INTENDING DEATH: THE DILEMMAS OF MERCY KILLING

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DECLARATION

I declare that the thesis entitled "INTENDING DEATH: THE DILEMMAS OF MERCY KILLING" has been prepared by me under the guidance of Dr. Debika Saha, Professor of Department of Philosophy, North Bengal University. No part of this thesis has formed the basis for the award of any degree or fellowship previously.

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I certify that Bhaswati De, has prepared the thesis entitled "INTENDING DEATH: THE DILEMMAS OF MERCY KILLING", for the award of PhD degree of the North Bengal University, under my guidance. She has carried out the work at the Department of Philosophy, North Bengal University.

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Dedicated with love to my soul-mate

Dr. Puspendu Chaki

&

My little Son **Pinak Pani**, who always asks,

“Why MumMum?”

Pluck this little flower and
Take it, delay not!
I fear lest it droop
And drop into the dust.

It may not find a place
In thy garland,
But honour it with a touch of pain
From thy hand and pluck it.
I fear lest the day end
Before I am aware,
And the time of offering go by.

Though its colour be not deep
And its smell be faint,
Use this flower in thy service
And pluck it while there is time.

Rabindranath Tagore
Gitanjali, 3rd Aasher, 1317

“Marte hai aarzoo mein marne ki
Maut aati hai par nahin aati”

MIRZA GHALIB

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BHASWATI DE
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ABSTRACT

The present study is an attempt to expound and examine the concept of "Mercy-Killing" which is also known as "Euthanasia" from its philosophical, moral and Practical standpoints. The present endeavor uses the two terms 'Euthanasia' and 'Mercy Killing' interchangeably. This is a burning issue in today's World. With the rise of advanced medical technologies, especially life-sustaining ones, the issue of euthanasia becomes the centre of disputes. People can be kept alive against their wishes or in states of pain. It is also possible to keep people alive who are in a persistent vegetative state. In cases like this, the use of medical technologies raises questions about the moral appropriateness of sustaining life or allowing someone to die. The issues associates with this debate are complex. There is a constant search regarding certain question like, what it is to be human, what is the purpose of life and whether or not life is a gift from God. The present dissertation tries to delve deep to the above questions.

The main text of the study has been divided into four chapters besides introduction and conclusion.

The first chapter traces the origin of the concept historically and how it has been developed and used in different period of history. Besides it shows the different classifications of the practice. While analyzing the concept this chapter traces the historical heritage of the term euthanasia. The advancement in the field of medicine and technology make this issue of euthanasia relevant and important in our present day society. While tracing the heritage of the term euthanasia it has been found that in

different periods philosophers have used this concept differently. In the Greek period both Plato and Aristotle were in favor of some sort of infanticide. The city-state Athens favored some sort of state assisted suicide. The Stoics also favored some kind of mercy killing. Though the term 'mercy killing' is not at that time in vogue, this term has been used differently. Besides the Stoics, Judaism forbids suicide and does not even discuss mercy killing. In 17th century Francis Bacon insisted that doctors should assist the dying patient to make a fair and easy passage from life. Besides the historical analysis, classifications of different types of euthanasia have been focused in this chapter. The concept of brain death has also been discussed in this chapter.

The second chapter focuses on the ethical perspectives of the issue. In analyzing the issues, it brings out the question of autonomy and its relation to other theories. There are different views like consequentialism and nonconsequentialism which have been thoroughly discussed. Kant's moral theory is one of the main themes of this chapter. There are different arguments for and against euthanasia which have been highlighted here also.

Indian tradition of mercy killing is the thrust of the third chapter. It discusses the different perspectives of Indian tradition like Hinduism, Jainism, Buddhism, Yoga, Islamic and others.

India is a cosmopolitan country with an amalgamation of many cultures, traditions and religions. Here religion plays a very crucial role. This chapter is divided in to two sections. First section deals with the standpoints of Hinduism and Buddhism regarding mercy-killing Ancient Indian philosophical tradition justifies the idea of man willing his own death. As per Hindu mythology, Lord Rama and his brothers took Jal Samadhi in river Saryu near Ayodhya. Besides that, this section highlights the viewpoints of Samkhya-Yoga, Jainism and The Sikh view of mercy-

killing. Judaism and Islam are two other mono theistic religions which have had a global influence in regard to issues concerning the end of life. The Christian religion is also mostly against mercy-killing. The Christian religion believes that human beings are created in the image of God and thus their life belongs to God. Birth and death are part of the life processes which God has created, so humans should respect them and therefore no human being has the authority to choose the time and manner of his or any other human's death. Here we discussed Thalaikoothal, which is the traditional practice of genocide or involuntary euthanasia, by their own family members, observed in some part of southern districts of Tamil Nadu state of India. In the second section, the current legal position on mercy-killing (euthanasia) and assisted suicide in India and the response of the Indian Judiciary are the point of discussion. Here we discussed Venkatesh case, who was dystrophic patient, wanted to be granted the right to die. He sought to enforce the right so that he could donate organs before they were affected by his illness. Lastly this section deals with the most debated case of Aruna Shanbaug which is still the center of lively debate even in 2014.

Critical observation is the main tune of the fourth chapter. By way of analysis and comments this chapter tries to unveil how complex the problem is and how it affects the medical profession. 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 and Living Will 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.

PREFACE

The present study is an attempt to expound and examine the concept of "Mercy-Killing" which is also known as "Euthanasia" from its philosophical, moral and practical standpoints. The present endeavor uses the two terms 'Euthanasia' and 'Mercy Killing' interchangeably. This is a burning issue of our time. With the rise of advanced medical technologies, especially life-sustaining ones, the issue of euthanasia becomes the centre of disputes. People can be kept alive against their wishes or in states of pain. It is also possible to keep people alive who are in a persistent vegetative state. In cases like this, the use of medical technologies raises questions about the moral appropriateness of sustaining life or allowing someone to die. The issues associated with this debate are complex. There is a constant search regarding certain question like, what it is to be human, what is the purpose of life and whether or not life is a gift from God. The present dissertation tries to delve deep to the above questions.

The main text of the study has been divided into four chapters besides introduction and conclusion.

The first chapter traces the origin of the concept historically and how it has been developed and used in different periods of history. Besides it shows the different classifications of the practice and the concept of Brain Death.

The second chapter focuses on the ethical perspectives of the issue. In analyzing the issues, it brings out the question of morality and law associated with this practice. Besides it tries to present Kant's moral theory, followed by different problems and other related issues.

Indian tradition of mercy-killing is the thrust of the third chapter. It discusses the different perspectives of Indian tradition like Hinduism, Jainism, Buddhism, Yoga, Islamic and others.

Critical observation is the main tune of the fourth chapter. By way of analysis and comments, this chapter tries to unveil how complex the problem is and how it affects the medical profession.

In spite of different kind of controversies the present thesis supports voluntary euthanasia. While supporting, it should be necessary to be cautious about the legalized aspects of voluntary euthanasia. This point has been thoroughly discussed in chapter four, section one. We are very much aware that there are certain merits and demerits of voluntary euthanasia, yet the present thesis supports the stand point of those patients who are lingering everyday, severe pains to get rid from this position. In fact there are a large number of patients all over the world who in the name of living, face a kind of unbearable pain every moment. The present thesis supports their standpoints morally. The society always gives importance to the misuse of voluntary euthanasia, but it is a kind of irresponsibility not to pay attention towards the voices of those helpless numb and weak people who are facing this unbearable pains everyday.

CONTENTS

Introduction

In the fifth century B.C.E. Biomedical ethics began its journey in the school of Hippocrates. As it is well known, the Hippocratic Oath forms the basis of medical ethics. The Oath is as follows "I will use treatment to help the sick according to my ability and judgment, but never with a view to injury or wrong doing." The maxim of medical practice stands on this principle. In Plato's Republic a more fundamental question of ethics is raised "What must a man be, and what paths must he take if he would live the best possible life?"[1] So it may be said that biomedical ethics is grounded in the study of moral philosophy.

The Hippocratic tradition was carried on through the centuries by, among others, the Jewish philosopher and physician Moses Maimonides (1135-1204). But it was the English physician Thomas Percival who first used the term "medical ethics" when he published a book with this title in 1803. In 1971, Van Rensselaer Potter described "bioethics" as "a new discipline that combines biological knowledge with knowledge of human value systems."[2]

Biomedical ethics is a species of practical normative ethics. It is the study of what one is obligated or permitted to do, or prohibited from doing, in different contexts of biotechnology, medical practice, and medical research. Normative ethics is concerned with how people's behavior ought to be implemented. It is "normative" in the sense that it specifies norms or standards of right and wrong action and behavior. We employ principles and theories of normative ethics to motivate and justify actions and policies in biomedicine. In contrast, descriptive ethics is concerned with how people do in fact behave, not how they ought to behave. Evolutionary theories of morality are descriptive in the sense that they claim that morality serves an adaptive purpose, enhancing human survival through social cooperation.

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1. Plato , The Republic , trans, A.D.Lindsay, J. M. Dent Ltd, London Everyman's Library, 1992, book ii, page 41.
2. Walter Glannon: *Biomedical Ethics*, New York, Oxford, Oxford University Press. 2005. p-1

Similarly, sociological and anthropological accounts of morality are descriptive in the way they focus on behavioral patterns among people in different cultures. The two types of ethical theory we have just outlined are to be distinguished from meta-ethics. While normative ethics deals with the substantive question of which actions are right or wrong, good or bad, meta-ethics deals with the formal question of the point of ethics. It focuses on the meaning of terms like "right," "wrong," "good," and "bad," and on the form of arguments used to justify actions. Meta-ethics is concerned with whether there are ethical facts independent of our normative judgments and social conventions, facts that ground these judgments and conventions. Put in another way, whereas normative ethics focuses on the content of morality, meta-ethics focuses on the nature of morality.

In the second half of the twentieth century, development of medical practice and research spread widely. Humans were entered in to medical experiments without consent and without any consideration of the risk of harm to them. There were abuses that led the patient in problems. This led to a gradual shift in decisional authority from doctor to patient. As a result the question of autonomy came to the forefront.

The right to self determination is the main motto of autonomy. Individuals with the capacity for autonomy have the right to exercise that capacity. This includes the right to accept or refuse medical treatment in accord with one's interests. There are mainly two traditions from where this question of autonomy has been developed, one is Immanuel Kant's principle of respect for persons as autonomous ends-in–themselves and the other is J. S. Mill's principle of liberty, which says that a person owes his or her own body and mind.[3]

3. Mill J.S, Utilitarianism, On Liberty, considerations of Representative Government, edi- H.B Acton, J. M. Dent Ltd, London Everyman's Library, 1992,p-78

Progress in medical technology over the years influenced medical profession thoroughly. There are various ways through which the patients get benefits i.e. in case of kidney failure; it is possible to take the availability of dialysis. But there are certain cases where the debate arises regarding the mode of treatment. There is a question which draws heated debate. Should doctors be allowed to assist terminally ill patients to die? Here comes the question of 'euthanasia'. The word 'euthanasia' comes from Greek root which means "good death". The Oxford English Dictionary states that the original meaning, "a gentle and easy death," has evolved to mean "the action of inducing a gentle and easy death." In modern times, the word has been most closely associated with the concept of mercy killing: allowing or helping someone to die who is suffering from an incurable illness.

Construing euthanasia (from the Greek, meaning "good or happy death) narrowly, some philosophers have taken it to be the equivalent of killing. Since allowing someone to die does not involve killing, allowing to die would not actually be an act of euthanasia at all. By this account, then, there are acts of allowing to die, which may be moral, and acts of euthanasia, which are always wrong.

Other philosophers interpret the meaning of euthanasia more broadly. For them euthanasia includes not only acts of killing but also acts of allowing to die. In other words, euthanasia can take an active or passive form. Active (sometimes termed positive) euthanasia refers to the act of painlessly putting to death persons suffering from incurable conditions or diseases. Injecting a lethal dosage of medication in to a terminally ill patient would constitute active euthanasia. Passive euthanasia, in contrast, refers to any act of allowing a patient to die.

Not providing a terminally ill patient the needed antibiotics to survive pneumonia would be an example of passive euthanasia.

It is tempting to view the debate between the narrow and the broad interpretations of euthanasia largely in terms of semantics. While the meaning of euthanasia certainly is a factor in the disagreement the issue involves more than mere word definition.[4]

Since euthanasia, by this definition, is killing a patient, euthanasia is always morally wrong. But allowing a patient to die does not involve killing a patient. Therefore, allowing a patient to die does not fall under the moral prohibition that euthanasia does; allowing a patient to die may be morally right. The other side, the broad interpretation, considers act of allowing patients to die acts of euthanasia, albeit passive euthanasia. They argue that if euthanasia is wrong, then so is allowing patient to die (since it is a form of euthanasia). But if allowing patients to die is not wrong, then euthanasia is not always wrong. Generally, those favoring the broad interpretation, in fact, claim that allowing patients to die is not always wrong; that euthanasia, therefore, may be morally justifiable. With the possible moral justifiability of euthanasia established, it is conceivable that acts of active euthanasia, as well as passive, may be moral. What determine their morality are the conditions under which the death is caused, and not the manner in which it is caused. It's within these broad interpretations that the most problematic cases of death decisions fall- including the Quinlan case.

The western way of thinking about dying has changed from the eighteenth century meaning of dying. In the eighteenth century euthanasia was used in its original sense. Today, what euthanasia means, is the result of advancement in the field of medicine and the changes in life-style. The causes of death today are different from the causes of death in the eighteenth century. At present, accidents, homicide and suicide are the main causes of death among the

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4. Jeffrey Olen & Vincent Barry: *Applying Ethics*- A Text with Reading Wadsworth Publishing Company, Belmont, California, A division of Wadsworth INC. 1999. p. 227-228.

young, and chronic terminal diseases are the causes of death among the old. Now, a day, when a person dies, his death is sudden or unexpected or long and drawn out with pain or due to mental or physical deterioration and the death occurs mostly on a hospital bed. But back in eighteenth century the death was due to an infectious disease and so was not unexpected or drawn out, and it was possible then to die ‘gently’ and ‘quietly’ in one’s house, on one’s bed with all the family members and friends around him.

But in the late 1960s the use of the mechanical ventilator changes the definition of death. This new technology changed the whole scenario. Mechanical ventilation, artificial hydration and nutrition that could control blood pressure helped doctors to extend lives that would have ended without these interventions.

There have been a number of cases over the past three decades in which people have sought to change the laws regarding euthanasia. In general, we recognize a basis in the law that allows people to refuse treatment, even life-saving treatment for them, if they are judged to be mentally and legally competent to do so. Otherwise, to treat them without their consent could be judged as a form of unpermitted touching. Other issues about the law and euthanasia have been crystallized by certain well-publicized cases. The noted cases of Karen Quinlan in 1975 and Nancy Cruzan in 1983 are good examples of such high-profile cases. In Ms. Quinlan’s landmark case, the issue was whether a respirator that was keeping her alive could be disconnected. For some still unknown reason (some say it was a combination of barbiturates and alcohol), she had gone into a coma from which doctors judged she would not recover. When they were assured of this her parents sought permission to retain legal guardianship (since by then she was twenty-one years old) and have her respirator disconnected. After several court hearings and final approval by the Supreme Court of the State of New Jersey, they were finally

permitted to disconnect her respirator. While they expected she would die shortly after her respirator was removed, she lived on in this comatose state for ten more years. One of the basic reasons given by this court for its opinion in this case was that Karen did not lose her right of privacy by becoming incompetent and that she could thus refuse unwanted and useless interventions by others to keep her alive. None of the various state interests or social concerns that might override this right was found to be relevant in her case.

Nancy Cruzan was twenty-five years old at the time of her accident in 1983, which left her in a permanent vegetative state until her death eight years later. In her case the issue brought to the court was whether a feeding tube providing her with food and water could be withdrawn. This case eventually reached the U.S. Supreme Court, which ruled that such life-saving procedures could be withdrawn or withheld, but only if there was "clear and convincing evidencing" that is what Nancy herself would have wanted. Eventually some such evidence was brought forward. By that time those protesting her case had withdrawn, and her feeding tube was removed and she was allowed to die.

Despite such cases there is no state in this country that permits active euthanasia or mercy killing. Active euthanasia is practiced somewhat openly in The Netherlands, even though it is officially against the law. It is estimated that about five thousand or more incidences occur there each year. Legislation to officially legalize it has been proposed but not passed. However, only token sentences are given for violations of the law. In early 1993 the Dutch parliament approved rules according to which doctors would not be prosecuted if they notified the appropriate government agency and followed these guidelines: The person requesting to be put to death must be competent at the time of the request and the request must be consistent and repeated. The person's suffering must be intolerable, and euthanasia must be performed only by

a physician after consultation with another physician. In 1990 a California proposition to legalize active euthanasia for those with a terminal illness who request it either at the time of illness or who have done so earlier through an advance directive failed to obtain the necessary signatures for a ballot measure. In the state of Washington in 1991, a similar ballot measure also failed. Nevertheless, polls through the years have shown a modest support for some change in the law regarding active euthanasia. The reasons for the support and for the opposition are varied.

So what exactly is ‘euthanasia’? To say that it is mercy killing does not really tell a person much. Why is it such a controversial issue? Why is it such a big deal today? Is it a new issue? Is euthanasia suicide? Is it murder? The present study tries to explore the above issues.

