EUTHANASIA: A GENERAL AND A SPECIAL CASE STUDY IN THE NAGAON DISTRICT OF ASSAM WITH SPECIAL REFERENCE TO MORAL DILEMMAS AND RELIGIOUS DIMENSIONS

Submitted to

UNIVERSITY GRANTS COMMISSION
NORTH EASTERN REGIONAL OFFICE
GUWAHATI, ASSAM

By

DR NAMITA KALITA
ASSISTANT PROFESSOR
DEPARTMENT OF PHILOSOPHY
NOWGONG GIRLS' COLLEGE
NAGAON, ASSAM

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Dedicated
to
All the Doctors of Nagaon

Statement

I do hereby declare that the matter written in this dissertation is the result of investigations carried out by me in the Department of Philosophy, Nowgong Girls' College, Nagaon, Assam (India). I have carried out my work under the guidance of Dr Archana Barua, Professor, Department of Humanities and Social Sciences.

In keeping with the general practice of reporting observations, due acknowledgements have been made wherever the work described is based on the findings of other investigations.

Namita Kalita

(Namita Kalita)

Principal Investigator

Certificate of the Guide

This is to certify that **Namita Kalita** has completed her research work under my supervision, for this MRP. Certified further that her dissertation entitled **" Euthanasia: A General And Special Case Study In The Nagaon District Of Assam With Special Reference To Moral Dilemmas And Religious Dimensions"** is the results of her own investigations during the period she worked here as a research scholar in strict conformity with the rules laid down for the purpose. The work has not been submitted previously for any degree to this or any other Institutions or Universities.

Archana Barua

IIT, Guwahati

November, 2011

(Dr Archana Barua)

Professor

Department of Humanities and
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IIT, Guwahati, Assam (India)

Acknowledgement

It is really a great pleasure and privilege on my part to express profound sense of indebtedness and gratitude to those who have helped me and gave me valuable advice in this academic adventure.

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I take this opportunity to express my gratefulness to the IITG Central library, NEHU Library, Pune University Library, Vanaras University Library, North Bengal University Library, Cotton College Library, Guwahati University library and many other libraries for giving me necessary Textbooks, Journals and other related necessary materials for the present research work.

I appreciate the constant inspiration, encouragement and co-operation of the principal of Nowgong Girls' College Dr Ajanta Dutta Bordoloi, all my friends, colleagues and relatives who helped by giving me mental strength.

I take this opportunity to express my gratefulness to the Hospitals and doctors of Nagaon District.

Last but not the least, I will never forget how my baby helped me in a sense that whenever I was in trouble her smiling cute face helped me to forget all the bad things and all the sufferings of the world. I don't know from where I got so much strength and energy to do such a hard work. Thank God for giving me such an innocent baby in my study period.

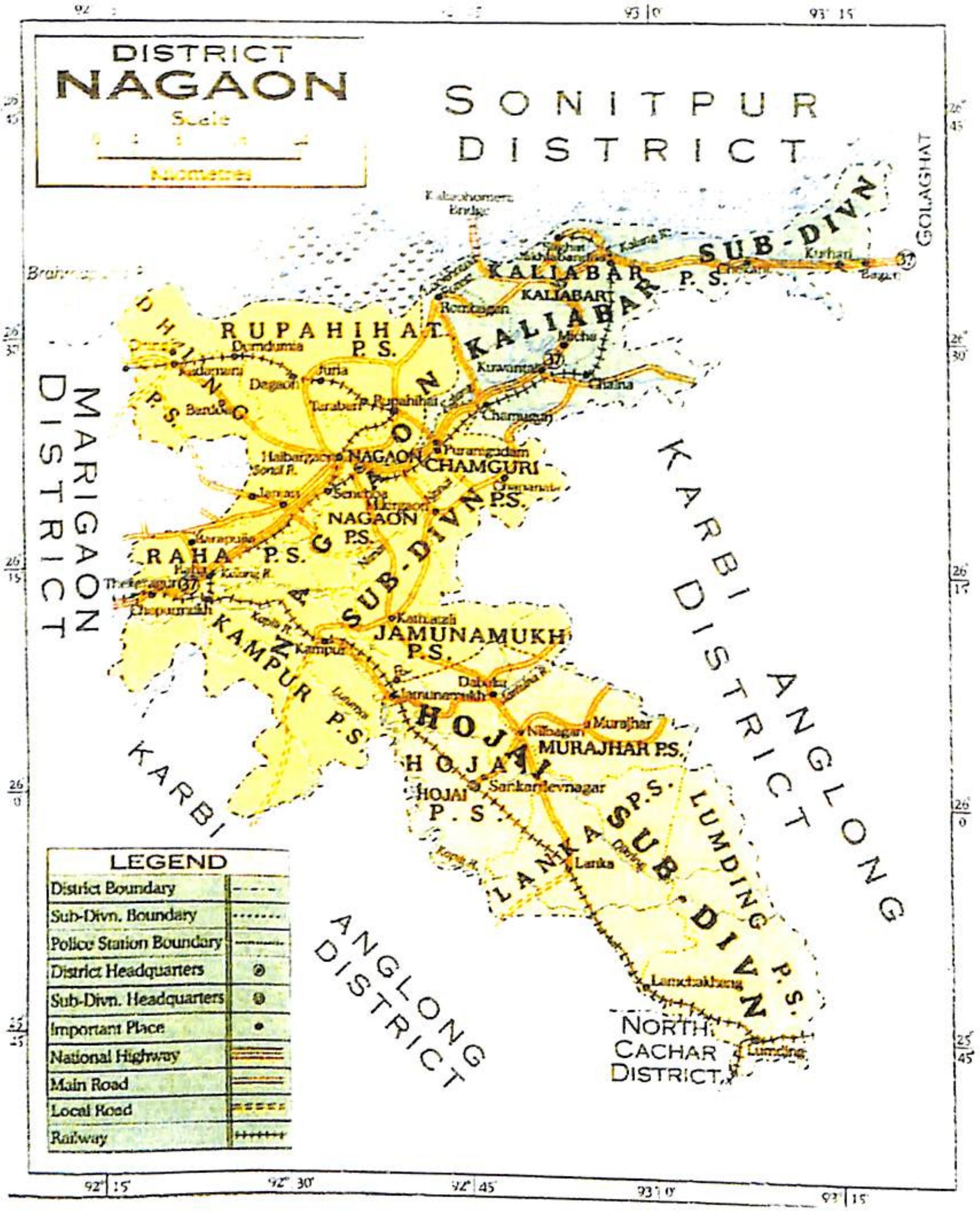
Dated, Nagaon
28/11/15

Namita Kalita
(Namita Kalita)
Principal Investigator

Content

ABBREVIATION

NHS	National Health Service
WHO	The World Health Organization
REB	Research and Ethical Boards
EFGCP	The European Forum for Good Clinical Practice
CPR	Cardiopulmonary Resuscitation
NRL	National Right to Life



A Map of Nagaon District

Chapter- I

Introduction

Chapter-1

Introduction

1.1 General Introduction

The study of medical ethics becomes important in the present age. It deals with all the issues that are related to medical approaches with a scientific and philosophical study. The so called function of medical ethics is to see the ethicality in all the issues that arise theoretically as well as practical field as doctor and patient relation, doctor's oath, medicine and also euthanasia, abortion, suicide and largely genetic engineering. In the late sixties, we began to realize that modern medical technology is not always beneficial. Life is not always worth living and sometimes suffering is so unbearable or the quality of life so poor that prolongation of life is itself an evil. This project will try to give a look at whether euthanasia is permissible or not from the history base cases to the current issues with the special help of Kantian and utilitarian ethics keeping in the mind about the position of doctors and others. The field study will cover entire Nagaon District Hospitals (Govt., Private) from the interactions with doctors, patients and family members with the help of some functioning cases of Euthanasia from the angle of moral and religious dimensions.

1.2 Origin of the Research Problem:

The problem arises in euthanasia as one doctor have to take oath to take care of, save patients life at any cost but here arises the real contradiction between doctor's oath and euthanasia. Is it a crisis between the professional ethics and patient's right for a doctor? There are some moral and religious issues are there which don't permit to take life.In the above background a couple of research questions are formulated in the following manner:

(a) Sometime Patients refuses to give consent. According to dawidowicz, killing was never administer because of a "sick or dying person's intolerable suffering" or "because of a patient's own feelings about the valueless of his life." What to do in this situation?

(b) Sometime some issues are coming where killing was done without the patient's consent and without the family's knowledge. Why and how?

(c) The paradigm case advanced by cost-benefit exponents of euthanasia is of a 'person who wants to go on living, but the cost of keeping him alive is so great that letting him die is the lesser of evils'. May be there is a condition also that by someone's life the whole family will die without food because of paying the cost of a single person and there is no hope that one day he/she will cure. In this condition what should be the decision?

(d) Whether we should left the Patient to die in agony or better to kill?

(e) Who will take the decision about euthanasia?

1.3 Interdisciplinary Relevance:

This project is an anthropocentric study. Despite of this approach, this research has interdisciplinary relevance with medical science, Psychology, Law etc.

1.4 Review of Research and Development in the Subject:

First of all I want to make it clear that there are lots and lots of net materials in the website and search engine. In this research work of course I have to take help some of them to know the current issues which and where it is going on but right now this is not complete review of this study. This is just a starting point. I have incorporated this with the help of some selected materials which are already in my collections. This work I really wanted to do with some textual and primary data not with the secondary data provided by net.

1.4.1 International Status:

We have to consider the recent initiatives in various U.S. states which would have allowed certain forms of euthanasia or physician-assisted suicide. Here we see that we cannot exclude psychological and emotional factors because ultimately they seem to determine whether some person or group believes in the slippery slop or not.

In the Netherlands, there is almost equal access to health care and almost no one will have to pay extremely high hospital bills; euthanasia is usually performed in the context of a long-standing physician-patient relationship, and there has been a long, intense and broad discussion on euthanasia.

According to British voluntary euthanasia Society, EXIT, voluntary euthanasia should be the 'lawful right of the individual, in carefully defined circumstances and with the utmost safeguards if, and only if, that is his expressed wish and EXIT maintains that it does not entail 'getting rid of old', the infirm and the unwanted nor for the deformed children and mental defectives.

Michael Tooley finds it rather puzzling as to why the slop argument should be employed as an objection to voluntary euthanasia for a person who has a 'rational desire that his life be terminated'. For Tooley the philosophical problem is not so much a question of justifying euthanasia as one of examining the reason why many people view voluntary euthanasia as morally objectionable. There are many books on this area but there is a gap between Euthanasia from the moral dilemmas and religious perspectives which I want to focus with the help of books mention later on.

1.4.2 National Status:

There is a very important stand of thought, according to which human freedom has greater priority than life. According to Singer, Even if it were possible to eliminate pain and for all patients to be guaranteed a painless death. It would still be wrong to prohibit a patient from expressing this right.

To overcome the uncertain legal status of living wills there have been several proposals of "Natural Death Acts", according to which a patient may indicate a limit to treatment for certain disease process. Natural Death Acts, however, are not facilities for euthanasia; they refer strictly to the right to remove oneself unwanted forms of therapy.

1.5 Literature Review:

A selected literature review has provided the necessary guideline for the research work. This has helped in understanding the research problem from different perspectives and also to identify the research gap that keeps room for fresh look at the research problem.

There are many books on this area but there is a gap between Euthanasia from the moral dilemmas and religious perspectives which I want to focus with the help of these books.

R.Chadwick, ,(Ed.) *Ethics and the Professions*. Avebury, U.K.:Aldershot(pp. 1-13).

BaYles, M. D., *Professional ethics* (2^{nd} ed.). Belmont, CA: Wadsworth, 1989.

The journals of Value Inquery 24: 55-65,C Kluwer academic publishers. Printed in Netherlands, 1990.

T.G. Roupas, "The Value of Life", *Philosophy and Public affairs* 7, no 2, Princeton University Press.,1978.

Tom L. Beauchamp and James F. Childress., *Principles of Biomedical ethics*, 1998.

Dwyer. Susan., Feinberg. Joel.,(Ed) *The problem of Abortion*, third edition, This book raised some issues like -

a) Understanding the problem of abortion
b) Unspeakable crime of abortion
c) How it is related to euthanasia

Richard. C. Mcmillan, (Ed.) *Euthanasia and the Newborn: conflicts Regarding Saving Lives*, D. Reidel publishing company. (1987).This book will help us to analysis some issues like

(a) Could lives be saved?
(b) High Technology, high costs and the very low birth-weight Newborn
(c) Public Policy and Life and Death Decisions regarding Defective Newborns.

Meena kelkar, "Biomedicine, Ayurveda and Woman", *Issues in Medical Ethics*, VII(i), January-march, 1999. She raised some issues which are related to abortion and woman health. Abortion is also a topic to discuss under euthanasia. This is not possible to list all the books here. So these books and journal articles should be counted as a sample list.

Biomedical Ethics by Walter Glannon is a brief philosophical introduction to the most important ethical questions and arguments in six areas of biomedicine: the patient-doctor relationship; medical research on humans; reproductive rights and technologies; genetics; medical decisions at the end of life; and the allocation of scarce medical resources. Topics cover both perennial ethical issues in medicine, such as doctors' duties to patients, and recent and emerging ethical issues in scientific innovation, such as gene therapy and cloning Ideal for courses in contemporary moral problems, introduction to ethics, and introduction to bioethics Contents: Chapter1: History and Theories Introduction The Need for Theories Consequentialism and Deontology Virtue Ethics and Feminist Ethics Communitarianism and Liberalism. The Rejection of Theories: Casuistry and Cultural Relativism Conclusion Further Reading. Chapter 2: The Patient Doctor Relationship Introduction Informed Consent Therapeutic Privilege Confidentiality Cross-Cultural Relations What Sort of Doctors Do We Need ?Conclusion Chapter 3: Medical Research on Humans Introduction Design of Clinical Trials Equipoise, Randomisation, and Placebos Problems with Consent Vulnerable Populations Protections and Justice Conclusion Further Reading Chapter 4: Reproductive Rights and Technologies Introduction Abortion. The Moral Status of Embryos Surrogate Pregnancy Sex Cloning Conclusion Further Reading Chapter 5: Genetics Introduction Genetic Testing and Screening Preimplantation Genetic Diagnosis (PIGD) Gene Therapy Genetic Enhancement Eugenics Conclusion Further Reading Chapter 6: Medical Decisions at the End of Life Introduction Defining Death Withholding and Withdrawing Treatment Double Effect Euthanasia and Physician-Assisted Suicide Futility Conclusion Further Reading Chapter 7: Allocating Scarce Medical Resources Introduction Setting Priorities QALYs Age-Based Rationing Organ Transplantation Two-Tiered Health Care Conclusion Further Reading.

1.6 Significance of The study

The proposed study is very significant as this is now very crucial situation for a man who is going to die as he is having an incurable disease which is really unbearable. Many factors are there which we can't overlook. On 11th May, 09 this type of issues was telecasted by India T.V. at 9 p.m. Therefore, it is really customary to know what will be the right action for such patients who want to die. This study will certainly help to re-think the issues and it will help doctors, patients, family members and other people.

1.7 Objectives

Some objectives to this study are as follows.

