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Euthanasia Laws, Slippery Slopes, and (Un)Reasonable Precaution

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ABSTRACT: The article examines the so-called slippery slope argument (SSA) against the legalization of active voluntary euthanasia (AVE). According to the SSA, by legalizing AVE, the least morally controversial type of euthanasia, we will take the first step onto a slippery slope and inevitably end up in the moral abyss of widespread abuse and violations of the rights of the weakest and most vulnerable patients. In the first part of the paper, empirical evidence to the contrary is presented and analyzed: None of the forecasted regrettable trends can be elicited from the body of existing statistical data. Accordingly, we have no good reason to believe either that we already are, or are sooner or later going to be, sliding into a moral abyss. A related question is then considered: Would it not be wiser and safer to stick to the *status quo* and preserve the existing legal ban on AVE even if the risk of its abuse is uncertain and may well turn out to be relatively low? It is argued that such an appeal to precautionary reasoning fails to justify an outright legal ban on AVE for at least two reasons: (i) it grossly underestimates the hidden moral costs of current legal arrangements (competent terminal patients suffer both disrespect for their autonomous will and deprivation of the good of a timely death) and (ii) the ban is both too inefficient and disproportionate to qualify as a *reasonable* measure of precaution.

KEY WORDS: Euthanasia laws, moral calculus, precautionary principle, slippery slope arguments, timely death.

1. Introduction

Almost two decades after the well-publicized and vigorously contested legalization of active voluntary euthanasia (AVE) and physician-assisted suicide (PAS) in the Netherlands, Oregon and Belgium, and with more recent enactments of such laws in a number of other countries (Luxembourg and Canada) and federal states (Washington, Vermont, Montana, California and, since last

June, the Australian state of Victoria), legalization of euthanasia has found its way back onto the front covers of popular magazines and into professional journals. Emotions are still running as high on both sides of the dispute as ever, with one considerable difference – there is now a wealth of empirical evidence against which charges of damaging and irreversible changes in our attitudes to, and practice of, death that legalization is supposed to initiate can be tested. In the first section of the paper, I aim to do just that – see which, if any, of the cataclysmic predictions made at the turn of the century have come true. My tentative and cautious answer, based on available empirical data, is: "Very few, if any at all." But I also acknowledge the fact that the data are assembled by means of very different methods and, as a result, are of unequal quality and difficult to compare and generalize, let alone project into the future. Hence, the short- and long-term effects of legalization on the practice of euthanasia may still be, for all we know, unknowable at this moment. In the second part of the paper, I therefore consider the possibility that the existing overall ban on euthanasia may be morally called for by precautionary reasoning or the ethics of risk management. If the long-term risks and benefits and losses and gains to various groups of patients, as well as to society at large, of lifting the existing ban are very much uncertain, would it not be wiser to maintain the legal *status quo* and thereby avoid a potential moral catastrophe at the (acceptable) cost of forsaking small benefits to what is a tiny minority of terminal patients anyway? As tempting as this reply may be, it is nevertheless wrong. Neither is the threat of large-scale moral abuse and rights-violations of vulnerable patients realistic enough, nor can the current outright ban on all forms of euthanasia be considered a proportionate and hence reasonable response to this threat. Or so I will argue.

Here, then, is the plan of the paper. I first present and briefly discuss the structure of slippery slope arguments (SSAs) in general and in the context of the debate on the legalization of euthanasia in particular. Next, I identify the warning signs of sliding down the slope and provide a check-up list of problematic trends. I then go on to register and assess some methodological concerns about how representative and reliable the collected evidence really is. If our situation is one of profound uncertainty, at least when it comes to the long-term effects of legalization, what would be the most reasonable thing to do: Maintain the legal *status quo* or remove the ban? In section 3 I provide a set of criteria for a reasonable use of precautionary reasoning and adopt what I believe to be the most plausible version of the precautionary principle for the purpose of this inquiry. In section 4, I apply the principle to euthanasia and conclude that the moral risks of legalization are typically exaggerated, while at the same time the moral costs of current legal and social arrangements are seriously underestimated. Once the moral record is set straight, the case for maintaining the legal *status quo* begins to fall apart. In the concluding section, I briefly consider and reject two objections against the thesis of the moral equivalence between forceful termination and forceful prolongation of life – (i) that the harm of being forced to die is incomparably bigger than the harm of being forced to go on living, and so the former is justifiably of paramount concern to the state; and (ii) that being forced to die, unlike being forced to go on living, is not simply harmful but also wrong and unjust and hence the only proper object of legal regulation. I conclude with a plea for a change to the law.

2. Slippery slope arguments (SSAs)

Slippery slope arguments (SSAs) belong to a group of arguments from consequences. We deride a certain action or measure by pointing to short- or long-term consequences which both its proponents and its opponents find equally unacceptable. More precisely, the basic idea behind an SSA is that a particular action, despite appearing unobjectionable in and of itself, ought to be resisted, because by performing this action we will have stepped onto a slippery slope and eventually end up, after a series of small slides, in a morally dreadful place. The strength of any particular SSA thus crucially depends on the plausibility of corresponding causal claims – are the small, gradual, almost imperceptible changes which connect the initial, morally unproblematic action with the resultant, morally disastrous outcome somehow inevitable, impossible to stop once set in motion, or can we stop the train of events at any point if we only choose to do so?

2.1. Basic types of slippery slope arguments

In the philosophical literature (van der Burg 1991; LaFollette 2005; Warnock and Macdonald 2008; Hartogh 2009; Šuster 2015; Keown 2018), it is customary to distinguish between two basic types of SSAs: (a) the logical (or conceptual), and (b) the empirical. In the logical/conceptual version of the SSA, one typically argues that if we did A for reason R (or in accordance with principle P), then we should, on the pain of inconsistency, also do B (and C, and D, and…), since the very same reason, R (or the very same principle, P), which supports doing A also speaks in favor of performing B (and C, and D, and…); however, doing B (or at least doing C, or doing D, or…) would be clearly immoral, hence we ought to refrain from A as well. In the empirical version of the SSA, on the other hand, it is typically argued that if we were to do A, then sooner or later, given certain unalterable characteristics of human psychology, social and cultural norms, economic incentives and pressures, and so on, either we or other people would inevitably start doing B (and C, and D, and…) as well; doing B (or at least doing C, or doing D, or…) is morally forbidden, however, hence the need to resist the initial temptation to do A.

In the context of legalizing euthanasia, as in many others, the strongest versions of SSAs are the hybrid ones, those combining the two aforementioned insights: Since there is no principled difference between (reasons that justify) doing A and (reasons that justify) doing B (as well as between doing B and doing C, and between doing C and doing D), logic, in combination with certain powerful internal and external factors (temptation, routine, financial incentives, social norms and expectations, and the like) will sooner or later, and inevitably, lure us (and enough others) into doing B (and C, and D) once we have started (considering) doing A (permissible); but B (or at least C or D) is clearly impermissible, hence we shouldn't do A either. In other words, one can argue either (i) that once we accept, say, benevolence as the trumping consideration in favor of the merciful killing of those among terminal patients who clearly want to die, there is, from a purely logical or rational point of view, only a small step from granting a patient's request for merciful death (the 'A') to not bothering to investigate whether this is what they really want for themselves (the 'B') and from this to disregarding their express wish to continue living (the 'C'). Or, alternatively, one could argue (ii) that it is relatively easy, psychologically speaking, to make the transition from merciful killing on the explicit request of the patient (the 'A') to merciful killing regardless of her will (the 'B') and eventually against it (the 'C').

