CHAPTER – VIII

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“There is .......... A time to be born and a time to die, a time to plant and a time to pluck up that which is planted” – Ecclesiastes. (cited by Dr. Joseph Fletcher in “Morals and Medicine”).

Enigmatic euthanasia is a fertile centre of socio-politico-legal morass and at the intersection of medicine, ethics, law and politics, the issue of euthanasia is inspired by the profound human suffering, shaped by clashing cultural values and practices regarding death and dying, and colored by the historical specter of human rights abuses. John Keown in his book ‘Euthanasia, Ethics and Public Policy : An argument against legalization, forcefully argues that neither voluntary euthanasia nor physician-assisted should be legalized, and it appears that his argument is directed not against the principles or practice, but based on pragmatic reason that the traits of euthanasia cannot be effectively controlled, and that legalization will inevitably lead down the ‘slippery slope’ to ‘involuntary active euthanasia’ i.e. murder.

Can it be a wise thought if we ponder over whether ‘Euthanasia’ is a problem or controversy or a controversial problem at any given time? If Euthanasia is construed to be an act of killing a person by another person to grant that another person a reliable relief on permanent basis from incurable and incessant pain and suffering, whatever may be the reason or situation, were not such acts considered without condemnation, if not encouraged on pro-active basis? Were such acts condemned by the general gentry and prudent people? Epics of all parts of the globe echoed and attributed heroic
quality to persons who resorted to such self-killing, and episodes are abounded. History recorded the glory and valour of kings and emperors whose fortunes were eclipsed by defeat in battles and finally succumbing to voluntary abdication of life. For a considerable period, suicide by Royal family members was not considered as an act of timidity but a tide of majestic end. Further, terminating the life to end the pain in extreme cases was considered to be an act of extreme prudence and critical sagacity.

But with the change of times, the human attitude appears to have undergone vibrant metamorphosis and started looking at the act of 'self-elimination' aimed at eliminating the incurable pain and suffering as 'culpable suicide.' A pure and casual act of medical prudence and phenomenon is being treated by theological, moral and ethical doses of high concentration rather than objective, systematic, logical and pragmatic potions of 'peaceful or meaningful end.' Purity is often polluted by extraneous causes or factors – is the experienced assertion of sensibility.

Further, there is a very sharp, acrimonious and paradoxical contentions that a physician ought not to abandon a patient on the ground that the case is proved incurable; and yet his presence may continue to be highly useful to the patient, and comfort to the relatives around him, even in the last period of a fatal malady, and by alleviating pain and other symptoms, and by soothing mental anguish, the physician may accord an angelic touch. On the other hand, there is also a conceivable conviction that 'every human being of adult years and sound mind has a right to determine what shall be done with his own body. The State has, no doubt, interest in the health and
life of its citizens, and it may not be illogical to view that the State's interest lessens as the potential for life diminishes. Aggressively, one may ask 'what business is it of the State to require the continuation of agony when the result is imminent and inevitable? What concern prompts the State to interfere with a mentally competent patient's "Right to Define (his/her) own concept of existence", of meaning, of the universe, and of the mystery of human life.'

What does the law consider? Is it a Right to Life? Is it a Duty to Live or a Right to suffer agony?

In the words of Krishna Iyer J., "Holistic Secularism, Humanistic Value-milieu, camaraderie of theological pluralism and patriotic, democratic statesmanship are sine qua non of Indian panorama in its developmental dimension. When technology and industry, violative of nature's intoxicated expansion vitiates the virtue of earth, air and water, it is a malefic menace to life in all its facts. Values changed for the worse since technology in its lucrative populism, is turning terrorist and science in its pride of discoveries, is becoming 'thanatonic'... God, the supreme Savior, has suffered the syndrome of sacerdotal splittism. Every cause has a martyr. Religion is no exception. Man is the victim, and God is the villain. We must save God, the Infinite, from goofy, greedy, gold-hungry gods in parochial apparel and political haberdashery".¹

Hence, the need to scan the subject 'compassionate killing'.

The people practicing medicine should have an analytical viewpoint while having a debate on euthanasia. There is a need to understand the

¹ Kerala Law Commission Report on Medical treatment for terminally ill patients.
arguments and counter arguments given for euthanasia so that formal guidelines can be worked out regarding this vital issue, for the primary goal of, all the medical practitioners is to infuse control in all patients to live gracefully and to die peacefully.¹

At this juncture, it may be pertinent to enquire as to why and when and under what circumstances a patient intends and wishes death. Bascom PB, Tolle SW. enumerate certain situations which prompt a patient to ask for death: –

➢ Being a burden

➢ Being dependent on others for personal care

➢ Loss of autonomy

➢ Loss of control

➢ Loss of control of bodily functions

➢ Loss of dignity

➢ Loss of independence

➢ Loss of meaning in their lives

➢ Pain or physical suffering

➢ Poor quality of life

- Ready to die
- Sees continued existence as pointless
- Tired of life
- Unable to pursue pleasurable activities
- Unworthy dying
- Desire to control circumstances of death

The patient asks for death when his psychological purview changes from 'why me' to 'what next'. An initial request for death should be interpreted as a call for information about the future and an appeal for a commitment to respond to anticipated suffering.¹

WHY IT HAS BECOME AN ISSUE?

People who want assisted suicide to be legalized believe that individual should be able to control the time and circumstances of their own deaths. Some argue that actively causing one's own demise is no different from refusing life-supporting treatment.

But opponents fear that vulnerable individuals may be coerced into assisted suicide to ease the financial burden of caring for them. They also worry that assisted suicide could ease pressure to provide better palliative care and find new treatments and therapies. Religious opponents argue that

God, not humans, should decide the time for death. Many medical professionals maintain that it is never permissible for doctors to help kill a patient.

8.1. INTERNATIONAL AND NATIONAL SCENARIO ON EUTHANASIA

Taking into consideration of the ethical aspects involved in euthanasia, it is important to realize that the content of legislation legalizing euthanasia is seldom dictated by the positions one takes on particular moral issues. For example, the view that voluntary euthanasia is morally permissible in certain circumstances does not by itself settle the question of whether euthanasia should be legalized. The possibility of legalization of euthanasia may also carry with it other aspects like abortion, value of human life etc. For. Ex. The practice of non-voluntary euthanasia i.e. in the case of severely disabled new born infants. Voluntary euthanasia, on the other hand, could be defended on the distinct ground that the State should not interfere with the free, informed choices of its citizens in matters that do not cause harm to others.

It is observed that the legal definitions of homicide in the west changed somewhat as a result of new attitudes towards the elderly and the terminally ill. Traditionally, European codes acquitted a person for a "mercy killing", whereas Anglo-American codes did not do so. But in the 1990s, a widespread "Right to Die" movement in North America and Europe sought the legalization of certain forms of euthanasia. As per the Britannica Book of the year 2007, the procedures for the assessment of the decision process leading to physician-assisted suicide and voluntary euthanasia – which were
Can there be a Right to Assisted killing?

The implication of the term 'euthanasia' is itself cloaked in ambiguity. However, the problem that arises here is that the term terminally ill has no precise definition. For instance, Jack Kervorkian, a famous proponent of euthanasia, defined terminal illness as any disease that curtails life even for a day. Some laws define terminal as one from which death will occur in a relatively short time or within a span of six months. The focal point is that all these definitions show ambiguity and medical experts have acknowledged that it is virtually impossible to predict the life expectancy of a particular individual.

Arguments in favor of legalization of euthanasia are typically premised on the assumption that requests for euthanasia are a "rational" decision, given the circumstances of terminal illness, pain, increased disability, and fears of becoming (or continuing to be) a burden to family and friends. Given the possibility that these symptoms and circumstances may not be relieved, even with aggressive palliative care and social services, the decision to hasten one's death may seem rational.

However, it is emphasized that this issue hovers around an invaluable asset called life. Just as a mistaken diagnosis is possible, so is a mistaken prognosis. It must be remembered that death is final and a chance of error too great to approve the practice of euthanasia.
Research has shown that ninety percent of the pain can be alleviated by proper pain control methods. Appropriate care can make a huge difference. This goes to show that medicine and technological breakthroughs have a fitting reply to almost every problem and the extent of medical commitment is irrefutable.

In contradiction, if the life of every terminal patient is dubbed as meaningless life, impetus to research, which is the answer to therapeutic medicine, would be foiled. If legalized, doctors would be forced to perform such acts against their consent that would amount to a violation of the Hippocratic Oath which states: "I will prescribe regimen for the good of my patients according to my ability and my judgment and never do harm to anyone. To please no one will I prescribe a deadly drug, nor give advice that may cause his death." Thus, the possibility that a physician may directly hasten the death of a patient - one whom the physician has been presumably treating in an effort to extend and improve life - contradicts the central tenet of the medical profession.¹

Cross Currents on Euthanasia

Experts denouncing the legalization of euthanasia say it should not be allowed in a country where already the old and destitute are considered a burden and there's no social system to support them. People might exploit this law to fulfil their selfish interests.says Dr. Bishnu Prasad Panigrahi, an anesthesiologist, Max Heart and Vascular Institute, “ The entire world is

debating for a long time but the countries have not made mercy killing legitimate because life and death are the two fine acts of God and mere mortals have no right to interfere. Laws are open to misuse and malpractice, which gives a bad name to medicine.”