1) The purpose of this research is to make conscious the concept of euthanasia
2) How it can be functioning?
3) From philosophical point of view, it aims at change in the attitude towards life and death by accepting life and death as unavoidable events of human life with the help of some moral dilemmas and religious perspectives keeping in the mind to see both the position of patients and doctors.
4) This project will try to give a look at whether euthanasia is permissible or not from the history base cases to the current issues with the special help of Kantian and utilitarian ethics keeping in the mind about the position of doctors and others.

1.8 Methodology

Both the quantitative methods used in human sciences of man and the qualitative methods in philosophy of man are trying to answer the same question, "What is Man?" but are going about it in different ways. The noted philosopher Sir Karl Raimund Popper (1902-1994) theorized that man concurrently exists in three distinct worlds: namely, 1) the physical world of nature, 2) the internal world of ideas, thoughts and emotions, and 3) the social world of inter-subjectivity. The physical world of nature more properly belongs to the natural sciences, but the internal worlds of ideas, thoughts and emotions, as well as the social world of inter-subjectivity belongs to the jurisdiction of philosophy. Hence, the philosophy of the human person does not study only the human person, but also includes the investigations into such person's internal worlds of ideas, thoughts and emotions, as well as such person's social world of inter-subjectivity. However, there is general type of science that is similar to the philosophy of the human person in the sense that it also has the human person as well as his internal and social worlds as its inquired object.

This project in its present form is much benefited by the adoption of the Phenomenological Methodology introduced by Edmund Husserl and later adopted by Heidegger, Jean Paul Sartre, among others, though in a modified form that is now more hermeneutical in nature. Phenomenology became primarily a set of methods and attitudes for the study of the conscious experience of others. The people in question tell their own story, in their own terms. So "fidelity to the phenomenon as it is lived" means apprehending and understanding it in the lived context of the person living through the situation .The Phenomenology Methodology aims at the following:

1) BRACKETING: is suspending or setting aside our biases, everyday understandings, theories, beliefs, habitual modes of thought, and judgments. Part of the larger process of *epoche'*.
2) EPOCHE': Learning to look at things in a way such that we see only what stands before our eyes, only what we can describe and define.

3) FACTICITY: a belief in factual characteristics of real objects. In Phenomenology, by bracketing our facticity, we transfer our focus from assumed things “out there” to our experience.

4) FIRST OPENING: A direct experience of a person, object, or event, before any of our mental screens of filters change it.

5) PHENOMENOLOGICAL REDUCTION: is (1) an attempt to suspend the observer’s viewpoint. (2) Hearing another person’s reality and focusing on the central, dominant, or recurring themes which represent the essential qualities or meanings of that person’s experience. Social construction of the body and human subjectivity. The Phenomenological method ensures that the logico-empirical considerations themselves are fully founded and grounded in the Phenomenology of our experience. The term ‘experience’ should not be understood in a narrower sense; rather it should be understood in terms of inward and outward expressions of man. Hence self-reflection is the starting point of our study although gradually this qualitative and the subjective methodology aims at exploring the following:

6) Interpretation and description and analysis of data that are not quantitative.

7) A reflective and introspective approach.

8) Meaningful Dialogue between one doctor to other doctor.

9) Phenomenological approach which is based on reason and understanding.

10) Since applied philosophy aims at “forging of a common universe of discourse in the encounter among people,” there are some philosophers like Paul Masson Oursel, Kwee Swan Liat, and F.S.C. Northrop who preferred to approach applied Philosophy from the Phenomenological point of view. It is Max Scheler who first grasps the methodological

similarities between some characteristic techniques used in the applied philosophy.

In order to solve the problem of Euthanasia we have to adopt the philosophical and scientific methods; viz. observation, induction, deduction, analysis, synthesis, phenomenological method etc.

1.9 Location of the study

General study has done here with the text and journals of Euthanasia. The study will be carried out in the hospitals of Nagaon District of Assam.

Questionnaires with case study: Personal interview with the doctors, patients, family members and with other people.

In the later chapters this research will apply above mentioned methods to get a correct conclusion to help those people who are and who will be puzzled in that situational position.

Chapter- II

Euthanasia: What it is?

Chapter- II

Euthanasia: What it is?

2.1 Euthanasia: What it is

Euthanasia is also known as assisted suicide, physician-assisted suicide (dying), doctor-assisted dying (suicide), and more loosely termed mercy killing, means to take a deliberate action with the express intention of ending a life to relieve intractable (persistent, unstoppable) suffering. Some interpret euthanasia as the practice of ending a life in a painless manner. Many disagree with this interpretation, because it needs to include a reference to intractable suffering. In the majority of countries euthanasia or assisted suicide is against the law. According to the National Health Service (NHS), UK, it is illegal to help somebody kill themselves, regardless of circumstances. Euthanasia has been a very controversial and emotive topic for a long time.

The term *assisted suicide* has several different interpretations. Perhaps the most widely used and accepted is "the intentional hastening of death by a terminally ill patient with assistance from a doctor, relative, or another person". Some people will insist that something along the lines of "in order to relieve intractable (persistent, unstoppable) suffering" needs to be added to the meaning, while others insist that "terminally ill patient" already includes that meaning.

2.2 Medical Definitions of Euthanasia

According to MediLexicon's medical dictionary: **Euthanasia** is:

1. *"A quiet, painless death."* or
2. *"The intentional putting to death of a person with an incurable or painful disease intended as an act of mercy."*

2.3 Euthanasia classifications

There are two main classifications of euthanasia:

2.3.1 Voluntary euthanasia

This is euthanasia conducted with consent. Since 2009 voluntary euthanasia has been legal in Belgium, Luxembourg, The Netherlands, Switzerland, and the states of Oregon (USA) and Washington (USA).

2.3.2 Involuntary euthanasia

Euthanasia is conducted without consent. The decision is made by another person because the patient is incapable to doing so himself/herself.

2.4 There are two procedural classifications of euthanasia:

2.4.1 Passive euthanasia

This is when life sustaining treatments are withheld. The definition of passive euthanasia is often not clear cut. For example, if a doctor prescribes increasing doses of opioid analgesia (strong painkilling medications) which may eventually be toxic for the patient, some may argue whether passive euthanasia is taking place in most cases, the doctor's measure is seen as a passive one. Many claim that the term is wrong, because euthanasia has not taken place, because there is no intention to take life. **Passive Euthanasia** is: *"A mode of ending life in which a physician is given an option not to prescribe futile treatments for the hopelessly ill patient."*

2.4.2 Active euthanasia

Lethal substances or forces are used to end the patient's life. Active euthanasia includes life ending actions conducted by the patient or somebody else. Active euthanasia is a much more controversial subject than passive euthanasia. Individuals are torn by religious, moral, ethical and compassionate arguments surrounding the issue. **Active euthanasia** is: *"A mode of ending life in which the intent is to cause the patient's death in a single act (also called mercy killing)."*

2.5 The Distinction between Active and Passive Euthanasia

We turn next to questions about the moral permissibility of active euthanasia. The distinction between active and passive euthanasia is accepted by most health care practitioners and has become the cornerstone of many debates on the morality of euthanasia. The general assumption is that actively killing someone is morally worse than passively letting someone die. But, in a famous article titled "Active and Passive Euthanasia"(1975), author James Rachels challenges this reasoning. From a strictly moral standpoint, he argues, there is no difference between the two, and since we accept passive euthanasia, we should also accept active euthansia, since it is more merciful. For Rachels, the outcome of both active and passive euthanasia is ultimately the same: the death of the patient on humanitarian grounds. The difference between the two is often played up because we frequently hear of terrible cases of active killings, but not of passive killings.

A common argument in favor of the active-passive distinction is that, with passive euthanasia, the doctor does not have to do anything: he just let's nature take its course. However, Rachels responds, letting the patient die is an action that the doctor performs by not performing other actions. It is parallel to insulting someone by not shaking their hand. Suppose, for example, that a doctor let an otherwise healthy patient die who was suffering from a routinely curable illness; this would count as an intentional killing, even though it was done passively. He writes, If a doctor lets a patient die, for humane reasons, he is in the same moral position as if he had given the patient a lethal injection for humane reasons. If his decision was wrong, if, for example, the patient's illness was in fact curable, the decision would be equally regrettable no matter which method was used to carry it out. And if the doctor's decision was the right one, the method used is not in itself important.

According to Rachels, not only is there no real moral distinction between active and passive euthanasia, but, by improperly creating such a distinction we do more harm than good. Techniques of passive euthanasia prolong the suffering of the patient, since it takes longer to passively allow the patient to die than it would if active measures were taken. In the mean time, the patient is in unbearable pain. Since in either case the decision has been made to bring on an early death, it is cruel to adopt the longer procedure.

Finally, the active and passive euthanasia distinction encourages physicians to make life and death decisions on irrelevant grounds. For example, Down's Syndrome infants sometimes have correctable secondary problems, such as having an intestinal obstruction; but decisions are made to forego corrective surgery (and thus let the infant die) simply because the parents do not want the burden of having a Down's Syndrome child. Rachels noticed that this situation is absurd, no matter what view one takes of the lives and potentials of such babies. If the life of such an infant is worth preserving, what does it matter if it needs a simple operation? Or, if one thinks it better that such a baby should not live on, what difference does it make that it happens to have an unconstructed intestinal tract? In either case, the matter of life and death is being decided on irrelevant grounds. It is the Down's syndrome, and not the intestines, that is the issue. The matter should be decided, if at all, on that basis, and not be allowed to depend on the essentially irrelevant question of whether the intestinal tract is blocked. The active and passive euthanasia distinction merely encourages these groundless decisions.

Again, Rachels' central point is that society should accept active euthanasia since we already accept so called passive approaches, and there's no legitimate moral difference between the two.

2.6 Options for terminal patients or those with intractable suffering and pain

Patients with a terminal or serious and progressive illness in most developed countries have several options, including:

2.6.1 Palliative care

The World Health Organization (WHO) defines palliative care as:

"An approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual".

One goal of palliative care is for the patients and families to accept dying as a normal process. It seeks to provide relief from pain and uncomfortable symptoms while integrating psychological and spiritual features of patient care. Palliative care strives to offer a support system to help patients live their remaining time as actively as they can and to help families bereave and deal with the illness of a loved one.

Since pain is the most visible sign of distress among patients receiving palliative care, affecting about 70% of cancer patients and 65% of patients dying from non malignant diseases, opioids are a very common treatment option. These medicines form part of well-established treatment plans for managing pain as well as several other symptoms that patients encounter. Often, opioids are chosen during palliative care in spite of the side effects such as drowsiness, nausea, vomiting, and constipation.

Some type of palliative care is given to about 1.2 million Americans and 45,000 new patients each year in England, Wales, and Northern Ireland. About 90% of these patients have cancer, while the remaining patients have heart disease, stroke, motor neuron disease, or multiple sclerosis. The providers of the palliative care include in-patient care, hospital support services, community care, day care and outpatient care.

2.7 Refusing treatment

In the USA, UK and many other countries a patient can refuse treatment that is recommended by a doctor or some other health care professional, as long as they have been properly informed and are of sound mind. In the UK, the Mental Health Act 1983 excludes children and people under the age of 18 years.

According to the Department of Health, UK, nobody can give consent on behalf of an incompetent adult, such as one who is in a coma. Nevertheless, doctors take into account the best interests of the patient when deciding on treatment options. A patient's best interests are based on: What the patient wanted when he/she was competent, The patient's general state of health, the patient's spiritual and religious welfare.

2.8 The patient's autonomy impacts that of the doctor:

It is self evident that where a patient's autonomy is followed to the extent of their receiving a prescription for lethal medication or being put to death at the end of a needle, the autonomy of the doctor is compromised.

The obvious riposte is: So what? There is a Conscience Clause in Lord Joffe's Bill. Doctors with objections do not need to be involved. But we know that the Conscience Clause in the 1967 Abortion Act has only worked partially, and that the legalisation of abortion has kept many doctors (of different faiths and none) away from obstetrics and gynaecology and from general practice. However, it is possible to get away from abortion issues as a doctor and still have plenty of career choice. But there is no branch of medicine where a doctor can entirely avoid issues of death and dying.

Further, the abortion conscience clause has only applied partially to professionals in some disciplines and not at all to some members of the health team. What impact therefore might euthanasia legislation have on the recruitment and retention of appropriate staff in all disciplines? Staffing is a key issue for the National Health Service and it would be foolish to add to an ever growing problem.

2.9 Most patients have 'a question behind the question'

It is the experience of those working with the dying that the (relatively few) who currently ask for euthanasia usually have another question behind their question. This may be a physical question: they want a distressing symptom palliated. It may be a psychosocial issue: they want an honest discussion with their family about approaching death. It may be a spiritual question such as 'Why me?' or 'Why now?' When the real issue is dealt with, following the old adage 'no treatment without a diagnosis', the request for euthanasia goes away.

So to perform euthanasia, even with the proposed safeguards, would far more often undermine autonomy than underline it.

There are some deliberated request-Why not euthanasia for them? There are indeed a very few deliberated requests. Supporters of euthanasia ask with considerable compassion and force why, with safeguards, there cannot be a law to accommodate exceptional cases. The answer is a development of the one just given. For all the possible reasons hinted at , and bearing in mind the uncertainty always about prognosis, to change the law to allow euthanasia for this small minority within a minority would mean that euthanasia would be performed far more often when all would agree it was 'wrong' than when some would see it as 'right'. For the sake of protecting that majority, the minority forego a right they don't actually have anyway.

This may be utilitarian but that is the way it has to be within complex, modern inter-connected societies. We all readily accept limitations on our 'freedoms' in order to protect vulnerable others, road traffic regulations being one example. And John Donne's famous words 'no man is an island' hint at the issues of community and relationships which are always there in the euthanasia debate. Respect for the right of autonomy has to be balanced with the restrictions that acknowledge responsibilities.

2.10 Allowing 'voluntary euthanasia' leads to euthanasia which is not

'Slippery slopes' do exist in the euthanasia debate. If we change the law to allow voluntary euthanasia for those who are suffering and have the capacity to ask for it, surely compassion means we should similarly provide euthanasia for that patient who is suffering at least as much but does not have the capacity to request it? This slippery slope of logic is an inevitable consequence of doctors ever deciding that any patient's life is not worth living. (Proponents of voluntary euthanasia may want to argue that it is the patient who decides, but they must be reminded that the doctor has to agree with them)

There are other slippery slopes too, of practice and of changes in doctors' attitudes. The progression from voluntary euthanasia to non-voluntary euthanasia (the patient does not have capacity to make the request) or involuntary euthanasia (a patient with capacity is not consulted) is well documented in the Netherlands.

The 1991 Remmelink Report was a statistically valid analysis of all the 129,000 deaths in the Netherlands in 1990. 3% of them were by euthanasia. Of that 3%, 1 in 3, that is, 1% of all deaths in the Netherlands in 1990, were euthanasia 'without explicit request'. In 1990 Dutch doctors killed more than 1,000 patients without their request. This is not respect for patient autonomy but doctor paternalism of the worst kind, and European medicine has been there before. The swing over the last 30 years from doctor paternalism to patient autonomy in UK medicine is to be welcomed, but autonomy has to have limits. These four arguments show that the person who truly supports patient autonomy rejects euthanasia.

