

FALSE MERCY IN MERCY KILLING

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Introduction

Often the killer says, "I loved my father/mother and I could not bear to see him/her suffer." This is what everyone says, when he or she is not able to bear to see his or her beloved one suffer. It is true that in this case the killer could not bear to see him or her suffer, but the genuineness of that love is not so clear. In our day-to-day life, we also experience the same. No doubt, however, sometimes mercy killers themselves are not free enough from torturing feelings to make a sane decision. By consenting to help their patients die, they may simply be evading the painful and difficult task of providing adequate care for the dying. Euthanasia is seen as an end to intolerable suffering or a hopeless situation. For some it is a way of easing a transition that is already occurring. Others see it as a right or an entitlement to a person's last expression of human dignity. Homicide is still another way of understanding

euthanasia. It is an unjustified usurpation of power to oneself, an overstepping of the bounds of the stewardship of one's body. However, euthanasia is commonly understood as mercy killing. Can it be called mercy killing, while the act is performed with full knowledge, freedom and consent? If so, it is a human act wherein one is actively involved in the destruction of another human being.

People who feel emptiness in their life would like to end their life without knowing that they do not have the right to take away their life on their own. If they were asked why they take such a decision, the answer would be that they do not want to impose the burden of their stay on others especially on those who take care of them. Another reason would be that they would like to ease the financial burden they would incur, if they were treated well. Thus, people go on adding up the reasons why they end up their lives drastically by means of a lethal injection or by other means. But it is quite evident that no one has the authority to take away his or her own life because this life was given to him/her gratuitously by God the Almighty.

1. What Is Euthanasia?

"Euthanasia is a component of two Greek words - *eu* and *thanatos* - meaning, literally, 'a good death'."¹ Generally it means the bringing about of a painless death which is considered to be a good death² i.e., 'mercy killing' by so many means. Some would

¹ Benedict M. Ashley & Kevin D.O'Rourke, *Ethics of Health Care* (St. Louis: The Catholic Health Association of United States, 1986) 375; Helga Kushe, "Euthanasia," in Peter Singer (ed.), *A Companion to Ethics* (Oxford: Blackwell Publishers: 2001) 294.

² Paul Carrick, *Medical Ethics in the Ancient World* (Washington: Georgetown University Press, 2001) 147.

argue that in euthanasia mercy is shown to those who are hopelessly ill and to those who are suffering from serious sickness. In the case of voluntary euthanasia respect for autonomy is very much recognized. For example A ends the life of B, for the sake of B. Already in Greek and Roman times practices like infanticide, suicide and euthanasia were widely accepted.³

2. What Is Euthanasia Not?

There is no euthanasia unless the death is intentionally caused by an act of commission or omission, Thus, some medical actions that are often labelled “passive euthanasia” are no form of euthanasia, since the intention to take the life is lacking. These acts include not commencing treatment that would not provide a benefit to the patient, withdrawing treatment that has been shown to be ineffective, too burdensome or is unwanted, and the giving of high doses of pain-killers which may reduce pain and which at the same time may eventually endanger life, when they have been shown to be necessary. All those are part of a good medical practice, allowed by law, when they are properly carried out. The idea that people with disabilities are not worthy of society’s acceptance or resources is not new. We see this kind of alienation throughout history, often masked as benevolence

A man or a woman, even if seriously sick or prevented in the exercise of his or her higher functions, is and will be always a person. He or she will never become a vegetable or an animal. For, the intrinsic value and personal dignity of every human being does not change.

³ Helga Kushe, “Euthanasia,” in Peter Singer (ed.), *A Companion to Ethics* (Oxford: Blackwell Publishers: 2001) 294.

3. Types of Euthanasia

3.1. Voluntary Euthanasia

Euthanasia is voluntary when it is performed at the request of the patient. In voluntary euthanasia the deadly act is carried out by *A at the request of B, for the sake of B*. There is a close connection between voluntary euthanasia and assisted suicide,⁴ where one person will assist another to end his or her life. For example, in assisted suicide A obtains the drugs for B and helps B to consume it to put an end to his/her life.

