Is there a logical slippery slope from voluntary to non-voluntary euthanasia?

Abstract

John Keown has constructed a logical slippery slope argument from voluntary euthanasia (VAE) to non-voluntary euthanasia (NVAE). VAE if justified implies that death can be of overall benefit, in which case it should also be facilitated in those who cannot consent (NVAE). Hallvard Lillehammer asserts that Keown's argument rests on a fallacy. However, *pace* Lillehammer, it can be restated to escape this fallacy. Its validity is confirmed by applying to VAE some well-established general principles of medical decision making. Thus, either VAE and NVAE must be accepted together or, if NVAE is regarded as unacceptable, VAE should also be rejected.

Slippery slope arguments in the history of the euthanasia debate

Slippery Slope arguments have been important in the euthanasia debate for at least half a century. In 1957 the Cambridge legal scholar Glanville Williams wrote a controversial book, *The Sanctity of Life and the Criminal Law*, in which he presented the decriminalising of euthanasia as a modern liberal proposal taking its rightful place alongside proposals to decriminalise contraception, sterilisation, abortion, and attempted suicide (all of which the book also advocated).[i] Opposition to these reforms was in turn presented as exclusively religious and particularly Roman Catholic. Thus Williams asserted that "euthanasia can be condemned only according to religious opinion" (1957, p. 312).

The following year, in response to this book Yale Kamisar, then associate professor of law at Minnesota wrote a substantial paper entitled, "Some Non-Religious Views against Proposed 'Mercy Killing' Legislation". Kamisar did not accept Williams' assertion that euthanasia could only be rejected on the basis of religious arguments. Kamisar wrote as "a non-Catholic and self-styled liberal" (1958, p. 974) and appealed exclusively to "utilitarian ethics" (1958, p. 974 n. 21). The fundamental argument of his paper invoked what he called the "wedge principle" and would later be called the "slippery slope" argument. He urged that in practice permitting "mercy killing" would not be confined to voluntary euthanasia but that pressure would be put on the vulnerable to end their lives and the incompetent would be killed without their consent. Williams replied (1958).

It would be difficult to exaggerate the influence either of Glanville Williams' book or of Kamisar's rebuttal in the debate over legalisation of euthanasia. These set the terms of the debate for much of the next fifty years. Following Williams, euthanasia, and latterly physician assisted suicide, another form of "medically assisted dying", have continued to be advocated as progressive causes, and opposition has continued to be caricatured as exclusively religious (Battin 1998). Following Kamisar, the dominant political argument against changing the law has been based on some form of slippery slope (Gay‐Williams 1983; Gelfand 1984).[ii]

The major change between the Kamisar / Williams debate and contemporary slippery slope arguments on euthanasia is that since 1984, there has been a major jurisdiction that has

tolerated voluntary euthanasia: the Netherlands. This legal toleration was subsequently formalised through statute and other jurisdictions have also brought in legislation for euthanasia (Belgium and Luxembourg) or physician assisted suicide (Oregon and Washington). These legal changes allow the predictions of Kamisar and others to be tested empirically. Does evidence from these countries bear out the presence of a slippery slope, or, on the contrary, does it demonstrate that euthanasia or physician assisted suicide can be regulated effectively without adverse effects on the vulnerable, on those who cannot consent, or on standards of palliative care?

In principle it would seem straightforward to evaluate the empirical evidence for or against a slippery slope. In practice this is complicated by many factors, not least the difficulty of international comparisons or of discovering how much practice falls outside regulations and reporting (before and after legalisation) (for some discussion of these difficulties see for example Lewis 2007). Furthermore, the evidence that has been collated provides such an embarrassment of riches (thousands of cases a year analysable in many different ways) that advocates and opponents both have some scope to see in the data the conclusions they wish to see.

There is, perhaps unsurprisingly, little sign as yet of a consensus as to the interpretation of this data. Even where opponents can show clear abuse (for example the thousand plus deaths a year without consent uncovered by the first Remmelink Report (Amarasekara and Bagaric 2001, p. 188; Keown 1995, p. 269; Keown 2002, p. 94)), this does not show that the abuse was *due* to the legalisation of euthanasia, still less does it show that euthanasia will *necessarily* cause such abuse. Similarly, even where proponents can show evidence of a decline in reported cases between two well-chosen points (as is possible, for example, in the Netherlands between 2001 and 2005) this does not show that the underlying trend is downwards nor does it show that there is not a slippage in some other respect, for example in relation to the categories of patients affected. Finally both opponents and proponents face the difficulty of integrating recorded data on voluntary euthanasia and non-consensual life-termination with the growth or decline in what are often seen as separate practices, such as withdrawal of treatment or terminal sedation, sometimes with the aim of ending life. Advocates and opponents of euthanasia are thus in a continual struggle to out-narrate one another and to show that taken as a whole this great human experiment is either a reassuring success or is a salutary warning.

Without understating the importance of continued empirical research on euthanasia and continued analysis of new data, there is an evident need for supplementary arguments which could give clarity to this debate. Just as data from epidemiology needs to be supplemented by research into the biochemistry and causal workings of disease, so empirical research into an alleged “slippery slope” needs to be supplemented by rigorous analysis of the logic of the policy and its implications. In a short but clear-sighted article in 1971 Paul Ramsey drew attention to the role of “principle” in slippery slope arguments. “There is always some principle behind the wedge hammering it in… some flaw in moral reasoning… urges us down slippery slopes.” (1971, p. 11) The principle at stake, that is, the inner logic of a proposal, provides a credible mechanism for a slippery slope argument. Thus, in addition to empirical slippery slope arguments based on prediction (before the fact)

or reported evidence (after the fact), it is possible to construct "logical slippery slope" arguments which begin with an analysis of the proposal and aim to demonstrate that this leads logically to an unacceptable conclusion. This paper will examine a recent example of a logical slippery slope argument about euthanasia, but before considering this particular argument it is helpful to consider the slippery slope as a form of argument more generally.

