

Euthanasia: A Socio-Legal Study in the City of Lucknow

THESIS

**SUBMITTED TO THE
BABASAHEB BHIMRAO AMBEDKAR UNIVERSITY
LUCKNOW**

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BHIMRAO
AMBEDKAR
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2021



**This thesis is dedicated to my
family and teachers**





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DECLARATION

I, **Abhishek Srivastava**, hereby declare that this research work embodied in this Ph.D. thesis titled “**Euthanasia: A Socio-Legal Study in the City of Lucknow**” has been carried out by me under the supervision of **Dr. Sanjeev Kumar Chadha**, Head, Department of Law, School of Legal Studies, Babasaheb Bhimrao Ambedkar University (A Central University) Lucknow, 226025.

This Research work is an original work and it has not been previously submitted in part or full for any other degree or diploma in this or any other University.

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CERTIFICATE

This is to certify that the thesis titled “Euthanasia: A Socio-Legal Study in the City of Lucknow” submitted by Mr. Abhishek Srivastava, is an original research work and has not been previously submitted in part or full for the award of any other degree or diploma to this or any other University.

The thesis submitted to Babasaheb Bhimrao Ambedkar University, Lucknow satisfies all the requirements as stipulated in the *Doctor of Philosophy (Ph.D.) regulations, 1999 as amended in 2013* and it is fit for submission and evaluation for the award of the degree of Doctor of Philosophy of the University.

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Abhishek Srivastava

LIST OF ABBREVIATIONS

A.LR.Fed	-	American Law Reports Federal
AC	-	Appeal Cases
ACLJ	-	American Centre for Law and Justice
ACLU	-	American Civil Liberties Union
AD	-	Anno Domini
AIDS	-	Acquired Immuno Deficiency Syndrome
AIR	-	All India Reporters
AllER	-	All England Reports
AMA	-	American Medical Association
AMD	-	Advance Medical Directives
Art.	-	Article
BBC	-	British Broadcasting Corporation
BCE	-	Before the Common Era
BC	-	Before Christ
BE	-	Buddhist Era
CE	-	Common Era
CFD	-	Concern for Dying
CMA	-	Canadian Medical Association
Col.	-	Column
COVE	-	Coalition of Organizations for Voluntary Euthanasia
Cr.LJ	-	Criminal Law Journal
DNR	-	Do Not-Resuscitate

DPP	-	Director of Public Prosecutions
DWDA	-	Death with Dignity Act
Eg.	-	Exempli Gratia (For example)
ERGO	-	Euthanasia Research and Guidance Organization
Et. al.	-	And others
Etc.	-	Etcetera
FCA	-	Federal Court of Australia
GMC	-	General Medical Council
HL	-	House of Lords
i.e.	-	That is
Ibid.	-	In the same place
ICCPR	-	International Covenant on Civil and Political Rights
ICU	-	Intensive Care Unit
IPC	-	Indian Penal Code
IVAE	-	Involuntary Active Euthanasia
JCC	-	Japanese Criminal Code
KEM Hospital	-	King Edward Memorial Hospital
Ltd.	-	Limited
MD	-	Doctor of Medicine
MDH	-	Missouri Department of Health
MTA	-	Medical Treatment Act
NSW	-	New South Wales
NVAE	-	Non-Voluntary Active Euthanasia
ORTD	-	Oregon Right to Die

P. or pp	-	page(s)
PAS	-	Physician Assisted Suicide
PEG	-	Percutaneous Endoscopic Gastrostomy
PTI	-	Press Trust of India
PVS	-	Persistent Vegetative State
RDMA	-	Royal Dutch Medical Association
ROTTIA	-	Rights of The Terminally Ill Act 1995, Australia
SC	-	Supreme Court
SCC	-	Supreme Court Cases
SCJ	-	Supreme Court Journals
Sec.	-	Section
SRD	-	Society for the Right to Die
Supra	-	Above
U/s.	-	Under Section
UK	-	United Kingdom
UOI	-	Union of India
USA	-	United States of America
VAE	-	Voluntary Active Euthanasia
VELS	-	Voluntary Euthanasia Legalisation Society
Viz.	-	Namely
Vol.	-	Volume
Vs.	-	Versus
PIL	-	Public Interest Litigation
NGO	-	Non-Governmental Organization

TABLE OF CASES

S. No.	Description	Page No.
1.	Aruna Shanbaug v. Union of India and others, (2011) 4 SCC 454	12, 13, 116,142, 147, 150, 197, 295,
2.	Airedale NHS Trust v. Bland1993(1) All ER 821 (HL)	10, 86, 127, 172, 193, 195
3.	Baxter v. State of Montana No. ADV-2007-787 (Mont. 1st Jud. Dist. Ct 2000).	10, 137
4.	Brittany Maynard Case, 1 IOSCT 2841(2014).	135
5.	C.A Thomas Master v. Union of India, 2000 CriLJ3729	155
6.	Chena Jagdeeswar v. State of Andhra Pradesh16th April, 1987 Laws (APH)- 1987	139
7.	Common Cause (A Regd. Society) v. Union of India and Another (2018) 5 SSC 1W.P.	14, 117, 118, 159, 161,163, 164, 288, 296
8.	Cruzan v. Director, Missouri Department of Health, 1 IOSCT 2841 (1990).	135
9.	Debbie Purdy v. Director of Public Prosecutions. (2008) EWHC 2565	130, 212
10.	Dying v. State of Washington case, 49 F.3d 586,588 (9th Cir.1995).	134
11.	Gian Kaur v. State of Punjab (1996)2 SCC 648.	11, 100, 139, 161, 294
12.	Kevorkian v. Thompson, 947 F. Supp. 1152 (E.D. Mich. 1997).	133
13.	Krischer v. McIver 697 So.2d 97 (Fla. 1997).	137
14.	Mahesh Mahan Singh Shribas v. State of Maharashtra CriLJ 4380(Bom)	141
15.	Naresh Marot Rao Sakhre v. Union of India 1996 (1) Bom CR 1995 CriLJ 96	139
16.	M.SD v. NHS Trust Hospital 2005	204
17.	M.C. Mehta v. Union of India	37

18.	Nikhil Soni v. Union of India & Others (2015) Cri LJ 4951	52,156, 158
19.	Maruti Shripati Dubal v.State of Maharastra	11, 99, 286, 294
20.	P. Rathiman v. Union of India (1994)3 SCC 394	11, 139, 294
21.	People v. Campbell, 124 Michigan App. 337-338	133
22.	Postma case	79
23.	Pretty v. United Kingdom, (2346/02) [2002] ECHR 423.	128, 212
24.	R v Adams (1957) Crim LR 365	66, 125
25.	R (On the application of Burke) v. GMC (2005) EWCA Civ 1181	191
26.	R v. Cox (2014) EWCA Crim 804.	166, 126
27.	R v. Carr	126
28.	R v. Arthur, 1981	126
29.	Raj Kapoor v. Laxman 1980 AIR 605	113
30.	Re Quinlan (70 N.J. 10, 355 A.2d 647 (NJ 1976).	132
31.	Re A children conjoined twins: surgical separation [2000] 4 ALL ER 961	170
32.	Re J (A Minor) Wardship medical treatment (1991) 1 FAM 33, CA.	191
33.	Sampson and Doe v. State of Alaska.	138
34.	Selvi and Others v. State of Karnataka, AIR 2010 SC558	141
35.	Siddheswari Bora v. State of Assam	140
36.	St. George's Healthcare NHS Trust v. S Case [1998] 2 WLR 936.	127
37.	Sue Rodriguez v. British Columbia (Attorney General) (1993) 3 SCR 519.	10, 74, 138, 212
38.	Vacco v. Quill 521 US 793 (1997)	9, 134
39.	Washington v. Glucksberg 521 US 702 (1997)	9, 134

TABLE OF CONTENTS

S. No.	Description	Page No.
	<i>Declaration</i>	<i>i</i>
	<i>Certificate</i>	<i>ii</i>
	<i>Acknowledgements</i>	<i>iii</i>
	<i>List of Abbreviation</i>	<i>v</i>
	<i>Table of Cases</i>	<i>vii</i>
	<i>Table of Contents</i>	<i>x</i>
I.	Chapter I - Introduction	1-34
1.1	Introduction	1
1.2	Statement of Problem	15
1.3	Literature Review	16
1.4	Objective of study	24
1.5	Hypothesis	25
1.6	Research Question	25
1.7	Significance of the problem	25
1.8	Research Methodology	25
1.9	Organisation of the Chapters	28
II.	Chapter II - Conceptual Analysis of Euthanasia	35-71
2.1	Introduction	35
2.2	Historical concept of Euthanasia	36
2.3	Meaning and definition	40
	2.3.1 Euthanasia	40
	2.3.2 Euthanasia and mercy-killing	42
2.4	Kinds of Euthanasia	43
	2.4.1 Consent of the patient	43
	a) Voluntary	43
	b) Non-Voluntary	43
	c) Involuntary	43
	2.4.2 Method of Euthanasia	44
	a) Passive	44
	b) Active	44
	2.4.3 Differences between voluntary, involuntary and Non-	45

	voluntary euthanasia	
	a) Voluntary euthanasia	45
	b) Non-voluntary euthanasia	46
	c) Involuntary euthanasia	46
2.5	Euthanasia and its multi-dimensional perspectives	47
2.6	Religious Concept	49
	2.6.1 Hindu view on Euthanasia	49
	2.6.2 Islamic thought	50
	2.6.3 Christian Thought	51
	2.6.4 Orthodox Judaism	51
	2.6.5 Jainism perspective	51
2.7	Political perspectives	52
2.8	The Shona Perception of Euthanasia	52
2.9	Practice of euthanasia in the State of Tamil Nadu	53
2.10	Euthanasia under the modern concept	54
	2.10.1 Human Dignity	54
	2.10.2. The Modern Concept of death	56
	2.10.3. The death with dignity	58
	2.10.4 End of Life Care	60
	2.10.5 The Regulation of Law by Criminal Law	61
2.11	Operational Concepts regarding euthanasia	62
	2.11.2 Brain death	62
	2.11.3 Terminal illness	62
	2.11.4 Coma	62
	2.11.5 Persistent vegetative state and Minimally Conscious State	63
	2.11.6 Palliative care	64
	2.11.7 Do not attempt Resuscitation (DNR)	65
	2.11.8 The doctrine of double effect	65
	2.11.8.1 Factors involved in the doctrine of Double Effect	66
2.12	Assisted suicide/dying, euthanasia, suicide and murder: A distinction	66
2.13	Conclusion	70
III.	Chapter III - Comparative Analysis of Euthanasia in different countries	72-124
3.1	Introduction	72
3.2	Euthanasia in the American Continent	72
	3.2.1 Historical background	72
	3.2.2 Legalization of Euthanasia	73
	3.2.3 Death with Dignity Act	73

	3.2.4 Canadian bill “Euthanasia C-384, 2010” and “Bill 52, 2014”	74
	3.2.5 Mexican bill on euthanasia	75
	3.2.6 Euthanasia in the Southern and Central America	75
	3.2.6.1 Judicial support to euthanasia in Columbia	75
	3.2.6.2 Uruguay indirectly supports euthanasia	76
	3.2.7 Anti-euthanasia beliefs in American Continent	76
	3.2.7.1 Compassionate approach of the ELCA	77
	3.2.8 Progressive View	77
3.3	Euthanasia in the European continent	78
	3.3.1 Netherland Perspective	78
	3.3.2 Enactment of Law	79
	3.3.3 France a progressive state	80
	3.3.4 Belgium and Luxembourg an anti-euthanasia view transformed	80
	3.3.5 Italy- the controversial battle	82
	3.3.6 Suicide tourism of Switzerland	83
	3.3.7 Sweden confirms patient’s autonomy	84
	3.3.8 Discordant altitude towards euthanasia in Spain	84
	3.3.9 Germany recognizes patient’s right of autonomy	85
	3.3.10 Changing perspective of the United Kingdom	86
	3.3.11 Awaiting, a legislation on Euthanasia	87
3.4	Euthanasia in the Australian Continent	88
	3.4.1 Support for Euthanasia	88
	3.4.2 The Voluntary Euthanasia Bill 2012	89
	3.4.3 Northern Territory of Australia	89
	3.4.4 The Dying with Dignity Bill 2009	90
	3.4.5 The religious approach towards Euthanasia	91
	3.4.6 Libertarian view on Euthanasia	92
	3.4.7 Medical fraternity outlook	92
3.5	Euthanasia in the Asian continent	92
	3.5.1 Religious view about euthanasia	93
3.6	Euthanasia in the Asian continent	94
	3.6.1 Scope for change in approach in Japan	94
	3.6.2 China following the footsteps of Japan	94
	3.6.3 The National Health Act 2007 of Thailand	95
	3.6.5 Euthanasia in the gulf	95
	3.6.6 Euthanasia: Indian Perspective	96
	3.6.6.1 Euthanasia in India: The Philosophical and Historical Perspective	96
	3.6.6.2 Ethical and Conceptual view of Euthanasia in India	97
	3.6.6.3 Euthanasia and Suicide	98
	3.6.6.4 Euthanasia and Physician Assisted Suicide (PAS)	99

	3.6.6.5 Legal Extent of Euthanasia in India	100
	3.6.6.6 Role of Law Commission: A Chronology	114
3.7	Comparative study	119
	3.7.1 Australian and European continent	119
	3.7.2 Australian and American continent	119
	3.7.3 Australian and Asian Continent	120
	3.7.4 Australian and African Continent	120
	3.7.5 American and European continents	120
	3.7.6 American and Asian continent	121
	3.7.7 American and African continents	121
	3.7.8 European and Asian continent	121
	3.7.9 European and African continent	122
3.8	Conclusion	122
IV.	Chapter IV- Judicial Response Towards Euthanasia	125-166
4.1	Introduction	125
4.2	In United Kingdom:	125
	4.2.1 Dr. John Bodkin Adams Case	125
	4.2.2 Dr. Leonard Arthur Case	126
	4.2.3 Dr. Carr Case	126
	4.2.4 R vs. Cox Case	126
	4.2.5 Airedale NHS Trust vs. Bland Case	127
	4.2.6 St. George's Healthcare NHS Trust vs. S Case	127
	4.2.7 Pretty vs. United Kingdom Case	128
	4.2.8 Debbie Purdy v. Director of Public Prosecutions	130
4.3	In United states of America	132
	4.3.1 Karen Ann Quinlan Case	132
	4.3.2 People v. Campbell	133
	4.3.3 Dr. Jack Kevorkian's Case	134
	4.3.4 Washington vs. Gluck berg Case	134
	4.3.5 Quill vs. Vacco Case	134
	4.3.6 Cruzan vs. Director, Missouri Department of Health	135
	4.3.7 Brittany Maynard Case	135
	4.3.8 Baxter v. State of Montana	137
	4.3.9 Krischer v. Mclver	137
	4.3.10 Sampson and Doe v. State of Alaska	138
4.4	Canada	138
	4.4.1 Sue Rodriguez v. British Columbia (Attorney General)	138
4.5	In India	139
	4.5.1 Judicial intervention regarding "Right to Die"	141
	4.5.2 The Indian Story of Aruna Shanbaugh	141
	4.5.3 Judiciary evolved Passive Euthanasia in the landmark	146

	case of Aruna Shanbaug	
	4.5.4 Analysis of the judgement of the much sensational case: Aruna Ramachandra Shanbagh V Union of India:	147
	4.5.5 Some Judgements of the Honourable Supreme Court on mercy-killing at a Glance	151
	4.5.6 Landmark Judgment overturned – New dimension of Supreme Court	159
	4.5.7 Euthanasia for people suffering from rabies	165
4.6	Conclusion	166
V.	Chapter V- Socio-Legal, Ethical and Moral Issues Related to Euthanasia	167-214
5.1	Introduction	167
5.2	The Heart of the debate	168
5.3	Sanctity of life/vitalism/quality of life	169
	5.3.1 The Principle of sanctity of life: A Key issue in euthanasia debate	170
	5.3.2 Quality of Life Argument	174
5.4	Better Alternatives: An Argument	177
5.5	Patient Autonomy: Right to Choose Time and Manner of Death	179
	5.5.1 Challenges to the autonomy argument	180
	5.5.1.1 The right of the patient to choose to die must be counter balanced against the interests of society as a whole	180
	5.5.1.2 This right to die must be balanced against concerns that other patients who do not want to die will be pressurized into saying they do.	181
	5.5.1.3 There is a moral imperative or value which counterbalances the autonomy right?	181
5.6	Dignity of Life and Death	181
5.7	Slippery-Slope Argument	183
5.8	Concern over treatment of the vulnerable:	188
5.9	Euthanasia and disabled people	189
5.10	Heart of the debate related to Non-voluntary Passive euthanasia	190
	5.10.1 Reaching the decision: The Best Interests Test	190
	5.10.2 Withdrawal of treatment: An act or omission	191
	5.10.3 Removal of artificial feeding tube and hydration: is it justifiable	195
	5.10.4 Withdrawal of life sustaining treatment from PVS patients: Some Concerns	196

5.11	Physician Beneficent Responsibility to Patients	198
5.12	Intention/ foresight and doctrine of double effect	201
	5.12.1 Effects and double effects: Conceptual distinction and moral significance	202
5.13	Ordinary v. Extraordinary Means of Treatment	204
5.14	Physical Pain v. Psychological Suffering	206
5.15	Doctor-patient relationship	211
5.16	Human rights: a right to die	212
5.17	Advance Refusal: Some Concerns	213
5.18	Conclusion	214
VI.	Chapter VI- Data Analysis and Interpretation	215-277
6.1	Research Methodology	216
6.2	Universe of Study	216
6.3	Data Analysis and Results	217
6.4	Major Findings	270
6.5	Inferences and Implications	274
6.6	Suggestions for further Research	276
VII.	Chapter VII- Conclusion and Suggestions	278-316
7.1	Conclusion of the Study	278
7.2	Findings of conclusion	304
7.3	Suggestions	305
7.4	Suggested Draft legislation i.e. “Treatment of Terminally Ill Patients and Dignified Death Bill”, 2020.” on Euthanasia	308
	Bibliography	317-339
	Annexures
	Annexure 1
	Annexure 2
	Annexure 3
	Annexure 4



CHAPTER-I
INTRODUCTION



CHAPTER-I

INTRODUCTION

“Death with dignity is to die with grace, in the knowledge that you are loved”.

-Mother Teresa

1.1 Introduction:

Life on this earth is a great blessing of God. It is such a precious gift that even a painful one is a life at least.¹ There has been no greater gift in the past, nor will there be in the future, than the gift of life. Human life has some special value, a value quite distinct from the value of the lives of other living things.² A child comes in this world and he lives according to the time duration as allowed by the almighty. On the other hand, death is a natural part of the life cycle. In fact, it is a consequence of being born, it is the final universal experience. Death comes to us all and all creatures have to die one day. It is the only certain thing of life but what matters is getting there, how we die, does matter, and many of us do not find the gentle or sudden death for which we hope. Many of us here will find only wild deaths at the end of the road. We may wish that it was otherwise, but it is not.³ It implies the extinction of life. Mahatma Gandhi once said: It is as clear to me as daylight that life and death are but phases of the same thing, the reverse and obverse of the same coin.⁴ Death is not an event, it is a process, the various organs and systems supporting the continuation of life failing and eventually ceasing altogether to function, successively and at different times.⁵ During this sacred journey from birth to death, one accumulates both good and bad experiences of life and leaves this world with these experiences which are manifested

¹Shishir Srivastava, “Should Euthanasia be legalized in India”-? Available at <http://www.merineews.com/article/should-euthanasia-be-legalized-in-india/128617.shtml> (last visited on Oct 17, 2017)

²Murdoch Lazarev, “The Intrinsic Value of Human Life: A Critique of Life’s Dominion”, *MurUEJL*(2005) Available at <http://www5.austlii.edu.au/au/journals/MurUEJL/2005/7.html> (Last visited on July 27, 2017)

³Peter Baum, *NSW Parliament: Voluntary Euthanasia (1996)*, (ANU press, 2015) Available at <http://www.jstor.org/stable/j.ctt183q3f4.42>, (Last visited on July 19, 2017).

⁴Prashant Gupta, *I Wisdom of Gandhi*, 108 (Prabhat Prakashan, New Delhi, 2020).

⁵ Editorial, “Diagnosis of Death” 332 *British Medical Journal*, (1979) in Hazel Biggs, *Euthanasia Death with dignity and the Law*, 17 (Hart publishing Oxford- Portland Oregon USA, 2001).

in his soul. The journey brings him the experience of both pleasure and pain and his personality is developed accordingly.

According to Jeremy Bentham, “pleasure and pain are natural events. Pleasure and pain are in fact the masters of human conduct and must be served in all walks of life whether social, political, economic, moral, religious and in speech, thought and action. The whole superstructure of morality thus rests on the foundation of pleasure and pain.⁶ The real meaning of right to life and personal liberty should be enjoyed only in the ambience of physical and psychological growth. Hence States endeavour to provide this kind of environment to the individuals by granting fundamental freedom to them. But the struggle for civil liberties is still going on in both developed and developing countries.⁷

At one point of time various individual liberties were treated as being against morality like abortion or surrogacy. They were against the established religious principles.⁸ Gradually, after the integration of rationality, reasoning, justness, fairness, equity and good conscience into the legal system, the state provided limited space for freedom. But still, there prevails a disparity among different nations regarding one’s rights over his own body. It is so because of the fact that every society has its own parameters to decide moral and religious values. Every society takes into consideration decent values. An individual’s action can be discarded by the society members on the basis of its apprehensive impact on decent values.⁹

‘Right to die with dignity’ is the issue which concerns the right to have control over one’s own body, destiny and the nature itself including the right to decide the time and manner of one’s own death. Article 21 of our Constitution clearly speaks of the Right to live a dignified life as one of its facets.¹⁰ A person has a right to live a life with at least minimum dignity and if that standard is falling below that minimum level

⁶Shrinivas G. Sathaye, *A Philosophy of Living - An Introduction to Ethics*, 91, 97 (Asia Publishing house Bombay, 1st edn.,1963).

⁷Christopher W. Schmidt, “The Civil Rights-Civil Liberties Divide” (2014). Available at: http://scholarship.kentlaw.iit.edu/fac_schol/807 (Last visited on Nov 30, 2017).

⁸ “Abortion Euthanasia and value of human life” Available at, <http://www.markedbyteachers.com/gcse/religious-studies-philosophy-and-ethics/abortion-euthanasia-and-the-value-of-human-life.html> (Last visited on Nov 30, 2017).

⁹ Jeremy Bentham, *An Introduction to the Principles of Morals and Legislation* (1781) Available at <https://www.utilitarianism.com/jeremy-bentham/index.html> (Last visited on Nov 30, 2017).

¹⁰Sandeepa Bhat and D Shyamala “Euthanasia Regime: A Comparative Analysis of Dutch and Indian Positions”, *NUJS Working Paper Series Available At* <http://www.nujs.edu/workingpapers/euthanasia-regime-a-comparative-analysis-of-dutch-and-indian-positions.pdf>

then a person should be given a right to end his life.¹¹ The phrase covers a variety of concepts like suicide, euthanasia, assisted suicide etc.¹² In recent years our attitude towards death has changed. In the past, death was simply something that happened to us and had to be accepted. However, with the technological developments it has become possible to exercise greater control over our death. Many people now wish for quiet, peaceful and a controlled death but the extent to which people should have control of their or another's death is highly controversial.¹³

Before the industrial and scientific revolution, when the scientists had not invented artificial ways of keeping a terminally ill patient alive, like ventilators, heart & lung machines, artificial feeding methods, etc. such patients would have naturally died during the ordinary course of nature but with the scientific revolution, there was better and in-depth understanding of the human body. Simultaneously there was advent of new technology and machines, through which it is possible to prolong the life. Nowadays, a person who is in a persistent vegetative state, whose sensory systems are dead, can be kept alive by ventilators and artificial nutrition for years. Even though the patients are kept alive, often they will be in extreme physical pain and suffering (emotional, social and financial). Are these advanced intensive care procedures which we are referring here, any means to cure/control the disease or are they only prolonging the agony as well as the mere existence of terminally ill patients.¹⁴ Technology was limited to the hospital setting and used to treat emergencies, as opposed to those seen as coming to life as a natural result of the ageing process or the ravages of illness.¹⁵

In the light of these developments, legal, moral and ethical issues have arisen as to whether a person who is on ventilator support and intravenous nutrition should be kept alive for all the time to come till the brain-stem collapses or whether, in circumstances where an informed body of medical experts' opinion states that there

¹¹ S. Balakrishnan R.K. Mani, "The Constitutional and legal Provision in Indian Law for limiting life support" 9 *IJCCM* (2005 p. 108-114) Available at <http://www.ijccm.org/article.asp?issn=0972-5229;year=2005;volume=9;issue=2;spage=108;epage=114;aulast=Balakrishnan>, (Last visited on Sep 09, 2017).

¹² Spiti Sarkar, "Right to Die: To be or not to be?" Available at <http://www.legalservicesindia.com/articles/die.htm> (Last visited on Sep 17, 2017).

¹³ Jonathan Herring, *Medical Law and Ethics* 462 (Oxford University press, London, 3rd edn., 2010).

¹⁴ HT Thejaswi, "Present Status of Euthanasia in India from medico-legal Perspective" 14(1) *JPAFMAT* 60 (July 01, 2014). Pdf (1 July 2014) Available at <http://medind.nic.in/jbc/t14/i1/jbct14i1p59.pdf>.

¹⁵ Michael Davies, *Medical Law* 345 (Oxford University press, London, 2nd edn., 2009).

are no chances of the patient's recovery, the artificial support systems can be stopped. If that is done, can the doctors be held guilty of murder or abetment of suicide? These questions have been raised and decided in several countries and broad principles have been laid down in this regard. The 'withdrawal of life support systems' which is legally named as 'passive euthanasia' is allowed in most countries on the ground that it is lawful for the doctors or hospitals to do so in certain exceptional circumstances. Courts in several Countries grant declarations in individual cases that such withholding or withdrawal is lawful.¹⁶ However legalisation of withdrawal of artificial life prolonging machine or artificial feeding and hydration has still left some serious concerns. These concerns have opened up in many literatures.

Euthanasia has always been in the limelight as a subject matter of debate in the field of medicine and law. Justice 'Markandey Katju in the *Aruna Shanbaug case*¹⁷ opined that' "Euthanasia is one of the most perplexing issues which the courts and legislature all over the world are facing today. This court in this case, is facing the same issue and we feel like a ship in an uncharted sea, seeking some guidance by the light thrown by legislations and judicial pronouncement of foreign countries, as well as the submission of the learned counsel which are with us". Judicial opinion acknowledges that Euthanasia is a 'grey area' in the Indian criminal law.

Generally, every human being wants to live and enjoy the fruit of his life till the end of his life. There are situations where human beings wish to end their lives by unnatural means. This happens mostly in cases where one is suffering from a painful chronic and incurable disease. Euthanasia and physician assisted suicide (PAS) is essentially the doctrine that when, owing to disease, senility or the like, a person's life has permanently ceased to be either agreeable or useful, the sufferer should be painlessly killed either by himself or by another. The intentional termination of patient's life in such a situation by an act or omission of medical care is called euthanasia or mercy killing. This is the most active area of research in contemporary bio ethics.¹⁸

¹⁶Caesar Ray, "Position of Euthanasia in India: An Analytical Study" Available at https://www.researchgate.net/publication/259485727_POSITION_OF_EUTHANASIA_IN_INDIA_AN_ANALYTICAL_STUDY, (Last visited on Nov 19, 2017).

¹⁷Aruna Shanbaug VS Union of India and others, (2011) 4 SCC 454.

¹⁸Zachariah Thomas "Euthanasia-A Study of Law, Policy and Ethics", *2Journal of Evidence based Medicine and Healthcare*(August 03, 2015), Available at https://jebmh.com/latest_articles/92976(Last visited July 30, 2017)

Euthanasia is not something new or unknown to human civilization. In the ancient Greece and Rome, helping others die or putting them to death was considered permissible in some situations. For example, in the Greek city of Sparta new-borns with severe birth defects were put to death. Voluntary euthanasia for the elderly was an approved custom in several ancient societies. Many ancient texts including the Bible, the Koran and the Rig-Veda mention self-destruction or suicide.¹⁹ In India, the history of Vedic age is replete with numerous examples of suicides committed on religious grounds. The Mahabharata and the Ramayana are also full of instances of religious suicides. Most Hindus would say that a doctor should not accept a patient's request for euthanasia since this will cause the soul and body to be separated at an unnatural time. The result will damage the karma of both doctor and patient. Other Hindus believe that euthanasia cannot be allowed because it breaches the teaching of ahimsa (doing no harm). However, some Hindus say that by helping to end a painful life a person is performing a good deed and so fulfilling their moral obligations. Govardana and Kulluka, while writing commentaries on Manu, observed that a man may undertake the mahaprastha (great departure) on a journey which ends in death when he is incurably diseased or meets with a great misfortune, and that, it is not opposed to Vedic rules which forbid suicide.²⁰

There are two Hindu views on euthanasia: By helping to end a painful life a person is performing a good deed and so fulfilling their moral obligations. By helping to end a life, even one filled with suffering, a person is disturbing the timing of the cycle of death and rebirth. This is a bad thing to do, and those involved in the euthanasia will take on the remaining karma of the patient. The same argument suggests that keeping a person artificially alive on life-support machines would also be a bad thing to do. However, the use of a life-support machine as part of a temporary attempt at healing would not be a bad thing. The ideal death is a conscious death, and this means that palliative treatments will be a problem if they reduce mental alertness.²¹

¹⁹ "A General History of Euthanasia" A New Zealand Resource for Life related issues Available at <http://www.life.org.nz/euthanasia/abouteuthanasia/history-euthanasia> (Last Visited on Oct 30, 2017)

²⁰ Euthanasia, assisted dying, and suicide Available At <http://www.bbc.co.uk/religion/religions/hinduism/hinduethics/euthanasia.shtml> (Last Visited on Sep 30, 2017)

²¹ *Ibid.*

Muslims are completely against euthanasia. They believe that all human life is sacred because it is given by Allah, and that Allah chooses how long each person will live. Human beings should not interfere in this. Life is considered to be sacred and Euthanasia and suicide are not included among the reasons allowed for killing in Islam. Islamic religious texts say that Do not take life, which Allah made sacred, other than in the course of justice. If anyone kills a person - unless it be for murder or spreading mischief in the land- it would be as if he killed the whole people. Suicide and euthanasia are explicitly forbidden as it is said “Destroy not yourselves, Surely Allah is ever merciful to you”.²²

Christians are mostly against euthanasia. The arguments are usually based on the argument that life is a gift from God and that human beings are made in God's image. Birth and death are part of the life process which God has created, so we should respect them. Therefore, no human being has the authority to take the life of any innocent person, even if that person wants to die.²³

Sikhs derive their ethics largely from the teachings of their scripture, Guru Granth Sahib and the Sikh Code of Conduct (The Rehat Maryada). The Sikh Gurus rejected suicide (and by extension, euthanasia) as an interference in God's plan. Suffering, they said, was part of the operation of karma, and human beings should not only accept it without complaint but act so as to make the best of the situation that karma has given them.²⁴

The term ‘euthanasia’ has been defined as ‘an act or practice of procuring, as an act of mercy, the easy and painless death of a patient who has an incurable and intractably painful and distressing disease.’²⁵ The word ‘Euthanasia’ is derived from the Greek words ‘eu’ and ‘thanotos’ which literally mean “good death”. It is otherwise described as mercy killing. The death of a terminally ill patient is accelerated through active or passive means in order to relieve such patient of pain or

²²Euthanasia, assisted dying, suicide and medical ethics Available at <http://www.bbc.co.uk/religion/religions/islam/islamethics/euthanasia.shtml> (Last Visited on Sep 30, 2017)

²³Euthanasia, assisted dying, suicide and medical ethics Available at http://www.bbc.co.uk/religion/religions/christianity/christianethics/euthanasia_.shtml(Last Visited on Sep 30, 2017).

²⁴Euthanasia, assisted dying, and suicide Available At <http://www.bbc.co.uk/religion/religions/sikhism/sikhethics/euthanasia.shtml> (Last Visited on Sep 30, 2017).

²⁵McDonald, *Butterworth Medical Dictionary* (1999).

suffering. History says that Suetonius a Roman historian is the first writer who used the term Euthanasia.²⁶ But it appears that the word was used in the 17th Century by Francis Bacon to refer to an easy, painless and happy death for which it was the physician's duty and responsibility to alleviate the physical suffering of the body of the patient. The House of Lords Select Committee on 'Medical Ethics' in England defined Euthanasia as "a deliberate intervention undertaken with the express intention of ending a life to relieve intractable suffering". The European Association of Palliative Care (EAPC) Ethics Task Force²⁷, in a discussion on Euthanasia in 2003, clarified that "medicalised killing of a person without the person's consent, whether non-voluntary (where the person is unable to consent) or involuntary (against the person's will) is not euthanasia: it is a murder. Hence, euthanasia can be voluntary only". As far back as 300-400 BC, both Socrates and Plato accorded moral sanction to assisted killing and suggested that it was punishable in certain circumstances.²⁸

Briefly, 'euthanasia' may be classified into various categories as:²⁹

- Active euthanasia: It means a deliberate action to let the person die in order to alleviate pain and sufferings.
- Passive Euthanasia: It entails withholding of medical treatment for the continuance of life e.g. withholding of antibiotics, where without giving it, a patient is likely to die, or removing the heart lung machine, from a patient in coma.³⁰
- Voluntary Euthanasia: It is performed with the consent of the recipient. It involves a request by the dying patient or that person's legal representative.
- Non-voluntary Euthanasia: It occurs where the patient's consent is unavailable due to persistent vegetative state, coma, or absolute malfunctioning of brain.
- Involuntary Euthanasia: It is said to occur when a patient is killed against his express will. This is a criminal act of murder. Thus, Involuntary Euthanasia occurs where the recipient has not agreed to the procedure and is an unwilling participant.

²⁶V.V Pillay, *Euthanasia; Text Book of Forensic Medicine and Toxicology* 42-47(Paras Medical Publisher, Hyderabad, 16th ed., 2011)

²⁷Lar Johan Materstvedt, David Clark *et.al.*, "Euthanasia and physician-assisted suicide: a view from an EAPC Ethics Task Force" pdf available at <http://www.eapcnet.eu/LinkClick.aspx?fileticket=eoUoZKuuBeY%3d&tabid=684> (Last visited Nov 19, 2017)

²⁸Law commission of India, "241st report on Passive euthanasia" (August, 2012).

²⁹Jonathan Herring, *Medical Law and Ethics* 497, 498(Oxford University press, 3rd edn.2010).

³⁰Jonathan Herring, *Medical Law and Ethics* 497, 498(Oxford University press, 3rd edn.2010).

The efforts to legalize euthanasia and assisted suicide were started in early twentieth century in various countries of the world. Euthanasia was first legalized in Netherlands. Many countries of the world followed its footsteps and legalized right to die in its different forms. Various international documents recognize human dignity as the core of Human Rights Jurisprudence. Various nations have made laws which provide solution to this problem, having due regard to human dignity and worth, right to personal autonomy and self-determination and have adopted different criteria for dealing with this sensitive issue.³¹ Some countries have legalized euthanasia, whereas others have legalized assisted suicide only. But, even in such countries right to die has not been granted absolutely. It has been made subject to certain conditions and restrictions to prevent its abuse.³²

There are nations which have legalized right to die in any of its forms. In the Netherlands, euthanasia is regulated by the “Termination of Life on Request and Assisted Suicide (Review Procedures) Act”, 2002.³³ It legalizes euthanasia and physician assisted suicide in very specific cases. The law allows a medical review board to suspend prosecution of doctors who performed euthanasia when certain conditions are fulfilled.³⁴ Following conditions are required to be fulfilled:

- The patient’s suffering is unbearable with no prospect of improvement.
- The patient's request for euthanasia must be voluntary and persist over time (the request cannot be granted when under the influence of others, psychological illness, or drugs).
- The patient must be fully aware of his/her condition, prospects and options. There must be consultation with at least one other independent doctor who needs to confirm the conditions mentioned above.
- The death must be carried out in a medically appropriate fashion by the doctor or patient, in which case the doctor must be present.³⁵

³¹ Universal Declaration of Human Rights (UDHR), 1948, International Covenant on Civil and Political Rights (ICCPR), 1966 and International Covenant on Economic, Social and Cultural Rights (ICESCR), 1966

³²Dvk Chao, NY Chan *et.al.*, “Euthanasia Revisited”, 19*Family Practice: An International Journal* 128-134(2002) Available at <https://academic.oup.com/fampra/article/19/2/128/490935> (Last visited on Feb 20, 2018)

³³Jonathan Herring, *Medical Law and Ethics* 515(Oxford University press, 3rd edn.,2010).

³⁴ Termination of Life on Request and Assisted Suicide (Review Procedures) Act, 2002,Art. 2

³⁵Michael Davies, *Medical Law* 353(Oxford University press, 2nd ed., 2009).

- The patient is at least 12 years old (patients between 12 and 16 years of age require the consent of their parents).

However, there are certain exceptional situations which are not subject to such restrictions of law as they are normal medical practice. These are (a) stopping or not starting a medically useless (futile) treatment, (b) stopping or not starting a treatment at the patient's request and (c) speeding up death as a side-effect of treatment necessary for alleviating serious suffering.³⁶

Belgium became the second country in Europe after Netherlands to legalize the practice of euthanasia in September 2002, subject to certain conditions. Patients wishing to end their own lives must be conscious when the demand is made and repeat their request for euthanasia. They have to be under “constant and unbearable physical or psychological pain” resulting from an accident or incurable illness.³⁷ Unlike the Dutch legislation, minors cannot seek assistance to die. It only applies to patients who are above the age of 18 years. In contrast, the Dutch legislation allows even a 16-year old to request lethal treatment or assistance in consultation with his parents, and a child aged 12 to 15 with his parent’s consent.³⁸ In U.K., Russia, Spain, Austria, Italy, Germany and France euthanasia or physician assisted suicide is not legal.

Article 115 of the Swiss Penal Code considers suicide not a crime and assisting suicide a crime if, and only if, the motive is selfish, otherwise not. However, legally, active euthanasia is illegal in Switzerland. The Swiss law is unique because the recipient need not be a Swiss national and a physician need not be involved. Many persons from other countries, especially Germany, go to Switzerland to undergo euthanasia. It does not require the involvement of physician nor is that the patient terminally ill. It only requires that the motive must be unselfish. Switzerland has an unusual position on assisted suicide; it is legally permitted and can be performed by non-physicians. However, euthanasia is illegal.³⁹

³⁶*Ibid.*

³⁷Jonathan Herring, *Medical Law and Ethics* 518, 519(Oxford University press, 3rd edn.,2010).

³⁸ Shaun D. Pattinson, *Medical law and Ethics*, 550(Sweet and Maxwell UK, South Asian edn., 2013)

³⁹Subhash Chandra Singh, “Euthanasia and Assisted Suicide: Revisiting Sanctity of life” pdf Available athttp://14.139.60.114:8080/jspui/bitstream/123456789/12413/1/010_Euthanasia%20and%20Assisted

Active Euthanasia is illegal in all states in U.S.A. Euthanasia has been made totally illegal by the United States Supreme Court in the cases *Washington v. Glucksberg*⁴⁰ and *Vacco v. Quill*⁴¹ but, Oregon was the first state in U.S.A. to legalize physician assisted death under the Oregon Death with Dignity Act, in 1997. Under the Act, a person who sought physician-assisted suicide would have to meet certain criteria. Washington was the second state in U.S.A. which allowed the practice of physician assisted death in the year 2008 by passing the Washington Death with Dignity Act, 2008. Montana was the third state (after Oregon and Washington) in U.S.A. to legalize physician assisted deaths, but this was done by the State judiciary and not the legislature. On December 31, 2009, the Montana Supreme Court delivered its verdict in the case of *Baxter v. State of Montana*⁴² permitting physicians to prescribe lethal injection.

In Canada, Euthanasia and physician assisted suicide is illegal.⁴³ Though patients have the right to refuse life sustaining treatments. Moreover, the Canadian Supreme Court in *Sue Rodriguez v. British Columbia (Attorney General)*⁴⁴ rejected the plea of Rodriguez, a woman of 43, who was diagnosed with Amyotrophic Lateral Sclerosis (ALS) to allow someone to aid her in ending her life. The court said that in the case of assisted suicide the interest of the state will prevail over individual's interest.

In England, the House of Lords in *Airedale NHS Trust v. Bland*⁴⁵ permitted non voluntary euthanasia in the case of patients in a persistent vegetative state. It was a case relating to withdrawal of artificial measures for continuance of life by a physician. It was held that it would be unlawful to administer treatment to an adult who is conscious and of sound mind, without his consent. Such a person is completely at liberty to decline to undergo treatment, even if the result of his doing so will be that he will die. It was further held that if a person, due to accident or some other cause becomes unconscious and is thus not able to give or with-hold consent to medical

%20Suicide_Revisiting%20the%20Sanctity%20of%20Life%20Principle%20%28196-231%29.pdf (Last Visited on Sep 25, 2017)

⁴⁰521 US 702 (1997)

⁴¹521 US 793 (1997)

⁴²No. ADV-2007-787 (Mont. 1st Jud. Dist. Ct 2000).

⁴³The Criminal Code of Canada, RSC 1985, C-46, S.241(b).

⁴⁴(1993) 3 SCR 519.

⁴⁵1993(1) All ER 821 (HL)

treatment, in that situation it is lawful for medical men to apply such treatment as in their informed opinion is in the best interests of the unconscious patient. It is not lawful for a doctor to administer a drug to his patient to bring about his death, even though that course is prompted by a humanitarian desire to end his suffering, however great that suffering may be. All the judges of the House of Lords in this case were agreed that Anthony Bland should be allowed to die.

After the *Airedale*⁴⁶ case as decided by the House of Lords it has been followed in a number of cases in U.K., and the law is now fairly well settled that in the case of incompetent patients, if the doctors act on the basis of informed medical opinion, and withdraw the artificial life support system if it is in the patient's best interest, the said act cannot be regarded as a crime. The question, however, remains as to who will decide what the patient's best interest is where he is in a persistent vegetative state (PVS). In some other countries like India the debate about its legalization is still going on.

In India, the sanctity of life has been placed on the highest pedestal. The right to life under Article 21 of the Indian Constitution has received the widest possible interpretation by the Supreme Court. This right is inalienable and is inherent in us. The Indian Constitution is silent about whether right to die is or is not a fundamental right under Article 21. Whether the right to die is included in Article 21 of the Constitution came for consideration for the first time before the Bombay High Court in the *State of Maharashtra v. M.S. Dubal*.⁴⁷ The Supreme Court in *P. Rathiman v. Union of India*⁴⁸ upheld the Bombay High Court's decision. However, in *Gian Kaur v. State of Punjab*⁴⁹, a five Judge constitution Bench of the Court overruled P. Rathinam's case and held that right to life under Article 21 of the Indian Constitution does not include the right to die or the right to be killed. The Court held that the right to life is a natural right, embodied in Article 21. However, suicide is an unnatural termination or extinction of life and, therefore, incompatible and inconsistent with the concept of Right to life. It was held that this concept was unrelated to the Principle of sanctity of life or that Right to live with dignity.

⁴⁶*Ibid.*

⁴⁷1987 CrLJ 743.

⁴⁸(1994)3 SCC 394.

⁴⁹(1996)2 SCC 648.

In the path breaking judgment of *Aruna Shanbaug v. Union of India*⁵⁰ Euthanasia in its passive form has taken legal roots in India. This judgment broke new ground, sanctioning passive Euthanasia or withdrawal of life support systems on patients who are brain dead⁵¹ or in a permanent vegetative state (PVS).⁵² Aruna Shanbaug was a former nurse from Haldipur, Karnataka in India. In 1973, while working as a junior nurse at King Edward Memorial Hospital, Parel, Mumbai, she was sexually assaulted by a ward boy and has been in a vegetative state since the assault. On 24 January, 2011, after she had been in this state for 37 years⁵³, the Supreme Court of India responded to the plea for Euthanasia filed by Aruna's friend journalist, Pinki Virani, by setting up a medical panel to examine her. The Court turned down the mercy killing petition on 7th March, 2011. However, in its landmark judgment, it allowed passive Euthanasia in India. The Court clarified that active Euthanasia, involving injecting lethal injection to advance the death of such a patient, was a crime under law and would continue to remain so. The Hon'ble Court laid down certain guidelines which will continue to be law until Parliament makes a law on this subject. Those are as under: (i) a decision to discontinue life support should be taken either by the parents or the spouse or other close relatives. In the absence of any of them, such a decision can be taken by a person or a body of persons acting as a next friend. Also, the decision taken by the doctor attending the patient should be a bonafide one and in the best interests of the patient. (ii) The Supreme Court made it mandatory to take approval from the High Court concerned, even if the decision is taken by the near relatives or doctors or next friend to withdraw life support, because in India the possibility of mischief being done by relatives or others for inheriting the property of the patient cannot be ruled out. (iii) The Court also prescribed the procedure to be adopted by the High Court when such an application is filed. The Court propounded that a Bench of at least two judges should decide this application, after taking opinion from a committee of three reputed doctors to be nominated by the Bench after careful examination of the patient by those doctors. The Court also directed that notice should

⁵⁰(2011) 4 SCC 454.

⁵¹Brain death is the complete loss of brain function (including involuntary activity necessary to sustain life). It differs from persistent vegetative state, in which the person is alive and some autonomic functions remain.

⁵²A persistent vegetative state (PVS) is a disorder of consciousness in which patients with severe brain damage are in a state of partial arousal rather than true awareness. After four weeks in a vegetative state (VS), the patient is classified as in a persistent vegetative state.

⁵³Pinki Virani, *Aruna's story, the True Account of a Rape and its Aftermaths* Penguin (Books India, Mumbai, 1999).

be issued to the State and close relative or the next friend and after hearing them; the High Court should decide this application.⁵⁴

Although the Supreme court dismissed the petition of euthanasia and did not allow euthanasia in the present case because of noble spirit, outstanding and unprecedented dedication of hospital staff in taking care of Aruna, but it cleared the way for many sufferings who want to die with dignity. With respect to the social, legal, medical and constitutional perspectives, the court said, that the question of law involved requires careful consideration by a constitutional bench of the court for the benefit of humanity as whole. In the current context, the contentious issue of Euthanasia once again came to the Supreme Court.⁵⁵ The court issued notice to all the states and Union territories on legalizing passive euthanasia. The court also appointed former solicitor General Mr. T.R. Andhyarujina as amicus curie to assist it on the issue. The former attorney General Mukul Rohatgi said that the Government doesn't accept Euthanasia as a principle. The Court has no jurisdiction to decide the issue. It's for the legislature to take a call after a thorough debate and taking into account multifarious views.⁵⁶

On 9th March, 2018 a five- judge bench of the Supreme Court recognized and gave sanction to passive euthanasia and living will/ advance directive. This implies that from now Right to Die with Dignity is a Fundamental Right. The judgment has been delivered by a Bench comprising of Chief Justice of India Dipak Misra, Justice A.K. Sikri, Justice A.M. Khanwilkar, Justice D.Y. Chandrachud and Justice Ashok Bhushan. The matter was referred to it by a three -Judge bench, which held that the Constitution Bench in the case of Gian Kaur v State of Punjab, had not ruled upon the validity of active or passive Euthanasia, even though the bench had ruled that Right to Live with Dignity under Article 21 of the Constitution of India was inclusive of the right to die with dignity. The Three – Judge Bench then noted that the judgment pronounced in *Aruna Shanbaug v Union of India* is based upon a wrong proposition that the Constitution Bench in the case of Gian Kaur v State of Punjab had upheld

⁵⁴ *Supra* note at 52.

⁵⁵ Sanjeev Kumar Tiwari, "Concept of Euthanasia in India – A Socio- Legal analysis Concept of Euthanasia in India – A Socio- Legal analysis" 2 *International Journal of Law and Legal Jurisprudence Studies* Available at, <http://ijlljs.in/wp-content/uploads/2015/04/AMBALIKA.pdf>

⁵⁶ SC wants euthanasia debate, seeks states' views in 8 weeks, Available at, <http://epaperbeta.timesofindia.com/Article.aspx?eid=31804&articlexml=SC-wants-euthanasia-debate-seeks-states-views-in-17072014001022>. (Last visited on Jan 20, 2018).

passive euthanasia. However, the Five-Judge Bench in the case of *Common Cause (A Regd. Society) v. Union of India and Another* has now unanimously held that the Two-Judge Bench in the case of Aruna Shanbaug had wrongly ruled that passive euthanasia can be made lawful only by legislation through an erroneous interpretation of the judgment in Gian Kaur case. The Judges in their judgment have also laid down the procedure for a “Living Will” or an “Advance Directive” through which terminally ill people or those with deteriorating health can choose not to remain in a vegetative state with life support system if they go into a state where it will not be possible for them to express their wishes.

Over the years the issue of euthanasia has been a complicated issue upon which there have been heated debates, not only within the confines of courts, but also among elites, intelligentsia and academicians alike. The Supreme Court of India however, through its judgment in the case of *Common Cause (A Regd. Society) v. Union of India and Another*⁵⁷ has now settled the position of Passive Euthanasia in India. Thus, the cloud upon right to live with dignity and right to die with dignity has now been cleared by the Apex Court for once and for all.

