Semester – 2

PHILCC204: Ethics

EUTHANASIA

Unit – 3

Dr. Ameeta Jaiswal

Head, Department of Philosophy

Patna Women's College

Euthanasia is derived from the Greek word euthanatos, meaning good death. 'Eu' means well or good and 'thanatos' means death; hence, euthanasia refers to the practice of ending a life in painless manner. According to the House of Lords select committee on Medical Ethics, the precise definition of euthanasia is "a deliberate intervention undertaken with the express intention of ending a life to relieve him of intractable suffering."

Euthanasia is, thus, merciful killing a terminally-ill patient to relieve him from intractable pain or someone who is in an irreversible coma. It is commonly known as "mercy-killing" in which the death of a terminally ill patient is hastened either by giving him a lethal injection or by withdrawing medical procedures that prolong his life.

The most important aspect of euthanasia is that it involves taking a human life. Hence, the person whose life is being taken must be someone who is believed to be suffering from some incurable disease or injury the recovery of which is not possible. Another important aspect of euthanasia is that the action is deliberate and intentional. Euthanasia is practiced only because of patient's sufferings and the hopelessness of treatments. Doctors who are the most important persons involved in euthanasia need to practice it with the sole intention of relieving the patient from acute pain and not for any personal benefit.

Kinds of Euthanasia

Before we enter into the controversy regarding the implications of euthanasia, let us first distinguish between the different kinds of euthanasia. Euthanasia is classified into two

important types; the first distinction is between voluntary and involuntary euthanasia and the second is between active and passive euthanasia.

Voluntary euthanasia is conducting mercy killing of a terminally ill patient with his consent. Physician assisted suicide is a form of voluntary euthanasia where the patient takes the last step in his death by giving his consent. For example, a patient in the last stage of cancer may ask to be killed with a fatal injection of morphine to relieve him from sufferings.

Involuntary euthanasia is euthanasia conducted without the explicit consent of a terminally ill patient since the patient is incapable of giving his or her consent. In the modern world, the term is usually applied to medical situations as in the case of comatose adults or in the case of new-born babies with severe defects. However, in case of involuntary euthanasia, the consent of the patient's family members or relatives can be obtained.

Active Euthanasia means use of lethal substance or forces to kill a terminally ill patient. For example, an individual can use a euthanasia machine to perform an active voluntary euthanasia.

Passive Euthanasia is allowing the terminally ill patient to die by withholding treatment or when doctors refrain from using life saving devices necessary to keep alive a terminally ill patient or a patient in a persistent vegetative state.

Voluntary and involuntary euthanasia can be both active and passive. In voluntary euthanasia a person can ask for death by either active or passive method. Similarly, involuntary euthanasia can also be conducted by active or passive method. Hence, they are four kinds of euthanasia.

i. Active voluntary euthanasia
ii. Active involuntary euthanasia
iii. Passive voluntary euthanasia
iv. Passive involuntary euthanasia

Passive voluntary euthanasia – Among these four types of euthanasia, voluntary passive euthanasia seems to be the easiest to justify and involuntary active euthanasia is the most difficult to justify. Voluntary euthanasia, both active and passive can be justified if it can be shown that there is a fundamental moral right of the terminally ill patient to determine his or her own destiny when life becomes worthless, painful and miserable.

ETHICAL ACCEPTABILITY OF EUTHANASIA

There are two different viewpoints concerning the ethical acceptability of euthanasia.

1. The conservatives argue that euthanasia is morally wrong because it is contrary to natural law or against the commandments of God. It violates God's absolute dominion over human life. They appeal to the principle of sanctity of human life and say that the intentional termination of innocent human life is always immoral. Moreover, it leads to disrespect for the sanctity of human life. This view is represented by thinkers such as St. Thomas Acquineas, Gay-Williams, Joseph V. Sullivan, Joseph Fletcher, Tom L. Beauchamp and others.

2. The liberals maintain that euthanasia is morally acceptable for the reason that it provides an end to the horrible pain and suffering of terminally ill patients. They argue that it is cruel and inhuman to refuse the plea of a terminally ill patient that his or her life be mercifully and peacefully ended to avoid further suffering and dignity. Voluntary euthanasia is both rational and morally acceptable on the grounds of individual autonomy, and rights of the terminally ill patients to determine their own destiny. The liberals claim that individuals should be free to do so as they choose as long as their actions do not result in harm to others.

Thus, the issue of euthanasia involves certain moral or ethical questions such as:

1. If life is a gift of God, does God insist upon His gift being kept forever irrespective of the bad consequences it has to the recipient?

2. Does euthanasia violate the nature and dignity of human beings?

3. Is not the quality of life the deciding factor in taking life and death decisions?

4. Is it morally permissible to terminate the life of a patient to relieve him of acute pain and suffering?

5. It is always morally wrong for a medical practitioner to practice euthanasia even if the patient is suffering tremendously and asks for death?

6. Is it not wrong and inhuman to refuse the plea of a terminally ill patient to end his / her life peacefully?

7. Is there an intrinsic moral difference between killing and letting die a terminally ill patient?

8. Is cessation of treatment or withdrawing life support devices in case of a terminally ill patient an act of intentional killing of that person?

9. How does an action which is merciful and beneficial to many concerned and does not violate the rights of any person be labeled as morally wrong?

