# ***Weithman Handout***

1. From p. 2:

> The empirical kind makes a factual prediction that a seemingly acceptable law or policy is likely to have unacceptable results. The claim is often that adopting a particular practice or policy will gradually change the attitudes of practitioners or the general public, leading them to accept what they previously, and rightly, regarded as unacceptable.
>
> Some empirical slippery-slope arguments are based on pure speculation. They claim to be making a prediction about what is likely to occur, but without empirical evidence to support the claim a slippery slope is likely, all they can maintain is that a slippery slope is possible. Such arguments have very little weight.

2. From p. 23:

> If MAID is being normalized as just another treatment option, that's disturbing. We may disagree about what the eligibility criteria should be, but PAD should always be regarded as a last resort, when there is no other way to prevent unbearable and unmitigable suffering or to respect autonomous choices that reflect patients' deepest values.

3. From p. 16:

> it now seems to me that it is justifiable to impose more restrictive capacity requirements for eligibility for AD than for treatment refusal. I base this view on two important moral differences between PAD and refusing treatment. The first is that only PAD requires the participation of health care professionals. This is not the case when health care professionals respect treatment refusals. They are required only to refrain from forcing unwanted treatment on patients. If physicians are going to help people to die, they should regard their requests as well-considered and voluntary, and not merely "the disease talking."

4. The argument:

(1) PAD requires that health-care professionals participate in giving effect to their patients' decisions. (assumption)

(2) Health care professionals should ensure that their patients' requests are well-considered and voluntary, and not merely "the disease talking" if they are going to participate in giving effect to their patients' decisions. (assumption)

(3) Health care professionals should ensure that their patients' requests for PAD are well-considered and voluntary, and not merely "the disease talking". (from 1 and 2)

(4) Health care professionals need to ensure that their patients' requests are well-considered and voluntary, and not merely "the disease talking" only if they are going to participate in giving effect to their patients' decisions.[1] (assumption)

(5) Respecting refusal of life-sustaining treatment does not require that health-care professionals participate. (assumption)

(6) If patients refuse life-sustaining treatment, health care professionals need not ensure that the refusal is well-considered and voluntary, and not merely "the disease talking". (from 4 and 5)

(7) "it is justifiable to impose more restrictive capacity requirements for eligibility for AD than for treatment refusal." (from 3 and 6)

C: Even if severely depressed patients meet the capacity requirement for treatment refusal, there are justifiable capacity requirements for eligibility AD that they do not meet. (from 7)

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[1] The conclusion C could be reached even if (4) and (6) were weakened to say that it is more important for physicians to make sure patients' requests are well-considered and voluntary in cases in which they are going to act on those requests than in cases in which they are not. Since weakening (4) and (6) in this way would not affect the questions I want to raise about the argument, I will leave the simpler and stronger formulation of the premise in place.