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The Empirical Slippery Slope from Voluntary to Non-Voluntary Euthanasia

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I . Introduction

Slippery slope arguments appear regularly whenever morally contested social change is proposed.[1] Such arguments assume that all or some consequences which could possibly flow from permitting a particular practice are morally unacceptable.

> Typically, "slippery slope" arguments claim that endorsing some premise, doing some action or adopting some policy will lead to some definite outcome that is generally judged to be wrong or bad. The "slope" is "slippery" because there are claimed to be no plausible halting points between the initial commitment to a premise, action, or policy and the resultant bad outcome. The desire to avoid such projected future consequences provides adequate reasons for not taking the first step.[2]

Thus the legalization of abortion in limited circumstances is asserted to lead down the slippery slope towards abortion on demand[3] and even infanticide;[4] and the legalization of

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References

1. On slippery slopes generally, see F. Shauer, "Slippery Slopes," *Harvard Law Review* 99 (1985): 361–82; W. van der Burg, "The Slippery-Slope Argument," *Ethics* 102 (1991): 42–65, at 42–3 (noting that the slippery slope argument has been invoked against the legalization of abortion, euthanasia, in vitro fertilization, and DNA research); B. Freedman, "The Slippery-Slope Argument Reconstructed: Response to Van der Burg," *Journal of Clinical Ethics* 3 (1992): 293–7. See also, B. Williams, "Which Slopes Are Slippery?" in M. Lockwood, ed., *Moral Dilemmas in Modern Medicine* (Oxford: Oxford Univ. Press, 1985): 126–37, at 126–7 (pointing out that slippery slope arguments are often applied to matters of medical practice); D. Walton, *Slippery Slope Arguments* (Oxford: Clarendon Press, 1992); D. J. Mayo, "The Role of Slippery Slope Arguments in Public Policy Debates," *Philosophical Exchange* 21–22 (1990–91): 81–97; J. P. Whitman, "The Many Guises of the Slippery Slope Argument," *Social Theory & Practice* 20 (1994): 85–97; E. Lode, "Slippery Slope Arguments and Legal Reasoning," *California Law Review* 87 (1999): 1469–1544.

2. W. Wright, "Historical Analogies, Slippery Slopes, and the Question of Euthanasia," *Journal of Law, Medicine & Ethics* 28 (2000): 176–86, at 177.

assisted suicide to lead inexorably to the acceptance of voluntary euthanasia[5] and subsequently to the sanctioning of the practice of non-voluntary euthanasia – even involuntary euthanasia of "undesirable" individuals.[6]

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3. See, e.g., J. Keown, "Euthanasia in the Netherlands: Sliding Down the Slippery Slope?" in J. Keown, ed., *Euthanasia Examined: Ethical, Clinical and Legal Perspectives* (Cambridge: Cambridge Univ. Press, 1995): 261–96, at 262, 287–8.

4. See C. Li, "The Fallacy of the Slippery Slope Argument on Abortion," *Journal of Applied Philosophy* 9 (1992): 233–7; J. D. Arras, "The Right to Die on the Slippery Slope," *Social Theory & Practice* 8 (1982): 285–328, at 288; L. E. Weinrib, "The Body and the Body Politic: Assisted Suicide under the *Canadian Charter of Rights and Freedoms*," *McGill Law Journal* 39 (1994): 619–43, at 637.

5. See, e.g., *Krischer v. McIver*, 697 So. 2d 97, 109 (Fla. S.C. 1997) (Harding J., concurring); Y. Kamisar, "Physician-Assisted Suicide: The Last Bridge to Active Voluntary Euthanasia," in Keown, *Euthanasia Examined*, *supra* note 3, 225–60, at 245; H. Hendin, "Scared To Death of Dying," *New York Times*, December 16, 1994, at A39 ("The Netherlands has moved from assisted suicide to euthanasia, from euthanasia for the terminally ill to euthanasia for the chronically ill, from euthanasia for physical illness to euthanasia for psychological distress and from voluntary euthanasia to involuntary euthanasia").

6. See, e.g., Y. Kamisar, "Some Non-Religious Views Against Proposed 'Mercy Killing' Legislation," *Minnesota Law Review* 42 (1958): 969–1042, at 1030–41 (discussing the "parade of horrors" that could occur following the legalization of euthanasia); Canadian Law Reform Commission, *Euthanasia, Aiding Suicide and Cessation of Treatment*, Working Paper No. 28 (1982): at 46; G. Gelfand, "Euthanasia and the Terminally Ill," *Nebraska Law Review* 63 (1984): 741–78, at 764–5; J. Gay-Williams, "The Wrongfulness of Euthanasia," in R. Munson, ed., *Intervention and Reflection: Basic Issues in Medical Ethics* (Belmont, CA: Wadsworth, 1983) 156–63; J. V. Sullivan, "The Immorality of Euthanasia," in M. Kohl, ed., *Beneficent Euthanasia* (Buffalo, NY: Prometheus, 1975): 12–33, at 23–6; G. Grisez, "Suicide and Euthanasia," in D. J. Horan and D. Mall, eds., *Death, Dying and Euthanasia* (Washington: University Publications of America, 1980): 742–817, at 811 (comparing the possible future legal stance on euthanasia in the United States and other western societies to the experience of Nazi Germany); A. M. Capron, "Euthanasia in the Netherlands: American Observations," *Hastings Center Report* 22, no. 2 (1992): 30–3, at 32–3 (drawing a comparison with the euthanasia programme in Nazi Germany); K. Amarasekara and M. Bagaric, "The Legalisation of Euthanasia in the Netherlands: Lessons to be Learnt," *Monash University Law Review* 27 (2001): 179–96, at 181; D. Callahan, "When Self-Determination Runs Amok," *Hastings Center Report* 22, no. 2 (1992): 52, 54.

A. Distinguishing the Empirical from the Logical Argument

There are many varieties of the slippery slope argument. The distinction encountered most frequently is between the logical and empirical forms of argument. James Rachels explains:

> The logical [or conceptual] form of the argument goes like this. Once a certain practice is accepted, from a logical point of view we are committed to accepting certain other practices as well, since there are no good reasons for not going on to accept the additional practices once we have taken the all-important first step. But, the argument continues, the additional practices are plainly unacceptable, therefore, the first step had better not be taken.... Th[e empirical or psychological] form of the argument is very different. It claims that once certain practices are accepted, people shall in fact go on to accept other, more questionable practices. This is simply a claim about what people will do and not a claim about what they are logically committed to.[7]

The empirical slippery slope argument has the most credibility and is most often used by opponents of the legalization of euthanasia or assisted suicide.[8] Before beginning the analysis of this argument, the next two sections identify the particular argument to be addressed and describe its significance in a legal context.

B. Which Slippery Slope Argument?

This article concentrates on the slippery slope argument most widely employed in the context of discussion about the legalization of euthanasia and assisted suicide: the legalization of voluntary active euthanasia will lead to acceptance of non-voluntary active euthanasia.[9]

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7. J. Rachels, *The End of Life: Euthanasia and Morality* (Oxford: Oxford University Press, 1986): at 172–3. See also, Van der Burg, *supra* note 1, at 43; Williams, *supra* note 1, at 126; Arras, *supra* note 4, at 288–9; J. Glover, *Causing Death and Saving Lives* (London: Penguin Books, 1977): at 165–8; D. Lamb, *Down the Slippery Slope: Arguing in Applied Ethics* (London: Croom Helm, 1988): at 61; Lode, *supra* note 1, at 1477, 1483; Keown, *supra* note 3, at 261–2.

8. On logical slippery slope arguments in the assisted dying context, see P. Lewis, *Assisted Dying and Legal Change* (Oxford: Oxford University Press, 2007): at 164-9.

9. Other examples of slippery slope arguments made in this context include the fears that legalization will legitimize the horrors of the Nazi genocide; erode the rights of the disabled; or promote the idea that only some lives are inherently worthwhile. For an example

Another slippery slope argument is sometimes made in this context: the argument that legalization of assisted suicide will lead to acceptance of euthanasia.[10] This argument, however, is of significantly less interest as an empirical proposition. The historical and empirical evidence in the Netherlands does not reflect a move from the legalization of assisted suicide to voluntary euthanasia.[11] Moreover, other jurisdictions which have legalized assisted dying have either included both assisted suicide and euthanasia from the outset (for example, the Northern Territory of Australia),[12] or have legalized assisted suicide but have

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of the latter argument, see R. Sherlock, "Liberalism, Public Policy and the Life Not Worth Living: Abraham Lincoln on Beneficent Euthanasia," *American Journal of Jurisprudence* 26 (1981): 47–65, at 49–50 (arguing that the decision to allow euthanasia requires an answer to the question of when a life is not worth living; even to discuss such an answer poses a threat to the fundamental principle of equality before the law and the principles derived there from). See generally, C. Schneider, "Rights Discourse and Neonatal Euthanasia," *California Law Review* 76 (1988): 151–76, at 167–71; D. A. J. Richards, "Constitutional Privacy, The Right to Die and The Meaning of Life: A Moral Analysis," *William & Mary Law Review* 22 (1981): 327–419, at 398.

