EUTHANASIA AND ASSISTED SUICIDE IN PERSONS WITH ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS)

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DECLARATION

I Declare that:

1. This project report is based on a study carried or undertaken by me in the Department of Philosophy, University of Benin under the supervision of Professor Omonjezele Peter

2. This work has not previously been submitted for award of a degree elsewhere.

3. All ideas and views are product of my personal research effort and where the views of others have been expressed, they have duly acknowledged.

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CERTIFICATION

This is to certify that this project work was carried out by DAVID FELIX UFOMA under the supervision of PROFESSOR OMONJEZELE PETER and that the project report is adequate for the award of bachelor of sciences (B.A), Degree in Philosophy from the Department of Philosophy, University Of Benin, Benin City.

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Date:_____

DEDICATION

This project work is dedicated to GOD ALMIGHTY for HIS Grace and Mercies to me and to my Wonderful Parents and the entire UFOMA'S Family for making my academic pursuit a reality.

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I wish to accord special thanks to all those who have contributed to this work and have influenced my life in one way or another whose names were not mentioned ,please know that you are thankfully acknowledged in my heart

May GOD in HIS Infinite wisdom, love mercy, and kindness bless you all abundantly (Amen)

Above all, I, indeed express my gratitude to GOD ALMIGHTY for turning my dream into reality, who saw me through by granting me the Wisdom, Knowledge, Protection and Inspiration to get to this height.

TABLE OF CONTENT

CHAPPTER ONE

INTRODUCTION

1.1 Background to the study

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

Countries have attempted to legalize medically assisted suicide for terminally ill patients, through what is generally referred to as death with dignity." voters have rejected the legalization of medically assisted suicide because of fears that assistance in death will establish the predicate for coercion, abuse and possibly involuntary extermination of people based on a diagnosis of terminal illness. Yet anecdotal reports in newspapers throughout the United States indicate that more often than one realizes, a person suffering from a terminal

illness chooses to end a prolonged decline into death and seeks assistance in executing such a decision. Many of the accounts of assisted suicide involve people suffering from acquired immune deficiency syndrome (AIDS).

Euthanasia and assisted suicide in patients with AIDS is occurring with an unknown frequency. AIDS patients often seek assistance from compassionate doctors who risk their careers and legal prosecution by facilitating their deaths (Slome, 1990). Persons with AIDS sometimes request medications from several physicians in an effort to accumulate enough pills to successfully commit suicide. To avoid legal liability, physicians who grant a patient's request for lethal medications may prescribe sedatives or narcotics with specific, carefully worded instructions about lethal dosage, and the dangers of combining the medication with alcohol (Slome, 1990).

The cost of health care, the social attitude toward HIV and AIDS infection, and the preliminary stage of medical research in this area create a heightened possibility for persons with AIDS to contemplate suicide regardless of the stage of their disease progression. The legalization of physician assistance in such decisions may make suicide an expectation for persons with AIDS rather than a legal and voluntary option. Thus, AIDS fuels valid fears on individual regarding medically assisted suicide and also provides a context for assessing the merit of legalizing such an option. AIDS is a compelling impetus for medical assistance in death and a mandate for safeguards to protect against the potential for coercion and abuse associated with medically assisted suicide.

legalizing medically assisted suicide runs counter to the basic ideal of modern health care, which operates to extend life as long as possible. Nevertheless, some people afflicted with protracted, irreversible and terminal illnesses seek assistance through medication in order to die peacefully and without pain when they can no longer endure the suffering associated with the natural course of dying." Medically assisted suicide entails the assistance by a physician, through either prescribing or administering an overdose of sedative medication, when a person decides to terminate his or her life (Seay, 2001) Increased individual exposure to the "lingering death of a loved one" as a consequence of life-sustaining treatment has fostered public support for medically assisted death (Harris,2003) Many people seek an earlier alternative to refusing life-prolonging measures in a hospital setting.

1.2 Statement of the problem

Current efforts to legalize euthanasia place our society at a critical juncture. These efforts have received growing public attention, due to new publications giving advice on methods of suicide and some highly publicized instances in which family members or physicians killed terminally ill persons or helped them kill themselves. There is fear that the legalization of euthanasia will have detrimental effect with regard to vulnerable population and to the fact that it will transform a healing profession into a killing profession. The slippery slope argument should be enough reason to criminalize euthanasia and or assisted suicide. This is so because if euthanasia is legalized, people especially the physicians and

family members or relations who may have certain interests on the death of the patient may take advantage of the legal frame-work in place to coax the patient into voluntary euthanasia.

There are certain interests that infiltrate in the mind of the decision makers of euthanasia which include: the relatives-who may have a vested interest in the estate of the terminally ill person; the doctor who has lost interest in a protracted and difficult case; and the hospital administrator, who is short of beds. These factors play a secrete role when deciding on what becomes of the terminally ill patients. In view of this, no other person will bear witness as to what transpired between the family relatives and the physician except death.

Those who advocate euthanasia have capitalized on people's confusion, ambivalence, and even fear about the use of modern life-prolonging technologies. Further, borrowing language from the abortion debate, they insist that the "right to choose" must prevail over all other considerations. Being able to choose the time and manner of one's death, without regard to what is chosen, is presented as the ultimate freedom. A decision to take one's life or to allow a physician to kill a suffering patient, however, is very different from a decision to refuse extraordinary or disproportionately burdensome treatment.

Legalizing euthanasia would also violate convictions about human rights and equality. The Declaration of Independence proclaims our inalienable rights to "life, liberty and the pursuit of happiness." If our right to life itself is diminished in value, our other rights will have no meaning. To destroy the boundary between healing and killing would mark a

radical departure from longstanding legal and medical traditions of our country, posing a threat of unforeseeable magnitude to vulnerable members of our society. Those who represent the interests of elderly citizens, persons with disabilities, and persons with AIDS or other terminal illnesses, are justifiably alarmed when some hasten to confer on them the "freedom" to be killed.

1.3 Research Objectives

The broad objective of the study is to examine euthanasia and assisted suicide in person with acquired immune deficiency syndrome (aids). Specifically the purpose of this study include to:

1. Determine the condition that is permissible for patient to arrange for euthanasia in AIDS
2. Examine the condition permissible for physician to arrange for euthanasia in aids patient
3. Examine whether patient consent is needed in euthanasia in aids
4. Determine public perception in assisted suicide in person with acquired immune deficiency syndrome (AIDS).

1.4 Research question

Against the backdrop of the above, the following research were addressed:

1. What condition is permissible for patent to arrange for euthanasia in AIDS
2. What condition is permissible for physician to arrange for euthanasia in aids patients.
3. Does patient consent needed in euthanasia

4. What is the perception of the public in assisted suicide in person with acquired immune deficiency syndrome (AIDS),

1.5 Significance of the study

This investigation is aimed at euthanasia and assisted suicide in persons with acquired immune deficiency syndrome (AIDS), Thus knowledge obtained would be useful in the formulation of recommendations to address euthanasia and assisted suicide in person in Nigeria and the world at large.

The study can serve as a guide to medical personnel, policy makers and stakeholders of medical institutions in the country and it can also be used as a guide to other researchers who may wish to carry out further research on related topics.