In voluntary euthanasia, first of all the person is suffering from a distressing and incurable condition. Secondly, illness or accident has robbed him or her of all his or her rational faculties. Thirdly, he or she is no longer able to decide between life and death. If the patient is still competent, then the person who ends the patient's life in the appropriate circumstances acts upon his or her request which ends up in death.

3.2. Involuntary Euthanasia

Euthanasia is involuntary when it is performed on a person who would be able to give or withhold consent to his or her own death, but has not given consent. It is because he or she was not asked or because he or she was asked but withheld consent, wanting to go on living. For example, A shoots B without B's consent to save him or her from falling into the hands of a sadistic torturer. It is involuntary, when the person who is killed made an expressed wish to the contrary.

⁴ Peter Singer, *Practical Ethics* (Cambridge: Cambridge University Press, 1999) 176.

3.3. Non-voluntary

Euthanasia is non-voluntary when the person whose life is ended cannot choose between life and death for himself/herself. For example, A is a hopelessly ill person or handicapped newborn infant and illness or accident has rendered the formerly competent person permanently incompetent. When this person is killed without his/her consent or without request for death, the act of killing is called non-voluntary euthanasia. All these three kinds of euthanasia - voluntary, involuntary and non-voluntary euthanasia - can be either active or passive.

3.4. Active Euthanasia

Active euthanasia is the direct and deliberate killing of a person out of concern for his/her own good.⁵ It is an action which of itself and by intention causes death, with the purpose of eliminating all suffering.⁶ Active euthanasia is also called direct euthanasia or the direct killing. In active euthanasia A kills B by administering lethal medicine or any other means. For example, the Nazis put to death those people who were senile, insane, and defective without their consent.⁷

3.5. Passive Euthanasia

Passive euthanasia occurs in a clinical situation when one omits necessary acts or withdraws therapies so that one will not impede what is inevitable – the patient's death. Here the patient's

⁵ Brad Hooker, "Rule-Utilitarianism and Euthanasia," in Hugh LaFollette (ed.), *Ethics in Practice: An Anthology* (Oxford: Blackwell Publishers, 1997) 46.

⁶ Pope John Paul II, *Evangelium Vitae*, no. 65

⁷ Some hold that Nazi "euthanasia" programme was not "euthanasia" at all. It did not seek to provide a good death for human beings who were leading a miserable life. It was aimed at improving the quality of the *Volk* and eliminating the burden of caring for "social ballast" and feeding "useless mouths". Cf. Peter Singer, *Writings on an Ethical Life* (New York: The Ecco Press, 2000) 202.

death is foreseen but not aimed at or intended. For example, removing (withdrawing) a respirator from the hopelessly ill patient will contribute to the death of the patient. However, the important moral difference is severity of the disease affecting the patient and not the acts of commission or omission of the physician and it is the former (severe disease) that causes death. In such severe cases continuation of treatment does not in any way ensure even an atom of progress but could only delay the dying process. It involves letting go opportunities to prevent the death of someone out of concern for that person's own good.⁸ Passive euthanasia is also known as indirect euthanasia.

According to Thomas A. Shannon, this distinction (active and passive) is confusing methodologically and psychologically.⁹ There is widespread agreement that omissions as well as actions can constitute euthanasia. The Roman Catholic Church, in its *Declaration on Euthanasia*, defines euthanasia as 'an action or omission which of itself or by intention causes death'.¹⁰ Whenever an agent deliberately and knowingly engages in an action or an omission that results in the patient's foreseen death, he or she has performed active or passive euthanasia.

The use or non-use of technological interventions in medicine to save a life raises many a question. One would ask to what extent could a doctor try to save a patient's life? What type of treatments

⁸ Brad Hooker, "Rule-Utilitarianism and Euthanasia," in Hugh LaFollette (ed.), *Ethics in Practice: An Anthology* (Oxford: Blackwell Publishers, 1997) 46.

⁹ Thomas A. Shannon, *An Introduction to Bioethics* (New Jersey: Paulist Press, 3rd ed., 1997) 104.

¹⁰ Sacred Congregation for the Doctrine of the Faith: *Declaration on Euthanasia* (Vatican City: 1980) 6.

must he carry out in order to save a person? Some would argue that there are times when life-sustaining treatment should be withheld and a patient allowed to die. Again this raises the pressing need for criteria to distinguish between permissible and impermissible omissions of life-sustaining means. They are ordinary and extraordinary means of treatment.

