

# The slippery slope and the application of euthanasia laws in the Netherlands and Belgium

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**BY**  
**JOCELYNE SAINT-ARNAUD, PH.D.**  
**UNIVERSITÉ DE MONTRÉAL**  
**HÔPITAL DU SACRÉ-COEUR DE**  
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Université   
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 **HÔPITAL DU SACRÉ-COEUR  
DE MONTRÉAL**  
**HSCM**

# Presentation of the content

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- The laws on euthanasia in the Netherlands and Belgium: similitudes and differences
- The definition of the argument of slippery slope
- Analysis of the results of empirical studies in three cases that could indicate a slippery slope
  - Vulnerable groups
  - Number of declared vs non-declared cases of euthanasia
  - Interpretation of legal criteria

# Presentation of the content

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- Ethical discussion
  - Respect for autonomy
  - Partnership
  - Beneficence/non-maleficence
  - Equity
  - Conflicts between moral obligations generated by the four principles
- Recommendations if a law on euthanasia is enacted in Québec

# The laws on euthanasia in the Netherlands and Belgium (2002)

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**Definition of euthanasia:** intentionally ending of a person's life at that person's explicit request

## **Criteria or legal due care requirements**

The act must be conducted by a physician who has informed the patient about his or her health condition and prospects (BE/NL)

The person who makes the request must be competent, incurable with unbearable suffering and without prospect of improvement (BE/NL)

The request has to be explicit, voluntary, well considered (BE/NL), repeated, and without external pressure (BE)

# The laws on euthanasia in the Netherlands and Belgium (2002)



A second physician must be consulted (BE/NL)

A formal notification must be made to the local coroner before the study by one of the five Regional Euthanasia Review Committees in the Netherlands and to the Federal Euthanasia Control and Evaluation Committee in Belgium

An incompetent person may have access to euthanasia, if he or she had requested it in advance directives written when he/she was competent (BE/NL)

# The Laws in the Netherlands and Belgium (2002)

## Main Differences

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The Netherlands	Belgium
Oral request	Written request
	If death is not expected in the short term, more procedural requirements need to be met, such as a 2th consultant
Access to children of 16-18 years old with the assent of parents and to children of 12-16 years old with the consent of parents	
Type of suffering not specified	Physical or psychological suffering
Medical assisted suicide included	Medical assisted suicide is not explicitly included in the law

# The argument of slippery slope

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- A process that develops during a certain period of time
- First we agree that a type of practice is morally right for a group with specific characteristics, and then we are gradually directed to enlarge the access to other groups which do not possess the initial specific characteristics
- In doing so, we are conducted to accept practices that are ethically unjustified on the basis of initial criteria

# Vulnerable groups

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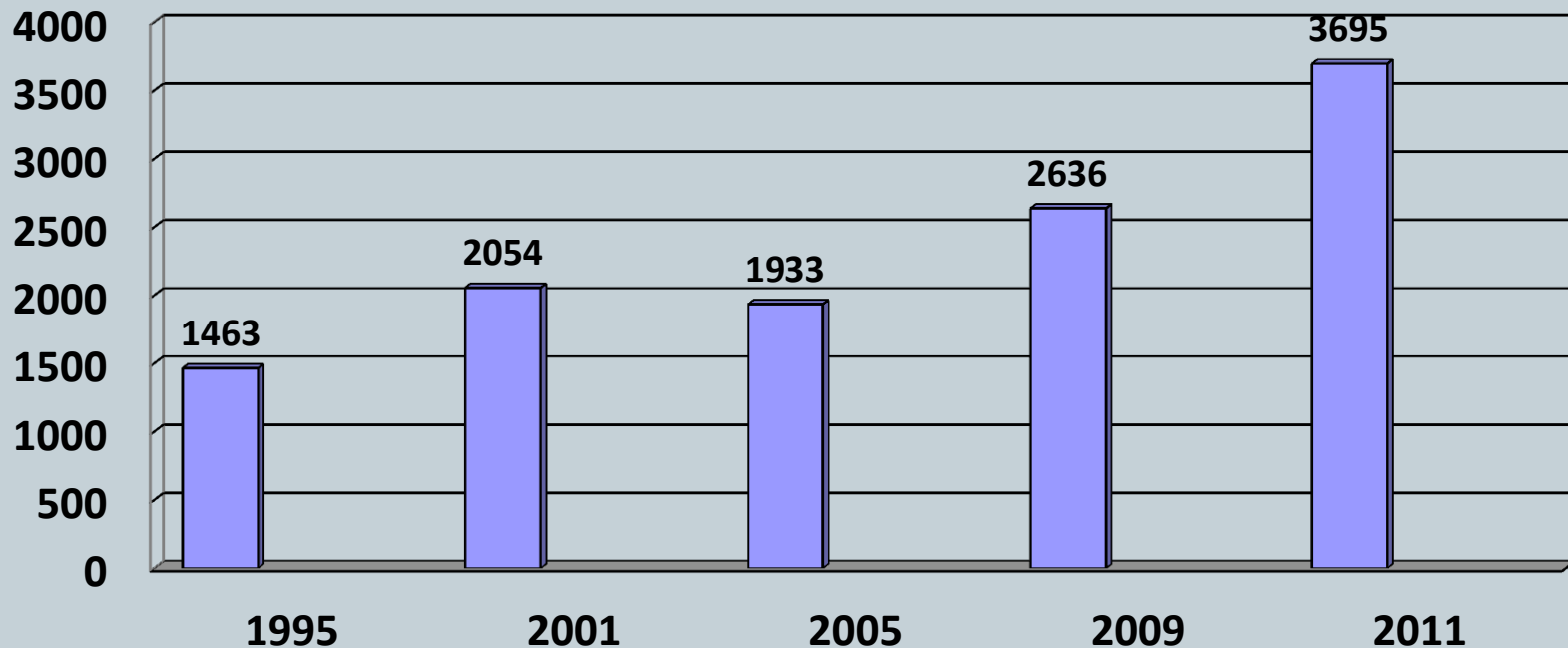
- Norwood et al, 2009
- Battin et al, 2007
- Chambeare et al, 2010
- Cohen et al, 2010