Chapter- III

Professional Ethics

3.1 What is a Profession?
3.2 Professional Codes of Ethics
3.3 General Autonomy
3.4 What are the Basic Principles of Medical Ethics?
    3.4.1 Autonomy
    3.4.2 Justice
    3.4.3 Beneficence
    3.4.4 Non-maleficence
3.5 Values
3.6 Principle of double effect
3.7 Respect for human rights
3.8 Conflicts between autonomy and beneficence/ non-maleficence
3.9 Informed Consent
3.10 Confidentiality
3.11 Ethics committees
3.12 Truth-telling
3 .13 Futile Medical Care

Chapter-III

Professional Ethics

In this chapter, we will briefly present some concepts and suggest some readings that take a look at the history of what is meant by a profession, some differing ways to think about professional ethics, and a brief analysis of what is meant by professional responsibility. We will then offer some preliminary thoughts on how to identify ethics issues in what you teach, and offer some beginning ideas of how to begin emphasizing these issues in the classroom.

3.1 What is a Profession?

"Profess" is a public declaration, vow on entering a religious order. a commitment (vows) to serve for a good end.16th century is acommitment to learned pursuits (three learned professions are divinity, law, and medicine, then the military); being an authority on a body of knowledge, belonging to an occupation; being skilled, being a fractioned, not an amateur.

19th century (late) is a new professions have come into existence, and the old professions are more esteemed according to Oxford English Dictionary.

1. When group of individuals sharing the same occupation organize to work in a morally permissible way, or to work to support a moral ideal. (i.e. Doctors organize to cure the sick, librarians organize to promote access to information, etc.)
2. Members set and follow special standards for carrying on their occupational work.

At least one of these standards must go beyond what law, the marketplace, ordinary morality.What an ordinary moral person must do and public opinion demand. i.e. a good mercenary only needs to fulfill the terms of his contract, a good, professional soldier must serve his country honorably, even when ordinary morality, law,and public opinion do not require it.)

These special standards are morally binding to "professed" members of the profession. If a member freely declares (or professes) herself to be part of a profession, she is voluntarily implying that she will follow these special moral codes. If the majority of members of a profession follow the standards, the profession will have a good reputation and members will generally benefit; if the majority of members violate these voluntary standards, professed members of a profession will be at a disadvantage or at the least receive no benefit from declaring a profession.

A Professional is a member of an occupational group (characterized above) who sees other members, including those employed elsewhere, as peers/colleagues, exercises judgment in the performance of occupational tasks and follows relevant professional standards, accepts the profession's agreement to work in a morally permissible way (often expressed as a code of ethics) as determining in part the obligations of the role.

3.2 Professional Codes of Ethics

A code of ethics prescribes how professionals are to pursue their common ideal so that each may do the best she/he can at a minimal cost to herself and those she/he cares about (including the public). The code is to protect each professional from certain pressures (for example, the pressure to cut corners to save money) by making it reasonably likely (and more likely then otherwise) that most other members of the profession will not take advantage of her/his good conduct. "A code is a solution to a coordination problem." (Davis, Michael, *Thinking Like an Engineer*, pp.153-4).

3.3 General Autonomy

Individual governs his or her own conduct, often using moral rules as a basis, and exercises a considerable degree of discretionary judgment within her/his daily work, but accepts the limits within a cooperative practice. Profession Prescribes standards for itself. Is accountable to the public. When Obligations Conflict, important questions to ask: What seems to be the primary obligation? Which violation will cause more harm? Knowledge/ consent of those affected? Is there a way to make these obligations compatible?

3.4 What are the Basic Principles of Medical Ethics?

Bioethicists often refer to the four basic principles of health care ethics when evaluating the merits and difficulties of medical procedures. Ideally, for a medical practice to be considered "ethical", it must respect all four of these principles: autonomy, justice, beneficence, and non-maleficence. The use of reproductive technology raises questions in each of these areas.

3.4.1 Autonomy

Requires that the patient have autonomy of thought, intention, and action when making decisions regarding health care procedures. Therefore, the decision-making process must be free of coercion or coaxing. In order for a patient to make a fully informed decision, she/he must understand all risks and benefits of the procedure and the likelihood of success. Because ARTs are highly technical and may involve high emotions, it is difficult to expect patients to be operating under fully-informed consent. The principle of autonomy recognizes the rights of individuals to self-determination. This is rooted in society's respect for individuals' ability to make informed decisions about personal matters. Autonomy has become more important as social values have shifted to define medical quality in terms of outcomes that are important to the patient rather than medical professionals. The increasing importance of autonomy can be seen as a social reaction to a "paternalistic" tradition within healthcare. Some have questioned whether the backlash against historically excessive paternalism in favor of patient autonomy has inhibited the proper use of soft paternalism to the detriment of outcomes for some patient. Respect for autonomy is the basis for informed consent and advance directives.

Autonomy is a general indicator of health. Many diseases are characterised by loss of autonomy, in various manners. This makes autonomy an indicator for both personal well-being, and for the well-being of the profession. This has implications for the consideration of medical ethics: "is the aim of health care to do good, and benefit from it?"; or "is the aim of health care to do good to others, and have them, and society, benefit from this?". (Ethics - by definition - tries to find a beneficial balance between the activities of the individual and its effects on a collective.) By considering autonomy as a gauge parameter for (self) health care, the medical and ethical perspective both benefit from the implied reference to health. Psychiatrists and clinical psychologists are often asked to evaluate a patient's capacity for making life-and-death decisions at the end of life. Persons with a psychiatric condition such as delirium or clinical depression may not have the capacity to make end-of-life decisions. Therefore, for these persons, a request to refuse treatment may be taken in consideration of their condition and not followed. Unless there is a clear advance directive to the contrary, in general persons lacking mental capacity are treated according to their best interests. On the other hand, persons with the mental capacity to make end-of-life decisions have the right to refuse treatment and choose an early death if that is what they truly want. In such cases, psychiatrists and psychologists are typically part of protecting that right.

3.4.2 Justice

The idea that the burdens and benefits of new or experimental treatments must be distributed equally among all groups in society. Requires that procedures uphold the spirit of existing laws and are fair to all players involved. The health care provider must consider four main areas when evaluating justice: fair distribution of scarce resources, competing needs, rights and obligations, and potential conflicts with established legislation. Reproductive technologies create ethical dilemmas because treatment is not equally available to all people.

3.4.3 Beneficence

The term beneficence refers to actions that promote the well being of others. In the medical context, this means taking actions that serve the best interests of patients. However, uncertainty surrounds the precise definition of which practices do in fact help patients.

James Childress and Tom Beauchamp in *Principle of Biomedical Ethics* (1978) identify beneficence as one of the core values of healthcare ethics. Some scholars, such as Edmund Pellegrino, argue that beneficence is the *only* fundamental principle of medical ethics. They argue that healing should be the sole purpose of medicine, and that endeavors like cosmetic surgery and euthanasia fall beyond its purview.

Requires that the procedure be provided with the intent of doing good for the patient involved. Demands that health care providers develop and maintain skills and knowledge, continually update training, consider individual circumstances of all patients and strive for net benefit.

3.4.4 Non-maleficence

The concept of non-maleficence is embodied by the phrase, "first, do no harm," or the Latin, *primum non nocere*. Many consider that should be the main or primary consideration (hence *primum*): that it is more important not to harm your patient, than to do them good. This is partly because enthusiastic practitioners are prone to using treatments that they believe will do good, without first having evaluated them adequately to ensure they do no (or only acceptable levels of) harm. Much harm has been done to patients as a result, as in the saying, "The treatment was a success, but the patient died." It is not only more important to do no harm than to do good; it is also important to know how likely it is that your treatment will harm a patient. So a physician should go further than not prescribing medications they know to be harmful, he or she should not prescribe medications (or otherwise treat the patient) unless she knows that the treatment is unlikely to be harmful; or at the very least, that patient understands the risks and benefits, and that the likely benefits outweigh the likely risks.

In practice, however, many treatments carry some risk of harm. In some circumstances, e.g. in desperate situations where the outcome without treatment will be grave, risky treatments that stand a high chance of harming the patient will be justified, as the risk of not treating is also very likely to do harm. So the principle of *non-maleficence* is not absolute, and balances against the principle of *beneficence* (doing good), as the effects of the two principles together often give rise to a *double effect* (further described in next section).

Depending on the cultural consensus conditioning (expressed by its religious, political and legal social system) the legal definition of non-maleficence differs. Violation of non-maleficence is the subject of medical malpractice litigation. Regulations therefore differ over time, per nation.

3.5 Values

A common framework used in the analysis of medical ethics is the "four principles" approach postulated by Tom Beauchamp and James Childress in their textbook *Principles of biomedical ethics*. It recognizes four basic moral principles, which are to be judged and weighed against each other, with attention given to the scope of their application. The four principles are:

- Respect for autonomy - the patient has the right to refuse or choose their treatment.
- Beneficence - a practitioner should act in the best interest of the patient.
- Non-maleficence – "first, do no harm".
- Justice - concerns the distribution of scarce health resources, and the decision of who gets what treatment.

Other values that are sometimes discussed include:

- Respect for persons - the patient (and the person treating the patient) have the right to be treated with dignity.
- Truthfulness and honesty - the concept of informed consent has increased in importance since the historical events of the Doctors' Trial of the Nuremberg trials and Tuskegee syphilis experiment.

Values such as these do not give answers as to how to handle a particular situation, but provide a useful framework for understanding conflicts. When moral values are in conflict, the result may be an ethical dilemma or crisis. Sometimes, no good solution to a dilemma in medical ethics exists, and, on occasion, the values of the medical community (i.e., the hospital and its staff) conflict with the values of the individual patient, family, or larger non-medical community. Conflicts can also arise between health care providers, or among family members. Some argue for example, that the principles of autonomy and beneficence clash when patients refuse blood transfusions, considering them life-saving; and truth-telling was not emphasized to a large extent before the HIV era.

3.6 Principle of double effect

Double effect refers to two types of consequences that may be produced by a single action, and in medical ethics it is usually regarded as the combined effect of beneficence and non-maleficence. A commonly cited example of this phenomenon is the use of morphine or other analgesic in the dying patient. Such use of morphine can have the beneficial effect of easing the pain and suffering of the patient while simultaneously having the maleficent effect of shortening the life of the patient through suppression of the respiratory system.

3.7 Respect for human rights

The human rights era started with the formation of the United Nations in 1945, which was charged with the promotion of human rights. The Universal Declaration of Human Rights (1948) was the first major document to define human rights. Medical doctors have an ethical duty to protect the human rights and human dignity of the patient so the advent of a document that defines human rights has had its effect on medical ethics. Most codes of medical ethics now require respect for the human rights of the patient.The Council of Europe promotes the rule of law and observance of human rights in Europe. The Council of Europe adopted the *European Convention on Human Rights and Biomedicine* (1997) to create a uniform code of medical ethics for its 47 member-states. The Convention applies international human rights law to medical ethics. It provides special protection of physical integrity for those who are unable to consent, which includes children.No organ or tissue removal may be carried out on a person who does not have the capacity to consent under Article . As of

December 2013, the Convention had been ratified or acceded to by twenty-nine member-states of the Council of Europe.

The United Nations Educational, Scientific and Cultural Organization (UNESCO) also promotes the protection of human rights and human dignity. According to UNESCO, "Declarations are another means of defining norms, which are not subject to ratification. Like recommendations, they set forth universal principles to which the community of States wished to attribute the greatest possible authority and to afford the broadest possible support." UNESCO adopted the *Universal Declaration on Human Rights and Biomedicine* to advance the application of international human rights law in medical ethics. The Declaration provides special protection of human rights for incompetent persons.

In applying and advancing scientific knowledge, medical practice and associated technologies, human vulnerability should be taken into account. Individuals and groups of special vulnerability should be protected and the personal integrity of such individuals respected.

3.8 Conflicts between autonomy and beneficence/non-maleficence

Autonomy can come into conflict with beneficence when patients disagree with recommendations that healthcare professionals believe are in the patient's best interest. When the patient's interests conflict with the patient's welfare, different societies settle the conflict in a wide range of manners. In general, Western medicine defers to the wishes of a mentally competent patient to make their own decisions, even in cases where the medical team believes that they are not acting in their own best interests. However, many other societies prioritize beneficence over autonomy.

Examples include when a patient does not want a treatment because of, for example, religious or cultural views. In the case of euthanasia, the patient, or relatives of a patient, may want to end the life of the patient. Also, the patient may want an unnecessary treatment, as can be the case in hypochondria or with cosmetic surgery; here, the practitioner may be required to balance the desires of the patient for medically unnecessary potential risks against the patient's informed autonomy in the issue. A doctor may want to prefer autonomy because refusal to please the patient's self-determination would harm the doctor-patient relationship.

Individuals' capacity for informed decision-making may come into question during resolution of conflicts between autonomy and beneficence. The role of surrogate medical decision makers is an extension of the principle of autonomy. On the other hand, autonomy and beneficence/non-maleficence may also overlap. For example, a breach of patients' autonomy may cause decreased confidence for medical services in the population and subsequently less willingness to seek help, which in turn may cause inability to perform beneficence.

The principles of autonomy and beneficence/non-maleficence may also be expanded to include effects on the relatives of patients or even the medical practitioners, the overall population and economic issues when making medical decisions.

3.9 Informed Consent

Informed consent in ethics usually refers to the idea that a person must be fully informed about and understand the potential benefits and risks of their choice of treatment. An uninformed person is at risk of mistakenly making a choice not reflective of his or her values or wishes. It does not specifically mean the process of obtaining consent, or the specific legal requirements, which vary from place to place, for capacity to consent. Patients can elect to make their own medical decisions, or can delegate decision-making authority to another party. If the patient is incapacitated, laws around the world designate different processes for obtaining informed consent, typically by having a person appointed by the patient or their next of kin make decisions for them. The value of informed consent is closely related to the values of autonomy and truth telling.

3.10 Confidentiality

Confidentiality is commonly applied to conversations between doctors and patients. This concept is commonly known as patient-physician privilege. Legal protections prevent physicians from revealing their discussions with patients, even under oath in court. Confidentiality is mandated in America by HIPAA laws, specifically the Privacy Rule, and various state laws, some more rigorous than HIPAA. However, numerous exceptions to the rules have been carved out over the years. For example, many states require physicians to report gunshot wounds to the police and impaired drivers to the Department of Motor Vehicles. Confidentiality is also challenged in cases involving the diagnosis of a sexually transmitted disease in a patient who refuses to reveal the diagnosis to a spouse, and in the termination of a pregnancy in an underage patient, without the knowledge of the patient's parents. Many states in the U.S. have laws governing parental notification in underage abortion.

Traditionally, medical ethics has viewed the duty of confidentiality as a relatively non-negotiable tenet of medical practice. More recently, critics like Jacob Appel have argued for a more nuanced approach to the duty that acknowledges the need for flexibility in many cases. Confidentiality is an important issue in primary care ethics, where physicians care for many patients from the same family and community, and where third parties often request information from the considerable medical database typically gathered in primary health care.

3.11 Ethics committees

Often, simple communication is not enough to resolve a conflict, and a hospital ethics committee must convene to decide a complex matter.These bodies are composed primarily of healthcare professionals, but may also include philosophers, lay people, and clergy - indeed, in many parts of the world their presence is considered mandatory in order to provide balance. With respect to the expected composition of such bodies in the USA, Europe and Australia, the following applies.

