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Euthanasia: An Understanding

Dharmender Kumar Nehra, Pradeep Kumar and Sheetal Nehra

> *Death a friend that alone can bring the peace his treasures cannot purchase, and remove the pain his physicians cannot cure. —Mortimer Collin*

It is universal truth that death is the only certainty in this uncertain world. Everyone knows that death will occur eventually, whether one likes it or not. It affects everyone, whichever social group people belong to: whether they are young or old, poor or rich, the pauper or the king, the ruler or the ruled, the sinner or the pious. In addition, one has to face the death of loved ones, even before one have to face own death and this is what makes death poignant, impregnable and fearsome. Despite all this knowledge, it is very difficult for most of us to think about death of oneself and that of loved ones. Most of us feel afraid of death, as perhaps the most basic human response to death is flight from death but some people seem to see death as a simple solution to their complex problems. Anthropologist Ernest Becker (1973) argued that "the idea of death, the fear of it, haunts the human animal like nothing else; it is the mainspring of human activity—activity designed largely to avoid the fatality of death, to overcome it by denying in some way that it is the final destiny for man".

In addition everyone wants to die painlessly; but this is not the destiny of some with an incurable illness or injury. To end their suffering, dying patients may take their own life, in some cases

Dharmender Kumar Nehra, Clinical Psychologist, State Institute of Mental Health (SIMH) PGIMS Bt. B.D. Sharma, University of Health Sciences, Rohatk , Haryana dknehra@yahoo.com

Pradeep Kumar, (M,Phil), Psychiatric Social Worker, SIMH, PGIMS, Rohtak, Haryana. pradeep.meghu@gmail.com.

Sheetal Nehra, Deaprtment of Psychology, M.D. University, Rohatk.

violently (Ripamonti et al., 1999; Filiberti & Finlay, 1997). In addition it is very difficult for the family members to see the agony of the patient when everyone concerned knows that death is inevitable and there is not a ray of hope in sight for any improvement. The issue of the right to end one's life (Euthanasia) has indeed caught national and international fancy and the mere utterance of these words is sufficient to elicit fierce, divided and often passionate opinions though confidential due to legal and social sanctions. Euthanasia is increasingly being touted as a beguilingly simple solution to the tragedy of a badly managed terminal illness. It is the bringing about of a gentle and easy death in the case of an incurable and painful disease. This issue has become highly controversial in recent years, as it has been legalized in Holland while relatives are being imprisoned in other countries for helping their loved ones to die. These high profile cases evince the distinct gap between those who believe that a person has the right to end their lives if they are in pain and those who believe that euthanasia is a last resort of an uncaring society.

MEANING AND HISTORY OF EUTHANASIA

The word *euthanasia* is derived from two Greek words which mean "a good death" (*eu*, well, and *thanatos*, death). In the current debate, Euthanasia has been defined as 'the bringing about of a gentle and easy death for someone suffering from an incurable and painful disease or in an irreversible coma' (Pearsall & Trumble, 1996). Usually, 'euthanasia' is defined in a broad sense, encompassing all decisions (of doctors or others) intended to hasten or to bring about the death of a person (by act or omission) in order to prevent or to limit the suffering of that person (whether or not on his or her request) (Gevers, 1996). Perhaps a clearer definition is: *The intentional killing by act or omission of a person, whose life is no longer felt to be worth living.*

Historically Euthanasia was practiced in Ancient Greece and Rome: for example, hemlock was employed as a means of hastening death on the island of Kea, a technique also employed in Marseilles and by Socrates in Athens. Euthanasia, in the sense of the deliberate hastening of a person's death, was supported by Socrates, Plato

and Seneca the Elder in the ancient world, although Hippocrates appears to have spoken against the practice, writing "I will not prescribe a deadly drug to please someone, nor give advice that may cause his death" (noting there is some debate in the literature about whether or not this was intended to encompass euthanasia) (Mystakidou et al., 2005; Stolberg, 2007; Gesundheit et al., 2006).

