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Abstract

Government authorities in Bangladesh recently were placed in an awkward and extraordinary position of having to make a presumably difficult decision: how to respond to a man's request to have his two sons and grandson euthanized. This is an extraordinary request for a developing country's health service authorities to consider, especially in the context of a Muslim-majority population where any appeal to the legitimacy of suicide (and, by extension, physician-assisted suicide) would be automatically rejected as contrary to Islamic moral and jurisprudential principles. Here the case is reviewed in the context of arguments that engage non-voluntary euthanasia and the local context of inadequate health service delivery.

Keywords

Involuntary active euthanasia, non-voluntary active euthanasia, Duchenne muscular dystrophy, Bangladesh

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A Request for Non-voluntary Euthanasia in Bangladesh: A Moral Assessment

Norman K. Swazo
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Introduction

In January 2017 Mr. Tofazzal Hossain, living in the southwestern rural area of Meherpur Bangladesh, made an extraordinary request of local government authorities: to be given permission to euthanize his two sons and grandson.¹ This would be an entirely novel case of “legally sanctioned killing”² in Bangladesh were the request to be approved. There is no country now lawfully permitting non-voluntary active euthanasia,³ except for the Groningen Protocol in the Netherlands that concerns terminally ill infants specifically, notwithstanding ongoing debate about the legality and morality of involuntary and non-voluntary active euthanasia. Indeed, a grant of legal permission would be contrary to Bangladesh’s signatory commitment under international law to the United Nations *Convention on the Rights of the Child*, ratified by the government in 1990,⁴ as well as contrary to the *Declaration of the Rights of the Child* (1990), the latter expecting national governments to assure “special safeguards and care” as well as a right (under Principle 4) to “the benefits of social security” because of a child’s “physical and mental immaturity.”⁵ It would also be contrary to the country’s constitutional recognition of Islam as a state religion, given that Islamic jurisprudence prohibits suicide and Islamic bioethics also is often presented as prohibiting euthanasia (some discussion on this factor follows later).

From the father’s perspective, the argument in favor of active euthanasia was rather uncomplicated on the basis of facts:

- (1) His sons (Abdus Sabur, age 22, diagnosed at age 10, and Rahinul Islam, age 13, diagnosed at age 8) and grandson (Sourav, diagnosed in 2016, yet a child, age not specified) suffer from Duchenne muscular dystrophy (DMD);
- (2) His wife is mentally challenged and is unable to assist with their care;⁶
- (3) A recently divorced daughter is now living in his home and requires his financial support;
- (4) His income is limited to his sale of fruit locally;
- (5) Either (a) he should have treatment provided them (by government health service) or (b) he should have them euthanized;
- (6) There is no public (government authorized and provided) medical care available to his wards;
- (7) It is not the case that he can afford their treatment.

Therefore, his two sons and grandson should be euthanized, in which case the government commissioner in Meherpur should provide the requisite permission for these acts of active euthanasia.

Mr. Hossain remarked further concerning his long-term burden: “I have taken care of them for years. I took them to hospitals in Bangladesh and India, I sold my shop to pay for their treatment but now I’m broke...The government should decide what it wants to do with them. They are suffering and have no

hope of recovery. I can't bear it any longer."⁷ The Meherpur commissioner's office visited Hossain's home to assess the situation and informed the relevant central government ministry accordingly.

It is well known that DMD is a currently incurable genetic disease transmitted primarily from mother to sons; those affected having low life expectancy (death usually by teenage years, but in some cases longer); these individuals likely manifesting sequelae of the muscular defects, including compromised respiratory function (thus less breathing efficiency and mental dullness due to hypoxia, estimated at 30% probability of learning disability or serious mental deficiency); and damage to the heart muscle (cardiomyopathy) leading to circulatory problems including blood clots.

According to the Muscular Dystrophy Association⁸ in the USA, options for treatment are limited to assistive devices (ankle-foot braces; standing walkers; wheel chairs; transfer boards; etc.) and alleviation of symptoms (physical therapy with range-of-motion and progressive resistive exercise; medication (corticosteroids in Bangladesh are available at a cost of BDT250 per 100 20 mg. tablets, equivalent to US\$3.11 cost),⁹ with special education service for developmental disability. These services are of such cost that Mr. Hossain cannot afford either the assistive devices or the medication for the three individuals, not to mention the problem of managing their care at home without others within the family to assist with regularity. In short, his burden, he asserts, exceeds his personal ability to manage.

