Is introducing assisted dying a slippery slope?

The Oregon Death with Dignity Act, passed in 1994, is one example of a piece of legislation that has stood, virtually unchanged, for 30 years. The Canadian model, often held up as an illustration of gradual widening and loosening of eligibility criteria, is not an appropriate comparator as the situation experienced in Canada following the ruling in Carter v. Canada ([2015]1 SCR 331 - Carter v. Canada (Attorney General) - SCC Cases) could not happen in Scotland. The model it uses is not the terminal illness model used in the Bill, and the constitutional position of the Canadian Supreme Court is fundamentally different. In Carter, the Supreme Court of Canada declared that the blanket ban under s. 241(b) of the Criminal Code of Canada was unconstitutional and a breach of the Canadian Charter of Rights and Freedoms (specifically the right to life, liberty, and security of the person under s7). As a result, Bill C-14 was introduced to allow for Medical Assistance in Dying (MAiD). This was initially a more restrictive law, which was subsequently expanded further, in order to implement the original judgment in Carter.

This mandated introduction, and then subsequent widening of a statute is a particular feature of the Canadian constitutional arrangement which could not be replicated in Scotland. And even if a future Scottish Parliament were to consider changes, the 'legislative creep' that could effect change to eligibility criteria would have to go through the same robust parliamentary process as any other Bill. Gradual and increasing loosening of criteria specified in an Act is not a foregone conclusion, and the law can and does stand as a bulwark against sliding down the slippery slope.[1]

4.1 A slippery slope?

Emily Jackson[2] details tree types of slippery slope:

1) logical slippery slope
2) empirical slippery slope - poor practice claimed in countries with AD proves that disintegration and abuse are inevitable

---

[1] Sivers, Sarah. *Clarity, compassion and choice — what next for Assisted Dying for Terminally Ill Adults (Scotland) Bill and why status quo is 'anything but safe'. Law Society of Scotland Journal. 15th May 2025. https://www.lawscot.org.uk/members/journal-hub/articles/clarity-compassion-and-choice-what-next-for-assisted-dying-for-terminally-ill-adults-scotland-bill-and-why-status-quo-is-anything-but-safe/*

[2] Jackson, Emily and Keown, John. Debating Euthanasia Hart, Oxford, 2012 (reprinted 2013 & 2014): 53-62

3) psychological slippery slope - once we become accustomed to the idea of AD “it becomes easier for society to take further steps to actively end the lives of those whose life has become not worth living or who deserve a dignified exit.”

The logical slippery slope is not necessarily very logical. It makes an assumption that expansion is inevitable. When the legalisation of gay marriage was proposed, some opponents argued that it would be a slippery slope to polygamy, incest and bestiality[3] [4] [5] [6]. In the case of AD, nothing will pass into law that is not the settled will of the people and supported by a majority of elected politicians. As Oregon has proven over the years, neither expansion nor contraction are inevitable.

With the second classification, the empirical slippery slope, this will continue to be open to any anecdote or claim of abuse or issue that is identified within monitoring and reporting being presented as proof of degradation within or of the system. Correlation is not the same as causality. Finding poor practice in any area of medicine does not equate to a negation of the value in general of that area of medicine. We do not shut down all post-natal care units in hospitals because of issues found in one. Most systems, as instituted, are subject to regulation, evaluation and iterative improvement.

In seeking to make a case for the existence of a slippery slope Woodruff (for The International Association for Hospice and Palliative Care)[7] for example cites examples without context or comparison with similar practices within health systems that do not practice AD. He includes decisions as part of his dataset which are controversial but are common in jurisdictions where AD remains illegal, such as withdrawal of medical support in futile cases, withdrawal of medical support in cases where a patient can no longer give consent, terminal sedation/double-effect and of course iterative adaptation and change in the law.