Euthanasia was strongly opposed in the Judeo-Christian tradition. Thomas Aquinas opposed both and argued that the practice of euthanasia contradicted our natural human instincts of survival, as did Francois Ranchin (1565–1641), a French physician and professor of medicine, and Michael Boudewijns (1601–1681), a physician and teacher (Stolberg, 2007; Gesundheit et al, 2006). Nevertheless, there were voices arguing for euthanasia, such as John Donne in 1624, (Mannes, 1975), and euthanasia continued to be practiced. Thus, in 1678, the publication of Caspar Questel's *De pulvinari morientibus non subtrahend*, ("*On the pillow of which the dying should not be deprived*"), initiated debate on the topic. Questel described various customs which were employed at the time to hasten the death of the dying, (including the sudden removal of a pillow, which was believed to accelerate death), and argued against their use, as doing so was "against the laws of God and Nature". This view was shared by many who followed, including Philipp Jakob Spener, Veit Riedlin and Johann Georg Krünitz (Stolberg, 2007). In spite of opposition, euthanasia continued to be practiced, involving different techniques *i.e.* bleeding; suffocation and removing people from their beds to be placed on the cold ground (Stolberg, 2007).

Suicide and euthanasia were more acceptable under Protestantism and during the Age of Enlightenment, and Thomas More wrote of euthanasia in *Utopia*, although it is not clear if Thomas More was intending to endorse the practise. Other cultures have taken different approaches: for example, in Japan suicide has not traditionally been viewed as a sin, and accordingly the perceptions of euthanasia are different from those in other parts of the world (Otani, 2010).

In the mid-1800s, the use of morphine to treat "the pains of death" emerged, with John Warren recommended its use in 1848. A similar use of chloroform was revealed by Joseph Bullar in 1866. However, in neither case was it recommended that the use should be to hasten death. In 1870 Samuel Williams, a school teacher, initiated the contemporary euthanasia debate through a speech given at the Birmingham Speculative Club, which was subsequently published in a one-off publication entitled *Essays of the Birmingham Speculative Club*, the collected works of a number of members of an amateur philosophical society (Emanuel, 1994). Williams' proposal was to use chloroform to deliberately hasten the death of terminally ill patients.

Robert Ingersoll argued for euthanasia, stating in 1894 that where someone is suffering from a terminal illness, such as terminal cancer, they should have a right to end their pain through suicide. Felix Adler offered a similar approach, although, unlike Ingersoll, Adler did not reject religion, instead arguing from an Ethical Culture framework. In 1891, Alder argued that those suffering from overwhelming pain should have the right to commit suicide, and, furthermore, that it should be permissible for a doctor to assist – thus making Adler the first "prominent American" to argue for suicide in cases where people were suffering from chronic illness (Dowbiggin, 2003).

America also saw the first attempt to legalize euthanasia, when Henry Hunt introduced legislation into the General Assembly of Ohio in 1906. In January 1936, King George V was given a fatal dose of morphine and cocaine in order to hasten his death. At the time he was suffering from cardiorespiratory failure, and the decision to end his life was made by his physician, Lord Dawson (Ramsay, 2011).

A 24 July 1939 killing of a severely disabled infant in Nazi Germany was described in a BBC "Genocide under the Nazis Timeline" as the first "state-sponsored euthanasia". *The Telegraph* noted that the killing of the disabled infant—whose name was Gerhard Kretschmar, born blind, with missing limbs, subject to

convulsions, and reportedly "an idiot"— provided "the rationale for a secret Nazi decree that led to 'mercy killings' of almost 300,000 mentally and physically handicapped people". While Kretchmar's killing received parental consent, afterwards, most of the 5,000 to 8,000 killed children were forcibly taken from their parents.

