

Chapter-1

Concept of Mercy Killing: Challenges of the Present Age

This chapter is devoted to analyze the historical development of Euthanasia. One of the methodological assumptions that the present study follows is this: No thought originates or comes out of blue; the historical conditions are always there. In line with this methodology this chapter analyses the historical development of the practice of Euthanasia.

This chapter is divided in to two sections. In the first section the historical developments of the practice of Euthanasia are narrated. In the second section, it discusses the different classifications of euthanasia .This section also highlights the concept of brain death.

The euthanasia issue, or the right to choose death, has become the “new think” question for several reasons, the primary one being the fear of a lingering death. The much discussed and highly publicized Karen Quinlan case turned public attention to the wisdom of prolonging some lives.¹There is little doubt that modern understanding of the human organism and the technology for sustaining it, has changed the practice of medicine from an art to a science. The pronounced diminution in impact of disease which was once fatal has affected people’s perceptions of the traditional views of death and dying. A new mysticism has grown up around man’s achievements in medicine; it has become expected that whenever disease gains entrance into the body, the physician can almost ritually pull from his or her therapeutic bag of tricks a drug or an operation to reverse the course of the disease. One result of this has been a blurring of the line between life and death. People have come to believe that they can employ physicians to tell death to wait. There are a number of distinctions ethicists make when discussing the morality of particular euthanasia cases: Was the death voluntary or involuntary? Was the death

1. Fletcher Joseph, “The ‘right’ to live and the ‘right’ to die” *The Humanist*, p.13

brought about through active or passive euthanasia? Was the patient killed or was the patient allowed to die of natural causes? What were the intentions of the persons whose action or inaction led to the patient's death? If the patient was allowed to die, was it because the medical staff withheld extraordinary treatment or did they withhold ordinary treatment?

Section-I

1.1 Concept of Euthanasia: Historical and Philosophical Analysis

The ancient Greeks and Romans generally did not believe that life needed to be preserved at any cost and were, in consequence, tolerant of suicide in cases where no relief could be offered to the dying, or in the case of the Stoics and Epicureans, where a person no longer cared for his life. A form of euthanasia was practiced in the City State of Sparta in ancient Greece. It may be called as a form of eugenics which means getting rid of disabled persons. In Both Plato and Aristotle's writings, traces are visible in favor of infanticide. In describing his model state Plato sounds a lot like Spartans when he remarks that the children of inferior parents, and any deformed offspring of others, they (the guardians) will secretly put out of the way as is fitting. Though euthanasia was not a common practice but suicide as a form of euthanasia was advocated by many people at that time. Plato in his Republic comments "Then along with such judges you will give the city doctors such as we describe..., they will permit the unsound in body to die, and actually put to death those who are incurably corrupt in soul."² The Stoics also approved suicide when illness or pains were too much bear. There are philosophers like the Pythagoreans, Aristotelians and Epicureans who opposed suicide. In general, the wise men of Greece supported in some form or other, a kind of euthanasia, though it was not acknowledged in present form. The Greek ideas are accepted by Romans also in general, suicide was punishable but there are cases where illness and pain weariness of life led

2. Plato- *The Republic*. Trans. A.D.Lindsay. J.M.Dent & Sons Ltd. London. Everyman's library. 1992.

people to end their life. The ancient Roman Orator and statesman Cicero said that a good death is the ideal way of respecting natural law and public order by departing from the earth with dignity and tranquility. Euthanasia can be seen as a way to assure that a person dies in a dignified and appropriate manner. It makes a great deal of difference whether a man is lengthening his life or his death. But if the body is useless for service, why should one not free the struggling soul? Perhaps one ought to do this a little before the debate is due, lest, when it falls due, he may be unable to perform the act.³ In Judaism suicide is forbidden and does not even discuss mercy killing. Philosophers like Augustine and theologians like Thomas Aquinas made it very clear that suicide and any other form of shortening life came under category of murder. This was true through the time of the reformation and remains wherever the influence of Biblical Confessionalism is felt. English common law from the 1300s until the middle of the last century made suicide a criminal act in England and Wales. Assisting other to kill themselves remains illegal in that jurisdiction.

Thomas More in his *Utopia* sanctions voluntary euthanasia. “Those who are suffering from incurable diseases receive the best possible palliative care, and people come and sit with them and talk to them. But if their disease not only is incurable, but also causes them unremitting, excruciating pain, then the priests and public officials urge the patient to recognized that they are no longer capable of fulfilling any of life’s duties, that they are now a nuisance to others and a burden to themselves, and that they are alive although it is past time for them to die. They tell them that they should not allow this dreadful disease to feed on them any longer, and, now that it is torture to be alive, they should not hesitate to die. They should put their hope in the life to come, and they should either break out of this present life, as they would escape from a prison or a torture chamber, or else agree to let others rescue them. In so doing

3. Roman Stoic writer (Epistulac Morales)

they would be acting wisely, for their death would put an end not to pleasure, but to terrible suffering. Moreover, they would be following the advice of the priests, who interpret to us the will of god, and so their action would be pious and godly.”⁴

If the patient finds these arguments convincing, he either starves himself to death, or put painlessly out of his misery. But this is strictly voluntary. So Thomas More, in describing a utopian community, envisaged such a community as one that would facilitate the death of those whose lives had become burdensome as a result of “torturing and lingering pain.”