10. For examples of this argument, see *supra* note 5.

11. See H. Weyers, "Euthanasia: The Process of Legal Change in the Netherlands," in A. Klijn et al., eds., *Regulating Physician-Negotiated Death* (Amsterdam: Elsevier, 2001): 11–27. According to the 1990, 1995 and 2001 Dutch studies of "medical behaviour which shortens life", assisted suicide is "relatively uncommon" in the Netherlands, occurring in 0.2% (95% confidence interval [CI] 0.1%-0.3%) of all deaths in 1990, 1995 and 2001 (based on death certificate studies [or 0.3% (1990, 95% CI 0.2%-0.4%), 0.4% (1995, 95% CI 0.2%-0.5%) and 0.1% (2001, 95% CI 0-0.1%) of all deaths (based on interviews)]), while voluntary euthanasia took place in 1.7% (1990, 95% CI 1.4%-2.1%), 2.4% (1995, 95% CI 2.1%-2.6%) and 2.6% (2001, 95% CI 2.3%-2.8%) of all deaths (based on death certificate studies [or 1.9% (1990, 95% CI 1.6%-2.2%), 2.3% (1995, 95% CI 1.9%-2.7%) and 2.2% (2001, 95% CI 1.8%-2.5%) based on interviews]). B. D. Onwuteaka-Philipsen et al., "Euthanasia and other End-of-Life Decisions in the Netherlands in 1990, 1995, and 2001," *Lancet* 362 (2003): 395–9, at Table 1, drawing on P. J. van der Maas et al., "Euthanasia, Physician-Assisted Suicide, and other Medical Practices Involving the End of Life in the Netherlands, 1990-1995," *New Engl. J. Med*. 335 (1996): 1699–1705; P. J. van der Maas et al., "Euthanasia and other Medical Decisions Concerning the End of Life," *Lancet* 338 (1991): 669–74. See also, M. E. Newman, "Active Euthanasia in the Netherlands," in A. S. Berger and J. Berger, eds., *To Die Or Not To Die? Cross-Disciplinary, Cultural and Legal Perspectives on The Right to Choose Death* (New York: Praeger, 1990): 117–28.

12. See Lewis, *supra* note 8, at 157-8.

shown no signs of legalizing euthanasia (for example, Oregon).[13] For this reason, this variant of the slippery slope argument will not be discussed.

C. The Legal Significance of the Slippery Slope Argument

Slippery slope arguments are used extensively in legal contexts.[14] Frederick Shauer suggests an explanation for this:

> [L]egal decisionmaking concentrates on the future more than does decision making in other arenas ... [T]oday's decisionmakers [are called upon] to consider the behavior of others who tomorrow will have to apply or interpret today's decisions. The prevalence of slippery slope arguments in law may reflect a societal understanding that proceeding through law rather than in some other fashion involves being bound in some important way to the past, and responsible in some equally important way to the future.[15]

In the assisted dying context, the legal significance of the dispute over the empirical slippery slope argument is enormous. In *Rodriguez,* the 1993 decision of the Supreme Court of Canada holding that the criminal prohibition against assisted suicide was not unconstitutional, the perspective of those critics of Dutch practice who rely on the slippery slope argument was accepted unquestioningly by Mr. Justice Sopinka (writing for the majority). Without providing sources, Mr. Justice Sopinka wrote:

> Critics of the Dutch approach point to evidence suggesting that involuntary active euthanasia (which is not permitted by the guidelines) is being practised to an increasing degree. This worrisome trend supports the view that a relaxation of the absolute prohibition takes us down "the slippery slope."[16]

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13. See Lewis, *id.* at 150-3. Belgium has explicitly legalized only euthanasia, although assisted suicide may be folded into the regulatory regime. See *id.*, at 153-7.

14. See Lode, *supra* note 1.

15. Shauer, *supra* note 1, at 382–3.

16. *Rodriguez v. British Columbia (Attorney-General)* [1993] 3 S.C.R. 519, 603 (S.C.C.). The case is discussed in Lewis, *supra* note 8, at 14, 119-22.

In 1997, in *Washington v. Glucksberg* and *Vacco v. Quill*, the United States Supreme Court held similarly that state bans on assisted suicide were indeed constitutional.[17] Chief Justice Rehnquist relied on an almost identical argument to that of Mr. Justice Sopinka, although he did buttress it with sources, citing critics[18] whose use of the Dutch experience has been heavily criticized by Dutch researchers.[19] Chief Justice Rehnquist simply stated that

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17. *Washington v. Glucksberg*, 521 U.S. 702 (1997); *Vacco v. Quill*, 521 U.S. 793 (1997), both discussed in Lewis, *supra* note 8, at 15.

18. *Washington v. Glucksberg*, 521 U.S. 702, 734–5 (1997), citing C. Gomez, *Regulating Death: Euthanasia and the Case of the Netherlands* (New York: The Free Press, 1991): at 104–13; H. Hendin, *Seduced by Death: Doctors, Patients and the Dutch Cure* (New York: W.W. Norton and Co., 1997): at 75–84; Keown, *supra* note 3, at 289; A report of Chairman Charles T. Canady to the House Judiciary Subcommittee on the Constitution, of the Committee on the Judiciary, House of Representatives, *Physician-Assisted Suicide and Euthanasia in the Netherlands*, 104th Congress, 2nd Session, September 1996; Executive Summary published as "Physician-Assisted Suicide and Euthanasia in the Netherlands: A Report to the House Judiciary Subcommittee on the Constitution," *Issues in Law & Medicine* 14 (1998): 301–24 (heavily reliant on the work of Hendin and Gomez).

19. See J. Griffiths, A. Bood, and H. Weyers, *Euthanasia and Law in the Netherlands* (Amsterdam: Amsterdam University Press, 1998): at 23, note 15. The authors' comments on Herbert Hendin (one of the most vociferous critics of the Dutch approach) are that his research methods are inadequate, and that his analysis is "so filled with mistakes of law, of fact, and of interpretation, mostly tendentious, that it is hard to be charitable and regard them as merely negligent." See also, Griffiths, Bood and Weyers, *id.*, at 217, note 54 discussing one of the "irresponsible claim[s]" made by Hendin; H. Weyers, Book Review, "Herbert Hendin: De Dood als Verleider. Weinig Overtuigende Verwoording van Een Bekend Standpunt Tegen Liberalisering van Euthanasie," ("Herbert Hendin: Death as Temptress. An Unconvincing Presentation of a Well-Known Objection to the Liberalization of Euthanasia Policy") *Medisch Contact (Medical Contact, Official Journal of the Royal Dutch Medical Association)* 52 (1997): 173–5; J. Griffiths, Book Review, "Een Amerikaan over Euthanasie in Nederland," ("An American's View of Euthanasia in the Netherlands – Review of C.F. Gomez, *Regulating Death: Euthanasia and the Case of the Netherlands*, 1991") *Medisch Contact* 48 (1993): 1208–9. Researchers outside of the Netherlands have also criticized these critics. See, e.g., J. Downie, "The Contested Lessons of Euthanasia in the Netherlands," *Health Law Journal* 8 (2000): 119–39, at 132–5; T. E. Quill, Book Review, "Linda L. Emanuel, ed., *Regulating How We Die: The Ethical, Medical, and Legal Issues Surrounding Physician-Assisted Suicide*," *Journal of Health Policy & Law* 25 (2000): 391–402, at 393 (describing "the glib and biased accounting of the Dutch experience in the U.S. literature", citing Hendin, *supra* note 18); R. Dworkin, "Assisted Suicide: What the Court Really Said," *New York Review of Books* 44(14) (1997): 40–4, at 43, note 13. An exchange between Hendin and Dworkin is found at "Assisted Suicide and Euthanasia: An Exchange," *New York Review of Books* 44, no. 17 (1997): 68–70, at 69–70.

"regulation of the practice may not have prevented abuses in cases involving vulnerable persons, including severely disabled neonates and elderly persons suffering from dementia."[20] No attempt was made to investigate whether regulation is related to the incidence of abuse, or whether abuse occurs more frequently in the Netherlands than in other jurisdictions – questions which will be addressed in the next section.

II. The Empirical Slippery Slope Argument

The empirical slippery slope argument allows that there is a relevant moral and/or legal distinction between, for example, voluntary and non-voluntary, or involuntary, euthanasia, but that "we are bad at abiding by [that] distinction":

> Once we allow voluntary euthanasia ... we may (or will) fail to make the crucial distinction, and then we will reach the morally unacceptable outcome of allowing involuntary euthanasia; or perhaps even though we will make the relevant distinction, we will not act accordingly for some reason (perhaps a political reason, or a reason that has to do with weakness of will, or some other reason).[21]

Whether this failure to abide by the relevant distinction will occur is often difficult to resolve if the social change is new and innovative and evidence from other jurisdictions is unavailable. The Netherlands has become the primary battleground of empirical slippery

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20. *Washington v. Glucksberg*, 521 U.S. 702, 734 (1997). See also, the concurring opinion of Souter J., *id.*, at 785–6 (recognizing that the Dutch "evidence is contested"); *Vacco v. Quill*, 521 U.S. 793, 809 (1997). The Dutch experience was also mentioned briefly in the earlier decision of the Second Circuit in *Quill v. Vacco*, 80 F.3d 716, 730 (1996), citing New York State Task Force on Life and the Law, *When Death Is Sought: Assisted Suicide and Euthanasia in the Medical Context* (1994): at 133–4. ("As to the interest in avoiding abuse similar to that occurring in the Netherlands, it seems clear that some physicians there practice nonvoluntary euthanasia, although it is not legal to do so.") The first decision in the Ninth Circuit in *Compassion in Dying v. Washington*, 49 F.3d 586, 593 (1995) identified a state interest in "preventing abuse similar to what has occurred in the Netherlands". See also, *The Queen on the Application of Mrs Dianne Pretty v. Director of Public Prosecutions* [2002] 1 A.C. 800, [55] (H.L.), citing Keown, *supra* note 3, at 261–96.