Some important euthanasia related journey/movements are: Bill to legalize euthanasia defeated in British House of Lords (1936), voluntary euthanasia act introduced in US Senate (1937), national society for legalization of euthanasia founded (1938), Nazi use of involuntary euthanasia changes public perception of euthanasia in the US (1940), committee of 1776 physicians for legalizing voluntary euthanasia founded (1946), world medical association condemns euthanasia: poll shows declining support for the physician assisted suicide (1950), group petition the UN to amend the declaration of human rights to exclude euthanasia (1952), Pautine Taylor becomes precedent of the euthanasia society of America (1962), Donald MC Kinney becomes precedent of the euthanasia society of America (1965), First living will written (1967), Havward medical school committee defines irreversible coma as a criterion for death (1968), Hastings center founded (1969), idea of patients' rights gain acceptance (1970), US senate hold first national hearing on euthanasia (1972), American hospital association adopts patients bill of rights (1973), society for the right to die founded first US hospice opens (1974), supreme courts rules in Quinlan case that respirator can be removed from coma patients (1976), nation's first aid in dying statute signed into law in CA (1976), eight states have right to die bills (1977), world federation of right to die societies forms (1980), American medical association supports withholding or withdrawing life prolonging medical treatment in certain circumstances (1984), California state bar becomes first public body to support physician aid in dying (1987), public opinion surveys show more than half of American support physician assisted death (1990), choice in dying formed (1991), California death dignity act is defeated (1992), New York task force publishes report against physician assisted suicide (1994), US supreme court rules there is no right to die (1997), Maine death with dignity act is defeated (2000), Netherland legalizes

euthanasia (2001), supreme court upholds Oregon death with dignity act in Gonzales v Oregon (2006), Luxembourg legalizes PAS and euthanasia (Feb 2008), Washington death with dignity act is passed (Nov 2008), state of Montana legalizes PAS (Dec, 2008), Massachusetts death with dignity ballot measure defeated (Nov 2012).

TYPES OF EUTHANASIA

There is a debate within the medical and bioethics literature about whether or not the non-voluntary (and by extension, involuntary) killing of patients can be regarded as euthanasia, irrespective of intent or the patient's circumstances. In the definitions offered by Beauchamp & Davidson and, later, by Wreen, consent on the part of the patient was not considered to be one of their criteria, although it may have been required to justify euthanasia (Wreen, 1988; Beauchamp et al., 1979), others see consent as essential. However, Euthanasia may be classified according to whether a person gives informed consent into three types: voluntary, non-voluntary and involuntary (Perrett, 1996; Lafollette, 2002).

1. **Voluntary euthanasia:** Euthanasia conducted with the consent of the patient is termed voluntary euthanasia. Active voluntary euthanasia is legal in Belgium, Luxembourg and the Netherlands. Passive voluntary euthanasia is legal throughout the U.S. per *Cruzan v. Director, Missouri Department of Health*. When the patient brings about his or her own death with the assistance of a physician, the term assisted suicide is often used instead. Assisted suicide is legal in Switzerland and the U.S. states of Oregon, Washington and Montana.
2. **Non-voluntary euthanasia:-**Euthanasia conducted where the consent of the patient is unavailable is termed non-voluntary euthanasia. Examples include child euthanasia, which is illegal worldwide but decriminalized under certain specific circumstances in the Netherlands under the Groningen Protocol.

3. **Involuntary euthanasia:** Euthanasia conducted against the will of the patient is termed involuntary euthanasia.
4. **Passive and active euthanasia:** Voluntary, non-voluntary and involuntary euthanasia can all be further divided into passive or active variants (Rachels, 1975). A number of authors consider these terms to be misleading and unhelpful. Passive euthanasia entails the withholding of common treatments, such as antibiotics, necessary for the continuance of life (Harris, 2001). Active euthanasia entails the use of lethal substances or forces, such as administering a lethal injection, to kill and is the most controversial means. Active euthanasia results from acts of commission, like administration of medications that hasten the process of dying such as barbiturates, opioids, etc. Passive euthanasia involves acts of omission which often involves withdrawing of life-supporting measures like artificial feeding and artificial respiration (Tillyard, 2007; Patra & Patro, 2012).

LEGAL STATUS OF EUTHANASIA

It's important to discuss the legal status of euthanasia. Passive euthanasia in India. On 7 March, 2011 the Supreme Court of India legalized passive euthanasia by means of the withdrawal of life support to patients in a permanent vegetative state. The decision was made as part of the verdict in a case involving Aruna Shanbaug, who has been in a vegetative state for 37 years at King Edward Memorial Hospital. The high court rejected active euthanasia by means of lethal injection. In the absence of a law regulating euthanasia in India, the court stated that its decision becomes the law of the land until the Indian Parliament enacts a suitable law. Active euthanasia, including the administration of lethal compounds for the purpose of ending life, is still illegal in India, and in most countries.