Chapter-1

Concept of Mercy Killing: Challenges of the Present Age

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

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

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

1. Fletcher Joseph, "The 'right' to live and the 'right' to die'" *The Humanist*, p.13

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

Section-I

1.1 Concept of Euthanasia: Historical and Philosophical Analysis

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

2. Plato- *The Republic.* Trans. A.D.Lindsay. J.M.Dent & Sons Ltd. London. Everyman's library. 1992. Book-111, p-91.

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

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

3. Roman Stoic writer (Epistulac Morales)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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8. Simms, M. "Severely Handicapped Infants," *New Humanist*, 98 no. 2, 1983, pp. 1-8.
9. Kew, S., Handicap and Family Crisis (London: Pitman), 1975.
10. Hare, R.M., "Survival of the Weakest," in *Moral Problems in Medicine*, ed. S.Gorovitz et al. (Englewood Cliffs, NJ: Prentice-Hall), 1976, pp.-364-9.

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

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

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

Euthanasia has been a large issue in the courts during this century. The first doctor was charged for performing euthanasia in1935. Harold Blazer was charged for the death of his daughter. His daughter was a victim of cerebral spinal meningitis. He killed her by placing a handkerchief soaked with chloroform over her face until she died. He had taken care of her for thirty years. In his trial he was acquitted. The first doctor to be found guilty was Joseph Hassman in 1986. He injected a lethal dose of Demerol into his mother-in-law by the request of her family. He was sentenced to two years probation, fined $10,000, and ordered to perform 400 hours of community service.

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

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

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

Section-2

2.1 Classification of different types of Euthanasia:

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

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

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

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

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

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

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

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

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

13. Ibid p. 112-114.

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

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

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

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

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

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

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14. Definition of Euthanasia by the *Netherlands State Commission on Euthanasia.*
15. Baughman W.H, Bruha,J.C. and Gould F. J., "Euthanasia: criminal, court, constitutional and legislative considerations," *Notre Dame Lawyer* 48, 1973, pp- 1202-1260.

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

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

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

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16. Russell O. Ruth , "Moral and legal aspects of euthanasia," *The Humanist* 34, 4 ,1974, pp- 22-27.
17. Kamisar Yale, "Euthanasia legislation: some non-religious objections," in *Euthanasia and the Right to Die*, Downing A. B. , (ed). (London: Peter Owen, Ltd, 1969, pp.85-133.
18. Brill Howard W., "Death with dignity: a recommendation for statutory change," *University of Florida Law Review* 22 ,1970, pp- 368-383.

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

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

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19. Powledge Tabitha M. and Steinfels P, "Following the news on Karen Quinlan," *Hastings Center Reports* 5, 6 ,1975, p- 28.
20. Morison Robert S., "Dying," *Scientific American* 229, 3 ,1973, p. 61.

The cessation of the employment of extraordinary means to prolong the life of the body when there is irrefutable evidence that biological Death is imminent is the decision of the patient and\ or his immediate family. The advice and judgment of the physician should be freely available to the Patient and or his immediate family.[21] The statement of the AMA quoted above is entirely appropriate; for it appears that a request for passive euthanasia by the terminal patient and his or her immediate family is not uncommon in the experience of most physicians. In a survey of over 400 doctors representing all major specialties, 38 percent reported hearing such a request from a terminal patient and 54 percent reported hearing such a request from the family of a terminal patient. A much smaller percentage (12 percent and 9 percent, respectively) of physicians indicated hearing requests for active euthanasia from terminal patients and their families.[22]

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

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

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

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

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

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

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23. Ibid, pp-110-111.
24. The President's Commission Report, "Deciding to Forego Life Sustaining Treatment" (March 1983): pp- 82-89.
25. *New York Time*, Dec. 5, 1976.

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

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

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

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

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

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

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26. The case occurred in Oakland, California. The Jury in the case found the defendant guilty even though California did not at that time have a "brain death" statute. *San Francisco Examiner* , May 1972..
27. Ad Hoc Committee of the Harvard Medical School to Examine the Definition of Brain Death, *A Definition of Irreversible Coma*, 1968. 205 J.A.M.A 377.
28. Ibid p. 107-108

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

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

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

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

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

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

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

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

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

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

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

30. President Commission for the study of Ethical Problems in Medicine, *Defining Death: A Report on the Medical, Legal and Ethical Issues in the Determination of Death* Washington, DC:US Government Printing Office, 1981, pp 24-25.
31. *Defining Death*, pp.-67-72.

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

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

Chapter-2

Ethical Perspectives of Mercy Killing

This chapter is designed to raise moral questions such as: is it ever right for another person to end the life of a terminally ill patient who is in severe pain or enduring other suffering? Under what circumstances euthanasia is right? Or wrong? This chapter is divided in to two sections. In the first section, the historical background of the moral questions of Euthanasia are narrated. Here the question of autonomy has been brought into limelight. Kant's moral theory is one of the main topics that have been brought into attention. In the second section, the nature of the moral debate and the adverse cases of euthanasia have been highlighted.

Section-I

1.1 Historical background of the moral questions of Mercy Killing.

For thousands of years, Philosophers and religious thinkers have addressed the ethics of mercy killing. These debates have rested on broad principles about duties to self and to society as well as fundamental questions of the value of human life. Many great thinkers have contributed to this debate, ranging from Plato and Aristotle in ancient Greece to Augustine and Thomas Aquinas in the middle Ages, and Locke, Hume and Kant in modern times.

Aristotle believed that suicide was unjust under all circumstances because it deprived the community of a citizen.[1] The moral issue of killing oneself is examined by Aristotle when he discusses the problem of suicide, although we must state that he did not pay so much attention to it as his teacher Plato did. He contributes to this problem through some passages in the

1. Aristotle, The Nichomachean Ethics, Trans, Haris Rackham, Wordswarth Classics, 1996, book5-1138a, p-135.

Nicomachean *Ethics*. Here he opposes to suicide and says that men, who have committed a number of crimes and are hated for their wickedness, actually flee from life and kill themselves. In his discussion of justice in the fifth book, he regards suicide as an act of injustice, since it is the voluntary infliction of bodily harm not in retaliation and therefore contrary to the law.[2] He considers it as an act of injustice against the state rather than against himself, for he suffers voluntarily and nobody suffers injustice voluntarily. So, it is blameworthy for someone to cause unnecessary harm to himself and contrary to the right rule of life.

However, it is questionable what Aristotle has in mind in either of the above books. In his Ethics he refers to virtuous people who are habituated to wrong actions and having developed a distorted moral vision could end up harming themselves as well as other people. He does not explicitly mention the case of diseased people who suffer from incurable diseases and may undergo painful treatments. Would Aristotle morally justify the act of a moral agent-citizen who suffering from a terminal, degenerate disease begs for a mercy death (an assisted suicide, or physician assisted suicide), or even commits suicide on his own? The answer would be negative and unequivocal. In his discussion of courage in the third book he says: "But to seek death in order to escape from poverty, or the pangs of love, or from pain or sorrow, is not the act of a courageous man, but rather of a coward; for it is weakness to fly from troubles, and the suicide does not endure death because it is noble to do so, but to escape evil".[3]

In other words, a voluntary death is morally unjustifiable under any circumstances even if those include the case of a miserable or not easily to endure life. But why would Aristotle exclude those cases of terminally diseased people that suffer so much pain? This is because such a person would be a coward, who is not habituated to good actions and his decision is not a

2. ibid., .
3. Aristotle, *Nicomachean Ethics*, book-3,

proper moral choice, the result of reasoning and a rational desire. "the more a man possesses all virtue, and the more happy he is, the more pain will death cause him; for to such a man life is worth most, and he stands to lose the greatest goods, and knows that this is so, and this must be painful".

An interesting question that would arise, however, is to what extent such an approach to the issue of euthanasia violates the principle of moral autonomy. What about the right to a more dignified death, if life is not endurable? Isn't this a moral agent's right? On the basis of what we said earlier, Aristotle would not recognize such a right, for a moral agent is, on the one hand, a free person to plan his/her own life and make his/her own moral choices on hard life cases, and on the other, she/he is a citizen, hence an organic part of whole **a**nd it is pure injustice, if not to say selfishness, to view civil life in such a way.[4] As far as the moral autonomy of a person is concerned, there seems to be an apparent violation but not a real one. In fact, the Eudemonia definition of free will (or voluntariness) allows an agent to do things in his power, but it makes a distinction between a moral mistakes. In the latter case no blame is attached to the agent, but in the former it is, if this could have been foreseen and avoided. [5] Not all error is blameworthy, but only ignorance of what one should and could easily have known, or error that is due to negligence. It is also important to consider the effect of one's action on both his/her life and the lives of other people (the distinction about what one is doing and the mistakes about the effect of what one is doing is discussed in his *Nicomachean Ethics*,. So, a moral agent is free to choose his/her own course of action but s/he is also a rational agent whose choices must be in accordance with the mean, with virtue. And such a moral agent would never harm others or cause harm to oneself.

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4. Miller, Fred. D, Nature, *Justice and Rights in Aristotle's Politics*, Oxford: Clarendon Press, 1995, pp- 47-56 .
5. Kenny, Anthony *Aristotle's theory of the will*, New Haven: Yale University Press, 1979, p.59

What we have noticed throughout our examination so far, is that the Aristotelian approach to the above moral issues becomes clearer once we direct our attention to his ethical doctrine of the development of ethical understanding and his theory of action. The Aristotelian *arete* (virtue, excellence) denotes not only the notion of a habituated good ethos but also an advanced stage of ethical understanding that relates to good ethical judgment. Or, as Aristotle himself says: "*For virtue makes us aim at the right mark and practical wisdom makes take the right mean*." To be wise is an excellence; it is the disposition to judge rightly about human goods. According to this, for Aristotle, an ethical manager is a good planner who aims towards a good end. In fact, wise planning and deliberation have to satisfy two criteria: they must conduce to the desired end and the end must be good, that is, it must lead towards eudemonia (ultimate happiness), and since we referred to the domain of business, that would be ultimate success from which supreme happiness derives. And even more important, such an advanced ethical understanding enables a manager to resolve conflicts of interests without violating a party's rights. On innumerable occasions, people in business face ethical questions in which a balance has to be found between the different and often conflicting rights and interest of the parties involved. So, the ethical manager is the person who will be able to weigh up rights and interests in the most successful and proper way. Such a capacity is very important for in the domain of business ethics there is not always a well-defined code of conduct that guides one's course of action.[6] As a result a misapprehension of the ends, that is maximization of a company's profit at the expense of both employees and consumers, or a very calculative utilitarian approach to business, would cause enormous problems to a company in the long run. It would not survive.

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6. Solomon, Robert C , "Corporate Roles, Personal Virtues: An Aristotelian Approach to Business Ethics", in Donaldson, Thomas & Werhane, Patricia H (ed.), *Ethical issues in Business: a philosophical approach*, New Jersey: Prentice Hall Series, 1996, pp.45-59

Thus, the capacity of a "good judgment" is what would be the Aristotelian response to an ethical manager who wishes to maintain a good personal profile and promote the image of his company. And this capacity comes with experience and proper education and upbringing. It is also what is going to help somebody achieve the proper choice in determinate circumstances as in the cases of euthanasia. It is what will help an agent balance and weigh conflicting concerns and come to a "fair" conclusion. At the same time, the Aristotelian ethical manager must be a man of integrity and an advocate of truth-telling to the extent that this does not violate the objectives of the corporation he serves. Moreover, she/he should be virtuous in the sense that she/he has acquired certain excellences that enable him/her to manifest his/her thoughts and actions in a way that suits the particular endeavors. There must be an honest dealing, fair play, good knowledge, wit and an experienced moral vision. For Aristotle, a moral agent should be endowed with the necessary capacities, the prerequisites for a good life. She/he should be able to reach the right decision on a hard life case that relates to any moral issue. And above all, when such a hard reasoning takes place, the Aristotelian moral agent must consider oneself as an integral part of a whole, a part of a community that develops every day and needs all of its members to be active and co-operative, for it is through such a conception of a commitment that a moral agent can fulfill his/her desirable ends. In other words, she/he must consider the choice and the effect that such a choice would have on both his/her life and the lives of everybody involved.

There are at least three kinds of questions relevant to suicide or euthanasia.

Ethical questions about terminating life.

Ethical questions about terminating one’s own life.

Ethical questions about terminating someone else’s life.

These questions are clearly interrelated. From the perspective of virtue ethics that Plato and Aristotle hold, the kinds of the act relevant to each of these questions may fall under different virtues. Aristotle argues that the kind of act described in (2) raises questions about courage and on some occasions about justice, but the same need not be the case with the kind of act described in (3). According to Philippa Foot euthanasia is not merely the termination of one person's life by another person. If it were, then all homicides would be cases of euthanasia. Further, contrary to typical dictionary definitions those are often based on etymology, euthanasia is not a quiet and pleasant death. Again, if these were the case, all homicides carried out in a quiet and pleasant way, for example, by first administering anesthesia or some kind of tranquilizer to the victim would be cases of euthanasia.[7]

What seems essential to euthanasia is that the termination of the life of an individual is for the good of that individual. Understanding euthanasia in the way introduces several other types of question and problem.

(a) Under what circumstances is the death of a person a greater good for that person than any other alternative?

(b) Who is to make the determination as to whether the termination of life is the greater good for a particular person?

(c) How is the determination to terminate a life to be made?

(d) Who is to terminate a human life?

These questions are neither merely neither theoretical nor trivial; on the contrary, they are practical and of great importance they are, literally, questions of life and death. Most of all, none of them is easy, despite some recent claims to the contrary. Here the question of autonomy arises about the termination of life and suggest that much remains to be determined about the

7. Georgios Anagnostopoulos: 'Euthanasia and the Physician's Role: Reflections on Some Views in the Ancient Greek Tradition'. *Bioethics -Ancient Themes in contemporary Issues,* edited by Mark G. Kuczewski and Ronald Polansky. London, England, 2002, pp- 251-252.

rightness or wrongness of decisions about terminating life even if autonomy is given its appropriate place.

Many contemporary philosophers argue in favor of the primacy of individual autonomy, insisting that a necessary and sufficient condition for a justified act of terminating a human life is the exercise of autonomy in the decision process by the person whose life is to be terminated. They argue that decisions regarding termination of life must be made by the one whose life is to be ended and that every individual has a right to terminate his/her life. They thus speak in support of voluntary euthanasia and find nothing wrong with such a practice. Autonomy has an important role to play in any ethical system. Clearly, however, it is central to the conception we have of a person as an agent who deliberates and chooses without external coercion or interference. In the legal sphere, autonomy is most important in creating and protecting a "space" within which an agent can make the choices he/she wishes to make.

Yet not all of the questions mentioned above are easily disposed of by merely assuming autonomy. This is the question, whether or how the exercise of autonomy affects the moral character of a choice or act and whether all likely cases of euthanasia are cases in which autonomy has any meaningful role to play.

Many, if not most, cases of euthanasia are cases in which the subject whose life is to be terminated is not in a position to determine anything at all. Insisting that one should have made a determination with regard to the termination of one's own life prior to becoming incapacitated, and thus prior to becoming unable to make any decisions regarding one's own life, is not a strong argument because in some cases, humans are born without the relevant capacities for making such decisions, or they lose these capacities before they are developed to the degree required for making the kind of judgments pertaining to matters of life and death.[8]

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8. ibid, p- 253.

2.1 The Moral Status of Euthanasia:

Human happiness and welfare is the main subject matter of utilitarianism. Respecting people's own choices about how they will die surely would have some beneficial consequences. For example, when people know that they will be allowed to make decisions about their own lives and not be forced into things against their will, they may gain a certain peace of mind. Moreover, knowing themselves better than others, they also may be the ones best able to make good decisions in situations that primarily affect them. These are good consequentialist reasons to respect a person's wishes in euthanasia cases. But it is not just the person who is dying who will be affected by the decision. Thus it also can be argued that the effects on others, on their feelings, for example, are also relevant to the moral decision-making. However, individual decisions are not always wise and do not always work for the greatest benefit of the person making them or others. For example, critics of euthanasia worry that people who are ill or disabled would refuse certain life-saving treatment because they lack or do not know about services, support, and money that are available to them. There are cases where it has been said that people must receive information about care alternatives before they may refuse life-saving treatment.[9] On consequentialist grounds we should do that which, in fact, is most likely to bring about the greatest happiness, not only to ourselves but also to all those affected by our actions. It does not in itself matter who makes the judgment. But it does matter in so far as one person rather than another is more likely to make a better judgment, one that would have better consequences overall.

Moreover, from the perspective of rule utilitarian thinking, we ought to consider which policy would maximize happiness. Would a policy that universally follows individual requests regarding dying be most likely to maximize happiness? Or would a policy that gives no

9. Reported in *Medical Ethics Advisor*, vol, 7 no. 4 April 1991, pp-50-54.

specially weight to individual desires, but directs us to do whatever some panel decides, be more likely to have the best outcome? Or would some moderate policy be best, such as one that gives special weight to what a person wants but does not give absolute weight to those desires? An example of such a policy might be one in which the burden of proof not to do what a person wishes is placed on those who would refuse. In other words, they must show some serious reason not to go along with what the person wanted.[10]

The question of personal autonomy in euthanasia decisions is important in nonconsequentialist reason or moral norm. The idea is that autonomy is a good in itself and therefore carries heavy moral weight. We like to think of ourselves, at least ideally, as masters of our own fate. A world peopled by robots would probably be a lesser world than one peopled by persons who make their own decisions even when those decisions are unwise. In fact, according to Kant, only in such a world is morality itself possible. His famous phrase "an ought to implies a can," indicates that if and only if we can or are free to act in certain ways can we be commanded to do so. According to a Kantian deontological position, persons are unique in being able to choose freely, and this ought to be respected. However, in many euthanasia cases a person's mental competence and thus autonomy is compromised by fear and lack of understanding. Illness also makes a person more subject to undue influence or coercion. How, in such instances, do we know what the person really wants? These are practical problems that arise when attempting to respect autonomy. In addition, there are theoretical problems that this issue raises. Autonomy literally means self-rule. But how often are we fully clear about who we are and what we want to be? Is the self whose decisions are to be respected the present self or one's ideal or authentic self? These issues of selfhood and personal identity are important but the present chapter is not highlighting the above.

