

Chapter-4

Critical observations on mercy killing

This chapter presents some very difficult and painful dilemmas associated with mercy-killing which people from different areas like doctors, patients, family members and moral philosophers face in our day to day lives. The dilemma of assisted suicide creates sometimes complex situations to our physicians and Court systems. The present chapter is divided into two sections. In the first section we are trying to bring into limelight Dr, Jack Kevorkian thinking about euthanasia. According to him when any doctor assists some patients to commit suicide, they are doing a compassionate work. Advocates of euthanasia think that it is precisely their deep respect for human life that allows them to support suicide for the terminally ill. Here the arguments for and against voluntary euthanasia are discussed. The concept of Advanced Directive is being the center of discussion in the second section. The complicated case of Terri Schiavo and the concept of 'persistent vegetative state' (PVS) are also part of our discussion.

"Euthanasia", commonly known as assisted suicide has become one of the most talked about social issues in the World. But there is no doubt that every patient or person has the right to live or the right to die. This is what we believe and understand freedom to be, by having the right to privacy, liberty, and the control over his or her body. The reason for this is because euthanasia becomes a serious issue with families, when an accident puts a patient in a comatose state and or otherwise incapable of making a competent decision, the family members fall in a state of fix. We have already observed that James Rachel recognizes two forms of euthanasia. First, he states that mercy sometimes requires mercy killing because the pain involved in a

terminal illness may be greater than the life itself. Secondly, he states that the Golden rule would be adequate enough to escape the extreme pain. The morals of this Golden rule are as follows, if it is right for me then it must be right for another individual.

Section-I

The role of compassion is one of the major issues in medical practice and ethics. Those who argue in favor of euthanasia hold that it is an act of mercy; it is a compassionate response to suffering of a fellow human being. When Dr. Jack Kevorkian was constructing the suicide machine that would help Janet Adkins kill herself in 1990, he gave it a name which he thought described its function: the *mercitron*. It seems a strange name for a machine which manufactures death; but Kevorkian isn't the only one to use the name "mercy" to describe his trade. The popular term for physicians helping terminally ill patients to commit suicide is "mercy-killing." And there seems to be widespread consensus that when doctors assist some patients to commit suicide, they are doing a compassionate work. It's a new consensus detected by pollsters: According to a 1991 Roper poll surveying people in California, Oregon, and Washington, 60 percent say the law should be changed so doctors can legally help patients with suicide. And whereas 15 years ago, 53 percent of Americans said that suicide was always wrong, that figure now hovers at only 41 percent.¹ Against this, supporters of the hospice movement have argued that it is only a perverse kind of compassion that kills the suffering person. This raises the following question: Is euthanasia ever the appropriate expression of compassion or mercy? While a patient's suffering might indeed be a terrible thing, and our inability to alleviate it may be deeply unfortunate, we should not allow ourselves to be 'blinded by (understandable) humane and sympathetic impulses' or to be moved by 'momentary impulses of pity sympathy to abandon our reasoned moral convictions' Under Kantian

1. Dubler Nancy and Nimmons David, "*Ethics On Call*" Crown Publishing, 1992, p.167.

influence, compassion or pity has been rejected as a morally appropriate motivation for acts of benevolence. Medical law and ethics have followed the example set by the natural science by attempting to discover principles that have the same degree of objectivity, rationality and universality characteristic of scientific laws. In the process of transforming medicine from an art into a science, the requirements of rationality and objectivity seemed to necessitate a rejection of compassion both as a means of understanding and as a motive for alleviating the patient's suffering. An important shortcoming of technological medicine, as guided by the principle-based ethic, is that it neglects the patient's emotional, psychological or existential suffering. Medical science focuses on explaining the origin of physical pain, on benefiting the biological organism and on respecting the autonomy of the patient as a rational being. This virtue has played an important role in the establishment and development of medical practice, but has been rejected or neglected by enlightened scientists and ethicists. We have heard countless appeals for a more humane medicine, but when faced with the choice between compassion and science, physicians and patients understandably opt for the later. Here we need not make such a choice, that compassion is compatible with the scientific approach. Against the view held by philosophers such as Plato and Kant, it has been shown that compassion is not only (or merely) an emotion but contains both cognitive and moral elements. Insofar as it is a means of understanding a person's suffering, compassion offers a valuable corrective to the purely scientific, distanced mode of explaining physical conditions. This understanding also makes it possible to appropriately respond to – and hence alleviate – the suffering of a specific individual. The Aristotelian account of compassion differs significantly from the Christian virtue of pity. The association of pity with guilt, shame and divine forgiveness lies at the basis of the Nietzschean view that a person can only maintain his dignity and self-respect through an

affirmation of his solitude, and by rejecting the pity and benevolence of others. The Aristotelian view of compassion may serve to strengthen or restore a person's sense of self-respect, since it is based on the recognition of the seriousness and unreservedness of the suffering of a fellow human being.²

But, along with the growing acceptance, even welcoming, of euthanasia and physician-assisted suicide, have received increasingly dire warnings about the practice from ethicists and thinkers. Such prominent names as former Surgeon General C. Everett Koop, the late award-winning novelist Walker Percy, and the Jewish-Christian ethical group the Ramsey Colloquium have all explicitly warned that the new welcoming of euthanasia is a phenomenon fraught with danger. According to all three, the "mercy" offered by euthanasia can only be offered by those who, logically and emotionally, hold to a conception of the human person radically different from that of traditional medicine: the price of accepting euthanasia's "compassion" is denying that humans have any inherent worth apart from their productivity or utility. As Walker Percy says, such "tenderness" leads inevitably "to the gas chamber"-to societies in which the scope for "mercy killings" swells to include not only the terminally ill, but those deemed socially useless as well.³

This warning was perhaps most forcefully given by the Ramsey Colloquium, a periodic gathering of prominent Jewish and Christian ethicists and thinkers. In the wake of a November 1991 referendum in the state of Washington to decriminalize physician-assisted suicide-a referendum that came within 4 percentage points of victory-the group published a "Declaration on Euthanasia" to help fight the trend towards growing toleration of the practice. The Declaration reads in part: ...Euthanasia is contrary to our faith as Jews and Christians, is based upon a grave moral error, does violence to our political tradition, and undermines the integrity

-
2. Van Zyl Liezl: *"Death and Compassion: a virtue-based approach to euthanasia."* Ashgate publishing Company, 2000. pp-8-9.
 3. Walker Percy, *The Thanatos Syndrome*, Farrar, Straus, Giroux, 1987. Pp.358-362.

of the medical profession....In relating to the sick, the suffering, the incompetent, the disabled and the dying, we must learn again the wisdom that teaches us always to care and never to kill. Though it sometimes seems compassionate, killing is never a means of caring.⁴

For those involved in the Ramsey Colloquium, too, the "compassion" leading to mercy-killing is the first step towards a society in which the integrity of all life is abandoned. For most persons it may still seem a long way from supporting a right for voluntary euthanasia for the terminally ill to a society where all respect for life is abandoned. Advocates of euthanasia, in fact, often argue that it is precisely their deep respect for human life that allows them to support suicide for the terminally ill.

"No decent human being would allow an animal to suffer without putting it out of its misery," argues renowned author Isaac Asimov in a critic's blog for the bestselling suicide manual *Final Exit*. "It is only to human beings that human beings are so cruel as to allow them to live on in pain, in hopelessness, in living death, without moving a muscle to help them." But what is the nature of this help that only supporters of euthanasia claim to be able to give? All doctors are bound by their Hippocratic Oath-and by the nature of their profession itself-to strive their utmost to alleviate suffering in their patients. Advocates of euthanasia argue that in some cases, the only remedy that can ease pain is when they are willing to prescribe death. Describing his client's most recent case of assisted suicide, Michael Schwartz, the lawyer for Dr. Jack Kevorkian, said the doctor was simply alleviating suffering in the only way left. "This is a case of medicine. It is a situation where the object was to alleviate the pain and suffering for patients who wish to have that pain and suffering put to an end."⁵

This may have provided an argument in favor of assisted suicide ten or fifteen years ago. But medical advances in the area of pain control now allow doctors to do completely soothe

4. 'Crisis magazine', Feb. 1992.

5. "'Dr. Death' aids cancer patient with her suicide," quoted from the article Killing as Caring, in *critical issues* Vol-1 issue-1 Associated Press Nov 24 1992

intense suffering that this argument for accepting euthanasia has become virtually useless. Advances in such devices as morphine drips and treated skin patches effectively guarantee that no terminally ill patient will suffer a painful death. According to Professor Robert Spitzer, a philosopher and authority on medical ethics: "Such significant advances have been made in the last two or three years by pain control experts that now it can be said with assurance that you will almost certainly not die an agonizing death. It can be said with assurance that total pain control may be had in the vast majority of the diseases leading to death."⁶ Dr. Cecily Saunders, the founder of the modern hospice movement, argues that advances in pain control management have made the euthanasia option completely unnecessary. Strangely enough, even advocates of physician-assisted suicide admit that traditional medicine can eliminate virtually all pain. Derek Humphry, author of *Final Exit*, amazingly concedes that doctors can eliminate virtually all pain for those who are terminally ill. "Certainly, modern pharmaceutical developments have provided us with wonderful analgesics, which, with shrewd management, control terminal pain in about 90 percent of the cases".⁷ According to Humphry, doctors assisting in suicide are not just relieving unbearable physical agony, but they are claiming to end the psychic pains that often attend illness: the pain that can beset those who lose their beauty, their hobbies, and their ability to be productive in the world. Even the most ardent supporters of a right to physician-assisted suicide admit that their campaign is about far more than the relief of physical suffering. If traditional medicine can now soothe the frayed nerves of the terminally ill and calm their broken bodies, what then is the appeal of euthanasia? Humphry gives the answer, one that should give pause to all who hold that euthanasia is solely about the relief of physical suffering: It is not just pain, or fear of pain, that drives people into the arms of the euthanasia movement. It is the symptoms of an illness, and often the side effects of medication, that damage the quality

6. "A Reason to Die: Euthanasia comes to Washington State," *Crisis* magazine, October 1991, p.21.