According to these guidelines, passive euthanasia involves the withdrawing of treatment or food that would allow the patient to live. Forms of active euthanasia, including the administration of

lethal compounds, are legal in a number of nations and jurisdictions, including Switzerland, Belgium and the Netherlands, as well as the US states of Washington and Oregon, but they are still illegal in India.

Elsewhere in the world active euthanasia is almost always illegal. The legal status of passive euthanasia, on the other hand, including the withdrawal of nutrition or water, varies across the nations of the world (Beauchampet et al., 1979). As India had no law about euthanasia, the Supreme Court's guidelines are law until and unless Parliament passes legislation. India's Minister of Law and Justice, Veerappa Moily, called for serious political debate over the issue. The following guidelines were laid down:

1. A decision has to be taken to discontinue life support either by the parents or the spouse or other close relatives, or in the absence of any of them, such a decision can be taken even by a person or a body of persons acting as a next friend. It can also be taken by the doctors attending the patient. However, the decision should be taken bona fide in the best interest of the patient.
2. Even if a decision is taken by the near relatives or doctors or next friend to withdraw life support, such a decision requires approval from the High Court concerned.
3. When such an application is filed the Chief Justice of the High Court should forthwith constitute a Bench of at least two Judges who should decide to grant approval or not. A committee of three reputed doctors to be nominated by the Bench, who will give report regarding the condition of the patient. Before giving the verdict a notice regarding the report should be given to the close relatives and the State. After hearing the parties, the High Court can give its verdict.

After the court ruling *The Telegraph* consulted with Muslim, Hindu, Jain and Christian religious leaders. Though generally against legalizing euthanasia, Christians and the Jains thought passive euthanasia was acceptable under some circumstances. Jains and

Hindus have the traditional rituals *Santhara* and *Prayopavesa* respectively, wherein one can end one's life by starvation, when one feels their life is complete. Some members of India's medical establishment were skeptical about euthanasia due to the country's weak rule of law and the large gap between the rich and the poor, which might lead to the exploitation of the elderly by their families.

The debate about the legalization of active steps to intentionally end life as a means to end suffering remains controversial. Many people feel that euthanasia is no better than murder and think that it should most definitely be illegal whereas others think that euthanasia is acceptable and that it stops unnecessary suffering of terminally ill persons and can have agreement to the legalization of euthanasia. People who advocate euthanasia agree that euthanasia would be used only for those who are terminally ill but there are many definitions of the word 'terminal'. Others believe that euthanasia is also against one of the basic concept of morality, that is killing is wrong. It is against religious beliefs, legal traditions and medical ethics. It is also a rejection of the importance and value of human life.

Views against Euthanasia

- It may be pain and depression instead of a sane mind that makes people ask for euthanasia.
- It may be misused to eliminate people.
- A disease incurable today may be curable tomorrow. In the age of new technologies and discoveries in medicine, an issue has arisen over whether a person on life-support, respirators, and feeding tubes has right to live or die.

Views in favor of Euthanasia

- Being the sole custodian of one's life, one has the right to end his life when he wishes: It is generally accepted that as an expression of autonomy *i.e.* one's right to make independent choices without any external influences, a competent adult can refuse medical treatment, even in

situations where this could result in his/her death. For instance where a person has been totally incapacitated physically and mentally who does the decision making for him. Much of the pro-euthanasia argument is based on a commitment to the notion of personal autonomy. Yet people with disabilities, those suffering from chronic physical or mental pain or otherwise vulnerable are more susceptible to the power of suggestion and therefore less autonomous. Proponents argue that euthanasia allows terminally ill people to die with dignity and without pain and state that society should permit people to opt for euthanasia if they so wish. Proponents also state that individuals should be free to dictate the time and place of their own death. Finally, proponents argue that forcing people to live against their wishes violates personal freedoms and human rights and that it is immoral to compel people to continue to live with unbearable pain and suffering.

- Helping some die (to relieve pain and suffering) does not amount to murder.
- It would help by reducing unnecessary financial burden.

