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Abstract	Opponents of medically assisted dying have long appealed to 'slippery slope' arguments. One such slippery slope concerns palliative care: That the introduction of medically assisted dying will lead to a diminution in the quality or availability or palliative care for patients near the end of their lives. Empirical evidence from jurisdictions where assisted dying has been practiced for decades, such as Oregon and the Netherlands, indicate that such worries are largely unfounded. The failure of the palliation slope argument is nevertheless instructive with respect to how slippery slope arguments can be appraised without having to await post-facto evidence regarding the effects of a proposed change in public policy. Close attention in particular to the norms operative in a given institution and how changes to policy will interact with those norms enable slippery slopes to be credibly appraised.	

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Palliation and Medically Assisted Dying: A Case Study in the Use of Slippery Slope Arguments in Public Policy

Michael Cholbi

Whether in the form of active euthanasia or assisted suicide, the movement for physician aid in dying continues to gain ground worldwide. As of 2018, some form of physician-assisted dying is now legally available in Belgium, Canada, Colombia, Germany, Luxembourg, Switzerland, and in seven American states. Legislative bodies continue to debate assisted dying in several Australian states, with Victoria having approved an assisted dying bill in 2017. In addition to aid in dying becoming more available in more places, it is increasingly available to a wider spectrum of patients. Belgium, the Netherlands, and Switzerland now extend the legal right to assisted dying to those with mental or non-terminal illnesses, and Belgium allows assisted dying for minors under prescribed conditions.

As access to physician aid in dying has expanded, the body of empirical evidence concerning the practice's effects has grown significantly. With Oregon having implemented its Death with Dignity Act in 1997, the Netherlands having legalized euthanasia in 2001, and several other jurisdictions now permitting physician-assisted dying, we now possess nearly a generation's worth of empirical data by which to assess the effects of expansion of physician aid in dying. Many disputes concerning the morality or justifiability of physician aid in dying are essentially immune to empirical evidence. For instance, no amount of empirical evidence can logically controvert the claim that physician aid in dying violates a cornerstone principle of medical ethics, namely that physicians may not intentionally kill (or contribute to the intentional killing of) their

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patients. However, to whatever extent debates about the moral justifiability of legalizing medically assisted dying turn on empirical questions, we are now better positioned than ever to answer those questions. More specifically, opponents of medical aid in dying have long hypothesized that its legalization or acceptance would harm patients and erode important elements of the culture of medicine—that deviating from the status quo would place us on a 'slippery slope' with unintended but terrible results.

This chapter has two objectives: The first is substantive, but modest. I will muster evidence to show that one slippery slope posited by opponents of medical aid in dying—that its introduction would set back the provision of palliative care at the end of life—has not materialized. The second is more methodological: I will offer some reflections on what we can learn about the appraisal of slippery slope arguments from the fact that these predictions concerning medically assisted dying's effects on palliative care have not been borne out. While the evidence concerning these effects is (to my mind) decisive, it would be valuable to be able to credibly appraise slippery slope arguments before the policies at issue are implemented. The palliation slope highlights several argumentative burdens that proponents of a slippery slope argument must meet in order for us to evaluate the argument's credibility prior to a policy change.

The Argumentative Dialectic Surrounding Slippery Slopes

The literature on slippery slope arguments agrees on their general contours: An initial, seemingly acceptable, deviation from the status quo is instigated that in turn leads to an outcome morally worse than the status quo. We should, according to such reasoning, therefore reject the initial deviation on the grounds that it will culminate in a morally worse state of affairs overall. The plausibility of slippery slope arguments thus turns partially on their empirical predictions. In the case of assisted dying, these arguments are typically put forth against a background in which the status quo allows for individuals to refuse or forego treatments or medical interventions that may extend their lives but disallows physicians (or anyone else) from assisting individuals in measures intended to shorten their lives. The slippery slope arguments against assisted dying thus predict that while allowing physicians to assist individuals to die under certain conditions is not morally untoward, acknowledging such a 'right to die' will set us on a slippery slope in which our practices evolve—or perhaps *de*volve—in morally abhorrent directions.