According to the Chief Executive of Voluntary Health Association of India (VHAI), Alok Mukhopadhaya, euthanasia should be legalized but with strict parameters to avoid its misuse which is very likely in a country with a large number of illiterate populace and rampant unethical medical practice.

Henk Jochemsen says, Acceptance of euthanasia for people who are tired of life will further social pressure, to those who feel themselves to be a burden to others, to ask for euthanasia.

"Banning intentional killing protects each of us impartially, embodying the belief that all are equal, whether they are young of old, fit or sick, able or disabled," said Prof. Peter Millard of the British organization, ALERT (Against Legalized Euthanasia - Research and Teaching).

The precious words of Thomas Jefferson strike a chord: The care of human life and happiness and not their destruction is the first and only legitimate object of good governance.¹

To wet our process of thinking on this highly controversial and burgeoning topic of 'Right to Mercy Killing', the views expounded by two eminent personalities of American life i.e. Derek Humphry, founder president

of the Hemlock Society and author of FINAL EXIT, a suicide manual for terminally ill; and Father Richard Gula, s.s., Ph.D, a Professor of moral theology at St. Patrick’s Seminary in Menlo Park, California, in a symposium on “Legalizing Euthanasia: Ethical Perspectives on Medicine and Dying”, are of great relevance, since they refer to the clash of ‘individual case ethics’ and ‘societal ethics’.

Derek Humphry moved by the tragic end of his first wife, and avowedly committed and wedded to propagate the cause of legalizing euthanasia, emphasized that the extreme pathetic condition of a suffering victim who is cautious of his/her impending death and non-availability of any remedial cure to avoid pain, will prompt any sensitive human being to shelve one’s own views, be religious or ethical, and get prepared to comply with last “Death Bed Wish”. He candidly declares that he is an atheist and for him, to consider the last wish of a patient like “Will you help me die?” for compliance is “A MATTER OF SITUATIONAL ETHICS.” Of course, even Derek Humphry, as presented in his “Final Exit”, the request of patient seeking for assistance in voluntary killing shall not be taken very casually, but should be dealt with all care and probabilities and possibilities of sustaining a harmonious and fraternal society. He suggests that a written request addressed to a Doctor stating that “I have had all I can take. The pain and suffering are too much. I wish to die. Help me” is to be obtained from the patient, and the physician would have to obtain the opinion of a second doctor and both the doctors have to tread cautiously to avoid the legal consequences.
In contra distinction, Father Richard Gula, forcefully attacks the "paradigm of individual case analysis" of euthanasia. His main thrust is that discussion on euthanasia should not be governed by individual case ethics but by societal ethics. Father Gula states that 'the sanctity of life' principle is probably the common ground principle and that there are two extreme positions that can give 'sanctity of life' as a principle a bad name. One extreme is VITALISM that tries to absolutize physical life an idol out of biological existence and for this no cost is too great to keep this biological life going. The second extreme interpretation leads to 'UTILITARIAN PERSPECTIVE', which values life for its usefulness, which says that only the strongest and the fittest ought to survive, and danger is the "abuse of undertreatment."

Father Gula intends to consider 'the sanctity of life' cautiously from the "middle position." This midway interpretation recognizes that -

"we have limited dominion over life. It's the interpretation of the principle that recognizes we have ought to care for life and promote it and enhance it in order to allow our stewards of life, that we ought to care for life and promote it and enhance it in order to allow our lives to flourish and to achieve our potential. This is the interpretation that wants to respect life in all its forms and in all its stages."

He further says that this middle-path interpretation entails two obligations –

a) Positive one – to nurture and support life; and

b) Negative one – not to harm life;
And ultimately to appeal to sanctity of life in a discussion of euthanasia is to create a presumption in favour of life.

Then the second obligation is the principle against the prohibition of killing. Gula looks at three ways of interpreting this obligation

a) That there is no moral difference between killing and allowing to die – that once you decide that life no longer needs to be sustained, because the use of treatment would be futile, then it makes no difference whether you actively intervene or simply withhold or withdraw treatment.

b) That there is qualified moral difference – that the distinction holds but gives way at a certain point. Some will say when the person has gone beyond the reach of human care, when there is no longer the capacity to receive love, or to receive comfort, then the distinction dissolves. Others will say when the person is in intractable pain and there is nothing more that can be done to relieve the pain, then the distinction between killing and allowing to die dissolves. Others would say when the patient is overtaken by the dying process – that is to say, once you have decided that nothing more needs to be done, that life has reached its limits, then it makes no difference whether you withhold treatment or intervene, because in that condition, you are not usurping the dominion that is not yours.

c) The third position says that the distinction hold all the way through.

The next principle is the 'principle of autonomy' which is at the core of the discussion – whether euthanasia ought to be legalized?. Father Gula says
that in American culture, ‘autonomy’ is interpreted as ‘the right to self
determination’, and that autonomy is there to maximize self interest, i.e. we
are able to pursue our own goals and life plans without external constraints.
When we interpret autonomy this way, we answer the question “whose life is
it any?” in favour of the one whose life is in question. This is the solid ground
for supporting euthanasia.

Here is a pertinent question. Can the principle of autonomy be used to
challenge euthanasia? Some argue that the very interpretation of autonomy
that says that you have the freedom to have another person intervene to take
your life is a contradiction of what autonomy means – that actually what you
are doing is giving away your freedom. The other way of looking at it is to
say that euthanasia is not primarily a private affair. It is a public or societal
action that involves others, and therefore it is some thing that ought to be
treated as a form of public action.

Then coming to the principle of ‘Common Good’, to show that
euthanasia ought to be sanctioned as a public practice, we need to be able
to show that we can justify it in more than the individual case. This is the
principle that says that when we establish a policy, we are sanctioning
actions as a common practice. When we apply that principle to euthanasia,
we need to ask, “how does the goal of my own private killing contribute
towards making society the context in which human life can flourish?”

Finally, there should be a discussion on “the perspective of virtue.”
Gula says that ‘Virtue asks whether or not a policy on euthanasia creates the
right kind of relationship between the physician and the patient, and would a
policy on euthanasia create the right kind of community in which health care is delivered. The perspective of virtue asks that the physician deliver compassionate care within the limits of the physician's role. The trust that we extend to medical profession to heal and protect life is something that we would want to sustain and the perspective of virtue asks whether that kind of trusting relationship would be enhanced or hindered if euthanasia became part of the options that are available to the physician. The perspective of virtue looks on ourselves as a community of interdependent in which we are partners to one another. It sustains the community of trust and care by promising not to abandon anyone, and it tries to be realistic about accepting the limits about what it means to be human. We recognize that life will not be free of suffering, that life will be burdensome, and there will be tragedy. The perspective of virtue tries to be realistic about accepting that. It encourages us to construct structures of support which will enable us to raise those who suffer into the network of the supportive, caring community.

Giving such an emphatic rationale on the internationally debated issue, Father Gula concludes that with regard to such a fragile topic of euthanasia, "we cannot convert individual cases into public policy without having something remaining. The common good resists the temptation." He further opines that ultimately euthanasia is going to turn not on the basis of principles we argue but on the 'kind of people' we are, and warrants an introspection - "Are we a virtuous people that creates a community of caring
or are we going to compromise that in the way we allow euthanasia to become a practice in our healing society?

Father Gula holds that "in addition to personal virtue, we also need communal virtue. Our communal life must witness to those fundamental religious and moral convictions that nurture a vision of life that includes death as an inevitable outcome. A virtuous community provides the strictures and develops the skills that enable us to provide companionship, sympathy and support in the time of trial. Already a movement is under way to improve end-of-life care by educating health-care providers to respond better to the needs of dying patients, by creating new care settings or improving existing ones, by seeking changes in methods of pain for appropriate care by educating the public through conferences, town meetings, television programming and even web sites, by providing adequate relief of pain by withholding or withdrawing treatments that only prolong dying, by keeping company with those who are lonely and by being a resource of meaning and hope for those tempted to despair".

Cardinal Joseph Bernardin's death touched the hearts of many. When he spoke about suffering, fear, pain and humiliation, he spoke out of his own experience. He showed that we can exercise not just by being in control, but also by consenting to our limits and surrendering to what is beyond human control. He joined his suffering with the paschal mystery of Jesus and trusted in the goodness of God.

