

# Medical Ethics in India Today: Concerns and Possible Solutions

Sunil K. Pandya

Department of Neurosurgery, Jaslok Hospital & Research Centre, Dr. G. V. Deshmukh Marg, Mumbai 400026.  
Email: [shunil@vsnl.com](mailto:shunil@vsnl.com)

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## Introduction

We live in unhappy times.

We are told that India is shining and that our gross domestic product is booming. Our foreign exchange reserves show a steady upward trend.

Despite these we continue to have huge numbers of very poor persons. Most of them are denied the basic necessities of life – food, health, education and opportunities for advancement.

The medical profession is uniquely equipped to help these unfortunates by relieving pain, healing sickness where possible and caring at all times. Barring a few exceptional individuals and groups, doctors have failed in their duties by the very poor.

And yet, most doctors are affluent, some obscenely so. How have they acquired their riches?

Are we doing all we can for our people and for our country or have we preferred to restrict our efforts to our own welfare?

Are we honest in our dealings with our patients and with each other?

There are many such concerns. Time will permit consideration of just a few of them here.

## Primary concern

There appears to be a slow but progressive decay of character in many members of the medical profession.

## Some of the evidence

1. We are happy receiving gifts from manufacturers of drugs, implants and instruments. We take it for granted that these companies will pay for our air travel in business or first class to and fro national and international conferences and fund our stay in expensive hotels merely because we use their products.

2. I know of instances where companies pay consultants for every implant used by them during surgery. Where several companies manufacture similar implants, the consultant may juggle the use of implants such that he has a secondary source of steady income from each of them.

3. A few years ago the then managing director of Glaxo India narrated at a meeting on medical ethics how a senior and famous doctor in Mumbai demanded that his company pay for him and his family to travel to and fro and within the United States. The marketing director of the company strongly recommended that this expense be sanctioned as the doctor was in a position to hurt the sale of Glaxo products throughout India.

4. Several companies running computerized tomography and magnetic resonance scanners routinely offer kickbacks to consultants and family physicians referring patients to them. Rarely – if ever – are these payments refused.

5. I do not know of any organization of medical doctors that has fought a sustained campaign against corruption in the medical profession, malpractices such as the sale of organs for transplantation or similar misdeeds. As with our Parliament and Legislative Assemblies, so with our medical associations, we have several rotten eggs rising to august positions within them.

## Possible solutions

1. Reward and honour individuals practicing ethical medicine.

2. Penalise and rigorously discipline unethical doctors.

3. Teach ethics in schools and colleges.

4. Restore ethics to the medical curriculum.

**Cautionary note:** Examples set by teachers, and not precepts spouted by them, govern the actions of students.

## **Deterioration of education in public sector medical colleges**

### **Earlier:**

1. These colleges were the fountainheads of medical education all over India.
2. They set the pace and led the way in teaching, patient-care and research.
3. The finest consultants in the city and the state competed to teach and work in these colleges.

### **Now:**

1. These colleges are decaying.
2. They are bereft of teachers whose sole interests are the welfare of their students and patients.
3. Municipal medical colleges in Mumbai have demonstrated once again the ill-effects of permitting full-time teachers to indulge in private practice. All guidelines are openly flouted. Senior teachers are seen in private hospitals in the mornings and afternoons, attend several private hospitals, and divert patients from their teaching hospitals for personal profit.

### **Possible solutions**

1. Public sector hospitals must be restored to the eminence they enjoyed in the 1940s and 1950s.
2. To do so, boards of administration constituted such that government or municipal nominees are in the minority must govern them. Unimpeachable judges, industrialists, social workers, scientists, media personnel and medical doctors must have the right to hire and fire so that the institutions are staffed by the cream of the medical profession.
3. Merit and merit alone must form the criteria for selection at all levels of appointments.
4. Performance must be rewarded. Lack of performance must lead to a search for its causes and their removal.
5. The emoluments of staff members must be comparable to the earnings of doctors in private practice. Additional privileges such as subsidies for the education of their children, provisions for the purchase of homes to be used after retirement (as in the case of IAS officers and judges) and fully paid quinquennial attendance at the finest international medical conferences will ensure their loyalty to their institutes.

6. These institutes must be fully equipped, the equipment being scrupulously and efficiently maintained.

### **Lack of bold initiatives by the profession**

#### **An example**

1. The Medical Council of India and their counterparts in the states are corrupt, inefficient and riddled with politics. They are unresponsive to the people at large and the medical profession in particular.

2. Unlike similar institutions in other countries (the General Medical Council in Britain is an example), they take up no cause in the public interest, debate no vital issue, issue no guidelines on vexing topics and have no influence with legislators or government.

3. They have not bothered to exercise the powers given to check unethical medical practice. On the contrary they have connived at recognising substandard private medical colleges and frustrate attempts at cleansing their own Augean stables.

#### **Possible solutions**

1. Associations of doctors can act in concert to force action by governments and improve the medical councils.
2. As with public sector medical colleges, the medical councils must be freed from the clutches of politicians – lay and medical – greedy for power. They must be reconstituted into unimpeachable, democratic and efficient watchdogs and policy makers.
3. Associations of medical doctors, together with the medical councils, should debate contentious and vexing medical matters and provide streams of guidelines for the general public, medical profession, our law-makers and the judiciary. Some examples of subjects crying out for such discussion: a) persons with incurable disease (such as advanced muscular dystrophy or motor neurone disease) and terminally ill persons asking for a good death; b) inclusion and exclusion criteria for admission to intensive care units; c) the treatment of ‘acute chest pain’ in a powerful politician or industrialist sentenced to prison.

### **Conclusions**

Philosophers teach us that all problems are soluble given patience, will and effort.

The passage of time has exacerbated our ethical problems as we lack the inclination and the will to address them. We are at a stage where the ills are so grave that nothing short of drastic action will work.

A glance at the suggested solutions for the problems enunciated above will show that we face an arduous and painful uphill task.

We can shirk it only at the cost of the well-being of our future generations.

In the meanwhile, may I pass on to you some principles that have stood my teachers and myself in good stead?

- THE GOLDEN RULE *Do unto others, as you would have others do unto you.* I have often found it helpful to ask myself, 'Were I the patient, what course of action would I have wished the doctor to follow?'
- THE PATIENT COMES FIRST — The *raison d'être* of our profession is the patient. We are here to

serve him. The sick patient, often in physical pain and always in mental distress, deserves our fullest attention and calls for the best qualities of our mind and heart. His interests and decisions must prevail above all else except when the patient is *non compos mentis*. In the latter instance, the decisions of his family must prevail.

- THE POOR PATIENT DESERVES SPECIAL CONSIDERATION — He has nowhere else to go. He does not possess the means to command or demand. In our milieu he is often reduced to seeking help with bowed head and hands folded together. And he is ill. Medical malpractice against this group is particularly abhorrent.
- ACT WITHOUT FEAR OR FAVOUR — Ensure that your decisions and actions are scientific, humane, effective and in the best interests of the patient and his family. Record them. Once this is done, you need fear no individual, administrator or tribunal.

## Towards A Suicide Free Society

Ajai R. Singh

M.D. Psychiatrist, Aditi Hospital, Mulund. Also Editor, *Mens Sana Monographs* (<http://www.msmonographs.org>).  
Email: [mensanamonographs@yahoo.co.uk](mailto:mensanamonographs@yahoo.co.uk)

### Introduction

What is it that makes an individual carry out the final act of self-termination?

Let me add a rider right in the beginning. We are not discussing here the rare but important self-willed deaths like *samadhi*, *sati*, *jouhar*, *seppuku* (*hara-kiri*) and *samlekhana*, which find religious and social sanction in certain sections of society. We are interested here in talking about preventable suicides in those whose lives appear in danger of premature termination, and where appropriate strategies and approaches are much needed to preserve, promote and prolong life-sustaining processes.

For those who are in the midst of living, and so preoccupied with all its joys and travails, there is often no time, or inclination, even to pause and ponder over this question. But pause we shall here, and look at some familiar, though often ill-understood and unrealised, life-situations. In the lay public, in media people, even in professional care-givers.

Let me present some vignettes for your consideration.

### Case 1. The perplexed, Speechless Relative/Friend/Acquaintance

A phone call at an odd hour. The hushed voice of a known person. Announcing the demise of another known person. You are suitably grieved. But the voice is not satisfied. It wants to continue. You listen. It was not a natural death. It was...(hush)... suicide.

You are shocked. Benumbed. Too lost for words. Like how most people are. Left perplexed, and peculiarly stilled, when the suicide of an acquaintance comes to their notice.

And then the train of thought takes off. How could it be? He, of all people? Didn't think he was that type. Didn't know things were that wrong with him.

Then you ruminate a bit and realize, well, things were not that good with him, really. He did often talk of the darker side of life these days. Seemed to have lost the zest or zing to live. Remained morose, aloof. Often drank alone, listened to prolonged sessions of melancholic music, avoided people. Seemed unusually preoccupied in setting things in order. *O God, and he did express ideas life was not worth living.* Would be better if it all ended. Especially in those few moments of candour when inebriated, or when he came seeking your company when he felt very lonely. Well, you gave him company, tried to cheer him up, and he did get involved in the proceedings a bit. You felt good he sang, and opened up, and spoke his heart out. Felt good he trusted you, came to you when in distress, although it was quite an emotional drain handling him. But didn't for even a moment guess he would end his life thus. Didn't for a moment guess things were *that* bad with him.

All too familiar a story?

Well, why not.

When we are too often busy offering homemade succour, neglecting tell-tale signs of imminent danger, the inevitable catastrophe falls like a bomb, benumbing us, often leaving us tongue-tied, and strangely lost. Not just for words, but for solutions. For words only follow thoughts, and significant thoughts only follow mental resolutions of consequence. That is why we often find grievers/close relatives at a loss to express themselves on a suicidal death, besides of course the obvious reason that they do not know what are appropriate words for the occasion.

*'Suicide can be prevented. While some suicides occur without any outward warning, most do not. Prevent suicide among loved ones by learning to recognize the signs of someone at risk, taking those signs seriously and knowing how to respond to them. The emotional crises that usually precede suicide are most often both recognizable and treatable'* (*Warning Signs of Suicide*, 2006).

And what do you do? A simple straight forward guideline is as follows (AFSP What to do, 2006):

**'Be Willing to Listen**

- *Take the initiative to ask what is troubling them and persist to overcome any reluctance to talk about it.*
- *If professional help is indicated, the person you care about is more apt to follow such a recommendation if you have listened to him or her.*
- *If your friend or loved one is depressed, don't be afraid to ask whether he or she is considering suicide, or even if they have a particular plan or method in mind.*
- *Do not attempt to argue anyone out of suicide. Rather, let the person know you care and understand, that he or she is not alone, that suicidal feelings are temporary, that depression can be treated and that problems can be solved. Avoid the temptation to say, "You have so much to live for," or "Your suicide will hurt your family.'*

The remedy is actually just a willingness to help. And being aware how. The rest follows.

**Case 2. The Committed Reporter**

You have newly joined the prestigious news channel. You always wanted to appear live on air, and make an impact, a difference in the lives of people. This was your opportunity.

The call from the news-room is frantic, and urgent. An elderly couple has jumped, probably to death, from their sixth floor residence in an uptown area in the city. Rush to the scene, and send news of the event, including live coverage. It's most urgent. We would like to be the first to break the news for our viewers. It's a juicy story for sure, guaranteed to raise flagging TRIP Scores, besides raising social awareness of this ghastly incident, and social malady. Win-win from all sides, if ever there was one.

You rush. Report. Analyse with the spirited communication skills for which you are known, and were hired by your employers. The news item is well received by viewers all around. They are appropriately shocked, and remain glued to the TV set. Gory pictures add to the discomfiture, and appeal, of the rooted viewer. And living rooms are full of spirited discussions about the callousness of today's younger generation, the isolation and loneliness of growing old, the paradoxes of a city that is gregarious and yet chillingly neglectful at the same time.

You feel happy at a job well done. And feel you justly deserve the accolades that come your way for being a cub reporter who shows signs of making it big in the profession.

Except for a small problem

A couple of days later, in a shockingly similar incident, two AIDS patients, taking a cue from the earlier suicide pact reported so prominently in the media, jump from the third floor of a hospital building.

And the thought blinds you. Did we go overboard in our reporting? Did we pull the trigger for this unhappy sequel by our sensational reporting?

And you are suitably chastened to want to know what responsible suicide reporting was all about.

And then you read. Including, for reporters, how to avoid:

- i) Detailed descriptions of the suicide, including specifics of the method and location;
- ii) Romanticizing someone who has died by suicide. Avoid featuring tributes by friends or relatives. Avoid first-person accounts from adolescents about their suicide attempts;
- iii) Glamorizing the suicide of a celebrity;
- iv) Oversimplifying the causes of suicides, murdersuicides, or suicide pacts, and avoid presenting them as inexplicable or unavoidable;
- v) Overstating the frequency of suicide.

And, for editors, how to avoid:

- i) Giving prominent placement to stories about suicide. Avoid using the word "suicide" in the headline;
- ii) Describing the site or showing pictures of the suicide.

(For more details, see *At-a-Glance - Safe Reporting on Suicide* at [http://www.suicidepreventionlifeline.org/pdf/at\\_a\\_glance.pdf](http://www.suicidepreventionlifeline.org/pdf/at_a_glance.pdf) for a simple straightforward list of recommendations for reporters and editors. See also [http://www.afsp.org/index.cfm?fuseaction=home.view\\_page&page\\_id=7852\\_EBBC-9FB2-6691-54125A1AD4221E49](http://www.afsp.org/index.cfm?fuseaction=home.view_page&page_id=7852_EBBC-9FB2-6691-54125A1AD4221E49) for the original recommendations on which the earlier report is based. Both accessed 20 Oct 2006. For a more scholarly recent exposition, see Pirkis *et al*, 2006.)



### Case 3. The Unsensitised General Practitioner

A patient comes and sits silently in the clinic. Asking for this pill and that for some ill-defined aches and pains. You are a busy general practitioner. You find it odd she comes so often, and feels challenged you can hardly make a proper diagnosis. You give some concoction which seems to work, at least for the time being. Till she is back again, in a few days, with some shifting problem. You shrug your shoulders, write out something else, and get busy with more serious cases that challenge your diagnostic acumen. Especially after you have attended impressive consultant's CMEs on cardiology and gastroenterology, you would like to be able to diagnose difficult cases in your clinic itself. So you can guide the patient more impressively, even hopefully treat him in your own clinic. Or, if referral has to occur, you can carry out clever discussions about the intricacies of diagnosis and therapeutics with the well-known senior consultant. Who is then suitably impressed with your knowledge. So what you are a general practitioner.

And all this while the poor lady keeps coming often to the clinic. And keeps looking to talk to you with beseeching eyes. You are disconcerted with the way she keeps looking at you, but accept it as some patient's fixation for some doctors. You know how it is with them. Firmly to be resisted, the professional relationship to be properly kept distant. You briskly, rather brusquely, write out a new prescription, and get rid of her.

You receive a telephone call from the nearby physician's hospital. She is battling between life and death, with a serious suicidal attempt. Feeling stunned, and somewhat guilty, and wary too, you rush to the nursing home. You are worried your reputation should not be besmirched.

And then the picture unfolds. Of personal misery, and emotional isolation, and continuous physical and mental torture by an uncaring husband and scheming in-laws. Her visits to your clinic were her only respite from drudgery and insult. She wanted some free time of the good doctor to talk about her personal problems, but you seemed too preoccupied. She beseeched with imploring eyes, thinking the good doctor would understand. You took it otherwise, and hastily prescribed pills.

Fortunately, she was saved, diagnosed, treated,

well. The story could have ended in a suicidal death as well.

Again, somewhat familiar?

Well, how often suicides are missed, suicidal attempts go unprevented, simply because family practitioners are not sensitized to the subtle signs of this problem.

And suitably chastened, you note the results of a recent study that identifies two key strategies of reduction in suicide rates: physician education in depression recognition and treatment, and restricting access to lethal methods (Mann *et al*, 2005).

Physician education. That's the important key element for you.

### Case 4. The Spirited/Committed Counsellor

Look at another scenario. A 'client' talks of suicidal ideas in counselling. You, the psychologist/counsellor is empathetic, sincere, helpful. Spends long sessions with the client. Distrustful of psychiatrists who just prescribe pills and give ECTs. The client appears a difficult case, but then you know how some cases are. You persevere all the more.

The 'client' is just saved in the nick of time from getting asphyxiated by hanging.

Psychiatric examination reveals severe depression. ECTs and medication are indeed required, along with counselling.

The 'client' is better off as a 'patient'. At least sometimes, it is true this way.

A smart psychologist/counsellor would know the limits of her expertise and would not allow her activism, or personal opinion against biological approaches, to limit her professionalism. Which is, to cater to the welfare of her client, superceding all other considerations, whether of personal likes or therapeutic preferences.

And that makes you also look to the merits of the biological approach in suicide prevention. Which leads you to many studies which have found that biological approaches are indeed effective in suicide prevention. For example, higher prescription rates of antidepressants correlate with decreasing suicide rates in adults or youth in Hungary (Rihmer, Belso and Kalmar, 2001), Sweden (Carlsten, Waern, Ekedahl and Ranstam 2001), Australia (Hall *et al* 2003), and the United States (Gibbons, Hur and Bhaumik 2005;

Olfson, Shaffer, Marcus and Grenberg, 2003). Geographic regions or demographic groups with the highest selective serotonin reuptake inhibitor prescription rates have the lowest suicide rates in the United States (Gibbons, Hur and Bhaumik, 2005) and Australia (Hall et al, 2003). Suicide rates in 27 countries fell most markedly in countries that had the greatest increase in selective serotonin reuptake inhibitor prescriptions (Ludwig and Marcotte, 2005). Patient population studies report lower suicide attempt rates in adults treated with antidepressant medication (Simon, Savarino, Operskalski and Wang, 2006) and in adolescents after 6 months of antidepressant treatment compared with less than two months of treatment (Valuck et al, 2004). Randomized controlled trials can be informative when higher-risk patients are studied and indicate an antisuicidal effect for lithium in major mood disorders (Theis-Flechtner et al, 1996) and clozapine in schizophrenia (Glick et al, 2004; Meltzer et al, 2003).