In 17th century Francis Bacon expressed similar ideas in ‘The New Atlantis’. He insisted that doctors should assist the dying patient “to make a fair and easy passage from life”. In 18th century Rousseau talks about “virtuous suicide”. In his essay ‘Of Suicide’ David Hume wrote that when life has become a burden, both courage and prudence should engage us to rid ourselves at once of existence. Immanuel Kant is not favoring the cases of euthanasia as it goes against his formulation of categorical imperative. His formulation of categorical imperative talks about rational being: Since man is a rational being, he has no right to formulate such a maxim like, if I am in a terrible condition, I have the right to take my life or reserve the right to the doctor or my family members. It is not possible to convert this kind of maxim into universal law. As Kant speaks of humanity as an end, so according to Kant, no man has the right to take his life. German philosopher Arthur Schopenhauer states that individualism and human autonomy should be honored. According to him every man has his right to his own life and person. Whenever the terrors of life reach the point at which they outweigh the terrors of death, a man will put an end his life. In ‘Leviathan’ Thomas Hobbs propounded ethical egoism. This theory holds that its any action increased one’s happiness, then it is right, in this connection

4. More, Thomas, *Utopia*, ed &trans David Wootton, Hackett publishing company, Indianapolis, 1999, p-128.

Hobbes shows that it is not possible for us but to act for our interest and therefore such actions are ethical.

After the civil war, voluntary euthanasia was promoted by advocates, including some doctor. Support peaked around the turn of the century in the U.S. and then grew again in the 1930s. In 1931 Dr. C Kellick Millard, health officer for the city of Leicester drafted 'The Voluntary Euthanasia Bill'. In 1935 The British Euthanasia legalization Society is formed to promote Millard's bill, but it is defeated the next year in the House of Lords. In 1939 a bill legalizing euthanasia is introduced in New York, but is shelved because of war. The first major effort to legalize euthanasia in the United States arose as part of the eugenics movement in the early years of the twentieth century.⁵ This issue of euthanasia in a different form first came into light in 1920's, when German Professor, Alfred Hoche and Karl Binding, argued in their book 'The Permission to Destroy Life Unworthy of Life', that patients who request 'death assistance' should, under carefully controlled conditions, be able to obtain the help of physicians in terminating their lives. They asserted that killing was consistent with medical ethics in certain instances, where people are suffering from serious brain damage, mental retardation and severe psychiatric illness, because they were considered to be mentally dead. Thus, terminating their lives was not homicide but rather 'an allowable useful act'.

When the Nazi's came to power in Germany in 1933, they distorted the ideas articulated by Hoche and Binding in to sinister new shapes. One of the first laws they enacted provided for compulsory sterilization of people with hereditary diseases. This accorded with their belief that the first obligation of medical science was attending to the health of the German nations 'folk body', not the health of individual patients. Nazi's then identified entire groups of people who, they thought, a threat to the folk body' -i.e. criminals, physically and mentally handicapped,

5. Kopelman, Loretta M., deVile, Kenneth A., eds. *Physician-assisted suicide: What are the issues?* Dordrecht: Kluwer Academic Publishers, 2001. pp-1-10.

homosexuals and inferior races. On this pretext, mass extermination of what they considered to be 'undesirables', mostly Jews was ruthlessly carried out by them as the next step.

The euthanasia movement emerged in Britain in 1935 with the founding of the Voluntary Euthanasia Society. In the United States the Euthanasia Society of America founded in early 1938, initially advocated legalization of only voluntary euthanasia. The first case of euthanasia became known in 1938 itself, when a German child 'known as Baby Knauer' was put to death by physicians saying that his life deemed empty and meaningless as the child was blind, retarded and his one arm and one leg were missing. The child's father sought permission from Adolf Hitler for the practice of euthanasia on his son. The atrocities committed by the Nazi's during World War II, came to the fore in 1945 and revealed the Holocaust for the first time. There came a gap of at least generation after the Nazi's genocide attempt and medically aided euthanasia sank into general disrepute because of this horrible fact. However, In the 1970s, when the memories of the World War II faded, interest in assisted death began to be revived. The stress was on 'death with dignity' the tragic case of Karen Ann Quinlan brought the euthanasia issue into sharp focus in 1975.

Every few years a case of disputed life and death decisions regarding an infant seems to appear in the news. They are called Baby Doe cases in order to protect the family's privacy. Those that have drawn the most criticisms are cases like the one in which an infant born with Down's syndrome was left untreated and died. Down's syndrome is a genetic anomaly that causes mental retardation and sometimes physical problems as well. In this case the child had a repairable but life-threatening blockage between the stomach and the small intestines. The parents refused permission for the surgery to repair the problem, and the doctors followed their wishes and let the infant die. Critics of this case protested that this surgery was simple and

effective, and the infant, though retarded, could lead a happy life. Not to treat in such cases has been interpreted as not using what would be considered ordinary means of life support, ordinary because the benefits to the patient would outweigh any burdens. Such cases have been criticized for their “buck-passing”--shifting responsibility for the death to nature, as though in this situation but not elsewhere in medicine we should “let nature take its course.”⁶ Because the infant is not able to express his wishes, these will always be cases of non voluntary euthanasia. While strong arguments can be made for treatment in such cases, in other cases knowing what is best is not so simple. Sometimes it is difficult to tell whether treatment is always in the baby's best interest. Moreover, some cases raise again the issue of determining when an individual is dead. There are cases, for example, parents of a newborn with anencephaly, or no upper brain, wanted their child declared brain dead so that its organs could be used for transplant. However, such infants are not brain dead according to statutes of some states like California or Florida.

