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Editorial: Looking Beyond Disaster at the Boundaries

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One of the programmes of Eubios Ethics Institute is Youth Looking Beyond Disaster (LBD) Training programmes, and from 12-15 April we will hold the tenth forum, this time in Istanbul, the boundary between Europe and Asia. The LBD program enhances our effectiveness for disaster reslience. Disasters have no boundary. We invite all readers to the forum. We will also have a further forum in July or August in USA.

I also have the pleasure to announce the publication of the recent book from Eubios Ethics Institute, ***Philosophy and Practice of Bioethics across and between Cultures***, Editors: Takao Takahashi, Nader Ghotbi & Darryl R. J. Macer, which includes over twenty papers from the Kumamoto Bioethics Roundtables. Later in 2019 we will start a series of Tohoku/Sendai Bioethics roundtables, so please keep an eye out for the announcements on the websites.

In this issue of the journal we have 8 papers, to fllow on the ten papers in the January 2019 issue, both with extended number of pages because of the increasing number of submissions. We welcome more papers, and there may be some more discussion of the gene editing ethics featured in the Bangkok Statement in the January 2019 issue and accompanying papers.

In this issue there are a range of bioethics issues included, from reproductive services and health care to end of life care. We offer perspectives from different countries and different groups of persons.

Juichiro Tanabe presents a holistic model for peace, Buddhism and post-liberal peacebuilding: Building a holistic peace model by interconnecting liberal peace and Buddhist peace, at the start of the issue. The scope of bioethics as the love of life must include ways that we can make peace not only with our own decisions, and the client-professional relationship, but also within and between societies.

- Darryl Macer

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Analysis of euthanasia from the cluster of concepts to precise definition

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Abstract
There are common concepts between euthanasia and suicide because euthanasia is historically connected with the discourse on suicide. In widespread literature on euthanasia there is confusion over the concepts and definitions. These definitions are analyzed in this paper and along with other conclusions and distinctions the researcher has substantially defended his definition of euthanasia. There are two different usages of the term euthanasia: a narrow construal of euthanasia and broad construal of euthanasia. Contrary to other researches, the researcher agrees only with the narrow construal of euthanasia, i.e. active euthanasia. The researcher's definition of euthanasia is: intentionally causing a terminally ill person's death through an action performed by a physician. As a result, passive euthanasia is expunged from the definition of euthanasia. In addition to that, the definition excludes suicide, assisted suicide, and physician-assisted suicide.

1. Introduction
Concepts are at the core of philosophical investigation. Describing concepts and definitions is one of the main tasks of philosophical practice and activity. Likewise, attempting to understand the meaning of the output of various disciplines and questioning their underlying principles besides clarity are also key tasks of philosophy. Regarding bioethics, especially euthanasia, philosophy plays a role in all the above-mentioned areas of conceptualizing, defining, clarifying, understanding beside discussing its ethical dimensions and evaluating the scores of arguments that are part of the narrative and discourse on the subject.

The complexity of defining euthanasia emerges from its historical background and current usage. In other terms, the issue of euthanasia is both old and new. It's traditional and the underpinnings of its discourse are old, connected with suicide on which thinkers and philosophers since the ancient period have held positions. The late twentieth century represents two aspects of the issue of suicide. The debate becomes divided into two separate discourses: suicide and euthanasia. Both these subjects became separate along with their subject matter and arguments, though there is an unavoidable overlap between them. The nature of euthanasia became special because it touches on medical profession and debate over rights and duties. Thus, euthanasia became an interdisciplinary subject of legal analysis in various countries.

The origin of euthanasia, most of its conceptual framework, and some of its main arguments is in suicide. Therefore, a lucidity of the issue, clarity of the concepts, and precision of the main definitions employed in the discourse are sought in the following sections of the paper.