The inherently speculative nature of slippery slope arguments has led many philosophers to reject them as fallacious or at least prima facie suspect.[1] Still, many will concede that even if slippery slope arguments are suspect as a class, there may nevertheless be instances of such arguments that have merit and are rationally persuasive.[2] With respect to slippery slope arguments then, how are we to separate the rationally persuasive wheat from the sophistical chaff? In

order to endorse a slippery slope argument, we must have good reason to believe that the predicted bad outcome would represent a morally worse state of affairs than the status quo, and the deviation from the status quo must lead (or must be likely to lead) to the predicted bad outcome. Yet, these conditions are nevertheless insufficient to distinguish compelling slippery slope arguments from other arguments that merely posit negative effects of some change in policy or practice. For example, taxing tobacco might lead to a decline in business at small neighborhood grocers, but this negative effect would not likely be the result of any 'slippery slope.'

Douglas Walton has recently offered a painstaking analysis of what further distinguishes slippery slope arguments.[3] As Walton depicts them, slippery slope arguments tacitly assert that while the norms governing the status quo are stable and enjoy a high level of allegiance among those subject to them, the norms embodied in the deviation will not be stable in this way. In fact, individuals subject to the new norms will lose their bearings and become unable to stop themselves from sliding toward the morally untoward outcome. Walton's analysis accords well with the image of the slippery slope (and similar metaphors): Deviating from the status quo unleashes a process wherein agents or institutions can no longer control the sequence of events initiated by that deviation. Though the initial deviation is benign, the 'momentum' unleashed via the initial deviation culminates in an irreversible and catastrophic state of affairs.

The Palliation Slope

One slippery slope argument offered by opponents of medically assisted dying is that its introduction would lead to reductions in, or stymie recent progress in, the availability or quality of palliative care for terminally ill patients.[4] Opponents argue that popular support for medically assisted dying stems from the inadequacy of existing palliative care. Allowing physicians to hasten death would allegedly make it "too easy … for society to escape its obligation to render dying more comfortable."[5] It would be better all things considered for patients to opt for end-of-life palliative care instead of assisted dying, but because such care is often poor or inaccessible, many will opt for assisted dying instead.[6] The legalization of assisted dying, these arguments contend, must await the day when societies have achieved "full availability and practice of palliative care for all citizens."[7]

Opponents of assisted dying may not intend that the threats to palliative care posed by the introduction of legalized assisted dying turn result *entirely* from a slippery slope. Nevertheless, it seems apparent that they are utilizing slippery slope reasoning to some extent. The introduction of assisted dying, some opponents of assisted dying seem to believe, would inject into medical norms the prospect of physicians or other medical professionals willfully contributing to patient deaths. This deviation from existing norms would ostensibly result in a shift away from adequate palliative care provision to the use of assisted dying as a way to end, rather than therapeutically manage, patient

suffering at the end of life. Once medicine's menu of options is expanded to include assisted dying, that option is supposed to crowd out palliative alternatives.

Certainly no one could rightfully oppose improvements in palliative care. But have the predictions suggested by this argument turned out to be correct? There is little evidence to indicate that the introduction of medical assisted dying has eroded the quality or availability of palliative care.[8] The quality and availability of palliative care varies significantly in the United States, for example.[9] But these variations do not track whether a state's residents have access to medically assisted dying. A recent report from the Center to Advance Palliative Care suggests that the relationship between the quality and availability of palliative care and the legality of medically assisted dying is in fact the opposite of what opponents of assisted dying have predicted: Many of the states with legalized assisted dying (Oregon, Washington, Colorado, Montana, and Vermont) were given among the report's highest grades for palliative care, and no state that ranked in the bottom half has legalized assisted dying.[10] In a similar vein, a Scottish government report comparing the provision of palliative care globally indicates that those nations with histories of legalized assisted dying (Belgium, the Netherlands, and Luxembourg most notably) are among the world's best in providing such care.[11] Such findings should be taken with a grain of salt: There are many more factors that influence palliative care provision besides the availability of assisted dying. But the accumulated evidence does not support the contention of a slippery slope culminating in poor provision of palliative care. Rather than being incompatible, assisted dying and palliative care appear complementary in practice.