Local Reaction

Subsequent to government review, the decision was taken to assist Mr. Hossain with some (minimal) medical care at government cost. Nonetheless, the case is especially of concern as a request to government authorities, because it amounted to a request for both *involuntary* and *non-voluntary active* euthanasia, the former in the case of the elder son and the latter in the case of the younger son and grandson. All three individuals are aware of their physical condition, despite the difficulties they have with mobility at home and confinement to bed except for occasional assisted transfer outdoors. All three are cognitively functional, although perhaps with some mental dullness onset characteristic of the disease's progressive degeneration. The eldest son provided no opinion to the public media on his father's request, except to say he counsels his father not to worry. A medical doctor who has assisted with treatment of the family remarked, "It's a humanitarian case. Everyone should come forward [to help]."¹⁰ This physician, of course, does not look to euthanasia as the solution to Mr. Hossain's dilemma.

However, the case has provided an opportunity for government authorities and medical professionals to engage a rather difficult, even usually unengaged, subject, viz., euthanasia in general. "Nezamuddin Ahmed, head of Bangladesh's sole palliative care centre in the country's capital, Dhaka, said: 'I think this will lead to a healthy debate about assisted death,'" even as he believes the government should improve palliative care service options before moving to consider any legislative or public policy engagement of euthanasia.¹¹ By contrast, Nur Khan Liton, head of local rights group Aim O Salish Kendra, opined that, "[most] Bangladeshis would oppose the mere discussion of euthanasia."¹² Voicing the expected religious view, cleric and Islamic scholar Fariuddin Masoud commented that, "Euthanasia is completely illegal in Islam. It is the government's duty to take responsibility of every citizen,"¹³ in which case there should be no public discussion of any form of euthanasia.¹⁴ Clearly, if there is to be no "public" discussion on this moral issue as a matter of Islamic doctrine, then *a fortiori* neither is there to be any specifically government discussion of this issue in the Parliament or by the Ministry of Health. (In Bangladesh public law follows due process of proposals considered by Parliament and the relevant ministries of government, with approval by the Prime Minister's Cabinet and implementation under the regulatory authority of the superintending ministry.)

While acknowledging Bangladesh is a Muslim-majority country that will defer to Islamic doctrine when pertinent to the development of public law and policy, nonetheless this in and of itself does not lead to the conclusion that public deliberation is thereby foreclosed. On the contrary, as B.A. Manninen argues, “It is a rather disturbing trend when the general public fails to take the time to educate itself about a certain controversial issue before criticizing or condemning it. This does a disservice to all by conveying a faulty view of the actual issue, thereby precluding the possibility of discussing its ethical implications intelligently or accurately.”¹⁵ The point applies also to Bangladesh in present case. Accordingly, the issue is engaged here to contribute to public deliberation in Bangladesh on an important ethical question, precisely because there is at present no public law or public policy that provides guidance in the matter of either passive or active euthanasia, whether voluntary, involuntary, or non-voluntary. In the following discussion moral assessment concerns professional norms of practice, deontological ethical reasoning on the issue of euthanasia, and specifically Islamic jurisprudential reasoning pertinent to moral assessment.

Issues of Moral Assessment

A. Professional Norms and the Slippery Slope

Despite current religiously based prohibition of euthanasia in Bangladesh, albeit not explicit in public law but only generally understood to be prohibited by Islamic doctrine as such, there remains the question about the morality of (1) a request that amounts to non-voluntary active euthanasia and involuntary active euthanasia and (2) whether a governmental permission would be morally justified. How does one assess such a request, recognizing that a *utilitarian*¹⁶ might indeed permit such an act while a Kantian *deontologist*¹⁷ may not? To answer these questions, we shall consider first some notable classical discussions and then some recent discussions in relation to slippery slope type consequences. Thereafter we will briefly consider the matter with reference to Islamic ethics.