Father Gula further says that “facing pain, suffering and death in ourselves and in others is the price of being human. While this fact is biologically determined, there is nothing fixed about how we will respond to it. What sickness and the threat of death do to us is one thing; and what we make of them is another. If life has no particular meaning when every thing is going well, then what can life mean when every thing goes wrong?” He opines that we will be able to shape public attitudes towards death only when we compellingly witness to our religious convictions about life, suffering and death.¹

Further, the medical profession can assuage pain, but they can not go beyond a certain point, particularly where the patient has developed tolerance of the drugs. Lord Chorley in his parliamentary debates observed that ‘if an animal is suffering from pain, it is against the law, not to put it out of its misery. But to put a fellow human being, who is suffering from the same sort of pain is one of the most heinous offences. This is anomalous’. (Parliamentary Debates (Lords), 28-11-1950, Vol. 169, Col. 556). Earl Huntingdon observed that ‘it is not the doctor who is the arbiter of the patient’s fate. It is the patient who has to insist that his suffering is incurable. The doctor merely says that a particular disease is incurable at the present time and the pain is agonizing. There is also a strong view that SANCTITY OF HUMAN LIFE DOES NOT IMPLY THE FORCED CONTINUANCE OF AN EXISTENCE IN PAIN AND SUFFERING.

¹ www.religion-online.org.
Lord Dawson, an eminent physician, while opposing the Bill in 1936, made the following observation with all courage and clarity and brevity:

"The medical profession moves with thought and caution in such matters. Opinion, tradition, even codes of conduct, exert guidance. Is it not better thus? A woman has endured a disease with incomparable bravery for nine years, has pursued her calling and directed and sustained her home. At long last, by the extension of the disease and diminishing strength, she is crushed by pain and complete disability. She has sought peace and kindly death and called to witness how hard she fought. Is submerging of her sufferings to be denied her because her life might the shortened by two or three months? That can only be decided by her doctors, who know the thoughts and feelings of the patient and the realities of her state. This is some thing which belongs to the wisdom and conscience of the medical profession and not to the realm of the law..... If any of our colleagues think that in the case I have mentioned the patient should struggle on to the end, he would act accordingly and there would be no chiding amongst us." ¹

Law on Assisted Dying in Netherlands and Belgium are restricted to doctors. Assisted Suicide (but not euthanasia) is not illegal in principle either in Germany or in Switzerland, but a Doctor's participation in Germany would violate the code of professional medical conduct and might contravene of a doctor's legal duty to save life. The Assisted Dying for the terminally ill Bill proposed in the U.K. in 2005 focused on doctors, whereas the proposal on Assisted Dying of the Norwegian Penal Code Commission Minority in

¹ Parliamentary Debates (Lords) (1-12-1936) Vol.103. Cols. 483 and 485.
2002 did not. Professional medical organizations in all these countries except Dutch maintained the proposition that medical assistance in dying conflicts with basic role of doctors. However, in Belgium and Switzerland and for a time in the U.K. the organizations dropped their oppositions to new legislation. To-day they regard the issue as primarily a matter for society and politics. This 'neutral stance' differs from the official position of the Royal Dutch Medical Association which has played a key role in the developing the Dutch practice of Euthanasia as a "Medical end-of-life decision" since the 1970s.

Assisted Killing is legalized in Belgium and Netherlands and openly practiced in Switzerland. But the same is illegal in Germany, Norway and U.K.

We do not deny that there is a view point which asserts that while a person may claim a right to live, he or she nevertheless has no right over ending his or her own life. Irrespective of the how this view point is justified, whether because of the will of God or because of the fact that man is a social animal, this view point is quite honourable and justifies the fact that those who share it reject for themselves the thought of shortening a life to which they confer a value inferior to none. This view point was expressed in law by a strict condemnation of euthanasia.

However, one must recognize that such a view point is no longer is shared by all members of our society. There is a different view point which places the autonomy of the person at the centre of the debate and which is
shared also by some catholic people who want to live their faith in freedom and responsibility.

Any pluralistic and democratic society must allow every citizen to live this last act of their life, that of choosing their own death, according to their private convictions; such a society must not fail to favour the co-existence of different concepts of the direction that one wishes to give to one's life or one's death, rather than allow one kind of morality to prevail over another. That freedom can not be obtained clandestinely i.e. as long as euthanasia is criminalized, as long as the compassionate gesture of the physician who meets a request for euthanasia is indictable as that of an assassin. In other words, the role of the law is not to impose one moral standard over another which was actually the case before the change of the law.¹

Among 988 patients interviewed, 60% supported PAS in abstract and 10.6% seriously consider for themselves at the time of initial interview. 10.3% patients were considering PAS at the time of second interview, done after two months. However, half of those were newly contemplating PAS and half of those previously considering PAS were no longer considering the option.²

In so far as the role of Physicians is concerned, the moral beliefs and actions regarding PAS vary from one physician to another. A non-judgmental stance should be taken despite complex legal and moral issues.

¹ Jacquelline Herremans – www.iheu.org/node/11101 (international humanist and ethical union.

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It is ascertained in a study conducted on 2761 physician, 60% agreed that PAS should be legal in some cases. However, only 46% were willing, if PAS were legal, to prescribe lethal medication. 31% were unwilling to prescribe for moral reasons even if PAS would have been legal. 7% reported having written a prescription knowing that the patient intended to use it to take his/her own life. Some physicians provide lethal prescriptions to terminally ill patients even in jurisdictions where the practice is illegal.1

8.2. CONSTITUTIONAL IMPLICATIONS OF RIGHT TO END LIFE:

The emerging right to life debate threatens to turn into a debate over the meaning of the Constitution itself. For example, the Fourteenth Amendment of U.S. constitution prohibits the States from depriving “persons” of their ‘life, liberty, or property, without due process of law.’ Then –

a) Are P V S patients ‘persons’ within the meaning of the 14th Amendment?

b) If they are persons, do they have a life which is protected from State deprivation?

c) Might PVS patient, even if they have no ‘life’, nonetheless have protected ‘liberty’ and ‘interest’?

d) What might constitute a State deprivation of a protected ‘life’ or ‘liberty’ of brain injured or seriously ill patient?

All of these intriguing questions, of course, were unimaginable to those who drafted the language that at the centre of thing emerging debate.

When does a person cease to be a “Person”?

Do we identify ‘persons’ through a biological, philosophical, or a religious inquiry? If the original intentions of framers guide constitutional personhood, then whatever type of enquiry the framers wanted should be pursued. However, the intentions of the thirty ninth Congress with respect to how fourteenth amendment ‘personhood’ should be interpreted are far from clear. While it is possible to draw some conclusions as to about when personhood was thought, in 1868, to begin, belief about when it might end was limited by the state of 19th century medicine. The technology for prolonging life that exists today was inconceivable in 1868. During the 19th century and first half of the 20th, the condition now known as ‘Persistent Vegetative State’ was known. Any injury substantial enough to cause upper brain death was certain to produce actual death as well. Biological (existences) cryogenically preserved in cylinders of liquid nitrogen, as some are today, were even further from the imaginings of the drafters and ratifiers of the 14th amendment. At some point, constitutional personhood ends for us all. For the framers of the 14th Amendment, the answer to the question of when personhood ended seemed obvious: Personhood ended when life ended, and that was the moment the heart and lungs stopped working. Modern technology has turned what was in 1868 an inconsequential question into one that the Courts will soon have to answer.

When history and constitutional text yield ambiguities rather than answers, Constitutional interpretation should be guided by moral and economic consequences that might follow from equally plausible alternative
meanings. As is the fashion today, however, consequences driven decisions must be explained conclusively by reference to original intentions, text, and case law.¹

The learned author says that there are strong arguments for taking consequences into account when deciding constitutional cases. Some constitutional provisions, such as the Equal Protection Clause, contain language that invites attention to consequences, while others do not. The language of the Due Process Clause invites attention to the consequences of extending process. Consequences appear relevant to deciding whether a process is 'due'. What process is due should depend in part on an analysis of what adverse effects persons might suffer if the process is denied. On the other hand, it is more of a stretch to argue that the consequences of various life prolongation measures are relevant to the question of whether the recipients of such measures are 'persons'. Justices that will ultimately decide the scope of 14th Amendment 'Personhood' may feel compelled to hide the real basis for their decisions, which may will be consequences that attach to various possible interpretations of persons.

An interpretation of "persons" that covers PVS patients would mean increased societal resources devoted to life prolongation measures. If PVS patients are persons, public hospitals must continue to devote millions of dollars in beds, equipment and labour to maintain these people. Many of the 35,000 people on a national waiting list for organ donors will have to wait longer, many head injury victims, frequent sources of donated organs, will be

kept in a PVS state until their organs are no longer suitable for transplant. Some families of PVS patients, if unable to make successful 'Right to Die' claims on behalf of their PVS family member, will suffer financial, and emotional stress that otherwise could have been avoided.¹

The U.S. Supreme Court paid more attention to the question of "when Fourteenth Amendment personhood begins" rather than to the question of "when it ends". In Roe vs. Wade, the state argued that fetuses were "persons" but the Court concluded that were not persons stating that the word 'person' has application only postnatal. The attributes of life and humanness, which were of no particular concern to the Court in Roe, were central to its conclusion five years earlier that illegitimate children were 'persons' within the meaning of 14th Amendment. The Court in Levy v. Louisiana (391 U S 68 – 1968) stated its unsurprising conclusion thus: "We start from the premise that illegitimate children are not 'non-persons'. They are humans, alive, and have their being. They are clearly 'persons' within the meaning of the Equal Protection Clause of the Fourteenth Amendment."

