamond, while at the same time they avoid cholesterol-containing food. Rather, it is the way in which some dangers are portrayed. The slippery slope argument functions less as a reason for some people to hold a certain position than as a cause for holding it. Causes are sometimes more powerful than reasons, but whether this is an advantage, depends on one’s rhetorical purposes: is it to convince people or to influence them emotionally? The weakness of the argument, of course, lies in the virtual impossibility to substantiate it with empirical data. Moreover, it remains to be seen in this case how the process of legalization of euthanasia is related to the observations we made: has legalization contributed to the slippery slope, or has it prevented a further slide down? We would, for example, need reliable data from other countries, but these are virtually absent.²¹ This weakness becomes more tolerable once we realize the limited function and scope of the slippery slope metaphor in any moral discussion: it serves as a heuristic device with instrumental force, not as a *quasi* empirical or logical truth; if properly used, it may help us identify the core of our moral values, and detect threats to these values. Any serious moral evaluation will have to reach beyond the argument of the slippery slope.

Before we proceed to the last section, one remark needs to be made. As said, different moral theories have different responses to the threat of a slippery slope. A utilitarian will be eager to know about the risks, but he will not be alarmed as long as the risks, even in the gloomiest of scenarios, clearly outweigh the benefits.

In a mixed deontology, however, to which most versions of a Christian ethic can be reckoned, the calculation is not so easily made. Whenever innocent human life is threatened, however small in number, there is reason for caution. The elusiveness of moral logic and the unpredictability of future developments justify some skepticism towards the slippery slope argument, but they equally justify an alertness towards the few signs that reach us from the unknown future.

Three Slippery Slopes

There may or may not be a slippery slope in the Dutch euthanasia practice. So much can be said at the onset: thirty-five years of discussion, twenty years of tolerating, and a little less than ten years of legislation, roughly matching the time it took Germany to go all the way down the slippery slope, did not even remotely bring the Netherlands so far down.²² Several studies have been published to monitor the occurrence of euthanasia and assisted suicide and to compare this with the number of cases reported by physicians. Until now, none of these surveys indicates that the slope on which the Dutch are moving is especially steep.²³ Nevertheless, some observations from a Dutch context do warrant some caution.

Shifting Paradigms

Euthanasia is a liberty, not an obligation—not for patients, not for doctors. Despite this, it has become common practice in many hospitals and doctor's practices to interview only applicants who are not principally opposed to performing euthanasia. A physician may deny performing euthanasia in concrete cases—an estimated 70 percent of all requests are denied—but many of those who refuse on principal grounds, are considered harsh, dogmatic, and immoral. Those coming from medical school who are against euthanasia may have a hard time finding an appropriate working place. As for the patients, no one can even remotely be forced to request euthanasia. In the midst of the rather dramatic change in public attitude towards euthanasia which took place in the past decades, and which was materialized in a law, some may have a hard time keeping their own track. In the clinical practices of the doctors I know, it does occasionally happen that relatives of a patient, not the patient him- or herself, insist that the doctor puts an end to the suffering by performing euthanasia. A story of a friend of mine is indicative of this change. My friend, a man in his early forties, works in a social facility in my hometown. Some time ago, his boss was diagnosed with cancer. Within some months, the disease had become so serious that this man requested euthanasia and died. The next day, the team to which the young man belonged, heard the news in an official announcement. He was shocked and reacted emotionally: "How could this happen? A man is not a dog!" The deputy chef considered this remark to be so off-limit, that he sent my friend home for several weeks. To be sure, he could have expressed himself a little more

sophisticated, or respectfully. What exactly was so intolerable about his remark? Was it the fact that he compared his boss with a dog? That was just the thing he did not want to be the case. Was it the fact that he reacted without concern for the inherently tragic character of the situation—with or without euthanasia? Whatever he said, he wanted to express that he had wished his boss to die a more dignified death. Perhaps he was afraid of a slippery slope. The fact, however, that this expression of moral concern was not understood, and that his freedom to stick to his own evaluation was not respected, might in itself be seen as a sort of slippery slope. Do the Netherlands not have a tradition of tolerance? Do these and similar incidences not indicate the risk that in a *laissez-faire* society, the only thing to be tolerated may be tolerance itself?

