CHAPTER IV: PROXY CONSENT IN MEDICAL PRACTICE

In the last chapter the centrality of informed consent in the medical practice has been analysed while focusing on the theoretical as well as practical issues involved in the physician-patient relationship. It is obvious from the previous discussion that context of informed consent does not exhaust the world of medical practice. There are situations in which the autonomy of the patient has not been enforced within the existing locus of physician-patient relationship. Instead, intervention of 'significant others' becomes imperative and the relationship between the patient and physician takes a different dimension.

The justification of proxy consent is based upon a very simple logic of clinical practice throughout the history of medicine. Parental consent (vicarious) is required and is deemed sufficient for therapy for child’s good; guardian consent is required for the ward who is not capable of taking care of oneself, presumed or deemed consent is resorted to by the physicians in emergency cases where there is no time to seek informed consent. Proxy consent therefore depends upon the principle of beneficence and consequently the consenting subject is deemed to be one who has the best interest of the patient.

Engelhardt analysed the context of proxy consent by listing situations under which guardians are called upon to give consent. He says “proxy consent is composite of practices: (1) the choice of authorised agent on behalf of an authorising individual;
(2) the choice of parents (or their assignees) on behalf of infants they have produced;
(3) the choice of guardians on behalf of unemancipated minors whom they are rearing;
(4) the choice of guardians in terms of the best interest of another as understood within a particular moral community; and (5) the choice by a guardian in terms of the best interests of another as understood with reference to what a rational and prudent person would choose."

A brief explanation of the five contexts that Engelhardt refers to is necessary for a proper understanding of what is proxy about proxy consent. To begin with it must be noted that the logic of informed consent applies to proxy consent as well. And the complex problems and moral tensions involved in informed consent are also involved in the proxy consent and more so, since the individual giving the consent is other than the patient. There is certain gradation of responsibility involved in proxy consent from the adult who specifically appoints a proxy to a guardian for whom it may not be that his actions are in the best interest of the patient.

If the individual has specifically appointed a proxy with clear instructions or with a blanket instruction to act in his (patient’s) best interests, the proxy is seen as an "extension of the freedom of the first". The above situation is very uncommon as in most cases there are no advance directives or instructions on behalf of the patient. The guardians may be called upon to decide both for competent and non-competent or for those who have never been competent, and such guardians cannot be regarded as extension of another individual’s freedom. The moral authority of such individuals may
be due to their being parents (having given birth to the child or adopted) and their decisions (for instance, to refuse treatment for severely defective new-born or refusal of cosmetic surgery on grounds of religious convictions) are necessarily seen as that what would be in the best interests of the individual. The best interests of individual in such cases are seen as best interest of the community or according to values of the society etc. The justification for such decisions is seen as a reconstruction of what the individual would have wanted, if he/she were to have a value system of a particular community. Again, there would be cases wherein a guardian may in absence of any instructions, choose what any rational and prudent person would choose immaterial of the particular community he or she belongs to. There is, therefore, a case for secular ethics based upon a universal value system within the specific and particular communities and their value systems.

Making Choices For Others: Three Forms Of Paternalism

The principle of paternalism is based upon the practice of paternal administrator, regulator who knows (like the father in the case of his child) what is in the best interest of the individual. The principle of paternalism is not invoked by physicians alone in medical practice, even patients under the stress of the disease want to be treated as children by health professionals. Paternalism is unavoidable as the same is resorted to in case of infants and the extremely senile individuals. It is not ironic that the paternalistic attitudes and roles are reversed in the life span of a family.
Engelhardt recognises three different forms of paternalism, namely, *paternalism of incompetents, fiduciary paternalism, and best interests paternalism*. Paternalism of incompetents refers to the paternalistic attitude towards individuals who have never been competent, such as infants or severely mentally retarded individuals. *Fiduciary paternalism* refers to paternalistic attitude towards individuals whose decision making is left to others not because they are the best judges, but because they are compelled to take decisions. Explicit fiduciary paternalism presupposes an explicit permission to another individual to make decisions as in the case of physician-patient interaction wherein the physician is explicitly asked by the patient to act in patient’s best interests. In the case of implicit fiduciary paternalism the patient may not have explicitly authorised an individual to decide on his behalf. But there is an implicit presumption that others will make certain sort of decisions on his behalf. Short term paternalistic interventions (like public intervention in case of accident victims) are justified on the ground that reasonable and prudent individuals would act in a particular manner under certain circumstances. *Best interest paternalism* (also called strong paternalism) refers to attitude of individuals who under circumstances override the competent refusal of an individual in order to achieve the best interests of the patient.

The principle of autonomy and beneficence come under strain in proxy consent particularly in the case of minors. The tension seems to be based upon the conflict between autonomy and beneficence. Among the five different grounds on the basis of which proxy consent was justified (see p. 108), the first three grounds are based upon argument of ‘being in authority’ and the next two (fourth and fifth) are based upon
'are authority'. In the case of 'being in authority', the proxies claim the right to be respected, not because theirs is the 'best choice', but because others cannot intervene with the patients without their permission. Those who 'are authorities' (as against 'being in authority' - autonomous) claim the right to decide because they know what is the best (beneficence). The issues become more complex when we consider various types of 'individuals' that are treated as patients, namely, new-borns and foetuses, severely mentally retarded, comatose patients, individuals suffering from last stages of Alzheimer’s disease, terminal patients, patients with rare and unknown diseases, etc.

Proxy Consent And Emancipation Of Minors

To begin with, proxy consent is given by guardians in the case of foetuses and new-borns. These are not yet persons in strict sense and also are not bearers of rights that we accord to persons. There are cases in which foetal surgical intervention is sought in the best interest of foetus - but this amounts to intrusion into the mother’s body. The idea of proxy consent must have a comprehensive connotation to account for all types of cases, and should not treat some situations as 'exceptions to the rule'. A review of legal exceptions to the rights of proxies (parents, guardians or others) is necessary for a comprehensive understanding of proxy consent.

One of the major legal exceptions to the rights of parents/guardians is in relation to emergency. It is obvious that when threat of permanent disability or even death is possible physicians and others may treat the patient without consent. This presumed consent is justified on the ground that any reasonable or prudent individual would
choose such mode of treatment. In such situations physicians assume deemed consent
till such time guardians who are in authority arrive on the scene.

Similarly exceptions are envisaged on the ground of public welfare which allows
physicians and others to treat minors for drug addictions, etc. It may also be possible
that minors who have emancipated from the guardians under certain circumstances
may not depend upon proxy consent of parents for treatment. Although society
enforces parental rights and moral responsibility for children, such rights are restricted
within the norms of community, society and the economic goals of the state. The
moral right and responsibility of parents are upheld so long as they are competent to
morally and legally carry out their responsibilities.

There is however a further conflict between the rights of parents and the rights of
children 'to be left alone'. The major issue in this conflict is not so much the minors
emancipation from the guardian or parental controls but what is perceived as in the
best interest of the ward. There are some grey areas of medical intervention which
throw up conflicting understanding of what would be in the best interest of the ward.
For example, in the case reproductive choices, mature minors reject parent authority
in medical intervention and assert their right for consent.