10. Can voluntary euthanasia be distinguished in principle from euthanasia without request?

11. Do patients enjoy a "right to die" and if so what does it mean?

12. Why should a person suffering from a painful and miserable condition of life be required, either legally or morally to prolong his agony?

13. Does a terminally ill person who is rational and fully informed have the freedom to decide whether or not to prolong his life?

14. Can voluntary euthanasia be safely regulated or is the "slippery slope" to euthanasia (without request) unavoidable?

The above questions throw light on four important issues associated with euthanasia:

(i) The value of human life

(ii) The morality of the act of killing

(iii) Personal autonomy

(iv) The fear of slippery slope

The Intrinsic Value of Human Life

Ethics is mainly concerned with prescribing values and giving value judgments. Value and value judgments which enter decisively into the ethical decisions we make, whether consciously or unconsciously, are correlated closely with deeply held metaphysical beliefs. Those who, standing with the Judeo-Christian tradition, affirm life (with all the problems and difficulties) to be a good gift from the hands of the God will be prone to

value life above death. Those who, less directly connected to any religious tradition, nevertheless, affirm an evolutionary and optimistic world will also tend, on the whole and except under extreme stress, to value life above death.

Eminent theologians and philosophers like Thomas Aquineas, John Locke and Immanuel Kant argue that since human life is not simply our property but a gift or loan from God, we have no right to damage or destroy it.

Against the above view Margaret Pabst Battin argues that if a gift is genuine, then the donor has relinquished his/her rights of control: *"If life is really a gift from God to the individual, it is that person's right to do with it as he or she chooses."*[i] She then observes that it would nevertheless be wrong to destroy a gift, if it were useful to someone else or if it were of intrinsic value. But if the life one is given is an unsatisfactory one- involving a diseased or deformed body, severe poverty, desperate political repression, terrifying insanity, unbearable grief or deprivation, we would be very much less likely to claim that one is obliged to be grateful for it. She further says, *"The individual who receives from an omnipotent God, a life disfigured by pain or deformity cannot excuse the donor on grounds of limitations, and may begin to suspect that the donor's intentions are not the best."*

The objections raised by critics like Battin, Rachael, Harris and Dworkin against the intrinsic value of human life are as follows-:

- If life is a gift, then the beneficiary may do with it as she pleases.
- We are not obliged to be grateful for an unsatisfactory gift.
- All the more are we not obliged to be grateful for an unsatisfactory gift from an omnipotent God whose intentions must be malevolent.
- We are not obliged to avail ourselves of the opportunity to perfect our souls that suffering presents.
- We may return a loan when we cannot care for it properly.
- When it is impossible to use one's life for good, suicide is permissible.
- The special value of human life lies in its 'biographical' dimension, not its 'biological' one;
- The special value of human life lies in the individual's autobiography.

- Suffering is only worth bearing so long as it is compatible with the exercise- or at least the recovery of 'biographical' life.

According to these thinkers the body is seen as the material substratum and instrument of consciousness. *"If a living human individual is not yet conscious or never again will be conscious, it is not a person but a potential person or vegetable. Moreover, if bodily life is not intrinsically good but is valuable only as a necessary condition for preferred conscious states; when suffering prevails over satisfaction in a person's experience, his or her quality of life is poor and if there is no prospect of improving, he or she is better off dead."*

Hence, the special value of individual human life lies in the opportunity it affords to hear and respond to a call from God to make a unique contribution to the maintenance and promotion of created goods in the world. The exercise of this responsibility can take dependent, receptive and appreciative forms, as well as assertive ones. It can consist in the handicapped child's sheer delight in simple things or the elderly patient's heartfelt gratitude for the care he receives as much as thrusting public achievements of an adult is his prime.

On the other hand it remains reasonable to regard human life and the opportunity for responding to one's vocation that it affords- as a gift or loan from God that deserves gratitude and obliges care and responsible management even when that gift involves considerable suffering. Likewise, suffering as such does not render it unreasonable to persist in viewing human beings as God's servants and sentinels who have a duty to carry out the tasks assigned to them.

Also, not all physical suffering is redemptive (as has been said about Jesus Christ), some suffering can be as intense and relentless as to make responding to anything other than pain, including a vocation, inconceivable. Furthermore, severe brain damage can rob a human being even of the very capacity for consciousness that is the precondition of response.

Therefore, it is better to discriminate between human biological or bodily life that is able to support biographical or better, responsible life and that which is not; and to ascribe sanctity to the former but not the latter. It is important to note, however, that our concept of responsible life includes responsive as well as assertive modes. Nor is its value simply decided by the individual. The notion of absolute autonomy is incoherent as the equivocation of those who propose it suggests and subversive of human community.

In addition to conclusions, our engagement with critics of the traditional view of human life and sufferings has raised three important questions that we must take with us beyond this chapter- Can the will to die or an act of suicide ever be an expression of the responsible management of the gift of human life? Could this be so in a situation where

someone has become permanently incapable of performing any beneficial service, however broadly and generously conceived? Or if there were sufficient reason to suppose that the social acceptance of suicide and voluntary euthanasia as 'rational' acts might undermine society's general high esteem for the lives of human, individuals, and so jeopardize ordinary commitment of its members to support one another in adversity, could a patient's very refusal to adopt a suicidal intention constitute such a beneficial service?