7. Humphry Derek *Final Exit*, Dell, 1992, p.134.

of people's lives, a person may not wish to live with throat cancer after the tongue has been removed and the face disfigured; or if reading or watching television is the great comfort of life, loss of sight is a tremendous blow if added to the knowledge that death is impending.⁸

There are various controversies engulfing on euthanasia and there have been cases against it as well. As per a certain debate group euthanasia is something that absolutely destroys social life and also damages the respect that one requires to be a part of the society. The society becomes devoid of senses all thanks to the continuous practice of euthanasia and as per the critics this procedure diminishes whatever the sanctity that society imbibes in us. The critics want to say that the procedure of mercy killing is something that devalues life and should not be accepted. The complete quality of life is absolutely undermined and overall, the society undergoes massive devastation. The social ills get a major kick start and are increased by several folds. There are several cases against and there are many protests against the agenda that wishes to make this procedure legalized. The opponents of euthanasia or the so called critics claim that after this becomes legalized the abuse potential increases by several folds. Slightly related to this argument is the one where it is stated that the people with the power might simply get intoxicated with it and likewise there would be a severe misuse of the same. The argument against euthanasia is also called the "wedge theory".

Yale Kamisar is the professor of law from the famous University of Michigan and he is also known as one of the staunchest spokespersons against the cause of euthanasia. He has come up with a three prolonged attack on the concept of this mercy killing and his attack includes and is based on the risk of abuse, the risk of mistake and the wedge theory. The ones who are responsible for propounding the wedge theory say that once society accepts that the entire concept of a man's life can be terminated all because of its decreased quality, then there would

8. *Ibid*, pp. 21-22.

be immense abuse of the same. There wouldn't be any way to limit it. Legalized voluntary euthanasia is sure to lead to involuntary euthanasia since it would be pretty much impossible to firmly draw a line of rational distinction between the ones who wish to die and those who are killed as per as the society's whims.⁹

The proponents of the wedge theory further say that the Nazi experiences with euthanasia are just an example of how this procedure of "mercy killing" is merciless completely. Euthanasia according to these people is nothing but society's way of riding of the people whom they decide shouldn't live long. Seriously no one is to decide who is to live and who is to die. We are all mortals and we live under the same sky and thus in the wedge theory people vehemently are against the total concept of euthanasia. Turning back the pages of history again it is seen that the inhuman systems of killings by the Nazis were merely camouflaged by the term "euthanasia" and if this is repeated in the modern day scenario then perhaps nothing can be done.

Arguments in support of voluntary euthanasia

John Stuart Mill, one of the architects of democratic doctrine, advanced the principle in the following way, "That 'the only purpose for which power can be rightly 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'.¹⁰ Accordingly, democratic societies can make laws to prohibit murder and robbery, but should not make laws to prohibit sex before marriage, religion, or voluntary euthanasia. This is because terminally ill patients who desire euthanasia for themselves are not physically harming other people. Mill's philosophy can be reduced to the statement that, in any legal issue between an individual and the state, the burden of proof for showing that an individual's behavior is undesirable, always rests upon the state,

9. Fletcher. J. "*Ethics and euthanasia,*" in *to Live and To Die, When, Why, and How?* Williams Robert.H (ed.), New York: springer-Verlag. 1974, pp-98-112.

10. Mill. J.S , *Utilitarianism*, p-78.

not upon the individual. The onus is thus on those opposed to euthanasia to 'prove' that voluntary euthanasia is fundamentally flawed.

People with extensive brain damage, along with many other sick and injured people, are financial and emotional burdens on their families and on society. Such burdens are often tremendous, and, some argue, they serve no significant purpose since patients in such situations gain absolutely nothing from their maintenance except the continuation of a minimal and worthless existence. The main point of this argument is that finances should not be a determining factor where human life is concerned. It is true that the emotional burden is often difficult to bear, but here again we should not sanction the sacrifice of one human life to ease the emotional burden on another.¹¹

There is another factor which is associated with euthanasia that may be called the human factor. This is a rather impersonal term, disguising the fact that patients are people; they are people with feelings, and they are loved by friends and relatives. These people must be treated in a humane and compassionate way. Peoples are now living longer, and our ailments are often well treated with drugs. But for some people these drugs do not provide a good quality of life, and they may suffer from continuous pain, discomfort or loss of dignity. Some people would like to choose the option of euthanasia. To deny terminally ill patients the right to euthanasia is to condemn them to a miserable existence, contrary to their wishes. It is hard to establish any difference in moral character between someone who denies a legitimate request for voluntary euthanasia, and who subsequently watches that person die a slow and painful death, and someone who watches a cancer-ridden pet writhe in agony without putting it down. Most of the peoples think that, if anybody are terminally ill, are of sound mind and not clinically depressed, and choose euthanasia, then it is morally right. For acts such as voluntary euthanasia that impact

11. O. Ruth Russell's, "*Moral and legal Aspects of Euthanasia*", *The Humanist*, 1974, pp-22-27.

directly on an individual, the moral and humane thing to do is what is right for the individual, and only each individual knows what this is. Voluntary euthanasia is moral and humane because it is what the individual wants. The gist of the above analogies is that not providing the option of voluntary euthanasia in the above situations is inhumane and callous. In a humane society the prevention of suffering and the dignity of the individual should be uppermost in the minds of those caring for the terminally ill. When the quality of life is more important than the quantity of life, in this situation voluntary euthanasia is a good option.

Arguments against voluntary euthanasia

Mercy killing is a direct violation of the Value of life Principle, especially since, unlike defense of the innocent, war, and capital punishment; it usually involves taking the life of an innocent person. As in the mercy death situation, the argument here is that murder is murder regardless of motive; therefore, mercy- killing is nothing less than premeditated murder. This argument is even more convincing here than in the case of mercy death because in this case people either haven't or can't give their consent to the termination of their lives.

Euthanasia opponents claim that a terminally ill patient could be incorrectly diagnosed, and could possibly recover, so euthanasia should be forbidden. It is foolish to claim that incorrect diagnoses and prognoses could never occur. But for all practical purposes, they can be ruled out. Dr Alistair Browne has analyzed the situation in the following way that it is frequently beyond all reasonable doubt that the diagnosis is correct or some cure will not be discovered in time to help, and it is not clear why this should not be sufficient. The law has never taken a "pigs might fly" attitude towards the risks attendant on any activity. We only need to establish "guilt beyond reasonable doubt" to send a person to prison or even to his execution, and it is not possible to require more without making the enforcement of the law impossible.

Why a more stringent standard should be demanded in the cases of assisted suicide and active voluntary euthanasia yet needs to be explained.

The slippery slope argument is a common sensationalist argument of the clergy and other euthanasia opponents. It claims that if right to assisted suicide and active voluntary euthanasia were instituted, it would lead to an increased rate of non-voluntary euthanasia, then euthanasia of those who are not attractive to society, those with fanatical political beliefs, extreme religious or cultural values and so on. Thus if we do not draw the line where it is, we will not be able to prevent substantial harm to others. This argument has no merit. For there to be evidence of a slippery slope there would need to be evidence of more non-voluntary deaths within a tolerant, legalized voluntary euthanasia framework. Studies have found that a 'group of people being helped to die without consent existed in all surveyed countries, irrespective of whether there was an environment of decriminalization or harsh legal sanction'. Moreover, it seems that a tolerant environment for voluntary euthanasia, decreases, rather than increases, the number of non-voluntary deaths. This has certainly been the case in the Netherlands. If there were a slippery slope, it is going the wrong way for those opposing euthanasia. The line on what will be permitted will be drawn by the elected representatives of the Australian people in each jurisdiction. Despite scaremongering, there will be no slippery slope. Good governance demands legislative oversight of voluntary euthanasia.¹²

The clergy and other euthanasia opponents argue that assisted suicide and active voluntary euthanasia are unnecessary because of the extraordinary developments in palliative care and pain control. Advances in palliative care are always welcome. In some, perhaps many cases, the need for assisted suicide and active voluntary euthanasia will be reduced through developments in palliative care. But these developments do not wither away the need for