A classical argument presented by Gerald Dworkin holds that, “under certain circumstances, it is *morally* permissible, and ought to be *legally* permissible, for physicians to provide the knowledge and/or the means by which a patient can take her own life.”¹⁸ A physician, in short, facilitates a patient’s death. The rationale in the case of permissible assisted dying concerns the patient’s interests specifically (in contrast to what may be identified as professional duties of a physician): (1) removing an individual from continued pain and suffering, and (2) responding to a patient’s sense of dignity, both in the case of established “terminal illness” or “an intractable, incurable medical condition that the patient experiences as incompatible with her fundamental values.”¹⁹

In both cases (1) and (2) the operative assumption is that the patient makes the request directly, being capable and competent to do so. The Bangladesh case is clearly different, since the two sons and grandson do not themselves make this request; nor is it clear that they have been consulted so as to consider their views or to assure their consent has been given, consistent with the usual appeals to individual autonomy (even while acknowledging that this may not be fully applicable in the case of the younger son and grandson due to their age). In this case, consistent with customary patriarchy in a Muslim family, it is the father’s judgment that is assumed to be determining and, both *de facto* and *de jure*, the sole source of the request. And, indeed, one can argue here, as Leon Kass might argue, that it is not an appeal to autonomy that is pertinent to the decision here; but, instead, “the miserable and pitiable condition” of the dystrophied bodies of these three individuals that, so the father argues, “justifies” the physician’s intervention to assist their deaths, in the absence of the father’s financial ability to provide treatment and lack of committed and sustained governmental medical treatment.²⁰ Kass makes a pertinent distinction here that is relevant to determining the motivation for action involved here; i.e., the father does not deliberate or decide with reference to any question about his sons’ autonomy, but instead focuses only

on their physical condition as one that is degenerative without hope of improvement until death, a condition that, because miserable and pitiable, in his view calls for relief he deems a consequence of active euthanasia.

Thus, as Kass remarks, were one accepting of this appeal, “Not the autonomous will of the patient, but the doctor’s benevolent and compassionate love for suffering humanity [ostensibly] justifies the humane act of mercy killing.”²¹ In other words, “Good and humane intentions can sanctify any deed,” including, therefore, the physician’s act of killing so motivated.²² It is in this sense that Mr. Hossain readily disputes an outsider’s incredulity in the face of his request, to the effect that one does not understand the “severity” of the situation—to be measured in the suffering of the sons and grandson as well as the father’s own distress under the circumstances.

Of course, Kass rejects the permissibility of voluntary active euthanasia, whether accounting for patient request or the physician’s motivation. For him, further, “the true parent refuses ‘to surrender or abandon the child, knowing that it would be deeply self-contradictory to deny the fact of one’s parenthood, whatever the child may say or do’—‘the role of the parent’ is such that one ‘should never ‘give up’ on one’s children.’”²³ While appealing to a criterion of consistency, i.e., to avoid self-contradictory behavior, it is also presupposed here that there are norms of parenthood that are somehow governing. However, an appeal to the miserable and pitiable condition of these individuals presumably would still be a factor in a parent’s or physician’s assessment of a request for non-voluntary or involuntary active euthanasia, as in present case. The question then is whether that is a sufficient reason to authorize an affirmative response to the father’s request. And, clearly, there is no obvious justification to accept the father’s argument insofar as it presents a false dilemma (limiting the options to government provided medical care or active euthanasia) when there are other interventions possible (e.g., local charity organization support; non-governmental organization (NGO) support, etc.

One more obvious protest against accepting such a request is the consequentialist slippery slope argument, which is expected at the least “to give us pause” if not “to stop us in our tracks” completely and thereby to take a different path in view of unacceptable consequences predicted with a view to some degree of importance (very, moderate, low) and degree of probability (high, moderate, low).²⁴ And, indeed, as R.G. Frey reminds, this sort of argument does not present us with a claim of causal necessity thereby: “The claim is not that we shall be compelled through causal necessity to descend the slope...[The] claim is rather that if we take step A, then it becomes empirically very likely that we shall take steps B and C.”²⁵ In the case of physician-assisted suicide or assisted dying (whichever conceptual form of the issue suits one), “a slippery slope argument suggests that we shall nevertheless be led down the slope of taking life to terminating the incompetent or to justifying involuntary termination”²⁶—not to mention a subsequent point on the slope that is non-voluntary termination of life. This would be especially so in the case of those who are poor and/or elderly, or even, as in present case, those who are poor and children having incurable disease, are seemingly cognitively competent if otherwise minimally mentally dull and whose care is dependent on “a surrogate decision maker.” The present case, as a first publicly discussed case in the Bangladesh media, raises the issue of slippery slope insofar as (1) were the father’s requested action sanctioned it would set a precedent and could lead to further such actions taken under similar circumstances of medical prognosis; (2) the action, so sanctioned, would mean there was insufficient public deliberation as to justification of public law, policy, and regulation consistent with pertinent moral conceptual distinctions (active/passive euthanasia; voluntary/involuntary/nonvoluntary; etc.), in which case individuals could be harmed and wronged by government permitted active euthanasia.