Engelhardt, while granting autonomy to parent/guardians in decisions regarding their
wards lays down criteria for intervention on behalf of the ward. Such interventions are
based upon principle of beneficence and/or concern for autonomy of the ward. When
there is clear and convincing evidence that the guardian’s acts of commission or omission are contrary to the best interest of the ward, intervention on behalf of the ward is justifiable. For instance, when such actions or inactions injure the body or the mind of the ward judged by the standard of a reasonable and prudent person, intervention by the physicians, etc. on behalf of ward is a must.⁴

Proxy Consent And Experimentation

We have seen in the earlier chapter that it is necessary that non therapeutic research with children be carried out for advancement of medical science. Discussions on legal, moral and medical aspects on non-therapeutic experimentation with children range from outright condemnation to legal, moral and social justification on ‘humanitarian’ grounds.

Paul Ramsey in Patient as Person, argued that “to attempt to consent for a child to be made an experimental subject is to treat a child as not a child. It is to treat him as if he were an adult person who has consented to become a joint adventurer in the common cause of medical research. If the grounds for this are alleged to be the presumptive or implied consent of the child, that must simply be characterised as a violent and false presumption.”⁵

Taking into account the various issues relating to social good, medical practice on the ground of common benefit to mankind assumes, that experimentation with children without consent is permissible. Such a position is justified on the ground that health
care professionals treat patients not only for their own good but for the good of profession. It is argued that medical knowledge and skills must be passed on to a new generation of professionals and in this process, patients function as a medium. If medical knowledge is to increase and new problems are to be tackled, research and experimentation is a must. The conflict between principle of patient autonomy and beneficence as well as paternalism cannot come in the way of advancement of medical knowledge.

That the two extreme positions are both undesirable for the medical practice is obvious from the history of medicine. A brief analysis of the positions will help us to find a prudent via media that does not allow humans to be treated as instrumental values, and at the same time allows the possibility of research and advancement of medical knowledge.

The theoretical implications of parental consent is required for child’s own good. This vicarious consent is also a sufficient ground for directing the medical intervention in the case of a minor. The context within which such a consent is procured or given is close to the concept of presumed consent, as it is presumed that the course of actions would be what the child wishes, or would wish if the child was competent to decide for itself. McCormick relies heavily on traditional moral argument when he argues that the “what the child would wish” assumes that if he were capable of a choice, what he would choose would depend upon his moral oughtness. In other words, what the child would do is such that if he was capable of making a choice, he would choose what he
ought to choose as a morally obliged person. The natural law tradition argues for certain values that we uphold, and the knowledge of which is available to human reason without divine or non-natural intervention. In short, the ‘construction’ of child’s wishes is not the result of adult capriciousness and arbitrariness, but based upon the facts “(1) that there are certain values definitive of our good and flourishing, hence values that we ought to choose and support if we want to become and stay human, and that therefore, these are good also for the child; and (2) that these “ought” judgements, at least in their more general formulations, are a common patronage available to all men, and hence form the basis on which policies can be built.” How does this help the traditionalists to justify experimentation with children?

The first premise for developing the argument from traditional moral perspective is to expand the scope of all that is good for human life in one’s own case, to that of all human beings. Individual ought to take into account the efforts that go into realising the good of others. And since, when something is factually good, we say that we ought to do so, and if this is true of all of us, with certain restrictions it must be true of the infants. In short, if maintenance of health, control and cure of disease and growth of humans as humans are values that we share and struggle to realise, the experimentation with infants (if absolutely inevitable) should be considered as part of this objective and consequently morally justifiable.

McCormick employs an understanding of social good to argue for non-therapeutic experimentation with human beings. He says that personal good is not to be conceived
individualistically, but socially, that is in relation to others. One expresses such a concern when one consents to donate an organ without endangering one's own life. Taking some degree of risk, pain and inconvenience for the sake of others, McCormick recognises as an act of concern for 'others'.

That infants are different from adults is obvious from the fact that the decisions of consenting adults (in the case of organ donations or participation in human experimentation) depend upon the individual personality. An adult can be said to be mature, voluntary, recognises personal individual good from personal social good, and has a value system that determines his choice. On the other hand an infant can neither be said to recognise personal individual good from personal social good nor can he perform voluntary action.

Again, there could be situations in which presumption of consent is reasonable in the case of an infant. The example of a child who needs blood transfusion of another child would be justified on the ground that presumed consent in such a case is not unreasonable, because the resultant good is at no or negligible cost to the donor child. Therefore, when an experiment involves no or negligible risk or pain or inconvenience to the child and the experiment promises considerable benefit to other children, one could presume that the child would consent for such an experiment. In other words, it could be presumed that the child would choose or ought to choose an action that will benefit others. It may be interpreted on the basis of various declarations such as U.S.
Guidelines on Human Experimentation and the Helsinki Declaration that “low risk” means “no realistic risk.”

**Understanding ‘Person’**

Experimentation and research with human foetus raises issues radically different from experimentation with infants and other human beings. The discussions relating to experimentation with foetus presuppose a prior understanding of what is ‘person’. In other words, the question is whether we recognise foetus as a person and accord him the moral values that we accord to adult humans and infants. It is therefore necessary at this stage that we clarify this issue before proceeding with the question of whether foetal research should be permitted as a public policy and whether such actions are morally permissible.

The *Belmont Report* in Part B has laid down ethical principles on the basis of which experimentation with human beings for biomedical and behavioural research was permitted.

‘Person’ is a ‘thing’ but is different in the sense that he/she is not treated as such. The distinction between ‘Person’ and ‘thing’ is not a distinction in terms of set and subset; but is significantly understood in terms of *attitude*. In the Kantian sense, persons, not things are of unconditional worth, persons are ends in themselves. Respect is an attitude to persons, not to things. One of the psychological characteristics (philosophically significant) of person is self-consciousness. ‘Person’ is one who is
conscious of his own identity through time. As Kant puts it, "that which is conscious of the numerical identity of itself at different times is in so far a person". For Leibniz, person is synonymous with 'self' as "the consciousness or the reflective inward feeling of what it is: thus it is rendered liable to reward and punishment". Both rationalist and empiricist definitions of 'personhood' are characterised by "self-awareness" or rationality. For instance, for Locke, "a thinking intelligent being, that has reason and reflection can consider itself as itself, the same thinking thing, in different times and places, which it does only by that consciousness which is inseparable from thinking and seems to me essential to it."

Historically the definition of person is not identical with human beings. For instance, slaves in Ancient Greece had no legal rights and hence were not treated as persons (that is, not ends in-themselves). Aristotle while justifying 'slavery' called them "living instruments for the conduct of life". Person is any being having legal rights and duties. But not every human being is in this sense a person. For example, children, infants and idiots have no rights and hence are they persons? Again not every legal person is a human being, for example, corporations, associations, etc.

In the context of bio-ethics, not all humans are equal (apparent from divergent capacities) example, competent adults, mentally retarded adults, children, infants, foetuses, etc. Even common sense and law (judiciary) recognises these differences in spite of the 'principle' that "all men are equal". There is, therefore, a need of deciding the moral status of persons and mere biological life. The question is to assess the
moral significance (rather than emotional relating) of different categories of human life and animal life as well.