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10. Wolff Susan, "The Ethics and Economics of Death," (Conference at San Francisco Medical Center) Nov. 1989.

In case of consequentialist or act utilitarian, we should only be concerned about our actions in terms of their consequences. The means by which the results come about do not matter in themselves. They matter only if they make a difference in the result. Generally, then, if a person's death is the best outcome in a difficult situation, it would not matter whether it came about through the administration of a lethal drug dose or whether it resulted from the discontinuance of some life-saving treatment. Now, if one or the other means did make a difference in a person's experience (as when a person is relived or pained more by one method than another), then this would count in favor of or against the method. If we take the perspective of a rule utilitarian, we would be concerned about the consequences of this or that practice or policy. We would want to know which of the various alternative practices or policies would have the best result overall. Which would be the best policy: one that allowed those involved choosing active euthanasia one that required active euthanasia in certain cases, one that permitted it only in rare cases or one that prohibited it and attached legal penalties to it? Which policy would make more people happy and fewer people unhappy? One that prohibited active euthanasia would frustrate those who wished to use it, but would prevent some abuses that might follow if it were permitted. Essential to this perspective are predictions about how a policy would work.

The argument that there would be abuse has been given various names depending on the particular metaphor of choice: the "domino effect," "slippery slop," "wedge," or "camel's nose" argument. The idea is that if we permit active euthanasia in a few reasonable cases, we would slide and approve it in more and more cases until we were approving it in cases that were clearly unreasonable. In other words, if we permit euthanasia when a person is dying shortly, is in unbelievable path, and has requested that his life be ended, we will then permit it when a

person is not dying or has not requested to be killed. The questions to ask are: Would we slide down the slope? Is there something about us that would cause us to slide? Would we be so weak of mind that we could not see the difference between these cases? Would we be weak of will, not wanting to care for people whose care is costly and burdensome? This is an empirical and predictive matter. To know the force of the argument, we would need to show evidence for one or the other position about the likelihood of sliding. 11

Many arguments and concerns about active and passive euthanasia are not based on appeals to good or bad results or consequences. Arguments about the right to die or to make one's own decisions about dying are nonconsequentialist arguments On the one hand, some argue that respecting personal autonomy is so important that it should override any concerns about bad results. Thus we might conclude that people ought to be allowed to end their lives when they choose as an expression of their autonomy, and that this choice should be respected regardless of the consequences to others or even mistakes about their own situations.

On the other hand, some believe that there is a significant moral difference between killing a person and letting a person die. Killing people except in self-defense is morally wrong, according to this view. Just why it is thought wrong is another matter. Some rely on reasons like those purported by natural law, citing the innate drive toward living as a good in itself, however compromised, a good that should not be suppressed. Kant used reasoning similar to this. He argued that using the concern for life that usually promotes it to make a case for ending life was inherently contradictory and a violation of the categorical imperative.12

As a deontological theory, Kant's moral position is not interested in consequences, but only in the actions themselves and their motives or maxims. Accordingly, we shall apply the categorical imperative to the problem of whether to perform euthanasia and see what his theory

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11. Presentation at The University of California at San Francisco Medical Center, Conference on "The Ethics and Economics of Death," Nov. 1989.
12. Kant Immanuel: Groundwork of the Metaphysics of Morals, Trans. & ed Mary Gregor, Cambridge Unive University University Press, Cambridge, 1998.

advises. Taking active voluntary euthanasia first, given what he says about suicide (the voluntary taking of one's own life to avoid pain) as a serious breach of the categorical imperative, it seems clear that Kant would condemn this out of hand as even worse than suicide, because *another* person, the doctor, is taking a life, and in Kant's book this makes it murder. The formula of universal law bids us universalize our maxim, which would be something like, "when my life is nothing but pain and is running out, I'll ask someone else to kill me painlessly.' Kant would argue that this is not consistently will able as a universal law because you would have to will that reason universally kills off reason, which is a contradiction in conception. It therefore breaks the moral law and *must not be done ever by anyone.* The formula of ends, which bids us treat persons as ends in themselves and never only as a means, agrees with this outcome because it would condemn the patient's abuse of his autonomy in breaching the formula of universal law, and would forbid others from aiding and abetting this immoral decision. The patient is using his very own rational nature, the source of the moral law, as a mere means to avoid pain, and is therefore not treating himself as an end in himself, thereby breaching the formula of ends.

Non-voluntary active euthanasia is also banned under both formulations of the categorical imperative because, again, it's the killing of a rational moral person by another rational moral person, and reason is not logically or morally allowed to kill anyone. Also, this would not be treating the patient as an end in themselves but purely *as a means* to reduce pain. Such an action looks to the consequences, whereas according to Kant morality is not founded on this. It's more difficult to see what Kant would say regarding passive euthanasia, whether voluntary or non-voluntary, because the categorical imperative deals only with positive actions, not passive inactions or omissions. On the one hand' from what Kant says about the notorious

axe murderer incident, you must do your duty to tell the truth, even though it means passively letting the murderer kill his victim who is hiding in your house. So, in some circumstances, Kant does not have a problem with letting other people die, as long as you yourself don't actively kill them. But, on the other hand, there are aspects of passive euthanasia that aren't particularly inactive. Pulling the plug on a life-support machine is, after all, an action, and the withdrawal of food to a patient is a particular decision with its own maxim, so the categorical imperative should cover both of these cases, and it would seem to say that each decision, whether to stop food or to switch off life-support, was done with the deliberate intention and maxim of shortening a life that would otherwise have continued for longer. This, again, would be a case of reason terminating reason and therefore wrong; but perhaps not. Take the following example.

Surely someone who is in an irreversible coma, or suffering from advanced Alzheimer's and doesn't know what day it is or who they are, let alone have the capability of rational moral thought, is no longer, or ever will be again, a rational source of the moral law; in other words, they're not a person or end in themselves in the Kantian sense- not even *potentially* so. If this is the case, then we don't have a duty to treat them as such, so it should be okay with the categorical imperative to perform passive euthanasia on them; this is not a case of reason killing reason, or of treating an end in itself as a mere means. In fact, why not resurrect the possibility of active non-voluntary euthanasia on the Kantian grounds that we are killing a non-rational human? The categorical imperative says nothing about how we should treat this type of being. They are therefore beyond the moral sphere, being even lower functioning than many animals.

Kant is strong on human dignity and the respect owed to persons, but worrying unconcerned about human suffering and the consequences for the patient. Suppose, Kant would

have no objection to a patient being given pain relief on request, but it would seem that he can't consistently advocate pain relief that induces a coma-like state or even mental confusion or befuddlement, because this interferes with a person's reason and autonomy. Would Kant then have the patient keep his conscious reason while screaming in pain? It would appear so. Even stranger results occur if we try to defend Kant's position by attempting to bring euthanasia into line with the categorical imperative under the description of 'helping others when they are in need', instead of Kant's notorious suicide example. Kant thinks it an imperfect duty to help others in need, because not to do so is to will a universal law where no one helps anyone else, which means willing that you yourself would not be helped when you want and need it. This is a contradiction in will since, although we can conceive such a possible world, we can't will such a world because, as rational but vulnerable beings, we will at times need help to continue living, and willing such a world would deny us this help. So, if it is an imperfect duty to help others in need, shouldn't be an imperfect duty to help others in need of an easy and painless death? 13

There are two problems, one is that, in any clash between imperfect and perfect duty, perfect duty always wins. This means that, if it's a perfect duty not to kill or let die a rational being in pain in order to ease their pain (euthanasia, in other words), then trying to defend euthanasia on the grounds that it's an imperfect duty to help others will always lose out to the absolute prohibition against euthanasia, based on our perfect duty not to kill. The second is that, even if it is an imperfect duty to perform euthanasia, with no opposing perfect duty not to do so, this still results in the absurdity that you only have to perform euthanasia some of the time, and you get to pick who gets help and who doesn't because imperfect duties don't require universal obedience at all times. A weakness in Kant's theory is that it doesn't always give us clear or

13. Stewart. N., *Ethics-An Introduction to Moral Philosophy*, Policy Press,U.S.A, 2009, pp.-88-91.

consistent moral advice regarding euthanasia. A further weakness is that it's contrary to our strong intuitions concerning the desirability and rationality of reducing pain and ending life when the alternative is a living hell.

Section-II

3.1 Morality and the Law:

Considering the moral arguments regarding euthanasia, we should first distinguish moral judgments about euthanasia from assertions about what the law should or should not be on this matter. Although we may sometimes have moral reasons for what we say the law should or should not do, the two areas are distinct. There are many things that are moral matters that ought not to be legislated or made subject to law and legal punishment. Not everything that is immoral ought to be illegal. For example, lying, while arguably a moral issue is only sometimes subject to the law. In our thinking about euthanasia, it would be well to keep this distinction in mind. On the one hand, in some case we might say that a person acted badly, though understandably, in giving up too easily on life. Yet we also may believe that the law should not force some action here if the person knows what he or she is doing, and the person's action does not seriously harm others. On the other hand, a person's request to end his or her life might be reasonable given their circumstances, but there might also be social reasons why the law should not permit it. These reasons might be related to the possible harmful effects of some practice on other persons or on the practice of medicine. Just be because euthanasia might be morally permissible, does not necessarily mean that it ought to be legally permissible. There have been number of cases over the past three decades in which people have sought to change the laws regarding euthanasia. In general, we recognize a basis in the law that allows people to refuse treatment, even life-saving treatment for themselves, if they are judge to be mentally and legally

competent to do so. Otherwise, to treat them without their consent could be judged a form of unpermitted touching or battery. Other issues about the law and euthanasia have been crystallized by certain well-publicized cases. The noted cases of Karen Quinlan in 1975 and Nancy Cruzan in 1990 are two examples of such high-profile cases.[14]

Despite such cases there is no state in this country that permits active euthanasia or mercy killing. Active euthanasia is practiced some what openly in The Netherlands, even thought it is officially against the law. It is estimated that about five thousand or more incidences occur there each year. Legislation to officially legalize it has been proposed but not passed. There has been a long standing debate on whether euthanasia should be legalized. On one side it has been argued that for people on life support systems and people with long standing diseases causing much pain and distress, euthanasia is a better choice. It helps in relieving them from pain and misery. In cases like terminal cancers when the patient is in much pain and when people associated with them also are put through a lot of pain and misery, it is much more practical and humane to grant the person his/her wish to end his/her own life in a relatively painless and merciful way. On the other hand there are ethical issues and political issues concerning the same subject. Oregon, Belgium and The Netherlands are the only places in the world that have laws specifically permitting assisted suicide. In 1997, Oregon was the first to enact the physician-assisted suicide law in the United States. This law, known as the Death with Dignity Act, requires the Oregon Department of Human Services to collect and analyze data on the people involved in the act and to publish annual reports. In this way statistics are maintained. This law allows only physician-assisted suicide. Euthanasia is still illegal.

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14. Karen Quinlan, 70 N.J. 10, 335 A. 2d 647 (1976), & *Nancy Cruzan v. Director, Missouri Department of Health, United States Supreme Court,* 110 S.Ct. 2841

4.1 The Nature of the debate:

This debate is largely a debate about what is ethical. A question that arises include: Is it right to commit suicide? Is it ethical for someone else to help? Is it right to put others to death at their own request or at the request of family members? These questions are important because they help to define our society and our culture. The way people deal with and respond to issues of life, ritual, and death serves to shape the nature of our society. This is why society must attempt to decide what is right; what is ethical conduct for the various actors in our communities when we face death. There are several reasons why this debate has surfaced in the 1980's. Death is nothing new; it has existed for thousands of years. Each culture has developed its own rituals and mechanisms for dealing with death. These mechanisms serve to provide solace, a sense of continuity, and allow the culture to continue even as the members of the community cannot. However, our own culture has experienced many shattering changes that have altered the nature of dying. Suddenly we are forced to rethink the issue of death and we must decide what types of behavior are ethical when someone is dying. Before we can examine the debate about the ethics of dying, we must examine why the debate exists.

Perhaps the main reason that death has changed in western culture has to do with advances in medicine and technology. Many of the diseases that have historically killed people are now no longer a threat to most individuals. Medicine has made a variety of advances in the treatment of diseases such as smallpox, tuberculosis, malaria, pneumonia, polio, influenza, and measles. People now rarely die of such traditional causes. Life expectancy has risen to almost 75 years in the developed countries. The quality of life has also changed fundamentally during the past 100 years. Not only does almost everyone in the developed countries have enough to eat, but people eat higher on the food chain. There is a great deal more meat and animal fat in

modern diets. Just these differences alone have changed death significantly. People now develop heart disease, adult onset diabetes, cancers, and AIDS. These types of diseases are more the result of lifestyle than bacteria. With these new diseases, suffering is often more prolonged and treatment is frequently quite painful. Also, as people are living longer, the diseases of the aged have become increasingly prevalent. Many more people now suffer from problems like senile dementia and Alzheimer's disease. These diseases ruin the mind while preserving the body, allowing life to continue long after any quality that the life might have is gone. Throughout history, death has been a family affair. People usually died in the home after a short period with an illness or as the result of an accident. Today, increasingly, death occurs in an institutional setting such as a convalescent home or hospitals, after a variety of technologies are applied in an attempt to prolong the life of the sick person. Often these technologies can be quite effective. People can now live for months and even years attached to a variety of tubes and technologies. "About 75% of all deaths in 1987 occurred in hospitals and long term care facilities, up from 50% in 1950 . . . The Office of Technology Assessment Task Force estimated in 1988 that 3775 to 6575 persons were dependent on mechanical ventilation and 1,404,500 persons were receiving artificial nutritional support. This growing capability to forestall death has contributed to the increased attention to medical decisions near the end of life." [15]

People realize that the chances of facing the institutionalization of death increase daily, and they feel a profound lack of control. Surveys have consistently indicated that a large majority of people in the Developed Countries would like to be allowed to end their lives before incurable and painful diseases finally kill them. Because of the changes that have impacted death, with regard to both how and where we die, the debate about how we should be allowed to die has been renewed. It will define the terms that are relevant to the debate, examine the legal

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15. Internet Sources.

state of euthanasia today, discuss the ethics of euthanasia by examining arguments made by proponents and opponents of euthanasia, and by applying several Normative Ethical Theories to the issue. Finally, it will explore the power implications that infuse the debate on euthanasia and present arguments in favor of moving toward a care based ethic of dying and away from the current rights based ethic.

Actually this issue or the right to choose death has become an important task for the ethics, and doctors. What is human? When does it become human? When does it cease to be human? Are the questions which occupy our concern in the present day? To cite the case of Karen Quinlen case in April, 1975. For reasons still unclear, Karen Ann Quinlen ceased breathing for at least 15 minutes period. Failing to respond to mouth-to mouth resuscitation by friends she was taken by ambulance to Newton Memorial Hospital in New Jercy. She had a temperature of 100 degrees, her pupils were unreactive, and she did not respond even to deep pain. Physicians who examined her, characterized Karen as being in a “chronic persistent, vegetative state”, and later it was judged that no form of treatment could restore her to cognitive life. Her father, Joseph Quinlan asked to be appointed her legal guardian with the expressed purpose of discontinuing the use of the respirator by which Karen was being sustained. Eventually the Supreme Court of New Jersey granted the request. The respirator was turned off. However, Karen Ann Quinlen remained alive but comatose until June 11, 1985, when she died at the age of thirty one. Although widely publicized the Quinlan case is by no means the only one that has raised questions concerning euthanasia.

We know that active euthanasia is not generally accepted by most people in various countries, where as passive euthanasia, though not legal everywhere, is practiced in many countries by the physicians, since passive euthanasia saves them from any legal prosecution.

The traditional view that there is an important moral difference between active passive euthanasia is one that was endorsed by J. Gay-Williams. Active euthanasia involves killing and passive euthanasia letting die, and this fact has led many physicians and philosophers to reject active euthanasia as morally wrong, even while approving of passive euthanasia.16

James Rachels challenges both the use and moral significance of this distinction for several reasons. First, active euthanasia is in many cases more humane than passive. Second, the conventional doctrine leads to decisions concerning life and death on irrelevant grounds. Third, the doctrine rests on a distinction between killing and letting die that itself has no moral significance. Forth, the most common arguments in favor of the doctrine are invalid. Therefore, in Rachel's view the American Medical Association's policy statement endorsing the active-passive distinction is unwise. According to James Rachels the distinction between active and passive euthanasia is thought to be crucial for medical ethics. The idea is that it is permissible, at least in some cases, to withhold treatment and allow a patient to die, but it is never permissible to take any direct action designed to kill the patient. This doctrine seems to be accepted by most doctors, and it is endorsed in a statement adopted by the House of Delegates of the American Medical Association.

