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Support for Voluntary Euthanasia with No Logical Slippery Slope to Non-Voluntary Euthanasia

ABSTRACT. This paper demonstrates that acceptance of voluntary euthanasia does not generate commitment to either non-voluntary euthanasia or euthanasia on request. This is accomplished through analysis of John Keown's and David Jones's slippery slope arguments, and rejection of their view that voluntary euthanasia requires physicians to judge patients as better off dead. Instead, voluntary euthanasia merely requires physicians to judge patients as within boundaries of appropriate deference. This paper develops two ways of understanding and defending voluntary euthanasia on this model, one focused on the independent value of patients' autonomy and the other on the evidence of well-being provided by patients' requests. Both avoid the purported slippery slopes and both are independently supported by an analogy to uncontroversial elements of medical practice. Moreover, the proposed analyses of voluntary euthanasia suggest parameters for the design of euthanasia legislation, both supporting and challenging elements of existing laws in Oregon and the Netherlands.

INTRODUCTION

This paper will address the ethics of euthanasia, understood as an interaction between a patient and a physician in which the physician behaves in a way that is intended (or at least expected) to lead to the death of the patient, for the patient's own sake. Forms of euthanasia are often categorized as active or passive, with the distinction lying in the extent to which the physician either actively causes the patient's death or else passively allows the patient to die of an underlying medical condition. That distinction will not play a role in my analysis, but it is worth noting that I will be focusing on, and defending, paradigmatically active instances of euthanasia. Another common distinction, one that will play

a significant role in my analysis, is between voluntary, non-voluntary, and involuntary forms of euthanasia. An instance of euthanasia counts as voluntary if the patient requests or endorses the physician's assistance in ending the patient's life. Non-voluntary cases occur when the patient is unconscious or otherwise incompetent to endorse or reject the physician's plan. Finally, euthanasia is involuntary if the patient is opposed to the physician's plan, or if the patient is capable of forming a judgment and is not consulted. Having identified this category of involuntary euthanasia, and distinguished it from the non-voluntary, I will set it aside for the purposes of this paper. My attention will instead be focused on voluntary cases, and on how they relate to non-voluntary ones.

One final preliminary distinction must be drawn, this time between two ways in which a physician can promote the death of the patient. On the one hand, the physician could administer a medical treatment, such as an injection, that is intended to end the patient's life. On the other hand, the physician could provide the patient with access to a medical means of ending the patient's life, perhaps by prescribing an intentionally lethal overdose of a controlled substance that the patient would then be able to obtain and ingest. The terminology for labelling these categories is itself controversial and contested. In the interest of clarity, I will stipulate and adopt what I take to be the most common usage, despite recognizing that this usage is not ideal. I will, therefore, restrict the label "euthanasia" to the former sort of cases, those in which the physician administers the medical intervention that leads to the patient's death. I will refer to the latter sort of cases, those in which the physician provides access to the means of ending one's life, as instances of "physician-assisted suicide."¹ This will allow me to reserve the label "physician-assisted dying" for the category that includes both sorts of cases. Most of my analysis will be focused on euthanasia, but when I discuss existing laws and regulations I will need to refer both to physician-assisted suicide and to the general category of physician-assisted dying.

One natural way of understanding the interaction between the patient and the physician in cases of voluntary euthanasia is that the patient makes an autonomous request for assistance and the physician complies just in case she concurs that the patient is indeed better off dead. This way of thinking about voluntary euthanasia has opened the door to a slippery slope argument according to which acceptance of voluntary euthanasia commits one to endorsing non-voluntary euthanasia. I will first explain the force of this slippery slope argument, and a related argument involving a

slippery slope to euthanasia on request. I will then develop two alternative ways of understanding and defending voluntary euthanasia, one focused on autonomy and the other on evidence of well-being, and demonstrate that neither of them are susceptible to these slippery slope concerns. On the contrary, my proposed vindications of voluntary euthanasia are perfectly compatible with a rejection of both non-voluntary euthanasia and euthanasia on request. Next, I will provide independent support for these approaches to voluntary euthanasia by drawing an analogy to uncontroversial medical practice in cases where there are multiple possible courses of treatment. Finally, I will consider the implications of my proposed analyses of voluntary euthanasia for possible regulations governing the practice. If my analysis is successful, in addition to rebutting the slippery slope arguments, it will provide greater clarity regarding the nature of voluntary euthanasia, strengthen the arguments in favor of allowing it, and provide insight into the proper design of legislation governing it.

THE SLIPPERY SLOPE ARGUMENTS

A slippery slope argument asserts that even though a given practice may not itself be objectionable, if we allow it we will inevitably end up endorsing and allowing some other practice, which is objectionable. Moreover, this latter practice, which is at the bottom of the slippery slope, is held to be so deeply objectionable that we must not allow the otherwise innocent or perhaps even beneficial practice at the top of the slope in order to avoid sliding to the bottom. An argument of this sort depends, therefore, on two claims: one about the slipperiness of the slope and the other about the undesirability of ending up at the bottom. For the slippery slope arguments I consider, I will be focusing on the slipperiness of the slopes, and so for the sake of argument I will grant the relevant claims about the importance of avoiding the bottoms of the slopes. My aim will be to show that the slopes in question are not nearly as slippery as they are purported to be, and that one's assessment of the practice at the top of the slopes therefore should not depend on one's assessment of the practices at the bottoms: one can embrace what is at the top without being committed to endorsing the bottoms, and, conversely, one cannot argue against accepting the top on the grounds that the bottoms are objectionable.

According to some slippery slope arguments, the slipperiness of the slope is an empirical claim. The idea is that, in light of various facts about human psychology or about a particular society, establishing a given

practice now is likely to lead to the establishment of another practice in the future. This is a prediction of what is likely to happen in the future as a result of what we do now, and as such it asserts an empirical slippery slope. Other slippery slope arguments take a logical form. Here the idea is that relevant similarities between the two practices make it the case that simply by endorsing the supposedly benign practice one is already committed to endorsing the malign one. Whatever reasons there are for supporting the one equally compel support for the other.