The issue of euthanasia was extensively dealt with by the Law Commission of India in their 196th report and further in the 241st report. The major issue before the Law Commission was of withholding or withdrawing medical treatment (including artificial nutrition and hydration) from terminally ill-patients. The Law Commission addressed many questions namely, as to who are competent and incompetent patients, as to what is meant by informed decision, what is meant by best interests of a patient, whether patients, their relations or doctors can move a court of law seeking a declaration that an act or omission or a proposed act or omission of a doctor is lawful, if so, whether such decision will be binding on the parties and doctors, in future civil and criminal proceedings etc. Law Commission recommended having a law to protect patients who are terminally ill, when they take decisions to refuse medical treatment, including artificial nutrition and hydration.⁵⁸ On the basis of the recommendation of apex court and Law commission in August 2016 “The medical treatment of

⁵⁷ *Common cause (A registered society) v. Union of India and Others*, (2018) 5 SSC 1W.P. Writ petition (Civil) NO. 215 Of 2005

⁵⁸ Law commission of India 241st report on Passive euthanasia, (August,2012) Available at <http://lawcommissionofindia.nic.in/reports/report241.pdf>

terminally- ill patients (Protection of Patients and Medical practitioner) Bill, 2016 was introduced in upper house of the parliament.⁵⁹

Recently a petition in the supreme court has restarted the debate of active euthanasia or physician-assisted suicide after it sought the response of the central government in a petition to allow assisted death for persons suffering for ‘rabies’.⁶⁰

1.2 Statement of Problem:

End-of-life processes such as euthanasia and physician-assisted suicide are controversial topics that society has distinct views on. Gender, the person’s personality, or their previous life experiences, especially those relating to death may influence these views. To find out if these are contributing factors, a survey study is needed to administer. What happens if that family member is suffering or is in a persistent vegetative state? The family would then have some decisions to make as to whether to continue with treatment, keep the person on a ventilator, or to just keep them comfortable until they passed. If they chose to keep the person comfortable until they died by taking them off of a ventilator or taking out their feeding tube, this would be considered a form of passive euthanasia.

Euthanasia and physician-assisted suicide may be considered a form of murder by many, but what if they were faced with the decision with one of their own family members? In India, the debate over euthanasia, patient autonomy and the interests of the state in the preserving the life of persons is currently singing out in various fora, including the court and the executive. While the ethical implications of these acts have been debated endlessly, there is a need to debate how such a law would be operationalized. This will help to ensure the constitutionally guaranteed right to bodily integrity and autonomy, and to minimize misuse of the law. The Bill introduced related to euthanasia in 2016 is a starting point, and must take these debates into account to be implemented effectively.

⁵⁹Centre finally comes up with a draft bill on passive euthanasia, *Available at*, <https://timesofindia.indiatimes.com/city/mumbai/Centre-finally-comes-up-with-a-draft-bill-on-passive-euthanasia/articleshow/52283576.cms> (Last visited Jan 20, 2018).

⁶⁰The Delhi High Court in an order had turned down the plea by the petitioner NGO, ‘all creatures great and small’ October, 2019 leading to the appeal to supreme court. *Available at* <https://www.Hindustantimes.com/india-news/plea-in-supremecourt-restarts-debate-on-euthanasia/story> (Last visited on April 4th 2020)

The legalization of euthanasia in India will raise a number of social-ethical and legal issues which need to be resolved. For instance, who in India will certify the critical nature of an illness which demands euthanasia? What will be the acceptable parameters? Moreover, amazing developments in the field of medical science offer new hope to such patients who were once considered to be a lost cause. Another cause for worry is the danger of there being ulterior motives in wanting someone to be subject to euthanasia. The probability of its misuse whether it is demanded for property, money, or because of animosity among family members is very high. There exists no legislation laying down the procedure to permit a person to take her own life. These issues make euthanasia a highly complex issue.

Several Petitions also extend to asking for permission to terminate unwanted, accidental or dangerous pregnancies. Thousands of farmers in Vidarbha took their lives when faced with a dehumanizing existence. Rabies patients are also demanding death with dignity. Thus, when a person chooses to end her life because she can no longer live with dignity, the question needs to be asked is not whether he can waive her constitutional right to life, but whether he has a right to choose.

1.3 Literature Review:

Davies Michael (2009) explained the definitional problem related to euthanasia. He has also discussed the various case law. According to him high technology medicine to sustain life which, only a few year ago, would have ended at a much earlier stage. In the relatively recent past, patient at home. Technology was limited to the hospital setting and was used to treat in emergencies, as opposed to those seen as coming to the end of life as a natural result of the ageing process or the ravages of illness.⁶¹

Pattinson Shaun D (2013) described the various types of end of life decisions on the part of doctors and patient involvement. The doctor's part in the end of life process could involve 1. Administering lethal treatment, withholding life- sustaining support 3. Withdrawing life- sustaining support, or 4. Assisting the patient to self-administer lethal treatment (i.e. physician assisted suicide). On the part of the patient there are situations where the patient is apparently competent to consent or refuse and

⁶¹Michael Davies, *Medical Law*342-375(Oxford University press, 2nd edn., 2009).

the situation where the patient appears to lack such competence. The author has explained voluntary (where a competent patient consents), involuntary (where a competent patient does not consent), non-voluntary (where the patient lacks the competence to make an end of life decision).⁶²

There are two kinds of euthanasia - Active and Passive. Herring Jonathan (2010) defines active euthanasia as the 'intentional' killing of a terminally ill patient by a physician, or by someone, such as a nurse, who acts on the direction of the physician. It may be voluntary, non-voluntary, and involuntary. In voluntary active euthanasia the doctor intentionally kills the patient at the patient's request and so with the patient's consent. In non-voluntary active 'euthanasia', the doctor intentionally kills the patient without the patient's request because the patient is unable to make a request or actively give his or her consent. In involuntary 'active euthanasia' the doctor intentionally kills the patient without the patient's consent when patient consent is possible to get but is not sought. In passive euthanasia the doctor allows the patient to die, either by withholding treatment or by discontinuing treatment, where the relevant treatment is designed to keep a patient alive who is terminally ill. Like active euthanasia, it may be voluntary, non-voluntary, and involuntary. So far as the historical background of euthanasia is concerned, Jonathan Herring holds the view that people's attitudes towards death are often marked by their ethical or religious beliefs. Some therefore regard death as no more than a passage to the start of a joyous after-life. To others, death is the final chapter of their story, which should reflect the values and principles, which they have treasured during their lives.⁶³

Chochinov Harvey and Breitbart William (2000) have taken the view that interest in euthanasia or physician assisted suicide appears to be more a function of psychological and social factors (e.g. depression, social support, fears of becoming a burden to one's family/friends) than of physical factors (e.g. pain, symptom distress, disease status).⁶⁴

Virani Pinki (1998) recreates the true- and real-life tragedy of an Indian woman named as Aruna Ramchandra Shanbaug who was attacked by a ward boy with

⁶² Shaun D. Pattinson, *Medical Law and Ethics* 526-593 (Sweet and Maxwell, UK, 3rd edn., 2013).

⁶³ Jonathan Herring, *Medical Law and Ethics* 462-551 (Oxford University press, 3rd edn., 2010).

⁶⁴ Harvey Chochinov, William Breitbart, *Handbook of Psychiatry in Palliative Medicine* (2000).

the dog chain and brutally raped in the King Edward Memorial hospital (KEM) in Bombay in 1973 where she was serving as a nurse. She was strangled and sexually assaulted in a ward and has lived in coma since the last thirty-seven years and died on the morning of 18th May 2015.

It is a non-fiction book in which the facts are presented in fiction format. The author has recreated every event related to Aruna. Recreating the real-life tragedy is not an easy task as it needs minute investigation which has been done by the author in the process of writing the book. A young woman who came out from her small village in Karnataka to be a nurse in Bombay where she had joined KEM as staff nurse and was raped on the eve of her wedding to a doctor and abandoned by her family and thereafter left utterly helpless. She was tossed between a convalescent home and hospital where she once treated people to health and now where she lied barely alive. Author's investigation also unearthed the crowning tragedy: Aruna's rapist a sweeper in the hospital, walked a free man after a mere seven years in prison for robbery and attempt to murder.⁶⁵

Roy Caesor⁶⁶ explained euthanasia and its application in three different occasions of a living person since the very birth. He also throws light upon the ancient societies of the countries like Greek and India that how the custom of self-destruction was been practiced. He also covered the attitude towards life in different religions like Hindu, Muslim, Christian and Sikh. He has differentiated the two terms suicide and euthanasia.

Emanuel Ezekiel J. (1999) has taken the view that while legalizing euthanasia and PAS we should first analyse the harm and benefits of euthanasia. According to him if we legalize euthanasia or PAS, how many people will have their needless pain and suffering relieved? To determine this number he suggests five factors: (1) how many people are there who die each year; (2) what proportion of these patients have a recognizable and distinct dying process during which they can request euthanasia or PAS; (3) what proportion of these patients would be competent to request euthanasia or PAS; (4) what proportion of these patients would have unremitting pain that would

⁶⁵Pinki Virani, *Aruna's story, the True Account of a Rape and its Aftermaths* (Penguin Books India, Mumbai, 1999).

⁶⁶Caesor Roy, "Position of euthanasia in India-An analytical study" Available at <https://www.researchgate.net/publication/259485727> (Last visited on Jan 22, 2018).

justify euthanasia or PAS; and (5) what proportion of these patients would actually want euthanasia or PAS. Legalizing euthanasia is not the solution of the pain and suffering of the patients. The author has emphasized on providing better and more mental health care, home care, spiritual care and improvement of national health care system.⁶⁷

Meyers David W. (1973) described that euthanasia can be carried out by the physician in one of three general ways: (1) by an affirmative act designed to bring about death, such as the injection of air into a patient's veins; (2) by refusing to commence, or continue further, ordinary medical treatment required to maintain life; or (3) by refusing to commence, or continue further, "heroic" or "extra-ordinary" measures, such as the use of a heart-lung machine following a massive stroke. Each of these means of allowing, or causing death to occur as the case may be involves different considerations affecting the legality of euthanasia. According to him if the physician followed generally recognized professional standards in withholding or terminating whatever treatment he did, the issue of euthanasia should not arise and the law need not be involved, as the doctor has simply allowed death to occur naturally. If he has not, but has overstepped current bounds, as defined medically, then the issue of euthanasia is raised and the physician's conduct becomes criminal, unless expressly condoned by legislative enactment.⁶⁸

Sharma Seema (2017) has taken adverse view against legalizing euthanasia and has explained how Dutch and Belgium legal system where euthanasia has been legalized in a specific situation may not be applied to a country like India.⁶⁹

Crocker Kelly has taken the utilitarian approach of less pain suffering and a thought experiment comparing the common 'euthanization' of animals through which he has given arguments in favour of euthanasia and physician assisted suicide. He has

⁶⁷ Ezekiel J. Emanuel, "What Is the Great Benefit of Legalizing Euthanasia or Physician-Assisted Suicide?" *Ethics*, 109, No. 3 *The University of Chicago Press* 629-642 (April 1999),: available at <http://www.jstor.org/stable/10.1086/233925> (Last visited on July 19, 2017 08:16)

⁶⁸ David W. Meyers "The Legal Aspects of Medical Euthanasia" 23, No. 8, *Bio Science, The Dilemmas of Euthanasia* 467-470 (Aug., 1973), Published by Oxford University Press on behalf of the *American Institute of Biological Sciences* available at <http://www.jstor.org/stable/1296606>, (Last visited on July 19, 2017 08:01).

⁶⁹ Seema Sharma, "Legal challenges to euthanasia India: A Critical study" 7 No. 2 *International Journal of Research in Economics and Social Sciences (IJRESS)* February- 2017 (February- 2017) Available at: <http://euroasiapub.org>, (Last visited on March 03, 2018).

also addressed the issue of corruption of the doctor's role as a healer, slippery slope and the fear of abuse that are always raised against euthanasia and PAS.⁷⁰

Jain Pralika has have precisely taken the view that India is a country highly influenced by religion and traditional beliefs. It is a multicultural country with an amalgamation of many cultures, traditions and religions. Therefore, it is not surprising that people of our nation have various points of view on the issue of life and death. Part III of the Constitution of India, secures to the people of India, certain basic, natural and inalienable Fundamental Rights. In India, the 'sanctity of life' has been placed on the highest pedestal.⁷¹

Pawar Sujata (2010) is of the view that although 'freedom of life and personal liberty' under Article 21 is expressed in negative phraseology but it has imposed a positive duty upon the state to take steps for guaranteeing better quality of life and dignity to people. The text of Article 21 has remained the same throughout the years but the context has been intellectually interpreted by the Indian judiciary, so as to read in variety of other related rights so necessary for the true enjoyment of the right to life. According to Sujata Pawar, the concept of death implies extinction of life.⁷² The Supreme Court of India has rightly taken the view that death is the only certain thing in life. Whoever is born must die.

Sarkar Spiti⁷³ has taken the view that euthanasia, physician-assisted suicide and suicide are the species of the same genre. In earlier times, it was used as an omnibus term to signify a painless death. In its modern context, the term is used as a deliberate euphemism to reduce the culpability of an act, which is a subset of murder, by injecting the term 'mercy'. The fact remains that euthanasia or mercy-killing is all about giving license for the right to kill.

Rajawat J.S. (2010) writes that passive euthanasia allows one to die by withdrawing or withholding life supporting means. Life supporting means may further

⁷⁰Kelly Crocker, "Why Euthanasia and Physician assisted suicide are morally permissible", Available at <https://fsu.digital.flvc.org/islandora/object/fsu:209906/datastream/PDF/view> (Last visited on Sep 15, 2017).

⁷¹Pralika Jain, "Euthanasia and the Society". Available at www.indlawnews.com/display.aspx74379. (Last visited on Dec 23, 2017).

⁷²Sujata Pawar, "Right to Die, How far Right? Judicial Responses", Of *LJ*. 280-288 (2010).

⁷³Spiti Sarkar, "Right to Die: To be or not to be?" Available at <http://www.legalservicesindia.com/articles/die.htm> (Last visited on Sep 17, 2017).

be ordinary or extra-ordinary. Ordinary means such as nutrition and hydration, which are never to be withheld since they are one's basic rights in order to survive. However, one may not be obliged to use extra-ordinary means to sustain life, such as discontinuance of medical treatment which is burdensome, dangerous, and extra-ordinary to the expected outcome. To withdraw a life supportive treatment as condition worsens, is letting one die and not a direct killing. In this case, it is the disease that is killing and not the one who withdraws or consents to withdraw the treatment. He further says that propounders of active euthanasia have closed their ear to the God's command: thou shall not kill. The goal is to eliminate or relieve suffering by an evil means of death. The suffering of a patient may be lessened, but this act of killing can never be justified. These patients, whether having an incurable disease, being elderly or suffering in the other ways, are crying out for help and love. Palliative care, not death is the answer. Suffering and pain are manageable in this advanced scientific age. Painkiller can be prescribed as long as there is no danger. Consciousness of patient is strongly encouraged, so that if dying, one may be prepared to accept to meet the Almighty.⁷⁴

Kamath Aditya points out another point of difference, that euthanasia or mercy killing essentially involves pain and suffering due to some incurable medical ailments while suicide need not involve any such malady. Then there is the question of consent. Consent to kill one self is implied by the very commission of the act but in euthanasia the consent has to be in the form of a request essentially by the patient himself or close kith and kin.⁷⁵

Ekta Jayita in her article, "Death: Dying with Dignity"⁷⁶ explained that the importance of asking these questions and the necessity of finding an answer to them has prompted a study of death and the dying process in recent years. It is known as Thanatology (derived from the Greek word "thanos", which means death). While Thanatology has evolved into a wide field involving the study of various phenomena related to death, including suicide, aging, terminal illness, comma and persistent vegetative state, AIDS and medical ethics, its most significant contribution has been to try and provide the dying with dignity and comfort in their final moments. Rites of

⁷⁴J.S. Rajawat, "Euthanasia", *CrLJ*, 321-324 (2010).

⁷⁵Aditya Kamath, "Euthanasia, Suicide and Theology". Available at www.law4u.net.com. (Last visited on Feb 23, 2018).

⁷⁶Available at www.lifepositive.com/Spirit/.../Dyingjwithjdignity32004.asp (Last visited on Nov 15, 2017).

passage have lost their sanctity in modern times, and have become mechanical, hospital and medication driven events. Thanatologists are seeking to provide a dignified passage to the dying, at times by using music, shamanic rites, prayer, and by making available love and support i.e. quality end-of-life care. This approach has been adopted in several hospices and care centers for the terminally ill around the world.

Colabawalla B. N. (1996) is of the view that pain is not the only factor in suffering. One has to take into account mental distress caused by other manifestations of the disease, such as loss of control over bodily functions or loss of cognitive existence, causing a sense of loss of dignity of life.⁷⁷

Narula Reenu (1999) took the view that that modern medicine has the ability to control pain. Today, advances are constantly being made in the treatment of pain and as they advance, the case for euthanasia/assisted-suicide is proportionally weakened. Thus, anti- euthanasia people argue that pain can be alleviated by proper pain control methods. Modern medicine has the ability to control pain. A person who seeks to kill him or herself to avoid pain does not need legalized assisted suicide but a doctor better trained in alleviating pain. Appropriate care can make a huge difference. Pro- life activists say that nearly all pain can be eliminated and in those rare cases where it can't be eliminated it can still be reduced significantly if proper treatment is provided. It is a national and international scandal that so many people do not get adequate pain control. But killing is not the answer to that scandal. The solution is to mandate better education of health care professionals on these crucial issues, to expand access to health care, and to inform patients about their rights as consumers. There are board certified specialists in pain management who will not only help alleviate physical pain but are skilled in providing necessary support to deal with emotional suffering and depression that often accompanies physical pain. Moreover, they say that, "Death with dignity" may be a catch phrase with euthanasia activists, but there's nothing dignified about the methods they advocate.⁷⁸

⁷⁷B. N. Colabawalla, "Understanding Voluntary Euthanasia: A Personal Perspective", *4Indian Journal of Medical Ethics*, (Jan-Mar, 1996). Available at http://www.ijme.in/041_ed007.html. (Last visited on Nov 21, 2017).

⁷⁸Reenu Narula, "Whose life is it anyway", *The Tribune*, Sunday reading, March 14, 1999. Available at <http://www.tribuneindia.com/1999/99mar14/Sunday/headl.html>. (Last visited on Jan 5, 2018).

Sinha Sumantra (2005) said that when one cannot create, one should not destroy. Thus, for them respect for life is the central, political or social concern and consciousness as to the value of life must be strengthened among people.⁷⁹

Marwaha Shalini (2004) has taken the view that legalizing euthanasia will deface the precious human life and hence it is against morality and greater common good. Legalizing euthanasia is a mere political tactic. The ultimate goal is a much broader death license. Moreover, they emphasize on the non-feasibility of implementation of laws governing euthanasia. Request for euthanasia or assisted suicide is typically a cry for help. It is in reality a call for counselling, assistance and positive alternatives as solutions for very real problems.⁸⁰

Hagelin j, Nilstun T. (2004) explained how the phrasing of the questions and the response alternatives would influence the answers to questions about legalization of euthanasia. Results compared from two different surveys in populations with similar characteristics.

The alternatives “positive”, “negative”, and “don’t know” (first questionnaire) were replaced with an explanatory text, “no legal sanction”, four types of legal sanctions, and no possibility to answer “don’t know” (second questionnaire). Four undergraduate student groups (engineering, law, medicine, and nursing) answered. They concluded that an introduction of an explanatory text and a wider range of response alternatives produced differences between the results of the two surveys conducted.⁸¹

Hettenhausen Chelsea N. (2012) pointed out that end-of-life processes such as euthanasia, physician-assisted suicide, and the death penalty are controversial topics that society has contrasting views on. Gender, the person’s personality, or their previous life experiences, especially those relating to death may influence these views. To find out if these were contributing factors, a survey was administered to 120 students attending a small Midwestern university (52 men, 68 women). The

⁷⁹Sumantra Sinha, “Euthanasia, Suicide & Theology”, *Delhi Law Review (Students Edition)*, 119-127(2005).

⁸⁰Shalini Marwaha, “Euthanasia, Personal Autonomy and Human rights: An Intricate Legal and Moral Global Perspective”, *13Guru Nanak Dev. University Law Journal*, 95-103 (2004).

⁸¹J Hagelin, T Nilstun “Surveys on attitudes towards legalization of euthanasia: importance of question phrasing”.*30 Journal of Medical Ethics*, (2004)

survey was given in the class setting. The results indicated that religion, whether one is liberal or conservative, and experiences with death did have a significant influence on participants' beliefs of euthanasia, physician-assisted suicide, and the death penalty. However, gender and certain personality characteristics did not.⁸²

Another study was conducted to determine the attitudes regarding euthanasia and physician-assisted suicide in the Muskegon County area with regard to age, gender, religion and the level of education with 225 individuals (Merrill Gail, 2001). The data collected looked at the various demographics of age, gender, religion, degree of religiosity and the level of education and compared these with regard to the question relating to attitudes about euthanasia and physician-assisted suicide. The conclusion of the survey revealed that age, gender, and educational level did not have an impact on the person's answer as to allowing 'euthanasia' and 'physician-assisted suicide' to terminally ill patients. However, religious preference and degree of religiosity were significant with regard to 'attitudes on euthanasia and physician-assisted suicide'.⁸³

1.4 Objectives:

- To study whether euthanasia can be an answer to cases where a person is suffering from terminal illness or in coma or in persistent vegetative state or brain dead.
- To analyze various reasons giving rise to a debate over euthanasia.
- To study the legal position of euthanasia in various countries including India.
- To study the role of judiciary in interpreting right to life and its horizons.
- To study the role of the Law Commission of India in this regard.
- To undertake a comparative study of the recommendations of the Supreme Court and the Law Commission of India.

⁸²Chelsea N. Hettenhausen, "Attitudes toward End-of-Life Processes: Gender, Personality, and Life Experiences" (2012). *available at* <http://www.mckendree.edu/academics/scholars/issue15/hettenhausen.htm> (Last visited on April 13, 2018)

⁸³Gail Merrill, "Attitudes On Euthanasia and Physician-Assisted Suicide Based on age, gender, religion and level of education in Muskegon County", Thesis *available at* <https://scholarworks.gvsu.edu/theses/596/> (Last visited on April 13, 2018)

1.5 Hypothesis:

The tentative assumption which can be drawn from research point of view are as follows-

1. Legalization of euthanasia in India involves major complex issues which need to be addressed with law.
2. There is a growing demand for legalizing euthanasia in India from different stake holders.
3. Due to the advancement of recent medical technologies people are now very much aware about euthanasia and its socio-legal implications.

1.6 Research Questions:

- Why is there a need to make a law governing the subject.
- What are the effects of recent view which has been taken by Supreme Court of India regarding living will?
- When and who decides the point of final withdrawal of life support?
- How does an individual come to the conclusion that an unconscious patient would prefer death to “suffering”?
- Whether there is any mechanism to ensure that a living will is genuine.
- What is the safeguard to ensure that it is really his will and who will certify that his condition is bad?
- What is the attitude of different stakeholders towards Euthanasia?
- What is the perception of respondents towards legalizing euthanasia in India?

1.7 Significance of the Problem:

Health care professionals on a regular basis are faced with euthanasia issues. There are many factors that influence peoples’ feelings regarding euthanasia from both the standpoint of the medical profession and from a family’s point of view. These include religious beliefs along with the degree of religiosity, age of the person dying and age of the family members who are making the decisions, level of education which may influence their understanding of what euthanasia is, previous experience involving cases of painful dying of a terminally ill patient, and family environment. Euthanasia involves not only a decision by the family but also a

decision by the physician who is requested to perform it. The physician will have his/her own personal beliefs regarding euthanasia.

This research will be important from the following point of view-

- ***Social Welfare:***

A socio-legal research can be very much helpful to achieve social welfare. This research being of socio-legal importance assists us to judge the magnitude of the good or bad consequences of euthanasia.

- ***Comparative Study:***

It is a fact that the legislature considers the law prevailing in other countries at the time of law making. This research is important to find out what the law is in other countries with respect to euthanasia.

- ***Law Reforms:***

Research is a significant tool for any development or law reform according to the need of society. So, this research may be playing an important role from the point of view of law reforms in relation to Euthanasia.

- ***Effectiveness:***

This research will be helpful in laying down effective policies and principles to make the law on euthanasia an effective instrument in protecting an individual from the misuse of the machinery engaged.

1.8 Research Methodology:

Framework of study-

The research will consist of conducting a sample survey of the persons of different fields above the age of 18 years through the method of questionnaire. It will be a convenience sampling. The sample survey will be conducted during the period of research with 400 individuals. The persons below 18 years will be excluded from the study.

Universe of Study-

The following locations will be included for the distribution of questionnaire-

Sanjay Gandhi post graduate institute of medical sciences, King George medical University Lucknow, Students of different Universities like Babasaheb Bhimrao Ambedkar University, Ram Manohar Lohia National Law University, Lawyers of the Lucknow bench of the Allahabad High Court as well as the civil court. The empirical study of the present research will comprise of the views of various sections of the public, which includes patients, families/ relatives of critical patients in 'coma' and PVS, doctors, nurses, lawyers, judges and is intended to be conducted in the city of Lucknow which is the capital of the state of Uttar Pradesh. The residents of the city are mostly working class and are quite busy in their stressful professional life due to which they are unable to give sufficient time to their families, especially when both the spouses are working. Therefore, it would be rather interesting to know their views on the concept of right to die with dignity i.e. euthanasia. Another reason to conduct the empirical study of the present research in this city is that in order to fulfil the multifarious needs of the patients, a large number of multi-specialty hospitals like the King George Medical University and the Sanjay Gandhi Post Graduate Institute of Medical Sciences have been established in the city where the patients who suffer from chronic diseases and are in extreme pain and suffering also come from different cities. Therefore, the views of the doctors in these hospitals and terminally ill patients getting treatment from these hospitals as well as their families can be obtained through empirical study.

Data collection-

The proposed study will be an empirical one and the materials have been collected from primary and secondary sources including the web resources. The primary data will be collected through questionnaire from sample surveys conducted in the city of Lucknow. The secondary data will be collected from books, journals, internet, newspapers, magazines etc.

Data Analysis-

The collected data will be edited, analyzed and summarized. Then it will be analyzed with help of SPSS to draw the inferences and conclusion. Descriptive, analytical, informative and evaluative methods will be adopted in the study to draw the inference and conclusion.

1.9 Organisation of the Chapters:***Chapter I: Introduction***

This chapter throws light on the inquisitiveness of the researcher to opt for the highly debated issue and outlines a general awareness on the insight of the topic. This chapter also elucidates the need for the study of the contentious issue, highlighting the objectives and the methodology undertaken by the researcher. The research questions that are formulated by the researcher are pin pointed in the chapter. The overall idea of the subject has been put forwarded in the chapter. The researcher also focuses on relevant review of literature pertaining to the perplexed issue. The researcher brings out the significance of the study and takes a stand to clarify the concept of euthanasia in the mind of the people. A general approach of the society is projected by the researcher, when at times the people are perplexed and cannot justly decide for themselves or their relatives.

Chapter II: Conceptual Analysis of Euthanasia.

The second chapter of this thesis attempts to describe about the meaning, concept and some other related terms of euthanasia. Historical and religious concepts have also been described briefly along with operational concepts. Euthanasia is mainly of two types: Active or Positive Euthanasia and Passive or Negative Euthanasia. Additional classifications are also present in the research work like, Voluntary, Involuntary, and Non-voluntary. The researcher has also made an attempt to differentiate these terms and try to tell about the related terms like Physician Assisted Suicide (PAS), Brain Death, Suicide, Murder, Doctrine of Double Effect and Human dignity & Euthanasia. An attempt has been made to roll off various euthanasia devices for terminally ill patients. The researcher has then discussed the main points of the controversy that if the right to life means a meaningful and dignified life, does that also mean a right to

die with dignity. The researcher has therefore discussed the meaning of right to die with dignity. Because, once the relationship of death with dignity is understood, only then the concept of Euthanasia can be perceived. The researcher has then focused on the concept meaning and kinds of Euthanasia in the context of death with dignity and then distinguished it from the concepts like mercy-killing, suicide and physician assisted suicide. Another very important concept has also been discussed i.e. Withdrawal of life support in cases where the patient is kept on artificial life sustaining machines.

Chapter III: Comparative Analysis of Euthanasia in different countries.

In this chapter, the researcher has analysed the law prevailing in certain countries in different continents of the world. In all these countries, the concept of euthanasia has been extensively discussed. The issue is not only limited to one country, it is rather transnational in character, because it deals with the matters of death, which comes to everyone. None is left untouched. Therefore, it is very important to understand how various countries have dealt with the issue and what laws they have made, if any, to accommodate the cases in which patients ask for a dignified death.

Various countries have adopted different criteria for dealing with this issue. Some countries have legalised euthanasia, whereas others have legalised assisted suicide only and there are some countries also, which have not legalised right to die in any of its forms. But, if we observe the laws of the countries in which right to die is legalized in various forms, one thing is common, and it is that right to die has not been granted absolutely. It has been made subject to certain conditions and restrictions. This shows that in order to prevent its abuse, law has provided certain safeguards which must be followed while performing Euthanasia. Euthanasia under Indian scenario has been discussed elaborately

The international perspective in this chapter examines the implementation of euthanasia in various countries. Further, implementation of passive euthanasia in India within permissible limits is highlighted by the researcher through the various law commission reports and Parliamentary debates. In particular, the researcher has attempted an analysis about the position of euthanasia in different countries. This chapter takes an initiative to make an analysis of the different Acts in the countries at

the international level. The ways of administering euthanasia in different countries is projected by the researcher in this chapter. It is further seen that not all countries have the same ways of administering euthanasia. For example, the country of Switzerland welcomes tourist euthanasia. Also, the reasons are not same in all countries like, in Netherlands even mental depression is cited as a reason behind euthanasia.

One of the main reasons for the debate over Euthanasia is the advancement in science and technology. Science and technology have the ability to prolong life, even if it is painful and full of agony. The purpose of law is to cater to the needs of people. It has to keep pace with the changing needs of society. A law which does not do so is a bad law. It needs to be amended or changed. So, various countries have made efforts to make laws which provide solution to the problem, having due regard to human dignity and worth personal autonomy and self-determination.

Netherland was the first country in the world to legalize Euthanasia, subject to certain conditions. Therefore, in this chapter the researcher has discussed at length how this concept came into being after a lot of discussions debates, argumentations and deliberations. Its evolution through the various judgments of the courts has also been discussed whereby various requirements for the performance of euthanasia have been laid down, subject to which it has been legalized i.e. requirement of due care.

Belgium followed the footsteps of Netherlands, which was later followed by Luxemburg. In Switzerland Euthanasia is not allowed, but it allows assisted suicide under certain circumstances.

In the United Kingdom though the law does not permit Euthanasia but cases have come before the courts whereby they have started recognizing right to die in certain circumstances subject to certain conditions. It should be noted that in the United Kingdom and United States of America (USA) the attempt to commit suicide has been decriminalized. The reason is that in such cases the accused is already a victim of circumstances and punishing him for attempt to commit suicide amounts to double punishment. Such persons should rather be reformed through counselling. In the United States of America also Euthanasia is illegal. But the state of Oregon made a law on assisted suicide. However the courts in USA have started recognizing the right to die in certain circumstances subject to certain safeguards. In November 2014,

Brittany Maynard, 29, the young, terminally ill American cancer patient became the face of the controversial right to die movement. She ended her life in Oregon. She was diagnosed with a likely stage 4 glioblastoma, a kind of malignant brain tumour. Within weeks, in course of researching possible treatments and realizing it was futile, she became an advocate of a dignified death instead of undergoing endless rounds of debilitating chemotherapy and radiation, which was already proving useless in her case. She had moved from California to Portland.

In some other countries including India the debate about its legalization is still going on, the research work deals with the legislative and constitutional measure relating to the right to die in India. In this chapter, the researcher has discussed the relevant provisions of the Constitution of India and other laws concerning the right to die vis-a-vis euthanasia. Firstly, the concept of fundamental rights under Part III of the Constitution has been discussed including Article 21 with reference to right to die and Euthanasia. The meaning and extent of this right as interpreted by our judiciary has also been discussed. The relevant provisions under Indian penal code related with the subject matter of the study have also been discussed. The question of applicability of various defences under chapter 4 of the Indian Penal Code to those who perform Euthanasia has also been discussed at length, not only this, the provisions relating to attempt to commit suicide have also been discussed. It should be noted that the debate regarding the decriminalization of attempt to suicide is also going on in India. The Law Commission of India and the Hon'ble Supreme Court of India are in favour of decriminalizing the attempt to commit suicide. The researcher has also discussed the role of the Law Commission of India relating to the right to die and Euthanasia. Law commission in its 2006 report recommended the legalization of withdrawal of life support system subject to certain conditions and recommended a bill for that purpose. However, in the aftermath of *Aruna Ramachandra Shanbaug vs Union of India* the Law commission of India had a look into the matter and gave another report in 2012 reconciling its earlier recommendations and the recommendations of the Hon'ble Supreme Court. The report of 2012 has also been discussed in detail.

Chapter IV: Judicial Response towards Euthanasia.

In chapter 4, the judicial approach towards the right to die and Euthanasia in other countries including India has been discussed. The researcher also described various

landmark judgements of Indian courts and Courts of various Countries that focused upon the key issues related to euthanasia. Judgments like Maruti Shripati Dubal, P. Ranthinam, Gyan Kaur and Aruna Shanbaug, Common cause are well explained. The landmark judgements given by the courts of some other countries are also described in this research work like the Airdale Case, Conjoined twin Case, R vs Cox, Pretty case etc. In few 'countries' 'euthanasia' is legalized which is also described here. Here, comes the role of courts in interpreting various provisions of the Constitution and other laws. The Supreme Court in a number of cases has given different interpretation to the right to life. These cases have been discussed in detail before the Aruna Ramachandra Shanbaug's judgment but it is humbly submitted that our courts did not give a clear-cut verdict on Euthanasia. However, in Aruna Ramachandra Shanbaug's case, for the first time in the history of Indian judicial system Euthanasia was discussed at length. The Supreme Court Legalized Euthanasia in its passive form and that too for brain dead patients. The case has been discussed in detail covering the recommendations of the Hon'ble Supreme Court regarding the safeguards to be followed while performing Euthanasia in its passive form. It should be noted that the court has followed the principle of best interest of the patients as the paramount consideration in such cases.

Chapter V: Socio-legal, ethical and moral issues related to Euthanasia

There are two sides of the same coin. While there are proponents of the right to die and euthanasia, there are opponents also who criticise it on one or the other ground. Euthanasia involves various ethical, legal, moral, socio-political issues. The debate over euthanasia is a result of the contradictions involved in those favouring and opposing it. There are arguments against legalising euthanasia. It is also called a Conservative point of view. To prove their argumentation, opponents rely on various justifications like principle of sanctity of life, human life is the property of God, State has an interest in protecting the lives of its citizens, slippery slope argument, compromising the dignity of others, medical ethics, need to find out alternatives and many more. In contrast, proponents of euthanasia also base their arguments on one or the other ground. To them, quality of life is more important than its sanctity and dignity. Moreover, patients need to be relieved of the pain and agony and there should be respect for patient's autonomy and self-determination. According to them, this will

also help in organ use, organ transplantation, medical research, education and training etc. So, the continuous tussle between these groups has led to the debate over euthanasia. Each side opines that the other is not able to understand its philosophy. In an effort to come to particular solution to this debate, many countries have legalised the right to die in one form or the other for example, Netherlands, Oregon (U.S.A.) etc. But the matter of concern here is that even in countries, which have legalised it, there is always a scope of slippery slope i.e. misuse of the provisions allowing euthanasia or assisted suicide to satisfy personal motives and vested interests. If the law allows something, it may allow aggravations of it. People may kill their near ones under the garb of euthanasia.

Chapter VI: Data Analysis and Interpretation

Chapter six relates to the field work on the basis of questionnaire method which is one of the most suitable methods for the investigation of socio-legal problems. The researcher has used the tool of questionnaire to collect data from large, diversified and scattered persons from different places to deal with the empirical data and its analysis. The empirical research has been conducted in the city of Lucknow, capital of the state of Uttar Pradesh. Data has been collected from the people belonging to different professions like doctors, lawyers, academicians, nurses and patients' relatives, in order to have complete analysis of various issues concerning the right to die and Euthanasia. The data has been collected in the form of a questionnaire containing various questions relating to the issue. The data collected from the person shows their view points on various issues. The data has been analysed in this chapter and various findings have been recorded.

Chapter VII: Conclusion and Suggestions- Draft Legislation on Euthanasia.

Chapter VII deals with conclusions and suggestions. In this chapter, the researcher has concluded the whole research and mentioned various recommendations and suggestions given by different authorities that need to be considered while making a law on the subject. At last, the researcher has concluded this research work and given some suggestions which in his opinion will help the terminally ill patients in ending their suffering. Many opponents of euthanasia are saying that it will be abused. Thorough investigation has been done by the researcher while laying down the major

findings and recommendations. Further, the researcher also proposed a Draft legislation taking into consideration the advances in modern medicine and the debate over the subject of law. Certain concrete suggestion for improving the techniques in palliative care is forwarded by the researcher in the thesis. While promoting the concept of living will⁶, the researcher has duly highlighted the significance of this concept in this chapter. Further, the researcher has supported that ‘passive euthanasia’ and ‘active voluntary euthanasia’ should be accepted in the India. The suggestions made in the thesis are in approximately conformity with the guidelines of the Supreme Court as well as the Law Commission of India. Hence, the researcher has made a humble attempt to justify the reasons for the acceptance of the proposed Bill in this chapter from all aspects- morally, legally and socially.

In this chapter, the researcher firmly establishes that a law in this regard is the need of the hour in India. Lastly, perhaps no law has ever been written that cannot be or has not been abused. The arguments in support of euthanasia law state that the time will come when euthanasia in certain circumstances will be accepted, practiced and we will wonder how society had continued so long in its unkind customs in dealing with the hopeless suffering.



CHAPTER-II
CONCEPTUAL ANALYSIS OF
EUTHANASIA



CHAPTER-II

CONCEPTUAL ANALYSIS OF EUTHANASIA

“Death is something inevitable. When a man has done what he considers to be his duty to his people and his country, he can rest in peace”.

-Nelson Mandela

2.1 Introduction

Euthanasia is a method adopted to relieve patients from severe pain and trauma caused by terminal illness.¹ This “terminal illness”² must be certified and must be a universally accepted illness. In popular terms, it is the ending of life upon the request of suffering patient in pain to his physician. A More common name is “mercy killing”, although the two concepts have different connotations. As already discussed in introductory chapter the term “euthanasia” refers to ‘painless easy death’ or “good death”.³ However, practically speaking it is not as easy as it seems to be. It is a multi-dimensional concept that has constantly been a subject matter of debate and discussion in the field of law, political and social sciences as well as medical technology. Euthanasia is an emotional and dramatic topic which encompasses both pain and pleasure. Euthanasia is “a gentle and calm death”⁴, where life is destroyed by one’s own willingness, not out of depression but because that is the last room left for the patient.⁵ The euthanasia debate, being a contemporary debate, has created lot of controversies with no concrete solution in the years to come.

¹T.L. Beauchamp, *Ethical Issues in Death and Dying* 188 (Prentice Hall, New Jersey 1978)

² An active and progressive disease having no cure according to the doctors, University of Birmingham, www.birmingham.ac.uk/projects/hcna (Last visited on May 27th, 2018)

³ A general history of euthanasia, www.life.org.nz (Last visited on June 12th, 2018)

⁴ Euthanasia, body, life, history, beliefs, cause, time, person and human, www.deathreference.com/EnGh (Last visited on June 12th, 2018)

⁵ Messinger Josef Thane, A gentle and easy death: From ancient Greece to beyond Cruzan towards a reasoned legal response to the societal dilemma of euthanasia, <https://heinonline.org/get-pdf/denlr71> (Last visited on May 27th, 2018).

2.2 Historical Concept of Euthanasia

The development of the ideology of euthanasia in light of state and law in the nineteenth century can be studied in four stages-⁶ Firstly, it deals with the political and philosophical teachings of the ancient Greek philosophers- Plato, Aristotle and Socrates who perceived euthanasia something inevitable just like death. According to them, the attributes of euthanasia are harmless to the society. Secondly, it involves medieval and political teachings. At that time, the church did not have a positive attitude towards euthanasia. The third stage began in early modern period where the degree of euthanasia was in high spirit and could be well reflected in the contemporary history. Thomas Hobbes, David Hume, Michel de Montaigne, Arthur Schopenhauer, Francis Bacon advocated the right to voluntary death as natural as the right to life. During contemporary history, these scholars have influenced the western philosophical thought. On one hand, criminalization of euthanasia due to its latent meaning violates constitutional right to live a dignified life and on the other hand, even if there is no wrongful intention in murder, the act itself is made a criminal activity and punishable. In the 20th century, culture and science has put immense emphasis on human body and needs. It has led to unlimited freedom for individuals and thus revisiting the theories about euthanasia. The state should respect and protect everyone's freedom during his life. The topic is deeply sensitive for its obvious problems. It demands great concern and a serious notice of the society. The ethical reasons around euthanasia in different states have also played a great impact in taking a decision on the subject in legal aspect.⁷

Human beings are born as prisoners as stated by Plato, the great Greek philosopher, who opined that human beings cannot decide their own fate. If a human being is destined to suffer, he would definitely suffer and no one except God could free him from the clutches of sufferings. According to Plato, just like pets are guided according to the directions of men, not expecting them to act contrary to their decisions, the same is with human beings as they are under the control of their master. Since God gives life, only He can take it away. The contrary is expressed by David

⁶Gabrielyan Armen, The phenomena of euthanasia in criminal- Legal, Criminological and Medical-Biological Aspect at p.17, Rigas Steradian Universitate,2014, <https://www.rsu.lv/files/dissertations> (lastvisited on March 19th, 2018)

⁷*Supra note 1* at p.189

Hume⁸ stating that if God is the master of human destiny then human beings have no right to prolong life and lengthen it through medication. If destruction of life is contrary to God's wishes, so also its preservation then both would be criminal and arbitrary as God have ownership over our lives in totality. According to Hume, God has made human beings as rational animals and only human beings have the power of logical interpretation and God's creation is justified only if human beings make proper use of their sound knowledge. According to him there is no harm in ending life, provided life itself becomes meaningless and burdensome.⁹ According to American legal scholar, Baldwin, if a person can be recovered, all means should be exhausted in curing him but if a person cannot survive at all, he should not be left to merciless layouts to be kept medically alive.¹⁰

Starting with the Hippocratic Oath Medical Professionals codes prohibit killing, and thus holding the intrinsic value of life and definitely above all others are the ethical principles. Assisted suicide weakens the relationship between the doctor and the patient and enhances chances of it being misused. Suetonius was a noted Roman Historian, who stated that active euthanasia does not come within its purview. These are books which cite Frankincense, which was administered to kill incurable patients.¹¹ In ancient times, even the half burnt bodies, dead bodies and the patients with incurable diseases were thrown into the Ganga river, so that they could purify their sins and have a good life in their next birth. But the Supreme Court gave strict directions in the case of *M.C Mehta V Union of India*.¹² It adopted "Polluter Pays Principle". It was directed by the Honorable Supreme Court to shift the factories to remote or distant places. The ancient Greek philosopher Plato opined that the people suffering from mental and physical illness are already deprived of their right to life and hence they should be left behind to die. The first Christian to refer euthanasia is Thomas Moore. Utopia priest stated –"if the sickness of the body takes toll on the patient and is not only distressing but also agonizing, then it is better that the priest or

⁸ David Hume was a Scottish philosopher, historian, economist and essayist, who is best known today for his highly influential system of philosophical empiricism, skepticism and naturalism.

⁹ James Fieser, "Euthanasia from Moral Issues that Divide Us", <https://www.utm.edu/class/6-euthanasia> revised on 09.01.17 (last visited on Jan. 10th, 2018)

¹⁰ *Ibid.*

¹¹ Erdemir Demirhan Aysegil, Elciogly Omur, "A short history of euthanasia laws, and their place in Turkish law", www.eubios.info (Last visited on May 18th 2018)

¹² 1988 AIR 1115, 1988 SCR (2) 530

the public officials either free the man themselves or permit him to free himself.”¹³ In year 1939, Adolf Hitler had started the T4 Euthanasia Program (named for the Chancellery officer) to eliminate the physically and mentally unstable, emotionally disturbed and incurable patients and aged people. The program was officially discontinued in 1941. A school master Samuel William in 1870 was the first advocate to popularize the euthanasia concept.¹⁴ The Greece and Romans administered euthanasia by abortions and were constantly engaged in mercy-killing one after another. During 17th and 18th centuries euthanasia became a burning issue of discussion. World War II changed the scenario as Hitler and Nazis killed thousands of people by gassing, drugs and starving them. In the 20th and early 21st century, the idea of euthanasia was widely criticized and debated. Netherlands was the first country to legalize euthanasia.¹⁵ The Romans and the Greeks were of the opinion that the incurable patients should be removed from the society as they were unproductive and burdensome on the society. Plato in his infamous “Republic” had outrightly condemned physicians who allowed patients to undergo lingering death. In Nazi, nearly two lakhs mentally ill patients were administered euthanasia.

Coming to ancient Indian history, the great saints and sages have from time immemorial practiced this kind of death. In Mahabharata, the concept of “Ichhamrityu” could be seen in the guru of the Pandavas and Kauravas. Even Lord Rama and his brother after fulfilling their duties gave up their lives by taking Samadhi in River Saryu in Ayodhya. No legislation was there to restrict those saints and they were worshipped as Gods. Going through the Indian History, the founder of Maurya Dynasty, Chandragupta Maurya, with his guru Muni Bhadrabaahu who was the disciple of Jainism adopted self-willed death by fasting. One of the early patriots of India, VeluTampi, died by asking his younger brother to eliminate him as he was about to be killed by his enemies. A wounded soldier requested his companion to shoot him to get rid of his pain.¹⁶ The Indian philosophers have justified the idea of willingness for one’s death (Ichhamrityu). The idea of euthanasia was also supported by the Father of the nation. It was stated by David Hume that suicide and its extension

¹³*Ibid*

¹⁴Kannan K Justice, *A Textbook of Medical Jurisprudence and Toxicology*, 26 (Lexis Nexis publication, New Delhi, 25th edn.,2010)

¹⁵ands-eblogspot.com/2012/05/(Last visited on June14th, 2017)

¹⁶*Ibid*.

were a person's inherent personal rights. The thinkers were in favour of the laws regarding suicide and euthanasia as according to them it did attack personal liberty. Some people condemn the practice as homicide whereas others argue it as an inherent right to choose euthanasia.¹⁷

According to Mahatma Gandhi, as long as a person could be nourished with care and love, euthanasia could be prevented. This reflects his support for palliative care in India.¹⁸ In the Gujarati Weekly, "Navjivan" in October 1928 and "Young India" in the same year, the father of the nation, expressed his views on euthanasia. Referring to the killing of the ailing calf which was done at his instructions, Gandhi stressed on human feelings and humanity rather than artificial prevention to prolong suffering. He faced strong protests against himself. According to him, when a doctor, wields his knife on any part of the patient's body, he does not commit Hinsa and likewise depending upon the compelling situations, he may sever life from his patients in his greater interest.¹⁹ The practice is "mercy-killing". This small instance of the calf projects Gandhi as a strong supporter of active euthanasia. In the case of Parchure Shastri, Gandhi advised him to end his life by fasting rather than drowning. He followed the footsteps of Gandhi who himself took care and it clearly showed that Gandhi emphasized on "care" when "cure" was impossible, where the patient recovers in mind and achieves victory in life.²⁰ According to Gandhi, euthanasia is the last resort and the case has to be judged from its facts and circumstances rather than adopting a stereo-type principle in the most vital and complicated cases. In a talk with Jairam Das, Doulatram, Mahatma Gandhi said that lingering death is always pathetic. On May 21st in 1935, he opined that a quick death is the death of all beings²¹ In the 'Two pioneers of euthanasia written around 1800', Michael Stolberg had cited certain people who made fun of these suffering people who has been hanged though not dead.²²

¹⁷"A brief History of Euthanasia", <https://www.theodysseyonline.com> (Last visited on June 14th, 2017)

¹⁸Joris Gielen, "Mahatma Gandhi's views on euthanasia and assisted suicide", jme.bmj.com.>*global medical ethics paper* (Last visited on June 14th, 2017)

¹⁹Times of india.indiatimescom>articleshow, January 3rd, 2005 12 A.M IST, (Last visited on June 14th, 2017)

²⁰Vinith Rao, "Mahatma Gandhi and the early debates on euthanasia", March 24th 2016, www.gandhitopia.org (Last visited on June 14th, 2017)

²¹*Ibid.*

²²Hiattanna, The History of Euthanasia movement, Jan 6th, 2016, <https://daily.jstor.org> (Last visited on June 14th, 2017)

2.3 Meaning and definition:

2.3.1 Euthanasia:

Peter Singer defines the expression ‘euthanasia’ as “the killing of those who are incurably ill and in great pain or distress for the sake of those killed, and in order to spare them further suffering or distress”. Another reputed thinker “Harris defined ‘euthanasia’ as “a deliberate intervention undertaken with the express intention of ending of life, to relieve intractable suffering”²³.