U.S. recommendations suggest that Research and Ethical Boards (REBs) should have five or more members, including at least one scientist, one non-scientist, and one person not affiliated with the institution. The REB should include people knowledgeable in the law and standards of practice and professional conduct. Special memberships are advocated for handicapped or disabled concerns, if required by the protocol under review.The European Forum for Good Clinical Practice (EFGCP) suggests that REBs include two practicing physicians who share experience in biomedical research and are independent from the institution where the research is conducted; one lay person; one lawyer; and one paramedical professional, e.g. nurse or pharmacist. They recommend that a quorum include both sexes from a wide age range and reflect the cultural make-up of the local community.The 1996 Australian Health Ethics Committee recommendations were entitled, “Membership Generally of Institutional Ethics Committees”. They suggest a chairperson be preferably someone not employed or otherwise connected with the institution. Members should include a person with knowledge and experience in professional care, counselling or treatment of humans; a minister of religion or equivalent, e.g. Aboriginal elder; a layman; a laywoman; a lawyer and, in the case of a hospital-based ethics committee, a nurse.

The assignment of philosophers or religious clerics will reflect the importance attached by the society to the basic values involved. An example from Sweden with Torbjörn Tännsjö on a couple of such committees indicates secular trends gaining influence.

3.12 Truth-telling

Some cultures do not place a great emphasis on informing the patient of the diagnosis, especially when cancer is the diagnosis. American culture rarely used truth-telling especially in medical cases, up until the 1970s. In American medicine, the principle of <u>informed consent</u> now takes precedence over other ethical values, and patients are usually at least asked whether they want to know the diagnosis.

3.13 Futile Medical Care

The concept of medical futility has been an important topic in discussions of medical ethics. What should be done if there is no chance that a patient will survive but the family members insist on advanced care? Previously, some articles defined futility as the patient having less than a one percent chance of surviving. Some of these cases are examined in court.Advance directives include living wills and durable <u>powers of attorney</u> for health care. In many cases, the "expressed wishes" of the patient are documented in these directives, and this provides a framework to guide family members and <u>health care</u> professionals in the decision-making process when the patient is incapacitated. Undocumented expressed wishes can also help guide decisions in the absence of advance directives, as in the Quinlan case in Missouri."Substituted judgment" is the concept that a family member can give consent for treatment if the patient is unable (or unwilling) to give consent themselves. The key question for the decision-making surrogate is not, "What would you like to do?", but instead, "What do you think the patient would want in this situation?".

Courts have supported family's arbitrary definitions of futility to include simple biological survival, as in the <u>Baby K</u> case (in which the courts ordered a child born with only a brain stem instead of a complete brain to be kept on a ventilator based on the religious belief that all life must be preserved).In some hospitals, medical futility is referred to as "non-beneficial care." There should be protection for a disabled child's right to life, ensuring that this right is protected even over the wishes of parents or guardians in cases where they want to withhold treatment.

Chapter – IV

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Chapter –IV

OVERVIEW of Nagaon District and Some Other Issue

4.1 Case Study

A man named Hiren had stomach cancer and, while he managed his illness more or less successfully, after about 3 years it got the best of him and treatments were ineffective. During his final months he was vomiting blood, lost about half his body weight, was incapable of walking, and experienced a degree of pain that he never had before. While he was hospitalized some of the time, he preferred to live out his remaining days at home, and his wife took on the responsibilities of caring for his basic needs as he lay in bed. A meticulous planner, Hiren foresaw the possibility of a horrible end to his life and consequently stockpiled a lethal dose of medication; as a backup precaution, he had a loaded gun by his bed. Even with pain killers, his suffering eventually became overwhelming; he resolved to end his life, but by then was too weak to take the drug himself or even pick up his gun. He asked his wife to assist him, but she couldn't bring herself to do it. He turned to family members, friends, or anyone who might be there visiting. While sympathetic to his struggle, they all refused, many out of fear of being prosecuted for murder. He finally died at home in his bed.

4.2 Analysis

Most of us hope to live long and stay healthy throughout our allotted time on this planet, and would say that we'd like to die painlessly at 100 years of age while in good health. The realities of death and too many people die in miserable conditions with illnesses that linger on and on, such as what happened with Hiren. All societies, as far back as human history gives us records, have struggled with how best to deal with people experiencing these sorts of deaths. Invariably the question arises: are we morally justified in killing people in this situation as a means of putting them out of their misery? In recent times this has been associated with the notions of "the right to die" and "death with dignity." In this chapter we will look at some of the options surrounding this issue and their possible moral justifications.

4.3 Background

Moral controversies about end of life desires for death usually involve three conditions: the person seeking death (1) is terminally ill, (2) is in intense pain, and (3) voluntarily chooses to end his life to escape prolonged suffering. For brevity, in the discussion below we will use the expression "end-of-life situations" to refer to cases in which these three conditions apply.

4.4 Distinctions

4.4.1 Suicide:

There are different ways of bringing on the death of someone who is in an end-of-life situation. First is **Suicide**, which is succinctly defined as self-killing. People kill themselves for a variety of reasons, and in many cases are the result of mental health problems, and, consequently, are nothing but tragic. The type of suicide situation that is relevant for us, though, is one which involves the three end-of-life conditions listed above. If Hiren had successfully taken a lethal dose of drugs or shot himself, that would have counted as a suicide of this sort. There several obstacles to this approach; one, as we've seen, is that some people may not have enough control over their bodies to successfully perform a death causing act. Many people do not know how to even successfully carry out a suicide or have access to the right drugs to do so. There is also the issue of courage: overriding one's survival instinct is perhaps one of the most difficult tasks a human can perform, and the degree of mental resolve necessary for end-of-life-type suicides may be impossible for some people to muster. Many people who have attempted end-of-lie suicide have failed; in the aftermath they report that, while they wished they would have succeeded, they doubt whether they could regain the courage to try again.

4.4.2 Assisted Death:

A second method is *assisted death*, sometimes called assisted suicide. This is where a third party provides a person with the resources to carry out his or her suicide. For example, it would have been an assisted death if Hiren's wife handed him the pills or his loaded gun, and Hiren himself used these to kill himself. What's critical with assisted death is that the third party only provides the death causing agent, and the person seeking death himself actually carries out the death-causing act. Spouses and family members, though, are not necessarily the best third-parties to assist in death. Sometimes there may be conflicts of interest, such as if Hiren's wife was getting tired of playing nurse to him and wanted the situation resolved quickly. The ideal assisted death would be one that was done under the supervision of a physician, who would be impartial, know details of the patient's prognosis, and know what the most effective death-causing medication would be.

4.4.3 Mercy Killing:

A third method is *euthanasia*, which literally means good death, and can be succinctly defined as "mercy killing." Here it is the third party that actually performs the death causing act, and not the person himself who is seeking to die. If Hiren's wife took his gun and shot him, or injected him with a lethal dose of drugs, that would count as euthanasia. There are different types of situations in which euthanasia might be carried out, and this leads to additional distinctions. First, there is the distinction between active and passive euthanasia. Active euthanasia is where a third party performs a consciously overt action that brings about the death of the person, such as if Hiren's wife had shot him herself. In a clinical setting, a doctor might actively perform euthanasia by administering a lethal dose of drugs to the patient, through pills or an injection. By contrast, passive euthanasia is when the third party allows the patient to die by not intervening. Frequently this is done by taking a patient off life support, or deciding to not put a patient on life support to begin with. Other times physicians can allow a patient to die by not treating a secondary illness that the patient has. Suppose, for example, that Hiren got an infection that was easily curable with an antibiotic drug. If Hiren took the antibiotic, then he would still live out his remaining weeks in pain from the cancer. But, if he didn't take the antibiotic, then, in his already weak condition, the infection would cause him to die in a matter of days. Accordingly, Hiren's doctor might decide to forego the antibiotic and, by not intervening, allow Hiren to die sooner than he would have otherwise.

4.4.4 Conscious and Unconscious state of a man: A Dilemma

Another distinction is between voluntary and non-voluntary euthanasia, Voluntary euthanasia is when a competent adult requests or gives informed consent to a particular death causing action. This is the scenario that we have so far been presuming with Hiren's case: he is conscious, rational, and in a proper mental state by which he can make a willful request. Often, though, people do not have the mental competence to make these decisions, such as when they are unconscious, delirious, or demented. In these cases an act of euthanasia would be nonvoluntary when the decision is made by a third party, and not the person himself who is to die. For example, if Hiren fell into a coma, Hiren's wife might have made the decision to terminate his life. It is important to note, though, that the term "nonvoluntary" does not mean the same thing as "involuntary." An involuntary act is one which is imposed on a person against his will, such as if Hiren did not want to die and his physician gave him a lethal injection anyway. This would clearly be a case of murder, and not mercy killing. Rather, with nonvoluntary euthanasia, a patient is incompetent to make a decision, and a third party steps in as a surrogate to make the call on behalf of the patient's best interests.

4.4.5 Brain Death: Another dilemma

Another crucial issue is the definition of death. In many non-voluntary euthanasia situations patients are not just mentally incompetent, but so brain damaged that questions arise about whether the person is already dead. The bodies of comatose people can be kept alive virtually indefinitely through artificial life sustaining treatment, and doing so makes no sense if they have crossed the line between life and death. But what exactly is that line? There are three theories about when death occurs. The first and most accepted one today is the neurological theory which maintains that brain death constitutes the real death of the person. On this view, death occurs for a person when he or she fails to engage in the surrounding world, and brain death is a sign that this has occurred. Persons that we designate as "living" must be receptive to stimuli from their surrounding environment, and be able to act to obtain what they need from that environment. When the brain can no longer sustain these abilities we presume that the person is dead.

Second is the two deaths theory which holds that the death of a person's conscious processes is distinct from the death of the person's body. In essence, the death of your brain could occur while your body remains fully alive. The problem with this approach is that it is to unconventional: we don't think about people as going through two deaths, and, throughout human history we've understood death to be a single event. To be sure, there are difficulties finding the boundary between life and death, but those difficulties do not justify creating a new dual notion of death. Third is the bodily integration theory, which is that the overall integrity of the body rather than the condition of the brain that determines whether the person is dead. Many biological mechanisms in brain dead people remain active, such as the ability to maintain bodily temperature, heal wounds, and fight infection. Brain dead people grow with age and reach sexual maturity. With all of these functions remaining active, it is best to err on the side of caution when considering whether a comatose person is actually dead. Thus, on this theory, the sign of life is whether a person's body functions in an integrated way. A criticism of this theory, though, is that mere ongoing biological activity in various cells or tissues is not in itself sufficient to mark the presence of a living organism. As the neurological theory maintains, some interactive engagement with the outside world is needed to designate human life.

4.5 Palliative Care

A final issue that's relevant to end-of-life situations concerns palliative care, typically associated with hospice programs. Palliative care aims at reducing the suffering of dying patients, typically through pain medication, once medical treatments such as chemotherapy are deemed ineffective. Hospice programs do not provide assisted death or active euthanasia, but instead focus on improving dying patients' quality of life during their final days.

4.6 What People Think of Nagaon Districts:

As a whole, the population of Nagaon District is sympathetic to both passive euthanasia and assisted death, as reflected in three recent surveys :

1) "Which comes closest to your view? In all circumstances, doctors and nurses should do everything possible to save the life of a patient. Sometimes there are circumstances where a patient should be allowed to die."

   Always Try To Save Life: 88

   Sometimes Allow to Die: 10

   Unsure: 2

2) "When a person has a disease that cannot be cured and is living in severe pain, do you think doctors should or should not be allowed by law to assist the patient to commit suicide if the patient requests it?"

Should: 86%

Shouldnot : 8%

Not Unsure: 6%

3) "Do you think a person has a moral right to end his or her own life under any of the following circumstances?"

i) "When this person has a disease that is incurable"

Yes: 83%

No: 9%

Unsure: 8%

ii) "When this person is suffering great pain and has no hope of improvement"

Yes: 80%

No: 14%

Unsure: 6%

iii) "When this person is an extremely heavy burden on his or her family"

Yes: 89%

No: 2%

Unsure: 9%

iv) "When this person is ready to die because living has become a burden"

Yes: 83%

No: 8%

Unsure: 9%

4.7 Ethical Issues

Whether the issue is euthanasia or physician's assisted death, the heart of the controversy is whether there are any morally justifiable reasons to kill oneself, and since ancient times philosophers have weighed in on this issue. We will look at the views of three classic philosophers on the subject. Next, when we turn to the contemporary moral debate regarding end-of-life situations, we find a special challenge. On the one hand, virtually all parties agree that certain types of death assistance measures are justified such as passive euthanasia. On the other hand, virtually all parties also agree that there are limits to exactly what can be done to end someone's life, for example, you cannot euthanize someone who doesn't want to die. Thus, the challenge is to find some criteria by which to distinguish acceptable from unacceptable death-assistance measures. We will look at three possible criteria for making that distinction.

4.8 Suicide

Philosophers of the past often analyzed morally controversial actions such as suicide by considering whether they violated one of our three fundamental moral duties: duties to God, duties to oneself, or duties to other people. We noted earlier that people end their lives for many reasons, and often as a result of depression. To narrow our field of inquiry, we will consider only suicides in end-of-life situations.

4.8.1 Thomas Aquinas's View:

Regarding whether suicide violates our duties to God, Thomas Aquinas (1225-1274) argues that "it belongs to God alone to pronounce the sentence of death and life" Life is God's gift to us and is subject to his special authority. He gives us a wide range of freedom so that we may carry out our daily tasks and routines. However, ending our lives is not subject our own freedom, but instead to the power of God. As Plato suggested, when it comes to our lives, we are like soldiers who are placed upon guard in life, and we must not abandon our obligation or desert our post.

4.8.2 David Hume's View:

Against this argument, David Hume (1711-1776) suggested a different view of what the divine being expects of us: God takes a completely hands off approach to governing the world, and does not micromanage anything that takes place in our lives. God established general laws of nature to regulate the physical events of the world, and left it to us to navigate our way through the world with the use of our human minds. Our normal human activity involves imposing our own purposes on the physical world, such as when we alter the flow of a river. Now, according to Hume, suicide is just another situation in which we alter the physical world specifically our physical bodies for our own purpose. He writes, "It would be no crime in me to divert the Nile or Danube from its course, were I able to effect such purposes. Where then is the crime of turning a few ounces of blood from their natural channel?" " Of Suicide". We might think that taking our own lives is different than changing the flow of a river, and God has reserved the former right especially for himself. But, Hume argues, if determining the time of death is entirely up to God, then it would also be wrong to lengthen our lives, such as through medicine: "it would be equally criminal to act for the preservation of life as for its destruction." The causes of human death are seemingly arbitrary and insignificant: the most trivial thing can end our lives, such as a hair or fly that carries a disease. It is absurd to say that through our own human choice we cannot rightfully "dispose of what depends on such insignificant causes". Thus, for Hume, suicide does not violate any duty towards God.