As for the third type, the psychological slippery slope, this assumes that such legislation is accepted by the public with such positive alacrity that they will

---

[3] https://slate.com/news-and-politics/2004/05/slippery-slop.html

[4] https://uknowledge.uky.edu/law_facpub/459/

[5] https://epgn.com/2013/11/21/24095589-the-end-of-the-slippery-slope/

[6] https://www.bbc.co.uk/news/magazine-33463436

[7] https://iahpc.org/resources/publications/euthanasia-and-physician-assisted-suicide/euthanasia-and-physician-assisted-suicide-are-they-clinically-necessary-or-desirable/#arguments-for-and-against-assisted-dying 22/04/25

become desensitised to killing and more killing will inevitably be demanded. There was no pre-existing legal euthanasia Germany before Aktion T4 and as Emily Jackson points out[8], the Nazi mass murders (much cited by opponents of AD) were not motivated by the desire to treat compassionately those suffering intractably, but by a vile bigoted eugenics extermination doctrine. However, as an example, Woodruff[9] cites the journalist Wesley Smith's comparison of AD to murderous practice in Nazi Germany. As Schuklenk[10] argues:

> "How one moves from a "voluntary autonomous request" in a liberal democracy to "murdered-against-their wishes" does escape me, to be honest. What does the evidence tell us? A major survey of assisted dying practices in Belgium, Luxembourg, the Netherlands, Switzerland, Oregon, Washington and Montana concluded in 2013 that "the average person requesting assistance in dying is an elderly, well-educated, middle-class cancer patient"(Stecketal.2013). With regard to the Netherlands, a favourite target of opponents of assisted dying, a large study from the country, published in the leading medical journal The Lancet, concluded that "there is no apparent disproportionate use [of Assisted Dying in the Netherlands] in vulnerable populations"(Lo2012)."

In terms of the psychological slippery slope, it is also worth noting that many laws are not adopted with alacrity, but in reality tolerated by the public with a level of pragmatism, possibly even continuing discomfort. Legal does not mean loved.

As Jackson[11] concludes:

"The slippery slope claim is not that it would be *challenging* to regulate euthanasia effectively, but rather it would be *impossible*. Without more persuasive evidence, hypothetical and pessimistic speculation about our

---

[8] Jackson, Emily and Keown, John. Debating Euthanasia Hart, Oxford, 2012 (reprinted 2013 & 2014): 53-62

[9] https://iahpc.org/resources/publications/euthanasia-and-physician-assisted-suicide/euthanasia-and-physician-assisted-suicide-are-they-clinically-necessary-or-desirable/#arguments-for-and-against-assisted-dying 22/04/25

[10] Schuklenk, Udo. Assisted Dying in Canada, Healthcare Papers Vol. 14 No. 1 42 https://www.academia.edu/9188749/Assisted_Dying_in_Canada?email_work_card=view-paper

[11] [11] Jackson, Emily and Keown, John. Debating Euthanasia Hart, Oxford, 2012 (reprinted 2013 & 2014): p62

inability to regulate euthanasia does not offer adequate justification for a refusal to contemplate what effective regulation might involve."

Schuklenk et al[12] distinguish the claims of AD opponents as

> "two basic forms of slippery slope argument. Both types are present in the assisted suicide and voluntary euthanasia debate. Some slippery slopes are *conceptual*. They claim the concepts used to set up criteria governing a practice are fuzzy, and that this conceptual vagueness will lead to the practice being abused. Others are *causal*. They claim that if a certain decision or policy is implemented, that could in and of itself be morally acceptable, causal mechanisms will be put in motion that will unavoidably lead to making other, much more morally dubious, decisions."

Schuklenk et al note that opponents of AD will argue that in the notion of 'competence' there's no fixed point of definition, and therefore there will be variations and outliers that may include the 'less competent'. Opponents also argue that such looseness will be open to abuse. This is countered by the argument that while there remains no perfect system in medicine, experienced professionals will be involved, who have a practical understanding of the established paradigms and guidelines.