Two different types of moral questions can be raised about such cases. One is the question, who would be the best to decide whether to provide or deny certain treatments? The other is what are the reasons to provide or deny care? Some insist that the primary decision-makers should be the parents because not only do they most likely have the infant's best interests at heart, but also they will be the ones to provide care for the child. Needless to say, we can imagine situations in which the parents would not be the most objective judges. They might be fearful, disappointed at the child's birth, or they might simply disagree about what is best to do. A presidential commission established to review medical ethical problems concluded that parents ought to make decisions for their seriously ill newborns, except in cases of decision-making incapacity, an irresolvable difference between them, or a choice that is clearly not in the infant's best interests. A society has an interest in protecting and providing for its children, and

6. From a comment made by a review of this text, Robert .p Tucker of Florida Southern College, who had had some hospital experience in this regard.

is therefore obligated to step in, in cases of parental neglect or abuse. However, just what constitutes neglect or abuse and what is reasonable parental decision-making is far from clear. There are practical legal difficulties involved in treatment decisions for children. What would be the best policy regarding ill newborns? Should the federal government require state child abuse agencies to monitor treatment of newborns and withhold funds if states did not comply? Critics of such a policy believe that this would be an unwarranted state interference in legitimate medical decision-making. Obviously more than medical decisions about diagnosis and prognosis are involved in such cases. These are judgments about what is best to do-- they are value or moral judgments. Finding the best balance between the need to protect children and to support parents in difficult and painful decision-making remains a continuing problem.

We have sketched the philosophical difficulties that lurk behind the idea that decision-making should be based on “the best interests of the infant.” These difficulties are one reason why we think this approach is misguided. There is, however, another- more straightforward- reason: many other factors should be taken into account- including the interests of the parents and of any children they already have. There is no reason to assume that the momentary interests of the infant, or the interests of the person who the ill or handicapped infant might become, should automatically outweigh all these other interests. The birth of a severely handicapped infant can dramatically change the lives of the parents and siblings. It is, for example, often pointed out that the survival of a handicapped child is also the creation of a handicapped family.⁷ While that judgment may be too severe in some cases, in others it is the simple truth.

7. Singer, P., *Practical Ethics* Cambridge: Cambridge University Press, Indian Edition 2010 , pp181-184.

To disregard these other interests altogether is incompatible with the principle of equal consideration of the interests of all those affected by our decision- and such a principle is fundamental to ethics.⁸ When speaking about equal consideration of interests, there is also one other interest which we have not, so far, mentioned: the interests of the “next child in the queue.” One of the more firmly established findings about families with a disabled child is that they are less likely than other families to have a further child.⁹ Shouldn’t we take the interests of that child into account- the interests of the child who will not be born if the seriously ill or handicapped child survives?

The argument that we should take the “next child” into account has been well put by R.M. Hare (1976).¹⁰ Discussing the question of whether a fetus known to be a handicap, Hare asks us to suppose that a couple have planned to have two children. During the second pregnancy it is found that the fetus has a serious handicap. If the handicapped fetus lives, the couple will not have any more children. If the fetus is aborted, the couple will seek to have a second child. There is a high probability that this second child will be normal. In this situation, Hare argues, we should consider not only the interests of the child now in the womb, but also the interests of the possible child who is likely to live if, and only if, the fetus dies.

The same sort of reasoning can be applied after a seriously ill or handicapped child is born. Should we exclude the “next child” from our deliberations on whether to treat a handicapped infant? We think we should not- at least not if we believe that treatment is justified in terms of the interests of the future child or person. There is, of course, another reason as well: the pain and suffering that will sometimes have to be inflicted in our efforts to achieve the survival of a sick or handicapped infant.

8. Simms, M. “Severely Handicapped Infants,” *New Humanist*, 98 no. 2, 1983, pp. 1-8.

9. Kew, S., *Handicap and Family Crisis* (London: Pitman), 1975.

10. Hare, R.M., “Survival of the Weakest,” in *Moral Problems in Medicine*, ed. S.Gorovitz et al. (Englewood Cliffs, NJ: Prentice-Hall), 1976, pp.-364-9.

It is true that we should not always try to preserve every infant's life by all available means because quality and kind of life constitute a proper basis for life and death decisions in the practice of medicine. What we have not yet discussed is how an infant should die when it has been decided that its life should no longer be sustained.

It is frequently thought that a morally relevant distinction exists between "doing something" that result in death, and merely "doing nothing" that also results in death- or between killing a patient and allowing a patient to die. Thus it is often thought that letting die is sometimes permissible in the practice of medicine but killing is not. Depending on this distinction, doctors will frequently not act to preserve the life of a child-as they did, for example, when they decided that Stephanie should not be resuscitated should her heart fail- but not take active steps to end the infant's life. While we can understand that it may sometimes be psychologically easier for doctors to decide not to resuscitate an infant than to administer a lethal dose of a drug, there is no intrinsic moral- and arguably no legal- difference between bringing about an infant's death by an omission or an action. If all other factors, such as intention, motivation, and out come are the same, then killing an infant and allowing it to die are morally equivalent.¹¹ Does this mean that it is morally irrelevant whether an infant's life is ended actively or passively? We do not think so. Once the decision has been made that an infant should be allowed to die, it will often be better to hasten death than to stand by and wait until "nature" takes her often cruel course. Would it not have been better if Stephanie's life had ended sooner than it did, if those responsible for her care had at least spared her the suffering she endured between the time it had been decided that her life should not be prolonged by resuscitation and the time when her heart finally failed? We believe the answer is a resounding "yes."

11. Kuhse, H. "A Modern Myth. That Letting Die is not the Intentional Causation of Death: some reflections on the trial and acquittal of Dr. Leonard Arthur," *Journal of Applied Philosophy*, 1984, pp. 21-38.

Euthanasia has been a large issue in the courts during this century. The first doctor was charged for performing euthanasia in 1935. Harold Blazer was charged for the death of his daughter. His daughter was a victim of cerebral spinal meningitis. He killed her by placing a handkerchief soaked with chloroform over her face until she died. He had taken care of her for thirty years. In his trial he was acquitted. The first doctor to be found guilty was Joseph Hassman in 1986. He injected a lethal dose of Demerol into his mother-in-law by the request of her family. He was sentenced to two years probation, fined \$10,000, and ordered to perform 400 hours of community service.