The arguments I will be considering in this paper take this logical form. This is not because I take empirical slippery slope arguments to be uninteresting or unimportant, but because I take logical slippery slope arguments to be particularly troublesome: if successful, they indicate that there is something problematic at the heart of the practice at the top of the slope. The practice cannot be redeemed simply by putting in safeguards to prevent against an unwanted slide to the bottom. Rather, according to a logical slippery slope, a clear understanding of what is at the top reveals that by venturing to the top we have already slid to the bottom, not in the sense that we cannot institute the practice at the top without simultaneously instituting the practice at the bottom but in the sense that once we have instituted the practice at the top we are committed to instituting the one at the bottom. It is not just that any potential safeguards aimed at blocking the slide would be likely to fail, but that one would even attempt to impose such safeguards only out of confusion.

According to the primary slippery slope argument I will consider, advanced most prominently by John Keown (2002) and David Jones (2011), the logical slippery slope lies between allowing voluntary euthanasia and allowing non-voluntary euthanasia.² From the perspective of those who raise this objection, non-voluntary euthanasia is abhorrent, and so in order to avoid mistakenly slipping into acceptance of non-voluntary euthanasia we must not embrace voluntary euthanasia. As I have said, a proponent of voluntary euthanasia could respond by rejecting this assessment of non-voluntary euthanasia (e.g., Singer 1979). But my aim will be to show that one need not do that. I take this to be important because it allows voluntary euthanasia to be assessed on its own, rather than having our views of it be hostage to our views regarding non-voluntary euthanasia. My intention is therefore to remain neutral about the merits of non-voluntary euthanasia, but demonstrate that even if non-voluntary euthanasia is genuinely objectionable, that does not preclude allowing voluntary euthanasia.

The key to Keown's and Jones's analysis is the idea that an instance of voluntary euthanasia requires the physician to make an independent judgment confirming that the patient is better off dead. Keown and Jones then assert that once one grants that physicians are capable of making "better off dead" judgments, one will have no way to avoid endorsing non-voluntary euthanasia. As Keown puts it:

[T]he real, rather than the rhetorical, justification for [voluntary euthanasia] is not the patient's autonomous request *but the doctor's judgment that the request is justified because death would benefit the patient*. . . . The doctor decides whether the request is justified, that is, whether the patient would indeed be better off dead. And if a doctor can make this judgment in relation to an autonomous patient, a doctor can, logically, make it in relation to an incompetent patient. Moreover, if death is a "benefit" for competent patients suffering from a certain condition, why should it be denied incompetent patients suffering from the same condition? (2002, 77, italics in original)

Hallvard Lillehammer (2002) and Stephen Smith (2005) have both criticized Keown for misinterpreting the significance of the physician's judgment in cases of voluntary euthanasia. They endorse Keown's understanding of the physician-patient interaction in cases of voluntary euthanasia, conceding that in order for an instance of voluntary euthanasia to be justified the physician must make an independent judgment that the patient is better off dead. But they point out that the physician's judgment is a necessary condition for the justification of voluntary euthanasia, not a sufficient one. A justified case of voluntary euthanasia, they insist, requires two things: a patient's autonomous request and a physician's independent confirming judgment. All cases of non-voluntary euthanasia, by definition, lack the autonomous request from the patient, and so the conditions jointly necessary to justify voluntary euthanasia can never both be present in cases of non-voluntary euthanasia.

This analysis, offered by Lillehammer and Smith, may initially appear compelling. But it seems to me that Jones has effectively responded to it by calling attention to and making explicit the idea expressed in the final sentence of the quote from Keown above. Jones embraces Lillehammer's and Smith's claim that justified cases of voluntary euthanasia require both an autonomous request from the patient and an independent judgment confirming that the patient is better off dead. And he admits that they are correct to point out that in cases of non-voluntary euthanasia there cannot be an autonomous request from the patient, and so one of the necessary conditions for justifying voluntary euthanasia can never be realized in

cases of non-voluntary euthanasia. Nonetheless, Jones points out that once we accept that the patient's autonomous request and the physician's confirming judgment are jointly necessary and sufficient conditions for justifying voluntary euthanasia, it becomes very difficult to deny that the physician's judgment is, on its own, a sufficient condition for justifying non-voluntary euthanasia. As Jones puts it:

[W]hen the patient cannot request an option . . . then it cannot be contrary to autonomy to act for the patient on the basis of overall benefit. It is arbitrary to withhold an intervention that has been conceded to be of overall benefit to a patient simply because he cannot request it. (2011, 399–400)

The central point here is that Keown's and Jones's argument for the slippery slope does not depend on mistaking a necessary condition for a sufficient one, as Lillehammer and Smith suggest. Instead, Keown and Jones are making a claim about what set of necessary and sufficient conditions we are committed to endorsing for cases of non-voluntary euthanasia, given the view that the autonomous request and the physician's judgment are jointly necessary and sufficient in cases of voluntary euthanasia.³ Specifically, their idea is that the rationale for restricting voluntary euthanasia to cases in which it is requested by the patient is grounded in the importance of respecting the patient's autonomy. For cases in which the patient is incompetent, and so unable to exercise autonomy, they view this consideration as inert, leaving the physician in a situation where the appropriate course of action is to do whatever is deemed best for the patient. Given their conception of voluntary euthanasia, granted by Lillehammer and Smith, as involving physicians making independent "better off dead" judgments, they conclude that physicians can similarly judge incompetent patients to be better off dead, and then have no reason not to perform non-voluntary euthanasia.