The validity of slippery slope arguments

Slippery slope arguments take the form,

> we should resist some practice or policy [at the top of the slope] on the grounds that allowing it could lead us to allow some other practice or policy that is clearly objectionable [at the bottom of the slope]. (Lode 1999, p. 1471)

Between top and bottom may be many little steps, many gradations, and the slope is slippery because it is impossible to decide "where do you draw the line?" (Schauer 1985, p. 378) If we step on to the top of the slope then we find ourselves sliding inexorably towards the bottom. Slippery slope arguments (or a different metaphor for the same kind of argument is "the thin end of the wedge", or again "opening the floodgates") are extremely common in politics and in practical ethics. Eric Lode cites examples of such arguments used to oppose,

> gun control legislation, prohibitions on flag burning, the banning of racist 'hate speech' on college campuses, decriminalizing marijuana, requiring HIV-positive physicians to disclose their HIV status to their patients… abortion, human gene therapy, [and] various kinds of searches and seizures conducted without a valid warrant. (Lode 1999, pp. 1472-1473)

It would not be difficult to add to the list. Politicians and commentators both on the left and on the right use "where do you stop?" arguments to defend the status quo against moves that they believe will have bad consequences further down the line. Nevertheless, while common in popular debate, slippery slope arguments "have a bad philosophical reputation" (Enoch 2001, p. 629) and logicians often include "the slippery slope" in lists of fallacies. This is because the greater the number of steps, the less secure the path from A to B. A good example of this is a speech made by Clarence Darrow in the famous Scopes "monkey trial" of 1925.

> If today you can take a thing like evolution and make it a crime to teach it in the public school, tomorrow you can make it a crime to teach it in the private schools, and the next year you can make it a crime to teach it to the hustings or in the church. At the next session you may ban books and the newspapers. Soon you may set Catholic against Protestant and Protestant against Protestant, and try to foist your own religion upon the minds of men. If you can do one you can do the other. Ignorance and fanaticism is ever busy and needs feeding. Always it is feeding and gloating for more. Today it is the public school teachers, tomorrow the private. The next day the preachers and the lectures, the magazines, the books, the newspapers.

> After [a]while, your honor, it is the setting of man against man and creed against creed until with flying banners and beating drums we are marching backward to the glorious ages of the sixteenth century when bigots lighted fagots to burn the men who dared to bring any intelligence and enlightenment and culture to the human mind. (Moran 2002, p. 92)

While this is a great piece of rhetoric, a moment's reflection is enough to make us doubt that a restriction on what is taught in a state school in America in the twentieth century would in fact lead inexorably to burning people for heresy. In this example many of the steps are unconvincing but even if each had more plausibility, the sheer number of steps makes the argument as a whole implausible.

On the other hand while some examples of slippery slope arguments are implausible and exaggerated rhetoric, there are significant changes that happen gradually where the first small step has been an important stage in the establishment of a much bigger change. Volokh illustrates this by juxtaposing two judgements (Volokh 2003, p. 1136):

> Sandra Starr, vice chairwoman of the Princeton Regional Health Commission . . ., said there is no "slippery slope" toward a total ban on smoking in public places. "The commission's overriding concern," she said, "is access to the machines by minors."
>
> New York Times, Sept. 5, 1993, § 1, at 52.
>
> Last month, the Princeton Regional Health Commission took a bold step to protect its citizens by enacting a ban on smoking in all public places of accommodation, including restaurants and taverns. . . . In doing so, Princeton has paved the way for other municipalities to institute similar bans . . . .
>
> The Record (Bergen County), July 12, 2000, at L7.

This can also be seen by considering the strategy of someone who wants to effect a major change. If it is not possible to effect change all at once (in Volokh's example, a ban on smoking in public places) reformers might first attempt to make some seemingly insignificant change (restricting the access to cigarette machines) and then use this as a precedent for further changes. If this "device of stages" is a good strategy for someone who wishes to effect a major change then concern about "where this will all lead" is at least sometimes a good reason for resisting a seemingly insignificant change (Enoch 2001, p. 634). As Sissela Bok remarked, if slippery slope is an argument for caution sometimes that caution is justifiable. (1971, p. 11)

Hence despite an evident distaste among some philosophers for this "rather shady" (Dworkin 1990, p. 42; Whitman 1994, p. 85) style of argument, there is a general if reluctant (e.g. Enoch 2001; LaFollette 2005) consensus in the philosophical literature that empirical slippery slope arguments can be valid and many regard them as useful (Govier, 1982; Lamb 1988; van der Burg 1991; Williams 1995; Lode 1999; Volokh 2003). These arguments are

valid, insofar as there is good reason to think that the policy under consideration will in fact make more likely the establishment of an objectionable policy.

Logically slippery slopes

In addition to such "causal" (Johnson and Blair 1977, pp. 163-169), "psychological" (Rachels 1986a, pp. 172-173), or "empirical" (Glover 1977, pp. 165-168) slippery slope arguments, philosophers commonly describe at least two forms of *logical* slippery slope. The first is what Trudy Govier calls the *conceptual*, "relating to vagueness" (1982, p. 303). This Glover (1977, p. 166) and Walton (1992, ch. 2) simply call "the logical slippery slope", and van der Burg calls it "L_2": his second kind of logical slippery slope (1991, p. 62). This argument rests on the claim that where there are a number of small steps, none of which is significant in itself, then there is no way to distinguish between the very first and the very last stage. If you take the first step then you have no reason to stop until you reach the last step. This is sometimes illustrated by a gruesome (though seemingly mythical) experiment in which a bucket of water containing frogs is gradually heated. The bucket is set up so that the frogs can jump out at any point, but if the temperature is raised each time by only tiny amounts then there is never a change that is big enough to trigger the frogs to act. The result, so goes the cautionary tale, is that some frogs stay in the bucket until they are boiled to death.

