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Revisiting Euthanasia: Critical Analysis of Slippery Slope Effect

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ABSTRACT

The paper attempts to draw an analysis of Euthanasia and Assisted suicide standards in This Netherlands and Belgium. The practice of legally protected euthanasia has been prevalent in these countries for several decades now. The paper raises a question on the scope and permissibility of psychiatric euthanasia in the case of non-terminal psychic suffering as practiced in the Netherlands and Belgium. Suicide prevention and physician aided dying in non-terminal illnesses are contrary and give rise to a moral dilemma. However, this points out to the need of articulating standards through which a person's mental suffering could be evaluated, posing a serious philosophical challenge. The problems of slippery scope have been set forth as experienced by these countries for which the legal safeguards and its transgression shall be discussed. India has lately legalized passive euthanasia through a landmark judgment and given acceptance to the concept of a living will. The criticism and grey areas of euthanasia in India and the suitability of psychiatric euthanasia in the Indian socio-cultural environment shall be explored.

INTRODUCTION

Euthanasia is an interwoven concept of law, medicine, ethics, and religion. It is an ongoing debate between reducing suffering and preserving life. How we die, live, and are cared for at the termination of life is significant for individuals, their families, and society. Euthanasia is an act of intentionally wanting to terminate one's life for releasing suffering. The suffering and pain of dying patients can be understood to be unbearable. But these could also stem from psychological conditions, such as depression, anxiety, helplessness, or interpersonal suffering causing a feeling that one's life has ended in meaning but has not yet ended biologically. For some people, a sense of dominance over the manner and timing of their death brings a sense of comfort. However, is it reasonable to ask medicine to relieve all human suffering?

Euthanasia was defined by House of Lords Select Committee on Medical Ethics as "a deliberate intervention undertaken with the express intention of ending a life, to relieve intractable suffering"[1] It is derived from a Greek word which literally translates to "good death" or easy death and is mostly known as mercy-killing. It is a practice of putting an end to life to relieve pain and has become the most controversial topic of bioethics as it gives rise to agonizing moral dilemmas and debates. Active euthanasia is when a person is deliberately caused to die with the help of medical professionals, for example by administering a lethal injection. Whereas, passive euthanasia is when the death of the person concerned is linked to the omission of some act, such as withdrawal of life support. Active euthanasia is presently allowed in Belgium, Netherlands, Luxembourg, Columbia, and Canada, and recent legislation grants permission in Hawaii also. Whereas, assisted suicide is legalized in Switzerland, Germany Japan, Canada, and a few parts of the USA[2]. In Benelux countries, euthanasia can only be performed by a doctor after a voluntary request is made by patients suffering from an incurable disease that causes unbearable suffering having no signs of relief.[3]

EUTHANASIA AND PHYSICIAN-ASSISTED SUICIDE IN THE NETHERLANDS AND BELGIUM

The **Netherlands** has laid down liberal conditions necessary for the execution of euthanasia. The "Termination of Life on Request and Assisted Suicide (Review Procedures) Act" does not mention the term "euthanasia", but uses the term "termination of life on demand", without providing it any definition.

1 Harris NM, The euthanasia debate J R Army Med Corps (2001)

2 MC,1O countries where euthanasia and assisted suicide are legal,(October25,2014) www.therichest.com/…/10-countries-where-euthanasia-and-assisted-suicide-are-legal/

3 Božidar Banović and Veljko Turanjanin, euthanasia: murder or not: a comparative approach, (October,2014) www.ncbi.nlm.nih.gov