That leads to a healthy respect for biological findings, and a new found appreciation for what the psychiatrist tries to do with his suicidal patient. And a healthy collaborative initiative of psychiatrist-clinical psychologist results, to carry the mental health movement forward.

### **Case 5. The Stunned Psychiatrist**

The patient comes, promptly referred by a sensitized family physician. Major depression is the diagnosis. ECTs and antidepressants are prescribed. The mood uplifts, the patient smiles after many months, relatives are gratified, you, the psychiatrist, once again convinced about the merit of recent biological advances which have revolutionized psychiatric care.

Except for one nagging problem. The patient appears well, but seeks more time to discuss personal unresolved issues. You no longer have the time, rather have poor inclination to devote time for 'unproven procedures' like psychotherapy, when clear-cut guidelines of biological approaches seem so appropriate. You contemplate sending the patient for 'some psychotherapy, or counselling, or whatever', but are concerned the counsellor may take over the patient, or may brainwash the patient to undervalue, and finally give up, psychiatric treatment. Which would not be in her welfare. So you desist from taking that step.

The patient seeks your time. You step up doses. The patient wants to explore what's wrong inside her psyche, and her reaction to the surroundings. You, the good doctor, are busy writing the latest in the string of 'me-toos' that promise alleviation of life-situations.

You are baffled when you get a call that your patient has made a suicidal attempt after ostensibly recovering from a major depression. And rather than look to the obvious, and offer her psychological succour, you look into the literature to find justification why suicidal attempts may be made even after the patient's depression appears ostensibly controlled. How the newer antidepressants may carry a risk of increased suicidal attempts etc. And feel suitably enlightened, though equally perplexed. How could something that removes depression increase chances of its most important sequelae? The thought hankers in a logical corner of the mind, but is promptly silenced by overwhelming research data that it indeed is so.

Come to think of it, again, not that unfamiliar a scenario. Which prompts the biologically oriented you to look for evidence whether psychosocial approaches work. And you find it does:

'Promising results in reducing repetition of suicidal behavior and improving treatment adherence exist for cognitive therapy (Brown et al, 2005), problem-solving therapy (Hawton et al, 2002), intensive care plus outreach, (Hawton et al, 2002) and interpersonal psychotherapy, (Guthrie et al, 2001) compared with standard aftercare. Cognitive therapy halved the reattempt rate in suicide attempters compared with those receiving usual care (Brown et al, 2005). In borderline personality disorder, dialectical behavioral therapy (Hawton et al, 2002) and psychoanalytically oriented partial hospitalization (Bateman and Fonagy, 2001) improved treatment adherence and reduced suicidal behavior compared with standard after care. Intermediate outcomes such as hopelessness and depressive symptoms improve with problem solving therapy, and suicidal ideation is decreased with interpersonal psychotherapy, cognitive behavior therapy, and dialectical behavioral therapy (Gaynes et al, 2004).' (Mann et al, 2005. Parenthesis added.)

Suitably chastened, the psychiatrist develops a healthy respect, and curiosity about psychosocial approaches to suicide prevention and control, and by extension, towards their role in all other conditions. The biological fixation is got rid of, and come to think of it, serves the biological approach better. For blind

followers hardly contribute to any significant progress anywhere.

And the psychiatrist also listens to what his clinical psychologist colleague has been saying all along. Suddenly her views no longer appear a rant. And the background is now set for a forward thrust to the mental health movement based on mutual respect and healthy give and take of ideas and approaches.

### **What Do The Vignettes Implore Us To Do?**

A question that would arise in some of you is: what do these vignettes try to achieve. Well, if even now an answer has to be given, let me say they draw attention to what happens, but need not really. Saner approaches to suicide prevention are available, if only care-givers and the lay intelligent citizens are aware of what can be done, and get rid of some easily removable mental roadblocks.

All that the vignettes describe happening in their initial part, really need not be happening at all. For we now know that although suicide is a complex, multifactorial medico-social malady, we also know some simple straightforward means can work to reduce suicide rates and prevent the next suicide in one's own neighbourhood, one's circle of acquaintance, one's patient population. And the movement to make society suicide free is really a tangible, though distant, goal.

But before we decide to do something actively about it, and get charged to really make society suicide free some day, let's know some ground realities, and then lay down a relevant action plan.

### **Ground Realities**

#### **1. Completed Suicides**

About 873,000 people die by suicide every year (WHO, 2006). These are 2002 figures, which have risen to a million, according to some authorities (2006 WMHDay Educational Packet, 2006). 1998 figures for India (that is the latest WHO Figure available as per my knowledge) were 12.2 males and 9.1 females per 100,000, that is, 21.3 per 200,000. Which means, more than 1,00,000 of completed suicides are by Indians, according to today's population figures (WHO, 2003). In 2001 the yearly global toll from suicide exceeded the number of deaths by homicide (500,000), and war (230,000), (WHO, 2004).

Suicides are under-reported by 20-100%. Which means it is more likely 13,00,000 people all over and 1,60,000 in India must be dying of suicide every year (taking mean of 20-100% reporting i.e. 60%; Singh and Singh, 2003).

The World Federation For Mental Health gave a slogan for Mental Health Day, 10 Oct 2006. This year's campaign theme was significant in that it was related to mental illness and suicide:

*'This year's campaign theme is "Building Awareness-Reducing Risk: Mental Illness and Suicide." It was selected to call attention to the fact that suicide is often a consequence of failing to recognize and treat serious mental illnesses, such as depression and schizophrenia. Studies from both developed and developing countries show a high prevalence of mental illness among those who die by suicide. The World Health Organization estimates that, of the 1 million people who die from suicide each year, up to 90% have at least one, often undiagnosed and untreated, mental illness or abuse alcohol or other drugs. These facts should motivate governmental bodies and officials to pay greater attention to the negative social and economic consequences that result from failure to implement progressive national policies and strategies to address the unmet needs of people with mental illnesses and at-risk for suicide' (2006 WMHDay Educational Packet, 2006).*

The key point to be noted here is that 90% of the estimated 1 million who died from suicide had an often *undiagnosed* and *untreated* mental illness, or suffered from alcohol or drug abuse.

In other words, means to diagnose and treat mental illness, alcohol and drug abuse can drastically reduce suicidal deaths. That's it. Plain and simple.

Another important point is not to resign to the inevitability of suicide:

*'One of the key messages that the World Federation for Mental Health hopes will be communicated through local World Mental Health Day campaigns is that suicide should not be accepted as a tragic but unavoidable aspect of mental illnesses. A number of research studies have shown that at least one-fifth of suicides among people with serious mental illnesses are preventable' (2006 WMHDay Educational Packet, 2006).*



This is very important for professional caregivers to understand. For suicide prevention strategies work, and need more committed implementation. Resignation to the inevitability of suicide is itself suicidal to the goal to make society suicide free at some time in the near/distant future.

## 2. Attempted Suicides

Attempted suicides are eight to ten times the number of fatal suicides (Heyd and Bloch, 1984). This means more than 8.7 million all over the globe and nearly 1 million in India attempt suicide every year.

We know how much burden is placed on caregivers and health-care delivery systems when a suicidal attempt is made, besides of course its psychosocial sequelae.

Completed and attempted suicides are reaching epidemic proportions and hence qualify to be made the focus of public health policy in India and abroad.

## 3. Three-Pronged Attack

What do we do? Let us look here at a three-pronged attack.

### i. Reduce Social Isolation

Suicide is found more in the widowed, single or divorced, those with alcohol or drug abuse, those with chronic physical and mental illness, and those living alone or in lodging homes. The key factor is social isolation. Hence methods to reduce social isolation are the first important step in reducing suicide rates. We shall look at some methods to prevent social isolation in describing population at risk sometime later in this communication.

### ii. Prevent Social Disintegration

Social disintegration is another notable factor responsible for the rise in suicides rates in societies. For example, Lithuania reported the world's highest suicide rates following collapse of the former Soviet Union (Haghighat, 1997). Similarly suicides are more common in migrants and changing populations, who experience social disintegration (along with social isolation). Hence preventing social disintegration is another important step in bringing down societal suicide rates. We shall come back to this later.

### iii. Treat Mental Disorder

This is probably the most important step in reducing suicide rates (which is not to devalue what

other approaches can, and should, achieve of course). Various authorities quote figures that between 90% (Mann et al 2005), 95 percent (Sadock and Sadock, 2003) and 98 percent (Bertolate, 1993) of all persons who commit or attempt suicide have a mental disorder.

Depression is one psychiatric disorder where suicidal threat is the greatest. It accounts for 80 percent of this figure (Sadock and Sadock, 2003).

*'All of the warning signs of suicide are magnified in importance if the patient is depressed. Although most depressed people are not suicidal, most suicidal people are depressed. Serious depression can be manifested in obvious sadness, but often it is rather expressed as a loss of pleasure or withdrawal from activities that had been enjoyable'* (Warning Signs of Suicide, 2006).

Psychiatric disorders are present in at least 90% of suicides and more than 80% are untreated at time of death (Henriksson, Boethius and Isacson, 2001; Lonnqvist et al, 1995). Depression is untreated or undertreated in general, (Hirschfeld et al, 1997; Coyle, 2003), even after suicide attempt (Oquendo, 2002). Thus, treating mood and other psychiatric disorders is a central component of suicide prevention (Goldsmith, Pellmar, Kleinman and Bunney, 2002). Therefore better and more affordable psychiatric care is the first important step in suicide eradication.

Although most depressed people are not suicidal, two-thirds of those who die by suicide suffer from a depressive illness. About 15 percent of the population will suffer from depression at some time during their life. Thirty percent of all depressed inpatients attempt suicide (Facts and Figures, 2006). Hence specialised Centers to treat Depression, like there are Heart Institutes, are the need for the hour (Singh and Singh, 2003).

## 4. Action Plan

Hence to make society suicide-free, a three-pronged attack is necessary (Singh and Singh, 2003):

- 1) Reduce Social Isolation.
- 2) Prevent Social Disintegration.
- 3) Treat Mental Disorder.

Moreover, the attack will have to be mounted on a war footing. The need is to first of all identify suicide prevention as public health policy. Just as we think in terms of malaria or polio eradication, or have

achieved smallpox eradication, we need to work towards suicide eradication. Just as we have got sensitized to the AIDS epidemic, we also need to be aware of the suicide epidemic raging all around us.

If that appears farfetched, just remember that man landing on the moon, wireless communication, digital mobile communication technology, and the Internet were all farfetched ideas once upon a time.

The need is to become aware of the problem, not get overwhelmed by the enormity of the task, and plan concrete steps towards achieving the goal of making society suicide free.

### Concrete Steps

The problem having been identified, what concrete steps could be taken in the form of points of action need to be identified by concerned individuals and agencies as well. Let us make a start with some points:

#### **I) Identify the population at risk (these can suffer from social isolation and social disintegration)**

- a) Those living alone.
- b) Widows without children and without financial security.
- c) People living alone in lodging homes for prolonged periods.
- d) Those who suffer great financial loss or severe loss of self-esteem.
- e) People without social or financial support (e.g. recent farmers' suicides)
- f) Those who have made past suicidal attempt.
- g) Psychiatric patients with suicidal ideation, or with past suicidal attempt.
- h) Those chronically ill with medical illnesses like cancer, AIDS, Chronic renal disease, other debilitating illnesses etc.
- i) Students failing SSC, HSC exams with stressful parent-child interaction at home and/or no one to communicate with.
- j) Migrants with poor financial/ social support. They are likely to suffer the greatest social disintegration.

For a further exposition, see Risk Factors for Suicide (2006) where psychiatric disorders, past history, genetic predisposition, neurotransmitters, impulsivity and demographics of risk factors are succinctly stated.

#### **II) Establish Centers to treat Depression, like there are Centers to treat Cardiac Diseases**

At least 90 percent of people who kill themselves have a diagnosable and treatable psychiatric illness — such as major depression, bipolar depression, or some other depressive illness; as also Schizophrenia, and alcohol or drug abuse, particularly when combined with depression. Family histories of suicide, suicide attempts, depression, or other psychiatric illnesses are as important.

Depression emerges as a key diagnostic entity in suicide. Hence, as mentioned earlier, Depression Centers to treat it, as well as well sensitized family physicians who can diagnose (and possibly treat, at least its simpler and early cases), with suitable patient awareness and public awareness campaigns through such specialized Depression Centers, is the need of the hour.

#### **III) Remove Social Stigma attached to suicide/ suicidal attempt by mental health awareness campaigns that Depression is treatable, as are all psychiatric sicknesses**

Public campaigns need to be mounted on a war footing that depression indeed is treatable, that the warning signs of depression and impending suicide are to be recognized and handled, like the warning signs of any clinical condition or catastrophe. Related intimately with this is removal of the stigma associated with psychiatric illness, with suicidal attempt, with labeling of patients, with the social discrimination and boycott they and their care-givers experience. And equally important, support groups for the survivors of suicide attempts, as well as for the relatives of those who have had to face a suicide/suicidal attempt in their family- all these are crying needs of an enlightened and socially conscious society and citizenry.

#### **IV) Socio-political changes may be necessary, but gross destabilization is to be avoided**

This is a rather under-researched area today, but needs further robust evidence based enquiries. Whenever social transitions are abrupt, disruptive of traditional means of support and succour, and cultural

onslaughts take place without developing appropriate means of emotional and social support, not just the socio-cultural fabric is disrupted, the sequelae are gross deviance in behaviour of vulnerable populations. The commonest to suffer are those at the fringe of existence. And it does not require much to push some of them off the brink.

Gross destabilization of societies, and wholesale rejection of traditional support systems may wreck havoc with societies' and individuals' fragile psyches. Spurt in suicides, addictions, delinquency, and interpersonal violence can be agonizing sequelae.

The obvious solution is we plan for social change that grows on members of a society rather than being hastily implanted, uprooting well established traditional support systems. A change that grows on to, and with, the individual, rather than uproots and alienates him from himself, and others.

### Concluding Remarks

Suicide is multi-factorial, and a challenge before the mental health professional of today, as much as a socially conscious government, an intelligent public, and a committed care giver. A movement that adopts some of the methods outlined above, which is ready for a protracted fight, is imbued with the will and desire to work to make society suicide-free one day, and never loses sight of its objective, howsoever distant seems the goal, and howsoever dim the prospect of reaching it appear the picture at present- that is the goal and spirit we must envisage for the modern man in modern society. For besieged though he may be with stressors from numerous quarters, he has also developed the resilience to fight back, and survive. And scientific evidence and modern medicine, with all their drawbacks, are still firmly determined in working to relieve his misery, to offer cure at times, but to attempt to find comfort always (Singh and Singh, 2006). Committed in spite of numerous constraints to find better and more efficient means to reduce distress, remove disability, to confront and prevent premature death.

The three pronged attack of reducing social isolation, preventing social disintegration and treating mental disorder will be the method to reduce distress, prevent disability, and prevent death in the field of suicidology.

Let this be the path for the committed scientist, care-giver and clinician to charter in this century.

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**Note :**

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## Transplantation – Some Critical Issues

P. Seshadri

Head, Dept. of Philosophy, Guru Nanak Khalsa College, Mumbai.

Email: seshadri4all@hotmail.com

### Introduction : Why Philosophy ?

As the world keeps shifting towards a globalized structure, 'materialism' becomes the key word. As more money comes into the hands of those who make an effort for it, the greater the kind and degree of comforts, privileges and facilities that they can garner. Of late even education has come within the ambit of the service-sector, so much so that any specialized field is available to the highest bidder.

Resources and capacities also define the way we look at the world, our professions, our life and our culture. The impact of the progress in science and technology can be seen in the paradigm shift in values and its effect on an individual's thoughts, ideas and goals. A question that any reasoning individual wants to answer is: 'what is my place in this universe'? The answer will indicate how we go about protecting the position we value to be our legitimate gain.

But before we answer this question, another one: 'why philosophy'? For those whose concerns are limited to the factors of daily life, philosophy, whether at the intellectual or pragmatic level, is a waste of time. For those who need a proof for everything, like the logical positivists, it is sheer nonsense. For those who have lived their active life and need something to keep them engaged in old age, philosophy is an excellent pastime. And for those who are none of these, philosophy is just philosophy, an ambivalent and mysterious term whose meanings others have to decipher. But as human beings, most people who have felt the need to exercise their rationality or intellectual prowess, spontaneously or out of necessity, raise questions such as:

- a) What is my life's worth?
- b) What are my duties as an individual?
- c) Should I care for anyone other than myself?
- d) Is life sacred?
- e) Should God's purpose, or nature's ways, and man's goals be congruent and consistent?

f) Do I owe anything to the future generations?

Philosophy not a Pastime or Hobby.

Any one trying to answer such questions is indulging in philosophy – philosophy is neither a pastime for an idle mind, nor a hobby for the leisurely. It is a serious activity for all those whom claim to be human beings, for it has to do with values, goals and methods within the context of a society's culture in its totality at any given time. Difficult for those who do not want to take the trouble to think, analyze and be critical; but unavoidable because a normal person is programmed to philosophize. Otherwise, we would not have realized the heights of intellect, knowledge, culture and civilization that we have reached and are trying to preserve.

One such pinnacle has to do with life and health.

The question raised above ('what is my place in the universe?') can be answered from three angles:

1) From the religious perspective, man is God's agent and partner in running the universe according to the divine plan. Man is 'duty-bound' to participate in the divine mission. In other words, man is just a spoke in the divine wheel and keeps moving with it – he has no significance otherwise. For the faithful, though, man is definitely God's 'special' creature.

2) Evolutionism suggests that the laws of the universe (or nature) are homogenous and that man is subject to all these as any other living or non-living thing in the world. He is not unlike the rest of nature – he is just a 'thing' like the other things around. Mankind is just one small speck in the universe. It is man's foolishness to think of himself as a special creation of God.