Both the above definition mainly emphasizes on relieving pain and suffering, however the word ‘killing’ used by Singer makes euthanasia more suspectable than ‘deliberate intervention’.

According to *Webster’s New Explorer Encyclopedia Dictionary*, euthanasia is “The act or practice of killing or permitting the death of hopelessly sick or injured individuals (as a person or domestic animal) in a relatively painless way for reasons of mercy.”²⁴

According to *Black’s Law Dictionary* (8th Edition), Euthanasia means the act or practice of killing or bringing about the death of a person who suffers from an incurable disease or condition especially a painful one, for reason of mercy. Thus, to define in literally terms, it means putting a person to painless death especially in case of incurable suffering or when life becomes purposeless as a result of mental or physical.²⁵

According to *New Oxford Dictionary* defines ‘euthanasia’ as “the painless killing of a patient suffering from an incurable and painful disease or in an irreversible coma.”²⁶ It is the process whereby human life is ended by another in order to avoid the distressing effects of an illness. It cannot be equated to suicide because of the requirement of third person’s intervention in the termination of life. Therefore, the two concepts are both factually and legally distinct. Similarly, it is very pertinent to note here that euthanasia cannot be equated to assisted suicide because in assisted suicide, the third

²³NM. Harris, “The Euthanasia debate”, 147 *JR Army Med Corps* 367-370 (Oct., 2001)

²⁴*Webster’s New Explorer Encyclopedia Dictionary*, 629 (2006)

²⁵A Bryan, Garner, *Black Law Dictionary* West group, 8th edn., 2004).

²⁶*New Oxford dictionary*, 267(2007).

party only assists in the termination of life by a person and he does not per se terminate the life. But in case of euthanasia the third party is actively involved in the termination of life by means of his act or omission. While assisted suicide refers to the self-termination of life, euthanasia refers to the termination of life by the intervention of a third person. Further suicide may be committed for various reasons ranging from distress in family, finance. Relationships etc. However, Euthanasia, in its strict sense, is confined to the cases where a person is in a serious medical condition.

Collins English dictionary defines it “as the act of killing someone painlessly especially to relieve suffering from an incurable illness.”²⁷

The Columbia Encyclopedia defines Euthanasia as “Either painlessly putting to death or failing to prevent death from natural causes in cases of terminally illness or irreversible coma. The term comes from the Greek expression for good death.”²⁸

The American Medical Association’s (AMA) Council on Ethical and Judicial affairs states that “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 reason of mercy. In this report, the term euthanasia will signify the medical administration of a lethal agent to a patient for the purpose of relieving the patient’s intolerable and incurable suffering.”

According to the *Indian Society of Critical Care Medicine Committee* for the Development of Guidelines for limiting life-prolonging interventions and providing palliative care towards the end of life, “Euthanasia is the intentional killing of a patient by the direct intervention of a doctor ostensibly for the good of the patient or others.”

According to the *House of Lords Select Committee on Medical Ethics*,²⁹ the precise definition of euthanasia is “a deliberate intervention undertaken with the express intention of ending a life, to relieve intractable suffering”. This definition has followed by Harris. The intractable suffering as mentioned in definition may be due to diseases categorised as painful disease, in which the patient suffers unbearable and

²⁷ *Collins English Dictionary*, 534 (1998)

²⁸ *The Columbia encyclopedia*, (Columbia University Press, 6th edn., 2003)

²⁹ “House of Lords Select Committee on Medical Ethics”, Report, HL Paper 21-1 20(Session 1993-94).

excruciating pain. A chronic disease is a long lasting one. Whereas an incurable disease is one whose cure has not been found till date.

According to *Law commission Of India* ‘Euthanasia’ is the act of killing someone painlessly, especially, for relieving suffering of a person from incurable illness. It is also called ‘mercy-killing’.³⁰

2.3.2 Euthanasia and mercy-killing

Euthanasia is performed on the terminally ill patients whereas “mercy-killing” is performed on any person. Both include sympathetic feelings but mercy-killing may be committed upon insane and handicapped whose rights are well recognized by the states.³¹ Mercy killing may also be administered on an extremist but the same is not in case of euthanasia as it is administered only to incurable patients and the sole object is to give a dignified exit, peace and end sufferings. According to Aquinas, suicide is wrong as it is opposed to self-love.³² But, mercy-- killing itself signifies to have mercy and love upon one’s life so that he is not made an effigy in the hospital bed. According to him, the words active, passive, voluntary and involuntary are merely ornamental and there can be no logical link between these words as the person fails to express his consent. However, the researcher is of the opinion that euthanasia in passive form is only the last resort with informed consent of the competent patient or a patient in a vegetative state where it could be a representative right to terminate life which could be exercised only in the best interest of the patient. Active euthanasia is a cruel act as it is directly killing a person.³³ Sufferings and happiness are part of daily life. When a person is depressed and sadness overwhelms him, he is occupied by negative thoughts of or hopelessness. Under such circumstances, it becomes difficult or rather impossible to follow proper suggestions and system.³⁴ Moreover, there is a limit to everything. The advocates of euthanasia opine that if suffering reaches an extreme point, it is better not to live only for the sake of taking the pain. But what is noteworthy is who is to fix the criteria for death? There is every chance of misusing it if it is legalized and there would be no solution in future.

³⁰ The Law Commission of India 196th report,15 (2006)

³¹ Ghuge Sharmila, *Legalizing Euthanasia: A pedagogue’s perspective*59-60 (Himalayan Publishing House)

³² www.academia.edu>What-Aquinas Got wrong: A person’s Right to Suicide (Last visited on April 9th, 2018)

³³ www.acquinasonline.com>Questions>euthanasia (Last visited on April 8th, 2018).

³⁴ <https://ogradwellbeing.com>> sadness, suffering and depression are part of life (April 9th, 2018).

2.4 Kinds of euthanasia³⁵

Euthanasia can be categorized on the basis of

2.4.1 Consent of the patient³⁶ - According to this, euthanasia could be-

(a) **Voluntary**- It is the most supported euthanasia around the world. The reason of acceptance of voluntary euthanasia that it is conducted with the consent of the patient. It means the patient is administered lethal drugs so that he could have the end of his painful life. It is done by a physician at the request of the patient. Here in this case, it is to be seen that the consent to be given should be free from all sense of coercion that is, the choice of Euthanasia is an instance of unconstrained self-determination. This is the most acceptable form of Euthanasia at international level. Such a request is voluntary without coercion from any family members or otherwise. In this form of euthanasia, there is no coercion from the family members and hence emphasis has been given to give due recognition to its form as it upholds the principle of self-determination. It is based purely on utilitarianism as advocated by Jeremy Bentham that every person has a right to gain pain and avoid pleasure. As opined by Dworkin³⁷ life is pertinent but the dignity of human life is associated with life. However, the counter is that it should be made to alleviate pain and not life. Focus should be given on peaceful life rather than peaceful exit.

(b) **Non-Voluntary**- This occurs when the person concerned has been unable to express an opinion, usually because he or she lacks the capacity so to do, but others consider that it is in his or her best interest to end his or her life at this time.³⁸ According to Peter Singer “ When the individual is incompetent to give consent or to refuse euthanasia and has no prior decision” then that is known as non-voluntary euthanasia.³⁹ It is a type of euthanasia where the explicit consent of the individual concerned is not available, such as when the person is in unawareness state such as persistent vegetative state or in coma.

³⁵ D.K Ganguly, *Medical Jurisprudence and Toxicology*, (Dwivedi Agency, 2012) at p.72

³⁶ Lily Srivastava, *Law and Medicine*, 217-218(Universal Law Publication Company, 2nd edn.,2010)

³⁷ Ronald Dworkin, *Life's Dominion: An Argument about Abortion and Euthanasia* 235 (Harper Collins, 1993)

³⁸ Jonathan Herring, *Medical Law and Ethics*497, 498(Oxford University press, 3rd edn.2010).

³⁹ Peter Singer, *Practical Ethics* 179 (Cambridge University Press, Cambridge, 2ndedn., 1993).

(c) **Involuntary**- It is done against the willingness of the patient. It is conducted without consent of patient. This type of euthanasia is performed when someone makes a decision for another person incapable of doing so. As stated by Peter Singer Euthanasia is recognized to be 'involuntary' when the person killed is capable of consenting to her own death, but does not do so, either because he/she is not asked, or because he/she is asked and chooses to go on living.⁴⁰ This type of euthanasia generally treated as murder and it is not supported even by supporters of euthanasia.

2.4.2. Method of Euthanasia-

(a) **Passive**- The deliberate omission of life lengthening act is called Passive Euthanasia. It deals with withdrawing and withholding treatment through aggressive saving means. It involves not doing something to prevent death as when doctor refrain from using device necessary to keep alive a terminally ill patient or a patient in a persistent vegetative state (PVS). It means allowing patients suffering from terminal illness to call upon their physicians to withdraw their life sustaining treatment. Thus, in Passive Euthanasia, it means that something is not done that would have preserved the patient's life. A number of families due to practical difficulties and financial hardships request the doctors to remove ventilation, feeding tubes or medication and other life support systems. Though it is not permitted by any Act of the Parliament except for some guidelines of the Supreme Court, it has been practiced since long, when the patient's family would run short of money. Passive euthanasia is silently in practice although hospital records show otherwise. It does not prolong life. It prolongs death.⁴¹

(b) **Active**⁴²- A deliberate life shortening act is called 'active' Euthanasia. Active Euthanasia involves painlessly putting individuals to death for merciful reasons, as when a doctor administers a lethal dose of medication to a patient. This involves causing the death of a person as a response to a request from that person. In active Euthanasia something is done to end the patient's life. The status of euthanasia in India and many other states was at fluxing in absence of a law prior to the guidelines of the Supreme Court, which has made the position clear to a great extent. The pro

⁴⁰Peter Singer, *Practical Ethics* 179 (Cambridge University Press, Cambridge, 2ndedn., 1993).

⁴¹J Rachel *The End of Life* 86(Oxford University Press, London 1985)

⁴²Jonathan Herring, *Medical Law and Ethics* 497, 498(Oxford University press, 3rd edn.2010).

euthanasia and anti-euthanasia debates are at full swing and it is not possible to get immediate solution to the problem. If a dependent human being having lost everything with no hope is pressurized by the emotions of his family, it will certainly lead to voluntary euthanasia and that is the main fear of anti-euthanasia debate. These are some cases which allow euthanasia and there are cases which do not. The group strongly opposing euthanasia opines that since life and death are inevitable, no one can control it. As per them, the ethical manner in ending life has on one hand -pain management and on the other hand-letting nature to take its course.

In fact, both voluntary and involuntary euthanasia can be practiced passively or actively. Some thinkers are in disagreement with the terms ‘active’ and ‘passive’. They consider both the term confusing and unhelpful.⁴³ Generally active and passive euthanasia are termed as killing and letting die respectively. However, Rachels rejects the distinction because he holds that “we owe extensive positive duties, so that letting someone die becomes as morally unacceptable” as killing them.⁴⁴ There is no morally significant distinction between terminating the life by deliberate omission or by deliberate intervention. This issue will be discussed elaborately in chapter 5.

2.4.3 Differences between voluntary, involuntary and Non-voluntary euthanasia:

a. Voluntary euthanasia

The person wishes to die and says so. This includes cases of:

- asking for help for dying
- refusing burdensome medical treatment
- asking the medical treatment to be stopped, or life support machines to be switched off
- refusing to eat
- simply deciding to die

⁴³NM. Harris, “*The Euthanasia debate*”, 147 *JR Army Med Corps* 367-370 (Oct., 2001)

⁴⁴J Rachel *The End of Life* 160 (Oxford University Press, London 1985)

b. Non-voluntary euthanasia:

Non-voluntary euthanasia is the opposite of involuntary euthanasia in which the consent of the individual concerned is unavailable.⁴⁵The person cannot make a decision or cannot make their wishes known. This includes cases where:

- The person is in a coma.
- The person is too young.
- The person is senile.
- The person is mentally retarded to a very severe extent.
- The person is severely brain damaged.
- The person is mentally disturbed in such a way that they should be protected from themselves.

c. Involuntary euthanasia:

The person wants to live but is killed anyhow. This is usually murder but not always. Consider the following examples:

- A soldier has their stomach blown open by a shell burst. They are in great pain and screaming in agony. They beg the army doctor to save their life. The doctor knows that they will die in ten minutes in any case. As he has no painkilling drug with him he decides to free the soldier from further pain and shoots them dead.
- A person is seen at a 10th floor window of a burning building. His clothes are on fire and fire brigade has not yet arrived. The person is screaming for help. Another person has a rifle with him and he shoots the screaming person dead.
- A man and a woman are fleeing from a herd of alien monsters notorious for torturing human beings that they capture. They fall into a pit dug to catch them. As the monsters lower their tentacles into the pit to drag the man out,

⁴⁵Hugh LaFollette, *Ethics in practice: an anthology* 25-26 (Oxford: Blackwell, 2002)

he begs the woman to do something to save him. She shoots him, and then kills her.⁴⁶

2.5 Euthanasia and its multi-dimensional perspectives

As said by Pope, a man will always be a man, even if he is seriously ill and is not in a position to perform higher functions, depending on the sentiments and perplexing scenario, the values inherent in human being and dignity would not be altered.... Pope John Paul II, 2004. India is a country where culture and religion has reached a culminated point and an argument against the practice of euthanasia commonly starts with religion. Life and death are issues which form the foundation of any religion and hence many people look into the concept of euthanasia from the religious point of view. God has accorded man with highest dignity among all his creation. This dignity and human life should be persuaded. It is this inherent dignity which prohibits killing of human life either by opting to active means or passive means. If anyone is asked about the type of death he desires, then without any reluctance, the answer would be to die unknowingly within a short span of time and in a familiar place. In the given situation, both the patient and family desire to attain standard of empathy and control on the situation for the both so that peace ensues. To fulfill the desires, it is important for the family members and the care givers to candidly discuss all the possibilities with the patient before-hand. But, the crux of the issue is that most of the family members do not prefer discussing this issue with the patient or care providers. Patients are cornered out leaving them alone. Finally, such families look for ways to end sufferings and wishes for a quicker death. It is most painful to see the loved ones go through the throes of death.⁴⁷ Eric Cassel describes the suffering to have its root in physical and emotional reaction to life threatening illness. It is not that the body but the person, philosophically, the life force “within his person suffers. According to Kubler and Ross, there is nothing to fear in death. It can be the most wonderful experience of one’s life”.⁴⁸ Indian religions are characterized by a diversity of religious beliefs and practices. No law in India allows killing of humans. Many supporters of euthanasia put forth their views that the opposition to legalization is

⁴⁶ “Encyclopedia of Crime and Justice” (2002)

⁴⁷ Goswami Chandra Dinesh, “Palliative Cancer Care, our perspective”, *Bhabani Offset & Imaging Systems Pvt. Ltd*, Guwahati at p.19-22

⁴⁸ *Ibid* at p.22

basically due to religious reasons and the secular objectives are only to cover the underlying the sanctity of life with religious convictions. When it comes to finding the meaning of life, as is evident in the history, people in the world have always gone deep into religion and morality.

Technological advancements in the field of medicine have enabled physicians to move effectively, care for their patients and save lives that would otherwise be lost. The developments have led to certain peculiar situation. On one hand, there is possibility of delaying the dying process beyond the normal course which causes great suffering to the patient as well as the family members, care givers and friends and relatives. There are moral controversies and issues on the other end. For example, is it ethical to withdraw a life support system which is considered not an appropriate extension of dying process? Moral and ethical beliefs are buried deep into the sentiments of the people in such a manner that killing somebody even to relieve them of pain and suffering under the pretext of giving a dignified death would not be at any cost tolerated. But, in the name of implementation of the schemes of the welfare state and in the name of religion can the person who is unable to decide for his own be given to suffer and be allowed to have an animal existence devoid of care and neglected by others? A compassionate person can carefully get along with such discussions keeping in mind the following points:

1. Time given to the patient. The patient is a keen observer of the body language of the care giver.
2. Observance of patience and exuberance at times,
3. Giving false assurance to the patient- “you will get well soon”.
4. Role of nurses play a significant role and their perfection can be attained by proper training.
5. Assuring the patient that he is going through difficult times and the bad phase would be over and life would take a turning point.
6. The care giver should pacify the situation to keep the patients at ease as much as possible and cleanliness should be maintained.

The question however remains unanswered as to what would happen to a patient if he is unable to express his feelings to anyone. It is a silent shriek. Craving

for death is really pitiable. Should he be given to suffer in the name of preserving religious values?⁴⁹ The question of brain and death are influenced by the customs, traditions and beliefs in a society. It speaks of relieving acute pain in the process of termination of life. The means to acquire relief from pain is to learn the techniques of pain management. Visitors to an extent should not be plenty to create helplessness among the patients. If a man is inflicted by disease and is made to seclude himself from the rest, the negative thoughts, his pain and sufferings would naturally make him uncomfortable. The doctors should be able to revitalize the emotions in the patient there by imbining a feeling that he is not alone. Not all types of euthanasia are mercy-killing. It is not possible to administer physician assisted suicide as nobody can really read the patient's mind as to whether he hopes for early recovery or awaits death. Euthanasia and assisted suicide have been brought to the lime light time and again. "Thou shalt not kill" is stated in the sixth commandment of the Bible. In India, there is law which punishes individual even for attempting suicide. Hence practicing euthanasia has been a subject of much debate in this country. Before the law relating to euthanasia is brought into existence, the issues relating to its misuse should carefully take in to consideration by the legislature.

2.6 Religious Concept:⁵⁰

2.6.1 Hindu view on Euthanasia:

The Hindu Philosophical view is expressed in religious book "Bhagavad Gita" that death is merely a step in the continuum of birth, life, death and rebirth. Lord Krishna urges Arjun to be focused at his goal and fulfill his destiny as death levels all. In Hindu mythology, there are instances where some humans were given the right to choose death. This clearly indicates that Hinduism totally does not disregard euthanasia. It has been pointed out that in Hinduism, the word for suicide, *atmahatya* also has the ingredients of intention. In Hinduism, the killing of oneself is condemned, if it is influenced by selfish motives. The evil basically sprang from ignorance and wrong passion. Objectively, it was this manifestation of the desire to attain liberation to avoid karmic consequences. In this context, dharmashastras prohibited

⁴⁹ "Respecting the religious and cultural needs of patients, <https://gmmh.nhs.uk>> download (Last visited on July 12th 2018).

⁵⁰Roy Debayan, How Islam, Christian and Hinduism view living will and passive euthanasia, <https://www.news18.com>>news>india, (Last visited on July 12th, 2018)

suicide.⁵¹ However, Hinduism proudly speaks of enlightened souls who chose their own mode of death. The Pandavas, in Mahabharata, had gone for the “mahaparasthana”-a great journey. They were on their pilgrimage when they left their bodies thriving on air and water. Self-immolation, drowning at holy places through the Himalayas are instances of venerated death. Then, the ultimate goals of immortality could finally and definitely be attained.

Such deaths of the highly enlightened people have never been equated with suicide as per popular Hindu body system. As per Hindu tradition, death acts as a means to relieve the soul from self and as the cosmic impermanence to reach the ultimate liberation i.e. moksha. Crawford considers “spiritual death” as a death in which the individual is in a state of calm and peace which is called a good death or a death in peace. The concept of “Ichamrityu” according to Crawford is acceptable to the Indian society. But, the concept of euthanasia is not. However, this view was also criticized saying that “Ichamrityu” can be attained only by highly enlightened soul at complete peace at the time of leaving the body. This is there for all mortal souls. However, Hinduism thoughtless rigid and dogmatic than other religions, would remain sceptic in their view about euthanasia. It has been proposed that the Hindu concept of “ahinsa” could be a ground for not accepting euthanasia. However, there does not exist certain accepted ways of bringing about a good death. For example, “prayopavesa” is a way of bringing good death by people who are contended with life and have no worldly responsibilities or desires in this life. It is only suitable for elderly ascetics. The term “Prayopavesa”⁵²- “fasting until death”, should be highlighted in this regard. It means fasting to die because a person is contended with his life. It is a way of expressing his inner happiness. There is a positive note attached to “moksha” which means complete liberation from cycle of birth and re-birth. An instance that is worth mentioning is Satguru Sivaya Subramuniya Swami who died in the similar manner on November, 2001. He was detected with intestinal cancer.

2.6.2 Islamic thought

Prophet Mohammed holds the view that all killings except what the law allows is prohibited. According to Islam, human life is a gift of Allah and hence it is sacred. It

⁵¹<http://ibnlive.in.com/news/euthanasia-an-indian-perspective/454714-3.html> (Last visited on July 12th, 2018)

⁵²www.lifebeyond.org/terminal-illness.html (Last visited on July 12th 2018)

is only Allah who would decide how long each person shall live. According to the Islamic Code of Medical Ethics, it is meaningless to keep a person alive in the vegetative state using scientific or medical heroism. The physician's duty is not to prolong death but save life. It is the process of life that the doctor aims to maintain and not the process of dying. It is to be noted that Muslims can not kill as per their scriptures except for justice.⁵³ The tradition of Prophet Mohammed also prohibits killing of innocent souls as he states-“The biggest of great sins are to join others as partners in worship with Allah, either to murder a person or to be dutiful to his parents or to give a false witness”.⁵⁴

2.6.3 Christian Thought

This view is moderate as it holds that permitting euthanasia is discarding God's life but living a useless life is also refusal to accept God's will to die. The participant of Christian thought said that euthanasia and assisted suicide were unacceptable. Extraordinary means of preserving life which had lost all meaning were forbidden. Sick persons as far as possible should be treated with care. However, the catholic church opines that discontinuing medical treatment which is burdensome, dangerous and detrimental can be legitimate as it amounts to refusal of over-zealous treatment. The legitimate interest of the patients must be respected. But palliative care should also be courage.⁵⁵

2.6.4 Orthodox Judaism

It rejects the concept of brain death. It does not belief in advocating euthanasia at all. It condemns active euthanasia and regards it as murder. It opines that, if anything comes in the way of natural death, it should be removed. In other words, it paves way for passive euthanasia as it allows withdrawal of treatment taking into consideration, the situation.⁵⁶

2.6.5 Jainism perspective

Santhara is a unique fast undertaken by a person who has served all purposes of life or when his body is not in a position to serve any purpose of life. It is believed that

⁵³www.bbc.co.uk/religion/euthanasia (Last visited on July 16th 2018)

⁵⁴“Euthanasia: A Muslim Perspective”, www.scielo.org.za/scielo (Last visited on July 16th 2018)

⁵⁵<https://www.catholicnewsagency.com/resources/life-and-family/euthanasia-and-assisted-suicide/weuthanasia-catechism-of-the-catholic-church>, Euthanasia (Last visited on July 18th 2018)

⁵⁶www.bbc.com/Judaism/jewishethics (Last visited on July 18th 2018)

through fasting, the soul attains moksha or liberation. The person stops eating or drinking after taking the vow of Santhara. In this process, he doesn't consciously long for death but leaving all worldly relations, love, hatred and feelings, forgiving everyone and having pure feelings for humanity embraces liberation from life.⁵⁷In 2006, three Jain woman embraced death by refusing food and water from the Jain Community. After the discussion on life and death from the religious point of view, it becomes pertinent to understand the relevance of such context.⁵⁸Freedom of profession or freedom to practice any religion along with propagation of their own religion is protected under Article 25 of the Constitution, though it is not an unrestricted right. A practice howsoever ancient cannot be allowed to infringe the right to life guaranteed under Article 21 of the Constitution.

2.7 Political perspectives⁵⁹Even from this angle, it seems difficult to allow the controversial term. There is a controversy about the moral acceptability of allowing patients to die under a variety of circumstances. This cites that there are still many good reasons to maintain legal prohibitions on some of these acts to punish actors who violate these prohibitions even though their acts are of an acceptable nature.

2.8 The Shona Perception of Euthanasia⁶⁰

The 'Shona' is an ethnic group in Africa who are guided by their own rules and regulations. This community tried to understand and study euthanasia from a traditional and ethical point of view. Though they come from a under developed community, they totally condemned killings of any sort. They are not at all barbaric and they give much value and weight to human life. According to them, killing a person is wrong both morally and legally. They stress on the fact that the person who kills anyone is really dangerous not only for the person killed but also for the entire society. The offender is bound to suffer and the society from where he hails is also affected. They are opposed to euthanasia and condemn all technical aspects to kill

⁵⁷*Nikhil Soni V Union of India & Others* (2015) Cri LJ 4951, decided on 10th August, 2015

⁵⁸Padmanabhan Sumitra, "Guzarish: A Film on Euthanasia and death wish", googleweblight.com (Last visited on July 20th 2018)

⁵⁹*Supra* note 16

⁶⁰Mawere Munyaradzi, "The Shona Conception of Euthanasia: a quest to depart from Zimbabwe Tradition", 3No.4 *The Journal of Pan African Studies*, (Dec, 2009)

person. They are against passive euthanasia and according to them adequate medicines should be given to any patient till he breathes his last.

The western scholars have been grouped as pro-euthanasia and anti-euthanasia. The anti-euthanasia is not holding totally ethnic views but they value human life. According to them, God has given life and solely God can take away life. Allowing euthanasia maybe an easy remedy in the hands of the person to kill themselves if they suffer from any sort of stress. They have given a rigid and narrow interpretation to the concept. Margaret Battin and Fredrick Stenn, are some of the strong supporters of euthanasia on moral, religious and rational grounds. According to them, euthanasia is inherently and morally wrong. To have his life terminated is his basic right and to allow would be naturally wrong.

2.9 Practice of euthanasia in the State of Tamil Nadu

In Tamil Nadu, in a village called Virudhunagar village, forced euthanasia was used to eliminate elderly people for first century. It is to eliminate those elderly people who are only burden on the family. This was highlighted by Ansh Singh Luthra in a documentary on euthanasia. The practice is commonly, known as “Thalaikoothal”, and is administered to the adult. The locals described the procedure where the victim is given oil bath and various drinks including coconut water, possibly to induce shock.⁶¹The elders of the village are much concerned about their fate and yet they too do not want to be the burden to the family. In fact, the elders of the village do not want to comment on the issue as according to them euthanasia is not a new form of phenomenon to India. It is masked in secrecy and more particularly, prevalent among the poorer sections of the community.⁶²

A self-help book ‘Veda’ mentored by Help Age India shares stories of practice in Virudhunagar Elders’ Development Association.⁶³Sometimes, the victims are forcefully fed cow’s milk, glasses after glasses by getting their noses pinched shut, an act namely milk therapy resulting in breathing problem causing death. It is also

⁶¹“Forced euthanasia practiced in Virudhunagar Village in Tamil Nadu”, news18.com (Last visited on July 22th 2018)

⁶²*Ibid*

⁶³www.you.tube.com watch (Last visited on July 24th 2018)

administered in bad faith to gain control over one's assets. The history actually started before the British Empire when a Prince gave his ailing mother in law, a peaceful exit but some people think that it started in the beginning of 1950s, as an answer to the poverty-stricken conditions of Indians. It is a family decision and it paves the room for active euthanasia which the law strictly prohibits.⁶⁴

2.10 Euthanasia under the modern concept

2.10.1 Human Dignity:

Human dignity is an expression that can be used as a moral and a legal term. The term is very complex and so ambiguous that it lacks an adequate definition. Today, it is used in different ways. Etymologically, it has Latin roots: *humus* meaning what is earthly or an earthling and *Dignities* is worthiness, worth, beauty. Generally, *humus* means what is proper to the kind that we are or to the species of rational animals, referring in particular to their kindness (humanity) and their fallibility (all too human). *Dignitas* is derived from a Latin root *dignus* meaning worth, fittings.⁶⁵

Generally, dignity means the standing of one entitled to respect, i.e. his or her status, and it refers to that which in a being (in particular a personal being) induces or ought to induce such respect: its excellence or incomparability of value"⁶⁶. These two words brought together forms the expression human dignity which refers to the highest value, or to the fact that they are a presupposition for value.

Generally, much of bioethics was a two-concerned contest between utilitarian and human rights perspectives, with the latter emphasized on individual autonomy and individual entitlements against collective welfare. More recently, bioethical debates have been peppered with claims that certain practices violate human dignity irrespective of their beneficial consequences or the existence of free and informed consent.⁶⁷ To confuse matters, the concept of human dignity is also invoked outside of the new Dignitarian alliance of duty-based and compromise theories. Utilitarian are

⁶⁴ [article.lawtimes.com >collection>news>in southern India, relatives quietly kill their elders>law times](http://article.lawtimes.com/collection/news/in-southern-india-relatives-quietly-kill-their-elders) (Last visited on July 12th 2018)

⁶⁵ <http://etymonline.com> accessed on 31.04.17.

⁶⁶ http://eprint.nuim.ie/archive/00000392/01/human_dignity.

⁶⁷ Deryck Beyleveld and Roger Brown sword, *Human dignity in Bioethics and Bio law* Ch. 1 and 2 (Oxford University Press, London, 2001)

reluctant to present their concerns about disutility in the terminology of human dignity, but they have, at times quite happily hijacked the terminology of rights and might well start to use dignity in this way. Paradoxically, the human rights perspective often grounds its entire position in respect of human dignity. The premise of human rights and in human dignity are reflected in post-Second World War Human Right Instruments. The Preamble and Article I of the Universal Declaration of Human Rights, e.g., takes as a fundamental premise that the claim that we each have on our lives are inalienable and are intrinsic in human dignity. Within the human rights tradition, however, dignity is used to emphasis individual choice and autonomy, rather than constraint.

The famous debate between Hart and Devlin on the enforcement of “private morality” can be understood as clash of the empowerment and constraint perspective.⁶⁸ It follows from the existence of two competing conceptions of human dignity- dignity as constraint and dignity as empowerment that human dignity can be cited by the opposing sides on issues of medical controversy. Consider the request of a patient to be put to death by his doctor, often known as “voluntary euthanasia”. Those relying on dignity as constraint typically condemn such a practice as violating human dignity, even where the patient makes a free and informed decision. Those relying on dignity as empowerment will point to this free and informed decision-making as a reason why prohibiting the doctor from acting on the patient’s request may prevent the patient from “dying with dignity”.⁶⁹

It is also possible to use “dignity” to refer to something else, as this terminology can carry many loads on many paths. The language of dignity is at its most insightful articulation of a modern conflict within bioethics. It usefully explains why otherwise opposed moral position find themselves in what appears to be two-covered contest between, come one hand, an “empowerment” alliance attracting the support of rights-based theories and, on the other, a “constraint” or “Dignitarian” alliance of duty based and (conservative) compromise positions.

⁶⁸H.L.A Hart, Reviewed work, *The Morality of Law by Lon L. Fuller*, 78 No. 6 *Howard Law Review*, 1281-1296(April, 1965).

⁶⁹Deryck Beyleveld and Roger Browns word, *Human dignity in Bioethics and Bio law* Ch. 1 and 2 (Oxford University Press, London, 2001)

Advancements for assisted dying stresses on the practice by focusing on personal autonomy. The medical situation will hold little value when “unbearable suffering” becomes the ultimate criteria for demanding euthanasia. Euthanasia should not be a choice for those whose life tends to be not rosy. No matter, how strict the law becomes, it cannot be denied that it would fail to extend protection to the vulnerable sections of the society. The question is whether legal euthanasia would allow people to ask for their life to be ended based on their autonomous choice.⁷⁰ Medical Professionals have an inherent ethical dedication towards preservation of life and to provide relief from suffering. Beneficence, autonomy and justice are the well accepted moral principles governing the society at large. Technological and medical advances have really created confusion and conflicts between application of these moral principles and use of certain types of medical treatment. The doctors usually put at ethical contradiction as they are bound by the norms laid in the Hippocratic Oath and International code of Medical ethic. The main consideration of the doctor on one hand is to relieve pain and on the other is to protect the life of patients. Both the duties are contradictory to one another because when a doctor tries his level best to relieve pain from his patient, how could he withstand by seeing his patient living in severe pain where the disease is incurable? Every moment, the patient awaits death or in fact cries for the same.

2.10.2. The Modern Concept of death:

Definitions of death are important in euthanasia debate, since the justice with terminally ill patients can only be done by a clear understanding of the precise meaning of the term “death”. The concept of death itself has changed over time, from the recognition of death as being cessation of the heart to the current position in which death is generally recognized by the medical profession as being brain stem death.⁷¹ There is excessive amount of thoughts has been spent on the question of when a person is dead. There are several definition of death which have emerged, in which the “whole-brain” definition has been recognized which is: a person is dead if and only if all that person's brain functions have irreversibly ceased functioning”.⁷² This

⁷⁰Freedomofthought.blogactiv.eu Euthanasia- a new lifestyle choice? (March 10th,2017)

⁷¹J.K. Mason and McCall Smith, *Law and Medical Ethics*, 993(Oxford University Press, 8thedn., 2011)

⁷² Herring Jonathan, *Medical Law and Ethics* 465 (Oxford University press, 3rd edn., 2010).

definition differs from the definition accepted by the courts. Black's Law Dictionary states that death is 'the cessation of life', the ceasing to exist; defined by physicians as a total stoppage of the circulation of the blood, and a cessation of the vital functions consequent thereon, such as respiration, pulsation, etc.⁷³ In that it takes only spontaneous heartbeat and respiration to be indicative of life. Patients who have suffered irreversible loss of brain function but continue to breathe would be counted alive under previous medical practice and legal statute but now they are pronounced dead.⁷⁴ The respiration and other functions occur, but are artificially sustained, and the patient is only left at ventilator but life is not going in its regular course. The definition differs from the so-called 'cerebral-death' definition of death in that whereas, according to the latter, a person is dead as soon as he is irreversibly in coma state which occurs as soon as the neocortex is permanently nonfunctioning. Whole-brain death requires, additionally, that spontaneous heartbeat and respiration have also permanently ceased a state which does not occur until the activity of the brain stem, as well as that of the neocortex, has permanently shut down".⁷⁵

The whole-brain definition of death has been endorsed by a number of medical associations, including the World Medical Association, the Canadian Medical Association, the American Medical Association, and the American Electroencephalographic Society. It has passed into law in majority of European countries, Australia, 18 states of the United States (Alaska, California, Georgia, Idaho, Illinois, Iowa, Kansas, Maryland, Louisiana, Michigan, Montana, New Mexico, North Carolina, Oklahoma, Oregon, Tennessee, Virginia, and West Virginia), and the Province of Manitoba. It is also currently being considered by Great Britain, and has recently received the endorsement of the Law Reform Commission of Canada.

Brain stem death is widely accepted in UK as a medical definition of death. It is claimed that a person whose brain stem is dead has ceased to live in anything but a mechanical way. At present the department of Health's *A code of practice for the*

⁷³Henry Campbell, M.A Black, *Black's Law Dictionary* 488(ST. Paul., MINN, West Publishing Company, Revised 4thedn., 1971)

⁷⁴Margaret P. Battin and Leslie P. Francis, *et.al.*, (eds.), *1 Death, Dying and the Ending of Life* 47(Ashgate Publishing Company, USA, 2007)

⁷⁵ This redefinition of Death is advocated by R. Veatch. *The whole-brain-oriented concept of death: an outmoded philosophical formulation.* In Beauchamp and Walters, reference (i): p.267-276

diagnosis of Brain Stem Death set out in detail the definition of brain stem death. This outlines three requirements that must be met before the doctor makes a diagnosis of brain death:⁷⁶

- i. It must be concluded that coma is not due to reversible cause, such as drug overdose.
- ii. It must be demonstrated that the several components of the brain stem have all been permanently destroyed. Significantly this includes the respiratory centre.
- iii. It must be proved that the patient is unable to breathe spontaneously.

According to Jonathan Glover “The only way of choosing (between competing definitions of death) is to decide whether or not we attach any to the preservation of someone irreversibly comatose. Do we value ‘life’ even if unconscious, or do we value life only as a vehicle for consciousness?”⁷⁷ The very fact that the person who is in persistent vegetative state or irreversible coma with loss of whole brain functioning is just like sculpture put in a shop that cannot move without any external support. Therefore, the brain stems dead theory of death very much supports quality of life approach.

2.10.3. The death with dignity:

There have been remarkable changes occurred in man’s control over both birth and death. Radical changes have taken place in belief and practices pertaining to the beginning of life. Family planning and birth control, instead of being condemned, are now accepted as a duty and responsibility. In spite of strong opposition, especially from the medical profession and organized religion, today birth control is accepted practice throughout up the world.⁷⁸ We have the example of abortion which is recognized as sin in traditional Indian thought. Now it is legalized with law with certain safeguard and upheld the women’s right of personal autonomy.

⁷⁶Herring Jonathan, *Medical Law and Ethics* 465 (Oxford University press, 3rd edn., 2010).

⁷⁷Jonathan Glover, *Causing Death and Saving Life* 45(Oxford University Press, 1987) in Margaret P. Battin and Leslie P. Francis, *et.al.*, (eds.), *1 Death, Dying and the Ending of Life* 58 (Ashgate Publishing Company, USA, 2007)

⁷⁸Ronald Dworkin, *Life’s Dominion*, 179 (Harper Collins, London, 1993)

The spotlight is now being focused and shifted also on the other end of life on man's novel power over death.⁷⁹ According to Ronald Dworkin "Abortion is a waste of the human life. Death intervenes before life in earnest has even begun. Now we turn to decisions that people must make about death at the other end of life, after life in earnest has ended. We shall find that the same issues recur, that the moral questions we ask about the two edges of life have much in common".⁸⁰ Because of the amazing success of medical science and technology, physicians are now able to keep the body functioning beyond its natural span, long after the mind and spirit have ceased to exist, even sometimes almost indefinitely by artificial means. They can produce what some have called a living death or, as David Hendin has said, "Dying is rendered obscene by technology." This power has reached such a stage and keeps increasing so rapidly, that many people are now asking what are we doing with this new power to prolong life. A new freedom is being demanded today: the freedom to choose death vis. a vis. right to die with dignity which paved a way to justify euthanasia.⁸¹ More and more people are now realizing that the right to die with dignity, so long denied to countless people is a basic human right that should be available to those hopelessly ill patients who request it.

Advances in the medical sciences now allow the living and dying to be prolonged, a fact which has raised awareness about issues relating to death and dying in the community at large and the medical professionals. Dworkin sentiments also reflect a commonly held belief that modern medicine can compel the people to endure life beyond what they perceived to be dignified bounds. Sometimes, the doctors also engage in excessive treatment to prolong the lives of terminally ill. As a result, there are repeated calls for bringing the legal reforms which should permit euthanasia and assisted suicide.

Today, it is common to keep the people alive and bring them back from the brink of the death, where in the past they would have died. But it should be borne in mind "what kind of life they are living?": The lives of increasing number of patients are prolonged by advanced medical facilities, but the doctors in charge of such patient

⁷⁹O. Ruth Russell, "Freedom to Die: Moral and Legal aspects of euthanasia, (New York, revised ed. 1977).

⁸⁰Ronald Dworkin, *Life's Dominion*, 179 (Harper Collins, London, 1993)

⁸¹O. Ruth Russell, "Freedom to Die: Moral and Legal aspects of euthanasia, (New York, revised ed. 1977).

have to decide as to continue their life saving treatment or to hasten their death by the administration of lethal drugs. The ability to preserve life despite trauma and terminal illness, has resulted in raising concern of the people demand right to die with dignity rather than to endure a perceived indignity of a dependent existence.

The phrase “dying with dignity” is drawing the attention of ethicists and non-ethicists and forms the basis of euthanasia debate. Human Dignity however, is a nebulous concept. One may define it as the calm death without the pain and suffering while others define it as an existential maturity, where dying is done in harmonious and calm way. In other words, it means the respect for individual autonomy. One should be free to decide as to how, when and in what manner he would die. Patients requesting euthanasia often opt for it as they did not wish to see their loved one suffering and they fear of becoming dependent on others, loose control on all bodily functions, risk of losing quality of life and many other reasons. The argument that human lives possess dignity which is inherited and inviolability is the high mark or traditionalists’ attempt to present the sanctity of life as a self-evident moral concept.

As a part of creator’s revelation of moral reality, the natural law witnesses the fact that Homo sapiens have no “original and rightful jurisdiction” over the gift of life. The natural law theory believes that human possess no moral claim regarding the claim of life regardless of these claims being the beginning of life, life enhancement or life termination matters. It inhibits in itself the quality of life as well as the timing when it would terminate since life is understood to be endowment.

2.10.4 End of Life Care:

It basically means the care provided to one who is approaching close to one’s life regardless of the issue known to him or not. Enhancing the quality of life and dying a dignified and peaceful death are main basis of a good life. It is a bit difficult to specify when a patient would move into its terminal stage. Therefore, it is pertinent for the competent patient to be a part of the decision making in the treatment phase in the process of life. At the juncture of life and death, some spiritual, social and cultural aspects are always of much importance which has a binding towards saving life.⁸²Life

⁸²[rnao.ca >sites>rnao-ca>files > End-of-care During the Last days and Hours- Nurses](http://rnao.ca/sites/rnao-ca/files/End-of-care_During_the_Last_days_and_Hours_-_Nurses) (Last visited on May, 2018)

is followed by death. Death is as much a reality as life is. The reality of death cannot be discarded by anyone. With technological advancements, cardiac activity could be managed for many days though the brain ceases to function irreversibly. In such situations, support system helps to prolong life despite the severity of the underlying disease. However, the outcome is very bleak. These situations have brought in many new ethical and moral dilemmas in the context of financial, emotional, spiritual and social factors. Most importantly, the scarcity of the resources imposes the need for their optimal use that result in their rationing or selective allocation. Further, the dilemmas include the decisions about how much support to extend to a patient who is unlikely to survive or how to treat a patient who is unable to tolerate the acute pain longer.⁸³To overcome the ethical and moral dilemmas encountered by medical practitioners in such situations, in 1999, the British Medical Association brought out the guidelines for deciding certain matters like whether treatment should continue, though in vain, till last. But, for the patients at present, in India, there are no other professional organizations or legally sanctioned standards to guide the medical practitioners.⁸⁴In the 21st century, it's time that good quality of life be associated with quality death so that an unequivocal definition of death could be forwarded.

2.10.5 The Regulation of Law by Criminal Law

Pain and Symptom Relief Approaches⁸⁵

In case, a patient suffers from any serious disease or acute pain, this regulation could be of help. The two approaches- “Double effect” and “medical exception” could be practiced without infringing the terms of criminal law which causes bodily harm. In other words, it affords protection to the doctor whose good actions result in the death of their patients and if the doctor could make a case that the patient administered medicine unknowingly. Ventilation and artificial machineries keep people alive when they would have otherwise died.⁸⁶A tender touch can be soothing enough to simple pain at times. In case of child birth, the pain may be intense but the result gives pleasure. The same cannot be said about patients with vegetative state as the end

⁸³Komen G. Susan, End-of- life care, <https://ww5komen.org>> Content > End (Last visited on July 16 2018)

⁸⁴ S Luttrell, “Withdrawing or withholding life prolonging treatment”-NCBI-NIH, <https://www.ncbi.nlm.nih.gov>> articles (Last visited on July 16 2018)

⁸⁵BBC- “ethics-Euthanasia: The doctrine of double effect”, www.bbc.com> euthanasia > overview (Last visited on July 16th 2018)

⁸⁶*Ibid*

result is always destructive and hence leaves behind a trace of awful experience with multi-dimensional aspects of humiliation with the close associates of the patients.

2.11 Operational Concepts regarding euthanasia:

2.11.1 Assisted Suicide: It is committed by a doctor. The doctor knowingly and intentionally provides an adult with the means by dint of which he could terminate his life.⁸⁷

2.11.2 Brain death⁸⁸

A state of prolonged irreversible cessation of all brain activity, including lower brain stem function with the complete absence of voluntary movements, responses to stimuli, brain stem reflexes, and spontaneous respirations. Explanation: This is the most severe form of brain damage. The patient is unconscious, completely unresponsive, has no reflex activity from centers in the brain, and has no breathing efforts on his own. However, the heart is beating. This patient can only be maintained alive by advanced life support (breathing machine or ventilator, drugs to maintain blood pressure, etc.). These patients can be legally declared dead ('brain dead') to allow their organs to be taken for donation.⁸⁹

2.11.3 Terminal illness⁹⁰:Defining the term “terminal illness” has proved to be a daunting task. Among the plethora of definitions, an “illness”, almost unanimously, is said to be an abnormal condition of the body, or a disability. The World Health organization defines health as “a state of complete physical, mental and social well-being and not merely the absence of disease and infirmity.”⁹¹

2.11.4 Coma: Patients in coma have complete failure of the arousal system with no spontaneous eye opening and are unable to be awakened by application of vigorous sensory stimulation. Explanation: These patients are unconscious. They cannot be awakened even by application of a painful stimulus.

⁸⁷ [Eprints.gla.ac.uk/declarations on euthanasia and assisted dying](http://eprints.gla.ac.uk/declarations-on-euthanasia-and-assisted-dying/), ISSN :0748-1187(Print) 1091-7683 (online journal) homepage (Last visited on May 16, 2018)

⁸⁸ *Supra* note, 74

⁸⁹ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4166875/>(Last visited on July 16, 2018)

⁹⁰ https://en.wikipedia.org/wiki/Terminal_illness (Last visited on June 2nd2018)

⁹¹ CPR, DNR, Physician-assisted suicide: ICMR definitions on End of Life Care, Details, speciality.medicaldialogues.in/cp-dnr-physician-assisted-suicide-imrdefinitions-on-end-of-life-care/details, (Last visited on April 13th, 2018)

2.11.5 Persistent vegetative state and Minimally Conscious State:

According to the New England Journal of Medicine, “*the vegetative state is a clinical condition of complete unawareness of self and the environment, accompanied by sleep wake cycle, with either complete or partial preservation of hypothalamic and brain stem autonomic functions.*”⁹²“In addition, patient in a vegetative state shows no evidence of sustained, reproducible, purposeful or voluntary behavioral responses to visual, auditory, tactile or noxious stimuli; show no evidence of language comprehension or expression, have bowel or bladder inconstence, and have variably preserved cranial nerve and spinal reflexes. In other words, persistent vegetative state is a vegetative state present one month after acute traumatic or non-traumatic brain injury or lasting for at least one month in patients with degenerative or metabolic disorders or developmental malfunctions”.⁹³

Vegetative State (VS) is complete absence of behavioral evidence for self or environmental awareness. There is preserved capacity for spontaneous or stimulus-induced arousal, evidenced by sleep wake cycles. i.e. patients are awake, but have no awareness. Explanation: Patients appear awake. They have normal heart beat and breathing, and do not require advanced life support to preserve life. They cannot produce a purposeful, co-ordinate, voluntary response in a sustained manner, although they may have primitive reflexive responses to light, sound, touch or pain. They cannot understand, communicate, speak, or have emotions. They are unaware of self and environment and have no interaction with others. They cannot voluntarily control passing of urine or stools. They sleep and awaken. As the centers in the brain controlling the heart and breathing are intact, there is no threat to life, and patients can survive for many years with expert nursing care. The following behaviors may be seen in the vegetative state.”⁹⁴

Sleep-wake cycles with eyes closed, then open Patient breathes on her own Spontaneous blinking and roving eye movements Produce sounds but no words Brief, un sustained visual pursuit (following an object with her eyes) Grimacing to pain,

⁹²“Medical Aspects of the Persistent Vegetative state”, *The New England Journal of Medicine* (May, 1994)

⁹³*Ibid.*

⁹⁴<https://www.msmanuals.com/professional/neurologic-disorders/coma-and-impaired-consciousness/vegetative-state-and-minimally-conscious-state> (Last visited on April 13th, 2018)

changing facial expressions Yawning; chewing jaw movements Swallowing of her own spit Non purposeful limb movements: arching of back Reflex withdrawal from painful stimuli.⁹⁵

Some patients with severe alteration in consciousness have neurologic findings that do not meet criteria for VS. These patients demonstrate some behavioral evidence of conscious awareness but remain unable to reproduce this behavior consistently. This condition is referred to here as the minimally conscious state (MCS). MCS is distinguished from VS by the partial preservation of conscious awareness”. To make the diagnosis of MCS, limited but clearly discernible evidence of self or environmental awareness must be demonstrated on a reproducible or sustained basis by one or more of the following behaviors:

Following simple commands. Gestural or verbal yes/no responses (regardless of accuracy). Intelligible sounds, purposeful behavior, including movements or emotional behaviors (smiling, crying) that occur in relation to relevant environmental stimuli and are not due to reflexive activity.

Some examples of qualifying purposeful behavior include: Appropriate smiling or crying in response to the linguistic or visual content of emotions but not to neutral topics or stimuli Vocalizations or gestures that occur in direct response to the linguistic content of questions reaching for objects that demonstrates a clear relationship between object location and direction of reach touching or holding objects in a manner that accommodates the size and shape of the object pursuit eye movement or sustained fixation that occurs in direct response to moving or salient stimuli.⁹⁶

2.11.6 Palliative care:

World Health Organization defines it as “Palliative care is an approach that improves the quality of patients and their families facing the problem associated with life threatening illness, through the prevention and relief of suffering by means of early

⁹⁵Pinki Virani, *Aruna's story, the True Account of a Rape and its Aftermaths* Penguin (Books India, Mumbai, 1999).