According to the law, various requirements need to be fulfilled. Firstly, the request must originate from the patient and must be voluntary. Another requirement includes that the patient must be suffering from "unbearable and hopeless" suffering and euthanasia must be performed with the necessary care. **Unbearable suffering** can be regarded as a far more subjective term than untreatable. The "unbearable" extend of suffering cannot be determined. It only depends on the patient's perspective, his/her mental strength, and physical capacity to bear the pain. This idea of "unbearable suffering" hasn't been laid down appropriately, and discussions on the concept "unbearable" are in a state of continuous confusion.[4] Belgium lacks proper guidelines for management, administration, and control of requests made for euthanasia on the grounds of mental sufferings. Keeping in mind the on-going intense debates and arguments about the ethical validity of the same, it has become inevitable to form clear guidelines, with detailed protocols that can be applied in practice.[5] Though Psychiatric medical aid in dying is quite unusual its emerging use is visible in Belgium and the Netherlands and for a varied range of disorders and emotional conditions which also include **personality disorders and feelings of loneliness**. Apprehensions have been voiced about the inaccuracy in the evaluation of eligibility, and on the view that family is excluded from this process.

Concerns have also been raised regarding the **"slippery slope"** effect which claims that even if a theoretical line is drawn between voluntary and non-voluntary euthanasia, an inclination is bound to occur in practice because the measures to prevent it cannot be made fully effective. Illustration of this argument can be the experience of legalization of abortion in England, where only therapeutic abortions were allowed but are now widespread[6]. The fear is that the Dutch legislation can be said to be rapidly leading to an acceptance of euthanasia in the face of comparatively minor discomfort or of conditions which, although distressing, are not regarded as either permanent or terminal."[7] These are very major concerns that need to be catered to through robust suicide prevention and other mental health programs. Unfortunately, no such prevention schemes are provided. Rather, the desire to die is upheld with the lethal jab or the poison pills forcing it towards normalization. Also, the provision of an advance directive (living will) can now substitute the verbal request for euthanasia, meaning that a patient suffering from dementia can more easily(without their verbal consent) be exposed to euthanasia.

4Thienpont L, Verhofstadt M, Van Loon T, Euthanasia requests, procedures and outcomes for 100 Belgian patients suffering from psychiatric disorders: a retrospective, descriptive study, *BMJ Open (*2015), https://bmjopen.bmj.com/content/5/7/e007454

5 ibid

6 For excellent expositions of the "slippery slope" argument against euthanasia

7 Mason & McCall Smith, Law and Medical Ethics, Oxford

SWITZERLAND

In Switzerland assisted, suicide is not formally legalized but it is accepted because a law from the 1900s decriminalizes suicide. But euthanasia is illegal. In order to commit suicide, a person needs to seek help from someone having no selfish intention or any motive of personal gain from the death. The rest of the countries need euthanasia or assisted suicide to be carried out exclusively by physicians, it is only Switzerland that permits non-physicians to assist suicide[8].

LEGAL SAFEGUARDS AND THEIR TRANSGRESSION

- **Voluntary and Written Consent**

Overall countries, the request for euthanasia must be made voluntarily, informed, and lasting over time. The person making the request must convey the consent in written form and needs to be competent at the given time of making it. Regardless of the safeguard measures, in the Netherlands, almost 500 people are involuntarily Euthanized in a year.[9] Attempts to get these cases to court for the trial have proved to be futile, evidencing that the judicial system is showing increased tolerance of such transgressions over time.[10] Belgium has thrice the euthanasia deaths (voluntary and non-voluntary) as compared to the Netherlands[11]. ("Involuntary euthanasia" is a situation in which a person is competent to but has not given any consent, and "non-voluntary euthanasia," to a situation in which a patient is not able to express consent, like in the situation of severe dementia or coma). In many cases, the physicians even proceed without consent because they are of the opinion that the patient's "best interest" lies in it. [12]

- **Mandatory Reporting**

Though reporting is a major requirement in all countries, it is mostly ignored[13]. In Belgium, only half of the actual cases of euthanasia are reported to the "Federal Control and Evaluation Committee ".[14] Over 20 percent of the cases go unreported in the Netherlands[7]. This 20 percent makes up only those cases which can be traced, the actual number could be much higher.[15]