Competent rational adults have unquestionable moral obligations. But what about infants and mentally retarded as well as foetuses? If the categorisation is based on metaphysical commitments or doctrines, there will be divergent views. One should use the secular reflection, that is treat X as a person if and only if he is a rational being. Rationality is claimed if there is evidence for it. In brief, as John Harris puts it, "a person will thus be any individual capable of valuing its own life. Such a being will, at the very least, be able to conceive of itself as an independent centre of consciousness, existing over time with nature that it is capable of envisaging and wishing to experience."\(^{12}\)

Persons are 'persons' when they have characteristics of persons, when they are self-conscious, rational and in possession of a minimal moral sense. Since persons are central, the moral discourse will be person-oriented and hence rational arguments would be person-defined. Infants and foetuses are regarded as potential persons. In the strict sense, persons are persons as moral agents. However there are various other uses of 'person' not in the strict sense, but in the social sense. The various senses of persons is as follows:

\(P_1\) - Persons as moral agents.

\(P_2\) - Persons to whom full rights are accorded - infants.

\(P_3\) - Neonates, who are not yet as strong and secure as infants.
$P_4$ - Those who were $P_1$ (moral agents) but are no longer so, and can interact minimally, for example people with Alzheimer’s disease in advanced stage.

$P_5$ - Retarded or those who will never be $P_1$ (moral agents).

$P_6$ - Severely or permanently comatose, that is, those who cannot interact minimally.

$P_7$ - Dead Bodies.

There is a difference between persons who are moral agents and persons to whom rights of moral agents are ascribed. One can blame or hold responsible $P_1$ (moral agents), as they have rights and duties. One cannot, however, blame infants. They are bearer of rights and not duties. $P_1$ have rights as part of morality itself. But rights of persons to whom the moral agents’ rights are ascribed are created by particular communities. There is also a distinction between humans with moral standing who play a social role and those that do not.

The purpose of this discussion is not to exhaust the various senses in which the term ‘Person’ is used. It is pertinent to note the various attitudes towards humans, higher animals, lower animals, plants and other inanimate entities. Ethically, it is universally accepted that humans are persons and treated as such. $P_2$-$P_6$ are also humans although they are not rational at that point of time. They were or will be fully self-conscious, rational and with minimal moral awareness. Most cultures treat all such cases as ‘persons’.
Moral Status Of Embryo And Foetus

Traditionally the question regarding moral status of embryo (for that matter even foetus) depended upon two prior questions, namely, when does life begin? and when does life begin to matter? To the orthodox moral theologians, it is indisputable fact that not only life begins at the time of conception, but the moral status of the person is linked up with the first moment of life. The scientific claim that life begins at the time of conception and that there is continuous process of development leading to maturity, is taken as an axiom by the ‘pro-life’ moral philosophers. Reacting to those who would claim that there is life even in ova and sperm, the ‘pro-life’ activists would argue that a new *individual* begins at the time of conception.

That the above argument is ‘absolutist’ is obvious from the fact that there are situations in which embryo is not treated with the status of the individual. For instance, conception in the fallopian tube or when fertilisation does not result in an embryo but in a tumour as in case of hydalidiform mole are cases wherein the resultant embryo is not invested with all rights and protections that we extend to ‘persons’ believed to be formed at the time of fertilisation. Again, the fertilised egg is a cell mass which divides into two major components, the embryoblast and the trophoblast - embryoblast becomes the foetus and the trophoblast becomes the extraembryonic membranes, the placenta and the umbilical cord. Geneticists have pointed out that trophoblastic derivatives are alive, are human, and have the same genetic composition as the foetus - but discarded at the time of birth. Besides, the fertilised egg is not a new individual,
as it is often split resulting into twins which may occur even two weeks after fertilisation.

One of the most quoted arguments on behalf of 'embryo as person' is potentiality argument. Major criticism against potentiality argument is that just because something \((x)\) will become a person \((P_x)\) is not a good reason for treating the same as if it is \(P_x\). Surely, I would not like myself to be treated as a dead person because I will finally die one day. That the fertilised egg is a potential new human being has to be supported by other premises, namely, that certain other things would happen (like implantation) and certain other things would not happen (like spontaneous abortion). If such additional premises are accepted, then even sperm and ova are to be treated as potential new human beings.

Two conclusions may be derived from the above discussion. First, life is a continuum and that individual emerges gradually. And second, it is not important when life begins, but when life begins to morally matter. The answer to the second query is largely determined by the socio-cultural value system mitigated by certain universal values that we profess as humans.

Even if it is granted that foetus is a person, one may have to decide what status we attribute to "non viable foetus" which is one that is incapable of extra-uterine survival? In experimental situation, viable foetus is treated as a child, and hence may be discussed in the context of presumed consent. The issue takes a new dimension when
the "nonviable foetus" is said to be either in utero or ex utero. Again, the status of "nonviable foetus" in utero be distinguished on basis of whether the foetus is alive or dead, there is a plan for abortion or not. Similarly, the "nonviable foetus" ex utero be distinguished on the basis of whether the foetus is such due to spontaneous abortion or induced abortion, and whether the foetus is alive or dead. The above distinctions are not unnecessary 'hair-splitting' exercise, but necessary for deciding in favour or against a public policy regarding experimentation with foetus.

The questions of experimentation with foetus will depend upon how we treat the foetus. In other words, what is our attitude towards foetus, namely whether we treat foetus as "disposable maternal tissue", "potential human life" or "person". If the nonviable foetus is viewed as "disposable maternal tissue" then experimentation of all sorts cannot be stopped or controlled on moral grounds. If "nonviable foetus" is treated as "protectable humanity" or "person" with rights, then decisions regarding the nonviable foetus will be similar to that of infants and children. However, such decisions regarding nonviable foetus will take into account the maternal health. The differences in attitude towards "nonviable foetuses" is a clear indication of cultural differences in the value systems of specific communities.

It needs to be emphasised at this stage, that although there is a distinction between experimentation with children and foetuses, there is continuity between the justification of experimentation with infants/children and foetuses. If one takes the position that all experimentation with terminally ill children is immoral as it constitutes
abuse, and regards nonviable foetuses as persons, all experimentation with living foetuses would be deemed immoral. On the other hand, if one justifies at least some experimentation with children, then the same justification could be extended to experimentation with foetuses.

There are, therefore, three possible positions one could adopt in the case of experimentation with foetuses. Firstly, the nonviable foetus must be protected but be valued less than viable foetus or new-born. Secondly, the foetus is a fellow human and be treated as such and in the case of experimentation, the same should be treated as a child. The nonviable foetuses in this position are comparable to an unconscious patient, dying patient or person condemned to death. Since it is immoral to conduct experimentation with these categories of humans, similarly experimentation with living foetuses is morally unacceptable. Third position holds that foetuses being a fellow human being, be treated in the same way as one treats a child. In brief, the position is an extension of experimentation with children. Experimentation with children is morally permissible if there is no discernible risk or discomfort for the child or foetus, the experiment is genuinely necessary for medical knowledge and will give benefit to foetuses and children and appropriate consent is obtained. McCormick adopts the third position which may be treated as moderate one. He consequently analyses all categories of foetuses discussed above. 14

McCormick points out that in the case of foetus in utero where no abortion is planned, experimentation is morally justifiable as in the case of experimentation with
children provided appropriate proxy consent is obtained. He however questions the necessity of such experimentation as absolutely necessary. In the case of foetus *in utero* where abortion is planned, McCormick questions the morality of deriving any benefits from the results of an immoral action. In other words, if all planned abortions are immoral, the question of whether the foetus is living or dead is immaterial and any moral legitimation of accrued benefits from such immoral actions would undermine the moral sensitivity of the community.