⁹⁶“Medical Aspects of the Persistent Vegetative state”, *The New England Journal of Medicine* (May, 1994)

identification and impeccable assessment and treatment of pain and other problem physical, psychological or spiritual.”⁹⁷

Palliative care provides:⁹⁸

- a) Relief from pain and other distressing symptoms,
- b) Affirms life and regards dying as normal process
- c) Neither intends to hasten or postpone death
- d) Integrates the psychological and spiritual aspect of patient care
- e) Offers a support system to help patient live actively till the death
- f) Offers the support system to help the family to cope during the patient illness and in their own bereavement.
- g) Uses the team approaches to address the need of the patients and their families including bereavement, counselling etc.
- h) Will enhance the quality of life and may also positively influence the course of illness
- i) Is applicable in early course of illness, in conjunction with other therapies that are intended to prolong the life, such as chemotherapy and radiotherapy.
- j) Includes those investigations which are needed for better understanding and managing clinical distressing.

2.11.7 Do not attempt Resuscitation (DNR): A writing indicating that the patient does not want any further treatment. It expresses the wishes of the patient or surrogate.⁹⁹

2.11.8 The doctrine of double effect: This doctrine says that if doing something ethically good has a morally wrong side effect it’s ethically right ‘to do it providing the bad side effect was not intended.’¹⁰⁰ This is true even if you foresaw that the bad effect would probably happen. The principle is used to justify the case where a doctor gives drugs to a patient to relieve stressful symptoms even though he knows doing this may curtail the patient’s life. This is because the doctor is not aiming directly at

⁹⁷Abdulaziz Al-Mahrezi and Zahid Al-Mandhari, “Palliative Care: Time for Action” *Oman Medical Journal*, available at, <https://www.Ncbi.nlm.nih.gov/pmc/articles/pmc4852088/> (Last visited on April 4th 2017)

⁹⁸John Keown, *The Law and Ethics of Medicine* 310 (Oxford University Press, 2012)

⁹⁹<https://emedicine.medscape.com> article> (Last visited on June 13th, 2018)

¹⁰⁰Shaun D. Pattinson, *Medical Law and Ethics* 571(Sweet and Maxwell, South Asian 3rd edn.,2013)

killing the patient – that bad result of the patient’s death is a side-effect of the good result of reducing the patient’s life. Many doctors use this doctrine to justify the use of high doses of drugs such as morphine for the purpose of relieving suffering in terminally-ill patients even though they know the drugs are likely to cause the patient to die sooner.¹⁰¹

2.11.8.1 Factors involved in the doctrine of Double Effect:

The good result must be achieved independently of the bad one: For the doctrine to apply, the bad result must be the means of achieving the good one. So, if the only way the drug relieves the patient’s pain by killing him the doctrine of double effect does not apply.¹⁰²

The action must be proportional to the cause: If I give a patient a dose of drugs so outsized that it is certain to kill them and that is also for greater than the dose needed to control their pain. I cannot use the Doctrine of Double Effect to say that what I did was right¹⁰³.

The drug must be appropriate: I also have to give the patient the right medicine for their symptoms. If I give patient a fatal dose of pain-killing drugs, it’s no use saying that my intention was to relieve their symptoms of pain if the patient was not suffering from pain but from breathlessness.¹⁰⁴

The patient must be in a terminal condition: If I give a fatal dose of pain reliever drugs and they would have recovered from their disease or injury if I had not given them the drugs, it’s no use saying that my objective was to relieve their pain. And that applies even if there was no other way of controlling their pain.

2.12. Assisted suicide/dying, euthanasia, suicide and murder: A distinction

In the suicide, the person commits this offence by killing himself through any means either by stabbing, poisoning or any other method.¹⁰⁵ In murder, the person

¹⁰¹Jonathan Herring, *Medical Law and Ethics*523 (Oxford University press, 3rd edn.2010).

¹⁰²*R v Adams* (1957) Crim LR 365

¹⁰³Encyclopedia of Crime and Justice (2002)

¹⁰⁴*R v Cox* (2014) EWCA Crim 804.

¹⁰⁵Jonathan Herring, *Medical Law and Ethics*476 (Oxford University press, 3rd edn.2010).

deliberately takes the life of another person.¹⁰⁶ Reasons may be several like jealousies, one sided love, or to commit any other offence relating to person or property or reputation. Literally, assisted suicide means the suicide of the patient suffering from an incurable disease, effected by the taking of lethal drugs provided by a doctor for this purpose. According to Law commission Of India ‘Assisted suicide’ is where a doctor assists a patient by giving him medicines at the request of a patient who is unable to withstand pain, for enabling the patient to bring his life to an end. ‘Assisted Suicide’ is different from Euthanasia. It is basically ‘suicide’ because it is an act of the patient himself who puts an end to his life, while Euthanasia is always the act or omission of a third party. The patient here, however, seeks the assistance of a doctor to suggest and give him drugs which he can administer to himself in order to commit suicide. In a way, it may amount to ‘abetment’ of suicide. In ‘assisted suicide’ the doctor actively assists the patient and gives him the medicines which enable the patient to use it to commit suicide. The patient wants to commit suicide because he is unable to bear the pain and suffering.¹⁰⁷

Assisted death is a model that includes both i.e. physician assisted suicide and voluntary active euthanasia. It suggests the degree of involvement and behavior. Physician assisted suicide entails making lethal drugs available to the patient to end his own life. The role of the physician is passive in nature; there is no direct participation in the act of ending the life. But in voluntary active euthanasia, the physician takes an active role in carrying out the patient’s request and usually involves intravenous delivery of the lethal substance.

As previously discussed, ‘euthanasia’ is the act of deliberately ending the person’s life to relieve the person from unbearable pain or intolerable suffering. It can also be defined as the intentional killing by the act or omission of a person whose life is felt not living worth of. In Euthanasia, in particular, in active involuntary euthanasia, the doctor injects the patient with a lethal dosage of medicine but in assisted suicide, the doctor prescribes the lethal dose to the patient and the patient takes it or administers it to himself. In both, the ‘intention’ element is important.

¹⁰⁶ *Ibid* at 469

¹⁰⁷ Marc Strauch and Key Wheat, *et.al.*, *Text, Cases and Materials on Medical Law and Ethics* 567 (MPG Books Group, 2012)

Euthanasia is carried out 'by a doctor administering drugs to the patient himself. Mercy killing is a well-known phenomenon in every culture. It happens when someone causes the death of another individual based on the belief that death would be good for the victim. When the fact and opinions point that death would be the ultimate best choice, then the death resulted of such an act is known as merciful death. The duly appointed person on behalf of the patient, who has ceased to act as a full person, has examined all the medical facts and recommendations and after examining the facts they come to the conclusion that death is the wise choice, it also comes under the merciful death.

Why Euthanasia is an Issue?

Those in favour of euthanasia argue that it should be up to the patient, whereas those against argue that euthanasia could be misused, leading to very disturbing situations. Should a terminally ill patient in a great deal of pain and discomfort be allowed to terminate their life, if that is what the patient desires? In addition, who has the right to deny a patient who is in complete suffering a less painful ending to their lives? These questions cause a huge amount of controversy, and have been strongly debated.

The pro-life people allege that suffering is part of the human condition and part of life's experience. In addition, medication can be improved to help a person's quality of life and make their deaths as humane as possible. Furthermore, even if a person is in a state of sedation they still biologically exist and still have what some would say an obligation to live their life until its natural conclusion. A strong ethical argument against the use of euthanasia is that it could soon become a slippery slope, with the legalisation of involuntary euthanasia following it. There is also concern that doctors could end up killing very sick patients without asking for their permission, and in the worst-case scenario, begin to kill off patients to free up beds in hospitals, or to save money. These situations show how dangerous it could be to let the legalisation of euthanasia lead into the legalisation of involuntary euthanasia.

Opponents claim that if Euthanasia is allowed then people who are terminally ill, critically injured or simply old may well feel compelled to choose an option they do not really want to take. If Euthanasia is allowed, in some cases, people whose

treatment may be costing relatives or the state a lot of money may die because they are not worth the cost of keeping them alive. This is not something that anyone want to feel as in essence it takes away his or her freedom of choice on the matter of his own life. Even if the relatives of those ill people may be suffering from watching their loved one's condition deteriorate, they have no right to either decide or put pressure on a person to end their own life because of their own suffering. Just as it may be the individual's right to die it is also the right of the individual's right to "rage against the dying of the light" with their support of their family so to speak. While it may be an "agony to watch a loved one deteriorate" many will also want to spend as long as possible with their loved ones, and more than likely a family will be split on the matter meaning that the views of the family would have to have no impact on the matter.

On the other side of this moral issue, there is a strong argument that people should have the right to terminate their lives, whenever, and however they may wish. Many supporters of the "Right to die" believe that everyone has the right to control their body and life, and should be free to decide at what time, and in which manner they will die. Since the right to life gives a person the right to not be killed if they do not want to, proponents of euthanasia argue that respect for this right will prevent euthanasia being misused, as killing a patient without their permission would violate their human rights. It can also be argued that because death is a private matter, if there is no harm to any other people, there is no right to deny someone's wish to die. Supporters of this believe that if euthanasia promotes the best interests of all the parties concerned, and no human rights are violated, then it is morally acceptable for voluntary euthanasia to take place.

Proponents assert that Euthanasia allows patients to terminate their perpetual state of suffering and die with dignity, respect, comfort, peace, and free themselves of pain, when the patients cannot perform physical, emotional, and social tasks. They maintain that Euthanasia relieves suffering. If a terminal patient faces a long, slow, painful death, surely it is much kind to spare them this kind of suffering and allow them to end their life comfortably. Painkilling medications used to alleviate symptoms often have unpleasant side effects or may leave the patient in a state of sedation. It is not as if they are really 'living' during this time; they are merely waiting to die. They

should have the right to avoid this kind of torturous existence and be allowed to die in a humane way. Further to this, families of individuals suffering with such diseases see their bright, happy relative in such a pitiable state. Their loved one suffers a slow and painful death. Surely, it is kinder to put a mother, father, brother or sister out of their misery and allow them to die a peaceful death, as is their last wish.

It is clear shown that there are strong arguments from both sides, and the debate as to whether euthanasia should be allowed still continues. As far as researcher concerned, he believes that if a terminally ill patient's life holds nothing but suffering, then it should be an acceptable option to help them die as long as the patient requests it, and sufficient permission is given. In addition, keeping a person alive against their will and making him or her withstand pain and suffering is not different from torture, and thus should not be allowed: if a patient wants to die, and his or her condition is truly hopeless, relatives, doctors, and law should not prevent them from doing so. From my perspective, Euthanasia is not killing; it is more like bringing a patient's inevitable death closer. There are diseases that cause severe suffering; sometimes, a patient might try to commit suicide to end this suffering; life for such patients is worse than death.

2.13 Conclusion

It is concluded that the most pertinent and notable point raised by the opposition of euthanasia is that it would lead to misuse by doctors. The patients rely on doctors for healing their pain and so it is unacceptable on the part of them that they would kill patients under the guise of the law. It is really to be thought whether arming the medical practitioners with such power would lead to many unlawful deaths and that cannot be rationalized in any manner. The patients have utmost confidence upon the doctors and so the doctor is under an obligation to protect the patient and help him survive. No doctor should think of death for his patients or else the patients will lose faith upon the doctors and this will be bad for the society. The doctor should try pain management by proper diagnosis of the disease. The doctor is duty bound to choose best for his patients and provide high quality care with the supportive teams during last hours of his life. On the other hand, the supporters are of the opinion that when the doctors are given the power to examine patients without any hesitation and fear,

they are regarded as messiah from Heaven, competent enough to heal the wounds and injury of the patients. Why can't they be given the power to declare that a particular patient is incurable so that he does not have a prolonged suffering life? To make a fool proof system, proper monitoring system should be there. They should be charged with the responsibility to check any kind of mishandling by the doctors. Whatever, be the measures, the main aim of the investigator is to see that the patient is relieved of his pain and suffering in any form. Considering the financial position and mental stability of such patients- an instant legislation is necessary which contains provisions for appointment of an investigator. Euthanasia, no doubt, is tremendously influenced by public debates and media reports. Our history has been the witness that both life and death are embraced by the people, as so beautifully put by Dr. Rabindra Nath Tagore in Gitanjali that- as he loved life, he will love death too.



CHAPTER-III

COMPARATIVE ANALYSIS OF EUTHANASIA IN DIFFERENT COUNTRIES



CHAPTER-III

COMPARATIVE ANALYSIS OF EUTHANASIA IN DIFFERENT COUNTRIES

“Death is our friend, the truest friend. It delivers us from agony. I do not want to die of creeping of my faculties -a defeated man”.

- Mahatma Gandhi

3.1 Introduction

It has been observed that legal status of euthanasia present in most of the countries around the world is similar. It is illegal, but it has forced, pressurized people to travel overseas where allowed to get life-ending drugs, or to end life. This has increased the stress and difficulty on the terminally ill who are already facing unbearable difficulties in life. It has further been observed that it is not possible for everyone who is desirous to do so because of the financial constraints. There are many people who sensibly take a decision to end their painful life which is not worth living. It is therefore essential for all countries to review their legislation on euthanasia. It is necessary to take an over view about the concept of euthanasia in different continents.

3.2 Euthanasia in the American Continent¹

3.2.1 Historical background

In traditional American societies, various forms of euthanasia were prevalent. The elderly, Inuit’ (“Eskimos”) who were incapable of a dignified living used to voluntarily die by exposing themselves to the freezing cold. The Inuits used to do this in sacred place or any outdoor location. This type of voluntary submission to embrace death by the aged was prevalent throughout America. The Traditional elder American who could no longer contribute to the family, community or look after their basic

¹ Legality of Euthanasia *available at:* http://en.wikipedia.org/wiki/legality_of_euthanasia (Last visited on April 17th, 2019). Euthanasia is illegal in America. US states of Oregon, Vermont, Washington, New Mexico and Montana, Switzerland, Albania, Colombia, Germany and Japan, Assisted Suicide is legal.

needs had no right to live. It was unfair that they were a burden on their families and community. The Younger generation who were severely disabled, diseased or suffered from incurable, ongoing pain also shared the same view of termination of life. The new-borns born were not an exception. New-borns with severe, birth defects were also euthanized. They were placed in a natural body of water, usually a stream or river, to drown. Therefore, it can be observed that traditional Americans opined that, if a human was not fit for a dignified life then he should be allowed to die. They should not be forced to spend a life not worthy of living.

3.2.2 Legalization of Euthanasia

Euthanasia thus was prevalent in the American continent as a norm or part of their traditional practice. The Americans therefore made efforts to legalize this practice. A society working for euthanasia was established in 1938 by the Reverend Charles Francis Potter, which sincerely made efforts to change the law. It was called as “euthanasia society of America”². But it was in late 1970s and the 1980s that Americans favoured right to die with dignity and proposed to have legislation on euthanasia for those who were suffering from terminal illness.³

The local campaign groups tried various measures to ‘aid’ in making laws. There were groups which conducted surveys, which showed that, 75% of the Americans were in favour of euthanasia. In the cities of Washington and New York, groups moved the court to challenge the laws which restrained people to aid euthanasia. The apex court held that assisted suicide was constitutional and that the issue was up to each individual state to decide whether they have to ban it, or allow it.⁴

3.2.3 Death with Dignity Act⁵

The two cities Washington and California in 1991-92 moved a proposal for 'Death with Dignity Act'.⁶ It proposed active participation of physicians in aiding the

² Derek Humphry and Ann Wickett, *The Right to Die: Understanding Euthanasia*, 18 (1986).

³ *Ibid*

⁴ O. Russell, *Freedom to Die: Moral and Legal Aspects of Euthanasia*, 64-86 (1977).

⁵ On October 27, 1997, Oregon enacted the Death with Dignity Act which allows terminally-ill persons to end their lives through voluntary self- administration of lethal medications, expressly prescribed by a physician for that purpose. The Act requires the Oregon health authority to collect information about the patients and physicians who participate in the act, and publish an annual statistical report. Available at <https://www.oregon.gov/oha/ph/ProviderpartnerResources/Evaluationresearch/deathwithdignityact/pages/index.aspx>

vulnerable patients who desired to terminate life.⁷ This was with strict guidelines, regulations and control. They insisted that, irretrievably sick people that were capable to make a request should be helped by Doctors to receive lethal dose under strict stipulation.⁸ But unfortunately when put to vote, the 'Death with Dignity Act' lost the vote by 54% to 46%. In spite of the same, The American 'right to die' campaigners never left hopes and again proposed for the 'Death with Dignity Act' in 1994.⁹ This time the Act was passed by a vote of 51% to 49%. It was the first legislation in the world on euthanasia. The opponents i.e. 'National Right to Life Organization' challenged the act in court of law holding its implementation. Finally, it came into force on 27th October 1997. The act allowed doctor assisted suicide for terminally ill with strict checks and guidelines.¹⁰ The lethal drugs were prescribed by Doctors, and the administration of the dose had to be done by the patients themselves. The Doctor before prescribing had to be confident on the diagnosis made by them. The prediction made about the consequences of the sickness and also the requestors capacity to administer lethal dose. Further they had to be satisfied that the patient had lost his independence. He was unable to contribute in any of the activities that were essential to keep him happy or make his living pleasurable. Further it was also essential that he sensed loss of self-respect. The Oregon and Washington were the states to implement it.

3.2.4 Canadian bill “Euthanasia C-384, 2010” and “Bill 52, 2014”

Canada also considered euthanasia as a crime. Aiding death was a crime. The violator was penalized. 14 years of punishment was prescribed in Canada for the offence.¹¹ However, it has been observed that prosecution has been rare for this offence by the court. Efforts were made in 2010 for legalization.¹² A bill “Euthanasia C-384” was

⁶ The Washington Death with Dignity Act, Initiative 1000, codified as RCW 70.245 Passed on Nov, 2008. This Act allows terminally ill adults seeking to end their life to request lethal doses of medication from medical and osteopathic physicians. These terminally ill patients must be Washington residents who have less than six months to live. Available at <https://www.doh.wa.gov/youandyourfamily/illnessandDisease/DeathwithDignityAct>.

⁷ *Ibid*

⁸ Raymond Whiting, *A Natural Right to Die: Twenty-Three Centuries of Debate*, 37 (2002).

⁹ Derek Humphry and Ann Wickett, *The Right to Die: Understanding Euthanasia*, 18 (1986).

¹⁰ *Ibid*

¹¹ According to S. 241(b) of the Criminal Code of Canada “Everyone who aids or abets a person to commit suicide, whether suicide ensues or not, is guilty of an indictable offence and liable to imprisonment for a term not exceeding fourteen years.

¹² In Canada, Euthanasia and physician assisted suicide is illegal even though patients have the right to refuse life sustaining treatments. Moreover, the Canadian Supreme Court in *Sue Rodriguez v. British*

presented in the parliament. The bill permitted the physicians to assist the terminally ill to die with dignity. This also ensured that the doctors would not be prosecuted for murder. The bill had specified strict measures before its implementation. But the Canadian House of Commons rejected the bill. The MPs who rejected the bill feared of the slippery slope and also that the citizens might also be euthanized against their wishes. They emphasized that the government should in fact improvise 'ending life care facilities' for the citizens, rather than legalizing euthanasia. Due to the rejection of the bill and importance given to palliative care, there has been a reduction of euthanasia supporters in Canada. However, it has hardly restrained efforts for legalizing. The apex courts decisions delivered protecting interest of the patients, made its way for the Quebec National Assembly to legalize euthanasia via the bill 52, 2014. The bill defined euthanasia as a form of health care and was approved by 94-22 votes.

3.2.5 Mexican bill on euthanasia

Mexico legalized passive euthanasia. The Mexican bill presented in the legislature on 22nd April, 2008 was wholly supported by the senate casting 70 votes in its favour against 0 votes in opposition. According to the bill, the physicians were allowed to withdraw life supporting system and medication in case of terminally ill patients. Such patients or their family members had to give their unequivocal consent to the physicians for the suspension.

3.2.6 Euthanasia in the Southern and Central America

3.2.6.1 Judicial support to euthanasia in Columbia

Columbia does not have a legislation favouring euthanasia. Ending life is a crime in Columbia. Traditionally conservative, the Columbians prohibit abortion in all situations. But the lands progressive judicial system has out placed the community's outlook on social issues like euthanasia. The Columbian Constitutional court in 1997 permitted euthanasia in case of terminally ill patients, who gave their consent to do so and where medical treatment was not available. The court in this case also defined

Columbia (Attorney General) rejected the plea of Rodriguez, a woman of 43, who was diagnosed with Amyotrophic Lateral Sclerosis (ALS) to allow someone to aid her in ending her life. The court said that in the case of assisted suicide the interest of the state will prevail over individual's interest.

terminally ill and restricted the authorization to only those people. According to the court those who were suffering with acute pain, extreme suffering and with no chances of recourse were allowed euthanasia.¹³ It however refused euthanasia to people suffering with degenerative diseases. Since then euthanasia or ending life is not a crime. Thus, Columbia is the only Catholic nation where active euthanasia is permitted, practiced informally. The proponents are striving to legalize this practice to reduce abuse. While the opponents are taking efforts to ban the practice as it contradicts the legislation of the state. Columbian court directed nation to have a legislation to regulate the practice of euthanasia and ratify it, as physicians discreetly assist the terminally ill patients on their requisition. Following the Constitutional Court sentence of 1997, on March the upper chamber (Senate) of the Congress of Columbia held a “public hearing” on the proposed law that would fully legalize euthanasia in Columbia.¹⁴

3.2.6.2 Uruguay indirectly supports euthanasia

Uruguay does not have legislation for euthanasia in its favour, but it has been observed that nurses and physicians in number of hospitals carry out euthanasia. This may happen in regular course as there have been no judicial sentences so far for the act. The judges in number of cases have not penalized people or awarded punishments to those who have assisted in death if it was solely done on humanitarian and compassionate ground on repeated wishes of the patient. Due to this, the populace of Uruguay is in distraught situation. Being a predominantly Christian nation, the bishops persuading to defend life and take care of the totally helpless people in all its stages, euthanasia comes down to its traditional concept of it being a crime.

3.2.7 Anti-euthanasia beliefs in American Continent

A predominant Catholic continent portrays euthanasia as a great sin. According to them God is sovereign master of all our lives. It is he who has gifted this life to us and hence duty bound to accept it gratefully as bestowed on us. It is an obligation on us to conserve it in his honour. We thus being the stewards of the almighty have no right to dispose it off. In case we attempt to do so it is contravention of the divine law, offence

¹³ [http://assisted suicide.org/blog/2007/04/10/Columbia-takes-step-towards-legal-euthanasia/](http://assisted-suicide.org/blog/2007/04/10/Columbia-takes-step-towards-legal-euthanasia/) (Last visited on April 25th, 2019)

¹⁴ S.S. Das, *Law on Euthanasia*, 44 (Thomson Reuters, South Asia, 2015).

against humanity and a crime for which there is no forgiveness. They believe that euthanasia means giving the individual the rights to be the master of one's body and showing lack of gratitude towards oneself. This attitude would also reflect on the social obligations towards others and develop a contrary attitude towards self-preservation.

3.2.7.1 Compassionate approach of the ELCA

The Archbishop of Canterbury states that the church cannot in any circumstances mitigate on euthanasia. The American Evangelical Lutheran Church, the chief Lutheran organization of United States also affirms that intentional killing of man, who is supposed to be the representative of the almighty is converse to the principles of Christianity. However, the ELCA admit the refusal of treatment by the health care professionals. This shall be done when it is confirmed that the risks and burdens outweigh the benefits. The physicians should conclude that artificially governed nourishment and hydration necessarily shall not improve the sick person's situation or avoid his demise. Further the competent sick and their authorized representatives or their close designated family members should have identified their desires, in such situation it could ethically be accountable to withhold, suspend treatment and permit demise to transpire. This acceptance is based on the veracity of the doctor, as it is strongly believed that the physicians work for conserving life of the sick. They need to take care of his health. It is believed that this liability includes the management of pain, which may even result in an earlier death. They also believe that physicians who feel that they are accountable towards the patient's health take efforts to select minor sin in adverse situations. However, this lenient approach is restricted to the circumstances mentioned above.¹⁵ Like any other churches, they condemn and oppose the legalization of physician-assisted death. As they strongly feel that the potential for abuse is huge. Public control and regulation is difficult and it can increase private killing of one person by another vulnerable people.¹⁶

3.2.8 Progressive View

However, some Americans express in the present age with advanced modern medicine and humane care facilities such mercy killings are no longer essential. However, the contemporary American traditionalists opine that assisted suicide

¹⁵ O. Russell, *Freedom to Die: Moral and Legal Aspects of Euthanasia*, 64-86 (1977).

¹⁶ *Ibid*

should be a matter of authorized, sanctioned individual option that they should be allowed to exercise. They thought that people of sound mind should exercise this option for themselves, and along with them the immediate family members who are taking care of those who are in a permanent mental vegetative state and unable to take a decision for themselves.¹⁷

3.3 Euthanasia in the European continent

There are different views prevalent in the European continent on euthanasia, or how to treat terminally ill.

3.3.1 Netherland Perspective¹⁸

In the entire world, Netherlands was the first country where active and passive euthanasia and assisted suicide was practiced in full swing.¹⁹ The Dutch accepted euthanasia since 1973.²⁰ They believed that, when it was inevitable to control suffering of a patient, they should not be made to suffer further. If they did so it was like penalizing that patient who was already going through hell. They believed in euthanasia with stipulations. The rules were rigid and applicable to patients with incurable condition, facing unbearable suffering.²¹ The doctors played a major role. They along with the physical condition had to verify the mental faculties of a person, who made death requests. Further, they had to observe certain guidelines when

¹⁷ <http://www.weeklystandard.com/content/public/articles/000/000/015/930uapms.asp?page=> Last visited on March 23rd, 2019)

¹⁸ In Netherland, euthanasia is regulated by the “Termination of Life on Request and Assisted Suicide (Review Procedures) Act”, 2002. It allows euthanasia and physician assisted suicide (PAS) in very specific cases. The law allows a medical review board to suspend prosecution of doctors who performed euthanasia when certain conditions are fulfilled.

Following conditions are necessary to be fulfilled:

The patient's pain and suffering must be unbearable with no prospect of improvement. The request for euthanasia by the patient's must be voluntary and persist over time (the request cannot be granted when under the influence of others, psychological illness, or drugs).

The patient must be fully aware of his/her condition, prospects and options. There must be consultation with at least one other independent doctor who needs to confirm the conditions mentioned above. The death must be carried out in a medically appropriate fashion by the doctor or patient, in which case the doctor must be present.

The patient is at least 12 years old (patients between 12 and 16 years of age require the consent of their parents). However, there are certain exceptional situations which are not subject to such restrictions of law as they are normal medical practice. These are (a) stopping or not starting a medically useless (futile) treatment, (b) stopping or not starting a treatment at the patient's request and (c) speeding up death as a side-effect of treatment necessary for alleviating serious suffering.

¹⁹ Helen Weyers, “Explaining the emergence of euthanasia law in Netherlands: how the sociology of law can help the sociology of bioethics”, 28 No.6, *Sociology of Health and Illness*, 802-816(2016)

²⁰ John Griffiths *Euthanasia and law in the Netherlands*, 307 (1998).

²¹ *Ibid.*

committing euthanasia. Further it was essential for them to take a second medical opinion before euthanasia was administered. This was carried by the Dutch not only because of tradition but also because of the “Postma case” of 1973.²² In this case the doctor had assisted the lady to smoothen the progress of her mother’s death after she had expressed frequent request to die.²³ The court's in this case, opined and set criteria when a doctor could terminate the life of a terminally ill. This laid down criteria which became a precedent in the cases to follow in the year 1980 and thereafter. However, this did not legalize euthanasia. It was illegal for new-born, critically ill patient under 12 years as they were held incapable to make life-or-death choice, late abortions were also banned. But definitely this led to more and more people receiving doctor-administered death. Doctors adhered to the guidelines of due care in all the cases.²⁴

3.3.2 Enactment of Law

A formal legalization was enacted by the Dutch parliament in 2001. “The Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002”²⁵ was introduced. It was made effective from first April, 2002. It legalized mercy killing and suicide with doctor’s aid in precise conditions and specific matters. The act to further safeguard the act made it mandatory to have a local evaluation commission. This commission comprised of physician, lawyers and the medicinal specialist. Opinion of committee was valued. The social factors such as loneliness, strained financial resources, and a loss of social skills were also to be considered before arriving at the decision. Thus there was a transformation in the understanding the subject. The clear in sights in the occurrence of euthanasia by the doctors with an aim to reduce the sufferings of the terminally ill was the major reason behind legalization. The act also

²² During this period, prominent proponents of euthanasia included Glanville Williams (The Sanctity of Life and the Criminal Law) and clergyman Joseph Fletcher (Morals and medicine).

²³ Ms. Postma was a doctor who terminated the life of her 78-year-old mother, who had been living in a nursing home and recovering from a cerebral hemorrhage. The deceased had made her desire to die known to both her daughter and the nursing facility staff. It was the first decision that, although not speaking directly to euthanasia per se, hinted that doctors who administer pain relievers in quantities likely to lead to death might escape criminal liability if they adhere to certain conditions i.e. the patient must be incurably ill; the suffering must be mentally or physically unbearable; there is an expressed wish to die; the patient is in the terminal phase of illness; and the person who accedes to the request is a doctor (preferably the doctor responsible for treatment)

²⁴ *Ibid*

²⁵ Jonathan Herring, *Medical Law and Ethics* 515(Oxford University press, 3rd edn.2010).

helped the medical fraternity. It increased the watchfulness of the doctors while performing life terminating acts.²⁶

3.3.3 France a progressive state

France does not legalize euthanasia. They do not have legislation for assisted suicide. At the same time suicide is considered a crime according to their legislation. “The Leonitte law of 2005” however allows the physicians to give pain-killing drugs that may have a side effect of reducing the life span, but it is illegal to administer drugs that may end life of the patient. Euthanasia in any form is illegal. Passive euthanasia which means to stop treatment of the patient has been done in most of the intensive care units of France.²⁷ This is done on consensus of the sick and his relatives who take care of him/her. This is performed in all cases where treatments and possible therapies fail to get the desired result making the condition intolerable for the patient. The Ethics committee also promotes the view that physicians should be given the authority to accelerate death in case the terminally ill urges and demands for his death and the patient is in a vegetative state. The debate on euthanasia has been reignited in 2013 when old couple commit suicide in the hotel room leaving a letter to be treated as a formal complaint for not respecting their right of liberty and the right to die with dignity. Georgette, Bernard Cases death has rejuvenated the supporters of euthanasia. Surveys conducted in France have shown broad support to euthanasia. Assisted suicide should be permitted to those suffering from incurable sicknesses. The French parliament also is considering presenting a bill in the parliament for legislation on euthanasia.²⁸

3.3.4 Belgium and Luxembourg an anti-euthanasia view transformed The history of Belgium, Luxembourg shows that it was not in favour of euthanasia. It has always opposed the legislation for euthanasia. This is basically because the majority of population is catholic. They strongly believe that it is God alone who has a right to decide when one’s life should end. Along with them the medical professionals also were not in favour of euthanasia. The proponents had to fight a strong battle for convincing people for euthanasia. Public debate was also held to pursue people.

²⁶ “Termination of Life on Request and Assisted Suicide (Review Procedures) Act”, 2002, Art 2.

²⁷ <http://www.nytimes.com/2005/04/14/world/europe/14iht-france.html> (Last visited on March 25th, 2018)

²⁸ *Ibid*

Initially euthanasia was administered only to the terminally ill patients. The steady expansion of euthanasia in the Netherlands has also helped in having legislation in Belgium.²⁹ In 2002 Belgium took the honour of being the second European country after Netherlands to formulate legalization on euthanasia. They administered it only to those who requested for it repeatedly.

The law allowed seriously and chronically ill people, suffering serious disabilities, suffering from anguish or mental illness, profoundly depressed” and those suffering with early dementia, to terminate their life. It was also made applicable to new-born babies who suffer disability. But to put into effect, the patients request, consensus of at least two physicians and board of specialist was mandatory. Thus, it allowed assisted suicide in rare and incurable cases only.³⁰

Now a days in Belgium even organ harvesting has developed with euthanasia. Organs of individuals are transplanted clinically for reuse. The medical fraternity largely supports it. It enables them to give life to a patient who would otherwise suffer death. This revolutionary change has been accepted from ethical, legal, and practical viewpoints in many countries that have legalized euthanasia. Here two requests are made from patients to administer euthanasia and to donate their organs after death.³¹

Luxembourg has followed the Dutch.³² It was not an easy task for them as it is primarily a state that follows Christianity. Further their medicinal fraternity was generally opposing the legalization as it was not easy for Luxembourg to have this change. In December 2008 parliament voted to legalize euthanasia, after a fervent public debate. Jean- Claude Juncker the then prime minister of the state pressed for the charter to be re-constituted. He opined that this shall enable Grand Duke Henri to pass an Act on the subject. This legislation for euthanasia and suicide with aid allowed patients in irretrievable situation to have a peaceful death. This act also emphasized on requisitions of patients to do so and along with that consensus of at least two physicians and board of specialist.³³

²⁹ Jonathan Herring, *Medical Law and Ethics* 518, 519(Oxford University press, 3rd edn.2010).

³⁰ *Ibid*

³¹ *Ibid*

³² <http://www.bbc.co.uk/2/hi/europe/73225520.stm> (Last visited on April 15th, 2018)

³³ *Ibid*

3.3.5 Italy- the controversial battle

Italy recognizes the terminally ill patient's authority to decline care and healing if desired. But at same time, it does not legalize euthanasia. There is no law in Italy pertaining to euthanasia. This has led to controversy and divided opinions in Italy. The politicians felt a need for legislation, after the court's decision in 2008 allowing Englaro who was in coma for about 20 years to remove her feeding tubes. The decision was a result of a 10 years legal battle by her father. However, the state's then Prime minister and the Vatican tried their best to intervene and oppose the request. However, her request had to be given results by shifting her to a private clinic, as the state prohibited the government hospitals from removal of life saving or health care devices. There was a difference of opinions among the senators, some agreed to expedite having a legislation to end life, while others were with the catholic view. The strong opposition from the Vatican Pope stating it is a false solution and assassination of a living being. They emphasized on life being a gift of god and therefore it has to be protected. They Laid emphasis on palliative care to reduce suffering and not treatment that would prolong life with undue suffering. The bishop suggested for more love to be given to such patients that would help them overcome the sufferings. Thus, the Roman Catholics were furious over the court's decision and prayed to god to forgive those who assisted her death. While the Cardinal Angelo Bagnasco, head of the Italian bishops, stated the necessity of a law that was for the good of the society. This had a mixed effect on the societal views. Subsequently there was flare in the debate on the subject again when a requisition for withdrawal of a machine was made in 2006 from a patient suffering from muscular dystrophy. This again led to bring about legislation for some form of euthanasia. But soon was brought to rest by the strong opposition of the catholic churches and a subsequent request from a 45-year-old sclerosis patient who expressed his desire to live in spite of the illness which had confined him to bed since 1998. The proponents upheld his desire and stated that those who have faith, it is essential for us to assist them to live to their religious values and hopes and also to assist those who don't have faith to recognize inspirational character. Thus, the regular controversial arguments for and against have not been able to have legislation in Italy.³⁴

³⁴<http://www.bbc.co.uk/2/hi/europe/73225520.stm> (Last visited on April 15th,2018)

3.3.6 Suicide tourism of Switzerland

Switzerland has a history of euthanasia. Since 1940, euthanasia has been illegal in Switzerland.³⁵ Assisted suicide with the help of physicians or without their involvement is legal in Switzerland. As a result, non-physicians have taken part in assisted suicide. An organization, named Dignitas which was set up in 1998 to assist people to end their life suffering with terminal illnesses is established in Switzerland. The organization supplies lethal dose of barbiturates to those who wish to terminate their life. These doses have to be taken themselves by patients. Many Europeans travel to Zurich because of Dignitas. Their staff works as volunteers. It has become a place where people who are disabled or depressed come to end their life. Further Switzerland does not have resident rules. Even foreigners who are critically ill can avail of this facility, which the state provides. Thus, suicide tourism has developed in Switzerland. Suicide entrepreneurs have opened pay suicide clinics where people from all over the world come to die. Suicide tourism is now not restricted to irretrievable patients but extended to those ones who desire. It is administered to people suffering with arthritis and mentally ill.³⁶ The Swiss Supreme Court upholds the constitutional right of assisted suicide for the mentally ill, Further it has been observed that an elderly couple from Belgium who didn't wish to live after the other had passed away was also allowed joint suicide. In another case U.K. parents took their quadriplegic son, who got crippled in a rugby accident, to Switzerland for suicide. Thus it can be said that there are no limits to which the Swiss suicide clinics can serve. Among the right to die organizations in Switzerland it is only Dignitas, in Zurich that accepts foreigners that are terminally ill or clinically sick, depressed beyond treatment. Swiss law is thus liberal; it punishes and prosecutes a person only if assists someone to commit suicide with a selfish motive.³⁷

³⁵ According to Article 115 of the Swiss criminal Code 311.0 "Any person who for selfish motives incites or assists another to commit or attempt to commit suicide is, if that other person thereafter commits or attempt to commits suicide liable to a custodial sentence not exceeding five years or to a monetary penalty".

³⁶ Subhash Chandra Singh, "Euthanasia and Assisted Suicide: Revisiting Sanctity of life" pdf Available at http://14.139.60.114:8080/jspui/bitstream/123456789/12413/1/010_Euthanasia%20and%20Assisted%20Suicide_Revisiting%20the%20Sanctity%20of%20Life%20Principle%20%28196-231%29.pdf (Last Visited on Sep 25th, 2017)

³⁷ *Ibid*

3.3.7 Sweden confirms patient's autonomy

Sweden approves Passive euthanasia. The doctors are allowed to halt life extending treatment to terminally ill patient if they wish strictly according to the new medical guidelines. The Swedish society of medicine levied these guidelines after a legal elucidation. In Sweden, the patient was given the right by law to decide when to terminate the treatment administered to him. At the same time, assisted suicide was punishable. To avoid the confusion the society approached the courts for a clarification in 2010. The ruling made passive euthanasia permissible on the patient's desire. The decision was given after understanding the whole situation and the probable consequences it would have if not permitted.³⁸

Swedish law emphasizes that the will of patients should be respected by the doctors. This can be done by doctors only when the sick are competent to take their own their own decisions. To enable them to take a right decision it is essential that the patients are intimated in detail about their prevalent situation and also have been told about the options available to them. "The Swedish Society of Medicine", now confers a great responsibility on Swedish doctors. Though passive euthanasia is allowed actively assisting someone to die, with lethal injections or by force still remains unlawful in the state.³⁹

3.3.8 Discordant altitude towards euthanasia in Spain

Euthanasia is illegal in Spain. The intensely discordant political and spiritual views about the subject in Spain has not been able to have legislation in the state. The Spanish Catholic Church criticizes euthanasia as immoral and antisocial. The person who assists people to end their own life can be tried and found guilty of manslaughter. According to them it is inhumane, immoral and an antisocial act. However, the Law of Patient Autonomy confirms the independence of the patient and the patient's authority denying medicinal care. Since 2002 patients have a right to deny it so. It is accepted in Spain. They believe, it is not a crime as the patient passes away because of his or her sickness. The Socialist government of Spain wants to legalize it. They

³⁸ <http://www.bbc.co.uk/2/hi/europe/73225520.stm> (Last visited on April 15th, 2018)

³⁹ *Ibid*

want to regulate the rights of patients, family members, and their doctors and also help the terminally ill patients to die without suffering. Though the opinion polls conducted reflect a strong support, Spain has been shaken by accusation of sedations resulting in untimely demises of their incurable patients. Pursuant to this in 2005 many doctors underwent investigation by regional health chief. The process continued till 2008, all doctors prosecuted were held not guilty but this restricted many doctors from sedating patients for fear of court action. The government also intends to regulate the palliative care of the terminally ill.⁴⁰

3.3.9 Germany recognizes patient's right of autonomy.

Euthanasia is illegal in Germany. However, since 1751 physician-assisted suicide is legal. During the Hitler's rule the removal of those who are unfit to live and those who produce inferior offspring had no right to survive. The Nazi regime principles of racial hygiene, racial purity, and national health had also continued. These were considered useless in German society, a threat against the Aryan purity and therefore were deemed unworthy to live. Honour killing was a norm in Germany due to the agenda of Nazis. Killing the vulnerable by them could be termed as euthanasia. This had tapered down with the downfall of the Nazis. There was no law on assisted suicide, as it was believed that physicians cannot violate the professional code of conduct and cannot breach their legal obligation to save life. Due to this many patients travelled to Dignitas to seek assistance. In view of this Dignitas, the Swiss organization, decided to open their first office abroad. They selected Germany to be their destination. The area office proposed only to offer assistance to those who desired to end their life. The office gave the required information and recommendation to assist people in their act. However, they had the authority to give medication to terminate life. This raised strong arguments, debates in Germany.⁴¹

“The German Society for Dying with Dignity” accepted the proposal of having an office of “dignitas” in Germany but it was observed that there were many who opposed it. More than half of the populace believed in escalation, enhancement in hospice care and development in palliative care. The German medical professionals also unanimously opposed the movement. A former Hamburg Justice Minister Roger

⁴⁰ *Ibid*

⁴¹ <http://www.bbc.co.uk/2/hi/europe/73225520.stm> Last visited on 15.04.18 at 4.00 p.m.

Kusch campaigned for assisted suicide. He suggested that the terminal sick individual should be fasten with two controlled intravenous injections injecting aesthetic and mortal matter simultaneously to enable a peaceful death of the patient. This movement was strongly opposed by the medical fraternity and the religious heads.⁴²

It is now legal in Germany, only to give life-shortening, drugs to a patient who has given their written consent. German medical professionals are also supposed to respect a patient's written consent. They are not into giving such patients advanced life-saving medical treatment.⁴³

3.3.10 Changing perspective of the United Kingdom.

United Kingdom does not recognize euthanasia.⁴⁴ Any active participation taken to end another's life with consent or not, is illegal. It is considered as murder or manslaughter. Imprisonment up to 14 years can be pronounced in case of assisting suicide.⁴⁵ Since, the "Human Rights Act", 1998 has been enacted, the proponents propagate that refusing a patient to relieve himself from the torturous miseries he suffers is inhuman. According to the European Convention on Human Rights, it amounts to violation of the right of privacy autonomy and demeaning the medical care given to the patient. The Suicide Act 1961 in United Kingdom declares suicide as legal. The campaigners submit that the legality of suicide amounts to discrimination. The denial of euthanasia means denial of an individual's inherent 'right to die' and live a dignified life. Hence, violation of rights according to the current legislation. However, in a landmark judgment pronounced in Airedale case 1993⁴⁶ by the House of Lords which allowed removal of life-saving care. The ruling allowed 'assisted suicides' that involve 'omissions' by the physicians. Then after the ruling was applied in many cases and has set the law in case of incompetent patients. The doctors are permitted to withheld treatment or withdraw machinery that was keeping the patient alive if that was the best thing to do for the sick.⁴⁷ The decision was also based on 13th Century principle; it is the onus of the state to take care of its subjects. This theory included protection of property and the individual in case they were incompetent to take care of themselves. The Court is a wing of the State, it has

⁴² *Ibid*

⁴³ *Ibid*

⁴⁴ Louis Bloom Cooper, Gravin Drewry, *Law and Morality*, 201-207 (1976).

⁴⁵ Michael Davies, *Medical Law* p. 343 (Oxford University press, 2nd edn. 2009).

⁴⁶ Airedale NHS Trust v. Bland 1993(1) All ER 821 (HOL)

⁴⁷ *Ibid*

therefore inherent jurisdiction which formerly belonged to the Kings. It is they who can therefore decide. Due to this there has been change, since 1993 it is not regarded as a crime. Omissions or actions to remove life-saving care are legal but active euthanasia is not approved. The Welsh and Scottish made clear division amongst the types of euthanasia. Passive euthanasia was permitted. The law in England, Wales and Scotland prosecutes a person assisting suicide or death as murderer.⁴⁸

In 2007, a bill was proposed in the Scottish Parliament, when Diane Pretty fought to permit her to assist her husband end his life, who was suffering from terminal motor neurone disease. A Scottish politician Margo MacDonald in the year 2008, suffered from a disease called "Parkinson's". She expressed his wish to terminate life in case his situation worsened to the extent where there is no revival. She organized open discussions on the issue of right to end life with assistance. In 2008 Keir Starmer QC, Director of Public Prosecutions, signalled that people who helped shall not be prosecuted. He did not prosecute Daniel James; a rugby player's parents who took him to Dignitas However the efforts made to convince the courts in this respect have failed. Active euthanasia thus remains illegal.⁴⁹

3.3.11 Awaiting, a legislation on euthanasia

Norway

Euthanasia is illegal even if it administered with good intentions. A charge of accessory to murder is levied on the person helping a patient to die. A Norwegian physician fought a long battle for legalization but in vain. The association for a dignified death is making representations for a change in the laws.

Finland

The term euthanasia not recognized in Finland. And hence there is no legislation in Finland for euthanasia. According to the Finnish legislation suicide is not an offence. Any competent person whether healthy or not can commit suicide. Further the legislation is silent about assisted suicide. An assister can assist for suicide and be safe from any kind of prosecution. It has been observed that the assister many of the times himself inform the law enforcement authorities about the assistance. Therefore,

⁴⁸ Available at <https://www.thesun.co.uk/news/1768769/euthanasia-law-uk-mercy-killing-debate-assisted-suicide-latest/> Last visited on March 23rd, 2018)

⁴⁹ *Ibid*

passive euthanasia prevails in Finland on the final choice of the person. The practice usually involves providing with sleeping pills or drugs asked for. Euthanasia now is an acceptable alternative for Finnish hospice care doctors if there is no revival. Cases where there is no resort and death is inevitable the doctors prefer it as an option. Euthanasia is thus gaining importance but yet time has not arrived for its legislation.

Poland

Poland condemns euthanasia. Being primarily Catholic country euthanasia is held to be an illegal act. Euthanasia in any of its type is not acceptable and considered illegal. It is not that the churches are against it but the medical fraternity also has strongly objected the same, thus there are no laws like the other states in the continent. The doctor's job is to save and assure human life if allowed to administer euthanasia people would lose faith in the savior and his actions. Hence euthanasia is morally and socially opposed.

3.4 Euthanasia in the Australian Continent

Australia is the smallest of the seven conventional continents. It comprises of Australia, Tasmania, New Guinea, Seram, Timor, and the adjacent isles. In Australia, euthanasia is not recognized. It is unlawful; it is a crime to assist in euthanasia. It is a criminal offence, according to the criminal legislation of Australia, charges of murder or manslaughter are levied on those who administer or assist euthanasia.⁵⁰ Although it is a crime, it has been observed that, prosecutions have been rare in Australia. In spite of all this the Australian law prohibits a doctor from acting on an appeal made by the vulnerable patient to have a peaceful death. It has twofold result of quickening person's demise and relieving him from the miseries of life. It has been observed that in Australia this is permitted even where the law permits a physician to offer palliative care to relieve an individual from pain and suffering.

3.4.1 Support for Euthanasia⁵¹

It is observed that majority of them are in support of euthanasia. The Australia Institute data of Nov 19, 2012 states that 70.6 per cent agree that euthanasia should be

⁵⁰ O. Ruth Russell *Freedom to Die: Moral & Legal Aspects of Euthanasia* 361-364 (1997).

⁵¹ The Australian Voluntary Euthanasia Society 'which was formed in October 1973, started publishing an AVES Newsletter in March 1974. Since then, the organizers, principally Jenny and Tom Parramore, have worked vigorously in many parts of Australia holding discussion meetings and organizing societies. Their stated aim is: To create a public opinion favorable to the view that an adult person, suffering, through illness or disability, severe pain or distress for which no relief is available, should be entitled by law to the mercy of a painless death if, and only if, that is his expressed wish; and to promote legislation to this effect.

legal. They insist that it has to be permitted with the assistance of physicians only, and should be allowed to help a person suffering from non-relievable and incurable disease. Euthanasia consequently exists as topic of ethical, spiritual, theoretical lawful and civil rights discussion.⁵² The inherent right to live has always been a challenge to vulnerable individuals who desire to die with self-respect. Several efforts were taken by legislature to make euthanasia lawful in various parts of Australia. However, Australia has always experienced strong opposition from a vocal minority. It has been observed that the, political leaders have therefore feared it and do not encourage to make it legal. They are extremely reluctant to act.

3.4.2 The Voluntary Euthanasia Bill 2012

An attempt by the legislature was made in form of a bill viz. “The Voluntary Euthanasia Bill 2012”. The Bill proposed voluntary euthanasia to be legal. If a vulnerable competent major who was able to take decisions requested for euthanasia on his own desire. Further, the proposal, also mentioned that administration and prescribing of drug, to end life was allowed. Similarly, inactions done for releasing life or retreating life support system was also acceptable. The bill also protected the, physicians and all the persons aiding the terminally ill patient in performance of euthanasia on their wish. They could not be prosecuted criminally nor did any civil liability accrue on the said act. However, the South Australian Parliament was not able to put into practice a law for euthanasia in their state. At present, mercy killing remains unlawful.