3) We can view man as autonomous – he has his freewill; and within the universal laws of nature, man exercises his reason as a voluntary agent and discovers the axiomatic principles of morality. So man is significant because he does not merely live an organic or instinctive life. His life is organized in terms of certain values that only he can realize, within the framework of his needs, instincts, habits and reason. He is not a thing, not an animal, not a God, and yet

something of all these. Man is an ethical being and his place in the universe is determined by his value-system. This will encompass his power of logic, an inherent sense of dignity and responsibility, beliefs and goals, rights and privileges, his life-plan and the endowments he has shared or bestowed for posterity. His ethical paradigm will consist of defining the basic human values, a holistic perspective of these values and how to realize them, how to determine and achieve the highest good in any given situation and how much his actions reflect his concern for the future generations.

One of the values that man wants to realize and promote is life. It is in fact one of the basic tendencies of all living things; but whereas animals and plants have to manage within their predominantly instinctive capacities, man can be creative – he can use his knowledge, skills and ideals to fulfill his needs, to an extent that the other living things cannot. He is in a much better position to reorient himself to identify, understand, and promote such favourable conditions as are necessary to sustain life.

### **The Issue of Transplantation:**

One contemporary method to sustain life is transplantation. It is one field that raises many moral questions, looking at the way it has come to be offered and promoted as a scientific tool for enabling a diseased person to live for some more years. There was a time when no doctor or medicine was seen in any advertisement in the newspapers or the TV. Today medical services and health-care products are on par with other services that people pay for and enjoy because of availability, affordability and, to some extent, necessity. Hospitals, doctors, medicines and tonics, food supplements and medical tourism promote themselves through direct or surrogate marketing. They enjoy corporate sponsorship and insurance coverage, making for a commercial jackpot for the promoters. And there are those who want to avail these to just be ‘modern’.

Here we are talking of moral scrutiny of one focus of medical technology. Transplantation is the surgical procedure of removing certain body tissues, parts, functional organs (partially or fully) from living or non-living (brain-dead) persons and implanting these in some one who is in need - to restore his health, or to extend his life. It is unlike the common corneal or skin tissue transplant, because organ transplantation necessarily involves a cadaver (a perpetually comatose casualty from an accident or one who has

suffered brain-death), or a living person who ‘can spare’ and is willing to donate an organ or a part of an organ, or a foetus. The purpose could be therapy, or for education and research. The beneficiary could be victims of heredity or trauma, or those suffering from organ damage or failure due to disease, or just ‘guinea pigs’.

### **Arguments For and Against**

Those who are in favour argue that:

- Life has the highest value; hence must be preserved at all cost.
- The higher the risks, higher the cost – benefits have a price-tag attached.
- Regularization will reduce unethical practices and reduce the demand-supply gap for organs.
- Vital organs can be harvested in course of time.

Those not in favour say that:

- It is exploiting the donor (a near and dear one, or a third party in need of money).
- It violates the principle of equity, as there is no national reserve or pool or organ bank. The benefit almost always is loaded in favour of the money-bags.
- Marketing strategies convert a luxury into a need, a craze and a fashion. An indirect implied suggestion by a medical authority is enough to put the fear of death in the patient and his/her relatives and an attractive offer is all that needs to be made.
- Is there any guarantee of a better or a bright future for the patient or the donor? And, at what cost?

### **Life, a Gift or Product ?**

In a sense the dispute boils down to whether ‘life is a gift’ or ‘life is a product’. For the religious and idealistic mind, life is sacred and has to be revered as the reward one earns due to *karmic* deeds. That means, I am beholden to God for giving me this gift of life and it includes all the physiological and anatomical accessories that make this body so energetic and active. (How these organic assets determine my personality or my existence as a person is beyond this essay). Naturally I have no business to interfere with what God has created according to His eternal wisdom and goals. I shall not, therefore, do

anything that will cause me any physical harm, deformity or dysfunction. Parting with an eye may not affect my life drastically, but definitely parting with a vital organ (in part or full) necessarily impacts my over-all biological functioning. And that is going against the law of nature or the divine will. It benefits neither the donor nor the recipient. And if, by any chance, it becomes a mass affair, it will lead to a world full of ill-equipped, drug-dependent human beings, not entirely fit. It is therefore immoral.

For the ones who believe in materialism and private enterprise, life is not a gift from a strange God. Life is product due to the cells one has inherited and it is due to the genes one is born with. It has nothing to do with one's *karma*, now, before, or after. To be born in this world is purely a lottery that one has won by luck due to his/her parents. So my body and its organs/parts are my private property. It is my concern and responsibility as to how I deal with these, not any one else's. It is also not a matter for public debate or opinion, for I am entitled to do what I want with my assets. And if I have an asset, why should I not use it for others' benefit or mine, any which way I deem fit?

### **Ethical Issues in Transplantation**

From a philosophical and ethical perspective the following issues emerge:

A] Is the human body, with its belongings, something that can be commercially dealt with? Nature is inviolable. If nature, or God, has given a structure and function to the living things, can man go against the law of nature, except at his own peril? When we look at the system called nature, there is a pre-determined role that all living and non-living things have to play. Man is one among the multifarious entities and all natural entities are inter-dependent. Whatever the claims of medical scientists about human beings able to lead a normal life with one kidney or a part of the liver, the questions, from a futuristic view, remain as to what the quality of life of the donor will be. Is the very act of parting with what is God's gift ethical or unethical? Giving life to someone or enabling someone to live a better or a longer life is morally praiseworthy and religiously rewarding. But is it ethical to go against one's own nature?

B] Who will decide the donor as well as the recipient? Medical fitness can be determined according to medical standards. The focus

predominantly is on the recipient. Will therapeutic care reduce for a potential donor? Statistics show that the success rate is higher if the donor is from the same family, race or ethnic background. Ethics committee in hospitals and counseling teams do have a significant say in the decision-making process. But one cannot rule out the possibility of inducements and extra-medical considerations.

C] Who should benefit? There are those who suffer due to natural causes and may have a favourable chance of survival. What about those who suffer a damaged organ due to self-indulgence, like alcoholics?

D] Management of suffering and pain is admirable and should be encouraged, no doubt. But prolonging a life just for the sake of it, without the person being useful to himself or society, does not seem to make any sense. In my opinion, death, from the religious point of view, is a step towards eternal life, and the course of natural life should be allowed to run its course without undue interference. In transplantation, both the donor and recipient need to readjust their routine life, with or without pain. While the recipient knows that he has to suffer the pain of his terminal disease, it is the donor who has to entertain new kinds of pain, in whatever form it comes.

E] Is it right, or wrong, to sell or share organs for money, or, without it? I had said earlier that there is a price-tag attached to transplantation. We read of people selling their organs not out of a sense of charity, but only for the money that it gets, out of economic compulsions. Parents donate their organs for the benefit of their children or spouse, out of love, not for money. Their only desire is to see that their sick child or husband or wife gets a new lease of life. Can one be sure that all will be well in the future? Will life be the same with intake of drugs throughout one's life?

F] The ordinary man is entirely dependent on the team of doctors for the details and quite possibly he may not be well-informed of all the nitty-gritty. There is a selfish desire in every human being to live as much as possible, and there is nothing wrong with it *per se*. Reducing the pain of suffering and/or death is a legitimate desire. But one cannot rule out one's ignorance or lack of informed opinion being exploited by emotional blackmail. Informed opinion should encompass alternative treatments that are available.

G] The donor (living or dead) is looked upon as a symbol of compassion, sacrifice and magnanimity.



In certain cases the patient's view is not considered or understood from his perspective. It is necessary to treat the whole person and not just the disease. Physiological imperatives need to be tempered with humanism. This could be possible in small families that are not too orthodox.

### **The Indian Context**

In the Indian context, there are issues that are peculiar:

1) In our predominantly paternalistic culture, the principle of autonomy versus determinism cannot be easily resolved. In most of the cases, it is the wife, the mother or the elderly who donate an organ. This does smack of a gender-bias, loaded heavily against women. Old grandparents will have no qualms about donating an organ towards their sunset years. But people who can live a healthy life for a good number of years in the normal course should be quite circumspect when it comes to living without a part of one's life-sustaining organs.

2) In a society where caste and class considerations still exist, is a secular approach possible to transplantation? Will inter-caste, inter-religious and inter-community cadaver transplantation help to increase social inclusiveness? Is it possible to have a secular view that goes beyond the religious framework?

2) Surrogate-decision making is another factor to be considered. The competence, motives and intentions of the family and the relatives with respect to the needs of a sickly person calls for a critical appraisal. One cannot permit incompetent minds and vested interests to decide on such a vital issue.

3) The principle of equality and equity needs to be looked into. Is it a monopoly of the rich, or everyone's interest will be protected by state policy and instruments (e.g., The Unified Anatomical Gift Act)?

4) Our society is known for its culture of corruption. There are ordinary labourers whose organs have been removed without their knowledge by unscrupulous members of the medical fraternity, in league with unethical brokers, in the name of blood test and medical examination. Trading in organs will be like any other commercial money-making enterprise in the hands of the corrupt.

5) From the moral perspective, it is difficult to decide what will be the 'proportionate good', if at all

it can be quantified, with respect to transplantation. It is possible that life will be cloned and illegitimate foetuses will be allowed just for the sake of harvesting organs. Will there be any respect or reverence or value for life in such a scenario? Transplanting cells from foetal tissue has shown encouraging results in the treatment of Parkinson's disease, diabetes, Alzheimer's disease, some liver disorders and injuries to the nervous system. Does the foetus have an ontological identity as a person, or is it to be discarded once its organs have been removed?

5) All major religions speak against abortion. Once transplantation is the in-thing, I wonder whether elective abortions will become regular just for the sake of harvesting organs. As an alternative, will it not be worthwhile if condemned healthy prisoners on the death-row (and we have many in our prisons!) are given the opportunity to do a penance by donating their organs before these suffer a damage? They are to die, in any case, and perhaps they will go to the gallows with a clear conscience that they did some good deed for some one's benefit.

### **Concluding Remarks**

Transplantation encompasses psychological, ethical, legal, medical, social, financial, religious, cultural and futuristic aspects. There are people who have benefited by transplantation and there are those who have not. The recipients know their medical parameters and the donors have to discover theirs. There is no guarantee that the expected quality of life for either will be hunky-dory, or that it will be an albatross round their neck for the rest of their life.

Let me conclude by saying that life, whether it is a gift or a product, is to be valued and celebrated. But it is better to suffer death at the earliest if the body is going to be kept alive only by technology and medicines. At least I can die with the feeling that my earnings and savings will go to my family, not to meet unending hospital bills. Prolonging life is meaningless if, post-transplantation, it becomes expensive, regimented, unmanageable and unenjoyable.

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### **Case studies:**

- a) K. Venkatesh's mother: "I am sure euthanasia for organ donation will become legal sooner or later. (Hyderabad, Dec. 2004).

- b) Is the EEG a fool-proof test of brain-death? – (Mark Young, Coroner, USA).      c) Rahul, a student of third-year engineering – Apollo Hospital, Hyderabad, Oct-Nov. 2006).
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### **About Author**

**P. Seshadri**, The author is also Chairman, Board of Studies in Logic & Philosophy, and a member of the Academic Council, Faculty of Arts; and Board of Examinations, University of Mumbai. This paper is prepared for the National Seminar on Bio-ethics, K.G. Joshi – N.G. Bedekar College, Thane, January 24<sup>th</sup>-25<sup>th</sup>, 2007). Mailing address: Prof. 21/2, Laavanya, Chheda Nagar, Chembur, Mumbai 400089. Tel: 25284002 (R) / 24096234 (C).

## Surrogate Arrangements: Market of Living Laboratories

Trevor Allis

*Sophia College for Women. Head, Department of Philosophy Mumbai 400610.*

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### Introduction

The benefits and boons of the rapid advances made in biomedical technology the world over is there for all to see and use – whether it be conducting a safe abortion or identifying and isolating cancerous cells for elimination. An area of biomedical technology that has greatly benefited especially married couples, is Assisted Reproductive Technologies (ART) – IVF being the first and a well known technique of them all. Other artificial procreation techniques are Artificial Insemination (AI), Gamete Intra-fallopian Transfer (GIFT), Zygote Intra-fallopian Transfer (ZIFT), Intracytoplasmic Sperm Injection (ICSI) and Assisted Hatching – Embryo Micromanipulation.

In recent times, especially in India, an unconventional reproductive arrangement that has attracted attention and is surrounded by controversy is surrogacy. Surrogacy is a medical cum social arrangement, using ART, between a woman – the surrogate - and (usually) a married couple where the former agrees through a quasi-legal contract to become pregnant for the latter. The surrogate further agrees to relinquish her claim as well as parental rights over the child in favour of the couple at the time of birth in exchange for a fee. In almost all surrogate arrangements it is assumed that the couple is infertile – generally, the wife – and that the husband is the ‘father’ of the resulting child given his genetic contribution.

As mentioned above, it is doubtless that ARTs in general and surrogacy in particular have brought unimaginable joy and happiness into the lives of married couples who are desirous of having children but cannot have them as ordained by nature. It would therefore be appropriate to start with some of the advantages of surrogacy.

### Advantages of Surrogacy

1. A surrogate arrangement is a boon to childless couples, childlessness being caused through infertility in either of the partners. For Indian women the anxiety to have a child is even greater for it could have disastrous implications on her marriage. Women who find themselves accused of being responsible

for childlessness begin to worry whether their husbands will abandon or divorce them apart from the real prospect of abuse and persecution by relatives.

2. Some pregnancies are high risk and could pose serious risks of premature births leading to deformities; at its worst, such pregnancies could prove fatal either to the life of the mother or child, or both. It is said that these are good enough reasons for transferring the burden of risk from one woman to another thereby benefiting the intending parents as well as the child. Thus the labour of the surrogate is nothing short of altruism, indeed a noble deed, why should anyone be against altruism?

3. Surrogate arrangements make possible the creation of non-traditional families. Though surrogate arrangements were initially designed to overcome the problem of infertility, the procedure has in time gained popularity even amongst single men and women, homosexuals, and even amongst couples with no apparent infertility problem at all.

4. Intending parents get far more satisfaction through such arrangements as the resulting child is genetically related to one or both the partners; after all blood runs thicker than water. Surrogacy scores high in comparison to adoption where the child is a complete genetic stranger to the family. Moreover, the process of adoption is a tedious and time-consuming process taking as much as 2 to 3yrs.

6. In recent times, the practice of surrogacy has taken the form of a source of livelihood for women whose husbands are either unemployed or poorly paid. A surrogate arrangement thus not only makes the woman financially independent but also empowers her.

### Problem with Surrogacy

Notwithstanding the benefits and advantages of this new artificial means of procreation it is an area that is fraught with ethical decisions that have the potential to create and play havoc with established moral concepts and values, disrupt families and distort family ties and most importantly bring taking procreation into the market place. Hence surrogate

contracts need to be approached with caution and reservation.

### Who is the 'Mother' of the Child?

One issue that has attracted considerable concern and debate as a result of surrogacy is the concept of 'mother'. Who is the 'mother' of the child in a surrogate arrangement? The new technique forces this question on us for re-examination because it separates the functions and contributions of the process of having a child among different women which otherwise, i.e., naturally, should have been assumed by one and the same woman. The process of procreation involves three contributions

- a) A woman who contributes her eggs
- b) A woman who carries the pregnancy
- c) A woman who nurtures and rears the child

Let us call them: genetic mother, gestational mother and social mother respectively. Who of the above is the 'mother' – the *real* mother so to speak, in this arrangement of three women and a baby? The question resolves itself into: Is the genetic mother or gestational mother the true mother of the child, where a dispute over the custody of the child arises?

One seemingly obvious and straightforward way to decide the matter is analogous to answering who is the father of the child. Since the father is unambiguously the one who contributes his sperms, equally, it may be argued, the woman who contributes her eggs should unambiguously be declared the mother of the child. I believe this response not only reinforces a patriarchal view of 'mother' in that it defines mother in terms of the definition of father, but also an oversimplistic understanding of motherhood. It is true that genetics is a helpful tool for law to settle the question of 'who is the mother?' in a determinate way when a child custody dispute arises; but in moral matters we ought to maintain some reservations in adopting a mammalian understanding of mother. The woman who has donated her eggs (for money) agrees to surrender or transfer her rights and duties in respect of the child to the gestational mother. It would be reasonable to say then that the gestational mother is the true mother in virtue of her being the recipient of the transfer of rights in addition to the fact that she will be giving birth to the child.

It is arguable then that the gestational mother has a greater claim than the genetic mother and her claim would get weightier if she also made the genetic contribution. In order to pre-empt such a situation,

couples usually see to it that the woman who gestates is not the same as the woman who donates her eggs. The only situation where the gestational mother would have a lesser claim would be where the genetic contribution came from both the intending parents as against the father only. This would considerably weaken her claim given the number of contributions made by her (only gestating) against two contributions made by the couple (both are the genetic parents). Even so, the genetic mother's claim – whether she is the wife of the child's father or an anonymous donor – is weakened by the fact that she is entirely nonexistent from two actual core roles involved in mothering, viz., carrying the child in the womb for nine months during which she establishes a close physical, psychological and emotional relationship with the child, and the role of feeding, nurturing and caring for the child immediately after birth. Moreover, this is in keeping with both the verb as well as noun meaning of mother. As a verb mother means to take care, to nurture, to love, etc.; as a noun it means to breast-feed. Who other than the gestational mother assumes these roles? This fact is significant, for to just write it off is the very negation of a respectable sense in which we understand and use the term mother in our everyday discourse. There is well-established evidence to show that the emotional bond between the pregnant mother and baby is desirable for successfully rearing babies. The social and emotional dimensions of 'mother' largely constitute the conceptual structure that informs our understanding of the concept of 'mother'. Thus, morally and psychologically, the gestational mother will always have a greater claim over the child she carries even if she makes no genetic contribution.

### Children as Commodities

I shall now focus on the view that opponents generally bring against a surrogate contract, namely, that it leads and involves the commodification of both women (the surrogate) and children and shall attempt to reinforce these charges. I shall begin with the charge of children as commodities.