# Declared euthanasia cases in the Netherlands (1995-2011)

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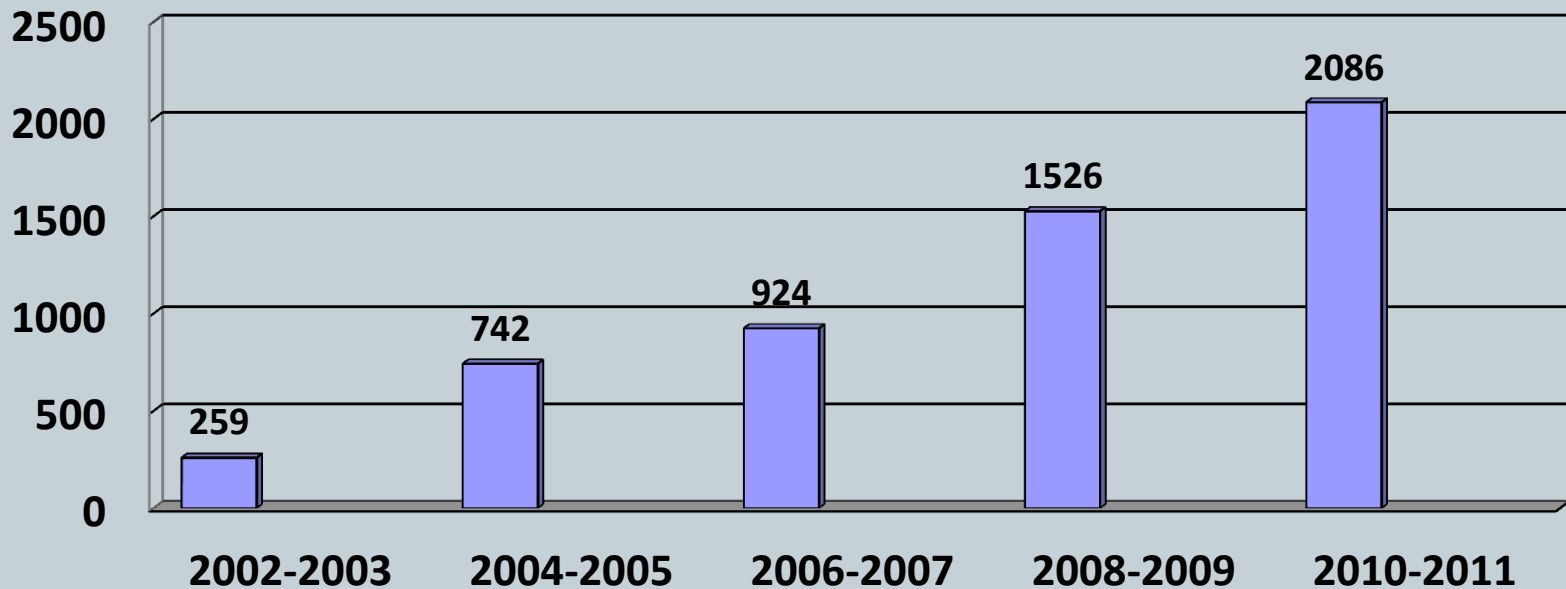
**Annual number of declared euthanasia cases  
In the Netherlands**