The three Levy criteria for personhood – humanness, aliveness, and being – derive from a plain meaning test for personhood that was absent in Roe. Humanness remains a constitutionally significant concept. Chimpanzees, even though they share nearly ninety-nine percent of human genetic material, are certain to find that the missing one percent deprives them of the status of persons for constitutional purposes. Of course, Humanness is both more limiting and more intuitively obvious than the other

¹ www.law.umkc.edu/faculty.
two criteria of Levy's decision i.e. Aliveness and being. Only one of the five to ten million species on the earth is human.¹

PERSONHOOD PRINCIPLE IN CRUZAN CASE:

In CRUZAN vs. DIRECTOR, MISSOURI DEPARTMENT OF HEALTH [497 US 261 (1990)] the Court considered a request by the parents of a 32 yr. old PVS patient for an order directing the withdrawal of artificial feeding and hydration equipment. The patients argued that the 'due process clause' did not allow Missouri to compel their daughter Nancy Cruzan, to remain on life support, absent clear and convincing evidence that Nancy had made a prior, express choice to avoid the treatment. According to the Cruzans, Missouri must allow the termination of life support when the weight of the evidence suggested that was the choice a PVS patient would make, were she competent to do so. The Cruzans argued that the Missouri heightened evidentiary standard was not supported by the substantial interests necessary under the Due Process Clause.

The Cruzans and Missouri agreed on one thing: Nancy Cruzan was a 'person' within the meaning of Due Process Clause. The Cruzans assumed that establishing personhood was a prerequisite to asserting a protected liberty interest in refusing unwanted treatment. The State recognized that Nancy Cruzan was a person when it asserted that its justification for a heightened evidentiary standard was its interest in "the preservation of human life." Given the position taken by the parties, it was not surprising that the Court in Cruzan assumed that Nancy was a 'person' albeit an

¹ World Resources Institute, World Resources 1987, at 78 (1987).
‘incompetent one’. The Court’s conclusion followed from the simple observation that Nancy was ‘not dead’.

If death is determined by applying established legal criteria, then the court was clearly correct in describing Nancy Cruzan as ‘not dead’. Missouri and most other States have adopted by statute a “whole brain death” standard for separating the living from dead. This definition of ‘death’ endorsed by a Presidential Commission in 1983, requires that both the cerebral cortex (upper brain) and the brain stem irreversibly cease to function. Under an alternative definition of death, the “upper brain death” standard, the irreversible cessation of function in the cerebral cortex alone would be sufficient evidence of death.¹

The reasons for adopting the ‘whole brain death’ standard are not based on a belief that a person with functioning brain stem, but no function in the cerebral cortex, has a ‘life’ that is worth preserving. Once the Cerebral Cortex dies, along with it die all psychological attributes of ‘personhood’—emotion, awareness of environment, and the ability to entertain thought or experience pain. The brain stem regulates respiration, circulation and certain involuntary reflexes. Thus persons who experience upper brain— but not whole brain death (i.e. P.V.S patients) may laugh, cry, grimace, yawn, swallow and open their eyes. Their eyeballs cannot track or focus, however, and no visual input is sent to the brain.

The ‘whole brain death’ standard triumph primarily for practical, not moral reasons. Whole brain death, for example, is easily diagnosed; upper

¹ Ibid.
brain death is not. Patients sometimes partially recover from vegetative state and it is tricky to judge the odds of recovery in a particular case. While it may be clear that the upper brain has suffered irreversible damage, it is not always clear that the damage is total. Only over a course of months or years does the cerebral cortex of a PVS patient come to be almost completely replaced by fluid bearing ventricles. In the earlier stages of PVS, there is no fool-proof test for its diagnosis. PVS is a clinical diagnosis, generally made after repeated physical examinations rather than by laboratory studies. A conservative upper brain death standard would insist upon the cessation of all electrical activity in the upper brain, not just cessation of the brain waves correlated with conscious thought.¹

The author cautions that an interpretation of 'persons' broad enough to encompass cryogenically preserved bodies, brains detached from bodies, genetically engineered super-humans, artificial intelligence, or other wonders that technology may bring us, would have far reaching adverse consequence. An approach that leaves to the states some room for interpreting 'persons' has several advantages. Finally, the Court should be sensitive to the moral concerns raised by a shift to more liberal state definitions of death. Morally dubious conduct must not be allowed to lead to morally wrong conduct. States should not deny requested life support or nutrition to a person retaining significant upper brain function.

In Cruzan's case, the Supreme Court has not been asked to decide whether PVS patients have a 'life' that may not be taken by the State without

¹ www.law.umkc.edu.
affording due process. Nancy Cruzan claimed that Missouri Law deprived her 'liberty' not her 'life'. It was her life – if she had one – which she wanted to end. Nonetheless, Court, in giving weight to Missouri's asserted interest in the "preservation of life", implicitly recognized that Cruzan had a life, and presumably would continue to have one until she met the state's criteria for issuance of a death certificate. But Justice Stevens, however, did not assume that Nancy Cruzan had a 'life.' The learned justice noted that a patient in PVS "has no health, and, in the true sense, no life, for the state to protect." 'Life is rarely thought to encompass every form of biological persistence by a human being.'

The National Council on Disability in U.S. opined that the issue of Physician-Assisted Suicide for persons with imminently terminal conditions appears to be like the plight of the mythical Jason whose ship, the Argo, had to sail between the two monsters, Charybdis land Scylla – neither choice is very appealing.

Opposing the legalization of assisted suicide seemingly deprives people with disabilities faced with imminent death and severe pain the only power they can have to decide when and how they will die, an ability to choose that might offer them some control, dignity, and measure of self-determination in an otherwise bleak situation; such control of one's own destiny, freedom of choice, and self-determination are key principles of the disability rights and independent living philosophies and cornerstones of the initiatives which the Council has advocated.
On the other hand, legalizing assisted suicide seems to risk its likely use, the ultimate manifestation of prejudice against people with disabilities in our society, as a means to unnecessarily and or to coerce the end of people with disabilities' lives; persons with disabilities know that many in society believe that they would be better off dead, and legalized assisted suicide offers a subtle and some times-not-so-subtle way to make that judgment a reality.

Competent adult patients seeking to lend their lives will generally fall into one of three groups.

First, there are those who are able-bodied enough to take their own lives. Suicide is not a criminal offence, and even if there is not right to commit suicide, the law undoubtedly recognizes that, on balance, the anguish caused by criminalizing suicide far outweighs any interest the State might have in preserving life. It is therefore, both lawful and relatively straightforward for patients in this group to end their suffering by taking their own lives.

Secondly, there are patients, such as Mr. B, who are sufficiently disabled that they are connected to artificial means of life support. Patients in this group have the right to insist that their doctors do some thing to bring their lives to a quick and painless end.

Thirdly, there are patients like Dianne Pretty, who fall somewhere in between. They are not sufficiently able-bodied to commit suicide, but neither are they sufficiently disabled to require artificial life support. Unlike those in
the first and second groups, this third group of patients has no option but to endure an unendurable death.¹

The learned author observes that absolute prohibition on euthanasia ignores the genuine needs of this small sub-sect of patients in distress for whom life has become unbearable, and the disregard of the individual patient's perspective is wholly at odds with the trend towards a patient-centered approach to medical law and ethics. In total ban of euthanasia, patients do not have the right to demand positive access to particular medical procedures. Unlike a competent patient's refusal of life-prolonging medical treatment, which must be respected by doctors, the principle of autonomy could not require doctors to comply with a request for euthanasia. Rather, the purpose of legislation would simply be to allow doctors to act lawfully when they help a patient to die.² Emily Jackson observes that while the general prohibition on doctors killing their patients would remain in tact, it should be acknowledged that an exceptionalness rule which forces some people to endure a death that we would not inflict on a pet hamster is cruel and morally indefensible.