> The intentional termination of the life of one human being by another -mercy killing - is contrary to that for which the medical profession stands and is contrary to the policy of the American Medical Association. The cessation of the employment of extraordinary means to prolong the life of the body when there is irrefutable evidence that biological death is imminent is the decision of the patient and/or his immediate family. The advice and judgment of the physician should be freely available to the patient and/or his immediate family. 17

However, a strong case can be made against this doctrine. In what follows, he will set out some of the relevant arguments, and urge doctors to reconsider their views on this matter. To begin with a familiar type of situation, a patient who is dying of incurable cancer of

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16. J. Gay-Williams, "The Wrongfulness of Euthanasia", in Ronald Munson, (ed.*) Intervention and Reflection, Basic Issues in Medical Ethics*, 2nd ed. 1983, pp-156-59

17. James Rachels : "Active and Passive Euthanasia, *New England Journal of Medicine*, vol. 292, no.2 (January 9, 1975), pp- 78-80.

the throat is in terrible pain, which can no longer be satisfactorily alleviated. The patient is certain to die within a few days, even if present treatment is continued, but the patient does not want to go on living for those days since the pain is unbearable. So he asks the doctor for an end to it, and his family joins in the request.

Suppose the doctor agrees to withhold treatment, as the conventional doctrine says he may. The justification for his doing so is that the patient is in terrible agony, and since he is going to die anyway, it would he wrong to prolong his suffering needlessly. If one imply withholds treatment, it may take the patient longer to die, and so he may suffer more than he would if no indirect action were taken and a lethal injection given. This fact provides strong reason for thinking that, once the initial decision not to prolong his agony has been made active euthanasia is actually preferable to passive euthanasia, rather than the reverse. To say otherwise is to endorse the option that leads to more suffering rather than less, and is contrary to the humanitarian impulse that prompts the decision not to prolong his life in the first place.

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

> ...When surgery is denied (the doctor I must try to keep the infant from suffering while natural forces sap the baby's life away. As a surgeon whose natural inclination is to use the scalpel to fight off death, standing by and watching a salvageable baby die is the most emotionally exhausting experience I know. It is easy at a conference, in a theoretical discussion, to decide that such infants should be allowed to die. It is altogether different to stand by in the nursery and watch as dehydration and infection wither a tiny being over hours and days. This is a terrible ordeal for me and the hospital staff - much more so than for the parents who never set foot in the nursery.18

James Rachels also said that why some people are opposed to all euthanasia, and insist that such infants must be allowed to live, and why other people favor destroying these babies quickly and painlessly. But why should anyone favor letting 'dehydration and infection wither a tine being over hours and days'? The doctrine that says that a baby may be allowed to dehydrate and wither, but may not for given art injection that would end its life without suffering, seems so patently cruel as to require no further refutation. The strong language is not intended to offend, but only to put the point in the clearest possible way. His second argument is that the conventional doctrine leads to decisions concerning life and death made on irrelevant grounds. Consider again the case of the infants with Down's syndrome who need operations for congenital defects unrelated to the syndrome to live. Sometimes, there is no operation, and the baby dies, but when there is no such defect, the baby lives on. Now, an operation such as that to remove an intestinal obstruction is not prohibitively difficult. The reason why such operations are not performed in these cases is, clearly, that the child has Down's syndrome and the parents and doctor judge that because of that fact it is better for the child to die.

But notice that this situation is absurd, no matter what view one takes of the lives and potentials of such babies. If the life of such an infant is worth preserving, what does it matter if it needs a simple operation? Or, if one thinks it letter that such a baby should not live on, what

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18. Shaw A, "*Doctor, Do We Have a Choice*?" The New York Times Magazine, January 30, 1972, p-54

difference does it make that it happens to have an unobstructed intestinal tract? In either case, the matter of life and death is being decided on irrelevant grounds. It is the Down's syndrome, and not the intestines, that is the issue. The matter should be decided, if at all, on that basis, and not be allowed to depend on the essentially irrelevant question of whether the intestinal tract is blocked.

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

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

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

In the second, Jones also stands to gain if anything should happen to his six-year-old cousin. Like Smith. Jones sneaks in planning to drown the child in his bath. However, just as he enters

the bathroom Jones sees the child slip and hit his head, and fall face down in the water. Jones is delighted; he stands by, ready to push the child's head back under if it is necessary, but it is not necessary. With only a little thrashing about, the child drowns all by himself, "accidentally," as Jones watches and does nothing. Now Smith killed the child, whereas Jones "merely" let the child die. That is the only difference between them. Did either man behave better, from a moral point of view? If the difference between killing and letting die were in itself a morally important matter, one should say that Jones's behavior was less reprehensible than Smith's. But does one really want to say that? He thinks not. In the first place, both men acted from the same motive, personal gain, and both had exactly the same end in view when they acted. It may be inferred from Smith's conduct that he is a bad man, although that judgment may be withdrawn or modified if certain further facts are learned about him - for example, that he is mentally deranged. But would not the very same thing be inferred about Jones from his conduct? And would not the same further considerations also be relevant to any modification of this judgment? Moreover, suppose Jones pleaded, in his own defense, "After all, Rachel's said that he didn't do anything except just stand there and watch the child drown. Its means he didn't kill him; he only let him die." Again, if letting die were in itself less bad than killing, this defense should have at least some weight. But it does not. Such a "defense" can only be regarded as a grotesque perversion of moral reasoning. Morally speaking, it is no defense at all.

Now, it may be pointed out, quite properly, that the cases of euthanasia with which doctors are concerned are not like this at all. They do not involve personal gain or the destruction of normal healthy children. Doctors are concerned only with cases in which the patient's life is of no further use to him, or in which the patient's life has become or will soon become a terrible burden. However, the point is the same in these cases: the bare difference

between killing and letting die does not, in itself, make a moral difference. If a doctor lets a patient die, for humane reasons, he is in the same moral position as if he had given the patient a lethal injection for humane reasons. If his decision was wrong if, for example, the patient's illness was in fact curable the decision would be equally regrettable no matter which method was used to carry it out. And if the doctor's decision was the right one, the method used is not in itself important.

The AMA policy statement isolates the crucial issue very well; the crucial issue is "the intentional termination of the life of one human being by another." But after identifying this issue, and forbidding "mercy killing," the statement goes on to deny that the cessation of treatment is the intentional termination of a life. This is where the mistake comes in, for what is the cessation of treatment, in these circumstances, if it is not "the intentional termination of the life of one human being by another?" Of course it is exactly that, and if it were not, there would be no point to it.

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

the other factors the murderer's motive of personal gain, for example, contrasted with the doctor's humanitarian motivation account for different reactions to the different cases.[19]

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

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

A number of points need to be made here. The first is that it is not exactly correct to say that in passive euthanasia the doctor does nothing, for he does do one thing that is very important: he lets the patient die. "Letting someone die" is certainly different, in some respects, from other types of action - mainly in that it is a kind of action that one may perform by way of not performing certain other actions. For example, one may let a patient die by way of not giving medication, just as one may insult someone by way of not shaking his hand. But for any purpose of moral assessment, it is a type of action nonetheless. The decision to let a patient die is subject to moral appraisal in the same way that a decision to kill him would be subject to moral appraisal: it may be assessed as wise or unwise, compassionate or sadistic, right of wrong. If a doctor deliberately let a patient die who was suffering from a routinely curable illness, the doctor would certainly be to blame for what he had done, just as he would be to blame if he had needlessly killed the patient. Charges

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19. James Rachels : *The Right Thing To Do: Basic Reading in Moral Philosophy*, 1989.

against him would then be appropriate. If so, it would be no defense at all for him to insist that he didn't "do anything." He would have done something very serious indeed, for he let his patient die. Fixing the cause of death may be very important from a legal point of view, for it may determine whether criminal charges are brought against the doctor. But Rachels does not think that this notion can be used to show a moral difference between active and passive euthanasia. The reason why it is considered bad to be the cause of someone's death is that death is regarded as a great evil and so it is. However, if it has been decided that euthanasia even passive euthanasia is desirable in a given case, it has also been decided that in this instance death is no greater an evil than the patient's continued existence. And if this is true, the usual reason for not wanting to be the cause of someone's death simply does not apply.

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

no moral difference between the two, considered in themselves (there may be important moral differences in some cases in their *consequences*, but, as Rachels pointed out, these differences may make active euthanasia, and not passive euthanasia, the morally preferable option). So, whereas doctors may have to discriminate between active and passive euthanasia to satisfy the law, they should not do any more than that. In particular, they should not give the distinction any added authority and weight by writing it into official statements of medical ethics.

Philippa Foot expressed her view in the following way:

> Where then do the boundaries of the 'active' and the 'passive' lie? In some ways the words are themselves misleading, because they suggest the difference between act and omission which is not quite what we want. Certainly the act of shooting someone is the kind of thing we were talking about under the heading of 'interference, and omitting to give him a drug a case of refusing care. But the act of turning off a respirator should surely be thought of as no different from the decision not to start it; if doctors had decided that a patient should be allowed to die, either course of action might follow, and both should be counted as passive rather than active euthanasia if euthanasia were in question. The point seems to be that interference in a course of treatment is not the same as other interference in a man's life, and particularly if the same body of people are responsible for the treatment and its discontinuance. In such a case we could speak of the disconnecting of the apparatus as killing the man, or of the hospital as allowing him to die. By and large, it is the act of killing that is ruled out under the heading of noninterference, but not in every case.[20]

Philippa Foot discusses the above point by citing the distinction that James Rachels draws between active and passive euthanasia. James Rachels believes that this distinction should be relevant everywhere and he has pointed to an example in which it seems to make no difference which is done. If someone saw a child drowning in a bath it would seem just as bad

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20. Appling Ethics, p-252.

to let it drown as to push its head under water. If 'it makes no difference' means that one act would be as iniquitous as the other, this is true. It is not that killing is worse than allowing to die, but that the two are contrary to distinct virtues, which gives the possibility that in some circumstances one is impermissible and the other permissible. To Rachels, both the cases are not good. Is it justice to push the child's head under the water? Something one has no right to do. To leave it to drown is not contrary to justice, but it is a particularly glaring example of a lack of charity. Here it makes no practical difference because the requirements of justice and charity coincide; but in the case of the retreating army they did not: charity would have required that the wounded soldier be killed had not justice required that he be left alive. In such a case it makes all the difference whether a man opts for the death of another in a positive action, or whether he allows him to die. An analogy with the right to property will make the point clear. If a man owns something, he has the right to it even when its possession does him harm. But if one day it should blow away, maybe nothing requires us to get it back for him; we could not deprive him of it, but we may allow it to go. This is not to deny that it may be an unfriendly act or one based on an arrogant judgment when we refuse to do what he wants. Nevertheless, we would be within our rights, and it might be that no moral objection of any kind would lie against our refusal.[21]

Philippa Foot's arguments may be analysed in the following way

Foot agrees with Rachels' judgment in the case of Smith versus Jones, as she says that in this case the requirements of justice and charity coincide, and that the one action "would be as iniquitous as the other". But if she does agree with Rachel that Jones's action is as wrong as Smith's, on the grounds that considerations of charity are *precisely* as weighty as considerations of justice in this case, she needs to explain why the situation is any different in other cases. In

21. Jeffrey Olen & Vincent Barry: *Applying Ethics- A Text with Reading*, Wadsworth Publishing Company, Belmont, California, A division of Wadsworth INC. 1999, pp -244-258.

particular, how can she maintain that it is morally worse to kill an innocent person than merely to allow an innocent person to starve to death?

Foot describes a crucial case of a retreating army as follows:

> Suppose, for example, that a retreating arm has to leave behind wounded or exhausted soldiers in the wastes of an arid or snowbound land where the only prospect is death by starvation or at the hands of an enemy enormously cruel. It has often been the practice to accord a merciful bullet to men in such desperate straits. But suppose that one of them demands that he be kept alive? It seems clear that his comrades have no right to kill him, though it is quite a different question whether they should give him a life-prolonging drug. The right to life can sometimes give a duty of positive service, but does not do so here. What it does give is the right to be left alone. 22

Foot's view here is that one has an obligation to refrain from shooting the soldier if he wants not to be shot, but no obligation to enable him to live longer if he wants to live longer. Thus she says that the right to life can sometimes give a duty of positive service, but does not do so here. What it does give is the right to be left alone. And Foot contends that in accepting this conclusion, we have arrived at the distinction involved in the active versus passive euthanasia distinction.

Foot is right about the retreating army case. But once one is clear about that case, it is also clear that it does not support any conclusion to the effect that the active versus passive euthanasia distinction is significant in itself. To see this, consider a person who has been reflecting for some time on the question of whether to go on living, who is not in an emotionally disturbed state, and who decides to commit suicide, even though such an action is contrary to his or her own interests. A person may very well have the right to commit suicide in cases where it is contrary to his or her own interest. But on the other hand, it may very well be argued that it is not morally right to assist such a person to commit suicide - so that allowing the person's death, at his or her own hands, is permissible, but not bringing that person's death

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22. Ibid, *Applying Ethics*, pp – 252.

about, even when that is what the person wants. Why so? The reason is, first of all, that each person has a prima facie right that others not interfere with his or her actions, but does not have a prima facie right that others act in some particular way; and secondly, that while acting contrary to one's own interest is not prima facie wrong, acting contrary to someone else's interests is. So while it may not be wrong to allow someone else to act contrary to his or her own interests, it would be wrong to assist him or her to do this.

The soldier who will be captured by the enemy and tortured and killed, and who nevertheless asks not to be shot, has a right to demand that he or she be allowed to act contrary to his or her own self-interest. But the same soldier does not have a right to demand that others assist him in acting contrary to his or her own self-interest.

J. Gay- Williams argues that euthanasia—that idea, if not the practice –is slowly gaining acceptance within our society. Cynics might attribute this to an increasing tendency to devalue human life, but he does not believe this is the major factor. The acceptance is much more likely to be the result of unthinking sympathy and benevolence. Well-publicized, tragic stories like that of Karen Quinlan elict from us deep feeling of compassion. We think to ourselves, "she and her family would be better off if she were dead." It is an easy step from this very human response to the view that if someone (and others) would be better off dead, then it must all right to kill that person.[23]

Although he respects the compassion that leads to this conclusion, and he believes the conclusion is wrong. And he tries to show that euthanasia is wrong. It is inherently wrong, but it is also wrong judged from the stand-point of self-interest and of practical effects.

It is important to be clear about the deliberate and intentional aspect of the killing. If a hopeless person is given an injection of the wrong drug by mistake and this causes his death,

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23. Foot Philippa , "*Euthanasia*" Philosophy and public Affairs, vol. 6 , 1977, pp. 85-112.

this is wrongful killing but not euthanasia. The killing cannot be the result of accident. Furthermore, if the person is given an injection of a drug that is believed to be necessary to treat his disease or better his condition and the person dies as a result, then this is neither wrongful killing nor euthanasia. The intention was to make the patient well, not kill him. Similarly, when a patient's condition is such that it is not reasonable to hope that any medical procedures or treatments will save his life, a failure to implement the procedures or treatments is not euthanasia. If the person dies, this will be as a result of his injuries or disease and not because of his failure to receive treatment. The failure to continue treatment after it has been realized that the patient has little chance of benefiting from it has been characterized by some as "passive euthanasia." This phrase is misleading and mistaken.[24]

In such cases, the person involved is not killed (the first essential aspect of euthanasia), nor is the death of the person in tended by the withholding of additional treatment (the third essential aspect of euthanasia). The aim may be to spare the person additional and unjustifiable pain, to save him from the indignities of hopeless manipulations, and to avoid increasing the financial and emotional burden on his family. When I buy a pencil it is so that I can use it to write, not to contribute to an increase in the gross national product. This may be the unintended consequence of my action, but it is not the aim of my action. So it is with failing to continue the treatment of dying person. I intend his death no more than I intend to reduce the GNP by not using medical supplies. His is an unintended dying, and so-called "passive euthanasia" is not euthanasia at all.

Every human being has a natural inclination to continue living. Our reflexes and responses fit us to fight attackers, flee wild animals, and dodge out of the way of trucks. In our daily lives we exercise the caution and care necessary to protect ourselves. Our bodies are

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24. Rachels James **"**Active and passive Euthanasia," *New England Journal Medicine***,** vol. 292, pp. 78-80. and , Foot, Philippa. 'Killing and Letting Die' Jay L. Garfield Patricia Hennessey(eds.) University of Massachusetts Press, pp-100-103.

similarly structured for survival right down to the molecular level. When we are cut, our capillaries seal shut, our blood clots, and fibroses is produced to start the process of healing the wound. When we are invaded by bacteria, antibodies are produce to fight against the alien organisms, and their remains are swept out of the body by special cells designed for clean-up work. Euthanasia does violence to this natural goal of survival. It is literally acting against nature because all the processes of nature are bent towards the end of bodily survival. Euthanasia defeats these subtle mechanisms in a way that, in a particular case, disease and injury might not. It is possible, but not necessary, to make an appeal to revealed religion in this connection.[25] Man as trustee of his body acts against God, its rightful possessor, when he takes his own life. He also violates the commandment to hold life sacred and never to take it without just and compelling cause. But since this appeal will persuade only those who are prepared to accept that religion has access to revealed truth. He believes to recognize that the organization of the human body and our patterns of behavioral responses make the continuation of life a natural goal. By reason alone, then, we can recognize that euthanasia sets us against our own nature.[26]

Furthermore, in doing so, euthanasia does violence to our dignity. Our dignity comes from seeking our ends. When one of our goals is survival, and actions are taken that eliminate that goal, and then our natural dignity suffers. Unlike animals, we are conscious though reason of our nature and our ends. Euthanasia involves acting as if this dual nature –inclination towards survival and awareness of this as an end- did not exist. Thus, euthanasia denies our basic human character and requires that we regard ourselves or other as something less than fully human.