I will simply assume, as uncontroversial, that hybrid, logico-empirical forms of SSAs are the strongest, most convincing of all, both in the context of the euthanasia debate and elsewhere. Also, for the purpose of this article, I'm going to ignore a significant body of philosophical literature (Govier 1982; Enoch 2001; LaFollette 2005) highly critical of what its authors consider either the sloppy use or outright abuse of slippery slope arguments in debates on public policy. I do agree that this type of argument is often misused and will eventually argue that it is also mistakenly invoked in the ongoing debate on euthanasia, but as I'd like to preserve as much common ground with my opponents as possible, I won't dwell on this.

2.2. SSAs in the debate on euthanasia

Here is the most common form of SSAs that one can find in the debates on the legalization of euthanasia:

(1) If, for the sake of respecting patients' autonomous will and/or preventing their suffering, active euthanasia is legalized for those terminal patients who want to die, then human life is going to lose its unconditional value which, in turn, will create similar social expec-

tations and pressures towards other terminally ill patients (and their doctors and relatives) as well. (The 'first step'.)

(2) If human life is rendered conditionally valuable and as a result the pressure to terminate their lives is increased on those terminally ill patients who don't want to die yet, then many of them will ask their doctor to euthanize them despite their preference for continued living, and eventually doctors are going to start euthanizing those patients who are either unable to rationally and autonomously form or clearly express their will, or are not terminally ill at all.

(3) But killing terminally ill patients against their will or without their valid consent, not to mention killing people who are not even terminally ill, is morally abhorrent and ought to be prevented at any cost. (The 'moral abyss'.)

Hence:

(4) We ought to see that active euthanasia remains inaccessible to all terminally ill patients, including those among them who not only prefer immediate death to continued living but would also benefit from it.

Here, then, is the slippery slope objection against legalizing euthanasia in a nutshell. Legalization of active voluntary euthanasia, admittedly the least problematic form of euthanasia, will eventually, after a series of small but inevitable changes in our attitudes to, as well as law and practice of, hastening the death of terminally ill patients, push us (in)to a moral abyss of unsupervised and unsanctioned mass euthanasia of each and every patient – from the comatose, demented and minors to chronically ill, depressed and those who prefer death over life because they are simply tired of living – and for all sorts of reasons and excuses – including relief of simple discomfort, concern for, or the loss of, dignity, existential anxiety and despair.

Now even though sliding down the slope is supposed to be slow and gradual and as such often difficult to notice, some phenomena are said to be characteristic for, or indicative of, it. Legalization of voluntary active euthanasia will, its opponents typically assert, gradually but predictably, bring about:

(i) an increase in the number of requests for active voluntary euthanasia

(ii) an increase in the proportion of granted requests for euthanasia

(iii) an increase in the number and/or proportion of cases of non-voluntary and involuntary euthanasia (euthanasia without request or EWRs)

(iv) an increase in the number of euthanasia cases among members of vulnerable groups (women, elderly, children, people with no health insurance – where applicable, poor and disabled people, and so on)

(v) an expansion of the range of those eligible for euthanasia from competent to incompetent patients (minors, elderly, demented, or chronically depressed)

(vi) a relaxation of the legal safeguards against abuse and the corresponding increase in the frequency and magnitude of abuse

(vii) a growing disregard of prescribed procedures (neglect of the duty to discuss the issue with the patient or their family, the duty to consult another doctor, to document, and report about, cases, and the like)

(viii) a broadening of the scope of 'legitimate' reasons for euthanasia requests (from unbearable physical pain and suffering over unbearable psychological pain and discomfort to the lost sense of control and dignity and, eventually, the loss of the meaning of life and even existential boredom)

(ix) a growing disrespect of the unconditional value of human life, or a changed, and irreversibly so, attitude towards it.

Has any of this materialized?

3. Evidence from 'social laboratories'

In the nineties, when it all began, the heated debate on the merits and demerits of legalization, and the growing opposition to it, was based more on speculation and imagination than on facts and evidence. The little data there was (most critics, foremost Callahan (1992), Kumar and Bagaric (2001) and Keown (2004), appealed to inconclusive findings of the first and the second Remmelink report), was interpreted uncharitably and then extrapolated, with little thought given to what actually forms the appropriate comparison class. In the absence of prima facie compelling, let alone conclusive, empirical evidence, false analogies were drawn in support of such doomsday reasoning. The bitter lesson from the Nazi 'euthanasia program' was supposed to be clear enough to silence rare calls for a legal change along the Dutch and Belgian lines. Today, more than a decade after the passage of the first laws on euthanasia, however, there is no need to base our judgment and decision on speculation and dubious analogies. Instead, we have plenty of carefully assembled empirical data from large, natural-size 'social laboratories' to rely on:

- Netherlands (AVE and PAS legalized in 2001, after being more or less tolerated for many years)
- Belgium (AVE and PAS decriminalized in 2002)

- US states of Oregon (PAS decriminalized in 1998), Washington (PAS decriminalized in 1998) and (since very recently) Vermont, Montana and California
- conditionally Switzerland (where assisted suicide has been legal since 1942)
- Luxemburg (AVE and PAS legalized in 2009)
- Canada (AVE and PAS legal since 2016)
- The Australian state of Victoria (AVE legal since June 2019).

Let me briefly summarize those empirical findings.[1] Some of the trends forecast at the turn of the century have no doubt materialized. But they seem to belong to unproblematic categories. Take, for instance, the least problematic of all, the number and proportion of cases of active voluntary euthanasia (AVE). In the Netherlands, we have witnessed a small, but steady rise in both figures since 2001. After a sudden and significant decline in 2005, one which is yet to be explained, the trend took another sharp turn upwards and reached its first peak in 2010, only to be superseded in every following year except 2018. The latest number of euthanasia cases is 6585 (in 2017) for the Netherlands and 2022 (in 2015) for Belgium, meaning that in less than a decade the number of euthanasia cases in both countries has more than doubled. It is important to put this significant surge into perspective, however – at 4.5 percent the cases of AVE and PAS still make up a relatively small proportion of the total number of deaths. The same goes for the ratio between expressed and granted requests for euthanasia – approximately every second request that was made repeatedly over a longer period of time by a terminally ill patient was granted in 2010 and around seven out of ten were granted in 2016, comparable to the period before legalization and an indication that euthanasia has not come to be treated as a default option by physicians simply because they no longer need to fear prosecution. The data from Oregon reinforce this point. The number of Death-With-Dignity-Act prescription recipients has risen steadily over the years and reached a new high with 249 in 2018. This was accompanied by a similar trend in the growing number of physician-assisted suicides which also peaked in 2018 at 168. And yet the ratio between all the prescriptions that were issued and those that were eventually used to terminate life has remained steady in the long run – around two

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[1] In this section, I draw heavily on the following sources: Battin et al. 2007, Buiting et al. 2010a, Chambaere et al. 2010, Chambaere et al. 2015, Dierickx et al. 2016, Emanuel et al. 2016, *Euthanasia in Belgium,* Griffiths 2008, Heide 2019, Heide et al. 2017, Heide et al. 2007, Keown 2018, Levy 2011, Onwuteaka-Philipsen et al. 2012, *Oregon's Death With Dignity Act. 2018 Data Summary*, Rietjens et al. 2009, Rurup et al. 2011 and Warnock and Macdonald 2008.

thirds of the patients with a prescription for a deadly drug end up obtaining and using it. At a total number of 1459 since the law was passed in 1997, DWDA-related deaths only account for a tiny fraction of all annual deaths in the state of Oregon. More precisely, less than half a percent (Oregon Death With Dignity Act. 2018 Data Summary). In Switzerland, every hundredth death is an instance of assisted suicide.