The lack of sympathy for the opponents of euthanasia was reflected by the Minister of Health. When the Senate took a vote on the new law on April 10, 2001, more than 10,000 people demonstrated outside the parliament building—the first time after the much debated NATO decision in 1980 to install nuclear warheads on Dutch soil that such a large crowd came to The Hague for a political protest. Minister of Health Dr. Borst, a fierce advocate of the law, refused to receive a delegation of the protestors. Four days later she declared in an interview, “Unfortunately, I have lost every form of contact with the opponents, with people who think like they do.”²⁴ In the course of only a few decades, we actually have witnessed something like a paradigm shift: not the advocates, but the skeptics now carry the burden of proof.

The American historicist James Kennedy argues in his excellent study about the Dutch euthanasia debate, that this debate was not so much characterized by a lively exchange of pros and cons, but rather by its opposite: silence about the deepest disagreements.²⁵ An argument frequently used to convince critics was that the legalization of euthanasia was a matter of “when,” not of “if,” just like it is useless to walk backwards in a speeding train or, as the Dutch say, to fight windmills. This can be considered a slippery slope: after a discussion has reached an outcome, the “winners” no longer listen to the arguments of the “losers.”

However, some anomalies contradict the conclusion that the paradigm shift is complete and that euthanasia has become an undisputed practice. These signs do not come from the traditional opponents—some of whom have become less critical than they were—but from many of those who once argued in favor of a euthanasia law. The Dutch Association for Voluntary Euthanasia recently complained in its Quarterly that an increasing number of so called “sorry-doctors” refuse to perform euthanasia.²⁶ Feedback or intervision meetings of doctors, who volunteer as second opinion doctors for colleagues facing a euthanasia request, are called “sob-sessions.”²⁷ After years of experience, doctors find that they do not get used to the psychological and emotional burden of an intentionally caused death. Of all the physicians I know personally or professionally, many of whom are not opposed to euthanasia if the suffering cannot be relieved otherwise, there is not one who has not become more cautious and more critical in the face of a

euthanasia request than ten years ago.²⁸ Alongside this hesitation, we can observe a remarkable (albeit late) interest in palliative care in the Netherlands since 1995. In almost every region in the country, initiatives have been taken to establish hospice care. Instead of arguing that treatment of pain and discomfort could not be better, hospitals now compete in the introduction of advanced palliative care units.

With or without Request?

Essential in the Dutch acceptance of euthanasia has been the stress on individual liberty. *Involuntary* euthanasia, i.e., termination of life against the patient's will, is far beyond the scope of any euthanasia advocate. Reason for concern, however, are the findings of the Rummelink report (see note eight) that in about one thousand cases physicians admitted that they had actively caused or hastened death without the request of the patient. The impossibility to treat pain effectively was given as a reason in about 30 percent of these cases. The remaining 70 percent were motivated with a variety of motivations, from "low quality of life," to "all treatment was withdrawn but the patient did not die."²⁹ Although there is clearly reason for vigilance here, the concern is not so much that of a slippery slope.

In 1998, there was the *van Oyen* case. a physician who terminated the life of a severely ill elderly woman. The patient had not requested euthanasia, the doctor had not treated the symptoms of her condition, nor had he consulted a colleague. Doctor van Oyen was found guilty, not for denying the due care criteria (which he clearly had done), but for not reporting the case, and the court imposed a minor, and conditional punishment. This case was hardly seen as a victory by anyone. Rather, many advocates of the right to euthanasia were worried about the relatively mild verdict of the court; many were upset how easily the due care criteria of the new law could be set aside.