In the case of foetus *ex utero* as a result of spontaneous abortion, to experiment with the foetus (whether living or dead) with proxy consent is morally justifiable, provided there is no pain for the foetus if it is living. In the case of induced abortion, if the same was morally legitimate, experimentation is morally justifiable if proxy consent is obtained. McCormick however points out that in case induced abortion is morally illegitimate, and the foetus is living, one may question the moral legitimacy of proxy consent.

McCormick however notes that the moral sensitivity while deciding the above issues will depend upon the cultural pragmatism of the community and its moral orthodoxy. Western industrialised societies value medical technology, evaluate moral actions in terms of cost-benefit calculations, value youth, pleasure, health etc., marginalise senility, retardation, defectiveness, etc. In brief, there is strong faith in effective and quick intervention to preserve what is seen as good and elimination of what is seen as
unwanted. McCormick goes to the extent of saying that such cultures translate morality into efficiency.

Finally, the question regarding legitimacy of foetal experimentation becomes complex in the context of *in vitro* experimentation. In the case of *in vitro* fertilisation, the reproductive process takes place outside the human body and consequently the question of right of the mother/woman become meaningless. There is, in other words, no violation of privacy, integrity of woman's body etc. in the case of *in vitro* fertilisation. More importantly, in the case of *in vitro* fertilisation, the spare embryos (after the successful implantation of one fertilised egg) are available for experimentation or the same 'condemned' to destruction. There is a prior question that has to be settled at this stage before deciding whether experimentation in the case of spare embryos is morally legitimate.

Engelhardt while arguing that foetuses are not persons in strict sense - they are the biological products of persons - claims that there are no sustainable moral arguments against non-therapeutic experimentation with foetuses. Foetuses will become strict persons only sometime after birth. In the early gestation period, foetuses have minimal mental life, argues Engelhardt, and hence they do not appear to suffer like other normal adult mammals. If Engelhardt's position is accepted, then there is no moral restriction on conducting experimentation with spare embryos, provided proxy consent is obtained. And such a proxy consent is more of the nature of legal requirement than based on moral considerations.
Recent literature on this issue takes a different form of argumentation. This is particularly so when the slippery slope argument is employed to argue against non-therapeutic experimentation with human embryo. The American legislations controlling federal funding for experimentation with spare embryos has tried to lay down clear guidelines regarding human embryo research. And the subsequent Human Embryo Research Penal in its report articulated what is legally permissible (sic. morally) and what is not in terms of research with spare embryos. The philosophical presuppositions of the guidelines are based upon our understanding of what constitutes pain and suffering, what is the scope and limitation of consent, and what type of ownership right do individuals claim vis-à-vis the embryos, particularly spare embryos.

The understanding that embryos are not persons in strict sense does not necessarily lead to the conclusion that nothing is wrong with killing an embryo or experimenting with it in whatsoever manner. Pain and suffering are a major criterion for deciding whether experimentation with embryo should be permitted, as human sensitivity is against inflicting pain on any sentient being (even when such animals are used for food and other human purposes). Of course, at another level one may question the moral justification of killing animals for human consumption.

It was commonly accepted that embryo is not capable of feeling pain during the first few weeks of life as for almost eighteen weeks central nervous system has not been
formed. The *Human Embryo Research Panel* considered additional embryonic stages, namely 14 days (appearance of primitive streak), 18 days (beginning of neural tube development) 22 days (onset of foetal heartbeat), and suggested on the one hand that serious moral consideration should be given to the embryo, and on the other that it does not have the same moral status as infants and children. The panel has identified various factors (such as genetic uniqueness, potential for full development, sentience, brain activity, degree of cognitive development, human form, capacity for survival outside mother’s womb, degree of relational presence to mother and others,) that could be used to assess the moral status of embryo. The report had argued that no single factor can be used to justify moral status of the embryo. But the increased presence of the above mentioned qualities enhance the moral status of embryo/foetus. The process culminates at birth when substantial development has taken place and the foetus is capable of independent existence outside the womb of the mother.

Taking into account the various embryonic stages mentioned above, the report of panel had suggested embryo before 14 days has no moral status except that it has the biological uniqueness. In the next stages (14 days when primitive streak sets in and 18 days when neural tube development begins), the embryo possesses the quality of respectability and consequently has enough qualities not to permit arbitrary research.

There have been criticisms to the panel’s recommendations as such minute differentiations may not necessarily raise the moral status of embryo or foetus. The recommendations are both vague and difficult to apply. Besides, the recommendations
seem to be concerned more with the instrumental concern of permitting or not permitting research, rather than intrinsic concern for human subjects.

The question regarding who has the moral right to determine the fate of embryo fertilised in vitro and the nonviable foetus needs to be analysed on the basis of the distinctions made above. In the normal circumstances, abortion against the will of the mother does not arise, as it is morally unacceptable that there is outside interference with the mother’s body. In such cases if the mother decides to abort the foetus, what should be the fate of such aborted foetus? Is mother’s consent required to conduct experiment with such aborted foetus? The answer to this, in the first instance will depend upon the moral nature of abortion. If abortion itself was immoral, then the mother has no more right to determine what should happen to the aborted foetus. Secondly, if the abortion was ‘morally legitimate’ (for instance to save the life of mother etc.) then the question has to split into two parts: whether the foetus is alive or dead. If the foetus is nonviable and there is definite need for morally legitimate experimentation, seeking consent from the mother is not necessary. If we are not morally bound to preserve the life of such foetuses then seeking consent from anyone does not arise. But in the case of aborted foetus which is alive and the mother desires that it should live, the foetus should be treated as a premature birth, and taken care and subsequently restored to the mother.

The issue regarding consent in case of nonviable foetuses, the expressed concerns are not moral. They are legal concerns that arise within the scope of property rights. The
mother claims the right to foetus by virtue of the foetus growing in the womb of the mother. Although in many legal cases such property rights have been upheld, it is both rationally and morally not justifiable. There may be situations in which something growing in the body of mother may not necessarily belong to the mother (e.g. viruses). Again, the mother may be restricted and harangued in order to prevent harm being done to foetus.

One can argue in similar manner the case of embryo *in vitro*, the only difference being that in this case there is no mother. No woman has a right that the egg she has donated be implanted. She has only a, perhaps contractual right that it be implanted in her if she wants it. In brief if the experimentation envisaged is morally justifiable as the same is for the benefit of mankind, then “there is no moral virtue in killing or allowing embryos to die when they could rather be used to benefit us all and there is less virtue in allowing human cadavers to go to waste, when we could, with, say, transplantation order or the like, save very many lives.”

The moral reasoning involved in the objections against experimentation with embryo seem to vary from situation to situation. So long as there is no justification for treating embryo as a sort of creature that is morally entitled for the same status as that of persons, (by way of concern, respect and protection) there is no moral objection to prevent experiments that would benefit mankind without risks and pain to other persons. Mary Warnock while admitting that there must be some law to prohibit commercial exploitation of embryos, argues that the ‘slippery slope’ argument in its
most general form must be resisted, or else there would be no progress and advancement of knowledge.

Abortion And Consent

The discussion regarding consent in the case of abortion requires that we understand the basic moral issue involved in the abortion debate. A brief review of the most orthodox position will suffice to show that the moral concern in the case of abortion is same as in the case of embryo and foetus. In the abortion debate, greater emphasis on the right of mother will be recognised by all in view of the relationship between the mother and the foetus.