Admittedly, on Jones's view, the slope from endorsing voluntary euthanasia to endorsing non-voluntary euthanasia is not frictionless. One could stop the slide by denying the premise implicit in Keown's discussion and explicit in Jones's, according to which the lack of a request is no reason against providing a beneficial treatment to an incompetent patient. But this is a very costly move. If the lack of an autonomous request, or the lack of consent, prevents physicians from performing non-voluntary euthanasia, even when the physician judges that to be the most beneficial course of action for the patient, then an analogous lack of request or consent will similarly block any other treatment for incompetent patients. In other

words, physicians would no longer be able to provide standard care for unconscious patients, such as amputating a limb to prevent gangrene or performing an appendectomy to prevent sepsis.⁴

One might try to resist the analogy here, by claiming that we can distinguish between non-voluntary euthanasia and standard medical treatment. But in cases where the physician judges euthanasia to be best for the patient, I see no room to permit standard medical treatment for incompetent patients on the grounds that such treatment is in the patient's interests, even though the patient has not requested it, and simultaneously deny non-voluntary euthanasia on the grounds that the patient has not requested it, even though it is (judged to be) in the patient's interests. As a result, the slope from endorsing voluntary euthanasia to non-voluntary euthanasia, while not frictionless, is exceedingly slick.

Jones also makes explicit how Keown anticipates and responds to another potential objection to the slippery slope argument. The worry here is that one might deny that justified cases of voluntary euthanasia require physicians to make independent judgments that patients are better off dead. As Jones explains, Keown attempts to address this objection by identifying another potentially slippery slope, this time between the sorts of cases that defenders of voluntary euthanasia typically have in mind and the idea that physicians should provide assistance ending one's life to any competent adult who requests it. A representative example here could be a jilted lover who wants to end his life solely because his paramour has abandoned him. Jones's and Keown's claim is that in order to avoid endorsing voluntary euthanasia for the jilted lover, one must recognize that voluntary euthanasia is permissible only when the physician makes an independent judgment confirming the merits of the patient's request. Moreover, as we have just seen, they believe that once one understands voluntary euthanasia in this way, one will have no choice but to endorse non-voluntary euthanasia. Their argument can therefore be understood as a dilemma. If one accepts voluntary euthanasia for suffering, terminally ill patients, one must also accept either (1) non-voluntary euthanasia or (2) voluntary euthanasia for jilted lovers.

As stated above, some advocates of voluntary euthanasia may be perfectly willing to endorse non-voluntary euthanasia, but my aim in this paper is to show that this is not necessary in order to endorse voluntary euthanasia and avoid inconsistency. Similarly, advocates of voluntary euthanasia could respond to the jilted lover case by embracing the idea that all competent adults should have access to euthanasia. Some may

find that response appealing. My aim, however, is to show that it is not necessary. The benefit of my proposed response to Jones and Keown is that it prevents possible concerns about non-voluntary euthanasia or about voluntary euthanasia for jilted lovers from spilling over into concerns about all instances of voluntary euthanasia. In addition, if I am correct, my response to Jones and Keown helps clarify the physician–patient interaction in cases of voluntary euthanasia, which in turn helps set parameters to guide the regulation of voluntary euthanasia.

AUTONOMY-ORIENTED APPROACH

I will argue that there are two ways of understanding and defending voluntary euthanasia that circumvent slippery slope arguments like the ones discussed in the previous section, because they are compatible with the rejection of both non-voluntary euthanasia and euthanasia on request. Each is grounded in a way of conceiving of the interaction between the physician and patient that differs from that adopted by Keown, Jones, Lillehammer, and Smith. In this section, I develop what I call the autonomy-oriented approach, and in the following section I will develop what I call the evidential approach, where the evidence in question is evidence regarding the patient’s well-being. As will become clear, this distinction is not intended to set up an impenetrable barrier such that all autonomy-oriented considerations remain on one side and all considerations involving well-being remain on the other. Each of my proposed approaches to voluntary euthanasia could aptly be characterized as involving considerations of both autonomy and well-being. Nonetheless, I view the two as sufficiently different, both in themselves and in the ways in which they interact with the slippery slope arguments, that it is best to treat them separately, and I have labelled them in a way that is intended to call attention to the fundamental importance of autonomy in one and the fundamental importance of evidence about well-being in the other.

Rather than invoking a Kantian or neo-Kantian conception of autonomy, I will simply understand autonomy as the normative authority to determine what one will do and what will happen to oneself.⁵ Insofar as this sort of self-control or self-government has fundamental normative significance, respect for autonomy favors allowing individuals to exercise autonomous control over their lives. It is worth emphasizing that on this sort of view autonomy is independent from well-being. The reason for you to respect my autonomy is not that I will be better off if you do so. In fact, it might be the case that I will be worse off if you respect my autonomy: even

in those cases where I am aiming to promote my well-being I may have misjudged how to do so. Nonetheless, the idea here is that my autonomy is itself intrinsically significant.

This way of characterizing the importance of autonomy may appear to depend on what has been called the “myth” of the “in-control agent,” but the sense of autonomy I am appealing to is intended to be fully compatible with a relational rather than an individualistic conception of autonomy.⁶ I agree with advocates of relational conceptions of autonomy that human beings are deeply interdependent, that emotions appropriately play an important role in decision-making, and that in most cases an individual’s aims are not exclusively self-regarding (Dodds 2000, 216; Walter and Ross 2014, 819–21). I further agree that it is important, when possible, for patients to draw support and advice from a network of relatives and friends when faced with momentous decisions, and that physicians can be important parts of such support networks (Dodds 2000, 231–32; Carse 2006, 44). Nonetheless, on the autonomy-oriented approach to voluntary euthanasia, the fundamental idea is that there are substantial reasons to respect the (relationally) autonomous wishes of a patient that are independent of considerations regarding the patient’s well-being.⁷

One important thing to notice is that understanding and defending physician-assisted dying from an autonomy-oriented perspective is quite common. Consider this statement, phrased in perhaps an overly individualistic way, from the recent judicial decision that temporarily legalized physician-assisted suicide in New Mexico:

This Court cannot envision a right more fundamental, more private or more integral to the liberty, safety and happiness of a New Mexican than the right of a competent, terminally ill patient to choose aid in dying. (*Morris, Mangalik, and Riggs vs. Brandenburg*, D-202-CV 2012-02909 (Second Judicial District Court of New Mexico 2014), 12 (Sect. II, para. HH))

The idea here is not that such patients will necessarily choose in ways that most benefit themselves, but rather that there are powerful reasons to respect their choices, regardless of what one thinks of the decisions they have made.

