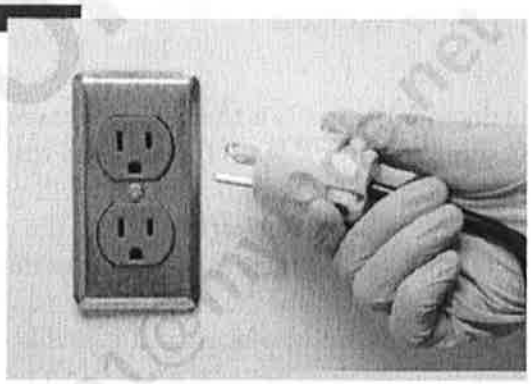
CHAPTER 8

WHOSE LIFE IS IT ANYWAY? EUTHANASIA, ASSISTED SUICIDE, SUICIDE



Concept photo for "Pulling the Plug" on life support in hospital showing doctor's hand pulling the life support equipment plug from wall.
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LEARNING OBJECTIVES

After reading this chapter, you will be able to:

- **8.1** Discuss the morality of mercy killing and assisted suicide.
- **8.2** Critically analyze the relation between what is legal and what is moral in end-of-life care.
- **8.3** Articulate the utilitarian and Kantian arguments about suicide, assisted suicide, and euthanasia.

8.1 A MATTER OF MERCY

Faithful Fido, your family's beloved old beagle, has been around as long as you can remember. He hasn't been doing well lately, however, staying in a corner and moaning, not excited about going out and in fact obviously in pain. The veterinarian's diagnosis is that Fido has metastatic stomach cancer, that is, cancer that has spread to other parts of his body. His condition is terminal; he will not get better but instead will continue living in increased pain until he dies. It is no secret in the medical community that

painkillers are not effective in alleviating the sort of pain cancer brings, unless they are given in such a high dose that it is the patient who will be killed, not just the pain. Out of mercy and out of love, you ask the veterinarian to euthanize Fido. That course of action seems moral. It is legal, and perhaps, above all, it is merciful.

Old Belgian shepherd in front of white background.
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Sebastian, your favorite uncle, has been around as long as you can remember. He hasn't been well lately, however, staying in bed late after nights of poor sleep, no longer excited to get together with the family, always tired and in fact always in pain. The doctor's diagnosis is that Uncle Sebastian has metastatic cancer, which is spreading to his lymph glands and his bones. His condition is terminal; he will not get better but instead will go on living in increased pain until he dies. He himself would like to die rather than go through months of invasive, useless medical procedures that will only add to his pain. And yet, what seemed like the right thing to do in the case of Fido, the old beagle, is illegal in most places, and it is also considered immoral by many. Are we treating dogs better than we treat people?

Older ill man with nasal cannula sleeping in hospital bed.
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The question is difficult, and the answers are in a state of flux. In the case of Uncle Sebastian, there were two widely accepted options. Both illustrate what is at best a gray area in the healthcare of people who are dying. One is the hospice movement, which has grown considerably in the last few decades. In hospice care, the patient is not put through any medical procedures or given any medications other than those that will make him or her less uncomfortable, that is, painkillers. Because Uncle Sebastian happened to be a doctor, he was put in charge of his own hospice care at home and thus in control of his pain medication.

When the pain became unbearable, he gave himself enough morphine to die with dignity, at his home surrounded by family and friends rather than in a hospital connected to a myriad tubes. A patient who is not a doctor does not have that option, but he or she has another: a **do not resuscitate (DNR) order** signed by the patient and posted at the head of the hospital bed. That means should the patient have the good fortune to have a heart attack and stop breathing, the doctors and nurses will do nothing to bring that patient back. A strictly Kantian outlook says that the doctors do nothing in this case that the patient dies. That in fact the doctors kill the patient precisely by doing nothing is open to debate. DNR orders are common in hospitals in the United States, and they are legal.

