

# Pulling up the runaway: the effect of new evidence on euthanasia's slippery slope

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## Abstract

*The slippery slope argument has been the mainstay of many of those opposed to the legalisation of physician-assisted suicide and euthanasia. In this paper I re-examine the slippery slope in the light of two recent studies that examined the prevalence of medical decisions concerning the end of life in the Netherlands and in Australia. I argue that these two studies have robbed the slippery slope of the source of its power - its intuitive obviousness. Finally I propose that, contrary to the warnings of the slippery slope, the available evidence suggests that the legalisation of physician-assisted suicide might actually decrease the prevalence of non-voluntary and involuntary euthanasia.*

*(Journal of Medical Ethics 1998;24:341–344)*

**Keywords:** Suicide - assisted; ethics - medical; euthanasia; legislation; jurisprudence

Even though there may be some cases in which physician-assisted suicide could be justified, to allow it to occur, some say, is to let go a runaway train that will take us to unintended and frightening destinations. After assisted suicide, we will be carried inevitably to voluntary euthanasia, but that is only the beginning. As the runaway gains momentum, social mores will be gradually blurred and distorted. Patients will lose trust in their doctors. Families will begin to pressure their elderly and infirm to take up the option of ending their lives. The community's respect for life will wain and, as a result, there will be an increase in the suicide rate and a decrease in palliative-care funding. Always gaining speed, we will hurtle onward and downward. Next we will allow non-voluntary euthanasia, where incompetent patients will be killed without their specific request. At first, only the elderly and demented will be affected, but, under the pressure of economic rationalism, malformed children, the mentally handicapped and mentally ill will soon follow. Finally, speeding out of control, we will run out of track and be plunged into the abyss of involuntary euthanasia, where even competent individuals are killed against their will.<sup>1-9</sup>

The details of our decline and exactly where we will end up vary from author to author, but, for all, our original well-intended action placed us upon a slippery slope that is the genesis of future woes. The slippery slope is the major weapon in the armamentarium of those who believe physician-assisted suicide and voluntary euthanasia should remain illegal. In recent times two studies have been published that, taken together, provide a strong rejoinder to the slippery slope. In the context of the Australian parliament's quashing of the Northern Territory Rights of the Terminally Ill Act and the US Supreme Court's deliberations over physician-assisted suicide the results of these studies could not have been more timely. This paper looks again at the slippery slope, reviews these studies and examines their implications for this debate.

## The slippery slope

The slippery slope does not try to argue its case by drawing conclusions from carefully constructed premises, nor does it rely upon a systematic review of empirical evidence. Any sort of formal argument for the slope's predictions would be quickly bogged down in detail and uncertainty. The predictions are in the complex realms of societal attitude shifts and behaviours. A formal argument would involve a great deal of extremely detailed analysis. It would need to use tools drawn from descriptive ethics, psychology, sociology, jurisprudence and politics. It would draw on empirical evidence wherever possible, and where it could not, it would need to examine historical precedent and draw careful parallels between events in the past and the feared events of the future.

Those who make use of the slippery slope, however, do not concern themselves with such matters.<sup>10</sup> They do not need to because, the slippery slope is not really an argument at all. Rather, it is a stern and knowing warning - an ethical "beware the Ides of March".

The slippery slope is what Daniel Dennett has termed an intuition pump.<sup>11</sup> Intuition pumps bypass the uncertain and exhausting path of con-

vincing readers with careful and detailed argument in favour of a more easily travelled byway that speeds readers to a conclusion based upon their gut feeling. Intuition pumps replace argument with slogans and telling images. They are designed to convince readers of the truth of what they already suspected.

Although intuition pumps do not depend upon empirical evidence, they will utilise such facts as are available to further their cause. In 1991 the results of a study from the Netherlands provided the slippery slope intuition pump with high octane fuel.

### The Rummelink study

In 1990 the Dutch government commissioned the Rummelink study to determine the prevalence of euthanasia and other medical decisions concerning the end of life in the Netherlands.<sup>12</sup> The study involved detailed interviews with 405 physicians, the mailing of questionnaires to the physicians of a sample of 7,000 deceased people and the collection of information concerning a further 2,250 deaths derived from a prospective study amongst those interviewed. One of the study's findings was that life termination by the administration of lethal drugs without an explicit persistent request from the patient accounted for 0.8% of Dutch deaths.