The above arguments are, He believes, sufficient to show that euthanasia is inherently wrong. But there are reasons for considering it wrong when judged by standards other than

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25. Ibid., p-299.
26. McIntyre.Ray.V in "*Voluntary Euthanasia: The Ultimate Perversion*," Medical Counterpoint, vol. 2, pp-26-29.

reason. Because death is final and irreversible, euthanasia contains within it the possibility that we will work against our own interest if we practice it or allow it to be practiced on us. Contemporary medicine has high standards of excellence and a proven record of accomplishment, but it does not possess perfect and complete knowledge. A mistaken diagnosis is possible, and so is a mistaken prognosis. Consequently, we may believe that we are dying of a disease when, as a matter of fact, we may not be. We may think that we have no hope of recovery when, as a matter of fact, our chances are quite good. In such circumstances, if euthanasia were permitted, we would die needlessly. Death is final and the chance of error too great to approve the practice of euthanasia. Also, there is always the possibility that an experimental procedure or a hitherto untried technique will pull us through. We should at least keep this option open, but euthanasia closes it off. Furthermore, spontaneous remission does occur in many cases. For no apparent reason, a patient simply recovers when those all around him, including his physicians, expected him to die. Euthanasia would just guarantee their expectations and leave no room for the “miraculous” recoveries that frequently occur.

Finally, knowing that we can take our life at any time (or ask another to take it) might well incline us to give up too easily. The will to live is strong in all of us, but it can be weakened by pain and suffering and feelings of hopelessness. If during a bad time we allow ourselves to be killed, we never have a chance to reconsider. Recovery from a serious illness requires that we fight for it, and anything that weakens our determination by suggesting that there is an easy way out is ultimately against our own interest. Also, we may be inclined towards euthanasia because of our concern for others. If we see our sickness and suffering as an emotional and financial burden on our family, we may feel that to leave our life is to make their

lives easier.[27] The very presence of the possibility of euthanasia may keep us from surviving when we might.

Doctors and nurses are, for the most part, totally committed to saving lives. A life lost is, for them, almost a personal failure, an insult to their skills and knowledge. Euthanasia as a practice might well alter this. It could have a corrupting influence so that in any case that is severe doctors and nurses might not try hard enough to save the patient. They might decide that the patient would simply be "better off dead" and take the steps necessary to make that come about. This attitude could then carry over to their dealings with patients less seriously ill. The result would be an overall decline in the quality of medical care. Finally, euthanasia as a policy is a slippery slope. A person apparently hopelessly ill may be allowed to take his own life. Then he may be permitted to deputize others to do it for him should he no longer be able to act. The judgment of others then becomes the ruling factor. Already at this point euthanasia is not personal and voluntary, for others are acting "on behalf of" the patient as they see fit. This may well incline them to act on behalf of other patients who have not authorized them to exercise their judgment. It is only a sort step, then, from voluntary euthanasia (self-inflicted or authorized), to directed euthanasia administered to a patient who has given no authorization, to involuntary euthanasia conducted as part of a social policy. Recently many psychiatrists and sociologists have argued that we define as "mental illness" those forms of behavior that we disapprove of. This gives us license then to lock up those who display the behavior. The category of the "hopelessly ill" provides the possibility of even worse abuse. Embedded in a social policy, it would give society or its representatives the authority to eliminate all those who might be considered too "ill" to function normally any longer. The dangers of euthanasia are too great to all to run the risk of approving it in any form. The first slippery step may well lead to a

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27. Ibid.,pp -300-301.

serious and harmful fall. J. Gay Williams hopes that he has succeeded in showing why the benevolence that inclines us to give approval of euthanasia is misplaced. Euthanasia is inherently wrong because it violates the nature and dignity of human beings. But even those who are not convinced by this must be persuaded that the potential personal and social dangers inherent in euthanasia are sufficient to forbid our approving it either as a personal practice or as a public policy. Suffering is surely a terrible thing, and we have a clear duty to comfort those in need and to ease their suffering when we can. But suffering is also a natural part of life with values for the individual and for others that we should not overlook. We may legitimately seek for others and for ourselves an easeful death, as Arthur Dyck has pointed out. Euthanasia, however, is not just an easeful death. It is a wrongful death. J. Gay believes that euthanasia is not just dying, it is killing.[28]

Psychiatrist Dr. Daniel Gorman discussed passive and active euthanasia. The CMA supports the commonly held view that passive euthanasia is morally permissible in certain circumstances while active euthanasia is always wrong. In its policy summary on physician-assisted death, the CMA stated that both euthanasia and assisted suicide fall under this heading and said CMA members "should specifically exclude participation in" either practice. But the definition of physician-assisted death is qualified: "Physician-assisted death, as understood here, does not include the withholding or withdrawal of inappropriate, futile or unwanted medical treatment or the provision of compassionate palliative care, even when these practices shorten life." Two recent cases involving physician-assisted death not only illustrate the difference between passive and active euthanasia but also raise the question of whether active euthanasia should sometimes be allowed.

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28. Dyck Arthur, "*Beneficent Euthanasia and Benemortasia*," in Kohl, pp- 117-129

In October 1991, Ms. X, who had lung cancer and had been placed on a respirator at the former St. Mary's Hospital in Timmins, Ont., informed family members that she wanted a breathing tube removed so that her suffering would end. They supported her decision and conveyed it to de la Rocha. In accordance with standard practice, he removed the tube and administered 40 mg of morphine in 3 doses to ensure that she did not experience a suffocating feeling. He broke with standard practice, however, by then administering potassium chloride, causing her heart to stop.

In April 1993 he was convicted in criminal court of administering a noxious substance. His sentence was suspended, however, and he was given 3 years' probation. In an April 1995 hearing before the Discipline Committee of the College of Physicians and Surgeons of Ontario he was charged with professional misconduct because of the conviction in court, as well as failure to maintain the standard of practice. He pleaded guilty to the first charge and the college did not proceed with the second. His penalty was a 90-day license suspension that would be lifted if he wrote a guideline on withdrawing life support from terminally ill patients.[29]

Mr. Y, had undergone 6 operations for esophageal cancer, and in November 1996 was being treated for severe infections at the Queen Elizabeth II Health Sciences Centre (QE II) in Halifax. When his family requested that life supports be withdrawn, he was extubated and given large doses of morphine and hydromorphone. About 2 hours later he remained in extreme distress, and Morrison is alleged to have administered nitroglycerin even though his blood pressure was already very low. After about 10 more minutes she is alleged to have administered potassium chloride, causing him to die within seconds. In February 1997 Morrison received a 3-month suspension from the QE II. During an interview with Halifax police, a colleague of hers said that the patient's death was "basically active euthanasia," and he accused the hospital

29. College of Physicians and Surgeons of Ontario. Dr. Claudio Alberto Gonzales de la Rocha, Timmins [case summary]. *Members' Dialogue* 1995.

of covering up the incident. Morrison was arrested in May 1997 and appeared in court on a charge of first-degree murder. She pleaded innocent and was freed on $10 000 bail; in November, the Crown announced that it would seek a finding of manslaughter. A preliminary hearing was held in February 1998, and Judge Hughes Randall ruled that he would not commit her for trial because there was insufficient evidence for a jury to convict her of any offence. At the time of writing, the College of Physicians and Surgeons of Nova Scotia had not yet reviewed the case. In these cases, the main ethical issue does not involve a simple decision about whether euthanasia is right or wrong, but whether the distinction between passive and active euthanasia is morally relevant. Virtually everyone agrees that in the circumstances described it was morally permissible for the doctors to allow their patients to die by extubating them and administering narcotics. Many believe, however, that in the same circumstances it was wrong for them to cause the death of their patients by administering potassium chloride. It has been already discussed in this chapter that James Rachels challenges the doctrine that passive euthanasia can be morally permissible but active euthanasia cannot. He argues that killing someone is not, in itself, worse than letting someone die, and so active euthanasia is not worse than passive euthanasia. In his view, we should decide whether euthanasia is permissible in a particular case, irrespective of the means by which death would be brought about. Then, if we think that euthanasia is indeed permissible, we should favor the means that is most humane. Consequently, in cases where a dying patients suffering cannot be adequately relieved by palliative care, active euthanasia should actually be favored over passive euthanasia because it ends the suffering more quickly. Rachels key premise is that killing is not, in itself, worse than letting die. He defends this view by proposing two hypothetical cases.

• Mr. Smith stands to gain a large inheritance if his young cousin were to die. Motivated by greed, Smith sneaks into the bathroom while the cousin is taking a bath and drowns her.

• Mr. Jones also stands to gain a large inheritance if his young cousin was to die, and he too sneaks into the bathroom, planning to drown her. Just as Jones enters the bathroom, the girl slips, hits her head, and falls face down, unconscious, in the water. Jones is poised to force her head back down should it be necessary, but it is not. The girl drowns while Jones does nothing. Rachels reasons that if killing is, in itself, worse than letting die, then it must always be worse than letting die. He then asks whether Smith's actions were more reprehensible than Jones'. Surely they were not, he argues, for it is ludicrous to suggest that Jones behaved better because he did not actually kill his cousin but "merely" let her die. Thus, Rachels concludes, there is no inherent moral distinction between killing and letting die. If this conclusion is correct, why do many people think that killing is worse than letting die? The reason, Rachels argues, is that they "conflate the question of whether killing is, in itself, worse than letting die, with the very different question of whether most actual cases of killing are more reprehensible than most actual cases of letting die." Most cases of killing involve murderers with evil motives, whereas most cases of letting die involve physicians acting out of compassion. Consequently, we come to think of killing as worse than letting die even though our moral reactions to these cases are really based on the different motives for ending life. Rachels maintains that when the motives and other circumstances are the same, as in the Smith and Jones cases, it becomes clear that whether a person is killed or allowed to die is morally irrelevant. Therefore, he believes that the means of bringing about death should play no part in decisions about euthanasia.[30]

In "Killing and letting die," Philippa Foot claims that Rachels' view is "extremely implausible" and offers examples in which the distinction between killing and letting die clearly

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30. Applying Ethics, pp -41-43.

seems to be morally relevant. Here are two of them, slightly embellished. First consider the dilemma of Dr. Brown, who has a limited supply of a drug and six patients who will die without it. The dilemma arises because one patient needs the entire supply of the drug to survive, while the other five need only one-fifth of the amount. Should he let one die to save five? Then consider the dilemma of Dr. Green. She has five patients who will die unless they undergo organ transplantation, but the organs they require are unavailable. It occurs to her, however, that there is a healthy clinical clerk on the ward with all the organs necessary to supply the five patients. Should she kill one to save five? Both dilemmas involve choosing between life for one person and life for five. The only difference is that Brown would have to let one die to save five, whereas Green would have to kill one to save five. But this difference is morally critical, for it is obvious that Brown should choose life for five, whereas Green should choose life for one. We must now ask why the distinction between killing and letting die seems morally relevant in the Brown and Green cases, but not in the Smith and Jones cases. Foot argues that the answer lies in the kinds of rights and duties associated with killing and letting die. Rights can be divided into two types, negative and positive.

Negative rights are our rights not to be interfered with — not to be harmed, for instance, or not to have our property taken away. Positive rights are our rights to goods and services, such as our right to food and medical care. Corresponding to a person's negative and positive rights are other people's negative and positive duties: we have a negative duty not to harm others and a positive duty to feed the hungry. Foot argues that the difference between the Smith and Jones cases is that Smith fails in his negative duty not to kill, whereas Jones fails in his positive duty to lend assistance. The moral significance of this difference is only academic, however, because in the circumstances described it is equally wrong to fail in either duty. The cases of Brown and

Green are more complicated. If Brown lets one person die to save five, he fails in his positive duty to provide the one person with medical care. If Green kills one person to save five, she fails in her negative duty not to kill the one person. Here, though, the difference is morally important. In the Brown case, the positive right of one person to medical care obviously does not outweigh the positive right of five others to medical care. In the Green case, however, the negative right of the clinical clerk not to be killed does outweigh the positive right of the five to receive medical care. This is because "it takes more to justify interference than to justify the withholding of goods or services." Consequently, it is morally permissible — indeed, required— for Brown to fail to provide one person with medical care, but it is wrong for Green to kill the clinical clerk. Foot's response to Rachels reveals that the distinction between killing and letting die can be morally relevant in some cases but not others. Therefore, Rachels' argument is invalid: although he is right that the distinction is morally irrelevant in the context of the cases involving Smith and Jones, it does not follow that the distinction is never morally relevant.

Objections to euthanasia from a nonreligious perspective have also been submitted. Perhaps the most popular of these is the so-called wedge argument.[31] The wedge argument submits that since killing is wrong, it should be restricted to as narrow a range of exceptions as possible, for if the number becomes large, wide latitude is given to legitimizing the taking of life and it becomes an easy policy for society to approve of. Thus, accepting passive euthanasia or worse yet, accepting voluntary active euthanasia will lead to involuntary active euthanasia. Those holding this opinion frequently support their views by citing the Nazi experience. Joseph Sullivan, for example, states that the Nazi government abused their euthanasia laws and put millions of innocent people to death. The murders were justified by reason of the compulsory

31. Alexander Leo , "*Medical Science Under Dictatorship*," The New England Journal of Medicine 241(1949): p- 39.

euthanasia legislation which at the time of its enactment was thought to include only "incurable mental cases, monstrosities, and the incurables that were a burden to the state…. However, once the state held this power of life and death over innocent members of society, the lives of all citizens were in danger."[32]

While the wedge argument regarding the relationship between voluntary and involuntary euthanasia may be true, the use of the Nazi experience to validate it is incorrect, as Joseph Fletcher points out. In those instances where people thought it right to kill others judged to be inferior, their actions stemmed from almost unlimited political power, not from the seductiveness of killing. If their beliefs included cruelty, their actions also reflected this.

Let us now return to the cases of Drs. de la Rocha and Morrison. Both involved terminally ill patients in extreme distress. Given Foot's conclusion that killing may be worse than letting die in some cases but not others, we must ask whether killing is worse in these two cases. The answer should be No, provided that appropriate consent was obtained. In both cases the patient or patient's family waived the positive right to medical care in order to relieve suffering. When removing life supports did not bring about death as quickly as hoped, however, they might also have been willing to waive the negative right not to be killed. If they were to waive this negative right by consenting to a lethal injection, why would it be considered immoral to administer it? Of course, administering a lethal injection is currently illegal, and so the doctors could not have asked for consent to do this. Instead, they had to make a difficult choice: either allow their patients suffering to continue, or relieve it by performing an illegal act for which they had not obtained consent. Although Foot, in an earlier article, acknowledges that active euthanasia can be morally acceptable, she opposes legalization of the practice because she believes that it would have adverse social consequences. Her main concerns are the

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32. Sullivan Joseph V , "*The immorality of euthanasia*," in Beneficent Euthanasia, Marvin Kohl (ed.), (Buffalo: Prometheus, 1975, pp. 12-33.

potential for abuse and the possibility that severely ill patients would feel pressured to request a lethal injection. Notice, however, that in the two cases under consideration Foot's concerns apply as much to passive euthanasia as to active euthanasia. Both practices would be equally liable to abuse, for withdrawing life support is as easy as providing a lethal injection. And just as patients could feel pressured to request a lethal injection, they could also feel pressured to request that life supports be withdrawn. Therefore, if we allow passive euthanasia in these cases, as virtually everyone agrees we should, we should also allow active euthanasia. Finally, there is another common position against legalizing active euthanasia — the "slippery-slope" argument. This is advanced in the CMA Policy Summary "Physician-Assisted Death": "Consideration should be given to whether any proposed legislation can restrict (active) euthanasia and assisted suicide to the indications intended. If active euthanasia or assisted suicide or both are permitted for competent, suffering, terminally ill patients, there may be legal challenges, based on the Canadian Charter of Rights and Freedoms, to extend these practices to others who are not competent, suffering or terminally ill. Such extension is the 'slippery slope' that many fear." It is true that it will not speculate on whether such legal challenges are likely to be successful, for this is obviously a question for legal experts. However, if the answer is yes, then perhaps active euthanasia should remain illegal in all circumstances. Let us not forget, though, that regardless of how hard we strive to deliver the best possible palliative care, there will always be times when our efforts fail. Consequently, the cost of prohibiting active euthanasia is that some terminally ill patients who want to die are allowed to suffer longer than necessary. Legalization of euthanasia is a very complex question where a definite yes or no cannot be said. . But if even those people don't want to live, that is their birthright. Anybody

can ask and request, but if they say. “No, we are not interested anymore, and then certainly they have every right to die.” He/she simply wants to die in peace.

In conclusion, though it is not ethical to assist or be involved in a human beings death, in some cases, taking into consideration the involved person’s quality of life, euthanasia should be legalized. It will lead to a person having an option to consult his/her medical practitioner and choosing the right time and right way to end his/her life. But at the same time laws should be in place to make sure that there are proper standards in place to avoid unnecessary deaths in our present day stress filled lives. If euthanasia is to be legalized it should be done after taking all necessary measures and safeguards to prevent its misuses.