Finally the study could contribute to further the research on euthanasia and assisted suicide in person with acquired immune deficiency syndrome (AIDS), and how to manage them by adding to the existing literature

1.6 Research Methodology

The instrument used for data collection is a well-structured questionnaire developed by the researcher. The questionnaire is made up of two sections. Section A consist of demographic variables (sex, age, marital status and educational status) of the respondents while section B consists of items which deal with euthanasia and assisted suicide in person with acquired immune deficiency syndrome (AIDS). All the items will be based on the

modified four point likert-Scale of Strongly Agree (SA), Agree (A), Disagree (D) and Strongly Disagree (SD).

The fully completed questionnaire will be analyzed using the descriptive statistics of frequency count and percentage.

1.7 Review of Literature

Among persons with AIDS, accounts of suicide have mostly been anecdotal or clinical. In a study of factors that influence suicidal intent, Schneider et al. (1991) compared suicidal ideation in 778 bisexual and gay HIV negative men with 212 HIV positive men, They concluded that "among HIV-positive (suicide) ideators, AIDS-related death and illness events predicted suicidal intent, but not current distress symptoms. Some suicidal ideation in response to AIDS-related events may be an effort. to cope rather than a manifestation of psychological distress" (Schneider et al., 1931, p. 776). That is, among the general population, suicidal ideation has mainly been associated with depression and hopelessness (See Schotte & Clum, 1982), whereas among HIV-positive men: "mood disturbance, loneliness, lack of perceived control over AIDS risk, and AIDS-related life events ... were associated with reporting suicidal ideation" (Schneider et al., 1991, p. 784).

Establishing the extent of AIDS-related suicide behaviour is difficult. It is likely that the number of AIDS-related deaths due to suicide is under-reported (Marzuk et al., 1988; Cote et al., 1992). This may be attributed to medical examinations where the medical examiner is unaware of the suicide victim being diagnosed with AIDS. Some physicians may unwittingly register a suicide as an AIDS-related death simply because the suicide was

unsuspected or carefully concealed. In other cases, suicides may not be documented at the request of family or friends, or to protect insurance benefits (Slome, 1990)

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

CHAPTER TWO

2.0 REVIEW OF LITERATURE

2.1 THE CONCEPT OF EUTHANASIA AN HISTORICAL PERSPECTIVE

Historically Euthanasia was practiced in Ancient Greece and Rome: for example, hemlock was employed as a means of hastening death on the island of Kea, a technique also employed in Marseilles and by Socrates in Athens. Euthanasia, in the sense of the deliberate hastening of a person's death, was supported by Socrates, Plato and Seneca the Elder in the ancient world, although Hippocrates appears to have spoken against the practice, writing "I will not prescribe a deadly drug to please someone, nor give advice that may cause his death" (noting there is some debate in the literature about whether or not this was intended to encompass euthanasia) (Mystakidou Parpa, Tsilika, Katsouda, & Vlahos., 2005; Stolberg, 2007; Gesundheit Steinberg, Glick, & Jotkovitz, 2006).

Euthanasia was strongly opposed in the Judeo-Christian tradition. Thomas Aquinas opposed both and argued that the practice of euthanasia contradicted our natural human instincts of survival, as did Francois Ranchin (1565–1641), a French physician and professor of medicine, and Michael Boudewijns (1601–1681), a physician and teacher (Stolberg, 2007; Gesundheit et al, 2006). Nevertheless, there were voices arguing for euthanasia, such as John Donne in 1624, (Mannes, 1975), and euthanasia continued to be practiced. Thus, in

1678, the publication of Caspar Questel's *De pulvinari morientibus non subtrahend*, ("*On the pillow of which the dying should not be deprived*"), initiated debate on the topic. Questel described various customs which were employed at the time to hasten the death of the dying, (including the sudden removal of a pillow, which was believed to accelerate death), and argued against their use, as doing so was "against the laws of God and Nature". This view was shared by many who followed, including Philipp Jakob Spener, Veit Riedlin and Johann Georg Krünitz (Stolberg, 2007). In spite of opposition, euthanasia continued to be practiced, involving different techniques *i.e.* bleeding; suffocation and removing people from their beds to be placed on the cold ground (Stolberg, 2007).

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

In the mid-1800s, the use of morphine to treat "the pains of death" emerged, with John Warren recommended its use in 1848. A similar use of chloroform was revealed by Joseph Bullar in 1866. However, in neither case was it recommended that the use should be to hasten death. In 1870 Samuel Williams, a school teacher, initiated the contemporary euthanasia debate through a speech given at the Birmingham Speculative Club, which was subsequently published in a one-off publication entitled *Essays of the Birmingham*

Speculative Club, the collected works of a number of members of an amateur philosophical society (Emanuel, 1994). Williams' proposal was to use chloroform to deliberately hasten the death of terminally ill patients.

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

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

in 24 July 1939 killing of a severely disabled infant in Nazi Germany was described in a BBC "Genocide under the Nazis Timeline" as the first "state-sponsored euthanasia". *The Telegraph* noted that the killing of the disabled infant—whose name was Gerhard Kretschmar, born blind, with missing limbs, subject to convulsions, and reportedly "an idiot"— provided "the rationale for a secret Nazi decree that led to 'mercy killings' of

almost 300,000 mentally and physically handicapped people". While Kretchmar's killing received parental consent, afterwards, most of the 5,000 to 8,000 killed children were forcibly taken from their parents.

2.2 HISTORY OF EUTHANASIA IN NIGERIA

The practice of euthanasia and assisted suicide can be said to be denuded of any history in Nigeria. What may however be said to be something similar to non-voluntary euthanasia was practised by the beleaguered Nupein the present Niger State. This practice was not limited to them alone; it also extended to all other ethnic groups who were involved in inter and intra tribal wars of the 19th and 20th centuries (Omipidan, 2014). The nature of this non-voluntary euthanasia was the killing of infants. These infants were usually exposed by their parents as a way of running for cover to avoid being caught by the enemies. Considering the fact that lots of things happened during wars, the children usually cry endlessly, largely due to illnesses and hunger. These cries may attract the enemies to know the hiding place of their allies. So as a way of avoiding being caught, they will abandon the children. This is so because the wailings of the babies could attract enemies to their place. To therefore avoid being caught by the enemies, babies will be abandoned while they too scurry to hide. Thus after being bitten by rain, sunshine, infections and most importantly hunger, many of them died.

What may be viewed as the present day euthanasia can also be related to the old practices in the present southeastern part of the country, wherein the custom and tradition of the people permits killing of twins. It was seen as abomination for a woman to give birth to

two set of children at a blow. The custom made it compulsory for the parents of such baby twins to kill them immediately or sooner after their birth, and throw them at the evil forest (Otani, 2010). However, what should call to our mind is the manner such infants were killed. It could be noted that some parents had the mind or morale to physically kill those children by either strangling them to death or stopping their breath. Some who could not have such mind looked for certain herbal concoction which they either prepared themselves, or obtained from a herbalist and administer such poisonous locally-made substance orally to the newly born twins, which would incidentally lead to their death.

It could be noted that it is obligatory upon the parents of such infants to kill them, because giving birth to twin is considered as taboo then, and any parents or family that refused to perform the killing would be either ex-communicated or banished from the village. It could be gathered that this practice persisted till late 1940's when the missionaries and foreign humanitarians such as Mary Sellessor fought vigorously against it. It took a serious intervention from both the Nigerian government and foreign humanitarians to stop this practice. But that notwithstanding, the practice kepton going until it was criminalized as infanticide. Thus, in the case of Rv. Chima, a woman gave birth to twins and within an hour afterward, she killed them because of a custom prevalent in her town that it was an abomination to give birth to twins. She was convicted of murder but on appeal, it was held that the conviction, if any, should have been for infanticide, and not murder.