12. Watt H. *Life and death in healthcare ethics: A short introduction*. London: Routledge, 2000 p-31-32.

voluntary euthanasia nor can they control all aspects of a patient's illness to the level desired by all patients. There are still numerous illnesses or conditions for which pain, extreme suffering, and loss of dignity are difficult or impossible to eliminate. Some patients will suffer the terror of breathlessness or vomit uncontrollably, others will be choking continuously or unable to swallow, others will be paralyzed, and still others will be helpless, weak, incontinent and totally dependent on others. Even if pain and distress are not the major problems, there is often a strong fear of the dependency that would result if all bodily functions, mental and physical, were sufficiently impaired. Palliative care is not an option for all people, since no amount of palliative care can relieve all distress. Voluntary euthanasia is a reasonable alternative for those who want it. Most of the Australian people, including the many thousands of members in Exit International and the state-based voluntary euthanasia societies, want voluntary euthanasia as an option.¹³

Some who argue against voluntary euthanasia claim that doctors must 'first, do no harm'. There are cases where persons suffer when palliative care has not provided adequate respite from pain and suffering. For many terminally ill people, staying alive is doing harm. The option of a peaceful death, before one vomit, is preferable for many people, such as terminally ill people with colon cancer. They should not be denied the right to have a peaceful death, a right that does not directly affect others. It is arrogant to impose one's belief systems on another individual, effectively denying the other the right of equality. Only terminally ill individuals themselves know what harm is. Those who opt for quantity of life regardless of the pain or suffering might not want voluntary euthanasia, and they need never request it. However, as many terminally ill patients consider that the quality of their life is more important than staying alive, the opinion of a peaceful death to alleviate their pain and suffering is more humane and

13. Kuhse, H., P. Singer, P. Baume, A. Clark, and M. Rickard, "End-of-Life Decisions in Australian Medical Practice", *The Medical Journal of Australia*, 166: 1997, pp-191-196.

valid alternative. Denying an individual's right to die is an arrogance that mostly derives from primitive religious teaching.

There are five objections which have been raised against voluntary euthanasia. Due to the progress in medical ethics, it is possible to provide effective palliative care and hospice care. Under these circumstances some are of opinion that voluntary euthanasia is unnecessary. But this counter-argument has several flaws. First, while both good palliative care and hospice care make important contributions to the care of the dying, neither offers universal cure. To get the best palliative care for an individual involves trial and error, with some consequent suffering in the process. Far more importantly, even high quality palliative care commonly exerts a price in the form of side effects such as nausea, incontinence, loss of awareness because of semi-permanent drowsiness, and so on. A rosy picture is often painted as to how palliative care can transform the plight of the dying. Such a picture is misleading according to those who have closely observed the effect of extended courses of treatment with drugs such as morphine, a point acknowledged by many skilled palliative care specialists. Second, though the sort of care provided through hospices is to be applauded, it is care that is available to only a small proportion of the terminally ill and then usually only in the very last stages of the illness (typically a matter of a few weeks). Third, and of greatest significance, not everyone wishes to avail themselves of palliative or hospice care. For those who prefer to die on their own terms and in their own time, neither option may be attractive. For many dying patients, the major source of distress is having their autonomous wishes frustrated. Fourth, as indicated earlier, the suffering that occasions a wish to end life is not always due to the pain occasioned by illness. For some, what is intolerable is their dependence on others or on machinery; for these patients, the availability of effective pain control will be quite irrelevant.¹⁴

14. Young, Robert, "Voluntary Euthanasia" The Stanford Encyclopedia of Philosophy, ed., Edward N. Zalta (summer 2014 edition, pp-1-16).

The second objection is related with the first which argues that we can never have sufficient evidence to be justified in believing that a dying person's request to be helped to die is competent, enduring and genuinely voluntary. It is certainly true that a request to die may not reflect an enduring desire to die (just as some attempts to commit suicide may reflect temporary despair). That is why advocates of voluntary euthanasia have argued that normally a cooling off period should be required before euthanasia is permitted. Here a question might be raised, what happens if a person is suffering with pain, or mentally confused because of the measures taken to relieve her pain, and so not able to think clearly and rationally about the alternatives? A person in those circumstances who wants to die should not be assumed to have a competent, enduring and genuinely voluntary desire to die. Here two important points arise. First, they do not account for all of the terminally ill, so even if it is acknowledged that such people are incapable of agreeing to voluntary euthanasia that does not show that no one can ever voluntarily request help to die. Second, it is possible for a person to indicate, in advance of losing the capacity to give competent, enduring and voluntary consent, how she would wish to be treated should she become terminally ill and suffer intolerable pain or loss of control over her life. 'Living wills' or 'advance declarations' are legally useful instruments for giving voice to people's wishes while they are capable of giving competent, enduring and voluntary consent, including to their wanting help to die. As long as they are easily revocable in the event of a change of mind (just as ordinary wills are), they should be respected as evidence of a well thought out conviction. It should be noted, though, that any request for voluntary euthanasia or physician-assisted suicide will not at present be able lawfully to be implemented outside of The Netherlands, Belgium and Oregon. 15

15. "*Voluntary Euthanasia*", *ibid.* pp- 10-13.

The third objection is related with one interpretation of the traditional ‘doctrine of double effect’ it is permissible to act in ways which it is foreseen will have bad consequences, provided only that

- a. this occurs as a side effect (or, indirectly) to the achievement of the act that is directly aimed at;
- b. the act directly aimed at is itself morally good or, at least, morally neutral;
- c. the good effect is not achieved by way of the bad, that is, the bad must not be a means to the good; and
- d. the bad consequences must not be so serious as to outweigh the good effect.

According to the doctrine of double effect, it is, for example, permissible to alleviate pain by administering drugs such as morphine, knowing that doing so will shorten life, but impermissible to give an overdose or injection with the direct intention of terminating a patient's life (whether at her request or not). This is not the appropriate way to give full consideration to this doctrine. However, there is one vital criticism to be made of the doctrine concerning its relevance to the issue of voluntary euthanasia. On one plausible reading, the doctrine of double effect can be relevant only where a person's death is an evil or, to put it another way, a *harm*. Sometimes the notion of ‘harm’ is understood simply as damage to a person’s interest whether consented to or not. At other times, it is understood, more strictly, as damage that has been wrongfully inflicted. On either account, if the death of a person who wishes to die is not harmful (because from that person's standpoint it is, in fact, beneficial), the doctrine of double effect can have no relevance to the debate about the permissibility of voluntary euthanasia.¹⁶

The fourth objection is related with active and passive voluntary euthanasia. There is a widespread belief that passive (voluntary) euthanasia, in which life-sustaining or life-prolonging

16. McIntyre, A., “Doing Away With Double Effect”, *Ethics*, The Chicago university Press, No-2, Vol- 111: 2001,pp- 219–255.

measures are withdrawn or withheld, is morally acceptable because steps are simply not taken which could preserve or prolong life (and so a patient is allowed to die), whereas active (voluntary) euthanasia is not, because it requires an act of killing. The distinction, despite its widespread popularity, is very unclear.¹⁷ Whether behavior is described in terms of acts or omissions (a distinction which underpins the alleged difference between active and passive voluntary euthanasia), is generally a matter of pragmatics rather than anything of deeper importance. Consider, for instance, the practice of deliberately proceeding slowly to a ward in response to a request to provide assistance for a patient subject to a 'not for resuscitation' code. Or consider 'pulling the plug' on an oxygen machine keeping an otherwise dying patient alive as against not replacing the tank when it runs out. Are these acts or omissions; are these cases of passive euthanasia or active euthanasia?

Further, the distinction between killing and letting die is unclear. For example we may take the case of a patient suffering from motor neurone disease who is completely respirator dependent, finds her condition intolerable, and competently and persistently requests to be removed from the respirator so that she may die. Even the Catholic Church in recent times has been prepared to agree that it is permissible, in cases like this, to turn off the respirator. But it seems odd to think that a case like this is best described as one in which the patient is allowed to die. In many cases, the most plausible interpretation of the physician's intention in withdrawing life-sustaining measures is to end the person's life. Consider the growing practice of withholding artificial nutrition and hydration when a decision has been made to cease aggressive treatment, and then see if we can generalize to cases like those of motor neuron sufferers.¹⁸ Many physicians would say that their intention in withholding life-sustaining artificial nutrition is simply to respect the patient's wishes. This is plausible in those instances

17. McMahan, J., *The Ethics of Killing: Problems at the Margins of Life*, New York: Oxford University Press, 2002. pp-455-462.

18. Winkler, E., "Reflections on the State of Current Debate Over Physician-Assisted Suicide and Euthanasia", *Bioethics*, July(3-4) 9:, 1995, pp- 313–326.

where the patient is still able competently to ask that such treatment no longer be given (or the patient's proxy makes the request); in the absence of such a request, though, the best explanation of the physician's behavior seems to be that the physician intends thereby to end the life of the patient. Permanently withdrawing nutrition from someone in, say, a persistent vegetative state does not seem merely to be a matter of foreseeing that death will ensue, but, rather, one of intending their death. What could be the point of the action, the goal aimed at, the intended outcome, if not to end the patient's life? No sense can be made of the action as being intended to serve to palliate the disease, or to keep the patient comfortable, or even, in the case of a person in a permanently vegetative state, of allowing the underlying disease to carry the person off. The loss of brain activity is not going to kill the person: what is going to kill the patient is the act of starving her to death.

