ETHICAL ISSUES ABOUT VOLUNTARY EUTHANASIA

JYOTISH CHANDRA BASAK

Euthanasia is a highly emotive and contentious issue, giving rise to a great deal of debate. In spite of its frequent discussion in public and professional media, there appears to be a lack of clarity about the concepts and definitions used in the debate. The ethical focus of the euthanasia debate concerns the moral legitimacy of voluntary euthanasia.

An effort to trace the origin of the controversy takes us back to Greek period. In ancient Greece we find Pythagoras, Plato and Aristotle are engaged in discussing the issue. Right from that time till presently thinkers devote considerable time in discussing this vexing issue. The rapid advancement of medical science along with the advent of sophisticated technology has made the issue more complicated.

The term 'euthanasia' refers to a manner of dying and particularly means a way of easy and good death. The term used in the sense at present time and the term as was used in the past, mainly in ancient Greece, varies in scope as the later was broader than the present one. The modern discussions restrict the concept to discussions of mercifully ending the life of a hopelessly suffering or defective patient. But the Greeks sometimes employed the term to describe the spiritual state of the dying person at the impending approach of death. There the meaning of the term was not anchored in medical context alone, though some of these contexts were also covered by it.

For the Greeks euthanasia did not necessarily imply a means or method of causing or hastening death. However, when quick-acing and relatively painless drugs such as hemlock were developed by the Greeks in the fifth century B. C., which allowed the individual to quit life in an efficient and bloodless manner, the linguistic result was that these forms of suicide were sometimes described as instances of euthanasia. But, even then, this ascription primarily involved a favourable appraisal of the subject's state of mind, not the means by which death came. Hence, on the whole, there were no rigidly followed rules which fixed the application of the term euthanasia to contexts involving terminal illness or suicide alone, even though these situations could be properly referred to in selected cases.

Thus it becomes evident that the term 'euthanasia' enjoyed in ancient Greece a broader scope in comparison to the narrower contemporary English usage of the term. Voluntary euthanasia is characteristically defined to mean that with the *prior consent of the patient*, either the doctor or someone else may bring about a relatively quick and painless death to one who is judged on medical grounds to be the victim of an untreatable, painful terminal illness or disability. This definition captures two allied meanings which wed to its older Greek ancestor:

1. Voluntary euthanasia normally connotes a genuine human concern for the *psychological state of mind* of the suffering patient for whom life has apparently become an intolerable burden; and

2. It crucially links the *moral appraisal* of the conduct of the patient and those supplying his medical services to the precondition that *the patient is free to make a reasoned decision* regarding the option to hasten or not to hasten his own death.

It should be borne in mind that Greek did not admit in voluntary euthanasia as part of their general concept of euthanasia at all. If someone's life was terminated without his consent, normally this was *prima facie* a case of homicide. Such cases did not qualify as euthanasia principally because for adults, at least, it was popularly held that those who involuntarily died at the hands of others did not die well. Typically, they were not thought to have experienced good deaths.

An obvious exception to all this was infanticide. In Hellenistic culture the victim of infanticide was treated in a peculiar way - it claimed that the infant was not really a human being until he was first fed. Since infants were usually killed before they were fed, popular moral condemnation did not normally attach to this deed. As for those infants who were fed, though they were later involuntarily killed as an act of mercy or prudence owing to their chronic and painful ill-health, their deaths were customarily deemed tragic and pitiable. Such deaths were not well considered good or easy deaths either for the victims or for the parents. Therefore, infanticide, which by its very nature involuntary since the infant lacks the verbal skills by which to give or withhold consent, was not customarily included in the Greek concept of euthanasia.

While talking about voluntary euthanasia, the current tendency is to freight the concept heavily with its moral, appraising sense. But in so doing, we miss the dominant ancient connotation of this term which *primarily* involved a psychological appraisal, and only secondarily a moral one. In order to illustrate the subtle difference let us put the two questions on after another.

- Pivotal ancient question regarding euthanasia: Did the subject voluntarily meet death with peace of mind and minimal pain?
- The looming contemporary question involving euthanasia is: Is euthanasia under any conditions morally justifiable?