Chapter- 3

The concept of Mercy Killing in Indian tradition.

India is a cosmopolitan country with an amalgamation of many cultures, traditions and religions. Here religion plays a very crucial role. This chapter is divided in to two sections. First section deals with the standpoints of Hinduism and Buddhism regarding mercy-killing Ancient Indian philosophical tradition justifies the idea of man willing his own death. As per Hindu mythology Lord Rama and his brothers took Jal Samadhi in river Saryu near Ayodhya.[1] Besides that, this section highlights the viewpoints of Samkhya-Yoga, Jainism and The Sikh view of mercy-killing. Judaism and Islam are two other mono theistic religions which have had a global influence in regard to issues concerning the end of life. The Christian religion is also mostly against mercy-killing. The Christian religion believes that human beings are created in the image of God and thus their life belongs to God. Birth and death are part of the life processes which God has created, so humans should respect them and therefore no human being has the authority to choose the time and manner of his or any other human's death. Here we discussed Thalaikoothal, which is the traditional practice of genocide or involuntary euthanasia, by their own family members, observed in some part of southern districts of Tamil Nadu state of India. In the second section, the current legal position on mercy-killing (euthanasia) and assisted suicide in India and the response of the Indian Judiciary are the point of discussion. Here we discussed Venkatesh case, who was dystrophic patient, wanted to be granted the right to die. He sought to enforce the right so that he could donate organs before they were affected by his illness. Lastly this section deals with the most debated case of Aruna Shanbaug which is still the center of lively debate even in 2014.

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1. S Cromwell Crawford. *Hindu bioethics* for the twenty-first century. State University of New York, p - 226.

Section-1

Several Religious Perspectives

In ancient India, suicide was regarded as permissible in some circumstances. In the Chapter titled "The hermit in the forest," Manu's Code says –"He may set out walking straight and steadfastly in a north-easternly direction, subsisting on water and air, until his body sinks its repose".[2] Two commentators of Manu, Govardhana and Kulluka, say that a man may undertake the Mahaprasthna (great departure) on a journey which ends in death, when he is incurably diseased or meets with a great misfortune, and also because it is taught in the Sastras and it is not opposed to the Vedic rules which forbids suicide. From these passages it is clear that in ancient India, a voluntary death by starvation was considered to be a befitting conclusion of a hermit's life.

Hinduism is less interested than western philosophers in abstract ideas of right or wrong. Rather it focuses on the consequences of our actions. Most Hindus would say that a doctor should not accept a patient's request for euthanasia since this will cause the soul and body to be separated at an unnatural time. The result will damage the karma of both doctor and patient.

Other Hindus believe that euthanasia cannot be allowed because it breaches the teaching of ahimsa (doing no harm). However, some Hindus say that by helping to end a painful life a person is performing a good deed and so fulfilling their moral obligations.[3]

There are two Hindu views on euthanasia:

- By helping to end a painful life a person is performing a good deed and so fulfilling their moral obligations.
- By helping to end a life, even one filled with suffering, a person is disturbing the timing of the cycle of death and rebirth. This is a bad thing to do, and those involved in the euthanasia will take on the remaining karma of the patient.

2. The Laws of Manu, trans, Wendy Doniger with Brain K. Smrith, Penguin, New York, 1991, chap-31-32
3. Robert D. Lane and Richard Dunstan, *Euthanasia: the debate continues*, August 1995, published by the Institute of Practical Philosophy at Malaspina University-college.

The same argument suggests that keeping a person artificially alive on a life-support machines would also be a bad thing to do. However, the use of a life-support machine as part of a temporary attempt at healing would not be a bad thing. The ideal death is a conscious death, and this means that palliative treatments will be a problem if they reduce mental alertness.

Buddhists believe the way a life ends, will influence greatly the way the next life begins. The transition between an existing life and the next depends on an individual's karma at the point of death; however, there is no telling if the next life will be an improvement from the last. When a Buddhist dies their state of mind should be selfless, enlightened, free of anger, hate or fear.[4] From one perspective, a person who helps other end a painful life and thereby reduces suffering is doing a good deed and will gain good karma. From the other perspective, euthanasia interrupts the timing of the cycle of rebirth and both the doctor and patient will take on bad karma as a result.

In early Buddhist writing there is no term synonymous with 'euthanasia'. But in the third *Parajika* of Vinaya there are discussions which point towards the concept of euthanasia like 'death would be better than life'. As it is well known compassion is an important Buddhist moral value, and there are sources which reveal an increasing awareness of how a commitment to the alleviation of suffering can create a conflict with the principle of respect for life. It is on the ground of compassion which might lead one to take life in order to erase suffering and is one of the main grounds on which euthanasia is commonly advocated. Here the motive for bringing about the death of the patient is said to have been compassion for the suffering of dying monk. But from the judgment of Buddha this action will be nothing but a kind of wrong action. According to Buddhaghosa the essence of the action's wrong doing was that the guilty monks 'made death their aim' (VA.ii. 464). So from the above analysis be may say that while compassion is always a morally good motive, it does not by itself justify whatever is done in its name. The question of autonomy is also involved with Buddhists teaching. Here

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4. Keown D. *Buddhist ethics*, Oxford University Press, Oxford, 2005, ch. 7

the free choice of the rational individuals comes to the forefront and the right to dispose his or her life arises. There is no doubt that Buddhism would agree with this principle up to a point, since the doctrine of karma advises that individuals have free will and are responsible their actions. But the discussion centered around third *parajika* points that there is some limit on the scope of this freedom. The question arises, whether life must be preserved at any costs? Regarding this point a comment of Buddhaghosa will be helpful.

> If one who is sick ceases to take food with the intention of dying when medicine and nursing care are at hand, he commits a minor offence (dukkata). But in the case of a patient who has suffered a long time with a serious illness the nursing monks may become weary and turn away in despair thinking 'when will we ever cure him of this illness?' Here it is legitimate to decline food and medical care if the patient sees that the monks are worn out and his life cannot be prolonged even with intensive care. (VA.ii.467)

Here the first patient seeks death, while the second simply accepts the inevitability of death and rejects further treatment as pointless. From the above it follows clearly that Buddhism does not believe there is a moral obligation to preserve life at all cost. Death is the most certain event of human life. To prolong life beyond its natural span with help of technology when no cure is visible is a denial of the reality of human mortality. Buddhism will view the above as a kind of delusion (moha) and excessive attachment (trisna).[5]

Samkhya and Yoga systems of Indian philosophy definitely have a common ethical perspective, which is of non-injury (Ahimsa). Samkhya and Yoga view of the fundamental characteristics and role of man in nature with a view to working out the Samkhya and Yoga position regarding the bioethical issues like euthanasia. Samkhya opposes any thinking, feeling and willing related to causing harm to any being, such as, killing a human embryo or fetus at any stage of it's existence in the womb, killing a fellow human being (may be terminally ill) for any reason whatsoever, destroying animals and plants, ravaging the sancity of wild life, consuming surplus

5. Keown,Damien, *Buddhist Ethics A Very Short Introduction,* Oxford University Press, Oxford ,2005, pp-109-112.

resources ect., because such an act would earn sin (adharma or papa) which would be force sinner to migrate to a lower order bio-family. Yoga also opposes any kind of killing, be it by one's own self or by others, not only as an action but also at the thinking and feeling level. That means no one should even think or killing anyone including one's own self, The opposite way the virtue guided action, enables a man to migrate to any family or higher order bio-family and at end to attain liberation. So, Samkhya and Yoga opposes the arguments offered for the moral permissibility of euthanasia.[6]

On the issue of Euthanasia, both Hinduism and Buddhism have unclear and conflicting viewpoints. According to one view, a doctor should not accept a patient's request for euthanasia since this will cause the soul and body to be separated at an unnatural time. The result will damage the *Karma* of the doctor and the patient. While another view is that a doctor would perform a good deed (*Karma*) and fulfill his moral obligation by bringing and end to the pain and suffering of the patient. Thus both Hinduism and Buddhism do not give a clear answer on the issue of Euthanasia. It appears that in some cases euthanasia may be permitted under both these religions.

Amongst the eastern religions, Hinduism and Buddhism have been very influential in understanding the right of a human to bring an end to his life. In Hinduism and Buddhism, human beings are captured in endless cycles of rebirth and reincarnation (Karma-Samara) [7] It is the deeds (Karma) of a human in the present life that determines his or her fate for the next life. The ultimate goal of mortal life is to achieve *moksha* or liberation from the cycle of death and rebirth. In both these religions, acts which lead to destruction of life are condemned only if they are in violation of the principle of Ahimsa (non-violence) and Karma. Destruction of life, in the form of suicide is not absolutely prohibited in both these religions. But there is a significant and growing percentage of Agnostics, Atheists, Humanists, secularists, non-Christians and liberal Christians in North America

6. "BBC-Religion & Ethics- Arguments in favour of Euthanasia", http//www.bbc.co.uk/religion/ethics/euthanasia/infavour print.html, p-5.
7. '*The Hindu: Is euthanasia ethical*?' retrieved from http://www.hindu.com/thehindu/hindu.htm.

who do not accept these theologically based arguments. They might argue: Each person has autonomy over their own life. Persons whose quality of life is nonexistent should have the right to decide to commit suicide, and to seek assistance if necessary. Sometimes a terminal illness is so painful that it causes life to be an unbearable burden; death can represent a relief to the intolerable pain. An active political question is whether individuals should be allowed to choose suicide, or whether they should be forced to follow the theological beliefs of the dominant religion. Jaina ascetics of ancient India are known to consider the practice of starving unto death as meritorious. In Jain community, anyone undertaking the vow of "Santhara" gives up on food when he or she feels his or her life has served its purpose and awaits death. "Santhara" is a religious act, a spiritual act. It is neither a desire to kill oneself, nor to cultch on to life, otherwise, that would be a suicide. 'Santhara' is just a graceful, courageous and peaceful way of confronting the imminent death and about embracing the death through resolve and penance." Santhara or Sallenkhana is a procedure in which a Jain stops eating with the intention of preparing for death. This is different from suicide as it is not taken in passionate mood of anger, deceit or other emotions, but is undertaken only when the body is no more capable of serving its owner as an instrument of spirituality and when inevitability of death is a matter of undisputed certainty. The intention is to purify the body, and remove all though of the physical things from the mind.[8] A terminally ill and 61-year-old, Vimla Devi, died after undertaking santhara for ten days. Practicing Jains say their traditions should not be interfered with. The rituals, they say, are not a modern-day phenomenon. "Why would somebody take the agony of fasting for 30, even 40 days at a stretch? 'Santhara' is just a penance one undertakes when he or she realizes that the body has become defunct anyway. So undertaking it one wish to alienate desires associated with the body. Mahaveer was the last and the most famous. The basic idea behind Jains' fasting is to acquire lowest possible negative Karma and purifies one self in the process. Santhara, in this sense, is the best way to purification. Jain

8. Coward, Harold G. et al, *Hindu Ethics*, Sri Satguru Publication, Delhi, 1991, p-88.

women more often do fasting than men. Fasting also purifies body and mind, and reminds the practitioner of Mahavira's emphasis on renunciation and asceticism, because Mahavira spent a great deal of time fasting. The sole intention is to purify the body, and remove all thought of the physical things from the mind. As well as giving up food and water, the ascetic abandons all desires and dislikes so that they can concentrate exclusively on the spiritual as they approach death. Santhara is different from suicide which is an act of cowardice of a frustrated and emotionally unstable mind. It is also different from mercy killing or euthanasia, Where a terminally patient who is unable to bear pain desires to die.[9] It is also an escapist route. Neither it is like a sati reserved for women who are burnt forcefully on pyre. On the other hand it is considered a more noble action as it requires a very high echelon of thoughts to be able to realize that one is open to death. Death in Jainism is nothing but transition from one experience to another. But it has a profound impact on all our future conditions of life. Here all our unfulfilled desires and ideas condense into an intense feelings and longings drawing us into the new environment and conditions congruent with our feelings. Hence it is equanimity is required at the time of death as it will determine which gati our soul will take. Santhara is always taken in contemplation of death, where one is sure that ones time has come and all other responsibilities are over. This ensures that all attachment to the materialistic life and body itself ceases. It may be noted that universally, law also treats actions done in "contemplation of death" or "causa mortis" as different actions from normal activities. For example gift in contemplation of death which would be ordinarily taxed is not taxed by law. In the same way, Santhara in contemplation of death is different from suicide or euthanasia.[10] The principle behind this is that a person while giving up this body with complete peace of mind, calmness, and patience, without any fear at all not only prevents the influx of the new karmas but also purges the old karmas which are attached to the soul. It is done by a person in complete

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9. Laidlaw, J, Riches& Renunciation: *Religion, Economy & Society among the Jains,* Clarendon Press, Oxford, 1995.
10. Gibson, Susanne*: Encyclopedia* of *Applied Ethics,* Academic Press,

control of oneself. Chandragupta Mauryo, Sane Guruji, Veer Savarkar and Vinoba Bhave are all have died through Sallekhana.

Sikhs derive their ethics largely from the teachings of their scripture, Guru Granth Sahib, and the Sikh Code of Conduct (the Rehat Maryada). The Sikh Gurus rejected suicide (and by extension, euthanasia) as an interference in God's plan. Suffering, they said, was part of the operation of karma, and human beings should not only accept it without complaint but act so as to make the best of the situation that karma has given them. This suggests that the Sikh reaction to situations where people think about euthanasia would be to provide such good care that euthanasia became an unattractive option. It was a mode of death, away of dying, distinguished from murder or suicide. In ancient times 'the freedom to leave' was generally recognized under certain circumstances - the sick or suffering to terminate their lives**.** The early Christians did not take this into consideration and believed that only God had the right to give and take life. Euthanasia has always been viewed as a felonious exercise of a divine prerogative by the Christians. Right from the 5th Century it has been the belief of the Christians that every human owes his existence to a loving being (God) who has graciously brought him or her into this world. Human beings are created in the image of God and thus their life belongs to God. Birth and death are part of the life processes which God has created, so humans should respect them and therefore no human being has the authority to choose the time and manner of his or any other human's death.

The Christians view 'suffering' as something in which humans can rejoice. Their belief is based on two reasons: (a) God used suffering as a means of producing spiritual maturity, (b) the fact that a human endured suffering was proof that humans are children of God. It is the duty of humans to console the suffering but not remove it. Thus, according to the Christian belief one should not abandon the life assigned to him or her but endure it in the hope of resurrection.

In the modern day world, the most vigorous opposition to euthanasia has come from the Roman Catholic Church, with the late Pope John Paul II describing euthanasia as an example of the “culture of death” in western societies.

"Euthanasia is a grave violation of the law of God, since it is the deliberate and morally unacceptable killing of a human person." (Pope John Paul II: Evangelium Vitae, 1995)

The Roman Catholic Church regards euthanasia as morally wrong. The Church has always taught the absolute and unchanging value of the commandment "You shall not kill". The Church regards any law permitting euthanasia as an intrinsically unjust law. According to the Church, life is a thing of value in itself and its value doesn't depend on whether it brings pleasure or pain. Suffering and pain do not stop life from being valuable, and they cannot be a reason for ending life. It has been a long-standing belief of the Roman Catholic Church that human beings do not have a right to die. Human beings are agents/stewards of God and take birth to carry out the work of divine intent on earth. Although human beings are free agents, their freedom does not permit them to end their own lives. The Roman Catholic Church strongly condemns euthanasia and suicide and considers them to be a rejection of God's absolute sovereignty over life and death.

Apart from Christianity, Judaism and Islam are two other monotheistic religions which have had a global influence in regard to issues concerning the end of life. According to the Jewish tradition, preservation of life is of paramount importance. Every moment of human life is precious and it is wrong to shorten the life of an individual. Like Christianity, Judaism also preaches that human beings are created in the image of God and does not consider pain and suffering to be justifiable reasons for an individual to bring an end to his life. But there exists one difference between Christianity and Judaism. According to Jewish tradition, a doctor cannot do anything to hasten death but “if there is anything that prevents a soul from departing”, the doctor can remove it. If that something is an impediment to the

natural process of death and the patient only survives because of it, under the Jewish law, a doctor is permitted to remove that thing. Like Christianity and Judaism, Islam also considers human life to be sacred. According to Islam, life is a gift of Allah and it is for Allah to decide that how long a person should live.

"And no person can ever die except by Allah's leave and at an appointed term."

Islam does not accept any kind of justification for the killing of a person and thus euthanasia and suicide are expressly prohibited in Islam.

There are two instances, however, that could be interpreted as passive assistance in allowing a terminally ill patient to die and would be permissible by Islamic law. The Islamic Code of Medical Ethics, issued by the First International Conference on Islamic Medicine held in Kuwait, in 1981, states: "In his/her defense of life, however, the doctor is well advised to realize his limit and not transgress it. If it is scientifically certain that life cannot be restored, then it is futile to diligently keep the patient in a vegetative state by heroic means or to preserve the patient by deep freezing or other artificial methods. It is the process of life that the doctor aims to maintain and not the process of dying. In any case, the doctor shall not take a positive measure to terminate the Patient's life"." The Islamic Code for Medical and Health Ethics" are devoted to the *Euthanasia and Physician-Assisted Death.* "Human life is sacred, and it should never be wasted except in the cases specified by shari'a and the law.[11]This is a question that lies completely outside the scope of the medical profession. A physician should not take an active part in terminating the life of a patient, even if it is at his or her guardian's request, and even if the reason is severe deformity; a hopeless, incurable disease; or severe, unbearable pain that cannot be alleviated by the usual pain killers. The physician should urge his patient to endure and remind him of the reward of those who tolerate their suffering.