Those opposed to the legalisation of physician-assisted suicide leapt on this result as the "proof" they had been looking for. The Dutch, they declared, had allowed physician-assisted suicide and voluntary euthanasia and as a result *nearly one per cent* of their citizens were falling victim to non-voluntary or involuntary euthanasia. Here, surely, was the slippery slope in action. The intuition pump went into overdrive. The results of the Rummelink study were widely quoted in this context and the slippery slope seemed steeper and slipperier than ever.<sup>13-18</sup> Moreover if this slippery slope prediction was "proven", then its other predictions looked stronger too. Fears of increases in the suicide rate and decreases in palliative-care funding were re-kindled by the results and rode them piggy-back down the slide.

Those who favoured the legalisation of physician-assisted suicide had several avenues of reply to these claims. First, things were not nearly as bad as the gross figures might suggest. A detailed analysis of the instances of life-terminating acts without explicit request revealed that in 59% of cases the physician did have information about the patient's wishes through discussion with the patient and/or a previous request. In all other cases discussion with the patient was no longer possible. In 86% of cases life was shortened

by a few hours or a day at most and no instances of involuntary euthanasia were discovered.<sup>19</sup>

Second, the Rummelink study had only provided a cross-sectional view of Dutch medical practice. No comparable study had been conducted in the Netherlands before, so it was impossible to know from that one result whether the incidence of non-voluntary euthanasia in Holland was actually increasing, decreasing or staying the same. Similarly no comparable study had been done outside the Netherlands and consequently there was no way of knowing if the Dutch level of non-voluntary euthanasia was really any higher or lower than that in comparable countries where euthanasia remained illegal.<sup>20-21</sup> Despite the exaggerated claims, the Rummelink study had not really "proven" anything about the slippery slope. The feared decline to involuntary euthanasia remained no more than a possibility.

These counter-arguments were obvious and commonsensical. Unfortunately though they were rather awkward and cumbersome to expound, and rather than injecting colour into the debate, they drained the drama away. Perhaps for these reasons they were rarely aired in either the scientific literature or the popular press. Often they were not heard at all, and even when they were, it was often too late. The slippery slope had done its work and intuition dictated that the slide to wrongful killing was inevitable.

### New evidence

Two more recent studies have poured sand into the engine of the slippery slope. The first study sought the prevalence of medical end-of-life events in the Netherlands five years after Rummelink; the second sought their prevalence in Australia.

The 1996 Dutch study used a methodology similar to the original Rummelink study and asked the same questions.<sup>22</sup> If the predictions of the slippery slope were correct then one would expect that the prevalence of non-voluntary euthanasia in the Netherlands to be on the rise. The results though, suggested that the opposite may be true. Though variations due to chance could not be ruled out, the prevalence of life-terminating acts without specific request had fallen since 1990 to 0.7% (down from 0.8%). The slippery slope's intuition pump began to splutter, but it was not yet dead. Perhaps, like playground slippery-dips, the slippery slope plateaus near the bottom. Perhaps all the damage was done in the first ten years that the Dutch allowed euthanasia. Perhaps a five-year gap between studies was insufficient to pick up any later damage wrought by the slope. The study did not prove the slope did not exist

but, contrary to expectation, it provided no evidence to support it.

The Australian study, by Kuhse and colleagues, also sought the prevalence of medical end-of-life decisions and used a methodology based upon the Dutch studies.<sup>23</sup> At the time the study was carried out physician-assisted suicide was illegal throughout Australia, and doctors assisting their patients to die risked criminal prosecution and long jail terms. The health systems of Australia and Holland are very similar in many ways and though the societies have significant differences there was no obvious reason, aside from slippery-slope effects, to suppose that their rates of non-voluntary euthanasia would be vastly different.

If the slippery slope were a reflection of reality, the rate of non-voluntary euthanasia in Australia should have been lower than that in the Netherlands. The results indicated that exactly the opposite was true. The rate of non-voluntary euthanasia in Australia was 3.5% (+0.8%), far higher than the 0.8% and 0.7% reported in the two Dutch studies.