Shift of Indications

The term, "slippery slope" applies to a third field: the reasons or indications for requesting euthanasia. In the early 1980s there was a relatively broad consensus in the Netherlands that euthanasia could be justified in some exceptional cases: severely diseased patients with a physical illness who were in a terminal phase, and for whose suffering and discomfort there was no remedy. In the two decades since then, palliative care has progressed so dramatically that pain and discomfort alone can hardly be as compelling a reason for euthanasia as when the debate started. Instead, reasons have shifted and new indications pop up: psychological suffering, loneliness, fear to become socially redundant or irrelevant, fear to be a burden to relatives and loved ones, fear for insufficient care, fear for the time when no one calls you by your first name, Alzheimer's disease, as well as the fear for the prospect of Alzheimer's. Rather than ready to die, elderly people are said to be "finished living" or "tired of living." Minister of

Health Dr. Borst was open about her own fears. In her personal advanced directive, she expresses the will to receive euthanasia in case she would reach a certain stage of dementia.³⁰ Much controversial were her comments in a newspaper interview four days after the new euthanasia law passed the Senate. She cited the example of two 95-year-old people she had known. “They were bored stiff but, alas, not bored to death—because that was indeed what they wanted most of all. If they had said ‘I’ve got a pill here and I’m going to take it,’ I would certainly have been at peace with that.”³¹ These and similar remarks caused unease, not only amongst the opponents to the law, but also amongst those who had supported the law as a compromise. The discussion was not so much about the fact that a free individual held the opinion she did, but rather that these comments were made by the Minister of Health.

This shift (or evolution) in indications is reflected in two widely noted court cases. In 1994, there was the Chabot case: a psychiatrist administered a young woman the means for suicide, despite the fact that her depression probably could have been treated successfully. According to the woman, she would, after such a treatment, “no longer be myself.”³² The Supreme Court found the psychiatrist guilty but did not impose any punishment, because it felt that Chabot, apart from not having a psychiatric consultant see the patient, had otherwise behaved responsibly. The case was seen as a triumph by euthanasia advocates, since it legally established mental suffering as a basis for euthanasia.³³ Secondly, there was the Brongersma case in which a physician had assisted Brongersma, an 86-year-old senator, to take his own life. The senator, who was physically and mentally healthy, suffered severely from a lack of social contacts, some age-related physical inconveniences, and from the virtual absence of future prospects. In December, 2002, the Supreme Court found the physician guilty. Although it did not impose any punishment, the case is noteworthy: the Supreme Court explicitly states that “being tired of life” (“finished living”) cannot be a reason for euthanasia or assisted suicide. This jurisprudence on the highest level entails that on the basis of the present law no physician is justified in helping someone to die who is tired of living.

Conclusion

When the new law was accepted in April, 2001, no one foresaw the unprecedented political turmoil into which the Netherlands would come shortly after. In the aftermath of the September 11 attacks, public concern was captured by themes such as limitation of immigration, public security, and a quest for the core values of our civilization. A few days after the assassination of its greatest critic on May 6, 2002, the broad coalition of socialists and liberals which had been in power for eight years, was washed away. A new government, led by Christian Democrats, vowed not to make any moves towards a further liberalization of euthanasia. Plans for additional legislation on nonvoluntary euthanasia, plans for

regulating the right to voluntary euthanasia for children, and hopes for a separate law on the right to assisted suicide for people who are “tired of life” have, at least for some time, become futile. Not only are other issues more pressing, but the country seems to need a pause in order to evaluate the results of twenty-five years of political debate on euthanasia. Instead of making the present regulations tighter (which would be against the political mores), the government intends to monitor, stimulate, and enforce the compliance with existing regulations. In this political climate, further developments on the euthanasia scene are unlikely.

Are the Netherlands moving down a slippery slope? As I have tried to show, using the slippery slope metaphor may itself be a slippery adventure. The logical version of the argument may be interesting philosophically, but due to the elusiveness of moral logic, it will probably only function in limited discussions in which the conversation partners already share the most essential descriptions and values. Under the limiting condition that every “is-to-ought” relation is complex, the empirical version, despite the unpredictability of future developments, may be of some use. We can thus draw some conclusions. In the process of legalizing euthanasia,

1. the right to active euthanasia increasingly becomes the norm and opponents to euthanasia have now the burden of proof;
2. active euthanasia is performed even on some categories of patients who are not (or no longer) competent, and no politician seems to bother much about it;
3. the grounds for granting someone active euthanasia (or assisted suicide) are shifting from beneficence (extreme physical suffering) to autonomy (any coherent and lasting request will do).