The view of Indian Philosophers

According to Indian thinkers, the individual self is a combination of the soul or *Atman* and body or *sarira*. While the soul is spiritual, permanent, eternal, free, indestructible imperishable, unchanging, blissful; the body is material, impermanent, changing, bound in the cycle birth, diseased, suffers in old age and is dead one day. On death, the body perishes, not the soul. It is said in the Gita that just as one discards old and torn clothes, similarly the soul discard the old or diseased body and acquires a new one at the time of birth.

Okklkafl th.kkZfu ;Fkk fogk; uokfux`g.kkfr ujks¿ijkf.kA
rFkk 'kjhjkf.k fogk; th.kkZU;U;kfula;kfr uokfu nsghAA

(Jhen~HkXon~xhrk] 2-22)

Further, Indian philosophers hold that it is the soul that is ultimately real and not the body which is made of up of the atoms of five material elements (panchamahabutas) - earth, water, fire, air and ether. On death, these five physical elements unite with their respective elements. The material body is viewed as a product of ignorance or maya which acts as a limitation over the soul and binds the soul to the world. At the time of liberation or moksa the soul becomes free from the bondage of the body. Hence, death in Indian Philosophy is accepted as a transition from one life to another. In Buddhism, it has been said that just as when the light of a candle in on the verge of extinction we enkindle another candle from it, similarly on death, consciousness transmigrates to another body. Hence, there is no permanent birth or death. Everything is in the state of flux or change.

Almost all Indian thinkers including the Buddhists and the Jains believe that the physical body and the worldly life that it leads together with the pleasures and pain, disease and death is the result of his own karmas or actions. They believe that the Law of Karma is the moral law persuading the universe. According to this law "as we sow so shall we reap." Just as good seeds bring good harvest similarly good actions bring happiness and bad actions lead to sufferings. So long as a jiva or an individual soul performs actions with desire (Kamya Karma), he has to undergo pleasure and pain and this continues until he reaps the fruits of all his actions. Since, it is not possible to reap the

fruits of all the actions in one life, a person takes birth again and again. But then Indian thinkers also believe that if a person performs selfless actions (niskama karma) he will not have to reap their fruits and hence can become liberated or attain moksa.

Hence, according to Indian thinkers pain and sufferings are the result of one's own karma which can be alleviated also by one's own action. They also uphold personal autonomy and freedom of choice of an individual to pursue on action as and when desired. Hence, the value of human life consists in accepting it together with the pain and pleasure as one's own prarabdha or destiny and trying for various means as preached by Indian philosophers to get rid of it. In case of terminal illness, Indian philosophers are divided in their opinion.ii

Sanctity of Life versus Quality of Life

It is harder morally to justify letting somebody die a slow, dehumanized and ugly death, than to justify helping him to escape from such misery. This is the case at least in any code of ethics which has a value system that puts humanness and personal integrity above biological life and function (humanistic and personal). It makes no difference whether such an ethics system is grounded in a theistic or naturalistic philosophy. We may believe that God wills human happiness or that man's happiness is, as Protageras thought, *a self-validating standard of the good and the right.* But what counts ethically is whether human needs come first not whether the ultimate sanction is transcendental or secular.

Moral Defence of Human Initiative for Active Euthanasia

Passive Euthanasia is already a fait accompli in modern medicine. Every day in a hundred hospitals across the land decisions are made clinically that the line has been crossed from prolonging genuinely human to only sub human dying; and when that judgment is made, respirators are turned off, life perpetuating intravenous infusions stopped, proposed surgery cancelled and drugs countermanded. Arguing pros and cons about negative euthanasia is therefore, merely flogging a dead horse. Humanist morality accepts a non-absolutistic attitude about preserving life. Indeed not only Protestant, Catholic and Jewish teachings take this stance, it is also true of Buddhist, Hindu and Muslim ethics. In short, the claim that we ought always to do everything we can to preserve any patient's life as long as possible is discredited. The issue about negative euthanasia is settled legally.

Traditional ethics based on the sanctity of life which was the classical doctrine of medical idealism in its pre-scientific phases must give way to an ethics of the "quality of life". This comes about for humane reasons. It is a result of modern medicine's success not failures. "New occasions teach new duties, time make ancient good uncouth," as Whittier said.

Moral judgments proceed from significantly different values, ideals and starting points. If God's will is against any responsible human initiative in the dying process or if sheer life is to be believed as more desirable than anything else, then those who hold such opinion will not find much merit in either kind of Euthanasia, active or passive. If on the other hand, the highest good is personal integrity and human well-being, then euthanasia in either form could be the right thing depending on the situation.

The Morality of Acts of Killing

One feature of traditional ethical analysis concerning Euthanasia that attracts critical attention is that it prohibits the killing of patients and yet permits them to be allowed to die. Critics argue that no general moral distinction can be made between active killing and passive letting die, for an agent is responsible for an act of omission as well as for what he commits. Some critics go on to infer from this that to be responsible for an act of omission that issues in death is to intend to kill and that since it is permissible to let patients die, it should also be permissible to kill them.

James Rachels opens his critique with two cases for consideration.

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.