The history of euthanasia in Nigeria cannot be without mentioning the Supreme Court decision in Medical and Dental Practitioners Disciplinary Tribunal. the Supreme Court per

among other things that, ‘if a competent adult patient exercising his right to reject life saving treatment on a religious grounds, thereby chooses a patch that may ultimately lead to his death, in the absence of judicial intervention overriding the patient’s decision, what meaningful option is the practitioner left with, other, perhaps than to give the patient the comfort?’48It was also the Supreme Court decision in this case that a patient has a constitutional right to object to medical treatment on religious grounds. In that decision, the Court held that “the right to freedom of thought, conscience or religion implies a right not to be prevented, without lawful justification, from choosing the course of one’s life, fashioned on what one believes in, and a right not to be coerced into acting contrary to one’s religious belief.” The court also stated that the physician can lawfully withdraw any form of treatment on a patient who by refusal of blood transfusion consented to die on ground of religion. A careful perusal of this judgment by the apex court in the country shows that the Supreme Court of Nigeria has expressly or by implication approved passive euthanasia in Nigeria.

Thus it can be said that euthanasia and or assisted suicide is illegal in Nigeria. This illegal status is however not as a result of any special legislation, but as based on existing laws which do not specifically provide for euthanasia and assisted suicide. (Manning, 2012). As started from the ancient time, across the countries and jurisdictions that have legalized same till date, debates on same are already on. A school of thought may be of the opinion that a call for legislation at this stage is premature, since agitation on the issue is yet to begin.

2.3 ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS) AND SUICIDE

The relationship between medical illness and suicide has generally been focussed on mental disorder or cancer (Lester, 1992), with little scholarly research about AIDS and suicide. In an attempt to identify risk factors for suicide in HIV screening, Rundell et al. (1992) compared 15 HIV positive suicide attempters with 15 HIV positive non- attempters of suicide. The risk factors for suicide attempts in the sample population were: "social isolation, perceived lack of social support, adjustment disorder, personality disorder, alcohol abuse, HIV-related interpersonal or occupational problems, and past history of depression.

Among persons with AIDS, accounts of suicide have mostly been anecdotal or clinical. In a study of factors that influence suicidal intent, Schneider et al. (1991) compared suicidal ideation in 778 bisexual and gay HIV negative men with 212 HIV positive men, They concluded that "among HIV-positive [suicide] ideators, AIDS-related death and illness events predicted suicidal intent, but not current distress symptoms. Some suicidal ideation in response to AIDS-related events may be an effort. to cope rather than a manifestation of psychological distress"

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Schneider et al. (1991, p. 785) theorized that, "in view of the severe, uncontrollable, future threat posed by AIDS, suicidal thoughts may serve the function of cognitive mastery

(Taylor, 1983)." That is, for asymptomatic persons with HIV, consideration of suicide may be helpful for the individual to continue to manage with a "greater sense of control in the face of a severe future threat" (Schneider et al., 1991). The authors illustrate such coping with the following response of a suicide ideator:

The researchers reported that suicidal ideation as an adaptive or coping function has been "relatively unexplored in the research literature" and "demands further investigation" (Schneides et al., 1991)

Copeland (1993) studied suicide in persons in Dade County, Florida, who were diagnosed with HIV/WIDS or who thought that they had the disorder. His study consisted of 25 case vignettes of completed suicides from 1985-1989. It appeared, in retrospect, that suicidal tendencies were observed in all of the cases. A range of methods were used, although it appeared that they used whatever was close at hand

2.4 TYPES OF EUTHANASIA

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

2.4.1 Voluntary euthanasia:

Euthanasia conducted with the consent of the patient is termed voluntary euthanasia. Active voluntary euthanasia is legal in Belgium, Luxembourg and the Netherlands. Passive voluntary euthanasia is legal throughout the U.S. per *Cruzan v. Director, Missouri Department of Health*. When the patient brings about his or her own death with the assistance of a physician, the term assisted suicide is often used instead. Assisted suicide is legal in Switzerland and the U.S. states of Oregon, Washington and Montana.

2.4.2 Non-voluntary Euthanasia

Euthanasia conducted where the consent of the patient is unavailable is termed non-voluntary euthanasia. Examples include child euthanasia, which is illegal worldwide but decriminalized under certain specific circumstances in the Netherlands under the Groningen Protocol.

Involuntary euthanasia: Euthanasia conducted against the will of the patient is termed involuntary euthanasia.

Passive and active euthanasia:

Voluntary, non-voluntary and involuntary euthanasia can all be further divided into passive or active variants (Rachels, 1975). A number of authors consider these terms to be misleading and unhelpful. Passive euthanasia entails the withholding of common treatments, such as antibiotics, necessary for the continuance of life (Harris, 2001). Active euthanasia

entails the use of lethal substances or forces, such as administering a lethal injection, to kill and is the most controversial means. Active euthanasia results from acts of commission, like administration of medications that hasten the process of dying such as barbiturates, opioids, etc. Passive euthanasia involves acts of omission which often involves withdrawing of life-supporting measures like artificial feeding and artificial respiration (Tillyard, 2007; Patra & Patro, 2012).

Views against Euthanasia

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

Views in favor of Euthanasia

• Being the sole custodian of one's life, one has the right to end his life when he wishes: It is generally accepted that as an expression of autonomy *i.e.* one's right to make independent choices without any external influences, a competent adult can refuse medical treatment, even in situations where this could result in his/her death. For instance where a person has been totally incapacitated physically and mentally who does the decision making for him. Much of the pro-euthanasia argument is based on a commitment to the notion of personal autonomy. Yet people with disabilities, those suffering from chronic physical or mental pain or otherwise vulnerable are more susceptible to the power of suggestion and therefore less autonomous. Proponents argue that euthanasia allows terminally ill people to die with

dignity and without pain and state that society should permit people to opt for euthanasia if they so wish. Proponents also state that individuals should be free to dictate the time and place of their own death. Finally, proponents argue that forcing people to live against their wishes violates personal freedoms and human rights and that it is immoral to compel people to continue to live with unbearable pain and suffering.

Helping some die (to relieve pain and suffering) does not amount to murder. It would help by reducing unnecessary financial burden. Opponents of euthanasia, on religious grounds, argue that life is a gift from God and that only God has the power to take it away. Others contend that individuals don't get to decide when and how they are born; therefore, they should not be allowed to decide how and when they die. They also raise concerns that allowing euthanasia could lead to an abuse of power where people might be euthanized when they don't actually wish to die.