2. Conceptual History of Euthanasia
Euthanasia is old in the sense that it is connected conceptually and historically with the historical debate of suicide. Suicide included concepts such as that Athenian law treated suicide as a crime (Mair, 2007, pp. 26-30), so the concept of crime developed. Hippocrates (460-370 BCE) worked on its approval through calling it anti-professional for a physician (Hippocrates, 2005); Plato worked against disapproval of suicide through concepts like judicial decree, excruciating misfortune, and moral disgrace (Plato, 1980, p. 268); Aristotle developed the concept of citizenry against suicide (Aristotle, 1999, p. 84); Annaeus Seneca (4 B.C.E.-C.E. 65) presented concepts like individual autonomy and quality of life in favor of suicide (Seneca. (1917/ 1998, pp. 35-39). Against suicide, Aquinas presented three concepts: self-perpetuation responsibilities, individual and communitarian responsibility, and divine authority over life (Aquinas, 1947, 11, 11, Q.64, Art.5.). Michel de Montaigne presented the concept of personal choice in favor of suicide (Ferngren, 1989, pp. 159-61).

During the Renaissance, Thomas More (1478-1535) defended suicide for issues like torturous and incurable illness by rationalizing concepts such as starvation and opium (More, 1999, p. 22.). David Hume (1711-1776) worked on the moral permeability of suicide when life is most plagued by suffering through concepts such as individual autonomy and social benefit (Hume, 2004, p.2-8). Other philosophers of the Age of Reason, such as John Locke and Immanuel Kant, opposed suicide. Locke argued that life, like liberty, represents an inalienable right, which cannot be taken from or given away by an individual (Ferngren, 1989, pp. 173-75). For Kant (1724-1804), suicide was a paradigmatic example of an action that violates moral responsibility. Kant believed that the proper end of rational beings requires self-preservation, and that suicide would therefore be inconsistent with the fundamental value of human life (Kant, 1785). This brief historical survey provides a score of concepts that are present in the discourse of euthanasia.

Euthanasia is new in the sense that most of the debate on the issue treats the matter as a consequence of advanced modern medical technology. The continuous

development of advanced medical technology has brought various moral issues under new scrutiny and ethical evaluation. For example, by using artificial life-sustaining technology delay of death is possible against the wishes of patients who may be in pain and or other forms of suffering. Moreover, it is also possible to keep people alive who are in a coma or a persistent vegetative state. In cases like these, sustaining life versus taking life or allowing someone to die become moral dilemmas in face of employing various life sustaining medical technologies and use of lethal injunctions and morphine.

3. Suicide and euthanasia: conceptual parallelism

The above concepts are present in the discourse and narrative given by proponents and opponents of euthanasia. These concepts directly or indirectly touch the issue of euthanasia from many perspectives and link the issue with philosophical tradition. Such mixture of concepts shows that the problem of euthanasia has a long history of philosophical discussion. However, most of the discussion revolves around the issue of suicide.

The discussion of suicide in a broader sense could be related to the problem of euthanasia since their aim is termination of life. Suicide is a general concept whereas euthanasia is special. Euthanasia is about terminally ill persons whereas suicide is a comprehensive concept including all forms of self annihilation. However, lines of distinction could be drawn between suicide and euthanasia. "Euthanasia is an alleged solution for the ills of dying, whereas suicide is an alleged cure for the ills of living" (Donnelly, John, 1998, p.10). On the other hand, wishing death and planning steps towards ending one's life is shared by both euthanasia and suicide. Both of these issues share many common threads which bring suicide and euthanasia on parallels, if not completely, nevertheless, partially. Therefore, in the historical sketch the distinction between suicide and euthanasia is irrelevant because suicide is general and in principle it includes euthanasia. And "Indeed, to justify either one, suicide or mercy killing, is to justify the other" (Fletcher 1987 / 1989, p. 91).

4. The need to define euthanasia

It is important to have a clear definition of euthanasia. As a matter of fact, defining euthanasia and the relevant terms deserve a thorough tactful analysis because much of the confusion which besets the contemporary euthanasia debate can be traced to imprecision in definition: "Lack of clarity has hitherto helped to ensure that much of the debate has been frustrating and sterile" (Otlowski, 1997, pp. 16-17).