21. D. Enoch, "Once You Start Using Slippery Slope Arguments, You're On A Very Slippery Slope," *Oxford Journal of Legal Studies* 211 (2001): 629–47, at 631 (describing rather than supporting this argument).

slope arguments in the debate outside the Netherlands over the legalization of euthanasia and assisted suicide.[22] This status "as the world's best 'test case' for disputes about physician-assisted suicide and euthanasia" has given "the experience of the Netherlands ... paramount importance [in] the debates over dying in the rest of the world".[23] A brief examination of the empirical evidence will suffice to illustrate the difficulties associated with resolving the competing arguments.

Most critics rely predominantly on Dutch evidence of cases of "termination of life without an explicit request" as evidence for the slide from voluntary euthanasia to non-voluntary euthanasia.[24] According to the three national surveys of "medical behaviour which

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22. See, e.g., Hendin, *supra* note 18, at 163–5; R. Fenigsen, "A Case Against Dutch Euthanasia," *Hastings Center Report* 19, no. 1 (1989): S22–30, at S24–6; J. Keown, "The Law and Practice of Euthanasia in the Netherlands," *Law Quarterly Review* 108 (1992): 51–78, at 61–78; J. Keown, "Further Reflections on Euthanasia in The Netherlands in the Light of The Remmelink Report and The Van Der Maas Survey," in Luke Gormally, ed., *Euthanasia, Clinical Practice and the Law* (London: The Linacre Centre, 1994): 219–40; Keown, *supra* note 3.

23. M. P. Battin, "The Euthanasia Debate in the United States: Conflicting Claims about the Netherlands," in H. Krabbendam and H.-M. ten Napel, eds., *Regulating Morality: A Comparison of The Role of the State in Mastering the Mores in the Netherlands and the United States* (Antwerpen: Maklu, 2000): 151–71, at 156–7.

24. See, e.g., Fenigsen, *supra* note 22, at 24–6 ("Those who contend that it is possible to accept and practice "voluntary" euthanasia and not allow involuntary [euthanasia] totally disregard the Dutch reality"); R. Fenigsen, "Dutch Euthanasia Revisited," *Issues in Law & Medicine* 13 (1997): 301–11, at 310–11; Keown, "The Law and Practice of Euthanasia in the Netherlands," *supra* note 22, at 61–78; Keown, "Further Reflections," *supra* note 22, at 219; Amarasekara and Bagaric, *supra* note 6, at 189; H. Jochemsen and J. Keown, "Voluntary Euthanasia under Control? Further Empirical Evidence from the Netherlands," *Journal of Medical Ethics* 25, no. 1 (1999): 16–21, at 17–18, 20; *Pretty v. United Kingdom* (2002) 35 E.H.R.R. 1, [31] (Eur. Ct. H.R.) (summarizing the intervention of the Catholic Bishops' Conference of England and Wales). See *contra*, H. Rigter, "Euthanasia in the Netherlands: Distinguishing Facts from Fiction," *Hastings Center Report* 19, no. 1 (1989): S31–2, S31–2 (arguing that there is no evidence of involuntary euthanasia in the Netherlands); G. M. Aartsen et al., "Letter to the Editor," *Hastings Center Report* 19, no. 5 (1989): 47 (agreeing with Rigter's assessment of euthanasia in the Netherlands and describing Fenigsen's article, *supra* note 22, as "completely misplaced"); Van der Maas, "Euthanasia and other Medical Decisions Concerning the End of Life," *supra* note 11, at 669, criticizing "ill-founded speculation" by Fenigsen (*supra* note 22) on the number of cases of

shortens life" in the Netherlands,[25] the cases in the "termination of life without an explicit request" category represent less than one percent of all deaths.[26] The figure of one thousand of these deaths from the first national survey in 1990 (known as the Remmelink survey[27]) is often cited by those who use the slippery slope argument.[28]

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euthanasia in the Netherlands.

25. The Remmelink Commission was appointed to carry out research into the practice of euthanasia in 1990. The research was published in full in English as P. J. van der Maas et al., "Euthanasia and other Medical Decisions Concerning the End of Life: An Investigation Performed upon Request of the Commission of Inquiry into the Medical Practice Concerning Euthanasia," *Health Policy* 22, nos. 1 and 2 (1992): 1–262 and P. J. van der Maas et al., *Euthanasia and other Medical Decisions Concerning the End of Life* (Amsterdam: Elsevier, Health Policy Monographs, 1992). A summary of the report was also published in the *Lancet*. See Van der Maas, "Euthanasia and other Medical Decisions Concerning the End of Life," *supra* note 11. Some of the results of the 1995 follow-up study were published in English in Van der Maas, "Euthanasia, Physician-Assisted Suicide, and Other Medical Practices Involving the End of Life in the Netherlands, 1990-1995," *supra* note 11, and G. van der Wal et al., "Evaluation of the Notification Procedure for Physician-Assisted Death in the Netherlands," *New Engl. J. Med.* 335 (1996): 1706–11. A summary of the third follow-up study in 2001 was published in English in Onwuteaka-Philipsen, *supra* note 11.

26. Onwuteaka-Philipsen, *supra* note 11, at Table 1.

27. See *supra* note 25. The evidence is that the cases in this category are "quite heterogeneous" including severely handicapped neonates, coma patients and terminal cancer patients. In over half of the cases, there is evidence of some earlier discussion with the patient regarding euthanasia or a previously expressed wish. L. Pijnenborg et al., "Life Terminating Acts without Explicit Request of the Patient," *Lancet* 341 (1993): 1196–9, at 1197; Griffiths, Bood and Weyers, *supra* note 19, at 226–7. This may account for the conclusion reached by Margaret Otlowski that "there is some basis for suggesting that the incidence of active termination of life without the patient's request reported in the Remmelink survey may be disproportionately high." M. Otlowski, *Voluntary Euthanasia and the Common Law* (Oxford: Oxford University Press, 1997): at 438. The category represents non-voluntary rather than involuntary euthanasia. "In all situations in which there had been no discussion with the patient and in which no wish of the patient was known, the patients were incompetent." J. J. M. van Delden et al., "The Remmelink Study: 2 Years Later," *Hastings Center Report* 23, no. 6 (1993): 24–7, at 25. Significantly, "most of these cases resemble death due to administration of pain relief more than they do euthanasia." Griffiths, Bood and Weyers, *id.*, at 228 ("In 65% of the cases only morphine or the like was used, and in only 8% were muscle relaxants used, whereas in the case of euthanasia muscle relaxants are now used 90% of the time"). See also, Van Delden, *id.*, at 25. A further indication that at least some of these cases would be better classified as due to the administration of pain relief is that "[a]lmost all [of them] involve patients with only a few hours or days to live." Pijnenborg, *id.*, at 1198.

The critics who rely on this slippery slope argument often omit two important elements, thereby using flawed logic. First, the argument is only effective against legalization if it is legalization which *causes* the slippery slope.[29] Second, it is only effective if it is used *comparatively*, to show that the slope is *more* slippery in the Netherlands than it is in jurisdictions which have not legalized assisted suicide or euthanasia.[30] Since these questions have not been addressed by critics, little attention has been paid to available evidence on causation and comparability.

A. The Causal Argument

In order to show that legalization causes a slippery slope from voluntary to non-voluntary euthanasia, one must show that (1) there has been an increase in the rate of non-voluntary

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28. See E. D. Pellegrino, "The False Promise of Beneficent Killing," in L. L. Emanuel, ed., *Regulating How We Die: The Ethical, Medical, and Legal Issues Surrounding Physician-Assisted Suicide* (Cambridge, MA: Harvard University Press, 1998): 71–91, at 88; *Washington v. Glucksberg*, 521 U.S. 702, 734 (1997); Keown, "Further Reflections," *supra* note 22; J. I. Fleming, "Euthanasia, the Netherlands, and Slippery Slopes," *Bioethics Research Notes (Occasional Paper No. 1)* (1992): 1–10, at 6–7; T. Cipriani, "Give Me Liberty and Give Me Death," *Journal of Law & Medicine* 3 (1995): 177–90, at 190.

29. J. J. M. van Delden et al., "Dances with Data," *Bioethics* 7 (1993): 323–9, at 327, citing Van der Burg, *supra* note 1, at 57. See also, Enoch, *supra* note 21, at 631; Griffiths, Bood and Weyers, *supra* note 19, at 300; Otlowski, *supra* note 27, at 439.

30. See Van Delden, *id.*, at 327; H. Kuhse and P. Singer, "Active Voluntary Euthanasia, Morality and the Law," *Journal of Law & Medicine* 3 (1995): 129–35, at 132; Griffiths, Bood and Weyers, *id.*, at 300–1. Raphael Cohen-Almagor views the comparative argument with scepticism, arguing that its use by the Dutch is a form of defensiveness: "Many Dutch scientists suggest that physicians in many countries are secretly doing what Dutch physicians are doing openly. However, this suggestion is dubious. There are not enough data to either support or refute this suggestion." R. Cohen-Almagor, *Euthanasia in the Netherlands: The Policy and Practice of Mercy Killing* (Dordrecht: Kluwer, 2004): at 147–8, citing only one source for his first sentence: L. Pijnenborg, "The Dutch Euthanasia Debate in International Perspective," in *End-of-Life Decisions in Dutch Medical Practice* (Rotterdam: Thesis, 1995): at 119–31. Section III.B *infra* examines the comparative evidence.

euthanasia following the legalization of voluntary euthanasia,[31] and (2) that increase was caused by the legalization of voluntary euthanasia.