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

2.5 EFFECTS OF PHYSICIAN-ASSISTED SUICIDE AND EUTHANASIA ON PARTICIPATING PHYSICIANS

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

An important component of the assisted suicide debate concerns the ability of medically ill patients to make competent, informed decisions about physician assisted suicide. The potential for such decision making to be compromised by the presence of pain, depression, or other psychosocial factors (e.g., fear of becoming a burden) is a significant concern in any assessment of a patient’s request for assisted suicide or euthanasia. Proponents of legalization of assisted suicide suggest that interest in a hastened death may be a rational decision for individuals with a terminal illness. Clinicians, family members, and medically

ill patients cite the potential for, and fear of, cognitive and/or physical deterioration, pain, and emotional suffering as the basis for such requests. Other proponents cite respect for patient autonomy as another justification for legalization of assisted suicide (Emanuel, 1994), suggesting that patients have the right to self-determination in choosing the time and manner of their deaths

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

Pro-euthanasia Argument

Legalizing euthanasia would help alleviate suffering of terminally ill patients. It would be inhuman and unfair to make them endure the unbearable pain. In case of individuals suffering from incurable diseases or in conditions where effective treatment

wouldn't affect their quality of life; they should be given the liberty to choose induced death. Also, the motive of euthanasia is to "aid-in-dying" painlessly and thus should be considered and accepted by law. Although killing in an attempt to defend oneself is far different from mercy killing, law does find it worth approving. In an attempt to provide medical and emotional care to the patient, a doctor does and should prescribe medicines that will relieve his suffering even if the medications cause gross side effects. This means that dealing with agony and distress should be the priority even if it affects the life expectancy.

Euthanasia follows the same theory of dealing with torment in a way to help one die peacefully out of the compromising situation. Euthanasia should be a natural extension of patient's rights allowing him to decide the value of life and death for him. Maintaining life support systems against the patient's wish is considered unethical by law as well as medical philosophy. If the patient has the right to discontinue treatment why would he not have the right to shorten his lifetime to escape the intolerable anguish? Isn't the pain of waiting for death frightening and traumatic? Family heirs who would misuse the euthanasia rights for wealth inheritance does not hold true. The reason being even in the absence of legalized mercy killing, the relatives can withdraw the life support systems that could lead to the early death of the said individual. This can be considered as passive involuntary euthanasia.

Here they aren't actively causing the death, but passively waiting for it without the patient's consent. It can be inferred that though euthanasia is banned worldwide, passive euthanasia has always been out there which can also be called as passive killing and moreover law doesn't prohibit it. Disrespect and overuse of (passive) euthanasia has always

existed and will be practiced by surrogates with false motives. These are the ones who don't need a law to decide for one's life. Present legal restrictions leave both the incurable patients as well as pro euthanasia activists helpless who approve euthanasia as good will gesture for patient's dignity. Health care cost is and will always be a concern for the family irrespective of euthanasia being legalized.

Cons of Euthanasia Argument

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

being mishandled. How would one assess whether a disorder of mental nature qualifies mercy killing? What if the pain threshold is below optimum and the patient perceives the circumstances to be not worthy of living? How would one know whether the wish to die is the result of unbalanced thought process or a logical decision in mentally ill patients? What if the individual chooses assisted suicide as an option and the family wouldn't agree?

2.6 PSYCHOLOGICAL, MEDICAL AND ETHICAL ISSUES

2.6.1 Relation between psychological factors, mental illness and euthanasia:

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

depression. It has been suggested that the key to preventing suicide is not in the study of the brain, but in the direct study of the human emotions (Shneidman & Schneidman, 1996).

2.6.2 Psychological Sectors and Euthanasia:

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

2.6.3 Psychiatry and Euthanasia:

The two places in the world where mercy killing is legalized are the state of Oregon in USA and the Netherlands. The latter has also approved of euthanasia and PAS for mentally ill patients. The laws pertaining to euthanasia and physician assisted suicide (PAS)

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

The attitude of mental health professionals is interesting with respect to euthanasia/PAS. Though a good number of psychiatrists endorse their support for PAS, only

a minority of them agree to involve in the assessment of patients requesting for PAS. If we look at consultation liaison psychiatrists (who are more likely to involve in the care of terminally ill), they uniformly oppose euthanasia and PAS.

2.6.4 Medical issues:

On a purely medical level, it is often argued that mental disorders are distinct from somatic disorders, and that the reasoning and practice adopted in somatic medicine should not therefore be simply applied in psychiatry. This argument is supported by the fact that the causes and psychopathology of mental disorders are often poorly understood and multifactorial (Kelly & McLoughlin, 2002). The DSM–IV is the most widely used system of psychiatric diagnosis. Although much better than its predecessors, but still there is a great need of considerable improvement. In many cases its categories seem to be artificial, in that they do not represent valid disease entities. It is probable that mental health and disease are dimensional in nature, rather than categorical as is presumed in DSM– IV. This is particularly true for the categories of personality disorders, which are among the least valid and reliable of DSM categories (Helmuth, 2003). All these reasons contribute to a scientifically weak basis upon which to rest such an important decision as euthanasia. Moreover, there are still too few long-term follow-up studies in psychiatry to predict the natural course of a psychiatric disorder. Since many patients do not have all the characteristics necessary in order to fit into any of the typical categories of DSM, 20–50% of them in almost any diagnostic group are assigned to the ‘not otherwise specified’ category, and are usually excluded from clinical research (Helmuth, 2003). Because of this, it is often

hard to predict what response might be expected from a certain treatment and when that response might occur (Schoevers et al, 1998; Kelly & McLoughlin, 2002). Furthermore, prognosis is often uncertain, with the result that it is rarely possible to describe a mental disorder as incurable (Schoevers et al, 1998; Kelly & McLoughlin, 2002; Helmuth, 2003; Sjoberg & Lindholm, 2003). Thus, relative to somatic medicine, in psychiatric medicine there is greater uncertainty regarding the various aspects of the decision process and whether the legal requirements concerning euthanasia are met.

2.6.5 Ethical issues:

The largest part of the discussion surrounds ethical issues. The first counter-argument against assistance with suicide in patients suffering primarily from a mental disorder is that one of the psychiatrist's basic responsibilities is to advocate for the vulnerable, disabled and infirm in our society and, when necessary, to protect them from themselves or others (Hamilton et al, 2000; Kissane, & Kelly, 2000). A classic manifestation of this task is the prevention of suicide. Assistance with suicide provided by the psychiatrist implies an attitude that is radically opposed to that medical goal (Burgess, & Hawton, 1998; Kerkhof, 2000; Kissane, & Kelly, 2000). Another important argument concentrates on the ambiguous notion of mental illness itself. If patients suffer in their environment and develop a mental disorder, it is difficult to ascertain whether the mental disorder and suffering are solely a natural reaction to an intolerable and/or hostile environment, or whether genuine mental disorder has ensued. Historical examples are the high numbers of suicide in unmarried mothers and gay men (once considered to be mentally ill) in social environments

where they were not accepted. Thus, the term ‘mental suffering stemming from mental disorder’ is vague and hard to define, and the potential for abuse is serious. A final but recurring theme in the literature is a fear of gradual social acceptance of the practice of euthanasia, which might lead to a less careful decision making process and to dealing less adequately with suicidal ideation and behavior (Vander, et al., 1996; Hamilton, & Hamilton, 2000; Onwuteaka, et al 2003).

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CHAPTER THREE

3.1 Acquired immune deficiency syndrome (AIDS)

CDC defines a case of AIDS as a disease, at least moderately predictive of a defect in cell mediated immunity, occurring in a person with no known cause for diminished resistance to that disease. Such diseases include Kaposi's sarcoma (KS), Pneumocystis carinii pneumonia (PCP), and serious Other opportunistic infections (OOI).[1]. These infections include pneumonia, meningitis, or encephalitis due to one or more of the following: aspergillosis, candidiasis, cryptococcosis, cytomegalovirus, norcardiosis, strongyloidosis, toxoplasmosis, zygomycosis, or atypical mycobacteriosis (species other than tuberculosis or lepra); esophagitis due to candidiasis, cytomegalovirus, or herpes simplex virus; progressive multifocal leukoencephalopathy, chronic enterocolitis (more than 4 weeks) due to cryptosporidiosis; or unusually extensive mucocutaneous herpes simplex of more than 5 weeks duration. Diagnoses are considered to fit the case definition only if based on sufficiently reliable methods (generally histology or culture).[2]

However, this case definition may not include the full spectrum of AIDS manifestations, which may range from absence of symptoms (despite laboratory evidence of immune deficiency) to nonspecific symptoms (e.g. , fever, weight loss, generalized, persistent lymphadenopathy) to specific diseases that are insufficiently predictive of cellular immunodeficiency to be included in incidence monitoring (e.g., tuberculosis, oral candidiasis, herpes zoster) to malignant neoplasms that cause, as well as result from, immunodeficiency.