One must bear in mind here that Mr. Hossain, as surrogate decision maker, seeks what amounts to *involuntary* active euthanasia in the case of the older son (i.e., he is mentally competent but has not having expressly consented to the proposed active euthanasia) and *non-voluntary* active euthanasia in the

case of the younger son and grandson [both not of age of maturity and subject to the proxy consent of the parent(s)].

B. A Kantian Concern for Non-voluntary Active Euthanasia

The Bangladesh case raises the question of the morality of both involuntary active euthanasia and non-voluntary active euthanasia, accounting here for the particulars of DMD and the father's burden and distress about the suffering of his two sons and grandson. One may consider reasoning analogically in view of concerns about non-voluntary active euthanasia in the case of patients suffering extreme dementia, and do so with reference to Kant's deontology. Obviously, the comparison to extreme dementia has its difficulties for a fully successful analogy, given available empirical evidence as to what a patient experiencing dementia understands and knows, including here self-awareness and competence to opine on his/her condition. As is well known, Kant argued against suicide.²⁷ Kant's argument concerns an individual's necessary duties to oneself. He considers that someone may identify what is *prima facie* a subjectively valid maxim and think this maxim morally authoritative so as to warrant an act of suicide.

Such a maxim might be formulated thus: "To escape from painful circumstances, I will destroy myself (i.e., commit suicide)." The question, of course, is whether this maxim may be construed objectively valid, thus as a universal practical law consistent with one's duties to humanity. Kant's analysis concerns the logical coherence of the maxim with the idea of humanity, all humans as rational beings obligating our respect for personhood insofar as persons have intrinsic worth and, thus, dignity. Logical coherence requires that one avoid a contradiction in the conception of the maxim. Kant is also concerned to assure that an individual distinguish between acting according to inclination (i.e., a motive of need or desire) and acting from duty (i.e., a motive of respect for moral law). Thus, Kant's argument is grounded on the distinction of persons and things, such that an individual may not use a person (in contrast to a thing) "merely as a means to maintain a tolerable condition up to the end of life." The latter is motivated by inclination, not duty. Kant concludes, "I cannot, therefore, dispose in any way of a man in my own person so as to mutilate him, to damage or kill him." The intended maxim, in short, is not objectively valid and is not the equivalent of a universal moral law. Suicide is, therefore, for all persons morally prohibited. The assumption is that this conclusion holds for active euthanasia, although the argument is to be provided.

Consider Robert Sharp's account of developments in moral assessment according to which, "some writers have claimed that the onset of dementia may circumvent the usual Kantian response, since dementia undermines our ability to be moral agents."²⁸ At issue here is an individual's capacity for moral agency, the absence of which may alter one's otherwise Kantian commitment to prohibit suicide and, by extension, assisted dying. This relates to the present case only in the sense that, as with dementia, DMD patients experience a progressive degeneration of cognitive ability which may, under some reasoning, undermine that individual's ability to be (and thus to be considered) a moral agent. Nonetheless, Sharp's concern is primarily one of slippery slope: "I worry that [some proponents, who "have argued that suicide would actually be morally required by rational beings who know that they will soon become irrational"] open the door to much more unsettling (at least to me) possibilities, including (but not limited to) the obligation to commit active, non-voluntary euthanasia against those patients who refuse to commit suicide."²⁹ The problem with respect to our present case is that someone might similarly argue that one suffering from DMD understands s/he will become irrational and thus has an obligation to enable active non-voluntary euthanasia—however repugnant such an argument may be.

The standard Kantian argument is that, as long as an individual is “still a rational, autonomous agent,” then “the volition of the patient must be respected, and he or she could not be forced into any action, much less death.” The same argument applies in the case of Mr. Hossain’s older son Abdus Saber—his DMD has not led to a diminished cognitive status or a sustained mental dullness that otherwise diminishes his capacity to judge his physical condition and to make informed decisions as to his personal care, in which case respect for Abdus Saber’s personhood and uncompromised moral agency prohibits any act of involuntary active euthanasia. The problem for Sharp, however, is that some writers go so far as to argue, “suicide would actually be morally required by rational beings who know that they will soon become irrational.”³⁰ One might structure an argument in present case consistent with the foregoing position, to the effect that:

If the older son Abdus Saber is a rational being and, thus, a person having freedom of will with capacity to choose his ends and the means to those ends, then Abdus Saber is a moral agent. But, *if* (thus *when*) he is no longer capable of choosing his ends, then Abdus Saber is no longer a moral agent. If (or when) Abdus Saber is no longer a moral agent, then Mr. Hossain, as parent and surrogate decision maker, may make moral decisions that concern Abdus Saber’s moral status and disposition (life or death). In present case, Mr. Hossain believes Abdus Saber should be euthanized (for the reasons already noted) and requested government permission to have this done. Respecting Mr. Hossain’s moral authority and preference here, the government should concur, deferring to Mr. Hossain’s rational autonomy as a responsible moral agent. Therefore, Abdus Saber should be euthanized.