In a 1988 issue of the Journal of the American Medical Association, an article titled "It's Over Debbie" describes how an anonymous doctor administers a fatal dose of morphine to a woman dying of ovarian cancer. In a 1989 issue of the New England Journal of Medicine, ten doctors associated with the nation's leading hospitals and medical schools declare their belief that "it is not immoral for a physician to assist in the rational suicide of a terminally ill person". In 1991, the New England Journal of Medicine published a detailed account written by Dr. Timothy Quill which discussed his decision to help a patient suffering from leukemia commit suicide. In 1990, Dr. Jack Kevorkian uses his suicide machine to help a woman suffering from Alzheimer's disease, one Janet Adkins, end her life in the back of a Volkswagen bus. Janet was the first of twenty patients who have been aided by him in the past three years. He remains committed to his practice. In 1991 the Hemlock Society publishes a how-to manual on committing suicide.

Each of these events has served to provoke ever widening media coverage of the issues surrounding euthanasia and physician assisted suicide, and a national debate has arisen around these practices. This debate is not merely limited to attorneys and physicians. Suddenly, these

issues and this debate are now a part of life in mainstream America, and many Americans face dilemmas that did not exist in simpler times; dilemmas that many would rather not have to face.

Section-2

2.1 Classification of different types of Euthanasia:

Euthanasia is generally classified in terms of certain subcategories, depending upon whether or not the person who dies by euthanasia is considered to be competent or incompetent and whether or not the act of euthanasia is considered to be voluntary, non-voluntary, involuntary, passive, or active. Generally euthanasia can take three forms: Voluntary, Involuntary and Non-voluntary.

Euthanasia is considered to be voluntary when it takes place in accordance with the wishes of a competent individual, whether these wishes have been made known personally or by a valid advance directive-that is, a written statement of the person's future desires in the event that he or she should be unable to communicate his or her intentions in the future. A person is considered to be competent if he or she is deemed capable of understanding the nature and consequences of the decisions to be made and capable of communicating this decision. An example of voluntary euthanasia is when a physician gives a lethal injection to a patient who is competent and suffering, at that patient's request.

Non-voluntary euthanasia is done without the knowledge of the wishes of the patient either because the patient has always been incompetent, is now incompetent, or has left no advance directive. A person is considered incompetent when he or she is incapable of understanding the nature and consequences of the decision to be made and/or is not capable of communicating this decision. In the case of non-voluntary euthanasia, the wishes of the patient are not known. An example of non-voluntary euthanasia is when a doctor gives a lethal

injection to an incompetent elderly man who is suffering greatly from an advanced terminal disease, but who did not make his wishes known to the physician when he was competent. Non-voluntary simply means not through the will of the individual. It does not mean against their will. Sometimes others must make the decision because the person or patient is incapable of doing so.¹² This is true of infants and small children and of persons who are in a coma or permanent vegetative state. This is also true of persons who are only minimally competent, as in cases of senility or psychiatric disorder. While in many cases deciding who is sufficiently competent to make decisions for themselves is clear, this is not always the case. What should we say, for example, of the mental competence of the eighty-year-old man who refuses a particular surgery needed to save his life and at the same time says he does not want to die? Is such a person being rational? Suppose that there is clear medical evidence that if he does not have the surgery he will die. In some cases, when a patient is not able to express his or her wishes, we can attempt to imagine what the person would want. We can rely, for example, on past personality or statements of the person. Perhaps the person had made comments to friends or relatives as to what he or she would want if such and such a situation occurred. In other cases a person might have left a written expression of his or her wishes in the form of a “living will.” Living will, or advance directive, has become more common in the last decade. In such a directive a person can specify that she wants no extraordinary measures used to prolong her life if she is dying and unable to communicate this. In another advance directive, a “durable power of attorney,” a person can appoint someone (who need not a lawyer) to be her legal representative to make medical decisions for her in the event that she is incapacitated. The form for durable power of attorney also provides for individualized expressions in writing concerning what a person would want done or not done under certain conditions. These directives at the

12. MacKinnon Barbara: *Ethics-Theory and Contemporary Issues*, Wadsworth Publishing Company, California, 1995 pp- 109-111

very least have moral force. They also have legal force in those states that have recognized them.¹³ These measures do give people some added control over what happens to them in their last days. To further ensure this, in December, 1991, the patient Self-Determination Act passed by the U.S. Congress went into effect. This act requires that health care institutions that participate in Medicare or Medicaid have written policies for providing individuals in their care with information about and access to advance directives such as living wills.

Involuntary euthanasia is done against the wishes of a competent individual or against the wishes expressed in a valid advance directive. Examples of involuntary euthanasia include a son who gives a lethal overdose of medication to his father who is suffering from cancer, but the father does not want the overdose.

All three kinds of euthanasia can be either active or passive. Active euthanasia typically involves a deliberate act which results in the patient's death. Passive euthanasia involves a deliberate omission for example, withdrawing or withholding life-sustaining treatment.

Some people limit the use of the term to cases called *active euthanasia*. In the past this was often called "mercy killing." These are cases in which we bring about death by our actions and instruments. This can be using drugs or death-causing devices. However, to define the term in this way narrows its use and eliminates from discussion the many other euthanasia cases about which we also have moral concerns. Dr. Jack Kevorkian, retired pathologist invented a "suicide machine." His first version consisted of a metal pole to which bottles of three solutions were attached. First a simple saline solution flowed through an IV needle that had been inserted into the person's vein. The patient then flipped a switch that started a flow of an anesthetic, thiopental, which caused the person to become unconscious. After sixty seconds a solution of potassium chloride followed and caused death within minutes by heart seizure. In a later version

13. Ibid p. 112-114.

of the machine, pushed a control switch, carbon monoxide flowed through a tube to a bag placed over their head. Some of the persons who used the machine that Dr. Kevorkian provided were not terminally ill. Almost all of his approximately twenty assisted suicide took place in Michigan. To attempt to prevent these incidents from taking place in the state, in 1993 the Michigan legislature passed a law against assisting a suicide. This law is currently being challenged in the courts. Some writers want to distinguish assisted suicide from euthanasia. They want to retain the term *euthanasia* for cases in which someone other than the person who dies causes the death.