It is important to note, with respect to the rising numbers and shares of deaths by euthanasia and PAS in the Netherlands, Belgium and Oregon, that this was both to be expected and that, given the morally unproblematic character of both AVE and PAS, it shouldn't really give rise to moral concerns. Let's look at some other, more troublesome categories then. Has the number of cases of non-voluntary and involuntary euthanasia increased? No, both the total number and the proportion of cases of euthanasia without request (or EWRs) among all deaths has either gone down, as in the Netherlands (from 0,8 percent in 1990 to 0,3 percent in 2015), or remained constant, as in Belgium. Has euthanasia perhaps become more frequent among members of vulnerable social groups? Not according to available empirical evidence:

> We found no evidence to justify the grave and important concern often expressed about the potential for abuse – namely, the fear that legalized physician-assisted dying will target the vulnerable or pose the greatest risk to people in vulnerable groups. The evidence available cannot provide a conclusive proof about the impact on vulnerable patients […]. Nevertheless, data shows that people who died with a physician's assistance were more likely to be members of groups enjoying comparative economic, social, educational and professional privileges. […] [T]here is no current factual support for the so-called slippery slope concerns about the risks of legalisation of assisted dying – concerns that death in this way would be practised more frequently on persons in vulnerable groups. (Battin et al. 2007: 597)

Once again, the data from Oregon appear to corroborate this verdict. Of altogether 168 registered PAS deaths in 2018, for instance, 79 percent were aged 65 years or older. The median age of death was 74 years. As in previous years, descendants were commonly white (97.0 percent) and well-educated (47.3 percent had a least a baccalaureate degree). Patients' underlying illnesses were similar to those of previous years. Most patients had cancer (62.5 percent), followed by neurological disease (14.9 percent) and heart/circulatory disease (9.5 percent). Most patients (87.5 percent) died at home, and most (90.5 percent) were enrolled in hospice care. Excluding unknown cases, most (99.3 percent) had some form of health care insurance. As in previous years, the three most frequently reported end-of-life concerns were loss of autonomy (91.7 percent), decreasing ability to participate in activities that made life enjoyable (90.5 percent), and loss of dignity (66.7 percent) (Oregon Death With Dignity Act. 2018 Data Summary).

Has the range of motives and reasons that are being acknowledged as legitimate grounds for a euthanasia request expanded? No, apart from a couple of highly publicized cases in Belgium and the Netherlands, by far the most common grounds (covering over 90 percent of cases) both for issuing and granting such a request are unbearable physical and psychological pain and suffering due to a terminal condition, the fear of the loss of dignity and little or zero prospects for recovery.

3.1. A preliminary conclusion

So far, then, empirical findings appear to have failed to vindicate the catastrophic scenarios envisioned by opponents of legalization. The total number of deaths by AVE and PAS, as well as their share in all deaths, rose slightly in the first years after the legalization and then rather sharply in the last couple of years (to approximately 4.5 percent of all deaths in both the Netherlands and Belgium (or, more precisely, Flanders), but this was to be expected and is not problematic in itself, since the vast majority of them (around 70 percent) come from cancer patients in the last stages of the disease and are estimated to have shortened their lives by a few days to a few weeks. The rate of cases of euthanasia without an explicit patient request (EWRs), instead of exploding, is either steadily declining (as in the Netherlands) or remaining stable (as in Belgium). Among the reasons given for granting patients' requests for AVE and PAS, terminal patients' wish to die a dignified death and the futility of treatment remain by far the most common. Despite some highly publicized cases, such as the deaf Belgian twins Marc and Eddy Verbessem, the Belgian transsexual Nathan Verhelst or Noa Pothoven, a troubled Dutch teenager victim of childhood sexual abuse, little, if any, transition to other more problematic reasons, such as tiredness of life or existential fatigue, has been observed. Furthermore, physicians seem to keep taking their duty to comply with the law on euthanasia seriously, if we are to judge by the rate of reported cases of AVE and PAS and their observance of the standards of due care.[2] And finally, the incidence of AVE, PAS and EWR among members of vulnerable groups (elderly, women, children, uninsured, poor, depressed, physically disabled, people with chronic non-terminal conditions, uneducated, members of racial and ethnic minorities,…) is no higher than in the population at large (AIDS-patients being the only exception).

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[2] The exact nature of, and the reason for, approximately 20 percent of cases of euthanasia that go unreported every year is disputed. The gap, however, seems better explained as a result of differing conceptualizations and taxonomies, rather than a deliberate attempt to cover up illegal killings (see Buiting 2010b).

3.2. Some remaining concerns

This, however, is an optimistic account of what goes on in the Netherlands and Belgium. Many critics would no doubt dismiss such optimism as unwarranted. After all, the Netherlands has seen the foundation of Levenseindekliniek, or End of Life Clinic, which matches doctors willing to perform euthanasia with those patients whose requests for aid in dying have already been rejected by another doctor for not meeting the legal requirements, and which was responsible for the euthanasia of some 750 people in 2017 (de Bellaigue 2019). In addition, the number of patients euthanized despite a psychiatric diagnosis, or with an explicit aim to end suffering caused by an incurable mental disease, is steadily on the rise. While in almost 90 percent of the total 6585 patients euthanized in the Netherlands in 2017, patients were suffering from cancer, heart and artery disease or diseases of the nervous system, such as Parkinson's and multiple sclerosis, three of those patients were nevertheless in an advanced stage of dementia and 166 in earlier stages. Furthermore, whereas ending of life without an explicit patient request decreased, from 0.8 percent in 1990 to 0.3 percent in 2015, other forms of hastening patient's death short of euthanasia have gained ground – the use of morphine to alleviate symptoms while taking into account possible hastening of death as a result increased, for instance, from 19 percent of all deaths in 1990 to 36 percent in 2010 and 2015, and the share of terminal patients provided with continuous deep sedation has increased from 8.2 to 18.3 percent of all patients between 2005 and 2015 (van der Heide 2017: 492).

John Keown, the most outspoken and influential among the critics of Dutch and Belgian euthanasia practice, believes the existent system of monitoring and control is clearly flawed and that we are indeed witnessing the sliding down a dangerous slope. He summarizes the reasons for pessimism thus (Keown 2018: 180–210):

(i) The system of control is flawed by design, since it is based on self-reports and it is naïve to expect the doctors violating euthanasia regulations to report their own unlawful conduct.

(ii) Despite the relatively stable numbers of reported cases of euthanasia, there is still a considerable number of those that remain unreported and hence unregistered and unchecked.

(iii) Due to a narrow legal definition of euthanasia as merciful killing on request, no record is kept of cases where doctors have intentionally shortened the life of their patient by stopping treatment.

(iv) Eligibility criteria have been gradually relaxed from 'unbearable physical suffering' over 'unbearable psychological suffering' to 'existential suffering and fatigue', 'completed life' and 'dignified death'.

(v) Euthanasia regulations and practice have been gradually amended to enable access to euthanasia for minors, and the number of patients with psychiatric disorders with requests for euthanasia granted despite a well-documented history of mental health issues is on a steady rise.

(vi) Incidences of non-voluntary euthanasia are not just disconcertingly high, euthanasia without patient's request has long been condoned by legal, medical, and political establishment in certain circumstances.

(vii) Euthanasia is being normalized and increasingly used as an alternative to palliative care, rather than the last resort.[3]

One promising way to dismiss this and similar evidence is to argue that even if all this is not just indeed happening, but is indicative and predictive of certain future trends, we are still firmly and safely within the boundaries of the legal, let alone morally permissible. So why panic? This is so (according to an explanation I borrow from Agnes van der Heide 2019) because when parliaments pass euthanasia laws, they typically do this against the tide of political, religious and cultural opposition which forces legislators to pass the most restrictive and conservative version of the law, one that not only restricts the right to euthanasia to the smallest possible subset of those patients who might benefit from it, but also erects a maximum number of obstacles on the path to exercising such a right.[4] It is hardly surprising, then, or so the argument goes, if later on, as the practice gains ground and becomes normal(ized), these pragmatic but essentially irrational obstacles are gradually removed one by one. This, in a sense, confirms the logico-conceptual version of the SSA, insofar as some restrictions that were initially imposed on the practice make little sense from both logical and normative perspective – in other words, they form an incoherent and/or normatively arbitrary set of norms. Take, for instance, the prohibition against euthanizing minors – what alone matters, from a moral point of view, is not the patient's age, but his or her decisional competence. And some minors do, and still others predictably will, display more of that quality than many adults belonging to the same group of patients. Excluding them from the group of patients eligible for euthanasia and PAS on the grounds of their youth hence amounts to unjust and unfair discrimination. We can apply the same reasoning to other more or less common

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[3] For a similarly alarmist (albeit journalistic) account of the current developments relating to euthanasia law and practice in the Netherlands and Belgium, see de Bellaigue (2019).