This form of argument is analogous to the ancient "sorites paradox": that taking one grain of sand makes no difference to a heap – it was a heap before and will be a heap afterwards – but if you carry on taking away one grain at a time then eventually there will be no heap at all! (Williamson 1994, ch. 1) There is never a single point when the heap ceases to be a heap, and there is no obvious place to draw a line, but you know that if you keep taking grains away then it will cease to be a heap. Govier gives a similar example: one hair more or less does not make the difference between being bald and not being bald but nevertheless if you lose all your hair one hair at a time then you will become bald (1982, p. 304).

The sorities paradox relies on the fact that there is no non-arbitrary place to draw a line when applying the somewhat vague concepts of ordinary life – like heaps and baldness. Nevertheless, in practical matters this problem can be solved by drawing a line that has an element of arbitrariness. Arbitrariness is unreasonable or unfair where there is a clear reason to choose one thing rather than another, but in the absence of clarity it is not unreasonable to draw a somewhat arbitrary line. Better this than no line. This can be illustrated by the example of speed limits: "A supporter of the logical version of the wedge argument might argue that either we should ban cars altogether or else allow driving at any speed anywhere." (Glover 1977, p.166). This example shows that the conceptual form of logical slippery slope is a fallacy. Even though one mile-an-hour more or less makes little difference this is not a valid argument against setting a speed limit. Speed limits are set by an imprecise balancing of danger and inconvenience and then rounded up or down (significantly, whether in miles-per-hour or kilometres-per-hour, speed limits are generally some multiple of five). This is clearly a useful thing to do notwithstanding the fact that there is some element of arbitrariness in where precisely the line is drawn. The conceptual slippery slope may represent a practical danger – that people will fail to draw a line because they are not forced to do so at any particular point – but this danger can be addressed

reasonably by deciding in advance on arbitrary lines. As John Harris says, “slopes are only slippery if they catch us unawares and we have strayed onto them inadequately equipped” (1985, p. 127). Hence, whereas empirical slippery slope arguments can be valid if they are well grounded, a logical slippery slope argument that relies on *conceptual* vagueness is never valid: it is a fallacy.

A second form of logical slippery slope is the *precedential* “relating to the need to treat similar cases consistently” (Govier 1982, p. 303). This is what James Rachels refers to as “the logical slippery slope’” (1986a, p. 72) and what van der Burg calls “L_1”: the first kind of logical slippery slope argument (1991, p. 44). This seems to be what Ramsey had in mind when he wrote that there is “always some principle behind the wedge hammering it in” (1971, p. 11). Such arguments rest on the claim that the justification for A will also apply to B. If we accept A then this is a “precedent” for accepting B.

Some people have disputed that this is really a slippery slope argument, preferring to call it an argument from consistency (Enoch 2001, p. 644; Smith 2005, p. 229) or an appeal to pernicious precedent (Den Hartogh 2009) or *reductio ad absurdum*. Nevertheless, it has a family resemblance to other forms of the slippery slope argument, and is commonly categorised together with them. Govier points out that it is often combined with a causal slippery slope argument, so that the force of the precedent is (at least in part) a *cause* that leads people down the slope to more objectionable practices (1982, p. 313). In any case it is difficult to see what is at stake in the debate over which arguments are called slippery slope arguments or whether they should be called something else. The key question is whether a precedential slippery slope argument can be valid and several authors argue convincingly that can be. Van der Burg puts the matter with admirable clarity: “Whenever it is demonstrated that there are no relevant differences between A and B and that B is clearly morally wrong, this is a valid and conclusive reason to reject A as well.” (1991, p. 45)

There is a strong reason for saying that logical slippery slope arguments that appeal to precedent or consistency can be valid, inasmuch as the same justification that applies to A also applies to B. Nevertheless, a number of authors have contended that this logical slippery slope argument is also a fallacy. The argument is set up so that the first step A is *prima facie* acceptable whereas the conclusion B is clearly objectionable. This is the whole point of using a slippery slope argument rather than examining the morality of A in its own right. Yet if there is an apparent difference between A and B this will be enough to contradict the premise that there are “no relevant differences” between A and B. As Govier argues, “if [A] is acceptable and the others are not, then there must be a relevant difference between them” (1982, p. 310). This point is reiterated by Enoch, “that like cases ought to be treated alike cannot serve as a justification for moving from the permissible A to the impermissible Z- because A and Z are not *like cases*” (Enoch 2001, p. 645 emphasis added, see also Lode 1999, p. 1487; Rachels 1986b, pp. 69-70).

If the logical slippery slope did indeed move from a permissible A to an impermissible Z then there would seem to be some relevant difference between A and Z, as Govier and Enoch assert. However, *pace* Govier and Enoch, this kind of argument need not start with a commitment to A being in fact permissible. The argument need only start with A not yet

agreed to be impermissible, much as all *reductio ad absurdum* arguments start by accepting the premise for the sake of the argument until it is shown to result in an absurdity. This point needs to be understood when characterising slippery slope arguments in general, as noted by van der Burg (1991, p.42):

> The basic structure of the argument is rather simple: if we allow A, B will necessarily or very likely follow (for A and B we can fill in certain acts or practices like euthanasia); B is morally not acceptable; therefore, we must not allow A either. Sometimes a further requirement is added: that A is in itself morally neutral or even justifiable. This does not seem to me a useful qualification: often the question is precisely whether A is justifiable, because the proposed principles that seem to justify A would justify B as well, and might therefore not be sound after all.

The premise that "the proposed principles that seem to justify A would justify B as well" forms the basis of a precedential logical slippery argument. This could be expressed as "there are no relevant differences between A and B" (e.g. van der Burg 1991, p.45) but it then becomes difficult to determine what counts as "relevant" differences. The key point is rather to establish a relevant *similarity* on the matter of ethical principle. If accepting A involves accepting principle X, and if principle X also justifies B, then accepting A will make it more likely that B will be accepted, notwithstanding that there may also be significant differences between A and B.

