[Excerpted from The Royal Society of Canada Expert Panel: End-of-Life Decision Making (Ottawa: Royal Society of Canada, 2011) at 88-90]

b. Slippery Slopes?

Two aspects of the Dutch experience need some further discussion here, as they are frequently referred to as evidence of a descent down a slippery slope, specifically with respect to vulnerable groups such as the elderly, the disabled, and incompetent patients.

With respect to euthanasia and incompetent patients there are two issues to be discussed: LAWER and the so-called "Groningen protocol." The publication of the LAWER cases in the Netherlands described above created a new dimension in the Dutch euthanasia debate. Since the middle of the 1980s, the debate had focused on voluntary euthanasia and assisted suicide with the explicit request of the patient as the central feature. This in part had been a deliberate attempt to narrow the discussion because it was felt that consensus was most likely to be achieved in cases of this sort. The Dutch even changed their definition of euthanasia to include only those cases in which there was an explicit request from the patient. The social impact of the LAWER cases, however, was to broaden the discussion. In particular, the results may have created the impression that the Dutch started hastening the end of life on request and ended up accepting non-voluntary ending of life; the so-called slippery slope often referred to by opponents of permissive legal regimes.[327] This, however, is not necessarily true, as it is simply not possible to know whether the LAWER cases occurred more or less often in the past. What is known is that the occurrence of such cases decreased in the Netherlands between 1991 and 2005. It is also known that their prevalence was higher in Belgium which did not tolerate voluntary euthanasia for many years.[328] In 2003, the results of a European study conducted in Belgium, Denmark, Italy, the Netherlands, Sweden and Switzerland were published.[329] The study design was the same as that used in previous studies in the Netherlands and in Belgium. In countries with a restrictive regime for assisted suicide and euthanasia, the incidence of non-voluntary cases was higher than of voluntary ones, as opposed to countries with permissive regimes. Apparently, therefore, the incidence of non-voluntary cases of assisted death is independent of the permissibility of euthanasia and assisted suicide. It may even be the case that an open and liberal policy leads to a reduction in non-voluntary assisted dying.

As was stated above, after the narrowing of the definition of euthanasia in 1985 to active voluntary euthanasia, societal debate in the Netherlands concentrated on competent patients. In 2005, however, the publication of the so-called "Groningen protocol" changed this as this

---

[327] Eg Keowan J. *Euthanasia examined*. Cambridge University Press, 1995.
[328] Bilsen J, Cohen J, Chambaere K, et al. Medical End-of-Life Practices under the Euthanasia Law in Belgium. *New England Journal of Medicine*. 2009; 361:1119-21.
[329] Heide A van der, Deliens L, Faisst K et al. on behalf of the EURELD consortium. End-of-life decision-making in six European countries: descriptive study. *Lancet*. 2003; 362:345-50.

protocol provided for the active ending of life of some newborns.[330] After a thorough discussion with the Dutch Paediatric Association, the government responded to this local protocol by issuing a ruling that led to a prosecutorial guideline and to the creation of a committee of experts to advise the Prosecutor in individual cases.[331] This has been cited as evidence of a slide down a slippery slope. However, a number of responses can be made to those who assert a slide. First, the ruling did not change the criminal law; active ending of life without request remains a criminal offense. Second, since the establishment of the committee in March 2007, only one case has been reported.[332] According to the committee, this is due to a number of developments of which the introduction of prenatal screening in 2006 is the most important one. By means of this screening, foetuses with severe malformations are detected early in pregnancy and often not brought to term. The protocol may simply not be used anymore. Third, the discussion of euthanasia of severely disabled newborns is not new in the Netherlands and did not arise with the Groningen protocol. Indeed, it predated the legislation. Therefore, the legislation cannot be said to have caused any slide down a slope. Finally, it must be remembered that, contrary to the approach advocated by the Panel, the Netherlands has traditionally relied upon two bases for justifying its permissive regime for assisted suicide and euthanasia – autonomy and beneficence. It is beneficence that is used as the foundation for the Groningen Protocol. As this is not a basis relied upon by the panel, it could not be used to justify any move to non-voluntary euthanasia in the regime proposed by the Panel.

In sum, there is no evidence from the Netherlands supporting the concern that society's vulnerable would be at increased risk of abuse if a more permissive regime were implemented in Canada.

5. Conclusions

[…]

Despite the fears of opponents, it is also clear that the much-feared slippery slope has not emerged following decriminalization, at least not in those jurisdictions for which evidence is available. Nor is there evidence to support the claim that permitting doctors to participate in bringing about the death of a patient has harmed the doctor/patient relationship. What has emerged is evidence that the law is capable of managing the decriminalization of assisted dying and that state policies on this issue can reassure citizens of their safety and well-being.

---

[330] E Verhagen, PJJ Sauer. The Groningen Protocol – Euthanasia in Severely Ill Newborns. N Engl J Med 2005; 352:959-962.
[331] Minister van Justitie en VWS. Regeling levenbeëindiging pasgeborenen. Staatscourant 13 maart 2007.
[332] Commissie levensbeëindiging pasgeborenen. Jaarverslag 2009/2010. Den Hag, 2011.