Acquired immune deficiency syndrome, a disease in which there is a severe loss of the body's cellular immunity, greatly lowering the resistance to infection and malignancy. [3] The cause is a virus (the human immunodeficiency virus, or HIV) transmitted in blood and in sexual fluids. a disease of the human immune system that is characterized cytologically especially by reduction in the numbers of CD4-bearing helper T cells to 20 percent or less of normal thereby rendering the subject highly vulnerable to life-threatening conditions (as Pneumocystis carinii pneumonia) and to some (as Kaposi's sarcoma) that become life-threatening and that is caused by infection with HIV commonly transmitted in infected blood**.** Especially during illicit intravenous drug use and in bodily secretions (as semen) during sexual intercourse. The human immunodeficiency virus (HIV) eats away at the T-cells of the body's immune system, thereby exposing it to infections. [4] Twenty-six diseases are now on the list of these "opportunistic" infections. Some of them are not actually infectious — Kaposi's sarcoma and cervical cancer, for example. (Guidelines for the Use of Antiretroviral Agents in Pediatric HIV Infection 2005-11-03)Others are — tuberculosis, herpes, pneumonia, and candidiasis among them. So, if you have one of these diseases, and you are HIV positive, and, in time, your T-cell count dips below a certain level, then you have AIDS.[4]

Signs and Symptoms

- The symptoms of AIDS are primarily the result of conditions that do not normally develop in individuals with healthy immune systems

- Most of these conditions are infections caused by bacteria, viruses, fungi and parasites that are normally controlled by the elements of the immune system that HIV damages.
- A person may remain asymptomatic, feel, and appear healthy for even years even though he or she is infected with HIV. While he or she does not exhibit AIDS, the immune system starts to be impaired.
- The person may exhibit neurological symptoms such as memory loss, altered gait, depression, sleep disorders or chronic diarrhea.
- This set of symptoms is often called AIDS-related Complex (ARC) by clinicians. As the symptom progress, the patient becomes an AIDS patient

3.2 Causes of Acquired Immune Deficiency Syndrome

AIDS is the ultimate clinical consequence of infection with HIV. HIV is a retrovirus that primarily infects vital organs of the human immune system such as CD4+ T cells (a subset of T cells), macrophages and dendritic cells. It directly and indirectly destroys CD4+ T cells. Once the number of CD4+ T cells per microliter (μL) of blood drops below 200, cellular immunity is lost. Acute HIV infection usually progresses over time to clinical latent HIV infection and then to early symptomatic HIV infection and later to AIDS, which is identified either on the basis of the amount of CD4+ T cells remaining in the blood, and/or the presence of certain infections, as noted above. In the absence of antiretroviral therapy, the median time of progression from HIV infection to AIDS is nine to ten years, and the median survival time after developing AIDS is only 9.2 months. However, the rate of

clinical disease progression varies widely between individuals, from two weeks up to 20 years.

Many factors affect the rate of progression. These include factors that influence the body's ability to defend against HIV such as the infected person's general immune function. Older people have weaker immune systems, and therefore have a greater risk of rapid disease progression than younger people. Poor access to health care and the existence of coexisting infections such as tuberculosis also may predispose people to faster disease progression. The infected person's genetic inheritance plays an important role and some people are resistant to certain strains of HIV. An example of this is people with the homozygous CCR5-Δ32 variation are resistant to infection with certain strains of HIV. HIV is genetically variable and exists as different strains, which cause different rates of clinical disease progression. There are a number HIV and AIDS misconceptions. Three of the most common are that AIDS can spread through casual contact, that sexual intercourse with a virgin will cure AIDS, and that HIV can infect only homosexual men and drug users. Other misconceptions are that any act of anal intercourse between gay men can lead to AIDS infection, and that open discussion of homosexuality and HIV in schools will lead to increased rates of homosexuality and AIDS[5].

Sexual transmission

Sexual transmission occurs with the contact between sexual secretions of one person with the rectal, genital or oral mucous membranes of another. Unprotected sexual acts are riskier for the receptive partner than for the in sertive partner, and the risk for transmitting

HIV through unprotected anal intercourse is greater than the risk from vaginal intercourse or oral sex. However, oral sex is not entirely safe, as HIV can be transmitted through both in sertive and receptive oral sex. Sexual assault greatly increases the risk of HIV transmission as condoms are rarely employed and physical trauma to the vagina or rectum occurs frequently, facilitating the transmission of HIV. Drug use has been studied as a possible predictor of HIV transmission. Perry N. Halkitis found that methamphetamine usage does significantly relate to unprotected sexual behavior. The study found methamphetamine users to be at a higher risk for contracting HIV.

Other sexually transmitted infections (STI) increase the risk of HIV transmission and infection, because they cause the disruption of the normal epithelial barrier by genital ulceration and/or microulceration; and by accumulation of pools of HIVsusceptible or HIV-infected cells (lymphocytes and macrophages) in semen and vaginal secretions. Epidemiological studies from subSaharan Africa, Europe and North America suggest that genital ulcers, such as those caused by syphilis and/or chancroid, increase the risk of becoming infected with HIV by about fourfold. There is also a significant although lesser increase in risk from STIs such as gonorrhea, chlamydia and trichomoniasis, which all cause local accumulations of lymphocytes and macrophages.

Transmission of HIV depends on the infectiousness of the index case and the susceptibility of the uninfected partner. Infectivity seems to vary during the course of illness and is not constant between individuals. An undetectable plasma viral load does not necessarily indicate a low viral load in the seminal liquid or genital secretions. However,

each 10-fold increase in the level of HIV in the blood is associated with an 81% increased rate of HIV transmission. Women are more susceptible to HIV-1 infection due to hormonal changes, vaginal microbial ecology and physiology, and a higher prevalence of sexually transmitted diseases. People who have been infected with one strain of HIV can still be infected later on in their lives by other, more virulent strains. Infection is unlikely in a single encounter. High rates of infection have been linked to a pattern of overlapping long-term sexual relationships. This allows the virus to quickly spread to multiple partners who in turn infect their partners. A pattern of serial monogamy or occasional casual encounters is associated with lower rates of infection. HIV spreads readily through heterosexual sex in Africa, but less so elsewhere. One possibility being researched is that schistosomiasis, which affects up to 50% of women in parts of Africa, damages the lining of the vagina.[6]

3.3 Research Design

The study employed the descriptive survey research design, which tends to describe euthanasia and assisted suicide in person with acquired immune deficiency syndrome (AIDS). This is because descriptive survey research design helps to gather information about present conditions in a population at a single point in time or relatively brief period (Badmus, Okonkwo & Okoh, 2012).