The discussions on euthanasia have made it a multidisciplinary subject; however, the issue in its essence is connected with medicine. On December 4, 1973, the House of Delegates of the American Medical Association (AMA) asserted its position on the issue of euthanasia as follows:

> *"The intentional termination of the life of one human being by another--mercy killing--is contrary to that for which the medical profession stands and is contrary to the policy of the American Medical Association. The cessation of the employment of extraordinary means to prolong the life of the body when there is irrefutable evidence that biological death is imminent is the decision of the patient and/or his immediate family. The advice and judgment of the physician should be freely available to the patient and /or his immediate family."* (as cited in Rachels, 1975 / 1994a, pp. 112-113)

The AMA's position on the issue came to be named as conventional doctrine on euthanasia (CDE) or traditional view. It is important to mention that AMA's position, although adopted in the United States; its message was adopted by the World Medical Association's Declaration on Euthanasia, adopted by the 38th World Medical Assembly, Madrid, Spain, in October 1987, states:

> *"Euthanasia, that is the act of deliberately ending the life of a patient, even at the patient's own request or at the request of close relatives, is unethical. This does not prevent the physician from respecting the desire of a patient to allow the natural process of death to follow its course in the terminal phase of sickness."* (World Medical Association, 2002, Section, 1)

The declarations by American Medical Association (AMA) and the World Medical Association can be helpful in developing concise and precise concepts and definitions that are important for any meaningful discourse on euthanasia.

5. Defining euthanasia

Euthanasia etymologically comes from two Greek words, *eu*, well, and *thanatos*, death; it means good or easy death (Baird & Rosenbaum, 1989, p. 9). Gradually the meaning of the word changed from easy death to the actual medical deed to make death easy. Finally, it gained the meaning of mercy killing. The common synonym for euthanasia in both lay and professional vocabularies has been mercy killing (Koop, 1989a, p. 69). Merriam-Webster's dictionary defines euthanasia as "an easy and painless death, or, an act or method of causing death painlessly so as to end suffering: advocated by some as a way to deal with victims of incurable disease" (2008). Similarly, the Euthanasia Society of America, founded in 1938, defines euthanasia as the "termination of human life by painless means for the purpose of ending severe physical suffering" (Hardon, 2004, Euthanasia, para.14). The American Medical Association's Council on Ethical and Judicial Affairs (1992) defines the term as follows: "Euthanasia is commonly defined as the act of bringing about the death of a hopelessly ill and suffering person in a relatively quick and painless way for reasons of mercy" (p. 2230).

Though euthanasia is mercy killing in the sense of painlessly putting a terminally ill patient to death, the above-mentioned definitions lack clarity and could lead to misunderstanding. There are other definitions which suggest that euthanasia also means refusing unwanted care or withdrawal of ongoing care (Adams, 1992, p. 2021). Therefore, there are two different uses of the term "euthanasia." The first is sometimes called the *narrow construal of euthanasia*. In this view euthanasia is equivalent to mercy killing. Thus, if a physician injects a patient with a drug with the intent to kill the patient, that would be an act of euthanasia; but if the physician withholds some extraordinary and excessively burdensome treatment from a patient and allows the patient to die in a natural way, that does not count as an example of euthanasia. The second view, is sometimes

called the *broad construal of euthanasia*, it includes both mercy killing and cessation of extraordinary medical treatment: *active euthanasia* and *passive euthanasia*. The broad construal is more widely used; although this paper supports the narrow construal of euthanasia.

Active euthanasia or euthanasia by action, also called mercy killing or positive euthanasia, is intentionally causing a person's death by performing an action such as giving a lethal injection. Passive euthanasia or euthanasia by omission, also called negative euthanasia, is the withholding or withdrawing the unnecessary and extraordinary medical treatment. Rachels (1983) widens the definition of active euthanasia; according to him it refers to the intentional and /or direct killing of an innocent human life either by that person, suicide, or by another, assisted suicide (p.19). Gifford (1993) describes the difference between the two types of euthanasia: "Passive euthanasia involves allowing a patient to die by removing her from artificial life support systems such as respirators and feeding tubes or simply discontinuing medical treatments necessary to sustain life. Active euthanasia, by contrast, involves positive steps to end the life of a patient, typically by lethal injection" (p. 1546).