It may be objected that a logical slippery slope is of no practical concern because people are often inconsistent and are not led primarily by logic. Furthermore, "whether the arguments do have this [social] force clearly depends on empirical processes" (van de Burg 1991, p.48). Nevertheless, while there are many non-rational forces in society that influence actions, these other forces are not consistent or reliable. In contrast the inner rationale of a policy or proposal will create a constant and consistent pressure in a particular direction. The logical slippery slope explains the gravity that pulls us down the slope. We noted above the view of John Harris that "slopes are only slippery if they catch us unawares" (1985, p. 127), but this is true only for the *empirical* slippery slope, or the *conceptual* kind of logical slippery slope argument. If the slope is a *valid precedential logical slippery slope* then it will be our very reasoning that impels us down the slope. An argument is not like a bus where you can get off at any stop you like: once you have accepted the premises you have to follow it to the end of the line.

A precedential logically slippery slope argument may therefore be a valid argument. However, this does not show that all arguments of that form are in fact valid, any more than all empirical slippery slope arguments are valid. As an empirical slippery slope argument will fail if it fails to establish a causal relationship, a precedential logical slippery slope argument will fail if it rests on a faulty analogy (Govier 1982, p. 305). To be valid and persuasive a precedential slippery slope argument will have to identify the principle in common and thus demonstrate that the cases are in fact relevantly similar. The remainder of this article examines an example of a precedential logical slippery slope argument in relation to euthanasia: John Keown's argument that accepting voluntary euthanasia leads logically to the acceptance of non-voluntary euthanasia.

Keown's logical slippery slope argument

In his book *Euthanasia, Ethics and Public Policy* (2002), John Keown sets out a logical slippery slope argument against legalising voluntary euthanasia, and then supplements this with evidence of an empirical slippery slope in practice. This mixing of logical and empirical forms of the argument produces what Govier describes as a "real slippery slope" (1982, p. 313). Indeed Den Hartogh claims that, while "logical slippery slope arguments" are typically distinguished from "causal arguments" in theory, "in practice this logical form is almost always incorporated into a prediction" (2009, p. 322). Nevertheless, the logical slippery slope that Keown sets out is presented as valid independent of further empirical evidence. Indeed while many commentators opine that "the empirical slippery slope argument has the most credibility and is most often used by opponents of the legalization of euthanasia or assisted suicide" (Lewis 2007 p. 197) Keown regards the logical form of the slippery slope argument against euthanasia as "even more formidable" (2002, p. 76) than the empirical argument. Given the significance of empirical versions of the slippery slope argument in the euthanasia debate over the last fifty years, the claim that there is there is a logical slippery slope that is "even more formidable" certainly warrants careful examination.

Keown's version of the logical slippery slope is clearly focused. He does not attempt to show that legalising euthanasia will inevitably lead to the atrocities that are associated with the Nazis (as does Grisez 1980), nor that numbers of those killed will inevitably rise, nor that palliative care will inevitably suffer, nor that discrimination against the elderly or the disabled will inevitably increase. He does not claim that allowing voluntary euthanasia will necessarily lead to "involuntary" active euthanasia (IVAE), i.e. killing against the wish of the person who is killed.[iii] Keown seeks to establish only two relatively modest conclusions:

(1) that "acceptance of VAE [voluntary active euthanasia] leads to the acceptance of NVAE [non-voluntary active euthanasia, where the patient is unable to express consent]" (2002, p. 76);
(2) and that "if the core justification of VAE is thought to be respect for patient autonomy, this is surely logically inconsistent with the requirement that the patient be suffering unbearably" (2002, p.79).

Keown's starting point for his argument is the fact that in the case of voluntary euthanasia, unlike suicide, what is necessary is not only the will and judgement of the patient but also the will and judgment of the doctor. This immediately leads to the question of why the doctor acquiesces in the patient's request. Before acting, the doctor must judge the patient's request to be justified such that acceding to the request would constitute a benefit to the patient. Crudely speaking, the doctor must decide whether to agree with the patient that "the patient would indeed be better off dead" (Keown 2002, p. 77). However, if the doctor can make such a judgement in the case of a competent patient, then the doctor can equally make an analogous judgement in the case of an incompetent patient. Keown illustrates this by considering the following example:

> Imagine two patients of Dr A: X and his brother Y. They are identical twins, with an identically painful terminal illness and suffering to an identical degree. They lie, side by side, in hospital. X, who is competent, pleads with Dr A for a lethal injection of potassium chloride because the "suffering is unbearable". Dr A agrees that death would indeed be a benefit for X and agrees to administer the injection to give him a "merciful release". X requests the same for his brother Y, who is incompetent, on the ground that he, too, must be experiencing "unbearable and useless" suffering. Is Dr A to deny Y the same benefit he has agreed to confer on X? If so, what has become of the doctor's duty to act in the best interests of his patient? (Keown 2002, p. 78)

The common feature which does the work here is the judgement that death may be a benefit. If death would be an overall benefit then it seems wrong to deprive someone of this benefit merely because he or she is not able to request it. In defence of this logical link between VAE and NVAE Keown states that "many leading philosophical advocates of VAE, such as Peter Singer and Helga Kuhse, Jonathan Glover and John Harris, also condone NVAE". (Keown 2002, p.79) These advocates of euthanasia are credible witnesses to the logic of their own position. Keown does not provide quotations from these philosophers but he easily could have. For example, Jonathan Glover has argued in print that

> Where someone is not able to express his own view about being alive or dead, it may sometimes happen that we think that his life is not worth living… Once there are grounds for thinking that someone would be better off dead, the argument seems to glide disturbingly smoothly towards the conclusion that undiluted killing is right where weaker policies fail to bring about the same result. I do not wish to retreat from this view…
> (Glover 1977, p. 194, p. 201)

Keown could also have quoted other less well known advocates of euthanasia such as Steven Neeley who, in the context of arguing that there is no slippery slope from VAE to IVAE, nevertheless concedes the logical link between VAE to NVAE. When the patient is not competent and "a situation calling for active voluntary euthanasia should present itself" then the decision should be "guided by the humanitarian credo of seeking to effect the will and best interest of the patient." (Neeley 1994, p. 64) The key logical move, which Glover and Neeley are clear-sighted enough to acknowledge, is that if euthanasia is regarded as being in the "best interest" of a competent patient who requests it, then it can also be in the "best interest" of an incompetent patient who is not able to request it.