In the other main type of euthanasia, passive euthanasia, we allow a person to die by not providing certain life-prolonging treatment. Measures to cure the individual or improve her or his health may have been ineffective, and thus are discontinued. Or, the patient or others could decide to avoid these measures altogether because the chances of the treatment being effective are slim or because the kind of life the treatment would provide if it did work would be too burdensome.

One type of action that is liable to be confused with active euthanasia but which ought to be distinguished from it is the giving of pain medication to very ill and dying patients. Physicians are often hesitant to give sufficient pain medication to such patients because they fear that the medication will actually cause their death. They fear that this would be considered comparable to mercy killing (active euthanasia), which is legally impermissible. However, recall the principle of double effect discussed before. According to it, there is a moral difference between intending something bad as a means to some good outcome and doing something in itself not wrong in order to achieve some good (even though one knows that in doing so one also risks causing an unintended bad result). The idea is that there is a moral difference between

intentionally giving someone a lethal dose of a drug, intending bring about a person's death, and giving the drug in doses intended to relieve the pain, knowing that the drug may weaken the person and may eventually cause the person to die. This latte action is not strictly speaking active euthanasia. Active euthanasia would be the intentional giving of a drug with the purpose of bringing about a person's death. In actual practice it may be difficult to know what is going on. People may also have mixed or hidden motives for their actions. Yet it would seem helpful to use this principle so that doctors are permitted to give their patients sufficient pain medication without fear of being prosecuted for homicide. The fact that they might cause addiction in their patients is another reason why some doctors hesitate to give narcotics for pain relief. This seems hardly a reasonable objection, especially if the patient is dying! 14

Active euthanasia or commission, on the other hand, is regarded a different light. A physician who deliberately hastens the death of a patient comes under those laws prohibiting homicide. If it is a willful, premeditated act, it is normally considered first degree murder. Common and criminal law regard life as sacred and inalienable, and look upon any killing, especially premeditated killing, as homicide. Consent is never a defense to murder, nor is humanitarian motives. "He nonetheless acts with malice if he is able to comprehend that society prohibits his act regardless of his personal belief."15

All types of active euthanasia may also be considered a form of suicide. It is a crime in most states to "deliberately aid, advice, or encourage another to commit suicide." Even in those instances where an individual may take his own life, if another gives aid to the willing person, his actions would be considered criminal. Applied to euthanasia, any person (including physicians) who assisted another in the taking of his or her own life in any way and regardless

14. Definition of Euthanasia by the *Netherlands State Commission on Euthanasia*.

15. Baughman W.H, Bruha,J.C. and Gould F. J., "Euthanasia: criminal, court, constitutional and legislative considerations," *Notre Dame Lawyer* 48, 1973, pp- 1202-1260.

of the circumstances is open to criminal charges. Although the law in theory is very adamant on the issue of active euthanasia, in practice it is quite ambiguous. Conscientious searches of court records by legal scholars have yielded remarkably few cases involving the charge of euthanasia. Even when active euthanasia is alleged to have occurred, grand juries returned an indictment in only one U.S. case; the defendant was later acquitted.¹⁶

Some authors justify this disparity between law and punishment on the grounds that the law must remain since it is still a necessary deterrent for cases in which it is doubtful that euthanasia is the proper course of action. According to Yale Kamisar the law forces rational deliberation as to whether or not euthanasia is the best choice in a given case, rather than it being the easy or expedient thing to do. If the circumstances are so compelling that the defendant ought to violate the law, then they are compelling enough for the jury to violate their oaths. The law does well to declare these homicides unlawful. It does equally well to put no more than the sanction of an oath in the way of an acquittal.¹⁷

As for cases in which the patient himself has refused life-saving treatment, courts have upheld the patient's right to refusal if withholding was based on religious scruples or on the treatment's limited probability of success. However, the courts have overridden this right, with the justification of state paternalism, where children, competent adults with dependents, or incompetent adults were involved. The attitude of the medical profession toward the dying patient also presents a problematic situation, but in general it may be characterized as an emphasis on cure to the exclusion of care. This may be due in part to the constraints of the Hippocratic Oath: "On entering the medical profession the doctor pledges to prolong and protect life and also to relieve the suffering of his patient."¹⁸ Perhaps a more important reason is the ever increasing number of malpractice suits being brought against physicians. It may be that

16. Russell O. Ruth, "Moral and legal aspects of euthanasia," *The Humanist* 34, 4, 1974, pp- 22-27.

17. Kamisar Yale, "Euthanasia legislation: some non-religious objections," in *Euthanasia and the Right to Die*, Downing A. B., (ed). (London: Peter Owen, Ltd, 1969, pp.85-133.

18. Brill Howard W., "Death with dignity: a recommendation for statutory change," *University of Florida Law Review* 22, 1970, pp- 368-383.

in the absence of laws to the contrary, physicians feel they must do all they can to prolong the existence of even dying patients beyond any reasonable expectation of recovery in order to escape this threat. Such was reputed to be the case with Karen Quinlan; medical authorities, out of fear of a malpractice suit, decided against turning off the resuscitator, even though the Quinlans signed a form authorizing the attending physician to do so.¹⁹ Medical technology has also contributed to the problem "... by failing to maintain the balance between the technological and the humane,... physicians have been seduced, if not actually betrayed, by their very competence."²⁰ The highly sophisticated life-sustaining therapies may blind the eyes of some medical specialists so that concern for the patient has been relegated to a secondary position behind the glamour of the machine.