In retrospect, that the introduction of assisted dying would not be likely to harm palliative care seems less surprising once we attend to the possible effects of its introduction on norms regarding end-of-life care. Here I believe proponents of this slippery slope have erred in two ways.

First, proponents of the palliation slope argument likely overestimated the extent to which the introduction of assisted dying represents a substantial deviation from existing medical norms. For one, studies have indicated that assisted suicide and medical euthanasia have long occurred even where they are illegal.[12] There exists a "measurable, fairly consistent incidence of physician-assisted suicide whether legal or not" across numerous jurisdictions.[13] Hence, legalization may not have altered norms so much as brought existing norms out into the open. Moreover, many medical communities and practitioners acknowledge that patients have a right to end their lives with medical professionals' help inasmuch as they have a right to passive euthanasia, including a right to cease life-sustaining treatments. In this regard, introducing legalized assisted dying, rather than challenging some putative norm *against* medical professionals helping their patients to die, merely tweaks an existing norm *allowing* medical professionals to help their patients to die by expanding the palette of means by which such help can be provided. Thus, if those advancing

this slippery slope argument concede that existing medical norms are acceptable rather than catastrophic, and introducing legalized assisted dying does not significantly alter those norms, then there does not seem to be any grounds for their not conceding the acceptability of assisted dying as well. Adam Feltz has recently conducted experiments concerning popular attitudes toward medical aid in dying and found that such attitudes depend far more on whether the request for medical aid in dying is voluntary than on whether the request is for passive or active euthanasia. Feltz' findings corroborate the hypothesis that legalizing assisted dying does not challenge the widely accepted norm according to which it is ethically permissible to honor voluntary requests for aid in dying, in whatever form those requests may take.[14]

Second, advocates of the palliation slope argument appear to believe that a norm that introduces assisted dying as an option will alter the psychological machinations of medical professionals, motivating them either to encourage patients to choose assisted dying even when they ought to prefer palliative care or to provide substandard palliative care. A change in legal rules is thus supposed to bring about a change in behaviors. This is typical slippery slope reasoning, inasmuch as it contends that deviating from the status quo will undo long-standing processes of habituation and thereby bring about an undesirable change in our values.[15]

But here I note that changes to legal standards and changes to evaluative norms are different. Norms do more than generate practical prescriptions. They also encode values. And it does not follow, logically or causally, that giving individuals more legal options changes their underlying evaluative norms. Indeed, the new options will be received in light of or with reference to existing evaluative norms. This appears to be the case with respect to norms regarding end-of-life care after the introduction of a legal option of medically assisted dying. In those jurisdictions in which it has been introduced, it appears to have been incorporated into a system of norms oriented around respect for patient autonomy and a commitment to minimizing patient suffering. Assisted dying has thus come to serve as one among an expanding menu of options for individuals with serious or terminal illness, but it has not supplanted palliative care among those options. In fact, its arrival appears to have stimulated greater interest and concern for the quality of said care. Underlying palliation and medically assisted dying are values that stand in harmony, rather than in tension. These practices are therefore not antagonistic either at the level of theory or the level of practice.[16]

There is not, then, a compelling basis for supposing any deep incompatibility between quality palliative care and assisted dying of the sort that this slippery slope argument assumes. "The quality or availability of palliative care" is not in "any way undermined by the availability of [assisted dying]."[17] Rather, the evidence suggests that the introduction of assisted dying does not alter existing medical norms surrounding end-of-life care or does not generate the necessary 'momentum' in the direction of poor palliative care. Instead of a

vast expansion in assisted dying at the expense of quality palliative care, assisted dying has come to function as an end point of a continuum of methods (including palliation) utilized to minimize end-of-life suffering. It thus appears possible both to respect patients' desires for assisted dying while we "promote the very best care for patients at the end of life."[18] To suppose otherwise is to succumb to a false dilemma.