Similarly, giving massive doses of morphine far beyond what is needed to control pain, or removing a respirator from a sufferer from motor neuron disease would seem, by parallel reasoning, to amount to the intentional bringing about of the death of the person being cared for. To be sure, there are circumstances in which doctors can truthfully say that the actions they perform, or omissions they make, lead to the deaths of their patients without them intending that those patients should die. If, for instance, a patient refuses life-prolonging medical treatment because she considers it useless, it might reasonably be said that the doctor's intention in complying is simply to respect the patient's wishes. The point is that there are many other circumstances in which it seems highly stilted to claim, as some doctors do, that the intention is anything other than the intention to bring about death — and hence, by an intention-based definition of killing, that the acts and omissions in question count as killings. This itself is a problem only if killing, in medical contexts, is always morally unjustified — a premise that

underwrites much of the debate surrounding this fourth objection. But this underlying assumption is open to challenge and it has been challenged by James Rachels.¹⁹ For one thing, there may well be cases in which killing, where requested, is morally better than allowing a death — namely, where the latter would serve only to prolong the person's suffering. Further, despite the longstanding legal doctrine that no one can justifiably consent to be killed (on which more later), it surely is relevant to the justification of an act of killing that the person killed has autonomously decided that he would be better off dead.

The slippery slope argument is the fifth objection that has been raised against voluntary euthanasia. Whereas it was once the common refrain that was precisely what happened in Hitler's Germany; in recent decades the tendency has been to claim that experience in The Netherlands has confirmed the reality of the slippery slope. Slippery slope arguments come in various versions. One (but not the only) way of classifying them has been to refer to logical, psychological and arbitrary line versions. The common feature of the different forms is the contention that once the first step is taken on a slippery slope the subsequent steps follow inexorably, whether for logical reasons, psychological reasons, or to avoid arbitrariness in 'drawing a line' between a person's actions. There is nothing logically inconsistent in supporting voluntary euthanasia while rejecting non-voluntary euthanasia as morally inappropriate. Some advocates of voluntary euthanasia, to be sure, will wish also to lend their support to some acts of non-voluntary euthanasia (e.g. for those in persistent vegetative states who have never indicated their wishes about being helped to die, or for certain severely disabled infants for whom the outlook is hopeless). Others will think that what may be done with the consent of the patient sets a strict limit on the practice of euthanasia. The difference is not one of logical acumen; it has to be located in the respective values of the different supporters (e.g.

19. Rachels, J., "*The End of Life: Euthanasia and Morality*", Oxford: Oxford University Press, chaps-7-8, 1986.

whether a person's self-determination or her best interests should prevail). It is also difficult to see the alleged psychological inevitability of moving from voluntary to non-voluntary euthanasia. Why should it be supposed that those who value the autonomy of the individual and so support provision for voluntary euthanasia will, as a result, find it psychologically easier to kill patients who are not able competently to request assistance with dying? What reason is there to believe that they will, as a result of their support for voluntary euthanasia, be psychologically driven to practice non-voluntary euthanasia? Finally, since there is nothing arbitrary about distinguishing voluntary euthanasia from non-voluntary euthanasia (because the line between them is based on clear principles), there can be no substance to the charge that only by arbitrarily drawing a line between them could non-voluntary euthanasia be avoided once voluntary euthanasia was legalized.

Section-2

The concept of Advance directive and Living Will:

Today there is widespread agreement that competent and informed patients have the right to refuse unwanted medical treatment, including life-sustaining treatment, for themselves. Many people also assume that this right can be extended into the future by way of advance directives, such as “living wills” or proxy directives. An advance directive is a legal document drawn up by a person stipulating their preferences with regard to end-of-life care should they become sick and unable to express these preferences themselves. The advance directive usually states that if the person has a terminal illness that they do not wish extraordinary resuscitative measures to be taken. The problem is that it is difficult for an advance directive to cover all the possible situations that may occur and there is a wide range of interpretation left up to the surrogate. Individuals may take “resuscitative measures” to mean either mechanical ventilation

or even just placing a feeding tube or intravenous infusion. Also a severe disabling stroke may be interpreted as “fatal” illness. An advance directive may in this way be used by a surrogate as a reason for not giving food and water to a patient with a severe but not-fatal medical condition.²⁰

Since being allowed to die seems to have become a significant moral issue of our time, and since this issue involves individual freedom and patients’ right over their own bodies, treatments, and lives, certain documents or directives have been created to allow people to inform others of the kind of treatment they wish to receive if and when they become seriously ill. Through such documents, people hope to ensure that they receive the kind of treatment they want even if they become too ill later to effectively communicate to others how they wish to be treated. Further, by such documents, these people hope to relieve their families, doctors, nurses, and hospitals of the burdens (economic, emotional, and moral) of making decisions that would allow them, as patients, to die their own natural deaths “with peace and dignity.” The first such documents, which were called “living wills,” were created by a group that started out by calling itself the Euthanasia Educational Council but now calls itself “Concern for Dying,” and which is located in New York . The first living will was fairly simple and expressed a strong rational and emotional desire to not have “artificial means or heroic measures” used when reasonable recovery from physical disability could not be expected. One of its problems, however, was that it stated that it recognized that the document was not “legally binding”. One way of enforcing one’s wishes and seeing that they are carried out is to legalize them (for example, in will having to do with one’s property and belongings). The wording of this first version of the living will, however, in effect negated this possibility through its own wording. Hoping to make the document more binding and to allow for the possibility of its being legalized, the organization

20. Saunders, Cicely, Baines, Mary and Dunlop, Robert, *Living with Dying : A Guide to Palliative Care*. New York: Oxford University Press, 1995.

put out a revised living will which not only eliminates the phrase having to do with recognition of its no legality, but expands and clarifies to whom the living will is directed.

A third revision of the living will goes even further by giving specific instructions of how to execute the will and even suggesting specific statements that could be added to the simple will to clarify a person's intentions concerning his treatment when he is dying. All three of these documents, of course, at least make clear how patients want to be treated when they can no longer make decisions for themselves, and they attempt to share the burden of decision making with those who became responsible for dying patients when they can no longer share or shoulder their own responsibility. The second and third documents, like the first, however, still do not legally enforce the desires of the person who executes it, and without legality, there is no guarantee that one's wishes will be carried out. A fourth document, legalized as part of the "natural Death Act" (AB306) in the State of California, is the first document created to allow patients' wishes to be fully made legal. California has then legalized a "living will" type document, called "Directive to Physicians." California residents who legally execute such a directive in accordance with the bill are guaranteed the same legal power as estate wills in determining the type of care they would receive. Presumably such a document could be challenged in court, just as other will are challenged, but, as far as it has known, no such court cases have yet arisen. A comparison of the three living wills, with the directive to physicians, readily shows that the latter provides much more extensive detail than the former three. Furthermore, the bill under which the directive was instituted gives it more force than the first two living wills have. People who wish to make out a directive to physicians may, of course, state their wishes in even more specific detail than the printed directive allows, provided that the document they execute contains the items required by the bill. For example, they could specify

how they wish to be treated for specific illness or injuries, making distinctions among heart failure, paralysis, coma from severe head injuries, and so on.

Regardless of how one feels about such documents, they are evidence of a growing concern on the part of human beings about the encroachment of medicine and medical technology on their freedom, lives, and dignity. These documents are also further evidence that people wish to have a strong voice in determining the nature of the medical treatment they receive and to exert individual control over their living and dying. Finally, it is important to note that none of these documents in any way authorizes either mercy death or mercy killing; they only pertain to allowing someone to die.

**To my Family, my Physician,
My Clergyman, my Lawyer**

If the time comes when I can no longer take part in decisions for my own future, let this statement stand as the testament of my wishes:

If there is no reasonable expectation of my recovery from physical or mental disability, I, _____ request that I be allowed to die and not be kept alive by artificial means or heroic measures. Death is as much a reality as birth, growth, maturity and old age – it is the one certainty. I do not fear death as much as I fear the indignity of deterioration, dependence and hopeless pain. I ask that drugs be mercifully administered to me for terminal suffering even if they hasten the movement of death.

This request is made after careful consideration. Although this document is not legally binding, you who care for me will, I hope, feel morally bound to follow its mandate. I recognize that it places a heavy burden of responsibility upon you, and it is with the intention of sharing that responsibility and of mitigating any feelings of guilt that this statement is made.

Signed-----

Date -----

Witnessed by:

**To my Family, my Physician, my Lawyer My Clergyman,
To any Medical Facility in whose Care I Happen to Be,
To any Individual Who May Become Responsible for my Health, Welfare, or Affairs**

Death is as much a reality as birth, growth, maturity and old age ___ it is the one certainty of life. If the time comes when I, _____, can no longer take part in decisions for my own future, let this statement stand as expression of my wishes, while I am still of sound mind.

If the situation should arise in which there is no reasonable expectation of my recovery from physical or mental disability, I request that I be allowed to die and not be kept alive by artificial means or "heroic measures." I do not fear death itself as much as the indignities of deterioration, dependence and hopeless pain. I, therefore, ask that medication be mercifully administered to me to alleviate suffering even though this may hasten the moment of death.

This request is made after careful consideration. I hope you who care for me will feel morally bound to follow its mandate. I recognize that this appears to place a heavy responsibility upon you, but it is with the intention of relieving you of such responsibility and of placing it upon myself in accordance with my strong convictions, that this statement is made.

Date -----

Witness -----

Witness -----

Copies of this request have been given to -----

22. *The Living Will as developed by the Euthanasia Education Council* (250 West 57th st., New York. Quoted from *The Dilemmas of Euthanasia*, edi., Behnke, J.A & Bok, S, Anchor Books, New York, 1975.p-155.