As for 'causal slippery slopes', where opponents argue that the introduction of even a very limited form of assisted dying must inevitably lead to further expansion, and into areas of great moral dubiety, Schuklenk et al[13] note that

> "Measures are taken, and watchdog institutions are put in place to guard against abuse. Under-discussed but crucial functions within liberal democracies such as auditors general and ombudsmen are just two such offices. There is no reason to think that this could not also be done in the case of assisted death."

All legislation is subject to amendment. Safeguards are put in place by legislation, often in part based on proven experience gained by other jurisdictions who have already introduced similar laws, including those related to assisted dying. Other safeguards can be instituted in response to

---

[12] Schuklenk et al (2011) *End-of-Life Decision-Making in Canada: The Report by the Royal Society of Canada Expert Panel on End-of-Life Decision-Making. Bioethics ISSN 0269-9702 (print); 1467-8519 (online) Volume 25 Number S1 2011:48* https://pmc.ncbi.nlm.nih.gov/articles/PMC3265521/

[13] ibid:49

potential issues that have been highlighted within the debate related to legislation, and those safeguards will be the law.

The only change in AD in Scotland can be a change in the law. There can only be change if it is the settled will of the people and of the Scottish Parliament to do so.

Oregon is a reasonable comparator with Scotland in terms of population size. In 2024, Oregon's population is estimated to be around 4.27 million. At the most recent count, Scotland's population was 5,463,300. It can be noted that there has been no evidence of the slippery slope predicted by opponents when AD was introduced in Oregon. As Beauchamp & Childress note:

> "To date none of the abuses some predicted have materialized in Oregon.The Oregon statute's restrictions have been neither loosened nor broadened. There is no evidence that any patient has died other than in accordance with his or her own wishes. The number of patients seeking prescriptions under the statute has been low and stable (at around sixty per year), and hastened death has not been used primarily by individuals who might be thought vulnerable to intimidation or abuse. Those choosing assisted death have had, on average, a higher level of education and better medical coverage than terminally ill Oregonians who did not seek assistance in dying. Women, people with disabilities, and members of disadvantaged racial minorities have not sought assistance in dying in disproportionate numbers. The overwhelming number of persons requesting assistance in dying are caucasian, and the gender of the requesters reflects the general population. Meanwhile, reports indicate the quality of palliative care has improved in Oregon. About one-third of the patients requesting assistance in dying ultimately decide not to use the prescribed drug."[14]

Deliens[15], with reference to Wels and Hamarat[16], found:

---

[14] Beauchamp, TL & Childress, JF. The Principles of Biomedical Ethics, 7th Ed. Oxford University Press (2013): p181

[15] Deliens L. Assisted Dying and the Slippery Slope Argument—No Empirical Evidence. *JAMA Netw Open*. 2025;8(4):e256849. doi:10.1001/jamanetworkopen.2025.6849 https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2833184

[16] Wels J, Hamarat N. Incidence and prevalence of reported euthanasia cases in Belgium, 2002 to 2023. *JAMA Netw Open*. 2025;8(4):e256841. doi:10.1001/jamanetworkopen.2025.6841 ArticleGoogle Scholar

> "Research evidence from Belgium does not support the repeatedly expressed concern that older people, disabled people, or people with psychiatric disorders would be under pressure to access euthanasia. On the contrary, evidence demonstrates that requests for euthanasia from persons 80 years or older are granted less often and withdrawn more often. The chances of accessing euthanasia were found to be also lower when depression was one of the reasons for seeking euthanasia."

Jackson Pickett[17] note that:

> "In both the Netherlands and Oregon, vulnerable groups are less likely to select euthanasia or assisted suicide. The mentally handicapped, psychiatric patients, and children are underrepresented among patients selecting euthanasia or assisted suicide in the Netherlands."