Finally, it is possible that the mechanization, so often a part of the care administered to the dying, reflects defensiveness toward death common to most people. Within this context, physicians themselves may view death as an indicator of ultimate failure. The entire training and preoccupation of the doctor has emphasized the curative power of medicine, making the concept of "giving up" entirely foreign to this operational directive. If death is viewed as defeat, then strenuous effort must be exerted by whatever means is available to defeat that final event. Such an approach may be the means whereby health care personnel cope with and repress the anxieties that a terminally ill patient evokes in them. There are some indications that the medical profession is beginning to grant greater importance to the issue of euthanasia and the care of the dying. In 1973, the American Medical Association House of Delegates condemned physicians agreeing to perform mercy killing but gave its approval to voluntary passive euthanasia for terminal patients:

19. Powledge Tabitha M. and Steinfels P, "Following the news on Karen Quinlan," *Hastings Center Reports* 5, 6 ,1975, p- 28.

20. Morison Robert S., "Dying," *Scientific American* 229, 3 ,1973, p. 61.

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.²¹ The statement of the AMA quoted above is entirely appropriate; for it appears that a request for passive euthanasia by the terminal patient and his or her immediate family is not uncommon in the experience of most physicians. In a survey of over 400 doctors representing all major specialties, 38 percent reported hearing such a request from a terminal patient and 54 percent reported hearing such a request from the family of a terminal patient. A much smaller percentage (12 percent and 9 percent, respectively) of physicians indicated hearing requests for active euthanasia from terminal patients and their families.²²

Philosophers have sometimes marked those measures that are ineffective or excessively *burdensome extraordinary*. They are often called “heroic” in the medical setting. Thus, a person’s hospital medical chart might have the phrase “no heroics” on it, indicating that no such measures are to be used. There are other cases in which what is refused would be effective for curing or ameliorating a life-threatening condition. And yet decisions are made not to use these measures and to let the person die. These measures are called “*ordinary*,” not because they are common but because they promise reasonable hope of benefit. The chances that the treatment will help are good and the expected results are also good. One of the difficulties with determining whether a treatment would be considered ordinary or extraordinary is making an objective evaluation of the benefit and burden. It would be easier to do this if there were such a thing as a normal life. Any measure that would not restore a life to that norm would then be considered extraordinary. However, if we were to set this standard quite high, using it might

21. Branson Roy and Casebeer Kenneth, “Obscuring the role of the physician.” *Hastings Center Report* 6, 1,1976,pp- 8-11

22. Brown N.K. , “The preservation of life,” *Journal American Medical Association* 211(1970): pp-76-82.

also wrongly imply that the lives of disabled persons are of little or no benefit to them.²³ What would be considered an ordinary measure in the case of one person may be considered extraordinary in the case of another; a measure may effectively treat one person's condition but another person will die shortly even if the measure was used a blood terminology can be misleading because many of the things that used to be experimental and risky are now common and quite beneficial. Drugs such as antibiotics and technologies such as respirators, which when first introduced were experimental and their benefit questionable, are now more effective and less expensive. In many cases they would now be considered ordinary whereas they once could have been considered extraordinary. It is their proven benefit in a time period and for particular individuals that makes them ordinary in our sense of the term, however, and not their commonness.²⁴

Several years ago, a *New York Times* article reported about a judge before whom a disputed medical case had been brought. The dispute concerned whether or not a woman's respirator could be disconnected. The judge was reported to have said: "This lady is dead, and has been dead, and they are keeping her alive artificially."²⁵

Did the judge believe that the woman was alive or dead? Presumably, she could not be both alive and dead, at least as we commonly regard life and death. It is noted this item to make the point that people, even judges, confuse questions about whether someone is dead or ought to be considered dead with other questions about whether it is permissible to do things that might hasten their death. This confusion also has practical upshots. The judge's comment seems to imply that the reason why the woman's respirator could be disconnected was because she was dead. However, we need not believe an individual to be dead in order to think it justifiable to disconnect her from a respirator and let her die. If someone is not dead we can then ask whether

23. Ibid, pp-110-111.

24. The President's Commission Report, "Deciding to Forego Life Sustaining Treatment" (March 1983): pp- 82-89.

25. *New York Time*, Dec. 5, 1976.

we may let him die. It seems useful here to think briefly about how we do determine whether someone is dead so as to distinguish this issue from other questions that are properly euthanasia questions.

Throughout history people have used various means to determine whether someone is dead and those means were a function of what they believe to be essential aspects of life. For example, if spirit was thought of as essential, and was equated with a kind of thin air or breathe, to know if a person was living one would check for the presence or absence of this life breath. If heart function was regarded as the key element of life, and the heart was thought to be like a furnace, one would want to feel the body to see if it was warm in order to know if the person was still living. Even today with our better understanding of the function of the heart and other organs and organ systems we have great difficulty with this issue. One of the reasons for this is that we can artificially maintain certain body functions such as respiration (oxygenation of the blood) and blood circulation. Apart from such intervention and control, the three major life systems-circulatory, respiratory, and nervous (including the brain)—fail together, if one closes, the others also cease in a very short time.