1. A Post-Legalization Increase in Non-Voluntary Euthanasia

Although there have been three major Dutch investigations, unfortunately the Dutch empirical evidence does not cover the period prior to effective legalization.[32] The first comprehensive Dutch survey took place in 1990. We do not know, therefore, whether the rate of non-voluntary euthanasia was lower or higher prior to effective legalization, or whether it has remained relatively stable.[33] While conceding this point, John Keown argues that the inference that non-voluntary euthanasia has in fact increased is more plausible than the inference that it has decreased or remained stable:

> [T]here is good reason to think that NVAE [non-voluntary active euthanasia] has indeed increased since 1984. Breach of the guideline requiring a request is more likely to occur in a situation in which some VAE is allowed than when none is allowed, if only because of the greater problems in policing a practice allowed according to professional guidelines than a practice which is legally prohibited. Moreover, the *official endorsement* of NVAE by, for example, the Remmelink Commission can only have served to lessen doctors' inhibitions against it. Despite the absence of prior statistics it is, therefore, more plausible to conclude that NVAE has increased since 1984 rather than remained static.[34]

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31. "To demonstrate a slippery slope one would need to show that something changed after introducing a certain practice and for this at least two investigations would be required." Van Delden, *id.* See also, Kuhse and Singer, *id.*; Otlowski, *supra* note 27, at 439.

32. M. A. M. de Wachter, "Active Euthanasia in the Netherlands," *JAMA* 262 (1989): 3316–19, at 3316–17; Van Delden, *supra* note 27, at 26. For a discussion of the relevant judicial decisions, see Lewis, *supra* note 8, at 76-83.

33. See J. Griffiths, "Comparative Reflections: Is the Dutch Case Unique?" in Klijn, *supra* note 11, 197–205, at 202 ("there is no evidence that ... termination of life without a request has become more frequent since legalisation in 1984").

34. J. Keown, *Euthanasia, Ethics, and Public Policy* (Cambridge: Cambridge University Press, 2002): at 146 (emphasis in original). John Griffiths suggests on the contrary that "it seems pretty clear that many of the things to which opponents of euthanasia point as the horribles to which legalisation will lead, in fact pre-existed legalisation of euthanasia in

The evidence of "underground euthanasia" described below casts doubt on Keown's claim that it is easier to police a prohibitive regime than a regulatory one.[35] The argument that doctors' inhibitions against non-voluntary euthanasia will have been lessened by legalization is even less persuasive, as if this were the case one would expect to see a gradual rise in the rate of non-voluntary euthanasia in the post-legalization period. Instead, the Dutch surveys of 1990, 1995 and 2001 reveal that the rate of non-voluntary euthanasia or "ending of life without explicit request" has remained stable since 1990 at 0.8% of all deaths in 1990 and 0.7% of all deaths in 1995 and 2001.[36] Paul van der Maas and Linda Emanuel therefore conclude that "neither the argument that such cases increase in number over time, nor the argument that open regulation lowers the rate, is well supported by the data."[37]

Neil Gorsuch makes a more moderate argument, contending that in the absence of evidence to the contrary, one would expect that the legalization of voluntary euthanasia and assisted suicide would cause an increase in the rate of non-voluntary euthanasia:

> [C]onsistent with the law of demand, legalizing voluntary assisted suicide and euthanasia (and thus reducing the "price" associated with the practices) would lead to an increase in the frequency of the practices when compared with baseline, prelegalization rates in any given country.... As nonconsensual killings become more acceptable – as they surely have in the Netherlands, where the government has sought to justify them as a "necessity," and where some, such as Griffiths, have urged their complete decriminalization – *one would expect the number of such cases to increase,* not remain constant as Kuhse seems to suppose. While an exception to the

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the Netherlands". Griffiths, *supra* note 33, at 202.

35. See *infra*, at section III.B and R. S. Magnusson, *Angels of Death — Exploring the Euthanasia Underground* (New Haven: Yale University Press, 2002).

36. Onwuteaka-Philipsen, *supra* note 11, at Table 1 (95% CIs 0.6%-1.1% and 0.5%-0.9% respectively). These figures are based on death certificate studies. The 1990 survey did not collect interview data on this issue, but the relevant interview figures for the other two surveys are 0.7% (1995, 95% CI 0.5%-0.8%) and 0.6% (2001, 95% CI 0.4%-0.9%).

37. P. van der Maas and L. L. Emanuel, "Factual Findings," in Emanuel, *supra* note 28, 151–74, at 160.

> law of demand is not inconceivable, any theory that depends on such an extraordinary exception would require considerable proof.[38]

In the absence of evidence relating to the period before legalization, Gorsuch's argument would be more persuasive if, instead of remaining stable, the rate of non-voluntary euthanasia in the Netherlands had risen steadily during the period after effective legalization, particularly during the late 1990s following the decisions in the *Prins* and *Kadijk* cases of neonatal termination of life.[39] On the contrary, Jocelyn Downie suggests that the fact that the rate of non-voluntary euthanasia in the Netherlands has not increased over the period of the Dutch surveys indicates that there is no slippery slope.[40]

Neither the interpretations by Keown and Gorsuch, on one side, nor Downie on the other, are sustainable on the basis of the current empirical evidence. The Dutch data does not precisely address the issue of legalization, as there is no evidence of the rate of non-voluntary euthanasia prior to legalization with which to compare the steady post-legalization rate. Similarly, no such evidence exists in relation to the period prior to legalization of assisted suicide in Oregon.[41]

In the absence of data on the rate of non-voluntary euthanasia in the Netherlands prior to legalization, the best hope for relevant data currently lies with a repeat of the pre-

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38. N. M. Gorsuch, "The Legalization of Assisted Suicide and the Law of Unintended Consequences: A Review of the Dutch and Oregon Experiments and Leading Utilitarian Arguments For Legal Change," *Wisconsin Law Review* (2004): 1347–1423, at 1395–6 (emphasis added), citing Griffiths, Bood and Weyers, *supra* note 19, at 267–98; H. Kuhse, "From Intention to Consent: Learning from Experience with Euthanasia," in M. P. Battin et al., eds., *Physician Assisted Suicide: Expanding the Debate* (New York: Routledge, 1998): 252–66, at 263–6. Kuhse's argument is discussed *infra*, text accompanying note 94.

39. See Lewis, *supra* note 8, at 129-33; J. H. H. M. Dorscheidt, "Assessment Procedures Regarding End-of-Life Decisions in Neonatology in the Netherlands," *Medicine & Law* 24 (2005): 803–29, at 804–6; Griffiths, Bood and Weyers, *supra* note 19, at 83, App. II-3, 341.

40. Downie, *supra* note 19, at 135–6.

41. *Id.*, at 137, note 56.

legalization survey in Flanders, Belgium which would allow a comparison between the rates of non-voluntary euthanasia in Belgium before and after legalization.[42]

2. An Increase Caused by Legalization

Discussion of this second step of the causation argument is entirely speculative in the absence of any evidence of an increase in the rate of non-voluntary euthanasia following legalization in any jurisdiction which has legalized. However, as John Griffiths points out, were there to be evidence of an increase in the rate of non-voluntary euthanasia following legalization, a causal link could not necessarily be inferred:

> [T]he contention assumes that the *reason* for the increase in the frequency of termination of life without a request – if it had taken place – would lie in the legalisation of euthanasia and not – for example – in the fact that such behaviour had come to be regarded as not always and under all circumstances objectionable.[43]

This argument does not preclude the possibility that changes in societal norms could be caused by legalization, in which case there could be a causal, albeit indirect, connection between legalization and an increase in the rate of non-voluntary euthanasia. Eric Posner and Adrian Vermeule suggest that changes in norms might precede legalization, thus negating the possibility of a causal link between legalization and an increase in the rate of non-voluntary euthanasia:

> Jochemsen and Keown, who are critics of Dutch euthanasia, argue that legalization has resulted in a slide down the slippery slope because the Dutch now condone some types of non-voluntary euthanasia.[44] But the authors cannot trace this change in attitude to legalization – legalization may have followed changes in attitudes – and in any event the change in attitudes can be attributed to benign causes: exposed to public debate about

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42. L. Deliens et al., "End-of-Life Decisions in Medical Practice in Flanders, Belgium: A Nationwide Survey," *Lancet* 356 (2000): 1806–11, at Table 5. The Belgian data is discussed *infra*, text accompanying note 56.

43. Griffiths, *supra* note 33, at 202 (emphasis in the original).

44. *Supra* note 24, at 20–1.

> euthanasia practices, the Dutch view toward euthanasia, unsurprisingly, has evolved.[45]

It is true that evidence of causation is likely to be difficult to establish.[46] Nevertheless, a significant increase in the rate of non-voluntary euthanasia within a short time during which legalization has taken place, would strongly suggest that legalization has had an influence on the rate of non-voluntary euthanasia. Although such evidence does not exist in relation to the Dutch model, again Belgium provides a good opportunity to collect evidence in the near future.[47]

In the absence of evidence of causation, or even of a post-legalization increase in the rate of non-voluntary euthanasia, critics of Dutch law and practice have drawn causative inferences simply from the evidence of the *existence* of non-voluntary euthanasia in the Netherlands. For example, Kumar Amarasekara and Mirko Bagaric argue:

> The ... *only* cogent evidence ... shows in a climate where voluntary euthanasia is openly practiced, there are also a large number of cases of non-voluntary euthanasia. It may be that the rate of non-voluntary euthanasia in Holland was not increased by the decision to give the green light to voluntary euthanasia. But given that we know that one state of affairs (ie where euthanasia is practiced with impunity) *definitely* leads to undesirable consequences and are unsure about the situation in the alternative state of affairs (where euthanasia is prohibited and this prohibition is enforced), logically we ought to opt for the later [sic] – speculative or possible dangers being accorded far less weight than certain ones.[48]

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45. E. A. Posner and A. Vermeule, "Should Coercive Interrogation Be Legal?" *Michigan Law Review* 104 (2006): 671–707, at note 67.