The Roman Catholic Church, theologically more articulate Christian group, teaches that human life is a sacred gift over which we have ‘stewardship’ but not complete dominion. Therefore, all are morally bound to sustain and protect life from conception to natural death. It is deemed a moral imperative that any health care system should assure care for all in terms of dignity of the human person and the good of society. The Church recognises all health care concerns as based upon fundamental belief regarding the dignity of the human person and the value of human life. Life is recognised as a precious gift from God, and this gift is to be protected, sustained with respect at every stage from conception to natural death. Each human being is person, and this personhood gives special dignity and basic rights to the individual.
All major religions believe in human dignity and human rights and provide a theological justification for the same. There are also other individuals who profess no specific religion but have strong convictions and defend human dignity. These beliefs therefore, at one level may be integrated into a religious worldview. It is not an exclusively religious teaching nor one that cannot be deeply held without faith or religious commitment. Almost all national constitutions recognise protection of life, liberty, and the pursuit of happiness as universal truths.

Catholic Church recognition that each person has a *right to life*, to bodily integrity and to the means necessary to sustain and develop life and health becomes the theological basis for opposing direct abortion. The Church at the same time emphasises right to health care, preventive and curative, as a responsibility of the individual person and of society. And since human life is a *continuum* from conception to natural death, health care includes education, research, care of the disadvantaged or disabled and care of the elderly.

One must appreciate Catholic Church's position when it (she) points out that abortion, in general terms is recognised as a matter of *free choice for a woman* and not a medical treatment. Studies show that most abortions are performed for personal reasons and not in consideration of the medical condition of the mother. Consequently, abortion is seen as an elective procedure that has social or ideological reasons, and not as a therapeutic procedure for some specific pathology. In developed societies the
major force behind legalisation of abortion has been the argument of free-choice for a woman. In India, it has been the socio-economic concern for population growth.

Catholic Church’s arguments against euthanasia and assisted suicide are similar to its moral opposition to abortion. Instead of looking at these issues as moral predicaments, the Church argues that developments in science and technology that cure ‘incurable’ diseases, that prolong life of terminally ill and dying, must be seen as avenues and part of our moral responsibility to sustain life. Catholic moral teaching emphasises that it is not permitted to destroy or directly terminate human life. Moral theologians, however, have developed principles to guide patients, physicians, paramedics and families to understand that it is morally permissible to discontinue life-sustaining technologies when death is imminent or when the treatment is useless, so long as care of the patient is continued. There are two theological beliefs that justify such a position. One, moral theologians recognise that human suffering has salvific character. Secondly, death is seen as transition from one life to another and never as an end in itself.

In some industrialised countries such as United States of America, England, Sweden, etc., where abortion and euthanasia are often treated as matters of privacy or individual choice beyond the reach of public moral accountability, the Catholic Church’s opposition is logical and consistent. It maintains that abortion and euthanasia are morally objectionable behaviours, destructive of human life, offensive to God and dangerous to the well-being of society. It also opposes all forms of health care systems that finance a social policy and strategy that condones abortion.
In the United States of America, the Catholic Church is particularly agitated at the Clinton administration’s proposal under which abortion is not limited in any way but is provided as a matter of choice. In other words, abortion is available for any reason, at any time during pregnancy without any limitations or qualifications and paid for by public funds. The choice of abortion need not be justified for therapeutic consideration. It may be purely for social reasons or personal convenience. Catholic Church considers abortion morally wrong committed both by the woman who obtains an abortion and by those who provide the service whether physicians or paramedics.

The American Catholic Church is particularly agitated that the new policy may recognise abortion as another optional service rendered by the hospitals and health care program. Such an action will institutionalise abortion as a matter of choice, easily available, socially acceptable and free from any moral considerations.

In a pluralistic society, theological considerations may not have universal acceptance and the rational consideration why abortion is morally acceptable needs to be reanalysed. As discussed earlier, central to the debate is the issue regarding personhood and the right of woman to determine its own life. The debate regarding ‘what is a person’ seems to be such that it is endless and futile as it will not lead to any solution. The problem is seen as insoluble in the context of abortion wherein the fertilised egg develops into a human being in a continuum of life change. The argument of potential persons is pointed out as fraught with difficulties as Jane English had
argued. She has pointed out that if we assume foetus is not a person, then abortion is nevertheless not permissible in the later months of pregnancy. And if we assume foetus is a person, then abortion is nevertheless permissible in the early months of pregnancy. Hence, abortion controversy does not depend upon the status of foetus as person or non-person. English has further argued that the concept of person is so vague, that attempts to use the concept to solve the abortion controversy is clarifying obscurum per obscurius. J. J. Thomson provides an elaborate argument that justifies abortion on the ground that women have right to control her own body. The Argument: “If a person, A, is dependent for her/his very survival upon the use of another person’s, B’s, body but B has no responsibility to preserve the life of A, then B violates no rights of A by severing their connection, even if this results in the death of A,” ... (and)... “the principle gives B the right to be freed from A but not the right to kill A.” (However), “the death of A is, ... not a wrongful death if A is totally dependent upon B for survival or the only way in which B can be freed from A entails the death of A.” The logic of the above argument is that abortion is permissible because the connection between woman and foetus cannot be severed without killing the foetus. It has been argued that the objective of abortion is termination of pregnancy and not termination of development of the foetus. If the former can be accomplished without the other, it is ideal. However, if it is not possible, then the moral burden is not on the mother who merely asserts her right over her own body.

The above argument seems to be inadequate as most of those who argue for justifiability of abortion claim that the woman has right not only to terminate
pregnancy, but also to terminate the further development of foetus. In other words, even if medical technology were to develop techniques that will allow *ex utero* development of foetus, the mother has a right to decide whether the foetus extracted from her body should be allowed to grow to its full potential.

In all the above arguments, the central premise is the right of woman to control one’s own body. And this right has been upheld by most of the legislations thus far enacted. And most of those who argue for the permissibility of abortion on the basis of the principle of right to control one’s body seem to accept the extraction from one’s body, but not death as the justification. But the question is whether foetus is to be treated as a tumour or fat tissue that can be discarded at any time. The general feeling that an expression of one’s right if it harms or goes against that of another, is regarded as morally unjustifiable, re-establishes the primacy of the question of moral status of foetus. In other words, should foetus be treated as person or non-person?

The principle of right to control one’s own body is not a simple right. It is a complex of rights that emphasises autonomy, non-interference and self-determination. These complex of rights justify condemnation of all forms of exploitation of one person by another. Similarly, it justifies non-interference with one’s body against one’s will and protects the right to determine for oneself what one desires to do with one’s body, how to use it. In the present context, it justifies the right to control one’s reproductive system such as when to have children, or use means to prevent conception. But such a complex of rights cannot justify killing of one’s children as this would involve
interference in the rights of another person. In the case of abortion, the issue is whether this complex of rights that allows control of one’s body and the reproductive system extends beyond conception. If this right is extended past conception then the right to control one’s reproductive system would also mean that the mother can ensure that the foetus does not develop further (*in utero* or *ex utero*).

David S. Levin argues that the controversy regarding abortion lies in the vagueness or hopelessly imprecision of the concept and that we must recognise that “foetuses are potential persons, neither fully persons nor utterly non-persons.” If the question of when the foetus becomes a person (choosing a point and deciding that all foetuses after this stage are to be treated as persons) is to be decided on the basis of stages of development, then there is likelihood of an arbitrary decision of a stage. For example, suppose a point is decided on the basis of independent survival of the foetus outside mother’s womb, the point will change from time to time depending on the development of biomedicine and its capacity of death with immature foetuses.

