EDITORIAL VIEW

Euthanasia: is it really a bad idea?

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ABSTRACT

'Euthanasia' or 'mercy killing' is a deliberate intervention undertaken with the express intention of ending a life, to relieve intractable suffering. The debate in favor of or against it is nothing new, but emanates from the days of Socrates, Plato and Hippocrates. Medical advances in the vital organ function support and treatments during later part of the twentieth century, and organ harvesting for transplantation have added newer dimension to this subject; whereas, religious teachings may not favor individual wishes. Financial and social cost of sustaining life of a incurable patient may force us to take unpopular decisions. The debate about euthanasia continues and is likely to continue for the times to come.

Key words: Euthanasia; Active euthanasia; Cardiorespiratory failure; Holy Quran; Critical care; End of life decisions

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Encyclopaedia Britannica defines 'euthanasia' or 'mercy killing' as an 'act or practice of painlessly putting to death person suffering from painful and incurable disease or incapacitating physical disorder OR allowing them to die by withholding treatment OR withdrawing artificial life support measures'.[1] House of Lords of Britain defines it as "a deliberate intervention undertaken with the express intention of ending a life, to relieve intractable suffering". Most of the controversies surrounding euthanasia debate emanate from different definitions.

The idea of ending the life in order to relieve a person of suffering has been debated since ancient time; Socrates and Plato supported it while Hippocrates seems to have opposed it when he wrote these words "I will not prescribe a deadly drug to please someone, nor give advice that may cause his death".[2] The debate was initiated in the modern times in nineteenth century when John Warren advocated using morphine to relieve the suffering of death; knowing that this may hasten death itself. The recommendation emphasized on relief of suffering and did not mention hastening of death. The movement advocating active measures to hasten death by using means like chloroform started on both sides of the Atlantic in late nineteenth century; the moves to earn a legal status have not succeeded in most of the countries. Practice of involuntary euthanasia by the Nazis involved killing children with serious disabilities during World War-II added a fresh, abhorable dimension to this philosophy.

Advances in the technologies to support vital organ function and treatments during later part of the twentieth century, for what were once considered incurable diseases, have added fresh dimensions to end of life debate. The definition of euthanasia would now include measures to withhold or withdraw the interventions aimed at extending the life of a patient who has little hope of a meaningful recovery. It would be appropriate to understand different types of euthanasia before its place in today's healthcare set up is discussed.

Depending on the patient's consent, euthanasia may be voluntary, non-voluntary or involuntary. Patient's consent qualifies the practice as voluntary; it may be non-voluntary when the patient has not consented and involuntary when the act is carried out against the patient's will.

Euthanasia may be active or passive; passive practices include withholding or withdrawal of measures that are necessary for continuation of life (artificial ventilation, dialysis, antibiotics, inotropes); active euthanasia involves the use of lethal substances or forces with an intent to kill. Active euthanasia is still considered homicide, although it is not punishable in Netherlands and Denmark if certain conditions are met. Passive euthanasia and assisted suicide are legal is United States of America.

Doctrine of double effect: when one's otherwise legitimate act (relieving severe pain) will also cause an effect one will normally be obliged to avoid (respiratory depression).[3]

Central to this debate is suffering of the patient and motive of the care provider, which should be alleviation of suffering in a case of terminal illness.

Let us get the perspective right

Conceded that there are strong arguments against active euthanasia; it is difficult to define a point when the patient is justified in demanding an end to his life. There would be a question mark on the rationality of a decision reached by a person in extreme agony. This is the reason these requests are not given a blanket approval in the countries where the practice has been legalized. More important than any other consideration is the explicit disapproval of taking one's own life in our faith. All divine religions; Judaism, Christianity and Islam explicitly prohibit taking one's life. Islam, of all the religions, addresses the issue of life and death in greatest detail; life is considered a sacred trust from Allah and man has no right to terminate it. This debate on euthanasia would have been a non-starter from Islamic perspective if modern technologies and approaches to healthcare had not given a fresh dimension to the concept of life and death.