If we juxtapose above two questions, it becomes evident that Greek thinkers put premium on psychological appraisal of the apparent stage of the subject's mind during his final conscious days and hours; whereas the contemporary thinkers emphasized on moral issues. However, there are no reasons to think that Greeks were oblivious to the moral challenge that voluntary euthanasia posed. They did not ignore the task of trying to furnish a coherent ethical defence of the practice. It is doubtless true that a psychological appraisal is not readily separable from the allied moral appraisal of whether the subject evinced sound thinking, on moral or other grounds, for choosing to withdraw from life. Hence the Greek thinking of euthanasia was indeed capable of bearing two senses, both psychological and moral, and in everyday discourse these two senses were mingled together.

What we now call voluntary euthanasia was construed by the Greeks and Romans as one possible type of suicide. The phrase bears a definite family resemblance to the Latin expression for suicide, *mors voluntaria*, which also stressed the voluntary nature of such dying. English word 'suicide', which literally means self-killing, lays stress on the peculiar fact that oneself is the object of one's killing. Greek and Roman expressions for suicide tended to emphasize suicide as a mode of death. Margolis has

argued that, given the culturally variable character of the ascription of suicide, there can be no truly value-neutral concept of suicide.[1]

Among the various divisions of euthanasia done on the basis of different principles voluntary euthanasia is only one. It (Voluntary euthanasia) means, as we have already seen, with the prior consent of the patient, either the patient or someone else may bring about a relatively quick and painless death to one who is judged on medical grounds to be victim of an untreatable, painful terminal illness or disability. Pythagorean opposed euthanasia on the basis of a moral principle which was predominantly religious. The religious principle was that it was a direct violation of an individual's higher duty to God to behave in such a way as to prematurely end his or another's life. The entire argument presupposes the crucial premises that:

- God exists.
- Man's highest moral duty is always to obey the commands of God.
- One of these divine commands unconditionally bars the individual from taking early leave from his embodied, earthly existence.

In *Republic* we find Plato supporting voluntary euthanasia for adults. He supported it in case of incurably debilitating disablement and incurably debilitating disease. By extension, involuntary euthanasia may also here be understood to be justified on similar grounds for incurably defective younger children. His grounds for supporting euthanasia appear to be primarily utilitarian and not religious in nature. In his ideal society, Plato envisions the welfare of the state as a whole to hold a higher worth than the welfare of any individual. Duties to the state here override duties to self and to family. Aristotle disagreed with Plato on his stand on euthanasia. In *Nicomachean Ethics* we find his unqualified opposition to suicide. We also find his opposition to the proposition that it is morally acceptable for a person suffering from an incurable disease or disability to quit life. His opposition is expressed in the context of his broader examination of the question of whether a person can be properly said to treat himself unjustly.

Stoics view death as nothing to fear. Death was viewed as the natural and inevitable resolution of human life itself. If it is so, the question then is: Did the stoic held euthanasia a rational act? Moreover, did they hold that each person possessed what amounts to a moral right to end his own life? Seneca's writings suggest affirmative answers to both these queries. But it has been done on strict qualifications. Stoic founder Zeno committed suicide in his old age prompted by the agonizing pain of a foot injury. When a person carries out an act of euthanasia, he brings about the death of another person because he believes the latter's present existence is so bad that he would be better off dead, or believes that unless he intervenes and ends his life, it will become so bad that he would be better off dead. The motive of the person who commits an act of euthanasia is to benefit the one whose death is brought about.

Debate about the morality and legality of voluntary euthanasia has been, for the most part, a phenomenon of the second half of the twentieth century and continued in the twenty first century. In the sixteenth century, Thomas More, in describing a utopian community, envisaged such a community as one that would facilitate the death of those

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[1] *Ethical Issues in Death and Dying*, (Ed. Beauchamp, Tom L. and Perlin Seymour, 1978); Prentice Hall, New Jersey,pp.92-7.

whose lives had become burdensome as a result of 'torturing and lingering pain'. But it has only been in the last hundred years that there have been concerted efforts to make legal provision for voluntary euthanasia. Until quite recently, there had been no success in obtaining such legal provision (though assisted suicide has been legally tolerated in some countries for many years).