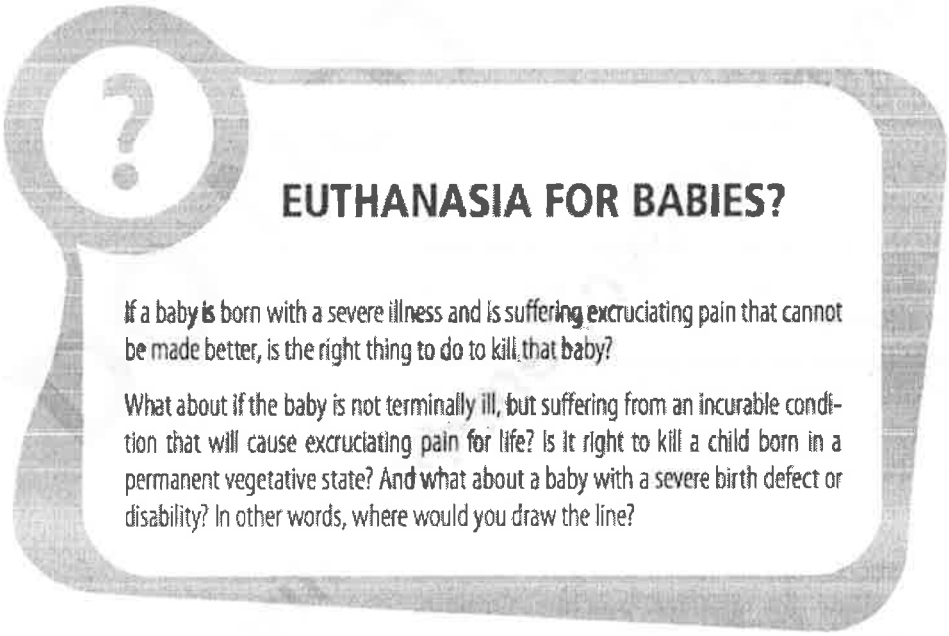
> ***"The only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant. Over himself, over his own body and mind, the individual is sovereign."***
>
> John Stuart Mill

8.2 SHOULD WE KILL BABIES?

The laws regulating what doctors may or may not do to end a life vary from state to state in the United States, as well as from country to country. In 2001, the Netherlands became the first country to legalize euthanasia, allowing doctors to end the life of adult patients at the patient's request. In 2008, the law was amended to allow parents to give consent for doctors to kill infants who are terminally ill and in severe pain. This new measure, known as the **Groningen Protocol**, is the first to allow euthanasia for newborn babies. If a newborn is not expected to live but must do nothing but suffer while waiting for a natural death, the Dutch law allows doctors to kill that baby.

Killing a patient is not legal, however, except in states that have adopted "Death with Dignity" laws that allow for assisted suicide: Oregon, Montana, Washington, New Mexico, Vermont, and most recently California. There are "Death with Dignity" bills pending in Connecticut, Hawaii, Kansas, Massachusetts, and New Hampshire. In Canada, the British Columbia Supreme Court in 2012 overturned the Canadian law against assisted dying. In Europe, doctor-assisted suicide and voluntary

active euthanasia are legal in the Netherlands, Belgium, Luxembourg, and Switzerland. The dissimilarities among countries have led to some painful legal dilemmas. Sir Edward Downes, the legendary music director of the BBC Philharmonic and a popular conductor at the Royal Opera House, Covent Garden, was severely ill, blind and deaf, in pain; his wife of 54 years, Joan, was diagnosed with terminal cancer. Sir Edward and Lady Joan decided to die together. They traveled to the Dignitas Clinic in Zurich in 2009, lay down together after drinking a clear liquid provided by the clinic, and died peacefully holding hands. Their son, who helped his parents obtain the hotel reservation in Switzerland for their final trip, was brought into Scotland Yard with a view to prosecuting him as an accessory to murder. He was cleared in 2010, using new guidelines now in place that state that anyone acting with compassion to help end the life of someone who has decided he or she cannot go on is "unlikely" to be charged. But the law is still in the books. In 2013, in Miami, Florida, a woman who tried to commit suicide and failed was arrested and charged with attempted manslaughter.



EUTHANASIA FOR BABIES?

If a baby is born with a severe illness and is suffering excruciating pain that cannot be made better, is the right thing to do to kill that baby?

What about if the baby is not terminally ill, but suffering from an incurable condition that will cause excruciating pain for life? Is it right to kill a child born in a permanent vegetative state? And what about a baby with a severe birth defect or disability? In other words, where would you draw the line?

8.3 KANT, MILL, AND THE LIMITS OF INDIVIDUAL LIBERTY

The arguments for and against suicide, assisted suicide, and euthanasia are as powerful as they are clear. That the killing of the innocent is wrong has been a foundational belief of Western civilization, one to which **Immanuel Kant** gave a solid moral basis. Clearly, Kant's categorical imperative reveals without any doubt the immorality of killing an innocent person—and who is more innocent than a cancer patient? The same argument applies to suicide or euthanasia: One cannot follow the categorical imperative and condone either; one cannot treat anyone, including oneself, as a means to end but rather always as an end in itself—even the aim in this case is the elimination of excruciating pain from cancer or the prospect of a slow and painful loss of control over one's own body.