Evaluating Slippery Slopes: ~~Three~~ Argumentative Burdens

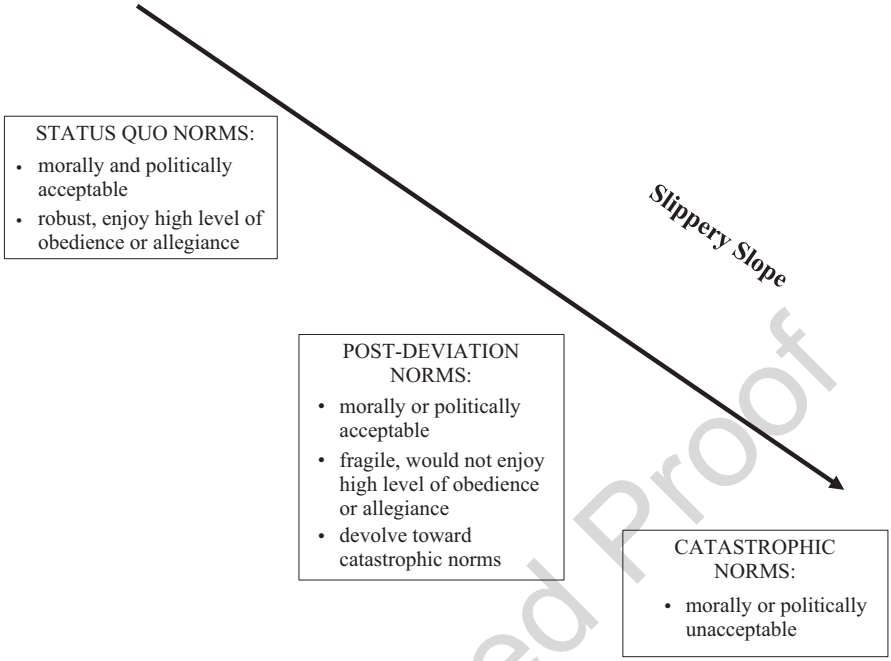
Slippery slope arguments typically arise in particular discursive contexts, namely, when the effects of a proposed policy change are uncertain or controversial. Presumably, questions about such effects are empirical and so demand empirical methods and evidence. I have observed that, unfortunately, many disputes about slippery slopes have a decidedly non-empirical flavor. Evidently comfortable in their proverbial armchairs, disputants rest content with advancing rival a priori narratives about how persons and institutions will respond to a proposed policy change.

Granted, human beings are not clairvoyant about how the social world changes in response to policy changes. But a priori theorizing about the effects of such changes is probably even less reliable. One possible 'solution' to the challenge of evaluating slippery slope arguments is to actually implement the proposed policy change and then measure its effects. This has the epistemic advantage that it gives us concrete evidence about these effects. The proof is in the public policy pudding, yes. But it would of course be salutary if we could rationally appraise slippery slope objections to a given policy change *before* implementing it. As section "The Palliation Slope" illustrated, relevant evidence accumulated over several decades has shown that the palliation slope was an unfounded worry. Yet, regardless of whether one supports or opposes medically assisted dying, surely it would have been more rationally (and morally) satisfactory to be able to appraise the palliation slope argument, however imperfectly, prior to jurisdictions preceding forward with the legalization of medically assisted dying.

Fortunately, there is a very wide evidential middle ground between the empirically uninformed and the empirically infallible—between rank speculation and factual guesswork. Our disputes about slippery slopes in public policy, I contend, should take place on this middle ground. Such disputes occur against a background of imperfect or limited information about the effects of proposed policy changes, and in order for such disputes to be fruitful, parties to these disputes bear certain dialectical burdens. Here I outline four burdens that *proponents* of slippery slope arguments bear, burdens suggested by the example of the palliation slope argument.

The following diagram illustrates the process by which slippery slopes are supposed to unfold:

DIAGRAM 1



AU5 **Diagram 52.1**

In advancing such an argument, a slippery slope advocate must: 242

a. *Couch the argument in terms of norms rather than rules.* Norms and rules are interrelated. Conformity to some rule sometimes occurs because of the acceptance of some norm, and norms sometimes emerge because of long-standing conformity to particular rules. But rules are not themselves norms, and advocates of slippery slope arguments err when they fail to focus on norms. The point of slippery slope arguments (at least in the public policy domain) seems to be that changing legal rules or institutional regulations will modify norms. If that were not what slippery slope arguments allege, they would have little argumentative force. For surely their proponents' worry is *not* with the new legal or institutional regime that will occur after some proposed reform is implemented. In the case of the palliation slope, their objection is not to assisted dying as such but to the hypothesized effects that it would have on norms concerning the provision of palliative care, namely, that the availability of assisted dying would erode those norms. 243 244 245 246 247 248 249 250 251 252 253 254 255 256 257

b. *Advance a plausible, empirically informed account of the existing norms relevant to the proposed policy change.* A proposed policy change does not occur in a normative vacuum. The rules it introduces will interact with 258 259 260

extant institutional norms and attitudes. Thus, a credible slippery slope argument must therefore begin with a fair and accurate representation of the existing norms with which the new rules will interact and (possibly) generate new norms. In the case of the palliation slope argument, its proponents seem to have underestimated how entrenched two of the four ethical pillars of modern medical practice—respect for patient autonomy and beneficence concerning the relief of patient suffering—are in those jurisdictions where medically assisted dying was legalized.

c. *Advance a plausible, empirically informed account of how the proposed policy change will interact with existing norms.* It is somewhat difficult to reconstruct the assumptions on which the palliation slope argument is based. But its proponents appear to have assumed that the legalization of assisted dying introduces two clashing rules—*provide patients' adequate palliative care* and *accede to terminal patient requests for assisted dying*—that ground two distinct and clashing norms, where such clash would ultimately be 'resolved' in practice by the latter triumphing over the former, that is, patients would be deprived of the palliative care to which they are entitled because of the ascendance of medically assisted dying. In retrospect, it seems clear that these rules were received against a normative backdrop in which larger norms regarding patient care were operative. The new rule ('accede to terminal patient requests for assisted dying') was folded into these larger norms. As a result, the hypothesized clash between palliation and assisted dying has not arisen.

d. *Provide a reasoned basis for supposing that whatever new norms are introduced by deviation from the status quo would in fact be fragile and thereby susceptible to devolution toward moral catastrophe.* Burdens a–c are largely a prequel to the central premise of a slippery slope argument, namely, that the proposed reform will introduce new fragile norms that are likely to devolve in a catastrophic direction. The palliation slope argument ~~does not, in my estimation, fail~~ at this precise point. Our best evidence rather suggests that the introduction of medically assisted dying simply did not generate a new norm that could even have served as the candidate for a fragile norm likely to trigger devolution toward poor palliative care. All the same, the question of whether a norm is fragile and hence susceptible to moral devolution cannot even be entertained unless we have a clear sense of what that norm is and whether it is likely to emerge as a new norm after the implementation of a proposed policy change.

Conclusion

Opponents of a given slippery slope argument may find it unconvincing for reasons unrelated to its predictions regarding the likely consequences of a policy change. Their reasons may be ethical instead of empirical: That the

hypothesized moral catastrophe either is not so catastrophic and/or its moral deficiencies are less weighty than the moral deficiencies of the status quo. Nevertheless, if opponents of a slippery slope argument wish to rest their case on empirical considerations, then they should insist that the evaluation of the argument operate from an empirically rooted 'middle ground,' one that does not require us to actually implement a revision to the status quo in order to evaluate its effects but also abjures a priori speculation about those effects. But in order to do so, proponents of slippery slope arguments need to be exact and forthcoming about how this devolution in norms is supposed to occur.

In the case of the palliation slope, had its proponents met burdens a–d, we need not have awaited the growing body of evidence against the palliation slope materializing. We could instead have insisted that proponents outline what norms they believe existing medical practice surrounding palliation and end-of-life care rest on, how assisted dying would introduce new norms, how these norms would interact with existing norms to produce a new fragile norm concerning palliation, and so on. While this is admittedly conjecture on my part, I venture that were palliation slope proponents forthcoming in these respects, the studies showing that this slope has not materialized would merely have *confirmed* what we already had strong but defeasible reason to believe, namely, that assisted dying would not undermine or slow the progress of quality palliative care. The fundamental mistake of the palliation slope argument was to assume without further investigation that medical practitioners engaging with patients at the end of life operate on a rather sinister set of norms, according to which they are eager to end the lives of difficult or burdensome terminal patients but these impulses are kept in check largely by the legal sanctions against intentionally contributing to patients' death. I have a good many reservations about the moral attitudes of the medical community, but I see no reason to endorse the cynical hypothesis that contemporary medicine's commitment to preserving quality life and relieving suffering through palliation is this shallow.

