The slippery slope of euthanasia

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Ricevuto il 27 ottobre 2020; Accettato il 16 febbraio 2021

ABSTRACT

It is argued that the "slippery slope" that could be created after the legalization of euthanasia and assisted suicide could open the door to euthanasia practices that go beyond those permitted by law.
In this respect, we address three specific circumstances in which we believe this could occur: 1) euthanasia techniques could be applied in non-terminal psychiatric patients and likewise in those with mental disorders or intellectual disabilities; 2) it could also be carried out in adolescents, children and neonates; and 3) involuntary euthanasia may be performed.
We provide specific data on these three situations that support the conclusion that all three are already taking place. At the same time, we conduct an ethical assessment of these practices, which we consider illicit.

RIASSUNTO

Il pendio scivoloso dell'eutanasia.

Alcuni sostengono che il "pendio scivoloso" che si potrebbe determinare dopo la legalizzazione dell'eutanasia e del suicidio assistito potrebbe aprire la porta a pratiche eutanasiche che vanno oltre quelle consentite dalla legge.
A questo proposito, prendiamo in considerazione tre circostanze specifiche in cui crediamo che questo potrebbe accadere: 1) le tecniche di eutanasia potrebbero essere applicate in pazienti psichiatrici non terminali e allo stesso modo in quelli con disturbi mentali o disabilità intellettuali; 2) l'eutanasia potrebbe essere effettuata su adolescenti, bambini e neonati; e 3) l'eutanasia involontaria potrebbe essere eseguita.
Il contributo fornisce dati specifici su queste tre situazioni che supportano la conclusione che tutte e tre hanno già luogo. Allo stesso tempo, viene realizzata una valutazione etica di queste pratiche che consideriamo illecite.

Keywords: euthanasia, assisted suicide, euthanasia in non-terminal patients with mental disorders and intellectual disabilities, euthanasia in minors, involuntary euthanasia.

Parole-chiave: eutanasia, suicidio assistito, eutanasia in pazienti non terminali con disordini mentali e disabilità intellettuali, eutanasia sui minori, eutanasia non volontaria.

1. Background

When a door is opened to give way to an issue with a significant bioethical burden, we know that it will go through it at that time. What we do not know is what will continue to go through that door over time and whether, at some point, what may

go through will be ethically illicit. This is what has become known as the "slippery slope" [1-5].

Theoretically, it is easy to speculate about the "slippery slope", or even deny that it exists. Against this, however, there are currently two experimental «laboratories» – the Netherlands and Belgium – that may shed light on this phenomenon, considering what has happened in them.

Although control measures have been put in place in both countries to try to halt the dreaded "slippery slope", achieving this seems to be an elusive goal [1], since the results have been very limited, if not lacking. Thus, the possibility of sliding down the "slippery slope" is one of the main objections that have been used to try to prevent the legalization of euthanasia and assisted suicide [1], although some experts disagree with it [6].

In countries where euthanasia and/or assisted suicide have been legalized and in others where legalization is currently being proposed, such as Spain, certain – usually stringent – conditions are required to legally support these practices. Nevertheless, these initial requirements have eased over time, until euthanasia and assisted suicide are accepted under virtually any circumstance. In fact, they have even expanded to so-called "involuntary euthanasia", i.e. euthanasia practiced without an express request from the patient.

In our view, the main bioethical, medical and social problems that may arise as a result of the "slippery slope" are: a) that euthanasia techniques can be applied to non-terminally ill patients, thus extending their use to practically anyone; b) that these practices may also be carried out in adolescents, children and neonates; c) that they may affect intellectually disabled persons or those with mental disorders; and d) more importantly, if that is possible, that they may extend to the practice of involuntary euthanasia. Some of these issues are discussed in this article.

2. Euthanasia in non-terminal psychiatric, intellectually disabled and mentally impaired patients

There are two main arguments used to justify the ethicality of euthanasia and assisted suicide in psychiatric patients: their right to autonomy and the so-called "party argument", which argues that severe suffering can justify both practices in patients with mental illness [7].