For medical law to be reinforcing Hippocratic values, rather than promoting optimum patient care or enhancing autonomy is now deeply anachronistic. Historically it is true that medical law was essentially synonymous with the profession's own internal standards of conduct. Medical practice was strongly paternalistic and while doctors were under a

² As per the Philosophers' Brief of R.Dworkin, T.Nagel, R. Nozick, J.Rawls, T.Scanlon and JJ.Thompson in the cases of Glucksberg and Vacco.
duty to act in their patients' best interests, it was doctors, as opposed to the patients themselves, who decided what those interests were. Since the 1960s, medical law and ethics have increasingly focused upon the patient's own perspective. The principle of patient autonomy is now dominant and medical law robustly protects the component adult-patient's right to have his/her decisions treated with respect. In relation to euthanasia, however, the current legal position necessitates a peculiar and willful disregard for the individual patient's point of view. Jackson chose to focus upon competent adult patients' access to voluntary euthanasia. Though he is not advocating an autonomy-based model for the regulation of euthanasia, he firmly believes that the concept of patient autonomy is of limited relevance. He argues that in those cases where the patient's belief that her suffering has become unendurable is shared by her doctor, the absolute prohibition of euthanasia unreasonably fetters the doctor's clinical discretion. Patients should not have a right to insist that their doctors kill them; rather it should be the freedom of medical profession to respond appropriately to their individual patients' needs, and not a patient's "right" to euthanasia.

When a system of law considers the lives of hapless infants, aged, infirm and persons with terminal illness as sacrosanct to be preserved and perpetuated with all deficiencies and deplorable pains, it appears that law adopts the sanctity of life ethic in a static manner overlooking the human misery as originating in debilitating illness.

Euthanasia presents a paradox in the code of medical ethics, for it involves a contradiction within Hippocratic Oath, to which most physicians
adhere as their standard of medical ethics. The oath includes both a promise to prolong and protect life when a patient is in the last and most painful stages of a fatal disease, and to prolong life violates the promise to relieve pain, but to relieve pain by killing violates the promise to prolong and protect life. Simply stated, the code of medical ethics holds that it is never right intentionally to take an innocent human life. In medical context, it is said that, it is absolutely prohibited to either intentionally to let a patient die or do any thing so as to sustain the human life on consideration of its quality.¹

The law does not say that if a patient is kept alive on mechanical life support systems, the artificial aid can not be withdrawn. Certainly, these systems have to be stopped at some point. Now the question is – what is that stage. The life support aid can be withdrawn when it cannot always give the expected result to revive the patient. In such a crucial situation the decision should be taken in consultation with another doctor. The American Medical Association has policy that says that a doctor can ethically withdraw all means of life-prolonging medical treatment, including food and water, from a patient in an irreversible coma. Yet the same policy insists that the physician should not intentionally cause the death.²

8.3. ARGUMENTS RAISED AGAINST EUTHANASIA:

"It is difficult to argue against euthanasia in a pluralistic society without appealing to the 'teachings of Sacred Scripture or the tradition of

Christian teachings and the consistently pro-life pronouncements of the magisterium." Says Michael Manning, a physician who entered seminary after practicing medicine for 13 years.¹

Euthanasia is usually suggested as a measure of relief for "terminally ill" persons who are bound to face death in a short span of time. The measure is meant to alleviate suffering by hastening the inevitable death. The argument that is usually raised is that in medicine, one can not ever say for certain what a person's life expectancy will be like, even if their medical condition is really hopeless. Increasingly, however, euthanasia activists have dropped references to terminal illness, replacing them with such phrases as "hopelessly ill", 'desperately', 'incurably ill', 'hopeless condition' and 'meaningless life'.²

According to Physicians for Compassionate Care Education Foundation (PCCEF) on the role and duty of physicians, the Physicians have the duty to safeguard human life, especially life of the most vulnerable, the sick, elderly, disabled, poor, ethnic minorities, and those whom society may consider the most unproductive and burdensome. Physicians are to use all knowledge, skills and compassion in caring for and supporting the patient. Medicine and physicians are not to intentionally cause death. The Patient-Physician trusting relationship is the most important asset of physicians and is for the protection of the patients. PCCEF opposes PAS because –

¹ Michael Manning, Euthanasia and Physician Assisted Suicide: Killing or Caring, P-86.
Doctor assisted suicide undermines trust in the patient-physician relationship.

Doctor assisted suicide changes the role of the physician in the society from the traditional role of healer to that of the executioner.

Doctor assisted suicide endangers the value that society places on life, especially for those who are most vulnerable and who are near the end of life.¹

But as per the article “Why Oregon patients request assisted death: Family Member’s views” by Linda Ganzini, Elizabeth R. Goy and Steven K Dobscha published in the Feb. 2008 issue of Journal of General Internal Medicine 23 (2): 154-157, 180 of the 246 persons died of PAS in Oregon, on requests from the family members. There is a startling revelation that most of the family members are choosing PAS not because of uncontrollable pain or suffering, but they are primarily concerned about future concerns. “Some Oregon clinicians have expressed surprise at the paucity of suffering at the time of the request among these patients.”.

This article demonstrates that the traditional role of ‘comforting and caring’ is being replaced and disregarded in favour of ‘intentional medical killing.’

¹ www.pccef.org.
Some arguments against euthanasia can be stated as follows:

(a) If once we begin to allow legislation of this kind, we put our foot on a "very slippery slope." ¹

(b) A disease which is incurable today may become curable tomorrow.²

(c) Doctors may err in their diagnosis of patients.

(d) Pain can be, and should be, assuaged. The two extremes of dying in pain and being killed do not exhaust the possibilities of the stricken patient. (Lord Horder).

(e) "It is the business of the medical profession to help and to heal, and not to go into this pathological excursion into the realm of the uncertain."³

(f) Euthanasia amounts to a reorientation of the doctor's functions. Doctors are sympathetic towards the efforts at securing biological control before the life begins and while such life lasts. But into this matter of putting an end to life, surely a new principle enters, and 'this principle is outside the doctor's reference'.⁴

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¹ Lord Archbishop of York, Parliamentary Debates (Lords) Vo. 169. col. 563.
² Lord Horder, Parliamentary Debates (Lords) Vol. 169, Col. 567.
⁴ Lord Horder in Parliamentary Debates (Lords) - 1-12-1936 Vol. 103, col.490.

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(g) The Christian believes that pain has a supernatural value.....
Throughout life, there is a residue of pain which cannot be alleviated. Further, there is sanctity of life..... "I can conceive nothing more dangerous than to suppose that by an Act of Parliament you can create another class licensed to bring death"....1

(h) A Bill legalizing euthanasia would allow murder in certain circumstances, and 'the limits within which it is allowed can never be so clearly defined that we may not have people stepping outside them'. (Lord Jowitt L.C)

2. It would bring the law into the bedrooms. Lord Dawson observed that – "The machinery of this Bill would turn the sickroom into a bureau and be destructive of our usefulness. The very idea of the sick chamber being visited by officials is something of which I have to think."2

R.J.D.George, senior lecturer in the Centre for Bioethics and Philosophy of Medicine, University College London states that –

a) Autonomy and suffering are the usual justifications for a change in law on euthanasia. The autonomy argument is thin. In all legislatures, the final decision for physician assisted suicide or therapeutic killing rests with the

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1 Earl Iddesleigh – Parliamentary Debates (Lords), Vol. 169, col. 573.
doctor. Patients' perception of total control over this type of death is illusory.

b) the cardinal argument against legalized euthanasia is the insoluble ethical conflict between meeting individual's demands for therapeutic death and ensuring that incapable, vulnerable or voiceless patients will not have lethal treatment prescribed as their best interest.

c) Treatments are medical goods. Since justice dictates that rights to appropriate treatment are universal, if assisted suicide is legal it becomes an optional treatment, not just for patients who want it but also for those who need it. A moral obligation exists for death to be a legitimate interest for all our patients. Therefore, assisted suicide or therapeutic killing becomes our proper duty towards any claiming or appearing to suffer unbearably, regardless of prognosis or capacity to consent. The inevitable accommodation of this shift in the status of assisted suicide and therapeutic killing is seen clearly in the Netherlands, where therapeutic killing is now extended to children, people with psychiatric illness and those who are mentally incapable.

Finally, he asserts that legalizing physician assisted or therapeutic killing is a far greater risk than compassion for the small minority pleading to be killed might imply.

Dr. Catherine Campisi, former Director of the California Department of Rehabilitation stated that "Assisted Suicide is a direct threat to any one that is viewed as a significant cost liability to public or private healthcare providers
It is argued on behalf of the State of Alaska in Sampson et al. vs. State of Alaska (09/212/2001) that 'the terminally ill are a class of persons who need protection from family, social, and economic pressures, and who are often particularly vulnerable to such pressures because of chronic pain, depression, and the effects of medication.' The Supreme Court of Alaska ruled unanimously that State laws punishing assisted suicide as manslaughter are to be upheld.¹

Lord Ponsonby has categorically stated that euthanasia is not an exclusively medical question, but it is an ethical, social and legal question.

The other argument is that euthanasia becomes a mode of health care cost containment by the government. In the U.S. large numbers do not have health insurance and the state has to bear the cost of medical treatment. Legalized euthanasia raised the potential for a situation in which doctors could find themselves better off financially if a seriously ill or disabled person chooses to die rather than receive long term care. It would also cause the Government less money, as they would pay less for treatment and care and replace them with the 'treatment' of death.