The whole issue seems to be dependent upon the primacy of metaphysics and such a ‘fixation’ may not contribute to the resolution of the problem. Instead, one may inquire into two crucial questions which are interdependent: what is the value of potential persons and what are reproductive *rights* and *responsibilities*. The understanding that each person has right to control his/her own body has been defined in terms of rights of autonomy, non-interference and self-determination. Implicit to this complex of rights is the right to control one’s reproductive system. It is under this
principle that societies recognise woman’s right to decide and control when one has children or even take various precautions to prevent conception. Coupled with this right is the moral responsibility to promote the well-being of the offspring. It is accepted that the responsibility does not begin with birth, but at the time of conception, as it is crucial for the health of the offspring that the mother behaves responsibly so that no harm is done to the foetus during the crucial period of development.

There is however another moral responsibility linked with the unique reproductive function endowed to woman. Simultaneous with right of autonomy, non-interference and self-determination is the moral responsibility to control one’s reproductive system. This responsibility ensures that woman does not indulge in reproductive processes without moral determination and due care for the potential persons that result from her actions.

Potential persons are as valuable as persons depending upon our decision to allow it (embryo or foetus) to develop into a full person. For example, killing a foetus that a couple wants is same as homicide. On the other hand, we do not seem to attach same value to foetuses that do not meet the above requirement. Besides, naturally aborted foetuses are not treated in the same manner as we treat infants or children who die due to diseases. It is obvious that personhood in strict sense is defined in terms of rationality and consciousness. But personhood in derived sense (‘social sense’)
depends upon our person attitudes. Potential persons that embryos and foetuses are, seem to provoke different attitudes under different circumstances.

From the above analysis it may be concluded that potential persons as in the case of foetuses be treated as persons and be accorded due rights. The same would apply to embryos and fertilised eggs, except in the case of spare embryos in _in vitro_ fertilisation. The question of consent to abortion ought to be linked up with the moral right and responsibility of the woman. It may be recalled that it is in rare cases (when there is life threat to the mother and there is no possibility of saving the foetus) that abortion is morally justifiable. Although the mother has the moral right to make decisions regarding her reproductive functions, the mother who has abdicated its responsibility regarding the reproductive functions has no moral right to consent for abortion. Reproductive function ought not be treated as individual, private and non-moral activity of a woman.

**Euthanasia and Consent**

Since the approval of “living will” bill by California Legislature (USA) in 1976, there have been many similar legislations in various countries that allow euthanasia under very unique conditions. A brief study of the California legislation, namely Natural Death Act (NDA) is presented as a paradigm case of ‘living will legislations’.

The main features of NDA and other similar legislations are: (i) The execution of a document or ‘living will’ directing or withdrawal of extraordinary life sustainers when
the individual is in a terminal condition. (ii) Definition of ‘terminal illness’ as that which will end in natural death whether life sustainers are used or not. (3) The verification of the prognosis by one or more physicians. (iv) Provisions for protecting compliance of the physicians, paramedic staff, etc. against criminal and civil liabilities.

What are the presuppositions of any such legislation? First, the legislation seeks to maintain self-determination of the patient to seek medical care. In other words, it asserts that medical profession is the servant of the patient. Physicians have no right to treat the patient unasked. In fact there is no need to assert this point, as it is implicit to medical ethics, that a patient seeks medical help. He does not surrender or abdicate his life to attending physician. The most unfortunate historical precedent was set when the Quinlans (Karen Ann Quinlan, New Jersey 1976) were forced to go to court to subtract their daughter from unnecessary artificial life sustainers.

The second presupposition of NDA is that it will free physicians, paramedical staff and health facilities from civil and criminal prosecution when they refuse to give unnecessary treatment demanded by patients or guardians of patients. The assumption is that the relations of patients demand excessive treatment, or demand to be overtreated and that the physicians cannot withdraw from giving such treatment. Actually, in normal medical practice, a physician can withdraw from treatment on conscience grounds. Again, studies of hospital functioning have pointed out that in most cases families do not demand excessive treatment. The closeness of family members to the patient have resulted into according them the status of co-physicians.
in deciding the line of treatment. Further, they are treated as *co-patients* as they 'suffer' with the patient.

The implications and consequences of such legislations may lead to threatening consequences. For instance, 'refusal to be treated' by any or all physicians is a fundamental right and has been codified. In the absence of a will or a document, the physicians may assume that the patient can be treated in any manner. Further, it is almost impossible for individuals to anticipate the future possible events to make such a will and the absence of such a 'living will' may leave the patient in a medico-moral limbo. This would be particularly so in the case of accident victims. The instate patients will be left entirely to the mercy of legal system and their fate will be decided by impersonal State. The most important consequence of such living wills is that the rigidity of legal system will enter into the delicate physician-patient relationship, particularly when the patient is in his or her last stage of life.

In spite of the above warnings, there is moral predicament regarding terminally and chronically ill patients demanding euthanasia. There are a number of physicians who are willing to help such patients in this regard. Again there are patients who wish to end the 'indignity' of life and demand that they be not treated anymore, but the physicians refuse to stop treatment. It is in such situations that a legislation seems to be necessary as without it patients seem to be unable to subtract themselves from the physicians or the health care system. Further, it seems that without such a legislation the physicians cannot render the type of treatment the patients seek and is appropriate
under the conditions. The type of legal interventions in force seems to be based upon the presupposition that physicians overtreat the patients (or refuse to treat properly) and patients demand to be overreated or demand euthanasia under least strain. The presuppositions seem to be based upon a hermeneutic of suspicion between the patient and the physician and attempts are made to protect the patient against the physician and the physicians against the patient. The need of the legislation is felt to protect both the patient and the physician from the impersonal health care system. Such a health care establishment has rules and regulations governing the activities of bureaucrats, physicians, paramedics, insurance agents, etc. each of whom play their role swiftly and efficiently in a given system. Since patients come in contact with physicians and paramedics, they (patients) carry the impression that physicians and paramedics are solely responsible for the treatment of the patients. It is the impersonal and sometimes inhuman world of huge health care system entangled in complex rules and regulations, that the Quinlans were fighting to subtract their daughter.

It may be noted that in a survey conducted by American Medical Association ninety four and half percent physicians surveyed stated that they normally adhere to terminally ill patient's expressed wishes, when approaching death. In another survey, hospital authorities admitted that normally they do not use extraordinary and costly treatment and such treatment is rare in case of terminally ill.

On the basis of the above analysis one may conclude that living will legislation is at best redundant and at worst creates conflict in the hitherto unique physician-patient
relationship. It tends to legitimise that what is bad in the health care system, as a living will to subtract oneself from being overtreated (patient) or being compelled to overtreat (physician) grants the possibility that in the absence of such living wills, the patient will be overtreated and the physician will be compelled to overtreat. The conflict of interest between administrators, pharmaceutical companies, insurance agents etc. on one side and physicians and patients on the other in the health care system, seems to be the sole \textit{raison d'etre} of such living will legislations.