[4] For instance, the Voluntary Assisted Dying Act passed in 2017 in the Australian state of Victoria includes no less than 68 safeguards against possible error and abuse (Wilmot and White 2019).

criteria of eligibility. Take the distinction between terminal and (incurable) chronic disease, or between physical and psychological suffering. Most legislators initially choose to draw a line within those two pairs of categories, allowing, for example, euthanasia for terminally ill patients who endure unbearable physical pain, but prohibiting it for patients who suffer unbearable pain, whether physical or psychological, due to an incurable chronic illness. But this kind of differential treatment is hard, if not impossible, to justify – after all, if suffering due to their medical condition is equally unbearable for the patient, and the condition causing this suffering just as incurable in both cases, why does it matter whether and/or how soon the disease will kill them, or whether the source of their unbearable suffering is physical or psychological in nature?

So, where does all this leave us? For the sake of the argument, I'll assume that it leaves us in a sort of epistemic limbo and corresponding agential paralysis. We cannot tell yet, at this moment in time and on the basis of available evidence, whether the fears and worries over the potential adversarial long-term effects of euthanasia legislation are justified or not, or determine their risk and/or magnitude with sufficient certainty and precision.

4. A reasonable measure of precaution?

A simple cost-benefit analysis – the most popular method for evaluating alternative social policies – would have us weigh the putative benefits of legalization for the first group, the competent and autonomous terminally ill patients, against the harms that it is likely to impose on the second, the incompetent and/or non-autonomous dying patients. This, in turn, requires answering the following two questions: (a) how big a risk is it that some people are going to suffer the harm and/or the wrong of forced, untimely death as a result of the legalization of AVE, and (b) how big a harm, or wrong, is it?[5] But what if neither the risk nor the size of such harm can be determined with sufficient precision to do the necessary calculation? Is it not the case

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[5] Elizabeth Anderson (1993, especially pp. 190–216) presents a strong case against using cost-benefit analyses (CBAs) in evaluating and justifying social policies. Her argument is that cost-benefit analyses are tailored to simulate efficiency characteristic of market allocations and so presuppose commodification of public goods, such as public health and safety as well as clean air and water (or environment). Even though CBAs are hailed as a device for rendering political/public institutions more responsive to people's values (as revealed in their hypothetical choices), they fail to serve this function with respect to non-commodity values. But isn't then a cost-benefit analysis badly misplaced in the present context, given that life is one of, if not the, most prominent non-commodity value(s)? Not really. For we are here considering moral costs and benefits, such as harms, wrongdoings and injustices, alone. And comparing those need not presuppose ascribing monetary value to them, and so objectifying and commodifying them in ways which threaten to compromise, or subvert, their true moral value.

then that we better err on the side of caution and avoid such a risk of harm altogether?

Precautionary reasoning is typically employed in situations with the following three features: there is (a) a threat of significant and/or irreversible harm; (b) scientific uncertainty about impact and causality; and (c) precautionary response on offer. It's played a prominent role in the debates over genetically modified food (Myhr 2010), global warming and climate change (Gardiner 2006), and genetically engineered human enhancement (Glannon 2008). The precautionary principle (PP) has also been invoked in medical ethics before, in the context of evaluating research into the expansion of human lifespan and the heated debate on human cloning, but with mixed results – while some welcomed this novel and expanded approach (see Glannon 2002), others criticized it as irrational and stifling scientific discoveries (Harris and Holm 1999). The precautionary principle is often criticized for being overly cautious and insofar irrational – for more precisely, precluding sure benefits for the sake of preventing merely potential, or even imaginary, harms.[6] Appeals to worst-case scenarios, with little or no regard for how improbable these are, may enjoy considerable popularity but fairly little credibility. As long as the magnitude of potential harm is not properly balanced against its probability, such appeals ponder to irrational fear.

To block this sort of criticism, and save the principle, David Resnik (2003) came up with the criteria for a legitimate appeal to, or the 'scientific use' of, the precautionary principle which I'll simply adopt for the purpose of assessing the merits of the existing ban on euthanasia as a precautionary measure. According to Resnik, the principle can be used scientifically, i.e., as a plausible principle of practical rationality (a principle that helps to guide our choices and actions in circumstances of uncertainty or even ignorance), provided that:

(1) potential threats addressed by the principle are not only enormous in magnitude but also plausible, and
(2) adopted measures of precaution are reasonable.[7]

We may then use epistemic criteria, such as consistency, coherence and explanatory power, to assess whether the threat is plausible, as well as practi-

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[6] For a particularly harsh critique, see Sunstein (2005, 2007).

[7] However, one feature of precautionary reasoning is ominously missing from the above formulation, namely that the threat of harm be serious and/or irreversible: "When an activity raises threats of *serious or irreversible harm* to human health or the environment, precautionary measures *which effectively prevent the possibility of harm* (e.g., moratorium, prohibition, etc.) *shall be taken* even if the causal link between the activity and the possible harm has not been proven or the causal link is weak and the harm is unlikely to occur" (Harris and Holm 1999: 358). I am grateful to Kian Mintz-Woo for alerting me to this point.

cal considerations, like effectiveness, proportionality, cost-effectiveness, realism and consistency, to determine whether the response to the threat is reasonable.

In the remainder of the paper I'll briefly address two of the abovementioned issues: a) is the threat that we are trying to deflect by an outright ban on euthanasia a plausible one? and b) is our response to that threat reasonable or, more precisely, efficient and proportionate?

4.1. Is the threat of harm plausible?

At least three types of potential threats could be said to be averted by the existing legal prohibition on euthanasia: (a) risk of harms (of forced and/or untimely deaths); (b) risk of wrongdoings (wronging people by depriving them of something that is either valuable to them or that they are entitled to do or to have, without compensating them for the said loss); and/or (c) risk of rights-violations/injustices (violating people's right to life/not-to-be-killed, right to autonomy or some similar right).

But how plausible are these threats? The empirical data collected, as we have seen, don't give an equivocal answer to this question. Not only do empirical data fail to substantiate slippery slope concerns, little so far suggests that even the very few and relatively insignificant changes in attitudes to, and practices of, assisted dying in the Netherlands, Belgium and Oregon, are *the effect of the legalization of AVE and PAS* rather than, say, *something that preceded it and only surfaced thanks to a closer monitoring upon legalization, or something caused by changes in other social, economic, cultural, and so on factors which accompanied, but were not the result of, the legal change*. Countries where euthanasia is still outlawed are simply the wrong comparison class for that purpose, even if their figures were to suggest (which they unequivocally do not) that euthanasia is neither as widely endorsed nor as commonly practiced as elsewhere. In order to prove the causality claim, we would need to compare not only the figures in those countries that have lifted the ban on euthanasia prior to legalization and afterwards, but also discount the influence of other variables, a task that requires assessing the truth value or, alternatively, the plausibility of difficult counterfactual claims.