3.4 Population of the Study

The population of the study comprises University of Benin Teaching hospital (UBTH), faculty of law and department of philosophy University of Benin, Benin city

3.5 Sample and Sampling Technique

Sampling Technique refers to statistical and research means used by researcher to arrive at a representative of the population. The sampling technique for this study is the convenience sampling technique. The convenience sampling technique was to select the sample size. The reason for the purposiveness is for easy accessibility. 100 respondents were selected from university of Benin teaching hospital, faculty of law, department of philosophy, 100 questionnaire will be administered.

The sample consist of 100 participant through a purposive random sample techniques, as shown below

Area	**Sample**
Department of Philosophy	40
UBTH	30
Faculty of Law	30
Total	**100**

3.6 Research Instrument

The instrument used for data collection is a well-structured questionnaire developed by the researcher. The questionnaire is made up of two sections. Section A consist of demographic variables (sex, age, marital status and educational status) of the respondents while section B consists of items which deal with euthanasia and assisted suicide in person with acquired immune deficiency syndrome (AIDs). All the items were based on the

modified four point likert-Scale of Strongly Agree (SA), Agree (A), Disagree (D) and Strongly Disagree (SD).

3.7 Validity of the Instrument

In order to ensure the reliability of the instrument, a pilot survey list will be conducted while carrying out the research, the outcome of the research noted that the instrument is reliable. Basic questions will presented that led to the selection of self-administered questionnaire as the preferred instrument for data collection and this could easily be completed by the sample subjected to the respondents.

The research instrument will be validated by the researcher's supervisor in the department. The questionnaire will be subjected to vetting by the supervisor for, suggestions and modifications. His criticisms, advice and suggestions will be effected in the final draft of the research instrument upon approval.

3.8 Reliability of the Instrument

The test-retest method of reliability was used to establish the reliability of the instrument. The instrument was administered to ten (10) respondents that are not part of the sample target and after an interval of two weeks, the instrument was re-administered to the same respondents. Scores from the two administrations were collated using Pearson Product Moment Correlation and co-efficient of 0.68 was obtained. This was interpreted as high reliability.

3.9 Administration of the Instrument

The instrument will personally administered by the researcher to the respondents. The researcher will introduce himself to the respondents, explained what the research is all

about as well as what was expected of them. Hundred (100) questionnaire will be administered to the respondents and it will be retrieved from the respondents after completion. The administration will be done with the aid of two trained research assistants who will be briefed on what to do

3.10 Method of Data Analysis

The fully completed questionnaire will be analyzed using the descriptive statistics of frequency count and percentage.

3.11 Presentation and Analysis of Data

This chapter is aimed at presenting the result obtained from our field study which was analyzed using the simple percentage method. In all a total of one hundred copies of questionnaire were distributed to respondents and were retrieved back. This accounted for the 100 percent used for the analyses. In all twenty questions were asked and respondents were free to give this or their opinions as names were excluded.

Section 'A' consists of the socio-demographic information of the sample population drawn for the study, while Section 'B' consists of twenty questions. Hundred (100) questionnaire were administered to the various faculty and department of the University of Benin.

Analysis of Demographic Data

The background information of the respondents obtained was given below as:

Age distribution

Age respondents	No of Respondents
21 - 30 years	38%
31-40 years	29%
41-50 years	19%
51 and above	14%
Total	**100**

Researcher 2021

From table above, the age distribution shows that 38% of the respondents were age brackets of 21-30, 29% of the respondents were age brackets of 31-40, 19% of the respondents were age of 41-50 and 14% of the respondents were age brackets of 50 and above.

Sex respondents	Respondents
Male	58%
Female	42%
Total	**100**

Researcher 2021

There are 58% of the respondents were male and 42% of the respondent were female, which implies that the majority of the respondents are male.

Educational status	Respondent
NCE/OND	0
HND/B.Sc/B.Ed	32
M.SC/MBA	37
P.HD/PROF	31
Total	**100**

Researcher 2021

The table above show 32% of the respondents are HND/B.SC/B.ED, 37% of the respondents are M.SC/MBA, while 31% of the respondents are P.HD/PROF.

RESEARCH QUESTION ONE:

What condition is permissible for patient to arrange for euthanasia in AIDS

SN		SA	A	SD	D
1	Physically or mentally ill patient with no prospect of Improvement	42%	34%	16%	8%
2	irreversible coma from diseases	58%	36%	4%	2%
3	Patient has the Right to commit Suicide	5%	7%	61%	27
4	the consent of the entire family member should be taken.	59%	32%	3%	8%
5	Right to dignified end of life should be bestowed upon the individuals	32%	14%	39%	15%

From the table above it is reveal that 42 percent of the total respondents strongly agreed; 34 percent of the respondents agreed; 16 percent of the respondents strongly disagreed while 8 percent of the respondents disagreed that Physically or mentally ill patient with no prospect of Improvement is permissible for patient to arrange for euthanasia in AIDS.

It was also reveal that 58 percent of the total respondents strongly agreed; 36 percent of the total respondents agreed; while 4 percent of the total respondents strongly disagreed; 2 percent of the total respondent disagreed that irreversible coma from diseases is permissible for patient to arrange for euthanasia in AIDS. It was also indicated in the above table that 5% percent of total respondents strongly agreed that Patient has the Right to commit Suicide in euthanasia in AIDS ; 7 percent of the total respondents agreed, 61 percent of the total respondents strongly disagreed while 6 percent of the respondents disagreed respectively. It was also indicated that 59 percent of the student strongly agreed; 32 percent agreed, 3 percent strongly disagreed; 8 percent disagree that the consent of the entire family member should be taken for patient to arrange for euthanasia in AIDS.

It was also indicated that 32 percent of total respondents strongly agreed; 14 percent of the total respondents agreed; 39 percent of the total respondents strongly disagreed while 15 percent of the total respondents disagreed that Right to dignified end of life should be bestowed upon the individuals

RESEARCH QUESTIONS TWO:

What condition is permissible for physician to arrange for euthanasia in aids patient.

S/N	ITEMS	SA	A	SD	D
6	Patient must be experiencing intolerable sufferings	41	23	32	4
7	Euthanasia must be performed by a physician after consultation with an independent colleague who has experience in this field.	53	22	9	16
8	Medical professions are known for saving life and not one that helps people to die.	70	19	4	7
9	There should be clear cut spinier of a penal of the Doctors of the hospital that the person in question cannot survive.	92	6	2	0
10	In the cases of AIDS, incurable diseases be granted by the judicial body as a matter of right	43	29	17	11

From the table above it is reveal that 41 percent of the total respondents strongly agreed; 23 percent of the respondents agreed; 32 percent of the respondents strongly disagreed while 4 percent respectively are of the opinion that Patient must be experiencing intolerable sufferings for physician to arrange for euthanasia in aids patients. From the table above it is indicated that 53 percent of the total respondents strongly agreed; 22 percent of the respondents agreed; 9 percent of the respondents strongly disagreed while 16 percent of the respondents disagreed respectively that Euthanasia must be performed by a physician

after consultation with an independent colleague who has experience in this field for physician to arrange for euthanasia in aids patients. From the table above it is indicated that 70 percent of the total respondents strongly agreed; 19 percent of the respondents agreed; 4 percent of the respondents strongly disagreed while 7 percent of the respondents disagreed respectively that Medical professions are known for saving life and not one that helps people to die. From the table above it is indicated that 92 percent of the total respondents strongly agreed; 6 percent of the respondents agreed; 2 percent of the respondents strongly disagreed while no respondent respondents disagreed respectively that There should be clear cut spinier of a penal of the Doctors of the hospital that the person in question cannot survive for physician to arrange for euthanasia in aids patients. From the table above it is indicated that 43 percent of the total respondents strongly agreed; 29 percent of the respondents agreed; 17 percent of the respondents strongly disagreed while 11 percent of the respondents disagreed respectively that In the cases of AIDS, incurable diseases be granted by the judicial body as a matter of right for physician to arrange for euthanasia in aids patients.