Having set out an argument that acceptance of VAE implies acceptance of NVAE, Keown imagines an advocate of euthanasia who denies that the doctor can or should make judgments about whether the patient is "better off dead". Such an advocate might assert that only the patient is in a position to make this judgement, in which case there would be no slippage to non-voluntary euthanasia. However, the price for this move is very high. For if the acceptance of the doctor is made not on the basis of overall benefit but only out of "respect for the patient self-determination" (Keown 2002, p. 79) how can this be limited to patients who are suffering unbearably? If the doctor cannot make a judgment as to what is beneficial for the patient then the doctor cannot limit euthanasia to cases of unbearable

suffering. The attempt to resist the move from VAE and NVAE by asserting the right of patients to self-determination thus leads to a second slippery slope towards including an ever larger category of patients not limited only to the terminally ill or those with "unbearably suffering".

On the basis of these two logical slippery slopes Keown concludes that while legislation might be framed to limit euthanasia to euthanasia "upon request" by patients experiencing "unbearable suffering" the justification for euthanasia "when taken to its logical conclusion" would apply equally to those who cannot request and to those with less severe suffering (Keown 2002, p. 80).

Criticisms of Keown's argument

Keown has constructed two prima facie credible logical slippery slope arguments in relation to euthanasia: from VAE to NVAE; and from restricting VAE to "unbearable suffering" to allowing VAE on request. In the light of Keown's argument[iv] it is no longer sufficient merely to dismiss the logical slippery slope against euthanasia as "very weak" (Shand 1997, p. 45) without further argument, nor to assert that "there is no logical reason to progress from VE to NVE" (Savulescu 2005, p. 15) or that "there is nothing logically inconsistent in supporting voluntary euthanasia while rejecting non-voluntary euthanasia as morally inappropriate" (Young 2010). Keown has presented just such a "logical reason" which, if valid, shows that it is indeed "logically inconsistent" to support voluntary euthanasia while resisting the move to non-voluntary euthanasia. If someone wishes to accept the one and oppose the other, and at the same time avoid the charge of logical inconsistency, then he or she must show the flaw in Keown's reasoning.

The challenge presented by Keown's arguments has been taken up in two substantial treatments by Hallvard Lillehammer (2002) and Stephen Smith (2005). Both critics acknowledge the potential significance of Keown's argument and pay him the compliment of constructing a detailed rebuttal. Indeed Smith goes so far as to say that "if any logical slippery slope argument is expected to work it is likely to be one such as Keown's" (Smith 2005, p. 225).

Nevertheless, while these critics consider Keown's logical slippery slope argument to be worthy of consideration, both argue that the argument in fact rests on a logical confusion. Lillehammer construes Keown's argument as a "dilemma" (Lillehammer 2002, p. 546). Either it is the idea of patient benefit that really does the work, in which case there is a slippery slope from VAE to NVAE, or it is patient autonomy that really does the work, in which case there is a slippery slope from "unbearable suffering" to permitting euthanasia on request for any patient. However, according to Lillehammer, this dilemma is troubling only if patient benefit and patient autonomy are regarded as independently justifying euthanasia. For someone who takes *both* to be necessary there is no inconsistency in accepting voluntary euthanasia for unbearable suffering, while rejecting both non-voluntary euthanasia and voluntary euthanasia on request for any patient. While Lillehammer does not express this in terms of formal logic, his point could be made by saying that if "A and B" is true then "A and not B" will be false and "B and not A" will be false.

Smith regards Lillehammer as having exposed the fallacy at the heart of Keown's argument: "Keown's argument confuses a *necessary condition* with a *sufficient condition*" (2005, p. 231).[v]

Lillehammer and Smith both press the point by re-examining Keown's illustration of the identical twin brothers X and Y. They portray Keown's argument as resting on the claim that the doctor must treat brothers X and Y identically or be charged with inconsistency. Yet in reality no two human beings are so alike that treating X in one way logically commits you to treating patient Y in exactly the same way. "Even identical twins who are very close in many ways (which is presumably why the hypothetical makes the two patients twins) are not identical in every respect" (Smith 2005, p. 233). This is evidently the case in relation to the experience of suffering, which may vary greatly from one person to another. It is also the case that direct communication with X gives the doctor a better quality of evidence of suffering than he has in the case of Y where he is relying on what someone else (albeit someone very close to the patient) says about him. "Since we do not know what Y wants, he is not, nor can he be, subject to *exactly* the same treatment" (Smith 2005, p. 233 emphasis added). Patient X is also conscious of his suffering, which Y may not be, and this also, arguably, puts the patients in different categories. This is not to deny that the doctor might think the same course of action is appropriate both for X and for Y, but "this will *not* be for *precisely the same reasons*" (Lillehammer 2002, p. 550). Thus a doctor is not necessarily inconsistent if he acts differently towards X and Y.

Lillehammer has proposed an elegant rebuttal of Keown which is followed in all its essentials by Smith. They charge Keown a logical confusion of necessary and sufficient conditions and use his own illustration against him to show that there are morally relevant differences between X (who requests euthanasia) and Y (who cannot request). However, while Lillehammer and Smith have shown that there are differences in these cases, this does nothing to undermine Keown's claim that there is also a relevant similarity in these cases capable of providing a logical precedent for non-voluntary euthanasia. Furthermore, the counter argument of Lillehammer and Smith rests on the assertion that "both the doctor's judgment and the autonomy interest of the patient are necessary to provide a sufficient justification", (Smith 2005, p.232). Yet neither Lillehammer nor Smith provides an adequate justification for this assertion and to accept it as an axiom without further argument seems to beg the question.