Opponents of euthanasia, on religious grounds, argue that life is a gift from God and that only God has the power to take it away. Others contend that individuals don't get to decide when and how they are born; therefore, they should not be allowed to decide how and when they die. They also raise concerns that allowing euthanasia could lead to an abuse of power where people might be euthanized when they don't actually wish to die.

It has been argued that permitting euthanasia could diminish respect for life. Concerns have been raised that allowing euthanasia for terminally ill individuals who request it, could result in a situation where all terminally ill individuals would feel pressurized into availing of euthanasia. There are fears that such individuals might begin to view themselves as a burden on their family, friends and society or as a strain on limited healthcare resources. Opponents of euthanasia also contend that permitting individuals to end their lives may lead

to a situation where certain groups within society *e.g.* the terminally ill, severely disabled individuals or the elderly would be euthanized as a rule.

Effects of Physician-Assisted Suicide and Euthanasia on Participating Physicians

The report by The New York State Task Force on Life and the Law stated: "Many physicians and others who oppose assisted suicide and euthanasia believe that the practices undermine the integrity of medicine and the patient-physician relationship. Medicine is devoted to healing and the promotion of human wholeness; to use medical techniques in order to achieve death violates its fundamental values. Even in the absence of widespread abuse, some argue that allowing physicians to act as 'beneficent executioners' would undermine patients' trust, and change the way that both the public and physicians view medicine.". The counter-argument has been expressed by Margaret Battin and Timothy Quill, editors of a book favoring legalization of PAS. These PAS advocates have stated that there is no evidence that PAS "legalization would corrupt physicians and thus undermine the integrity of the medical profession," and that "there is substantial evidence to the contrary."

An important component of the assisted suicide debate concerns the ability of medically ill patients to make competent, informed decisions about physician assisted suicide. The potential for such decision making to be compromised by the presence of pain, depression, or other psychosocial factors (e.g., fear of becoming a burden) is a significant concern in any assessment of a patient's request for assisted suicide or euthanasia. Proponents of legalization of assisted suicide suggest that interest in a hastened death may be a rational decision for individuals with a terminal illness. Clinicians, family members, and medically ill patients cite the potential for, and fear of, cognitive and/or physical deterioration, pain, and emotional suffering as the basis for such requests. Other proponents cite respect for patient autonomy as another justification for legalization of assisted suicide (Emanuel, 1994), suggesting that patients have

the right to self-determination in choosing the time and manner of their deaths.

Opponents of legalization, on the other hand, typically suggest that interest in hastening one's death is fostered by inadequate palliative care and that with pain management, social and environmental support, and mental health treatment, requests for assisted suicide will be markedly reduced (Cherney, Coyle, & Foley, 1994; Foley, 1995). In addition, opponents point to the possibility that assisted suicide may be viewed as a less expensive alternative to providing adequate end-of-life care and would therefore be increasingly appealing to health care providers as resources become scarce (Hendin, et al., 1997; Hendin & Klerman, 1993). These critics suggest that assisted suicide might be disproportionately requested and used by the poor, who often lack the resources to secure adequate palliative care. Finally, opponents argue that legalization of assisted suicide will inevitably lead to legalization of euthanasia and eventually will be extended to allow assistance in dying for patients without terminal or even medical illness (*i.e.*, the "slippery slope" argument (Hendin, *et al.,* 1997).

Ryan argue that "Even though there may be some cases in which physician-assisted suicide could be justified, to allow it to occur, some say, is to let go a runaway train that will take us to unintended and frightening destinations (Ryan, 1998). Since the pro-euthanasia lobby claims that much physical pain is un-relievable, it is important to know the truth. The latest figures from Oregon show that while 95% of patients requested euthanasia or assisted suicide for "loss of autonomy" and 92% for "loss of dignity" only 5% (3 people) requested it for "inadequate pain control" (2008 Summary of Oregon's Death with Dignity Act, released on 3 March 2009.)

PROS AND CONS OF EUTHANASIA

Maisie highlighted about the importance of pros and cons of euthanasia: is mercy killing humane? Do we have the right to assess whether a life is worth living? Should euthanasia be practiced for

terminally ill people only or even for the debilitated and mentally ill too? Euthanasia also known as mercy killing is a way of painlessly terminating one's life with the "humane" motive of ending his suffering. Euthanasia came into public eye recently during the Terri Schiavo controversy where her husband appealed for euthanasia while Terri's family claimed differently. This is a classical case shedding light on the pros and cons of mercy killing. Albania, Belgium, Netherlands, Oregon, Switzerland and Luxembourg are some places where euthanasia or assisted suicide has been legalized. Let's have a look at the arguments that will help us understand the reasoning for/against mercy killing.