Rachels then denies that Jones' behaviour was less reprehensible than Smith's for "both had exactly the same motive- personal gain, and both had exactly the same end in view when they acted" and he concludes from this that the bare difference between killing and letting die makes no moral difference. iii

Michael Tooley makes the same point, arguing that it is just as wrong intentionally to refrain from administering an antidote to someone who is dying of poisoning as it is to administer the poison, provided that the same motive is operative in both the cases, and concluding that the distinction between killing and intentionally letting die has no moral significance in itself. iv

Tooley further suggests that *"the reason why we tend to view killing someone as more seriously wrong than intentionally letting them die is attributable to other factors; that the motive in the first kind of case is generally more evil than in the second kind; that the alternative to letting someone die, saving their life, might involve considerable risk and expeditious and that refraining from saving someone's life is unlike killing them, in that it does not necessarily close down other routes to survival."* v

A so-called vegetable, the brain damaged victim of an auto accident, a micro cephalic newborn or a case of massive neurological deficit and lost cerebral capacity, who nevertheless goes on breathing and whose midbrain or brain stem continues to support spontaneous organ function, in such a situation is no longer a human-being, no longer a person, no longer really alive. It is personal function that count, not biological function. Humanism or the doctrine of man puts the homo and ratio before the vita. It holds that being human is more valuable than being alive.

To the objection that by taking decision about death we are playing God, the answer it that men are now turning to a 'God', who is the creative principle behind things- behind the test tube as much as behind earthquake and volcano. Genetics, molecular biology, foetology and obstetrics have developed to a point where we now have effective control over the start of human life's continuum. From now on it would be irresponsible to leave baby-making to mere chance and impulse, as we once had to do. What has taken place in birth control is equally imperative in death. The whole armory of resuscitation and prolongation of life forces us to be responsible decision makers about as much as about birth; there must be quality control in terminating of life as in its initiating. If we are morally obliged to put an end to a pregnancy when an amniocentesis reveals a terribly defective foetus, we are equally obliged to put an end to a patient's hopeless misery when a brain scan reveals that a patient with cancer has advanced brain metastases.

Peter Singer also holds the same view and says that, "there is no intrinsic moral difference between killing and allowing to die," although a significant difference can be introduced by factors other than the mere distinction between an act and an omission.

R. G. Frey argues that a patient's refusal of what he knows to be life sustaining or life saving treatment is an act of suicide; that a physician who acquiesces in it intends his patient's death; and that since the refusal of treatment is permitted, so should physician assisted suicide be."vi This conclusion may be accepted as Voluntary Euthanasia.

The really searching question of conscience is therefore, whether we are right in believing that the well-being of persons is the highest good. If so, then it follows that either suicide or mercy-killing could be the right thing to do in some exigent and tragic circumstances. This could be the case, for example, when an incorrigible human vegetable, whether spontaneously functioning or artificially supported, is progressively

degraded while constantly eating up private or public financial resources in violation of the distributive justice owed to others. In such cases, the patient is already departed and only his body is left and the needs of others have a stronger claim upon us morally. The fair allocation of scarce resources is as profound an ethical obligation as any we can imagine in a civilized society.

Another major feature of the traditional position that attracts criticism is the doctrine of double effects. Nowadays it is commonly articulated in terms of four conditions that render morally permissible an act that causes an evil effect that is foreseen. One often quoted version is Joseph Mangan's.

A person may licitly perform an action that he for sees will produce a good and a bad effect provided that four conditions are verified at one and the same time:

1. that the action in itself from its very object be good or at least indifferent.

2. that the good effect and not the evil effect be intended.

3. that the good effect be not produced by means of the evil effect.

4. that there be a proportionately grave reason for permitting the evil effect.

Jonathan Glover complains like the utilitarian that it makes a moral distinction between cases where the outcome is exactly the same as where one where patient refuses life sustaining treatment and another is assisted in coming suicide. Rachels comments, "*A pure heart cannot make a wrong act right; neither can an impure heart make a right as wrong-because the rightness and wrongness of acts is determined only by their effects."*[vii]

Hence, some important points have been raised as objections by the critics like:

1. A patient who refuses life saving treatment and a doctor who acquiesces in this refusal are both responsible for and so intend the death that ensues. To let a patient die, therefore, is morally equivalent to deliberately killing him and since the former is permitted, so should the latter be.

2. Where the outcome of the two acts is the same, there is no moral distinction between them.

3. Purity of intention is a criterion of the morality of character, not of act.

4. The doctrine of double effect sometimes prefers the act whose outcome is worse.

5. The doctrine contradicts itself by engaging in utilitarian calculation.

6. There is no reasonable, non-arbitrary way of distinguishing between intended and unintended effects, because the definition of what is intended shifts according to which description of an act is selected from a variety of legitimate accounts. Besides, the doctrine of double effect's separation of what is intended from what is foreseen can render gross irresponsibility morally permissible. Grisez writes, *"Moral responsibility is to be found first and foremost in one's choosing (of a plan) because it is primarily in such choosing that one determines oneself."*[viii]

Another way of putting this is to say that the crucial question is not whether the end justifies the means but what justifies the end? We believe that human happiness and well being is the highest good or sumnum bonum and that any ends or purposes which that standard or ideal validates are just, right, good. This is what humanistic medicine is all about; it is what the concepts of loving concern and social justice are built upon.

This position comes down to the belief that our moral acts including suicide and mercy killing, are right or wrong depend on the consequences aimed at and that the consequences are good or evil according to whether and how much they serve human values- consequential moral judgment.