In the remainder of the present article Keown's argument is restated to show more clearly that it need not fall prey to the fallacy identified by Lillehammer. The axiom invoked of Lillehammer and Smith is then set in the wider context of autonomy and best interests in medical decision making. This helps clarify the principle at work in the logical slippery slope from voluntary to non-voluntary euthanasia.

A revised statement of Keown's argument

Smith calls attention to an important passage in which Keown characterises the relation between the patient's request and the doctor's action.

> Consequently, the real, rather than the rhetorical, justification for VAE is not the patient's autonomous request but *the doctor's judgment that the request is justified because death would benefit the patient*. True, in the proposals currently advanced by campaigners for VAE, this judgment would not be made without a prior, autonomous request by the patient. But even under such proposals the autonomous request is not decisive. It serves merely to trigger the *doctor's* judgment about the merits of the request.
> (Keown 2002, p. 77 quoted by Smith 2005, p. 227. The emphasis is Keown's and is retained by Smith.)

This, as Smith rightly observes, "downplays the role of autonomy, and, in fact, reduces it to a rhetorical tool" (2005, p.228). No doubt Keown uses the language of "the real… justification" as opposed to "merely the trigger" in order to emphasise the role that the doctor's judgement plays in the decision. However, by describing the role of patient autonomy in such dismissive language Keown overstates his case and endangers his conclusion. Patient autonomy has an important role in medical decision making, not only in "triggering" the doctor's decision (based on impersonal criteria) but in constituting an important element of the human good (and hence patient benefit). Certainly the principle of patient autonomy has sometimes been presented in an extreme or exaggerated way, as though the doctor's role should be purely passive or mechanical (Callahan 1992). Nevertheless, the truth lies between these extremes and Keown's argument neither needs nor is served by his rhetoric. Keown does not need to show that the doctor's decision is more important than the patient's autonomous wishes (is the "real… justification"). He only needs to show that the doctor's decision *necessarily involves* a judgment about patient benefit.

If the doctor's decision to implement VAE involves a judgement that euthanasia is of overall benefit to the patient, then it is possible for doctors to make such judgements. However, if it is possible for doctors to make such judgements then *it cannot be ruled impossible* for the doctor to make such judgements in the case of non-competent patients. This does not imply, as Lillehammer and Smith read Keown as saying, that any two particular competent and non-competent patients must be treated identically. On the contrary, Lillehammer and Smith convincingly show that Keown's illustration proves the contrary. Treatment of a competent patient will involve communication with the patient and decision-making by the patient. Treatment of a non-competent patient, on the other hand, will rest on a best interest decision by someone else on behalf of the patient. However, it is Lillehammer and Smith who import the language of "exactly the same treatment" (Smith 2005, p. 233) for "*precisely the same reasons*" (Lillehammer 2002, p. 550). Keown neither asserts this nor needs to assert this. His argument is more modest: if a swift and easy death would benefit X then why would it not also benefit Y?

The key element of Keown's argument thus survives the criticisms of Lillehammer and Smith. It is not necessary to the argument to assert that the best interest decision of a doctor on its own is the "real" justification to treat X and Y. It is only necessary to assert that the doctor's judgment of patient benefit plays an essential role in both decisions, and

that conceding the principle that "a doctor can make the judgement that the patient would be better off dead" will necessarily affect judgments about non-competent patients. The key question is not whether a doctor is *obliged always* to make the same judgement about X and Y but whether he is *permitted sometimes* to make the same decision. If it is possible for the doctor to agree with X that he is better off dead then how can it be impossible to judge that Y might also be better off dead? If the doctor is able to make such a judgement and to act on it then NVAE is acceptable in principle. Hence Keown's argument demonstrates that acceptance of VAE implies acceptance in principle of NVAE.

In practice, as Glover remarks, "where someone is not able to express his own view about being alive or dead, it may sometimes happen that we think that his life is not worth living" (1977, p.194). It is not difficult to imagine why someone might think this. Someone may, for example, think he himself would not wish to live in such conditions, or may have evidence that the patient previously expressed a wish not to live in such a state, or may have the evidence of the patient's character from someone who knew him or her well, or perhaps all of the above. People are naturally uncomfortable with the idea of a doctor making a judgment on behalf of someone else that this person would be better off dead. Nevertheless, what Keown has shown convincingly is that this judgement is already implicit in the proposal to permit voluntary euthanasia. For a doctor must *agree* that euthanasia is indicated, and hence must make an *independent judgement* that death would be a benefit to this patient.

The second slippery slope

The first of Keown's logical slippery slopes is therefore valid and can be stated in a way that does not involve a fallacy. However, there is a problem with the way in which Keown presents his second logical slippery slope argument. The second argument starts with the premise that VAE is justified purely by appeal to patient autonomy and does not require a doctor to make a judgment about patient benefit. If this premise is accepted then this will indeed lead to a slippage from narrow criteria of "unbearable suffering" to acceptance of euthanasia on request. However, this premise is incompatible with the premise in his first argument. These arguments pull in opposite directions and therefore they cannot be used to show that acceptance of VAE will lead *simultaneously* to a slippery slope to NVAE and to a slippery slope to euthanasia on request.

If there is slippage to NVAE this can only be because judgements are made about patient benefit, but these very judgements will counteract the second kind of logical slippery slope. If Keown's argument is construed as a dilemma then at best this will show that either one slippery slope will occur (to NVAE) or another slippery slope will occur (to euthanasia on request). It cannot show that VAE will necessarily to extended "to patients who are incompetent *and* who are not suffering unbearably" (Keown 2008, p.80 emphasis added).[vi]

More care is needed therefore about how these two arguments might relate to one another. The second argument is based on a premise that is incompatible with the premise in the first argument. Furthermore the idea that autonomy alone provided sufficient reason for medical intervention undermines any sense of medical care or professionalism. The

second horn of Keown's dilemma in fact serves as a *reductio ad absurdum* of its premise. Construed in this way *the second argument helps establish the premise for the first argument*, that is, the necessity for a doctor's independent judgement of patient benefit. It should also be noted that the premise of the logical slippery slope argument will then be one that is accepted by critics such Lillehammer and Smith (see also Scoccia 2005). These authors agree that a judgment about patient benefit is a necessary element of the justification of euthanasia.