3.6. Ordinary and Extraordinary Means

Ordinary means what is well established and regarded as normal within the context in question; it is what we might expect a reasonable person to undertake and offers the possibility of real benefit to the patient. Extraordinary means is anything which doesn't fit into this criterion.¹¹

In medicine, a means is ordinary which is (1) scientifically established, (2) statistically successful, and (3) reasonably available. If any of these conditions is lacking, the means is considered to be extraordinary. In moral theology, a means is ordinary if it is beneficial, useful, or not unreasonably burdensome (physically or psychologically) to the patient. The common elements employed by theologians to determine whether something is ordinary means in a given case are: hope of benefit (that is not experimental), 'according to one's status (financially and psychologically), not difficult to use, and not otherwise unreasonable. The Church teaches that while extraordinary means are not unethical to undergo, it is not morally obligatory that one undergoes them.

¹¹ Kenneth Kearon, *Medical Ethics: An Introduction* (Dublin: The Columbia Press, 1995) 36.

The *Catechism of the Catholic Church* presents this magisterial teaching as follows:

Discontinuing medical procedures that are burdensome, dangerous, extraordinary or disproportionate to the expected outcome can be legitimate; it is the refusal of "overzealous" treatment. Here one does not will to cause death; one's inability to impede it is merely accepted. The decisions should be made by the patient if he is competent and able or, if not, by those legally entitled to act for the patient, whose reasonable will and legitimate interests must always be respected (no. 2278).

Life-sustaining means are regarded as ordinary and obligatory. Ordinary and extraordinary means are often expressed in terms of 'proportionate' and 'disproportionate' means of treatment. A means is proportionate, if it offers a reasonable hope of benefit to the patient; it is 'disproportionate' if it does not.¹² This distinction is morally significant. It is the distinction between proportionate and disproportionate means but not a distinction between means of treatment. Rather it is a distinction between proportionate and disproportionate benefits different patients are likely to derive from a particular treatment depending on the patient's medical condition and on the quality and length of life the patient is likely to gain from its employment.

This understanding of ordinary and extraordinary means suggests that an agent who refrains from using extraordinary means of treatment engages in passive euthanasia: A withholds potentially

¹² Sacred Congregation for the Doctrine of the Faith: *Declaration on Euthanasia* (Vatican City: 1980) 9-10.

life-sustaining treatment from B, for the sake of B. Again that the discontinuation of extraordinary or disproportionate treatment is a case of passive euthanasia would not be accepted as a valid argument. For, euthanasia, it is often argued, involves the deliberate or intentional termination of life. This brings us to one more distinction between deaths that are directly intended and death that are unintended but merely foreseen.

3.7. Intended and Unintended but Foreseeable Death

Euthanasia is ending a patient's life through an action or omission. But not all actions or omissions that result in a person's death are of central interest in the euthanasia debate. The euthanasia debate is concerned with *intentional* actions and omissions. When A administers a lethal injection to B to end B's suffering, A terminates B's life intentionally. This case is uncontroversial. When A turns off the respirator that sustains B's life, knowing that B will die as a consequence, then A terminates B's life intentionally. When A seeks to alleviate B's pain by increasingly large doses of drugs (pain relievers - morphine) that (A knows) will eventually bring about B's death, then A does not intentionally terminate B's life. His intention is to reduce the unbearable pain of the patient. This case is called pyramid pain killing. The Vatican's *Declaration on Euthanasia* thus holds that 'pyramid pain-killing' is accepted because, in this case, 'death is in no way intended or sought, even if the risk of it is reasonably taken.'¹³ In other words, even if A foresees that B will die as a consequence of what A does, B's death is only foreseen and not directly intended. Here the direct intention is to alleviate the pain and not to kill the

¹³ Sacred Congregation for the Doctrine of the Faith: *Declaration on Euthanasia* (Vatican City: 1980) 9.

patient. This distinction between the intended and foreseen results but unintended future consequences is formalized in the Principle of Double Effect. Thomas Aquinas applied the distinction between directly intended and merely foreseen consequences to actions of self-defence. When a person who is attacked kills the attacker, his or her intention is to defend him/herself and not to kill the attacker.¹⁴

4. Arguments for Euthanasia

4.1. Mercy

You would kill an animal wriggling in pain. Why not do as much for a human being? Why condemn anyone to spend his or her final days in misery? For, mercy killing or physician-assisted suicide would be painless. Mercy for a hopelessly ill and suffering patient in (voluntary) euthanasia is the reason for the moral permissibility of euthanasia.