From this perspective, when a patient makes a request for aid in dying, insofar as that request expresses the autonomous will of the patient, the physician has a good reason to comply. This is a legitimate reason even if the physician herself does not think that death is the best thing for the patient, or that the patient is better off dead. Admittedly, if the physician

thinks that the patient's well-being would be promoted by continued life, the physician will have to weigh that consideration against the importance of respecting the patient's autonomous request. And, as advocates of relational conceptions of autonomy emphasize, the physician's role may appropriately include emotional support and counseling that goes beyond simply providing information and supplying treatment. But the important point here is that on this way of understanding voluntary euthanasia, the physician need not make an independent judgment confirming the patient's view that death is a benefit. In fact, the physician might even believe that death is never a benefit for anyone in any circumstances, and still appropriately endorse instances of voluntary euthanasia, provided that the amount of well-being sacrificed in ending the patient's life is outweighed by the importance of respecting the patient's autonomy.

It should be clear why this way of understanding voluntary euthanasia blocks the primary slippery slope argument offered by Keown and Jones. The problem is that they incorrectly suppose that voluntary euthanasia requires the physician to make an independent judgment that the patient is better off dead. If physicians can endorse voluntary euthanasia without making such judgments, then there is no reason to think that by endorsing voluntary euthanasia they are committed to judging that certain incompetent patients are better off dead, and so there is no reason they must be committed to non-voluntary euthanasia.

It might seem that this way of understanding and vindicating voluntary euthanasia, although it avoids commitment to non-voluntary euthanasia, is poised to have difficulty with Keown's and Jones's other slippery slope argument, or the other half of their dilemma, by falling into endorsement of voluntary euthanasia for jilted lovers. But notice that on this approach to voluntary euthanasia, even though the physician is not required to make an independent judgment that the patient is better off dead, she still must make what I will call a boundary judgment. That is to say, she must judge that the patient is within the boundaries of appropriate deference. As suggested above, one natural way to cash out the relevant boundaries is in terms of the amount of well-being, or the length and quality of life, that the patient is sacrificing. It is perfectly reasonable for a physician to comply with requests for euthanasia in paradigmatic cases involving patients with low quality of life and little remaining life expectancy, on the grounds that the importance of respecting their autonomy outweighs competing considerations about promoting their well-being, and yet deny similar requests from patients who appear to otherwise have relatively long

and valuable lives ahead of themselves, on the grounds that in these cases promoting well-being outweighs respecting autonomy. The difference is the amount of well-being at stake. Where exactly the tipping point lies is difficult to determine, and it is an issue I will broach later, in the section on boundary judgments, but the key point for now is that there can be clear cases on either side even if the precise boundary is murky.

One might wonder whether these boundary judgments, which are undeniably physician judgments regarding the patient's well-being, are appropriate to include within a so-called "autonomy-oriented" approach to euthanasia. It is important to keep in mind, however, that this way of understanding and defending voluntary euthanasia is not autonomy-oriented in the sense that it treats autonomy as the only thing that matters. Rather, it is autonomy-oriented in the sense that it treats respect for autonomy as having importance independent of considerations of well-being. A view that gave consideration only to autonomy would indeed be unable to avoid the slippery slope to endorsing euthanasia on request for all competent adults. By balancing the importance of autonomy against considerations of well-being, through the boundary judgments, that slippery slope is blocked.

This may raise the concern that the inclusion of these boundary judgments revives the threat of the slippery slope to endorsing non-voluntary euthanasia. But notice that although the boundary judgments certainly are judgments regarding patient well-being, they are not the kind of well-being judgment Keown and Jones need in order to establish the slipperiness of that slope. Making the relevant boundary judgment does not commit the physician to thinking the patient is better off dead, merely that the amount of well-being at stake is sufficiently low that it is outweighed by the importance of respecting the patient's autonomy. That sort of judgment, applied to an incompetent patient, is clearly not enough to license non-voluntary euthanasia, even if a judgment that the patient is better off dead could be enough. What this helps reveal is that the structures of deliberation and decision-making are significantly different in cases of voluntary and non-voluntary euthanasia. In voluntary cases, although the physician plays an important role in facilitating and supporting the patient's deliberation, she does not need to decide on her own that the patient is better off dead. In contrast, non-voluntary cases require just such a decision from the physician.

EVIDENTIAL APPROACH

Another way of understanding and defending voluntary euthanasia that avoids commitment to non-voluntary euthanasia or unrestricted euthanasia on request is to view the patient's request for aid in dying as providing evidence about what is best for the patient. This way of understanding, and vindicating, voluntary euthanasia is inspired by John Stuart Mill's famous utilitarian arguments in favor of what he calls the liberty of tastes and pursuits (1863). The idea is that the patient is in a privileged epistemic situation with respect to evaluations of his own well-being. The patient may not always be correct about what will be best for himself, but he is generally more likely to be correct than anyone else. From this perspective, although there is no independent normative significance in respecting the patient's autonomy, the patient's request for assistance in ending his life is nonetheless a significant source of evidence that the physician must take into account in determining whether to proceed with voluntary euthanasia.

On this way of understanding voluntary euthanasia, Keown and Jones are right that the physician should comply only if she thinks that ending the patient's life is best for the patient, but it is important to notice that the physician's judgment that the patient is better off dead is not independent of the patient's request. Rather, it is grounded in the evidence that the request constitutes. As in the case of the autonomy-oriented approach, the physician will need to exercise her own judgment before appropriately complying. She will need to assign weight to the evidence grounded in the patient's request and balance it against competing available evidence, effectively determining whether the patient is within the boundaries of appropriate deference. But she does not need to make an independent judgment confirming the patient's evaluation.