At the same time, these and other experiences of the slippery slope are noticed and felt by many, and made explicit in a transparent public debate. Physicians who once defended the patient’s right to euthanasia now tend to refuse performing euthanasia. Palliative care initiatives focusing on the alternatives to active euthanasia are organized all over the country. Moreover, jurisdiction seems to have reached an equilibrium. A further loosening of the application of laws has not occurred since the Chabot verdict in 1994, and new legislation is not likely within the foreseeable future. Perhaps Dutch experiences in the euthanasia debate indicate that in an open and democratic society, self-corrective mechanisms may prevent many slippery slope nightmares from becoming true. Perhaps they prove that when euthanasia becomes legal, some unwanted or unexpected side-effects cannot be excluded. Perhaps they give reasons for caution in following the Dutch example. Do Dutch experiences justify at all the use of as strong a metaphor as the slippery slope? The answer depends, of course, on one’s view on death, dying, and the good society.

NOTES

¹ Unlike in some other countries, most Dutch people consider euthanasia to be more justifiable than assisted suicide.

² Strictly speaking, "Holland" refers to the two most populated provinces of the Netherlands. Because of the cultural and political dominance of these provinces, the term is used as *pars pro toto*.

³ For some comparative material, see Luc Deliens, et al., "End of Life Decisions in Medical Practice in Flanders, Belgium: A Nationwide Survey," *The Lancet*, vol. 356 (November 2000): 1806-11; D. E. Meier, et al., "A National Survey of Physician-assisted Suicide and Euthanasia in the United States," *New England Journal of Medicine*, vol. 338 (1998): 1193-201; and H. Kuhse, et al., "End of Life Decisions in Australian Medical Practice," *Medical Journal of Australia*, vol. 166 (1997): 191-96.

⁴ The Dutch Parliament (Congress) had passed the law in November, 2000. Since 1994, euthanasia was mentioned in a law concerning the disposal of human bodies after deaths, but apart from the requirement that a non-natural death should be reported to the Public Prosecutor, there were no material criteria for rightness or wrongness. Since November, 1998, some due care criteria were mentioned in a separate regulation. In some countries, such as Switzerland and in the American state of Oregon, assisted suicide is allowed, but not euthanasia. (Cf. note 1.) After the Dutch example, neighboring country Belgium accepted a similar euthanasia law on May 16, 2002, but with more constraints concerning the seriousness of the physical suffering.

⁵ Stated in section two of the Termination of Life on Request and Assisted Suicide (Review Procedures) Act. Information about the Dutch law and policy can be obtained at <http://www.minbuza.nl/>, click on "international site."

⁶ In his valuable discussion on the Dutch euthanasia debate, Herbert Hendin confuses the terms nonvoluntary (the patient has not been able to make a request) and involuntary (the doctor acts against the patient's will). Herbert Hendin, "Assisted Suicide and Euthanasia: the Dutch Experience," in *Last Rights: Assisted Suicide and Euthanasia Debated*, ed. Michael M. Uhlmann (Grand Rapids: Eerdmans, 1998), 374.

⁷ In effect, the Dutch term "euthanasia" matches the American term "active voluntary euthanasia."

⁸ The so called Rummelink-report. Professor Jan Rummelink was chairman of a government commission which investigated medical practice regarding euthanasia: P. J. van der Maas, J. J. M. van Delden, and L. Pijnenborg, *Euthanasia and Other Medical Decisions Concerning the End of Life* (New York: Elsevier, 1992); L. Pijnenborg, et al., "Life-terminating Acts Without Explicit Request of a Patient," *The Lancet*, vol. 341 (1993): 1196-99. For a discussion of this survey, see Hendin, "Assisted Suicide and Euthanasia," 377.

