**OLD OUTLINE**

Issue Question: Is there a slippery slope from voluntary euthanasia to involuntary euthanasia?

1. If medical doctors can receive potential benefits from euthanizing patients, then there is a slippery slope from voluntary euthanasia to involuntary euthanasia.
   1. For the sake of this argument, the definition of voluntary euthanasia is “when the person who is killed has requested to be killed.” (<http://www.euthanasia.com/definitions.html>)
   2. For the sake of this argument, the definition of involuntary euthanasia is “when the person who is killed made an expressed with to the contrary.” (<http://www.euthanasia.com/definitions.html>)
   3. Human nature is to vie for short term reward, in contrast of looking for long-term achievements.
      1. Doctors could decide to move on with a new patients by involuntarily euthanizing another patient.
   4. Potential psychopathic doctors could gain potential psychological rewards from euthanizing a patient.
      1. A psychopath is defined as someone who “manifests… amoral and antisocial behavior…” (<http://dictionary.reference.com/browse/psychopath>)
      2. According to modern science, any person can be a potential psychopath, including doctors and other medical practitioners.
         1. A famous example: Neuroscientist James Fallow discovered he was a psychopath via tests and even wrote a book about it. (<http://www.smithsonianmag.com/science-nature/the-neuroscientist-who-discovered-he-was-a-psychopath-180947814/?no-ist>)
2. Medical doctors can receive potential benefits from euthanizing patients.
   1. There would be more space in the hospital, allowing doctors to accept more patients.
      1. Oregon (which has a Death with Dignity law) frees up approximately 70 beds per year for other patients via euthanizing patients. (<http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year16.pdf>)
   2. More space in the hospital means more patients can come and pay the doctor for his/her services.
      1. The stream of income is more reliable if there is a constant flow of new patients coming in.
         1. This is because terminally-ill patients could die at any time, ending their payment period.
      2. Hospitals have an (increasing) tendency to ask patients to pay upfront – guaranteeing income. (http://www.businessweek.com/articles/2014-09-25/why-hospitals-want-patients-to-pay-upfront)
3. There is a slippery slope from voluntary euthanasia to involuntary euthanasia.

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Is there a slippery slope from voluntary euthanasia to involuntary euthanasia?

I stand in affirmation that there is a slippery slope from voluntary euthanasia to involuntary euthanasia. My main reasoning for this is lifted directly from the outline I proposed in class: “If medical doctors can receive potential benefits from euthanizing patients, then there is a logical slippery slope from voluntary euthanasia to involuntary euthanasia.” This logic seems straightforward enough: humans (including doctors) will often make decisions based on what is most relevant and rewarding to themselves, with disregard for long-term rewards or consequences. It’s a well-documented psychological phenomenon that humans often choose things which are immediately rewarding to themselves than choose something that can be good for long down the road (<http://www.princeton.edu/pr/news/04/q4/1014-brain.htm>). Therefore, if this premise can hold true if we can prove doctors can receive potential benefits from euthanizing patients, and prove how there is a direct link between the two. A further point of contention is the possibility for the mental health of a doctor to vary. Some doctors may in fact be psychopathic, as approximately 1% of the human population is (this statistic will be discussed and cited later). Due to the mental health fluctuations of doctors, the economic and societal pressures, and human desire for short-term rewards, I believe there is a slippery slope from voluntary euthanasia to involuntary euthanasia.

In order to properly discuss this argument, there needs to be a few terms defined to ensure there are no miscommunications and both sides have an even playing field from the beginning. For the purposes of this paper, “voluntary euthanasia” will be defined as “when the person who is killed has requested to be killed” (<http://www.euthanasia.com/definitions.html>). Likewise, “involuntary euthanasia” will be defined as “when the person who is killed made an expressed wish to the contrary” (<http://www.euthanasia.com/definitions.html>). Being the overarching question of this paper, it’s important to have a firm grasp on the definitions and differences between the two.

My first step in affirming my contention that there is a slippery slope is to illustrate that the argument holds logically. That if doctors can receive potential benefits from euthanizing patients, then there isa logical slippery slope from voluntary to involuntary euthanasia. I’m first just going to prove that there is a connection between the two premises. I’ve already discussed the psychological concept of delayed gratification – the human’s ability to resist the temptation for short-term reward in favor of long-term rewards – and how modern psychology has noted that most people fall prey to it (<http://www.psychologytoday.com/blog/obesely-speaking/201401/delayed-gratification-battle-must-be-won>). This is the philosophical concept of **Utilitarianism** viewed on a micro-scale. Humans typically make decisions based on the **Hedonic Calculus** of their own personal actions, with the intent to maximize happiness.

Doctors can often fall prey to the pressure of instant gratification – in this particular case, taking on more patients. Doctors have an increased pressure to take on more patients for a plethora of reasons, including (but not limited to): the patients want to see a doctors as soon as possible, the business-minded people of the hospital can make more money if more patients are dealt with in a quicker amount of time, etc. The immediate gratification would be to quickly euthanize a patient if they are demanding of a doctor’s time, even if involuntarily. This would allow the doctors to move on and receive instant praise and reward from the other patients and the business-minded people of the hospital. So, from an economic standpoint and a viewpoint of the other patients, it would make sense for a doctor to euthanize a patient and move on to others quickly.