What is a commodity? In order to see this consider what is involved in a market transaction. There must be a good or commodity for which there is a demand, there must be a seller who wishes to sell, a buyer who is willing to pay a (monetary) consideration for the good, and very often there is a broker or middleman or agent. The framework of the transaction is governed by a written contract, which is legally enforceable, and the tacit



understanding is that each party acts in a manner aimed at protecting his own rights and best interests within this framework. The issue before us is to specify the respects in which a surrogate arrangement treats children as commodities and why such treatment is morally objectionable.

First, there are clear parallels between a surrogate arrangement and a market transaction. The intending parents are the buyers because they are willing to pay, the commodities are eggs, parental rights, the child, and 9 months service; the egg donor and the surrogate mother the sellers, while the doctor(s) and surrogate agency are the brokers – they hire women, screen them and inseminate the chosen ones, and are responsible for facilitating the contract. A surrogate arrangement corresponds exactly to the formal requirements of buying and selling commodities in a market.

Second, the purpose of screening and interviewing the surrogate is akin to clients specifying the kind of product they want and the industry responds with ‘customized product’, or what in marketing is called ‘product differentiation’. Surrogate agencies allow intending parents to specify characteristics like height, colour, looks, I.Q, religion, race, in the hope that some of these traits would pass on to the offspring. Just as there are designer products aimed at satisfying selected customer needs there are designer babies aimed at satisfying the needs of the foster parents.

Third - and this is the clinching point -according to market norms, the seller transfers or relinquishes his rights and interest over the commodity in his possession in favour of the buyer for a monetary consideration. The only relevant factor, though unwritten, in the contract is that each party ensures the protection of their respective rights and interests – they should get the best deal. A surrogate contract operates on the same principle. The only relevant issues in the contract are the rights and interests of the two parties – surrogate mother and the couple. Parental rights are equivalent to property rights, they are disposable and transferable against payment.

### **The Rights of the Child**

What about the rights of the child? None of the contracting parties owe the child a right to have its best interest determined – parental trust. In order to see this more clearly, suppose it is reasonable to believe that it is in the child’s interest to remain with the

gestational mother; under the contract there seems no way of giving effect to the right. The right cannot be enforced because the father has an enforceable right in the contract that renders any such right to the gestational mother as null and void. The father has “paid” the surrogate for relinquishing her parental rights. There is no question of deciding which party is in a better position to promote the best interest of the child anymore than a manufacturing industry has to decide to look after the “interest” of its commodities or which customer can best protect the “interest” of its commodities.

These are good enough similarities and reasons how the surrogate contract replaces and disregards parental norms with respect to the rights and custody of the child with the market norms, in particular the priority accorded to monetary relationship over parental relationship. Hence it is nothing short of treating the child as a commodity.

What is morally objectionable about such treatment? Well, what is morally objectionable is that children, for that matter people, are not objects to be bought and sold. Why do we find slavery abhorrent? Why do we object to prostitution? What is ethically wrong with human trafficking? All involve an exchange of money for humans. Respect is a mode of valuation, which is distinct and contrary to monetary consideration as a mode of valuation. Humans are to be valued in terms of their rationality, moral agency, autonomy and beneficence. As Kant would say, they have inherent moral worth hence they deserve to be treated with respect. Commodities are generally valued in accordance with money; they have extrinsic or instrumental value, hence the question of respect does not arise. In so far as the terms and conditions of the rights and custody of the child in a surrogate contract is controlled by market norms in general and specifically by the wishes and desires of the couple, which in turn is acquired through monetary considerations, it leads to the commodification of the child which is morally objectionable. At the end of the day, proliferation of surrogate arrangements can only give rise to the BPO industry – Baby Producing and Outsourcing industry. If this is not commodification of children, what is?

### **Women’s Labour as Commodity**

Does a surrogate arrangement commodify women’s labour? The child is vulnerable to being treated as commodity in that the contract ignores specifying obligations of the concerned parties to do

what is in the best interest of the child. Surely, the surrogate is not in the same position as she is aware of her rights and duties, she voluntarily agrees to the terms of the contract and she signs the contract only after having legal counsel in the matter. In short, it is argued, it would not be fair to say that the surrogate mother is treated as a commodity because her autonomy is fully safeguarded and respected. But is that so?

The above defense of a surrogate contract uncritically assumes that commodification of one's body and voluntary consent is mutually exclusive. This is a mistaken argument. I shall shortly bring to light the underlying moral principle that often goes unnoticed, thereby falling prey to such a mistake. However, we first must take up two aspects of the women and commodification. First, why voluntary consent and commodification are not mutually exclusive, and second, how exactly does a woman's labour get commodified. Consider the first aspect: Am I absolved of moral guilt if I treat my neighbour cruelly because he has consented to such treatment by me? I may not treat him cruelly - that speaks about my character - but does that imply that there is nothing morally wrong with the 'cruelty contract'. Similarly, slave owners cannot justify slavery on the grounds that they do not treat their slaves disrespectfully, allow them some freedoms, or that they have consented to be slaves by contract. People involved in human trafficking cannot morally justify their deed by arguing that those trafficked are treated and given adequate respect, or that in any case they have voluntarily and legally consented to be treated that way. Despite this, why are slave owners (or slavery) and traffickers (human trafficking) not justified? The obvious reason is that there is something inherently morally objectionable with the contract itself - the consent of relinquishment of rights and interests (which involves the way people are treated) that has been extracted, whether voluntarily or non-voluntarily, by one party of another in the contract gives one of them the license to exploit and commodify the other, even if one does not actually do so.

The same reasoning applies to a surrogate arrangement. In so far as the intending parents extract a written commitment from the surrogate mother of the relinquishment of her parental rights over the child in favour of them, she is liable to be exploited and commodified, notwithstanding the fact that she has voluntarily consented.

### **How commodification occurs**

Let us now see how exactly the surrogate's labour involves commodification. The surrogate mother is reminded and counseled at regular sessions during her pregnancy to emotionally disengage from the child for fear that she may develop a parental relationship with the child rather than a relationship of a contract labourer, which it ought to be. Similarly, the contract stipulates that she should try to psychologically and emotionally sever herself from the child, thus denying the reality of the trauma the mother will go through after separation. In short, the counseling sessions and contract seek to alienate the surrogate's nine months labour from the emotional relationship that naturally develops between mother and child.

Once again, the market norm becomes clearly visible. In a market the producer is not emotionally attached to the product he produces for sale, he has no qualms about separating from the goods he owns. The surrogate contract similarly undertakes to manipulate the surrogate mother's emotions not to develop any loving or parental attachment towards the child. What is deemed more important after all in the contract is the monetary factor and not the maternal factor. And despite the fact that she agrees to emotionally estrange herself from her child she is naturally going to fail. It is this fact, Anderson points out, that the contract commodifies the surrogate's labour by requiring her to repress her parental love she naturally feels for the baby - the fruit of her labour, and denying the reality of such an emotional bond between mother and child. The contract has an inherent disregard and insensitivity towards the gestational mother by expecting her to transform her nine months labour of emotional relationship into an economic one with the same willingness and detachment as a trader does when he parts with his goods. If this is not commodification of women's labour then what is?

It would be instructional to uncover the principle which when ignored leads to the error in supposing that respecting and safeguarding the surrogate mother's autonomy does not lead to or involve her commodification. Elizabeth Anderson points out that the argument fails "to recognize that some rights in one's person are so essential to dignity and autonomy that they must be held inalienable". In other words, there are rights which are inalienable and cannot be traded off as alienable property. The

right to autonomy, for example, cannot be transferred or relinquished through the exercise of autonomy itself. The very (autonomous) act of an agent that marks him off from the category of 'commodity' cannot by that act itself include him in the category of 'commodity'. The right to autonomy is an inalienable right that cannot, without a contradiction, be turned into an alienable property. And this is precisely what the surrogate contract seeks to achieve. The surrogate mother is "counseled" into exercising her autonomy to relinquish her autonomy over the child. Her autonomy over the child is her parental love and affection which she has acquired by virtue of carrying the child for nine months. This is an inalienable right that cannot be traded off through a contract as alienable property. To do so is inherently morally objectionable.

### Legal Issues

A surrogate arrangement, at least in India, is a written contract signed on stamp paper between the surrogate and the intending parents. Problems arise where the surrogate decides to keep the child and refuses to relinquish the child to the couple, especially if she also happens to be the genetic mother. There is no legal framework to decide the merits of the case. The agreement being on stamp paper it is unclear how much of legal cover that provides the surrogate or the couple. From the contract point of view, the custody of the child should go to the intending parents. But it is arguable from an emotional or psychological point of view that the surrogate should be given custody, if she stakes claim to the child. There would have to be clear guidelines on this count if the practice is to be legalized.

What if the child is born physically or mentally retarded? Who would be responsible for the custody of the child? What if, in such a case, neither the surrogate nor the intending parents are willing to assume responsibility? Both would be legally justified in refusing to keep the child. The surrogate could argue that she entered into the contract for the money not the child; the couple could argue that they want value, i.e., a normal child, for their money. If the couple refuses to accept the child there would be great pressure on the surrogate to keep it, much against her wishes. She would have no choice in the matter if she were also the genetic mother. And this shows

the vulnerability not only the surrogate is exposed to but also the child. The surrogate and the child would be in the same situation just in case the couple changed their mind about taking custody of the child, just as the surrogate could change her mind about handing over the child to the couple. What happens to the child in such a situation? In case the surrogate, who has already been paid in advance for her services, falls sick and cannot continue her pregnancy without risk to her health, does she have a right to have the child aborted without the interference of the couple? Would she be liable to return the money of unfulfilled contract? Other scenarios would be: What if the couple seeks a divorce before the child is born? Who would be entitled to the custody of the child? What if both parents die before the birth of the child? And we again return to the situation described above.

### Conclusion

One of the aims of the paper is to highlight some of the reasons a commercial surrogate arrangement is fraught with moral and legal difficulties and decisions. Given the present state of biomedical technology, surrogate arrangements are the only alternative to infertility, apart from adoption. What is worrying is that such arrangements involve the exchange of big money and thus encourages the growth of 'living laboratories'. The IVF market, for instance, is a thriving industry; no wonder there does not seem to be any research addressed towards curing the problem of infertility. Equally worrying is whether in the near future surrogate contracts – essentially through market – would become a major, if not sole, means of acquiring children.

Is this the way children are meant to be born? We can already see other component industries that provide the "spare parts" for artificial reproduction – eggs, sperms; and now wombs – provided by brokers. The women who 'lease their womb' come from poor social and financial background – this is not empowerment, it is straightforward commodification.

One cannot stop the march of technology. What one can certainly do, however, is to demand strict government regulation of the reproductive market given the imminent presentation of the draft bill on surrogacy by the Indian Council of Medical Research (ICMR) to the central government to be tabled before parliament in 2007.

## Abortion: Rethinking and Revisited

Amita Valmiki

Head, Department of Philosophy, R.J. College, Ghatkopar (W) Mumbai - 400 086.

### Introduction

Bioethics is a branch of ethics that probes into the ethical issues found in the field of medicine and from the progress made in biological sciences. There are three basic aspects into which it furthers its investigation in life sciences. They are -

1. Ethical issues that arise in the relationship established between health care professionals and patients;
2. Wider issues of social justice in health care; and
3. Ethical issues raised by new biological knowledge and introduction of new technology in the life Sciences.

A major focus in bioethics generally, and treatment decision making in particular, is not only in the hands of health care professionals, but, today, patient's sharing and decision making plays an important role in many issues related to health care. In contemporary times, work in bioethics has focused on justice in the allocation of health care. Most bioethicists have supported a right to health care because of health care's fundamental impact on people's well-being, opportunity, ability to plan their lives, and even lives themselves. But there are few who defend an unlimited right to all beneficial health care, no matter how small the benefit and how high the cost. The new technological advancement has opened up avenues where in past it was impossible to implement.

So, bioethics today has made us think on issues like abortion, sex-determination test, euthanasia, suicide, surrogate motherhood, cloning, and a more recent development like the Human Genome Project, which seeks to map the entire human genome that will enable us to prevent genetically transmitted diseases.

If the benefits weighed are enormous, we have to consider the repercussions and measure the aftermath which cannot be underestimated. Bioethics, therefore, "is study of the moral and ethical questions

involved in applying new biological and medical findings, as in genetic engineering, neurobiology, and drug research" - as defined by Webster's II New Riverside University Dictionary.

### Abortion

Abortion as explained in Webster's II New Riverside University Dictionary is-"

1. The premature expulsion of a fetus from the womb, which may be either spontaneous (a miscarriage) or induced.
2. An operation to remove a fetus from the womb.
3. Cessation of normal growth, especially of an organ, prior to full development or maturation
4. An aborted organism.
5. One that is malformed or incompletely developed.

### Choice and Action

Abortion, in bioethics, is related to 'choice and action'. Most opposition to abortion relies on the "premises that the fetus is a human being, a person, from the moment of conception. The premise is argued for, but not well put. Take, for example, the most common argument when we are asked to notice that the development of a human being from conception through birth into childhood is continuous; then it is said that to draw a line, to chose a point in this development and say "before this point the thing is not a person, after this point it is a person" is to make an arbitrary choice, a choice for which in the nature of things no good reason can be given.

It is concluded that the fetus is, or anyway that we had better say it is, a person from the moment of conception. But this conclusion does not follow. Similar things might be said about the development of an acorn into an oak tree, and it does not follow that acorns are oak trees, or that we had better say they are. Arguments of this form are sometimes called "slippery slope arguments" - the phrase is perhaps



self-explanatory - and it is dismaying that opponents of abortion rely on them so heavily and uncritically.

Abortion is a topic that is viewed in suitability of a being as an appropriate object of direct moral concern. Ordinary moral reflection involves considering others. But which others or who ought to be considered? How are the various objects of moral considerations to be weighed against one another?

One can consider any topic under moral discussion, but can everything be thought of as an appropriate object of direct moral concern? How much beings are counted in moral sphere is not the only subject to be considered in abortion, but to what degree are they to be counted is equally important. Some philosophers (like Nozick) propose utilitarianism with regard to animals, and Kantianism with regard to humans. Similarly, the bodily autonomy argument in defense of abortion proposed by Thomson, does not deny that fetus is a person or moral patient, but sticks to the fact that fetus's claims are limited by the pregnant woman's prior claim to control her bodily destiny. So, in degree, we consider the moral patient, either the fetus or the pregnant lady - who is prior to whom?

Obviously according to Thomson, pregnant lady's wish is prior to fetus'.

Therefore, are we to morally legalize abortion? This is again discussed in connection with the fetus' status as a 'person'. It has often been thought that moral status should be tied to the condition of "personhood". It is also believed that 'persons' have moral status and their moral status is indeed more important than that of 'non-persons'. Therefore, 'personhood', on such belief, is a minimal condition for moral patiency (to be moral patient). Why do we have to accept this condition? Because moral patiency is said to be "co-relative" with moral agency (moral agents are those beings whose actions are subject to moral evaluation; while moral patients are those beings whose suffering - in the sense of being the objects of the actions of moral agents - permits or demands moral evaluation). A being has either both or neither. Considering this aspect, a 'person' is not only viewed as moral patient, but as specially privileged elite among moral patients, who possesses rights as well as interests.

### **The Jane Roe Case**

On this line if a fetus is considered 'a person', then it/he/her not only possesses definite rights but

also has vested interests. In the U.S.A., in 1973, in the Jane Roe case (a woman filed a case in Texas under this pseudonym), a woman was forbidden to go in for abortion of the fetus except when needed to save the mother's life. At that time Justice Blackmun wrote the majority opinion affirming the woman's right of privacy and due process and the right to an abortion up to the end of the first '—' three months of pregnancy. After the first trimester, the opinion said, States may make laws restricting abortion, if compelling state interest can be demonstrated.

Disagreeing with this judgment, Justice White and Justice Rehnquist held that the court was overstepping its authority, and creating something that had not before existed, a "right for pregnant mothers" taking precedence over "the right of potential life of the fetus". So, there was a big uproar about it, efforts were made in the direction of protecting local laws by restricting abortion, and to place in the Constitution an amendment forbidding abortion. This particular issue made life of some politicians prosperous. The issues at hand at that time were - bearing arms, and bearing children. Therefore abortion was thought as unethical. But Judith Jarvis Thomson, (as we have seen earlier), writing before the Supreme Court decision, laid out an argument for woman's right as over and against the fetus's right-to-life. Thomson rejected the idea that fetus was a person from the moment of conception and argued that all abortion was, therefore, not taking the life of a person. She defended the right of a pregnant woman to abort the fetus in many cases. Well, in some extreme cases like rape victim, or conceiving a deformed baby, or danger to mother's life, all might agree that abortion is a must. But Thomson's paper rebuts the claims of right-to-life arguments. The fetus's right-to-life does not give it the right to use mother's body. That right of occupancy is conditional upon other factors of her choosing, and of her sexual partner's, as in most of the pregnancies that we regard either as being willing or at least accepted by the woman as within the sphere of her responsibilities.

To Thomson's argument in favor of mother's right to abortion, Baruch Brody's reply is thought provoking. As put by Charles L. Reid, in his book "*Choice and Action - An Introduction to Ethics*", he gives the argument put forward by Brody in following words, "Thomson would be justified in saying a woman has no duty to offer a zygote conceived in a test-tube her uterus as a place of incubation because it has no other place to live. But a

woman cannot get rid of a foetus inside her without killing it. (Of course, we rule out the remote chance of finding another woman to have it implanted in her). So it isn't merely refusal to save a fetal life but the taking of fetal life that is involved here. I would not be morally obligated to save your life if it would bankrupt me to do so, but I have no right to take your life to prevent bankruptcy to myself. If a fetus is a person from the moment of conception, not even danger to the woman's life justifies killing it. Generally, then, Brody stresses the distinction between the duty to save a life and the duty not to take a life". (1) (Somewhere, though, Brody does allow one carefully restricted case where abortion would be morally right).