4.8.3 Aqunas' and Hume's outcome:

Whether suicide violates our duties to others, Aquinas argues that suicide causes social harm and thus violates our responsibility to society. Every person is a member of the community, and not just an isolated individual existing on one's own. We each have our own jobs and social roles that we fill, the combination of which makes up our society. In a sense, each person belongs to the community and, thus, "by killing himself a person injures the community." Hume has a response to this argument as well. Yes, we do have duties to society, but they all have limits. For example, my community cannot demand that I do volunteer work every waking hour of the day, regardless of the social good that it might do. In Hume's words, "I am not obliged to do a small good to society at the expense of a great harm to myself." That being so, he asks "why then should I prolong a miserable existence, because of some frivolous advantage which the public may perhaps receive from me?" If I am in an end-of-life situation, the good that I can do to society is very minimal. In fact, to tend to the endless complications of my terminal illness, I must resign all of my social activities. "Why may I not cut short these miseries at once by an action which is no more prejudicial to society?" Thus, in end-of-life situations, the interest I have in ending my misery outweighs the few remaining obligations that I have to society. Suppose further that my end-of-life situation is so horrible that I become a burden to others by draining financial resources and requiring around the clock attention. In such situations, my decision to end my life is not only morally permissible, but it may be morally praiseworthy. In Hume's words, "my resignation of life must not only be innocent but laudable." Hume is not suggesting that I would be morally required to kill myself in this situation, but, rather, that it would be an act of kindness towards others that I should place in the balance when making my decision.

Finally, whether suicide violates duties to oneself, Aquinas argues that it is wrong to kill oneself since it is contrary to the natural life asserting purpose of humans. By nature, everything in nature loves itself and resists deterioration and annihilation as much as it can. Humans are no exception, and suicide is contrary to this natural inclination "whereby every man should love himself."

4.8.4 Immanuel Kant's View:

Immanuel Kant (1724-1824) offers a similar rationale against suicide. For Kant, human life has a uniquely inherent value to it, and by killing myself I abandon my humanity and turn myself into a mere object to be used and abused. "The rule of morality," Kant says, "does not admit of suicide under any condition because it degrades human nature below the level of animal nature and so destroys it" (*Lectures on Ethics*). The duty I have to myself, then, is to preserve my humanity at all costs, and by killing myself I violate that duty. Hume's response to such arguments is that many suicides are done for good personal reasons that are consistent with duties to oneself: "age, sickness, or misfortune may render life a burden, and make it worse even than annihilation" (ibid). Yes, the instinct to survive is incredibly strong, and, following Kant, so too is our sense of the inherent value of human life. But this only shows that in some situations the motivation to die is so powerful that it overcomes the natural fear of death. People just don't throw away their lives while they are worth keeping, especially in end-of-life situations. Our natural horror of death is so great that "small motives will never be able to reconcile us to it." In end-of-life situations, my desire to die may very well overpower my natural instinct to survive and sense of inherent value, and my duty to myself may rest with ending my misery. Thus, for Hume, in at least some situations suicide does not violate duties to oneself.

4.8.5 Outcome of all these views:

What can we conclude about whether suicide violates duties to God, others, or oneself? In each case the question involves the range of freedom that we rightfully have. With duties to God, the issue is whether God has reserved for himself the decision to end my life, or, instead, has granted me the freedom to make that choice. With duties to others, it is a question of whether my obligation to society is more compelling than my freedom to choose my own destiny for myself. And, with duties to oneself, the issue is whether I have the freedom to determine for myself the value of my own life, or whether I am constrained by some special feature of human nature, such as a natural instinct to survive or the inherent value of human life. For normal and healthy people, untouched by terminal illness, it may be easy to relinquish these personal freedoms to the competing interests of God and others, or, more abstractly, to the life-asserting forces within human nature. But for people who suffer through end-of-life situations, these freedoms are not so easy to give up. It is short sighted for healthy people to make snap judgments about a phase of life that they have not yet experienced themselves, but someday in the future might. The moral question about suicide in end-of-life situations is not so much how I feel about it now as a healthy person. Rather, it is about imagining how I would feel about it in the future when I am in an end-of-life situation. By viewing it in that way, we will be in a better position to judge how much freedom we have in right to die situations.

4.9 Doctrine of Double Effect

Critics of active euthanasia sometimes defend a more modest means of mercy killing, and one particularly popular argument to this end is based on the doctrine of double effect. According to this doctrine, an act of killing is justified if the death is only a side effect (or an unintended consequence that one could foresee), but is not the primary intended consequence of one's act. For example, I am justified in killing someone in self defense since my primary aim is to protect my life, while the foreseen side effect is the death of the attacker.

Nothing hinders one act from having two effects, only one of which is intended, while the other is distinct from the intention. Accordingly, the act of self defense may have two effects, one is the saving of one's life, the other is the slaying of the aggressor. Therefore this act, since one's intention is to save one's own life, is not unlawful, seeing that it is natural to everything to keep itself in "being," as far as possible. (*Summa Theologica*, 2-2, Q. 64, A. 7)

Applied to the euthanasia situation, a physician is justified in administering an overdose of some pain medication to a patient if the primary aim is to relieve some ailment, while the secondary side effect is the death of the patient. The point is that, even though the physician knows with 100% certainty that the patient will die from the pain medication overdose, the act is morally justifiable since the doctor is intending only to alleviate the patient's pain, and not to kill the patient. The doctrine of double effect involves three specific conditions:

1. The act itself must be good, or at least morally neutral, independent of its consequences.
2. The agent must intend only the good effect. The bad effect can be foreseen, tolerated, and permitted, but it must not be intended.
3. The good effect outweighs the bad effect in circumstances sufficiently grave to justify causing the bad effect.

Walter R. Hunter, a practicing physician, graphically describes how he applied the doctrine of double effect with the mercy killing of an AIDS patient. The patient was having difficulty breathing, and, to slow down his respiratory rate, Hunter gave him a small injection of morphine. When this had no effect, he gave him another injection, then another until his breathing reached a normal rate. However, the patient's breathing continued to drop until after several minutes he stopped breathing altogether and died. Hunter writes,

> I knew that there was a slight risk of lethal side effects to the medications. But I knew that I might have to risk them, tolerate them in part or in totality if I were to attempt to ease his breathing. I did not intend for him to die, but I did intend to make his breathing easier. Had I intended the side effect of cessation of breathing, I would not have given incremental doses of medicine over time and

> observed his clinical response with each dose. I would have given a very large dose all at once to stop the breathing. (U.S. Senate Judiciary Committee Hearing, "Pain Relief Promotion Act," April 25, 2000)

A common criticism of the doctrine of double effect is that a doctor cannot meaningfully separate in his mind what he intends from what he merely foresees. For example, let's grant that Hunter intended to regulate his patient's breathing through the morphine injection. Let's also grant that he didn't hope for his patient to die. Nevertheless, by foreseeing the likelihood of his death through cumulative injections, his mental state might best be described as having regretful intentions. That is, once he foresaw the outcome and acted on it anyway, that act of "foreseeing" transformed into an intention, albeit a regretful one.

4.10 Ordinary vs. Extraordinary Care

Critics of active euthanasia within the Roman Catholic religious tradition sometimes defend more modest passive euthanasia procedures by distinguishing between ordinary care and extraordinary care. Generally speaking, ordinary care involves medical procedures that offer a reasonable hope of benefit to the patient but do not involve excessive pain, expense, or other inconveniences. The Church's view is that ordinary care should never be denied a dying patient. This is typically associated with food and water, which any patient would expect when staying in a hospital. Consequently, a food tube should never be removed from a dying patient, even if the patient is in an irreversible coma. By contrast, extraordinary care consists of procedures that are unusual, extremely difficult, dangerous, inordinately expensive, or have no reasonable hope of benefit to the patient. An artificial heart would be a good example. Because of the limitations of extraordinary care, physicians may be permitted to withdraw such procedures from dying patients. Thus, the distinction between ordinary and extraordinary care might serve as a practical guide to determine when passive euthanasia might be permitted.

One problem with the ordinary-extraordinary care distinction concerns how we determine whether a given medical procedure falls into one category or the other. Food tubes and artificial hearts may be obvious enough examples to many people, but what about respirators, dialysis machines, blood transfusions, or experimental drugs? None of these come with labels marking them as "ordinary" or "extraordinary." Catholic physicians may seek guidance on these procedures from their Church officials, but these decisions would not be morally binding on non-Catholic physicians. A second problem is that the removal of a food tube with dying patients is becoming a more common practice, and seriously compromises the value of the ordinary-extraordinary care distinction as a practical guide even with the most basic medical procedures.

4.11 Public Policy Issues

Many times our laws line up perfectly well with our moral values. Stealing is immoral, and it's also illegal. Playing tennis is morally permissible, and it's also legal. End-of-life situations, though, often involve a tension between our moral convictions and what we might want enacted into law. Many people feel that, generally speaking, active euthanasia and assisted death are morally permissible. However, because of the challenges in crafting safe public policies, these same people feel that active euthanasia and assisted death should not be legalized at least not yet. Thus, the political debate about end-of-life situations often focus on the practical problems with implementing death-causing procedures.

4.12 The Legal Status of Euthanasia

In the U.S., individual states enact their own laws regarding murder and homicide, and, accordingly, it is for each state to decide for itself how to handle end-of-life situations. Passive euthanasia is legal in all states, where the medical profession itself establishes guidelines for what types of treatment can be withheld from dying patients. As of now, though, no state permits active euthanasia, and only three state permits assisted suicide, namely, Oregon, Montana and Washington. Oregon was the first, and because of its uniqueness, other states look to it as a test case for what the effects of such a policy might be elsewhere. Enacted in 1994, the specific guidelines of Oregon's "Death With Dignity Act" are rather strict, and include the following conditions:

(1) The person must be suffering from a terminal disease (with less than six months to live) and voluntarily express orally in writing his or her wish to die;

(2) The person's decision must be an informed one regarding his or her prognosis and the alternatives to assisted death

(3) After the patient's initial request he or she must wait 15 days before receiving a prescription for the death-causing medication, and at that time the physician will offer the patient an opportunity to rescind the request. Oregon keeps detailed records of the patients who avail themselves of the "Death with Dignity Act", and a 2007 annual report notes the following:

During 2007, 85 prescriptions for lethal medications were written under the provisions of the DWDA compared to 65 during 2006. Of these, 46 patients took the medications, 26 died of their underlying disease, and 13 were alive at the end of 2007.

Most patients were well educated, insured, and enrolled in a hospice program. Among their end-of-life concerns, most indicated loss of autonomy, loss of ability to engage in enjoyable activities, and loss of dignity. About half also indicated concerns about losing control of bodily functions, burden on family, and inadequacy of pain control.

The U.S. Supreme Court addressed the issue of assisted suicide in two important cases. First, in *Vacco v. Quill* (1997), a group of physicians in

New York argued that assisted suicide should be legally permitted throughout the country. It is essentially the same as withholding life-saving treatment, they maintained, which is already legal in all states. The central issue was whether assisted suicide was different enough from withholding life-sustaining treatment (i.e., passive euthanasia) to justify different laws. The physicians maintained that they were sufficiently similar, and, thus, current bans on assisted suicide were arbitrarily discriminatory. The Supreme Court disagreed and argued that the two procedures are distinct in two important ways. First, the causes of death are distinct from each other: "when a patient refuses life sustaining medical treatment, he dies from an underlying fatal disease or pathology; but if a patient ingests lethal medication prescribed by a physician, he is killed by that medication." Second, the physician's intentions differ in the two procedures: when withholding life sustaining treatment, the intention is "to cease doing useless and futile or degrading things to the patient," but with assisted suicide, the intention is to end the patient's life. Thus, there are no grounds for legalizing assisted euthanasia nationwide based on any supposed similarities with passive euthanasia.

In the second case, *Washington v. Glucksberg* (1997), a different group of physicians argued that the ban on assisted suicide in the state of Washington violated a patient's Constitutionally protected liberty rights. The Supreme Court concluded that the Constitution's conception of liberty does not include the right to assisted suicide. First, they argued, there is a long history of prohibiting assisted suicide: "The history of the law's treatment of assisted suicide in this country has been and continues to be one of the rejection of nearly all efforts to permit it." Further, they argued, individual states have legitimate interests in preserving human life and "protecting the integrity and ethics of the medical profession," which assisted suicide threatens. Finally, states have an interest in "protecting vulnerable groups including the poor, the elderly, and disabled persons from abuse, neglect, and mistakes. The upshot of both of these cases is that individual states can legalize assisted suicide within their own borders if they so choose, just as Oregon did. However, the Constitution does not require that states must do this.

Just as Oregon has become a test case for assisted death, the country of the Netherlands is being closely scrutinized for its practice of legalized active euthanasia. Famous for its liberal social policies, such as legalized prostitution and drug use, the Dutch have turned a blind eye towards euthanasia since 1973, and finally legalized it in 2002. Like Oregon's "Death with Dignity Act," Dutch laws also have a checklist of requirements that must be fulfilled before physicians can directly administer a lethal dose of a drug to their patients. The Dutch government has issued reports on the practice of euthanasia in their country, which indicate that some abuses have taken place. Most notably, some patients were euthanized or assisted in death when their suffering was only emotional, but not physical. Critics of active euthanasia in the US have seen this as a warning for what might befall us if we follow Dutch policies. While the Dutch are unique by allowing active euthanasia, a handful of European countries permit assisted suicide. Belgium is one such country, and their active euthanasia laws are more lenient than those of the Netherlands. In one case, two twin brothers of 45 years old, who were born deaf, were progressively becoming blind, and they opted to be euthanized to avoid living in a condition of being both deaf and blind. In this case, while their decision was voluntary, they were not terminally ill, and their pain was emotional, not physical. Of the European countries that have legalized active euthanasia, Switzerland is the only one that allows outsiders to participate in the program, and this has led to a phenomenon in that country called "suicide tourism". That is, people in end-of-life situations travel to that country specifically to have a physician there assist them in suicide.

4.13 Who Decides

A major legal issue related to end-of-life situations concerns who should decide the fate of patients once they become incompetent to express their preferences. Suppose, for example, that Hiren fell into a coma and was put on life support and feeding tubes. There's no realistic hope that he will recover from the coma, and it is just a matter of a few months before he dies from his stomach cancer anyway. In this situation passive euthanasia might be a reasonable option, but Hiren himself is not in a position to voice his preference about discontinuing his treatment in essence, "pulling the plug" on the life-sustaining machines. Who should speak on Hiren's behalf?

First, his family members would have a say since they have the most at stake. Nevertheless, they should probably not be the sole determiners since they are too close to the situation. Their judgment to discontinue treatment might be clouded by mounting medical costs and other demands on the family. On the other hand, their judgment to continue treatment might be clouded by an unrealistic hope that Hiren will miraculously recover. Hiren's physician and hospital would also have input, but here too their judgments might be clouded by their own concerns, such as the desire to accelerate Hiren's death to free up hospital beds, or the desire to provide Bob with every possible treatment as a means of avoiding a malpractice law suit. When family members and hospitals cannot agree, sometimes a judge must intervene on behalf of the family or hospital and order a particular course of action, such as removing life support. The case of Terri Schiavo is a dramatic example of this. After being in a persistent vegetative state for eight years, her husband obtained a court order to remove her feeding tube. Terri's parents insisted that she was conscious, and, with the help of sympathetic advocacy groups and politicians, intervened to block the court order. After seven years of legal wrangling, the order was finally carried out and Terri died in 2007.

The issue of "who decides" is especially pertinent in cases of infants with deformities so serious that they have no reasonable hope of having a normal pain free life. Anencephalic infants, for example, are missing a major portion of their brain, and are often born blind, deaf and unconscious. Decisions about withholding treatment, and thus allowing them to die, typically rest on the quality of life that the infant can be expected to enjoy. The more dismal the quality of life, the greater the case for withholding treatment. With some defects, though, it is difficult to presume in advance what the overall quality of life would be for the infant. Children with Downs syndrome, for example, vary greatly in their cognitive abilities, from being in a nearly vegetative state to being close to normal.