Furthermore, one possible serious consequence of the "slippery slope" that can be created by opening the door to euthanasia is that it can be used in non-terminal psychiatric or neurological patients, and in mentally impaired or intellectually disabled persons, even if they do not expressly request it. This could be objectively even more serious, given that these patients do not usually have the intellectual capacity or sufficient discernment to be able to request euthanasia with full knowledge of what they are asking for.

Euthanasia in non-terminal psychiatric patients is permitted in the Netherlands, Belgium, Luxembourg, Canada and some North American states [8], with the peculiar characteristic that, since some psychiatric disorders are reversible, such requests can be retracted [9-11].

There is also another uncertainty added

to this, since there are no well-determined guidelines in these countries on how to act if euthanasia is requested for these patients [12].

Euthanasia in non-terminally ill patients with some type of dementia is also permitted in Belgium and the Netherlands [12; 13] if their psychiatric disorder causes them severe mental suffering [13], because if it were banned in these cases, serious discrimination could be incurred for these types of patients [14]. Nevertheless, in any case, given the heterogeneity of mental illnesses, euthanasia in these patients is a complex problem far from being resolved [15; 16], especially since, as already mentioned, such patients do not always have the intellectual capacity to responsibly exercise their right to autonomy [16-18]. As a result, the majority of Dutch psychiatrists are reluctant to accept euthanasia requests in psychiatric patients, as noted in a recent report, which found that only 39% of psychiatrists in the Netherlands accept euthanasia requests in these patients [19].

But apart from this theoretical consideration, the social reality is that, in both the Netherlands and in Belgium, euthanasia requests for psychiatric reasons for terminally ill patients are very few, accounting for only 3% of all euthanasia requests. Of these, only 2% are met [20], increasing to 24% in non-terminal patients [21; 22].

Moreover, quantitatively, between 2002 and 2013, 179 cases of euthanasia were recorded in the Netherlands in psychiatric patients or patients with dementia, which constitutes 0.5% of all euthanasia requests. More recent data show that, in 2018, there were 6,126 cases of euthanasia, corresponding to 4.4% of all deaths, and of these, 67 were psychiatric patients [23].

The most common clinical characteristics of psychiatric patients requesting euthanasia [24; 25] are depression and personality disorders [12]. In this respect, Kim et al. published an article on April 2016, in which they collected the clinical characteristics of 66 patients who requested euthanasia in the Netherlands. They found that 41% had depression, 15% anxiety and 52% had a previous history of attempted suicide [13].

Apart from the above, however, in the opinion of palliative care specialists, when euthanasia is requested by psychiatric patients, it should be borne in mind that this request is more often a cry for help than an express demand for euthanasia [26; 27]. Such requests therefore require a very thorough medical and ethical evaluation [28; 29].

In addition to strictly psychiatric illnesses, one of the neurological diseases with the greatest social impact is Alzheimer's disease, not only because of its high prevalence, but also because of the profound suffering it involves, both for the patients themselves and for their relatives or caregivers. However, euthanasia is sometimes requested for non-terminally ill Alzheimer's patients, which is a source of extensive ethical debate in the specialist literature [30; 31]. In this respect, possibly the first patient with Alzheimer's disease for whom euthanasia was sought was the Belgian writer Hugo Claus, who, having knowledge of incipient Alzheimer's, requested and was granted euthanasia in 2008 [25].

It is obvious that the request for euthanasia by some patients with Alzheimer's disease responds to the idea that death is preferable to allowing their disease to pro-

gress to its final stages [30; 31] although this dilemma does not only occur in Alzheimer's patients, but also in other types of dementia [30].

An added problem when assessing the ethicality of euthanasia requests for non-terminal psychiatric patients or those with dementia or Alzheimer's disease is that many patients are not competent to independently make responsible decisions. This role must therefore be assumed by a close relative or even by their attending medical team, which adds another layer of ethical difficulty to this issue [13; 33; 34]. Nevertheless, Varelius [35], and other authors [36; 37] consider that it is ethically acceptable in some circumstances to carry out involuntary euthanasia for psychiatric patients. Varelius [35] tries to base his judgment on the case of a patient who repeatedly tried to commit suicide, arguing that «the suicidal death of a non-competent psychiatric patient would necessarily be less natural than those of physically ill or injured patients who die as a result of non-voluntary passive euthanasia. I argue that it would not» [35], endorsing Appel's view that «suicide might be understood as part of the natural course of these illnesses» [38]. Thus, facilitating involuntary euthanasia in non-competent psychiatric patients may be a natural end for them and, therefore, ethically licit [35]. For this reason, some authors wonder why only voluntary euthanasia should be legally permitted, when patients to whom involuntary euthanasia is applied experience the same suffering as those who receive voluntary euthanasia [39].