⁹ L. Pijnenborg, ed., *End-of-life Decisions in Dutch Medical Practice* (Rotterdam: Erasmus University, 1995). Noteworthy is a similar survey published in 2000 about neighboring Belgium. Although the number of cases in euthanasia are about the same as in the Netherlands, the cases of euthanasia without request outweigh by far that of voluntary deaths. Luc Deliens, et al., "End of Life Decisions," 1810.

¹⁰ The differences between the United States and the Netherlands concerning the system of health care insurance explains why I will not address the argument made, e.g., by McCormick, that euthanasia, once legal, will be used as a means to reduce health care expenses. Richard A. McCormick, S.J., "Physician-Assisted Suicide: Flight from Compassion," in *On Moral Medicine: Theological Perspectives in Medical Ethics*, ed. Stephen E. Lammers and Allen Verhey, 2d ed. (Grand Rapids: Eerdmans, 1998), 670.

¹¹ Using the slippery slope argument does not necessarily imply using the term "slippery slope." Beauchamp and Childress, e.g., refer to terms such as, "the thin end of the wedge," "the foot in the door," and "the camel's nose under the tent." Tom L. Beauchamp and James F.

Childress, *Principles of Biomedical Ethics*, 4th ed. (New York: Oxford University Press, 1994), 229. Shewmon uses the term, "Pandora's box" as synonymous to "slippery slope." D. Alan Shewmon, "Active Voluntary Euthanasia: Opening Pandora's Box," in *Last Rights: Assisted Suicide and Euthanasia Debated*, ed. Michael M. Uhlmann (Grand Rapids: Eerdmans, 1998), 343.

¹² Leo Alexander, "Medical Science under Dictatorship," *New England Journal of Medicine*, vol. 241 (July 14, 1949): 39-47. See also Peter Singer, "Euthanasia: Emerging from Hitler's Shadow," in *Writings on an Ethical Life* (London: Fourth Estate, 2001), 201ff. The Vatican denounced the Dutch parliament's decision as an "aberrant" decision. "We find it hard to believe that such a macabre choice can be seen as a 'civil' and 'humanitarian' one," *L'Osservatore Romano* wrote in an editorial. "Killing a patient is a criminal act" and doctors conducting mercy killings are similar to "executioners." This type of argumentation which equates doctors to executioners may be said to equal the slippery slope argument *L'Osservatore Romano*, April 5, 2001.

¹³ D. Lamb, *Down the Slippery Slope* (London: Croom Helm, 1988), 3; and Wibren van der Burg, "The Slippery Slope Argument," *Ethics*, vol. 102, no. 1 (October 1991): 42-65. Inez de Beaufort distinguishes a third version. The apocalyptic slippery slope: a future scenario is sketched with such horrifying dimensions that it is not the likelihood, but the horror of this scenario which is the main appeal of this argument. Inez de Beaufort, "Op weg naar het einde?" in *Euthanasie: Knelpunten in een discussie*, ed. G. A. van der Wal, (Baarn: Ambo, 1987), 11. As I will argue below, the priority of the horror over the likelihood is not new; *mutatis mutandis*, it characterizes most uses of the empirical version.

¹⁴ As van der Burg has shown, there is also a looser version of the logical slippery slope argument. This version does not say that A and B are essentially identical. Rather, A and M share some essentials, M and N, ... Y and Z, and Z and B. "There may seem to be a clear distinction between abortion of a three-month-old fetus and killing a newborn child, but this distinction collapses as soon as we realize there is no such distinction between a three-month-old fetus and a three-month-and-one-day-old-fetus, etc." Van der Burg calls this the fallacy of the heap: "If one grain is not a heap and one more cannot make the difference, there can never be a heap." Van der Burg, "The Slippery Slope Argument," 44-45. The looser version can also be found in Bernard Williams, "Which Slopes are Slippery?" in *Moral Dilemmas in Modern Medicine*, ed. Michael Lockwood (Oxford: Oxford University Press, 1985), 126-37. Jochem Douma makes another subdivision of the logical version of the argument. The stronger one says that A will make it logically impossible to exclude B; the weaker one that A will make it logically difficult to exclude B. J. Douma, *Christelijke ethiek. Deel 6: Medische ethiek* (Kampen: Kok Publishers, 1997), 273.