4.14 Living Wills

One way of remedying the situation of "who decides" is with a *living will*, also called an *advance directive*. This is a document that I might fill out while I'm still mentally competent and indicates my preferences regarding the withholding of medical treatment to hasten my death. The following example was created by hospice organization called Caring Connections, which prepares easy to read living wills for each of the U.S. 50 States, based on their own unique state laws.

> I, John Doe, hereby give these advance instructions on how I want to be treated by my doctors and other health care providers when I can no longer make those treatment decisions myself.
>
> Agent: I want the following person to make health care decisions for me: [*space provided for name, relation, and contact information*].
>
> Alternate Agent: If the person named above is unable or unwilling to make health care decisions for me, I appoint as alternate: [*space provided for name, relation, and contact information*]

Quality of Life: I want my doctors to help me maintain an acceptable quality of life including adequate pain management. A quality of life that is unacceptable to me means when I have any of the following

☐ Permanent Unconscious Condition: I become totally unaware of people or surroundings with little chance of ever waking up from the coma.

☐ Permanent Confusion: I become unable to remember, understand or make decisions. I do not recognize loved ones or cannot have a clear conversation with them.

☐ Dependent in all Activities of Daily Living: I am no longer able to talk clearly or move by myself. I depend on others for feeding, bathing, dressing and walking. Rehabilitation or any other restorative treatment will not help.

☐ End-Stage Illnesses: I have an illness that has reached its final stages in spite of full treatment. Examples: Widespread cancer that does not respond anymore to treatment; chronic and/or damaged heart and lungs, where oxygen needed most of the time and activities are limited due to the feeling of suffocation.

Treatment: If my quality of life becomes unacceptable to me and my condition is irreversible (that is, it will not improve), I direct that medically appropriate treatment be provided as follows. Checking "yes" means I WANT the treatment. Checking "no" means I DO NOT want the treatment.

Yes/No. CPR (Cardiopulmonary Resuscitation): To make the heart beat again and restore breathing after it has stopped. Usually this involves electric shock, chest compressions, and breathing assistance.

Yes/No. Life Support / Other Artificial Support: Continuous use of breathing machine, IV fluids, medications, and other equipment that helps the lungs, heart, kidneys and other organs to continue to work.

Yes/No. Treatment of New Conditions: Use of surgery, blood transfusions, or antibiotics that will deal with a new condition but will not help the main illness.

Yes/No. Tube feeding/IV fluids: Use of tubes to deliver food and water to patient's stomach or use of IV fluids into a vein which would include artificially delivered nutrition and hydration.

Other instructions, such as burial arrangements, hospice care, etc.:

[*space provided for instructions*]

Organ donation (optional): Upon my death, I wish to make the following anatomical gift (please mark one):

☐ Any organ/tissue ☐ My entire body Only the following organs/tissues: [*space provided for instructions*]

[*signatures and notarization*]

The above living will is an exceptionally detailed one, which in many states is a necessity rather than a luxury. A Supreme Court ruling *Cruzan v. Director, Missouri Department of Health* (1990), established that individual states are within their rights to require that patients have a clearly articulated living wills before life-sustaining treatment can be withheld. A patient's mere verbal statement to a family member would not be sufficient. The justification for such strict standards is that we unfortunately cannot assume that family members will always act to protect the patient, and, thus, "A State is entitled to guard against potential abuses in such situations."

4.15 ARGUMENTS PRO AND CONTRA

4.15.1 The Conservative Position

The conservative stance regarding end-of-life situations is that all active measures such as suicide, assisted death or active euthanasia are wrong and should not be legalized. Some more moderate or passive measures are permissible, though, when it's a matter of letting nature take its course. The main argument against active measures in end-of-life situations are as follows; (for simplicity they will focus specifically on active euthanasia, but apply as well to suicide and assisted death).

1. *The wrongness of intentional killing*: active Euthanasia is wrong because it is deliberate killing, and societies throughout history have condemned killing others intentionally. A criticism of this argument is that there are many exceptions to the prohibition against killing particularly in cases of self-defense, war and capital punishment and there are good reasons to recognize active euthanasia as another exception.

2. *Slippery slope*: euthanasia will lead to abuses, and ultimately result in actively euthanizing people against their wills. While in some situations it may be tempting to put someone out of his or her misery through active euthanasia, society will get accustomed to the idea of killing people to solve problems. Eventually euthanasia will be permitted in non-end-of-life situations, that is, where a person isn't terminally ill, or in intense pain, or voluntarily requests it. Those most susceptible to euthanasia abuses will be the most helpless and vulnerable members of society. A criticism of this argument is that, as with any public policy, abuses with euthanasia can be reduced by enacting strict guidelines. At minimum, such guidelines would require that the above three end-of-life conditions be met.

3. *Possible recovery*: Euthanasia is wrong because we cannot tell for certain if a person's condition is really hopeless. There is always the possibility of some recovery, such as through a spontaneous remission or a new cure, or even a mistaken diagnosis. While this may be infrequent, it's

not worth risking the lives of those who might be lucky enough to recover. A criticism of this argument is that it wouldn't rule out situations in which the patient's prognosis has been checked and rechecked and all available options have been reconsidered. Again, a strict enough set of guidelines could virtually eliminate cases of possible recovery.

4. *No assurance of voluntariness*: even if patients appear to authorize euthanasia, we can't be sure that their consent is truly voluntary. They might not be in the proper state of mind to fully understand the options. Worse yet, they might be influenced by the preferences of family members who want to be free from the expense and burden of continued treatment. A criticism of this argument is that in many cases we can be sure of voluntary consent, particularly when patients make advance arrangements and repeated requests. Again, strict guidelines can reduce this possibility.

4.16 The Liberal Position

The liberal view regarding end-of-life situations is that individuals should be morally and legally permitted to decide whether to terminate their lives by either active or passive means. Here are the principle arguments for active euthanasia, which, again, also apply to suicide and assisted death.

1. *Exercising Autonomy*: people have a right to control their lives and choose their own means of dying. The idea of autonomy (which literally means self-rule) is a foundational component of a free society. So long as my actions don't harm others, I should be free to direct my life as I so choose, and this freedom extends to end-of-life situations. A criticism of this argument is that, while autonomy is an important moral ideal, no one has full autonomy. Our actions are always restricted by competing interests of society. Suppose, for example, that our society lacks the ability to construct a safe active euthanasia policy that protects the interests of those who are most vulnerable to abuse. In such a case, society's interests in protecting vulnerable people might outweigh the autonomy of those who desire active euthanasia.

2. *Dying with Dignity*: people have a right to conduct their lives with dignity and, when possible, to choose a dignifying way of dying. Like autonomy, the idea of human dignity is a foundational value of society. We should not be forced to endure degrading and humiliating situations in any component of our lives, and this includes the manner in which we die. End-of-life situations can be horribly degrading when patients lose control of their bodily functions and their ability to cope with excruciating pain. A criticism of this argument is that, while dignity is an important ideal, there are limits to what we can expect when claiming a right to dignity. Our jobs, for example, will always involve some indignity, as anyone who works on an assembly line or in customer service knows very well. The best we can hope for is to reduce indignities as much as our circumstances allow. In end-of-life situations, efforts should certainly be made to reduce indignities for patients, but this by itself does not mean that patients can demand death through active euthanasia.

3. *Showing Mercy*: people in end-of-life situations are typically in enormous pain, and our duty to be merciful and relieve suffering requires us to end their suffering through death if necessary. We routinely put animals out of their misery as an act of mercy and, in end-of-life situations, our duty to relieve suffering demands that we do the same for humans. A criticism of this argument is that our duty to relieve suffering is only one of many competing moral values that we have. For example, our moral tradition also acknowledges the duty of fortitude, that is, the ability to endure difficult situations, the duty to courageously face fear, and the duty of self-preservation; these values may be contrary to active euthanasia. The duty to relieve suffering should undoubtedly be shown towards dying patients, as is done in hospice programs, but showing mercy does not necessarily mean that we should actively put someone do death.

4. *The Golden Rule*: active euthanasia is supported by the Golden Rule. That is, I should do to others as I would want done to me. If I was in an end-of-life situation, I would want someone to kill me. Thus, treating others the same way, I should permit active euthanasia for others who are

in end-of-life situations. A criticism of this argument is that the Golden Rule does not apply to all of our desires, particularly desperate ones. I may desperately want you to give me a million dollars, or a heroin fix, or an army of slaves to do my bidding. However, this doesn't mean that I should reciprocate by giving you these things when you desperately desire them. The Golden Rule does suggest that I must give desperate people help and show them kindness, since that's what I'd want, but it does not hold me hostage to their specific requests.

4.17 A Middle Ground

On both sides of the euthanasia debate, there is great sympathy for people in end-of-life situations, and a shared conviction that artificially prolonging the lives of such people is not good. Hospice programs are widely available, and passive euthanasia policies are becoming more generous. Thus, there is already much middle ground on this issue, perhaps more so than with other controversial moral issues. The sticky issue, though, is how we should deal with the more aggressive measures of assisted death and active euthanasia. How far should the U.S. go? As a whole, the U.S. is more conservative than the Netherlands, and it is unlikely that Dutch policies regarding active euthanasia will be duplicated in the U.S. any time soon. Further, worries about potential abuses of legalized active euthanasia are at least somewhat justifiable. If the U.S. is to move in a more liberal direction, particularly with assisted death, which seems inevitable, it makes sense to first learn from the mistakes of places like the Netherlands.

Chapter- V

Utiliterianism

Chapter- V

Utiliterianism

5.1 Utiliterianism

Behind the devaluation of human life is the philosophy of utilitarianism. The value of an individual is measured by his or her usefulness to the group in the "strikingly primitive and vulgar form of utilitarianism" used to support euthanasia.

We have seen further consequences of this form of utilitarianism. After abortion was legalized, the rush was on to conduct research first on aborted fetuses and now also on human embryos specifically grown for that purpose. As a precursor to the legalization of infanticide, viable organs of defective newborns are being used for transplantation. In the view of this form of utilitarianism, it is morally right to sacrifice "inferior" humans for the benefit of others.

Already, the euthanasia movement has begun to have some success in changing the standards of patient care and in the attempted legalization of assisted suicide.

5.2 Redefining Patents Care:

The basic level of patient care is that of "comfort care". This includes the provision of pain control, a room with a comfortable temperature, a bed with clean sheets and adequate pillows, proper positioning, food, water, bathing, and other personal care in a supportive environment.

"Therapeutic care" is a higher level of care. This includes the use of medication, surgery, radiation, and other treatments to cure a disease, to remove diseased tissue, to shrink tumors, etc. Therapeutic care can be divided into usual and customary, such as giving an antibiotic, setting a broken bone, and removing a cataract; and "extraordinary care", such as the transplanting of hearts, lungs, etc. Within the medical profession, usual and customary care is almost always mandatory, while extraordinary care is judged by considering many factors.

As an indication of a movement toward euthanasia, court decisions in several states have moved the provision of food and water from "comfort care" into the level of "treatment" effectively, "extraordinary care". The family, the physician, or the medical facility can then decide to withhold food and water with the intent of causing death.

Since death by starvation and dehydration is a lengthy process, there is agitation to provide a quicker death through physician assisted suicide.

5.3 Suicide: Assisted Suicide

It is very rare that someone with a serious disability commits suicide. Rather, as society views seriously disabled and terminally ill individuals as burdens with unacceptable quality of life, these persons may feel an obligation to commit suicide.

Terminally ill patients who wish to commit suicide often have been found to have clinically diagnosable depression. Usually, those with clinical depression can be helped with professional counseling and medication.

With rare exceptions, those who commit suicide suffer from identifiable mental disorders. Family and friends need to be on the alert for signs of depression and other mental disorders so that help is obtained.

Immanuel Kant, the philosopher, has given convincing arguments against the rare cases of "rational" suicide in his *Lectures on Ethics.* To summarize his position: Suicide is strictly incompatible with respect for one's humanity: treating oneself as only a *means to the end* of avoiding pain or distress. Suicide is self-contradictory in that the power of free will (the right to choose) is used for its own destruction. Suicide degrades human worth to that of beasts or lower. Suicide is contrary to the highest duty a human being has toward himself or herself: respecting oneself as a person.

For defenders of physician-assisted suicide, there are embarrassing questions. Have those physicians examined the patients' records to find out if they have been given adequate pain medication or if they have been examined for depression? If patients have made "rational" choices for suicide, are not these physicians assisting them in ethically questionable acts? Finally, do not physicians who assist suicide help to create an atmosphere of distrust between physicians and patients: if the physician cannot cure you, will he care for you or will he kill you? It is reasonable to conclude that physicians who are involved in assisting suicide are doing a disservice both to their patients and to their profession.

Legalizing physician assisted suicide is a giant step toward legalizing euthanasia, in general. Patients who are not terminally ill will demand euthanasia based on equal protection under the law.

On June 26, 1997, the United States Supreme Court, in a unanimous decision, ruled that states have the right to prohibit physician-assisted suicides. The Court said such bans did not violate either the equal protection or the due process clauses of the U.S. Constitution. However, the ruling does not prohibit states from allowing physician-assisted suicide in narrowly defined cases.

5.4 The Holland Example

While it began with a few extraordinary cases, physician assisted suicide and euthanasia have now become routine in the Netherlands, accounting for almost 10% of all deaths there in 1990. More than half of the people did not ask to be killed.

Not only do physicians perform assisted suicide on terminally ill patients, but they also kill newborn infants and hospitalized seniors whose quality of life is judged to be too poor.

There is increasing concern about involuntary euthanasia among Dutch citizens with disabilities. Many of them are joining the Dutch Patients' Association which issues a wallet-sized card stating that it is "intended to prevent involuntary euthanasia in case of admission of the signer to the hospital."

Judges have set up guidelines to protect patients. These guidelines are to be honored before a doctor can kill a patient. They include repeated requests by a rational person to die, uncontrollable pain, witnesses, and two doctors who agree the criteria have been met. In practice, few of these guidelines are even considered; the need for repeated voluntary requests has been routinely ignored.

The lesson of physician assisted suicide in the Netherlands is how quickly the decision moves from a patient's request to a surrogate's request to a physician's personal decision.

The experience of the Netherlands should not serve as a precedent. There are positive alternatives to assisted suicide and euthanasia: pain management and Hospice care.

5.5 Can Pain be Controlled?

Contrary to pro euthanasia propaganda, physical pain, with rare exceptions, can be controlled if the physician knows the appropriate treatment for pain and is not afraid to prescribe a sufficiently high level of medication. Unfortunately, it is taking a long time to educate physicians in proper pain management.

Another type of pain that drives people to ask to be killed is emotional pain. The feelings of loneliness, isolation, hopelessness, despair, meaninglessness, loss of dignity, uselessness, weariness with life, and the general fear of being a burden to others can be overwhelming. In these cases, as with any emotional problem, the standard response should be psychological, family, and spiritual counseling.

5.6 The Hospice Alternative

Compassionate care is available for terminally ill people with only a few months to live and their families through the Hospice program. Great effort is made to keep patients comfortable during this final period of their life when curative treatment is no longer being sought. Attention is given to the emotional and spiritual needs of patients and their families, as well as to the physical needs of the patients. This care is provided both at home, with visits by nurses, social workers, chaplains, and counselors, and in skilled nursing facilities.