Apart from these considerations regarding the licitness of involuntary euthanasia, which we shall address more extensively in this paper, "an important objection against offering PAS [physician assisted suicide] to mentally ill patients is that this might reinforce loss of hope and demoralization". However, Berghmans, Widdershoven and Widdershoven-Heerding argue that «offering PAS to a patient with a mental illness [...] does not necessarily imply taking away hope and can be ethically acceptable» [40]. We declare ourselves absolutely opposed to this statement.

3. Euthanasia in adolescents, children and neonates

Another consequence that may be derived from the "slippery slope" that could develop after the legalization of euthanasia is that it may encourage, or even promote, euthanasia in adolescents, children and newborns, which can certainly be considered ethically very negative.

Euthanasia was legalized for adults in the Netherlands in 2002, but was also tacitly admitted for children. This acceptance increased in March 2005, when the so-called "Groningen Protocol" was adopted, promoted by a team of physicians from the University Medical Center Groningen, headed by Dr. E. Verhagen [41].

This protocol establishes that euthanasia can be applied to newborns if the following requirements are fulfilled: 1) the diagnosis and prognosis are certain; 2) hopelessness and unbearable suffering are present; 3) the diagnosis, prognosis, and unbearable suffering are confirmed by at least one independent doctor; 4) both parents give informed consent; and 5) the procedure is performed in accordance with the accepted medical standard [42].

The publication of this protocol sparked major social and medical controversy [43-47] assuming that it could lead down the "slippery slope" towards more widespread practice of euthanasia [48], something Verhagen himself denied in an article published in the Journal of Medical Ethics [42].

Irrespective of this controversy, though, and in practical terms, paediatric euthanasia rates in the Netherlands are very low: only five cases of euthanasia were reported in 2014 [49], four of them in teenagers aged 16 to 17 years, and one in a 12-year-old boy [50], although a further case was added in 2015 and another in 2016 [51]. Cases of euthanasia in newborns were even rarer, with only two cases reported in the last 10 years [52].

Euthanasia for adults was legalized in Belgium in 2002, although euthanasia for children was not included at that time. However, in February 2014, the Belgian House of Representatives legalized euthanasia for children of any age, by 86 votes in favour, 44 against and 12 abstentions. The law was enacted in March of that same year, following its approval by the Belgian monarch [48; 53].

It seems that one of the reasons argued for adoption of the law was that, in Belgium, paediatric palliative care was poor and insufficient to meet the needs of children who were candidates for euthanasia [54].

Additionally, the Belgian Royal Academy of Medicine helped to dictate the medical requirements necessary to legalize paediatric euthanasia, specifying that the request should be made in writing by the child him or herself, and that he or she should be «in a hopeless medical situation of constant and unbearable suffering that cannot be eased and which will cause death in the short term» [54; 55].

As expected, the adoption of this law triggered an extensive social and medical debate, given its radical nature, with Giglio and Spagnolo calling it «the most radical euthanasia law so far established in the world» [56]. For this reason, a group of 160 Belgian paediatricians strongly opposed it, questioning whether minors had sufficient "capacity of discernment" to be able to make their own decisions with responsible autonomy [57]. In addition to these medical professionals, representatives of the main religions, philosophical groups and other healthcare personnel also protested against the adoption of this law [58; 59], although, of course, its proponents argued quite the opposite [50; 60].

As in the Netherlands, however, social reality did not seem to support the need to legalize euthanasia in children, since as of December 2017, only three minors had been euthanized in Belgium [61].

The main ethical difficulty apparently posed by euthanasia in minors is that it is assumed that the child is a moral agent with sufficient capacity to be able to make his or her own decisions in the event of an incurable terminal disease [61]. This does not seem to be the case, even if the legal requirements required for this practice to be legal in adults are fulfilled [48; 60-62]. Accordingly, some experts believe that the "Groningen Protocol" and paediatric euthanasia in general are leading to involuntary euthanasia in minors [48].