That, besides weaker **Natural Law** justifications, is the principle behind not only the law in most countries but also the traditions of the Jewish, Christian, and Muslim religions, all of whose holy scriptures forbid suicide. But already in the 18th century, **Jeremy Bentham** addressed the religious objections head-on in his *Principles of Morals and Legislation* (1789), pointing out that a benevolent God would not only condone but command the ending of suffering if it is within our power to do so. Bentham urged those who believe in a merciful God to think about the meaning of mercy itself, explaining that "the dictates of religion would coincide, in all cases, with those of utility, were the Being, who is the object of religion, universally supposed to be as benevolent as he is supposed to be wise and powerful."

There have been glimmers of change, however slow: As early as 1957, Pope Pius XII used his encyclical authority to state that there is no moral obligation to apply "extraordinary measures" to dying patients. Pope John Paul II, as he lay dying in 2005, chose not to remain in the hospital with all the extraordinary measures provided by the most sophisticated medical technology available to extend his life. Instead, he went back to his apartments in the Vatican to die peacefully in his own bed. That was his choice in any case, argue the utilitarians as well as the existentialists: an always personal, always ambiguous choice.

Still, if you don't have a right to decide over your own life, what rights do you have? As the existentialist philosopher Albert Camus famously pointed out in the first line of his *Myth of Sisyphus*, suicide is the most

important philosophical question—and it is always personal. The utilitarian argument is most persuasively given in **John Stuart Mill's** essay *On Liberty*, where he stated that "over himself, over his own body and mind, the individual is sovereign." The argument for assisted suicide is classical utilitarianism at its clearest: Consider the consequences of the act, namely the end of pain and unhappiness for the individual who is actually suffering that pain and unhappiness. Is anyone else affected that directly? No. The decision, then, belongs to the individual.

READINGS: JAMES RACHELS: ACTIVE AND PASSIVE EUTHANASIA

The American utilitarian philosopher, James Rachels (1941–2003), a pioneer in the "Death with Dignity" movement, here develops a straightforward utilitarian argument for assisted suicide and euthanasia. He is also celebrated for his views on animal rights.

The traditional distinction between active and passive euthanasia requires critical analysis. The conventional doctrine is that there is such an important moral difference between the two that, although the latter is sometimes permissible, the former is always forbidden. This doctrine may be challenged for several reasons. First of all, active euthanasia is in many cases more humane than passive euthanasia. Secondly, the conventional doctrine leads to decisions concerning life and death on irrelevant grounds. Thirdly, the doctrine rests on a distinction between killing and letting die that itself has no moral importance. Fourthly, the most common arguments in favor of the doctrine are invalid. I therefore suggest that the American Medical Association policy statement that endorses this doctrine is unsound.

The distinction between active and passive euthanasia is thought to be crucial for medical ethics. The idea is that it is permissible, at least in some cases, to withhold treatment and allow a patient to die, but it is never permissible to take any direct action designed to kill the patient. This doctrine seems to be accepted by most doctors, and it is endorsed in a statement adopted by the House of Delegates of the American Medical Association on December 4, 1973:

The intentional termination of the life of one human being by another—mercy killing—is contrary to that for which the medical profession stands and is contrary to the policy of the American Medical Association.

The cessation of the employment of extraordinary means to prolong the life of the body when there is irrefutable evidence that biological death is imminent is the decision of the patient and/or his immediate family. The advice and judgment of the physician should be freely available to the patient and/or his immediate family.

However, a strong case can be made against this doctrine. In what follows I will set out some of the relevant arguments, and urge doctors to reconsider their views on this matter.

To begin with a familiar type of situation, a patient who is dying of incurable cancer of the throat is in terrible pain, which can no longer be satisfactorily alleviated. He is certain to die within a few days, even if present treatment is continued, but he does not want to go on living for those days since the pain is unbearable. So he asks the doctor for an end to it, and his family joins in the request.