These observations help us appreciate why, in retrospect, the palliation slope argument, now largely refuted, ought not to have been taken as seriously as it was. More generally, I am insisting that disputes about slippery slopes be empirical and *particular*. It will not do for proponents of slippery slope arguments to assert that deviations from the status quo will, somehow or other, result in fragile norms. They must instead offer analyses invoking particular norms rather than positing unnamed norms. In my observation, a good many slippery slope arguments do not live up to this demand and thereby come to enjoy greater credibility than they should. Proponents of such arguments enjoy two unfair dialectical advantages relative to their opponents when they do not invoke specific norms. First, to tacitly assert that somehow or other the hypothesized devolution of norms will emerge exploits individuals' propensity to devise some explanatory account, no matter how objectively implausible, to account for the alleged slipperiness. Those already inclined to accept a given

slippery slope argument are likely to engage in motivated reasoning, wherein the devolution is assumed and whatever norms or explanations they find antecedently plausible are mustered to account for that devolutionary process. Second, not specifying norms, and so on, enables proponents of slippery slope arguments to hinder their opponents' ability to cast their own reform proposals in the best light. Reformers who advocate for deviating from the status quo of course wish to avoid morally bad consequences and so will want to craft their reforms so as to mitigate those consequences. But without a specific explanatory account of how deviation from the status quo will introduce fragile norms that threaten catastrophic devolution, reformers are hamstrung in even considering how to fashion norms that best mitigate those bad consequences. If we lack knowledge of how the predicted consequences are supposed to ensue, then how are reformers supposed to fine-tune their proposals so that good outcomes obtain while bad consequences are avoided?

From the point of view of reformers, advocates of slippery slope arguments sometimes unleash an army of phantoms, a collection of unstated or underdescribed accounts of how deviations from the status quo will eventuate in catastrophe. Reformers are not likely to fend off this army, but this simply illustrates that this is not a fair clash of positions in the first place. Reformers—and those of their opponents who rely on slippery slope arguments, to the extent they are concerned with the truth and arguing in good faith—are owed more than just a gesture in the direction of fragile norms, devolution, and the like. An intelligent inquiry into the defensibility of a proposed reform in the light of slippery slopes cannot take place if we have little idea as to precisely what lubricates the hypothesized slope in the first place.

These observations regarding the argumentative dialectic surrounding slippery slope arguments are offered in a constructive and forward-looking spirit. Participants in such dialectics should insist that they be grounded in concrete accounts of the emergence of dangerous norms instead of ill-defined bogeymen.

Notes

1. For examples of such skeptical responses, see Hugh LaFollette, "Living on a Slippery Slope," *Journal of Ethics* 9 (2005): 475–499; Justin Oakley and Dean Cocking, "Consequentialism, Complacency, and Slippery Slope Arguments," *Theoretical Medicine and Bioethics* 26 (2005): 227–239; and Georg Spielthenner, "A Logical Analysis of Slippery Slope Arguments," *Health Care Analysis* 18 (2010): 148–163.
2. J.A. Burgess, "The Great Slippery-Slope Argument," *Journal of Medical Ethics* 19 (1993): 169–174; Jeffrey P. Whitman, "The Many Guises of the Slippery Slope Argument," *Social Theory and Practice* 20 (1994): 85–97.
3. "The Basic Slippery Slope Argument," *Informal Logic* 35 (2015): 273–311.
4. See Ben A. Rich, "Assisted Dying and Palliation," in Michael J. Cholbi, ed., *Euthanasia and Assisted Suicide: Global Views on Ending Life* (Santa Barbara: Praeger, 2017), pp. 288–89.