46. J. Arras has described this as "an extremely difficult problem of empirical prediction." Arras, *supra* note 4, at 296.

47. See *supra*, text accompanying note 42.

48. Amarasekara and Bagaric, *supra* note 6, at 190 (emphasis in original). The argument is reproduced in M. Bagaric, "The Kuhse-Singer Euthanasia Survey: Why it Fails to Undermine the Slippery Slope Argument – Comparing Apples and Apples," *European Journal of Health Law* 9 (2002): 229–41, at 233.

Logically, however, this does not follow. Amarasekara and Bagaric admit that there may be no link between legalization in the Netherlands and the rate of non-voluntary euthanasia, and yet in the next sentence assert that they "know" that legalization "*definitely* leads to undesirable consequences." How do they know this? Leaving aside the fact that there is no evidence of a post-legalization increase in the Dutch rate of non-voluntary euthanasia, the temptation to assume that the legalization of voluntary euthanasia causes non-voluntary euthanasia to occur, while understandable, should be resisted in the absence of evidence of causation. The presence of both legalization and non-voluntary euthanasia does not necessitate a causal connection between the two. As Stephen Smith has recently written:

> Groups may assume that the presence of A and B together leads to the conclusion that there is a connection. There may not always be such a connection or there may not be the right sort of connection for a slippery slope argument. In other words, the simple fact that A and B are present does not lend any authority to the claim that A led to B. More specific evidence, and more specific causal evidence, is required before a slippery slope claim can be verified.[49]

B. The Comparative Argument

The previous section illustrated that at present there is no *direct* evidence that legalization causes an increase in the rate of non-voluntary euthanasia. However, if rates of non-voluntary euthanasia are higher in jurisdictions which have legalized voluntary euthanasia than in those which have not, this may suggest *indirectly* that legalization has caused an increase in the rate of non-voluntary euthanasia. Conversely, if rates of non-voluntary euthanasia are higher in jurisdictions in which voluntary euthanasia remains illegal, the force of this empirical slippery slope argument is further attenuated. The first part of this section examines comparative evidence of the rates of non-voluntary euthanasia across jurisdictions

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49. S. W. Smith, "Evidence for the Practical Slippery Slope in the Debate on Physician-Assisted Suicide and Euthanasia," *Medical Law Review* 13 (2005): 17–44, at 22.

in which the legal status of voluntary euthanasia varies. The second part discusses the limits on the inferences which may be drawn from this comparative evidence.

1. Comparative Evidence

There is no evidence demonstrating that the Netherlands has a greater rate of non-voluntary or involuntary euthanasia than other Western countries.[50] Indeed, there is a significant amount of evidence demonstrating the prevalence of both voluntary and non-voluntary active euthanasia in various jurisdictions in which euthanasia has not been legalized, looking at criminal prosecutions,[51] admissions by doctors[52] and anonymous surveys of medical professionals. The survey evidence is the most cogent and has been the most hotly contested.

A. Survey Prevalence Evidence

As discussed in the previous section, the rate of "ending of life without explicit request" in the three Dutch surveys has remained stable.[53] While critics of Dutch practice tend to focus on the raw numbers of deaths in this category,[54] those in favor of legalization and those who defend Dutch practice have responded by citing surveys from other countries which indicate

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50. Griffiths, *supra* note 33, at 202; Griffiths, Bood and Weyers, *supra* note 19, at 301, note 4.

51. Some of the relevant cases are mentioned in Lewis, *supra* note 8, at 6-11, 95-7. See also, Otlowski, *supra* note 27, at 140–8; B. Sneiderman, "The Case of Robert Latimer: A Commentary on Crime and Punishment," *Alberta Law Review* 37 (1999): 1017–44, at ¶60, ¶85–¶87; Downie, *supra* note 19, at 137, note 57; L. Dietz et al., "Aiding, Abetting, or Counseling Suicide; Euthanasia and Assisted Suicide," 40A Am. Jur. 2d Homicide § 623 (2006) **(please clarify citation and provide full name of publication – this is a treatise available on Westlaw – I'm attaching it)**; J. M. Thunder, "Quiet Killings in Medical Facilities: Detection and Prevention," *Issues in Law & Medicine* 18 (2003): 211–35, at 213.

52. See generally, Otlowski, *id.* at 134–8; Magnusson, *supra* note 35.

53. See *supra*, text accompanying note 36.

54. See *supra*, text accompanying note 28.

that the rate of non-voluntary euthanasia in some Western jurisdictions which have not legalized euthanasia or assisted suicide is higher than it is in the Netherlands. For example, a 1996 Australian anonymous postal survey of doctors based on the interview questionnaire used in the 1995 Dutch study found that the rate of termination of life without explicit request was 3.5% of all deaths.[55] A 1998 death certificate study (based on the Dutch model) in Flanders, Belgium, prior to legalization, reported a rate of "ending of life without the patient's explicit request" of 3.2%.[56] The authors of this study have commented that "the fact that the figure is four to five times higher in Flanders than in the neighbouring Netherlands supports the conclusion that the Belgian rate is unexpectedly high ... another possibility is that the Dutch rate is unexpectedly low."[57]

However, a recent survey in the United Kingdom based on the same methodology as the Australian study reported a much lower rate of ending of life without explicit request from the patient of 0.33% of all deaths.[58] A pan-European study based on data from 2001-2002 found rates of ending of life without the patient's explicit request varied between 1.5% in Flanders, Belgium (prior to legalization) and 0.06% in Italy. This data is shown in the following table alongside the Australian data referred to earlier:

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55. H. Kuhse et al., "End-of-Life Decisions in Australian Medical Practice," *Medical Journal of Australia* 166 (1997): 191–6, at Box 4 (95% CI 2.7%-4.3%). Further Australian evidence is discussed *infra* note 62.

56. Deliens, *supra* note 42, at Table 5 (95% CI 2.7%-3.8%). The pilot study which preceded this study is described in F. Mortier et al., "End-of-life Decisions of Physicians in the City of Hasselt (Flanders, Belgium)," *Bioethics* 14 (2000): 254–67. See also, F. Mortier et al., "Attitudes, Sociodemographic Characteristics, and Actual End-of-Life Decisions of Physicians in Flanders, Belgium," *Medical Decision Making* 23 (2003): 502–10.

57. F. Mortier and L. Deliens, "The Prospects of Effective Legal Control on Euthanasia in Belgium: Implications of Recent End-of-Life Studies," in Klijn, *supra* note 11, 179–95, at 184, note 17.

58. C. Seale, "National Survey of End-of-Life Decisions Made by UK Medical Practitioners," *Palliative Medicine* 20 (2006): 3–10, at Table 2. The survey was carried out in 2004-2005. A full comparison between the Australian and U.K. data is found in Table 2.

Table 1: Rates of ending life without the patient's explicit request (percentage of deaths and 95% confidence interval)[59]

Country	*Australia*	*U.K.*	*Belgium*	*Denmark*	*Italy*	*Netherlands*	*Sweden*	*Switzerland*
Including SUDs*	3.5 (2.7-4.3)	0.33 (0-0.76)	1.5 (1.12-2.01)	0.67 (0.44-1.04)	0.06 (0.01-0.29)	0.60 (0.43-0.84)	0.23 (0.11-0.47)	0.42 (0.25-0.70)
Excluding SUDs*		0.36 (0-0.87)	2.26 (1.59-2.93)	1.02 (0.57-1.47)	0.11 (0-0.26)	0.90 (0.59-1.21)	0.31 (0.08-0.54)	0.61 (0.29-0.93)

*SUDs = sudden and unexpected deaths

The rates of non-voluntary euthanasia in Australia, Belgium (pre-legalization) and Denmark were all higher than the rate in the Netherlands, the only jurisdiction in which termination of life on request was lawful at the time of these surveys. Other jurisdictions in which voluntary euthanasia was and remains illegal had significantly lower rates of non-voluntary euthanasia, including the United Kingdom, Italy and Sweden.

B. Beyond Non-Voluntary Euthanasia Prevalence Rates

Although comparable evidence of rates of non-voluntary euthanasia from other jurisdictions is unavailable,[60] there is considerable evidence that both non-voluntary and voluntary euthanasia and assisted suicide are practiced in jurisdictions in which they are subject to criminal prohibition including Canada,[61] Australia,[62] New Zealand,[63] the United States[64] and

59. This data is from A. van der Heide et al., "End-of-Life Decision-Making in 6 European Countries: Descriptive Study," *Lancet* 362 (2003): 345-50, at Table 2; Seale, *id.*, at Tables 2 and 3; Kuhse, *supra* note 55, at Box 4.

60. "[E]pidemiological research concerning medical decision-making at the end of life is ... rather scarce". A. van der Heide et al., "End-of-life Decisions in 6 European Countries: A Research Note," in Klijn, *supra* note 11, 129–34, at 131.

the United Kingdom[65] as well as other European jurisdictions. The pan-European study discussed above also includes data on rates of euthanasia and physician-assisted suicide. This data is shown in the following table alongside the corresponding Australian data:

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61. See N. Searles, "Silence Doesn't Obliterate the Truth: A Manitoba Survey on Physician Assisted Suicide and Euthanasia," *Health Law Review* 4 (1996): 9–16, at ¶22, Table 4 ("A little more than one in seven doctors indicated they had facilitated a patient's request for assisted suicide or euthanasia by hastening her or his death"); Downie, *supra* note 19, at 137–8.