- **Physicians Only**

8 Legalizing euthanasia or assisted suicide: the illusion of safeguards and controls J. Pereira
9 ibid
10 ibid

11 Euthanasia and other end-of-life decisions: a mortality follow-back study in Belgium. BMC Public Health. (2009).
12 ibid
13 Rurup ML, The reporting rate of euthanasia and physicians-assisted suicide. A study of the trends. Med Care. (2008)
14 Reporting of euthanasia in medical practice in Flanders, Belgium: cross sectional analysis of reported and unreported cases. BMJ. (2010)
15 Dutch experience of monitoring euthanasia. BMJ. (2005)

The participation of nurses raises a reason for concern because all the countries, except Switzerland, require euthanasia performed exclusively by physicians. In many instances, the physicians are absent

- **Second Opinion and Consultation**

All the countries, excluding Switzerland, are required to ensure that all the requirements have been met before going ahead with euthanasia and this is done by consulting a second physician. In Belgium, a third physician is required to go through the case if the person's condition is considered as non-terminal. The consultant must be independent (not related to the care of the patient or with the care provider) and must give an impartial evaluation. However, this requirement is not always fulfilled. However, non-reporting of cases points to a lack of consultation by a second doctor.

SLIPPERY SLOPE EFFECT

The idea of "**slippery slope"** is a concept which states that one transgression of law leads to more and more exceptions until we reach a stage that would have been considered unacceptable right from the beginning. It also claims that once we accept one form of euthanasia, we will be led to the acceptance of other forms of euthanasia too. It is argued that euthanasia, which originally would be considered as a last-resort that too only in some selected cases, could with time become less of the last option and be more sought after. It could even turn into the first option in a few situations. The avoidance of laws and safeguard measures along with very little, if any, prosecution, leads to the phenomenon of a social slippery slope. None of the cases have been sent to the judiciary for further inquiry in Belgium. It has been reported that in the Netherlands, "16 cases (0.21% of all notified cases) were reported for judicial action in the initial 4 years after the euthanasia law was enacted but only a few were investigated and none of them were prosecuted". In a case, a non-terminally ill patient was given advice on how to commit suicide by a counselor. The counselor was acquitted. [29]. It is quite evident that there has been a growing tolerance towards transgressions of the legal norms, stipulating a change in societal values post-legalization of euthanasia and assisted suicide. In 1987, the Royal Dutch Medical Association brought out its guidelines for euthanasia and stated that "In case of no request from the patient, proceeding with administering euthanasia is a matter of murder or killing." But by 2001, the association was accepting of the new law mentioning that a "written wish in an advance directive" for euthanasia would be acceptable, and it is tolerant of non-voluntary and involuntary euthanasia. Nonetheless, making a request through an advance directive (living will) might prove to be morally questionable for not being harmonized with the act and may no longer be an affirmation of the will of the patient when euthanasia is carried out like in the case of Dementia. Initially, in the 1970 and 1980s, it was stated in the Netherlands that euthanasia and assisted suicide that is used as a last resort only in the cases of terminally ill patients suffering from intolerable pain. But by 2002, euthanasia in Belgium and the Netherlands was no longer confined to only terminally

ill cases. As mentioned before, Dutch law requires a person to be going through unbearable and hopeless suffering. Suffering could in essence be both physical and psychological. And also includes people with depression. In addition to it, in 2006 the Royal Dutch Medical Council introduced a new concept of "tired of living" where it was claimed that being over 70 years of age should be an acceptable reason to seek euthanasia. If implemented it would not serve the right purpose as a large number of weak elderly people already feel a sense of being a burden on their families and society and a sense of isolation contributing to their will to get euthanized. In Belgium, most of the critical care specialists ignore the requirement of 1 month as an interval in the case of patients (who are terminally ill) making the request for Euthanasia. It is required to wait for a period of one month after the first request has been received before euthanasia can finally be carried out or administered. An account from a specialist mentioned that "in his unit, the average time from admission until euthanasia was performed for patients that **seemed** to be in a **hopeless** situation was about 3.5 days".