¹⁵ The Dutch term here is "finished with life."

¹⁶ Rob Jonquière, *Trouw* (Dutch national morning paper), March 18, 2002.

¹⁷ Margaret Pabst Battin argues for a right to suicide on moral grounds, though aware of the "moral quicksand" into which the right to suicide "threatens to lead us." Margaret Pabst Battin, "Manipulated Suicide," in *Suicide: The Philosophical Issues*, ed. M. P. Battin and D. Mayo, (New York: St. Martin's, 1980). See also M. P. Battin, *The Least Worst Death* (New York: Oxford University Press, 1994), 115ff.

¹⁸ Van der Burg, "The Slippery Slope Argument," 512. Norman Daniels, "Wide Reflective Equilibrium and Theory Acceptance in Ethics," *Journal of Philosophy*, vol. 76 (1979): 256-82.

¹⁹ R. M. Hare, *Moral Thinking: Its Levels, Method, and Point* (Oxford: Clarendon, 1981), 103.

²⁰ For this reason, Inez de Beaufort prefers the term, "a winding road": one knows the first steps to go, but whether one will proceed along the road, is subject to later evaluation. Inez de Beaufort, "Op weg naar het einde?" 30; cf. Jack Kevorkian, "A Fail-safe Model for Justifiable Medically Assisted Suicide," in *Last Rights: Assisted Suicide and Euthanasia Debated*, ed. Michael M. Uhlmann (Grand Rapids: Eerdmans, 1998), 266: "The overriding concern of most critics is the fear of . . . the so called slippery slope. Surely the collective intelligence of the medical profession is equal to [allay such fears]."

²¹. See notes three and nine.

²². Michael Burleigh, *Death and Deliverance: "Euthanasia" in Germany 1900-1945* (Cambridge: Cambridge University Press, 1994). Euthanasia has been debated intensively in the Netherlands ever since J. H. van den Berg wrote his much disputed book, *Medical Power and Medical Ethics*. J. H. van den Berg, *Medische macht en medische ethiek* (Nijkerk: Callenbach, 1969). In this impressively illustrated book, psychiatrist and philosopher van den Berg strongly criticizes the way in which medical doctors use their power to keep alive forms of human life which otherwise would have died long before. Churches of all denominations have written reports since the beginning of the 1970s, pleading for limited acceptance of euthanasia as a last resort. The first cases of euthanasia were openly discussed in the mid-seventies; the first court-cases were held in the beginning of the 1980s, in which doctors were convicted but not punished. This jurisdiction was subsequently followed by legislation in two steps.

²³. A survey planned to be published in mid-2003 will be the first reliable source to shed light on whether the figures have stabilized, as some assume, or whether they have continued their way up.

²⁴. *NRC Handelsblad*, April 14, 2001.

²⁵. James Kennedy, *Een weloverwogen dood: Euthanasie in Nederland* (Amsterdam: Bert Bakker, 2002), 88ff.

²⁶. *Relevant, Quarterly of the Nederlandse Vereniging voor Vrijwillige Euthanasie*, November 1997. Margriet Oostveen, "Spijt: Voorvechters van euthanasie bezinnen zich," *NRC Handelsblad*, November 10, 2001.

²⁷. *Ibid.*

²⁸. As mentioned, the number of reported euthanasia cases has gone down in the past years, despite a procedure which was meant to encourage doctors to be frank and less afraid to report a case.

²⁹. Herbert Hendin, "Assisted Suicide and Euthanasia: the Dutch Experience," 374.

³⁰. I.e., when loved ones are no longer recognized and when a dementia would lead to incontinence.

³¹. *NRC Handelsblad*, April 14, 2001.

³². Bert Chabot, *Zelf-beschikt* (Alphen aan den Rijn: Balans, 1994), 53; Herbert Hendin, "Assisted Suicide and Euthanasia: the Dutch Experience," 378ff.

³³. *Ibid.*, 379.

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