At issue in the above argument, however, is Abdus Saber’s moral agency: Anticipating loss of his moral agency due to prospective cognitive impairment (i.e., assuming this is an effect of sustained respiratory dysfunction and hypoxia), it is being argued that Abdus Saber himself has a duty to authorize his death in advance of his deteriorated physical condition due to DMD. But, of course, the government (a) need not defer to the judgment of the father (since his moral reasoning may be in error) and (b) because the government itself has a public welfare and public health responsibility that weighs into the decision to be taken and may weigh against a recommendation for non-voluntary active euthanasia in a case such as the present one; and, more importantly, the government may contest the premise that anticipated loss of moral agency entails the moral duty stipulated.

As Sharp rightly notes, the appeal here is to what Kant has to say about suicide in his *Lectures on Ethics*, i.e., “suicide is wrong because it ‘contradicts the more basic principle to preserve the freedom of moral agents.’”³¹ The point here is to act such that one is concerned to maintain “the inherent dignity and freedom of moral agents,” i.e., “in cases where maintaining life would require us to sacrifice our moral dignity or autonomy, we have a duty to die.” In extreme dementia—or, in present case, in the case of extreme hypoxia degenerating Abdus Saber’s rational capacity “to the point of incompetence”—“those who suffer from the syndrome lose their rationality, autonomy, and humanity. They have a duty to die in order to avoid that fate.”³² Yet, the Kantian argument as expressed by the law of humanity specifies that one may not treat oneself arbitrarily, i.e., merely as a means, to some particular end, thus the need to account for an individual’s “intrinsic” worth and dignity.

The sort of argument presented above assumes “levels of selfhood” such as described by Daniel Callahan, “the highest of which is the moral self (fully rational, autonomous agent),” such that “this level is essential for human dignity and worth.”³³ However, Sharp counters the inference with the relevant question: “we must still ask why becoming a non-person [through the extreme dementia that entails loss of moral agency, autonomy, and thus human dignity; or, in present case of Abdus Saber, the loss of moral agency due to the cognitive impairment consequent to sustained hypoxia from DMD] is so terrible that

death is a better option.” Mr. Hossain’s argument is clearly utilitarian, accounting for his lack of the financial means to provide requisite treatment for his two sons and grandson, even as he accounts for the severity of their physical condition that for him requires relief through active euthanasia. But, Kant is not a consequentialist in his attention to categorical duties, in which case Mr. Hossain’s rationale in his request has no standing in a Kantian assessment. One may reasonably distinguish between the body and the mind and account an individual a person in view of his rational nature rather than his physical nature, such that the above argument is made that cognitive impairment entails loss of personhood. But this premise, in and of itself, is insufficient to conclude that the fact of cognitive impairment due to pathological causes means death is a better option than continued life.

At issue here instead is whether Mr. Hossain would violate the universal practical imperative not to treat his two sons and grandson merely as a means to *his own end* (in this case, removing *his* burden and personal distress in caring for them as their DMD promises their continued physical deterioration; which is to be distinguished from a clear benevolence and compassion that, accounting for the interests proper to the two sons and grandson, intends a genuine act of mercy, hence a *mercy-killing*). One must, then, distinguish between what is merely *convenient* to Mr. Hossain as head of household (i.e., what is a matter of his inclination to act according to perceived need or desire) and what his *duty* is (consistent with the personhood of the sons and grandson). This is so even if and when one reasonably anticipates loss of moral agency in the case of the elder son (contrasted here to lack of moral agency in the youngest son and grandson due to their age, which nonetheless is not sufficient reason for non-voluntary active euthanasia). If Mr. Hossain’s principal motive is self-interested, appealing to his own present inclinations and his projection of a highly probable growing burden and distress under the morally relevant circumstances, then the universal practical imperative central to deontology would be violated. Involuntary active euthanasia in the case of Abdus Saber would, thereby, be morally impermissible. And, furthermore, given the normal expectation that government authority has responsibility for the public welfare and public health, on grounds of benevolence (i.e., manifestation of a “good will” consistent with moral duty), then it would be morally irresponsible of the Bangladesh government authorities to grant Mr. Hossain his request, even if the extant public law or policy is silent on the question, as at present time.