11. The Islamic Code for Medical and Health Ethics In: Islamset site. http://www. Islamset. Com/ions/code 2004/index.html.

This particularly applies to the following cases of what is known as mercy killing: *a.* the deliberate killing of a person who voluntarily asks for his life to be ended; *b.* physician-assisted suicide; and *c*. the deliberate killing of newly born infants with deformities that may or may not threaten their lives. "The following cases are examples of what is not covered by the term "mercy killing": ***a.*** the termination of a treatment when its continuation is confirmed, by the medical committee concerned, to be useless, and this includes artificial respirators, in as much as allowed by existing laws and regulations; ***b***. declining to begin a treatment that is confirmed to be useless; and c. The intensified administration of a strong medication to stop a severe pain, although it is known that this medication might ultimately end the patient's life.[12]

There is another aspect of involuntary euthanasia which is known as Thalaikoothal in southern India. Thalaikoothal is the traditional practice of senicide (killing of the elderly) or involuntary euthanasia, by their own family members, observed in some parts of southern districts of Tamil Nadu state of India. The practice is illegal in India. Mercy killing of terminally-ill elderly persons is a crime in India. In law, it amounts to murder.

But what if there is a social practice by which ill elderly people are put to sleep, with the knowledge of all the family members? Shocking though it may seem, Virudhunagar and other southern districts in Tamil Nadu seem to have had a long-established practice called thalaikoothalby which elderly persons, often bed-ridden and terminally-ill, are given a ceremonial oil bath followed by tender coconut water in the belief that it would induce pneumonia, leading to eventual death. It is not unknown that at times some drugs are also added to hasten death! One such incident was reported recently in Virudhunagar. An 80-year-old man escaped from his house and fled to the house of a relative alleging that his children were planning a thalaikoothal function to kill him as they wanted to grab his property! How should society, State and the law deal with such incidents, especially when the

12. *Euthanasia*, Synod of the Great Lakes, Reformed Church in America, at: http://www.euthanasia.com/

entire family is involved? How do you prevent avaricious family members killing the elderly to grab property in the name of the social practice? Will criminalizing these acts help prevent it? Or will it make it worse, driving the practice underground? 13

Thalaikoothal is condemned as reflecting the callousness and indifference of society. It is said to mirror the selfishness of younger generations waiting to grab property and reveals ungratefulness to the elderly. All societies, at some time or the other, have to contend with the issue of dealing with terminal illness entailing great suffering with no hope of improvement. The problem is particularly acute in populations with a growing elderly population who live longer lives than their predecessors. What is required is a perspective shift from viewing the elderly as a burden to acknowledging their economic and social contribution to society. Care of the aged is a social obligation arising from the fundamental rights of the elderly to life and living; it is not an act of generosity of the State or welfare agencies. If society and the State refuse to acknowledge the inadequacy of current policy perspective and understanding and continues to under-perform in the provision of support to families and elders (as workers, pensioners and patients), then it is not the children who are callous and indifferent, but society and the State itself.

Section-2

T**he current legal position on mercy-killing and assisted suicide in India**

In India, euthanasia is undoubtedly illegal. Since in cases of euthanasia or mercy killing there is an intention on the part of the doctor to kill the patient, such cases would clearly fall under clause first of Section 300 of the Indian Penal Code, 1860. However, as in such cases there is the valid consent of the deceased Exception 5 to the said Section would be attracted and the doctor or mercy killer would be punishable under Section 304 for culpable homicide not amounting to murder. But it is only cases of voluntary euthanasia that would attract Exception 5 to Section 300. There is always prevailing the rival

13. Decan Chronicle, 15th June, 2010.

claims of the society and the individual and the question lies that which claim should prevail. Mostly in the cases of health concerns, the claims of the society prevail over the individual claim. But it has to be kept in mind while deciding that which side should the balance bend that how will this decision affect the society and the individual. In most of the health concerns, the whole society in gets affected, but here individual himself and affect family are getting more influenced by such a decision. Individual liberty is the hallmark of any free society. Thus, we should here consider the rights which accrue to the individual in such cases.

In India, euthanasia is absolutely illegal. If a doctor tries to kill a patient, the case will surely fall under Section 300 of Indian Penal Code, 1860. but this is only so in the case of voluntary euthanasia in which such cases will fall under the exception 5 to section 300 of Indian Penal Code,1860 and thus the doctor will be held liable under Section 304 of Indian Penal Code,1860 for culpable homicide not amounting to murder. Cases of non-voluntary and involuntary euthanasia would be struck by proviso one to Section 92 of the IPC and thus be rendered illegal. There has also been a confusion regarding the difference between suicide and euthanasia. It has been clearly differentiated in the case Naresh Marotrao Sakhre v. Union of India.[14] J. Lodha clearly said in this case. “Suicide by its very nature is an act of self-killing or self-destruction, an act of terminating one’s own act and without the aid or assistance of any other human agency. Euthanasia or mercy killing on the other hand means and implies the intervention of other human agency to end the life. Mercy killing thus is not suicide and an attempt at mercy killing is not covered by the provisions of Section 309. The two concepts are both factually and legally distinct. Euthanasia or mercy killing is nothing but homicide whatever the circumstances in which it is effected.” The question whether Article 21 includes right to die or not first came into consideration in the case State of Maharashtra v. Maruti Shripathi Dubal. It was held in this case by the Bombay High Court that ‘right to life’ also includes ‘right to die’ and Section 309 was

14. *‘The constitutional and legal provisions in Indian law for limiting life support Balakrishnan S, Mani RK’* retrieved from http://pagead2.googlesyndication.com

struck down. The court clearly said in this case that right to die is not unnatural; it is just uncommon and abnormal. Also the court mentioned about many instances in which a person may want to end his life. This was upheld by the Supreme Court in the case P. Rathinam v. Union of India. However in the case Gian Kaur v. State of Punjab1 it was held by the five judge bench of the Supreme Court that the "right to life" guaranteed by Article 21 of the Constitution does not include the "right to die". The court clearly mentioned in this case that Article 21 only guarantees right to life and personal liberty and in no case can the right to die be included in it. The Courts in India have time and again been grappled by the issue of permitting a person to die or not. The first case in which such an issue was brought before an Indian Court is *State v Sanjay Kumar*. In this case, a division bench of the High Court of Delhi criticized section 309 of the Indian Penal Code, 1860 as 'an anachronism and a paradox". This decision was followed by conflicting decisions of two High Courts. The Bombay High Court in *Maruti S. Dubal v State of Maharshtra* struck down section 309 as violative of right to life enshrined in Article 21 of the Constitution of India. Whereas the Andhra Pradesh High Court in *Chhena Jagadesswer v State of Andhra Prades* 15 held Section 309 as constitutionally valid. Pursuant to these judgments, the High Court of Delhi in the case of *Court of its own motion v Yogesh Sharma* took a radical step while interpreting the constitutionality of section 309. The Court provided the strongest ideological offensive against the outmoded offence and ordered that all the pending 119 attempted suicide cases in Delhi be quashed. The issue of whether the 'right to life' includes a 'right to die' came before the Supreme Court of India for the first time in the case of *P. Rathinam v Union of India*. The Supreme Court while arriving at a conclusion that Section 309 of the Indian Penal Code is outdated, irrational and cruel placed heavy reliance on the Forty Second Report of the Law Commission of India. During the early seventies, the Law Commission of India had recommended the deletion of the offence of attempt commit suicide from the Indian Penal Code, 1860. In *Rathinam's case*, the Supreme Court formulated

15. From (1996) 2SCC 648.

fifteen questions, one of which specifically stated: “Has a person residing in India a right to die?” While answering this question, the Court observed, “if a person has a right to live; question; whether he has a right not to live?” After making a deep and broad probe into morality, ethics, legality, and comparative study of the nations, the Apex Court ruled that Section 309 is violative of Article 21 of the Constitution of India and went on to observe, “The desire for communion with God may very rightly lead even a very healthy mind to think that he would forego his right to live and would rather choose not to live. In any case, a person cannot be forced to enjoy right to life to his detriment, disadvantage or dislike.” The Supreme Court dealt with the question of right to die once again in the case of *Smt. Gian Kaur v State of Punjab*. In this case, the Supreme Court held that right to die is not included in right to life. Having said this, the Supreme Court questioned, “that in the context of a dying man who is terminally ill or in a persistent vegetative state can he be permitted to terminate it by a premature extinction of his life in those circumstances.” The Court answered, “this category of cases may fall within the ambit of “right to die” with dignity, when death due to termination of natural life is certain and imminent and the process of natural death had commenced. These are not cases of extinguishing life but only of accelerating conclusion of the process of natural death, which has already commenced. The controversy even in such cases to permit physician-assisted termination of life is inconclusive. It is sufficient to reiterate that the argument to the period of suffering during the process of certain natural death is not available to interpret Article 21 to include therein the right to curtail the natural span of life.” In another case, *C.A. Thomas Master v Union of India*, the High Court of Kerala dealt with euthanasia. In this case, the Court entertained a writ petition filed by a citizen wherein he wanted the government to setup "Mahaprasthana Kendra" (Voluntary Death Clinic) for the purpose of facilitating voluntary death and donation/transplantation of bodily organs. The petitioner in this case was fit and

wanted to terminate his life because he wanted to die in happy state of affairs. The High Court dismissed his writ petition and placed heavy reliance on the judgment given in *Gian Kaur's case*.

Regarding the voluntary euthanasia in India let us discuss the attitudes of doctors. This has not been analyzed on a significant scale involving a large cross section of the profession. Extracts from a sample survey of 200 doctors carried out by the Society for the Right to Die with Dignity in Bombay, do offer some indications:

* 90% stated they had the topic in mind and were concerned.

* 78% argued that patients should have the right to choose in case of terminal illness.

* 74% believed that artificial life supports should not be extended when death is imminent; but only 65% stated that they would withdraw life supports.

* 41% argued that Living Will should be respected. 31% had reservations.

* Considerations involved ethics, morality, law and religion in that order of importance.

* More than 70% were apprehensive of the abuse of the law if one was enacted to legalize voluntary euthanasia.

Here we are presenting two resent cases of voluntary euthanasia in India Venkatesh, a 25-year-old muscular dystrophia patient, wanted to be granted the right to die. He sought to enforce the right so that he could donate organs before they were affected by his illness. The plea was rejected a day before his death by the Andhra Pradesh high court. The court ruled that the petition sought to violate the Transplantation of Human Organs Act, 1995, which had no provisions that allowed individuals to donate organs before they were brain dead. The court's caution in this case is understandable considering the implications of easing restrictions in organ transplant. However, the order indirectly reiterated the stated legal position that an individual had no right to end his life voluntarily. Our Constitution guarantees the right to life. The right to life is incomplete without the right to death. The

karma of life is a wheel that is completed only when birth is complemented by death. The right to die is built into the right to live. The state has every obligation to legally ensure the protection of life; protection in this case limited to prevention of homicide. However, the Indian state has expanded its territory to be the arbiter even in cases of suicide and euthanasia. Section 309 of the Indian Penal Code holds suicide a criminal act while euthanasia or mercy killing has been left open for debate. In December 2004 a two-judge bench of the Andhra Pradesh High Court dismissed the writ petition, Venkatesh, who sought permission to donate his organs in a non-heart beating condition. In his petition, Venkatesh had expressed his wish to be put off the life support system, which he had been on for a couple of months, so that he could donate his organs. It was argued that Venkatesh's organs would deteriorate if he were not allowed to commit euthanasia. The High Court dismissed the writ petition, in view of the Supreme Court judgment in *Smt. Gian Kaur v State of Punjab***.** The periodic filing of such petitions by permanently ailing citizens and their subsequent dismissals has fostered the debate on legalization of euthanasia in India. Venkatesh's story might have ended but it has brought to life the sensitive issue of euthanasia. While Netherlands and Belgium have defined this grey territory by making it legal, in India the grey zone is the law. Section 309 of the IPC says that attempted suicide is a criminal offense, but keeps mum on euthanasia. The irony is that it is the fear of misusing the law which is holding back experts from legalizing it. It is a conflict between the humane, the ethical and the legal.

Aruna Ramachandra Shanbaug a nurse who has been lying unconscious in a vegetative state for the last 37 years at King Edward Memorial Hospital, Parel, Mumbai. In 1973 she was attacked by a sweeper in the hospital who wrapped a dog chain around her neck and yanked her back with it. It is alleged that due to strangulation by the dog chain the supply of oxygen to the brain stopped and the brain got damaged. The Neurologist in the Hospital found that she had planters' extensor, which

indicated damage to the cortex or some other part of the brain. She also had brain stem contusion injury with associated cervical cord injury. 36 years had expired since the incident and Aruna Ramachandra Shanbaug was about 61 years of age. It was alleged that Aruna Ramachandra Shanbaug was in a persistent vegetative state (PVS) and virtually a dead person and had no state of awareness, and her brain was virtually dead. It was alleged that there is not the slightest possibility of any improvement in her condition and her body lies on the bed in the KEM Hospital, Mumbai like a dead animal, and this has been the position for the last 36 years. The prayer of the petitioner was that the respondents be directed to stop feeding Aruna, and let her die peacefully.16 Whilst the Supreme Court had held earlier that there was no right to die (suicide) under Article 21 of the Constitution and attempt to suicide was a crime vide Section 309 IPC, the Court had held that the right to life include the right to live with human dignity, and in the case of a dying person who was terminally ill or in a permanent vegetative state he may be permitted to terminate it by a premature extinction of his life in the circumstances and it was not a crime. The general legal position all over the world seem to be that while active euthanasia is illegal unless there is legislation permitting it, passive euthanasia is legal even without legislation provided certain conditions and safeguards are maintained. In India, if a person consciously and voluntarily refuses to take life saving medical treatment it is not a crime. Culminating the discussion the Supreme Court held that the law is now fairly well settled that in the case of incompetent patients, if the doctors act on the basis of informed medical opinion, and withdraw the artificial life support system if it is in the patient's best interest, the said act cannot be regarded as a crime.

The question remained as to who is to decide what is the patient's best interest where he is in a persistent vegetative state (PVS)? Most decisions have held that the decision of the parents, spouse, or other close relative, should carry weight if it is an informed one, but it is not decisive.

16. From BBC News dated-17 Dec. 2009.

It is ultimately for the Court to decide, as parents patria as to what is in the best interest of the patient, though the wishes of close relatives and next friend, and opinion of medical practitioners should be given due weight in coming to its decision. In India abetment of suicide (Section 306 Indian Penal Code) and attempt to suicide (Section 309 of Indian Penal Code) are both criminal offences. This is in contrast to many countries such as USA where attempt to suicide is not a crime. The Supreme Court recommended to Parliament to consider the feasibility of deleting Section 309 from the Indian Penal Code.

According to the petitioner, in the last 37 years after the incident, Aruna has become "featherweight" and her bones are brittle. She is prone to bed sores. It was alleged in the writ petition filed by Ms. Pinky Virani (claiming to be the next friend of Aruna Shanbaug) that in fact Aruna Shanbaug was already dead. The question to be decided was as to when a person could be said to be dead? After considering the report of Committee of doctors, the Supreme Court held that Aruna had some brain activity. She also recognized that persons are around her and expressed her like or dislike by making some vocal sound and waving her hand by certain movements. Aruna Shanbaug met most of the criteria for being in a permanent vegetative state. From the examination by the team of doctors, it could not be said that Aruna Shanbaug was dead. The next question was whether her life support system should be withdrawn, and at whose instance? The Supreme Court observed that there is no statutory provision as to the legal procedure for withdrawing life support to a person in PVS or who is otherwise incompetent to take a decision in this connection. It held that passive euthanasia should be permitted in certain situations. The Supreme Court laid down the following law until Parliament made a law on the subject:

i. A decision had to be taken to discontinue life support either by the parents or the spouse or other close relatives, or in the absence of any of them, such a decision could be taken even by a person

or a body of persons acting as a next friend. It could also be taken by the doctors attending the patient. However, the decision should be taken bona fide in the best interest of the patient. In the present case, the Supreme Court held that KEM hospital staffs were really Aruna's next friend and it was for the KEM staff to take a decision and the KEM staff had clearly expressed their wish that Aruna Shanbaug should be allowed to live.

ii. Hence, even if a decision was taken by the near relatives or doctors or next friend to withdraw life support, such a decision requires approval from the High Court concerned. In the opinion of the Supreme Court, while giving great weight to the wishes of the parents, spouse, or other close relatives or next friend of the incompetent patient and also giving due weight to the opinion of the attending doctors, the approval of the High Court should be taken. This would also be in consonance with the doctrine of *parens patriae.* The Supreme Court observed that Article 226 gave abundant power to the High Court to pass suitable orders on the application filed by the near relatives or next friend or the doctors/hospital staff praying for permission to withdraw the life support to an incompetent person of the kind above mentioned.