### **Earlier Views on Abortion Challenged**

But the Stoics believed that life does not begin until live birth. This is also accepted by Jewish faith, though there is difference of opinion on it. The Protestant community also agrees to this but with some modification; in so far as that can be ascertained; organized groups that have taken a formal position on the abortion issue have generally regarded abortion as a matter for the conscience of the individual and her family. The Aristotelian theory of "mediate animation" which was prominent through out the Middle Ages in Europe, continued to be an official Roman Catholic dogma until 19th century, despite opposition to this "ensoulment" theory from those in the Church who would recognize the existence of life from the moment of conception. The latter is now the official belief of the Catholic Church. Many non-Catholics, and physicians, also hold this belief.

This view is also challenged by new techniques and scientific advancement made in this field. Accordingly the technicians in this field ask the precise definition of the above-mentioned view. Because whatever definition is put forward, today have to consider new embryological data that purpose to indicate that conception is a "process" over time, rather than an event; and governed by new medical techniques such as menstrual extraction, the morning - after pill, implantation of embryos, artificial insemination, and even artificial wombs or surrogacy.

### **MTP Act 1971 and Woman's Liberation**

A number of points of interest come out of this discussion. In India, the Medical Termination of Pregnancy Act, 1971, equips women with legal provision to abortion. It provides that a pregnancy

may be terminated where the length of the pregnancy does not exceed twenty weeks, if two or more medical practitioners are of the opinion that the continuance of the pregnancy would involve a risk to the life of a pregnant woman or a grave injury to her physical or mental health. It can be pregnancy either through rape or where a pregnancy occurs as a result of failure of any device or method used by any married woman or her husband for the purpose of limiting the number of children. Somewhere we find that "this enactment has been hailed as a major landmark in India's social legislation and a far-reaching measure assuring the women in India freedom from undesirable and unwanted pregnancies". (2)

The women's liberation differed markedly from other groups that emphasized on women's rights. It differed because it "operated from a more informal structure - no written rules, no acknowledged leadership, no established roles, and usually no men allowed to participate". (3) They spoke (though with difference of opinions) on issues as consciousness raising, abortion, capitalism, and lesbianism. The feminist philosophers i) take women's interests, identities and issues seriously; and ii) recognize women's ways of being, thinking and doing, as valuable as those of men. Feminist philosophers criticize traditional ethics and traditional social and political philosophy. They often called the traditional view of ethics as "justice" perspective, contrasting it with a "care" perspective that stresses responsibilities and relationships rather than rights and rules, and that attends more to a moral situation's particular feature than to its general implications. From this point of view, the whole argument of abortion as something morally degrading the standard of female from high pedestal to low of lower most level in falsified. Is abortion morally justified or not is not the question here. It is what a woman desperately seeks that is the issue at hand. We cannot be neutral either to the foetus' right-to-life or a woman's right-to-live. We have to take a stand somewhere.

### **Concluding Remarks**

None of the solutions those that go against abortion or pro-abortion satisfy anybody logically; and it can go on and on. For me, a woman's right, her decision, does matter a lot. As a woman, I, myself think that she has a right to take decisions for herself. To abort the fetus is not a very simple and handy solution that she opts for in a given situation. A woman passes through lot of mental trauma; though the reason

for abortion may be anything. The decision of abortion is not as simple as broken furniture discarded from the house; it is a highly traumatic decision for her. And her right to take decision takes precedence over anything else. I am neither morally justifying abortion nor not justifying. My point is a woman's right to take decision is prior to anything else.

### Summary

Let us sum up the whole paper.

A) The *Conservatives* hold that the process through conception to birth is continuous and reaches to the point of human being. Hence, abortion is not justified.

B) The *Liberals* are of the opinion that abortion isn't killing a human being and that the human being comes into existence at birth. They distinguish between the fetus, very young infants, and us.

C) *Moderates* believe a fetus has a moral status for part of its life, like an animal; not any and every kind of treatment is right, but it is impossible to draw a line as to when abortion is killing a human being. Both the liberals and conservatives present no facts that the other side disputes to support the conclusion that a fetus is or is not a human being, but rather say, "Can't you see that it is (isn't)?"

D) We may add one more view point i.e. *Feminist* view point - the whole issue is not that abortion can be justified ethically or not; it is altogether different issue. We better ask - is a woman's right to take decision morally justified or not prior to any other bio-ethical issue? My conclusion is yes, she has the right to take decision and it is prior to anything else.

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## Euthanasia

Uma Shankar

Head, Dept of Philosophy, S.I.E. S. college of Arts, Science & Commerce

### Introduction

*Life is pleasant, death is peaceful, but the transition is painful.*

As Jame Rymes puts it, "Too many people are thinking of security instead of opportunity. They seem to be more afraid of life than death."

'Eu' means noble and 'thanatos' means death. Thus the English word 'euthanasia' was coined by Francis Bacon, which means painless death.

Ancient meaning of this word implied four important aspects –

- To induce death for those who suffer
- To put an end to life of the unwanted
- Care for dying
- To let the person die.

### Background

Historically many cultures have opposed euthanasia in general. It is commonly described as dying with dignity or mercy killing. To those people who have incurable or very painful diseases, euthanasia was adopted out of compassion.

There are various types of euthanasia, like active and passive, or direct and indirect, and so on. Hebrews believed God created humans so we must not determine our death. Life is precious. Greek perspective opposed induced death for sufferers. Aristotle opposed induced death as it reflects the notion of human value –the nobility of facing death bravely. Romans felt that good life be gets good death. By and large, Christians opined that God being sovereign creator and sustainer, one should not have self-induced death. St Augustine called it cowardly action. But contemporary Christians permit Euthanasia to terminally ill patients. Rationalists like Kant too believed that Self-killing is immoral.

In 1935, in England, Voluntary euthanasia legislation Society was founded. In England and U.S., Bills were introduced but none passed! Public opinion has shifted in favour of legalizing the issue of

Euthanasia. In 1900, 36% of the public responded with yes to it while in 1991 it was 63%.

Why this Shift? Some reasons are:

- Patients feel they are burden to family
- Fear of being forced to live in pain
- Dependency on life prolonging machines
- Awareness of Euthanasia being discussed.

### Case Study

Let us look at a case in U.S. In 1994, Oregon became the first state to pass a law permitting physician-assisted dying. Subsequently, at the patient's request, the physician provides a lethal dose of medication or sleeping pills that the patient can then ingest to end his or her life. But in 1997, the Supreme Court ruling did not find physician assisted dying to be a constitutional right. They nonetheless left legislation to individual states. So in 1997, Oregon *Death with Dignity Act* became official, with the first physician-assisted death occurring in 1998.

Generally speaking, society takes two attitudes –it prohibits taking innocent life and demands mercy and relief. How can we then define Euthanasia? Is it a case of individual liberty? Should we silently watch the pain and suffering and leave it to the hands of some supreme power?

### New Concept

Now laws have been enacted to enable people with terminally diseases to write a *Living Will*, requesting the near and dear ones to take a decision and not to continue with life sustaining procedures. The moral, legal and ethical issues surrounding death are relatively new for us and therefore we are unable to give a most satisfying answer.

Unfortunately, research suggests that many physicians ignore the wishes of their dying patients and needlessly prolong pain and suffering. In some cases the patients' request of not to prolong the treatment or continue medication have not been appreciated. Thus at present, the *living will* and



treatment tools available to patients are not completely successful in allowing them to express their wishes.

Jonas Salk in his book, *Man unfolding*, says, “the future of man requires the definition of value and of purposes to be served and of the roles that responsibility plays not by chance, not by moral demand, but by necessity for survival.” This reveals different attitudes toward value in human life. Value judgments are in part decisions relating to the self and to the system of desires that exist within the self. It is with respect to value judgment that we come face to face with conflicts within us and with others.

Man is a part of the universe of living things. He possesses the capacity of many responsibilities –towards himself, and towards other species. The concrete situation of the dying person is the beginning point for any consideration of the meaning of morality. There are at least three relevant domains to be considered –the medical aspect of the patient’s condition, the social, legal, religious responsibilities, and the relationship with the patient. Any attempt to answer the ethical question in the first two without reference to the third shall be futile.

The medical and ethical aspect constitutes the humanistic approach to the reality of the dying person. If an individual decides that there is no purpose in his living should we allow him to end his life? The three realms, which we need to consider in depth, are medical and hospital factor, legal, religious and social factor, and the existential reality of the dying person. What is very important is the dying person is real. Can we take any decisions that will go against his will?

From the legal stand point, there are issues where public policies and professional intersect. Sometimes the professional interests are subordinate to the public. In fact to a large degree, public policies on life sustaining treatment and euthanasia have long deferred to professionally formulated ethical policies and standards of behaviour.

In 1992 a commission of the Japan Medical Association concluded that a patient’s expression of wish to die with dignity should be respected but that active euthanasia should not be approved. Two years later the Science Council, the principal governmental body for all matters affecting medical research and life sciences, approved a report of its Special Committee on Death and Medical treatment, advocating removal of life support for patients in a deep irreversible coma, if they had previously stated their opposition to life –prolonging measures.

## Advance Directives: The Living Will

Luis Kutner proposed a ‘*living will*’ — a document directing that medical treatment must cease if the patient is vegetative and unable to regain his or her mental and physical capacity. The plight of the Quinlan family in trying to remove a ventilator from their daughter who was in a vegetative state, inspired the first U.S. State law granting legal status to living wills. Since then, nearly every state in United States has passed legislation authorizing living wills.

But living wills are made in broad terms and it calls for elaborate interpretations, lest they are misused. Today, these advance directives provide various instructions, namely the patient’s preference, his values, goals, while he is competent, in anticipation of future period of decisional incapacity. There are also provisions for Proxy directive, an instruction directive, and so on.

## Who decides?

When the patient has the capacity to decide, the state or the law governing human life intervenes. In patients who have the ability to decide about their lives can the State allow them to choose between lying or remove the life supporting system? Although the State has a strong interest in preserving the life of the individual and in upholding the sanctity of all human life, strangely even that fails “because the life that the State is seeking to protect in such a situation is the life of the same person who has competently decided to forgo medical intervention.”

However the courts in US concluded that in rejecting life –supporting system or life prolonging treatment, patients were not committing suicide. And health care providers were not helping suicide when they agreed to the wishes of the patients

When patients are not in a position to take decisions on these issues it was decided to have surrogate decision makers. They may take such decision on the basis of a wish stated by patients when they were competent.

Public policy not only supports the preservation of life but it also promotes patients’ well-being, including the relief of suffering. It is the responsibility of health care professionals to provide palliation and pain relief, even if it reduces the life of the patient.

American Medical Association reformed its stand on euthanasia:

*'For humane reasons, with informed consent, a physician may do what is medically necessary to alleviate severe pain or discontinue treatment in order to allow death. But he should not intentionally cause death.'*

David Lowell believes that euthanasia would threaten the physician –patient relationship and confidence in the doctors may give rise to suspicion. He may become an agent for death.

### **Religious dilemma**

One tends to agree with the declaration of the Vatican City in 1980 which says,

*'Nothing and no one can in any way permit the killing of an inhuman innocent human being whether a fetus or an embryo an infant or an adult, an old or one suffering from incurable disease or a person who is dying. Further no one is permitted to ask for this; act of killing either for himself or from another person entrusted to his or her care, nor can he or she consent to it'.*

Thus it is obvious from the religious point of view, Euthanasia is considered wrong or unethical, because we are trying to challenge even God, trying to decide the day and time of death which is beyond human limitations. When we cannot give life do we have right to take life?

From teleological point of view, where one sees purpose in every thing around us, perhaps suffering too has a purpose. From the concept of Law of Karma, each individual is born in order to fulfill his karma, and so pain and suffering may be part of karma. But in today's scenario, where medical advancement has an answer to every problem, we must try to minimize the suffering. But in extreme cases, where all doors seem to show dead ends, then one may consider the option of Euthanasia. Will it minimize the pain of the patient or will it add to a new set of fresh karma? Let us think.

Decision making for incompetent adults remains a perplexing issue. The price tag attached to medical treatments often forces the patient or his family to consider Euthanasia. The present day doctors ask, "how far do we go to save a life?"

### **Conclusion**

We are reminded of Winston Churchill's concern,

*"I am ready to meet my maker, whether my maker is prepared for the great ordeal of meeting me is another matter."*

According to Caplan, another reason euthanasia is an issue today is that many people have been disturbed by the prospect of being trapped by technology. Said Caplan:

*"You see some of these cases where people can't get treatments stopped, and they want the right to end it, so they don't have to wind up like a Cruzan."* (Nancy Cruzan died eleven days after a judge authorized her parents to order the removal of a feeding tube that had kept her alive in a persistent vegetative state for more than six years.)

Medical science has brought remarkable changes to our lives. Because of advances in medical technology, more people live longer, and more productively, than any generation in history. Unfortunately, these advances have created problems as well. The longer people live, the more likely they are to encounter chronic disease that requires long-term health care.

To conclude, it is rather difficult to conclusively state whether one should or one should not allow euthanasia. Some questions that still bother us are:

1. Are lifes sustaining treatments modern boons in the real sense?
2. Is not killing in itself morally worse than allowing to die?
3. Do we have a right to take a decision about our lives?
4. Can we trust any 'close' relative to be a surrogate decider on this issue?
5. To stop life supporting system is killing or allowing dying?

*Life is real! Life is earnest.*

*And the grave is not its goal.*

-Longfellow

## **Samlekhana is a Step Towards Self-realization**

**Utpala Mody**

*H-402, Vishal Apt, Sir M. V. Road, Andheri (E), Mumbai-400 069.*

*Email: u\_mody@yahoo.co.in*

### **Introduction**

In the present political life of our country, fast unto death for specific ends has been very common. The *Manusmriti* mentions some traditional methods of fasting unto death in order to get back the loan that was once given. The *Rajatarangi* refers to Brahmins resorting to fast in order to obtain justice or protest against abuses. Religious suicide is occasionally commended by the Hindus. With a vow to some deity they starve themselves to death, enter fire and throw themselves down a precipice.

Society and religions in the past approved different forms of voluntary deaths as acts of piety, conducive to religious merit. Sometimes such acts have been condemned as repugnant to all morals and human conscience. The Hindu *Dharma-sastras* sanction various modes of death. Even in certain non-Jaina sects there was, and is, current the custom of putting an end to one's life and treating it as a religious act — e.g. the custom called *Kamalapuja*, *Bhairavajapa*, *Jalasamadhi*; the practice of *Sati*, *Jauhur* and *Mahaprasthan* was glorified in India.

Though it is certain that all religions condemn suicide as unethical and opposed to religion, different faiths have their own reasons to approve of voluntary deaths in different forms motivated by acquisition of religious merit or hopes of having a better life in the next birth. The idea that one should escape births and rebirths in the world is in the spirit of most of the religions in the East. In fact, it is the aspiration of every religiously conscious individual to free himself from the fetters of the *karma* by leading a noble life of austerity and meditation.

### **Jaina Thought and Samlekhana**

The Jainas were opposed to such forms of death. They called such death as unwise (*balamarana*). It has no moral justification. The *Uttaradhyayana Sutra* condemns such practices and states that those who use weapons, throw themselves into the fire and water, and use things not prescribed

by the rules of conduct, are liable to be caught in the wheel of *Samsara*. Such persons are caught in the *moha-dharma*. Fasting unto death for specific purposes has an element of coercion, which is against the spirit of non-violence.

In addition to the twelve *vratas* a householder is expected to practice in the last moment of his life the process of *samlekhana*, i.e. peaceful or voluntary death. A layman is expected not only to live a disciplined life but also to die bravely a detached death.

*Samlekhana*, generally interpreted as ritual suicide by fasting, the scraping or emaciating of the *kasayas*, forms the subject of a *vrata* which, since it cannot by its nature be included among the formal religious obligations, is treated as supplementary to the twelve *vratas*.

It is a *vrata* of "fast unto death". It is a peaceful desire of death of a pious person who leaves possession of body, pleasures of senses and passions only with one single intention of purification and perfection-salvation. This *vrata* is taken usually at the end of life. It is voluntary victory over death.

"SAMYAK KAYA KASAYA LEKHANA ITI SAMLEKHANA]"

*Samlekhana* is gradual wearing/weakening of body and passions in the right perspective.

A praiseworthy (*sat*) process by which the body is emasculated (*lekhana*) is identified as *Samlekhana*; hence the *Samlekhana-tapah* is called a process "of scratching out the body to save the soul".

*Samlekhana* is a step towards self-realization. It is meant to free oneself from the bonds of the body, which is no longer useful. It is described as the process of self-control by which senses, pleasures and passions are purged off and destroyed.

*Samlekhana* could be embraced at the end phase of one's life span, but it is recommended that

the penance should be practiced throughout one's lifetime and its severest observance should come at the closing stage of the life span.

“*Samlekhana is facing death (by an ascetic or a householder) voluntarily when he is nearing his end and when normal life according to religion is not possible due to old age, incurable disease, severe famine, etc. after subjugation of all passions and abandonment of all worldly attachments, by observance of austerities gradually abstaining from food and water, and by simultaneous meditation on the real nature of the self until the soul parts from the body.*”

But *samlekhana* is not to be taken lightly. It is not to be universally practiced without distinguishing individual capacity and motivation. Certain specific conditions are laid down, which are to be strictly followed if one is to practice such fast unto death. *Samlekhana* is to be adopted in two cases: (a) in cases of emergencies and (b) as the end of a regular religious career.

The Jaina tradition looks at *samlekhana* as the highest end to be achieved in the course of the spiritual struggle, and finds there no cause for tears.

The analysis of the process of *samlekhana* shows that it has two primary stages, which are sometimes referred to as of two types. Accordingly, a distinction has been made in the practice of *samlekhana* as (a) the mental discipline (*kasaya-samlekhana*) which consist in the control of the passions and the attainment of the perfect equanimity of mind; (b) practice of fasting gradually which leads to the gradual mortification of the body (*kaya-samlekhana*). The two are complementary to each other, although the mental discipline is a necessary condition of the fast unto death.

### **Samlekhana and Suicide**

In the present scenario, *samlekhana*, which is popularly known as “*Santharo*” is taken as suicide. But *samlekhana* is not suicide. Suicide is killing oneself by means employed by oneself. The corresponding word in Sanskrit is “*Atmaghata* or *Atmahatya*” (self- destruction). The natural instinct of all living beings is self-preservation by protecting oneself against all odds, and attacks which are likely to cause injury to the body.