Suppose the doctor agrees to withhold treatment, as the conventional doctrine says he may. The justification for his doing so is that the patient is in terrible agony, and since he is going to die anyway, it would be wrong to prolong his suffering needlessly. But now notice this. If one simply withholds treatment, it may take the patient longer to die, and so he may suffer more than he would if more direct action were taken and a lethal injection given. This fact provides strong reason for thinking that, once the initial decision not to prolong his agony has been made active euthanasia is actually preferable to passive euthanasia, rather than the reverse. To say otherwise is to endorse the option that leads to more suffering rather than less, and is contrary to the humanitarian impulse that prompts the decision not to prolong his life in the first place.

Part of my point is that the process of being "allowed to die" can be relatively slow and painful, whereas being given a lethal injection is relatively quick and painless. Let me give a different sort of example. In the United States about one in 600 babies is born with Down's syndrome. Most of these babies are otherwise healthy—that is, with only the usual pediatric care, they will, proceed to an otherwise normal infancy. Some, however, are born with congenital defects such as intestinal obstructions that require operations if they are to live. Sometimes, the parents and the doctor will decide not to operate, and let the infant die. Anthony Shaw describes what happens then:

...When surgery is denied (the doctor I must try to keep the infant from suffering while natural forces sap the baby's life away. As a surgeon whose natural inclination is to use the scalpel to fight off death, standing by and watching a salvageable baby die is the most emotionally exhausting experience I know. It is easy at a conference, in a theoretical discussion, to decide that such infants should be allowed to die. It is altogether different to stand by in the nursery and watch as dehydration and infection wither a tiny being over hours and days. This is a terrible ordeal for me and the hospital staff—much more so than for the parents who never set foot in the nursery.

Family mourns for the dead in hospital.
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I can understand why some people are opposed to all euthanasia, and insist that such infants must be allowed to live. I think f can also understand why other people favor destroying these babies quickly and painlessly. But why should anyone favor letting "dehydration and infection wither a tiny being over hours and days?" The doctrine that says that a baby may be allowed to dehydrate and wither, but may not be given an injection that would end its life without suffering, seems so patently cruel as to require no further refutation. The strong language is not intended to offend, but only to put the point in the clearest possible way.

My second argument is that the conventional doctrine leads to decisions concerning life and death made on irrelevant grounds.

Consider again the case of the infants with Down's syndrome who need operations for congenital defects unrelated to the syndrome to live. Sometimes, there is no operation, and the baby dies, but when there is no such defect, the baby lives on. Now, an operation such as that to remove an intestinal obstruction is not prohibitively difficult. The reason why such operations are not performed in these cases is, clearly, that the child has Down's syndrome and the parents and doctor judge that because of that fact it is better for the child to die.

But notice that this situation is absurd, no matter what view one takes of the lives and potentials of such babies. If the life of such an infant is worth

preserving, what does it matter if it needs a simple operation? Or, if one thinks it better that such a baby should not live on, what difference does it make that it happens to have an unobstructed intestinal tract? In either case, the matter of life and death is being decided on irrelevant grounds. It is the Down's syndrome, and not the intestines, that is the issue. The matter should be decided, if at all, on that basis, and not be allowed to depend on the essentially irrelevant question of whether the intestinal tract is blocked.

What makes this situation possible, of course, is the idea that when there is an intestinal blockage, one can "let the baby die," but when there is no such defect there is nothing that can be done, for one must not "kill" it. The fact that this idea leads to such results as deciding life or death on irrelevant grounds is another good reason why the doctrine should be rejected.

One reason why so many people think that there is an important moral difference between active and passive euthanasia is that they think killing someone is morally worse than letting someone die. But is it? Is killing, in itself, worse than letting die? To investigate this issue, two cases may be considered that are exactly alike except that one involves killing whereas the other involves letting someone die. Then, it can be asked whether this difference makes any difference to the moral assessments. It is important that the cases be exactly alike, except for this one difference, since otherwise one cannot be confident that it is this difference and not some other that accounts for any variation in the assessments of the two cases. So, let us consider this pair of cases:

In the first, Smith stands to gain a large inheritance if anything should happen to his six-year-old cousin. One evening while the child is taking his bath, Smith sneaks into the bathroom and drowns the child, and then arranges things so that it will look like an accident.

In the second, Jones also stands to gain if anything should happen to his six-year-old cousin. Like Smith, Jones sneaks in planning to drown the child in his bath. However, just as he enters the bathroom Jones sees the child slip and hit his head, and fall face down in the water. Jones is delighted; he stands by, ready to push the child's head back under if it is necessary, but it is not necessary. With only a little thrashing about, the child drowns all by himself, "accidentally," as Jones watches and does nothing.