3.4.3 Northern Territory of Australia

This territory legalized euthanasia for a short span. In fact, it was the Northern Territory of Australia which has received the honour to legalize voluntary euthanasia for the first time in the world in July 1996. The legislation came to effect on 1st of July 1996 but lasted only for nine months. The majority of the revolvers were Catholic; they had made up their mind to knock over the legislation of the northern territory of Australia. To achieve their goal, they did not vest any power with the legislative assembly of the state. Hence the Act got repealed in March 1997 by the Federal Parliament. Today euthanasia is illegal in all states and territories of Australia.

⁵² K.D. Gaur, *Criminal Law: Cases and Materials*, 271 (2005).

Though this is the situation Australians strongly believe that terminally ill patients, with the assistance of the doctors should be allowed to die peacefully. They want their rights to make end of their life, restored through legislation.

Southern Australia

A number of reviews, assessments were organized in South Australia, to understand the approach and experiences, of health professionals towards euthanasia in practice. It has been observed that around 50% of the physicians examined have shown their willingness for legalization of euthanasia. In New South Wales majority supported for change in law to allow euthanasia. Similarly, a research was conducted amongst the Victorian nurses. It was observed that three fourth of the population surveyed were in favour of legislation that permitted the physicians to execute euthanasia. Amongst the said population 65% of the health care takers showed their willingness to participate in euthanasia if legalized. One more analysis of the research conducted on Victorian nurses who were basically indulged with the patients suffering from cancer and their palliative care also revealed that near about 40 % of them were in favour of legalizing euthanasia. They were also ready to help the doctors in performing euthanasia.⁵³

Additionally, it can be said that 50 per cent of the populace in the state were in favour for legislation, which could facilitate the physicians in taking measures to end the vulnerable life. This states that, medical professionals see a lot of sadness and unnecessary suffering. They genuinely feel that if euthanasia was legal, doctors would euthanize under instruction in the right circumstances.⁵⁴

3.4.4 The Dying with Dignity Bill 2009

A bill was introduced in 2009 in the Tasmanian parliament. The bill laid a provision of permitting the irretrievable sick people to terminate life on an appeal to the physician. The bill also stated that the doctor had to do so before the expiry of the 10th day when the desire was expressed to the physician. The proposed bill was introduced with stringent measures to avoid the possible misuse.

- The patient who requested euthanasia had to be above 18 years of age.

⁵³ <http://www.exinternational.net/page/australia> (Last visited on May 18th, 2018) at 4.00 p.m.

⁵⁴ *Ibid*

- The request made had to be verified by quite a few medical practitioners.
- Psychiatrist had to assess the patient's mental competency while taking the decision.

But the bid to introduce voluntary euthanasia legislation was rejected by the Tasmanian Parliament. This was basically because of the strong antagonism, resistance from the Anglican Bishop and the Catholic Church. They also manoeuvred the MPs of Tasmania to vote against the bill, mentioning it would cause great harm to the people of Tasmania. The objection was based on that it was only God who had the right to take away life. Intervention by any other person in the path of life and terminating life was condemned, and considered as a path to death. They were successful in their object. The MPs voted against the bill. The proponents have again forwarded a bill in 2014 to confirm the right of those suffering from an incurable illness and experiencing unbearable pain. They have urged for the aid of the doctor or a physician to end their life. This request made is solely with an aim to let themselves die with dignity. They also consider it necessary on humanitarian ground. However, the Prime Minister of the state has not considered this move. He does not favour the physicians support for permitting euthanasia with doctor's aid.

3.4.5 The religious approach towards euthanasia

Australia being a Christian dominant continent, the move towards euthanasia has been negative. The Christians believe life is given by God and humans are his images. Therefore, interference in life is strongly condemned by the churches. For them no one has the authority to interfere the progression of dying. It should not be disturbed in any case. Further they valued all the human lives and their inherent dignity equally. For them intelligence, achievements in life, mobility, utility were not the criteria to value life or dignity of a person. The Roman Catholics were also against euthanasia and held it morally wrong. They constantly preached and spoke about the commandment "You shall not kill". May it be a fetus, child, adult, old or a terminally ill, killing was banned. Pope John Paul II stressed that life was valuable and its measure cannot be decided on the wellbeing of a person and pleasure it brings. Therefore, suffering and pain could not be the cause of terminating life. According to them, each individual and all the people surrounding them should experience the course of dying with all its obscurity having faith in God. If they do so they would be said to die with dignity and loved unconditionally. Though they believe in human's

freedom they do not accept that it extends, to take an end of life decision. If allowed it shall overpower the Gods absolute supremacy of life and death.

3.4.6 Libertarian view on euthanasia

A minority Libertarian eloquent group but have always strongly supported euthanasia. They believe that it is nothing holy or to be blessed about having a human life. It is ethically insignificant to feel honoured about it. The value that humans possess are to be determined on the loss it would cause to him. Euthanasia therefore should be permissible for those terminally ill whose live's value has been insignificant. They also believe that killing such individuals or allowing them to die is one and the same. The intentions behind the act and its effect are always the same in both the cases. The distinction believed by people is a misnomer. Thus, they do not differentiate between passive or active euthanasia and state to be morally equivalent.

3.4.7 Medical fraternity outlook

The Australian medical practitioners believe in euthanasia. It has been observed that majority of doctors and nurses support and consider that they must be permitted in taking active measures to terminate the patient's life when they foresee the inevitable death of a patient. Before doing so they also feel it essential to take the consent of the patient and his relatives who care for the patient. Thus, the Australian community of doctors is evidently in support of voluntary active euthanasia. In spite of it till date they do not have legislation for euthanasia. The Australians thus believe that they are still backward in their approach towards Euthanasia as it is legal in many other countries. The illegalization in Australia is now forcing the citizens to travel abroad to get life ending drugs and thus adding to their stress of an already hard end of life. The proponents strongly believe that they are worthy of having a right to choose freely whether the incurable illness should make their lives a living hell. They also insist that they should be allowed to indicate beforehand their decision so that the illness does not make them undergo a living hell.

3.5 Euthanasia in the African continent

Euthanasia is a topic of debate in this continent too. The subject came in limelight in the year 2000; when "President Nelson Mandela" projected the end of life decisions.

He proposed to the then Law Commission to table a bill “End of Life Decision Act”. The bill proposed to give legal rights to the physicians to terminate life on the requisition of the patient. The doctors were allowed to administer a lethal dose or discontinue the treatment of a patient on certain conditions. The bill also allowed the patient to refuse life sustaining medication to which the physician ought to respond. Thus, the act provided for active euthanasia as well as passive euthanasia with assistance of physicians. However, the bill did not get the desired support and never went further. The most vocal group opposing the legislation was the ‘Doctors for Life’ organization, which questioned the practical enforcement of it in the state. They also pointed the poor functioning of the police and justice system. They apprehended the slippery slope and abuse of law in country rather than the usage of the law.

3.5.1 Religious view about euthanasia

African community believes in religious humanism. Human life is sacred and all that there is, is said to have its source from God. The people from Tiv, Nigeria, Ghana etc. call it as Aondo. They do not wish to surrender their control of their lives and hand it over to others. They do not believe in self-destruction and direct their hostility outwards rather than inwards. For them life is callous, hard. And religion and family safeguard self-destruction in any form. Further, they believe that when a person passes away, the soul passes to the world of the ancestral spirits where it persists to live. But if one commits suicide it turns into an evil spirit.

The Constitutional era in South Africa has shown that human rights have taken preference over moral, ethical beliefs. But still Euthanasia is marked as illegal in South Africa, and the law is silent. Intentional termination is considered as murder. Due to the apprehension of exposure to civil claims, criminal prosecution or professional censure some physicians are practising it secretly. The judicial trend in the continent depicts that a person suffering from terminal illness with no hopes of recourse should be allowed to end life. This has to be done by withdrawal of sustenance gadgets that keep the individual alive but in an unconscious state.

3.6 Euthanasia in the Asian continent

3.6.1 Scope for change in approach in Japan

The Japanese tradition does not permit them to speak about death and dying. Active euthanasia is not permitted in Japan; it is not socially or legally accepted in Japan. The conservative approach of the society is the major cause. Japan has no specific rules guidelines for euthanasia. The recent judicial judgments in Japan which has allowed passive euthanasia are responsible for the change. Individuals in Japan think that they should be able to have death with dignity. It now approves euthanasia only for those sick people who are suffering with an ailment where death is about to happen and there is no recourse possible.

Secondly, the patient's request for it is essential. This consent has to be obtained specifically after being informed about his health status. Thirdly, the medical professionals identify the real intention of the patient. Fourthly, the doctors should withdraw treatments in terminal phase for facilitating death with dignity. Though the instances are rare, there is a hope for the change. In spite of the complicated taboos on suicide, death and dying euthanasia is prevalent in the state.

3.6.2 China following the footsteps of Japan

The Chinese traditions are similar to the Japanese, speaking about death is a social taboo and the thought of it or mention of the word is considered as ill-boding. They believe that death, is a natural thing and no one has a right to interfere with it. The Confucianism belief which has a great impact on the Chinese culture lays emphasis on supporting their parents till they die. If not, it is considered as unfilial, that is disrespecting their parents. This has made the legislation of euthanasia in China a religiously heated debate. The opponents laid emphasis on improving palliative care rather than administering euthanasia. Proponents however have a different opinion regarding the need of legislation. They wish to die with dignity rather than to put up with the serious diseases. Euthanasia is widely accepted among intellectuals, common man and physicians. They are in favour of legislation of euthanasia. They submit that an individual should be well-informed about his status and allowed to take a rational decision about her own life.

3.6.3 The National Health Act 2007 of Thailand

In the Thai society which is primarily Buddhists, euthanasia is not legal and would probably not be legalized. Euthanasia raises many ethical and moral questions and therefore has been an unaddressed issue. But the Thai society has been changing; people are now more involved and aware about their human rights. The National Health Act 2007 has allowed a person to express his desire in writing to refrain from receiving health services, if they are in the final stages of life. Thus, passive euthanasia is permitted in Thailand if the patient consents.

3.6.4 Malaysia, a staunch opponent of euthanasia

Euthanasia is considered a crime. It is illegal. Being a Muslim country, it strongly condemns euthanasia. Malaysians believe that life is given by Allah and therefore it is he who only has the right to take it away. In case if any one deliberately hastens the death of another, they are charged with an offence of murder. The hastening of death amounts to culpable homicide if done with consent, and murder if done without consent. Thus, the law of the state precludes termination of terminally ill patient.

3.6.5 Euthanasia in the gulf

All the gulf countries do not recognize euthanasia. It is highly criticized, condemned by all these countries. Considered as a crime and punished for with life imprisonment. The states of Saudi Arabia, Dubai are against legislation on euthanasia. The populace thinks that it cannot be and should not be introduced as a legal practice. The dominance of the Muslim community in the gulf is the reason behind this strong rejection. They are evidently against the practice of euthanasia. For them Allah is the one and only one creator, life is the sacred gift of the creator and therefore it is only him who could put an end to our lives. According to them taking life means, disobeying him, showing disrespect to him. They believe that when you suffer, Allah tests you to bring in good for you. Further, it is accepted as true by the Muslims that, Allah has forbidden them from causing harm to their bodies or even killing themselves, as it really does not belong to them but Allah. Thus, no one can commit a suicide or assist any one in doing so as both are sins according to their religion. It is “haram” to support euthanasia, it is unlawful. Further they point to the cases of errors,

where the doctors have certified no recourse or cure and still miracles have taken place. They therefore forbid from ending life, which does not belong to humans. Apart from these perspectives, they feel that legalization of euthanasia might lead to undermining the efforts taken by the physicians and nurses. This also promotes lacking of faith in the almighty. As you succumb to the ailment you or the relatives think of ending it without having trust in god. It is further apprehended by them that the health authorities shall cut cost and use the medical facilities to the others. Thus it has been observed that the gulf has all the possible reasons of negation for euthanasia.

3.6.6 Euthanasia: Indian Perspective

India has been known for its unique characteristic of diversity. This diversity in India prevails because of its secular nature. The state respects all the different religions, communities, their culture and dialects. This plays a vital impact on the thought process of an individual in India. However, it not just the religion that influences once approach towards the subject but even the educational qualifications, his exposure to the outside world matter a lot. Euthanasia is a very old issue, with its roots in classical thinking. Throughout the course of history, however, it has been understood differently. In recent times the concept of Euthanasia has become increasingly under the spotlight due to the ongoing ethnicization of medicine. There are several other compounding factors making the issue of Euthanasia a pressing problem for contemporary society. One can expect that the controversy surrounding the moral acceptability of Euthanasia and legalization of all forms of Euthanasia will remain a challenge for our ageing societies in the twenty first century. On this background, euthanasia in India can be discussed from various angles.⁵⁵

3.6.6.1 Euthanasia in India: The Philosophical and Historical Perspective

According to Hinduism and Buddhism, human beings are captured in endless cycles of rebirth and reincarnation. The ultimate goal of mortal life is to achieve moksha or liberation from the cycle of death and rebirth. The fasting to death, is an acceptable way for a Hindu to end their life only in certain circumstances, provided, it is non-violent and occurs at the right time for this life to end i.e. when the body has served its purpose and becomes a burden. Prayopavesa is only for people who have fulfilled

⁵⁵ www.ij11js.in (Last visited on March 24th 2018).

their purpose, who have no desire or ambition left, and no responsibilities remaining in this life.⁵⁶

While suicide is often associated with feelings of frustration, depression, or anger, prayopavesa is associated with feelings of serenity and fulfilment. Jainism also allows a follower with full consent to put an end to his or her life, mostly by fasting, if he or she feels that moksha can be achieved that way. Muslim, Christian and Jewish laws are against euthanasia. They believe that all human life is sacred because it is given by God, and human beings should not interfere in this.⁵⁷

3.6.6.2 Ethical and Conceptual view of Euthanasia in India-

Ethical dilemma arises in the cases where two or more justifiable courses of conducts are available in a given set of circumstances. Euthanasia is one of the areas where we find such dilemma due to the presence of more than one courses of conduct that are justifiable on various grounds. No religion in India advocates for deliberate shortening of life. Thus, from ethical point of view, euthanasia is a moral sin in India because we believe that “God” is the author of life and no one else has a right to take it.⁵⁸ In India, on one side, life of a person has always been considered as most sacred of all as per its scriptures but on the other hand the same scriptures mention practices like Jauhar, etc. Jauhar was the Hindu custom of mass self-immolation by women in parts of the Indian subcontinent, to avoid capture, enslavement and rape by invaders, when facing certain defeat during a war. Even in Mahabharata, Bheeshma had a boon to live as long as he wished but then why is he allowed to die on a death bed of arrows as Pandavas watch him die, is it not suicide? Or murder. The Mahabharata refers to the Pandavas and Draupadi who gave up their kingdom and embarked upon ‘mahaprasthanas’ (the great departure) to meet death.” The notion of Kashi yatra and ‘mahaprasthanas’ must be understood in the same sense of surrender and abdication of power and authority. The concepts of samadhi and nirvana too form part of the heritage of Indian thinking.

The proponents of euthanasia argued that merely because these words don’t exist in the English dictionary doesn’t mean that they don’t exist at all for the people

⁵⁶ www.bbc.co.uk (Last visited on March 24th, 2018)

⁵⁷ Supra note 1 15.

⁵⁸ www.ncbi.nlm.nih.gov (Last visited on March 24th, 2018)

of India. For instance, the Manusmriti says: When a householder finds himself wrinkled and grey and when he encounters his grandchildren appear on the stage of life, he should ungrudgingly walk into wilderness. Indian scriptures indicate that the practice of voluntarily opting for death at a particular stage in life was integral to Indian Tradition.⁵⁹

3.6.6.3 Euthanasia and Suicide

Suicide and euthanasia cannot be treated as one and the same thing. They are two different acts. Therefore, we shall have to make a distinction between ‘euthanasia’ and ‘Suicide’.

Suicide as mentioned in Oxford Dictionary means the act of killing yourself Deliberately. Many ancient texts including the Bible, the Quran and the Rig-Veda mention self-destruction or suicide. In India, the history of Vedic age is replete with numerous examples of suicides committed on religious grounds. The Mahabharata and the Ramayana are also full of instances of religious suicides. Therefore, suicide could be termed as the intentional termination of one’s life by self- induced means for various reasons, such as, frustration in love, failure in examinations or in getting a good job, but mostly it is due to depression. Euthanasia has not been defined in the religious books but since it is very close to concept of suicide, therefore it can be presumed that it is prohibited by all religions. In Indian law intention is the basis for penal liability. An act is not criminal act if it is committed or omitted without the intention and law of crimes in India is based on the famous Roman maxim, “Actus non facit reum nisi men sit rea.” Now applying the above maxim in cases of Euthanasia one may conclude that since the victim has given the consent to die therefore, the accused is not liable for any offence. But does giving a consent for killing a person absolve the offender from his criminal liability is very important question. If answer to this question is in affirmative then euthanasia is not an offence. But the Indian law is very clear on this point. One may argue that giving the consent absolves a person from liability or he may plead the defence of “volenti non fit injuria.”

⁵⁹ www.iosrjournals.org (Last visited on March 24th, 2018)

Law relating to consent contained in Indian Penal Code is very exhaustive and leaves no ambiguity to explain it.

Section 87 of the Indian Penal Code⁶⁰ clearly lays down that consent cannot be pleaded as a defence in case where the consent is given to cause death or grievous hurt. The Bombay High Court in *Maruti Shripati Dubal case*⁶¹ has attempted to make a distinction between suicide and euthanasia or mercy killing. According to the court the suicide by its very nature is an act of self-killing or termination of one's own life by one's act without assistance from others. But euthanasia means the intervention of others human agency to end the life.

3.6.6.4 Euthanasia and Physician Assisted Suicide (PAS)

PAS means that the physician does not directly kill the patient but provides the means or prescribes the drug which is taken by the patient himself. In other words, the doctor merely assists or aids the patient in committing suicide. Those who attempt to draw a moral line between the practices often emphasize that the patient exercises more control in assisted suicide, remaining the final causal actor in his or her own death, while in euthanasia another person assumes that role, thus creating a greater chance for physician malfeasance.⁶² Yet, morally, in cases of assisted suicide and euthanasia alike, the patient forms an intent to die and the physician intentionally helps the patient end his or her life. 'Though an analytical distinction exists between assisted suicide and euthanasia, there is a great deal they share in common, and those who support legalizing one tend to support legalizing the other for the same or similar reasons whether it be out of a sense that fairness requires killing those who wish to die but who cannot kill themselves, a desire to promote individual autonomy whether it is expressed in terms of a desire to kill oneself or have another do so, or a sense that the actions serve a similar social utility in allowing patients to avoid needless suffering. In Dutch practice both are legal and they are "considered to be identical because intentionally and effectively they both involve actively assisting death. The physical

⁶⁰ Indian Penal Code, 1860 (Act No. 45 of Year 1860) S.87

⁶¹ *Maruti Shripati Dubal v. State of Maharashtra*; 1987 Cri.LJ 743 (Bomb).

⁶² J. See, e.g., John Deigh, "Physician-Assisted Suicide and Voluntary Euthanasia: Some Relevant Differences". *J. Crim. L. & Criminology* 1155, 1157-59 (1998); Timothy E. Quill et al "Care of the Hopelessly 111: Proposed Clinical Criteria for Physician Assisted Suicide," 327 *New Eng. J. Med.* 1380, 1381 (1992). Cited in Neil M. Gorsuch, *The Future of Assisted Suicide and Euthanasia*, 6 (2006).

difference, too, between assisted suicide and euthanasia certainly need not be, and frequently is not very great. As John Keown has asked what for example, is the supposed difference between a doctor handing a lethal pill to a patient; placing the pill on the patient's tongue; and dropping it down the patient's throat?" For Yale Kamisar, the benefit of PAD was expeditious relief from "utilitarian obstacles"-abuse of vulnerable patients in the administration of PAD and unsavory extensions of PAD beyond the realm of voluntary active euthanasia of competent patients nearing the end of a painful dying process. These predicted abuses would take the form of "unwilling or manipulated deaths of the most vulnerable members of society."⁶³ Some abuse would flow from medical mistake in diagnosis or mistake in assessing the competence of patients seeking PAD. Kamisar wondered how stricken patients facing terrible stress, pain, or effects of narcotic no analgesics could possibly make careful, considered judgments about PAD.

The Supreme Court in *Gian Kaur v. State of Punjab*⁶⁴ clearly held that euthanasia and assisted suicide are not lawful in our country. The court, however, referred to the principles laid down by the House of Lords in *Airedale*⁶⁵ case, where the House of Lords accepted that withdrawal of life supporting systems on the basis of informed medical opinion, would be lawful because such withdrawal would only allow the patient who is beyond recovery to die a normal death, where there is no longer any duty to prolong life.⁶⁶

3.6.6.5 Legal Extent of Euthanasia in India-

After discussing the legal position of right to die and euthanasia in various countries, we shall now discuss the law in India on the subject.

Section 300 of IPC and Euthanasia:

Euthanasia is unlawful under Indian Penal Code (IPC). There is an intention on the part of the doctor to kill the patient, therefore, such cases would clearly fall under section 300(1) of the Code⁶⁷. Section 300, IPC defines culpable homicide amounting to murder.

⁶³ *Ibid*

⁶⁴ *Gian Kaur v. State of Punjab* 1996 (2) SCC 648: AIR 1996 SC 946.

⁶⁵ *Airdale NHS Trust v. Bland*, 1993(1) All ER 821 (HL).

⁶⁶ www.indiankanoon.org(Last visited on March 24th, 2018)

⁶⁷ Indian Penal Code, 1860

The word 'homicide' means to cut or kill. Therefore, it means killing of a human being by another human being. Homicide is divided into two categories: lawful homicide and unlawful homicide. Lawful homicide consists of general defences contained in Chapter IV of IPC, whereas unlawful or culpable homicide is defined under section 299, IPC. This, culpable homicide can be of two types:

a. Culpable homicide amounting to murder (defined under section 300, IPC and punishable under section 302, IPC) and

b. Culpable homicide not amounting to murder (punishable under section 304, IPC).
The culpable homicide not amounting to murder covers two cases:

i. Cases covered under section 299 but not covered by section 300, and

ii. Cases covered under any of the five exceptions given under section 300, IPC.

Section 299 of IPC and Euthanasia:

Section 299 of the Indian Penal Code, 1860 reads as follows:

Sec. 299: Culpable Homicide:

Whoever causes death by doing an act with the intention of causing death, or with the intention of causing such bodily injury as is likely to cause death, or with the knowledge that he is likely by such act to cause death, commits the offence of culpable homicide.

Explanation 1: A person who causes bodily injury to another who is labouring under a disorder, disease or bodily infirmity, and thereby accelerates the death of that other, shall be deemed to have caused the death.

Explanation 2: Where death is caused by bodily injury, the person who causes such bodily injury shall be deemed to have caused the death, although by resorting to proper remedies and skillful treatment the death might have been prevented.

Explanation 3: The causing of the death of child in the mother's womb is not homicide. But it may amount to culpable homicide to cause the death of a living child,

if any part of that child has been brought forth, though the child may not have breathed or been completely born.

Exceptions of Section 300 and Euthanasia

Section 300, IPC defines murder in the following words:

Except in the cases hereinafter excepted, culpable homicide is murder, if the act by which the death is caused is done with the intention of causing death, or

Secondly- If it is done with the intention of causing such bodily injury as the offender knows to be likely to cause the death of the person to whom the harm is caused, or

Thirdly- If it is done with the intention of causing bodily injury to any person and the bodily injury intended to be inflicted is sufficient in the ordinary course of nature to cause death, or Fourthly- If the person committing the act knows that it is so imminently dangerous that it must, in all probability, cause death or such bodily injury as is likely to cause death, and commits such act without any excuse for incurring the risk of causing death or such injury as aforesaid.

There is a fundamental principle of criminal jurisprudence that is contained in the maxim “actus non facit reum, nisi mens sit rea” which means “the act does not make a person guilty unless the mind is also guilty”. Therefore, every crime has two elements:

(i) actus reus.

(ii) mens rea⁶⁸

Actus reus in ‘conduct crimes’ (e.g. abetment of an offence, perjury, possession of drugs or a firearm) means the act or conduct of the accused whereas actus reus in ‘result crimes’ (e.g. murder) means the consequences or result of the act of the accused. Mens rea means guilty mind. Whereas actus reus is the external element, mens rea is the inner element. The concurrence or coincidence between the two is a necessary requirement to constitute a crime. It should be noted that the term actus reus is not defined in IPC. Though a reference to it has been made in section 32 and section 33, IPC as follows:

⁶⁸ www.thefreelibrary.com ((Last visited on March 24th, 2018)

Section 32: In every part of this Code, except where a contrary intention appears from the context, words which refer to acts done extend also to illegal omissions.

Section 33: The word “act” denotes as well a series of acts as a single act: the word “omission” denotes as well as series of omissions as a single omission.

Therefore, the term ‘act’ means and includes:

- an act,
- illegal omission,
- series of acts,
- series of illegal omissions,
- partly act, partly illegal omission.

As stated earlier, murder as defined under section 300, IPC, is a result crime. Therefore, the actus reus of murder is death of the victim i.e. the result of the act (or illegal omission) of the accused. In case of active euthanasia (whether voluntary, non-voluntary or involuntary), the act of the accused, who is generally the doctor, causes the death (e.g. by giving lethal injection or dose). Therefore, the first element of murder is satisfied. The mens rea for the offence of murder is given under section 300 itself, in the form of intention, knowledge or reason to believe.

Section 302 of IPC and Euthanasia

Since, in cases of euthanasia (or mercy killing or physician assisted suicide), there is an “intention” on the part of the doctor (or any person) to kill the patient, such cases would clearly fall under section 300(1) of the Indian Penal Code, 1860. Thus, active euthanasia like a lethal dosage of an injection would tantamount to murder and therefore, punishable under section 302, IPC, which reads as follows:

Section 302: Whoever commits murder shall be punished with death, or imprisonment for life and shall also be liable to fine.

However, as in such cases, if there is the valid consent of the deceased above the age of 18, Exception 5 to section 300, IPC would be attracted, which provides that:

Exception 5: Culpable homicide is not murder when the person whose death is caused, being above the age of eighteen years, suffers death or takes the risk of death with his own consent.

Hence, the accused would be punishable under Section 304, IPC for culpable homicide not amounting to murder.

Section 304, IPC provides that: Whoever commits culpable homicide not amounting to murder shall be punished with imprisonment for life, or imprisonment of either description for a term which may extend to ten years, and shall also be liable to fine, if the act by which the death is caused is done with the intention of causing death, or of causing such bodily injury as is likely to cause death, or with imprisonment of either description for a term which may extend to ten years, or with fine, or with both, if the act is done with the knowledge that it is likely to cause death, but without any intention to cause death, or to cause such bodily injury as is likely to cause death. It shows that this section only reduces the gravity of the offence and the person charged is made liable for culpable homicide not amounting to murder. Thus, it is only the cases of “voluntary euthanasia” (where the patient consents to death) that would attract Exception 5 to Section 300, IPC.

Section 87 of IPC and Euthanasia-

Moreover, Section 87 contained in chapter IV of the Indian Penal Code (general defences) lays down that consent cannot be pleaded as defence in any case where the consent is given to cause death or grievous hurt.

It states that: Offence of murder is given under section 300 itself, in the form of intention, knowledge or reason to believe.

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Section 302: Whoever commits murder shall be punished with death, or imprisonment for life and shall also be liable to fine.

However, as in such cases, if there is the valid consent of the deceased above the age of 18, Exception 5 to section 300, IPC would be attracted, which provides that:

Exception 5: Culpable homicide is not murder when the person whose death is caused, being above the age of eighteen years, suffers death or takes the risk of death with his own consent. Hence, the accused would be punishable under Section 304, IPC for culpable homicide not amounting to murder. Section 304, IPC provides that: Whoever commits culpable homicide not amounting to murder shall be punished with imprisonment for life, or imprisonment of either description for a term which may extend to ten years, and shall also be liable to fine, if the act by which the death is caused is done with the intention of causing death, or of causing such bodily injury as is likely to cause death, or with imprisonment of either description for a term which may extend to ten years, or with fine, or with both, if the act is done with the knowledge that it is likely to cause death, but without any intention to cause death, or to cause such bodily injury as is likely to cause death. It shows that this section only reduces the gravity of the offence and the person charged is made liable for culpable homicide not amounting to murder. Thus, it is only the cases of “voluntary euthanasia” (where the patient consents to death) that would attract Exception 5 to Section 300, IPC.

Section 87 of IPC and Euthanasia-

Moreover, Section 87 contained in chapter IV of the Indian Penal Code (general defences) lays down that consent cannot be pleaded as defence if the consent is given to cause death or grievous hurt. It states that:

Section 87: Nothing which is not intended to cause death, or grievous hurt, and which is not known by the doer to be likely to cause death or grievous hurt, is an offence by reason of any harm which it may cause, or be intended by the doer to cause, to any person, above eighteen years of age, who has given consent, whether express or implied, to suffer that harm; or by reason of any harm which it may be known by the doer to be likely to cause to any such person who has consented to take the risk of that

harm. Thus, as regards death, the restriction is absolute and unconditional, though consent may have the effect of reducing the gravity of offence.

Section 92 of IPC and Euthanasia-

However, cases of “non-voluntary” and “involuntary euthanasia” would be struck by proviso one to Section 92 of the IPC and thus be rendered illegal. Section 92, IPC lays down that:

Act done in good faith for benefit of a person without consent- Nothing is an offence by reason of any harm which it may causes to a person for whose benefit it is done in good faith, even without that person’s consent, if the circumstances are such that it is impossible for that person to signify consent, or if that person is incapable of giving consent, and has no guardian or other person in lawful charge of him from whom it is possible to obtain consent in time for the thing to be done with benefit:

Provided that this exception shall not extend to:

Firstly, the intentional causing of death or the attempting to cause death;

Secondly. - That this exception shall not extend to the doing of anything which the person doing it knows to be likely to cause death, for any purpose other than the preventing of death or grievous hurt, or the curing of any grievous disease or infirmity;

Thirdly.- That this exception shall not extend to the voluntary causing of hurt, or to the attempting to cause hurt, for any purpose other than the preventing of death or hurt; Fourthly.- That this exception shall not extend to the abetment of any offence, to the committing of which offence it would not extend.

Withdrawal of Life Support System:

The discussion of this issue under Indian Penal Code (IPC), 1860 must necessarily start with the principle repeatedly laid down in several countries that under common law that a patient has to give his consent (informed consent) to medical treatment, including invasive treatment. Likewise, if a patient refuses medical treatment and wants nature to take its own course, his right to refuse such treatment is accepted by

the common law and is binding on the doctors, provided the decision is an informed decision.⁶⁹

If a competent patient states that the medical treatment being given to him or her is to be continued, the doctors are bound by the patient's decision and cannot discontinue the treatment. At the same time, it is well settled that it is not for the patient to require a doctor to give him a particular medical treatment where the doctor is of the view that that is not the appropriate treatment.

When the patient is competent and wants withholding or withdrawal of treatment, that decision is also binding on the doctors provided the doctor is satisfied that the patient is competent and that this decision of the patient is an informed one, i.e. that the patient has been informed about the granting or otherwise of the ailment, and the medicine or treatment available, patient is able to retain the information, weigh the pros and cons, and take an informed decision. But where the doctor is satisfied that the competent patient's decision is not an informed decision, or that it is based on wrong assumption or prejudices, phobia or hallucinations, then the doctor can ignore the patient's decision and decide what is in the best interests of the patient according to the view of a body of 70 medical experts.

The common law accepts that once the patient instructs the doctor that he is not willing for treatment, that decision is binding on the doctor and if a doctor attempts to treat or treats a patient against his will, it will amount to battery and in some cases, if death ensues, he may also be liable for the offence of murder.⁷⁰ While it is true that doctors have a duty by virtue of their profession to treat a patient and omission to treat may, in certain circumstances, be an offence, still, where the doctor obeys the competent patient's instructions, he is absolved of his professional duty and his omission will not be an offence.

In case the patient who refuses medical treatment and the doctor's precluded from administering medical treatment, the doctor must however be satisfied that the patient has taken an informed decision or the decision is voluntary. There are cases where a patient refuses blood transfusion on ground that such blood is evil, or because

⁶⁹ Mathjharan Karunakaran, *Law on consent and confidentiality in India: A need for clarity* (2011)

⁷⁰ www.scholarship.law.upenn.edu (Last visited on March 24th, 2018)

of needle phobia. If such is the case, the patient's refusal is not binding on the doctor and if he thinks that the best interests of the patient require treatment, he is not committing any offence even if the treatment is contrary to the patient's desire.

Act of Suicide and Euthanasia

With reference to competent patients, let us see if the patient or the doctor is guilty under our criminal law when these principles are correctly applied.

Section 309: Attempt to Commit Suicide⁷¹ (by patient)

So far as the patient is concerned, when he refuses treatment, is he guilty of 'attempt to commit suicide under section 309, IPC'?

Suicide' generally means 'a deliberate termination of one's own physical existence'. But, that is different from a patient allowing nature to take its own course. When a person is suffering from disease, he may take medicine to cure himself. There are different systems of medicine and he may feel that none is good enough. Further in the last four or five decades, medical science and technology have progressed so much but medical facilities available in other countries may not be available in India, or those available in India may not be available at the place where the patient is living and his decision not to take medicine may be based on those facts. Apart from these considerations, a patient may decide for himself that he will allow the disease or illness to continue and be not bothered by taking medicines or invasive procedures. An attitude where a patient prefers nature to take its course has been held in almost all leading countries governed by common law, as pointed out in the preceding chapters, as not amounting to an act of deliberate termination of one's own physical existence. It is not like an act of deliberate or intentional hanging or shooting one's self to death or attempting to drown in a well or a river or in the sea. In view of the settled law on this aspect, allowing nature to take its course and not taking medical treatment is not an attempt to commit suicide. Hence, there is no offence under section 309, IPC. In fact, in *Airedale* the House of Lords clearly held it is not suicide.

India has enacted the Mental Health Act, 2017⁷² presuming suicidal tendency as a consequence of severe mental stress and has enabled suicide survivors to get

⁷¹ Indian Penal Code, 1860.

sympathy, medical care and rehabilitation substituting hand cuffs and prison cells. The Act, 2017 has sparked hope for suicide survivors enabling them the right to live with dignity rather than facing penal action and social stigma and has paved the way to deface s. 309 of the Indian Penal Code.

Section 306: Abetment to Commit Suicide: (Abetment by Doctor in relation to Competent Patients - Physician-assisted Suicide)

So far as the doctor is concerned, let us consider if section 306 which deals with ‘abetment to commit suicide’ applies.

Once the competent patient decides not to take medicine and allows nature to take its course, the doctor has to obey the instructions. Administering medicine contrary to the wishes of a patient is battery and is an offence. The omission to give medicine is based on the patient’s direction and hence the doctor’s inaction is not an offence. In fact, when there is no attempt at suicide or suicide under section 309, there can be no abetment of suicide under section 306.

Even under Section 107 of the 1PC, which generally deals with ‘abetment’, the position is the same.⁷³ Under that section ‘abetment’ may be by a positive act or even by omission. If a doctor omits to give medical treatment at the instructions of a competent patient, he is not guilty of ‘abetment’ under section 107, because under section 107 the omission must be “illegal”. If under common law, the doctor is bound by the patient’s instruction for stoppage of treatment, it is binding on him and his omission is ‘legal’. As there is no requirement under the law that he can disobey the instruction, he is not guilty of abetting. In fact, if he disobeys and continues the medical treatment it will amount to battery or assault.

We have seen in Airedale (UK) and Cruzan (USA) the question of the doctor’s omission has been considered elaborately and it has been held that where there is no duty under common law to give or continue the medical treatment, the omission of the doctor does not amount to an offence.⁷⁴ Hence, the doctor is not guilty of ‘abetment of suicide’ under section 306 IPC, even if we read section 306 along with section 107 which deals generally with ‘abetment’.

⁷² Mental Healthcare Act, 2017 S. 115

⁷³ www.austlii.edu ((Last visited on March 24th, 2018)

⁷⁴ www.globalhealthrights.org (Last visited on March 24th, 2018)

Section 299, IPC: Culpable Homicide, where a patient who is competent refuses medical treatment and the doctor obeys and withholds or withdraws treatment, then does the doctor commit an offence under section 299, IPC? The question of ‘culpable homicide’ also arises where in the cases of incompetent patients and competent patients who have not taken informed decision, and the doctor takes a decision to withhold or withdraw treatment in the best interests of the patient.

As already stated, under section 299, whoever causes death by doing an act:

- i. with the intention of causing death, or
- ii. with the intention of causing such bodily injury as is likely to cause death, or
- iii. with the knowledge that he is likely by such act to cause death, commits the offence of culpable homicide.

Therefore, if death is caused with the knowledge that he, the doctor, is likely by such act to cause death, then, the act amounts to culpable homicide not amounting to murder.

Elaborating the above, it is stated that under the main part of section 299, the doctor is not guilty because he had no intention to cause death or bodily injury which is likely to cause death. But where he knows that withdrawal of life support will cause death, is he guilty under section 299? Now under this third part of section 299, he will be guilty only if the knowledge above mentioned was that the act of withdrawal would cause death. This third part gets attracted to the act of the doctor and he will be guilty of culpable homicide not amounting to murder, punishable under Part II of section 304.

The applicability of section 299 in the case of -

- (i) competent patients, informed decision,
- (ii) competent patients, no informed decision and
- (iii) incompetent patients

Competent Patient:

Informed decision the first and second parts of the section 299 do not apply because there is no 'intention' either to cause death or bodily injury likely to cause death. But the act may fall under the third part because the doctor has 'knowledge' that the act of withdrawal is likely to cause death. Therefore, there can be an offence under section 299. (As to 7 exceptions, these are discussed hereinafter).

Competent patient: No informed Decision

When a patient is competent but the decision is not an informed one, the doctor has to take a decision in the best interests of the patient. Here too, he may not have the intention referred to in the first and second parts of section 299 but he has the 'knowledge' referred to the third part of section 299. Therefore, he may be guilty of an offence under section 299 (As to exceptions, these are discussed hereinafter).

Incompetent Patient

Here the doctor is satisfied that the patient is incompetent and he takes a decision to discontinue treatment, in the best interests of the patient. Here too, there is no intention as referred to in the first and second parts of section 299, but he has the 'knowledge' referred to in third part of section 299. Here he may be liable for an offence under section 299. (As to exceptions, these are discussed hereinafter). However, it will not be an offence if the act comes within any exceptions provided in the Penal Code under Chapter -IV titled "General Defences". The researcher shall consider separately whether the exceptions in sections 76, 79, 81 and 88 of the Penal Code apply to protect the doctor.

Exceptions (General Defences) under Chapter IV, IPC

As the law now stands, physicians and surgeons who wish, in the interest of humanity, to respond to the patient's wishes in a suitable case, are inhibited from acting in accordance with their conscience for fear that they might be breaking the law of the land of which they are loyal citizens. It is also possible that a doctor in such a predicament may be exposed to blackmail. It is therefore necessary that doctors, who

act with care and humanity, must be protected from prosecution. Section 76, IPC reads as follows:

Section 76: Act done by a person bound by mistake of fact believing him bound by law: Nothing is an offence which is done by a person who is, cited by reason of a mistake of fact and not by reason of a mistake of law in good faith believes himself to be, bound by law to do it.

This section is referred because the “Guidelines for limiting life-prolonging interventions and providing palliative care towards the end of life in Indian Intensive Care Units” (Extensive study of the Position Statement of the Ethics Committee of India Society of Critical Care Medicine) contains an appendix (Legal Provisions in Indian Law for Limiting Life Support), in which section 76 has been discussed.

Section 76 is attracted to the case of doctors taking action to withhold or withdraw treatment in the case of refusal to medical treatment by a competent patient. Such refusal being binding on the doctor (provided, of course, the doctor is satisfied that the patient is competent and the patient’s decision is an informed one).

In such cases section 76 brings the doctor’s action under the Section 79:

Nothing is an offence which is done by any person who is justified by law or by reason of mistake of fact and not by reason of mistake of law in good faith, believes himself to be justified by law in doing it.

Section 79, IPC provides that:

The act of withholding or withdrawing medical treatment in all the three cases above i.e., competent patients who have taken informed decision, competent patients who have not taken informed decision, and incompetent patients, will fall under the exception if the said act is “justified by law”.

In light of the view taken by courts of various nations (including the judgments of the House of Lords, the American Supreme Court and judgments in Canada, Australia and New Zealand) the common law confers a duty on the doctor to withhold or withdraw treatment if so instructed by a competent patient. In the case of a competent patient who has not taken an informed decision and in the case of an incompetent

patient, the doctors are justified, under the circumstances to withdraw treatment if it is in the best interests of the patient⁷⁵ Hence, the action is ‘justified by law’ and in all three cases, he is protected by section 79 first part. If he is mistaken in his decision to withdraw life support, and the decision is in good faith, he is protected by second part of section 79, both in the case of competent and incompetent patients.

In respect of section 79, *Raj Kapoor vs. Laxman*⁷⁶ decided the meaning of the words “justified by law”. It was observed that: The position that emerges is this Jurisprudentially viewed, an act may be an offence, definitionally speaking: but a forbidden act may not spell inevitable guilt if the law itself declares that in certain circumstances, it is not to be regarded as an offence. The Chapter on General Exception operates in this provision. Section 79 makes an offence a non-offence. When? Only when the offending act is actually justified by law or is bona fide believed by mistake of fact to be so justified. It is also stated, after referring to dictionary that “Lexically the sense is clear. An act is justified by law if it is warranted, validated and made blameless by law.”

Section 81, IPC states that:

Act likely to cause harm, but done without criminal intent, and to prevent other harm: Nothing is an offence merely by reason of its being done with knowledge that it is likely to cause harm, if it be done without any criminal intention to cause harm, and in good faith for the purposes preventing or avoiding other harm to person or property. Explanation: It is a question of act in such a case whether the harm to be prevented or avoided was of such a nature and so imminent as to justify or excuse the risk of doing the act with the knowledge that it was likely to cause harm. This section may be applicable both in cases of competent or incompetent patients but involves proof of several questions of fact, even if there is no criminal intent. However, sections 76 and 79 give far greater protection than section 81. Further, this section covers cases of ‘necessity’ and only speaks of ‘harm to person or property’, whereas here we are dealing with death.

⁷⁵ www.bioline.org (Last visited on March 24th, 2018)

⁷⁶ *Raj Kapoor vs. Laxman*, 1980 AIR 605

3.5.6.6 Role of Law Commission: A Chronology

The Law Commission of India in the 42nd Report:

The Law Commission of India in the 42nd Report⁷⁷ recommended abolishing Section 309 of the India Penal Code, 1860. The Indian Penal Code (Amendment) Bill, 1978 was passed by the Rajya Sabha which provided for the abolition of Section 309. But the Lok Sabha was dissolved before passing the Bill and the Bill lapsed.

The Law Commission of India in the 156th Report:⁷⁸

The Law Commission of India in its 156th Report after the Judgement of Gian Kaur v. State of Punjab⁷⁹, recommended the retention of Section 309 of IPC.

The Law Commission of India in the 196th Report:⁸⁰

In the 196th Report of the Law Commission of India which was on ‘Medical Treatment to Terminally Ill Patient’s (Protection of Patients and Medical Practitioners)’, the Law Commission discussed various aspects of Euthanasia and legalized withdrawing of the medical support system of a terminally ill patient. The Law Commission recommended that legislation must be passed to protect the terminally ill patients who take the decision to refuse any medical treatment, hydration, or artificial nutrition so that they are not held guilty under Section 309 IPC. The Commission also recommended that the Doctors who assist such patients to end their lives and works in the best interest of the patients must not be penalized.

The following recommendations were given by the Commission-

It is to be declared that every ‘competent patient’ suffering from a terminal illness, has a right to choose or refuse medical treatment. The informed decision taken by such a competent patient becomes binding on the doctor. The doctor is bound to be satisfied that the decision taken by the competent patient is an informed decision and such an informed decision must be taken by him independently i.e. without undue influence or pressure from others.

⁷⁷ Law Commission of India, 42nd report on Indian Penal Code (June,1971)

⁷⁸ Law Commission of India, 156th report on The Indian Penal Code (Volume 1) August 1997)

⁷⁹ (1996)2 SCC 648

⁸⁰ Law Commission of India, 196th report on Medical Treatment to terminally Ill Patients(Protection of Patients and Medical Practitioners) March 2006

It was proposed that the doctor shall not withdraw or withhold treatment unless he has obtained an opinion from a body consisting of three expert medical practitioners from a panel prepared by high ranking Authority and the decision to withdraw such treatment must be based on guidelines issued by the Medical Council of India. Also, it was proposed that a Register must be maintained by doctors who propose to withdraw or withhold treatment. The Register must contain the reasons as to the patient is competent or incompetent, why the doctor thinks that the decision of the patient is an informed decision or not, the name, age, sex, and other details of the patient and what is in the patient's best interest.

The patient who decides to withdraw or withhold medical treatment must be protected from prosecution for the offence of 'attempt to commit suicide' under Sec. 309 of the Indian Penal Code, 1860. In the same way, the doctors must be protected from being prosecuted for 'abetment of suicide' under Sections 306 of the Penal Code, 1860, or of culpable homicide not amounting to murder under Sec. 304 IPC when the decision is taken in the best interests of patients and the decision was taken by the patient is well informed. The Commission was of the view that the doctors who comply with the provisions of the Law, must be protected from civil and criminal proceedings.

It was also recommended that an enabling provision must be provided under which the patients, parents, spouses, relatives, next friend, doctors or hospitals can move to a Divisional Bench of the High Court for obtaining a declaration that the proposed decision of continuing or withdrawing medical treatment be declared as 'lawful'. The High Court must decide such cases at the earliest and within thirty days. Once a declaration is given by the High Court, it will be binding in subsequent proceedings between the same parties. It is not necessary to move to the High Court in every case. In cases where the decision to withdraw treatment is taken in accordance with the law, it will be deemed to be 'lawful'.

The identity of the patient, doctors, hospitals, experts must be kept confidential. So, in the Court proceedings, the persons must be described by the English alphabets. Disclosing of identity is not permissible even after the disposal of the case.

The Medical Council of India should prepare and publish Guidelines in respect of withdrawing medical treatment. The Council may consult other expert bodies in

critical care medicine and publish the guidelines in the Official Gazette or on the website of the Medical Council of India.

The Law Commission in its 241st Report⁸¹:

The Law Commission in its 241st Report which was titled as “Passive Euthanasia-A Relook” discussed elaborately the matter of passive euthanasia in the light of the 196th Law Commission’s Report and the Supreme Court’s decision on *Aruna Shanbaug’s case*. The 241st report was drafted to clear the ambiguities in the 196th report. The 241st report dealt with passive euthanasia whilst the 196th report was regarding the withdrawal and withholding the medical treatment of terminally ill patients. In its 241st Report, the Law Commission had said that withdrawing life support for certain categories of people-such as those in persistent vegetative state (PVS) or in irreversible coma or of unsound mind, who lack mental faculties to make decisions for themselves should be allowed.

Summary of Recommendations in the 241st Report:

Keeping in mind the international lines the Commission under the chairmanship of P.V. Reddi recommended legalizing passive euthanasia in India too. The guidelines suggested in the 196th law Commission Report and the Aruna’s case will be considered and there is no legal or constitutional difficulty in the enforcement of such a law in our Nation.

A patient who is above 16 years and is able to take decision have been allowed to decide the continuation or withdrawal of life support system. The decision taken by such a patient will be followed by the doctors if he is satisfied that it is an informed decision.

In the case of an incompetent patient who is not able to make an informed decision, the decision will be taken by the relatives or doctor of such a patient whether to continue or stop the further treatment, but it is subject to the clearance by the High Court.

The High Court on receiving the application under the Bill can call for the opinion of the medical experts and the wishes of the family of such patients. Due

⁸¹ Law Commission of India, 241th report on Passive Euthanasia- A Relook, (August, 2012)

regard will be given to the best interests of the patient at the time of making an appropriate decision. While giving an order the court shall act as *parens patriae*.

The revised Bill further provides for the safety of doctors and the persons acting under their directions. Doctors are granted immunity from civil and criminal liability provided their actions are within the ambit of the Bill. Also, a similar immunity is provided to a terminally ill patient who is refusing medical treatment.

Despite the fact that medical treatment has been withheld or withdrawn, it is mandatory for doctors to provide palliative care to competent and incompetent patients.

The Medical Council of India is required to issue guidelines from time to time with respect to the matter to withdraw or withhold medical assistance to the terminally ill patient.

The Law Commission report followed a March 2011 decision by the Supreme Court which differentiated between active and passive euthanasia in the case of a nurse, Aruna Shanbaug. Shanbaug was in PVS for several decades, following a brutal rape. She died on 18 May 2015. The government's response came in a case related to considering the right to life comprising the right to die with dignity. The case was heard by a constitution bench comprising Justices Anil R. Dave, Kurian Joseph, S.K. Singh, A.K. Goel and Rohinton F. Nariman.⁸²

The government also said that a bill based on the report, the Medical Treatment of Terminally-ill Patients (Protection of Patients and Medical Practitioners) Bill was also pending consideration. The government had furnished an affidavit. The affidavit had also included the government's stand on Section 309 of the Indian Penal Code, which criminalizes attempt to commit suicide. He told the court that in December 2014, the government had decided to remove attempt to suicide as a criminal offence. He said that the decision had been sent to state governments for ratification.

