A Reply to Clifford on the Conceptual Slippery Slope

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As a recent trend analysis revealed an increase of performed psychiatric euthanasia cases since the Belgian law on euthanasia became effective, despite remaining unresolved matters of great concern (Dierickx, Deliens, Cohen, & Chambaere, 2017), dr. Cliffords' call not to ignore the potential risks of euthanasia law and practice is indeed essential. Because legalised euthanasia affects directly involved actors as well as health care systems and (inter)national societies, discussion of slippery slope arguments is necessary to stay alert and prevent ethically unacceptable acts from ever being accepted.

At the same time, it is important to safeguard against these discussions becoming purely philosophical, uncorroborated or even leading to a slippery slope fallacy, as might be the case when not based in scientific empirical evidence. Hence, it is striking that 15 years after introducting its euthanasia law, the Belgian euthanasia practice in psychiatric patients is still under-examined. We decided not to be involved in the – often emotionally driven – heated and sometimes oversimplified debates pro and contra, but instead to concentrate on dealing with the reality of clinical euthanasia practice in Belgium and finding ways of improving its transparency and quality.

In an effort to outline this reality, we would like to react to dr. Cliffords' assumption that unbearable suffering as a concept might 'lead almost effortlessly and uncritically to euthanasia'. As we stated in the introduction section of our paper (Verhofstadt, Thienpont, & Peters, 2017), unbearable suffering is a *necessary but insufficient* condition for granting euthanasia requests (others being the competent patient repeatedly uttering a voluntary and well-considered request, and suffering being rooted in an incurable medical illness without prospect of improvement) (*WET WE*, 2002). Furthermore, in case of non terminal patients, the euthanasia law

stipulates the specific legal requirement of due care that two additional independent physicians, one of whom specialized in the disorder, must be involved in careful assessment and evaluation of all legal requirements. Hence, in the context of psychiatric patients requesting euthanasia, consultations with at least one psychiatrist are mandatory.

The focus of our study was placed on just one of the key criteria, unbearable suffering, as it represents the most subjective and indeterminate key criterion in granting euthanasia requests in the absence of an overarching solid definition and psychiatric assessment tool (Dees, Vernooij-Dassen, Dekkers, & Van Weel, 2010; Verhofstadt et al., 2017). In order to contribute to vigilance regarding euthanasia practice, especially concerning the most vulnerable patient group of psychiatric patients, the assessment of key criteria such as unbearable suffering should happen as comprehensively and accurately as possible.

It is precisely this scientific involvement that might inform both the slippery slope discussion and questioning of euthanasia as end-of-life option on grounds of these arguments. Because there are grave concerns and potential dangers concerning clinical euthanasia practice, we strongly believe in scientific empirical evidence as important in informing the juridical, philosophical, political, societal and ethical arguments in this debate. This provides a sound basis to both legitimately question euthanasia and provide sufficiently built-in safeguards to protect against potential abuses.

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Dierickx, S., Deliens, L., Cohen, J., & Chambaere, K. (2017). Euthanasia for people with psychiatric disorders or dementia in Belgium: analysis of officially reported cases. *BMC Psychiatry*, *17*(1), 203. http://doi.org/10.1186/s12888-017-1369-0

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