# Declared euthanasia cases in Belgium (2002-2011)

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**Bisanual number of declared euthanasia cases  
in Belgium**



# Percentages of declared cases of euthanasia in the Netherlands by Onwuteaka-Philipsen et al, 2012

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Year	Declared cases	Declared cases	Evaluation of declared + non- declared cases
	%	N	N
1990	18	486	2700
1995	41	1466	3600
2001	54	2054	3800
2005	80	1933	2425
2010	77	3136	4050

# Characteristics of declared and non-declared cases in Flanders by Smets et al, 2010

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	Declared cases n = 72		Non-declared cases n = 64		
	n	%	n	%	p
Oral requests	13	17,6	55	87,7	< 0,001
Discussions	72	100	54	85,2	0,001
Consultation of another doctor	71	97,5	35	54,6	<0,001
Palliative care	46	63,9	21	33,0	<0,001
Barbituric, neuromuscular blocker or both	65	95,7	0		<0,001
Opioides	3	4,4	57	90,5	
By the doctor	69	97,9	27	43,0	<0,001
By the nurse	0		26	41,3	

# Reasons for not declaring euthanasia

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Reasons for not declaring	The Netherlands in 2005 (van der Heide et al, 2007) %	Flanders in 2007 (Smets et al 2010) %
Act not perceived as euthanasia	76,1	76,9
Administrative burden too heavy		17,9
Legal due care requirements possibly not met	9,7	11,9
Private matter between doctor and patient	6,6	
Fear of legal consequences		2,3

# Interpretation of legal criteria

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## **The double role of commissions:**

- Encourage declarations
- Control the application of the law

## **The interpretation of the law by the Commission on evaluation and control of euthanasia**

- The case of assisted suicide in Belgium

## **The interpretation of the criterion of non-tolerable and non-relievable suffering**

- ✦ The judgments of the courts in the Netherlands
- ✦ Study results concerning the conception of doctors about suffering and the difference between their conception and the one of consultants and commissions' members

# The limits of using empirical data in ethics

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**Scientific limits:** quality of inquiries to describe the actual medical practices. For example, questionnaires used to evaluate medical practices do not distinguish the use of opioids to relieve pain in accord with medical norms of practice, on the one hand, and overdose of opioids with the intention of ending life, on the other hand.

**Philosophical limits:** without entering into the «is and out » debate, empirical facts can help to grasp the reality of the context, but the ethical guidelines do not emerge from nor can they be derived from the facts. Facts are important, because without them, the guidelines could be inappropriate or not applicable. But we need an ethical framework in order to propose ethical guidelines.

# Ethical discussion

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## **Principle of respect for autonomy**

- Application of the conditions of a voluntary and informed consent without external pressure
- Respect for professional medical autonomy

## **Principle of partnership**

- Patient/doctor relationship
- Consensual decision-making process

## **Principle of beneficence/non-maleficence**

- Difference between suffering and pain
- Moral obligation to relieve pain and symptoms
- Last resort options: continuous and terminal sedation; euthanasia

## **Principle of equity**

- To apply the same rules or criteria to the same cases
- To provide adequately for the patient's needs



# Potential conflicts between obligations generated by the principles

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## Examples:

- 1) The principle of beneficence/non-maleficence implies relieving pain and symptoms as far as possible, but the patient has the right to refuse to be relieved on the basis of respect for autonomy
- 2) On the question of enlarging criteria to include the very old, handicapped babies or incompetent persons two arguments are confronted:
  - a) The risk of abuse in the case of vulnerable persons (beneficence/non-maleficence)
  - b) The principle of equity (fairness) that would oblige to review the criteria enacted in the law

# Recommendations if a law is enacted in Québec

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- 1- Limit futile treatments at the end of life
- 2- Limit access to euthanasia to competent persons and incompetent ones who had made a request in advanced directives
- 3- Favor assisted medical suicide when the patient is physically able to act
- 4- Refrain from offering euthanasia as an option of end-of-life care; the request ought to come from the patient
- 5- Discuss it in the context of doctor/patient relationship and after appropriate palliative care
- 6- Develop palliative care in health services and in medical training in university curriculum
- 7- Open practice to general practitioners who have a good knowledge of their patients, and teach them the technique of euthanasia
- 8- Apply sanctions for those who do not respect the rule of law

- Thank you for your attention!
- Your comments and questions are welcome
- To receive these slides, write to:
- [jocelyne.st-arnaud@umontreal.ca](mailto:jocelyne.st-arnaud@umontreal.ca)