Before the development of sophisticated means of life-support, the definition of death seemed fairly clear and unambiguous. It was widely understood as the cessation of life, defined by doctors as the stoppage of the circulation of the blood and other vital functions, such as respiration and pulsation. Being able to give precise conditions and tests for determining whether or when an individual is dead was particularly problematic just two to three decades ago. It was problematic not only because of the arrival of new medical technologies, but also because surgeons had just begun doing human heart transplants. One could not take a heart for transplant from someone considered living, but only from someone declared dead. Was an

individual whose heart function was maintained artificially, but who had lost all brain function, considered living or dead? We still wonder about this today. In one odd case a man accused of murder pleaded guilty to a lesser charge of assault and battery claiming that even though the victim had lost all brain function his heart was still beating after the assault. The defendant argued that it was the doctor at Stanford Medical Center who removed the heart for transplant who had killed this individual.²⁶

In 1968 an Ad Hoc Committee of the Harvard Medical School was set up to establish criteria for determining when someone is dead. This committee determined that someone should be considered dead if she or he has permanently lost all detectable brain function. This meant that if there was some unconscious brain function, for example, or if the condition were temporary (as perhaps in the case of barbiturate poisoning), the individual would not be considered dead. Thus, various tests of reflexes and responsiveness were required to determine whether an individual had sustained a permanent and total loss of all brain function.²⁷ This condition is now known *as whole brain death* and is the primary criteria used for legal determination of death. This is the primary criteria even when other secondary criteria or tests such as loss of pulse are used, for it is assumed that lack of blood circulation for more than five to ten minutes results in brain cell death.²⁸

Whole brain death is distinguished from other conditions such *as persistent vegetative state*. In this state, the individual has lost all cerebral cortex function but has retained good brain stem function. Many unconscious functions that are based in that area of the brain—respiratory and heart rate, facial reflexes and muscles, and gag and swallowing abilities—continue. Yet the individual in a permanent or persistent vegetative state has lost all conscious function. One reason for this condition is that the rate of oxygen use of the cerebral cortex is much higher than

26. The case occurred in Oakland, California. The Jury in the case found the defendant guilty even though California did not at that time have a “brain death” statute. *San Francisco Examiner*, May 1972..

27. Ad Hoc Committee of the Harvard Medical School to Examine the Definition of Brain Death, *A Definition of Irreversible Coma*, 1968. 205 J.A.M.A 377.

28. *Ibid* p. 107-108

that of the brain stem so that if deprived of oxygen for some time these cells die much more quickly than those of the brain stem. The result is that the individual in this state will never regain consciousness but can often breathe naturally and needs no artificial aids for maintaining circulation. Such an individual does not feel pain because he or she cannot interpret it as such. Since the gag reflex is good, individuals in this condition can clear their airways and because of this may live for many years. They go through wake and sleep cycles in which they have their eyes open and then closed. They are unconscious but “awake.” In contrast, someone who is not totally brain dead but who is in a coma is unconscious but “asleep.” Their brain stem functions poorly and thus they do not live as long as someone in a persistent vegetative state.

If we concentrate on the question of whether such individuals are dead or living, we can conclude two things. First, if someone is dead, euthanasia is not the question that needs to be addressed. In these cases disconnecting so-called life-sustaining equipment is not any kind of euthanasia. Second, if someone is not dead, we or that person may still judge that certain death-hastening actions or inactions are permissible. In thinking about euthanasia we should discuss only those cases in which someone is not dead. Only then can questions arise about what we may rightly do or refrain from doing that may then result in someone’s death. According to Singer that the brain death criterion is a “convenient fiction.” It was so readily accepted, because “it makes it possible for us to salvage organs that would otherwise be wasted, and to withdraw medical treatment when it is doing no good.” He argues that by accepting “brain death,” we have abandoned the “sanctity of life” ethic and now need to think again and adopt a new approach, “which will break out of the straitjacket of the traditional belief that all human life is of equal value.” The approval of brain death- that is, the permanent loss of all brain function- as a criterion of death has been widely regarded as one of the great achievements of

bioethics. It is one of the few issues on which there has been virtual consensus; and it has made an important difference in the way we treat people whose brains have ceased to function. This change in the definition of death has meant that warm, breathing, pulsating human beings are not given further medical support. If their relatives consent (or in some countries, as long as they have not registered a refusal of consent), their hearts and other organs can be cut of their bodies and given to strangers. The change in our conception of death that excluded these human beings from the moral community was among the first in a series of dramatic changes in our view of life and death. Yet, in sharp contrast to other changes in this area, it met with virtually no opposition. How did this happen?

Everyone recognize that the story of our modern definition of death begins with “The Ad Hoc Committee of the Harvard Medical School to Examine the Definition of Brain Death.” What is not so well known is the link between the work of this committee and Dr. Christian Barnard’s famous first transplantation of a human heart, in December 1967. Even before Barnard’s sensational operation, Henry Beecher, chairman of a Harvard University committee that oversaw the ethics of experimentation on human beings, had written to Robert Ebert, dean of the Harvard Medical School, suggesting that the committee should consider some new questions. He had, he told the Dean, been speaking with Dr. Joseph Murray, a surgeon at Massachusetts General Hospital and a pioneer in kidney transplantation. “Both Dr Murray and I.” Beecher wrote, “think the time has come for a further consideration of the definition of death. Every major hospital has patients stacked up waiting for suitable donors.”²⁹ Ebert did not respond immediately: but within a month of the news of the South Africa heart transplant, he set up, under Beecher’s chairmanship, the group that was soon to become known as the Harvard Brain Death Committee. The committee was made up mostly of members of the medical

29. Henry Beecher to Robert Ebert, 30 oct. 1967. The letter is in the Henry Beecher manuscripts at the Francis A Countway Library of Medicine, Harvard University, and is noted by David Rothman, *Strangers at the Beside*, New York, Basic Book, 1991, pp.160-1.

profession- ten of them, supplemented by a lawyer, a historian, and a theologian. It did its work rapidly and published its report in the *Journal of the American Medical Association* in August 1968. The report was soon recognized as an authoritative document, and its criteria for the determination of death were adopted rapidly and widely, not only in the United States but, with some modification of the technical details, in most countries of the world. The report began with a remarkably clear statement of what the committee was doing and why it needed to be done: Our primary purpose is to define irreversible coma as a new criterion for death. There are two reasons why there is a need for a definition: (i) Improvements in resuscitative and supportive measures have led to increased efforts to save those who are desperately injured is an individual whose heart continues to beat but whose brain is irreversibly damaged. The burden is great on patients who suffer permanent loss of intellect, on their families, on the hospitals, and on those in need of hospital beds already occupied by these comatose patients. (ii) Obsolete criteria for the definition of death can lead to controversy in obtaining organs for transplantation.