Pro-euthanasia Argument

Legalizing euthanasia would help alleviate suffering of terminally ill patients. It would be inhuman and unfair to make them endure the unbearable pain. In case of individuals suffering from incurable diseases or in conditions where effective treatment wouldn't affect their quality of life; they should be given the liberty to choose induced death. Also, the motive of euthanasia is to "aid-in-dying" painlessly and thus should be considered and accepted by law. Although killing in an attempt to defend oneself is far different from mercy killing, law does find it worth approving. In an attempt to provide medical and emotional care to the patient, a doctor does and should prescribe medicines that will relieve his suffering even if the medications cause gross side effects. This means that dealing with agony and distress should be the priority even if it affects the life expectancy.

Euthanasia follows the same theory of dealing with torment in a way to help one die peacefully out of the compromising situation. Euthanasia should be a natural extension of patient's rights allowing him to decide the value of life and death for him. Maintaining life support systems against the patient's wish is considered unethical by law as well as medical philosophy. If the patient has the right to discontinue treatment why would he not have the right to shorten his lifetime to escape the intolerable anguish? Isn't the pain of waiting for death frightening and traumatic? Family heirs who would

misuse the euthanasia rights for wealth inheritance does not hold true. The reason being even in the absence of legalized mercy killing, the relatives can withdraw the life support systems that could lead to the early death of the said individual. This can be considered as passive involuntary euthanasia.

Here they aren't actively causing the death, but passively waiting for it without the patient's consent. It can be inferred that though euthanasia is banned worldwide, passive euthanasia has always been out there which can also be called as passive killing and moreover law doesn't prohibit it. Disrespect and overuse of (passive) euthanasia has always existed and will be practiced by surrogates with false motives. These are the ones who don't need a law to decide for one's life. Present legal restrictions leave both the incurable patients as well as pro euthanasia activists helpless who approve euthanasia as good will gesture for patient's dignity. Health care cost is and will always be a concern for the family irrespective of euthanasia being legalized.

Cons of Euthanasia Argument

Mercy killing is morally incorrect and should be forbidden by law. It is a homicide and murdering another human cannot be rationalized under any circumstances. Human life deserves exceptional security and protection. Advanced medical technology has made it possible to enhance human life span and quality of life. Palliative care and rehabilitation centers are better alternatives to help disabled or patients approaching death live a pain-free and better life. Family members influencing the patient's decision into euthanasia for personal gains like wealth inheritance is another issue. There is no way you can be really sure if the decision towards assisted suicide is voluntary or forced by others. Even doctors cannot predict firmly about period of death and whether there is a possibility of remission or recovery with other advanced treatments. So, implementing euthanasia would mean many unlawful deaths that could have well survived later. Legalizing euthanasia would be like empowering law abusers and increasing distrust of patients

towards doctors. Mercy killing would cause decline in medical care and cause victimization of the most vulnerable society. Would mercy killing transform itself from the "right to die" to "right to kill"? Apart from the above reasons, there are some aspects where there is a greater possibility of euthanasia being mishandled. How would one assess whether a disorder of mental nature qualifies mercy killing? What if the pain threshold is below optimum and the patient perceives the circumstances to be not worthy of living? How would one know whether the wish to die is the result of unbalanced thought process or a logical decision in mentally ill patients? What if the individual chooses assisted suicide as an option and the family wouldn't agree?