Admittedly, this perspective will lead a physician to perform voluntary euthanasia only if she believes that there are at least some circumstances in which a patient is better off dead. Otherwise, the patient's request cannot serve as evidence that the patient is in such circumstances. As a result, it might seem as though this way of understanding and justifying voluntary euthanasia is susceptible to an argument like Keown's and Jones's. What, one might wonder, is to stop a physician from judging that an incompetent patient is better off dead, once she has committed herself to the view that in some cases death can be a benefit? While I concede that this line of thought generates some pressure in favor of non-voluntary euthanasia, I think it is a mistake to suppose that there is an inevitable slide from this way of vindicating voluntary euthanasia to an endorsement of non-

voluntary euthanasia. After all, it is appropriate for there to be a strong default presumption that it is not in a person's benefit to bring about his death, which means that it makes sense to require exceptionally weighty or compelling evidence before concluding, in any given case, that death is a benefit. If this default is taken to provide sufficient inertia, one might think that in the absence of a patient's express request, a physician can never have sufficient evidence to conclude that the patient is better off dead.⁸

This sort of view can be strengthened by thinking about appropriate strategies for physicians to adopt regarding the judgment that a given patient is better off dead. Physicians should be aware that caregivers typically underestimate quality of life and overestimate the likelihood of depression, compared to patients' self-assessment, and that healthy individuals in general overestimate the likelihood of patients wishing for hastened death (Lulé et al. 2013). In addition, physicians should be cognizant of potential bias generated by the financial interests that they or the institutions that employ them may have. In light of these considerations, it may be appropriate for a physician to conclude that her particular judgments of when an incompetent patient is better off dead are systematically unreliable. She may be confident some are correct, but unable to tell which. In that case, it could be perfectly coherent for her to judge both (1) that a particular patient is a seemingly appropriate candidate for non-voluntary euthanasia and (2) that the best way to promote that patient's interests is nonetheless not to administer non-voluntary euthanasia. Her skepticism about the reliability of her own ability to sort appropriate candidates for non-voluntary euthanasia from inappropriate ones makes these seemingly incompatible judgments coherent with one another.⁹ This demonstrates that on the evidential approach to voluntary euthanasia one's acceptance of euthanasia in voluntary cases is compatible with either embracing or rejecting non-voluntary euthanasia, which means that there is no logical slippery slope here and an argument against voluntary euthanasia cannot be grounded in the rejection of non-voluntary euthanasia.¹⁰

In addition, as with the case of the autonomy-oriented approach discussed in the previous section, this evidential understanding and defense of voluntary euthanasia passes the other half of Keown's and Jones's challenge by avoiding commitment to euthanasia for jilted lovers. This is because the idea that the patient's request constitutes evidence about what is in his best interests does not preclude the possibility of there being other evidence for the physician to consider. Moreover, the presupposition

behind the jilted lover challenge is that jilted lovers who are requesting euthanasia in virtue of being heartbroken should not receive aid in ending their lives because they will be much better off if they are denied that assistance. It is of course permissible to challenge that presupposition, and one might argue that jilted lovers should have access to voluntary euthanasia. Nonetheless, as indicated above, my aim is not to argue that jilted lovers are inappropriate candidates for euthanasia, but instead to show that the analysis of euthanasia under consideration is not committed to viewing them as appropriate candidates. As with the autonomy-oriented approach, this way of understanding euthanasia requires physicians to make boundary judgments that circumscribe appropriate deference to their patients' requests. In the section on boundary judgments I will consider where those boundaries may lie, but the critical point here is that there is no reason to think that jilted lover cases must necessarily be within those boundaries. And insofar as the jilted lover challenge is genuine, there are good reasons to think that such cases will be beyond the boundaries of appropriate deference.

INDEPENDENT SUPPORT

If my analysis in the previous two sections is correct, I have identified two ways of understanding the roles of the patient's request and the physician's judgment in cases of voluntary euthanasia that block any logical slippery slope from endorsement of voluntary euthanasia to acceptance of non-voluntary euthanasia, while also avoiding commitment to the conclusion that it is appropriate for physicians to comply with any and all patient requests for aid in dying. One possible way to revive the slippery slope worries would be for defenders of Keown and Jones to assert that my proposals about how to understand the interaction between physicians and patients in cases of voluntary euthanasia are incorrect, perhaps even that they are guilty of being rigged to avoid the slippery slopes rather than capturing the actual physician-patient interactions involved in cases of voluntary euthanasia. According to this line of objection, if we correctly understand what is going on in cases of voluntary euthanasia we will see that accepting voluntary euthanasia really does put one on a slippery slope to embracing non-voluntary euthanasia or euthanasia on request. I hope to show, however, that such an objection should not be convincing. This is because the ways of understanding voluntary euthanasia outlined above are closely analogous to standard accounts of how to understand interactions between patients and physicians in uncontroversial cases involving multiple

possible courses of treatment. This tight analogy demonstrates that my analyses of voluntary euthanasia are not *ad hoc* accounts designed solely with the aim of circumventing slippery slope arguments, but rather are grounded in independently motivated ways of understanding cases of voluntary euthanasia.

The central point is that it is standard medical practice for a physician to describe multiple possible courses of treatment to her patient and let the patient choose among them. As advocates of relational autonomy point out, it may be best for the physician to provide counseling and emotional support in addition to information about the alternatives and the potential benefits and risks that they pose. And in many cases the physician may even recommend a particular course of treatment, although it is not essential for her to do so. The patient, perhaps after receiving additional information or counseling from other physicians, then requests a selected course of treatment. At this point, the physician must make a boundary judgment, determining whether the patient's request is within the bounds of appropriate deference. If the physician judges that the requested treatment is beyond those bounds, she can refuse to comply.¹¹ So, for instance, a physician need not comply with a patient's request that his tonsillitis be treated with leeches or his suggestion that his stubbed toe warrants oxycodone.

Moreover, and this is important, the physician can provide a requested treatment without endorsing the patient's choice as correct. This is perhaps most vivid in cases where the physician makes a recommendation and the patient ends up choosing a different treatment option. In order to understand the physician's compliance in such a case, we need not think the physician changes her mind about what treatment is best. Rather, she merely needs to think that the patient's preferred treatment is within the bounds of appropriate deference. And the same is true even if the physician does not make a recommendation—she does not need to concur with the patient's request in the sense of thinking the patient has made the best choice in order to provide the treatment.