When such an application is filed the Chief Justice of the High Court should forthwith constitute a Bench of at least two Judges who should decide to grant approval or not. Before doing so the Bench should seek the opinion of a committee of three reputed doctors to be nominated by the Bench after consulting such medical authorities/medical practitioners as it may deem fit. Preferably one of the three doctors should be a neurologist; one should be a psychiatrist, and the third a physician. The committee of three doctors nominated by the Bench should carefully examine the patient and also consult the record of the patient as well as taking the views of the hospital staff and submit its report to the High Court Bench. Simultaneously with appointing the committee of doctors, the High Court Bench should also issue notice to the State and close relatives e.g. parents, spouse, brothers/sisters etc. of the

patient, and in their absence his/her next friend, and supply a copy of the report of the doctor's committee to them as soon as it is available. After hearing them, the High Court bench should give its verdict. The above procedure should be followed all over India until Parliament makes legislation on this subject. The views of the near relatives and committee of doctors should be given due weight by the High Court before pronouncing a final verdict which should not be summary in nature. With these observations, the petition was dismissed.

In a keenly-awaited verdict, the Supreme Court, 7th march 2011, dismissed a plea for mercy killing on behalf of a 60-year-old nurse, living in a vegetative state for the last 37 years in a Mumbai hospital after a brutal sexual assault, while holding that "passive euthanasia" can be permissible in exceptional circumstances. Active euthanasia (mercy killing) is illegal, yet "passive euthanasia" can be permissible in exceptional circumstances, a bench of justices Markandey Katju and Gyan Sudha Mishra said dismissing the plea filed on behalf of KEM hospital nurse Aruna amachandra Shanbaug. The apex court said that as per the facts and circumstances of the case, medical evidence and other material suggest that Aruna need not be subjected to euthanasia. The bench, however, said since there is no law presently in the country on euthanasia, mercy killing of terminally-ill patient "under passive euthanasia doctrine can be resorted to in exceptional cases." The Bench in its order said "Euthanasia is one of the most perplexing issues which the courts and legislature all over the world are facing today. This court, in this case, is facing the same issue, and we feel like a ship in an uncharted sea, seeking some guidance by the light thrown by the legislation and judicial precedents of foreign countries."[17] The bench clarified that until Parliament enacts a law, its judgment on active and passive euthanasia will be in force. However, the guidelines with regard to passive euthanasia were not immediately available.

The last decade has seen the articulation of the pros and cons of euthanasia. With the growth of scientific knowledge, the traditional moral views of the society have changed and there has been a

17. *The Hindu* , New Delhi 25th Jan. , 2011.

steady decline in the importance of theology in shaping social views on euthanasia. Euthanasia has become an immensely debatable issue in many countries as there has been a steady increase in the number of persons seeking permission to commit it. Consequently, nations around the globe are considering the revision of their laws on end of life choices. In these circumstances, it will only be in the fitness of things that the Indian Parliament also reconsiders the end of life choices available to the Indian citizens. From a religious standpoint, legalization of euthanasia might not appear to be a very welcome act. Almost all the major religious traditions of India begin with a strong predisposition towards preservation of human life. It is a common belief across all religious traditions that human life is precious and its existence should be preserved. However, the right of self-determination and the principle of dignity of a human being also find their roots in religion. Therefore, need of the hour is strike a balance between these principles.[18]

On a candid note, the concept of voluntary euthanasia does not appear to be a degrading concept. If permitted, the practice of voluntary euthanasia can bring an end to the pain and agony which a vast number of people are suffering from in our country. In cases where a person is suffering from an incurable disease and is in a hopeless condition, voluntary euthanasia should be allowed.

The arguments of the opponents of euthanasia are largely based on the fear of the misuse of the practice. Adequate safeguards can be put in place in order to check any misuse of the practice of euthanasia. It is proposed that voluntary euthanasia may be permitted if the following conditions are satisfied:-

- The person seeking euthanasia should be suffering from a terminally ill disease.
- He/she should be an adult of sound mind and capable of making a rational decision based on informed consent.

18.Robert D. Lane and Richard Dunstan, *Euthanasia: the debate continues*, August 1995, Institute of Practical Philosophy, Malaspina University-College.

- In case of a patient who is suffering from terminally ill disease, the request should be made by a minimum of three relatives of the person. Any person who makes such request should be well-informed about the condition of the person on whom euthanasia is to be practiced.
- The request should be made in writing and should be approved by an examination board consisting of three senior doctors, the local sub-divisional magistrate and the station house officer of the police station within whose local jurisdiction, the hospital is situate.

The government should set out appropriate guidelines to be followed by the examination board in case an application for euthanasia is made. Once such a system is put in place, it will help in bringing an end to the pain and agony of many who are suffering form incurable diseases in our country. It will also allow the use of medical facilities and equipment by other citizens who may be in need of such facilities in a developing country like ours.

"It would be appropriate to conclude with a quote from the judgment delivered by European Court on Human Rights at Strasbourg in the case of *Diane Pretty v The United Kingdom:*

The very essence of the Convention is respect for human dignity and human freedom. Without in any way negating the principle of sanctity of life protected under the Convention, the Court considers that it is under Article 8 that notions of the quality of life take on significance. In an era of

growing medical sophistication combined with longer life expectancies, many people are concerned that they should not be forced to linger on in old age or in states of advanced physical or mental decrepitude which conflict with strongly held ideas of self and personal identity."

In a country like ours, the religious aspects also have to be considered before taking such decisions. The Bible says, "Thou shalt not kill" And even Islam does not allow anyone to take away life. Is our society mature enough to understand the implications of this? We have cases, where doctors are often beaten up if the patient was not treated properly, what would happen to a doctor if he merely suggested Euthanasia to the relatives? Will the relatives be able to understand the suffering of the patient?

We can feel in this way that life is a gift, and even a life of pain is a life at least. Some people feel we don't choose when to be born and we should not be given the right to choose when to die. On the contrary, others feel that a life of pain is not a life but an imposition and we should be at least allowed to end it in a dignified peaceful manner. Euthanasia could be legalized, but the laws would have to be very stringent. Every case will have to be carefully monitored taking into consideration the point of views of the patient, the relatives and the doctors. But whether Indian society is mature enough to face this, after all it's a matter of life and death, is yet to be seen.

In the end, we also would do well to remember the following words of Mahatma Gandhi: Death is our friend, the truest of friends. He delivers us from agony. I do not want to die of a creeping paralysis of my faculties — a defeated man.

It is time we accept euthanasia in a restricted sense. If a person is leading a life of misery with no hopes of recovery, a medical and social enquiry should be allowed. But legislators should make it foolproof as there is a great risk of bogus certificates being issued. Actually legalization of euthanasia should depend on the cultural, social, economic and religious framework and beliefs of a country or a society. If euthanasia is to be legalized it should be done after taking all necessary measures and safeguards to prevent its abuse.

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

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1. Dubler Nancy and Nimmons David, "*Ethics On Call"* Crown Publishing, 1992, p.l67.

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 requiements 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. In sofar 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

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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

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4. ‘Crisis magazine’, Feb. 1992.
5. "'Dr. Death' aids cancer patient with her suicide," qoated 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

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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

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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,

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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

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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 Australians 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]

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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.

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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

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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:

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21. Thiroux .P. Jacques, *Ethics, Theory and Practice*, Macmillan Publishing Company, New York, Collier Macmillan Publisher London, 1986, p -182.

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 ----------

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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, aritificial 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

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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 respiration by machine when my brain can no longer 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 transplants 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 ----------

23. Ibid. *Ethics- Theory and Practice*, pp -184-186.

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 is 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-sortening 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).

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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 nonvountary;
2. Provision for active euthanasia at the request of the patient, including the proviso 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 from of the Living Will was developed by the Euthanasia Education Council, a nonprofit organization in New York City. This will asks that no artificial

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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 antieuthanasia 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

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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-malficence 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.

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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

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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

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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 examing 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 from, is that the court has no jurisdiction to decide this. It’s for parliament and the legislature to take a call after a through 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 Causs, 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 rest 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 month, 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

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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 from 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 in definitely 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 of 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.

CONCLUSION

The concluding remarks of the history of euthanasia remain still to be discussed. It is undeniably true that many issues surrounding death, dying, terminally illness deserve more debate. As one distinguished writer comments “death still needs to be demythologized”. We are always hesitant to face death and there is a constant fear which works unconsciously behind our every activity. So, educating the public on these dimensions can reduce the persistent fears many feel, when their own deaths or the deaths of others are imminent. This fear, which wants to be muted by the consolations of religious belief, is what primarily drives the demand for euthanasia. The history of euthanasia in the twenty-first century hinges on whether the nations of the world can conquer these fears and take the right steps to ensure that in future one may face the death with dignity. Death equalizes everyone. Thus how society defines what is and is not a good death potentially affects every human being. It is the ultimate question that lies at the heart of the evolving history of euthanasia.

Human life is the basis of all goods, and is the necessary source and condition of every human activity and of all society. Most people regard life as something sacred and hold that no one may dispose of it at will, but theists see in life something greater, namely a gift of God’s love, which they are called upon to preserve and make fruitful.

Ever since the time of Hippocrates in the fifth century BC, medical profession has been guided by the concept of the worth of each individual’s life. This was reaffirmed by the Geneva code in 1948, which states, “*I will show the utmost respect for human life from the time of conception.*” Hitler had a utilitarian philosophy of life. He preserved any person who had utilitarian value. The others he eliminated. If we think that life is gift of God, it should be cherished, supported and cared. Thus, we need to respect the unique and intrinsic value of human life for which we need to consider some practical steps in euthanasia.

- Doctors need to serve and care for their patients in love.
- Deliberate attempt to end or shorten life, whether by omission or commission, is wrong and should not be done.
- Our society need to proclaim the way of righteousness and truth and provide compassionate care. It must take a stand against taking innocent lives.
- Medical personnel and the people at large must be educated in moral and spiritual values. These should lead to sound legislation.
- Bring in the principle of love as the mainspring.

There is an intense opposition from the religious groups and people from the legal and medical profession. According to them it's not granting 'right to die' rather it should be called 'right to kill'. According to them it is totally against the medical ethics. Medical ethics call for nursing, care giving and healing and not ending the life of the patient. In the present time, medical science is advancing at a great pace. Thus even the most incurable diseases are becoming curable today. Thus instead of encouraging a patient to end his life, the medical practitioners should encourage the patients to lead their painful life with strength which should be moral as well as physical. The decision to ask for euthanasia is not made solely by the patient. Even the relatives of the patient play an important role in doing that. Thus, it is probable that the patient comes under pressure and takes such a drastic step of ending his life. Of course in such cases the pressure is not physical, it is rather moral and psychological which proves to be much stronger. Also added to that is the economical pressure. The patient starts feeling him to be a burden on the relatives when they take such a decision for him and finally he also succumbs to it. As suicide is not allowed then euthanasia should also not be allowed. A person commits suicide when he goes into a stage of depression and has no hope from the life. Another argument of the opponents is regarding the slippery slope. According to this argument, if voluntary euthanasia will be allowed, then surely it will lead to

consequently allowing involuntary and non-voluntary euthanasia also. If this is not done then surely it will lead to its abuse.

We have known that euthanasia means killing a person rather ending the life a person who is suffering from some terminal illness which is making his life painful as well as miserable or in other words ending a life which is not worth living. But the problem lies that how should one decide whether the life is anymore worth living or not. Thus, the term euthanasia is rather too ambiguous. This has been a topic for debate since a long time i.e. whether euthanasia should be allowed or not. In the present time, the debate is mainly regarding active euthanasia rather than passive euthanasia. The dispute is regarding the conflicts of interests: the interest of the society and that of the individual. Which out of these should prevail over the other? According to the supporters of euthanasia the decision of the patients should be accepted. If on the other hand we weigh the social values with the individual interest then we will clearly see that here the interest of the individual will outweigh the interest of the society. The society aims at interest of the individuals rather it is made with the purpose of assuring a dignified and a peaceful life to all. Now if the individual who is under unbearable pain is not able to decide for himself then it surely will hamper his interest. In that case it will surely be a negation of his dignity and human rights. Regarding this debate from legal point of view, Article 21 clearly provides for living with dignity. A person has a right to live a life with at least minimum dignity and if that standard is falling below that minimum level then a person should be given a right to end his life. It is also point out to the fact that as passive euthanasia has been allowed, similarly active euthanasia must also be allowed. A patient will wish to end his or her life only in cases of excessive agony and would prefer to die a painless death rather than living a miserable life with that agony and suffering.

Thus, from a moral point of view it will be better to allow the patient die painlessly when in any case he or she knows that he or she is going to die because of that terminal illness. So the question arises why to let increase that period of pain for him when in any case he is going to die. It is very important point on which, that a lot of medical facilities which amount a lot are being spent on these patients which are in any case going to die. Rather than spending those on such patients, it will be much better to use such facilities for those who have even fair chances of recovery. Thus, again the question lies that whom do we want to save using these medical facilities; those who are in any case going to die today or tomorrow or those who have fair chances of recovery. A point which is often raised against the supporters of euthanasia is that if such right will be granted to the terminally patients then there will be chances of abuse of it. Everyone should agree with this view that every right involves a risk of being abused but that doesn't mean that the right itself should be denied to the people. We should rather look at the brighter side of it than thinking of it being abused.

Today it is very important to protect, at the moment of death, both the dignity of the human person and most of them religious concept of life, against a technological attitude that threatens to become an abuse. Thus, some people speak of a "right to die", which is an expression that does not mean the right to procure death either by one's own hand or by means of someone else, as one pleases, but rather the right to die peacefully with human dignity. From this point of view, the use of therapeutic means can sometimes pose problems. In numerous cases, the complexity of the situation can be such as to cause doubts about the way ethical principles should be applied. In the final analysis, it pertains to the conscience either of the sick person, or of those qualified to speak for the sick person , or of the doctors, to decide, in the light of moral obligations and of the various aspects of the case. Everyone has the duty to care for his or her own health or to seek such care from others. Those whose

task it is to care for the sick must do so conscientiously and administer the remedies that seem necessary or useful.

However, is it necessary in all circumstances to have recourse to all possible remedies? In the past, moralists replied that one is never obliged to use “extraordinary” means. This reply, which as a principle still holds good, is perhaps less clear today, by reason of the imprecision of the term and the rapid progress made in the treatment of sickness. Thus some people prefer to speak of “proportionate” and “disproportionate” means. In any case, it will be possible to make a correct judgment as to the means by studying the type of treatment to be used, its degree of complexity or risk, its cost and the possibilities of using it, and comparing these elements with the result that can be expected, taking into account the state of the sick person and his or her physical and moral resources.

In order to facilitate the application of these general principles, the following clarifications can be added:

If there are no other sufficient remedies, it is permitted, with the patient’s consent, to have recourse to the means provided by the most advanced medical techniques, even if these means are still at the experimental stage and are not without a certain risk. By accepting them, the patient can even show generosity in the service of humanity.

It is also permitted, with the patient’s consent, to interrupt these means, where the results fall short of expectations. But for such a decision to be made, account will have to be taken of the reasonable wishes of the patient and the patient’s family, as also of the advice of the doctors who are especially competent in the matter. The latter may in particular judge that the investment in instruments and personnel is disproportionate to the results foreseen; they may also judge that the techniques applied impose on the patient strain or suffering out of proportion with the benefits which he or she may gain from such techniques.

It is also permissible to make do with the normal means that medicine can offer. Therefore one cannot impose on anyone the obligation to have recourse to technique which is already in use but which carries a risk or is burdensome. Such a refusal is not the equivalent of suicide; on the contrary, it should be considered as an acceptance of the human condition, or a wish to avoid the application of a medical procedure disproportionate to the results that can be expected, or a desire not to impose excessive expense on the family or the community.

When inevitable death is imminent in spite of the means used, it is permitted in conscience to take the decision to refuse forms of treatment that would only secure a precarious and burdensome prolongation of life, so long as the normal care due to the sick person in similar cases is not interrupted. In such circumstances the doctor has no reason to reproach himself with failing to help the person in danger.

Views, ideas, even concepts of ethics are fast changing in the context or 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 neighbour as ourselves, are the two foundations for our ethical and religious practice. Only a code of ethics based on sound principles can lead our society to lasting happiness, harmony and peace. The fact that, in India, even an attempt to suicide is punishable goes to show the extent of creditability accorded to the sanctity of life and the right to life as a whole. This apart, the decriminalization of euthanasia is unworkable in the Indian perspective, even on humanitarian grounds, as it involves a third person. No life that breathes with human breath has ever truly longed for death. One thing is clear that euthanasia or assisted suicide

controversy is likely to be a significant source of communal disagreement and political argument for many years to come.

In spite of all this dilemmas, in this age of fast and complex living there are some cases where we are pressurized to support mercy killing without considering its moral implications. It seems that time has come when we should consider the cases of Living Will which will help us to guide our life to run smoothly. As it is well known, Living Will is a kind of document which may help one to get the right direction in time of crisis. Here we may mention the case of the famous car racer Michael Schumacher. He is a seven-time Formula One World Champion and is widely regarded as one of the greatest F1 drivers of all time. Last six months, he was in a coma. Schumacher is now communicating via fluttering his eyelids, indicating signs of recovery. Doctors are also hopeful that he'll be able to sit in an advanced wheelchair that he can operate by using his mouth. His spokeswoman confirmed on June 16, 2014, she states that he will continue his long phase of rehabilitation, away from the public eye.

Here one may argue against mercy killing that it is possible to revert back from the coma state. As it happens in the case of Michael Schumacher. The media reported that Michael Schumacher is back from his coma state. But the question here arises whether mere blinking of eyes is worth for a good living or not. Quite related to vegetative state what is the satisfaction of living without being active? This is the question that haunts us even in this 21st century when technology attains its highest peak.

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