5.7 Predictions

Physician assisted suicide was originally aimed at killing terminally ill people in intractable pain. However, the meaning of physician assisted suicide is rapidly being broadened further to include the provision of death to suffering patients who are not terminally ill and then to patients who are judged unfit to live. As in the Netherlands, patients will be subjected to euthanasia to spare family members or caretakers from the burden of their care. At risk will be people with disabilities, mental retardation, mental illness, and frailty due to advanced age.

Many physicians and hospitals will refuse to perform assisted suicide, so for profit euthanasia centers will be established, much like present abortion centers. People in the group at risk will be pressured into choosing euthanasia, or their surrogates will make the choice for them. Given time and perspective, the families and surrogates may feel guilt for having participated in the decision.

5.8 What can we do?

Become informed about the advantages, limits, and appropriate use of medical technology. Ask your family physician about his position on pain management. Determine your hospital's policies on the use of medical technology and the rationing of medical care. Discuss with your family what kind of care you want if your condition prevents you from making decisions for yourself, then put your wishes in writing. Establish a durable power of attorney for health care instead of a "living will," using great care in your choice of the person to whom you grant that power. Help to educate others about these precautions.

Most importantly, adopt a critical attitude toward the notion of compassionate death and recognize the role of physician assisted suicide in the ongoing devaluation of human life.

Chapter- VI

Slippery Slope Argument with Special Reference to Euthanasia

Chapter- VI

Slippery Slope Argument with Special Reference to Euthanasia

In this chapter, I will try to discuss slippery slope argument with special reference to euthanasia and will try to explain how these types of discussions help us in social integration.

The main theme of the slippery slope argument is that if we take a first step A, B will necessarily or very likely to follow. B is merely not acceptable. Therefore we must not take step A. According to Kamisar- "Whether the first step is precious, is perilous, is worth taking, rests in part on what the second step is likely to be". The slippery slope argument is known by various titles. For example, it is called "the bald man argument" or "sorties or heap argument" etc. There are various types of slippery slope arguments and they should be carefully distinguished because the conditions under which they are conceiving arguments differ. There are an empirical (psychological/causal) version and two logical (conceptual) versions and there is a full or combined version. They are very popular in practical debates. To understand their popularity, we are to address their rhetoritical role. The main reason why they are so hard to attack is that they are based on controversial interpretation of reality and of future developments, interpretations that are strongly influenced by underlying attitudes, different backgrounds and emotions.

Voluntary euthanasia may be in some extreme cases perhaps morally justified. But, we should never do it, because this would be the first step on the slippery slop towards an inhuman society. Further steps could be the killing of severely handicapped newborn and then the killing of persons with a mental handicap, until we finally kill the useless elderly against their will. Arguments like this are very common in applied ethics. If we do A, which in itself may not be morally wrong, we will start a process which will lead to a clearly unacceptable result B. In order to avoid B, we must refrain from A. From a general example we will get a clear idea about it. For example, a student get one mark less and he did not get first class and because of that criteria he did not eligible for dissertation as there is a criteria in some university that if anybody will get 1st class then only he/she will eligible for the dissertation. Without fulfill this criteria no one will eligible to do dissertation but if we think that the boy/girl got only one mark less so we can allow him/her. Again we found another girl who got two marks less then again ignoring the criteria we allowed her. Like this we step in a slippery slop. There is always a possible risk that this action starts an uncontrollable process leading to undesirable consequences. Slippery slop arguments have a dubious standing in philosophy. There are always many questions like-Is the slippery slop argument is valid and is it plausible or not? Generally it is impossible to give any answer to these questions. The question should rather be under what conditions are which types of slippery slop arguments acceptable arguments. Many opponents of legalizing euthanasia consider even voluntary euthanasia is morally wrong. All forms of euthanasia should be legally prohibited in order to prevent horrible consequences. We can consider here one case. The govt. should not allow a manufacturer to dump PCB contaminate waste into the small stream, because the PCB would kill the fish and wild life in that river and pollute the drinking water for those downstream who use the river for that purpose. It is perfectly natural to say that dumping such waste causes the pollution of drinking water, even if the causal chain is quite long and complex. From one point of view, this is not a slippery slope. A criterion for calling something a slippery slope could be the actions should all be by the same person, group or institution. According to W. Van der Burg, it is essential that the first step and the next steps are somehow of a comparable nature.

In America at the very beginning there was no capital punishment but it was started with a person name Gilmore and after that capital punishment was started. If capital punishment is fully restored in there and radically extended it will not be necessary to show that Gilmare's death was causally responsible, but it is nevertheless plausible to suggest that his execution is an example of first step on a slippery slope. Bishop Joseph V Sullivan objected to the legalization of voluntary euthanasia. Again Rachcels also said that under any circumstances euthanasia must be condemned. According to Rachels the logical version argues that once one form of euthanasia is accepted then one is logically committed to an approval of euthanasia in other cases. He points out that there are rational grounds for distinguishing between the man in agony who wants to die and other cases, such as that of an old infirm person who does not want to die. He says, "Provide good grounds for thinking that euthanasia ought to be legally prohibited". Sullivan has overstated the prediction of horrible results, especially with his references to the compulsory killing of wounded soldiers, children and charity patients. For example, the concept of 'voluntary' might be stretched to apply to the killing of wounded soldier who does not want to die but has nevertheless freely volunteered for a mission the success of which depends on not leaving any wounded behind for enemy to interrogate. It could be argued that in one sense his death was voluntary.

From the above we get that the logical form of the argument holds that we are logically committed to accept B once we have accepted A. the first logical version states either that there is no relevant conceptual difference between A and B or that the justification for A also applies to B. Therefore, acceptance of A will logically imply acceptance of B. For example, "Once public officials cross the line of accepting seemingly innocent gifts like bottles of wines, there is no stopping and the road to corruptions is open." If accepting the larger bribe is clearly morally wrong, we should also refuse the bottle of wine. The question of whether there is any relevant conceptual difference between A and B is yet unclear. There is always arise one question, should an embryo be considered a person or not? Again concerning the question of whether abortion should be allowed, but not in other respects, e. g, concerning the questions of whether experiments with embryos should be allowed. Then the conclusion must be that, only with respect to the abortion problem, we have a clear line and a relevant difference between A and B, so that accepting abortion before viability does not logically commit us to infanticide. The second logical slippery slope argument holds that there is a difference between A and B but there is no nonarbitrary cutoff point on the continuum between them. This version holds that there is a difference between A and B, but that there is no such difference between A and M, M and N,……., Y and Z, or Z and B, and therefore, allowing A will in the end implies the acceptance of B. But this distinction collapses as soon as we realize there is no such distinction between a 3 months old fetus and a 3 months and 1 day old fetus, and so forth. There is one interesting question. If one hair less cannot make a man bald how can we ever call a man bald? If we start from the intuitive idea that killing a newborn baby is clearly wrong, and then go backward by small steps, we will end up proving that killing an embryo is equally wrong. The empirical version argues that doing A will, as the result of social and psychological process, ultimately cause B. Rachels argues, " once certain practices are accepted, people shall in fact go on to accept other, more questionable practices." This version involves an empirical prediction about what people shall do, and is therefore not about what they would be logically committed to believing. Rachels maintains that the slope argument can be refuted with evidence to the contrary. Historical and anthropological evidence is therefore cited in order to show that killing in one context does not lead to killing in another. The empirical slippery slope argument can be valid in almost all contexts. Only in the context of critical morality is its validity is doubtful. In other contexts, the empirical version may be valid in theory, but it is usually hard to judge whether it is plausible. Therefore, it is not a good argument against accepting A to say that, in the end; the same process will lead to accepting B, because not accepting A will not stop the process. The prohibition against killing is effective against involuntary euthanasia, but once we have accepted voluntary euthanasia, there will be no more barriers. Efforts to establish new reasonable and effective barriers between A and B will then probably be more fruitful. But we see that by setting a definite standard of conditions under which euthanasia will be permitted and we see that if A is a separate action that might as well not be taken does it make sense to discuss slippery slop argument as an argument against A.

The forgoing discussion has indicated that the slippery slope argument depends upon a combination of two factors. The first is that there is an argument over the alleged prediction of abuses and a consensus that there end results would be undesirable. The first factor is bound up with predictable consequences. The second is that the slope argument functions as a warning against reasoning to newly proposed moral boundaries with loose concepts. This factor is bound up with unpredictable consequences. Bernard Williams has captured there features in his distinction between horrible results and arbitrary results argument. The status of horrible argument depends primarily on argument regarding the horrible nature of end result. The arbitrary results argument does not depend upon prior argument regarding the horrible nature of the result, but rather on the prediction that once having stepped on the slope the stopping point will be arbitrary against reasoning with loose concepts.

David Lamb in his book *Down the Slippery Slop* in chapter 2 mentioned about the starting from small beginnings. An article published by an official German medical journal. In it we get a particular case involving the father of a deformed infant who asked Hitler for permission to have the child killed on merciful grounds. Hitler replied that if an investigation verified the facts of the case as presented by the father he would personally instruct physicians to carry out the father's request. Telford Tylor has pointed out that the euthanasia programmed was more of an "improvised affair". Euthanasia on request in a case where death was near and where there was unbearable suffering. Subsequently, however, they abandoned each of these criteria by small steps. In the late sixties, we began to realize that modern medical technology is not always beneficial. Life is not always worth living and sometimes suffering is so unbearable or the quality of life so poor that prolongation of life is itself an evil. For instance, we have to consider the recent initiatives in various U.S. States which would have allowed certain forms of euthanasia or physician-assisted suicide. Here we see that we cannot exclude psychological and emotional factors because ultimately they seem to determine whether some persons or group believes in the slippery slop or not. In another explanation is that many American simply condemn every form of active euthanasia, every step will then clearly be perceived as step down the slippery slop. In the Netherlands, there is almost equal access to health care and almost no one will have to pay extremely high hospital bills; euthanasia is usually performed in the context of a long standing physician-patient relationship, and there has been a long, intense and broad discussion on euthanasia. According to Dawidowicz, killing was never administered because of a 'sick or dying person's intolerable suffering or because of a patient's own feelings about the useless of his life. Dawidowicz says again that in no case did the patient ask for death. Killing was done without the patient's consent and without the family's knowledge. Families were informed that their kin had died of pneumonia or during an appendectomy. The lie was detected in instances when the family knew that the patient's appendix had been removed many years ago.

It is extremely difficult to argue against the case for voluntary euthanasia on behalf of a 'pain-racked', 'hopelessly incurable' cancer victim who has expressed a 'rational desire' to die. According to British Voluntary Euthanasia Society, EXIT, voluntary euthanasia should be the 'lawful right of the individual, in carefully defined circumstances and with the utmost safeguards if, and only if, that is his expressed with and EXIT maintains that it does not entail 'getting rid of old', the infirm and the unwanted or for the deformed children and mental defectives. Michal Tooley finds it rather puzzling as to why the slop argument should be employed as an objection to voluntary euthanasia for a person who has a 'rational desire that his life be terminated.' For Tooley the philosophical problem is not so much a question of justifying euthanasia as one of examining the reason why 'many people view voluntary euthanasia as morally objectionable. According to Tooley, the main reason why the slop argument is employed against voluntary euthanasia is because it is seen as a thread to the sanctity of life. There is a very important stand of thought, according to which human freedom has greater priority than life. According to Singer, even if it were possible to eliminate pain and for all patients to be guaranteed a painless death, it would still be wrong to prohibit a patient from expressing this right. According to Phillipa Foot, euthanasia should not be considered unless it is, in some sense, beneficial to the patient. As an advocate for beneficent euthanasia, Kohl is obliged to counter the slop objection that this would open the door to the killing of the crippled, the aged, and those who are a burden on the community and the public purse. There is difference between 'killing out of kindness' and the 'kindest way of killing'. Obviously, if one is to kill it is better to do it kindly. But this does not suggest that killing kindly is just. One might embark on an evil programme of killing and still do it kindly. The paradigm case advanced by cost-benefit exponents of euthanasia is of a 'person who wants to go on living, but the cost of keeping him alive is so great that letting him die is the lesser of evils. May be there is a condition also that by saving someone's life the whole family will die without food because of paying the cost of a single person and there is no hope that one day he will cure.

After this analytical exercise, we are now deal with the central question-when are slippery slope arguments good arguments? There are no general answers to this question. The only way to deal with them is careful analysis, to distinguish the versions of the argument involved and the contexts in which they are thought to apply, and then evaluate each of the versions in each of the relevant contexts. And even if after this analysis the conclusion is that the argument is not strictly invalid, it is rarely a fully conclusive argument but only a probabilistic argument, which should be considered more or less plausible and which can be overruled by other arguments.

Slippery slope arguments are based on interpretations of social reality and especially of the likelihood of future developments. Slippery slope arguments are often not so much rational arguments as expressions of an underlying feeling of concern about general trends in society. If so, they have to be taken seriously by trying to reformulate them and bringing the underlying concerns into the open public debate.

From the above discussion we get a general idea of the slippery slope argument and about euthanasia we see sometime that every people at some stage think that he/she is the only sufferer and he/she is only in that bad situation. But if we observed the situation then we get that he/she may be in sorrow for a days or may be for some years and it is the real fact that nobody cannot get-rid-of that bad situation and we see that everybody is in tensed somehow at for some period. But after a period the problems somehow over come so, we have to keep the passion for sometime. So, from my point of view, euthanasia is not good. We see that just after dying the person, someone gets the medicine. Like this, we see that the suffering and problems are to some extend get a solutions and the main thing is that life is valuable.

Chapter-VII

Summary and Conclusion

7.1 Summing Up: A Brief Over View of the Chapters in Light of the Research Questions
7.2 Importance of Communications
7.3 Control and Resolution
7.4 The right to die with dignity is justifiable
7.5 Major Findings
7.6 Implications of the Study
7.7 Scope for further Studies

Chapter- VII

Summary and Conclusion

7.1 Summing Up: A Brief Over View of the Chapters in Light of the Research Questions

In this concluding chapter this dissertation re-visits the research objective and the research questions in light of what we have discussed at some length about some of the key themes of this work. The opening chapter raised some issues and now it is time for re visiting some such issues in order to understand the dissertation's position in this regard. In its attempt at understanding euthanasia, doctor-patients relation, utilitarian view, whether it is authentic or acceptable or not from different philosophical views, the dissertation is rather an exploration of the first person subjective awareness about euthanasia and what it is. The following is an exploration in this direction.

This research reveals is that actual moral decision-making is situational; it is tailored to the demands of particular circumstances as well as the capacities and limitations of the persons enmeshed in those circumstances.

Many times our laws line up perfectly well with our moral values. Stealing is immoral, and it's also illegal. Playing tennis is morally permissible, and it's also legal. End-of-life situations, though, often involve a tension between our moral convictions and what we might want enacted into law. We trust that our study illustrates the difficulties of interpreting results from different questionnaires to support or oppose recommendations on the practices of euthanasia. Our hypothesis was that the outcome of questionnaires might be affected by the survey instrument used. The presents study confirms this hypothesis.