4.2. Financial Burden

It would relieve the family of a financial burden and an emotional strain. It would also relieve society of a financial burden. If a person is dying and nothing can be done, why should a person not be able to choose death now rather than later?

4.3. Respect for the Autonomy of the Persons

He or she has the right to determine his or her own destiny. If self-determination (autonomy) means anything, it should mean the right to determine one's fate and the circumstances that surround it.

¹⁴ Thomas Aquinas, *Summa Theologiae*, II, ii.

5. Arguments against Euthanasia

5.1. Euthanasia: Violation of the Law of God

Judaism and the rise of Christianity contributed greatly to the general feeling that human life is sacred and so must not be tampered with or desecrated. Human life is inherently precious and valuable and no one under any circumstances may end it. Euthanasia usurps the right of God to give and take life. It is a grave violation of the law of God/natural law, as it is the deliberate and unacceptable killing of a human person.¹⁵ So the view of the absolute inviolability of innocent human life remained virtually unchanged until the sixteenth century. The eighteenth century philosopher Immanuel Kant argues, "Man cannot have the power to dispose his life."¹⁶

The Church Magisterium absolutely condemns it¹⁷ as a crime in every nation. The major ethical/theological reason is that God is the Creator and alone has full dominion over life and death. Such a taking of life is an overstepping of human responsibility. Human beings are only stewards of their lives and, as such, have the duty to preserve it.

5.2. Euthanasia Is Secularistic Nature

One should not forget that the Christian understanding of human life does not exhaust in temporal happiness, progress and self-fulfillment but it reaches beyond this world. Euthanasia is largely of a utilitarian, immanent, secularistic nature. We look at the

¹⁵ John Paul II, *Evangelium Vitae*, no. 66.

¹⁶ Immanuel Kant, "Duties towards the Body in Regard to Life," *Lectures on Ethics*, trans. Louis Infield (New York: Harper and Row, 1986) 148 as quoted by Helga Kushe, "Euthanasia," in Peter Singer (ed.), *A Companion to Ethics* (Oxford: Blackwell Publishers: 2001) 294.

¹⁷ *Gaudium et Spes*, no. 27.

deformed, the insane and those suffering from hereditary disease as useless burden to society. For some euthanasia is as a manifestation of human progress and something in accordance with the common good. They have forgotten to see that it outrages the noblest instincts of humanity. Evil consequences might arise out it, if it were permitted. Once the barriers to killing are lowered, then no one is safe on the earth.

5.3. False Mercy

Mercy for a hopelessly ill and suffering patient in (voluntary) euthanasia is the primary reason for the moral permissibility of euthanasia. According to Thomas A. Shannon the motive of mercy or compassion is critical and serves as the key justification for it, if it is justified at all.¹⁸

“To have true compassion for the person who has made such a decision is to realize that the person is hopeless, alienated from community, and doubtful of God’s love. Here mercy entails staying by such a person’s side and through friendship helping him or her recover hope.”¹⁹

Pope John Paul II points out that it is a false mercy and indeed a disturbing ‘perversion’ of mercy. For him, true compassion leads to sharing another’s pain. It does not kill the person whose suffering we cannot bear.²⁰ In the case of the sufferer who is no longer really free to make a truly human decision, but is pleading to

¹⁸ Thomas A. Shannon, *An Introduction to Bioethics* (New Jersey: Paulist Press, 3rd ed., 1997) 104.

¹⁹ Benedict M. Ashley & Kevin D.O’Rourke, *Ethics of Health Care* (St. Louis: The Catholic Health Association of United States, 1986) 379.