Suicide is normally a misfortune of one's own making. A victim of suicide is either a victim of his mental weaknesses or of external circumstances

which he is not able to circumvent. In modern times, mental and ethical strength has been fast deteriorating, whether it be in an individual or in any social group. Disappointments and frustrations in personal life or love affairs, unexpected and unbearable economic loss in trade and business, sudden and heart-breaking grief brought on by the death of the nearest and dearest, appearance of some disease which is incurable, depression, an unexpected sudden shock, as causes, drive an individual to commit suicide under a sudden impulse.

The psychological and the sociological aspects of *samlekhana* reveal that none of these characteristics are to be found either in the adoption of the vow or its fulfillment.

### **Karma, Triratna and Samlekhana**

According to Jainas, the individual souls are pure and perfect in their real nature. They are substances distinct from matter. Through the incessant activity, the soul gets infected with matter. The *karma*, which is of eight types and which is material in nature, accumulates and vitiates the soul from its purity. The souls get entangled in the wheel of *Samsara*. This is beginningless, though it has an end. The end to be achieved is the freedom from the bonds of this empirical life. It is to be achieved through *Triratna*, “right faith”, “right knowledge”, and “right conduct”. The way to *Moksha*, which is the final end, is long and arduous. The moral codes of religious practices, which are rigorous, gradually lead to self-realization. In the final phase of self- realization, as also in emergencies, the Jaina devotee, an ascetic or a householder (*sravaka*) is enjoined to abstain from food and drink gradually and fast unto death. Death is not the final end and destruction of self. It is only casting off the body, freedom from the bonds of life. We are asked to accept a quiet death, as far as possible, within the limits of our capacity. This is *samlekhana*.

It is called “*Samadhi-marana*” or “*Samnyasa-marana*”. For a Jaina, the final emancipation by *samlekhana* is the ideal end to be devoutly wished for. If a pious man, self-controlled throughout his life were to die a common death, all his efforts at a spiritual progress would be wasted. He will not be free from the wheel of *Samsara*, because *samlekhana* is the highest form of *tapas*.

The same may be examined with reference to (1) intentions (2) situation (3) the means adopted, and (4) the outcome of the action or its consequences.



The sole intention of the person adopting the vow is spiritual and definitely not temporal. The adoption of the vow is preceded by purification of the mind, by a conquest of all the passions spread over a period of some years. The person adopting the vow wants to be liberated from the bondage of *karma*, which has been responsible for all his ills in the world and for births and rebirths in different states or *gatis*. Contrary to the suicidal intention, there is no desire to put an end to life immediately by some violent or objectionable means. There is no question of escaping from any shame, frustration or emotional excitement. There is no intention to harm oneself or any member of one's own family.

### Conclusion

From the ultimate point of view (*Niscaya-naya*), the self is pure and indestructible. The practice of *samlekhana* is compared to cutting or operating a boil on the body, which cannot be called destruction of body. In this sense, *samlekhana* is described as the final freedom of the soul from the bonds of life.

We are in a world where spiritual values have declined. The flesh is too much with us. We cannot look beyond and pine for what is not. *Samlekhana* is to be looked at as physical mortification, self-culture

and spiritual salvation. *Samlekhana* is, therefore, nothing but a wise, righteous and planned preparation for the inevitable death.

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## Ethics of In Vitro Fertilization (IVF)

Tabassum Shaikh

Dept. of Philosophy, G.M. Momin Women's College, Bhiwandi, Maharashtra

### Introduction

After the Flood, "God blessed Noah and his sons and said unto them 'Be fruitful and multiply and replenish the earth'" (*Genesis 9:1*).

Humankind, notwithstanding war, famine and disease, has heeded this call with natural exuberance and global consequences that challenge the planet's resources today.

Over the many centuries since God's injunction, children have been born by natural means. However, the world over, among couples of child-bearing age, there are many who are involuntarily infertile. For these couples, in vitro fertilization (IVF) offers new promise.

This promise is not without its critics. Social pressure, especially on women, is at the heart of much of the drive for biological parenthood. Nevertheless, the fact that many infertile couples are willing to spend lot of money, and risk the physical and mental demands of IVF rather than adopt a child, suggests a strong emotional need for biological offspring that is not influenced by social pressures.

### What is IVF?

Eggs and sperm are combined to produce fertilized eggs. These eggs are then implanted as embryo and grow into viable fetuses, which are carried by the original mother or a surrogate mother.

### IVF Procedure

IVF requires the intervention of a medical team. This intervention begins by taking a history of the couple. This is followed by physical and laboratory examinations that include a test for the sperm count of the male partner and a Pelvic staining of cervical secretion for the presence of Chlamydia for the female partner.

Once these tests are completed, fertility drugs are administered to the woman to stimulate her ovarian follicles to produce as many healthy eggs as possible. This is necessary because a single fertilized

egg or pre-embryo has only a small chance of survival. Eggs are retrieved 27 to 36 hours by a specific stimulation technique such as ultrasonographically guided aspiration or laparoscopy, and as many eggs as possible are obtained per single retrieval attempt.

The harvested eggs are inseminated by a sample of semen that contain sperm of good quality and are prepared by washing to induce capacitation. Each harvested egg has a 60% to 70% chance of being fertilized. Once cleavage occurs, the pre-embryos are transferred to the woman's uterus.

Sperm of poor quality reduces the chances for a couple to have sufficient embryos available for assisted fertilization. This problem has been addressed with intracytoplasmic sperm injection, in which a single captured sperm is injected directly into the egg.

### Ethical Issues

#### 1. Pressure on Women

"With the advent of new fertility technologies, social pressure to produce biologically related children is again intensifying," ... infertile women are urged to fulfill their 'full reproductive potential' regardless of economic, psychological or bodily cost," and ... feminist analyses frequently show how the market for these techniques is socially constructed." (Donchin, 1996). Nevertheless, Donchin maintains that there is a strong emotional need that is not influenced by social pressures. This need even has been called instinctual, which is reminiscent of the famous "maternal instinct" that supposedly endows women with an inborn knowledge of nurturing behaviour, but that actually is learned. New mothers, after all, must be taught how to nurse their infants!

Infertility is not simply a biologic problem to be solved by appropriate technology. It is a socially defined and interpreted category (Sherwin, 1992). Neither Donchin nor Sherwin deny that women desire biologic children, but they emphasize the social and economic pressures that far too often are down played or ignored. Men also are pressured to father biological children, especially now that research has shown that the problem of infertility is not always the woman's.

The actual procedure of in vitro fertilization (IVF) tends to be described in a rather detached manner. One seldom hears details such as: "... Some number of the newly fertilized eggs are transferred directly into the women's womb, with the hope that one will implant itself into the uterus. This procedure requires that a variety of hormones be administered to the women (often leading to dramatic emotional and physical changes), that her blood and urine be monitored daily at three- hour intervals. In some programmes, the woman is required to remain immobile for forty-eight hours (including up to twenty-four hours in the head-down position). This procedure may fail at any point and, in the majority of cases, it does. Most women undergo multiple attempts" (Sherwin, 1992).

Much of this passage describes discomfort and inconvenience, and one hopes that the technology will be improved with time. But the administration of drugs with unknown long-term effects and potential for harm to the women receiving them is a continuing problem. Repeated endocrine "storms" may not be benign therapy.

## 2. The Harm Principle

The harm principle, which probably is being violated in the use of infertility therapies, is entirely insufficient as a basis for the ethics of health-care professionals.

Doing good should be the central principle guiding their behaviour. The central question then becomes: What good will come of the procedure? Will unacceptable harms be inflicted in the process of achieving that good? The low success rate of IVF, and the actual and potential harms involved, suggest that these questions are particularly appropriate.

Respect for autonomy should not be violated in the interest of doing good. This principle includes a very strong requirement for informed consent. Just how well informed are the women who consent to the complex procedures of IVF? Ethics research in this area might be very revealing. Are women truly made aware of the low success rate and the threats to their health? Should they be informed that they are, to some extent, subjects of experimental therapy? If they are well-informed, does consent cure all, or should physicians refrain from offering untested therapies?

Our health-care "system" already accepts so many violations of distributive justice that one more

draws very little attention. Infertility treatments are available only to those who can pay for them. Insurance coverage for urgent health problems is increasingly threatened, so it is very unlikely that such very elective and not very successful forms of treatment will be covered in the near future. Do the infertile poor suffer less than the well-off? Are the charges reasonable or exorbitant? The Italian National Health Service is planning to cover infertility therapy. The outcomes will be interesting indeed!

## 3. The Possible Wrong Done to the Pre-Embryo

The number of pre-embryos that are transferred to the woman's uterus is determined by the chances of fertilization, and this varies with the woman's age. A sufficient number of pre-embryos are needed to increase the likelihood for pregnancy. Those that are not needed usually are frozen.

Embryos that are not transferred to a woman's uterus ultimately may be used for research purpose, or destroyed. Embryo in the uterus may be destroyed by selective pregnancy reduction. In these instances, further embryonic development has been halted by the action of a physician with the likely consent of the couple. Can the destroyed embryo be said to have been wronged? The answer to this question is contingent on the perceived ontological status of the embryo. If the embryo is viewed as a human being with the rights normally associated with personhood, arresting its development will be considered a wrong because it constitutes an act of murder. On the other hand, if the embryo is perceived as a bit of protoplasm, neither freezing nor destroying it is inherently unethical.

## Personhood

Considering the human pre-embryo to be protoplasm overlooks the fact that it differs from every cell in a woman's body and can be identified as human by its DNA. Thus, science supports the view that human life begins at conception. Some conclude from this that the pre-embryo is a person who possesses rights from the moment of conception.

However, personhood is a social construct that is shaped not only by an understanding of objective nature but also by community needs and values. It is not surprising that different concepts of personhood have been adopted at different times and places. Aristotle indicated that ensoulment (personhood)

occurs 40 days after conception for the male foetus and 80 days after conception for the female foetus. Muslims believe that personhood occurs 14 days after conception. From the 17<sup>th</sup> century onward, European common law recognized personhood only after quickening. Within this historical context, any attempt to decide when protoplasm is endowed with rights by merely resorting to a scientific examination of biologic processes is bound to fail.

A broadly accepted view in today's world is that the human organism becomes a person at the moment of birth. A competing position is that personhood begins at the moment of conception. Adopting this latter view weighs against selective pregnancy reduction and research on embryo, and might require that all embryos be implanted. The Catholic Church is the major proponent of the view that the life of a new human being begins at the moment the ovum is fertilized. According to Catholic teaching, viewing a human individual as a person dictates recognition of the rights of the pre-embryo as a person.

Is a pre-embryo a person from the moment the ovum is fertilized? According to Thomas Shannon (1997), the answer is no. He states that not until totipotency gives way to specialized cellular development, which occurs approximately 3 weeks after formation of the zygote, can we correctly speak of the pre-embryo as an individual. Before this time, the pre-embryo is not an individual and, therefore, cannot be a person. Although science cannot provide a concept of personhood, it appears, in this context, to have provided a necessary condition for human individuality without which personhood is not possible. However, Shannon acknowledges that the biology of the pre-embryo will eventuate in an individual who is a person.

Focusing on the argument from totipotency results in the conclusion that human individuality and, therefore, human personhood does not begin until some weeks after the ovum is fertilized. If we emphasize the fact that the fertilized ovum normally will develop into a person, then the argument from potentiality may lead us to conclude, along with the Catholic Church, that the embryo is a person from the moment of conception. Because the existence of personhood bars us from abusing or killing a person, the logical conclusion is that pregnancy reduction and embryo research are immoral. The Church would like us to believe that personhood occurs at the moment of conception, and Shannon would like us to believe

that prior to 3 weeks' gestation, the pre-embryo falls short of being a person.

As already noted, personhood is a social construct based on community needs and interests as well as on biology. These needs and values find their expression in the way we see things. For example, one person looking at the softly rolling hills of California reacts by "seeing" God as the invisible landscape architect who made the beautiful placements of the live oak trees; while another might "see" these placements as the effect of soil conditions, wind and rain. William Werpehowski "sees" the human face in the pre-embryo when he says,

*"Following fertilization, the human zygote is a genetically unique, individual human organism that in its immediate appearance displays to us the human countenance".*

However, many do not "see" a human countenance in the pre-embryo. For them, personhood is conferred on human organisms with whom human interactions are possible, or occur. We can cuddle a baby; we cannot cuddle a zygote. We coo at an infant and he or she responds by smiling; zygotes do not smile. An infant grasps a proffered finger; a zygote cannot. Babies have personalities and embryos do not. That is why babies are persons and embryos are not.

#### **4. The Possible wrong done to the infertile couple for the expected offspring by the Physician in using IVF**

The success of IVF depends on the number of embryos transferred to the uterus. Because the chance of survival of an embryo in conventional IVF is small, the more transfers made, the greater the chance of pregnancy. However, this increases the likelihood of multiple pregnancy, with the greatest chance occurring among women younger than age 35 and the least chance among those older than 40.

Multiple pregnancies present a threat to the physical and mental health of the mother. She may suffer from high blood pressure or uterine bleeding, or from complications associated with delivery by cesarean section. Accompanying these physical problems are possible emotional difficulties that might be experienced by both the pregnant women and her male partner. In addition, the couple will have to bear the medical costs of IVF as well as the costs of medical cure for their offspring, should there be ongoing medical problems.



Because iatrogenesis commonly is associated with medical interventions, the appropriate question to ask is not simply whether an intervention produces harm, but whether the harm so produced is outweighed by acknowledged benefits. The willingness of infertile couples to undertake IVF is a sufficient sign that the perceived benefits to them outweigh the burdens of financial costs and physical and mental risks.

### **5. The possible wrong done to the offspring by the infertile couple who uses IVF**

Multiple pregnancies also present a threat to the well-being of the offspring. There are problems associated with low birth weight and with pre-term birth. The few comparative studies that have been undertaken suggest that children born of IVF have a significantly greater risk for spina bifida and transposition of the great vessels, and that some of the drugs administered to women to stimulate the production of eggs increase the risk of serious birth defects.

Given these results and the scanty evidence, some argue that those who use IVF have an obligation to prove that the technologies employed are safe, and that IVF not be used until further evidence of its comparative safety is forthcoming. John Robertson has argued against this position by observing that the increased incidence of defects does “not justify banning the technique to protect the offspring, because without these techniques these children would not have been born at all”. He reasons that being alive is better than not existing and, therefore, the benefit of existence outweighs the harm of birth defects.

### **Transmitting a Serious Disorder**

Suppose a couple that uses IVF unknowingly produce a child who suffers from a serious disorder? Has this couple wronged their child? Before answering this question, let us consider the transmission of Huntington chorea. We can identify clearly all those who transmit the disease (the parents of each of the disease’s victims), and we know the precise risk factor of developing the disease (50%), when the disease is likely to develop (between the ages of 30 and 40), and the fact that the disease terminates in death approximately 15 years after its onset. Opinions differ concerning the morality of fertile couples that have the genetic predisposition for Huntington chorea having children. Optimists point out that these children

have a 50% chance of not having the disease, and even those who do may enjoy approximately 30 years of healthy life. Pessimists believe that a 50% risk is too high and point to the terrible effects of the disease once it develops.

Notwithstanding these conflicting perspectives, there is agreement on both sides about which facts are material and many, if not all, of these provide accurate information. This exactness of relevant information in the case of Huntington chorea dissolves when applied to IVF. Someone in the population of IVF users will have a child or children who will suffer from a serious disease. As is sometimes the case with coital conception, however, neither can we identify the parents in question nor can we tell which child will be affected by a serious disease and what that disease will be. All that we can say at present is that there is some evidence to suggest an increase in the number of serious disorders in this population compared with the frequency of these disorders among coitally produced children. A reasonable conclusion from these observations is that a severely damaged child has been harmed as a result of IVF technology, but has not been wronged.

### **6. The possible wrong done to the Community by the use of IVF on the parts of the Physical and the Infertile couple.**

Although the use of IVF may harm but not wrong the infertile couple or their offspring, the aggregate effect of IVF is an increase in harm compared with the effects of coital pregnancy. Does this indicate that the use of IVF wrongs the community? One might argue that the community is wronged because the financial resources needed to support the individual who are made ill by IVF are best spent elsewhere. However, this does not take account of the fact that distributive justice, albeit an important moral requirement, is in competition with other moral demands. These include the autonomy of the individual in attempting to overcome infertility, the obligation of the physician to try to rescue the sick infant, and the need for medical research to refine the technologies of IVF to eliminate or reduce the effects of illness and disease.

Society has adopted the rescue mentality even when such efforts are extremely expensive, and, in terms of the number of individuals affected, could be used more effectively in other medical arenas. Interest in allocating scarce resources ultimately may foreclose on expensive technologies such as IVF.

However, until that day arrives, it is difficult to support the contention that IVF wrongs society.

### **Conclusion**

There are numerous problems concerning the implementation of IVF, including whether there is a

right to this technology, whether such access should be funded by health insurance, and whether access should be limited to women of a specified age group. However, these problems take on meaning and importance only if IVF is perceived to be sanctioned ethically.

## Bioethics of Cloning

Himaja Vedula

Gayathri Vidyaparishad Degree College, Sector-8, M.V.P. Colony, Vishakhapatnam.

E-mail : vedula.himaja@gmail.com

### Introduction

Human beings are always remaking themselves, their values, and their ways of interacting with one another.

Cloning is a laboratory phenomenon and the word “clone” designates a “*viable human or animal generated from a single parent*”. A clone is a twin of the individual cloned with a time gap. The prospect of human cloning burst into the public consciousness in 1997, following the announcement of the successful cloning of Dolly the sheep by Ian Wilmut. Since then, it captured much attention and generated great debate, both in the United States and around the world.

Many people are repelled by the idea of producing children who would be genetically, virtually identical to preexisting individuals, and believe such a practice is unethical. But some see in such cloning the possibility to do good for infertile couples and the broader society. Some want to outlaw it, and many nations have done so. Others believe the benefits outweigh the risks and the moral concerns, or they oppose legislative interference with science and technology in the name of freedom and progress.