**To my Family, my Physician, my Lawyer and all Others Whom
It May Concern**

Death is as much a reality as birth, growth, maturity and old age--- it is the one certainty of life. If the time comes when I can no longer take part in decisions for my own future, let this statement stand as an expression of my wishes and directions, while I am still of sound mind.

If at such a time the situation should arise in which there is no reasonable expectation of my recovery from extreme physical or mental disability, I direct that I be allowed to die and not be kept alive by medications, artificial means or "heroic measures". I do, however, ask that medication be mercifully administered to me to alleviate suffering even though this may shorten my remaining life.

This statement is made after careful consideration and is in accordance with my strong conviction and beliefs. I want the wishes and directions here expressed carried out to the extent permitted by law. Insofar as they are not legally enforceable, I hope that those to whom this Will is addressed will regard themselves as morally bound by these provisions.

Signed -----

Date -----

Witness -----

Witness -----

Copies of this request have been given to -----

**To make best use of
Your LIVNG WILL**

1. Sign and date before

two witnesses. (This is to insure that you signed of your own free will and not under any pressure.)

2. If you have a doctor, give him a copy for your medical file and discuss it with him to make sure he is in agreement. Give copies to the most likely To be concerned “If the time Comes when you can no Longer take part in decisions For your own future”. Enter Their names on bottom line of The Living Will. Keep the Original nearby, easily and readily Available.

3. Above all discuss your intentions with those closest to you, now.

4. It is a good idea to look over your Living Will once a year and redate it and initial the new date and make it clear

1.a) I appoint -----
to make binding decisions
concerning my medical
treatment.

I have discussed my
views as to life sustain-
ing measures with the
following who under-
stand my wishes

2. Measures of artificial
life support in the face
of impending death
that are especially
abhorrent to me are:

a) Electrical or mechan-
ical resuscitation of my
Heart when it has
stopped beating.

b) Nasogastric tube fe-
edings when I am par-
alyzed and no longer
able to swallow.

that your wishes are unchanged.

Important

Declarants may wish to add
Specific statements to the Living
Will to be inserted in the space
Provided for that purpose above
the signature. Possible additional
Provisions are suggested below:

C) Mechanical respira-
tion by machine when
my brain can no long-
er sustain my own

breathing.

d) -----

3. If it does not jeopardize
the chance of my recovery to a
meaningful and sentient life or
impose an under burden on my
family, I would like to live out my
last days at home rather than in a
hospital.

4.) If any of my tissues are sound
and would be of value as trans-
plants to help other people, I
freely give my permission for
such donation.

The California Natural Death Act was passed in 1976. This Act became the precedent and template for other states interested in sanctioning living wills. The language of this first Living Will statute embodies the thinking of the time. This living will was intended for people with terminal illness and death anticipated imminently. It was meant to avoid unwanted life-sustaining treatment that would merely prolong the moment of death. More recent and generic advance directives and supplementary comments attached to Durable Power of Attorney for Health Care documents expand the scope of circumstances in which a mentally incapacitated person may forgo life-sustaining treatment.

Directive to Physicians

Directive made this _____ day of _____ (month, year), I _____, being of sound mind, willfully, and voluntary make known my desire that my life shall not be artificially prolonged under the circumstances set forth below, do hereby declare:

- If at any time I should have an incurable injury, disease, or illness certified to be a terminal condition by two physicians, and where the application of life-sustaining procedures would serve only to artificially prolong the moment of my death and where my physician determines that my death is imminent or not life-sustaining procedures are utilized, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally.
- In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this directive shall be honored by my family and physician(s) as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences from such refusal.
- If I have been diagnosed as pregnant and that diagnosis is known to my physician, this directive shall have no force or effect during the course of my pregnancy.
- I have been diagnosed and notified at least 14 days ago as having a terminal condition by _____ M.D., whose address is _____ and whose telephone number is _____. I understand that if I have not filled in the physician's name and address, it shall be presumed that I did not have a terminal condition when I made out this directive.

- This directive shall have no force or effect five years from the date filled in above.
- I understand the full import of this directive and I am emotionally and mentally competent to make this directive.

Signed -----

City, County and State of Residence -----

The declarant has been personally known to me and I believe him or her to be of sound mind.

Witness -----

Witness -----

It is clear from these discussions that current practices are much confused in this matter of shortening another's life- moralists disagree, religious viewpoints vary, and medical practice is inconsistent. Even in legal matters, law as it is written and law as it is practiced are vastly different. This in its turn encourages disrespect for the law is a situation that should be remedied. According to Ruth Russell the "best solution is to enact a comprehensive euthanasia law- one that would provide for active and passive euthanasia and that would meet a broad spectrum of needs and provide adequate safeguards for every case."²⁴ We are not entirely without precedent here for other countries have enacted this type of legislation. Most European countries do not classify passive euthanasia as homicide, and Switzerland even allows a physician to make poison available to a fatally ill patient provided the physician does not administer the poison himself. Several countries recognize "homicide upon request," which carries a more lenient punishment than would normally be exacted for murder. Thus far, only Uruguay has legalized active euthanasia performed at the request of the terminal patient.²⁵ Russell lists these as partial solutions to the euthanasia issue in the United States:

1. Amend the Constitution to recognize the right of an individual to life' liberty, and happiness which includes the right to death when one is suffering from an irremedial condition and happiness is no longer possible.
2. Amend the suicide laws to make assisted suicide legal in certain circumstances and in accord with legal safeguards permitting doctors to practice life-shortening tactics.
3. Amend the criminal code to distinguish euthanasia from murder (the Swiss Code identifies a murderer as a dangerous person or one with a depraved mind).

24. Russell Ruth O., "Moral and legal aspects of euthanasia," *The Humanist* 34,4 :1974 : p. 22.

25. Brill W. Howard, "Death with dignity: a recommendation for statutory change," *University of Florida Law Review* 22, 1970: p. 374.

4. Make “brain death” a legal criterion of death (this would solve only a minor part of the problem).
5. Legalize the Living Will.
6. Enact euthanasia laws pertaining to passive euthanasia to provide legal and professional immunity to physicians who discontinue life-prolonging treatments (Death with Dignity Act).
7. Enact active euthanasia laws which recognize the right of a patient to choose death and have the assistance of a qualified person to bring it about (voluntary Euthanasia Acts).

Russell submits, however, that any of these by itself is only a half-step or partial solution; what is needed is a comprehensive euthanasia law that would combine the best features of the above proposals as well as some additional provisions. The three parts of such an act should include:

1. Provisions for passive euthanasia, voluntary and nonvoluntary;
2. Provision for active euthanasia at the request of the patient, including the provision for deciding, with an advance declaration stating his or her wishes, when an irremediable condition occurs (Living Will);
3. Provision for positive euthanasia at the request of the next of kin or legal guardian when the individual is unable to speak for him/her.

She further suggests that the following safeguards be included:

1. Legislation would be permissive only, not compulsory.
2. No secret action should be permitted for either active or passive euthanasia; the decision and proceedings should be part of the public record.

3. A written, witnessed, and notarized request for euthanasia would be required from either the patient or the next of kin or guardian. It could be made in advance while in good health but could be revoked at any time by the person making it. If made in advanced it would have to be reaffirmed before euthanasia could be administered.
4. Two or more physicians would verify that the patient's condition is irremediable and that the request is a bona fide one executed without duress from others.
5. In cases where it is possible, application for euthanasia should be preceded by consultation with other- clergyman, hospital chaplain, psychologist, social worker, members of the family, etc.
6. The formal application should be filed at the Country Court House or other legally constituted authority where, after review, a permit may or may not be issued (application is authentic and properly completed; there is no evidence of coercion or foul play, etc.).
7. A waiting period would ordinarily be required to ensure that emotional distress did not prompt the application (e.g., 15-to 30-day wait period).
8. The administration of euthanasia would be the responsibility of the patient's physician or other medical person designated to carry out the physician's instructions and the patient's wishes.
9. The death certificate would indicate the action taken.
10. No physician or other medical personnel would be required to administer euthanasia if it is contrary to his/her conscience, judgment, religious beliefs, etc.)
11. No medical person or other specialist who performs an authorized act of euthanasia would be guilty of any offense.
12. No insurance policy in force would be vitiated.

13. Each person who has reached the age of maturity should be encouraged to lodge with the appropriate office his or her desires pertaining to euthanasia. Such persons would be issued cards to carry indicating these wishes.