²⁰ John Paul II, *Evangelium Vitae*, no. 66.

be put out of the pain or depression that has taken away the sufferer's capacity to think straight, then the mercy killer is simply a murderer putting to death someone no longer able to protect himself or herself.²¹ It involves suicide and cooperation to suicide or simply murder of the innocent. To yield to such a request is false compassion.²²

5.4. Christian Theology of Suffering

Misery and suffering are with sense and value. Christ gave a meaning to our human existence through his suffering, death and resurrection. If misery and suffering cannot be cured, Christian theology becomes waste. His suffering had a salvific value so also ours too. Hence, we are called to participate by our suffering in the redemptive work of Jesus and to complete what is lacking in his suffering (Col 1:24). It does not mean that the fight against suffering could be regarded as less urgent at any time. But we are to heal what is wounded and to cure what is sick and to combat misery and pain in all forms and to diminish and relieve it. There is neither obligation nor justification to prolong what is already despaired.

5.5. Physician and Patient Relationship

If euthanasia becomes acceptable, this may have a detrimental effect on the relation between patients and physicians and on the perceptions of health care facilities. If seriously ill persons know that physicians or hospitals could administer direct

²¹ Benedict M. Ashley & Kevin D.O'Rourke, *Ethics of Health Care* (St. Louis: The Catholic Health Association of United States, 1986) 379.

²² In the view of Thomas A. Shannon, suicide which occurs in a nonmedical context is an interruption of the life process and those who commit suicide are not suffering from a life threatening disease, whereas euthanasia is performed in anticipation of imminent or certain death from a disease. Cf. Thomas A. Shannon, *An Introduction to Bioethics* (New Jersey: Paulist Press, 3rd ed., 1997) 104.

euthanasia, individuals might be reluctant to be treated or even to enter such facilities. Trust in physicians and hospitals would vanish. The essential and generally only reason for euthanasia is that destruction of life is preferable to pain and senseless misery. This argument is not accepted as medicine can relieve the pain to a large extent.

Paul Ramsey describes the relationship that exists between the physician and the patient as follows:

The principle of an informed consent is a statement of the fidelity between the man who performs medical procedures and the man on whom they are performed ... The principle of an informed consent is the cardinal *canon of loyalty* joining men together in medical practice and investigation. In his requirement, faithfulness among men - the faithfulness that is normative for all the covenants or moral bonds of life - gains specification for the primary relations peculiar to medical practice.²³

Ramsey's idea of fidelity involved in clinical consent strongly suggests that clinical consent is convergent, a binding together of the parties. Therefore, the doctor-patient relationship is built on mutual trust. Here, consent is a joint adventure between the patient/subject and the physician/researcher. It lies at the heart of one's continuing search for cures to all men's diseases as a great human adventure.²⁴ First do no harm (*primum non nocere*) is the traditional phrase describing the ethical obligation of physicians/researchers to patients/subjects. Their primary responsibility is to

²³ Paul Ramsey, *The Patient as Person: Explorations in Medical Ethics*, 5.

²⁴ *Ibid.*, 11.

do no harm to their patients/subjects. When the physician/researcher is acting in the interests of patients/subjects and is responsible to the patient for his/her actions, the relationship that exists between them is called *therapeutic doctor-patient relationship*.²⁵ Physicians' first loyalty is to the patient. Of course they owe loyalty to guardians by virtue of their status.²⁶ Parents'/guardians' trust in the physician promotes honesty, cooperation, and confidence to accept medical help for the welfare of their patients. The physician's trust in parents promotes a partnership between them, with the goal of helping the patients.²⁷ Sometimes, the therapeutic relationship requires that physicians should have an obligation to say no to parents/guardians, when they request something illegal. It is their duty to convince them that good intentions and good conscience are not sufficient reasons to justify their actions.²⁸

5.6. Respect for the Autonomy of Persons

Respect for persons implies that "the rights inherent to persons must be honoured" and "persons are entitled to being treated in a dignified manner."²⁹ The principle of respect for persons means respect for the autonomy of persons. This principle

²⁵ Dora Black & Fiona Subotsky, "Medical Ethics and Child Psychiatry," *Journal of Medical Ethics* 8/4 (1982) 5.

²⁶ Edwin N. Forman & Rosalind E. Ladd, *Ethical Dilemmas in Pediatrics: A Case Study Approach*, 94.