Besides, at least on the face of it, the causality claim is counterintuitive. Why should the legalization of a less controversial type of euthanasia increase the incidence of more controversial types of euthanasia? There is nothing odd or surprising about the prediction that as soon as you legalize active voluntary euthanasia, the number of both requests issued by terminal patients and those granted by physicians is going to soar. For if there is considerable demand for some service, the provision of which comes at a high social and legal cost, then a significant reduction in the costs attached to it will predictably boost both demand for, and supply of, it. But there is no similarly obvious, social-psychological explanation for why legalization of *voluntary* euthanasia would cause an increase in the numbers of *non-voluntary* or even *involuntary* euthanasia.[8]

4.2. Is potential harm serious and irremediable?

Whatever the exact nature of catastrophic predictions, and we've seen them range from merely debating the relaxation of certain restrictions to tolerating or even encouraging mass executions of those deemed socially useless and/or burdensome, the most serious challenge the opponents of legalized euthanasia need to meet is to show that once the chain of events gradually leading to this dreaded outcome is set in motion, it can no longer be stopped . We may have set it in motion by first passing laws and then installing and regulating practices in a certain way, i.e., by our collective will and/or agency, but once we've done that there is no return, through deployment of the very same legal or political means, to a previous stage that we then realize was still morally acceptable or far superior. In other words, while it may have been in our collective power to set the said process in motion, it is no longer in our collective power to reverse or even just stop it. Not even, we are expected to believe, with the current foresight over, and acute warnings against, potential risks.

Now I'm quite happy to concede that if the worst, most catastrophic scenario or anything like it eventually comes true, the resultant harm will be very serious and irremediable – worldwide, tens of thousands of people are going to be killed either without their consent (more likely) or against their explicit will (less likely), and the harm of violent, non-consensual death is not something that any victim can be compensated for. That said, however, what reasons do we have for thinking the legalization of euthanasia is a one-way road to hell with no stops, sort of a journey on a runaway train? The unsubstantiated assumption of collective powerlessness in the face of an oncoming moral catastrophe strikes me as the weakest premise in the case against legalized euthanasia. The opponents' case rests on a specific interpretation and extrapolation of available empirical data from the Netherlands and Belgium. But even granting that these data indicate problematic trends in the practice of euthanasia in the aforementioned countries, there is still a long way to the conclusion that the Dutch and Belgian failure to block these developments is necessary rather than accidental, a flaw in the very idea of a merciful death,

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[8] Two kinds of arguments are usually adduced in support of the causality claim: historical analogies or precedents (foremost the legalization of abortion in the sixties and the legalization of same-sex marriages at the turn of millennium) and a priori reasoning.

not in its clumsy implementation. It is one thing to assert, on the basis of an allegedly poor Dutch and Belgian record, that their practice of euthanasia leaves a lot to be desired, and something completely different to convincingly show that not only can the Dutch and the Belgians not improve it, no one can – no matter what.

4.3. Is our response to the risk of harm (and rights-violations) reasonable?

The answer to the above question will depend both on the magnitude and the probability of expected harm (and rights-violations) due to legalization. Peoples' intuitions about the worst-case scenarios are too often shaped by the magnitude of harm alone. This is even more common when such scenarios are cognitively available to them and hence spring to mind more easily, as is the case with euthanasia, where opponents have managed to infect people's perception and grip people's imagination with the graphic tales of Nazi abuse. What is often overlooked as well in discussions on euthanasia is that for a fair assessment of different options (outright ban, *de facto* and *de jure* decriminalization, proper legalization, and so on) we need to take into account the benefits as well as the costs thereof and that with the alleged benefits in focus, the latter are too often overlooked. Cass Sunstein makes a valid point in this respect:

> In some contexts, people are acutely aware of the burdens imposed by attempting to eliminate worst-case scenarios; but in other contexts, they are not attuned to those burdens at all. In regulatory policy, for example, those who urge extensive precautions against the worst cases often disregard the possibility that those very precautions can inflict losses and even create risks of their own. Risks, and bad worst cases, may be on all sides. (Sunstein 2007: 7)

Hence, we should start paying more attention to the hidden social and moral costs of current legal arrangements (disrespect of autonomous will, deprivation of the good of timely death, the fear of the loss of dignity, lack of assurance, and so on) if we are to hope for a fair assessment of comparative (dis)advantages.

4.3.1. Hidden moral costs of a current legal ban

By focusing on what Cass Sunstein calls 'worst-case scenarios', we tend to ignore, or underestimate, the more or less hidden moral costs of current legal arrangements. The preference for the *status quo* would be rational, if its benefits clearly outweighed its costs, moral ones included. But is the outcome of such a cost-benefit analysis really so evidently in its favor? Such a conclusion is more often based on wild guesses and questionable assumptions than on statistical facts.[9]

Going back to our initial question, we first need to divide it in two: i) is the outright ban on euthanasia efficient? and ii) is the outright ban on euthanasia proportionate? The answer to both questions, I submit, is negative: The outright legal ban on (all forms of) euthanasia is inefficient, for euthanasia appears to be widely practiced, albeit covertly, despite the official ban. This suspicion is hard to prove, as due to the lack of research into daily end-of-life decisions, evidence is scarce. Not quite non-existent, however. According to a survey conducted in 1995 and 1996 in Australia (see Kuhse et al. 1997), for instance, AVE and PAS accounted for 1.8 percent of all deaths, doctors actively and intentionally ended patients' lives without explicit request in 3.5 percent of all deaths and 24.7 percent of all deaths were preceded by a decision not to treat with the intention to explicitly end life, figures not that different from those in countries with legalized euthanasia. These findings have been disputed and the numbers, even if correct, may not be representative of other countries. And yet, the sad truth is that we simply don't know the size of the phenomenon because of the lack of interest in researching the undercover practice. Too often, an outright legal ban on euthanasia is coupled with a total lack of control over who makes and carries out the bulk of the unavoidable end-of-life decisions,[10] as well as a much more lenient attitude to medical decisions which also either intentionally or predictably hasten the death of a terminally ill patient, such as withholding or withdrawing life-prolonging treatment and terminal sedation, for a simple reason that they are classified as either passive, i.e., permissible euthanasia, or not euthanasia at all. On the other hand, the outright ban is disproportionate, because current legal arrangements protect (the rights and interests of) one group of people, the incompetent terminal patients, at the expense of (the rights and interests

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[9] As well as opportunity costs, i.e., the benefits that we forgo when we postpone, or give up on, a disputed legal or political measure. For an elaboration of this point, see Harris and Holm (1999) and Hughes (2006).

[10] Empirical disputes are so intractable for a number of reasons (Smith 2007). Take, for instance, a seemingly simple issue, that of efficiency – which is more efficient in protecting the rights and interests of terminally ill patients, legal ban on euthanasia or its legalization and regulation? Since there is little, if any, evidence of the incidence of non-voluntary euthanasia prior to the legalization of voluntary euthanasia and PAS, and the corresponding evidence from countries with a legal ban is even scanter, we seem to lack any epistemic grounds for adjudicating between the two legal regimes even along this simple measure. We could, of course, try to compare the numbers in countries with restrictive legislation and those in countries that have relaxed their legislation. Opponents of legalization protest such comparisons, however, and insist that due to the uniqueness of each country's situation and its specific interplay of social, cultural, political, economic, and legal factors, other countries provide a wrong comparison class (Keown 2018: 81–82). While I don't find this objection convincing at all, I cannot pursue the issue any further here.

of) another, namely the competent terminal patients. In addition, it imposes, or allows, *actual* harm and injustice on the latter for the sake of preventing a merely *potential*, future harm and injustice to the former.