PSYCHOLOGICAL, MEDICAL AND ETHICAL ISSUES

Relation between psychological factors, mental illness and euthanasia: Emotional and coping responses to life-threatening illness may include a strong sense of shame, feelings of not being wanted, and/or inability to cope. Adjustment to the loss of previous function, independence, control, and/or self-image may be difficult. Each change may lead to tensions within relationships that further increase isolation and misery. A host of physical issues may accompany advanced illness. These may include pain, breathlessness, anorexia/cachexia, weakness/fatigue, nausea/vomiting, constipation, dehydration, edema, incontinence, loss of function, sleep deprivation, etc. Their presence, particularly if they are unmanaged for long periods, may markedly increase suffering. The prevalence of mental disorders, being strongly associated with an increased risk of suicidal behavior, also increases as the primary location of the disorder or dysfunction moves closer to the brain (Van & Marusic, 2003). Depression is the most common psychiatric disorder in the elderly. Despite it being a treatable condition little is understood about the improvement with medication, drug adherence and the follow up in treatment seeking elderly with depression. It has been suggested that the key to preventing suicide is not in the study of the brain, but in the direct study of the human emotions (Shneidman & Schneidman, 1996).

(a) **Psychological Sectors and Euthanasia:** Not surprisingly, it is concluded that desire for death among patients with terminal illnesses was likely a product of depression. Several methodological issues limit the conclusiveness of these findings. Most importantly, the diagnosis of depression was based on the same clinical interviews in which patients expressed their thoughts of suicide or interest in hastened death (Rosenfeld, 2000). "Depression is associated with poorer will to live and greater desire for a hastened death". Symptoms may include wish for death-Feelings of worthlessness, uselessness, guilt and the belief that one is a "burden" are common, agitation, brooding, preoccupation with thoughts of death or suicide, difficulty thinking and concentrating, May affect capacity to make decisions and lower resistance to outside pressure (Lyness, 2004). In cancer patients with < 3 months of life expectancy, depression was associated with requests for euthanasia. Elderly people, especially those with dementia are equally likely to be regarded as "better off dead" in Holland, whether or not they are in a position to actively request euthanasia. People with "mental suffering" and no physical illness have also been put to death in Holland (Spanjer, 1994).

(b) **Psychiatry and Euthanasia:** The two places in the world where mercy killing is legalized are the state of Oregon in USA and the Netherlands. The latter has also approved of euthanasia and PAS for mentally ill patients. The laws pertaining to euthanasia and physician assisted suicide (PAS) in both places do not make psychiatric assessment of patients mandatory. The concerned patient is sent for psychiatric assessment only if the physician in charge of the patient feels that the patient may be psychiatrically ill.

The Dutch guidelines for the termination of life of mentally ill require an opinion from an independent psychiatrist about the incurable nature of the illness from a prognostic point

of view. However, given the current understanding of mental illnesses nobody can truly claim the curability of any severe mental illness such as schizophrenia, schizoaffective disorder, bipolar affective disorder and obsessive compulsive disorder. All these illnesses are treatable to the point of sustained remission under prophylactic medication, but curability remains a dream. On the other hand, the boom in psychopharmacology has astonished the psychiatrists and the critics of psychiatry alike, with its ability to bring about improvement in some chronically ill patients who were resistant to all kinds of interventions given earlier. Thus nobody can predict with any degree of reliability that a particular patient will not improve in the future. Other issues that complicate the Dutch guidelines include the approach of psychiatrists towards treatment. (psychopharmacological vs psychotherapeutic), lack of guidelines regarding length of treatment before patient's wish is acted upon, issues related to countertransference enactment and the professional esteem of psychiatry. Assisting in suicide of mentally ill can send a pernicious message to those fighting against the mental illnesses. At the same time it will lead to a slippery slope, recovery from where will be almost impossible.

The attitude of mental health professionals is interesting with respect to euthanasia/PAS. Though a good number of psychiatrists endorse their support for PAS, only a minority of them agree to involve in the assessment of patients requesting for PAS. If we look at consultation liaison psychiatrists (who are more likely to involve in the care of terminally ill), they uniformly oppose euthanasia and PAS.