There are two things to notice about this description of the interaction between a physician and her patient. The first is that it is not at all controversial. That physician–patient interactions operate in this manner is a presupposition adopted by countless organizations offering advice to both patients and physicians, including, for instance, the U.S. Department of Health and Human Services and the American Cancer Society (AHRQ 2015; ACS 2015). Jones himself cites the guidelines for medical decision-

making of the United Kingdom's General Medical Council, which outline a procedure like the one described above, and he characterizes the set of guidelines as "helpful not because it is novel but precisely because it is not" (Jones 2011, pp. 396–97; GMC 2008, para. 5).

The other thing to notice is that this procedure is perfectly in line with the understanding of the roles of the patient and physician that are built into the defenses of voluntary euthanasia described above. From an autonomy-oriented perspective, the reason to allow a patient to choose between multiple courses of treatment in ordinary cases, even when the physician has a settled view about which of the options is best for the patient's well-being, is that such deference demonstrates appropriate respect for the patient's autonomy. Exactly the same analysis applies to cases of voluntary euthanasia, from this perspective, provided that the potential gains in well-being from continued life are sufficiently small to be outweighed by the importance of respecting patient autonomy. From an evidential perspective, the idea is either that the physician's own judgment of what is best for the patient is dependent on the patient's choice, or that the physician judges that the best strategy for promoting the patient's interests is to comply with the patient's request even though she herself believes the patient to be mistaken. And this applies both for cases of standard treatment and for responses to requests for aid in dying. Moreover, on both perspectives the idea of providing euthanasia as a response to romantic heartbreak can be viewed as akin to leeches for tonsillitis or oxycodone for a stubbed toe: not every patient request demands compliance.

As this reveals, the independent support for the two ways of understanding and defending voluntary euthanasia I have offered is the underlying idea that euthanasia is fundamentally a potential medical response to a patient's condition, which is to say that it is a treatment option. As I have attempted to demonstrate, viewing voluntary euthanasia in this way clarifies and strengthens the arguments in favor of allowing voluntary euthanasia, while at the same time avoiding commitments to non-voluntary euthanasia and euthanasia on request.

BOUNDARY JUDGMENTS

As I have emphasized at the outset, this paper is not intended to provide a comprehensive assessment of voluntary euthanasia. My analysis is primarily focused on rejecting the claim of a logical slippery slope from endorsing voluntary euthanasia to supporting non-voluntary euthanasia.

I have not addressed the possibility of an empirical slippery slope to embracing non-voluntary euthanasia, nor have I attempted to canvass all possible direct objections to voluntary euthanasia. Nonetheless, in the process of responding to the logical slope argument I have identified ways of defending voluntary euthanasia that generate what I take to be significant *pro tanto* reasons for permitting the practice.¹² Moreover, the role of appropriate boundaries of deference in my analysis generates implications for the design of regulations controlling the practice of voluntary euthanasia that are internal to the arguments I have developed. Even though it would be premature to reach definitive conclusions about the appropriate policies governing voluntary euthanasia in advance of a more complete analysis, it is worthwhile to explore where the appropriate boundaries of deference lie and what policy options my analysis supports. To this end, I will proceed by evaluating conditions related to those adopted in two prominent jurisdictions that allow physician-assisted dying, either in the form of what I am calling physician-assisted suicide or that of voluntary euthanasia: Oregon and the Netherlands (Oregon Public Health Division 2016a; Netherlands 2002).¹³

One commonly advocated restriction on physician-assisted dying is that the patient's request for aid in dying must persist over time. Under the Oregon Death with Dignity Act, this manifests in a requirement that the patient repeat the request after a 15-day waiting period. Given my proposed analyses of the justification of voluntary euthanasia, it is easy to see why this sort of restriction makes sense. The purpose of the waiting period is to ensure that the patient's request reflects his considered, stable judgment. This is important from either the autonomy-oriented or the evidential perspective. Determining the best length for the waiting period, however, is more difficult. One significant consideration is the importance of allowing adequate time for the process of psychosocial adaptation to disease and impairment to operate. Newly diagnosed or impaired patients often underestimate their prospective quality of life, and physicians tend to do so as well (Lulé et al. 2013). In many cases, a 15-day waiting period will not be enough time for this adaptation to occur. On the other hand, extending the waiting period prolongs the suffering or distress of those whose preference for aid in dying remains stable. My inclination would be to consider a 30-day waiting period as a compromise that gives more substantial opportunity for psychosocial adaptation to take hold while not excessively burdening patients with stable requests for aid, but continued research into the adaptation process may provide grounds for extending the waiting period further.

Another set of common restrictions involves the quality and length of life remaining to the patient if aid in dying is withheld. The Oregon law focuses on length, requiring that patients be diagnosed by two independent physicians as having a terminal illness with less than six months to live. In the Netherlands, there is an emphasis on quality of life, with euthanasia restricted to patients whose suffering is “lasting and unbearable” and for whom “no other reasonable solution” is available, as determined by both the patient and physician (Netherlands 2002, Ch. II, Art. 2.1.). On the analyses I have offered in this paper, these sorts of conditions seem well motivated, but they are nonetheless overly restrictive. The restriction to patients with terminal illnesses can draw support from the idea that when death is proximal regardless, the amount of well-being potentially sacrificed through euthanasia is limited. From an autonomy-oriented perspective this makes it more likely that considerations of autonomy outweigh considerations of well-being, and from an evidential perspective this lowers the potential costs of mistaken deference. The restriction to patients with indefinite, unbearable suffering operates similarly. But notice that the analysis I am suggesting as motivation for these restrictions amounts to an argument for permitting voluntary euthanasia when either condition is met. In contrast, each jurisdiction imposes one or the other condition on its own, unduly restricting access to physician-assisted dying.