An individual makes his decision how he will live while dying based upon his \textit{meaning} of life and death. A Christian (more particularly Roman Catholic) whose meaning of life is based upon his faith does not recognise any difference between purpose of living and purpose of dying. For such individuals living and dying is nothing but various stages of unification with his creator, God. All Semitic religions have the same metaphysical and religious beliefs of after life and therefore they seek death as an end of life. Similarly most religions have some form of eschatology or belief in after life. Catholic tradition taking into account the biomedical changes recognised the need for being treated as per the needs of the patient. The terms “ordinary” and “extraordinary” means of preserving life came to be accepted in the discourse of moral philosophy. The decision to discontinue “extraordinary” means of preservation of life is in harmony with the religious belief of the patient or his guardians in higher spiritual values to which other values are subordinated. For such individuals, any form of legislation that desires that one state the type of death one desires, is only a reinforcement of a mistaken belief that physicians have mastery over patients.
Legislations such as living will tend to exclude family from the responsibility of intervening on behalf of the patient. Most often there is an element of suspicion on the part of legislators that members of family tend to overtreat the patient, or that they have 'ulterior' motive for sustaining or not sustaining life of the patient. Instead, legislations tend to give physicians and State the right to implement or decide the course of action. It may be noted that family members and relations of the patient tend to know better the wishes of the patient. The living will legislations have remained silent on this count and by and large the role of relations have remained undetermined.

Since prolonging life is not always in an individual’s best interests, in the absence of a written directive, proxy decision to refuse treatment is morally justifiable. The justification is on the basis of principle of autonomy as relations or guardians represent the best possible judges of what the patient would have desired. Further the principle of beneficence justifies such proxy consent as any reasonable and prudent man would see that the prolongation of life under the circumstances would do more harm and suffering than good to the patient. There are however some grey areas in the proxy consent, such as in the case when the costs are taken into account while deciding the termination of extraordinary treatment. This is particularly so in health care system in which costs are debited to the family members or relations. It is paradoxical that insurance system in some health care programmes at one level was seen as responsible for the overtreatment of patients, and at another level is seen as a blessing while deciding (in case of proxy consent) when to stop extraordinary treatment.
In most living will legislations no attempt is made to include liability clauses in case the will is not implemented. There is no penalty for the violations that may occur and which will be against the expressed wishes of the patient. The absence of penalty clauses seem to give rise to the suspicion that living will legislations are meant to protect physicians from civil and criminal liability. The objective is not to protect the patient but the physician. As McCormick argues, "it is not clear why the legislation is written in the first place, for a medal, an armband, or even a written document without legal force would suffice to inform a physician of the patient's general philosophy of living or dying."  

Organ Transplantation And Consent

Organ transplantation has given hope when formerly death was inevitable. But the replacement of vital organs highlights major moral and philosophical problems in medicine concerning the role of physicians and nurses, patient autonomy, and respect for the dying and the dead. These include the morality of excising organs from a healthy donor, and related problems regarding an individual's consent to have organs removed for the benefit of others. These problems are not restricted to live organ donation: cadaveric organ removal raises problems over the definition of death, and raises further questions of fundamental moral and philosophical concern over procurement and distribution of organs. Guiding decisions in these areas is a mass of empirical knowledge, scientific theory, and philosophical beliefs concerning what it
means to say that someone is dead or alive, or whether given persons are competent to make a decision, or whether other considerations should override a competent decision.

Living donors present a problem for the 'do no harm' imperative in medicine as they are said to be harmed by the loss of the relevant organ. This applies only to irreplaceable organs (blood for instance is self-replenishing and can be collected without harm to the donor). There are risks involved in the donation of solid organs, such as kidneys, but the general consensus is that, if the risk is not too great, an individual who freely wants to donate an organ should not be prevented from doing so.

One objection to live donation of non-generating organs involves an appeal to the principle of totality. This principle acknowledges that a diseased limb or organ should be amputated or excised for the good of the body as a whole, but it forbids the removal of healthy organs as it would threaten the functional integrity of the body as a whole. On these grounds, so it would seem, the principle rules against live kidney donation. The principle of totality also underpins several cultural objections to post-mortem excision of organs, as in the case of traditional Japanese beliefs.

Objections based on the principle of totality should not be taken too seriously. Their weakness is revealed once the arbitrariness of the concept of totality is exposed. Human beings do not exist in a strictly biological sense apart from other humans. A
‘total’ human being is essentially social and to a certain extent totality implies a degree of dependence upon other humans. Thus when an individual is removed from a social environment, psychological, and possibly physiological, dysfunction can be predicted. Since man is a social being, it can be argued that the principle of totality must include a capacity to co-operate with others, respond to their needs, and receive help. Rationality and morality are also part of this totality. This implies an awareness of imperatives to come to the help of other human beings, and possibly experience some risk, falling short of self-destruction. Given that self-destruction is not an inevitable consequence of kidney donation, it would appear that the risk entailed and modest dysfunction are compatible with the principle of totality, especially when threats to social and psychological totality are apparent, such as the potential loss of a caring and loved relative. If there is no coercion, it is widely agreed that organ donation is one of the finest gestures of fraternity of which human beings are capable.

There are limits on imperatives to help others. It is important to recognise the distinction between moral and legal duties. Live organ donation is justified by the humanitarian desire to benefit others, but this does not justify obligatory harvesting or undue pressure to donate.

The ethical dilemmas of live donation continue to generate controversy. Arguments in favour stress the altruistic aspects of live donation while opponents refer to the emotional pressure on family donors. Further questions have been raised with regard to the very nature of voluntary donation, which requires two conditions: freedom from
coercion and a competent volunteer who is aware of the risks and possible consequences. Given the kind of atmosphere in which live donation is required, it is not always easy to determine whether the decision is free from psychological pressure, or to assess adequately the volunteer's perception of risks involved. It is not unusual for families to perceive one member as less valuable than another. It is not unusual to exert pressure on the least valuable member to donate a kidney to a more valuable member. On the other hand the burden of psychological pressure may be placed on the potential recipient, and many who have received organs from family members, have suffered considerable anxiety, including feelings of guilt and a sense of failure, if the graft from a close relative is rejected. One justification for the risks involved in live organ donation from relatives or spouse is that benefits might accrue to the donor which could bear the risk.

Live organ donation from minors and incompetent adults is clearly a highly controversial topic, for it is not always obvious that the voluntary principle has been maintained. This is not guaranteed by the legal advice of linking potential benefits with consent. Similar controversies arise over the practice of extracting bone-marrow from retarded siblings or minors. When this is done it is justified on the grounds that the risk to the non-consenting ‘donor’ is minimal. But it still breaches the principle that prohibits invasion of another person’s body without consent. The defence of this practice, that the child or retarded sibling would not object if it understood, is a presumption which scarcely provides a satisfactory basis for ethical conduct in a highly sensitive area.
The problem of live organ donation may never be fully resolved so long as the suspicion of coercion and deceit or fraud looms largely over medical practice. Cadaver donors are seen both as alternative to live organ donation and solution to the ethical dilemma faced in the organ transplantation. But the present issue takes an altogether different ethical dimension while determining death of a person. This is particularly so when the medical fraternity have accepted brain death as de facto death, for the procurement of organs.

First and foremost, in the interests of both scientific accuracy and ethical propriety it is essential to separate the questions relating to the need to obtain organs for transplantation from questions related to the conceptual and factual aspects of determining death. Under these circumstances physicians can be subjected to conflicting moral demands when the organs of one patient can be used to save the life of another. To avoid potential conflicts between the attending physician and the needs of the transplant team, practices have been consolidated which ensure that the donor’s physician should have no role in the transplantation procedure itself. This separation principle (questions regarding need for transplantation of organs and determination of death) was recognised in the earliest formulations of the definition of brain death.