The plain hard logic of it is that the end or purpose of both negative and positive euthanasia is exactly the same. Acts of deliberate omission are morally not different from acts of commission. No ethically disciplined decision maker could so blandly separate right and wrong from motives, foresight and consequences.

We can conclude by saying that the life of the human individual is precious because it is constituted and dignified by a unique vocation by God to promote what is valuable in the world. No one should want or intend to damage or destroy such precious, responsible life either as an end or as a means, for to do so would be to vitiate the agent's will, to corrupt his moral character, to jeopardize his fitness for life beyond death and to increase the likelihood of his committing further malevolent harm in the world. Nevertheless, it may be permissible to choose to act in such a way as to cause the death of a responsible individual (e.g. by means of a dose of morphine), provided that what was intended was something other than his death (e.g. pain relief) and that the possibility of his death was accepted with an appropriate and manifest reluctance (e.g. the dosage was proportionate to the level of pain, and no effective less risky alternative was available). Morally speaking deliberately to cause death in this fashion is not the same as intending to kill. Therefore, to permit the former is not a ground for permitting the latter.

Careful study of the Hippocratic Oath reveals that it says nothing at all about preserving life as such. It says that *"So far as power and discernment shall be mine, I will carry out regimen for the benefit of the sick and will keep them from harm and wrong."* The case for euthanasia depends upon how we understand 'benefit of the sick' and 'harm' and 'wrong'. If we regard dehumanized and merely biological life as sometimes real harm and the very opposite of benefit, to refuse to welcome or even introduce death would be quite wrong morally.

Personal Autonomy and The Principle of Beneficence

The one essential principle that should remain uppermost and permanently honoured in the mind of every doctor is the highest respect for the personal autonomy or self-determination of every patient for what the patient deems best for his or her own earthly existence. Dr. Heyd, Professor of Philosophy at the Hebrew University in Jerusalem has written, "the individual alone gives meaning to his life and decides whether his life is good and worth living or not….. The meaning of life is the matter of decision rather than of knowledge; for in fact there is nothing to be known hence…."

Autonomy is derived from the Greek words 'auto' meaning self and 'nomos' meaning law. The principle holds that, so far as is possible and consistent with the welfare of others, persons ought to be respected as and encouraged to be self-determining moral agents. Immanuel Kant (a rule deontologist) argued in his Groundwork of the Metaphysics of Morals that persons should always be treated as autonomous ends and merely as means to the ends of others.ix John Stuart Mill (one of the fathers of rule-utilitarianism) speaks of the individuality of action and thought in his celebrated treatise, On Liberty. What Mill means by individuality is similar to what Kant denotes by the term autonomy.

From the perspective of the principle of autonomy, the wish of someone to choose death rather than life ought to be respected, providing that sound evidence shows that the person concerned is mentally competent and rational (and that, therefore, the decision is in fact substantially autonomous).

On the other hand, there is the principle of beneficence which imposes on us a duty to benefit others, when in a position to do so. This principle is deeply embedded in the history of medicine and the medical ethics tradition. The Hippocratic Oath enjoins the physician not only to avoid inflicting harm on patients but positively to benefit them. Beneficence readily lends itself to paternalistic behaviour. In the ethical literature, paternalism refers "to practices that restrict the liberty of individuals, without their consent, where the justification for such actions is either the prevention of some harm they will do to themselves or the production of some benefit for them they would not otherwise secure."x In the normal course of events, it would be almost instinctive for the

physician to act paternalistically and beneficently to save the life of someone who had tried to kill himself, assuming that the suicidal person was not, at the time, mentally competent and rational. This, in turn, reflects a value judgment: “no one in his right mind” would want to kill himself; to want to kill oneself one must be, in this conception, mentally off balance or emotionally unhinged at least temporarily.

The principle of autonomy, therefore, is constantly in tension with the principle of beneficence. The wish to respect other people as self-determining moral agents (so long as their actions are not infringing upon the liberties of others or causing harm to them and so long as they are mentally competent and rational) is inherently opposed to the duty, negatively, to prevent harm from coming to them or positively to benefit them. Death is valued negatively in our culture; life is valued positively. Averting harm is equated with preventing someone else from dying and benefiting another is synonymous with intervening to enable that person to live.

In the absence of an underlying terminal and painful disease process, the principle of beneficence ought prima facie to take precedence over the principle of autonomy in responding to suicidal attempts or deserves. When the suicidal person does have an underlying terminal and painful medical condition or is in an advance state of decrepitude and is mentally competent and rational; however, the principle of autonomy ought prima facie to be ranked in priority over the principle of beneficence.

This leads to the following conclusions: if

(a) a person is either terminally ill or irreversibly decrepit in terms of physical functioning;

(b) and is in immitigable pain - whether physical or psychological or both;

(c) and is obviously mentally competent and rational; and

(d) has attempted to mitigate the harmful effects - especially predictable feeling of guilt of her action on those who will survive her, then it is morally licit to rank the principle of autonomy above the principle of beneficence in evaluating one’s duty to respond to that person’s suicidal attempts or desires.

However, from the theological perspective, suicide may be regarded as a predictable response to the breakdown of faith, hope and love. When terminal illness and the pain associated with it are experienced as essentially meaningless, when the future is perceived as holding nothing but further affliction and debilitation and there no longer appear to be grounds for confidence and courage with respect to what it is yet to be and when it seems that significant others no longer care nor want to be cared for, then the wish to choose death above life is eminently reasonable and understandable.