5. Diane E. Meier, Carol-Ann Emmons, Sylvan Wallenstein, et al., "A National Survey of Physician-Assisted Suicide and Euthanasia in the United States," *New England Journal of Medicine* 338 (1998): 1193–1201 (available at: http://www.nejm.org/doi/full/10.1056/NEJM199804233381706, accessed 22 Feb 2018); Ezekiel J. Emanuel, "Euthanasia and Physician-Assisted Suicide: A Review of the Empirical Data From the United States," *Archives of Internal Medicine* 162 (2002): 142–152, doi:https://doi.org/10.1001/archinte.162.2.142. (Available at: https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/214736#ira10015t4, accessed 5 Mar 2018); and Charles H. Baron, "Hastening death: the seven deadly sins of the status quo.," in T.E. Quill and M.P. Battin (eds.), *Physician-Assisted Dying: The Case for Palliative Care and Patient Choice* (Baltimore: Johns Hopkins University Press, 2004), p. 313.
6. Worries that medically assisted dying will weaken the provision of palliative care is a theme in several articles in Kathleen M. Foley and Herbert Hendin, eds., *The Case Against Assisted Suicide: For the Right to End-of-Life Care* (Baltimore: Johns Hopkins University Press, 2002).
7. K. Foley and H. Hendin, "A Medical, Ethical, Legal, and Psychosocial Perspective," introduction to Foley and Hendin, eds., *The Case Against Assisted Suicide*, p. 2.
8. Rich, "Assisted Dying and Palliation," p. 289.
9. Tamara Dumanovsky, Rachel Augustin, Maggie Rogers, Katrina Lettang, Diane E. Meier., and Sean R. Morrison, "The Growth of Palliative Care in U.S. Hospitals: A Status Report." *Journal of Palliative Medicine* 19 (2016) 8–15. https://doi.org/10.1089/jpm.2015.0351.
10. Center to Advance Palliative Care, "America's Care of Serious Illness: 2015 State-by-State Report Card on Access to Palliative Care in Our Nation's Hospitals." Available at: https://reportcard.capc.org/ (accessed 9 Mar 2018).
11. Health and Sport Committee, "A report for the Scottish Parliament by Professor David Clark: International comparisons in palliative care provision: what can the indicators tell us?" 15 Sept 2015. Available at: http://endoflifestudies.academicblogs.co.uk/wp-content/uploads/sites/22/2015/09/Scottish-Parliament-Palliative-Care-Report-20150915.compressed.pdf (accessed 5 Mar 2018). See also Kenneth Chambaere and Jan L. Bernheim, "Does Legal Physician-Assisted Dying Impede Development of Palliative Care?" *Journal of Medical Ethics* 41 (2015): 657–60.
12. Baron, "Hastening Death: The Seven Deadly Sins of the Status Quo," pp. 314–315.
13. Margaret P. Battin and Timothy E. Quill, "Introduction: False Dichotomy versus Genuine Choice: The Argument Over Physician-Assisted Dying," in Margaret P. Battin and Timothy E. Quill, eds., *Physician-Assisted Dying: The Case for Palliative Care and Patient Choice* (Baltimore: Johns Hopkins University Press, 2004), p. 5.
14. "Everyday Attitudes about Euthanasia and the Slippery Slope Argument," in Michael Cholbi and Jukka Varelius, eds., *New Directions in the Ethics of Assisted Suicide and Euthanasia* (Cham: Springer, 2016), pp. 217–38.
15. Anneli Jefferson, "Slippery Slope Arguments," *Philosophy Compass* 9 (2014), pp. 675–76.

16. Jan L. Bernheim, Reginald Deschepper, William Distelmans, Arsene Mullie, and Luc Deliens, "Development of Palliative Care and Legalization of Euthanasia: Antagonism or Synergy?" *BMJ* 336 (2008): 864–67; and Dick Willems, "Palliative Care and Assisted-Care Death," in Stuart J. Younger and Gerrit K. Kimsma, eds. *Physician-Assisted Death in Perspective* (New York: Cambridge University Press, 2012), p. 211.
17. Rich, "Assisted Dying and Palliation," p. 294.
18. Michael B. Gill, "Is the Legalization of Physician-Assisted Suicide Compatible with Good End-of-Life Care?," *Journal of Applied Philosophy* 26 (2009), p. 41.

Author Queries

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Queries	Details Required	Author's Response
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