Professor Emeritus Jocelyn Downie, in her review of the Supreme Court of Canada's ruling records that the Supreme Court confirmed that there is:

> "no evidence from permissive regimes that people with disabilities are at heightened risk of accessing physician-assisted dying; no evidence of inordinate impact on socially vulnerable populations in permissive jurisdictions; in some cases palliative care actually improved post-legalisation; physicians were better able to provide overall end-of-life treatment once assisted death legalised; the trial judge, after an exhaustive review of the evidence, rejected the argument that adoption of a regulatory regime would initiate a descent down a slippery slope into homicide."[18]

Nonetheless, as Dankwort[19] notes:

---

[17] Jackson Pickett "Can Legalization Improve End of- Life Care? An Empirical Analysis of the Results of the Legalization of Euthanasia and Physician-Assisted Suicide in the Netherlands and Oregon https://publish.illinois.edu/elderlawjournal/files/2015/02/Pickett.pdf

[18] Downie, Joyce (2016) *Permitting Voluntary Euthanasia and Assisted Suicide: Law Permitting Voluntary Euthanasia and Assisted Suicide: Law Reform Pathways for Common Law Jurisdictions Reform Pathways for Common Law Jurisdictions*. QUT Law Review Volume 16, Issue 1: 97 https://digitalcommons.schulichlaw.dal.ca/cgi/viewcontent.cgi?article=1906&context=scholarly_works

[19] Dankwort, Juergen. (2024). Voluntary Assisted Dying: The Impasse and a Way Forward. Canadian Journal of Bioethics / Revue canadienne de bioéthique, 7(4), 64–70. https://doi.org/10.7202/1114959ar

> "criticism about MAID gained traction even when only based on inconclusive evidence citing grey literature, often with identical sensationalized narrative accounts in the media".

Existing assisted dying laws vary. A number of states include access for those with a medically futile condition that causes unbearable suffering and who are simply experiencing a slower traumatic death - people with degenerative and chronic illnesses such as Motor Neurone Disease, Multiple Sclerosis, Parkinsons and Chronic Rheumatoid Arthritis. Others limit the choice to the terminally ill expected to die within a limited period of time. In both cases, extensive research and debate in those states led to the conclusion that the slippery slope simply has not manifested.

Critics of AD cite the growth in numbers of people resorting to AD after its introduction in various countries. This fails to take into account the numbers who would have previously sought to end their lives in isolation, and the numbers who otherwise would have died anyway, possibly in pain, possibly through self-starvation and dehydration or possibly via heavy dosage overdose, for example. As Schuklenk[20] observes:

> "If more people avail themselves of assisted dying over time, that should reasonably be seen as an indication of a service that is increasingly utilized by the populations it is intended to serve. That is not in its own right evidence of a problematic slippery slope."

The overwhelming majority of people who make use of the access provided by these laws have cancer. It should also be noted that many sufferers who choose to make themselves eligible for assisted dying choose not to go through with it, but are simply happy to have peace of mind that the choice is there for them if needed.

Oregon psychiatrist David Pollack, M.D. notes that:

> "I think there is enough accumulated experience in the states and other jurisdictions in which the practice of PAD is legally permitted to establish that the 'slippery slope' has not emerged nor does it appear to be emerging….The safeguards in the legislation or regulations in these jurisdictions have proven to be adequate to prevent an ever-growing

---

[20] Schuklenk, Udo. Assisted Dying in Canada, Healthcare Papers Vol. 14 No. 1 42 https://www.academia.edu/9188749/Assisted_Dying_in_Canada?email_work_card=view-paper

> approval of requests for PAD for inappropriate or excluded reasons/ criteria."[21]

As Justice Baudouin in Canada concluded after considering expert evidence:

> "Neither the national data in Canada or Quebec nor the foreign data indicate any abuse, slippery slope or even heightened risks for vulnerable people when imminent end of life is not an eligibility criterion for medical assistance in dying."[22]