Further, Non-profit Common Cause, which had petitioned the court seeking to include the right to die with dignity as a part of right to life under Article 21 of the

⁸² www.theconversation.com (accessed on 28.03.2018, Time 10:20pm).

Indian Constitution. Lawyer Prashant Bhushan, represented Common Cause, told the court that a living will, a declaration from a terminally-ill person, should be made a legal document.⁸³

Additional solicitor general P.S. Patwalia also told the court that there was a regulation which prescribed a similar process for withdrawing life support. He drew the court's attention to Regulation of the Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002, which said that "the question of withdrawing supporting devices to sustain cardio-pulmonary function even after brain death" would be decided by a team of three doctors. Euthanasia, as such, is considered an unethical conduct.

The court enquired whether removal of the words "brain death" would affect the meaning of passive euthanasia. It was Bhushan's contention that a person who has not suffered brain death should have the right to refuse life support, based on his or her living will.

The court also noted that continued life support was torture for the family as it is an expensive medical treatment. Passive euthanasia entails a patient being allowed to die by limiting medical intervention, not escalating already aggressive treatment, withholding or withdrawing artificial life support in cases that are judged to be medically futile. Active euthanasia involves administering lethal substances to end life.

Further, after years of debate and legal battles, the Union Government came up with a draft bill on passive euthanasia and living will in August 5th 2016. This Bill was introduced in Rajya Sabha to legalize passive euthanasia and advance directives. It gives patients the right to withhold and withdraw medical treatment to himself or herself and allow "nature to take its own course" and also legalize living will (direction for future treatment). The Bill provides protection to patients and doctors from any liability for withdrawing or withholding medical treatment and states that palliative care (pain management) can continue. This Bill was a step forward to legalizing passive euthanasia but it is still pending.

⁸³ *Ibid.*

3.7. Comparative study

3.7.1 Australian and European continent

The Australian continent, though being the smallest has not been able to formulate legislation on euthanasia. The strong support from the medical field and the majority of the populace supporting it has not brought the desired results of the majority. The government is also not ready to take the bold step fearing the minority. The want of legislation has forced people to travel abroad for it. The approach seems to more conservative than the European continent. In Europe, it has been observed that there is a growth in the permissive views towards right to die. There is an augmented prominence on self-determination. The advances in medication are not essentially making the life healthier and wealthier and therefore the necessity of the right has remained forever. Due to this, few countries like Netherland, Belgium and Luxembourg have come with laws in the 20th century. But the overall view of Europe which comprises of forty-seven states still hold the view that medical fraternity must stay away from the act. They must not indulge themselves even if the situation of the patient is vulnerable. The approach seems to more conservative.

3.7.2 Australian and American continent

Australia does not have a history of euthanasia practised in ancient times. It is only in the twentieth century that efforts have been made towards its legalisation. For a very short period of nine months, voluntary euthanasia did prevail in the northern Australian continent. But the religious protagonist did not support any kind of euthanasia. American history depicts that. euthanasia was prevalent even among the traditional American societies. Attempts for its legalisation have been comparatively faster in this continent. It was in the nineteenth century that bills were proposed in the house. As a result, some states have legislation on euthanasia. Judicial approach towards the subject has been progressive and therefore permitted voluntary euthanasia. The American churches though have criticized and opposed it. The ELCA has an empathetic approach towards it and has approved it in exceptional conditions.

3.7.3 Australian and Asian Continent

The Asian continent seems to be more progressive in its approach than the Australian continent. Legislations in this continent have been marginal. But judicial fraternity

has allowed passive euthanasia in most of the countries in this continent. But in countries where religious beliefs have an upper hand euthanasia is nowhere in their consideration. These countries have been staunch protestors like the Australian catholic bishops.

3.7.4 Australian and African Continent

The concept of euthanasia is comparatively new for the Africans as compared to the Australians. Though, new immediate steps were taken for its legalization. The concept was not supported; basically, from the physicians who apprehended the slippery slope. But the decisions in the continent have followed the general trend in legal systems. Both the countries are awaiting legislation.

3.7.5 American and European continents

Concept of euthanasia is not new in both these continents and is prevalent in the continents since B.C. It has been therefore observed that both these continents are comparatively more progressive on the subject than the others. It was these who paved the way for having legislation on the subject of euthanasia. It was the European continent who took, the first honour to legalise euthanasia. In spite of the discordant views prevalent in both the continents, the protagonists have never put down their battle on the subject. The Christian dominance in both the continents plays a major role in the perception of people towards the subject. It has been experienced that conservative Christian communities in these continents are against any kind of euthanasia. However, a few have allowed. The American continent thus has experienced a fight for legislation on euthanasia. Otherwise more or less both these continents have a similar insight and awareness about the subject.

3.7.6 American and Asian continent

America which is predominantly a catholic continent describe euthanasia as a sin. The Asian continent though not dominated with one religion does not recognise it. In passive euthanasia the countries in the gulf where Islam has dominance, it is considered as a sin. Both the religions Christianity and Islam in these continents puts emphasis on the same view point that life is a bequest of the almighty. It has to be preserved and no individual can disrespect it or cause harm to it. In spite of this

common reasoning to censure euthanasia, it has been observed that American continent is more advanced with its research on the topic and has made better progress. Some countries in the continent already have legislation on the subject. The Asian continent is on the stage of proposition. It has been observed in the Asian continent that judicial decisions in this continent have favoured passive euthanasia. This errand is applicable only if the patient is in irreversible stage of life. Further it has to be implemented with sufficient guidelines. Hence the situation prevalent leaves a scope for euthanasia laws to be enacted sooner.

3.7.7 American and African continents

The African continent believes in religious humanism and therefore does not accept the concept of self-destruction. There is no law prevalent on the issue unlike the American continent. Efforts have been made by the proponents for the same but results are yet to be achieved. Though not legalised, euthanasia does persist in a clandestine manner in this continent.

3.7.8 European and Asian continent

Amongst most of the Asian Countries thinking or even speaking about euthanasia was a sin. Though the situation has changed a lot the populace in general is not ready to accept it. The judiciary in many states has helped the proponents of the subject to persuaded people to think in those directions, which was difficult earlier. There is no legislation prevalent in this continent on the subject matter except for Thailand. The Buddhist culture which prevails, accepts self-sacrifice in exception. Compassion is the teaching of Buddhism and therefore it gives good reasoning to accept euthanasia in rare cases. The human being is also alleviated from the torturous life. The cultural and religious diversity in this continent is also the reason for these varied opinions in the continent. This is one of the causes for its slow growth as compared to Europe. Europe is predominantly governed by one religion that is Christianity. The changing views of one nation thus help in influencing the other with the same ideologies. The European continent in fact is the first to have legislation on Euthanasia. The emphasis on human rights, patient's autonomy is the main base behind it. But it has been observed that passive euthanasia has been accepted in both the continents.

3.7.9 European and African continent

European continent seems to be more advanced with the issue. There are states that have legislation on euthanasia. One of the states in the continent is also famous for suicide tourism which is not prevalent in the African continent. Populace of Africa are more against euthanasia than the European continent. However, the recognition given to human rights in the continent, shall surely reduce the gap between the two different opinions prevalent in the continent.

3.8 Conclusion:

The above study shows that legislation regulating euthanasia is globally a controversial issue. The problems of end-of-life issues are extremely complicated and complex. Factors like social, ethical, legal, moral and cultural are to be put into consideration while deciding about euthanasia. For almost all the religious systems such as Christianity, Islam, Buddhism, Hinduism and Confucianism prevalent, euthanasia is unacceptable. The deliberate act of taking life of a human being is always morally and ethically wrong. The societal and cultural taboos mostly all over do not accept it. They feel that they set a wrong precept to terminate people who are a burden on the family. The line blurs between what is permitted and what is not. In such circumstances, there rises a high possibility of innocent deaths. Trying to solve these problems through legislation is therefore often difficult. Morality and religion play a vital role. Societies where it is not morally accepted, there are huge arguments from a legal point of view. However, it has been experienced that passive euthanasia through refutation of drugs or withdrawal procedures is considered to be legal in almost all jurisdictions.

Even though the practice of euthanasia is illegal almost globally, surveys show that it does exist and is silently practiced almost in all the States. This makes the legislation of, euthanasia essential. Hence the question of legalising euthanasia is important. It has persuaded us to consider whether a person's genuine beliefs are to take precedence within strict and controlled boundaries or not. The proponents struggle, continuous demands have brought a great change all over. In many of the states, passive euthanasia has been legalized. The concept of life with dignity and the European Union guarantee, of the healthy family life, which comprises of the liberty

to assist in a family member's death, has forced the society to change its outlook. Legalisation of euthanasia shall be a logical step towards individual liberty and offer a choice of a dignified death, but eventually time will be the only actual decider in such a controversial topic.

It has been observed that most of the nation's disapprove euthanasia. It is considered illegal and a crime. In most of the states, religious belief that God is the ultimate decision maker of human's life is the major ground for its rejection. Legalization of euthanasia in any form has become debatable topic in many countries. But it has been observed that this concept is slowly changing. The empirical studies, the promotion of its benefits, awareness created among the public, their active participation in debates, the physician's viewpoints, the practical approach of the people all over the clear insights of characteristics of euthanasia has made a difference in the public opinion all over the globe. It has been observed that the qualified educated class is more in favour of euthanasia. There resentment for it is marginal. Amongst the various forms prevalent "Voluntary euthanasia" is a form that has been accepted in most of the nations. In the European continent Netherlands, Belgium and Switzerland are the states who believe in finishing of physical or psychological illness and extend individual autonomy. They have legalized euthanasia.

The termination of life with medical assistance has now been a vital fraction of termination of existence care. Good quality dying is a right of person's autonomy and an important goal, along with the traditional goals of prolonging life with the best possible treatment available. Individuals must be endeavoured with authority to finish his/her life in a dignified manner. If this right to die is not given people might be forced to severe resolutions as self-suicide to abstain suffering at home or in a hospital. Further places where euthanasia is legalized it has improved the physician's legal certainty in performing the act. That is because the medical fraternity which includes physician, nurse or pharmacist are assured that there would be no criminal or civil litigation for the act performed by them. This is so in case the physician is aiding, supporting the patient in exercising his or her right to die with dignity willingly. It has been observed that countries where passive euthanasia is generally accepted do not have clear grounds laid for refusal of treatment. At the same time regulation are not mentioned for active euthanasia which is very multifaceted issue

and therefore not approved by the states. However, euthanasia should be strictly controlled and monitored. The demand for euthanasia should be really autonomous, well-informed and no other options should be available to practice euthanasia. That is no one else should be allowed to take the decision for the sick, neither guardian nor family members. This could avoid its abuse.

More education and debate are essential all over to understand the subject. At the same time unravel the opinions about the acts, which should be and which should not be regarded as euthanasia. This shall enable all to explore the possibility of its legal regulation. Else there is a possibility that people may travel to nations like Switzerland who permit euthanasia or P A S, and the prohibition of euthanasia or PAS shall turn futile. The position of not accepting the 'right to die' when you can travel abroad to obtain legal death especially for the rest of Europe remains questionable.



CHAPTER-IV
JUDICIAL RESPONSE
TOWARDS EUTHANASIA



CHAPTER- IV

JUDICIAL RESPONSE TOWARDS EUTHANASIA

“Life is pleasant, Death is peaceful. It’s the transition that’s troublesome”.

- Matthew Arnold

4.1 Introduction

The Judiciary in the world as well as India has tremendously influenced the social scenario of the any country. Although people conscience is represented by the legislature, as a guardian of the Constitution, the Supreme Court of India has been playing a vicious role in imbibing the sentiments of the people both morally and legally. The fate of the country depends upon the policies and the turn up that takes in the policies is due to the latest dimensions in the judiciary.¹ The approbation and absurdities of the hotly debated issue can be studied in light of the judicial verdicts and pronouncements.

4.2 In United Kingdom:

4.2.1 Dr. John Bodkin Adams Case²: Dr. Adams was tried for the murder of an eighty-four-year-old woman in his care, who apparently respected the care, provided by the doctor and had named him as a beneficiary in her will. The patient was terminally ill and succumbed following the administration of large dose of narcotics prescribed by Dr. Adams. Devlin J. advised the jury that regardless of the health of the victim and motive of the accused, the law would treat as murder any action which intended to kill and did in fact kill. He also ruled that: “If the first purpose of medicine, the restoration of health, can no longer be achieved, there is still much for a doctor to do, and he is entitled to do all that is proper and necessary to relieve pain and suffering, even if the measures he takes may incidentally shorten human life. After a seventeen-day trial the Jury declined to convict. They deliberated for only

¹ Algero Garvey Mary, “The Sources of Law and the value of Precedent: A Comparative and Empirical Study of a Civil Law State in a Common Law Action”, Vol. 65 *Louisiana Law Review*, (2005)

Digitalcommons.law.lsu.edu >view content (Last visited on April 14, 2019)

² *R v Adams* [1957] Crim LR 365.

forty five minutes before finding Dr. Adams not guilty”. The Acquittal was also the outcome of the trial of Dr. Leonard Arthur, a paediatrician who was charged with the murder of a Down’s syndrome neonate.

4.2.2 Dr. Leonard Arthur Case³: The Child had been rejected by his parents who instructed Dr. Arthur that they did not wish the baby to survive. Subsequently a note was entered in medical records that the baby should receive “nursing care only”. The infant was not fed but received strong pain killing drugs, allegedly to ease his distress. He died three years later. The doctor argued that the child died of natural causes to Down’s syndrome and when evidence was revealed that other significant congenital abnormalities also existed, the charge was reduced to attempted murders. Despite being advised that doctors, like everyone else, must practise within the law, and that motive is irrelevant in determining intention, the jury failed to convict Dr. Arthur. This pattern was repeated in the trial of Dr. Carr.

4.2.3 Dr. Carr Case⁴ :His patient died after being injected with a huge dose of Phenobarbitone (a barbiturate). The doctor was charged with attempted murder. However, the patient had been suffering terribly from inoperable lung cancer and had requested that his inevitable death be hastened. Dr. Carr was acquitted.

4.2.4 R vs. Cox Case⁵: In this case, the clinician carried out the wishes of his distressed and dying patient and deliberately injected her with strong potassium chloride, a drug which causes death but has not therapeutic value in this form. She died soon afterwards. The jury was given no choice but to convict in this instance since the death had resulted from deliberate unlawful killing and was therefore categorized as homicide. Their extreme reluctance to find Nigel Cox guilty was apparent in the fact that many of them wept openly as the verdict was returned. The patient’s family considered that Dr. Cox had enabled their elderly relative to secure a merciful release from the terrible pain and distress she was enduring so that she could die with dignity. The case resulted in a considerable public debate and concern for the doctor, the patient, her family and others who may find themselves in a similar situation. These cases stand as authority for the basic premise that deliberately to take

³ *R v Arthur*, 1981.

⁴ *Dr. Carr Case*, 329 U. S. 675.

⁵ *R v Cox* [2014] EWCA Crim 804.

the life of another is a crime, reflecting Ognall J's comments that "prosecution is usually appropriate in these circumstances".

4.2.5 *Airedale NHS Trust vs. Bland Case*⁶: Against the above-stated background, this case was presented to the court to obtain a declaration that withdrawal of treatment leading to death was lawful, so that the medical attendants could avoid criminal prosecution. The condition of Anthony Blend offered no prospect of recovery or improvement so to maintain a regime of burdensome and invasive treatment was medically pointless. Yet to discontinue treatment would cause his death and give rise to criminal culpability. The House of Lords has permitted non-voluntary Euthanasia in the case of patients in a persistent vegetative state. The issues raised by these cases characterize the medico-legal dilemma generated by voluntary Euthanasia. Good medical practice requires that patients do not experience unnecessary and unwelcome suffering but the criminal law is inconsistent in its response to practitioners who take life-limiting decisions. Clinicians like Nigel Cox, who openly end their patient's lives out of compassion, are convicted, while Euthanasia through the subterfuge of selective non-treatment, and double effect, whereby beneficial medication is given in the certain knowledge that death will occur as a side effect, has been permitted.

4.2.6 *St. George's Healthcare NHS Trust vs. S Case*⁷: The House of Lords settled that a person has the right life-sustaining treatment as part of his rights of autonomy and self-determination. Recently, the British High Court in its historic ruling has held that "administration of Ventilation by artificial means against the claimant's wishes has been an unlawful trespass."

In this case a British woman was paralyzed from neck down. Ruptured blood vessels in her neck a year ago left her paralyzed and unable to breathe unaided. The doctors at the Hospital were keeping her alive by artificial means and had said that it was against their ethics to switch off the machine needed to keep her alive. But in this landmark legal case, the woman won the "right to die". The ruling follows a growing clamour by patients to put their own rights first-ahead of doctors and the law and to decide for themselves when it is time to die. It is the first time in Britain that someone considered to be in control of her full mental faculties, has asked doctors to switch off

⁶ *Airedale N.H.S. Trust v Bland* [1993] A.C. 789.

⁷ *St. George's Healthcare NHS Trust vs. S Case* [1998] 2 WLR 936.

life support in this way. The doctors have asked courts to sanction the switch off for people in a permanent vegetative state. Perhaps, it is the first time in modern history of England when the judiciary accepted the reality of the time by allowing a terminally ill patient “right to die” which may in future prove to be a supportive ground for Indian Judiciary to permit mercy killing to patients who are in permanent vegetative state with their consents.⁸

Some recent Developments in England in relation to Euthanasia In November 2005, a bill known as “An Assisted Dying Bill” was introduced in the House of Lords to this effect where under a competent and terminally ill major person suffering unbearably can request either for assisted suicide or voluntary Euthanasia. It sets requirements by an attending physician that the patient is likely to die of natural causes within a few months. The patient must sign a written declaration of intent and if this is not revoked within fourteen days of the date on which the request was first made, the patients can receive the means to take his/her own life or, if the patient is physically unable to do that, have his or her life ended through voluntary Euthanasia. All cases are to be reviewed by a medical committee.

4.2.7 *Pretty vs. United Kingdom Case*⁹: In Britain, Diana Pretty, 43 years old woman, suffering from motor neurone disease battled in the courts for the right to die in vain and finally died in 2002. After her demise, her husband Brian pretty continued nationwide Campaign for legalizing Euthanasia and delivered this case and the above-mentioned British High Court’s Case led to the introduction of Bill of November 2005 which has been discussed briefly just few lines above. The bill was intended to facilitate terminally ill patients to be able to obtain assistance in their dying processes. But unfortunately, path of the said bill has been blocked by the upper house of British Parliament i.e. House of Lords. The anti-euthanasia people which were around 1, 00,000 have signed a petition and the same has been submitted before the parliament along with a strong demonstration. In spite of the above hindrance, Mark Slattery, the chairman of an NGO named “Dignity in Dying” said that- “the campaign to introduce an assisted dying bill would continue in spite of hindrance.” It can be concluded from the above discussion that; euthanasia has become more socially acceptable in England

⁸ www.iasscore.in (Last visited on April 14, 2019)

⁹ *Pretty v. United Kingdom*, (2346/02) [2002] ECHR 423.

irrespective of the fact that legally speaking it amounts to a crime in the country. The case laws as discussed above are indicating the fact that there exists a sense of disharmony between law and social morality in this area and the criminal Justice system of England is ambiguous in its response to the situation in hand. It is incumbent upon the legislature to provide a clear-cut law for taking medical decisions by the physicians regarding the end of life of terminally ill persons within the said legal framework. In this way only, the respect may be given to the patient's right to autonomy. An entirely new offence of mercy killing could be created to overcome concerns about classifying euthanasia as homicide or euthanasia could become the subject of a special defence of homicide, described as mercy killing or legal Euthanasia whereby culpability could be defined without analysis of issue of causation or distinguishing between acts and omissions.¹⁰ However, protection for those who may fall victim to non-voluntary Euthanasia in the guise of mercy killing could become equally difficult to safeguard if the law were to be relaxed too far in favour of Euthanasia.

“The Living Will” in plain meaning this can be explained as a written or oral statement given by a terminally ill patient during his healthy times that in case if he or she would become incapable of giving an informed consent for withholding or withdrawing the life- prolonging machines due to some dreadful disease then the person named in the Will would be authorized to give such consent on behalf of such patient. It is significant to note that a “Living Will” will only become operational when the patient is unable to express his consent freely. This covers those situations in which the patient has become terminally ill and permanently unconscious. He/she can beforehand express his/her wish for receiving or rejecting any particular medical treatment. Only the things which are otherwise legal can be ensured and authorized through a living will. The physician cannot be compelled to do anything which is contrary to law. Any family member or a close relative or even a next friend can be appointed as proxy. The function of that proxy person will be to give a practical suggestion or assistance to the attending physician in order to arrive at a meaningful conclusion. The person making such living will would be under legal obligation to provide his/her doctor and legal advisor with the copies of such document. The document needs to be executed and completed correctly to ensure its authenticity

¹⁰ www.theguardian.com (Last visited on April 14, 2019)

through proper legal procedure. “Living Wills” have been given due consideration in the Report titled as- British Law Commission Report 231. The said report has been given after an analysis of numerous judgments. In these judgments, the use of the above mentioned will in specific medical circumstances has been discussed in elaboration. The report has given comprehensive recommendations about the operation and legal status of living wills. The use of such kind of legal documents will definitely increase in future and it would go a long way to facilitate the easy decision-making process regarding those patients who are in permanent vegetative state and need passive euthanasia after withholding or withdrawing the unwanted medical treatment. In summary, it can be said that an expert legal opinion should be taken regarding the drafting and interpretation of the provisions enumerated under a “Living Will”.

4.2.8 *Debbie Purdy v. Director of Public Prosecutions*¹¹: In 2008, a British woman Debbie Purdy from Bradford, West Yorkshire, with multiple sclerosis was granted her request for a full judicial review in her quest to find out if her husband can help her commit suicide without fear of being prosecuted under 2(1) of the Suicide Act, 1961. Purdy, said that she feared that her husband would be prosecuted if she chose to end her life with his assistance in Switzerland, where assisted suicide is legal. Purdy is currently a member of Switzerland's "Dignitas" group, which specializes in administering lethal doses of barbiturates to those who wish to die. She said that knowing whether or not Puente would be prosecuted will allow her to live longer. Purdy told that if she found out that her husband might be prosecuted, she would have to kill herself sooner, before her condition degenerates to the point where she would need Puente's assistance.¹²

This was a judicial review case in which the applicant sought to have the decision of the Director of Public Prosecutions declared invalid. She brought the case as the Director of Public Prosecutions, Sir Ken Macdonald, QC, had decided, contrary to her request, no to issue specific policy guidelines on the circumstances in which prosecutions for assisted suicide were likely. She argued that lack of proper guidance was a failure of an obligation on the DPP to provide clear law, and was a failure that

¹¹ *Debbie Purdy v. Director of Public Prosecutions*. (2008) EWHC 2565.

¹² *Ibid*

infringed her right to private and family life under Article 8 of the European Convention on Human Rights. The proceedings were a claim for judicial review and a claim under the Human Rights Act, 1998.¹³ However, the Divisional Court consisting of Scott Baker LJ. and Aikens J. held that Purdy's rights under Article 8 of the European Convention on Human Rights were not infringed. Accordingly, her claim of breach of Article 8 of ECHR failed. It was further held that:

“We cannot leave this case without expressing great sympathy for Ms Purdy, her husband and others in a similar position who wish to know in advance whether they will face prosecution for doing what many would regard as something that the law should permit, namely to help a loved one to go abroad to end their suffering when they are unable to do it on their own. This would involve a change in the law. The offence of assisted suicide is very widely drawn to cover all manner of different circumstances; only Parliament can change it.”

The court however, gave Purdy permission to appeal its decision. The House of Lords however allowed the appeal.¹⁴ Lord Hope opined that at the outset that it is no part of their function to change the law in order to decriminalise assisted suicide. If changes are to be made, this must be a matter for Parliament. Judges should not venture into that arena, nor would it be right for them to do so. Their function as judges is to say what the law is and, if it is uncertain, to do what they can to clarify it. Ms Purdy wants to be able to make an informed decision as to whether or not to ask for her husband's assistance. She is not willing to expose him to the risk of being prosecuted if he assists her. But the Director had declined to say what factors he will take into consideration in deciding whether or not it is in the public interest to prosecute those who assist people to end their lives in countries where assisted suicide is lawful. This presented her with a dilemma. If the risk of prosecution was sufficiently low, she could wait until the very last moment before she made the journey. If the risk was too high, she will have to make the journey unaided to end her life before she would otherwise wish to do so. Moreover, she was not alone in finding herself in this predicament. Statements have been produced showing that others in her situation have chosen to travel without close family members to avoid the risk of their

¹³ *Ibid*

¹⁴ Visit <http://www.theguardian.com/society/2008/oct/29/ms-sclerosis-purdy> (Last visited on Sep 28th 2018).

being prosecuted. Others have given up the idea of an assisted suicide altogether and have been left to die what has been described as a distressing and undignified death. It is patently obvious that the issue is not going to go away.¹⁵ House of Lords allowed the appeal and required the Director to promulgate an offence specific policy identifying the facts and circumstances which he will take into account in deciding, in a case such as that which Ms Purdy's case exemplifies, whether or not to consent to a prosecution under section 2(1) of the 1961 Act.

4.3 In United states of America

4.3.1 Karen Ann Quinlan Case¹⁶: This case appeared in the year 1975. Karen Ann Quinlan was a twenty-one-year old girl who had accidentally taken overdose of alcohol and valium. As a result of said overdose she went into a coma. But she was kept alive by a ventilator and other life-prolonging medicines. This case was also known as the "sleeping beauty" case. The whole nation started thinking about the solution to the miserable condition of the patient. Ultimately, Quinlan's case helped in redefining the term "brain Death" and the legal framework for voluntary and involuntary decision-making process in cases of such brain- dead patients. A petition for removal of life supports was filed before the New Jersey Supreme Court. The verdict came in 1976 and fortunately allowed removal of life supports on the ground of her irreversible condition and the right to privacy guaranteed by the surrogates. With this decision of approving passive euthanasia, the Court added a fuel to the right to die movement. As a result of this decision, in the very next year (1977) around 50 bills were submitted by thirty-eight legislatures to enact legislation for the expansion of the power of attorney and for sanctioning Living Wills etc. But on the other hand, the American-Medical Association further strengthened its opposition to euthanasia. It

¹⁵ For example, final moments in the life of 59-year-old Briton Craig Ewert were shown on TV in December 2008 as he takes a lethal dose of sedatives under medical supervision. It was a controversial documentary, titled "Right to Die?" The father-of-two had been diagnosed with motor neurone disease — a rare condition caused by the breakdown of nerve cells in the brain that control the muscles — five months before his death at Swiss euthanasia clinic, Dignitas. He decided that he didn't want to continue suffering as a prisoner in his own body. Prime Minister Gordon Brown, on being questioned in the House of Commons, hours before the documentary was screened, told the MPs: "I think it is very important that these issues are dealt with sensitively and without sensationalism and I hope broadcasters remember that they have a wider responsibility to the general public." He further explained his position: "I believe that it's necessary to ensure that there is never a case in the country where a sick or elderly person feels under pressure to agree to an assisted death or somehow feels it's the expected thing to do. That's why I've always opposed legislation for assisted deaths." Visit www.wikipedia.org.com. (Last Visited on 20.7.19).

¹⁶ In *re Quinlan* (70 N.J. 10, 355 A.2d 647 (NJ 1976)).

equally argued that passive Euthanasia is ethically acceptable but only in terminally ill cases where extraordinary or heroic procedures are required to maintain life in a manner inconvenient and inefficient for the patient.¹⁷

4.3.2 *People v. Campbell*¹⁸: The court reversed its previous rulings, stating "that it is 'extremely doubtful' that aiding or soliciting a suicide was a crime at common law, and that suicide, by definition, excludes homicide." The court held that the act of providing a gun and bullets to a person who had expressed the intent to commit suicide, while "morally reprehensible," was not a crime under the existing law of Michigan, and it invited the legislature to adopt a provision regarding "inciting suicides".

4.3.3 *Dr. Jack Kevorkian's Case*¹⁹: Dr. Kevorkian who was famously known as Dr. Death came in limelight in 1990's. He was a retired pathologist and he provided his assistance to 130 people approximately for committing suicide. He wrote a book titled as Prescription: Medicine. His practice was challenged in 1993 through a Michigan law prohibiting physicians-assisted suicide. But the American Civil Liberties Union supported Kevorkian and because of that support he argued that an express law forbidding the practice of active euthanasia amounts to denial of right to self-determination of an individual as to the manner or timing of his/her death. However, Kevorkian's argument suffered a setback when it was discovered that a large number of patients who have obtained help from him were actually not terminally ill. But he did not repent for what he did to a number of patients. Rather, he continued his practice until a Michigan court convicted him and awarded him an imprisonment in 1999 or a period of 10-25 years for the offence of second-degree murder of Thomas Youk, a patient who was suffering from Lou Gehrig's disease. Finally, his arrogance resulted in his downfall. A sixty minutes program on television was telecasted covering the death story of Thomas Youk. The court took a strict note of that and ultimately Dr. Death had to face the consequences of his irrational behaviour.²⁰

¹⁷ www.semanticscholar.org . (Last visited on April 14, 2019)

¹⁸ *People v. Campbell*, 124 Michigan App. 337-338; 335 N. W. 2d at 29-30.

¹⁹ *Kevorkian v. Thompson*, 947 F. Supp. 1152 (E.D. Mich. 1997).

²⁰ www.nytimes.com ((Last visited on April 14th, 2019)

4.3.4 *Washington vs. Gluck berg Case*²¹: In 1997 the United States of America's Supreme Court unanimously refused to issue an order for allowing assisted —suicide. The Court followed *Roe vs. Wade* case verdict in the present case. Chief Justice William Rehnquist stated that “assisted suicide posed substantial harm for individuals already at risk because of their age, poverty, or lack of access to quality medical care.”²²

4.3.5 *Quill vs. Vacco Case*²³: In this case, the second circuit court filed an appeal in New York's highest Court which held that there is no fundamental right existing to assisted-suicide. The court further clarified that that New York's laws against assisted suicide are unconstitutional when applied to physicians treating terminally ill patients who are not connected to life-support systems, because the laws do not provide these patients with equal protections. The court held that patients connected to life support systems could refuse connected to them and thus hastens their death, whereas patients not connected to such systems cannot exercise the same legal right to hasten their death. Hence it is against the principle of equality as enshrined in the American Constitution.²⁴

Hence, the Courts in America were usually against the concept of assisted suicide. But there was a clear support for passive euthanasia in case of those terminally ill patients who were lingering on their death beds with the help of life -prolonging machines. The following case laws will further clarify the situation as above discussed: *Dying vs. State of Washington case*²⁵

In this case the ninth circuit court noted that the State of Washington had already permitted a competent terminally ill patient to direct for withdrawal of life-sustaining measures. Further, the state interest in preventing suicide is diminished in situations involving terminally ill competent patients. The court held that “the decision of a terminally ill adult who ends his life in the final stages of an incurable and painful degenerative disease In order to avoid debilitating pain and a humiliating death is not senseless and does not come too early.”²⁶

²¹ *Washington v. Glucksberg*, 521 U.S.702 (1997).

²² www.reviewauthanasiablogspot.com (Last visited on April 14, 2019)

²³ *Vacco vs Quill*, 521 U.S. 793 (1997).

²⁴ www.newsday.com (Last visited on April 18, 2019)

²⁵ *Dying vs State of Washington case*, 49 F.3d 586,588 (9th Cir.1995).

²⁶ www.caselaw.findlaw.com ((Last visited on March 13th , 2019)

The debate about physician-assisted suicide remained in heat at the state level till early 2000s. The Supreme Court's decision in *Washington vs. Glucksberg* sanctioned the authority to take decision on active euthanasia to the state courts because the judges argued that each state had the right to protect its own residents and thus a federal decision would be inappropriate. Indeed, the court's position in *Washington* is quite similar to one taken in an earlier ruling on passive Euthanasia.²⁷

4.3.6 *Cruzan vs. Director, Missouri Department of Health*²⁸: In this case, the Supreme Court clarified that if there is no convincing evidence of an enduring consent on the part of a terminally ill patient the State could prohibit termination of treatment. This decision gave individual states the freedom to determine appropriate standards for involuntary passive euthanasia. A large majority of States supported and followed the precedents set in the *Quinlan* case in order to arrive at a practical reasonable decision. The proponents of physician-assisted suicide have expressed an expectation that responsible practices in Oregon and the Netherlands would convince the anti-euthanasia people. In summary, through this decision individual States have been conferred upon with huge power in matters of decision regarding the procedure for involuntary passive euthanasia within those States.

4.3.7 *Brittany Maynard Case*²⁹ : One case which actually forced the state of California (USA) to change its laws was that of Brittany Maynard (19 November, 1984 - 1 November, 2014). She suffered from terminal brain cancer and had decided quite early that she would end her own life "when the time seemed right." She was an advocate for the legalization of aid-in- dying (or assisted suicide). She graduated from the University of California, Berke School of Education. Brittany taught at orphanages in Nepal, and also travelled to Vietnam, Cambodia and other South east countries. On 1 January, 2014, she was diagnosed with a form of brain cancer, and had a partial craniotomy and a partial resection of her temporal lobe. The cancer returned in April 2014, and her diagnosis was then elevated to grade 4 astrocytoma with a prognosis of six months to live. She moved from California to Oregon to take advantage of that state Death with Dignity Law. She said that she had decided that "death with dignity was the best option for me and my family." Then she began

²⁷ *Ibid*

²⁸ *Cruzan vs. Director, Missouri Department of Health*, 1 IOSCT 2841 (1990).

²⁹ *Brittany Maynard Case*, 1 IOSCT 2841(2014).

lobbying for the cause for the right to die with dignity. She created the Brittany Maynard Fund and wrote an opinion piece for CNN titled “My Right to Death with Dignity at Brittany wrote in her Facebook post, “Goodbye to all my dear friends and family that I love. Today is the day I have chosen to pass away with dignity in the face of my terminal illness, this terrible brain cancer that has taken so much from me ... but would have taken so much more.” Her death was reported in the media on 2 November, 2014. In accordance with the Oregon state law regarding death with dignity, her official cause of death was mentioned as “brain tumour even though she had taken her own life. In fact, her story, and her lobbying, eventually made California adopt end-of-life laws for the terminally ill. However, while all the above cases were people who opted for death, a word must be said about a doctor who actually championed this cause to the point of becoming controversial, and even getting imprisoned. This was Jacob Jack Kevorkian (May 26, 1928).

He was a pathologist, euthenist, activist, painter, author, composer, and musician. He is best known for publicly championing a terminal patient’s right to die via the physician-assisted suicide route. He is said to have assisted at least 130 patients to that end. He was often portrayed in the media as “Dr. Death”. But many consider him a hero as he helped set the platform for reform. He famously said, “Dying is not a crime.”

In 1999, Kevorkian was arrested and tried for his direct role in a case of voluntary euthanasia. He was convicted of second-degree murder and served eight years of prison. He was released on parole on 1 June, 2007. The condition was that he would not offer advice nor participate nor be present in the act of any type of suicide involving euthanasia to any other person; nor would he promote nor talk about the procedure of assisted suicide.

After his parole period was over, he gave several talks and interviews. In an interview, when asked for his comments on existing laws in Oregon, Washington and Montana (California comes into effect in June 2016) which were meant only for the terminally ill, he remarked, “What difference does it make if someone is terminal? We are all terminal.” In April, 2010, he appeared on CNN, where he was asked “You are saying doctors play God all the time?”

Kevorkian said, “Of course. Anytime you interfere with a natural process, you are playing God.” His story was later made into a film (You Don’t Know Jack) which premiered on 24 April, 2010 on HBO. Al Pacino who featured as Kevorkian received Emmy and Golden Globe awards for his portrayal.

He was finally diagnosed with liver cancer. He died on 3 June, 2011. According to his attorney, Mayer Morgan Roth, there were no artificial attempts to keep him alive and his death was painless. The epitaph on Kevorkian’s tombstone reads, “He sacrificed himself for everyone’s”³⁰

4.3.8 *Baxter v. State of Montana*: The Montana Supreme Court in December, 2009, affirmed in the case of that physician-assisted suicide is not "against public policy" in Montana. The Court further ruled that state law protects doctors in Montana from prosecution for helping terminally ill patients die. The court declined to rule on the larger question of whether physician-assisted suicide is a right guaranteed under Montana's Constitution.³¹

4.3.9 *Krischer v. Mclver*³²: Florida Statute prohibits assisted suicide under Section 782.08. The Florida State Supreme Court upheld the constitutionality of Florida’s law prohibiting assisted suicide.184 On February 25, 1990, Theresa Marie (“Terri”) Schindler Schiavo, then 26 years old and living in Florida, suffered a cardiac arrest because of a potassium imbalance in her body, possibly brought on by an eating disorder. She was revived, but lack of oxygen had destroyed the centres of consciousness in her brain. She remained in a vegetative state, which was eventually classified as persistent and, in all likelihood, permanent. Schiavo’s husband, Michael Schiavo, became her conservator. At first, he and Terri’s parents, Robert and Mary Schindler, worked together to care for her, but in early 1993 they began to disagree. Michael Schiavo believed that his wife’s condition would never improve, but the Schindlers thought that she might recover some degree of consciousness if given the right therapy. In 1994, they filed the first of many suits that attempted to remove Michael from his position as Terri’s conservator. All were unsuccessful. Michael

³⁰ www.firstpost.com (Last visited on April 18th, 2019)

³¹ *Baxter v. State of Montana* MT DA 09-0051, 2009 MT 449

³² 697 So.2d 97 (Fla. 1997). Available at www.nightingalealliance.org/pdf/fl_kirscher_v_mclver_cco.pdf
- (Last visited on Feb 2nd, 2019).

Schiavo petitioned a Florida court in 1998 to allow him to have Terri Schiavo's feeding tube removed, claiming she had said that she would not want to be kept alive "on anything artificial." The Schindlers, devout Catholics (as was Terri), vehemently opposed this move. Terri had left no written directives and very little in the way of spoken comments, but on February 11, 2000, Florida circuit court judge George Greer ruled that Michael Schiavo had provided "clear and convincing" evidence of Terri's medical diagnosis (the Schindlers had claimed that she had more mental function than would appear in someone in a persistent vegetative state) and wishes and therefore could remove the feeding tube. The Schindlers appealed the decision, beginning the next stage of a long, bitter, and eventually very public personal and legal battle. The contest between Michael Schiavo and the Schindlers over Terri Schiavo's care eventually ended only with Terri Schiavo's death on March 31, 2005, two weeks after her feeding tube had been removed for the final time and 10 days after a three-judge panel of the 11th Circuit Court of Appeals, to which the congressional legislation had transferred the case, refused to order the tube reinserted. The Supreme Court also turned down a last-minute appeal. The Schiavo case established no legal precedents, but commentators agreed that it set a precedent in depth of conflicting emotions, not only in the Schindler- Schiavo family but also in the country at large. The case also brought a new degree of government intervention into what many felt should have remained a private or, at most, a judicial matter.

4.3.10 *Sampson and Doe v. State of Alaska*.³³: Alaska Statute, 11.41.120 prohibits assisted suicide. The statute was challenged in The Alaska Supreme Court, held that the Alaskan Constitution's guarantees of privacy and liberty do not afford terminally ill patients the right to a physician's assistance in committing suicide and that Alaska's manslaughter statute did not violate Sampson and Doe's right to equal protection.

4.4 Canada:

4.4.1 *Sue Rodriguez v. British Columbia (Attorney General)*³⁴ : The Court rejected the plea of Rodriguez, a woman of 43, who was diagnosed with Amyotrophic Lateral Sclerosis (ALS) to allow someone to aid her in ending her life. But, two years later,

³³ 31 P.3d 88, 99 (Alaska 2001). Available at www.allbusiness.com/legal/3495535-1.html. (Last visited on Feb 25th, 2019)

³⁴ (1993) 3 S.C.R. 519.

Ms. Rodriguez received the assistance of an unknown doctor and ended her life, in direct defiance of the court's decision.

4.5 In India

4.5.1 Judicial intervention regarding “Right to Die”: The Delhi High Court had criticized Section 309 of I.P.C for the first time in the leading case of *State V Sanjay Kumar Bhatia*.³⁵ Right to die was argued in the case. In *Chena Jagdeeswar V State of Andhra Pradesh*³⁶ it was clearly held by the High Court that Section 309 did not infringe the spirit and principle of Article 14 and 21 of the Indian Constitution. Honourable Lodha J held in the case of *Naresh Marot rao Sakhre V Union of India*³⁷ that euthanasia and suicide are contradictory to one another. While the former is an act of terminating one’s life either with the help of a doctor or withdrawing treatment, the latter is an act of self-destruction. In the famous case of *P. Rathinam V Union of India*³⁸, the Supreme Court overruled the decision given in *Chena Jagdeeswar V State of Andhra Pradesh*³⁹. It firmly decided that Section 309 of I.P.C was not against Article 21. But, in *Gian Kaur V State of Punjab*⁴⁰, the above case was set aside. It held that the right to die was not within the “right to life”⁴¹. The researcher would like to state some provisions in this context⁴². Section 107 of I.P.C states that abetment not only includes conspiracy but aiding in an offence or assisting or instigating also falls within the purview of the offence. Where a person should disclose a particular fact and avoids doing so as he tries to conceal it, he shall also incur penal liability. A doctor is treated to be a messiah for the people and so he should disclose the truth to the patients and not keep him under concealment of facts. A doctor cannot facilitate any activity which is against public policy. Indian Penal Code makes the facilitator equally liable. If any person abets suicide, he shall be liable for simple imprisonment of one year or fine or both. The provisions in I.P.C makes crystal clear that euthanasia is illegal in India, whether active or passive as Section 33 of I.P.C makes both

³⁵ 1986 (10) DRJ 31

³⁶ 16th April, 1987 Laws (APH)- 1987-4-22

³⁷ 1996 (1) Bom CR 1995 CriLJ 96, 1994 (2) MhLj 1850

³⁸ 1994 AIR 1844, 1994 SCC (3) 394

³⁹ *Supra* note 3

⁴⁰ 1996 AIR 946, 1996 SCC (2) 648

⁴¹ Shahnawaz, Indian Judicial Approach Regarding Right to Die, June 23rd, 2015, legal service India.com (Last visited on April 18th, 2019)

⁴² Ritika Bansal, *Euthanasia and Plea for Mercy-Killing* 76-77 (Universal Law Publication, New Delhi, 2013)

commission and omission of a guilty act an offence. Section 81 of I.P.C refers to such acts which are likely to harm a person but with no mens rea and as such it is to prevent other harm.⁴³ Acts done with consent whether express or implied for a person's benefit is a good defence in law. But, it should be borne in mind that the necessity must be to prevent greater harm and should be for common good.⁴⁴ A person can plead that he did the act in good faith like causing miscarriage, which is otherwise an offence, but is not regarded so if the circumstances justifies. Hence, the above statements hold that passive euthanasia may be permitted in rarest of rare cases but active euthanasia is not allowed in India. Many people in India have filed mercy killing petitions though all were rejected in absence of any adequate law on the controversial and perplexing issue. Amit Jain, requested euthanasia as he was suffering from spinal injury and was dependent on his married sister for twenty years. In 2008, a forty year old lady with a kidney ailment and her husband from Kolkata had written to the District Magistrate for euthanasia but in vain.⁴⁵ In *Siddheswari Bora V State of Assam*,⁴⁶ which was decided on 26th March, 1981, Siddheswari, the appellant in the case was convicted for killing her three years old daughter. She had two other daughters named Pilpili and Sumitra aged nine years and seven years respectively. On 26.3.74 at about 9 A.M, when the grandmother was working in the cowshed, they ran to inform her that their mother had killed their sister, Nileswari. The brother of the accused who was coming from market was sent to inform his father. Also, the father of the accused lodged complaint at about 1P.M implicating the accused in the crime.⁴⁷ That their mother had killed the child was testified by their close relative noted above. There were five incised injuries on the person's body as detected in the autopsy reports. One injury was on the neck and the other was on the occipital region of the head which is just over the back side of the neck. Sri Sharma who appeared as amicus curiae said that Siddeshwari has caused the offence as she was suffering from mental derangement. The daughter gave evidence that their mother was a mental patient. However, the defence was rejected as no similar traits

⁴³ *Ibid.*

⁴⁴ S.N. Mishra, Indian Penal Code (As amended by The Criminal Law Amendment Act),2013

⁴⁵ [www.supremecourtcases.com>index](http://www.supremecourtcases.com/index), S.S Das, Victory of Passive Euthanasia in India (Last visited on April 13th, 2019)

⁴⁶ LAWS (GAU)-1981-3-4

⁴⁷ [www.the.laws.com/Encyclopaedia/ Browse>Case](http://www.the.laws.com/Encyclopaedia/Browse>Case), Siddheswari Bora V State of Assam, (Last visited on (Last visited on April 13th, 2019)

under Section 84 could be found.⁴⁸ Moreover, it could be deduced from the confession of the accused that since the child was badly ill, the accused couldn't tolerate any more. The principle of "diminished responsibility" as applicable to English law seems to have taken care of mercy-killing in England.⁴⁹

The appeal in *Smt. Selvi and Others V State of Karnataka*⁵⁰ was dismissed by the High Court of Guwahati. It held that no persons should, by any forceful means, be subjected to any of the techniques in question, whether in inquiring any criminal case or otherwise. It would lead to invasion of personal liberty. The Hon'ble Apex Court in 192 of the said judgement held thus.⁵¹ So far, the judicial undertaking of privacy in our country has mostly stressed on the protection of the body and physical spaces from the intrusive action by the State. The same cannot be the basis for compelling a person to impact personal knowledge about an relevant fact.

An individual's decision to make a statement is the product of private choice and here should be no scope for any other individual to interfere with such autonomy, especially in circumstances when the person faces exposure to criminal charges or penalties." The Supreme Court observed that there is absence of consent by the petitioner for the tests as was held in *Mahesh Mahan Singh Shribas V State of Maharashtra*.⁵² But, what is noteworthy is that the –Lie Detector Test can be conducted only if the accused consents and such consent shall be recorded by the Judicial Magistrate.

4.5.2 The Indian Story of Aruna Shanbaugh

The contribution of Judiciary towards bringing a transformation in the phase of the Indian legal system in matters of a person's life, liberty and dignity has been phenomenal. The issue of euthanasia, although has a historical existence in India has never been legally addressed on a larger platform. However, the contribution of Indian Judiciary towards dragging the issue of euthanasia into limelight has been

⁴⁸ <https://www.casemine.com/judgement> (Last visited on April 17th, 2019)

⁴⁹ *Siddeshwari Bora V State of Assam*, Gauhati High Court, <https://www.casemine.com/judgement/in/56649,50b607dba348f010cd8> (Last visited on April 20th, 2019)

⁵⁰ *Selvi and Others V State of Karnataka*, 2010 Supreme 558 (SC)

⁵¹ Nayan Joshi, *Medical Jurisprudence and Toxicology*, 391-392 (Kamala Publishers, New Delhi, 2011)

⁵² *Shibas V State of Maharastra*, 2010, CriLJ 4380(Bom)

noteworthy. It is significant to discuss the relevant judgement that has given a structure by regulations to govern the much sensitive issue.

A journalist who was renowned named Pinki Virani is worth mentioning in this case. She had filed a writ petition under Article 32 of the Indian Constitution. The whole concept of euthanasia had come into limelight in India in the landmark case of *Aruna Shanbaug V Union of India*⁵³. A nurse named Aruna Shanbaugh was working in Mumbai in a hospital named King Edward Memorial Hospital. It was then when a tragic incident changed her entire life by permanently leaving her vegetative for rest of her life. She was brutally raped and strangled by a dog's chain. A sweeper working in the same hospital committed the heinous act. The supply of oxygen in her brain stopped and she suffered from a permanent haemorrhage. For forty years, she was in a vegetative state. Her brain was dead and she was unable to ventilate her feelings. She has left without any movements for years together with no sense of awareness. The prayer was moved to the court to withdraw the feeding tubes so that she could have peaceful exit. She was abandoned by her family. Her figure became skinny and one could easily lift her.

Her brittle bones were on the verge of breaking if caught by someone even accidentally. Her body became so light that it could be compared to a featherweight. With her wrists twisted inwards, she was prone to daily bed sores. Causing immense pain, even her tooth decayed. She was in a state of menopause and she survived only in mashed food that hardly she took. It was also alleged that Aruna Shanbaugh who was in persistent vegetative state was almost dead and showed totally no signs of development in her brain. She lacked awareness too.