C. Learning from the Groningen Protocol

Given that the present case also concerns non-voluntary active euthanasia in the case of the younger son and grandson, it behooves us to consider how a given protocol may assist in decision. The Netherlands some time ago was forced to public debate, and to consider guidelines proposed by the Groningen Academic Hospital on the question of euthanasia of terminally ill infants—a clear case of non-voluntary active euthanasia.³⁴ The protocol accounted for morally relevant circumstances that included several assurances be given:

1. The suffering must be so severe that the infant has no prospects for a future.
2. There is no possibility that the infant can be cured or alleviated of her affliction with medication or surgery.
3. The parents must give their consent.
4. A second opinion must be provided by an independent doctor who has not been involved with the child’s treatment.
5. The deliberate ending of life must be meticulously carried out with the emphasis on aftercare.

If one were to apply such a protocol to decision in the Bangladeshi case, it is clear neither the two sons nor the grandson is in a state of suffering so severe that any one has no prospects for a future. They have a future, albeit one of limited mobility with continuing degeneration with life expectancy to

approximately 30 years (assuming reasonable medical management of their condition). Further, while there is no possibility of cure for their DMD, there is some prospect of alleviation of their affliction through medication (corticosteroids), assistive devices, and physical therapy (this is only to say such alleviation is to be acknowledged, not to say that Mr. Hossain might afford such care or otherwise have it provided by governmental, NGO, or charity options). On point number 3, Mr. Hossain is sole surrogate decision maker, since the wife is mentally challenged and cannot contribute to decision; and, clearly, Mr. Hossain's request is evidence of his explicit (if not fully informed) consent to an act of non-voluntary active euthanasia for both younger son and grandson. Points 4 and 5 would, of course, depend on legislation or professional standards put in place to assure Mr. Hossain's request would be handled appropriately to satisfy these two conditions. In any case, under such a protocol governing non-voluntary active euthanasia, Mr. Hossain is not justified to pursue such action for his youngest son and grandson.

D. The Islamic Ethical View

It is important to understand that "religious pluralism in a secular society influences the content and method of moral argumentation on active euthanasia by religious traditions."³⁵ Yet, as noted earlier, Bangladesh is a Muslim-majority country with Islam designated the religion of state, despite constitutional protections for religious diversity and secular values. As such, most Bangladeshis understand and accept the prohibition of suicide and, by extension, an expected prohibition of any action characterized as active euthanasia, whether voluntary, involuntary, or nonvoluntary. The cleric's comments cited earlier are illustrative of such an opinion. This opinion is consonant with the general view that, "Islamic jurisprudence, based on a convincing interpretation of the Holy Koran, does not recognize a person's right to die voluntarily," thus ruling out voluntary euthanasia.³⁶ However, there is a close relationship between law and morality in Islamic thought even as there is a distinction of the two, thus Islamic jurisprudence proper (*usul al-fiqh*) and Islamic ethics proper (*'ilm al-akhlāq*).

One may consider here, e.g., Abdulaziz Sachedina's reminder that, "The importance attached to the issue of the quality of life has sometimes led Muslim scholars to evaluate suicide (in Arabic expressed as *intihār*, and *halākat al-nafs*) in very ambiguous ways. On the one hand, there is unanimity in declaring the act [of suicide, *intihār*] as irrational and impermissible; on the other hand, some interpretations in classical sources intimate a degree of extenuation, especially when coping with circumstances."³⁷ Dariusch Atigetchi observes similarly that, "the positions [on euthanasia] tend to oscillate between two polarities. On the one hand theoretical statements which in general condemn euthanasia (not well defined); on the other several medical-clinical pronouncements that seem to leave room for 'interventions' aimed at terminating or shortening the life of the patient who is in hopeless and very undignified conditions."³⁸ Further, Islamic law and ethics recognize a child's transition to an age of maturity (arbitrarily set, e.g., at age 15) and right to make decisions. Thus, e.g., Kamyar M. Hedayat and Roya Pirzadeh, both pediatricians, counsel from a Shi'a Islamic perspective that, "When there are 2 equivalent treatments, and an intellectually mature teenager chooses one and his father chooses the other one and they cannot be reconciled, the physician may respect the decision of his patient (Ayatollahs Sistani and N. Makarem-Shirazi, personal communication, June 1999)."³⁹ Whether such a view applies in the Sunni Islamic setting of contemporary Bangladesh would require further evaluation in relation to the dominant Hanafi and Salafi perspectives now influencing jurisprudential decision among religious authorities.