²⁷ *Ibid.*, 93.

²⁸ For example the use of growth hormones is recommended for some children, where the benefits are clearly worth the risks. In this case of growth hormone, parents have the right to calculate the risk/benefit ratio and the physicians have to give all the information about it. Sometimes there may arise a conflict between the parents and the physician regarding the growth hormone. In this situation, if the use of growth hormone is meant for the welfare of the child, the parents' right may outweigh. Cf. Edwin N. Forman & Rosalind E. Ladd, *Ethical Dilemmas in Pediatrics: A Case Study Approach*, 18-20.

²⁹ Jonathan D. Moreno, Arthur L. Caplan & Paul Root Wolpe, "Informed Consent," in Ruth Chadwick (ed.), *Encyclopedia of Applied Ethics*, Vol. II, 690.

holds that individual human beings should be respected and treated as autonomous agents and those with diminished autonomy are entitled to protection.³⁰ On this basis the principle of respect for persons includes two ethical convictions, namely respect for the autonomy of the person and protection for persons with diminished autonomy.

Autonomy means making decisions/choices relevant to one's own affairs³¹ and respect for the principle of autonomy means respecting the ability of persons to make decisions/choices of those persons who are competent to make their own decisions/choices,³² unless they are clearly detrimental to others.³³

The etymological meaning of 'autonomy' comes from the Greek words, 'autos' which means self and 'nomos' means the law of rule.³⁴ From these two terms it is derived that autonomy is self-determination or the capacity to decide for oneself. Therefore,

³⁰ Charles Weijer. "Research Methods and Policies," in Ruth Chadwick (ed.), *Encyclopedia of Applied Ethics*, Vol. III, 857; Carol Levine, Nancy Neveloff Dubler & Robert J. Levine, "Building a New Consensus: Ethical Principles and Policies for Clinical Research on HIV/AIDS," in Thomas A. Shannon (ed.), *Bioethics* (New Jersey: Paulist Press, 4th ed., 1993) 303.

³¹ Daniel E. Lee, "The Saikewicz Decision and Patient Autonomy," *Linacre Quarterly* 47/1 (1980) 67.

³² Reidar K. Lie, "The Ethics of the Physician-Patient Relationship," *Ethical Perspectives: Towards a Transdisciplinary Approach to Professional Ethics* 4/4 (1997) 263.

³³ John Stuart Mill argued that the freedom of persons could not be infringed upon unless they were a danger to others. Cf. John Stuart Mill, *On Liberty*, ed. C. V. Shields (Indianapolis: BobbsMerrill, 1956) 144 f.

³⁴ Tom L. Beauchamp & James F. Childress, *Principles of Biomedical Ethics* (New York/Oxford: Oxford University Press, 4th ed., 1994) 120; James F. Childress, "Autonomy," in John Macquarri & James F. Childress (eds.), *A New Dictionary of Christian Ethics* (London: SCM Press Ltd, 1986) 51; Soren Holm, "Autonomy," in Ruth Chadwick (ed.), *Encyclopedia of Applied Ethics*, Vol. I (Toronto: Academic Press, 1998) 267.

“an autonomous person is a self-determining person who “chooses or devises a plan for his or her life.”³⁵ In other words, an autonomous person is “capable of deliberation about personal goals and of acting under the direction of such deliberation.”³⁶ By autonomy Immanuel Kant means freedom of the will. Another way to put this is that “every person has the ability to understand the notions of right and wrong and to act accordingly.”³⁷ Therefore, human persons are to be treated as ends in themselves and never only as means.³⁸

“Being autonomous is not the same as being respected as an autonomous agent,” say Tom L. Beauchamp and James F. Childress.³⁹ In the field of medical ethics the principle of respect for autonomy of persons is to respect personal rights,⁴⁰ personal well-being and the personhood. In Kantian terms⁴¹ respect for personal rights is the recognition of one’s own capacity to decide

³⁵ Robert Young, “Informed Consent and Patient Autonomy,” in Helga Kuhse & Peter Singer (eds.), *A Companion to Bioethics* (Oxford: Blackwell Publishers, 1998) 441; Terrence F. Ackerman, “Balancing Moral Principles in Federal Regulations on Human Research,” in Thomas A. Shannon (ed.), *Bioethics: Basic Writings on the Key Ethical Questions That Surround the Major, Modern Biological Possibilities and Problems* (New Jersey: Paulist Press, 4th ed., 1993) 287.