Even in the worst-case scenarios, it will obviously depend on both the probability and the magnitude of potential harm – how likely is it that a significant proportion of terminally ill patients are going to be forced to end their lives prematurely and how big a harm or wrong is it to be rushed into a premature death, compared to the harm and injustice of being denied an immediate exit? I can think of three possible rebuttals of the charge of disproportionality:

(i) Incompetent, vulnerable, non-autonomous terminal patients vastly outnumber competent, autonomous terminal patients, in fact, within this group of patients, the latter form a tiny and in that respect a negligible minority.
(ii) The harm of forced death is incomparably bigger than the harm of forced life, and so prevention of the former is justifiably paramount, both morally and legally. (Call this 'the asymmetry claim', or AC.)
(iii) Forcing a person to die, unlike forcing her to live/go on living, is not simply harmful, but also wrongful, and since it is the business of the state to only protect its citizens against wrongful harm, competent terminal patients are not discriminated against or treated unjustly when legally denied this kind of last exit.

I will leave the consideration under (i) aside. It is a common and often heard complaint, but one with surprisingly little evidential support adduced in its favor. Let me address the other two objections in turn.

4.3.2. The notion, and the harm, of untimely death

Intuitively, it is much worse if your life is shortened than if it is prolonged against your will. Its intuitive appeal notwithstanding, however, AC is demonstrably false. We can see this by considering reasons for accepting the truth of the contrary claim, call it the equivalence thesis (ET): Morally speaking, being forced to live is, or can in principle be, just as bad as being forced to die.

To see this, we need another concept, that of a timely death. Let's say that S's death at t is timely iff it secures the maximum prudential value of S's life to S, that is, iff no death of S at any earlier or later point of S's life could secure equal or greater overall prudential value of that life to S. Correspondingly, then, S's death at t is untimely iff it fails to maximize the overall prudential/personal value of S's life for S.

We can add the following: The more detrimental the effect that untimely death has on the overall prudential value of S's life for S, the worse it is for S.

There are two types of untimely deaths, the premature and the delayed. Notice, however, that since they both deprive the subject of life of some amount of prudential value that her life has for her – premature death destroys life at a point when its overall value is still ascending, while the delayed one destroys it at the point when its overall prudential value has already begun to decrease – they are not just bad for her, and, insofar as they are harmful, prudentially bad for one and the same reason, the latter can in principle be worse than the former (if we conceive of the harm of untimely death as the deprivation of the good of a timely death, then the bigger the deprivation, the bigger the harm).

4.3.3. The wrongness (and even injustice) of being forced to live

This brings us to the third objection against my charge that an outright legal ban on euthanasia, even as a precautionary measure against the risk of harm, wrongdoing, or injustice, is disproportionate and hence unreasonable – namely that even if both premature and delayed deaths are harmful, only the former are in addition also wrongful and/or unjust (i.e., in violation of patients' rights) and hence a proper object of criminal law. The challenge for a proponent of the legal right to (be helped to) die, then, is to find a plausible candidate for a right (or a set of rights) that the state violates when it forces all terminally ill patients, irrespective of their will, to continue living.

Now, as already established in the previous section, an indeterminable, but possibly not insignificant subset of such patients is being harmed, and often harmed to the same extent, by having the option, and the good, of timely death precluded by an indiscriminate legal ban. But does this harm, whether we conceive of it as caused or merely allowed by the existing legal regime, really amount to wrongdoing or injustice? Surely there can be no such right as the right to a timely death, but without such a right, what other individual right (or valid moral principle) could possibly be violated by forced living? In this section, I'd like to argue, in broad brushstrokes, that this triumphant impression is mistaken. Foreclosing the option of a timely and/or dignified death doesn't just frustrate a person's legitimate interest, it also violates her right to life, or, if you wish, self-determination; as such it is the lawgiver's proper concern and/or proper object of criminal law for pretty much the same or very similar reasons for which we have outlawed killing people. Below is a sketch of an argument towards such a conclusion.

(1) The right to life entails a (liberty-)right to shape your life according to your own (reasonable) conception of the good.
(2) The time and the manner of one's death importantly determine the overall shape, duration and value of one's life.

Hence:

(3) Every person has a (defeasible) prima facie right to determine, in ideal conditions of choice, when and how they will die.

Hence:

(4) In criminalizing euthanasia and PAS, the state violates one's right to life.

The above argument is admittedly sketchy. In addition, many will find my broad interpretation of the right to life as a liberty-right to shape one's life in the light of one's conception of good, as stated in premise (1), overstretched. One way to block this objection would be to substitute a more controversial right, the right to (shape one's) life, with a less controversial one, the right to self-determination.[11] This, I submit, can, but need not, be done. My conjecture is that in the relevant context – and recall, the context is one of terminally ill patients who either due to their medical condition or the effects of drugs have permanently lost their capacity to form and, by extension, express their will – the two *de facto* come to the same. In other words, given that there is no valuable life left to protect by the right to life, the appeal to this right only makes sense from the point of view of due respect for the patient's autonomy or self-determination – insofar as taking their life is morally objectionable at all, it cannot be because we will have destroyed something valuable, but because of the disrespect of their autonomous will. Notice, however, that by definition, these patients have not only not declared their will, they have not even (as far as we know) formed one. How, then, can

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[11] Despite contrary appearance, the said substitution is not *ad hoc*. It is backed by what Dan Brock calls rights-based (as opposed to duty-based) accounts of the morality of killing. According to such accounts, "persons have a moral right not to be killed, but that right, like other rights, is theirs to use as they see fit so long as they are competent to do so; specifically, persons can waive their right not to be killed when they judge that their future is not on balance a good to them, and so its loss will not constitute a harm. In such cases, when they waive their right not to be killed by refusing life support, or by requesting terminal sedation, physician assisted suicide, or voluntary active euthanasia, these actions taken by their physicians (or others) will not wrong them by taking from them without their consent what is rightfully theirs, that is will not violate their right not to be killed. Nor will these actions harm the patient who reasonably judges further life to be on balance a burden and unwanted. In this rights-based view of the morality of killing, it will be the voluntariness of the patient's request for forgoing life support, terminal sedation, physician assisted suicide, or voluntary active euthanasia that is crucial to their moral permissibility. The rights-based account gives fundamental importance to individual self-determination or autonomy" (Brock 2004: 74).

doctors be guilty of disregarding it when they shorten patients' lives without the latter's explicit request? Accordingly, we can envision two kinds of cases of killings without explicit request – of patients whose will to live is simply ignored by doctors, and of patients who during their life have formed no morally binding will either way. By killing terminally ill patients from the first group, doctors would commit the same kind of injustice that terminally ill patients suffer whenever they are legally denied assistance in dying (whether in addition to other forms of injustice or as the only form). By killing patients from the second group, on the other hand, doctors would neither harm nor wrong their patients, since the latter can no longer either benefit from being (kept) alive or exercise their right to self-determination (or, for that reason, any related moral right).[12]

Let me offer an elegant practical solution to the above problem before turning to my last point. Not even the most carefully crafted euthanasia law can draw clear enough a line between permissible and impermissible mercy killings, the opponents of euthanasia warn us, and so we can realistically expect people to cross it occasionally, if not regularly. Notice, however, that some of the potential dangers of legalization to people's legitimate interest in, or right to, life could be countenanced otherwise, by measures much less severe and morally costly than the existing outright ban on euthanasia. If, for example, concerns about the fate of those terminally ill patients who are either permanently or temporarily incompetent are not exaggerated, then it might be wise to design a 'no-euthanasia for me, please' equivalent to a DNR (Do-Not-Resuscitate) instructions for doctors. Unlike DNRs, these DNE (Do-Not-Euthanize) orders would not only dispel the mystery of the patient's last will, they would also legally bind doctors to refrain from euthanasia no matter how appropriate they may judge it themselves. Such official declarations of will could be valid permanently (subject only to formal withdrawal) or for a limited time period (after which they'd need to be renewed) and embedded either within an opt-in or an opt-out system similar to the one that governs the procurement of organs for transplantation. People could then sign forms that would, depending on the model adopted, guarantee that their will regarding time, place and manner of death – be it in favor of continued

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[12] In a way, this dichotomy is an oversimplification. There will always be patients whose will is indeterminate, or indeterminable. Psychiatric and dementia patients belong to this group, and a lot of the debate about their proper treatment will revolve around both their well-being and autonomy: What's best for them, continued life or instant death? Who's to tell? Are they still capable to decide for themselves or should someone else take over? The hardest cases to handle will be those where a person's present preferences depart from her past will – shall we listen to preferences of her present self or let our surrogate decisions be guided by the will that her past self once undeniably formed? For an interesting way out of this conundrum, see Jaworska (1999).

life or immediate death – is known to, binding for and respected (or at least not ignored for reasons of uncertainty) by doctors. Well-known problems with advance directives non-withstanding, such a solution promises a much better compromise between acceptable risk and expected gain than the current legal *status quo*.