Conclusion

Our foregoing analysis leads to the conclusion that:

1. It is *morally impermissible* for Mr. Hossain to consider either (a) *involuntary* active euthanasia in the case of his elder son or (b) *non-voluntary* active euthanasia in the case of his youngest son and grandson. The argument here is *deontological*, i.e., duty-based, rather than utilitarian.

2. Islamic law and ethics normally restrict any physician actively intervening to terminate a patient's life, thus ruling out active euthanasia of whatever category. The question of medical futility, however, remains subject to debate and may influence a decision to euthanize on grounds of dignity. But, normally this is under circumstances of terminal illness, which does not apply in the case of Mr. Hossain's request.

It is also clear that:

3. The present analysis seeks to contribute to an informed moral and legal deliberation that is reasonably to be advanced in Bangladesh, despite the claim of some (religiously minded) individuals that such discourse should be impermissible in a Muslim-majority setting. The fact is that Bangladesh's Constitution provides for religious pluralism, despite the identification of Islam as a religion of state, in which case any argument reasonably allows for democratic principles including freedom of expression on these matters consistent with the development of public health policies and professional ethics. The Constitution also intends a secular approach to governmental authority (in contrast to a nation-state manifestly considered an "Islamic Republic"). Hence, there is today neither legal nor moral barrier to public deliberation about euthanasia in Bangladesh. More positively said, there are good and compelling moral and legal reasons to further this public discourse.

¹ Kushtia Office, (2017, Jan 24). Appeal for Euthanasia. *Prothom Alo*, Retrieved on January 24, 2017 from <http://en.prothom-alo.com/bangladesh/news/136745/Appeal-for-euthanasia>.

² The phrase 'legally sanctioned killing' is from Daniel Callahan, 'Aid-in-Dying': The Social Dimensions. In Bass, B. (Ed.) (1991). *Analyzing Moral Issues*. New York: McGraw Hill. 210.

³ Philosophers normally distinguish between active and passive euthanasia, the former identifying actions that deliberately cause death and the latter identifying actions that merely allow a patient to die. The distinction of voluntary, involuntary, and non-voluntary refers to individuals choosing, not choosing, or incapable of choosing, respectively.

⁴ United Nations, Office of the High Commissioner for Human Rights, *Convention on the Rights of the Child*, Retrieved on March 12, 2017 from <http://www.ohchr.org/EN/ProfessionalInterest/Pages/CRC.aspx>.

⁵ United Nations Childrens Fund (UNICEF), General Assembly, *Declaration of the Rights of the Child*, 02 September 1990, Retrieved on March 12, 2017 from <https://www.unicef.org/malaysia/1959-Declaration-of-the-Rights-of-the-Child.pdf>.

⁶ There is no publicly disclosed information as to what 'mentally challenged' here means, although generally it is understood locally to mean someone having some degree of mental illness (as manifest in capacity to comprehend and engage daily life events) even if not formally diagnosed as such by medical authorities. There is no public information provided whether she comprehends the husband's request or opines one way or the other on the matter. In the latter case, especially in the case of Bangladeshi Muslims living in villages, a woman is expected to restrict herself to the private domain of the household and would not be expected to counter her husband's authority.

⁷ Walker, Peter (2017, January 24). Bangladeshi Man Begg Government to Euthanize his Sons and Grandson Who Have Same Genetic Disorder. *Independent*. Retrieved on March 08, 2017 from <http://www.independent.co.uk/news/bangladesh-man-to-fazzal-begs-government-euthanise-sons-grandson-duchenne-muscular-dystrophy-a7543051.html>.

⁸ Muscular Dystrophy Association, Retrieved on 05 March 2017 from <https://www.mda.org>.

⁹ Average monthly salary in Bangladesh is approximately US\$342, yet this is not the level of income of a fruit-seller such as the father is, whose income varies by season and is usually a matter of daily income from daily sale at limited volume. A comparative cost of living is available at <https://www.numbeo.com/cost-of->

[living/compare_countries_result.jsp?country1=Bangladesh&country2=United+States](#). Bangladesh's poverty headcount ratio is evaluated by the World Bank to be 18.5% of population in 2010 at US\$1.90 per day (US\$57 per month.) See here <http://povertydata.worldbank.org/poverty/country/BGD>.