Apart from that, it seems reasonable to assume that children under the age of 12 cannot give the necessary informed consent for euthanasia to be carried out [52;

61], which should be a prerequisite for its application.

Moreover, it is also stated that, if there were sufficient paediatric palliative care units, which practically does not occur [54; 63-65] requests for euthanasia in children would diminish [66; 52]. Nevertheless, we still believe that the shortage of paediatric palliative care units is not sufficient reason to request that euthanasia be legalized in minors [48].

In relation to all this, as with adults, the practice of euthanasia in minors can have a clear negative impact on the professional activity of the doctors who treat them [67; 68].

In addition, in a paper especially dedicated to assessing the ethics of paediatric euthanasia, Marie Friedel stresses that this practice violates the principles of beneficence, non-maleficence, justice and autonomy held by principlism [54].

Finally, another aspect not always considered in assessing the ethics of euthanasia in children is the possibility of using the organs of euthanized minors for transplantation. Organ donation after euthanasia in adults has apparently been performed more than 70 times in Belgium and the Netherlands combined [69]. Shortage of organs for children who need them remains a problem. In 2017, for example, there were only six deceased donors younger than 16 years in the Netherlands and 11 in Belgium [70]. However, given the low number of paediatric euthanasia cases in the Netherlands and Belgium (mainly due to malignancy, which furthermore is a contraindication for organ donation), this does not appear to be a real solution to the need for organs for paediatric transplantation [71].

4. Involuntary euthanasia

One of the most serious consequences of the legalization of euthanasia, as we have already mentioned, is that involuntary euthanasia may be performed, although this has been questioned, and even denied, by some authors. However, in our view, there is currently sufficient evidence that this is the case, based on what has occurred in the two countries where euthanasia and assisted suicide have been legalized, the Netherlands and Belgium.

In fact, a paper published in 2005 that analysed what happened in the Netherlands after the legalization of euthanasia [72] found that of all the deaths that occurred in the country, 1.7% were due to acts of euthanasia, 0.4% of which were carried out without the patient's express request, i.e. they were involuntary euthanasia. This percentage was 0.7% in 2001.

In 2009, seven years after euthanasia was legalized in the Netherlands, another paper was published [73], containing data from 1,690 patients who had been euthanized; it found that euthanasia was applied in 1.4% of patients "without an explicit request". In other words, they had undergone involuntary euthanasia.

In 2012, a well-documented article on end-of-life practices in terminally ill Dutch patients was published in The Lancet [74], addressing among many other things, the issue of involuntary euthanasia. Some of the data from this study are shown in Table 1. It shows that deaths from euthanasia or assisted suicide without the express request of the patient ranged from 0.2% to 0.8%.

Table 1

Year	1990	1995	2001	2005	2010
Total Deaths	128,824	135,675	140,377	136,402	136,056
Number of cases	5,197	5,146	5,617	9,965	6,861
Deaths due to euthanasia	141 (1.7%)	257 (2.4%)	310 (2.6%)	294 (1.7%)	475 (2.8%)
Deaths due to assisted suicid	18 (0.7%)	25 (0.2%)	25 (0.2%)	17 (0.1%)	21 (0.1%)
Deaths without being explicitly requested by the patient	45 (0.8%)	640 (0.7%)	42(0.7%)	24 (0.4%)	13 (0.2%)

Dutch health authorities conduct a survey every five years on euthanasia and assisted suicide in that country.

In 2005, 2,425 deaths were found, of which 550 were carried out without an explicit request from the patient for euthanasia [75].

In 2010, 4,050 assisted deaths were found, of which 310 were carried out without explicit request of the patient.

In the last report, that of 2015, 7254 assisted deaths were found, of which 431 were carried out without having been explicitly required [76].

5. Conclusions

As a corollary to all of the above, we can conclude that involuntary euthanasia and assisted suicide are being practiced in the Netherlands in the percentages reported herein. Nevertheless, regardless of these figures, involuntary euthanasia practices are a reality for many Dutch patients. This is the most obvious proof of how far euthanasia practices can go as a result of the "slippery slope" that may be created after the legalization of euthanasia and/or assisted suicide.

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