The dilemma of defining death

Introduction of artificial ventilation and circulatory arrest have redefined the concept of death, which was synonymous with cessation of breathing or circulation; as a matter of fact they were not mutually exclusive, cessation of one would naturally lead to the end of the other. Mechanical ventilation has enabled patients to live without the ability to breathe, this would include brain stem dead patients. Death has been redefined in terms of cessation of circulation; this definition does not encompass the situations where circulatory arrest is induced as therapeutic measure during cardiac or neurosurgical procedures. "Moment of death" was easier to define when people dropped dead due to cardiorespiratory failure; now we understand death as a process rather than a moment. Loss of consciousness with intact circulation and respiration; loss of consciousness and respiration; absence of pulses with cardiac electric activity intact; and loss of cardiac electrical activity are but stages that lead to loss of capacity to maintain body temperature and setting in of rigor mortis, which are certain signs of death. The process can be halted or even reversed spontaneously or with support during the stages where death actually occurs. Cardiac activity is known to have occurred spontaneously within 4-5 minutes of cardiac arrest and after a much greater interval with cardiac life support. Labeling any one of these events as a marker of death of an individual is fraught with the risk of declaring some of the patients dead prematurely.

Brain stem death or widespread brain death was defined as a marker of termination of life in order to reach decisions regarding termination of life support or organ retrieval. Concept of brain stem death as a marker of death was first proposed at Harvard Medical School; brain stem dead people have, however survived on ventilator for extended periods. Loss of consciousness and respiratory drive notwithstanding, these patients have the capacity to carry out normal biological functions like wound healing, growth to puberty and beyond, getting pregnant and delivering normal babies.[4] President's commission on Bioethics in the US expressed their reservations on equating brain stem death with death of the individual as this did not automatically result in "loss of integrative function of whole body or failure of cardiovascular functions of the living organism". They proposed the term "total brain failure", which is "diagnostically distinct from all other injuries" instead. Not a great help in determining when to take a patient off the ventilator or retrieve the organs for donation.[5] Agreeing with this report would mean that decisions based on brain death criteria could have resulted in the death of patients who were "not really dead".[6]

End of life decisions and organ procurement in Islam

The relationship between man and his body have been made clear in Islam; they are determined by the following guiding principles

Value of human life where killing a soul is tantamount to killing the whole of humanity and saving a soul is like saving the whole of humanity.

Equality of humans; every life is as precious as the other.

The donor of life is God and the determinant of death is God. No man or authority has the right to decide the fate or end of a human life (aside of applying criminal laws).

For the purpose of organ donation a person is considered legally dead and all the Sharia's (Islamic Law) principles can be applied when one of the following signs is established:

Complete stoppage of the heart and breathing, which are decided to be irreversible by doctors.

Complete stoppage of all vital functions of the brain which are decided to be irreversible by doctors and the brain has started to degenerate. Under these

circumstances it is justified to disconnect life supporting systems even though some organs continue to function automatically (e.g. the heart) under the effect of the supporting devices.[7]

These principles were used to issue a religious decree (Fatwa No. 5) in favor of retrieving the organs from brain dead patients during the conference of Islamic Jurists held in 1986 in Amman, Jordan. Following verse from Holy Quran is cited in justifying organ procurement from dying patients; "*Whosoever killeth a human being for other than manslaughter or corruption on earth, it shall be as if he has killed all mankind. And whosoever saveth the life of one, it shall be as if he saved the life of all mankind' (Holy Quran 5:32)"*

The principle of greater good is applied here to justify terminating the life of a dying patient in order to save another. Ironically, the same verse is cited while denying the withdrawal or withholding of treatment in terminally ill patients. Whereas, sanctity of life is one of the cardinal principles of Islam, it explicitly forbids taking one's own or any other life except in the dispensation of justice under very specific conditions. Following verses from Quran forbid taking one's own life or the life of those who are under one's care.

And do not with your own hands cast yourselves into destruction (Holy Quran 2:195).