¹⁰ Walker, op. cit. note 2

¹¹ Ibid.

¹² Ibid.

¹³ Agence France-Presse (2017, January 24). Bangladeshi Father Sparks Euthanasia Debate with Plea for Mercy Killing of Sons, Grandson. Retrieved on March 08, 2017 from <http://interaksyon.com/article/136478/bangladeshi-father-sparks-euthanasia-debate-with-plea-for-mercy-killing-of-sons-grandson>.

¹⁴ The cleric's statement is subject to review and debate. For reasonable basis of debate, one may consider sources such as: Brock, Jonathan E. and Thomas Eich (Ed.)(2008). *Muslim Medical Ethics: From Theory to Practice*. Columbia: The University of South Carolina Press; Atigetchi, Darisuch (2007). *Islamic Bioethics: Problems and Perspectives*. Dordrecht: Springer; Ards, Berna and Vardit Rispler-Chaim (Ed.) (2011). *Islam and Bioethics*. Ankara: Ankara Üniversitesi Basımevi; Sachedina, Abdulaziz (2009). *Islamic Biomedical Ethics: Principles and Application*. Oxford: Oxford University Press..

¹⁵ Manninen, B.A. 2006. A case for justified non-voluntary active euthanasia: exploring the ethics of the Groningen Protocol, *Journal of Medical Ethics*, 32, 643-651. Retrieved on March 09, 2017, from <http://www.jstor.org/stable/pdf/27719743.pdf>.

¹⁶ By 'utilitarian' we mean here one whose moral deliberation and decision is guided by the principle of utility (acting such that one achieves the greatest good for the greatest number of individuals who stand to be affected by a particular decision). Here the deliberation decision depends on predicted consequences and a determination of net goodness (good consequences, benefits, advantages exceeding bad consequences, costs/risks, disadvantages).

¹⁷ By 'deontologist' we mean here one whose moral deliberation and decision is guided by universal law of morality (what Kant calls the "categorical imperative" and the "law of humanity," according to which individuals are always to be treated as autonomously deciding on the ends of life and never to be treated arbitrarily or merely as means to someone else's inclinations). Thus while a given individual may have some rule of action (maxim) s/he is following, such as rule must be evaluated for its objective validity, i.e., whether it counts as a universal practical law.

¹⁸ Dworkin, Gerald. 1998. "Introduction." In Gerald Dworkin, E.G. Frey, and Sissela Bok, (Ed.), *Euthanasia and Physician-Assisted Suicide*. (pp. 3-5, at 3). Cambridge: Cambridge University Press; italics added.

¹⁹ Ibid: 5

²⁰ Kass, Leon (1989). Neither for Love nor Money: Why Doctors Must Not Kill, *The Public Interest*, 94, 5.

²¹ Ibid.

²² Ibid: 28

²³ Dworkin, op. cit.15

²⁴ R.G. Frey, The Fear of a Slippery Slope, in Dworkin et al. 44

²⁵ Ibid: 45

²⁶ Ibid: 46

²⁷ Immanuel Kant, *Fundamental Principles of the Metaphysics of Morals*, trans. Thomas Kingsmill Abbott. Retrieved March 08, 2017, from <http://gopher.vt.edu:10010/02/107/5> and <http://www.euthanasia.com/kant.html>.

²⁸ Sharp, Robert. 2012. The Dangers of Euthanasia and Dementia: How Kantian Thinking Might Be Used to Support Non-voluntary Euthanasia in Cases of Extreme Dementia. *Bioethics*, 26(5), 231-235.

²⁹ Ibid. p. 231

³⁰ Sharp refers here to, e.g., D. Cooley (2007). A Kantian Moral Duty for the Soon-to-be Demented to Commit Suicide. *American Journal of Bioethics*, 7(6), 37-44.

³¹ Sharp, op. cit. p. 232

³² Ibid.

³³ Ibid: 233

³⁴ See here Manninen, op. cit.

³⁵ Campbell, p. 254

³⁶ Aramesh and Shadi, p. 35

³⁷ Sachedina, op. cit. p. 167-168

³⁸ Atigechti, op. cit. p. 285

³⁹ Hedayat and Pirzadeh, no page identifier in electronic version cited.

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