Even if the decision to resort euthanasia is voluntary, opponents believe that a patient could give into emotional and psychological pressures. If the choice of euthanasia is considered as good as a decision to receive

care, many people will feel guilty for not choosing death. Financial considerations, added to the concern about 'being a burden', could serve as powerful forces that would lead a person to 'choose' euthanasia or assisted suicide.

Some opponents raise the objection saying that in principle it may be justifiable, but once some thing is declared legal, the categories can be stretched to include a lot more instances than the one intended. A number of instances of pressure from family to burden of expenses, psychological depression due to longstanding illness, neglect by medical personnel can be fitted into the category of euthanasia, if it is legal. These other instances, which technically would fit the category, though not in real times, would tantamount to abuse of the license granted by the State.

Emphatic religious and philosophical objections are raised against euthanasia. Some believe that there is inherent value in human life and it should be sustained under all circumstances. Some believe that human life is endowment of God, and hence euthanasia would go against the Will of God. The Anglicans and Catholics have consistently argued that the terminally ill need care, they do not deserve to get killed. On the same lines, the medical community has consistently opposed mercy killing or assisted suicide reasoning that determining acceptable standards for 'quality of life' should not be the job of the doctor, but to use medical science effectively to
provide as much preventive or curative or relief assistance to a patient as possible.¹

REASONS AGAINST V.E:

1. Professional Role – VE could unduly compromise the professional roles of health care employees, especially doctors.

2. Moral – Some people consider euthanasia of some or all types to be morally unacceptable.

3. Theological – Euthanasia is considered to be a violation of the sanctity of human life and is considered as a sinful act/unjustified killings.

4. Feasibility of implementation – Euthanasia can only be considered ‘voluntary’ if a patient is mentally competent to make the decision. Competency is difficult to be defined.

5. Possibility of patients subjected to psychological pressure either due to economic paucity or prosperity of family members. If euthanasia become socially acceptable, the sick would no longer be able to trust either doctors or relatives. Many of those earnestly counseling a painless, dignified death, would be doing so mainly on financial grounds. EUTHANASIA WOULD BECOME A EUPHEMISM FOR ASSISTED MURDER.

6. Necessity – If the disease is expected to be cured, palliative care is the best choice.

UNFAVOURABLE ASPECTS OF EUTHANASIA:

➢ The assumption that most deaths are painful is wrong.

➢ The practitioners are increasingly willing to stop the futile treatments and use pain medications more aggressively and frequently; consequently there is no need for euthanasia.

➢ The distinction between active and passive euthanasia has to be maintained because of 'the intent' to deliberately end someone's life.

➢ The adverse consequences of legalizing euthanasia enumerated as follows:

➢ Euthanasia has 'abuse potential' – a certain and easy method to get rid of an objectionable relative.

➢ Predictions made by even highly skilled and competent physicians regarding disease prognosis may not be fulfilled and judging 'medical futility' may actually be futile.

➢ Patients will be under undue pressure to request euthanasia in order to relieve their families of distress – patients will be in dilemma.

➢ There will be a 'slippery slope' – initially the terminally ill could voluntarily request euthanasia, then the aged could, and then
involuntary euthanasia for incurably demented persons, absolute idiots and convicted murderers would be justified.¹

As could be perused from various arguments against euthanasia, one thing is crystal clear that the main thrust of the opposition to euthanasia breeds from the fear of misuse of right if it is permitted. Some construe that placing the discretion in the hands of the doctor would be placing too much power in his hands likely to be misused by him since the doctor is not a judicial officer. At the same time, we make not shirk from the placing the same kind of power in the hands of a judge.

However, Mrs. Borst-Eilers summarized the following criteria laid down by the Courts to determine whether the defence of necessity applies in a given case of euthanasia.

1. The request for euthanasia must come only from the patient and must be entirely free and voluntary.

2. The patient's request must be well considered, durable and persistent.

3. The patient must be experiencing intolerable (not necessarily physical) suffering, with no prospect of improvement.

4. Euthanasia must be the last resort. Other alternatives to alleviate the patient's situation must be considered and found wanting.

5. Euthanasia must be performed by a physician.

6. The physician must consult with an independent physician colleague who has experience in this field.¹

8.4. ARGUMENTS FOR EUTHANASIA:

"If I am not for me, then who is for me?"

"If I am just for me, then who am I?"

"And if not now, then when?"

Jewish Koan.

"Death is a great teacher and great healer too."

Rachel Naomi Remen – (Kitchen Table Wisdom)

Both proponents and opponents of Euthanasia are no doubt intellectuals.

The irony is that all intellectuals 'believe in belief.'

Proponents of euthanasia emphasize that when a person faces unbearable pain or disability, and dignity in his or her life is lost, it is only noble that a State grants him or her the right to choose to have death hastened. When the Federal Appeal Court in San Francisco voted 8-3 to annul a law barring assisted suicide that dated back 140 years in Washington State, the court said that competent adults have a constitutional right to seek help in choosing "a dignified and humane death rather than being reduced to a child-like state of helplessness" and the ruling was also followed in QUILL vs. VACCO.

Dr. Michael Irwin, 74 years, a retired GP and campaigner for the legalization of voluntary euthanasia who agreed to help a terminally ill friend commit suicide, was considered unfit to practice by the General Medical Council. Dr. Irwin stated that he knew of several doctors with “twinning” arrangements with fellow doctors to help each other commit suicide if a painful death threatened, and he admitted that he was twinned with a retired doctor in Glasgow. In a statement to the General Medical Council, Dr. Irwin said, “I believe passionately that in this apparently enlightened 21st century, terminally ill patients should have the right to obtain medical assistance to die, if this is their wish: to be able to pick a time for their death, preferably in their own familiar home environment.”

Some argue that euthanasia is not concerned with giving a right to the person who is killed, but to the person who does the killing. In other words, euthanasia is not about the right to die. It is about the right to kill. Euthanasia is not about giving rights to the person who dies, but instead is about changing the law and public policy so that doctors, relatives and others can directly and intentionally end another person's life. Since certain killing in certain circumstances is legalized by the State, the pro-euthanasia wing advocate that mercy killing should be legalized, as an act in the interest of humanism. The pro-euthanasia groups do not compare it to suicide, which is a private act. Euthanasia is not a private act. It is also of a particular

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1 [www.bmj.com/cgi/content/full/331/7519/717](www.bmj.com/cgi/content/full/331/7519/717).
public concern since it can lead to gross abuse, exploitation and erosion of standards, care for the most vulnerable people amongst us.¹

Neither law nor medical ethics requires that 'every thing be done' to keep a person alive. It would also be cruel and inhuman. There comes a time when continued attempts to cure are not compassionate, wise, or medically sound. Some proponents share the view that the modern medicine keeps human being alive for much longer than their natural longevity would permit. There is no point forcing people to stay alive 'hooked up' to machines.²

Some suicide friendly groups are of the opinion that rational decisions in favour of suicide can be taken and the freedom to take away one's own life is an important freedom, and should be recognized by the State. Some bio-ethicists are of the opinion that in some situations it is duty of the person to die, to alleviate others from emotional, financial burdens, or to promote world egalitarianism.³

Voluntary euthanasia could be defended on the ground that the State should not interfere with the free, informed choices of its citizens in matters that do not cause harm to others.

Favourable points for Euthanasia -

➢ It is human right born of self-determination.

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² www.internationaltaskforce.org.
³ Wesley J.Smith, 'Right to Die Movement is really about euthanasia, not compassion' (www.discovery.org/scripts/viewdb/index.php?)
It would produce more good than harm, by putting an end to the inescapable suffering.

There is no substantive distinction between active euthanasia and the withdrawal of life-sustaining medical interventions (passive euthanasia); in fact, active euthanasia is more controlled and timely.

Its legalization would not produce deleterious consequences.¹

Dr. B.R.Sharma, Reader in Dept. of Forensic Medicine & Toxicology. Govt. Medical College and Hospital, Chandigarh says that "in the debate on euthanasia, major disagreements relate to weight that is given to the self-determination of the patient. It is argued that denying the right to euthanasia would amount to forcing people to suffer against their will, which would be cruel and against their human dignity. The proponent's view on euthanasia seems to be a consequence of the infrastructure of the society and its interaction with the aspirations of people. A major factor in the acceptance of euthanasia is that the moral values in the modern society have become somewhat detached from religious values, creating a seemingly permissive culture. Multi party political system in many countries further keeps the political parties away from taking any initiative on a sensitive issue like euthanasia. Accordingly, the internationalization of the euthanasia debate seems imperative and International Human Rights Law, surely, can provide an adequate basis for such a debate. Clear guidelines regarding the criterion

and methodology of euthanasia need to be and can only be worked out by an open debate."