EUTHANASIA IN THE INDIAN CONTEXT

The decriminalization of suicide is critical as it has widened the scope for a different perspective towards 'Right to Die'. Law Commission of India, in its 210th Report, had recommended elimination of Section 309 IPC which talks about an attempt to commit suicide of IPC. In regard to it, 18 states and 4 Union Territory administrations expressed their support for the deletion of Section 309 IPC. Acting upon the responses from the states/UTs, the decision has been taken to scrap off section 309 of the Indian Penal Code. In the landmark judgment of ***Aruna Ramchandra Shanbaug v. The Union of India***, the Supreme Court of India chaired by CJI Dipak Misra, has laid down a clear difference between active and passive euthanasia. Passive euthanasia is when the doctor removes the artificial life support system that is keeping the patient alive. Passive euthanasia has been legalized for patients in a persistent vegetative state and brain dead patients by a five-judge bench of the apex court headed by the Chief Justice of India Dipak Misra and comprising Justices A.K. Sikri, A.M. Khanwilkar, D.Y. Chandrachud and Ashok Bhushan. Active euthanasia is when the doctor administers lethal medicines and injections for a painless death. The Supreme Court said that "active euthanasia is completely illegal whereas passive euthanasia has been permitted depending from case to case". For the First time in the country, legal recognition has been granted to advanced medical directives or living wills. A person can communicate in advance his decision regarding the withdrawal of life-saving treatment under the mentioned circumstances. The directives and guidelines shall remain in force till the time Parliament brings in the appropriate legislature for the same.

CONCLUSION AND SUGGESTIONS

- Nowadays, medicine has found a cure for even the most incurable and untreatable. Therefore, medical practitioners should be focused on encouraging the patients to lead their life with moral and physical

strength instead of ending it. The relatives of the patients play a pivotal role when a patient decides upon getting euthanasia administered. Therefore it is quite likely the patient might feel the pressure (psychologically) to end his life because of the economic pressure and the burden on the family. The provision of a living will is a benefit that only the educated can prevail. The poor and the illiterate might not have any means to access it. Many doctors have witnessed patients getting adapted to the situations they once thought would be unbearable or intolerable for them raising a doubt whether someone can predict precisely what would they go through when their conditions worsen in the future. The proposition of allowing euthanasia in terminal conditions as put forward by the Supreme Court can simply be misused by doctors, relatives, or even by the patients. In the absence of proper palliative care services in India, Euthanasia or termination of life cannot guarantee a decent painless death. The suicide cases in India are increasing at an alarming rate. According to WHO reports, India has the highest cases of suicides in South East Asia. In the year 2016, the number of suicides in India rose to about 2,30,000 cases[16]. Bankruptcy, indebtedness, failure in examinations, divorce, illegitimate pregnancy, rape, disputes, unemployment, and dowry are a few of the many mentally pressuring conditions under which people are committing suicides. These are the social bottlenecks that should be considered beyond the medical profession and medicine shouldn't be burdened to resolve societies shortcomings by means of euthanasia. It should rather be addressed to improve rehabilitation and aftercare. The government should actively promote palliative care policies patients who are most likely to opt for euthanasia such as elderly, poor, and terminally ill patients. There If patients are provided with good care then why would they opt for euthanasia? It has also been argued that allowing euthanasia will discourage the search for new cures and treatments for the terminally ill. Euthanasia undermines the motivation to provide good care for the dying, and good pain relief

Moreover, if we talk about considering euthanasia for psychological suffering it is bound to give rise to numerous concerns regarding the proper assessment of mental competence as it could be affected by the disorder. The psychic disorder must be incurable but most of the psychic disorders are known to change with time and have the possibility of becoming bearable owning to the said change. The request for ending one's life could stem from the disorder itself. Therefore, extending the euthanasia grounds to psychiatric (like in Netherlands and Belgium) might not be the best for India. If countries keep following the Dutch and Belgian example then there's no doubt that in a few decades euthanasia as a "choreographed farewell" will be a widely available option to anyone who finds like "unbearable".

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16 Gender differentials and state variations in suicide deaths in India: The Global Burden of Disease Study 1990–2016, (September 11, 2018)