Those who are in favour of voluntary euthanasia set out certain conditions for making it legally permissible. The conditions are stated with some care so as to give focus to the moral debate about legalization. There is also positive moral case underpinning the push to make voluntary euthanasia legally permissible. We also find morally grounded objections that have been advanced by those who opposed to the legalization of voluntary euthanasia. The following necessary conditions are given for admitting voluntary euthanasia. Advocates of voluntary euthanasia contend that if a person

a. is suffering from a terminal illness;
b. is unlikely to benefit from the discovery of a cure for that illness during what remains of his/her life expectancy;
c. is, as a direct result of the illness, either suffering intolerable pain, or only has available a life that is unacceptably burdensome;
d. has an enduring, voluntary and competent wish to die; and
e. is unable without assistance to commit suicide,

then there should be legal and medical provision to enable him/her to be allowed to die or assisted to die.

The central ethical argument for voluntary euthanasia - that respect for persons demands respect for their *autonomous choices* as long as those choices do not result in harm to others - is directly connected with the issue of competence because autonomy presupposes competence. People have an interest in making important decisions about their lives in accordance with their own conception of how they want their lives to go. In exercising autonomy or self-determination, people take responsibility for their lives; since dying is a part of life, choices about the manner of their dying and the timing of their death are, for many people, part of what is involved in taking responsibility for their lives. Many people are concerned about what the last phase of their lives will be like, not merely because of fears that their dying might involve them in great suffering, but also because of the desire to retain their *dignity* and as much control over their lives as possible during this phase.

Should Doctors Have A Dual Role - Preserving Life And Assisting Death?

Professional medical organizations maintain the position that medical assistance in dying conflicts with the basic role of doctors. It is assumed that if we legalize assisted suicide we need a doctor to do it. One day, in some brave new world, hope for by some and dreaded by others, assisted suicide may come to be regarded as the right of every citizen purely on the grounds of autonomy. Until then doctors looking after a patient—and presumably at least one independent doctor—will always be needed to advice on at least three points.

- Whether every reasonable option for good care and relief of symptoms has been carefully considered.

- The likely course of events if life is allowed to continue.
- The patient's mental state, in particular whether there is any evidence of a treatable depression.

In order to obviate the above difficulty it has sometimes been suggested that the state could provide - preferably not anywhere where patients are being cared for, but either in the patient's own home or in some special state euthanasia unit - whichever way of assisted suicide it judges to be the most humane - perhaps just the touch of a switch by the patient to emphasize total autonomy, or perhaps in some other way.

It is sometimes argued that legalization of euthanasia may increase openness in the doctor-patient relationship. It will create openness about care at the end of patients' lives, enabling a doctor to improve skills in providing supportive care to dying patients. Illegality, data suggest, constraints communication between patient and doctor. The illegality of euthanasia prompted some incurably ill patients to make their own arrangements to hasten their death rather than seek assistance from health professionals. Illegality creates a gulf between and separates interested patients and willing doctors, restricting communication about treatment in the final stages. The law not only denies patients the option of euthanasia, but also restricts discussion between doctor and patient about when to withhold treatment to prolong life, which is increasingly becoming an option. It is said that if higher status is attached to the 'living will' and greater use made of it to facilitate communication between doctor and patient, the gap could be bridged.

A society moving towards an open approach to assisted dying should carefully identify tasks to assign exclusively to medical doctors, and distinguish those possibly better performed by other professionals. The medical profession has traditionally maintained a clear distance from euthanasia and assisted suicide. However, since there is active debate in many countries and even enacted legislation in some countries, it has become increasingly difficult to justify such distances by simply referring to the law or to ethical arguments against any assistance in dying. It does not make it any easier for doctors that discussions in the media, courts, and legislatures often assume assistance in dying to be exclusively a physician's task. Legal regulations and medical ethical positions in regard to euthanasia, an empirical study suggest, are highly country specific. The country is the most important predictor of doctors' attitudes and practices in the field of end-of-life.

There are some medical academies which point out the basic incompatibility of assisted dying with the role of doctor. Faced with the increasing public acceptance of assisted dying, corresponding attempts to change the penal code, and actual changes of the law, the medical profession mostly strives to prevent or to slow down the process. What is actually happening may be described as a power struggle: society wants the option of physician-assisted death to be available, while the overwhelming majority of medical organizations continue to view such assistance as incompatible with their codes of professional ethics. Even so, there is no unanimity within the medical profession. Those specialists who are most likely to be entrusted with assisting in death, e.g. oncologists, palliative care doctors, are those who oppose legalization of assisted dying most strongly. The conflict is essentially between those who want the option of assisted dying to be available, and those who would be responsible for implementing it. A group of legal experts proposed that doctors assisting patients in suicide should neither be

prosecuted under criminal law nor censured by medical professional ethics. Some medical academy opined that assistance in suicide is not a part of a doctor's activity but assistance in suicide in individual cases has to be respected as the doctor's personal decision.