Nevertheless, before giving “permission” to someone who is terminally ill and in intractable pain to translate the suicidal into the deed, it is first of all necessary, from a theological perspective for the caregiver to attempt to help that person discover or recover faith, hope and love. In other words, one’s primary obligation, theologically understood, is to endeavour to enable the terminally ill and suicidal person to find or regain a sense of the meaningfulness of all human experience including pain. It is to attempt to facilitate in that person the capacity to look into the future with confidence and courage, especially if his vision can be extended beyond the horizons of time to the limitless vistas of eternity. And it is also to try to instil in him the conviction that he is essentially lovable no matter how his outward appearance may be changing, even deteriorating from day to day, making it more difficult for him to love himself and therefore, capable of loving and being loved.

Only after the attempt has been made, seriously and strenuously, to enable the dying person to find or regain faith, hope and love and has failed, is it morally permissible to acquiesce in her wish to choose death rather than life. Only then is it morally licit to allow her to express her autonomy in this ultimate way rather than intervening with beneficently paternalistic motivation to frustrate it.

However, it is one thing to acquiesce and another to assist. Acquiescing in a terminally ill person’s desire to end his life may be morally appropriate, especially when the conditions outlined above have been satisfied. The question arises as to whether the same can be said about assisting. The crucial point is that were one to say, “I will help you”, one would be acting autonomously and out of generosity, not because of a perceived moral obligation or duty. One of the main reasons for deciding to help a suicidal person in the circumstances we are considering is “compassion”. However, acting on the basis of the principle of beneficence would require of the person assisting a stronger conviction that in this particular situation, death would actually be a benefit, than acting on the principle of autonomy. Beneficence requires help as a duty; autonomy allows assistance as a freely offered gift. It also presumes that there is a ‘right’ to help which carries with it a concomitant duty. Beneficence requires help as a duty; autonomy allows assistance as a freely offered gift. There is no duty to help someone who wishes to die to accomplish her death since there is no corresponding ‘right’ to be helped to die. However, assistance may freely be proffered as an act of generosity and compassion- in circumstances where one not only respects, but also assents to the suicidal intention being expressed.

There are various factors which may lead one to go on to assent to views which, on other grounds, one might already respect, where the relationship between the potential helper and helpee is extremely close, where there is a high degree of assent to the values, beliefs and arguments being expressed by the person contemplating suicide, when the person rationally wanting to die cannot possibly accomplish this without

assistance and where there are ways in which the potential helper can in fact help, then while there may be no duty to assist, it would be difficult to argue that it would be immoral autonomously to choose to help. Were one so act, this would be an act of compassion and courage of the highest order. At this juncture we can cite the example of Bollywood movie '**Guzaarish**'. The movie revolves around the protagonist who is a quadriplegic and is demanding euthanasia. Though the court did not allow his petition to let him die a respectful death, the nurse offered to deliver him as she could not see him suffer any more. Finally, the protagonist was delivered by his nurse at the home itself and in the presence of his near and dear ones.

There is no duty to help someone to die, although, as has already been stated, one may voluntarily choose to provide assistance as a freely offered act of kindness. Where the motive for offering help is to benefit the person wishing to die, this is morally acceptable. But where the motive is selfish, as in an attempt to inherit the estate of the person wishing to die, this obviously would cast an altogether different light on the assistance being contemplated. Because motivation cannot be assessed before the fact, helping another person to die should never be given legal sanction.

However, when it is clearly established that the motivation of the helper (doctor) was that of compassion and altruism, laws treating assistance in suicide as a criminal offence should be struck down.

J. Gay-Williams is of the opinion that euthanasia is inherently wrong and it is also judged wrong from the standpoints of self-interest and of practical effects. He is of the opinion that euthanasia violates the natural goal of survival which every human-being possesses. The organization of the human body and other patterns of behavioural response make the continuation of life a natural goal. By reason alone, then, we can recognize that euthanasia sets us against our own nature. Furthermore, euthanasia violates our dignity which comes from seeking our ends. Leon Kass has written in his book, **"Neither for Love nor Money; why Doctors must not kill"** about medicine as a profession that "it is an inherently ethical activity, in which techniques and conduct are both ordered in relation to an over arching good, the naturally given end of health." He also submits to the rule that doctors must not kill even for the cause of relieving sufferings of the terminally ill. Gerald Dworkin writes in the "Nature of Medicine: Professing Ethically,"- relieving suffering is presented not as a goal, or even a part of the goal of medicine, but rather as a concession to the fact that physicians and patients are 'finite and frail'.xi

Also, contemporary medicine though has high standards of excellence and accomplishments, yet its knowledge is not perfect. 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. In such circumstances, if authority is

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 may pull us through. Euthanasia also leaves no room for the 'miraculous' recovery that frequently occur.

Finally, knowing that we can take our life at any time might as well incline us to give up life 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. 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, one 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 put an end to our life is to make their lives easier. The very presence of the possibility of euthanasia may keep us from surviving when we might.