Moreover, my analysis does not yet amount to an argument against permitting euthanasia when neither condition is met. That would require asserting that absent these conditions there is good reason to think that the magnitude of the well-being potentially sacrificed through euthanasia outweighs the importance of respecting the patient’s autonomy and overwhelms the evidential value embedded in the patient’s request. Earlier, in discussing the jilted lover challenge, I took it for granted that for healthy patients who are simply unhappy with the current course of their lives there is good reason to think that the well-being that would be sacrificed through death is sufficiently large to make voluntary euthanasia inappropriate. Some might contest that assumption, and endorse very widespread access to euthanasia on request, but as I have indicated above I will not attempt to address that approach in this paper. Instead, let me point out that even if we maintain the assumption it still might make sense to extend the boundaries of deference beyond those who are terminally ill or experiencing unbearable, interminable suffering. After all, unless we adopt an implausibly wide construal of what counts as suffering, individuals could have exceptionally low prospects for well-being without

experiencing unbearable suffering.¹⁴ And those individuals could be appropriate candidates for deference, on both the autonomy-oriented and the evidential approaches to voluntary euthanasia. How exactly to design regulations governing euthanasia that provide access to these people is beyond the scope of this paper, but the focus on people whose prospective well-being is sufficiently low to bring them within the boundaries of deference does, I take it, provide guidance on how to proceed here.

Yet another common set of restrictions involves the epistemic situation and decision-making capacity of the patient who is requesting aid in dying. In both the Netherlands and Oregon, aid in dying is permitted only if the patient is informed about other possible treatments and is capable of forming and expressing decisions regarding health care. The need for these sorts of restrictions is evident from either the autonomy-oriented or the evidential approaches to voluntary euthanasia: only if the patient is informed and competent does the request for aid in dying reflect the patient's autonomous will or serve as evidence of what is best for the patient.¹⁵

In addition, in Oregon but not the Netherlands, the physicians involved in each case are required to refer the patient for psychological evaluation if they believe the patient may be suffering from a psychiatric or psychological disorder. This, too, strikes me as an appropriate restriction from both the autonomy-oriented and the evidential perspectives, because, as above, it helps ensure that the request appropriately reflects the patient's autonomous will and it promotes the request's evidential value. Moreover, it may even make sense to impose a more stringent requirement in this vein than Oregon does. Currently, in Oregon, such referrals are very rare. Out of 218 patients who received prescriptions for lethal medications under the Death with Dignity Act in 2015, just five had been referred for formal mental health evaluation (Oregon Public Health Division 2016b, 4). This means that in the vast majority of cases the physicians' informal assessment of the patient's mental health was the only check ensuring that the patient was well situated to judge the alternatives and make an autonomous request. The requirement that two physicians must make this assessment independently helps strengthen the screen, but the fact that so few patients are referred for clinical evaluation suggests that it still may not be all that effective in practice. An alternative would be to require that all patients receive formal psychiatric or psychological evaluation before gaining access to aid in dying. This would have the disadvantage of constituting an additional impediment to the provision of aid in dying in

those cases where the patient's mental health is sound, but it would have the benefit of more tightly restricting such aid to cases where deference actually is appropriate.

Another potential concern, related to both my autonomy-oriented and evidential defenses of voluntary euthanasia, is the role of explicit or implicit bias in physicians' judgments about when to defer to their patients' requests.¹⁶ This worry manifests in at least two ways. To begin with, there is the concern, grounded in the evidence cited earlier about physicians' tendency to overestimate the likelihood of depression and underestimate the quality of life of patients suffering from disability, disease, or physical impairment, that physicians may be too quick to defer to requests for aid in dying from patients whose lives they undervalue. As suggested earlier, this concern can be partially alleviated by extending the waiting period, but it is also important for physicians to educate themselves about this bias and work to overcome it. Depending on the nature of the patient's condition, there may be cases in which it makes sense to anticipate substantial psychosocial adaptation on a more gradual timescale than imposed by a 30-day waiting period. In such cases it is appropriate for the physician to withhold deference beyond the length of the waiting period, even if she has a hard time imagining adapting when she projects herself into the patient's situation.

The other manifestation of the worry about bias is the concern that physicians may discount requests for aid in dying that come from individuals whose judgment they inappropriately disrespect. Such concern is potentially grounded in the difficulty faced by young women pursuing sterilization, who are likely to find physicians reluctant to defer to their judgment and honor the request.¹⁷ Insofar as this difficulty is symptomatic of a problem that women or other disadvantaged groups face in getting physicians to respect their autonomy, this creates the possibility of systematic discrepancies in access to voluntary euthanasia. I think there is some room for optimism here, given that there are clear connections between gender stereotypes that emphasize procreative roles for women and the resistance to requests for sterilization, whereas it is less evident how existing gender stereotypes would underwrite either explicit or implicit bias against deferring to women's requests for aid in dying. Nonetheless, the possibility of bias against deference according to gender, race, or other inappropriate factors is well worth taking seriously, and it is something that ought to be monitored in jurisdictions that allow voluntary euthanasia.¹⁸

Overall, identifying and adhering to precise boundaries is difficult. The idea internal to the defenses of voluntary euthanasia that I have offered is that the aim should be to defer to the patient's request only in those cases where the request truly reflects the patient's autonomous will or truly constitutes powerful evidence that death is a benefit. Whether this aim needs to be modified in light of further arguments about voluntary euthanasia is beyond the scope of this paper, and how best to achieve the aim insofar as it survives is open to debate and may require experimentation. It is nonetheless important to have provisionally identified considerations that ought to structure the debate, which is what I hope to have done.