Active and passive euthanasia are the main categories; however, they are further classified depending on the relevant factors or circumstances such as *Voluntary, Involuntary,* and *Non-voluntary euthanasia.* The American Medical Association's Council on Ethical and Judicial Affairs (1992) makes three distinctions concerning consent and euthanasia as follows:

> *"Voluntary euthanasia is euthanasia that is provided to a competent person on his or her informed request. Non-voluntary euthanasia is the provision of euthanasia to an incompetent person according to a surrogate's decision. Involuntary euthanasia is euthanasia performed without a competent person's consent."* (p. 2230)

These distinctions while combined with the active/ passive distinction form six different types of euthanasia: voluntary active, voluntary passive, non-voluntary active, non-voluntary passive, involuntary active and involuntary passive. Closely related to euthanasia are terms such as *assisted suicide* and *physician assisted suicide.* Assisted suicide is when 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. Likewise, when it is a doctor who helps another person to kill himself or herself it is called physician assisted suicide. However, there is a sharp difference between euthanasia and physician assisted suicide. The AMA's Council on Ethical and Judicial Affairs (1992) states as follows:

> *"Euthanasia and assisted suicide differ in the degree of physician participation. Euthanasia entails a physician performing the immediate life ending action (e.g., administering a lethal injection). Assisted suicide occurs when a physician facilitates a patient's death by providing the necessary means and /or information to enable the patient to perform the life-ending act (e.g., the physician provides sleeping pills and information about the lethal dose, while aware that the patient may commit suicide)."* (p. 2231)

6. Euthanasia: what it is and what it is Not

The researcher holds that euthanasia is only the narrow construal of euthanasia; that is active euthanasia alone. The researcher's contention is that since euthanasia enfolds the meaning of intentional, mercy killing in what has come to be known as passive euthanasia, intentional killing is not part of the withholding or withdrawing the unnecessary and extraordinary medical treatment. The confusion between suicide, assisted suicide, and physician assisted suicide, and euthanasia also deserve analysis. This confusion of terms is very widespread in the well circulated literature on euthanasia; most importantly, Rachels, as noted earlier, confuses these terms too; his definition of active euthanasia includes mercy killing, suicide, assisted suicide and physician assisted suicide (Rachels, 1983, p.19).

The researcher holds that passive euthanasia, suicide, assisted suicide, and physician assisted suicide are not euthanasia; only active euthanasia "mercy killing" is euthanasia. The researcher's understanding is consistent with AMA's definitions; intentionally causing a terminally ill person's death for the reasons of mercy by a physician. The definition includes: voluntary, non-voluntary, and involuntary active euthanasia. The definition excludes: suicide, assisted suicide, physician-assisted suicide and passive euthanasia.

The definition is based on the facts that: (1) the death is caused by an agent (human) instead of the subject (the patient), (2) the causing of death is intentional (3) the death is caused either by the request of the subject or the state of the subject to make it different from a pure homicide (4) the death is caused by commission or action and (5) the subject is terminally ill and (6) the agent to cause the death is a physician. Therefore, euthanasia as defined above will include only active euthanasia.

The reasons for not considering passive euthanasia as euthanasia include: (1) the death is natural, and not artificial (2) the death is not caused by action of any agent. Suicide, assisted suicide, and physician assisted suicide are excluded because the death is not caused by an agent other than the subject. The very integral factor of the notion of euthanasia is being killed by some agent (person) instead of the subject.

7. Conclusion

The study showed that there are two different usages of the term, euthanasia: narrow construal of euthanasia, which refers to mercy killing or active euthanasia; and broad construal of euthanasia, which refers to both active and passive euthanasia. The researcher agrees only with the narrow construal of euthanasia, i.e. active euthanasia. The researcher's definition of euthanasia is: intentionally causing a terminally ill person's death by performing an action by a physician. As a result, passive euthanasia is expunged from the definition because euthanasia means intentional mercy killing; and in passive euthanasia intentional killing is not part of the withholding or withdrawing the unnecessary and extraordinary medical treatment. Therefore, the researcher's definition includes only active euthanasia "mercy killing" as euthanasia. The definition excludes: suicide, assisted suicide, physician-assisted suicide and passive euthanasia. The very integral factor of the notion

of euthanasia is being killed by some agent (person) instead of the subject.