³⁶ Charles Weijer, “Research Methods and Policies,” in Ruth Chadwick (ed.), *Encyclopedia of Applied Ethics*, Vol. III, 857.

³⁷ Kenneth Kearon, *Medical Ethics: An Introduction*, 15

³⁸ Immanuel Kant, *Foundations of the Metaphysic of Morals*, trans. Lewis White Beck (New York: MacMillan, 1959) 46-48.

³⁹ Tom L. Beauchamp & James F. Childress, *Principles of Biomedical Ethics*, 125.

⁴⁰ Bernard Dickens, “Patients’ Rights,” in Ruth Chadwick (ed.), *Encyclopedia of Applied Ethics*, Vol. III, 465.

⁴¹ Paul Arthur Schilpp, *Kant’s Pre-Critical Ethics* (Evanston: North-western University Press, 1970) 165; Immanuel Kant, *Grounding for Metaphysics of Morals*, trans. James W. Ellington (Cambridge: Hackett Publishing Company, 1981) 20; Thomas Auxter, *Kant’s Moral Teleology* (Macon: Mercer University Press, 1982) 110; R. S. Downie & Elizabeth Telfer, “Autonomy,” *Philosophy* 46 (1971) 293.

⁴² Alexander M. Capron, “Human Experimentation,” in Robert M. Veatch (ed.), *Medical Ethics*, 137-39.

for himself or herself.⁴² Patients' rights to make health care decisions for themselves should be taken care of on the ground that they are autonomous persons and are capable of doing so on the basis of relevant information they are able to gather.⁴³ Patients' rights include an adequate opportunity for informed consent, privacy, confidentiality,⁴⁴ volunteering, self-mastery, freedom to choose, choosing their own moral position, and accepting responsibility for their choice.⁴⁵ Here, the main stress is placed on the importance of the freedom of choice for one's own personal development because recognizing one's own freedom of choice is an important aspect of the principle of respect for persons. The denial of it is a lack of respect for an autonomous person's freedom to act,⁴⁶ provided they make a responsible choice about their health care system.

5.7. Protection

Respect for the autonomy of persons also requires that those with diminished autonomy should be taken care of. It is true that not every human being is capable of self-determination or has the capacity for self-determination.⁴⁷ For some, the capacity for self-determination matures during an individual's life. Some, as a result of illness, disability or immaturity, do not have the mental abilities to

⁴³ Bernard Dickens, "Patients' Rights," in Ruth Chadwick (ed.), *Encyclopedia of Applied Ethics*, Vol. III, 465.

⁴⁴ Anton Vedder, *The Values of Freedom* (Utrecht: Aurelio Domus Artum, 1995) 30.

⁴⁵ Ruth R. Faden, Tom L. Beauchamp & Nancy M. P. King, *A History and Theory of Informed Consent*, 7-9.

⁴⁶ Eric J. Cassell, "The Principles of the Belmont Report Revisited: How Have Respect for Persons, Beneficence, and Justice Been Applied to Clinical Medicine?" *Hastings Center Report* 30/4 (2000) 13.

⁴⁷ Bruce Miller, "Autonomy," in Warren Thomas Reich (ed.), *Encyclopedia of Bioethics*, Vol. I (New York: Simon & Schuster MacMillan, 1995) 215.

⁴⁸ Carl Elliot, "Patients Doubtfully Capable or Incapable of Consent," in Helga Kuhse & Peter Singer (eds.), *A Companion to Bioethics* (Oxford: Blackwell Publishers, 1998) 454.

make decisions.⁴⁸ Others lose their self-determination because of certain circumstances that severely hinder their mental ability. Still others like incompetent patients do not have privacy in the sense of autonomy and self-determination.⁴⁹ Those who come under this category are infants, children, mentally impaired patients, and adult patients incapable of giving consent. They are considered as vulnerable. In this connection the principle of respect for the autonomy of persons requires that these people have the right to protection⁵⁰ against abuse, exploitation, and indignity.⁵¹