There are a number of possible explanations for this finding. Though the Dutch and Australian studies were methodologically similar they were not the same and it is possible that these differences account for the higher Australian figure. Another possibility is that the cultural differences between Australia and the Netherlands may account for the difference and if physician-assisted suicide were legalised in Australia the slope would simply have a lower starting point. Like the Dutch study, the Australian study could not prove that the slippery slope was false.

These studies are important not because they disprove the slippery slope but, because they rob it of the source of its power - its intuitive obviousness. Knowing these results it just no longer seems likely that the legalisation of physician-assisted suicide or voluntary euthanasia would lead inexorably to an increase in non-voluntary and involuntary euthanasia. None of the available evidence supports this conclusion.

### **Pulling against the slope**

The results also raise a new question. Would the legalisation of physician-assisted suicide actually lead to a decrease in the prevalence of non-voluntary euthanasia? The second Dutch study suggests that the prevalence of non-voluntary euthanasia may be falling in the Netherlands where physician-assisted suicide and voluntary euthanasia are allowed. The Australian study showed the prevalence of non-voluntary euthanasia there, where voluntary euthanasia and physician-assisted suicide were illegal, was much

higher than it was in the Netherlands. There are a number of reasons for thinking that the legalisation of physician-assisted suicide may have this paradoxical effect.

The legalisation of physician-assisted suicide allows the process to be made safer. What may appear to be a competent request for death at first glance may turn out to be motivated by depression or delirium and therefore not competently made. This incompetence may remain hidden without the second opinion of a psychiatrist. In Australia, the Northern Territory's assisted suicide legislation demanded a psychiatric opinion as part of the assessment process. Such a safeguard would be rare without such legislation, as those who provide a second opinion when physician-assisted suicide is illegal become accomplices to a crime.<sup>24-25</sup>

The legalisation of physician-assisted suicide and voluntary euthanasia enables these issues to be discussed more openly between patient and doctor. With the issue on the table it is possible for patients to ask their doctors to help them die without embarrassment or fear of rejection. In a recent moving editorial, Angell told of her father who, suffering prostate cancer, shot himself on the night before admission to hospital, perhaps believing that this was his last chance of a "dignified death".<sup>26</sup> If physician-assisted suicide were available then patients such as Angell's father may see taking their own lives as unnecessary.

Similarly, if it is possible for doctors to raise physician-assisted suicide with their patients they will be better placed to discover their desires concerning their deaths. In the Dutch instances of non-voluntary euthanasia, the doctor had information about the patient's wishes through discussion with the patient in 59% of cases. In the Australian study the corresponding figure was just 29%. It seems likely that the illegality of euthanasia in Australia was a factor in this difference.

Of course these studies provide no direct evidence that the legalisation of physician-assisted suicide *would* decrease the prevalence of non-voluntary euthanasia. Clear evidence could only be provided by a comparison of the rates of this type of death before and some time after the introduction of a new law. It does seem possible though, that the legalisation of physician-assisted suicide *could* provide a means of decreasing a worryingly high pre-existing prevalence of non-voluntary euthanasia.

### **Conclusion**

Taken together the findings of the Dutch and Australian studies work to erode the understandable suspicion that the legalisation of physician-assisted suicide or voluntary euthanasia would

lead to an increase in non-voluntary euthanasia. In casting doubt on the slippery slope's apparent likelihood, the studies have robbed it of its rhetorical force, and its power as an argument against such legalisation is drastically limited.

This is not to imply however that the slippery slope campaigns are without utility. Patients continue to die or are killed in circumstances that are of great ethical concern - both in states where euthanasia is allowed and in those where it is not.<sup>27-29</sup> The warnings of the slippery slopers may not equate to arguments against the legalisation of euthanasia and physician-assisted suicide, but they do highlight chilling possibilities if things are allowed to go wrong. Those interested in the formation of public policy will fail to heed their warnings at their peril and must shape legislation to avoid the pitfalls that the slippery slopers signpost.<sup>25</sup>

The possibility that the legalisation of physician-assisted suicide may actually decrease rather than increase the prevalence of non-voluntary euthanasia remains just that - a possibility. However, that possibility raises another: perhaps our metaphors will need revamping. Far from a runaway train hurtling downhill out of control, it may be that legalised physician-assisted suicide will one day be seen as *The Little Engine That Could*, pulling us uphill to safer ground. At least, that is my intuition.

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