Now Smith killed the child, whereas Jones "merely" let the child die. That is the only difference between them. Did either man behave better, from a moral point of view? If the difference between killing and letting die were in itself a morally important matter, one should say that Jones's behavior was less reprehensible than Smith's. But does one really want to say that? I think not. In the first place, both men acted from the same motive, personal gain, and both had exactly the same end in view when they acted. It may be inferred from Smith's conduct that he is a bad man, although that judgment may be withdrawn or modified if certain further facts are learned about him—for example, that he is mentally deranged. But would not the very same thing be inferred about Jones from his conduct? And would not the same further considerations also be relevant to any, modification of this judgment? Moreover, suppose Jones pleaded, in his own defense, "After all, I didn't do anything except just stand there and watch the child drown. I didn't kill him; I only let him die." Again, if letting die were in itself less bad than killing, this defense should have at least some weight. But it does not. Such a "defense" can only be regarded as a grotesque perversion of moral reasoning. Morally speaking, it is no defense at all.

Now, it may be pointed out, quite properly, that the cases of euthanasia with which doctors are concerned are not like this at all. They do not involve personal gain or the destruction of normal healthy children. Doctors are concerned only with cases in which the patient's life is of no further use to him, or in which the patient's life has become or will soon become a terrible burden. However, the point is the same in these cases: the bare difference between killing and letting die does not, in itself, make a moral difference. If a doctor lets a patient die, for humane reasons, he is in the same moral position as if he had given the patient a lethal injection for humane reasons. If his decision was wrong—if, for example, the patient's illness was in fact curable—the decision would be equally regrettable no matter which method was used to carry it out. And if the doctor's decision was the right one, the method used is not in itself important.

The AMA policy statement isolates the crucial issue very well; the crucial issue is "the intentional termination of the life of one human being by another." But after identifying this issue, and forbidding "mercy killing," the statement goes on to deny that the cessation of treatment is the intentional termination of a life. This is where the mistake conies in, for what is the cessation of treatment, in these circumstances, if it is not "the

intentional termination of the life of one human being by another?" Of course it is exactly that, and if it were not, there would be no point to it.

Many people will find this judgment hard to accept. One reason, I think, is that it is very easy to conflate the question of whether killing is, in itself, worse than letting die, with the very different question of whether most actual cases of killing are more reprehensible than most actual cases of letting die. Most actual cases of killing are clearly terrible (think, for example, of all the murders reported in the newspapers), and one hears of such crises every day. On the other hand, one hardly ever hears of a case of letting die, except for the actions of doctors who are motivated by humanitarian reasons. So one learns to think of killing in a much worse light than of letting die. But this does not mean that there is something about killing that makes it in itself worse than letting die, for it is not the bare difference between killing and letting die that makes the difference in these cases. Rather, the other factors—the murderer's motive of personal gain, for example, contrasted with the doctor's humanitarian motivation—account for different reactions to the different cases.

I have argued that killing is not in itself any worse than letting die; if my contention is right, it follows that active euthanasia is not any worse than passive euthanasia. What arguments can be given on the other side? The most common, I believe, is the following:

The important difference between active and passive euthanasia is that, in passive euthanasia, the doctor does not do anything to bring about the patient's death. The doctor does nothing, and the patient dies of whatever ills already afflict him. In active euthanasia, however, the doctor does something to bring about the patient's death: he kills him. The doctor who gives the patient with cancer a lethal injection has himself caused his patient's death; whereas if he merely ceases treatment, the cancer is the cause of the death.

A number of points need to be made here. The first is that it is not exactly correct to say that in passive euthanasia the doctor does nothing, for he does do one thing that is very important: he lets the patient die. "Letting someone die" is certainly different, in some respects, from other types of action—mainly in that it is a kind of action that one may perform by way of not performing certain other actions. For example, one may let a patient die by way of not giving medication, just as one may insult someone by way of not shaking his hand. But for any purpose of moral assessment, it is a type

of action nonetheless. The decision to let a patient die is subject to moral appraisal in the same way that a decision to kill him would be subject to moral appraisal: it may be assessed as wise or unwise, compassionate or sadistic, right of wrong. If a doctor deliberately let a patient die who was suffering from a routinely curable illness, the doctor would certainly be to blame for what he had done, just as he would be to blame if he had needlessly killed the patient. Charges against him would then be appropriate. If so, it would be no defense at all for him to insist that he didn't "do anything." He would have done something very serious indeed, for he let his patient die.