62. See Kuhse, *supra* note 55, at Box 4: 1.8% of deaths were due to voluntary euthanasia and assisted suicide (95% CI 1.2%-2.4%); C. D. Douglas et al., "The Intention to Hasten Death: A Survey of Attitudes and Practices of Surgeons in Australia," *Medical Journal of Australia* 175 (2001): 511–5 (5.3% of respondents reported giving a lethal injection or providing the means to commit suicide on request); H. Kuhse and P. Singer, "Doctors' Practices and Attitudes Regarding Voluntary Euthanasia," *Medical Journal of Australia* 148 (1988): 623–7, at 624 (29% of responding doctors had taken active steps to end a patient's life on request); C. A. Stevens and R. Hassan, "Management of Death, Dying and Euthanasia: Attitudes And Practices of Medical Practitioners in South Australia," *Journal of Medical Ethics* 20 (1994): 41–6, at 43 (18.8% of responding doctors had taken active steps to bring about the death of a patient; 49% of this group had never received a request from a patient); P. Baume and E. O'Malley, "Euthanasia: Attitudes and Practices of Medical Practitioners," *Medical Journal of Australia* 161 (1994): 137–44 (12.3% of reporting doctors had complied with a patient request to hasten death; 7% had provided the means for suicide).

63. See K. Mitchell and R. G. Owens, "National Survey of Medical Decisions at End of Life Made by New Zealand General Practitioners," *British Medical Journal* 327 (2003): 202–3 (5.6% of respondent doctors making an end-of-life decision at the last death attended had performed active euthanasia or physician-assisted suicide; 44% of these decisions had not been discussed with the patient, almost entirely because the patient was no longer competent). A direct comparison between this study and the most recent U.K. study is found in Seale, *supra* note 58, at Table 4: the rate of active euthanasia or physician-assisted suicide at the last death attended across all respondents (not simply those who made an end-of-life decision) was 3.1% in the New Zealand study (95% CI 2.1%-4.1%) and 1.4% in the U.K. study (95% CI 0.3%-2.5%).

64. The empirical evidence is reviewed in E. J. Emanuel, "Euthanasia and Physician-Assisted Suicide: A Review of the Empirical Data From the United States," *Archives of Internal Medicine* 162 (2002): 142–52, at 146, Table 4 ("Many studies indicate that a small, but definite, proportion of US physicians have performed euthanasia or PAS, despite its being illegal.... [T]he data provide conflicting evidence on the precise frequency of such interventions, with reported frequencies varying more than 6-fold even among the best studies").

65. See Seale, *supra* note 58, at Table 2; B. J. Ward and P. A. Tate, "Attitudes among NHS Doctors To Requests for Euthanasia," *BMJ* 308 (1994): 1332–4 (12% of responding doctors had taken active steps to hasten death on request); S. A. M. McLean and

A. Britton, *Sometimes A Small Victory* (Glasgow: Institute of Law and Ethics in Medicine, 1996): at App. III, Table 17, 31–2, discussed in Keown, *supra* note 34, at 61 and M. Freeman, "Denying Death its Dominion: Thoughts on the Dianne Pretty Case," *Medical Law Review* 10 (2002): 245–70, at 249, note 31 (4% of responding Scottish health professionals had assisted suicide). The House of Lords Select Committee on the Assisted Dying for the Terminally Ill Bill doubted some of the U.K. survey evidence: "Bearing in mind however the trend towards death taking place in hospital rather than at home, the increasing prevalence of team-working in clinical care, the greater tendency for people to litigate where they suspect malpractice, and the potential for confusion with the legal administration of drugs to prevent restlessness and anxiety in the last hours of life, we would be surprised if covert euthanasia were being practised on anything like the scale which some of these surveys suggest." House of Lords Select Committee on the Assisted Dying for the Terminally Ill Bill, *Report*, HL Paper 86-I (2005): at ¶239, *available at* <www.publications.parliament.uk/pa/ld200405/ldselect/ldasdy/86/86i.pdf> (last visited December 13, 2006).

Table 2: Rates of euthanasia and physician-assisted suicide (percentage of deaths and 95% confidence interval)[66]

Country		*Australia*	*U.K.*	*Belgium*	*Denmark*	*Italy*	*Netherlands*	*Sweden*	*Switzerland*
Including SUDs*	EUT**	1.8 (1.2-2.4)	0.16 (0-0.36)	0.3 (0.16-0.58)	0.06 (0.01-0.26)	0.04 (0-0.27)	2.59 (2.19-3.04)	-	0.27 (0.14-0.51)
	PAS***	0.10 (0.02-0.18)	0.00	0.01 (0-0.28)	0.06 (0.01-0.26)	0.00	0.21 (0.12-0.38)	-	0.36 (0.20-0.63)
Excluding SUDs*	EUT**		0.17 (0-0.51)	0.46 (0.17-0.75)	0.10 (0-0.24)	0.05 (0-0.15)	3.89 (3.49-4.29)	-	0.39 (0.13-0.65)
	PAS***		0.00	0.05 (0-0.15)	0.10 (0-0.24)	0.00	0.31 (0.13-0.49)	-	0.52 (0.22-0.82)

*SUDs = sudden and unexpected deaths
**EUT = euthanasia ***PAS = physician-assisted suicide

2. Difficulties Associated With The Comparative Evidence

A. Lack Of Reliable Data

Not only is there a dearth of pre-legalization evidence in the Netherlands,[67] but studies similar to those subsequently undertaken in the Netherlands are rare,[68] although the recent Australian, United Kingdom and pan-European research has provided some points of comparison.[69] However, the Australian survey has been heavily criticized on methodological grounds.[70] The more recent U.K. survey using similar methodology corrected one flaw in the

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66. This data is from Van der Heide, *supra* note 59, at Table 2; Seale, *supra* note 58, at Tables 2 and 3; Kuhse, *supra* note 55, at Box 4.

67. See *supra*, text accompanying notes 32–37.

68. Cohen-Almagor, *supra* note 30, at 26.

69. See Kuhse, *supra* note 55; Seale, *supra* note 58; Van der Heide, *supra* note 59.

70. Some of the criticism was canvassed by the Australian Senate Legal and Constitutional Legislation Committee in its report on the Bill to overrule the Northern Territory legislation. *Euthanasia Laws Bill 1996* (1997): at 88–9 (on the Northern Territory legislation, see Lewis, *supra* note 8, at 157-8). See also, K. Amarasekara, "Euthanasia and the Quality of Legislative Safeguards," *Monash University Law Review* 23 (1997): 1–42, at 15–16; Amarasekara and Bagaric, *supra* note 6, at 191; Gorsuch, *supra* note 38, at 1396–1400.

Australian study which had the effect of "artificially inflat[ing] the proportion of deaths receiving" end-of-life decisions.[71] The Australian data is nonetheless included here because it has become an important weapon in the armory of pro-legalization commentators.[72]

A further difficulty with the comparative evidence is that "legal and cultural differences" make valid comparisons difficult.[73] This is particularly true of comparisons between jurisdictions with very different health care systems.[74]

B. Effect of the Topic

Collecting data about the prevalence of euthanasia and assisted suicide is a difficult enterprise. Even though most surveys focus on disclosure by individual practitioners given guarantees of anonymity, rather than on reports to the authorities, under-disclosure is likely.

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71. Seale, *supra* note 58, at 6: "Sudden and unexpected deaths are excluded from Table 3 to control for an artefactual effect that applied to this and the Australian study, which chose deaths according to the most recent one nominated by the respondent. Significantly fewer such deaths were nominated by UK and Australian doctors than in studies based on samples of death certificates. The effect of this is to artificially inflate the proportion of deaths receiving ELDs [end-of-life decisions], a point not appreciated by the Australian investigators."

72. See, e.g., Kuhse, *supra* note 55, at 196 (noting that their study comparing Australia and the Netherlands weakens the assumption that countries openly practising euthanasia have higher non-voluntary euthanasia rates than countries not openly practising euthanasia); M. Otlowski, "The Effectiveness of Legal Control of Euthanasia: Lessons from Comparative Law," in Klijn, *supra* note 11, 137–55, at 141–3, 152–5; D. Morris, "Assisted Suicide under the European Convention on Human Rights: A Critique," *European Human Rights Law Review* 1 (2003): 65–91, 84.

73. Cohen-Almagor, *supra* note 30, at 26. See also, B. D. Onwuteaka-Philipsen et al., "End-of-Life Decision Making in Europe and Australia: A Physician Survey," *Archives of Internal Medicine* 166 (2006): 921–9, at 927–8. On social contexts as an influence on the strength of slippery slope arguments, see Lode, *supra* note 1, at 1493–4.

74. See Van der Maas and Emanuel, *supra* note 37, at 161; T. H. Stone and W. J. Winslade, "Physician-Assisted Suicide and Euthanasia in the United States," *Journal of Legal Medicine* 16 (1995): 481–507, at note 70; Griffiths, Bood and Weyers, *supra* note 19, at 304–5; Otlowski, *supra* note 27, at 452–4; M. P. Battin, "A Dozen Caveats Concerning the Discussion of Euthanasia in the Netherlands," in M. P. Battin, *The Least Worst Death: Essays in Bioethics on the End of Life* (New York: Oxford University Press, 1994): 130–44, at 140–1.