Exploring another psychological concept that is applicable to almost all ethical decisions: psychopaths and sociopaths. It’s not something that the zeitgeist contemplates often, but according to psychological studies by Meloy and others, psychopaths are thought to make up approximately 1% of the total population (<http://www.livescience.com/16585-psychopaths-speech-language.html>). And while this may not seem a large percent of the population, psychopaths are accredited with over half (50%) of all serious crimes. This is a very small minority committing the majority of all crimes in the United States. For the purposes of this discussion, we’ll define a psychopath as someone who “manifests… amoral and antisocial behavior…” (<http://dictionary.reference.com/browse/psychopath>).

Oftentimes the zeitgeist views doctors and other medical practitioners as flawless, incapable of committing atrocities. Of course, there are countless counterexamples to this thought process. It’s worth mentioning that there have been instances of doctors being psychopaths. One instance that drew some media publicity is the case of neuroscientist James Fallow who discovered he was a psychopath via testing (<http://www.smithsonianmag.com/science-nature/the-neuroscientist-who-discovered-he-was-a-psychopath-180947814/?no-ist>). With the possibility of doctors being psychopathic, they could gain potential psychological rewards from euthanizing patients in a Doctor Kevorkian-esque manner. Allowing voluntary euthanasia would pave the way for potentially psychopathic doctors to euthanize patients for ulterior motives, giving them short-term psychological rewards, and proving the existence of a logical slippery slope.

Culminating the idea of a psychopathic doctor and external influences that pressure them to take more patients at once and move quicker with each patient, allowing doctors to perform voluntary euthanasia would free up more space for more patients.

In 1994, the Death with Dignity Act was passed in the state of Oregon. This bill allowed terminally-ill patients to opt to take their own lives instead of waiting for their terminal illness to kill them. Proponents of this act say that this allows terminally ill patients to be in control of their end-of-life medical care, and have the ability to “die with dignity” before rotting away slowly. This act has been controversial and has been attempted to be repealed several times, and criticized by the Bush Administration. However, when put on the general ballot, the bill remained in place with a 60% vote in favor of the law.

This act has allowed patients to leave the hospital quicker by taking their lives. In fact, this piece of legislation is accredited to freeing up approximately 70 beds per year for other patients (<http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year16.pdf>). This could potentially be abused as a method for doctors to hurry up a patient’s stay by diagnosing them as terminally ill and suggesting ending their life. Psychopathic doctors or doctors that misdiagnosed an illness could potentially use this to achieve their short-term psychological rewards.

Furthermore, economic incentives drive the doctors to increase the speed in which they diagnose and treat patients. The influx of patients that could leave a hospital by permitting voluntary euthanasia and leading to involuntary euthanasia could cause a hospital to make a good amount more money. The flow of income is more reliable and constant is there is a constant inflow of new patients coming in, whose could be taking up the places of previously terminally-ill patients’ deathbeds. This is also coupled that hospitals are increasingly asking patients to pay upfront for medical services (<http://www.businessweek.com/articles/2014-09-25/why-hospitals-want-patients-to-pay-upfront>), which means that doctors are guaranteed more income for the hospital they work at by euthanizing patients.

With the strong external pressures being based both on economic and social pressures, and the potentiality for a psychopathic doctor (remember, it is estimated that psychopaths make up 1% of the human population) to abuse the system of “voluntary” euthanasia, I conclude that there is a logical slippery slope from voluntary to involuntary euthanasia. With the amount of doctors and the difficulty in regulating all of them equally, there are bound to be cases in which doctors abuse the system and involuntary euthanize a patient.

Furthermore, the definitions I proposed in this paper are dictionary-based definitions, and some medical practitioners may have varying definitions of what constitutes voluntary and involuntary euthanasia. For example, is it right to euthanize a patient that’s been in a coma for 10 or more years, despite them not being able to give consent? The ambiguity and moral greyness of some of these scenarios leaves the doctor and legislative branches open to interpret these cases in a not-so-straightforward way. If a doctor was accused of malpractice due to the death of a patient, the doctor may be able to get away with certain offences based upon the wording of any voluntary euthanasia law, and perhaps their own persistence that what they did was not wrong in any moral or ethical sense.

According to Edmund D. Pelligrino, MD and Professor Emeritus of Medicine and Medical Ethics at Georgetown University, this ambiguity can cause problems, especially when the doctor believes wholeheartedly that he is doing the right thing and that he has the legislation on his side (<http://euthanasia.procon.org/view.source.php?sourceID=000689>). This is the concept of statutory interpretation in action (<http://www.law.cornell.edu/wex/statutory_construction>). Essentially, every piece of legislation that is passed is up to courtly interpretation and may not end up as what the original framers of the law wanted. This is just another way that the law could be abused, no matter how careful they were to avoid any ambiguity.

Furthering the concept of statutory interpretation, this ties into John Locke’s concept of **Social Contract Theory**, that morality is the set of rules that all rational people should abide by, and that only the government can provide guarantees that people will not harm each other (<http://www.csus.edu/indiv/g/gaskilld/ethics/sct.htm>). However, this can only be achieved by legislation, and any attempts to legislate this will be in part ambiguous, allotting for a slippery slope.

Therefore, there is a logical slippery slope from voluntary to involuntary euthanasia. With the unpredictable nature of humans and their psychological predisposition to vie for short-term rewards, coupled with the potential economic and society pressures and the statutory interpretations of a voluntary euthanasia piece of legislation, it is incredibly hard to believe that it wouldn’t be abused and lead to instances of involuntary euthanasia.

**References**

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