Before knowing about the ethical issues of cloning, let us first look in brief at the procedure and applications of cloning.

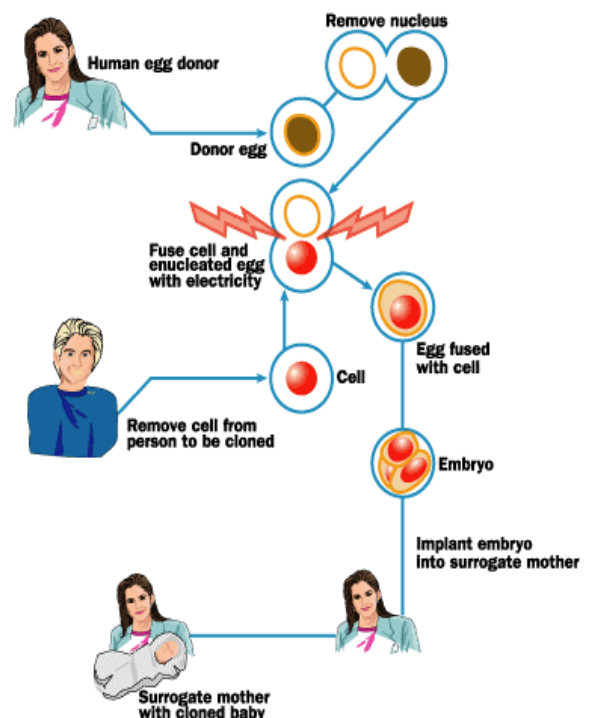
### Procedure

Cloning is done by a procedure called “SOMATIC CELL NUCLEAR TRANSFER”. Different types of somatic cells can be used for nuclear transfer, provided they are in a resting state. The nucleus of these cells are transferred to cytoplasm of a mature oocyte, i.e. an oocyte which is ready to be fertilized and has geared up the biochemical pathways for reprogramming and cleaving.

Before bringing the somatic cell into contact with the oocyte, the nucleus of the oocyte has to be removed.

Several methods are currently used for nuclear transfer in farm and laboratory animals. They can be divided into two groups, fusion and injection, depending on how the donor nucleus is brought into the recipient cytoplasm. In one procedure, the donor cell (karyoplast) is brought into contact with the membrane of the oocyte (the recipient cell or cytoplasm) and fusion of the two membranes is effected by an electric pulse (electrofusion) after which the nucleus enters the cytoplasm. In the injection method, the cellular membrane surrounding the donor nucleus has to be destroyed before or during mechanical injection of the nucleus into recipient cytoplasm.

Following the insertion of the donor nucleus, the recipient cell has to be activated to start the cleaving process. For reproductive cloning, the resulting embryo has to be transferred into the uterus of a surrogate mother.



## Applications

Cloning can be helpful in investigating a number of fundamental biological questions that remain to be answered such as:

\* Which factors are involved in genetic reprogramming of DNA?

\* Can all somatic cells be reprogrammed?

\* How and when does inactivation of the X chromosome occur?

\* Do cloned somatic cells keep their genetic imprinting? (Maternal and paternal zygotic genomes differ due to epigenetic imprinting resulting in their differential expression during embryogenesis).

\* How old are cloned organisms? (Ageing is a complex phenomenon where genetic and structural damage of DNA play a role that remains to be determined).

\* What makes a cell to differentiate?

## Ethical Aspects of Cloning

Now let us know the various ethical aspects of the cloning debate.

Even after a series of successful experiments, cloning remains an ethical issue and this cloning debate involves scientists, legislators, religious leaders, philosophers and many others. The notion of cloning raises issues about identity and individuality, differences between procreation and manufacture, and relationship between the generations.

The prospect of cloning to produce clones raises a host of moral questions, among them are the following:

1. Could the first attempts to clone a human be made without violating accepted moral norms governing experimentation on human subjects?

2. What harms might be inflicted on the cloned human as a consequence of having been made a clone?

3. Is it significant that the cloned human would inherit a genetic identity lived in advance by another—and, in some cases, the genetic identity of the cloned human's, rearing parent?

4. Is it significant that cloned humans would be the first human beings whose genetic identity was entirely known and selected in advance?

5. How might cloning to produce humans affect relationships within the cloning families?

6. More generally, how might it affect the relationship between the generations?

7. How might it affect the way society comes to view them?

8. What other prospects would we be tacitly approving in advance by accepting this practice?

9. What important human goods might be enhanced or sacrificed to approve cloning to produce human clones?

## The goodness of human freedom and existence

Cloning remains a black mark on human identity and individuality as the clone has more or less the same genetic constitution as its donor and resembles him/her even in the more complex features like the fingerprints and eye complexion. Thus individuality of humans goes out of the view.

Those who defend cloning on the grounds of human freedom make two kinds of arguments. The first is the claim that human existence is, by its very nature, “*open ended*,” “*indeterminate*,” and “*unpredictable*.” New technologies are central to this open-ended idea of human life, and to shut down such technologies simply because they change the “*traditional*” ways of doing things is unjustifiable. As constitutional scholar Laurence Tribe has argued in reference to human cloning:

*“A society that bans acts of human creation that reflect unconventional sex roles or parenting models (surrogate motherhood, in vitro fertilization, artificial insemination, and the like) for no better reason than that such acts dare to defy ‘nature’ and tradition (and to risk adding to life’s complexity) is a society that risks cutting itself off from vital experimentation and risks sterilizing a significant part of its capacity to grow.”*

Even though these kind of arguments are made, the ethics of research on human subjects suggest three sorts of problems that would arise in cloning-to-produce-children:

(1) Problems of safety

(2) A special problem of consent and



(3) Problems of exploitation of women and the just distribution of risk.

We shall consider each in turn.

### **(1) Problems of safety**

Concerns about the safety of the individuals involved in a cloning procedure are shared by nearly everyone on all sides of the cloning debate. Even most proponents of cloning generally qualify their support with a caveat about the safety of the procedure. Cloning experiments in other mammals strongly suggest that cloning humans is, at least for now, far too risky to attempt. Safety concerns revolve around potential dangers to the produced clone, as well as to the egg donor and the woman who would carry the cloned child to birth.

Risks to the clone must be taken especially seriously, both because they are most numerous and most serious and because—unlike the risks to the egg donor and birth mother—they cannot be accepted knowingly and freely by the person who will bear them. In animal experiments to date, only a small percentage of implanted clones have resulted in live births, and a substantial portion of those live-born clones have suffered complications that proved fatal fairly quickly. Some serious though nonfatal abnormalities in cloned animals have also been observed, including substantially increased birth-size, liver and brain defects, and lung, kidney, and cardiovascular problems.

### **(2) A Special Problem of Consent**

A further concern relating to the ethics of human research revolves around the question of consent. Consent from the produced clone is of course impossible to obtain, and because no one consents to his or her own birth, it may be argued that concerns about consent are misplaced when applied to the unborn. But the issue is not so simple. For reasons having to do both with the safety concerns raised above and with the social, psychological, and moral concerns to be addressed below, an attempt to clone a human being would potentially expose a cloned individual to great risks of harm, quite distinct from those accompanying other sorts of reproduction.

### **(3) Problems of Exploitation of Women**

Cloning may also lead to the exploitation of women who would be called upon to donate oocytes. Widespread use of the techniques of cloning would

require large numbers of eggs. Animal models suggest that several hundred eggs may be required before one attempt at cloning can be successful. The required oocytes would have to be donated, and the process of making them available would involve hormonal treatments to induce super ovulation. If financial incentives are offered, they might lead poor women especially to place themselves at risk in this way.

### **Other Issues of Importance**

So, keeping in mind the general observations about procreation, let us proceed to examine a series of specific ethical issues and objections to cloning human children:

- (1) Problems of identity and individuality
- (2) Concerns regarding manufacture
- (3) The prospect of a new eugenics
- (4) Troubled family relations and
- (5) Effects on society.

Cloning could create serious problems of identity and individuality. This would be especially true if it were used to produce “multiple copies” of any single individual, as in one or another of the seemingly far-fetched futuristic scenarios in which cloning is often presented to the popular imagination. Yet questions of identity and individuality could arise even in small-scale cloning, even in the (supposedly) most innocent of cases, such as the production of a single cloned child within an intact family. Personal identity is, we would emphasize, a complex and subtle psychological phenomenon, shaped ultimately by the interaction of many diverse factors. But it does seem reasonably clear that cloning would, at the very least, present a unique and possibly disabling challenge to the formation of individual identity.

Cloned children may experience concerns about their distinctive identity not only because each will be genetically essentially identical to another human being, but also because they may resemble in appearance younger versions of the person who is their “father” or “mother.” Of course, our genetic makeup does not by itself determine our identities. But our genetic uniqueness is an important source of our sense of who we are and how we regard ourselves. It is an emblem of independence and individuality. It endows us with a sense of life as a never-before-enacted possibility.

Everything of a clone is about the predecessor—from physical height and facial appearance, balding patterns and inherited diseases, to temperament and native talents, to shape of life and length of days, and even cause of death will appear before the expectant eyes of the cloned person, always with at least the nagging concern that there, notwithstanding the grace of God, go I.

The likely impact of cloning on identity suggests an additional moral and social concern: the transformation of human procreation into human manufacture, of begetting into making. Unlike natural procreation or even most forms of assisted reproduction—cloning would set out to create a child with a very particular genotype: namely, that of the somatic cell donor. Cloned children would thus be the first human beings whose entire genetic makeup is selected in advance. True selection from among existing genotypes is not yet design of new ones. Thus if cloning of humans comes into action then human birth will become similar to manufacturing of desired goods in industries as the process begins with a very specific final product in mind and would be tailored to produce that product. And also the clone will be psychologically affected with the relationships around him due to the reason that he has none called father, mother, brother or anything of that sort.

Cloning would be an experiment in family and social life, altering the relationships within the family and between the generations, for example, by turning “mothers” into “twin sisters” and “grandparents” into “parents,” and by having children asymmetrically linked biologically to only one parent. And it would represent a social experiment for the

entire society, in so far as the society accepts, even if only as a minority practice, this unprecedented and novel mode of producing our offspring.

None of the relations of a natural human being (a human born through natural means i.e., through sexual reproduction.) suits him and even the society’s remarks on him will be different, as the people around him will show a clear-cut demarcation.

### Many Unanswered Ethical Questions

Here, the natural reproduction of the cloned organisms also plays a role and makes a different sense with respect to cloning. For example, cloned cats multiply and raise different questions on cloning. They also leave many of the ethical questions unanswered. A few of them are:

(1) On what grounds could reproducing children by cloning be allowed or prohibited?

(2) Should cloning be allowed only for sterile couples or for homosexual couples who want biological offspring?

(3) Will a child born by “*asexual reproduction*” experience life as a “*unique individual*” or as a “*genetic prisoner*”? (4) Is a cloned child simply a twin of its genetic donor with a certain time lag?

All such issues preoccupy the minds of scientists and ethicists who see in cloning procedure the potential to endanger human identity. Thus, in spite of recent investigations and fast pace in science, cloning still remains a controversy with a lot of moral and ethical aspects and arguments following it.

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### About the Author

Name: Himaja Vedula.

Qualification: Pursuing graduation in life sciences.

Address: (1) Personal: F-5, Ranganayaki Apts., Krishna Nagar, Vishakhapatnam - 530002.

(2) College: Gayathri Vidya Parishad Degree College, Sector - 8, M.V.P Colony, Vishakhapatnam.

E-mail: vedula.himaja@gmail.com

# The Problem of Human Cloning and Multiplicity

Biraj Mehta

Department of Philosophy, University of Mumbai

## Introduction

*“What, then, is time?  
If no one asks me, I know.  
If I wish to explain it to one that asketh,  
I know not”*

- St. Augustine of Hippo

When St. Augustine of Hippo, the fourth century Church Father and philosopher, pondered the nature of time, even he, who had much to say about many things, expressed puzzlement, “Who,” he asked, “can even in thought comprehend it, so as to utter a word about it?...My soul is on fire to know this most intricate enigma.” (Langone, 2000, p.7).

Science too ponders over this elusive concept of time and discovers the Holy Grail that promises to unravel the secrets of eternity and immortality: - Cloning. The word clone in Greek means “twig”. A clone is an organism grown from the cells of one parent, instead of being produced by sexual means from the cells of two parents. Because a clone receives all its genes from the single parent, those genes are exactly the same as the parent and they direct the organism to develop in precisely the same form as the parent. (Hicks, 1992, p.56)

Nature itself is the greatest cloning agent. In about one of every seventy human conceptions, the fertilized ovum splits for some unknown reason and produces monozygotic (identical) twins. Each has a genetic makeup identical to the other. In cloning, this same operation is done intentionally in a laboratory.

Some very limited experimentation has been done on human embryos. (1) (Ray, Bohlin). In 1978, the Chicago *Sun Times* carried a review of a bestseller titled “*In His Image: The Cloning of a Man*”. It told the story of an elderly gentleman who set out to produce a clone of himself to race against time, a quest to produce replicas that would continue for generations, (without continuity of consciousness) and thus achieve a kind of immortality. (Hicks, 1992, p.56) The book set the entire scientific community and

everyone who read it sit up and read and talk more about cloning. “Experts “—explained the possibility of growing in the laboratory, from a single cell, human organs that would be identical to those inside a person’s body. These organs would be transplanted into the cell donor, replacing those damaged by age, disease, or trauma and restoring the physical functioning of youth. ... the duplicate form could also be frozen, they theorized? until such a time as its organs were needed as replacement parts: the clone would perform the role of a personal organ bank, rendering the current notions of aging and maximum life span obsolete.” (Hicks, 1992, p.57)

## A Multitude of Questions

A multitude of questions arise from discussions like these - How close are scientists to finding out a way to make a genetically perfect copy of individual human beings? Is the day dawning where one can make a choice between dying and living forever? Seeing through the eyes of the clone, what would this clone be like? Would it share the exact physical resemblances as well as the cell donors thoughts, likes, dislikes? What are the moral implications of such a project?

## Three Parts of this Paper

All these problems can be well illustrated and dramatized in Plato’s cave that is inhabited by the copies, replicas and clones of the real world. A visit into Plato’s enigmatic cave is reinterpreted as the scientist’s hub of harvesting clones and this part has been inspired by the movie ‘*The Island*’ directed by Michael Bay. It focuses firstly, to give a fictional representation of the questions raised. The second part of the paper raises some ethical issues related to the insatiable urge of human beings to survive. The third part of the paper aims to bring out the antithesis of Plato’s glorification of the real and the consequent condemnation of the copies and clones which eventually is a kind of appraisal of the quest of science and philosophy to defeat the natural process of nature and the possible alteration that cloning raises in the understanding of rebirth and immortality.

**I**

*Now the only real freedom is freedom from the known.*

- J. Krishnamurthy

1. "Imagine an underground chamber like a cave, with a long entrance open to daylight and as wide as a cave. In this chamber are men who have been prisoners there ever since they were children, their legs and necks being so fastened that they can only look straight ahead of them and cannot turn their heads. Some way off, behind and higher up, a fire is burning..." (Lee, 1974, p.241).

The prisoners in this cave know nothing of the outside world. All their needs are provided for and they see no need to question their existence. They know nothing of their purpose to belong there nor do they understand their emergence and departure from the cave. They believe that the departure from the cave is an escape into another better world. They have been taught that there exists a heaven, a real world or a place even better than the cave. It's just like a beautiful island with all the perfections and the only safe place beyond the cave. All men in the cave must depart gracefully and should wait patiently for the day when they be chosen to move out of this cave and go to this perfect destination. Their departure should be a joyous occasion<sup>3</sup> and in a way also their purpose of life. All the individuals in the cave are trained and educated to strive for this departure.

"Then think what would naturally happen to them if they were released from their bonds and cured of their delusions. Suppose one of them were let loose and suddenly compelled to stand up and turn his head..." (Lee, 1974, p.242) This individual would be able to undermine all carefully engineered and controlled conditions because of one quality; human curiosity. When he decides to investigate the nature of his controlled existence he treads on the rough ascent towards the light. On his way he sees a number of sights that at first seem incomprehensible and later horrifying. He sees secret chambers where there are huge pipes and huge water bags. In the water bags there are human like objects; naked and floating, they seem to be unaware of everything around them. The pipes were connected to the water bags and to their bodies. He then enters another room where there are more fully recognizable human bodies still devoid of consciousness, but their eyes are open. Above their eyes, there are screens where pictures of a beautiful island keep flashing. The voice in the video constantly

tells them that they contain within themselves the potential to become the chosen one to go to the island. All these sights baffle him and he feels a sense of being wronged every moment of his existence. He travels further and to his horror he sees people whom he had known as friends in the cave! They were first killed mysteriously and then their body was cut open and some body parts removed. These organs were then sealed and kept in what looked like huge refrigerators.

The entire episode was extremely painful and the individual cannot now see a single thing that he had earlier believed to be real! He is sure that things in the cave are not right and that the island does not exist. There was more to his existence in this cave. The cave was storehouse of some secrets that he was determined to unravel. The only way to know these secrets would be to get out of the underground cave and reach out for the surface where there would be sunlight. It is in daylight that his vision would be better and then he would be able to grasp the whole truth.

**He is a Clone**

He manages to come out of the cave with much difficulty and then, he feels the light of the sun shining on the twilight kind of existence in the cave. He realizes that he is a clone; a twin of the real people in the real world. They are the rich and famous who have plenty of wealth and power to buy their life. Their existence is secured by payments to insurance companies who harvest their clones in the cave and when the time comes to replace the faulty part of their body, the clones are used. The real people are the clients while the clones become their insurance policies. These are the clients who have the power and the insatiable urge to live, and they will do anything to survive. Their biological self is carefully decoded and through sophisticated technology, a replica is brought into existence. The replicas are incubated (the scenes of tubes and bags etc were actually huge incubators where the clones were "grown") and their physical self controlled to perfection before they are put through the sessions of artificially imprinting memories. Some visions of reaching out to the perfect island and some scenes from daily life are imprinted in their memories. It gave them a feel of their childhood memories and to make them believe in the aim to reach to the perfect island.