The first is that the Harvard committee does not even attempt to argue that there is a need for a new definition of death because hospitals have a lot of patients in their wards who are really dead but are being kept attached to respirators because the law does not recognize them as dead. Instead, with unusual frankness, the committee said that a new definition was needed because irreversibly comatose patients were a great burden, not only on themselves (why to be in an irreversible coma is a burden to the patient, the committee did not say), but also to their families, hospitals, and patients waiting for beds. And then there was the problem of “controversy” about obtaining organs for transplantation. The second striking aspect of the Harvard committee’s report is that it keeps referring to “irreversible coma” as the condition that

it wishes to define as death. The committee also speaks of “permanent loss of intellect” and even says, “We suggest that responsible medical opinion is ready to adopt new criteria for pronouncing death to have occurred in an individual sustaining irreversible coma as a result of permanent brain damage.” Now “irreversible coma as a result of permanent brain damage” is by no means identical to the death of the whole brain. Permanent damage to the part of the brain responsible for consciousness can also mean that a patient is in a “persistent vegetative state,” a condition in which the brain stem and the central nervous system continue to function, but consciousness has been irreversibly lost. Even today, no legal system regards those in a persistent vegetative state as dead.

Admittedly, the Harvard committee report does go on to say, immediately following the paragraph quoted above: “*We are concerned here only with those comatose individuals who have no discernible central nervous system activity.*” But the reasons given by the committee for redefining death- the great burden on the patients, their families, the hospitals, and the community, as well as the waste of organs needed for translation-apply in every respect to *all* those who are irreversibly comatose, not only to those whose entire brain is dead. So it is worth asking: why did the committee limit its concern to those with no brain activity at all? One reason could be that there was at the time no reliable way of telling whether a coma was irreversible, unless the brain damage was so severe that there was no brain activity at all. Another could be that people whose whole brain is dead will stop breathing after they are taken off a respirator, and so will soon be dead by anyone’s standard. People in a persistent vegetative state, on the other hand, may continue to breathe without mechanical assistance. To call the undertakers to bury a “dead” patient who is still breathing would be a bit too much for anyone to swallow.

We all know that the redefinition of death proposed by the Harvard Brain Death Committee triumphed. By 1981, when the United States President's Commission for the study of Ethical Problems in medicine examined the issue, it could write of "the emergence of a medical consensus" around criteria very like those proposed by the Harvard Committee.³⁰ Already, people whose brains had irreversibly ceased to function were considered legally dead in at least fifteen countries, and in more than half of the states of the United States. In some countries, including Britain, Parliament had not even been involved in the change: the medical profession had simply adopted a new set of criteria on the basis of which doctors certified a patient dead.³¹ This was truly a revolution without opposition. The redefinition of death in terms of brain death went through so smoothly because it did not harm the brain-dead patients and it benefited everyone else: the families of brain-dead patients, the hospitals, the transplant surgeons, people needing transplants, people who worried that they might one day need a transplant, people who feared that they might one day be kept on a respirator after their brain had died, taxpayers, and the government. The general public understood that if the brain has been destroyed, there can be no recovery of consciousness, and so there is no point in maintaining the body. Defining such people as dead was a convenient way around the problems of making their organs available for transplantation, and withdrawing treatment from them.

But does this way round the problems really work? On one level, it does. By the early 1990s, as Sweden and Denmark, the last European nations to cling to the traditional standard, adopted brain-death definitions of death, this verdict appeared to be confirmed. Among developed nations, only Japan was still holding out. But do people really think of the brain-dead *as dead*? The Harvard Brain Death Committee itself couldn't quite swallow the implications of what it was recommending. As we have seen, it described patients whose brains have ceased to

30. President Commission for the study of Ethical Problems in Medicine, *Defining Death: A Report on the Medical, Legal and Ethical Issues in the Determination of Death* Washington, DC:US Government Printing Office, 1981, pp 24-25.

31. *Defining Death*, pp.-67-72.

function as in an “irreversible coma” and said that being kept on a respirator was a burden to them. Dead people are not in a coma, they are dead, and nothing can be a burden to them anymore. Perhaps the lapses in the thinking of the Harvard Committee can be pardoned because the concept of brain death was then so new. But twenty-five years later, little has changed. Only last year the Miami Herald ran a story headlined “Brain-Dead Woman kept Alive in Hopes She’ll Bear Child”; while after the same woman did bear her child, the San Francisco Chronicle reported: “Brain-Dead Woman Gives Birth, then Dies.” Nor can we blame this entirely on the lamentable ignorance of the popular press. A study of doctors and nurses who work with brain-dead patients at hospitals in Cleveland, Ohio showed that one in three of them thought that people whose brains had died could be classified as dead because they were “irreversibly dying” or because they had an “unacceptable quality of life.”³²

32. Youngner, Stuart, “Brain Death”and Organ Retrieval: A Cross-sectional Survey of knowledge and Concept Among Health professionals,” *Journal of the American Medical Association*, 261, 1990, p-2209.