And the most important is the fear of slipping slope. "It is only a short step, then, from voluntary euthanasia to directed euthanasia administered to a patient who has given no authorization to involuntary euthanasia conducted as part of a social policy."xii If euthanasia is accepted as a social policy, it would give society or its representative the authority to eliminate all those who might be considered too 'ill' to function normally any longer. R. G. Frey has written in the article, The Fear of a Slippery Slope- "The bottom of this new slope has always been suggested to be non-voluntary/involuntary active euthanasia with the elderly, the severely mentally enfeebled, those in the later stages of senile dementia, and the severely physically handicapped being held to be possible cases in point.xiii

Dr. Jack Kevorkian writes in the chapter, The Lynching of Morality, "… They should know that the ultimate wellspring of morality is the mores of a people. As new conditions of life arise from the burgeoning conquests of parts of nature by science, technology, and even art, the mores adapt almost automatically… All ethics grow out of the mores and are a part of them."xiv

Dr. Jack Kevorkian came up with a new idea that criminals awarded capital punishment should be given the choice of donating their organs which will be the real retribution. He has written in his Book "Prescription: Medicine" chapter 5, Execution Par Excellence, "They are eager to give society real retribution by donating their organs and by helping science unlock some of nature's deepest secrets by submitting to otherwise impossible experimentation. But society will not allow it, and doctors refuse to accept it. In callously overriding the personal autonomy of the condemned by denying them the privilege of choice, we inflict on them the worst kind of suffering- far more agonizing them any physical pain- the crushing pain of 'a tortured mind and a turbulent soul denied any hope of requital.'

Regarding the morality of the act of performing euthanasia by doctors, Dr. Jack Kevorkian the inventor of suicide machine called Mecitron says, "…. no longer is there a need or even an excuse- for anyone to be the direct mediator of the death of another who is alert, rational and who for some compelling reason chooses to or must die. Performance of that repulsive task should now be relegated exclusively to a device like the Mecitron, which the doomed subject must activate. What is most important is that the participation of doctors or other health professionals now becomes strictly optional, either to insert a needle into the subjects vein to start the harmless saline infuse, or to monitor an ECG tracing to verify and document the occurrence of death. A doctor no longer need perform the injection."xv

Dr. Kevorkian in his provocative book, "Prescription Medicine" begins with a graphic account of a condemned man being put to death in the electric chair, after which he exposes the grotesque cruelty of all current methods of judicial execution. Following a gripping historical review of humankind's inventiveness in developing techniques for killing those found guilty of capital offence, he makes a compelling case for allowing condemned criminals to choose death by irreversible general anesthesia with the option of organ donation and/or human experimentation, procedures far more humane than any existing form of execution, even lethal injection. The thousands who die each year because suitable organs are unavailable underscore the senseless waste of condemned prisoners, many of whom would gladly donate organs or permit experiments on their person were it not for timid lawmakers and the 'Stone-age ethics of space age medicine'.

Having Seen the views of different philosophers regarding the ethical justification of euthanasia the following suggestion can be given.

SUGGESTIONS

- Euthanasia could be allowed, keeping in mind the following considerations

- The request must be made entirely of the patient's own free will and not under pressure from others.

- The patient must be experiencing unbearable suffering.

- He must be given alternatives to euthanasia and time to consider these alternatives.

- Doctors must consult with the team of his colleagues regarding euthanasia.

- Caring humanely for the dying and trying to help them find a dignified death is a fundamentally vital role for physicians.
- Patients have the right to fight for life even when the odds are poor.
- Doctors suggest comfort care or palliative care for terminally ill patients one of medicine's
- Highest mission is to allow hopelessly ill persons to die with as much comfort, control and dignity as possible. The philosophy and techniques of comfort care provide a humane alternative to more traditional, curative, medical approaches that can help patients to achieve this end.
- When an incurably ill patient asks for help achieving a dignified death, we believe that physicians have an obligation to fully explore the request, and under specific circumstances to carefully consider making an exception to the prohibition against assisting suicide.
- Doctors are in favour of a 'Good Death' for a terminally ill person alive only on life-supporting mechanisms but are bound by law.
- They strongly feel that quality of life is more important than quantity. Patients in a vegetative state with all the organs damaged cannot lead a dignified life.
- Family members play an important role in taking such decisions. Thus, sex and age are important factors for them. Arbitrary decisions based on their selfish motives cannot be ruled out.
- Human life is intrinsically valuable, no doubt, but when pain and the quality of life becomes unbearable, willful death can be condoned.
- Since the decision is determined by various factors, it has to be carried out very carefully; otherwise the Right to Die may become an expectation and a Duty to Die. Hence, the intention of those taking decision has to be taken into consideration.

- To develop a coherent personal philosophy with regard to having a good death. (End of life philosophy).
- Prepare a living will or Health Care Proxy and talk to your doctor about your advance directives.
- General public should pressure the govt. for changing restrictions on physician assisted suicide.
- There should be safeguards that minimise abuse but not prove so overly restrictive that suffering patients cannot find an escape.
- Policy makers should acknowledge the problem of intolerable end of life suffering.
- There should be state-owned hospice centres where terminally ill patients can be taken care of without being a burden on the family.

Government should make provisions for the Health Insurance of its citizens, especially for the poor and the economically deprived ones.

BIBLIOGRAPHY

1 Baird, Robert M. & Rosenbaum, Stuart E. (1989) **Euthanasia, The Moral Issue**, Prometheus Books, Buffalo, New York.

2 Biggar, Nigel, (2004), **Aiming to Kill- The Ethics of Suicide and Euthanasia**, The Pilgrim Press, Cleveland, Ohio.

3 Downing, A. B. (ed.) 1969, **Euthanasia and the Right to Death**, Nash, Los Angeles.

4 Dworkin, Gerald, Frey R. G., Bok Sissela (1998), **Euthanasia and Physician Assisted Suicide, For and Against**, Cambridge University Press.