Nor kill(or destroy)yourselves: For verily God hath been to you most merciful. (Holy Quran 4:29)

And slay not your children for fear of want. We shall provide for them and for you.Lo! Their slaying is a great sin. (Holy Quran 17:31)

Following verses emphasize the time of death is preordained

"Every soul shall have a taste of death. (Holy Quran 3-185)

Truly thou wilt die (one day), and truly they (too) will die (one day) (Holy Quran 3:185)

Nor can a soul die except by God's leave, the term being fixed as by writing (Holy Quran 39:42)

Allah takes away the souls upon their death; and of those who do not die during their sleep, those on whom He has passed the decree of death He keeps with Him and the rest He restores for a term ordained. Verily in this are signs for those who reflect. (Quran3:145)"

Financial cost of treating terminal conditions

Cost of treating malignancies has more than doubled during last 20 years, this is largely due to development of new drugs and diagnostic imaging technologies. Three factors are operating in this exponential increase in the cost. Firstly these drugs are recent developments that are largely carrying a patent, hence a premium on the price. The cost of production of these drugs is also high partly due to increasing cost of clinical trials and approvals and also since most of these drugs are biologics with a higher cost of production as compared to traditional therapeutic agents. There also is the issue of supply and demand as most of these drugs are in limited supply without the competitive market mechanisms. Secondly, these drugs are usually prescribed when first line therapies fail; this is a desperate situation for the patients and families who would generally agree to pay whatever it takes to give themselves a chance. Thirdly, the increased cost is due to over-utilization of care; trying off label treatments or therapies with dubious benefits.[8] It has been suggested that a substantial portion of the total cost of cancer care is for treatment delivered in the last months, weeks or days of life. Much of this care is of little to no therapeutic benefit and potentially inconsistent with patients' wishes.[9] The cost of care is largely borne by the patients and families in our society, mostly by stretching their resources. Approximately 25% of healthcare money is spent providing care for the last year of life; 20% of the patients die in critical care units in US. Major share of this money is spent on gaining a few extra days or months of life instead of making the last days comfortable.

Social cost of terminal care

There is little scientific data on the social cost of caring for terminally ill patients in our society. It is common knowledge that the families are primary care providers during terminal stages of illness in our society. Data from societies with similar social fabric has shown that although "you should care for your dear ones" was an idea ingrained, this often is enforced by the norms of the community; families adhere to accepted norms about continuity of care under the threat of gossip and social stigma.[10] Critical care is another area where therapies aimed at prolonging life (or illness) are may result in "post intensive care syndrome family".[11] Some of the children move to other cities in order to escape from caring their parents.[12] The pain is a lot less once the families resign to the fact that treatment is futile and agree to palliative care.

Deterrents to End of life decisions

In terminal illnesses there comes a point in time when active measures to cure the disease are not only futile, they prolong the patient's agony. It should be within the patient's rights to determine whether treatments aiming to prolong life should be continued or be substituted by those aiming to provide comfort and deal with the discomfort. Our society is, however, not based on individualism; the family has a key role to

play in these decisions. These decisions are influenced by faith and social pressures. Some of the factors that influence these decisions include.[13]

Family has a central role in deciding the course of treatment. The patients are often kept ignorant about the nature and severity of their illnesses.

Doctors do not inform the patients or families about the severity and extent of their illness. The concept of statistical probability of surviving and average predicted survival with or without treatment is not discussed.

The patients and families want the doctors to "try their best" and leave the rest to destiny.

Presence of parents is considered a source of blessing, serving them is a source reward in the hereafter. The thought of "letting them go" would be heretic.

No one has a right to terminate a person's life according to religious injunction. Life is considered a gift from Allah and suffering helps shed the sins.

Why not let them go in comfort and with dignity

Advances in medical knowledge and healthcare systems have increased average life span of humans, it has also introduced therapies to treat and cure illnesses. The patients get cured from debilitating illnesses and go on to live, long and meaningful lives. There comes a time when body is no longer able to cope with stresses of age or overwhelming illness; the survival in these terminal conditions is measured in very short time spans; from days to months. The cost of treating these conditions, financial and psychological, is overwhelming for patients, families and the society. The patients are undergoing intense suffering to gain a few more days of life, the families are paying a heavy price to keep them alive to fulfill their social and religious obligation, the society is allocates precious resources on treating patients who need comfort more than cure.

The patients have the right to be informed about the extent and severity of illness and probable life expectancy; as they are the best judges of their own pain and suffering. Why not give them the right to determine whether they wish to be treated or made comfortable? In case of patients with obtunded consciousness the families act as their surrogates; they need to consider the patient's best wishes instead of societal pressures while making these decisions. Religious scholars had the courage to issue a decree admitting the concept of brain for the purpose of organ donation for "greater good of the society". Let us hope they consider the futility of prolonging lives with ventilators or futile courses of exotic therapies.

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