The individual now used to the sunlight understands the scenes he witnessed in the secret



rooms of the cave much better. These replicas, once mature are brought out of the secret rooms into the main cave to live with other fellow replicas to lead a routine life of controlled existence and a patient waiting period of going to the island. The island ultimately is not any perfect world. It is where the clone goes when the client is in danger and requires his death for his survival. The island is the mass illusion created so that the process of killing gets easier and safer for the scientists who have not only managed to create life but now will also dictate the event of death. The clients are made to believe that their clones who are eventually the donors are a mere product of their money and lots of sophisticated expertise. They are harvests and investments that are grown to be cut and used when the time comes. The replicas are after all only biological resemblances of real people; they possess no soul and no human emotions.

### **The dawn of truth**

The dawning of this truth makes the individual dizzy and he feels the brightness of the sun hurting him. The intensity of the truth and sun send tremors to his "soul" that now realizes the falseness of his existence. But something about that moment was not false; there was a sense of determination to save his friends in the cave, to get them curious, so that they question their existence, to let the people in the real world know that he and his friends are also like them; almost real people... the brightness of the sun increases, the individual runs to escape the heat and reach out to the descent of the cave...the sun spreads its light far...to consume the truth of which it is the source.

## **II**

*Images consult  
one  
another,  
a conscience-  
stricken  
Jury,  
and come  
slowly  
to a sentence.*

- A. K. Ramanujan

The sun in the above illustration represents the world of biotechnology and the scientific community that has made it possible to create life without any "natural" intervention. Broadly speaking, all apprehensions against the technology of cloning can be traced to four reasons.

### **1) A clone would not be a "real human"**

Cloning creates a new life without a father and reduces a mother to the provider of an egg. This determination of science to create life for scientific research raises moral questions related to 'dignity of life' rather than protecting life. The religious groups that are against the technology of cloning believe that the status of the clones is very ambiguous. Are the clones, individuals born with a soul or without a soul? Souls, according to religious groups, enter when the sperm and egg fertilize into an ovum. But since in the process of cloning there is no use of any sperm, does the clone have a soul? If the soul were in fact present in the individual then would it be ethical to dispose them after research or use them as means to serve some end?

These questions for the pro cloning group sound irrelevant. This is because they would argue that a clone would have exactly the same status that an identical twin already does. Both are derived from a single fertilized ovum. So the question of their status and dignity of life etc does not arise. If a zygote is going to be regarded to have a soul because it is a potential human being, then the sperm, egg all should be regarded as having a soul. They are all potential human beings. Further they are made up of skin cells then skin cells should also be regarded as having a soul. Why should soul enter in only at conception? Also whether there actually is a soul can be disputed. There is no sufficient evidence to prove that there does exist an imperceptible aspect called soul to human beings that contributes to it really being one. (Dunham, Will) Yet one may still be tempted to ask this question keeping the above story in mind - if the clone is identical in every way to the original such that he feels, acts, maybe shares common interests and even displays similar behaviour patterns; then should this almost real human being (the curious individual of the cave) be treated like a sample to be studied or a product to be harvested? What happens to respecting his instinctive urge to survive? This almost takes us to another area of controversy that compares our scientists to Gods and the social implications of it.

### **2) Cloning is "playing God"**

Human cloning allows man to fashion his own essential nature and turn chance into choice. For cloning advocates this is an opportunity to remake humanity in an image of health, prosperity and nobility and eventually an ultimate expression of the unlimited

potentiality of human beings. But what happens to the dignity and uniqueness of each being that is a product of diversity in evolution? There would be a complete break down in all diversity if scientists are going to decide what comes into existence at what time and for how long. It prevents an entire species to evolve and disappear because now they have been guarded against all diseases!

The 'God complex' that the scientists try so hard to imbibe may not have fruitful results in the larger context of evolution. There is a certain place given to all by nature or may be God. We must respect it instead of trying to master it. The opponents would argue that playing God argument can be refuted in the following way - God may not have given human beings wings, but he gave them brains to make airplanes and fly (Ray, Bohlin). Similarly we may not have been born as creators, it does not mean that we cannot and should not use the rationality gifted to us to become one. No scriptures have ever mentioned that heart transplant or airplanes or cloning is unethical and therefore such questions should not arise. Also the anti-cloning lobby fails to see how many lives can be saved by embryo cloning and research in this field.

The advantages and the implications are tremendous and overwhelming. It is only a matter of time when scientists will be able to create organs that are a perfect match for those in need for a transplant. The cloned organ would be based on the recipient's genetic material and would not require the use of any other therapy where there is a danger of rejection of the organ, which is extremely fatal. It seems to be the ideal procedure in organ transplantation and can prove to be great sources of organ bank that can increase the longevity of life. Creating life out of inanimate matter may be like playing God, but "cloning creates life from life" and is just an extension of routine in vitro fertilization procedures. (Ray, Bohlin)

But, scientific advancements so far have proved that there is no guarantee that the cloned human beings will turn out to be normal. The fetus may suffer from some disorder that is not detectable by ultra sound and may in fact be disabled. They may even occur later in life. Such cases have been noticed in cloning other mammals and there is no reason to believe that it cannot happen in humans. Again, going back to our individual of the cave (who seemed to have none of these problems because of technology that was perfected), isn't our heart still filled with sympathy

for him and not the scientists who used stem cells from human embryos and breeds people for the purpose of harvesting tissues and organs from their bodies and then simply disposing them off! Is respect and reverence of life limited to the upward movement in the hierarchy of created to the creator? Does the created deserve no other treatment other than being keys to satiate the survival instinct of the creator? Does the clone not have the right to dignity and respect just like the originals of which they are exact copies in every way possible? Probably the answer lies in the fact that they are not exactly "natural".

### 3) Cloning is not "natural"

As mentioned earlier in the introduction of the paper, cloning is an artificial process where an organism grown from the cells of one parent, instead of being produced by sexual means from the cells of two parents.

People have very different views of what is "natural". Embryo cloning still depends on a human egg from a woman and sperm from a man. Human embryo cloning just tweaks apart a zygote at the two-cell stage, changing a single two-cell form of life into two one-cell forms of life. One can argue that God did not intend cloning to be done. But the same argument was used, largely in the past, to oppose such techniques as in vitro fertilization. It all depends upon what one is used to, and what one considers to be "natural. Moreover it has a lot of advantages when it comes to improving reproductive technologies. Human cloning can prove effective in understanding the causes of miscarriage which may lead to treatment to prevent abortions. This would be good for women who cannot bring fetus to develop. Also it would be useful in understanding how a morula (a mass of cell) can attach itself to a wall of the uterus and thus prove to be an effective contraceptive without any side effects. It could also help us understand how cancer cells develop and thus may prove useful in countering the disease. Parents who are known to be at a risk of passing a genetic defect to a child could make use of the cloning method. A fertilized ovum could be cloned and the duplicate tested for the disease. If it was found free from the problem then the other cell would also be safe and it could be implanted in the mother and be allowed to mature. Cloning could produce a reserve for spare parts. Fertilized ova could be cloned to multiple zygotes and while one is allowed to mature into baby the others are frozen for further use. Transplants thus become easier and more effective.

The IVF technology would also see a boost as there would be many eggs that can be used for fertilization procedure. Moreover homosexuals and lesbians may also elect to have a baby by an adult DNA cloning rather than artificial insemination where the opposite sex's sperm or egg is required. Since cloning only requires a single parent there would be no need to have an outsider as a donor. (B. Robinson) But cannot this entire process generate more disasters? It would mean that zygotes of a particular gender etc could be eliminated without requiring any abortion. Further is it not possible that a country may finance projects like Nazi Germany where humans are bred to maximize certain traits? Once the perfect human is developed, embryo cloning would replicate it and produce a whole class of humans maybe suitable for exploitation - individuals with sub normal intelligence and above normal strength. Also there is a danger of replicating a dictator into innumerable individuals and help him achieve his aim of ruling the world! Also the embryo has potential for life and could be interpreted as living. To divide it during cloning can be equaled to the act of murder or assault. To treat the embryo as a commodity and not a person is problematic and raises the implicitly recurring theme of sanctity of life.

#### 4) Cloning denies the “sanctity of human life”:

The advocates of cloning constantly talk of improving of quality of life and increasing longevity of human beings as the justified grounds of cloning. Among some of the other arguments one is that Cloning will deconstruct the very nature of motherhood, parenthood and family.

*“...it is suggested that man's alienation from reproduction... sense of disconnection from the seed during the process of conception, pregnancy and birth - has underpinned through ages a relentless male desire to master nature, and to construct social institutions and cultural patterns that will not only subdue the waywardness of women but also give men a illusion of procreative power and continuity. New reproductive technologies are the vehicle that will turn men's illusions of reproductive power into a reality. By manipulating eggs and embryos, scientists will determine the sort of children who are born - make themselves the father of humankind...scientists will now gain unprecedented control over all reproduction itself. Motherhood as a unified biological process will be effectively*

*deconstructed: in place of 'mother' there will be possibly only ovarian mothers or social mothers who raise them. Through the eventual development of artificial wombs, the capacity will arise to make biological motherhood redundant.” (Stanworth, 1987, p.16)*

Also, relationship between the family and a clone of one of the family members who is only a ‘delayed twin’ becomes complex; it eventually challenges the emotional bonding of all family members. Thirdly, a mockery of sanctity of life is obvious when, during the transplant, the clone could be robbed for a needed organ, or sometimes even loses a life. The activity seems nothing less than a murder.

The advocates of the cloning technology find this argument irrelevant; one has to separate possible abuses of a technology from the debate over whether a technology is moral. Quantum physics is not immoral because it has been used to design nuclear weapons. How is one to make sense of all these arguments that promise humankind an almost eternal youth and health? “If immortality is out of reach, many would gladly settle for a lesser, but still elusive, fate: to live for decades or centuries beyond the ordinary life span.” (Ettinger, 1964, p.132)

### III

*Two birds, companions and friends,  
Cling to the same tree.  
One of them eats the sweet pippala-berry:  
The other looks on, without eating.*

- Svetasvatara Upanishad, Book Four, Verse Six

Cloning is definitely an expression of the instinctive urge of humankind to postpone death indefinitely. This quest for immortality has been the core of philosophic speculations as well as scientific investigations. Philosophers have glorified immortality and imbued in the readers and listeners the quest to escape a fleeting existence marked by the event called death. They offer various solutions of spiritual emancipations. Similarly science strives to unravel all the secrets of existence so as to conquer it and assign a different role and status to the existence of the rational beings defying the complexities of “natural existence”.

The question that seems central to all ethical dilemmas of the science of cloning is what is this “natural existence”? Is “natural” that which is designed and governed by the master architect called



Gods, or is it that which is produced by nature, or is it that which is innate and not acquired, or is it anything that is man made and not divine? Correspondingly the question central to the philosophy of multiplicity is what is “real existence”? Is it that which is actual, certain, literal, positive, substantial, substantive, veritable, authentic, genuine, true, essential, internal, rational, intrinsic and innate; or is real that which is practical, and factual?

As observed earlier, Plato’s cave was a store house of all copies of the “real world”. They were replicas of the real and were constantly deceived into believing that they were real. It is only in “the better light of knowledge free from deception” that they realize that their existence is totally dependent on the outside world, which is the source of their existence. The relation between the multiplicity and the real is that of ‘presence’. The particulars are said to ‘share in’ or ‘partake of’ the forms.

The individual of our story in the cave is also a product of the DNA split of the real person of the outside world and thus his physical structure also ‘participates’ and contains the ‘presence’ of the real. But since this individual is not actually “real” in the sense that his origins are not mystical and divine but man made, this clone does not carry any sanctity that is normally attached to life. In fact his existence is only relevant so long as the real sees the significance of emancipation in it. Multiplicity and plurality is a threat to all rationality in the sense that absorption in it can make one forget the truth of its existence and in such cases the only solution is to eliminate it. Plurality of lives and the cycle of birth and rebirth has similarly been disrespected both in eastern and western traditional philosophies. Liberation and emancipation has always been interpreted as freedom from all kinds of plural recurring existence. It is only when an individual is freed from this circle of life and death that one can reach out to its real existence which is free from all pain, contradiction and defects.

### **Science and Immortality**

It is this naturally (in the essential sense) perfect state that can be defined as immortality. Science takes this quest for immortality to the more practical realm of facts. Incidentally, though the aim of both science and philosophy is same, philosophy would dispute the nature of this quest in the empirical world as a superficial activity. They would believe that only by making an appeal outside the factual realm can immortality be attained. Science redefines the concept

of immortality, rebirth and resurrection by making it all possible in the sphere of human experience. It stripes these concepts of all mystical and divine affinities and restricts its meaning to making the body immune to death, corruptibility and destructibility. The curiosity to know it all, the survival instinct and principles of adaptability dominate the quest. The search for immortality in this sense becomes natural for scientists.

This attitude of philosophy and science has raised the following question. What is it to be immortal? Immortality surely seems to be the core of all speculation. But what is this state? Is it ever lasting existence in the empirical sphere, or is it a merger into the enigmatic cosmic secrets that are out of the reach of all mankind? The answer in affirmative to the former question would imply that to multiply beyond the ordinary course of nature, i.e. cloning, is no doubt the highest humanitarian ideal. In that case, one must respect the multiplicity that in fact only seems dependent on the real. The relation is actually that of interdependence. Both require each other for their ever-lasting existence. If the answer were negative, then one would justify it by defining immortality that comes closer to the latter part of the question. In that case too one would require several births to understand and come to terms with their ignorance. It is only in the multiplicity of the existence that they will grasp its futility and aspire for a spiritual uplifting. Either way, plurality, clones or multiplicities of the same individual will have to be respected.

### **Concluding Remarks**

Before I end my paper I would like to caution all those who read this paper as a perspective defending the technology of cloning. This paper only aims to highlight the insight that as long as objectivity, ceaselessness and a glorification of permanence over impermanence remains the focus of all investigation, empirical or speculative, multiplicity that expresses itself in activities like cloning will have to be accepted as one of the methods to achieve immortality. What is natural, as mentioned above, can be disputed, and thus to call it unethical on those grounds is inappropriate. Once the world of clones is taken seriously and addressed with a little more respect, methods will have to be devised to preserve their integrity as well as serve the purpose for which they are brought into existence. Whether this is possible and whether this sensitivity will ever see the light of day, whether the light of the sun (of Plato’s cave)



consumes the truth or nurtures the truth, is a question that should not deter us from painting the possibilities.

If one is pessimistic to this whole prospect then the only possibility is to reject this technology. It would mean that one has to even do away with the seriousness of the glorification of metaphysical immortality principle which may beyond doubt be a simpler option.

To me this option seems unlikely to be embraced by larger race of humankind that seems obsessed from time immemorial to unravel the secrets of time and life. Besides it would also mean curbing human curiosity. If so, then the challenge before us then becomes as profound as Hamlet puts it, "...to be or not to be..."

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## The Jain Concept Of Sallekhana : A Loss Or a Gain ?

**Kokila H. Shah**

*Hon. Visiting Prof., K.J. Somaiya Centre For Studies in Jainism, Vidyavihar, Mumbai-400077.*

*Email: [shah\\_kokila@rediffmail.com](mailto:shah_kokila@rediffmail.com)*

### Abstract

The Concept of *Sallekhana* is an important contribution of the Jainas to biosocial ethics. *Sallekhana* is facing death by an ascetic or a layman voluntarily when he is nearing his end and when normal life is not possible due to old age, incurable disease etc. after subjugation of all passions and abandonment of all attachment. To begin with, it must be stressed that the vow of *Sallekhana* as propounded by Jainism is not suicide. It can be called voluntary death or passionless death. Its main objective is to make thin the passions that disturb equanimous state of the soul. The vow has psychological religious and spiritual significance. Psychologically, the individual is to fight against the feeling of grief, fear, anguish etc.

It is a vow to be adopted for seeking liberation of the soul from the body as a religious duty. The basic concept underlying the vow is that man, who is the master of his own destiny, should face death in such a way as to prevent influx of new *karmas*.

The object of the present paper is to give a brief outline of the Jaina concept of *Sallekhana* and evaluate it in the light of contemporary discussion.

Some has criticized this vow. Externally, critics might identify it with suicide. But one must not be misguided by external procedure of its observance. It is no doubt fasting unto death. But, considered philosophically, the man observing *Sallekhana* is definitely gaining from spiritual point of view, particularly in the special situation in which he is put. The problem of voluntary death can be viewed from different aspects- the factors of intention, situation etc. In my view, the observance of this vow is a conscious and well-planned penance for self-realization. However, if *Sallekhana* is considered only as a ritual or a tradition without consideration of noble intention, although there may be external accomplishment, spiritually there will be no gain.

In short, *Sallekhana* is preparedness to be fearless in the face of impending death. It is death through *Samadhi*.

### Introduction

Jaina religious system represents *sramana* current of thought, which lays adequate emphasis on practicing asceticism. As a system of philosophy, Jainism can be characterized as ethical realism in which right conduct is an essential condition for spirituality. It is important to develop an attitude of mind which brings about restraint, self-discipline and non-attachment. Focus is on equanimity of thought and conduct. Fasting, meditation and other austerities are the part of Jaina way of life. Penance occupies a unique place in Jainism. Perhaps, in the world religions, none parallels Jaina religion in the practice of penance, which is for spiritual purification.

*Sallekhana*, which is fasting unto death, is the intense penance which is undertaken by the aspirant at the last moments of his life. In Indian tradition, voluntary death such as practices of Sati etc. are not

new phenomena. Some religions do not advocate voluntary deaths. In Christianity the commandment is 'Thou Shall not kill, neither thyself nor another.' Medical termination of life is the discovery of 21<sup>st</sup> century. In Jainism sacrifice of one's life has never been criticized. Of course it should be for a good cause. Obviously when the cause is one's own spiritual good, it is advocated.

The object of the present paper is to give a brief outline of the conception of *Sallekhana* as recognized in Jainism and evaluate it in the light of contemporary discussions on it.

### Jaina Ethical Code and *Sallekhana*

Jaina ethical code is intended to discipline the body and the mind, to create an awareness of the higher values of life. There are many different kinds of vows to be followed by a householder and an