Open regulations of assisted dying brings doctors into a basic conflict: on the one hand, many doctors do not wish to have anything to do with a practice that they regard as incompatible with professional ethics; on the other hand, once opening up seems inevitable, they want to introduce safeguards they deem necessary. The more they get involved in these discussions, the more they are drawn, though unwillingly, into the role of experts in a field that extends far beyond medicine. Utilization of exclusive experts becomes pertinent exactly here.

It has been suggested that open regulation of assisted dying could also be implemented by establishing a suicide service outside clinical care, run by a designated interdisciplinary team. In this model assistance in dying would be restricted to these specialized services rather than to any one profession. It could ensure competent assessment of the person wanting to die according to standard regulations agreed on by the public. Any role conflict for clinicians faced with a patient's request for assistance in dying would thereby be avoided, as their role would be clearly confined to openly discussing the situation, indicating possible treatment or palliative care options, and offering further support in this respect.

If our society is willing to make assisted death an available option, the responsibility for such decisions must be spread as widely as possible, i. e., borne by the society as a whole. It is not enough that the law and ethical guidelines lay down limits for doctors who assist in dying and that observance of these conditions is monitored by lawyers and ethicists. Religious leaders (spiritual advisors), nurses, pharmacists, social workers be roped in when a particular difficult decision has to be taken. Whether or not a state-run-service for assisted dying is most appropriate instrument is another moot point, as this might be too bureaucratic and impersonal to meet the expectations and needs of the individuals wanting to die and their families. What doctors can do at this stage is to identify where medical expertise is essential in this field and to define those questions to which medical knowledge provides no answer.

Against this background of increasing public acceptance of assisted dying, the fundamental question of the appropriate role of doctors in an area that goes beyond medicine remains contentious. A society striving for an open approach towards assisted dying should carefully identify the tasks that should be assigned exclusively to medical doctors and separate out those that might be better performed by other professions.

We find instances where doctors argue against euthanasia. Peter Ravenscroft, a medical Professor in palliative care (of Australia), argues that when people suffers from an incurable illness, they should be given palliative care. Palliative care tries to improve the quality of a person's life, even the very last part of their life, without brining death. He says: 'I value sitting with dying patients or holding their hands. It reminds me that life is a great mystery and we all share characteristics of being human. We take part in all of life, including dying, but we are not masters of it.' If euthanasia is legalized, it may be easier to choose death instead of continuing to look for a better treatment. Ravenscroft's another argument for not making euthanasia legal is that people can be persuaded to

choose euthanasia when they do not really want to. It is unlikely that legal safeguards or guidelines can stop this from happening.

The oath of Hippocrates, from where the growth of medical ethics began, states: 'I will give no deadly medicine to anyone, even if asked'. On the other hand, some modern medical associations recommend preparing patients to use the mechanisms of medical decision-making that support the patients' exercise of control over end-of-life decisions. These mechanisms include

- Living wills
- Durable powers of attorney
- Advance directives

If we juxtapose the above two, it is found that medical associations have thus gone on record to reject euthanasia and physician assisted suicide as being incompatible with the nature and purpose of the healing arts. The prospect of the availability of euthanasia raises numerous concerns. Will euthanasia and physician assisted suicide prevent us from developing and advancing alternative methods of end-of-life care? Will euthanasia and physician assisted suicide become the tools of economic efficiency in an era of increasing health-care cost containment. And, will euthanasia and physician assisted suicide promote death as the solution to health and societal problems other than terminal illness.

Normative Ethical Theories and Euthanasia:

The controversy regarding the practice of euthanasia is essentially a controversy about ethics. The debate is a value debate among debaters who weigh values differently, who see the nature of the world and the place of humans in that world differently. The differences among the debaters can best be seen through an examination of value hierarchies. A value hierarchy is the manner in which a person orders his or her value system by ranking different values in order of importance. Such a value hierarchy was developed by Abraham Maslow, an American professor of psychology, in his book *Motivation and Personality*[2]. His hierarchy of needs attempts to explain various facets of human behaviour by showing how people can move up or down the hierarchy depending on which needs are met.