RESEARCH QUESTION THREE:

Does patient consent needed in euthanasia

S/N	**Items**	SA	A	SD	D
11	The requests for euthanasia must come from the patient	36	27	30	7
12	Suicide in person with AIDs is voluntary and well considered	35	37	15	13
14	(Physical or mental) with no prospect of improvement and with no acceptable solutions to alleviate the patient's	51	44	3	2

	situation.				
15	end-of-life-decisions should be left to the individual who is concerned	44	11	22	30

From the table above it is indicated that 36 percent of the total respondents strongly agreed; 27 percent of the respondents agreed; 30 percent of the respondents strongly disagreed while 7 percent of the respondents disagreed respectively that the requests for euthanasia must come from the patient. The table above it is indicated that 35 percent of the total respondents strongly agreed; 37 percent of the respondents agreed; 15 percent of the respondents strongly disagreed while 13 percent of the respondents disagreed respectively that Suicide in person with AIDs is voluntary and well considered. From the table above it is indicated that 51 percent of the total respondents strongly agreed; 44 percent of the respondents agreed; 3 percent of the respondents strongly disagreed while 2 percent of the respondents disagreed respectively that Physical or mental patient with no prospect of improvement and with no acceptable solutions to alleviate the patient's situation needed in euthanasia. From the table above it is indicated that 44 percent of the total respondents strongly agreed; 11 percent of the respondents agreed; 22 percent of the respondents strongly disagreed while 30 percent of the respondents disagreed respectively that end-of-life-decisions should be left to the individual who is concerned.

RESEARCH QUESTION FOUR:

What is the perception of the public in assisted suicide in person with acquired immune deficiency syndrome (AIDS)

S/N	ITEMS	SA	A	SD	D
16	assistance in death will establish the base for coercion	15	12	43	30
17	Medical professions are known for saving the life and not one that helps people to die	81	18	1	0
18	Legally sanctioned killing will always make any society move heartless about the death.	82	16	1	1
19	euthanasia may be misused by the masses in case of the property or elsewhere disputes	61	15	16	8
20	Euthanasia might brutalize those carrying it out	14	6	62	18

From the table above it is indicated that 15 percent of the total respondents strongly agreed; 12 percent of the respondents agreed; 43 percent of the respondents strongly disagreed while 30 percent of the respondents disagreed respectively that assistance in death will establish the base for coercion. From the table above it is indicated that 81 percent of the total respondents strongly agreed; 18 percent of the respondents agreed; 1 percent of the respondents strongly disagreed while non-of the respondents disagreed respectively that assistance Medical professions are known for saving the life and not one that helps people to die

From the table above it is indicated that 82 percent of the total respondents strongly agreed; 16 percent of the respondents agreed; 1 percent of the respondents strongly disagreed while 1 percent of the respondents disagreed respectively that Legally sanctioned killing will always make any society move heartless about the death. From the table above it is indicated that 61 percent of the total respondents strongly agreed; 15 percent of the respondents agreed; 16 percent of the respondents strongly disagreed while 8 percent of the respondents disagreed respectively that euthanasia may be misused by the masses in case of the property or elsewhere disputes. from the table above it is indicated that 14 percent of the total respondents strongly agreed; 6 percent of the respondents agreed; 62 percent of the respondents strongly disagreed while 18 percent of the respondents disagreed respectively that Euthanasia might brutalize those carrying it out

Discussion of Findings

The study was carried out to examine euthanasia and assisted suicide in person with acquired immune deficiency syndrome (AIDS). The condition that is permissible for patient to arrange for euthanasia in AIDS, from the findings it is reveal that majority of the respondent strongly agreed that Physically or mentally ill patient with no prospect of improvement is permissible for patient to arrange for euthanasia in AIDS which is in line with (Harris, 1995) The request for voluntary euthanasia must be made by whoever is the subject to intolerable or intractable pain or is suffering from terminal illness. The main argument in support of legalization of active voluntary euthanasia is based on the principle of self determination and right to self-autonomy. According to these two principles each

human being has value and is worthy of respect, he has his basic rights, and freedom including the final decision making capacity. Assisted suicide: Someone provides an individual with the information, guidance, and means to take his or her own life with the intention that they will be used for this purpose. When it is a doctor who helps another person to kill themselves it is called "physician assisted suicide or doctor assisted suicide" (www.religioustolerence.org/euthanasia). In doctor assisted suicide, the doctor provides the patient with medical knowhow (i.e. discussing painless and effective medical means of committing suicide) enabling the patient to end his / her own life (Vij Krishan, 2005). The right to physician assisted suicide is generally premised on two different Constitutional rights, the first is a privacy right referred to as "decisional privacy"- the right to make decisions of a highly personal nature without interference from the State. A second Constitutional basis for establishing the right to physician assisted suicide is found in cases addressing medical decision making regarding bodily integrity, autonomy and liberty. We are talking about a Constitutional right of choice, the right to make the choice whether or not to hasten inevitable death. What is protected by the Constitution is choice in matters of personal autonomy (Kline, Robert, 1996).

The study also show the condition is permissible for physician to arrange for euthanasia in aids patients which agreed with the findings which show that majority of the respondent strongly agreed that Patient must be experiencing intolerable sufferings for physician to arrange for euthanasia in aids patients; The study also show that Euthanasia must be performed by a physician after consultation with an independent colleague who has

experience in this field for physician to arrange for euthanasia in aids patients; 70 percent of the total respondent strongly agree that Medical professions are known for saving life and not one that helps people to die; The finding also shows that 92 percent of the total respondents strongly agreed that There should be clear cut spinier of a penal of the Doctors of the hospital that the person in question cannot survive for physician to arrange for euthanasia in aids patients; The findings also show 43 percent of the total respondents strongly agreed that In the cases of AIDS, incurable diseases be granted by the judicial body as a matter of right for physician to arrange for euthanasia in aids patients.

CHAPTER FOUR

4.1 Conclusion

Today there is ranging controversy all over the world as to its legal standing aside from the moral and ethical issues involved. Having seen that the law is not unprepared to reexamine former rigid attitude toward the sanctity of life those in favour of Euthanasia exhibit some zeal in supporting their views (Vij Krishan, 2008). The opponents of Euthanasia state that there are moral, religious and ethical obligations which cannot be ignored. They argue that no one has right to take away the life of an individual not even individual him or herself. The concept of sanctity of life is inviolable and doctors having taken an oath (The Hippocratic oath) “to preserve life at all cost” cannot justify a patient to die or passive means (Pillay, 2010). Euthanasia is may be good for the person who is really in a severe pain but at same side it may be dangerous if advantage is taken in wrong way, so it is must necessary that it should be done in a supervision with the rules. However, the result of implication of euthanasia needs to be reexamined again at regular intervals depending upon the evolution of society with regard to providing health care to disabled and terminally ill patients. The survey results will help in forming rules of euthanasia.