4.2 Bracket creep?

Opponents of assisted dying sometimes refer to Belgium as an example of 'bracket creep"[23], where eligibility for assisted dying has expanded. The inference is that changes of scope of activity and in the law are arbitrary and without a legal basis. An example cited by opponents of AD in Belgium, in very narrow circumstances, is that a child (and the child's parents) can request assistance to die. The question here is however a simple one - are you more compassionately protecting the child who is suffering horrifically and without sufficient relief by denying or by allowing access to an assisted death? The Belgian legislation provides for a child in a 'medically futile condition', and who is experiencing constant and unbearable suffering that cannot be alleviated, to request voluntary assisted dying. However, this law carries even greater safeguards, and stricter criteria, than the already strict laws relating to adults. "The relevance of age was regarded as less important than the capacity for discernment of involved issues and implications"[24], and must be assessed and confirmed by a multidisciplinary team including a clinical child psychologist and at least two doctors. The child's parents must also participate in, and approve of, the request. Passed into law by a two-thirds majority of the Belgian parliament, this is a recognition that even children can die from illnesses which, in spite of the best treatment, cause horrific suffering. Use of this provision in Belgium is extremely rare.

---

[21] Moran, Mark (2019) *How Should Organized Medicine Respond to Physician-Assisted Death?* Psychiatrics News, Volume 54, Number 3 https://psychiatryonline.org/doi/full/10.1176/appi.pn.2019.1b23

[22] Downie, Jocelyn & Schuklenk, Udo (2021) *Social determinants of health and slippery slopes in assisted dying debates: lessons from Canada. Journal of Medical Ethics, Volume 47, Issue 10: 667* https://jme.bmj.com/content/47/10/662

[23] https://www.academia.edu/49721225/Euthanasia_and_assisted_suicide_good_or_bad_public_policy?email_work_card=view-paper

[24] Radbruch et al (2016) *Euthanasia and physician-assisted suicide: A white paper from the European Association for Palliative Care*. Palliative Medicine Volume 30, Issue 2: 107 https://journals.sagepub.com/doi/epub/10.1177/0269216315616524

Contrary to the inference of opponents, this development did not occur casually or as a surreptitious 'creep' or 'slippery slope', but in fact through a process of extensive consultation and public and political debate and in this case a two-thirds majority in Parliament. No change would have occurred without public support and the assent of Parliament. As Schuklenk[25] confirms:

> "The bill in Catholic Belgium had overwhelming public and parliamentary support (BBC 2014). Extensive public consultations were held and opponents of the bill had their say. Their arguments lost. The vote mirrored societal trust in an assisted dying regime that built up over the years and is pretty much unwavering, despite concerted efforts on the part of religious groups."

In the decades that assisted dying has operated elsewhere, there remains a lack of verified proof in relation to predictions of enforced killing of the unwilling sick, disabled, aged or vulnerable.

Where the recording and reporting process linked to assisted dying has identified anomalies and possibly problematic outliers to be investigated, as recently has been reported in Canada, this is not evidence of failure or a slippery slope, as claimed by opponents, but proof that the reporting systems put in place are working.

4.3 Changes in law

As the Church of Scotland, longtime opponents of AD acknowledge:

> "as yet there are no examples from the international community where a jurisdiction has expanded eligibility criteria where it was initially restricted to terminal illness…. this would have to be done through the legislative process".[26]

Laws are in some cases adapted and changed over time. The evolution of any law only occurs where facts, shared morality, democratic consensus, and public, judicial and Parliamentary assent will allow.

---

[25] Schuklenk, Udo. Assisted Dying in Canada, Healthcare Papers Vol. 14 No. 1 42 https://www.academia.edu/9188749/Assisted_Dying_in_Canada?email_work_card=view-paper

[26] Church of Scotland. Joint Report of the Theological Forum and the Faith Action Programme Leadership Team on Assisted Dying. 2025 https://www.churchofscotland.org.uk/__data/assets/pdf_file/0004/133645/Volume-of-Reports-2025.pdf