The legislation Russell proposes should not be overly rigid but it should define the rights, roles, and responsibilities in the relationship between the doctor and the terminally (or critically) ill patients. Dr. Robert Veatch, from the Institute of Society, Ethics, and the Life Sciences, suggests that these inclusions be part of effective legislation: (i) provision be made to ensure that the wishes of the person, expressed while competent and never disavowed, remain valid even though that person may be unable to reiterate them during terminal illness; (ii) penalty clauses for failure to follow instructions or foregoing a document should be inserted; (iii) the rights of medical personnel to withdraw from a case for reasons of conscience, with the provision that adequate medical care be provided; (iv) that death resulting from withdrawal of treatment are not suicide (for legal and insurance purposes) and that medical attendants are not guilty of homicide for following directions.²⁶

It is inevitable, given our system of jurisprudence and constitutional law, that legislation lags behind public opinion, but a number of legal proposals for both passive and active euthanasia have been presented. A number of state legislatures have considered such laws. Perhaps the most popular is a call for the legalization of the so-called Living Will. This document is a statement declaring a person's wishes regarding treatment if that person should become terminally ill. It is to be signed by the person while still of sound mind and would serve as an expression of his/her wishes in the event that he/she would be unable to communicate them. The most commonly referenced form of the Living Will was developed by the Euthanasia Education Council, a nonprofit organization in New York City. This will asks that no artificial

26. Veatch, M. Robert "Death and dying: the legislative options," *Hastings Center Report* 7, 5, 1977, pp- 5-8.

means or heroic measures be used to keep the patient alive if there is no real chance of recovery, and requests only the alleviation of suffering. Less popular are proposals for comprehensive legislation permitting both passive and active euthanasia.

California was the first state to enact a euthanasia law, the natural Death Act, which came into effect on January 1, 1977. It was explicitly stated in this 'Act' that, under certain specified circumstances, euthanasia may be practiced on terminally ill patients. The main provisions as given in this 'Act' are as follows:

The Legislature finds that adult persons have the fundamental right to control the decisions relating to the rendering of their own medical care, including the decision to have life sustaining procedures withheld or withdrawn in instances of a terminal condition.

The Legislation further finds that modern medical technology has made possible the artificial prolongation of human life beyond natural limits.

The Legislature further finds that, in the interest of protecting individual autonomy, such prolongation of life for persons with a terminal condition may cause loss of patient's dignity and unnecessary pain and suffering, while providing nothing medically necessary or beneficial to the patient.

It further finds that there exists considerable uncertainty in the medical and legal professions as to the legality of terminating the use or application of life-sustaining procedures where the patient has voluntary and in sound mind evidenced a desire that such procedures be withheld or withdrawn.

In recognition of the dignity and privacy which patients have a right to expect, the Legislature hereby declares that the laws of the state of California shall recognize the right of an adult person to make a written directive instructing his physician to withhold or withdraw life-

sustaining procedures in the event of a terminal condition. The law allows a doctor to discontinue life-support equipment from a dying patient who has authorized it in advance. It can be acted on only after two doctors certify a patient hopelessly ill, with death imminent no matter what treatment is used. Under the law, a physician cannot be used or prosecuted for implementing Living Will. The document must be renewed every five years to remain valid.

The bill had a wide base of support on the way to its passage and signing including religious, professional, and senior citizens' organizations. However, fifteen months after its enactment (March 1978) doctors reported only a few of their patients had directed them to cut off life-sustaining procedures when death was imminent. Indeed, one of the main objections to it is its narrowness. For example, the directive is legally binding only if a patient has been certified as terminally ill at least fourteen days before the directive is signed. Moreover, the law contains a strict witness requirement and, coupled with the five-year renewal provision, diminishes the operational effectiveness of the law. According to one elderly citizen, "they've made it too difficult." Another voiced the objection that "people don't trust this act." It is feared that physicians would become insensitive to the needs and requests of terminal patients who did not have the proper documentation or whose case did not fit the narrow specifications of the Natural Death Act. (For example, Karen Ann Quinlan would not have qualified even though she might have signed a directive.) However, the bill's authors had deliberately constructed a limited bill anticipating subsequent legislation to clear up some of its vagueness. They felt it was important to get legislation on the book dealing with the easier cases first. This is exactly what is feared by the anti-euthanasia position. Dr. Philip Dreisbach, of Concerned Physicians and Attorneys Against Euthanasia, represents the views of several pro-life groups that fought its enactment. He said, "The governor has made a tragic mistake for the future of helpless patients and his own

political future. This is the Act that euthanasia groups in the United States and Europe have been waiting for. Governor Brown will be known as the first American governor to point us toward legalized medical homicide and suicide.”²⁷

According to opponents, legislation like this is making it all too plain that an antilife philosophy is being adopted by the American medical and legal professions. The abortion of live babies, fetal experimentation, neonatal euthanasia, and now legally mandated euthanasia—the “death brigade” is claiming an even wider circle of victims, with no apparent end in sight. In spite of some fundamental opposition, the movement to legislate death with dignity has gained momentum. In 1977 alone, forty states had considered legislation and eight have enacted legislation of some kind (Arkansas, California, Florida, Idaho, Nevada, New Mexico, North Carolina, and Virginia). Most of these assert the rights of competent persons to execute documents indicating that certain kinds of intervention should not be used when they become terminally ill (e. g., California Natural Death Act). Others sought to clarify who could make a decision for cessation of treatment for the incompetent, terminally ill patient. For example, the Florida Act transfers the Living Will authority to the next of kin, then to physicians.

It remains to be seen whether the California Natural Death Act or any of the other death-with-dignity legislation does in fact let the genie out of the bottle. Whatever their outcome, these do represent landmark efforts at legislation; an important step has been taken in trying to clarify some of the issues encompassed by euthanasia. The recognition is growing that care for the dying does have limits. By accepting passive euthanasia, a legal differentiation is made between ordinary and extraordinary means of treatment for terminal patients; some treatments are medically indicated and expected to be helpful while others are not. Passive euthanasia does not mean that the health care professional has given up on the terminal patient. The question

27. Egelko, Bob “*Living Wills’ cranked out in California*,” Champaign-Urbana News-Gazette (Nov. 22, 1976).

does not seem to be whether to treat or not to treat but rather *how* to treat. “Decisions to cease curative attempts are not abandonment of a patient but (now are) a part of good medicine.”²⁸ Here we are in the midst of something new in medical! Therapy- *no* treatment may also be good for the patient!

Moral thinking on these issues does not take place with a vacuum: one does not start out with a morally neutral attitude to life, and to the saving or taking of life, but with a presumption. This is the presumption that life is good, and that the duty of care to patients standard requires the medical professional to sustain their lives. It is presumed, in other words, that the duty of beneficence entails the sustaining of life, and that the duty of non-maleficence entails refraining from acting against life. Moreover, it is presumed that one owes the same duty of care to each patient. Care, in other words, is not to be compromised by judgments about the relative values of patients’ lives. Indeed, the obligation to care, and in particular the obligation to sustain life, is especially an obligation to care for sub-optimal human life – life which is damaged or diseased or deranged or weak or helpless. This presumption in favor of sustaining life is so important, and so fundamental to the ethos of the medical profession, that it can hardly be overstated. Nevertheless, powerful as it is, it is a presumption, not an absolute principle. It has its limits. We are all mortal: our death is an inevitability which medicine cannot finally ward off. Yet medicine may have at its disposal the means of prolonging life at a certain level; and there are situations in which it can recognize that it ought no longer to employ those means, that it ought to desist from further attempts to sustain life, because they would now be out of place. Some of these limits to the duty to sustain life are relatively clear and uncontroversial; and it is worth mentioning them because they can be reasonably distinguished from what is at issue in the question of euthanasia.

28. McCormick A. Richard, J. S., “*Notes on moral theology*,” *Theological Studies* 37: 1976, pp-87-107,

A related argument mustered in support of a personal autonomy right to self-determination trades on the ideas of ownership and property in order to justify a decision to commit suicide, to assist in a suicide or to commit voluntary euthanasia. Crucially, the kind of right claimed is the right to self-determine how 'owned property' can be treated and disposed of. Since property owners have a right to decide how property is treated and disposed of, and since 'the self' owns the attributes and assets that constitute 'the self' the self must determine how the self is treated and disposed of. As long as owners do not violate the rights of other owners, individuals possess the right to decide for themselves how their assets, including their lives, can be treated and disposed of. It should be observed that the very notion of 'self' owning the 'self' is deeply suspect. The idea that people own themselves gains some negative plausibility from the fact that a well known religious claim that persons can not be said to own their lives because they are deemed to be the property of god. Since it is not a reasonable secular argument to hold that persons are owned by god, and since persons do not belong to any other entity or thing, it is said to follow that persons must own themselves. Yet that conclusion does not necessarily follow. The concept of ownership implies that the thing owned can be meaningfully distinguished from the person owning the thing. As Kant recognized, thing and person are not one and the same. Yet, how can a person's corporeal existence X be meaningfully separated from the existent person Y, such that Y can be said to own X? The separation of X and Y is a metaphorical not a real separation. Since X and Y are really existentially inseparable, Y cannot literally be held to own X.