These results further show the difficulties of making direct comparisons of answers to questions with different wording and response alternatives in a population with similar characteristics. Answers to questions on whether to legalise euthanasia may thus be modified by the way in which the questions and possible responses are phrased. However, because of the challenges in crafting safe public policies, these same people feel that active euthanasia and assisted death should not be legalized at least not yet. Thus, the political debate about end-of-life situations often focus on the practical problems with implementing death-causing procedures.

The doctor may decide the best option for a patient who is declared as clinically brain dead is to switch of the life support machines; equipment without which the patient will die. The doctor in charge will talk to the patient's family. However, the final decision is the doctor's, and strict criteria must be met.

It has been argued that mainstream medical ethics is biased by the assumption of a framework in which individuals are not free to contract with one another to provide whatever medical treatment is demanded, subject to the ability to pay. Because the welfare state typically provides a high proportion of medical care, and because there are legal restrictions on what treatment may be provided and by whom, an automatic divergence may exist between patient wishes and the preferences of medical practitioners and other parties. Tassano has questioned the idea that beneficence might in some cases have priority over autonomy. He argued that violations of autonomy more often reflect the interests of the state or of the supplier group than those of the patient. Routine regulatory professional bodies or the courts of law are valid social recourses.

7.2 Importance of Communications

Many so-called "ethical conflicts" in medical ethics are traceable back to a lack of communication. Communication breakdowns between patients and their healthcare team, between family members, or between members of the medical community, can all lead to disagreements and strong feelings. These breakdowns should be remedied, and many apparently insurmountable "ethics" problems can be solved with open lines of communication.

7.3 Control and Resolution

To ensure that appropriate ethical values are being applied within hospitals, effective hospital accreditation requires that ethical considerations are taken into account, for example with respect to physician integrity, conflict of interest, research ethics and organ transplantation ethics.

7.4 The right to die with dignity is justifiable

1. I have provided substantial arguments in favour of voluntary euthanasia and the rights of an individual to choose how they should die and rebutted the major objections to voluntary euthanasia. Australia's current legislative regime for euthanasia is violates an individual's fundamental rights, is inappropriate in a multicultural society, runs contrary to popular opinion, is economically unsound, causes unnecessary pain and suffering, and is inhumane. It denies individuals the rights to their own lives.

2. If the status quo were to remain in Australia, it would have a deleterious effect upon those patients who would like to have the option of voluntary euthanasia. The right to die might be a right that is only ever exercised by a small minority of the population: terminally ill patients for whom palliative care is inappropriate, or perhaps people who might choose the option of rational suicide. However, those opposed to voluntary euthanasia should not, including by legislative fiat, deny individuals the right to die with dignity.

3. The arguments I have presented stand on their own if they are considered with an open mind, devoid as far as possible of any cultural, religious or other bias. They lead to the conclusion that the Medical Services (Dying with Dignity) Bill ought be enacted, possibly with amendments. If all individuals are to be respected, then Australia must observe the right to die with dignity. Despite the claims of those who oppose voluntary euthanasia, they do not know what is better for terminally ill patients more than the patients themselves. The rights of an individual must prevail.

7.5 Major Findings:

The main findings of the study are as follows:

1) Common people are not aware about Euthanasia.
2) In Assam it is not practiced openly though there might be some cases where euthanasia is practiced.
3) Most of the people refuse to accept the concept of euthanasia.
4) All people are agreeing that euthanasia may lead to slippery slope argument.
5) Deontologically, euthanasia should not be practiced as we have to do our duty to the near and dear one.
6) This type of practice euthanasia can lead to the slippery slope argument and one day we may not have any humanity to kill our parents and doctor can do it only to get one bed in the hospital.

7.6 Implications of the Study

The results of the present study have been significant value in the field of Education, especially in the field of Applied Philosophy. The philosophical implications are as follows-

- This study will help to learn the present medical conditions among the students of college level.
- It will help to create awareness among the students and the common people of the society about euthanasia.
- This study will help to learn what is going in the hospitals between doctor and patients.
- This study will help to make people conscious about the present day situation in the field of medical.
- It will make the new generation and the common people to alert about euthanasia.
- These studies will conscious people what to do or what not to do in a critical situation.
- This study will be very informative to the common people as euthanasia is not practice generally in Assam.

7.7 Scope for further Studies:

1) There is scope to combine some of the perspectives from contemporary theoretical medical ethics with Philosophy.

2) There is a scope to relate abortion and euthanasia specifically.

3) This supports a wide variety of alternative theories of the self while retaining the features of freedom and responsibility that, one can argue, have been central tenets of Western Philosophy and law since the Greeks.

4) Emphasis on an ethics of responsibility in contrast to one of rules, principles or values in recent years has led to a wide-spread interest in the work of Levinas as a necessary complement to so-called "postmodern" ethics.

5) There is a scope to study about slippery slope in a new direction.

The assisted suicide/euthanasia debate is still in its infancy, with the ultimate outcome very much in doubt. Public opinion polls show solid majority support for limited legalization, but the polls also demonstrate that popular support drops significantly when specific details of legislative proposals are examined. One thing is clear: euthanasia/assisted suicide controversy is likely to be a significant source of societal contention and political argument for many years to come.

BIBLIOGRAPHY

Bibliography

Original Texts & References:

Bayles, M. D. , *Professional Ethics*, CA.,1981.

Edward, W. Keyserlingh. "Medical codes and Oaths", *Encyclopedia of Applied Ethics*,Volume 3, Academic Press.,1998.

Lamp, David. ,*Down the Slippery Slope*, New York.,1988.

Mcmillan, C. Richard., and Engelhardt, Jr.Tristram.H, and Spicker, S. Stuart, *Euthanasia and the Newborn, Conflicts Regarding Saving Lives,* Kluwer Academic Publishing Group, Boston.,1987.

Beauchamp, T. L., and Childress, J. F., *Principles of Biomedical Ethics*, 4th ed. Oxford Press, New York.,1994.

Dworkin, R. *Taking Rights Seriously*, Harvard University Press, Cambridge,1977.

Piet, H. John., and Prasad, Ayodhaya., *An Introduction to Applied Ethics*, Cosmo Publication.,2000.

Swyer, Susan., and Feinberg, joel., *The Problem of Abortion,* 3rd Edition, Wadsworth publishing Company.

Singer, Peter.," Understanding Human Life", in to *Ethical Issues Relating Life and . Death*, edited by J Ladd, Oxford University Press, New York, pp. 41-61.,1979.

__________ "Justifying Voluntary Eauthanasia", in Ethical Issues in Modern Medicine, edited by John Arras and Robert Hunt, pp. 210-19.,1983.

Smart, J.S.C., and Williams, Bernard, *Utilitarianism For and Against,* Cambridge University Press.,1975.

R.Chadwick, ,(Ed.) *Ethics and the Professions.* Avebury, U.K.:Aldershot(pp. 1-13).

BaYles, M. D., *Professional ethics* (2nd ed.). Belmont, CA: Wadsworth, 1989.

Tom L. Beauchamp and James F. Childress., *Principles of Biomedical ethics*, 1998.

Dwyer. Susan., Feinberg. Joel.,(Ed) *The problem of Abortion*, third edition.

Richard. C. Mcmillan, (Ed.) *Euthanasia and the Newborn: conflicts Regarding Saving Lives*, D. Reidel publishing company.,1987.

Davis, Michael ,*Is Engineering a Profession in Japan?*, pp.7-8.

Davis, *Is Engineering a Profession Everywhere?,* pp. 8-9.

Paxton v., County of Alameda (1953) 119 C. A. 2d 393, 398, 259 P. 2d 934.

Davis, Michael. "Developing and Using Cases to Teach Practical Ethics." *Teaching Philosophy* 20:4, p.364., December 1997.

Davis, Michael., *Thinking Like an Engineer: The Place of a Code of Ethics in the Practice of a Profession,* Princeton University Press, 1991.

Davis, Michael "Is Engineering a Profession Everywhere?", *Philosophia* Published online March12, 2008.

Stroke, November 1996, and *New England Journal of Medicine,* December 19, 1996, reported in *Contemporary Long Term Care,* February 1997, p. 14.

Robert P. George and William C. Porth, Jr., "Death, Be Not Proud," *National Review,* 6/26/95.

Joseph Fletcher, *Situation Ethics: The New Morality.* The Westminster Press, 1966.

Peter Singer, *Practical Ethics,* second edition. Cambridge University Press, 1993.

Nilstun T , *Melltorp G, Hermeren G. Surveys on attitudes to active euthanasia and the difficulty of drawing normative conclusions. Scand J Public Health2000;**28**:111–16.*

Beauchamp TL, Davidson AI. *The definition of euthanasia. J Med Philos1979;**4**:294–312.*

Ubel PA, Asch DA. *Semantic and moral debates about hastening death: a survey of bioethics., J Clin* Ethics, 1997;**8**:242–9.

Pollard B . *Euthanasia in Europe.* Lancet2001;**357**:1039.

Kelleher MJ, Chambers D, Corcoran P, *et al. Euthanasia and related practices worldwide.* Crisis1998;19:109–15.

Vincent JL. *Forgoing life support in western European intensive care units: the results of an ethical questionnaire.* Crit Care Med,1999;27:1626–33.

Chochinov HM, *Wilson KG. The euthanasia debate: attitudes, practices and psychiatric considerations.,* Can J Psychiatry,1995;40:593–602.

Sullivan JL, *Pierson J, Marcus GE. Ideological constraint in the mass public: a methodological critique and some new findings.,* Am J Polit Sci1978;22:233–49.

Waller S., *Trends in public acceptance of euthanasia worldwide.,* Euthanasia Rev1986,**1**:33–47.

Kenis Y . *L'euthanasie active et les medecins: practique et opinions. Bulletin du Conceil* National Ordre des Medicins,1994;**3**:53–61.

Nilstun T , *Sjökvist P. From fact to recommendation: explicit value premises make the conclusion more convincing.* J Intern Med2001;**249**:121–5.

Hagelin J , *Carlsson HE, Hau J. Medical students' view on the use of animals in biomedical research. Scand* J Lab Anim Sci1997;24:151–60.

Kalton G , *Roberts J, Holt D. The effects of offering a middle response option with opinion questions.*, Statistician1980;29:65–78.

Presser S , *Schuman H. The measurement of a middle position in attitude surveys. Public Opin Q,*1980;44:70–85.

Nilstun T . *An inquiry among medical students. No to legalization of euthanasia, but yes to dropped charges or remission of sentence.* Lakartidningen, 2001,**98**:3417–18.

Schuman H , *Presser S. Questions and answers in attitude surveys: Experiments on question form, wording, and context. Thousand Oaks,* CA: Sage Publications, 1996.

Krosnick JA, *Holbrook AL, Berent MK, et al. The impact of "no opinion" response options on data quality—non-attitude reduction or an invitation to satisfice? Public Opin Quart,* 2002;66:371–403.

P Louhiala et al., *J Med Ethics*, 2006 .

Pekka Louhiala et al., *J Med Ethics*, 2015 .

G A M Widdershoven, *Euthanasia, Ethics and Public Policy.* An Argument Against Legislation ,J Med Ethics, 2005

K A Fenton et al., *Measuring sexual behaviour: methodological challenges in survey research.*, Sex Transm Infect, 2001 .

JOURNALS AND NEWS:

The journals of Value Inquery 24: 55-65,C Kluwer academic publishers. Printed in Netherlands, 1990.

T.G. Roupas, "The Value of Life", *Philosophy and Public affairs* 7, no 2, Princeton University Press.,1978.

Meena Kelkar, "Biomedicine, Ayurveda and Woman", *Issues in Medical Ethics*, VII(i), January-march, 1999.

Burke J. Balch, "Managed Care: The Evidence of Rationing Mounts," *NRL News,* 8/22/95, p. 9.

Jerome C. Arnett, Jr., "Canada's Single-Payer Health Scheme a Singular Failure," *National Right to Life News,* 8/11/93, p. 14 (reprinted from *The Wall Street Journal*).

Fr. Richard John Neuhaus, "Don't Cross This Threshold," *Wall Street Journal,* 10/27/2011.

W. Peacock, *Active Voluntary Euthanasia,* Issues in Law & Medicine, Winter 1987.

Senate Committee on Judiciary subcommittee hearing, *The Consequences of Legalized Assisted Suicide and Euthanasia*, 2006.

Andre, Judith. "Role Morality as a Complex Instance of Ordinary Morality." *American Philosophical Quarterly* 28:1,73-80., January 1991.

Asai A , Ohnisi M, Kariya A, ***et al.*** *Euthanasia and the family: an analysis of Japanese doctors' reactions to demands for voluntary euthanasia., Monash Bioethics Review,*2001;20:21–37.

Wolfe J , Fairclough DL, Clarridge BR, *et al. Stability of attitudes regarding physician-assisted suicide and euthanasia among oncology patients, physicians and the general public.* J Clin Oncol,1999;17:1274–9.

DICTIONARY:

Profession, II (7) a. Oxford English Dictionary. June, 2007.

ONLINE ACCESSED:

From "Glossary – Standards of Care" Online Ethics Center for Engineering & Science. 1/31/2011 6:57:46 PM National Academy of Engineering Accessed: Tuesday, October 21.

www.onlineethics.org/CMS/glossary.aspx ,accessed on 07/08/2011.

ENCYCLOPEDIA:

"Slippery Slope Argument" *Encyclopedia of Applied Ethics*, Volume 3, Academic Press.

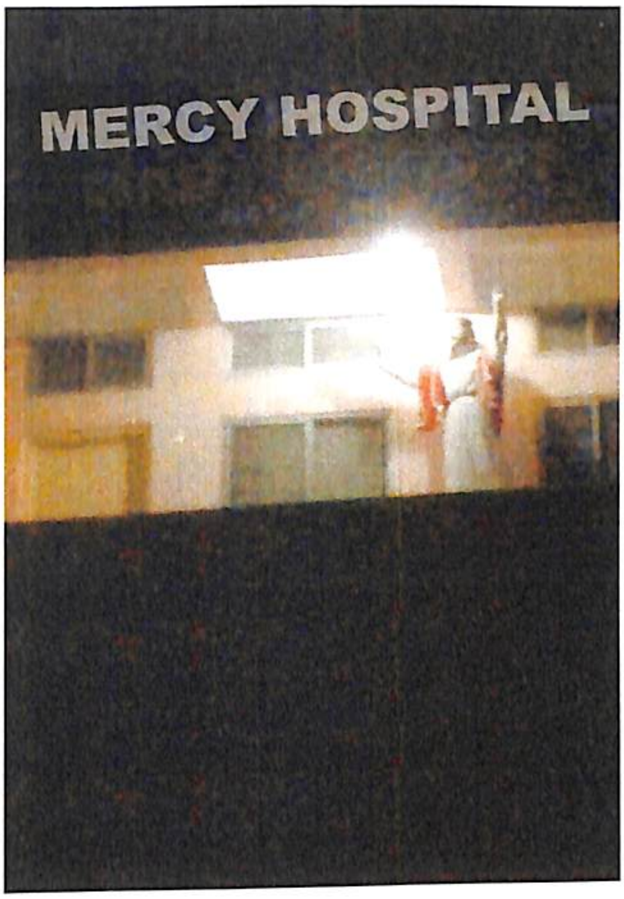
APPENDIX - I

(Some Photograph of The Hospitals of Nagaon District)

Appendix – I


Care Hospital
Research Centre


NURSING HOME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