JUSTIFICATION FOR VOLUNTARY EUTHANASIA:

1. Supporters of V.E. insist that CHOICE is fundamental principle for liberal democracies and free market systems.

2. Quality of Life – The pain and suffering a person feels during a disease, even with pain relievers, can be incomprehensible to a person who has not gone through it. Despite the best pain killers, it is very difficult for the patients to overcome the emotional pain.

3. Economic costs and human experience – It is a burden to keep people alive past the point they can contribute.

4. Pressure – All the arguments against VE can be used by society to form a terrible and continuing psychological pressure on people to continue living for years against their better judgment.

5. Sociobiology – Currently, many proponents and laws may tend to favour the dying or unhealthy for access to euthanasia. More liberal voluntary euthanasia policies would empower the individual to counteract any such biased interest on the part of the relatives.

ALTERNATIVES TO ‘GOOD DEATH:

Frank Ostaseki, Founding Director : Zen Hospice Project (Zen and Good Death-www.zenhospice.org) in his article states that a ‘good death’ must be understood as a death that directly addresses the needs of the dying
person; and it is to be considered as a journey from 'tragedy' to 'transformation' if the unfortunate victims are properly supported. Even though, Care Givers can hold open possibilities i.e 'open the doors', the choice 'to enter or not to enter the doors' should always reside with the person who is dying.

The Zen Hospice theory says that there is no real service unless both people (those who are cared for and the caregiver) are being served. A care giver working for the dying one, is also working on himself; the care giver watching his own mind, aware of his own grief and fear of dying. This may involve three key elements:

1. Presence.

2. Compassionate Companionship.

3. Supportive enquiry.

Ms. Rachel Remen, author of 'Kitchen Table Wisdom' says that –

“Service is not the same as helping. Helping is based on inequality. It's not a relationship between equals. When you help, you use your strength and help some one of lesser strength. It's one-up and one-down relationship and people feel this inequality. When we help, inadvertently take away more than we give diminishing people's sense of self-worth and self-esteem.”

In dying, spiritual support is every bit as important as good medical care and yet we rarely extend this kind of meaningful service.
The outcome of our society's debate on physician assisted suicide may depend on how well we communicate and act upon – a similar message. We are living at a time when some doctors and law makers think that the best solution for some patients' suffering is to give them the lethal drugs for suicide. Catholics committed to the dignity of each human person must insist: "Kill the pain, not the patient".

It is a compelling message. Some opinion polls show support for assisted suicide when it is presented as the only relief for a dying patient in unbearable pain. But when Americans are offered an alternative, they overwhelmingly say that society should concentrate on ensuring pain control and compassionate care for such patients – not on helping them take their lives. This preference is even stronger among dying patients themselves. When the medical journal – The Lancet – reported on interviews with cancer patients on June 29, 1996, it found that dying patients experiencing significant pain were more opposed to assisted suicide than the general public. "Patients with pain do not seem to view euthanasia or PAS as the appropriate response to poor pain management, indeed, Oncology patients in pain may be suspicious that if euthanasia or PAS is legalized, the medical care system may not focus sufficient resources on provision of pain relief and palliative care" wrote Dr. Ezekiel Emmanuel, a director the study.

Realizing that assisted suicide is less popular than improved palliative care, euthanasia advocates have resorted to the claim that there is not much difference between the two. Their argument goes like this:
“Let us be honest. Doctors commonly practice euthanasia now, under the guise of pain control. They give dying patients massive doses of morphine to suppress their breathing, and then call their death a mere side effect. They justify this hypocrisy by invoking an invention of Medieval theologians called “the principle of double effect”. Some times, they even sedate these patients into unconsciousness so they can starve them to death. This terminal sedation is really slow euthanasia. It would be far more candid as well as more humane to practice euthanasia openly.”

Of course, the American Medical profession and the Supreme Court rejected the aforesaid argument.

PAIN CONTROL:

Many doctors hesitate to give dying patient adequate pain relief because they fear that high doses of pain killers such as morphine will suppress the breathing reflex and cause death. Yet we now know that this fear is based on false assumptions, and on inadequate training of physicians in ‘pain management techniques’. Even among Oncologists who proudly deal with more patients in severe pain, there is too little knowledge of the medically appropriate use of analgesic drugs.

In reality, a very large dose of morphine may well cause death – if given to a healthy person who is not in pain and has not received morphine before. But when administered for pain, such drugs are taken up first by the

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patient’s pain receptors. In fact, patients regularly receiving morphine for
pain quickly build up a resistance to side-effects such as respiratory
suppression, so they can easily tolerate doses that would cause death in
other people. Fortunately, they build up a tolerance to the side-effects far
more quickly than to the drugs’ analgesic effects — so doctors need not
hesitate to increase dosages when needed to relieve pain. The question,
“what is the maximum dose of morphine for a cancer patient in pain?” has
one answer. “The dose that will relieve the pain”. As long as a patient is
awake and in pain, the risk of hastening death by increasing the dose of
narcotics is virtually zero. Unrelieved pain is itself a stimulant, which
overwhelms any depressive effects of narcotics. Patients whose unrelieved
pain is distorting the very fabric of their lives need adequate pain control the
way a diabetic needs insulin to function properly.

Very rarely it may be necessary to induce sleep to relieve pain and
other distress in the final stage of dying. Euthanasia advocates call this
“Terminal Sedation”, but it is the same kind of sedation that is sometimes
needed to calm distressed or restless patients with non-terminal conditions.
While some terminally ill patients may die under such sedation, this is
generally because they were imminently dying already.

In competent medical hands, sedation for imminently dying patients is
a humane, appropriate and medically established approach to what is often
called “intractable suffering”. It does not kill the patient, but it can make his
or her suffering bearable. It may also allow a physician the time to reassess
a patient’s pain needs. The terminally ill sedated patient may later be
withdrawn from the sedative and brought back to the consciousness, with his or her pain under control.

The factual evidence supports these claims. In 1992, the Journal of American Medical Association (JAMA) reported on 97 terminally ill patients who died after life-support was withheld or withdrawn. 68 of the patients received pain killing drugs or sedatives to relieve pain and other distress while dying - and they lived longer than the patients who did not receive drugs. The study found that the dosages of these drugs were chosen to ensure relief of suffering, not to hasten death.

Only recently has the medical profession begun to appreciate that unrelieved pain can itself hasten death. It can weaken the patient, suppress or her immune system, and induce depression and suicidal feelings. It can keep patients from living out their lives with a modicum of dignity, in the fellowship of their family and friends. So adequate pain relief can actually lengthen life. According to a JAMA news item of March 25, 1992, part of modern medicine's task may be that of "killing pain before it kills the patient." Or as the Catholic Health Association says in its 1993 guide Care of the Dying: A catholic perspective: "unrelieved agony will shorten a life more surely than adequate doses of morphine."

In short, when dosages of pain killing drugs are adjusted to relieve patients' pain, there is little if any risk that they will hasten death. This fact alone should put to rest the myth that pain control is euthanasia by another name.
HOSPICE CARE IN THE U.K.: 

In 2003, there were 170 hospices and palliative care centers in England and 216 in the U.K. There were 59,000 patients in the UK being cared for by them. In 2003, 29,000 patients being cared for in a hospice or palliative care setting died. There are 51 beds per one million adults in the U.K. However, the availability of beds in hospices and palliative care centers varies in different parts of the country as do the extent of the services offered. [NICE-2004:paraE53] The average length of stay in the hospice is 13.5 days. There are only 332 palliative community based services and 247 palliative day care centers. 

At present, 95% of hospice care is funded by charities and voluntary organization. In 2001 less than a quarter of in-patient hospices were managed by the NHS and the rest of the NHS provided only a third of the total funding (BMA 2004:367). The Government has said it now recognizes the importance of palliative care and by 2004 will spend 50 million pounds per annum to improve palliative care services (a 38% increase on the 2000 figure (DoH-2003) These measures will be designed to reduce inequalities in accessing specialist palliative care [NHS Executive-2002]

ASSISTED SUICIDE AND PAIN CONTROL:

Mr. Doerflinger, Associate Director for Policy Development, Secretariat for Pro-life Activities, National Conference of Catholic Bishops and Dr. Gomez is Assistant Professor of Medicine at the University of Virginia Health System and Medical Director of its Palliative Care Program in
their article "Killing the pain and not the patient" have stated that Pain Control and other elements of palliative care must be clearly distinguished from intentional killing of patients. In trying to blur this distinction, euthanasia advocates only show their own indifference to the goal of promoting better care for dying patients.

In Logic and in practice, two very different paths lie before the medical profession and our society: What Pope John Paul II has called 'the false mercy' of assisted suicide and euthanasia and the "way of love and true mercy" that dedicates us to compassionate care(The Gospel of Life No. 66-67). It is literally a choice between Death and Life.

The learned authors bring a picture analysis and comparison of Assisted Suicide and Pain Control. They say that Assisted Suicide and good Palliative Care are not only distinct – they are radically opposed to each other.