CONCLUSION

I have argued that proponents of a logical slippery slope from accepting voluntary euthanasia to endorsing non-voluntary euthanasia have grounded their analysis in a mistaken conception of the interaction between physicians and patients in cases of voluntary euthanasia, and that defenders of voluntary euthanasia have done so as well. Rather than understanding voluntary euthanasia as requiring a physician to make an independent judgment that the patient is better off dead, I have suggested that the physician instead should be seen as making a judgment that the patient is within the boundaries of appropriate deference. I have developed two ways of understanding and defending voluntary euthanasia that fit this model. The first is focused on the idea that there are good reasons to respect the patient's autonomy that are independent of considerations of well-being, and the second is focused on the idea that a patient's request for euthanasia constitutes significant evidence regarding what is best for the patient. I have further shown that both of these defenses of voluntary euthanasia avoid potentially problematic slippery slopes to endorsing non-voluntary euthanasia or endorsing unrestricted euthanasia on request. In addition, by identifying an analogy to uncontroversial, standard practice in cases involving multiple possible courses of treatment, I have demonstrated that these ways of understanding voluntary euthanasia accurately reflect appropriate physician–patient interactions. Finally, I have argued that my proposed ways of understanding voluntary euthanasia provide insight into how to construct regulations governing the practice. The key is to focus on the extent to which the patient's request reflects his autonomous will. From an autonomy-oriented perspective, there are independent reasons to respect the patient's will, and these considerations must be balanced against the amount of prospective well-being potentially sacrificed through

death. From an evidential perspective, the patient's request for aid in dying constitutes evidence regarding the patient's prospective well-being, and this evidence must be balanced against competing available evidence. Work remains to be done in determining precisely which regulations make sense with these considerations in mind, and also in balancing these considerations against other potentially legitimate reasons to expand or restrict access to voluntary euthanasia, but I have sketched some preliminary answers.

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NOTES

1. This has the unfortunate consequence that laws such as Oregon's Death with Dignity Act will count as permitting physician-assisted suicide even though the law itself stipulates that ending one's life under the provisions of the law does not count as suicide. The insistence that the Oregon law does not permit suicide is important both legally, in terms of consistency with federal law and in terms of the impact on insurance benefits for those who participate in the Act, and politically, for supporters of the Act who do not want to be characterized as endorsing suicide. I am therefore reluctant to use the term "physician-assisted suicide" here, but retain it nonetheless because of its widespread use in academic writing, and because, setting aside the legal and political considerations, it does seem to accurately characterize the phenomenon in question.
2. For an argument for the existence of an empirical slippery slope from voluntary to non-voluntary euthanasia, see (Amarasekara and Bagaric 2004).
3. Notice that this understanding of Keown's and Jones's argument not only positions them to rebut the objections of Lillehammer and Smith but also provides a response to the related objection raised by Young (2013), who claims that Keown begs the question against his dialectical opponent and offers no reason not to think that a patient's request is a necessary (and impossible) condition for justifying non-voluntary euthanasia.
4. Thanks to an anonymous reviewer for suggesting these particular examples.
5. Compare (Dworkin 1988). For a Kantian analysis of euthanasia, see (Velleman 1999).
6. For discussion of the myth of the in-control agent, see (Carse 2006), and for an articulation of an alternative relational conception of autonomy, see

(Mackenzie and Stoljar 2000). For discussion of relational autonomy in the context of medical decision-making, see (Dodds 2000) and (Walter and Ross 2014). Thanks to an anonymous reviewer for encouraging me to engage with feminist criticisms of traditional accounts of autonomy and to consider how my analysis coheres with relational conceptions of autonomy.

7. Mackenzie and Stoljar (2000) provide a helpful explanation of why concerns about individualistic conceptions of autonomy do not undermine the importance of autonomy altogether. I should also note that in addition to posing objections to the hyper-rationality, independence, and self-interest associated with some traditional conceptions of autonomy, both they and Dodds (2000) raise important concerns about the impact of social oppression on an individual's capacity for autonomy. Those concerns speak to the need for large-scale social reforms that go well beyond the question of whether to allow voluntary euthanasia, but addressing those issues and identifying how to proceed in resolving them is beyond the scope of this paper.
8. For a discussion of some difficulties associated with judging an individual to be better off dead, see (Barrie 2015), which is primarily aimed at showing that healthcare metrics such as quality-adjusted life years cannot, on their own, ground such judgments.
9. Notice that one need not adopt a rule-consequentialist theory to reach this conclusion. For discussion of this sort of thought process in standard consequentialist reasoning, see (Hare 1981).
10. Notice that the aim here is not to argue against non-voluntary euthanasia or show that physicians will not or should not embrace it. Rather, the aim is to show that resolving the question of whether to allow voluntary euthanasia is not dependent on having an answer to the question of whether to allow non-voluntary euthanasia, and that settling the former question positively does not require one to settle the latter positively as well.
11. As an anonymous reviewer has pointed out, this right of refusal can be understood as grounded in the importance of respecting the physician's own autonomy.
12. By "*pro tanto* reason" I mean a reason that carries genuine normative weight, even though it may not fully settle the issue, because in a full analysis it would be balanced against other, potentially competing, *pro tanto* reasons.
13. It is important to keep in mind that Oregon law explicitly rejects the label "physician-assisted suicide" for the practice it permits, but I am using that label here to conform with what is a fairly standard usage in academic literature.
14. Compare (Varelius 2007), although he endorses broader access to aid in dying than I am advocating.

15. For more on the relationship between autonomy and informed consent, see (White 2013).
16. Thanks to anonymous reviewers for raising these issues.
17. See (Lawrence et al. 2011), although notice that in addition to concluding that Ob/Gyn physicians are prone to discourage young women from seeking sterilization (up to 70% would do so, depending on the woman's circumstances), they also conclude that nearly all such physicians are willing to assist in fulfilling the request if the patient persists (91% perform the procedure and 7% refer the patient to another physician likely to perform it).
18. I am unaware of any systematic data on requests for aid in dying that are denied, but comparisons between the demographics of end-of-life Death with Dignity Act patients in Oregon and overall Oregon demographics suggest that if there is a problem with unequal access to aid in dying it may be more along racial or ethnic lines than gender lines: in 2015 the Oregon patients were 57.6% female, in comparison to 50.5% of the overall Oregon population, whereas 93.1% of the Oregon patients were in the category "White alone, not Hispanic or Latino," in comparison with 87.6% of the overall Oregon population (Oregon Public Health Division 2016b; United States Census Bureau 2016).

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