Keown may have evidence of an empirical slippery slope in relation to the "unbearable suffering" criterion, and may regard the concept of autonomy as playing a pernicious role in this, but he cannot appeal to a *logical* slippery slope to establish this while at the same time insisting, rightly, that VAE necessarily involves a decision about patient benefit. Thus Keown's second conclusion, that there is a logical slippery slope to euthanasia on request, is effective only for those who accept its premise. However, if the second argument is used as a *reductio* it can buttress the premise in Keown's primary argument, which is a premise fully consonant with good medical practice, and this adds cogency to the logical slippery slope from VAE to NVAE. Hence responding to the criticisms of Lillehammer and Smith generates an argument that is more cogent though narrower in its conclusion.

'Assisted dying' and end of life medical decision making

The force of Keown's logical slippery slope can be confirmed by applying to VAE some well-established general principles of medical decision making. In general, judgements about patient benefit guide the doctor in which treatments to offer patients and how to respond to requests for treatment (in the case of competent patients), while they justify treatment in the absence of consent (in the case of non-competent patients). If, for the sake of argument, euthanasia is classified as a legitimate form of medical assistance in dying[vii] then one can see how the principles of patient autonomy and patient benefit would then apply.

The United Kingdom's General Medical Council has set out a basic model for medical decision making which it invokes throughout much of its more specific ethical guidance. This basic model is helpful not because it is novel but precisely because it is not. The model gives expression to standards of ethical practice that are widely acknowledged in different jurisdictions and upheld by many different schools of moral philosophy and jurisprudence. The standard model is set out (GMC 2008, para 5) as follows:

> If patients have capacity to make decisions for themselves, a basic model applies:
>
> (a) The doctor and patient make an assessment of the patient's condition, taking into account the patient's medical history, views, experience and knowledge.
>
> (b) The doctor uses specialist knowledge and experience and clinical judgement, and the patient's views and understanding of their condition, to identify which investigations or treatments are likely to result in overall benefit for the patient. The doctor explains the options to the patient, setting out the potential benefits, risks, burdens and side effects of each option, including the option to have no treatment.

> The doctor may recommend a particular option which they believe to be best for the patient, but they must not put pressure on the patient to accept their advice.
>
> (c) The patient weighs up the potential benefits, risks and burdens of the various options as well as any non-clinical issues that are relevant to them. The patient decides whether to accept any of the options and, if so, which one. They also have the right to accept or refuse an option for a reason that may seem irrational to the doctor, or for no reason at all.
>
> (d) If the patient asks for a treatment that the doctor considers would not be of overall benefit to them, the doctor should discuss the issues with the patient and explore the reasons for their request. If, after discussion, the doctor still considers that the treatment would not be of overall benefit to the patient, they do not have to provide the treatment. But they should explain their reasons to the patient, and explain any other options that are available, including the option to seek a second opinion.

If this scheme were applied to euthanasia then it would clearly rule out IVAE as it states that patients "have the right to accept or refuse an option" (GMC 2008, para 5(c)). Furthermore the guidance states that a doctor "must not put pressure on the patient to accept" a particular option (para 5(b)). Nevertheless, a doctor may properly "recommend a particular option which they believe to be best for the patient" (para 5(b)). Thus if euthanasia were regarded as a legitimate medical option then it would be an option that a doctor could recommend and could bring up spontaneously with the patient. This is not an arbitrary move but is simply an implication of the premise that euthanasia could be thought of as beneficial and as a possible option in medical practice.

The GMC guidance also brings out well the principle that doctors must "identify which investigations or treatments are likely to result in overall benefit for the patient" (para 5(b)). This shows how a doctor's judgment of "overall benefit" plays a role in what options to propose and in what requests of the patient to accept. If the doctor "considers that the treatment would not be of overall benefit to the patient" (para 5(d)) then he or she should not provide the treatment. Applied to euthanasia this simply illustrates Keown's central point that the doctor must make a judgement about patient benefit before agreeing to a request for VAE.

The GMC have also provided guidance on treatment of patients who cannot consent, especially in the context of end of life decisions. This is complicated by the possibility that patients may have made advance refusals of treatments or made arrangements to appoint a proxy decision-maker, the legislation for which varies in different parts of the United Kingdom and even more between other jurisdictions. Nevertheless the overall structure of the decision making is of general relevance:

> (a) The doctor, with the patient (if they are able to contribute) and the patient's carer, makes an assessment of the patient's condition taking into account the

> patient's medical history and the patient and carer's knowledge and experience of the condition.
>
> (b) The doctor uses specialist knowledge, experience and clinical judgement, together with any evidence about the patient's views (including advance statements, decisions or directives), to identify which investigations or treatments are clinically appropriate and are likely to result in overall benefit for the patient.
>
> (f) In circumstances in which there is no legal proxy with authority to make a particular decision for the patient, and the doctor is responsible for making the decision, the doctor must consult with members of the healthcare team and those close to the patient (as far as it is practical and appropriate to do so) before reaching a decision. When consulting, the doctor will explain the issues; seek information about the patient's circumstances; and seek views about the patient's wishes, preferences, feelings, beliefs and values. The doctor may also explore which options those consulted might see as providing overall benefit for the patient, but must not give them the impression they are being asked to make the decision. The doctor must take the views of those consulted into account in considering which option would be least restrictive of the patient's future choices and in making the final decision about which option is of overall benefit to the patient.
>
> (i) If a legal proxy or other person involved in the decision making asks for a treatment to be provided which the doctor considers would not be clinically appropriate and of overall benefit to the patient, the doctor should explain the basis for this view and explore the reasons for the request. If after discussion the doctor still considers that the treatment would not be clinically appropriate and of overall benefit, they are not obliged to provide it. However, as well as explaining the reasons for their decision, the doctor should explain to the person asking for the treatment the options available to them. These include the option of seeking a second opinion, applying to the appropriate statutory body for a review (Scotland), and applying to the appropriate court for an independent ruling.
>
> (GMC 2010, para 16. Subsections (c)-(e) and (g)-(h) are here omitted as these concern technical and legal provisions on advance decisions and proxies which vary from place to place and do not alter the overall shape of the decision making process.)