(c) **Medical issues:** On a purely medical level, it is often argued that mental disorders are distinct from somatic disorders, and that the reasoning and practice adopted in somatic medicine should not therefore be simply applied in

psychiatry. This argument is supported by the fact that the causes and psychopathology of mental disorders are often poorly understood and multifactorial (Kelly & McLoughlin, 2002). The DSM–IV is the most widely used system of psychiatric diagnosis. Although much better than its predecessors, but still there is a great need of considerable improvement. In many cases its categories seem to be artificial, in that they do not represent valid disease entities. It is probable that mental health and disease are dimensional in nature, rather than categorical as is presumed in DSM–IV. This is particularly true for the categories of personality disorders, which are among the least valid and reliable of DSM categories (Helmuth, 2003). All these reasons contribute to a scientifically weak basis upon which to rest such an important decision as euthanasia. Moreover, there are still too few long-term follow-up studies in psychiatry to predict the natural course of a psychiatric disorder. Since many patients do not have all the characteristics necessary in order to fit into any of the typical categories of DSM, 20–50% of them in almost any diagnostic group are assigned to the 'not otherwise specified' category, and are usually excluded from clinical research (Helmuth, 2003). Because of this, it is often hard to predict what response might be expected from a certain treatment and when that response might occur (Schoevers et al, 1998; Kelly & McLoughlin, 2002). Furthermore, prognosis is often uncertain, with the result that it is rarely possible to describe a mental disorder as incurable (Schoevers et al, 1998; Kelly & McLoughlin, 2002; Helmuth, 2003; Sjoberg & Lindholm, 2003). Thus, relative to somatic medicine, in psychiatric medicine there is greater uncertainty regarding the various aspects of the decision process and whether the legal requirements concerning euthanasia are met.

d **Ethical issues:** The largest part of the discussion surrounds ethical issues. The first counter-argument against assistance

with suicide in patients suffering primarily from a mental disorder is that one of the psychiatrist's basic responsibilities is to advocate for the vulnerable, disabled and infirm in our society and, when necessary, to protect them from themselves or others (Hamilton et al, 2000; Kissane, & Kelly, 2000). A classic manifestation of this task is the prevention of suicide. Assistance with suicide provided by the psychiatrist implies an attitude that is radically opposed to that medical goal (Burgess, & Hawton, 1998; Kerkhof, 2000; Kissane, & Kelly, 2000). Another important argument concentrates on the ambiguous notion of mental illness itself. If patients suffer in their environment and develop a mental disorder, it is difficult to ascertain whether the mental disorder and suffering are solely a natural reaction to an intolerable and/or hostile environment, or whether genuine mental disorder has ensued. Historical examples are the high numbers of suicide in unmarried mothers and gay men (once considered to be mentally ill) in social environments where they were not accepted. Thus, the term 'mental suffering stemming from mental disorder' is vague and hard to define, and the potential for abuse is serious. A final but recurring theme in the literature is a fear of gradual social acceptance of the practice of euthanasia, which might lead to a less careful decision making process and to dealing less adequately with suicidal ideation and behavior (Vander, et al., 1996; Hamilton, & Hamilton, 2000; Onwuteaka, et al 2003).

CONCLUSION

It is well accepted fact the after all, each and every one of us will have to die one day, later the better obviously. Current research findings have indicated that an emergence of terminal illness is commonly experienced as having a devastating effect on patient's lives and that patient feels loss of control and independence. In addition they fear being a burden to their families, experiencing emotional or physical pain, eating disorder patients are ambivalent over changing their eating patterns and sometimes feel not ready or

able to change. An extremely ill and doesn't want to continue suffering, should he/she be forced to stay alive. However, there is a paucity of studies investigating the maintaining factors of the disorder. It is emphasized to increase effort to provide continuity of care. Presented research study plan might be effectively used to evaluate community functioning.

Furthermore, it is well-established that the presence of dysfunctional cognitions indicates a vulnerability to psychopathology and bears strong relationships with psychological distress. Psychiatric co-morbidity should be taken in to account when complicated treatments like anti-retroviral drugs are required. It is equally important to treat these conditions in order to achieve better compliance in the treatment, something that is crucial in conditions like HIV. The given pharmacological intervention ameliorated the patient's mental illness and contributed to his ongoing compliance regarding the HIV associated drugs. It is important to examine the thoughts, feelings and attitudes we have regarding death and dying, to see whether or not they are realistic and healthy. As mentioned above, when people approach death they will at times experience disturbing emotions such as fear, regret, sadness, clinging to the people and things of this life, and even anger. They may have difficulty coping with these emotions, and may find themselves overwhelmed, as if drowning in them.

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