5 Gorsuch, Neil M. (2006), **The Future of Assisted Suicide and Euthanasia**,

Princeton University Press, U.S.A.

6 Humphry, Derek (2002), **Final Exit**, Published by Dell Publishing, New York.

7 Kant, Immanuel (1963), **Lectures on Ethics**, Translated by Louis Infield, Harper, New York.

8 Kant, Immanuel, (1959), **Foundations of the Metaphysics of Morals**, Translated by Lewis White, Beck, Bobbs-Merrill, Indianapolis.

9 Keown, John (1998) - edited **Euthanasia Examined Ethical, Clinical and Legal Perspectives**, Cambridge University Press, Great Britain.

10 Kevorkian, Jack Dr. (1991), **Prescription Medicine**, Published by Prometheus Books, New York.

11 Kohl, Marvin (ed.) 1975, **Beneficent Euthanasia**, Prometheus Buffalo, New York.

12 Ladd, John (ed.) (1973), **Ethical Relativism**, Wadsworth, Belmont.

13 (1979), **Ethical Issues Relating to Life and Death**, Oxford University Press, New York.

14 Lillie, William, (1975), **An Introduction to Ethics**, Allied Publishers, New Delhi.

15 Mackenzie, John S. A. (1975), **A Manual of Ethics**, Oxford University Press, Delhi.

16 Quill, Timothy E. (M.D.) (1994), **Death and Dignity, Making Choices and Taking Charge**, W. W. Norton and Company, New York.

17 Rachels, James (ed.) 1986, **The End of Life, Euthanasia and Morality**, Oxford University Press, Oxford.

18 Radhakrishnan, S. (1977), **Indian Philosophy**, 2 vols., George Allen and Unwin, London.

19 Regan, Tom (ed.) 1986, **Matters of Life and Death**, Random House, New York.

20 Ross, W. D. (1939), **Foundations of Ethics**, Oxford University Press, Oxford.

21 Smith J. Wesley (2005), **Forced Exit**, Published by Encounter Books, New York.

22 Satyanarayana, Y. V. (2010), **Ethics - Theory and Practice**, Published by Dorling Kindersley (India) Pvt. Ltd., licensees of Pearson Education in South Asia.

23 Wanzer Sidney M. D. & Glenmullen Josepth M. D. (2008), **To Die Well**, A Merloyd Lawrence Bork Lifelong Book, DA Capo Press, U.S.A.

24 Young, Robert (2009), **Medically Assisted Death**, Cambridge University Press

25 Jamison, Stephen (1995), **Final Acts of Love: Families, Friends, and Assisted Dying**, Putnam, New York.

26 Magnusson, Roger S. (2002), Angels **of Death: Exploring the Euthanasia Underground**, Yale University Press, New Heaven.

27 McKann, Charles F. (1999), **A Time to Die: The Place for Physician Assistance**, Yale University Press, New Heaven.

28 Quill, Timothy E. (1996), **Midwife Through the Dying Process: Stories of Healing and Hard Choices at the End of Life**, Johns Hopkins University Press, Baltimore.

29 World Medical Association Policy: **"The World Medical Association Resolution on Euthanasia."** Adopted by the World Medical Association General Assembly, Washington, 2002, accessed at http://www.wma.net/e/policy/e13b.htm

30. **“Doctor Aids First Legal Euthanasia Act"**, British Medical Journal, volume 313, p. 835. (October 5, 1996)

[i] Battin, Prohibition and Invitation, p. 217.

[ii] Copy from 1st Chapter, pg. 7, para 1.

[iii] James Rachels, "Active and Passive Euthanasia" in Killing and Letting Die, ed. Bonnie Steinbock and Alastair Nor cross, 2nd edition (New York: Fordham University Press, 1994), p. 116.

[iv] 103-104.

[v] Ibid, p. 107.

[vi] R. G. Frey, 'Distinctions in Death' in Gerald Dworkin, R. G. Frey and Sissela Bok.

[vii] Rachels, "More Impertinent Distinctions and a Defence of Active Euthanasia" in, Killing and Letting Die, Steinbock and Norcross, pg. 141-2.

[viii] Grisez, Christian Moral Principles, pp. 239, 240 (9.F.2,3).

[ix] I. Kant, Groundwork of the Metaphysics of Morals (trans. H. J. Paton, 1964, pp. 95-96.

[x] Beauchamp, "Paternalism" in Encyclopedia of Bioethics, W. T. Reich ed. 1978, pp. 1194-1201.

[xi] Euthanasia and Physician. Assisted Suicide For & Against by Gerald Dworkin, R. G. Frey and Sissela Bok, pg. 12.

[xii] National Conference of Catholic Bishops, Guidelines for Legalization on life sustaining treatment, 1984, p. 526.

[xiii] Euthanasia and Physicial- Assisted Suicide: For and Against, by Gerald Dworkin, R. G. Frey and Sissela Bok, pg. 58.

[xiv] Dr. Jack Kevorkian. Prescription: Medicine, pg. 180.

[xv] Dr. Jack Kevorkian, Prescription: Medicine, pg. 233-34.