'Brain death' is defined in various ways even in medical practice. The definitions of brain death range from 'brainstem death' to 'whole-brain death'. There are medical practitioners who define 'whole-brain death' in terms of 'neocortical death'. There are
other definitions of ‘brain-death’ that do not refer to brain at all. They only refer to consciousness or mental activity. There are various relativistic definitions of brain death and they seem to largely depend upon the societal concerns or cultural values. There seems to be lack of clarity regarding what constitutes ‘brain death’ because of the absence of a universal medical criteria determining brain death.

Philosophically analysed, brain death could mean various things on different occasions. For instance, (1) it could mean breakdown of functions of the brain. It could also mean (2) irreversible breakdown of the functions as in the case of renal failure. It could also mean (3) death of whole human being due to complete and irreversible breakdown of brain function. Critics have pointed out that the transition from (1) to (3) is unwarranted, and the above definitions will lead to a dualism of human being and human person.

Although it is not part of the present study to analyse the various definitions of death and the medical criteria laid down for deciding the same, it is enough to point out that there is methodological confusion regarding the concept of purely medical confirmation of death.30 There is one more serious objection which seems to be at the centre of all definitions of ‘brain death’. The critics of brain death claim that the reasons provided for the claim of irreversibility of loss of brain-functions or destruction of brain, are unwarranted. There are reported cases in biomedicine where individuals in a state of coma for a long period of time have regained consciousness (sic brain functions).
Philosophers have rightly pointed out that matters of moral concern should inform medical criteria for death and organ removal. Respect for the body of the deceased is a feature of all religious and secular belief systems. The body represents the past memory of the departed person, and wanton mutilation is unacceptable. To lose respect for the body of a dead human being is indicative of disrespect for that person, the next of kin, and ultimately for all human beings in general. Although respect for the deceased reveals cultural variations, violation of the body's integrity for therapeutic purposes, such as transplantation, is rarely prohibited.

Routine Procurement And Presumed Consent

Laws based upon presumed consent empower physicians and coroners to remove organs and tissues from a deceased patient without prior consent. In the USA many states have enacted laws authorising the removal of corneas and pituitary glands on a presumed-consent basis, but do not extend this to the removal of solid organs, such as hearts, livers and kidneys. In Austria, Czechoslovakia, Denmark, France, Belgium, Israel, Poland and Switzerland, solid organs can be procured on a presumed-consent basis.

There are strong utilitarian arguments in favour of routine procurement. It would save time and lives, increase the supply of organs, reduce costs, avoid awkward and very often painful requests of distressed relatives, and eliminate the effort of carrying donor cards. The major ethical problem concerning routine procurement is not over the
mutilation of the corpse, as most religious and secular moral systems acknowledge that organs can be removed under appropriate conditions. The question is primarily whether organs should be removed without express consent. There are, however, precedents as in the case of most Western countries, post-mortems are conducted for law-enforcement purposes without seeking consent of next of kin. This practice does not appear to greatly offend society in general. If organs can be removed for autopsies as a matter of public interest, then why not for the purpose of transplantation? Critics usually appeal to loss of autonomy and the opportunity to exercise generosity. If organ donation is one of the supreme gifts that one individual can bestow on another, it is argued, then society cannot afford to lose such altruistic practices, the benefits of which spread further than the demand for more transplantable organs. Routine procurement policy could be implemented by contracting our arrangements for those with religious and moral objections, and thus incorporate an element of consent, so that an individual who has not expressed a wish to the contrary may be presumed to have consented to donation. It is argued that some countries have at its disposal sufficient information on the beneficial aspects of organ transplantation. Under such circumstances it can be presumed that the individuals would have made their objections known in their lifetime. Criticisms against such routine procurement and presumed consent comes from some theologians who see such a method as coercive and against civil rights of the minorities.

It may be impossible to reach a clear-cut decision in favour of either policies based on the doctrine of presumed consent or those based on express consent. There are two
levels of the argument which need to be distinguished. At one level we find practical arguments based on the need for organs and the beneficial consequences of maximising the harvest. The decision here between taking and giving would simply turn on which side a most convincing argument for the strategy is presented that would lead to the maximisation of supply. Thus, if the overriding objective is a policy to maximise the number of organs under most efficient methods then a policy of presumed consent with contracting-out provisions would be most innocuous strategy, provided that there are safeguards to minimise distress caused to relatives. Yet on another level there are conflicts which may only be resolved by a general shift in the moral climate. For it is impossible to weigh up and assess arguments which counter the interests of the dead and the living. Those who resist proposals for the routine salvaging of organs, express concern for matters such as the integrity of the corpse (emphasising its symbolic role), the emotional feelings of the relatives, and a wide range of notions of respect for the being that was. Opponents who dismiss these objections as signs of emotional immaturity have not even begun to address the moral issues, which lie at the heart of most of the world's cultures.

NOTES

2 Ibid. p. 262.
3 Engelhardt refers to indentured servitude of both, which is due to minor's receiving parental support while not seeking emancipation.
6 Ibid. p. 61.

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The Belmont Report of the National Commission for Protection of Human Subjects of Biomedical and Behavioural Research of U. S. A. lays down Ethical Principles and Guidelines for the Protection of Human Subjects of Research which are common to all forms of human experimentation whether it is with adults, children, infants, foetuses and embryo.


Ibid.

Ibid.


"Absolutist" arguments are those that tend to argue to all or none without taking into consideration the context/situation, which may radically change the status of embryo.


Spare embryo generally refers to fertilised eggs in in vitro fertilisation procedure when multiple eggs are fertilised and only one or two used for implantation. The remaining fertilised eggs are deemed to be spare. In more specific terms it may also refer to deliberately produced embryos (in the fertility clinic) either for perfecting fertilisation techniques or for other therapeutic reasons.


'Slippery slope' argument holds that an action should not be permitted (or is deemed illegitimate) because it will lead to a consequence which is deemed harmful or morally wrong. J. S. Freeman has recognized three types of slope arguments - "logical" slope argument, "empirical" slope argument and "full" slope argument. ("Arguing Along the Slippery Slope of Human Embryo Research", The Journal Of Medicine And Philosophy (JMP), Vol. 21, No. 1, 1996, pp. 61 - 80.) The argument has also been presented as the principle of dangerous precedent and in this form it argues that one should not do even "right action for fear you or your equally timid successors, should not have the courage to do right in some future case, which ex hypothesis is essentially different, but superficially resembles the present one. Every public action which is not customary, either is wrong, or, if it is right, is a dangerous precedent." (F. M. Cornford, The Microcosmographia Academica, Cambridge, 1908 quoted in John Harris (1983), p. 236.)


Moral theologians have always glorified suffering of a type as part of their attempt to solve the problem of evil.


In USA there is a system of required request whereby hospitals are under obligation to request relatives of dying patients to consider organ donation after the death of the patient in question. The required request presupposes dissemination of information regarding impending death, counselling of relatives of patients, etc. While implementing required request it was argued that the supply of donor organs will increase without sacrificing the principle of voluntarism. There has not been substantial increase of donor organs in spite of such a system. England, and many other countries have opted for education on donation of organs and donor-card system.