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The surrogacy industry in Georgia and Japanese patients

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Abstract

On 19 February 2015, a law regulating reproductive medicine (surrogacy) passed the legislative process in Thailand and was next enacted with the approval of the cabinet and King Bhumibol Adulyadej in July 2015. Since then, some intermediary surrogacy agencies based in Thailand, including Japanese surrogacy agencies, have developed a multinational surrogacy industry with branches in Georgia. This paper is an attempt to clarify the present state of the Georgian surrogacy industry, and also the risks inherent in the Georgian surrogacy industry. The paper aims to provide information which is relevant to the Japanese patients seeking surrogacy treatment as well as researchers in reproductive medicine. Japanese couples need to carefully examine the various options offered by foreign surrogacy agencies and hospitals, because some of them operate without being well versed in the support they provide over procedures to have surrogate children recorded in Japanese family registries so that they may acquire Japanese nationality. Those who are planning to participate in Georgian surrogacy tourism should keep up with the latest legal developments in Georgia, and ponder deliberately whether they still want to go ahead and take part in the reproductive medicine programs there, if at all.

1. Introduction

Thailand's status as a surrogacy hub in the early 21st century has rivaled India's, greatly galvanizing its economic development. However, the industry has seen dramatic upheaval in the country since 2014. Patients from developed nations seeking surrogacy treatment fled Thailand *en masse* with the enactment of the *Protection for Children Born Through Assisted Reproductive Technologies Act, 2015*, on July 30th, 2015. While these refugees initially found greener pastures in Nepal and the Mexican state of Tabasco, public outcry over the flood of gay couples seeking surrogacy arrangements led the authorities in Nepal and Tabasco to issue complete bans on commercial surrogacy by the end of 2015.

In response to these developments, many organizations turned their attention to Cambodia as an alternative site for surrogacy operations, where the lack of legislation concerning reproductive medicine *de facto* permitted surrogacy treatment. Among them was the New Life Global Network (NLGN), which opened a local branch in the country in March 2015. However, the Cambodian government soon followed suit with its neighbor by announcing a complete ban on commercial surrogacy in all medical facilities in Phnom Penh on November 3rd, 2016. (Readers can find an early account

8. Conclusion

In a nutshell, discrimination based on gender is profoundly embedded in our society and culture. It would take years and years to uplift woman's significance in our society, guard their rights, and consider them as equal members and ultimately sustain their dignity and self-determination. Child's gender should not be perceived as determinant of their future and status. In the hospitals, ethical committees should deal such cases and counseling of the family or the mother should be done. Nurses should be educated to directly report such incidences without any fear. Pros and cons of the situation and their harmful effects on the family's future should be explained. Most of these actions are done due to misconception, unawareness and societal pressures, which could be dealt effectively.

At community level, nurses need to work through eliminating gender labels, promoting female education; their rights in domestic life and providing them with equal opportunities. Importantly, awareness of role and status of women in societies in the light Islam should be enlightened by removing the misconceptions of patriarchal society. Moreover, social stigmas associated with any gender should be eliminated to counter such preferences. Additionally, ultrasounds should not be used to disclose the gender of the baby. This would cause problems for the mother, as she would have to undergo unsafe abortion due to familial pressure and jeopardize her health.

Furthermore, illegal abortions should be of high priority for the government to take actions on. Immediate banning of such actions should be done. Multiple audits should be done to ensure no performance of unsafe abortions in the state and punitive measures should be taken against those who practice unsafe abortion. Moreover, awareness campaigns through social media and public sessions should be conducted about hazards of unsafe abortion and revolutionary gender rules and equalities. A hotline service should be started for women to reach out in case of forced abortions or domestic violence.

In the end, ban on sex selective abortion is not the way to achieve these goals, as they do not cure the core problem. This reduction in discrimination is possible by shifting our concern towards addressing the circumstances that initiate this partiality. Female education should be available at easy access and within the community, so that it influences and welfares at the grass root levels. Moreover, their fundamental rights, and security should be reinforced. Non-governmental organizations should be self-reliant to develop an in depth understanding of hurdles and taboos against women and formulate operational and pertinent campaigns to eradicate the root causes.

Likewise, system of dowry should be banned in our societies so that no one considers the baby girl as a burden on them. As the part of making policies regarding these recommendations, representatives of women from urban and rural areas should be involved in implementation strategies. In a nutshell, only if the thinking and perceptions change, only then this world would be a better place for newborn female children. The apprehension is that sex selective abortion would reinforce gender discrimination and disseminate gender norms negatively.

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