Proponents of euthanasia have a different value hierarchy than do the opponents. Doerflinger argues for a particular value hierarchy when he contends that life is the supreme good and that all other good must come only after life is secured[3]. His logic states that without life, no other value or good can exist, and hence it is a prerequisite for all other values. Proponents of euthanasia also believe in the value of life, but they do not place it as highly on their hierarchy. Instead a proponent of euthanasia might argue that individual rights are supreme value, or that quality of life is more important than the value of life itself. The logic here is that although life is clearly an important value, there may be times when life itself is not worth living. If a person has no individual rights, or if a person has a low quality of life, they may make the decision to end their life because it is no longer worth living, no longer a good life.

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[2] Maslow, Abraham; *Motivation and Personality*: NY: Harper, 1987.
[3] Doerflinger, R.: Assisted Suicide: pro-choice or anti-life? 1989, Hastings Center Report.

One of the main reasons for which the debate about euthanasia has been so hotly contested was that it challenged the value systems of people. The people who believe in individual rights and quality of life as the supreme value see their value hierarchy threatened by the power of the state. One way of examining values and ethics is to see if they are worthwhile is through the use of normative ethical theories. By examining a problem or particular policy through the lens of a normative ethical theory, we can determine if the system needs changing or if a particular policy option is an ethical one. There are several normative ethical theories that have been proposed by philosophers. Let us recount some of these.

Ethical Egoism: Ethical egoism is found in the *Leviathan* of Thomas Hobbes. It operates from the general rule that if any action increases my own good, then it is right. Hobbes argues that we cannot help but act in our own self-interest, and therefore, such actions are ethical. Ethical egoism in the context of euthanasia would contend that if a person wants or does not want to end their life using euthanasia, the desire is motivated by a need for self-benefit, and is therefore an ethical action.

Utilitarianism: John Stuart Mill articulated utilitarianism. It operates from the general rule that if any action increases overall good, then it is right. The corollary to this is that if any proposed direct moral rule, when generally acted from, increases overall good, then it is a correct direct moral rule. In the context of euthanasia, we must examine the practice to determine if it increases the overall good in order to determine if it is ethical.

Rights Theory: Based on Kant and Locke, Jefferson and some others used rights theory as the basis for government. Rights were established in the constitution and assigned to the judiciary for their protection. Rights were conceived as natural, protected by law and not created by law. There are very few natural rights, and most of these are established negatively. Euthanasia proponents rely heavily on rights theory as justification for euthanasia.

These normative ethical theories can be used to illustrate the conflicts that surround the various actors involved when the problem of euthanasia considered. When a decision needs to be taken, there are several points where a decision can potentially occur. These points are where decision makers reside: the individual, the family, the physician, and the state. In each of these cases, there are normative ethical theories that can illustrate the value conflict which occurs at each level.

The normative ethical theories of ethical egoism and utilitarianism illustrate the value conflict and the ethical dilemma involved. Egoism may lead one to die as the individual may believe that based on their self-interest and to their personal benefit, it would be better to die. The individual may be experiencing a great deal of pain, loss of bodily functions, and face with the spending the remainder of their life as an invalid. On the other hand, egoism may lead one to want to live under conditions that might dictate otherwise. A person might dictate that all available medical technology ought to be brought to bear in the preservation of their life.

Seen from utilitarian perspective, a person may choose to live for the good of others. For the sake of loved ones and the pain they might feel because of death, or because of the premium that society places on life, a person may choose to go on living even though they might make an individual choice to die if such considerations did not exist. By the same token, a utilitarian perspective may lead to a person to choose death.

The pain and financial burdens that family members or society might have to endure could be so great that although the person might want to go on living, it would be in the best interest of the family or of society that the individual should choose to die.