Totally irresponsive to the harsh reality, she could hardly recognise whether any food went into her body. It was also doubtful whether her sense organs were active. She is not able to swallow or digest any liquid food. The food went down on its own although there was no effort on her part.⁵⁴ As the mashed food was put in her mouth, it went to the body artificially. Her body is nothing but a skeleton. In the bed itself, her excreta and the urine got discharged. She showed no positive response to the situations. Being totally oblivious of the surroundings in and around her, her

⁵³ *Aruna Ramchandra Shanbaug V Union of India*, AIR 2011 SC 1290

⁵⁴ 53, no.3, *Journal of the Indian Law Institute*, New Delhi (July-September, 2011), 458

existence in the world was only in the form of occupying a hospital bed. She was also devoid of the human touch. There were no visitors to see her. Headed by Mr. Justice Markandey Katju, the case was placed before the Honourable Bench. A doctor's team was appointed by the Court for examination of the patient's reports. Dr. J.V. Divatia, an anaesthesia, Professor Dr. Roop Gursahani, Neurologist and Dr. Nilesh Shah, Professor of Psychiatry were appointed in this case. It was reported that Aruna Shanbaugh was not aware of her surrounding circumstances. The court raised the following questions for consideration.⁵⁵

1. Whether withdrawing or withholding life sustaining therapies in the case of patients who are in vegetative state was permissible?
2. Whether the wish of the patients expressed previously be given respect?
3. Whether there was any mechanism to solve the issue, if no such wish is expressed by the incapacitated patient?
4. Who could act as a valid surrogate?

The court here ruled out the "principle of personal autonomy" and permitted withdrawing of support within permissible parameters. The Court further declared that the patient's 'best interest' be considered.⁵⁶

This case marks a turning point imbuing a thought provoking respond among every individual of the society. But the judgement failed to prove fruitful with no productive response. Moreover, Aruna died struggling with humiliation and mercilessly with not even a drop of sympathy or apathy either from the courts or legislature. However, the issue has for the first time created a sensation in the country and it has drawn the attention of the judiciary to think a new about the fact so as to what should be the priority-a quality life or bare survival. The judgement given in Aruna, however, could not solve the much-debated issue and in fact left room for more controversies in future. The never-ending solution to this controversial issue, however, remained unresolved by the legislative organ of the government and the

⁵⁵ *Ibid* at p.460

⁵⁶ <https://economictimes.indiatimes.com>> The Aruna Shanbaugh case which changed euthanasia laws in India (Last visited on June 3rd, 2019)

cries of many Aruna's in the county are yet to be answered by the pedestal of the country which is certainly not expected to turn a deaf year to the human pain and agony. However, it should be noted that the Supreme Court did not give a laid-back position to this issue and have made all attempts to find ways in the form of guidelines.

The researcher, however, opines that the story of Aruna, have to be looked from two angles. One-sided comments would not justify to the pathetic story. On one hand, the researcher feels it was better to administer euthanasia upon her as she was leading a life which was a mere physical existence, though not an animal like as the staff of the hospital nurtured her with much care and affection. Her teeth had decayed with skeleton like body and on top of that she had stop menstruating long back, less for her age than her physical inability. In other words, she was living for the sake of living and was a mere vegetable. Living in a hospital, bed-ridden for forty years was a life of humiliation as it was clearly showed by the doctors that she had no chance of recovery.⁵⁷

On the other hand, the researcher appreciates the judgement that it did not allow euthanasia in her case particularly, as medical reports indicated that she showed happy indications where she was offered food like fish and chicken. And, the nurses could make out when she felt suffocated in the room while surrounded by many people. The hospital authorities loved her immensely and took care of her even more than a family. They were quick enough to catch the responses made by her and could make out when she felt happy or sad. Former Dean of Kem Hospital Dr. Pragna Pai said- "Comatose was not applicable to Aruna. I used to go and talk to her and when you tell her some story, she would start laughing or smiling or when you start singing some prayers or shlokas, she would look calmly and peacefully, as if she is also joining the prayers".⁵⁸

Her case show cases the circumstances where a mechanism should have been invented to detect the actual human feelings. One cannot rationalize death in her case as nobody could grasp her feelings as to whether she wanted a peaceful exit or was

⁵⁷ <https://www.indiatimes.com>>everything you need to know about Aruna Shanbaugh, whose case led to India's euthanasia debate (Last visited on June 3rd, 2019)

⁵⁸ *Supra* note 8 at p.85

pinning hopes to recover and rise up from the much painful situation like a successful warrior achieving victory. Death cannot be glorified in the cases when the actual state of feelings of the person is unknown. Aruna might be longing for the doctors to give her a normal life someday. The judiciary cannot move forward to make legislation killing persons. They had to be extra careful in deciding such sensitive issues which is catering debates from the world at large.

It is said that so long there is hope, there is life and everything seems to be beautiful even in acute pain and sufferings. The act of Judiciary in the case of Aruna is commendable as the facts clearly suggest that she showed no signs of recovery. Pinki Virani, a journalist took a step from her own angle as Aruna was suffering immensely. But, that cannot justify taking away life from her as there was nothing to portray what actually she felt. There was nothing to ventilate her feelings.

So, the judiciary has rightly taken the decision in her case of not allowing euthanasia upon her as it would be mere killing and would also go against the law of the land. The Supreme Court also had to follow that I.P.C does not distinguish between killing and letting die.⁵⁹ The doctors, relatives, friends or any family members- all must be accountable and answerable for any harm upon the patient. Therefore, there is a need for a law regarding the matter. The matter has to be examined and debated upon.⁶⁰ But, that cannot justify taking away life from her as there was nothing to portray what actually she felt. There was nothing to ventilate her feelings.

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⁵⁹ Purnima Gupta and Ashutosh Hajela, “Notion of Euthanasia in India: Rational V Humanitarian Approach”, 4 no. 9 *Reader’s view/Short Article, A Monthly Legal Journal in English*; (September 2013) 28

⁶⁰ Hemant Kumar, “Passive Euthanasia, Time to enact Law”, Vol XVII *Magazine for Legal Professionals and Students, Lawyers Update*, (April, 2011) 13

4.5.3. Judiciary evolved Passive Euthanasia in the landmark case of Aruna Shanbaug

The Supreme Court has laid down the following procedures to be followed-⁶¹

1. When a patient is kept alive with artificial machineries without consciousness, the person is involuntarily functioning through machines and when there is no improvement in the patient's conditions at all or any sign of future improvement, the High Court can pass appropriate orders on the petition filed in the patient's best interest by a next friend and the treatment withdrawn.
2. When any petition is filed by the next friend, the Chief Justice of High Court should form a Division Bench to decide the matter.
3. A panel constituting three doctors- a neurologist, a psychiatrist and a physician would be consulted by the Bench to seek their opinion.
4. The High Court should give the next friend an opportunity of being heard and give them a copy of the report of the panel members and render the final verdict.
5. The High Court should give an expeditious judgement without delay. Other highlights of the judgement are as follows-
 - a. Active Euthanasia would be treated as a crime in India as it involves pushing a lethal injection.
 - b. Until and unless a new law is enacted by the Parliament, the judgment would hold good.
 - c. The Supreme Court had adopted a comprehensive procedure before withdrawing treatment of any person and has not given the full authority to the guardian with utmost respect to the wishes of the next friend.
 - d. The Supreme Court further stated that the Kem hospital is free to change its mind. If at all they do so, they could administer passive euthanasia upon Aruna, if the Bombay High Court approves it.
 - e. The decision focused on protection of the patients and at the same time provides safeguards against the misuse.

⁶¹ Rajesh Sethi, *Euthanasia- Legalising Euthanasia in India* 98 (Vidya Prakashan Mandir Limited, Meerut, 2015)

Harish Salve (2011), Solicitor General and Senior Counsel said: The Supreme Court judgement underscores the need for the government to enact a law on the subject.⁶² Iqbal Chagla (2011) has also taken a positive view of the Supreme Court judgement that it strides a very nice balance between the compassionate need of a terminally ill patient to end his or her life and to abuse relatives.⁶³

Reacting on the judgement in Aruna's case, former Union Minister M.Veerappa Moily (2011) commented that the government is examining whether an adequate legislation is needed for passive euthanasia. There is no question of concurring or not concurring with the judgement. According to him, one cannot resort to these decisions. Only judicial order is not sufficient. Therefore, there is a need for serious debate regarding the highly sensitive issue.⁶⁴

Dr. Samiran Nadi (2011) said "It will open the flood gates to ending life"⁶⁵ and Dr. Pragnya Pai (2011), however opposed the judgement by stating that- "Birth, growing up and death are not optional but inevitable. Some people cannot decide if a person will live or die."⁶⁶ According to Aurobindo Savitri, „Death-bound illness is not at all we are "The glory of life is integral to its renunciation where the supreme need of misery demands it".

4.5.4 Analysis of the judgement of the much sensational case: Aruna Ramachandra Shanbagh V Union of India:

The Hon'ble Court held that certain criteria have to be met to declare the person dead-⁶⁷

- a. Interaction with the environment and his capacity to receive and to choose his set of actions.
- b. the basic felt needs that drives the organism to act and obtain what is required whereas the situation in the above case is varied.

⁶² Harish Salve is a Indian lawyer, who give his view on euthanasia, <https://timesofindia.indiatimes.com>> (Last visited on Sep 17th, 2019)

⁶³ Iqbal Chagla is an India's leading lawyer in Mumbai who expresses his views on terminally ill patients.

⁶⁴ Hemant Kumar, "Passive Euthanasia, Time to enact Law", Vol XVII, Part 4 *Magazine for Legal Professionals and Students*", *Lawyers Update*, (April, 2011) 13

⁶⁵ *Ibid.*

⁶⁶ *Ibid* at 14

⁶⁷ Analysis of *Aruna Ramchandra Shanbaug V Union of India*, 13thfeb 2015, iilsindia.com (Last visited on June 6th, 2019)

The researcher on careful analysis of the judgment could highlight the following vital points regarding the much sensational case-

- **Permanent Vegetable State not applicable to Aruna's conditions-** Aruna, as the reports indicated along with the counter affidavit filed by Dr. Pazar that she made response by „ah“ and „uh“ and was not completely ignorant of what was happening around her. She showed a sign of displeasure by making certain vocal sounds when she was surrounded by number of people in the room and a sigh of relief when the people left the room. Most significant is that her signs could be easily grasped by the staff of the nursing home which looked upon her with utmost care and love. Based on the reports furnished by the physicians, it could be said that Aruna did not suffer from brain dead. Terminating her life would amount to killing.⁶⁸
- **Aruna– not in a state of coma-** Coma is a state where the patient is awake with no sense of awareness but that was not the case with Aruna. She reacted to the food and the hospital staff could gather information from her signs whether it was a sign of satisfaction or otherwise. Aruna was very much aware of the environment although she never laughed or cried.⁶⁹ She was not merely an effigy.
- **Disparities in the reports of Pinki Virani and the reports furnished by the team of doctors-**The writ petition filed by the journalist vindicated that Aruna was leading a life devoid of care and dignity and she had no life in real sense and was simply a skeleton like figure placed just like in a museum. Her family abandoned her long back and now that she has no one to look after as she had been lying in the hospital bed number four (04) since years with humiliation, there must be end to her physical existence. On the other hand, the team of doctors reported that she was leading a life under proper care and attention of the hospital staff and they were waiting for her recovery. Though her family left her, the staff of the nursing home was a family for her as they took notice of her

⁶⁸ Kasturi & Mounica, Symbiosis Law School, Pune, Aruna Ramchandra Shanbagh V Union of India: case analysis-Lawctopus, Jan.7th, 2015, <https://www.lawctopus.com> (Last visited on June 18th, 2018)

⁶⁹ *Ibid.*

slightest gesture and in fact did more than what a family could have ordinarily done. So, allowing euthanasia would have been disregarding the care taken by the nursing home⁷⁰

- **Best interest of the patient-**In the case of Aruna, the hospital authorities would be treated as „the next friend“ and not Pinki Virani, although she acted as a public-spirited person. The staff was ready to nurture her and was not ready to let her die even though her conditions deteriorated when she suffered from malaria. But they took enough care for her early recovery and pinned hopes upon their treatment.
- **Advocating Palliative care-** It was quite visible in the case of Aruna. The efforts of the hospital authorities clearly showed the element of care even though cure was far behind. Despite the fact that she discharged urine in bed and needed assistance to discharge stool, yet the team of doctors were surprised to see not even a single sore by her side.
- **Article 21 also includes clean environment⁷¹-** It is to be noted that in the case of Aruna, there was no question of violation of fundamental right. The writ petition, therefore, was disallowed. The environment in which Aruna was kept was quite hygienic and the team of doctors couldn't even find a single trace of unhygienic symptoms. In fact, the hospital authorities were quick enough to respond to her needs and gave her more than that could be usually expected.
- **Terminal Illness or coma not fully applicable in case of Aruna** –Despite terminal illness, euthanasia could not be administered in case of Aruna because of the reactions she showed at times regarding her likes and dislikes. Also, it was difficult to detect whether she wanted death or had a hope for recovery.
- **Aruna Shanbaugh was not declared brain dead-** Aruna Shanbaugh was not totally brain dead. Coma was also not totally satisfied in her case as a complete

⁷⁰ Kasturi Mounica, Aruna Ramchandra Shanbaugh V Union of India: Case Analysis, <https://www.lawctopus.com/academilke> (Last visited on June 18th, 2018)

⁷¹ Right to clean and healthy environment as a Fundamental Right in India, lexpress.in/environment/right-clean (Last visited on June 18th, 2018)

absence in her behavior was not indicated and no such evidence was found evident from the voluntary responses, she made at times.⁷²

- **Theory of Slippery Slope-** According to Shreyans Kasliwal, “The Slippery Slope argument, in short, is that permitting voluntary euthanasia would over the years lead to unnecessary deaths.”⁷³ This would eventually end up allowing even non-voluntary and involuntary euthanasia. The decisions however would differ from time to time.
- **Vaccum in the interpretation of the concepts of ‘suicide’ and ‘right to die’-** There exists a gap bridge between the very concepts of suicide and right to die.⁷⁴ A wider interpretation is demanded into this aspect. Five principles could be deduced for paving way for passive euthanasia in future-
 - a. **The Principle of Motive** i.e. every action is to be considered as law considers every action behind the human acts. The doctors who assist or carries out euthanasia is said to commit crime if it is not with the approval of the patient. According to Darwin, man has evolved from animal species and it is only his rational capacity to judge and exercise free faculty of choice and development.⁷⁵ Human life gets forfeited when its relevance extinct due to acute suffering and agony and instead of life and death what remains is only matter of breath and heartbeat. Whether life is meaningful or burdensome, whether to own or disown is a supreme freedom implicit in fundamental right to life.⁷⁶ Euthanasia is the most sensitive experience of human freedom and liberty.
 - b. **The Principle of Certainty** with regard to death i.e. if there are no signs of recovery, the withdrawal of life support does not constitute homicide.⁷⁷
 - c. **Principle of Injury**, by means of which it could be said that decision of euthanasia hurt patients and relatives but withholding death aggravates the humiliation and human sufferings.

⁷² *ArunaShanbaug V Union of India and others*, <https://indiankanon.org/doc> (Last visited on June 18th, 2018)

⁷³ www.bbc.com/ethics/slippyslope (Last visited on May 25th, 2018)

⁷⁴ Udit Raj Sharma, “Case Comment”, *Nikhil Soni V Union of India* (2015)

⁷⁵ V.R.Krishna Iyer, *Law and Life* 148(Universal Law Publication Co.,2009)

⁷⁶ *Ibid.*

⁷⁷ *Supra* note 75 at p.78

d. Principle of hardship- Life support measures- principle of hardship is a qualitative approach qualitative approach.

e. Custom- The role of physician is to preserve life but society is dynamic and to adapt the law to the dynamic needs of the society is the order of the day. Euthanasia is the process to get rid of suffering, pain and distress. According to Justice Hari Swarup, dignity is fundamental and the basic principle. It is destroyed when a person is left in utter distress and trauma as life becomes meaningless in that case.⁷⁸

The Judiciary is proactive in taking decisions in support of right to health, which of course means sound health. It further states that emerging medical care formed a core component of the right to health which in turn was recognized as forming vital part of the right to life.⁷⁹ Right to life as imposing a positive obligation on the state to safeguard the life of every person stating that preservation of human life was of utmost importance and that the Court emphasized on the welfare state. Adequate medical assistance for the people should be provided to the people by the state. The government also discharges the responsibilities of running hospitals and health centres⁸⁰

4.5.5. Some Judgements of the Honourable Supreme Court on mercy-killing at a Glance:

Jeet Narayan of Mirzapur wrote a letter to the president of India pleading mercy-killing as a last resort for his sons who were paralysed below neck, although his plea was rejected. Durgesh, Sarvesh, Sushil and Brijesh were the four sons of Mr. Jeet-all aged from thirteen to twenty-two. heir plea was rejected and so they had to spend their life in a humiliated condition awaiting death.⁸¹ The problem is that what to do in such situation- Is it enough if the state keeps them alive in order to portray the schemes of welfare state as it is unlikely for the state if it does not protect its people?

⁷⁸ *Supra* note 75 at p.79

⁷⁹ [https://www.legalindia.com/right to health](https://www.legalindia.com/right-to-health) (Last visited on April 24th, 2019)

⁸⁰ Anita Menon, *Right to Life and Right to death- a study*, 25(ICFAI University Press, Dehradun, India, 2009)

⁸¹ [www.thaindian.com>newsportal>health1>famouseuthanasia cases across the world-The Indian News.](http://www.thaindian.com/newsportal/health1/famouseuthanasia-cases-across-the-world-The-Indian-News), March 7th, 2011, ICT BY IANS, (Last visited on June 16th, 2018)

Or, are they protected in the manner that the state is simply not allowing them to die? What can be done under such a state?

The researcher opines about the significance of the guidelines of the Supreme Court. Just as in case of succession, a definite process is followed to take the succession certificate in order to be entitled to the property of the deceased, similarly, a definite process should be under taken for these patients. It finds reference in the guidelines of the Supreme Court. In a welfare state, the state cannot do away with its responsibilities towards such patients. It is not a protective relief if such patients are kept alive only for the sake. At least, the state can fund for these suffering patients so that money does not take a toll on them when health have already taken. The area is grey.

Presently, the state plays an active role in every sector. Then, how could this vital area be left unattended to which a promising answer is the need of the hour. There are many patients suffering and out of which some comes to lime-light whereas others are dying in a manner actually uncalled by a welfare state. There should be a strict process and the rights of the patients to have a shield in the welfare state should be recognized. The researcher feels that this is a grey area which requires immediate notice of a law.

The guidelines of the Supreme Court would definitely be beneficial or else patients are left clueless as to what to do in many cases. It is the primary duty of a welfare state to protect mankind and provide welfare mechanisms. In this case, these people have no money after spending huge funds for the recovery. At least, funding by the state could be of great help to these poor victims as financial crisis is a major problem which already makes a person hopeless and he is in laid back position. The income and expenses are not in the hands of state. They cannot be equated in most of the cases a cost of living is so high that the state by going through the circumstances of each case could naturally fund for these needy group.

Another person was Dilip Manchua aged thirty years, a stag picker who got paralysed in 2008. He was from Jamshedpur and filed mercy-killing petition before President Pratibha Patel. But he ultimately died.⁸²

⁸² Hazia Ambereen, "Have Mercy on Terminally Ill and Legalise Euthanasia", Jamiajournal.com.2013/02/08(Last visited on June 16th, 2018)

Dinesh Pratap Singh also knocked the door of High Court for the same reason. Despite the fact, that there is no law for euthanasia in India, the people directly show their reluctance to lead a life devoid of quality.⁸³

The case of Karibasamma, a retired school teacher who hails from Bangaluru was in the Ananda Dharma old age home in Davangere. She was bed-ridden as was suffering from intervertebral disc prolapsed, commonly known as slip disc, for the past fifteen years and since 2003, she had been awaiting death, seeking permission to end her life but in vain. In 2010, she also wrote to the Prime Minister for mercy-killing. The Bengaluru High Court rejected her request for mercy-killing which was sought for the patients in persistent vegetative state. According to the Bengaluru High Court, the patient in this case did not come under the said category.⁸⁴ Chaudhury, GS, ISCCM and Prof of medicine at PGIMS, Rohtak cited about a boy aged eighteen years suffering from quadriplegic after an accident. He couldn't breathe. His parents disposed of their lands to incur the expenses of his death prolonging machineries but he died after one month and a half. The problem is endless as these patients are denied KU beds as persons with permanent vegetative state occupy it only to meet death in an undignified manner.⁸⁵

Now, the pertinent question which the researcher ponders is that simply refusing person to die is not enough as in these disgusting situation deaths is better than prolonging it. The researcher opines that in India, the number of government hospitals are less in number compared to the population and one factor that brings the person from richness to rags is the disease, that too in a state, where prices of all essential commodities including the treatment of the expenses are skyrocketing.

Chantal Sebire, who was a French woman around fifty years of age was suffering from facial tumour which was incurable, which left her disfigured and blind. She was in acute pain and agony. She could not seek the help of doctor's assisted suicide. She compared her life with an animal. She was not in a position to demand the right to die but only sought for death with dignity.⁸⁶

⁸³ www.supremecourtcases.com/index2 (Last visited on June 17th, 2018)

⁸⁴ Shalini Saxena, "Pleading for death"-The pioneer April 27th, 2014, www.dailypioneer.com/special/pleading (Last visited on June 16th, 2018)

⁸⁵ m.timesofindia.com-End of life distinct from euthanasia, experts say-Oct 12, 2014, 05.56 A.M IST, (Last visited on June 16th, 2018)

⁸⁶ Harris Samuel French woman loses euthanasia bid in Paris, 7.20 A.M GMT 18th March,

The researcher opines that euthanasia is the only option left to a patient whose prayers are unanswered by God and doctors. The situation has no response in our country and that is the major problem. In a developing country like India, where unemployment, poverty and famine are major problems, how to afford remaining in hospital beds for years with no chances of recovery and awaiting death thereby using machineries which further prolongs death and accelerates suffering? If the state cannot provide with agile solution, it has also no right to keep the person as a humiliated figure thereby serving as an antique piece to serve as an illustration in history.

In one of the cases, in Andhra Pradesh, the mother seeks euthanasia for a nine-month-old child. Gyana Sai was detected with a rare liver disease known as Biliary Atresia.⁸⁷ She suffered from the illness since birth. The researcher wonders how a mother can claim death for her child unless the situation is of the worst kind. A mother generally would try to give up her own life in order to save the life of her children's life and would leave no stone unturned to bring her child to normal so that he could lead a healthy life. But no parents could remain a fix by seeing their children dying each day which is so painful. It is as if the child already suffered hell with no fault of his own. Then, what could the parents do in such situation? Euthanasia is not a right but it is a prayer so that the suffering person gets exit from the world in a dignified manner rather than sparing years and time where he not only himself becomes a humiliated figure but also dooms the entire family. The researcher however, feels that it should be allowed only by seeing the circumstances of each case as the state cannot afford to remain a silent spectator in these cases. Simply protection does not keep the person alive. It equally demands preservation. The „quality of life and „value of life“ are at a tug of war as both are significant from its own dimensions. But, without quality, everything is in vain. Life is no doubt, precious and it should be treasured but the question is that in what manner? Is it only for the sake or the true spirit of life shall be valued?

The answer is, the quality of life is much more significant than increasing the number of years to life. It is not worthy showing to the world as to how the physicians

[www.telegraph.co.uk>worldnews>Disfigured](http://www.telegraph.co.uk/worldnews/Disfigured) (Last visited on June 16th, 2018)

⁸⁷ [www.news18.com>newstopia>664mercy-killing](http://www.news18.com/newstopia/664mercy-killing) (Last visited on June 16th, 2018)

keep a life alive by their new trends of research. The real worth would be to cure the patient through their long research work and inventions or to provide them with best palliative care. The state should take up the responsibility as it is the guardian of the people as enshrined in Part IV of our Constitution. The goal is to give a healthy life to the patient or to provide with such care which makes him develop a liking towards life rather than developing hatred towards one-self or the state for not giving anything fruitful. Life should be a blessing rather than a curse as viewed by the researcher and every attempt should be made by the state to develop these patients, thereby not simply giving a laid-back position.

In Agra, a man seeks euthanasia by writing to Pranab Mukherjee, then the President of India, for all his six children from eight to sixteen years of age. They were suffering from a rare disease. The disease paralysed their low bodies. It further affected their vision. They also had lost their oratory power. In other words, they were simply alive for the sake of remaining so.⁸⁸

In the case of *C.A Thomas Master V Union of India*,⁸⁹ the Kerala High Court dismissed the writ petition filed by a citizen wherein he wanted the government to set up “Mahaprasthan Kendra” (Voluntary Death Clinic) for the purpose of noble vision i.e. transplantation of bodily organs and voluntary death.⁹⁰

In 2005, Mohd.Yugnus“ from Kashipur, Odisha requested the President for mercy killing on the ground that his children were suffering from incurable disease but it was rejected.⁹¹ A similar petition was filed by Mr. Triakeswar Sinha from Patna which was also rejected.

The proponents of physician suicide opined that personal autonomy is the main crux of euthanasia whereas the anti-euthanasia view is that autonomy can never be the reason or ground for allowing destruction of life. But it is really perplexing to comment on the two adjectives of construction and destruction as the meanings might take different twists depending upon the social understanding of the process of life and death.

⁸⁸ Upreti and Meenakshi, Agra: Man seeks euthanasia for all six children suffering from rare disease, June

01,2015,9.50 A.M, IST (Last visited on June 16th, 2018)

⁸⁹ 2000 CriLJ3729

⁹⁰ 2000CrLJ 3729

⁹¹ <https://timesofindia.indiatimes.com>> (Last visited on July 17th, 2018)

In *Nikhil Soni V Union of India*⁹² a case was filed by a practicing lawyer in Rajasthan High Court. It was in public interest litigation to declare the principles of Santhara which is prevalent among the Jain community as illegal. This case was filed under Article 226 of the Indian Constitution for directing the Union of India through Secretary, Department of Home, New Delhi and the State of Rajasthan to declare Santhara as illegal.⁹³

Para 4 of the writ petition mentions certain instances which are as follows⁹⁴-

1. On 7th October, 1993, Sohan Kumarji had made a vow of Santhara. She fasted for twenty days and embraced death.
2. Premji Hirji Gala in Nov. 1994 fasted for two hundred and twelve days to meet death.
3. Jethalal Zaveri fasted for forty-two days in 1997 and died.
4. Nirmalanada fasted for three weeks on Jan, 10th 1997 and died.
5. Haraklalji Bhairulalaji Mehta, hailing from Rajasthan, in October 2000 Ahmedabad, fasted for twenty-three days and died.
6. In a Jain temple, in Gohana Town, Sadhvi Nerbhay Vani fasted for twenty days on May 23rd and died. Muni Matiryaji Maharaj, a woman from Bikaner, Rajasthan died after fasting for thirty-five days.
7. Another petition was filed by Vimla Jain who was given the status of Sadhvi. Her family members gave wide publicity to her fast by displaying the photographs in the newspapers. Even her decorated body was made a publicity stunt. But no action was taken by the police in connection to this glorification of death which is an offence under I.P.C. In this case, the practice of Santhara prevalent among the Jains was challenged. The petitioner reposed his faith on the Constitution of India to be governed by the law of the land which was just, fair and reasonable. The petitioner relying on the Constitution of India was governed by the law of the land. Mr. P.C Bhandari, Mr. Rakesh Chandal, Mr. Abhinav Bhandari and Mr. Dinesh Pareek represented the respondents. They were lawyers and also the members of Jain community. The state of Rajasthan

⁹² D.B.Civil Writ petition No. 7414/2006 (Public Interest Litigation)

⁹³ *Nikhil Soni V Union of India and another*, 10th august, 2015, <https://indiankanoon.org> (Last visited on July 17th, 2018)

⁹⁴ *Ibid.*

was represented by Additional Advocate General along with Mr. Anuroop Singhi, Mr. Ajeet Bhandari, Mr. Saurabh Jain, J.K Singh, Mr. Sunil Nath and Mr. Uday Sharma, who participated in the hearing with consent.

Present members were Hon'ble CJ Mr. Sunil Amburani, Hon'ble Mr. Justice Veerender Singh Siradhana and for Petitioners- Mr. Madhav Mitra, Mr. Nishant Sharma and Veerendra Singh. It was alleged that the petitioner has taken allegation against the Jain community and so the petition is set to be dismissed.

Santhara is a religious practice. Dharma, Artha, Karma and Moksh-all four objectives are those which all Hindu men seek to attain. Among the categories of these cases, Santhara is one of them. According to supporters of Santhara, this practice is in consonance with the right to die with dignity which is an indispensable attribute of human life. This is a process of uniting with the universe by becoming still at mental level devoid of pain, pleasure, feelings, wants and dying painlessly. But it is submitted by the petitioner that even if an act is done with the consent of the person to end his life, it is punishable under I.P.C. It is based on the notion that when human being cannot bestow life upon anyone. He has no authority to take it away either morally or legally. As Santhara is not a religious practice and is adopted only occasionally, the court had directed to stop its practice. It further held that any complaint made in this regard shall be registered as a criminal case and investigated by the police. In this case, the respondents failed to establish with supportive evidence that Santhara is an essential religious practice. It is not an important part of religious practice to attain Nirvana or Moksha. Euthanasia is a modern term to provide 'Moksha'. The oath is taken by doctor to serve their profession in their best possible way and the word 'best' should be judged from its true perspective rather than from the standpoint of theory.⁹⁵

Article 21 does not protect Santhara.⁹⁶ The court's reasoning is arbitrary taking into consideration the aspect of dignity and secondly, India being a secular country is free to profess one's own religious belief. The "right to die" with dignity is not to be equated with the right to life. Article 25 immune only essential religious practices and

⁹⁵ "Santhara: A Path to Death" - Legal Services India, www.legalservicesindia.com/article>(Last visited on July 17th, 2018)

⁹⁶ Sukrith, Parthasarathy The flawed reasoning in the Santhara Ban, Aug 24th 2015, 00:56 IST, www.thehindu.com (Last visited on August 11th, 2018)

ceremonies. In *Nikhil Soni V Union of India*, it was held that in number of scriptures preaching, articles or practices, Santhara was held to be a pertinent religious issue. It was also not necessary for the attainment of salvation of soul. It means the Court is totally regarding this practice as baseless. This analysis has put forth that the Jain's right to freedom of religion infringed in unsatisfactory manner.⁹⁷

The concept of dignity was stressed in *Maneka Gandhi V Union of India*.⁹⁸ It deals with the fundamental values cherished by our people since the time immemorial. The issue of Santhara has given rise to many controversies as it is not suicide that has been projected as a peaceful way to meet salvation of the soul where it becomes difficult to lead a normal life either due to disease, old age or natural calamity.⁹⁹

Analysis of the Judgement-

1. Religious practice has to be considered in India as secularism is considered to be the basic feature of the Constitution.
2. Consent as interpreted in the case of *Aruna Shanbaug V Union of India*, was clearly stated by the Supreme Court that the life care mechanism can be withdrawn whenever the patient consents.
3. Refusal to take food on treatment does not attract penalty in India.
4. Age old doctrines or beliefs cannot be done away with as custom is one of the sources of Indian Jurisprudence. This practice forms the essential part of Indian tradition, culture and ideology as it existed since Vedic times.¹⁰⁰
5. The Jains believed that the main goal of life is the attainment of moksha. It means liberation from the cycle of death and re-birth. The above view was given by the Hindu Philosophy.¹⁰¹
6. Santhara and Sati is distinguished because Santhara is a voluntary practice whereas Sati is something where the widow had to comply with the traditional belief despite her will.

⁹⁷ supra note 32

⁹⁸ AIR 1978

⁹⁹ Akriti Gaur, "Feeding life into the Santhara Debate"- *The wire*, <https://thewire.in> (Last visited on August 17th, 2018)

¹⁰⁰ <https://www.thehindu.com>books> (Last visited on August 17th, 2018)

¹⁰¹ Uma Mysorekar, "Safe Passage: A Global Spiritual Sourcebook for Care at the End of life", *The Hindu response*, <https://books.google.co.in>books> (Last visited on August 17th, 2018)

7. Santhara is to be distinguished from euthanasia as euthanasia is the only viable option available for terminally ill patient when they have no chances of recovery. Santhara was taken to attain purification of soul.

4.5.6. Landmark Judgment overturned – New dimension of Supreme Court the Supreme Court of India referred the issue of euthanasia to a five judge Constitutional Bench which was raised through a PIL. It stated that it is essential to have a clear law on the matter. There have been discrepancies of opinions on the verdicts pronounced earlier. In 2011 a verdict on passive euthanasia was given on a wrong premise. The Apex Court referred the matter to a Constitutional Bench to benefit in terms of human race. Considering the pertinent questions of law which is a reflection of social, legal, medical and Constitutional perspectives, it is necessary to have a clarification of the law. It was also in view of Aruna's case. It is for the benefit of entire human race", the Court said.¹⁰² Chief Justice of India, P. Sathasivam said that they would look into the matter and lay down extensive guidelines on the subject. It further held that it will go into all aspects of the society while delivering its view points¹⁰³

A Common cause society was registered in Delhi under Dr. Surendra Dhelia, a general Secretary. A writ petition was filed in the *Common Cause V Union of India*¹⁰⁴, and others and Society for Right to Die with Dignity. Dr. Surendra Dhelia, is also associated strongly with this cause¹⁰⁵ The petition under Article 32 of the Constitution of India in public interest was to bring into notice the major issues, relating to infringement of fundamental right to life, liberty and privacy. The Society for Right to die with dignity is the intervener. It is affiliated to the World Federation of the Right to Die Societies. The requisite for the organized basis was strongly felt and the first society was founded in England in 1935, by intellectual giants like George Bernard Shaw and H.G Wells. In the year, 1938, a Christian theologian, had established a society in the United States. Other countries like Europe, Australia and Japan followed the suit subscribing to the concept of "right to die with Dignity" Presently, the global significance of it is earmarked by the establishment of the World Federation of Societies for Right to Die about twenty five years ago, having

¹⁰² Supreme Court of India to revise the issue of Mercy-killing- Deccan Chronicle, Current Affairs, Feb 26th, 2014 (Last visited on March 19th, 2019)

¹⁰³ *Ibid.*

¹⁰⁴ I.A No.13 of 2014 in Writ Petition (Civil)No.463 of 2012)

¹⁰⁵ I.A No. 215/of 2008 in W.P (Civil) No.215 of 2005

membership of thirty societies from twenty countries of the world representing more than five million people. In 1980's, a leading Indian thinker Mr. Minoo Masani founded the society. The applicant Society has represented India in several international conferences of the World Federations of the Right to Die Societies. After Mr. Minoo Masani's death, it was led by a Director of Board of the said World Federation of the Right to Die Societies for two years. The society which is the applicant no.1 has founded to get the legal sanction of an advanced directive executed by the individual and so that they can choose for themselves and also to create awareness and opinion in favour of the aims and scope.

The society advocates right to die with dignity and strongly supports on the concept of voluntary euthanasia. It is the submission of the applicant that taking into consideration the needs of the people, law should make euthanasia rather facilitating and not compulsive. It further stated that the living will should be considered as a sort of insurance policy against the maleficence of undignified process of dying which may be imposed on the individual by means of modern medical technology. The society wanted permission from the Court to furnish available and relevant scientific and social materials for consideration.¹⁰⁶ Passive euthanasia was legalized by the Apex Court of our country on 9th March 2018. It also permitted living will for passive euthanasia under strict supervision and criteria. The court has framed guidelines in detail by using its extra-ordinary power and clearly held that the guidelines will be effective unless the Parliament makes a law.¹⁰⁷ The Bench comprising justices DY Chandrachud, AM Khanwilkar, AK Sikri, and Ashok Bhushan provide guidelines for execution of living will. It further narrated the circumstances under which medical board will approve of passive euthanasia.

An NGO named, A Common Cause Society, had recognized their right to have a dignified death. This right was recognized by a Bench of 3:2. The Bench gave a nod to right to live with dignity that includes accelerating the dying process in case there is no hope to recover.¹⁰⁸ It was opined by the Chief Justice of India that the

¹⁰⁶ *Supra* note 75

¹⁰⁷ Passive Euthanasia Permissible with Guidelines, Says Supreme Court, <https://www.ndtv.com/indianews/passiveeuthanasia-permissible-with-guidelines-says-supremecourt-1821608> (Last visited on March 19th, 2019)

¹⁰⁸ Supreme Court says passive euthanasia is permissible, ET Online, March 9th, 2018, 11.00 A.M IST,

concept of living will had become popular in many countries abroad. Be, it advanced directive in the form of surrogate or living will, certain countries have already legalized it thereby giving it a legal sanctity. Priority shall be given to advanced directive and right to self-determination though the sanctity of life which would in any case mean preservation from humiliation and ensure dignity.¹⁰⁹

The Supreme Court held that¹¹⁰ -

- a. The right to die with dignity as fundamental right.
- b. An adult human being having mental capacity to take an informed decision has right to refuse medical treatment including withdrawal from life saving devices.
- c. A person of competent mental faculty is entitled to execute an advance medical directive.

The apex court concluded that-

- i. The Constitution Bench in *Gian Kaur's case* held that the “right to life: including right to live with human dignity” would mean the existence of such right up to the end of natural life, which also includes the right to a dignified life up to the point of death including a dignified procedure of death. The above right was held to be part of fundamental right enshrined under Article 21 of the Constitution which we also reiterate.¹¹¹
- ii. We agree with the observation made in the reference order of the three Judge Bench to the effect the Constitution Bench in *Gian Kaur's case* did not express any binding view on the subject of euthanasia. We hold that no binding view was expressed by the Constitution Bench on the subject of Euthanasia.¹¹²
- iii. The Constitution Bench, however, noted a distinction between cases in which physician decides not to provide or continue to provide for treatment and care,

<http://www.ecoti.in/HPPDwy> (Last visited on March 21th, 2019)

¹⁰⁹ <http://www.livelaw.in/breaking-right-die-dignity-fundamental-right-Scallowspassiveeuthanasialivingwill-issues-guidelines/Live Law>, March 9th, 2018 at 11:05 A.M (last visited on March 24th 2019)

¹¹⁰ *Common cause (A registered society) v. Union of India and Others*, (2018) 5 SSC 1W.P. Writ petition (Civil) NO. 215 Of 2005, p. 537, 538.

¹¹¹ *Id.* At 533,534.

¹¹² *Common cause (A registered society) v. Union of India and Others*, (2018) 5 SSC 1W.P. Writ petition (Civil) NO. 215 Of 2005, p. 534

which could or might prolong his life and those in which he decides to administer a lethal drug even though with object of relieving the patient from pain and suffering. The later was held not to be covered under any right flowing from Article 21. Thus, the law of the land as existing today is that no one is permitted to cause death of another person including a physician by administering any lethal drug even if the objective is to relieve the patient from pain and suffering.

- iv.** An adult human being of conscious mind is fully entitled to refuse medical treatment or to decide not to take medical treatment and may decide to embrace the death in natural way.
- v.** Euthanasia as the meaning of words suggest is an act which leads to a good death. Some positive act is necessary to characterize the action as Euthanasia. Euthanasia is also commonly called “assisted suicide” due to the above reasons.
- vi.** We are thus of the opinion that the right not to take a lifesaving treatment by a person, who is competent to take an informed decision¹¹³ is not covered by the concept of euthanasia as it is commonly understood but a decision to withdraw lifesaving treatment by a patient who is competent¹¹⁴ to take decision as well as with regard to a patient who is not competent to take decision can be termed as passive euthanasia, which is lawful and legally permissible in this country.
- vii.** The right of patient who is incompetent¹¹⁵ to express his view cannot be outside of fold of Article 21 of the Constitution of India.
- viii.** We also are of the opinion that in cases of incompetent patients who are unable to take an informed decision, “the best interests principle” be applied

¹¹³ Section 2(e) of “The medical treatment of terminally- ill patients (Protection of Patients and Medical practitioner) Bill, 2016 has defined “Informed decision” as the decision as to continuance or withholding or withdrawing medical treatment taken by the patient who is competent and who is or has been informed about- 1. The nature of his or her illness 2. Any alternative form of treatment that may be available 3. The consequences of those of treatment and 4. The consequences of remaining untreated.

¹¹⁴ Section 2(c) of “The medical treatment of terminally- ill patients (Protection of Patients and Medical practitioner) Bill, 2016 has defined “competent patient” as a patient who is not an incompetent patient.

¹¹⁵ Section 2(d) of “The medical treatment of terminally- ill patients (Protection of Patients and Medical practitioner) Bill, 2016 defined incompetent patient as a patient who is a minor below the age of 16 years or person of unsound mind or a patient who is unable to- 1. Understand the information relevant to an informed decision about his or her medical treatment 2. Retain the information 3. Use or weigh the information as part of the process of making his or her informed decision. 4. Make an informed decision because of impairment of or disturbance in the functioning of his or her mind or brain 5. Communicate his or her informed decision (whether by speech, sign language or any other mode) as to medical treatment.

and such decision be taken by specified competent medical experts and be implemented after providing a cooling period to enable aggrieved person to approach the court of law.

- ix. An advance medical directive is an individual's advance exercise of his autonomy on the subject of extent of medical intervention that he wishes to allow upon his own body at a future date, when he may not be in a position to specify his wishes. The purpose and object of advance medical directive is to express the choice of a person regarding medical treatment in an event when he loses capacity to take a decision. The right to execute an advance medical directive is nothing but a step towards protection of aforesaid right by an individual.
- x. Right of execution of an advance medical directive by an individual does not depend on any recognition or legislation by a State and we are of the considered opinion that such rights can be exercised by an individual in recognition and in affirmation of his right of bodily integrity and self-determination.¹¹⁶

The Supreme Court in the Common Cause case¹¹⁷ has categorically recognized the right to die with dignity as fundamental right but there are several inconsistencies in Indian legal system. The Mental Healthcare Act, 2017 has not only recognized Advanced Directives¹¹⁸ but also laid down provisions to deal with a suicide survivor as a sufferer of mental distress and has cast duty on the government to ensure his care, treatment and rehabilitation and also to decriminalize attempted suicide under s. 309 IPC as was upheld by the Supreme Court in the P. Rathinam and recommended for

¹¹⁶ *Common cause (A registered society) v. Union of India and Others*, (2018) 5 SSC 1W.P. Writ petition (Civil) NO. 215 Of 2005, 535,536

¹¹⁷ *Ibid.*

¹¹⁸ According to S. 5 of The Mental Healthcare Act, 2017 "Every Person who is not a minor, shall have the right to make an advance directive in writing (a) the way the person wishes to be cared for and treated for a mental illness; (b) the way the person wishes not to be cared for and treated for a mental illness; (c) the individual or individuals, in order of precedence, he wants to appoint as his nominated representative as provided under section 14. (2) An advance directive under sub-section (1) may be made by a person irrespective of his past mental illness or treatment for the same (3) An advance directive made under sub-section (1), shall be invoked only when such person ceases to have capacity to make mental healthcare or treatment decisions and shall remain effective until such person regains capacity to make mental healthcare or treatment decisions. (4) Any decision made by a person while he has the capacity to make mental healthcare and treatment decisions shall over-ride any previously written advance directive by such person. (5) Any advance directive made contrary to any law for the time being in force shall be ab initio void.

deletion in the Aruna Shanbaug.¹¹⁹ Contrarily, draft of the Treatment of Terminally Ill Patients (Protection of Patients and Medical Practitioners) Bill, 2016 under s. 11 has proposed that advanced medical directive (living will) or medical power-of-attorney executed by a person shall be void having no effect and shall not be binding on any medical practitioner. In the light of the judgement, the Common Cause (2018), the Draft Bill must be amended to accord legal validity to both Advanced Directives and Medical Attorney authorisation. The Supreme Court has not categorically decriminalised attempted suicide in the instant Writ, therefore s. 309 IPC still remains operative heralding grave contradiction in the law. The Apex Court or legislature must address such legal discrepancies.

Poor status of education and legal awareness among common masses in India may become another cause of exploitation of advanced directives by greedy heirs and needs to be suitably addressed by the government for the best use of new right added in the folder of fundamental rights. In absence of adequate medical insurance and affordable medical health care for prolong illness, economic constraints on a middle-class family becomes most pressing consideration in opting for passive euthanasia, which may lead to undue haste in making of advanced directive to save families from medical expenses. The kin and relatives of a patient are compelled to admit the patient in expensive private hospitals due to poor infrastructure in the government hospitals. Mere enabling of passive euthanasia as fundamental right by the judiciary is not a solution until government rightly ties the issue with the intended aims by placing due emphasis on healthcare and medical insurance especially for poor and marginalized people. Recognizing right to have dignified death for terminally ill persons is only one side of the coin but the question remains unanswered as how this right will be interpreted and decided with reference to people demanding to embrace death due to various pressing reasons such as old age, destitution and lack of opportunity to die with honour in India. This has the potential to open floodgates for the Writ of Mandamus in various Indian constitutional courts.¹²⁰

¹¹⁹ According to S. 115 of The Mental Healthcare Act, 2017 (1) Notwithstanding anything contained in section 309 of the Indian Penal Code any person who attempts to commit suicide shall be presumed, unless proved otherwise, to have severe stress and shall not be tried and punished under the said Code. (2) The appropriate Government shall have a duty to provide care, treatment and rehabilitation to a person, having severe stress and who attempted to commit suicide, to reduce the risk of recurrence of attempt to commit suicide.

¹²⁰ G.K Goswami and Siddhartha Goswami "Right To 'Die with Dignity': Analysis Of 'Common Cause V. Union of India'" 60:1 *Journal of the Indian Law Institute* (2018) 110

Recent instance of the demand of euthanasia was on January 10th, 2018. A couple in Mumbai, Narayan Lavate and Iravati Lavate who were eighty-eight years and seventy-eight years respectively made an application to the executive Head of the country. He sought permission for allowing active euthanasia or assisted suicide. They expressed their will for having a dignified way out of life. It is to be noted that none are suffering from any illness but having no children to look after and fearing worst life due to their increasing age. It was admitted by the Lavates that after exhausting all legal remedies to terminate their lives through a doctor assisting in death, they had been the members of Switzerland based Dignitas, a society where physician assisted suicide is possible through legal provisions. While Iravati has a passport, Narayan was unable to have it and, in his absence, she didn't want to die as there would be nobody to take care of him. They lived in the Grant Road area of South Mumbai. They had taken a kitchen chawl to take shield with no responsibilities. After their retirement from the state transport office in the year 1989, they wanted to go for assisted suicide. He was quoted saying that he wanted active euthanasia and that there was a pending Bill in the Parliament pertaining to euthanasia.¹²¹ Iravati retired in 1997. She was the principal of a school run by the Aryan Educational Society and she said- "I am old and cannot even walk easily due to metro rail work here. My survival is not possible with the meagre pension. But, why, wait till an illness affect us"?¹²² The couple has also sent a Draft bill on euthanasia to NCP leaders namely, Sharad Pawar, Supriye Sule, former law minister Ram Jethmalani, Abhishek Manu Singhvi former Sabha member Karan Singh and Congress leader.

4.5.7 Euthanasia for people suffering from rabies:¹²³

On January, 2020 the supreme court sought the centre's response to a PIL seeking euthanasia for persons afflicted with rabies, which has a 100% fatality rate and is accompanied by extreme pain which is unmitigable by medicine. A bench of Chief Justice SA Bobde and Justice BR Gavai and Surya Kant sought responses of ministries of health and family welfare, as well as ministry of environment, forest and

¹²¹ <https://indianexpress.com/article/india/assisted/suicide-couple-seeks-presidents-nod-5018311>, Mumbai

couple seeks President Ram Nath Kovind's nod for assisted suicide, updated Jan 10th, 2018,5: 22A.M (Last visited on Jan 01st, 2109)

¹²² *Ibid.*

¹²³ "Can rabies patients opt for euthanasia" Available at <http://timesofindia.indiatimes.com/india/can-rabies-patient-opt-for-euthanasia/articleshow/73164110.cms> Last visited on May 25th, 2020)

climate change, after senior advocate Sonia Mathur pointed out that the SC's 2018 judgement allowing passive euthanasia left out persons suffering from rabies. Demanding recognition of right to die with dignity available to rabies patients, petitioner Anjali Gopalan's NGO "All Creatures Great and Small" said the SC's 2018 Judgement did not envisage "a situation where the death is inevitable regardless of assistance of medical facility. In such a situation, when the dignity of patient is jeopardised by the nature of diseases itself, it calls for different treatment for such patients". This burning case shows that despite supreme court ruling in common cause case, euthanasia debate is not yet settled. Euthanasia issues time and again continue to emerge in new situations with the demand of active voluntary euthanasia.

4.6 Conclusion

The Supreme Court acting as a guardian of the Constitution has made all attempts to raise the level of human dignity of mankind through judicial interventions. The Courts have adopted its reasoning power to state as to why they refused euthanasia in the first occasion. Pain management is another dilemma and the patient cannot be left to suffer merely because there is no law. The guidelines would definitely be a blessing in case a person wants to get rid of his aggressive curative treatment and opt for palliative care. However, the Supreme Court had clearly held that only on the strict supervision of the concerned authorities could passive euthanasia be allowed. In a democratic country like India, active euthanasia may be not possible however, this is demanded time to time by few persons. But the person who performed 'active voluntary euthanasia' should not be punishable for murder i.e. separate offence may be created. Apart from this, passive euthanasia should be brought within the ambit of the Constitution. Very rightly, the Supreme Court in India, established it. However, it does not mean that all persons can seek for passive euthanasia whether they are terminally ill or not. Thus, there is a need of legislative response in order to resolve the issues related to euthanasia.



CHAPTER-V

SOCIO-LEGAL, ETHICAL AND MORAL ISSUES RELATED TO EUTHANASIA



CHAPTER-V

SOCIO-LEGAL, ETHICAL AND MORAL ISSUES RELATED TO EUTHANASIA

“It is the cowards who die many times before that death. However, brave people will die only once”.