Whether euthanasia respects the autonomy of the person or not, it involves first of all the deliberate taking of a person's life; and secondly, life is taken for the sake of the person because he/she is suffering from an incurable or terminal disease. Hence it is the direct killing of the incurably sick at their request or at the request of the legal representatives. In countries like Belgium and Holland, the direct killing of the incurably sick, the mentally sick and of the incurably crippled is officially planned and directed towards the destruction of those vulnerable beings without mercy

Conclusion

A physician may admit that a patient is incurable and cease trying to effect a cure; however, physician should not cease trying to find a remedy for disease itself. As long as there is a slight hope for curing patients or checking the progress of their illness, the

⁴⁹ Paul Ramsey, "The Saikewicz Precedent: What Is Good for an Incompetent Patient?" *Hastings Center Report* 8/6 (1978) 37.

⁵⁰ Eric M. Meslin *et al.* (eds.), "Principlism and the Ethical Appraisal of Clinical Trials," *Bioethics* 9/5 (1995) 407.

⁵¹ Bernard Dickens, "Patients' Rights," in Ruth Chadwick (ed.), *Encyclopedia of Applied Ethics*, Vol. III, 465.

physician should use the available remedies at hand. The patient, considering his medical prognosis as well as other spiritual and temporal circumstances of life, determines in consultation with the physician whether a particular means is ordinary or extraordinary from an ethical point of view. If the means are ordinary, then they must be utilized; if the means are extraordinary, they may be utilized but need not be. Minimal means of maintaining the patient's comfort and well-being are always considered ordinary means.

If the patient is unable to make decisions for himself/herself, then the family or the guardian, in consultation with the physician, under certain conditions, may speak for and make decisions for him/her.⁵² The family or the guardian has the right and obligation to determine whether the means in question are ordinary or extraordinary, and whether extraordinary means will be utilized. In making this decision, the family or the guardian decides for the patient. The decisions made by them are based on what the patient/person would be likely to do if competent. They are made for benefit of the patient, not solely for the benefit of the family. For, "the interests of the third party and those of the incompetent are so close that in choosing his or her own interests, the third party will choose very much as the incompetent would do."⁵³

The best-interest standard is making a choice among the available options.⁵⁴ The parents, doctors, nurses try to identify the

⁵² This is called substituted judgment doctrine, which is a legal doctrine. Cf. Gerald Dworkin, "Consent, Representation, and Proxy Consent," in Gaylin, W. & Macklin, R. (eds.), *Who Speaks for The Child: The Problem of Proxy Consent*, 197-198.

⁵³ Gerald Dworkin, "Consent, Representation, and Proxy Consent," in Gaylin, W. & Macklin, R. (eds.), *Who Speaks for The Child: The Problem of Proxy Consent*, 199.

⁵⁴ Allen E. Buchanan & Dan W. Brock, *Deciding for Others: The Ethics of Surrogate Decision-making*.

person's immediate and long-term interests and then determine whether the benefits of an intervention or procedure outweigh the burdens.⁵⁵ This standard seems to rest on objective standards of what a reasonable person would find appropriate for the ordinary child.⁵⁶ But the context of difficulties like the hopelessness of a patient's condition and the pain and suffering of the patient is also an important moral consideration. Thus the ethical debate on direct euthanasia is between *motive* (mercy) and *rule* (do not murder) and between the value/dignity of life and the indignities to which a person is submitted during terminal illness.

Suffering and death are part of our life and we need to think about long-term quality care for our elderly. This is very much ignored in our society. We need to think about best medical system i.e., rehabilitation interventions, quality primary care and various prevention initiatives. Best health care system alone can provide care and support as we live our final days.

⁵⁵ Loretta M. Kopelman, "Children: Health-Care and Research Issues," in Warren Thomas Reich (ed.), *Bioethics: Sex, Genetics & Human Reproduction*, 194.

⁵⁶ Alexander Morgan Capron, "The Authority of Others to Decide about Biomedical Interventions with Incompetent," in Willard Gaylin & Ruth Macklin (eds.), *Who Speaks for the Child: The Problem of Proxy Consent* (New York/London: Plenum Press, 1982) 126.