4.3.4. Is there anything distinctly wrong (and unjust) about being rushed to death?

Let me finally briefly explore the other remaining avenue. We could grant to the opponent that the violation of one's right to self-determination is not as serious an offence as the violation of one's right to life. What right(s), then, could we be violating when we force a patient to die, but not also when we force her to keep on living? Two candidates for such a right spring to mind: (a) the liberty-right to choose the time and manner of one's death and (b) the claim-right not to be killed.

Now, it is immediately clear that the first candidate is a non-starter. Since the right to choose the time and manner of one's death, provided there is such a right, is violated in both cases, i.e., both when your life is taken away from you without your consent and when you are forced to go on living, it cannot provide moral grounds for a legal discrimination between them. Another idea, that harms are only wrong(ful) as long as they are non-consensual (Feinberg 2000), fares no better in that respect, for both types of untimely deaths are (equally) non-consensual and to that extent (equally) wrong. The same goes for the suggestion that it is only wrong to cause a certain type of harm to those who are not indifferent to being so harmed (Belshaw 2016), since, by stipulation, all those deprived of the good of a timely death are deprived of something that they appreciate and (would) want for themselves, whether this good is denied to them by premature or delayed death.

The claim-right not to be killed (against one's will) is the sole survivor, then. This right clearly manages to account for the difference between cases of killing someone against her will and forcing someone to go on living, for even if we want to qualify it to something like the right not to be killed against one's own will, we will have violated it only when we kill someone who would have liked to live, but not also when we refuse to kill someone who wants to die. This impression is mistaken, however. While there may or may not be such a thing as an unqualified right not to be killed against one's will (I personally doubt there is), the right under consideration is of a different kind – namely the right not to be killed *without one's explicit consent, or clear expression of one's rational and autonomous will*. And such a right, if indeed there is such a right, is surely even more controversial than an unqualified right not to be killed *against one's will*. But if so, then the right that the argument in favor of the asymmetry claim is premised upon becomes suspicious and cannot really carry the argumentative weight without further proof.

There is another reason to be skeptical of the prospects of this line of argumentation. As already shown, no evidence so far backs the claim that terminally ill patients are currently being rushed to death against their will.[13] What may be happening are relatively isolated cases where incurable patients with low quality of life (measured by any reasonable standard), no prospect of recovery and no decisional capacity left to form a morally binding will are euthanized. Unless one implausibly both assumes that the right to life is inalienable and identifies the said right with a right not to be killed under any circumstances (which boils down to a view that killing human beings is never permissible), the ascription of such a right to a person with no valuable life left to live and no capacity to either appreciate or denounce, choose or reject her own future life, cannot really be motivated by a plausible theory of either moral rights or the wrongness of killing.[14] But then such rare killings either won't constitute injustices at all (since there is no right to be violated), or will at best amount to a less alarming kind of harmless wrongdoings (since the violated right no longer protects the bearer's vital interests or conditions of her free and rational agency).

It is important to be clear about the proper scope of the above argument. I'm not suggesting that victims of killings suffer either the same kind of injustice as the victims of forcible living, nor that the injustice they suffer is of exactly the same magnitude. Instead, the argument aims to establish a somewhat weaker claim – that the inescapable trade-offs at the end of life are, and will continue to be, between different kinds of injustices, not between injustices and mere harms, or even just (regrettable but not really culpable) denials of benefits. This by itself will not tip the balance in favor of legalization, of course. It will, however, make the outcome of moral calculation much more uncertain, dependent more on empirical details and less on a priori moral reasoning.

5. Conclusion

More than a decade since the ground-breaking introduction of the legal right to die in the Netherlands, the US federal state of Oregon and Belgium, pro-

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[13] Or to use the established terminology, there is some evidence of non-voluntary euthanasia, but none so far of involuntary euthanasia. The former occurs when the patient is not mentally competent (anymore) and could not request euthanasia, the latter when the patient is mentally competent but did not request euthanasia (Emanuel et al. 2016: 80).

[14] I myself have criticized Kantian-inspired objections against a legal right to die in Klampfer (2001) and (2002).

posals to legalize active voluntary euthanasia are still met with staunch opposition and vigorous criticism. In the paper, I set out to examine the most popular and influential objection against legalization, the so-called slippery slope argument (SSA). According to the SSA, by legalizing active voluntary euthanasia, the least morally controversial type of euthanasia, we will nevertheless take the first step onto a slippery slope and inevitably end up in the moral abyss of widespread abuse and right-violations of the weakest and most vulnerable patients.

Have almost two decades of closely monitored practice validated such fears? Not really. There is no compelling empirical evidence that by legalizing euthanasia we will bring moral disaster upon ourselves. Absent such evidence, however, the existing outright legal ban on euthanasia cannot be morally justified, not even on the assumption that the possibility of such a disaster cannot be completely ruled out. Even as a measure of precaution, such a ban is both inefficient and excessive.

Bibliography

Anderson, E. 1993. *Value in Ethics and Economics* (Harvard, MA: Harvard University Press).

Battin, M. P. et al. 2007. "Legal Physician-Assisted Dying in Oregon and the Netherlands: Evidence concerning the Impact on Patients in 'Vulnerable' Groups", *Journal of Medical Ethics* 33, 591–597.

Bellaigue, C. de 2019. "Death on Demand: Has Euthanasia Gone Too Far?", *The Guardian*, 18 January 2019.

Belshaw, C. 2016. "Death, Pain and Animal Life", in T. Višak and R. Garner (eds.), *The Ethics of Killing Animals* (Oxford and New York: Oxford University Press), 32–50.

Brock, D. 2004. "Terminal Sedation from a Moral Right's Perspective", in T. Tännsjö (ed.), *Terminal Sedation – Euthanasia in Disguise?* (Dordrecht: Kluwer Academic Publishers), 71–80.

Buiting, H. M. et al. 2010a. "No Increase in Demand for Euthanasia Following Implementation of the Euthanasia Act in the Netherlands: Pain as a Reason for Euthanasia Request was Increasing Before Implementation but Declined Subsequently", *Evidence Based Medicine* 15, 59–160.

Buiting, H. M. et al. 2010b. "Physicians' Labelling of End-of-Life Practices: A Hypothetical Case Study", *Journal of Medical Ethics* 36, 24–29.

Burg, W. van der 1991. "The Slippery Slope Argument", *Ethics* 102, 42–65.

Callahan, D. 1992. "When Self-Determination Runs Amok", *The Hastings Center Report* 22, 52–55.

Chambaere, K. et al. 2010. "Physician-Assisted Deaths Under the Euthanasia Law in Belgium: A Population-Based Survey", *Canadian Medical Association Journal* 182, 895–901.

Chambaere, K. et al. 2015. "Recent Trends in Euthanasia and Other End-of-Life Practices in Belgium", *New England Journal of Medicine* 372(12), 1179–1181.

Dierickx, S. et al. 2016. "Euthanasia in Belgium: Trends in Reported Cases Between 2003 and 2013", *Canadian Medical Association Journal* 188(16), 407–414.