Control of pain and suffering eliminates the demand for assisted suicide. As Dr. Herbert Hendin notes in his 1997 book 'Seduced by Death', some terminally ill patients have suicidal thoughts, but "these patients usually respond well to treatment for depressive illness and pain medication and are then grateful to be alive." Such treatment responds the underlying reasons why patients ask for death, instead of treating the patient himself as the problem to be eliminated. When pain control and other care improves, Assisted Suicide becomes largely irrelevant.
ASSISTED SUICIDE UNDERMINES GOOD PAIN MANAGEMENT?

During the Supreme Court's January 1997 oral arguments on its assisted suicide cases, Justice Stephen Breyer noted a remarkable fact from a report by the British Parliament's House of Lords. The Netherlands which has allowed assisted suicide and euthanasia for years had only 3 hospices nationwide, while Great Britain which bans these practices had 185 hospices. He had placed his finger on one of the most insidious efforts of legalization; once the "quick and easy" solution of assisted suicide is accepted in a society, doctors lose the incentive to pursue more difficult but life affirming ways of truly caring for patients close to death. The converse is also true. "Prohibiting assisted suicide sets a clear limit to doctors' option so they can commit themselves to the challenges of accompanying patients through their last days. As one physician said after years practicing hospice medicine: "only because I knew that I could not and would not kill my patients was I able to enter most fully and intimately into caring for them as they lay dying."¹

The assisted suicide movement is willing to discredit modern pain control to advance its own cause. Euthanasia advocates know that when they equate assisted suicide and modern pain management, they are not just elevating the status of assisted suicide – among people who oppose direct killing of the innocent, they are undermining good pain control. They do not seem to care that their arguments will make doctors and patients more distrustful of legitimate practices that can truly help people live with dignity in their last days.

But strong voices are being raised to make sure that they do not get away with this. In an April 1997 report on constitutional arguments about assisted suicide, the prestigious New York State Task Force on "Life and the Law" urged people on all sides of the assisted suicide issue to keep important distinction clear. Noting that "many physicians would sooner give up their allegiance to adequate pain control than their opposition to assisted suicide and euthanasia.,” the Task Force warned that "characterizing the provision of pain relief as a form of Euthanasia may well lead to an increase in needless suffering at the end of life.”

This warning is even raised by some who do not oppose physician assisted suicide in principle. “Clinicians must believe, to some degree, in a form of the principle of double effect in order to provide optimal symptom relief at the end of life”, writes Dr. Howard Brody in the April 1998 Minnesota Law Review. Dr. Brody does not oppose assisted suicide in all cases, but he knows that many doctors do – and he knows that they will not practice good palliative care if it is seen as tantamount to euthanasia. "A serious assault on the logic of the principle of double effect,” he writes, “could do major violence to the (already reluctant and ill informed) commitment of most physicians to the goals of palliative care and hospice"

8.4. EUTHANASIA IS NOT A REGIONAL ISSUE BUT A GLOBAL ISSUE:

Geriatrics is not a local issue but universal issue. Unthinkable liberty for euthanasia is equally reprehensible as parochial limitations surrounding it. Considering euthanasia as a taboo or taking secretive measures to hasten a patient's death are equally unacceptable. Although International Human
Rights Law Instruments do not address euthanasia directly, but taking into consideration not just the rules but the entire decision making process makes it possible for euthanasia to be discussed on an international level. The ICCPR and ECHR focus on issues such as self-determination and human dignity, the right to life and the right not to be subject to cruel, inhuman or degrading treatment, that are central in several euthanasia debates around the world. Now a day, morality is more and more pervaded by the liberal notion of autonomy. This has for example led to the acceptance of homosexuality. However, with regard to euthanasia, it seems imperative to acknowledge the limit of autonomy.

The transition to a more liberal morality is also demonstrated by the doctrine of "A margin of appreciation". That is the State is allowed a certain measure of discretion on account of the non-existence of consensus, with regard to what is necessary for the protection of morality. With regard to euthanasia, a State needs to balance the protection of vulnerable people, for example, the dying with the protection of the right to freedom of others. (Dudgeon vs. U.K, A 45 1981, para 47). A State has a duty to provide terminal care and to prevent at least excesses with regard to euthanasia, which supposedly may occur not only in Netherlands but also in many other countries. In this respect, it is imperative that an international debate is started on the practice of euthanasia. Openness of both proponents and opponents will be vital if they are to constructively criticize each other on such topics as good terminal care, self-determination and the right to life vs. the duty to live.
It has been argued by many that Netherlands has no palliative care because it has got euthanasia, implying that euthanasia occurs as a premature solution or that Netherlands has euthanasia because it does not have palliative care, implying that adequate palliative care makes a liberal euthanasia policy unnecessary. With regard to the 'slippery slope' it has often been argued that the Netherlands has had a development in which assisted suicide, then voluntary euthanasia, then non-voluntary euthanasia and finally involuntary euthanasia were successfully accepted. Further more, it is held that a development from euthanasia on terminally ill patients to euthanasia on psychiatric patients may not be far away. In other options, the number of euthanasia cases in Netherlands is increasing faster which is apparent from official records.

Many argue that legalizing euthanasia would plant in the minds and hearts of severely ill, but still conscious patients a seed of despair; a sense of defeat before the end of battle that would, in turn, complicate their collaboration in their own treatment. In the lay community and among "less productive" or "non productive", old, or incapacitated people, there would be a fear of being put on a "Death List" as a result of not -- very -- clear process. All these would damage the medical profession's standing and image in the community. It is important to distinguish between treatment aimed at ending the patient's life and medical treatment around the life, or between decisions aimed at ending the patient's life (which are non-medical) and decisions that treatment would be disproportionately burdensome to the patient as death seems inevitable. Good care aims at ending patient's suffering, not their life.
Another argument of enacting a regulation by the governments of different countries to regulate the practice of euthanasia reminds us the following words of Miguel A Faria – "The lessons of history sagaciously reveal that whatever the government has sought to control medical care, medical practice and physicians (whether directly or indirectly) the results have been as perverse as they have been disastrous. In our own century, in the Soviet Union, in Nazi Germany and in fascist Italy, medicine regressed and descended to unprecedented barbarism under the aegis of or in partnership with the State."¹

Wesley J Smith, an attorney and consultant for the International Task Force on Euthanasia (ITFE) and author of "Forced Exit": The Slippery Slope From Assisted Suicide to Legalized Murder, sketches a pinching criticism on the perverted trends of certain protagonists of legalization of Euthanasia, that remind us of Dr. Frankenstein who unleashed a terrible monster in the name of benefiting mankind. He makes a comparative analysis of the situation prevailing in Netherlands, Belgium and Switzerland and makes a broadside on euthanasia advocates who cling irrationally to the ‘hubristic and foolish notion that they are competent to administer death.’ He charges that the common human failing known as ‘Self Delusion’ is rampant in the euthanasia movement. Though the euthanasia advocates recognize the inherent danger of legalization of euthanasia, still they peddle that ‘guidelines will protect against abuse’ despite overwhelming empirical evidence to the contrary. Too many people think with their hearts instead of their brains.

Euthanasia has been around long enough and practiced sufficiently enough for us to detect a pattern. Killing is so to the public as a last resort justified only in cases where nothing else can be done to alleviate suffering. But once the reaper is allowed through the door, the categories of killable people expand steadily toward the acceptance of death on demand. For example, in the case Dutch Law on euthanasia, despite the presence of supposedly ironclad protections against abuse – such as the doctrine of ‘Force Majeur’ and the stipulation that patient give multiple requests for euthanasia – quickly ceased meaningfully to constrain mercy killing. Consequently, Dutch doctors now legally kill terminally ill people, chronically ill people, disabled people and depressed people who ask for it. Euthanasia has also entered the pediatric wards, where eugenic infanticide has become common even though babies cannot ask to be killed.

In 2002, the Belgians legalized Dutch-style euthanasia under ‘strict guidelines’, and euthanasia culture quickly began to swallow Belgium whole. Where as the ‘slide down the slope’ (slippery slope) took decades for the Dutch to reach the current morass, Belgian euthanasia went off the rails from day one. During the first year of passing the law, 203 people were officially reported to have been administered with euthanasia, though the actual toll is closer to 1000. Further, the Belgian euthanasia advocates have been demanding to expand the categories of killable people and to permit minors to request for euthanasia and also to include people with degenerative conditions, such as Alzheimer’s who are not imminently dying.
The Swiss have also unleashed the culture of death into their midst. Rather than authorizing doctors to commit euthanasia, however, Swiss law instead permits private suicide facilitation. As a result, Switzerland has become a destination for “Suicide Tourists” who travel there not to ski, but to receive a poison cocktail. A private group that goes by the name “DIGNITAS” facilitates most Swiss assisted suicides. Lawyer Ludwig Minelli, the founder of Dignitas, believes that ‘severe depression can be irreversible and that he is justified’ in helping ‘mentally ill’ to die.