



Invited Commentary | Ethics

Assisted Dying and the Slippery Slope Argument—No Empirical Evidence

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While the social and political debate around assisted dying remains fierce and unrelenting, legalization of assisted dying has expanded significantly in Europe, North America, and Australia during the past 20 years. Assisted dying (euthanasia and/or physician-assisted suicide) practices are now legal in more than 30 jurisdictions, increasing the number of people with access to assisted dying to more than 280 million.¹ Belgium passed a law on euthanasia on May 28, 2002, and the law became effective as of September 23, 2002. Belgium's Law of Euthanasia defines euthanasia as "the intentional termination of a person's life by a doctor at that person's explicit request."² The law further specifies that the request by the patient should be voluntary, well-considered, and repeated and not the result of any external pressure. Furthermore, a request can only be legally granted by the physician when the patient is in a medically futile condition resulting from a serious and incurable condition caused by illness or accident, and the patient experiences constant and unbearable physical or mental suffering that cannot be alleviated. The physician willing to explore such a request is required to ascertain that all these due care requirements are met. The attending physician needs to consult at least 1 other independent colleague who also needs to assess the legal requirements.

It is worth noting that the term euthanasia is not used in most countries, as it is in Belgium and the Netherlands. The terms euthanasia and assisted suicide are controversial in most countries, even among proponents of legal regulation. Assisted suicide evokes associations with suicide, and the term euthanasia was used in Nazi Germany to include the murder of people with disabilities. In Canada, the official term for assisted dying is medical aid in dying (MAID). In Australia, it is called voluntary assisted dying, and in New Zealand, the term assisted dying is commonly used. In the US, the term physician-assisted suicide was common for a long time, but now MAID is also often used. In Canada, MAID covers both euthanasia (administration by a physician) and physician-assisted suicide (self-administration by the patient). In the US, MAID only covers physician-assisted suicide.

The report by Wels and Hamarat³ studies the development and prevalence of euthanasia in Belgium for a complete dataset of euthanasia cases for more than 20 years of registration (2002-2023). The study is based on population data from the euthanasia cases reported to the Belgian Federal Commission for the Control and Evaluation of Euthanasia. This study is a robust empirical study that properly investigates and tests the hypothesis of the slippery slope argument by controlling for demographic changes in the population to analyze trends in the prevalence of euthanasia.

While most studies on trends in assisted dying focus on the development of absolute prevalence over time, they do not control for the impact of sociodemographic changes in the assisted death populations. Wels and Hamarat³ control for these changes by examining the magnitude of increase by rate ratios by age, sex, region, and euthanasia characteristics. The prevalence rates (PRs) for euthanasia among female individuals has slightly risen (1.03; 95% CI, 1.03-1.04), while cases related to psychiatric disorders (PR, 0.95; 95% CI, 0.93-0.97) and deaths in care homes (PR, 1.00; 95% CI, 0.99-1.01) have not shown significant increases. Although the prevalence of euthanasia in Belgium is increasing year by year, a substantial part in this increase in euthanasia prevalence can be attributed to demographic changes, particularly the aging of the population.

The report by Wels and Hamarat³ concludes that early increases in prevalence were mainly due to the regulatory onset of the implementation of the new law, while recent trends reflect a growing influence of demographic factors and regional adjustments. The investigators suggest no evidence of the slippery slope argument. The argument of the slippery slope assumes that there will be an

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inevitable and undesirable expansion of life-ending acts in medical end-of-life practice—for example, toward vulnerable groups who cannot properly fend for themselves—if euthanasia or assisted suicide is legalized.

Other arguments by proponents and opponents of legalizing assisted dying can be summarized as follows.⁴ According to proponents, assisted dying is sometimes the only option to relieve unbearable suffering of patients with a life-threatening condition. The argument that legalizing assisted dying safeguards an individual's right to self-determination at the end of life was often at the forefront in the countries that passed laws allowing assisted dying. People are enabled to choose a dignified death, which would be less feasible with other forms of suicide that do not involve a professional clinician. On the other hand, opponents argue that assisted dying violates medical-ethical principles and the oath taken by physicians, and it could undermine the relationship between the physician and the patient. Opponents also argue that in the end-of-life care trajectory, suffering can almost always be alleviated by adequate pain management, palliative care, and palliative sedation.

A lack of empirical evidence for the slippery slope argument demonstrated by the report of Wels and Hamarat³ confirms extended evidence from Belgian euthanasia practice published in the *New England Journal of Medicine*, *Lancet*, *JAMA*, and *BMJ*, among others, by the End-of-Life Care Research Group.⁵ These studies have never shown that vulnerable people would have easier access to assisted dying in Belgium. These studies have also demonstrated that the highest request rates for euthanasia are found among people with a higher educational degree (university degree) and not by those with lower educational attainment or with a low socioeconomic status. Furthermore, 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.

A recent study published in *JAMA Internal Medicine* collected publicly available data for 20 jurisdictions with legal assisted dying and compared assisted deaths as a proportion of all deaths for the most frequent underlying diseases.⁶ A total of 184 695 assisted deaths from 20 jurisdictions between 1999 and 2023 were collected. While absolute assisted death rates varied per jurisdiction, the relative proportion of rates by disease was remarkably similar across all jurisdictions. The differences in assisted death rates across the diseases were substantial, with amyotrophic lateral sclerosis having the highest rates, but they were far greater than the differences accounted for by eligibility criteria across the legislations. The authors concluded that their results are consistent with the idea that assisted dying is driven heavily by illness-related factors common to people with those illnesses and inconsistent with the idea that assisted dying is driven substantially by factors that are external to the individual and that vary by jurisdiction.⁶ Hence, this large-scale study also suggested the absence of a possible slippery slope.⁶

ARTICLE INFORMATION

Published: April 23, 2025. doi:10.1001/jamanetworkopen.2025.6849

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Conflict of Interest Disclosures: None reported.

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