If corporeal existence cannot be separated from the idea of self, life itself cannot be separated from the idea of self either. In order for something to be my property, it must be

capable of being separated from me and thus be capable of being transferred to another—I can own a book, the fruits of my labor, a piece of land, even my severed body parts—all can be transferred to others—but I cannot literally own my life for life is not some kind of property attribute that can be existentially separated from my essential self. Perhaps it might be argued that peculiar talk of ‘self’ owning ‘self’ can be set aside if it is interpreted to mean that a person owns his or her ‘body’. Here, however, we must question the intelligibility of seeking to differentiate ‘body’ from ‘person’ such that a body can be considered to be a mere physical thing that is the property of some sort of ‘inner’ being. In this connection Peter Singer’s view regarding euthanasia may be discussed. Singer, a preference utilitarian raises the issue of the morality of killing from a different perspective. Singer’s criterion of person plays an important role in the application of his basic moral principle. Singer thinks voluntary euthanasia morally justified, and he argues in favour of its legalization under certain conditions.²⁹ According to him non-voluntary euthanasia is justified in some cases like that of handicapped infants. “Killing them therefore, cannot be equated with killing normal human beings, or any other self-conscious beings.... No infant- disabled or not- has a strong a claim to life as beings capable of seeing themselves as distinct entities existing over time.”³⁰ Since disabled babies are not persons, it is on classical utilitarian grounds the question whether they can or should be killed has to be settled. The main reasoning stands on the following question. Will the babies future life be ‘worth living’ in the sense that there is a surplus of pleasure over pain? This reasoning applies to babies in general, not just disabled ones. There are two reasons that Singer offers. The first reason is, having a baby is a happy experience under normal circumstances. Secondly, a normal baby will usually have a life worth living. Here the parents attitude counts more to Singer. The cases that Singer have in mind are the following, severe cases of *spina bifida*,

29. Singer Peter, *Practical Ethics*, Cambridge University Press, Cambridge, Reprinted Indian edition, 2010, pp176-181.

30. *Ibid*, p-182.

Down's syndrome and haemophilia. It may be commented here that the prime consideration would be to change the social conditions or practices and not to consider whether killing would be the best solution. Today an individual's rights over one's own life are highly valued. And yet the commonsense moral view is that there are limits to this right. It is limited, for example, when it conflicts with the interests or rights of others. Under what conditions and for what reasons should a person's own wishes prevail in euthanasia matters? How important is voluntary consent?

In cases of voluntary euthanasia, where the patient, relatives, and doctors all agree on this, then it's an open and shut case- it should be done, either actively or passively, according to the patient's preference. Where the patient disagrees with the relatives and/ or doctors, then it's more problematic. How does one decide how much weight to give the patient's preference, in contrast to that of several close relatives, and in comparison to the expertise of the doctors? Or does the patient get an absolute right of veto over anyone else's preference, since it's their life after all? In non-voluntary euthanasia it will obviously be the relatives in combination with the doctors who decide in the light of their preferences regarding what's in the best interests of the patient. In none of these situations does preference utilitarianism make any moral distinction between active and passive euthanasia or bother with the doctrine of double effect. If the decision is made to proceed with a request for euthanasia, the doctor should be entirely free to administer a lethal injection, the clear purpose of which is to end life in accordance with the patient's wishes. 31

Utilitarianism has some counter-intuitive aspects which count against it. For instance, none of the versions sketched above is concerned about the motives and character of the relatives and medical staff. It doesn't really matter if they have ulterior self-serving motives for

31. Stewart. N, "Ethics-An Introduction to Moral Philosophy", Policy Press,U.S.A, 2009, pp -87-88.

what they do, as long as the greatest happiness or least pain is achieved. But this would encourage corruption of the whole business of euthanasia, and perhaps turn it into a kind of scam for those on the make. Act utilitarianism, in particular, would even seem to advocate involuntary euthanasia if the pleasure of the relatives and doctors outweighed the fear and pain of the unwilling patient. Rule utilitarianism scores over act utilitarianism in this respect, because this sort of thing is devastating to tried-and-tested social rules against murder, and rule utilitarianism's strength is in protecting these and rejecting individual acts which undermine them. But, on the other hand, rule utilitarianism would also reject some individual acts of euthanasia that would reduce a patient agony without tending in least to undermine happiness-protecting rules banning killing, and this too is unacceptable to the moral intuitions for ordinary person. But preference utilitarianism improves on act utilitarianism by outlawing any possible type of involuntary euthanasia provided it gives the patient's preference a veto over all others. On the whole, utilitarianism is a big improvement on divine command theory as applied to euthanasia, because it suites better with most people's moral intuitions concerning patient welfare. Most people these days prefer less pain and more dignity to the dubious benefits of being made in God's image. If euthanasia is to be legalized it should be done after taking all necessary measures and safeguards to prevent its abuse.³²

Britain is by no means the only place where this debate is current. One obvious reason is that in the West more people are living into their 80s and 90s. Old people (and their families) are the most likely to face difficult choices about quality of life versus sheer survival. The existence of the much-publicized Dignitas clinic near Zurich means it is Switzerland which is often associated around the world with assisted suicide. Ludwig Minely , the founder of this clinic is the main person who help to expand this movement of 'right to die'. In the website of

32. Ibid ,p -85

this Dignitus clinic the following words are written ‘to live with dignity, to die with dignity.’ In 1998, this clinic started in Zurich. Till today this clinic helped 1701 people to die. In this list the Germans occupied, the first position, 840 people. Besides the German, there are citizens almost all over the world including even India. It has been in the news that one Indian has enrolled his/her name.³³ Now the Supreme Court of India decides to adjudicate the legality of active and passive euthanasia and the emerging concept of ‘Living Will’ after shying away for decades from examining this highly emotive and legally complicated issue. According to Attorney general Mukul Rohatgi, the government does not accept euthanasia as a principle.³⁴ Government’s stand on euthanasia, in whichever form, is that the court has no jurisdiction to decide this. It’s for parliament and the legislature to take a call after a thorough debate and taking into account multifarious view. Now at present the court agreed it was a matter of public policy and that parliament and the legislature were competent to decide it. But Counsel Prashant Bhushan, for PIL petitioner NGO Common Caus, said the issues were debated in public for decades and the legislature had not yet taken the first step. The court wanted a country-wide debate. A constitution bench of Chief Justice R.M. Lodha and Justice JS Khehar, J Chelameswar, A.K Sikri and R.F Nariman sought views of all states and Union territories on the PIL in eight week. And it requested senior advocate T,R.Andhyarajina to assist the court as *amicus curiae*.

The issue concerns the right of a terminally ill person, after doctors unanimously rule out chances of survival. Active euthanasia would involve a doctor injecting a lethal medicine to trigger cardiac arrest. In passive euthanasia, doctors with consent from relatives, withdraw the life support system of a person being kept alive with the help of machines. Explaining “Living Will”, Mr. Bhushan said, that given the Unanimity that a person had the right to refuse a particular medicine or treatment, why should he/she be not allowed to execute slipped into a

33. Ananda Bazar Patrika.

34. Times of India, 15th July 2014.

vegetative state with a terminal disease with no chance of recovery, doctors should not keep him/ her alive with the help of life support?

In the Netherlands, doctor-assisted suicide was legalized in 2002. That change followed a couple of decades when assisted suicide was acknowledged to be getting more frequent but was unregulated. Now about 2,300 people opt to die by assisted suicide in the Netherlands each year, out of a population of almost 17 million. If someone in Holland approaches their doctor wishing to die there are stringent safeguards and a second doctor experienced in the field must be consulted. The patient must be suffering unbearably and have no hope of recovery. Sometimes that judgment can be relatively clear-cut. Far more contentious would be the case of a clinically depressed patient who believed life was simply not worth living. However, the Royal Dutch Medical Association (KNMG) says its members overwhelmingly favor the present system. They say few Dutch doctors exercise their right to opt out of such discussions. By comparison, the Dignitas clinic in Switzerland provides a far better list as discussed above. In the US, the issue remains one for the individual states, although there have been failed attempts to outlaw the practice at a federal level.

The first state to permit assisted suicide was Oregon in 1998. This followed a ballot initiative. It is thought that about 400 people there have taken advantage of the law. After a long gap, Oregon was joined last year by neighboring Washington, also after a ballot. The first actual cases were in March this year. In theory, Montana became the third US state on the list in December 2008. But in Montana the position is very different. The change came not after a

referendum and all the attendant debate, but because of a court ruling. District Judge Dorothy McCarter ruled that, under the constitution of Montana, 76 year-old retired truck-driver Bob Baxter had the right to ask his physician to help him die. Mr. Baxter died of leukemia shortly after the ruling was issued. The state of Montana has asked the state's Supreme Court to overturn that ruling. The fact there seems to be a new momentum to the debate in the USA is not accidental - the organization 'Compassion & Choices' has been lobbying hard to make assisted suicide more acceptable to more Americans. So far, it seems to be having some success. And whether or not Montana ultimately allows assisted suicide 'Compassion & Choices' have other states on their target list. 35

The Concept of "persistent vegetative state" (PVS)

The concept of "persistent vegetative state", is a permanent condition in which severe brain damage causes the patient to have reduced awareness and an inability to respond meaningfully to the environment. The patient with PVS is typically one who suffers a severe head injury, a prolonged cardiac arrest or multiple strokes. The patient with PVS is able to open their eyes and look like they are awake, but seems to be totally unresponsive to their surroundings. The patient may be able to breathe on their own or need a ventilator. The patient is usually unable to swallow and needs a feeding tube. When PVS is established it is usually permanent. There are several problems about the diagnosis of persistent vegetative state:

1. There is no objective *test* with which to make the diagnosis. The diagnosis is made when a patient suffers a severe brain injury and shows no sign of recovery. The diagnosis becomes more definite with time, but recovery is unlikely 12 months after a traumatic injury and 3 months after non-traumatic injury.³⁶ Occasional patients who have appeared to have

35. Voluntary Euthanasia Society of the Netherlands. (Internet Resources)

36. Gormally Luke, *Euthanasia and Assisted Suicide*, Linacre Centre for Healthcare Ethics. (Internet Resources)

persistent vegetative state have started to communicate in a limited, but conscious and meaningful manner after a period of years.³⁷

2. We cannot assume that patients with persistent vegetative state do not have any conscious brain activity. We do not at present have any way of determining how much conscious activity, if any, is occurring in any individual patient with persistent vegetative state. ³⁸

On 25 February 1990, Terri Schiavo, 26 years of age, collapsed in the hall of her apartment and experienced severe hypoxia for several minutes. She had not executed a living will or a durable power of attorney. Four months after her injury, Mrs. Schiavo was judged incompetent and her husband, Michael Schiavo, was appointed her legal guardian without objection from her parents, Robert and Mary Schindler. Because she was unable to swallow, Mrs. Schiavo underwent placement of a percutaneous endoscopic gastrostomy (PEG) tube. By late 1990, Mrs. Schiavo was determined to be in a persistent vegetative state.