This is particularly so in jurisdictions in which these acts are illegal,[75] although some researchers have reported high response rates.[76] In Roger Magnusson's study of the euthanasia underground in the United States and Australia, he found evidence of practiced deception amongst practitioners:

> Deception permeates every aspect of illicit euthanasia practice. By all accounts, health care workers are remarkably accomplished in their deception. Deceptive practices contribute to the *invisibility* of euthanasia, and help to perpetuate the myth that because euthanasia is prohibited, it never occurs.[77]

The presence of criminal prohibitions makes the comparative evidence difficult to assess. Looking at the rather scant Canadian evidence, Lorraine Weinrib observes:

> It may well be that the criminal prohibition in Canada hides the incidence of assisted suicide, particularly in respect to the terminally ill. Without any data for Canada, it is not possible to pinpoint our place on the slippery slope, i.e. whether there is a problem to avoid or a problem to regulate.[78]

Even post-legalization, practitioners may be reluctant to report cases which did not comply with the relevant criteria,[79] and this reluctance may extend to disclosure to

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75. Searles, *supra* note 62, at ¶27 ("If the response rate is thought to be low, this is due predominantly to the controversial nature of the subject matter of this investigation. Physicians were asked if they have ever committed indictable offences, punishable by harsh professional and criminal sentences."); M. T. Muller et al., "Euthanasia and Assisted Suicide: Facts, Figures and Fancies with Special Regard to Old Age," *Drugs & Aging* 13 (1998): 185–91, at 189; Downie, *supra* note 19, at 137; Seale, *supra* note 58, at 6.

76. Emanuel, "The Practice of Euthanasia and Physician-Assisted Suicide in the United States," *supra* note 64, at 512.

77. Magnusson, *supra* note 35, at 229.

78. Weinrib, *supra* note 4, at note 77.

79. Mortier and Deliens, *supra* note 57, at 179; J. M. Cuperus-Bosma et al., "Physician-Assisted Death: Policy-Making by the Assembly of Prosecutors General in the Netherlands," *European Journal of Health Law* 4 (1997): 225–38, at 236–7; B. Sneiderman, J. C. Irvine and P. H. Osborne, *Canadian Medical Law: An Introduction for Physicians, Nurses and other Health Care Professionals* (3rd ed.) (Scarborough, Ontario: Carswell, 2003): at 727 (quoting G. van der Wal, *Euthanasia En Hulp by Zelfdoding Door Huisartsen (Euthanasia and Assisted Suicide by Family Physicians)* (Rotterdam: WYT Uitgeefgroep,

researchers despite guarantees of anonymity. Practitioners who are involved in a number of assisted deaths may not remember each one, which may result in inadvertent under-reporting or under-disclosure.[80] Reports may also be moulded so as to better fit the relevant criteria, and this may also affect disclosure to researchers.[81]

3. Drawing Inferences from the Comparative Data

A. The Problem of the Baseline

Even if the rate of non-voluntary euthanasia is higher in some jurisdictions which have not legalized (such as Australia) than in jurisdictions which have (such as the Netherlands) this could be consistent with the proposition "that different countries have different baseline (prelegalization) rates ... because of unrelated cultural phenomena."[82] For example, Clive

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1992): at 12: "physicians, having been informed about the requirements for prudent care, only report those cases of which they are almost certain that they will not be prosecuted"); H. Jochemsen, "Why Euthanasia Should not be Legalized: A Reflection on the Dutch Experiment," in D. N. Weisstub et al., eds., *Aging: Decisions at the End of Life* (Dordrecht: Kluwer Academic Publishers, 2001): 67–90, at 77. The 1995 Dutch research indicated, however, that failure to report was generally related to a failure to meet one of the procedural requirements (such as obtaining a written request; consultation with another physician; or providing a written report). "There were no major differences between reported and unreported cases in terms of the patients' characteristics or the basis for the decision to provide assistance (i.e., whether there was an explicit request and unbearable and hopeless suffering)." Van der Wal, *supra* note 25, at 1708. Similar results were reported in later research. See B. D. Onwuteaka-Philipsen et al., "Dutch Experience of Monitoring Euthanasia," *British Medical Journal* 331 (2005): 691–3, at 692, and in earlier research amongst family doctors only. See G. van der Wal et al., "Euthanasia and Assisted Suicide II. Do Dutch Family Doctors Act Prudently?" *Family Practice* 9 (1992): 135–40, at 137–40.

80. R. Pool, *Negotiating a Good Death: Euthanasia in the Netherlands* (Binghamton, NY: The Haworth Press, 2000): at 110, 114 (based on a small, non-scientific sample).

81. Van der Wal, *Euthanasia and Assisted Suicide By Family Physicians*, *supra* note 79, at 12, translated in Sneiderman, Irvine and Osborne, *supra* note 79, at 727.

82. Gorsuch, *supra* note 38, at 1395.

Seale has proposed the following explanation for the low rates of both non-voluntary and voluntary euthanasia found in his recent U.K. survey:[83]

> The lower relative rate of [end-of life decisions] involving doctor-assisted dying in the UK, and the relatively high rate of [non-treatment decisions],[84] suggests a culture of medical decision making informed by a palliative care philosophy. Historically the UK developed palliative care approaches earlier than the other countries in which the survey has been done, supporting this interpretation. The situation may also reflect, amongst GPs in particular, fears arising from the Harold Shipman scandal in which a UK GP was convicted of causing the deaths of numerous patients by administering lethal injections.[85]

There is some evidence that the rate of non-voluntary euthanasia may be inversely proportional to the rate of discussion with patients, families and colleagues.[86] For example, Freddy Mortier and Luc Deliens suggest that one explanation for the relatively high Belgian rate of non-voluntary euthanasia is that "in Belgium, the patient's autonomy is legally less clearly recognized and paternalistic medical practice appears to be more widely accepted."[87] Patients' rights have only recently been recognized by statute in Belgium.[88] The higher Belgian rates of failure to discuss with the patient both non-treatment decisions and palliative

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83. See *supra*, text accompanying notes 58–59 and note 66.

84. The U.K. rate of non-treatment decisions as a percentage of non-sudden deaths was 33.4% (95% CI 27.1%-39.8%). Several European jurisdictions have significantly lower rates. For example, the rate in Belgium (pre-legalization) was 22.8% (95% CI 20.9%-24.7%). Denmark and Sweden had similar rates to Belgium. Italy's rate was much lower, at 5.6% (95% CI 4.6%-6.6%). The Netherlands and Switzerland had rates comparable to the U.K. Seale, *supra* note 58, at Table 3, using data from Van der Heide, *supra* note 59, at Table 2.

85. Seale, *id.*, at 8.

86. C. Seale, "Characteristics of End-Of-Life Decisions: Survey of UK Medical Practitioners," *Palliative Medicine* 20 (2006): 653-9.

87. Mortier and Deliens, *supra* note 57, at 186–7. The Belgian data is discussed *supra* notes 56–57 and accompanying text.

88. Law concerning the rights of the patient of August 22, 2002, discussed by H. Nys, "Recent Developments in Health Law in Belgium," *European Journal of Health Law* 13 (2006): 95–9.

measures intended to shorten the patient's life (in comparison to the Netherlands) are consistent with this explanation.[89] Helga Kuhse et al., in their Australian study, suggest that prohibition may be linked to low rates of discussion with patients and families: "it may be that, because existing laws prohibit the intentional termination of life, doctors are reluctant to discuss medical end-of-life decisions with their patients lest these decisions be construed as collaboration in euthanasia or in the intentional termination of life."[90]

Due to the problem of the baseline, the comparative evidence does not rule out the possibility that legalization of voluntary euthanasia has caused or would cause a change in the rate of non-voluntary euthanasia. To repeat, the best evidence which could be obtained on this point would be evidence of a significant change in the rate of non-voluntary euthanasia within a short time period during which legalization of voluntary euthanasia has taken place. At present, no such evidence exists.[91]

B. Comparing Jurisdictions which have Legalized with those which Have Not

What can be inferred from the comparative data on the prevalence of non-voluntary euthanasia? Margaret Otlowski has argued that the inference to be drawn is that prohibition *causes* the higher prevalence rates in jurisdictions which have not legalized – Australia and pre-legalization Belgium – than in the one which has – the Netherlands:

> These research data from Belgium suggest that these practices are not peculiar to common law jurisdictions or to the particular approach of the common law, but rather, *are the product* of an outright prohibition on euthanasia under the criminal law, however this might be achieved.[92]

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89. Mortier and Deliens, *supra* note 57, at 186–7.

90. Kuhse, *supra* note 55.

91. See *supra*, text accompanying notes 46–47.

92. Otlowski, *supra* note 72, at 143 (emphasis added), 148. A similar argument was made by the Voluntary Euthanasia Society in its intervention in *Pretty v. United*

Helga Kuhse makes a similar argument, drawing on the evidence that the rate of non-voluntary euthanasia in Australia is significantly higher than the Dutch rate:[93]

> There seems to be good evidence to suggest that laws prohibiting the intentional termination of life, but permitting the withholding or withdrawing of treatment and the administration of life-shortening palliative care, do not prevent doctors from intentionally ending the lives of some of their patients. There are also good reasons to believe that such laws ... encourage hypocrisy and unconsented-to termination of patients' lives.[94]

Once again, the inference of causation has not been proven. As Gorsuch has pointed out, factors other than the presence of prohibition could have caused these higher rates.[95] Indeed, the fact that high rates are not found in other jurisdictions which have prohibited assisted dying (such as the United Kingdom, Italy and Sweden)[96] casts doubt on the inference proposed by Otlowski and Kuhse.