Fixing the cause of death may be very important from a legal point of view, for it may determine whether criminal charges are brought against the doctor. But I do not think that this notion can be used to show a moral difference between active and passive euthanasia. The reason why it is considered bad to be the cause of someone's death is that death is regarded as a great evil—and so it is. However, if it has been decided that euthanasia—even passive euthanasia—is desirable in a given case, it has also been decided that in this instance death is no greater an evil than the patient's continued existence. And if this is true, the usual reason for not wanting to be the cause of someone's death simply does not apply.

Finally, doctors may think that all of this is only of academic interest—the sort of thing that philosophers may worry about but that has no practical bearing on their own work. After all, doctors must be concerned about the legal consequences of what they do, and active euthanasia is clearly forbidden by the law. But even so, doctors should also be concerned with the fact that the law is forcing upon them a moral doctrine that may well be indefensible, and has a considerable effect on their practices. Of course, most doctors are not now in the position of being coerced in this matter, for they do not regard themselves as merely going along with what the law requires. Rather, in statements such as the AMA policy statement that I have quoted, they are endorsing this doctrine as a central point of medical ethics. In that statement, active euthanasia is condemned not merely as illegal but as "contrary to that for which the medical profession stands," whereas passive euthanasia is approved. However, the preceding considerations suggest that there is really no moral difference between the two, considered in themselves (there may be important moral differences in some cases in their *consequences*, but, as I pointed out, these differences may make active euthanasia, and not passive euthanasia, the morally preferable option). So, whereas doctors may have to discriminate between active and passive euthanasia to satisfy the law, they should not do any

more than that. In particular, they should not give the distinction any added authority and weight by writing it into official statements of medical ethics.

READINGS: ANNA ACTON: THE PROGRESSIVE CASE AGAINST ASSISTED SUICIDE

Ana Acton, a prominent disability community advocate and executive director of the FREED Center for Independent Living, here makes a succinct utilitarian argument against assisted suicide.

I've spent my professional life fighting to improve the lives of those living with a disability. I've pushed for services, treatment and medical coverage for those with disabilities while helping them establish independent lives. I joyfully celebrated the 10th anniversary of the US Supreme Court's landmark decision affirming the right of individuals with disabilities to live in their community of choice and fully rejected the state of Georgia's attempt to institutionalize the elderly and those with disabilities. I also reject the attempt by a small group of wealthy elites trying to turn assisted suicide into some right-wing or religious debate. Certainly there may be people who support or oppose assisted suicide based on one of those factors, but at its heart opposing assisted suicide is decidedly progressive.

We all must take a skeptical look and acknowledge the role that money and power play in end-of- life decisions, and how assisted suicide is being used by some health care companies and decision-makers to increase their bottom line by denying treatment.

Physician assisted suicide disproportionately affects the poor and people living with disabilities. That explains, at least in part, why there is widespread opposition from virtually every disability rights group in the nation, including the National Council on Disability, the American Association of People with Disabilities (AAPD), the National Council on Independent Living (NCIL), the National Spinal Cord Injury Association, the World Institute on Disability and FREED.

Assisted suicide doesn't exist in a vacuum as proponents would lead you to believe with their simplistic slogan. Rather, the current profit-driven

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health care system urges doctors to reduce care in order to cut costs. A lethal prescription costs no more than $300. Compare that to the cost of treatment for most long-term medical conditions and serious illnesses that can run into hundreds of thousands giving insurance companies or others making treatment cost decisions a direct financial incentive to suggest assisted suicide in lieu of expense.

This isn't a theoretical problem. In Oregon where assisted suicide is legal, cancer patients Barbara Wagner and Randy Stroup were denied coverage of their chemotherapy prescribed by their doctor but were informed by their health care provider, Oregon's state run health plan, that it would pay for their assisted suicide. In California, the most recent state to make assisted suicide legal, a compromise reached with the powerful insurance industry lobby led to the law's stipulation that a patient choosing assisted suicide would not be eligible to receive life insurance for his family. When assisted suicide is offered as a "choice" and coverage for care is denied, the patient is left with no control over their medical choices and no real choice at all.