It can be seen that this decision-making process reflects a significant portion of the decision-making process that occurs with competent patients. As in the case of competent patients, the doctor identifies options that may "result in overall benefit for the patient" (GMC 2010, para 16(b)). The doctor involves carers or others close to the patient in the decision because they may have knowledge of the patient's "wishes, preferences, feelings, beliefs and values" (para 16(f)). These are relevant because the judgment of overall benefit is not purely a matter of impersonal clinical factors, but also, for example, of how much of a benefit or a burden these factors would be to a particular person.

In the absence of the patient's own decision someone has to decide and this responsibility generally falls to the doctor, with assistance from carers or, if one has been appointed, to a proxy-decision maker. The doctor makes a decision based on a judgment of "overall benefit". If someone else (a carer, a relative, or a proxy) makes a request on behalf of the patient this is treated analogously to a request from the patient: it also is subject to the "overall benefit" judgment of the doctor. If the doctor does not think the option would be of overall benefit he or she does not have to provide it.

If euthanasia were to be regarded as a legitimate medical option in end of life care, then *ex hypothesi* it would be an option that would sometimes be regarded as resulting in "overall benefit" to the patient. This judgment would be necessary if a doctor were to accede to a patient's request for VAE. However, the very same judgment would permit NVAE. The fundamental logic of medical decision-making, as seen in documents such as the guidance of the General Medical Council, confirms the validity of Keown's logical slippery slope argument. A justification for VAE must involve a decision that euthanasia is of "overall benefit" and a decision that euthanasia is of "overall benefit" will be sufficient to justify NVAE in some cases.

Smith asserts that "both the doctor's judgment and the autonomy interest of the patient are necessary to provide a sufficient justification [for euthanasia]", (Smith 2005, p.232). This seems to imply that judgments of benefit in the absence of an autonomous request are contrary to respect for the patient's "autonomy interest". However, when the patient cannot request an option and has made no advance statement or plan in this regard then it cannot be contrary to autonomy to act for the patient on the basis of overall benefit. It is arbitrary to withhold from patients who cannot request an intervention which has been conceded to be of overall benefit to them. The logic of Keown's slippery slope argument is simply that "A and B" implies B. If euthanasia is justified by autonomy and benefit to the patient then it can be of benefit to the patient, and this will be of practical relevance when a person is not in a position to exercise autonomy.

The validity of this logical slippery slope argument does not, of course, decide the issue of whether it is right or wise to legalise voluntary euthanasia. Faced with the valid conclusion that VAE implies NVAE someone has two options: either to accept both together or to reject both together. As Michael Gillette observes,

> the slippery slope is a tool for clarifying the implications of our views. Either the slippery slope opens our eyes and forces us to accept as right some things that initially seemed untenable, or it shows us the unreasonableness of our initial, unreflective view.
> (Gillette2002)

What the logical slippery slope argument rules out is the supposition that we could allow the first step without committing ourselves to the conclusion. To reiterate: an argument is not like a bus where you can get off at any stop you like, once you have accepted the premises you have to follow it to the end of the line. If voluntary euthanasia were accepted as a legitimate form of medical assistance in dying it would also be acceptable for non-

competent patients. Keown's argument has indeed "raised the stakes in the euthanasia debate" (Lillehammer 2002, p. 546). Either an advocate of legalising VAE must bite the bullet and also accept NVAE or, if NVAE is regarded as too dangerous or unpalatable, this is a valid and cogent reason to reject VAE as well.

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[i] For an assessment of arguments and evidence presented in Williams' book on these various different issues see Keown and Jones 2008.

[ii] Other cultural factors have also emerged which have affected the debate, not least the rise of the palliative care and hospice movement and of the disability rights movement, both of which have been sources of opposition to euthanasia. Nevertheless, the place of slippery slope arguments in the debate continues to be central.

[iii] It is important to notice that Keown's argument establishes a logical link only between VAE and NVAE. It does not establish a link between VAE and IVAE (as Lillehammer recognises 2002, p. 547, n.6). Indeed Keown's argument reinforces the difference between NVAE and IVAE. In the case of IVAE someone is killed against his or her express wishes. This clearly contradicts the principle of autonomy. However, the treatment of non-competent patients in accordance with their overall benefit (including, *ex hypothesi*, NVAE) is *not* contrary to patient autonomy, as autonomy is not in play and the doctor has to rely on overall benefit as a guide.

[iv] Calling this "Keown's argument" is not to deny that versions of the argument have been presented before; for example by Kass (1989), Callahan (1991) (see McCarrick 1992), and Gormally (1995) whom Keown acknowledges. A similar argument is also given by Amarasekara and Bagaric (2004) on the basis of juris prudential considerations. Nevertheless Keown has produced a usefully clear statement of the argument which has attracted detailed criticism.

[v] The same argument in its essentials occurs in Battin (1998, p. 26) Dworkin (1998, p. 10), prior to Keown, and is reiterated by Griffiths (2008, p. 514).

[vi] Of course different sections of the public, politicians and doctors could slip down different slopes, so that in society as a whole there could be slippage in both directions, but whether or not this happened would be a contingent empirical question, not a matter of logic. Logically Keown offers us a choice of two slopes.

[vii] It should be noted that this premise is fiercely disputed, as euthanasia is often criticized for being incompatible with the ethos of medicine, for example by Kass (1989), Capron (1992), Jones (2007, pp.205-212). However, this is to engage in a different kind of argument: not about slippery slopes but about the morality of euthanasia per se, the role of the physician and the nature of medicine. A slippery slope argument, like a *reductio ad absurdum*, concedes a premise for the sake of argument to see what then would follow.