Kumar Amarasekara and Mirko Bagaric have argued that the Australian data does not refute the slippery slope argument but rather reinforces it. They contend that although voluntary euthanasia has not been legalized in Australia, the non-prosecution of such cases means that the description of Australia as a jurisdiction in which voluntary euthanasia is prohibited is inappropriate:

> [T]he surveys merely demonstrate that legislation is futile. If non-voluntary euthanasia is greater where it is illegal as in Australia than where it is

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Kingdom (2002) 35 E.H.R.R. 1, [27] (Eur. Ct. H.R.): "The Dutch situation indicated that in the absence of regulation slightly less than 1% of deaths were due to doctors having ended the life of a patient without the latter explicitly requesting this (non-voluntary euthanasia). A similar studies [sic] indicated a figure of 3.1% in Belgium and 3.5% in Australia. It might therefore be the case that less attention was given to the requirements of a careful end of life practice in a society with a restrictive legal approach than in one with an open approach that tolerated and regulated euthanasia."

93. See *supra*, text accompanying notes 36, 55.

94. Kuhse, *supra* note 38, at 263.

95. Gorsuch, *supra* note 38, at 1395.

96. See *supra*, text accompanying notes 58–59.

> practised openly as in the Netherlands, then the effectiveness of all legislation has to be questioned. Australian law which prohibits the intentional termination of life by an act or omission 'has not prevented the practice of euthanasia or the intentional ending of life without the patient's consent.' It is equally certain that decriminalising legislation which imposes conditions under which voluntary euthanasia may be administered will not be complied with.
>
> The prevalence of non-voluntary euthanasia [in Australia] is attributable not to the ban on voluntary euthanasia but to the faulty exercise of a discretion not to prosecute violations of the ban.[97]

The logic of this argument is flawed. The evidence that "non-voluntary euthanasia is greater where it is illegal as in Australia than where it is practised openly as in the Netherlands"[98] is equally consistent with the inference that legalization has a beneficial effect on the number of cases of non-voluntary euthanasia! Moreover, if the cause of non-voluntary euthanasia is the failure to prosecute those who commit it, then perhaps the fact that there have been a small number of such prosecutions in the Netherlands could explain the lower rate of non-voluntary euthanasia there.[99] Amarasekara and Bagaric's analysis also cannot explain the low rate of non-voluntary euthanasia in the United Kingdom, another jurisdiction in which such prosecutions are rarely brought.[100] Indeed, all of these inferences are entirely speculative. In order to determine which, if any, of these conclusions is valid, one would need to compare the rate of non-voluntary euthanasia in a jurisdiction where euthanasia is not legalized but is not prosecuted, with one (comparable in other respects) in which cases are vigorously prosecuted. No such data exists.

4. Beyond The Rates Of Non-Voluntary Euthanasia

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97. Amarasekara and Bagaric, *supra* note 6, at 191, citing Kuhse, *supra* note 55, at 196. See also, Bagaric, *supra* note 48, at 236–8.

98. Amarasekara and Bagaric, *id.*

99. See Lewis, *supra* note 8, at 127-36.

100. See Lewis, *id.* at 95-7.

Although the paucity of the data does not allow us to reach any firm conclusions on the empirical slippery slope argument, insights from the survey evidence and other qualitative studies may provide evidence that legalization has some benefits in relation to the way in which voluntary, non-voluntary and even involuntary euthanasia occurs, particularly in jurisdictions with relatively high apparent rates of covert voluntary and non-voluntary euthanasia such as Australia and Belgium. Roger Magnusson's study suggests that particularly

> disturbing practices, including "botched attempts," strangulations, and the practice of euthanasia in the absence of any prior relationship between doctor and patient, are disproportionately evident in countries where euthanasia is more difficult to access, and where it defaults to an invisible "underground."[101]

If non-voluntary euthanasia is present regardless of legalization, open regulation may be preferable to a covert underground.[102] There is, for example, evidence showing that the presence of consultation with another physician as a safeguard in cases of assisted dying is far less likely to be present in jurisdictions which have not legalized.[103] Even if appropriate baseline-sensitive evidence were to show an increase in the rate of non-voluntary euthanasia following legalization in a particular jurisdiction, such an increase in an open, regulated environment might be preferable to the hidden world of disturbing practices described by

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101. Magnusson, *supra* note 35, at 262. See also, Emanuel, "The Practice of Euthanasia and Physician-Assisted Suicide in the United States," *supra* note 64, at 509. That is not to say that there are no clinical difficulties in jurisdictions which have legalized euthanasia. See, e.g., J. H. Groenewoud et al., "Clinical Problems with the Performance of Euthanasia and Physician-Assisted Suicide in the Netherlands," *New Engl. J. Med*. 342 (2000): 551–6.

102. Magnusson, *supra* note 35, at 263; Searles, *supra* note 62, at ¶25. See also, R. Magnusson, "Underground Euthanasia and the Harm Minimization Debate," *Journal of Law, Medicine & Ethics* 32 (2004): 486–95, at 492.

103. Emanuel, "The Practice of Euthanasia and Physician-Assisted Suicide in the United States," *supra* note 64, at 511; Willems, *supra* note 62, at 67.

Magnusson in which "health care workers who perform euthanasia determine the conditions for their own involvement."[104]

Moreover, prohibition may simply encourage doctors to terminate life in ways which are more difficult to detect, by using large doses of pain-relieving medications, for example:

> To a considerable extent, a doctor can choose how to bring about a shortening of his patient's life and how to describe what it is that he has done. If one of the possibilities is unattractive for any reason, for example because it is illegal, he can accomplish the same result in a different way or under a different name. To the extent the horribles predicted should euthanasia be legalised were already taking place before legalisation but were characterised by the responsible doctor as deaths due to abstention or pain relief, it is not surprising that legalisation [in the Netherlands] has not led to a slippery slope. All that has happened is that what was taking place already has to some extent come out into the open as "euthanasia", where it can be subject to some control. For precisely the same reason, no downward slippery slope is to be expected in other countries with similar levels of physician-negotiated death; they, too, have nowhere to go but up.[105]

However, the evidence from the pan-European studies does not indicate that those jurisdictions with low rates of voluntary euthanasia, assisted suicide and termination of life without request have correspondingly higher rates of symptom alleviation with possible life-shortening effect.[106] Thus the advantages of legalization may be less significant in those jurisdictions whose baseline rates of covert practices are relatively low.

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104. Magnusson, *supra* note 35, at 4.

105. Griffiths, *supra* note 33, at 203. For evidence of this use of pain relieving drugs, see Douglas, *supra* note 62 (36.2% of respondents reported giving pain-relieving drugs with the intention of hastening death); Seale, *supra* note 58, at Table 4 (comparing U.K. and New Zealand rates of cases where the intention of intensifying alleviation of pain or symptoms was partly to end life among responding general practitioners: the U.K. rate was 4.0% (95% CI 2.1%-5.9%); the New Zealand rate was 13.7% (95% CI 11.8%-15.6%, calculated using data from Mitchell and Owens, *supra* note 63)); Deliens, *supra* note 42, at Table 1. Among end-of-life decisions, the rate of alleviation of pain and symptoms with opioids in doses with a potential life-shortening effect and an additional intention to shorten the patient's life was 5.3% (95% CI 4.6%-6.0%); Kuhse, *supra* note 55, at Box 4. 6.5% of all Australian deaths were preceded by the alleviation of pain and suffering through the administration of opioids in sufficient doses to hasten death where the decision was partly intended to hasten death (no CI provided).

IV. Conclusion

In relation to the empirical slippery slope argument, greater caution is needed before relying on the "Dutch experience" when discussing proposals for the regulation of assisted dying in other jurisdictions, and the possible consequences of such regulation. There is no evidence from the Netherlands that the legalization of voluntary euthanasia caused an increase in the rate of non-voluntary euthanasia. It is possible that post-legalization research in Belgium may eventually shed some light on this issue. Evidence in relation to other jurisdictions is mixed: while rates of non-voluntary euthanasia in some prohibitive jurisdictions are higher than the Dutch rate, in other prohibitive jurisdictions the rates are lower. Lacking solid baseline evidence, the current evidence does not support the drawing of inferences either that legalization causes an increase in the rate of non-voluntary euthanasia or that such rates are higher under a prohibitive approach. Furthermore, it seems likely that cultural factors may significantly influence baseline rates, thus further decreasing the possibility of drawing inferences from evidence in one jurisdiction as to what will happen in another.

Judges, commentators, and interest groups have relied on arguments that the Dutch are sliding down a slippery slope with little attempt to evaluate the data robustly or to consider the effect on such arguments of the vastly different social context. In the absence of evidence on the issues of causation and comparability, reliance on the slippery slope argument is suspect.

Slippery slope arguments often make distinctly unhelpful contributions to debates over legalization. It is to be hoped that we can move on from the divisive, polarized arguments over alleged abuses which have dominated foreign discussion of euthanasia in the

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106. See Seale, *id.* at Table 3; Van der Heide, *supra* note 59, at Table 2. In fact, the reverse may be true. See the data on Italy and Sweden in Onwuteaka-Philipsen, *supra* note 73, at Table 3.

Netherlands to take advantage of the open, systematic discussion, "lack[ing] in ideological rigidity" which characterizes the Dutch public debate.[107] Instead, we should learn from the experience in jurisdictions which have legalized assisted dying, while recognizing that because of different social contexts and diverse baseline rates of covert practices, those experiences do not translate directly to other jurisdictions.

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107. Griffiths, Bood and Weyers, *supra* note 19, at 305. See also, Van Delden, *supra* note 27, at 27 ("medical decisions concerning the end of life ... are ... a part of modern medicine, and we had better openly discuss them").