Chapter Four

The Slippery Slope: Are The Dutch Sliding Down or Are They Clambering Up?

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**Introduction: The Nature of the Claim**

The specter of a “slippery slope” from euthanasia in the Dutch sense of medical behavior that terminates life at the request of the person concerned (including assistance with suicide*) to a general disrespect for human life and human autonomy, ending in the wholesale slaughter of the impaired, the sick and the otherwise expensive or undesirable, is the biggest gun that foreign critics of Dutch policy bring to bear. Inevitably (or at least probably) and “logically” (or at least in fact) allowing euthanasia will lead to the legal acceptance (or to public acceptance, or at least to the actual practice) of forms of medical killing that are obviously wrong. What precisely the latter are and why they are so obviously wrong is, apart from ominous allusions to the Nazis or the like, not usually made clear and even more rarely actually argued.

The slippery slope is itself a bit of a slippery customer, hard to pin down, usually more a bit of suggestive rhetoric than a serious argument. The way it generally is invoked in discussions makes it seem suspect, a last resort invoked by someone whose real concerns lie elsewhere but who fears his arguments against euthanasia itself may not be persuasive or who, for one reason or another, does not choose to make them. After all, if you have good reasons to think euthanasia is morally or otherwise wrong you do not need the slippery slope to bolster your argument. The only position in the debate that honestly depends on it is that of the person who has no

Based largely on: Griffiths J, Bood A and Weyers H. Euthanasia and Law in The Netherlands, Amsterdam University Press/Michigan University Press, 1998 Detailed support for the assertions made here about Dutch law and practice are to be found in that book.

* Throughout the remainder of this chapter, the term "euthanasia" includes assistance with suicide.
real objection to euthanasia but fears it will lead to practices to which he does object. The weaker the suggested link to repellent practices in the future, the less convincing it is to argue for the rejection of A when one's real objection is to B.

The slippery slope argument is widely supposed to come in both a conceptual and an empirical version, but I think this is mistaken, at least in the case of euthanasia. The conceptual version holds that once one has accepted A, based on principle P, one is bound to accept B because it also follows from P. Since B is, it is assumed, obviously repellent, it follows that P is flawed and that A, which depends on it, must be rejected. In the case of euthanasia, the argument is two-pronged: (1) Euthanasia might be based on the principle of personal autonomy (P₁), but that principle would also require accepting termination of life at the request of the patient even if no terminal illness or suffering is involved; such practices are, it assumed, repellent; therefore P₁ is flawed and euthanasia must be rejected too. (2) Euthanasia might be based on the principle of beneficence (P₂), but that principle would also require accepting termination of life to end suffering even when the patient has not requested such a thing; such a practice is, it assumed, repellent; therefore P₂ is flawed and euthanasia must be rejected too.

The conceptual version of the slippery slope argument, thus reduced to its essentials, seems almost childishly simplistic. It assumes a kind of primitive moral reasoning in which a given social practice is taken to be based on but one justifying and limiting principle. In fact, as H.L.A. Hart showed long ago for the practice of punishment, a complex social practice always rests on and is delimited by a number of principles that are not entirely consistent, or at least not reducible to a single common denominator. In the case of punishment, it is social utility that justifies the practice, but the requirement of moral accountability limits its application.

In the case of medical behavior that shortens life, most people, in making moral judgments, similarly treat various principles as relevant, and their specific positions on particular sorts of medical behavior that shortens life are based on a subtle balance. Dutch research shows that the Dutch public do not treat autonomy and beneficence as unidimensional alternatives but consider both principles relevant in their assessment of the acceptability of medical behavior that shortens life and come to different