The family might also experience an ethical dilemma that is also illustrated by the competing theories of ethical egoism and utilitarianism. The dilemma would be most relevant in the case of an incompetent individual who is unable to make their own decision whether to die. Egoism might lead the family to choose to keep the individual alive because they are unable to live with the knowledge that they pulled the plug on a loved one. They would be more at peace knowing that they had done all they could to keep the individual alive. Alternatively, egoism might entice the family to choose to allow the individual to die. They may conclude that the emotional and financial trauma on the family would be so intense that it would be in their interest to prevent medical treatment from continuing.

A utilitarian perspective may cause the family to keep an individual alive. They may decide that it is harmful to society to weaken the value of life, and that there is a possibility of saving life, in any condition, it should be done for the good of everyone. However, the same perspective may lead the family to conclude that the individual should be allowed to die. They may believe that society would be forced to bear the burden of an individual utilizing such expensive medical care, and that such resources might be better allocated if they were used on those who were not beyond hope.

The physician also faces an ethical dilemma. The universal imperative of the profession revolves around the Hippocratic Oath. Doctors have a duty to preserve life at all costs. Society commits physicians to preserve life. Since life is most precious commodity, nothing should be done to take it away. It is this universal imperative that generates arguments for the opposition of euthanasia which intimate that the practice would severely damage the ethical image of the profession. In conflict with the universal imperative stands the doctrine of patient autonomy and the rights of the patient. The physician has a duty to respect the wishes of the patient. If the patient is in a permanent vegetative state, and the individual or family has indicated a preference for death of that person, the doctor has a duty to respect those wishes.

Rights theory and patient autonomy have generated arguments regarding paternalism, and also have proponents to assert privacy and self-determination interests in the right to die.

At the state level, the value conflict can be illustrated by examining utilitarianism and rights theory. Rights theory contend that the state has a limited right to intrude on the affairs of the individual. Only in the face of a compelling state interest does the state have the right to limit individual rights to privacy and self-determination. In most cases, there is no compelling state interest when an individual decides to die. A compelling state interest can only exist if there is a significant threat to society, or the interest of a third party at stake. The state make utilitarian considerations that include the risk of physician abuse, the image of medical profession, the effect that such practices would have on the value accorded to life in society, the costs of keeping terminally ill patients alive, and the burden those patients place on social support systems. The state must balance all of these utilitarian considerations, and then must decide what power the state has in the face of individual rights.

From the above discussion it becomes clear that an analysis of normative ethical theories does not provide a clear answer to what should be done in the case of euthanasia. Normative ethical theories provide no basis for consistent decision making because there is no consensus of the good. Differences between individual value hierarchies and lack of agreement on what constitutes 'good' means that people can use normative ethical theories, but they provide no clear mechanism for determining which decision is the best. Further factors complicating the discussion on euthanasia are the power interests which attempt to control both the subject and the debate. Two of the most powerful profession involved in the debate is - the medical profession and the legal profession, as they have a significant stake in the outcome of the debate. Foucault's landmark study of the medical profession demonstrates how the medical profession has empowered itself through the development of a specific knowledge and concerning the body. It is this discursive formation about and knowledge of the body that has given the medical profession a privileged position of power in our society. Physicians have the power over issue of life and death in our society and they have used this power to shape the debate on euthanasia. The medical profession has a significant stake in this debate because they do not want to be seen by society as killers. They want to retain their image as healers. More importantly, they want the power to decide when the treatment of the patient should be terminated. The legal profession is in an analogous position to the medical profession. As a profession with a specialized knowledge and vocabulary concerning the legal system, the legal profession is in a similar position of power. If the legal community advocates the legalization of euthanasia, its power over this legal issue gives the profession an abnormally large voice in the debate.

R. Pirsig, an American philosopher, in order to examine the issue of euthanasia from both philosophical and practical standpoint examines the metaphysics of quality and the ethic of care[3]. Pirsig argues that the world is not composed of substance, subject and object, mind and matter; it is composed primarily of value. The value is the reality that brings the thought into mind. Value is not a subspecies of substance rather substance is a subspecies of value. When we reverse the containment process and define substance in terms of value, the mystery disappears: substance is a stable pattern of inorganic values. Using the terms quality, value and moral almost interchangeably, Pirsig says that quality and morality is the primary reality of the world and the world is primarily a moral order. He talks of two sorts of quality: static and dynamic quality. Dynamic quality is responsible for progress. It is the evolutionary force that has led to the explosion of life, the creation of cultures, cities, art and literature. Static quality is responsible for preservation. Once a dynamic advance has occurred, static quality is what prevents the slide back down the evolutionary spiral. Retention of adaptations such as clothing, fur, tools; and things like libraries, ritual and laws are examples of static quality or static pattern of value preserving the advances made by the dynamic quality.