The state's supposed safeguards also haven't stopped the mentally ill from obtaining the lethal drugs by "doctor shopping," where patients interview doctors until they find one willing to write the deadly prescription.

Michael Freeland, a man with a 40-year documented history of depression coupled with multiple suicide attempts, doctor shopped until he found a physician sympathetic to the pro-assisted suicide movement who wrote him a prescription for the lethal pills. Keep in mind, Freeland had no underlying disease and was not terminally ill. He only needed mental health care and compassion.

Another supposed safeguard is the six month rule that only patients with less than six months to live can qualify for assisted suicide. We all know someone who has outlived their doctor's prognosis. That's no fault of doctors, but no one is perfect. Doctors do their best to define how long a sick patient has left, but doctors are fallible and are often wrong with these diagnoses, which is deadly in the case of assisted suicide.

Despite these serious flaws, Oregon's law continues to be the model for other state legalization efforts. This year, a small handful of lawmakers in Connecticut, Massachusetts, New Hampshire and New Jersey attempted to advance legislation that would copy the deeply flawed Oregon model of physician-assisted suicide. Once again, hundreds of thousands of dollars

in advertising and lobbying by pro-assisted suicide pushers was rendered void by the powerful testimony of Disability Rights Advocates, palliative care specialists, hospice workers and physicians. Both Democrat and Republican lawmakers rightly saw assisted suicide legislation as dangerous to the most vulnerable people in our society.

Connecticut's assisted suicide bill was sent to the Judiciary Committee and has little hope of being voted on this year. Governor Chris Christie publically expressed his opposition to New Jersey's bill, New Hampshire overwhelmingly rejected theirs by a stunning vote of 219-66 and the Massachusetts legislature sent theirs to study and with no chance of moving forward this year; Massachusetts voters turned out to vote assisted suicide legalization down in 2012.

I recognize that additional assisted suicide legislation will continue to be pushed in additional states and advocates for such a law will again introduce legislation in states that have previously rejected their arguments. But Disability Rights advocates will be at the forefront to push back because of the dangers it poses.

Since 1997, roughly 600 people have utilized Oregon's assisted suicide law. Without minimizing their suffering, it's troubling to think how many more have been affected and will be affected by the deadly mix between assisted suicide and profit-driven managed health care.

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FOR DISCUSSION: DNR ORDERS: LETTING DEATH JUST HAPPEN

Euthanasia, that is, killing a patient, is not legal in the United States. However, do not resuscitate (DNR) orders are common in every hospital. DNR orders allow the medical team to respect the patient's wishes and do nothing should that patient's heart stop. In other words, the doctors and nurses will stand by and pretend they cannot bring back the patient who has a DNR order on file, though another patient without a DNR who suffers, say, the same exact heart attack will be designated Code Blue and will indeed be brought back to life.

Is the use of DNR orders the same act as killing the patient? That is, is letting someone die the same as killing that person? Note that the act itself, or the lack of action, may be different; but the consequences are the same.

And, if both the patient and the doctor have already agreed that the patient is better off dead, as is the case with DNR orders, should it follow that euthanasia, then, should be legal?

CHAPTER PHILOSOPHERS

Bentham, Jeremy (1748–1832), British philosopher who is considered the father of utilitarianism; active in law and politics as well as ethics, he was an early proponent of women's rights, abolition of slavery and the death penalty, and decriminalization of homosexuality.

Kant, Immanuel (1724–1804), German philosopher who maintained that suicide, and by extension assisted suicide or euthanasia, is clearly forbidden by the categorical imperative that says one should act always as if according to a maxim that one would willingly turn into a universal law; one cannot make a universal law that says innocent people should be killed; therefore, a particular innocent person—say, a cancer patient in excruciating pain—cannot be killed, because he or she is certainly innocent.

Mill, John Stuart (1806–1873), British philosopher who perfected classical utilitarianism.

KEY TERMS

Do not resuscitate (DNR) order legally binding document written by a doctor and signed by the patient or someone designated with the patient's power of attorney, stating the patient's wish for the hospital to do nothing if the patient's heart stops. A more recent term, used less often but becoming more common, is allow natural death (AND) orders, a more palatable phrasing that focuses on what is being done rather than what is being withheld by the hospital.

Groningen Protocol 2008 euthanasia law in the Netherlands—the first to allow euthanasia for newborn babies. If a newborn is not expected to live but must do nothing but suffer while waiting for a natural death, the Dutch law allows doctors to kill that baby.