The Schiavo case rests critically on the concept of the persistent vegetative state and the certainty of the prediction that a patient in this state will have no meaningful recovery. The persistent vegetative state is distinguished from several other states of reduced consciousness. Brain death implies the loss of not only all higher brain functions but also all brainstem functions, including papillary light reflexes, reflex eye movements, respirations, and gag generally accepted as a criterion for death. Coma is a complete state of unresponsiveness to stimuli, although the patient may have brainstem reflexes. Stupor and obtundation refer to states of reduced consciousness in which meaningful responses are still possible, if the patient receives enough stimulation. Finally, the “locked-in syndrome” denotes the condition of a

37. Andrews K, Murphy L, Munday R, Littlewood C. Misdiagnosis of the vegetative state: retrospective study in a rehabilitation unit. 1996; 313:13-16.

38. Childs NL, Mercer WN. Brief report: late improvement in consciousness after post-traumatic vegetative state. *N Engl J Med* 1996;334:24-25. (report of a 16 year old patient with PVS who recovered significantly after 17 months).

patient who is paralyzed and cannot move or speak but is completely awake. Such patients can often communicate by blinking their eyes or looking up and down.

The American Academy of Neurology, along with representative of the American Neurological Association, the Child Neurology Society, the American Association of Neurological Surgeons, and the American Academy of Pediatrics, set up a Multi-Society Task Force to establish criteria for diagnosing the persistent vegetative state. In 1994, the Task Force published its findings, which have been adopted as a practice guideline by the American Academy of Neurology. The Task Force estimated that 10,000 to 25,000 adults and 6000 to 10,000 children in the United States are in the persistent vegetative state. The criteria for this diagnosis must be met at least 1 year after traumatic brain injury in young patients and at least 3 months after nontraumatic illnesses.

The Task Force reviewed case series from the literature, which included 434 adults and 106 children with traumatic brain injury and 169 adults and 45 children with nontraumatic injuries, mostly related to hypoxia. Of the patients in the persistent vegetative state for more than 3 months after nontraumatic injuries, the probability of moderate disability or good recovery was 1% (99% CI, 0% to 4%), but for patients still in the persistent vegetative state at 6 months, this probability was 0%. No patient, even those with traumatic brain injury, has been reported to recover after a full year of being in the persistent vegetative state. Delayed recoveries after traumatic brain injury are more common than with nontraumatic brain injuries. Certainly, no patient has recovered after 15 years, the period during which Terri Schiavo survived in this state. The criteria make clear that the patient can have periods of sleep alternating with periods of an awake-like state, in which his or her eyes are open and may move

about, and the patient may breathe, yawn, and open his or her mouth, but not interact meaningfully with others...

Even Catholics who accept the same basic moral principles may strongly disagree on how to apply them to patients who appear to be persistently unconscious—that is, those who are in a permanent coma or a “persistent vegetative state”(PVS). Some moral questions in this area have not been explicitly resolved by the church’s teaching authority.³⁹

On some points there is wide agreement among Catholic theologians:

- An unconscious patient must be treated as a living human person with inherent dignity and value. Direct killing of such a patient is as morally reprehensible as the direct killing of anyone else. Even the medical terminology used to describe these patients as “vegetative” unfortunately tends to obscure this vitally important point, inviting speculation that a patient in this state is a “vegetable” or a subhuman animal.
- The area of legitimate controversy does not concern patients with conditions like mental retardation, senility, dementia or even temporary unconsciousness. Where serious disagreement beings is with the patient who has been diagnosed as completely and permanently unconscious after careful testing over a period of week or months.

Some moral theologians argue that a particular form of care or treatment is morally obligatory only when its benefits outweigh its burdens to a patient or the care providers. In weighing burdens, they say, the total burden of a procedure and the consequent requirements of care must be taken into account. If no benefit can be demonstrated, the procedure, whatever its burdens, cannot be obligatory. These moralists also hold that the chief criterion to determine the benefit of a procedure cannot be merely that it prolongs physical life, since physical life is not an absolute good but is relative to the spiritual good of the person. They assert that the spiritual

39. K . Andrews, L. Murphy, R. Munday. C. Littlewood. , Misdiagnosis of the vegetative state: retrospective study in a rehabilitation unit. 1996; 313: pp- 13-16.

good of the person is union with God, which can be advanced only by human acts, i.e., conscious, free acts. Since the best current medical opinion holds that persons in the persistent vegetative state (PVS) are incapable now or in the future of conscious, free human acts, these moralists conclude that, when careful diagnosis verifies this condition, it is not obligatory to prolong life by such interventions as a respirator, antibiotics or medically assisted hydration and nutrition. To decide to omit non-obligatory care, therefore, is not to intend the patient's death, but only to avoid the burden of the procedure. Hence, though foreseen, the patient's death is to be attributed to the patient's pathological condition and not to the omission of care. Therefore, these theologians conclude, while it is always wrong directly to intend or cause the death of such patients, the natural dying process which would have occurred without these interventions may be permitted to proceed. While this rationale is convincing to some, it is not theologically conclusive and we are not persuaded by it. In fact, other theologians argue cogently that theological inquiry could lead one to a more carefully limited conclusion. These moral theologians argue that while particular treatments can be judged useless or burdensome, it is morally questionable and would create a dangerous precedent to imply that any human life is not a positive good or "benefit." They emphasize that while life is not the highest good, it is always and everywhere a basic good of the human person and not merely a means to other goods. They further assert that if the "burden" one is trying to relieve by discontinuing medically assisted nutrition and hydration is the burden of remaining alive in the allegedly undignified condition of PVS, such a decision is unacceptable because one's intent is only achieved by deliberately ensuring the patient's death from malnutrition or dehydration. Finally, these moralists suggest the PVS is best seen as an extreme form of mental and physical disability, one whose causes, nature and prognosis are as yet imperfectly understood—and not

as a terminal illness or fatal pathology from which patients should generally be allowed to die. Because the patient's life can often be sustained indefinitely by medically assisted nutrition and hydration that is not unreasonably risky or burdensome for that patient, they say, we are not dealing here with a case where "inevitable death is imminent in spite of the means used." Rather, because the patient will die in a few days if medically assisted nutrition and hydration are discontinued, but can often live a long time if they are provided, the inherent dignity and worth of the human person obligates us to provide this patient with care and support.

Further complicating this debate is a disagreement over what responsible Catholics should do in the absence of a final resolution of this question. Some point to our moral tradition of probabilism, which would allow individuals to follow the appropriate moral analysis that they find persuasive. Others point to the principle that in cases where one might risk unjustly depriving someone of life; we should take the safer course. In the face of the uncertainties and unresolved medical and theological issues, it is important to defend and preserve important values. On the one hand, there is a concern that patients and families should not be subjected to unnecessary burdens, ineffective treatments and indignities when death is approaching. On the other hand, it is important to ensure that the inherent dignity of human persons, even those who are persistently unconscious, is respected and that no one is deprived of nutrition and hydration with the intent of bringing on his or her death.

It is not easy to arrive at a single answer to some of the real and personal dilemmas involved in this issue. In study, prayer, and compassion, we continue to reflect on this issue and hope to discover additional information that will lead to its ultimate resolution. In the meantime, at a practical level we are concerned that withdrawal of all life support, including nutrition and hydration, not be viewed as appropriate or automatically indicated for the entire class of PVS

patients simply because of a judgment that they are beyond the reach of medical treatment that would restore consciousness. We note the current absence of conclusive scientific data on the causes and implications of different degrees of brain damage, on the PVS patient's ability to experience pain and on the reliability of prognoses for many such patients. We do know that many of these patients have a good prognosis for long-term survival when given medically assisted nutrition and hydration, and a certain prognosis for death otherwise—and we know that many in our society view such an early death as a positive good for a patient in this condition. Therefore we are gravely concerned about current attitudes and policy trends in our society that would too easily dismiss patients without apparent mental faculties as non-persons or as undeserving of human care and concern. In this climate, even legitimate moral arguments intended to have a careful and limited application can easily be misinterpreted, broadened and abuse by others to erode respect for the lives of some of our society's most helpless members.

Views and ideas and even concepts of ethics are fast changing in the context of the progress of science and technology. The traditional institutions in our society, which protect human life and spiritual values are gradually being pushed aside or getting eliminated. Love is the foundation of ethics. Loving our God with all our heart, soul and mind and loving our neighbor as ourselves, and the two foundations for our ethical practice. Only a code of ethics based on sound principles, can lead our society to lasting happiness, harmony and peace.