Having divided the concept of quality into dynamic and static, Pirsig talks about four separate levels of value or quality. These he terms, in ascending order of level of evolution, inorganic quality, biological quality, social quality, and intellectual quality. Each level of quality has worth in its own right. Each higher level of quality depends on

[3] Pirsig, R. : *Lila: An Enquiry into Morals*, 1991.

the lower levels of quality for existence, but each higher level of quality is also more valuable than its lower level. This evolutionary structure of the metaphysics of quality shows that there is not just one moral system rather there are many. In the metaphysics of quality there is the morality called the 'laws of nature' by which organic patterns of value triumph over chaos. There is a morality called the 'law of the jungle' where biology triumphs over the inorganic forces of starvation and death. Again, there is a morality where social patterns triumph over biology, 'the law'. And finally, there is an intellectual morality, which is still struggling with its attempts to control society.

The metaphysics of quality says that if moral judgments are essentially assertions of value and if value is the fundamental ground-stuff of the world, then moral judgments is the fundamental ground-stuff of the world. Because the metaphysics of quality takes such a fundamentally different view of the universe and because it claims to be able to easily resolve ethical dilemmas, it would be useful to use this new metaphysics to examine the intractable ethical problem of euthanasia. To determine which course of action is morally correct, Pirsig says the process is simple. One simply acts to preserve the highest form of evolutionary quality. Pirsig uses the following example to illustrate this principle: '… given a choice of two courses to follow and all other thing being equal, that choice which is more dynamic, i.e. at a higher level of evolution, is more moral…it is more moral for a doctor to kill a germ than to allow the germ to kill his patient…the patient has moral precedence because he is at a higher level of evolution.' In the course of euthanasia we can determine which courses of action are morally correct by examining the patterns of value that are associated with it.

This unique value of making value judgments allows us to move from a dualistic life/death, healing/killing framework toward a more logical and moral ethic of care. Such a move places the intellectual capacity of the individual in the center of the issue and moves the rule based approach out. This also displaces the power roles of the legal system and the medical establishment. When the intellectual capacity of the individual, and the dynamic quality which engenders it, is placed in the forefront, the legal system and the medical establishment are placed in their appropriate roles of protecting the right of the individual so long as the right of the individual does not harm the rights of others, and helping the individual carry our decisions regarding their own medical condition. The individual plays the role of actor, the legal system to the role of protector, and the medical establishment to the role of helper. The proper ethical choices are now made by the appropriate actors, and individuals in all parts of the system are empowered.

Slippery Slope:

Slippery slope is the notion that a small steps today will inevitably lead to bad policies later on. When applied to the euthanasia debate, it claims that the acceptance of certain practices, e.g. voluntary euthanasia, will invariably lead to the acceptance or practice of concepts which are currently deemed unacceptable, such as non-voluntary or involuntary euthanasia. In order to prevent these undesirable practices from occurring, it is argued, we need to resist taking the first step. British bioethicist David Albert Jones makes a vigorous defense of a famous statement of the slippery slope from voluntary active euthanasia to nonvoluntary active euthanasia. John Keown is of the opinion that the slippery slope is a logical one which does not require empirical support. If death is a benefit, it will be regarded as inconsistent to deny it to people just because they cannot

request it. Dr. Jones argues: The validity of this logical slippery slope argument does not decide the issue of whether it is right or wise to legalize voluntary euthanasia. Faced with the valid conclusion that voluntary active euthanasia implies nonvoluntary active euthanasia: either to accept both together or to reject both together. “An argument is not like a bus where you can get off at any stop you like; rather, once you have accepted premises you have to follow it to the end of the line. If voluntary euthanasia were accepted as a legitimate form of medical assistance in dying, then it would also be acceptable for noncompetent patients. An advocate of legalizing Voluntary active euthanasia either must bite the bullet and also accept nonvoluntary active euthanasia or must concede that if nonvoluntary active euthanasia is regarded as too dangerous or unpalatable, then this is a valid and cogent reason for rejection of voluntary active euthanasia as well.