Euthanasia encompasses various dimensions, from active (introducing something to cause death) to passive (withholding treatment or supportive measures); voluntary (consent) to involuntary (consent from guardian) and physician assisted (where physician's prescribe the medicine and patient or the third party administers the medication to cause death thus it

can be said that euthanasia and or assisted suicide is illegal in Nigeria. This illegal status is however not as a result of any special legislation, but as based on existing laws which do not specifically provide for euthanasia and assisted suicide. One last point requires emphasis: Contrary to widespread belief, competence is not an existential state, a state of being. It is not people who are competent but decisions. So the same person may be competent to make one decision but not another. This is the case with young children, those with dementia, the confused old, mental health patients, and individuals temporarily or permanently unconscious. There are many instances in health care where the patient's consent is appealed to and used, where her actual consent is unobtainable. These are circumstances in which the patient is either unconscious or unable to process the information required to give a valid consent, or is temporarily or permanently lacking the relevant capacity to consent. Again, children are an obvious case in point.

4.2 Recommendation

In view of the foregoing it is recommended that the Nigeria government especially the judicial and legislative organs should take a bold stance on how to address what amounts to double standards in the existing laws governing euthanasia practice in the country. As it stands now, no one can surely say whether or not passive euthanasia is a crime under the Nigerian law.

There is an urgent need for Nigerian Government to enact a specific law, guiding or governing the euthanasia/assisted suicide. Going by the modern trend in medical technology,

the issue of euthanasia has become a global trend which requires a specific law to either expressly criminalize or decriminalize the practice. The taciturnity of the Nigerian law on the subject has become overdue, hence the need for a specific legislation on that aspect.

Nigerian authorities should not bend only in criminalizing euthanasia via its criminal law. They should also do well in providing an alternative treatment or care centres such as hospice care, palliative care, and other medical centers for the management of terminally ill patients. They should make the services of such centers either free of charge or affordable within the reach of every citizen of Nigeria suffering pain as a result of terminal sickness. This, when done is believed to achieve much results rather than criminalizing it. Even if such practice is criminalized without adequate hospice care or other life care services, the law will not be effective; people will go ahead doing "their thing" underground. There is also a need for value orientation among Nigerians pertaining to their steadfastness in upholding their cultural perspectives on the sanctity of life. They should not allow western civilization to make them jettison their cultural value in this aspect. To achieve this goal, the press, mass media, and other social networks have a pivotal role to play. Moreover, seminars and workshops should be always organized to enable our citizenry uphold the doctrine of sanctity of life enshrined in the Nigeria constitution.

Finally, it should be advised that the pleas of the terminally ill patients, who sometimes request death, should not be understood as implying a true desire for euthanasia, but an anguished plea for help and love. In view of this it is suggested that we should always

show this people love and care, rather than canvass for their death via euthanasia. Life is a precious gift from God, which is sacred and should always be treated as such.

APPENDIX

QUESTIONNAIRE

DEPARTMENT OF DEPARTMENT OF PHILOSOPHY, FACULTY OF ARTS, UNIVERSITY OF BENIN, BENIN CITY, EDO STATE.

Dear Respondent,

ADMINISTRATION OF QUESTIONNAIRE

I am an undergraduate student of the above-named institution currently undertaking research on **Euthanasia and Assisted Suicide in Persons with Acquired Immune Deficiency Syndrome (AIDS).** The study is a prerequisite for the partial fulfilment for the award of Bachelor of Arts degree in philosophy.

I therefore crave your indulgence to assist in filling the questionnaire. Any information given will be treated with utmost confidentiality. Your response is highly appreciated.

Yours faithfully,

Ufoma David Felix

Instruction

Kindly tick (√) on that which agrees with your opinion.

Section A (Demographic Data)

1. Age: 21-30( ), 31-40( ), 41-50( ), 51 and above ( ).

2. Sex: Male ( ), Female ( ).

3. Education status: NCE/OND ( ), HND/B.SC ( ), M.SC/MBA ( ), P.hD/Prof. ( )

Section B (Opinionated section)

SA= Strongly agree

A= Agree

D = Disagree

SD= Strongly disagree

SN	**What condition is permissible for patient to arrange for euthanasia in AIDS**	SA	A	SD	D
1	Physically or mentally ill patient with no prospect of Improvement	42	34	16	8
2	irreversible coma from diseases	58	36	4	2
3	Patient has the Right to commit Suicide	5	7	61	27
4	the consent of the entire family member should be taken.	68	32	0	0
5	Right to dignified end of life should be bestowed upon the individuals	32	14	39	15

	What condition is permissible for physician to arrange for euthanasia in aids patients.				
6	Patient must be experiencing intolerable sufferings	74	23	2	1
7	Euthanasia must be performed by a physician after consultation with an independent colleague who has experience in this field.	62	38	0	0
8	Medical professions are known for saving life and not one that helps people to die.	81	19	0	0
9	There should be clear cut spinier of a penal of the Doctors of the hospital that the person in question cannot survive.	92	6	2	0
10	In the cases of AIDS, incurable diseases be granted by the judicial body as a matter of right	43	29	17	11
	Does patient consent needed in euthanasia				
11	The requests for euthanasia must come from the patient	55	27	11	7
12	Suicide in person with AIDs is voluntary and well considered	63	36	1	0
14	(Physical or mental) with no prospect of improvement and with no acceptable solutions to alleviate the patient's situation.	51	44	3	2
15	end-of-life-decisions should be left to the individual who is concerned	89	11	0	0

	What is the perception of the public in assisted suicide in person with acquired immune deficiency syndrome (AIDS)				
16	assistance in death will establish the base for coercion	15	12	43	30
17	Medical professions are known for saving the life and not one that helps people to die	81	18	1	0
18	Legally sanctioned killing will always make any society move heartless about the death.	82	16	1	1
19	euthanasia may be misused by the masses in case of the property or elsewhere disputes	61	15	16	8
20	Euthanasia might brutalize those carrying it out	14	6	62	18

Appendix 1

QUESTIONNAIRE

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Dear Respondent,

ADMINISTRATION OF QUESTIONNAIRE

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I therefore crave your indulgence to assist in filling the questionnaire. Any information given will be treated with utmost confidentiality. Your response is highly appreciated.

Yours faithfully,

Ufoma David Felix

Instruction

Kindly tick (√) on that which agrees with your opinion.

Section A (Demographic Data)

4. Age: 21-30( ), 31-40( ), 41-50( ), 51 and above ( ).

5. Sex: Male ( ), Female ( ).

6. Education status: NCE/OND ( ), HND/B.SC ( ), M.SC/MBA ( ), P.hD/Prof. ( )

Section B (Opinionated section)

SA= Strongly agree

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	What condition is permissible for physician to arrange for euthanasia in aids patients.				
6	Patient must be experiencing intolerable sufferings	74	23	2	1
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	experience in this field.				
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15	end-of-life-decisions should be left to the individual who is concerned	89	11	0	0
	What is the perception of the public in assisted suicide in person with acquired immune deficiency syndrome (AIDS)				
16	assistance in death will establish the base for coercion	15	12	43	30
17	Medical professions are known for saving the life and not one that helps people to die	81	18	1	0
18	Legally sanctioned killing will always make any society	82	16	1	1

	move heartless about the death.				
19	euthanasia may be misused by the masses in case of the property or elsewhere disputes	61	15	16	8
20	Euthanasia might brutalize those carrying it out	14	6	62	18

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