Emanuel J. E. et al. 2016. "Attitudes and Practices of Euthanasia and Physician-Assisted Suicide in the United States, Canada, and Europe", *JAMA* 316(1), 79–90.

Enoch, D. 2001. "Once You Start Using Slippery Slope Arguments, You're on a Very Slippery Slope", *Oxford Journal of Legal Studies* 21, 629–647.

Euthanasia in Belgium. Ten Years On. Dossier of the European Institute of Bioethics, http://www.ieb-eib.org/en/pdf/20121208-dossier-euthanasia-in-belgium-10-years.pdf [accessed September 10, 2019].

Feinberg, J. 2000. *Harmless Wrongdoing* (New York: Oxford University Press).

Gardiner, S. 2006. "A Core Precautionary Principle", *Journal of Political Philosophy* 14, 33–60.

Glannon, W. 2002. "Extending the Human Life Span", *Journal of Medicine and Philosophy* 27(3), 339–354.

Glannon, W. 2008. "Psychopharmacological Enhancement", Neuroethics 1, 45–54.

Govier, T. 1982. "What's Wrong with Slippery Slope Arguments?", *Canadian Journal of Philosophy* 12, 303–316.

Griffiths, J. 2008. "Physician-Assisted Suicide in the Netherlands and Belgium", in D. Birnbacher and E. Dahl (eds.), *Giving Death a Helping Hand* (Dordrecht: Springer), 77–86.

Harris, J. and Holm, S. 1999. "Precautionary Principle Stifles Discovery", *Nature* 400, 398–398.

Hartogh, G. den 2009. "The Slippery Slope Argument", in H. Kuhse and P. Singer (eds.), *A Companion to Bioethics* (Malden, MA: Blackwell Publishing), 321–332.

Heide, A. van der, et al. 2007. "End-of-Life Practices in the Netherlands Under the Euthanasia Law", *The New England Journal of Medicine* 356, 1957–1965.

Heide, A. van der, et al. 2017. "End-of-Life Decisions in the Netherlands Over 25 years", *The New England Journal of Medicine* 377, 492–494.

Heide, A. van der 2019. "Developments in End-of-Life Decision Making Practices in Europe", paper presented at the *Third International Conference on End-of-Life Law, Ethics, Policy and Practice* in Ghent, March 7–9 2019.

Hill, T. E. Jr. 1991. "Self-Regarding Suicide: A Modified Kantian View", in *Autonomy and Self-Respect* (Cambridge: Cambridge University Press), 85–103.

Hughes, J. 2006. “How Not to Criticize the Precautionary Principle”, *Journal of Medicine and Philosophy* 31(5), 447–464.

Jaworska, A. 1999. “Respecting the Margins of Agency: Alzheimer’s Patients and the Capacity to Value”, *Philosophy & Public Affairs* 28(2), 105–138.

Jones, D. A. 2011. “Is There a Logical Slippery Slope from Voluntary to Non-Voluntary Euthanasia?”, *Kennedy Institute of Ethics Journal* 21, 379–404.

Kamisar, Y. 1995. “Physician-Assisted Suicide: The Last Bridge to Active Voluntary Euthanasia”, in J. Keown (ed.) 1995, 225–260.

Keown, J. (ed.) 1995. *Euthanasia Examined. Ethical, Clinical and Legal Perspectives* (Cambridge: Cambridge University Press).

Keown, J. 1995. “Euthanasia in the Netherlands: Sliding Down the Slippery Slope?”, in J. Keown (ed.) 1995, 261–296.

Keown, J. 2004. *Euthanasia, Ethics and Public Policy. An Argument Against Legalization*, 1st Edition (Cambridge: Cambridge University Press).

Keown, J. 2018. *Euthanasia, Ethics and Public Policy. An Argument Against Legalization*, 2nd Edition (Cambridge: Cambridge University Press).

Klampfer, F. 2001. “Suicide, Euthanasia and Human Dignity”, *Acta Analytica* 16(27), 7–34.

Klampfer, F. 2002. “Persons, Agents, and the End-of-Life Decisions”, in C. Kanzian, J. Quitterer and E. Runngaldier (eds.), *Persons. An Interdiscplinary Approach. Papers of the 25th International Wittgenstein Symposium, August 11–17, 2002, Kirchberg am Wechsel*, Vol. 10 (Kirchberg am Wechsel: Austrian Ludwig Wittgenstein Society), 109–111.

Kuhse, H. et al. 1997. “End-of-Life Decisions in Australian Medical Practice”, *Medical Journal of Australia* 166, 191–196.

Kumar, A. and Bagaric, M. 2001. “The Legalisation of Euthanasia in the Netherlands: Lessons to be Learnt”, *Monash University Law Review* 27, 179–196.

Kumar, A. and Bagaric, M. 2004. “Moving from Voluntary Euthanasia to Non-Voluntary Euthanasia: Equality and Compassion”, *Ratio Juris* 17, 398–423.

LaFollette, H. 2005. “Living on a Slippery Slope”, *Journal of Ethics* 9, 475–499.

Levy, G. 2011. *Assisted Death in Europe and America. Four Regimes and Their Lessons* (Oxford: Oxford University Press).

Lillehammer, H. 2002. “Voluntary Euthanasia and the Logical Slippery Slope Argument”, *Cambridge Law Journal* 61, 545–550.

Myhr, A. I. 2010. “A Precautionary Approach to Genetically Modified Organisms: Challenges and Implications for Policy and Science”, *Journal of Agriculture and Environmental Ethics* 23(6), 501–525.

Onwuteaka-Philipsen, B. D. et al. 2012. "Trends in End-of-Life Practices Before and After the Enactment of Euthanasia Law in the Netherlands from 1990–2010: A Repeated Cross-Sectional Survey", *Lancet* 380, 908–915.

Oregon's Death With Dignity Act. 2018 Data Summary. https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year21.pdf [accessed September 10, 2019].

Raz, J. 2012. "Death in Our Life", *Oxford Legal Studies Research Paper* 25/2012, https://ssrn.com/abstract=2069357 [accessed September 10, 2019].

Resnik, D. B. 2003. "Is the Precautionary Principle Unscientific?", *Studies in the History and Philosophy of Biological & Biomedical Sciences* 34, 329–344.

Rietjens, J. A. C. et al. 2009. "Two Decades of Research on Euthanasia from the Netherlands. What Have we Learned and What Questions Remain?", *Bioethical Inquiry* 6, 271–283.

Rurup, M. L. et al. 2011. "The First Five Years of Euthanasia Legislation in Belgium and the Netherlands: Description and Comparison of Cases", *Palliative Medicine* 26, 43–49.

Scoccia, D. 2005. "Slippery Slope Objections to Legalizing Physician-Assisted Suicide and Voluntary Euthanasia", *Public Affairs Quarterly* 19, 143–161.

Smith, S. W. 2007. "Empirical Research in the Debate on Physician-Assisted Suicide and Voluntary Euthanasia", *Clinical Ethics* 2, 129–132.

Sunstein, C. R. 2005. *Laws of Fear. Beyond the Precautionary Principle* (Cambridge: Cambridge University Press).

Sunstein, C. R. 2007. *Worst-Case Scenarios* (Cambridge, MA: Harvard University Press).

Šuster, D. 2015. *Moč argumenta: neformalna logika v teoriji in praksi (Engl. The Power of Argument: Informal Logic in Theory and Practice)* (Maribor: Aristej).

Volokh, E. 2003. "The Mechanisms of the Slippery Slope", *Harvard Law Review* 116, 1026–1134.

Warnock, M. and Macdonald, E. 2008. *Easeful Death. Is There a Case for Assisted Dying* (Oxford: Oxford University Press).

Willmot, L. and White, B. 2019. "Assisted Dying in Australia: A Time of change?", paper presented at the *Third International Conference on End-of-Life Law, Ethics, Policy and Practice* in Ghent, March 7–9 2019.