– William Shakespeare

5.1 Introduction:

Concepts of life and death are being one of the most controversial and debatable issues. There are enough efforts have been put on the justifying meaning of life and established that life is not mere live with animal existence but dignity of life is prime and paramount. Now the focus has been shifted to death related issues. Death cannot be considered to be the reverse of life, but it is an integral part of it. However, it is fact that in recent times society’s attitude towards death has been changed. The rapid and extraordinary progress in the modern medicinal technologies has drastically changed the whole course of death. Previously, death was normally something happened and it was acceptable for all of us. Now with development of high-quality life sustaining measures like artificial ventilator etc., the possibility to exercise control over dying process has increased to great extent. These lives sustaining machine initially developed to treat potentially curable patients, not for those who has no chances of recovery. This raise the questions regarding moral, ethical, social, emotional dilemma to the medical professionals as well as relatives that how much effort should be put to treat a incurable terminally patient with extreme pain and suffering. Now many people want peaceful, dignified and controlled death. They search their options to reach peaceful and quite death in the form of passive euthanasia (withdrawal or withholding life-saving treatment).

In normal situations patients have been given continued care and treatment which are neatly apparent. But in case of severe or final stage of painful disease she /he can be either sustained forever in their own existing painful conditions or can be

allowed to die. The dilemma involved in fluctuating between these two alternatives is often a crucial and a debatable topic in all the ages and the ages to come. In these situations, questions can be raised from ethical, social, legal and medical perspective which needs to be addressed in an altruistic and judicious manner. If we are about to terminate the life of an innocent patient who is in a painful condition but prefers to live then the ethical question arises; how we can take the life of others? This is against the medical ethics. And another question is, whether it is ethical to keep him/her alive just because we cannot morally let him/her die? Can his/her family insist on keeping the patient alive or his/her life is not to be continued? What are the legal rights of the patient and his/ her family? What is the responsibility of the physician in providing medical care? Is it legal to discontinue the care? Can the patient herself influence the decision taken regarding her future medical care? In this chapter an attempt has been made to analyze these debatable issues which forms the corner stone of this chapter.

5.2 The Heart of the debate:

Before getting into the detail of the debate over the issue it is useful to summarize two contrasting one is in support and other is against of euthanasia:

The supporter claims that there is nothing more horrific than a slow, pain-filled undignified death. People faced with such a possibility should have the option of ending their life at a time and in a way of their choosing. We live in a society which emphasizes the right to autonomy: to make decisions over how we live our lives. To render illegal the killing of a person desperate to die is to deny them the power to make one of the important and intimate decisions of their lives.

On the other hand, opponents of 'euthanasia' argue that to permit one person to kill another is a profound violation of a crucial moral principle: the sanctity of life. To legalize euthanasia to undermine the all lives are of equal value. Support for the euthanasia is premised on the assumption that there are some lives that are not worth living. That implies that there are some lives that are of greater value than others and that is an idea. Further, any move to change the law will have a particularly harsh impact on vulnerable people who will be easily manipulated into agreeing to euthanasia.

5.3 Sanctity of life/vitalism/quality of life

At the heart of much of the debate on euthanasia is the principle of the ‘sanctity of life’. Unfortunately, there has been considerable division over what exactly that principle means. It is clear it has been used by judges and commentators to mean very different things.¹ It is perhaps helpful to distinguish the principles of vitalism, sanctity of life, and quality of life.²

- I. **Vitalism:** This holds that human life has an absolute moral value. It is never justifiable to kill another person. Doctors should take all reasonable steps to keep humans alive. It is therefore impermissible for doctors to do an act which causes a patient to die or to fail to take reasonable steps to keep a person alive.

- II. **Sanctity of life:** This also holds that human life is a fundamental basic good. It states that a person should not be intentionally killed, be that through an act or an omission. Sanctity of life seeks to value the good of life itself. That good exists independent of any disability or incapacity. Craig Paterson argues: ‘it is always and everywhere wrong to intentionally kill an innocent person regardless of any further appeal to consequences or motive.’³ However, the theory of sanctity of life can be distinguished from vitalism in two regards:
 - a. First, the principle accepts that an act which shortens the life of a patient can be justifiable if it is not done with the intent to kill. It is the intentional killing which is outlawed by the principle and so it would support the doctrine of double effect.

 - b. Second, it may be permissible to withdraw treatment if the reason for doing so is that it offers no hope of benefit. The principle would not, however, justify withdrawal of treatment because the patient's life was not worth living.⁴ It does not therefore agree with vitalism that life should be protected at all costs.

¹ J. Keown, *Euthanasia Ethics and Public Policy: An Argument Against Legalization* 43 (Cambridge University Press, London, 2002)

² *Ibid.*

³ Craig Paterson, “Assisted Suicide and Euthanasia: A Natural Law Ethics Approach” 20 no. 3 *Kings Law Journal* (Jan 2009) 181

⁴ J. Keown, *Euthanasia Ethics and Public Policy: An Argument Against Legalization* 43 (Cambridge University Press, London, 2002)

III **Quality of life:** Here the basic approach is concerned with assessing the value of the patient's life. It holds that certain lives are not worth living and that it is therefore right to end them. It rejects the argument put forward by supporters of the sanctity of life approach that there is something good about life in and of itself. By contrast it is claimed that what makes a life good are the experiences of the person and their interaction with others. A life which can no longer be experienced, and in which relationships with others are impossible, is a life that has lost its goodness. Some supporters of this approach would attach great weight to the assessment of the individual themselves as to whether they thought their life still had value.

5.3.1 The Principle of sanctity of life: A Key issue in euthanasia debate

For many opponents of euthanasia, at the heart of the issues surrounding euthanasia is the principle of the sanctity of life. The lives of every member of society should be valued so highly by our society that they should not be intentionally destroyed, even if that is what the particular individual wishes. Supporters argue that once the principle is departed from, it inevitably becomes necessary to value some lives as less than others and not worth living. By contrast, the sanctity of life principle values all human lives equally and emphasizes that killing represents a unique wrong.⁵ The House of Lords Select Committee on Medical Ethics⁶ concluded that the prohibition on intentional killing was ‘the cornerstone of law and of social relationships.’⁷

Lord Justice Ward put forward an insightful definition of the sanctity of life in the *Re A*, the conjoined twin’s case:

*“The sanctity of life doctrine holds that human life is created in the image of God and is therefore possessed of an intrinsic dignity which entitles it to protection from unjust attack. The ‘right to life’ is essentially a right not to be intentionally killed”.*⁸

The principle is supported particularly by those writing from a religious perspective, who often start from the principle that each person has been made in the

⁵ L Gormally, *Euthanasia Clinical Practice and the Law* 248(Linacre Centre for Health Care Ethics, 1994)

⁶ House of Lords Select Committee on Medical Ethics (1993)

⁷ Special Committee of Canadian Senate (1993)

⁸ *Re A children conjoined twins: surgical separation* [2000] 4 ALL ER 961 per Ward LJ at 999J-1000A and 1000G-H

image of God and is equally precious in God's sight, However the principle is also supported by those of no religious persuasion but who are attracted by its insistence of the equal value of all human life. Somerville⁹ emphasizes the importance of the 'secular sacred', respecting the mysteries of life and death, which is of importance to the religious and non-religious. She also emphasizes the 'deeply intuitive sense of relatedness or connectedness to other people and to the world and the universe in which we live',¹⁰ which means that each person's life has value for the whole of society. Allowing death to occur when 'it's time has come' is part of recognizing the mystery of life and death. She admits this all sounds rather vague, but insists that this does not detract from the fact it has been intuitively felt to be true by so many people for so long. Emily Jackson,¹¹ by contrast contends that it is impossible to have a secular understanding of the principle of sanctity of life. She argues the principle only makes sense based on religious values. As a result, she argues it should play no role in secular law.

Opponents of the principle of sanctity of life generally accept that life is precious and valuable, but they reject the insistence that all life must be valued for its own sake.¹² In other words, supporters of euthanasia often take the view that there comes a point where a person's life is so wracked with pain and indignity that its special value has been lost. Rachels,¹³ for example, argues that there is a difference between having a life and being alive. To keep a person alive on a life support machine for years on end, even though there is no prospect of an improvement in her or his condition, is not to value the preciousness of life, but to demean it. Such commentators argue that the sacredness of life turns not on being alive, but on having a life worth living.¹⁴ This is why we regard the death of a person in the full flush of health and youth as a tragedy, but the death of person who months ago ceased to interact with the outside world as almost a blessing.

Ronald Dworkin, considering the position of a patient suffering from

⁹ Margaret Somerville, *Death Talk* 505-522 (McGill-Queen's University Press, 2001)

¹⁰ *Ibid*

¹¹ Emily Jackson, "Whose Death is it Anyway? Euthanasia and the Medical Profession" 57 *Current Legal Problem* 412-442 (2004)

¹² Margaret Otlowksi, *Voluntary Euthanasia and the Common Law* 216 (Oxford University Press, London 2000)

¹³ J Rachel *The End of Life* 86 (Oxford University Press, London 1985)

¹⁴ J. Harris "The Right to Die Lives: There is no Personhood Paradox" 13 *Medical Law Review* 386 (2005)

Alzheimer's, says that such a person: is no longer capable of the acts or attachments that can give [life] value. Value cannot be poured into a life from the outside; it must be generated by the person whose life it is, and this is no longer possible for him.¹⁵ He sees value in life as about making something of one's life and living in earnest. Therefore, once a person is in great pain near the end of their life then if, to them, their life has lost its value, then that person's life is no longer of special value and no longer protected by the sanctity of life principle.

We can now specify clearly the difference between supporters and opponents of the sanctity of life view: Supporters of sanctity of life argue that life in and of itself is valuable. Even a person in a 'coma', with no awareness of the outside world and with no friends or relatives to be concerned about them has value by virtue of being human. To reject such a view leads one to value the lives of disabled people less than others. Finnis¹⁶ claims:

Human life is indeed the concrete reality of the human person. In sustaining human bodily life, in however impaired a condition, one is sustaining the person whose life it is, in refusing to choose to violate it, one respects the person in the most fundamental and indispensable way.

Opponents of sanctity of life emphasize that what makes life valuable are the things that people do with it. It is the experiences people have, their relationships and activities which give life meaning. A person with no experiences (or only pain-filled ones) and no capacity for relationships has lost the goodness of life.¹⁷ Of a person suffering from PVS, Harris argues: 'It is a living human body (as in a sense it often is when brain death is diagnosed on a life-support system-it is warm, the blood circulates and so on) but it is not the living body of a person'.¹⁸

The principle of sanctity of life has been approved by the judiciary. For example. Lord Goff of Chieveley said in his speech in leading UK case¹⁹: "the fundamental principle is the principle of the sanctity of human life-a principle long recognized not only in our own society but also in most, if not all, civilized societies

¹⁵ Ronald Dworkin, *Life's Dominion: an Argument about Abortion and Euthanasia* 230 (Harper Collins, 1993)

¹⁶ J.M. Finnis, "Bland: Crossing the Rubicon?" 109 *LQR* 329(1993)

¹⁷ J. Harris "The Right to Die Lives: There is no Personhood Paradox" 13 *Medical Law Review* 386(2005)

¹⁸ *Ibid*

¹⁹ *Airdale NHS Trust v. Bland* (1993) 1 All ER 821

throughout the modern world- But this principle, fundamental as it is, is not absolute.” Lord Goff had wrongly understood sanctity of life to be the same as vitalism. Supporters of the principle of sanctity of life face a number of difficulties:²⁰

- a. Many supporters of sanctity of life support the current legal position that a patient is entitled to refuse life-sustaining treatment, However, this can involve the death of a person. The distinction supporters make is between an act causing a death which is said to infringe the sanctity of life principle and an omission causing death, which does not. Whether the difference between an act and an omission is sufficiently strong to justify such a crucial distinction is a matter of debate.²¹
- b. Most supporters of the sanctity of life accept that a person can kill another in self-defence. So, it is acknowledged that the principle of sanctity of life is not without exceptions: there are competing values which can justify the intentional killing of someone.²² Why is it, then, that supporters of sanctity of life are not willing to consider any circumstances in which euthanasia is justified? Is it not, for example, possible to say that the life of someone dying in pain is a life which is valued by society, but the on-going pain justifies the end of the life?²³
- c. Supporters of the sanctity of life suggest that permitting euthanasia would involve having to accept that some people’s lives are not worth living. This can be challenged. It is perfectly possible to say that every person is equally valued, but not every life is, although to say to Someone we value you, but not your life will be seen as a contradiction to some.
- d. Most supporters of the principle of sanctity of life believe that human life is precious and more valuable than the life of other animals. However, one factor that might be said to distinguish a human and other animal is consciousness and interactive abilities. Yet when these are lost, opponents of euthanasia are unable

²⁰ J. Keown, *Euthanasia Ethics and Public Policy: An Argument Against Legalisation* 54(Cambridge University Press, London, 2002)

²¹ J. Keown, *Euthanasia Ethics and Public Policy: An Argument Against Legalisation* 58-59(Cambridge University Press, London, 2002)

²² J. McMahan, *Ethics of Killing* (Oxford University Press, 2002)

²³ Mark Stauch and Kay Wheat, *Cases and Material on Medical Law*, 669(Routledge-Cavendish, London 2004)

to explain why there is not the end of human life.²⁴

In fact, both supporters and opponents of euthanasia respect the inviolability of life, it is just that they are emphasizing different aspects of sacredness. The supporters of sanctity of life do not treat the death of a seriously ill person as much of a tragedy as the death of a young person, but similarly opponents of sanctity of life are unwilling to support euthanasia where the person is in good health. This artificial contradiction in this way. Life has value in three ways: subjectively (for the person themselves), instrumentally (it produces useful things for society and other people), and non-instrumentally or intrinsically (it is in and of itself valuable, just as a great painting is). As to the intrinsic value of life, he suggests that this flows from ‘two combined and intersecting bases of the sacred ‘natural and human creation’.²⁵

Natural creation mean that a person’s life is the highest product of natural creation: the greatest achievement of God’s or evolution’s creationary process. A life is, as such, like a great work of art. By human creation he sees the human effort that has been put into the person’s life: by their parents, carers, and friends, but ultimately by the individual her or himself. Hence, we see the death of a teenager as a waste of human investment and a tragedy, but death after a full life as less so. The difference between those who take a conservative or liberal view on euthanasia depends on the weight placed on the natural creation and the human investment. Those who emphasize natural creation are likely to oppose euthanasia, and those who emphasize the human investment are likely to support it. Dworkin’s argument, however, is that most people recognize that life is sacred in both these ways, the argument is over which understanding of sacred should take precedence.²⁶

5.3.2 Quality of Life Argument:

In Chapter one, the religious perspective states that life is a gift from God with intrinsic value and that to be alive is reason enough to never end one’s own life. Contemporary philosopher Don Marquis takes a similar perspective when he argues against abortion. “The loss of one’s life is one of the greatest losses one can suffer.

²⁴ J. Harris “The Right to Die Lives: There is no Personhood Paradox” 13 Medical Law Review 386(2005)

²⁵ Ronald Dworkin, *Life’s Dominion: An Argument about Abortion and Euthanasia* 83 (Harper Collins, 1993)

²⁶ *Ibid.*

The loss of one's life deprives one of all the experiences, activities, projects, and enjoyments that would otherwise have constituted one's future. Therefore, killing someone is wrong, primarily because the killing inflicts (one of) the greatest possible losses on the victim."²⁷ Although his argument is not religiously based, Marquis draws on the same assumption that life is inherently good. The religious argument assumes that any life is better than no life at all, suffering or no suffering. Marquis assumes that there are inevitably good, pleasant and worthwhile experiences in one's life. Although he may be right in the case of abortion because the fetus has the potential of an entire lifetime, this is not the case with terminally ill patients who are in their final stages of life.

Marques' account of autonomy is based on two qualities that are innately human, that of the 'discontinuation' account and the 'desire' account. Marquis argues that people value the experience of living and want that experience to continue. Killing or murder would be the discontinuation of all experience, something no grown person wants. The desire account states that we have a strong desire to continue living, not for life in itself, but for our value of the 'goodness' that comes from the experiences while living.²⁸

The 'desire' and 'discontinuation' accounts fall under human autonomy because they are reasons, we use to exercise our autonomy. According to Marquis argument, it is natural for humans to have a desire to live in order to gain good experiences. Therefore, when an individual loses that desire to continue living, he must no longer be experiencing "good" things. This loss of desire is clearly an extremely powerful change if it reverses what is part of human nature. This change should be taken very seriously because it means that the lack in quality-of-life is powerful enough to cause our autonomous decision to end life to override our natural desire to continue living.

Marquis also claims that the concept of 'value' is key to determining what is 'good'. He claims that others, aside from the individual, can define value. However,

²⁷ Don Marquis, "Why Abortion is Immoral" *Contemporary Issues in Bioethics*, ed. Tin Beauchano, LeRoy Walters, Jeffrey Kahn, and Anna Mastroianni 346 (Belmont CA, Thompson Wadsworth, 2008)

²⁸ *Ibid* at 347

this is not an autonomous decision and therefore false. Value for quality-of-life is subjective and therefore must be evaluated by the individual who is living those specific experiences.²⁹

The main trouble that proponents of PAS and euthanasia see with these two arguments is their inability to take into account the importance of the quality-of-life according to the individual. In the field of ethics there is an ongoing discussion about the various ways to talk about quality-of-life. There are general divisions that separate the different variations of quality-of-life. The first level is a state of 'well-being' where an individual is healthy, both mentally and physically, because she is active; she does not rely on any consistent medication to keep her healthy and is most likely in her youth. The second division is later on in life when her body is no longer in tip-top shape because age physically takes a toll on her but she still has all of her mental capacities and health. The third general division is what we might consider a state of 'minimal quality-of-life' because she is either physically incapable of taking care of herself and/or is mentally unstable. Specific examples may include constant physical pain, insanity, severe-depression, loss of mental and/or physical abilities, suffering from a non-terminal illness, suffering from a terminal illness or semi to totally vegetative states. These are all reasons given either by individuals who no longer believe they live a high quality-of-life or ethicists and lawmakers when it comes to comatose patients.

It is clear from both the anti-PAS/euthanasia arguments that human life is valued more than other life forms. Why is this? It is based on the rational mind of self-awareness and self-determination. It is also important to note that the quality-of-life standards above also place a high amount of weight on the human mind because a rational mind is not only valuable, but it is a defining human attribute. Autonomy encompasses the two qualities of self-awareness and self-determination. Therefore, as humans we have the ability to determine the way in which we live our lives as long as it does not cause harm to others, the natural capacity to place a subjective value on our own lives, and the right to plan our own end when we no longer experience a quality-of-life worth living.

²⁹ *Ibid.*

The quality-of-life determined by the individual patient is based on the mental and physical capabilities that he may no longer manage or possess. It is the responsibility of the physician and society to accept individual evaluation of life's worth because it is the individual and no one else who can determine when the goodness of life is outweighed by the badness.

A more specific example of the application of autonomy with respect to quality-of-life is when a patient is dying a painful death caused by liver cancer. We will call our patient 'X'. His life's work focuses on geological exploration around the world that requires him to be very physical on a daily basis. He has found joy in his work and being outdoors for thirty plus years. 'X' is now hooked up to machines that function in place of his liver, he has a constant morphine drip monitored by around the clock nurses to handle his constant pain. The only chance 'X' has to survive this cancer is by some miracle recovery. Instead of choosing palliative-hospice care, 'X' wishes to end his pain and suffering because his quality-of-life denies him the joy and purposed it served before. 'X' decides that a life restricted to a hospital bed while dependent on machines is not one worthwhile enough to continue living. This personal assessment may not make sense to all people, but Jacob's autonomous evaluation of his quality-of-life is no less valid.

Philosophers such as Dan Brock argue in favor patient autonomy with several restrictions that do not permit just anyone to kill himself or herself. These restrictions are noteworthy because they keep the argument restricted to euthanasia and PAS without allowing any form of suicide or killing. In his article 'Voluntary Active Euthanasia', Dan Brock considers quality-of-life as one's "Own conception of a good life, at least within the bounds of justice and consistent with other doing so as well."³⁰ He also says that self-determination can be carried out when the person is assumed to be reasonable and has the decision-making capacity.

5.4 Better Alternatives: An Argument

According to the arguments of philosophers Felicia Cohn and Joanne Lynn, there are better alternatives to euthanasia and PAS that do not involve sacrificing the

³⁰ Dan W. Brock, "Voluntary Active Euthanasia" Vol 22, No. 2, *The Hastings Centre Report*, pp.10-22 (1992)

patient's life. However, in order to reach these alternatives, we need to redirect the focus of medical care in our country to concern ourselves more with the terminally ill instead of discarding. Due to the extent in quality of medical care that our country has at its disposal with options such as hospice care and palliative care, there should be no reason for doctors and patients to resort to killing.³¹

Palliative care is medical treatment that reduces the pain and suffering of a disease, no matter if the disease is fatal or not. Treatment deals with the reduction of the symptoms of a disease and not with the disease itself. It is about making the patient as pain-free and suffering-free with her disease as possible.³²

Hospice care is a more specific type of palliative care because it too does not treat or cure illnesses but its focal treatment is comfortable end of life treatment. Most patients who receive hospice care are usually dying from terminal illness such as HIV/AIDS and cancer or even simply old age. This is the point in a patient's illness that he decides to no longer receive treatment to cure an illness. Instead he accepts his death is near and hospice care is available to make it as comfortable as possible, both physically and psychologically. Hospice care can be done at home, in the hospital, or in hospice facilities that are specifically for dying patients. Around the clock care is available depending on the severity of the patient's illness. It is focused on what the patient needs and wants according to his personal standard of quality-of-life. This standard can range from physical, emotional, spiritual and psychological quality. It is argued that our health care system needs to rearrange its priorities to take better care for those with terminal illness. They say that currently there is insufficient care and attention paid to terminally ill patients. Once that is fixed, there will be no excuse or reason for PAS.

One of the main reason patients seek "Euthanasia and PAS" is to avoid the pains and physical suffering caused by terminal illness or to stop their current suffering. However, with medical technology today the standard of care has increased to encompass many means of dealing with suffering from physical pain. Physical pain is much more commonly treated today than it used to be with medicines such as

³¹ John Keown, *The Law and Ethics of the Medicine* 309 (Oxford University Press, 2012).

³² J. Herring, *Medical Law and Ethics* 542(Oxford University Press, 2010).

morphine and services like around the clock nurse care. Therefore, pain is not sufficient ground for PAS.

Hospice-palliative care began in the India in the 1986.³³ Hospice care is the psychological treatment of the patient's family members. The decision to withhold treatment is a difficult one to deal with as a family because the death of a loved one is a near and inevitable fate. Hospice-palliative care encompasses all aspects of comfort, physical and psychological for every member affected.

Philosophers Cohn and Lynn, along with other 'better alternatives' advocates, believe our basic medical standard of care has increased so much in the last century to a point where suffering patients can always find other means for end of life treatment besides PAS or euthanasia. The only issue is figuring out how to redirect our social consciousness to focus on making these options more available and popular so that they become the first resorts for dying patients.

5.5 Patient Autonomy: Right to Choose Time and Manner of Death

It is often assumed that one of the strongest arguments in favour of legalizing euthanasia and assisted suicide is respect for patient autonomy, it might be argued that a patient's right to make decisions about her medical treatment should extend to being able to decide when and how she dies. To die quickly and painlessly, perhaps at home and with people we love, is obviously preferable to a lonely, protracted, and frightening death.³⁴ According to Coggon 'personal autonomy' is a rational individual's capacity to make an informed, un-coerced decision.³⁵

This is, in simple terms, the argument that people should be permitted to live their lives as they wish, as long as their choices do not harshly impact on others. The alternative, of the Government or other people dictating to us how we should live our lives, is seen by many as unacceptable paternalism. This principle underlies much

³³ The First palliative care established in Mumbai in 1986, Then over the next five years, it established two more branches in Delhi and Goa. Then two major developments occurred in 1990s. One was the formation of the pain and Palliative care Society in Calicut in the South Indian State of Kerala in 1993 and the Indian association of Palliative Care in 1994. Currently in Lucknow (State of Uttar Pradesh) Sanjay Gandhi Post Graduate Institute of Medical Sciences has formed a specialized Palliative Care Ward for the pain management of patients.

³⁴ Emily Jackson, *Text, Cases and Materials* 953 (Oxford University Press 3rd ed. 2013)

³⁵ J. Coggon "Ignoring the moral & intellectual shape of the law after Bland: the unintended side-effect of a sorry compromise" *Legal Studies* (2007) 110-125

liberal political thought. To supporters of euthanasia it should dominate the debate on euthanasia: people should be able to choose how to die.

5.5.1 Challenges to the autonomy argument:

Opponents of euthanasia tend to argue against an approach based on autonomy in one of four ways: either by accepting that autonomy is an important principle but arguing that there are other interests that need to be weighed against it, by saying that in the context of euthanasia it is not possible to be confident that the person has made a genuine free choice, that autonomy cannot be used to justify an act which leads to death, or that the argument proves too much as it would justify euthanasia in circumstances which would be unacceptable. These will be looked at separately. First, there is the argument that other principles or values can be used to outweigh the principle of autonomy. But what might those be? Here are three possible contenders:

5.5.1.1 The right of the patient to choose to die must be counter balanced against the interests of society as a whole:

Dying is not an individual matter, it has an impact on others and society as a whole. It is, however, difficult to identify precisely the harm that relatives or society as a whole will suffer by permitting euthanasia. Clearly there will be the grief relatives suffer, but how does this compare with the pain of watching someone die in a slow painful way? But is there more? The House of Lords Select Committee³⁶ held:

“We acknowledge that there are individual cases in which euthanasia may be seen by some to be appropriate. But individual cases cannot reasonably establish the foundation of a policy which would have such serious and widespread repercussions. Moreover, dying is not only a personal or individual affair. The death of a person affects the lives of others, often in ways and to an extent which cannot be foreseen. We believe that the issue of euthanasia is one in which the interests of the individual cannot be separated from the interest of society as a whole.”³⁷

³⁶ House of Lords Select Committee (1993)

³⁷ House of Lords Select Committee Para (1993).

5.5.1.2 This right to die must be balanced against concerns that other patients who do not want to die will be pressurized into saying they do.

In other words, it is better to have a legal system that denies some people the right to autonomy to die as they wish, than to have a legal system whereby some people could be killed under the label euthanasia against their wishes. In essence this argument is connected to the “slippery slope” argument mentioned below. As we shall see, there is heated debate over whether, once voluntary euthanasia is permitted, it is possible to put in place mechanisms which ensure that involuntary euthanasia is not permitted.

5.5.1.3 There is a moral imperative or value which counterbalances the autonomy right?

The argument here is not that there are the interests of others or particular members of society which need to be protected, but there are moral principles which the law should uphold, such as the sanctity of life (to be discussed shortly), even if, in doing so, the autonomy rights of individual members of society are infringed. So, the argument here is not that there are specifically identified harms, but there is damage to the moral fibre of society, which justifies an infringement of people’s autonomy.³⁸ However, Dworkin³⁹ argues that autonomy is a basic right that the state cannot limit without compelling reason. His main point is that government’s understanding of the importance of life, which is inherently objective and holistic, will not justify limits on individual actions.

5.6 Dignity of Life and Death:

Many commentators supporting euthanasia argue in terms of protecting the dignity of the dying person. Indeed, one of the leading campaigning groups in favour of allowing euthanasia and assisted dying recently changed its name to Dying in Dignity. The argument based on dignity is that when dying, a person gradually loses the control of physical and mental functions, and helplessness and dependence on others increases. In one survey a majority of respondents stated that the one thing worse than death is the distress of loved ones having to care for you over a lengthy period of

³⁸ J. Keown, *Euthanasia Ethics and Public Policy: An Argument Against Legalization* Ch 5 (Cambridge University Press, London, 2002)

³⁹ *Supra* note 25

physical deterioration. It is not simply the inability to care for oneself which is demeaning, but the inability to offer care and support to others. To enable a person to die with dignity, to die before they have reached the stage when they are dependent on others for even the most basic of functions, is an option that people should have a right to take. The concept has even received judicial support. Munby J stated:

“The recognition and protection of human dignity is one of the core values-in truth the core value-of our society and, indeed, of all the societies which are part of the European family of nations and which have embraced the principles of the Convention. It is a core value of the common law, long pre-dating the Convention. The invocation of the dignity of the patient in the form of declaration habitually used when the court is exercising its inherent declaratory jurisdiction in relation to the gravely ill or dying is not some meaningless incantation designed to comfort the living or to assuage the consciences of those involved in making life and death decisions: it is a solemn affirmation of the law’s and of society’s recognition of our humanity and of human dignity as something fundamental.”

Critics of such arguments suggest that the notion of dignity has been barely defined. Even if euthanasia is regarded as dignified for the person who dies, does it respect the dignity of those who have to do the killing or society as a whole? A report by the Linacre Centre suggests that we need to distinguish between two meanings of dignity:

- a. The basic worth that each person has by virtue of being human.
- b. The quality which some people have because they have shaped their lives to honour what is of true worth.

The report argues that the first sense of dignity cannot be lost, even if a person has lost their mental faculties. Even when suffering in great pain that person has the dignity that comes from being a person. To kill them would not be to respect their dignity in that sense. It could be suggested that allowing a patient to die in pain against his or her wish is undignified. But killing a person hardly seems to be according him or her much concern or respect or placing much value on the person’s life-it would seem to be the antithesis of respecting one’s dignity.

It has also been argued that the notion of dignity has a social dimension. A person's sense of dignity in part depends on how they are treated by society and those they relate to. If a person at the end of their life is feeling undignified this may say as much about our society's attitudes towards the elderly and dying, as it does about an individual's own values.

Critics of the dignity argument also tend to emphasize the benefits of palliative care which, it is claimed, enable a more dignified and good death than that offered through euthanasia. However, supporters of euthanasia will claim it should be for individuals to decide whether palliative care offers them an acceptable alternative to death. Others have characterized the notion of a dignified death as an idealized social construct. Death is nasty and painful normally; to try and pretend that it is not and demand from medics a perfect pain-free death represents the ultimate denial of the reality of death.

5.7 Slippery-Slope Argument:

Proponents of the second group of arguments are less concerned with intentions involved in the difference between 'killing' and 'letting die'. Instead, the argument steers away from the legalization of 'Euthanasia' and PAS and the consequences of eventual legalization of more extreme cases.

This segment is focused on the 'slippery-slope' argument and arguments similar to it. There are several versions of the argument that depend on the variables that cause the slippery-slope. In addition, there are two types of slopes, an "empirical and a conceptual slope"⁴⁰. The empirical slope argues that after a first step in one direction, in this case legalizing 'Euthanasia' and PAS, something bad in human nature is opened and will cause further problems that will soon be out of our control. The conceptual slope argues that after that first step, no matter how small or big, we will be led to treat similar cases similarly and eventually this will lead to extreme cases. "Once physicians are permitted to kill one kind of patient because 'quality of

⁴⁰ Gregory E. Pence, *Classic Cases in Medical Ethics: Accounts of the Cases that Shaped and Define Medical Ethics with Philosophical, Legal and Historical Backgrounds* 68(McGraw-Hills, London, 1995)

life' is so low as to make 'life not worthy to be lived', then not only can, but the same reasoning will be used in similar cases.⁴¹".

The variables involved in both empirical and conceptual slippery-slope arguments are:

1. Financial burdens on the families of the patient,
2. Financial greed and incentives involved for doctors,
3. Medical laziness where physicians no longer want to deal with a sickly patient, and
4. Insensitive moral acceptance of killing that will broaden to a wider range of people to those not terminally ill. In the most extreme cases of this argument, PAS will lead to voluntary active euthanasia, and finally to doctors killing their patients without consent, otherwise known as involuntary active euthanasia. Generally, anti-euthanasia' believe the first step towards a change in what we consider morally and socially acceptable can quickly be abused and be morphed into something negative.

Countries like India where health care is a business and a very expensive one at that, the financial burden on families of patients is a very real problem. In addition to health care expenses, the technology today adds to the problem because there are so many tools to keep patients alive longer compared to twenty or fifty years ago. This leaves families liable to pay for end of life treatment such as machines, nursing homes and treatments that can last years for a terminally ill patient.

However, if "Euthanasia and physicians-assisted suicide" is legalized, it opens up another option for the terminally ill. Of course, "Euthanasia and PAS" will help those patients who prefer death as opposed to end of life treatment in the final stages of their terminal illness. But what of those who still desire to live yet feel that they are a financial burden on their families? Proponents of "Euthanasia and PAS" argue that families are made of people who love and care for one another, so naturally their concern for the patient overrides the issue of money. However true this may be, it

⁴¹ *Ibid.*

does not deal with the indirect pressure the patient feels no matter what her family members tell her.⁴²

For example, 'X' has a terminal illness that requires she have 24 hour care to handle her feeding tube. Her daughter 'Y', a single mother with son 'Z' in his senior year of high school, has to help pay for her mother's care. 'X' understands that she may have several years left, which of course 'Y' will have to pay for. But she also knows that 'Z' has aspirations to go to college. 'Y' cannot afford to pay for both her mother's medical treatment and her son's 4-year college degree. 'Z' has no other option but to go a local community college. Although 'Y' and 'Z' tell 'X' that her life is more important than anything, including 'Z' immediate education, 'X' feels awful and burdensome. If the option of "Euthanasia and PAS" is available to 'X', she very well might feel inclined to end her life earlier than she wants because she cannot deal with the guilt of denying 'Z' his college education. By making "Euthanasia and PAS" available to patients like X, an opportunity presents itself to end life early even when it is undesired. Many cannot deal with the pressure of knowing that others they love are suffering due to their own misfortune of illness.

A second financial variable is the greed of doctors and the hospitals where they work. Just as it is expensive for families to pay for their relatives, it is also costly for institutions to keep patients. Terminally ill and elderly patients who must remain in the hospital until their death are expensive for the hospital. Patients are not unaware of their situation, especially if society begins to complain politically about their cost on. With the legalization of "Euthanasia and PAS", patients will feel the social pressures from the institutions and from public debate about where our health care money is spent.

As for the doctors, they make their money on surgery, not the elderly and terminally ill who just require upkeep and maintenance procedures. So, when a cancer patient takes up a hospital bed instead of a patient who needs an organ transplant, the doctors see this as an opportunity lost to make money. There is a societal assumption that physicians are morally driven and that money is not a factor. However, the very industry they work in is one of the biggest businesses in the country like India. With

⁴² S. Smith "Evidence for the Practical Slippery Slope in the Debate on Physician-Assisted Suicide and Euthanasia" 13*Medical Law Review* (2004) 17-44

“Euthanasia and PAS” available to doctors, the greedy ones or those suffering financial setbacks are likely to influence their patients in the direction of PAS as a reasonable option.

Along similar lines, doctors are susceptible to laziness in their work. After treating a sickly patient who he knows is going to die soon, the doctor could get tired of treating his patient. Again, doctors are human and not morally immune to such things as laziness. “Euthanasia and Physicians-assisted suicide” is the perfect outlet for these kinds of doctors who want an easy way out. Of course, we cannot assume physicians ordinarily take this approach to their work, but once a trend starts with a few lazy doctors, it becomes less of a shock to colleagues and more of a norm.

This leads us to one version of the empirical slope arguments that the legalization of “Euthanasia and PAS” will open the door to the moral acceptability of killing. This argument assumes the worst in human nature and that abuse is inevitable. The role of a physician is to treat his patient and to make sure she is in the best health. Society values a physician’s role as one who does the opposite of killing patients as stated earlier in the chapter regarding the Hippocratic Oath. If one of our only professions that protects against death is allowed to kill, then the sanctity of the position is gone along with the security of civilians when they visit the doctor. The health of the country cannot afford to be skeptical of our doctors and their decisions because there will be no one left to care for our wellbeing.

Opponents to the slippery-slope argument point out that the foundations for the arguments are not based on much factual evidence but on assumptions. However much this may be the case, Holland is a very real example of how the slippery-slope works. Not only is PAS legal and socially acceptable, euthanasia is also accepted although not entirely legal. One of the more startling realities in Holland is not only the moral flexibility in their laws, but the frequency that physicians and their patients manoeuvre their way around such laws to perform outlawed procedures. Too much discretion is left to the physician to analyse the individual cases instead of following government regulation.⁴³

⁴³ J Keown *Euthanasia, ethics, and public policy: an argument against legalisation* 58-59 (2002)

In the documentary and discussion *Choosing Death* featured by Frontline News, the focus is on Holland and displays how their medical practice really works. The first few cases presented are not as controversial because they follow laws and deal with only terminally ill cancer patients in their last few years and maybe months to live. The patients must request euthanasia from the physician in order for the act to be socially acceptable and for the physicians to avoid prosecution. The second round of patients become younger and lack any physical illness; instead two of the patients face mental instability. Neither of these patients will die from their illness but instead believe their lives are not worth living because they have lost their ‘humanness’ quality that is so important to them. Similar to the previous group, these two patients request euthanasia. However, one of them is a 24-year old girl who claims to suffer from a mental inability to allow herself to eat. Is this reason enough to perform euthanasia? According to the slipper-slope argument, this can lead to euthanasia of those who are not terminally ill, and even to the very young.

Most of the countries including India fear that once we legalize “Euthanasia and PAS”, our country will fall into the same downward spiral as Holland. Physicians in Holland have euthanized not only their patients who are in the final few weeks or days of their lives, but they have also moved to euthanize AIDS patients who are not in late stages of the disease but instead, those who want to avoid any amount of suffering. Doctors have also agreed to euthanize younger patients with mental illnesses who have expressed their desire to end life. Patients suffering from mental illness are not mentally competent and therefore cannot decide whether to end their life or not. The most extreme case in the film demonstrates euthanasia performed on a physically deformed infant whose parents decided they did not want their child to suffer. The most frightening aspect of this last case is that physicians act on decisions from third parties. It is an understanding in the US and in Holland that a parent or guardian does have the legal right to be a guardian over their children until a certain age. In many cases this is not problematic because the adult is more knowledgeable than the child in what is the best life decision. In the case of life and death however, it is not that simple. No individual has the legal or moral right to decide the death of another. Euthanasia in Holland is a clear example of the slippery-slope theory. Once one form of euthanasia is morally acceptable, justification for more extreme measures is bound to follow. Slippery slope argument in the context of practice, the argument

here is that whatever safeguards were put in place they would not be effective in ensuring that there was only euthanasia where the patient voluntarily accepted.⁴⁴

Battin⁴⁵ There are three kinds of abuse that could occur in the context of a legal system which approved of euthanasia:

Interpersonal abuse: A person may be encouraged or pressurized into agreeing to be killed. This could be by overt pressure, or by indirect means.

Professional abuse: Doctors may not want to waste time in expensive and time-consuming medical procedures, and may encourage patients to agree to euthanasia. Consciously or not a doctor may exaggerate the pain in the future. There may even be concerns fit physician who have made medical mistakes may seek to cover them up by encouraging euthanasia. The concept of doctors trying to manipulate their patients into euthanasia may appear fanciful, but it is not difficult to find examples of doctors who have illegally killed quite a number of their patients.

Institutional abuse: The medical and legal structures themselves may encourage the use of euthanasia and manipulate patients into agreeing to be killed.

5.8 Concern over treatment of the vulnerable:

Linked to the ‘slippery slope’ argument is the concern that permitting voluntary euthanasia would work against the interests of vulnerable people. Those people suffering poverty, confusion, or general vulnerability may be pressurized into agreeing to euthanasia against their wishes. Keown has claimed that many people who consent to euthanasia may in fact simply be suffering from severe pain, distress, depression, or ‘demoralization’, and are therefore not in a position to make a rational decision. It should not be forgotten that people are often expected to take decisions over their medical treatment in the alien environment of hospital without clothes, friends, and support. Indeed, for the less well off, the alternatives to euthanasia or assisted suicide may well be less attractive than those well able to afford high quality

⁴⁴ S. Smith “Evidence for the Practical Slippery Slope in the Debate on Physician-Assisted Suicide and Euthanasia” 13 *Medical Law Review* (2004) 17-44

⁴⁵ MP Battin, et al. “Legal Physician-Assisted dying in Oregon and the Netherlands: evidence concerning the impact on patients in Vulnerable groups” 33 *Journal of Medical Ethics* (2007) 591

nursing care.⁴⁶ There are concerns that euthanasia will work against the interests of women and those in ethnic minorities, Katrina George⁴⁷ lists the following factors as meaning that women's choices about euthanasia may not be voluntary: 'structural inequalities and disparities in power-most evident in women's experience of violence-and social and economic disadvantage and oppressive cultural stereotypes that idealize feminine self-sacrifice and reinforce stereotyped gender roles of passivity and compliance? No doubt the articulate, well-educated, and assertive will be in a position to take informed decisions about whether or not they wish to end their lives, but will the depressed, the despairing, and the poor? Nor should it be forgotten that unscrupulous relatives, concerned that the medical and eating costs will decimate their inheritance, have an interest in encouraging euthanasia. This is particularly so given evidence that many people nearing the end of their lives are desperate not to be a burden to their families.

Despite all of these points there is a concern about the validity of consent from vulnerable groups in many kinds of medical treatment, but these do not normally mean that the treatment (if thought useful) is not made available.⁴⁸ The argument, to be convincing in and of itself, would also need to show that it would not be possible to protect vulnerable groups from improper manipulation by providing careful independent advice from trained counsellors, for example. It should also be remembered that vulnerable groups should be an issue of concern under the current law, where they can be left without treatment or provided pain-relieving (but killing) drugs with little regulation or supervision.⁴⁹

5.9 Euthanasia and disabled people

There have been concerns about euthanasia from those writing from a disability, perspective; in particular that legalizing euthanasia would send the message that the lives of disabled people were not worth living. More often the writing. We been concerned about the way the arguments are phrased. The weight placed on autonomy is seen as misplaced by some writers, pointing out that disabled people's

⁴⁶ J Keown *Euthanasia, ethics, and public policy: an argument against legalisation* Ch. 5 (2002)

⁴⁷ Katrina George, "Autonomy and Vulnerability at the Death Bed" *6UWS Law Review* (2006) 139

⁴⁸ MP Battin, et al. "Legal Physician-Assisted dying in Oregon and the Netherlands: evidence concerning the impact on patients in Vulnerable groups" *33 Journal of Medical Ethics* (2007) 591

⁴⁹ J. Herring "Protecting Vulnerable Adults" *10 Oxford Legal Studies Research Paper* (2010)

autonomy severely restricted. Others have been concerned that opponents of euthanasia have been too quick to describe disabled people, as vulnerable and easily coerced or incompetent. Looking at the position of depressed people, are concerned that assisted suicide and euthanasia would only further isolate those suffering with depression, rather than forcing society to properly face up to the challenges offered by depression.⁵⁰ It is noticeable that a survey of Swiss assisted dying clinics found that among older users 'weariness of life' was more common as an explanation for seeking to die than terminal illness. A similar point can be made about those suffering from other forms of physical or mental disability.

5.10 Heart of the debate related to Non-voluntary Passive euthanasia:

5.10.1 Reaching the decision: The Best Interests Test:

It is well settled law that court's as well as medical professional's first and paramount consideration must be the best interest of the patient. The great respect for sanctity of life imposes a strong presumption in favour of taking all steps capable for preserving life except some extraordinary circumstances. The main problem is how to define those circumstances. It is known fact that court never sanctions steps to terminate life. Even in the most critical situation (extreme disability) there is nothing to approve the steps to terminating life or hastening death. The court is only concerned with the circumstances in which the steps should not be taken to prolong life.⁵¹

The normal approach to ascertaining best interests will be used. The views of the doctor will be relevant but will not be determinative. Assuming that the life-sustaining treatment will be regarded as serious treatment for the purposes determining the best interest of the patient the independent medical experts will become involved besides the doctors engage in treatment. When considering the best interests of the patient, UK law makes an important point about what factors a doctor should consider: Where the determination relates to life-sustaining treatment he must not, in considering whether the treatment is in the best interests of the person concerned, be motivated by a desire to bring about his death.⁵² This reflects the approach of the law that although it may be permissible for a doctor to do an act

⁵⁰ H. Biggs, *Euthanasia Death with Dignity and the Law* 34(Oxford University Press, 2001)

⁵¹ Taylor J in Re J (A Minor) Wardship medical treatment (1991) 1 FAM 33, CA.

⁵² Section 4(5) of the "Mental Capacity Act, 2005.

which she or he foresees may cause death, she or he must not do an act for the purpose of causing death.

However, in deciding what is in a patient's best interests there is contrary views and dispute over what factors can be taken into account. It is clear the level of pain and suffering or intolerability is the most certain and general touchstone to determine the best interests of patients⁵³ but it is not the sole test to determine the best interests.⁵⁴ It cannot be done with mathematical or any precision. As stated by Taylor LJ: "I consider the correct approach is for the court to judge the quality of life of the patient would have to endure if given the treatment, and decide whether in all circumstances such a life would be so afflicted as to that patient."⁵⁵

Moreover, Hoffman J applied "balance sheet approach" to determine the best interests of the patient. He has made following observation "The test is one of best interests, and the task of the court is to balance all the factors. The Court of Appeal have suggested that the best and safest way of reliably doing this is to draw up a list on which are specifically identified, on the one hand, the benefits or advantages and, on the other hand, the burdens or disadvantages of continuing or discontinuing the treatment in question."⁵⁶ Therefore it show that there is not an unanimous view to determine the best interest of the patients as some considered intolerability and some quality of life. However, there should be a balanced approach including all factors not only medical factor but ethical moral, social, emotional and other welfare factors.⁵⁷

5.10.2 Withdrawal of treatment: An act or omission-

A preliminary question is what conduct, in the context of providing medical care, will be regarded in law as an omission rather than an act? For example, a common means of sustaining the life of a critically ill patient in hospital is to place him on a ventilator. If, in a given case, a doctor decides that there is no hope of recovery and

⁵³ *R (On the application of Burke) v GMC* (2005) EWCA Civ 1181

⁵⁴ *Re J (A Minor) {Wardship medical treatment}* (1991) 1 FAM 33, CA.

⁵⁵ *Ibid.*

⁵⁶ *NHS Trust v MB* (2006) EWHC 507 {Fam}

⁵⁷ Section 2(b) of "The medical treatment of terminally- ill patients (Protection of Patients and Medical practitioner) Bill, 2016 provides not only medical factor as a single factor but also included ethical, moral, social, emotional and other welfare factors to decide best interests of the patient.

switches the machine off, could he not be said to have acted to bring about the patient's death?⁵⁸

We have seen that the law draws a distinction between actively and passively taking a patient's life. Both withholding and withdrawing life-sustaining treatment are, in law, omissions. No legal wrong is committed by an omission unless there is a legal obligation to act, which there will not be where a patient validly refuses treatment or where the treatment is not in the patient's best interests. There are two issues of controversy here. First, whether the distinction between an act and omission is morally sufficient to justify the conclusions drawn by the law. Secondly, whether withdrawing (as opposed to withholding) life-sustaining treatment or care is properly characterized as a mere omission. These questions are important to both voluntary and non-voluntary end of life decisions.⁵⁹

Few commentators consider the distinction between killing and letting die to be one of major moral significance. However, few criticized this distinction. Rachels rejects the distinction because he holds that we owe extensive positive duties (i.e. duties to assist), so that letting someone die becomes as morally unacceptable as killing them. Keown also doesn't consider any moral difference between act and omission.⁶⁰

Harris and Finnis, who agree on little else, agree that the law's reliance on the distinction is morally indefensible. They argue that there is no morally significant distinction between terminating life by deliberate omission and terminating life by deliberate intervention. Finnis rejects the distinction because he holds that intentionally terminating the life of an innocent human is always wrong whether it is done by an act or an omission (i.e. the sanctity of life position). Harris rejects the distinction because he holds that we are responsible for anything that we voluntarily and knowingly bring about, irrespective of whether we bring it about by an act or an omission. Harris does not, however, hold that deliberately terminating life by act or omission is always wrong. He presents an account of the "value of life" that takes respect for 'persons' as fundamental, where persons are defined as those capable of

⁵⁸ Mason and McCall Smith's, *Law and Medical Ethics* 1123(Oxford University Press, 7th edn., 2006)

⁵⁹ J. Herring, *Medical Law and Ethics* 524 (Oxford University Press, 2010).

⁶⁰ James Rachels, , *The End of Life: Euthanasia and Morality*. 112 (Oxford University Press; 1986)

valuing their own existence.⁶¹ By implicitly relying on preference utilitarianism, he moves from the fact that persons value their own existence to the moral principle that it is prima facie wrong to kill persons against their will. On this account, persons who do not want to live are not wronged by having their wish to die granted whether it is by act or omission. Thus, despite adopting radically different moral positions, Finnis and Harris both reject a bright line between terminating life by act and terminating life by omission.

The distinction between killing and letting die evokes controversy because it does not turn on the outcome (a patient can be killed by an act or an omission), the doctor's state of mind (the doctor can intend to kill by act or omission), or the patient's consent (the patient can be killed or left to die without or with consent).⁶² It is therefore difficult to find a convincing reason why this distinction should be drawn as a matter of ethical principle. It is, nonetheless, possible to conceive of theories offering such a reason. Perhaps, for example, a theory that rejects all positive duties that have not been voluntarily assumed, according to which letting someone die can only be immoral if it involves a failure to comply with voluntarily accepted responsibilities.⁶³

By defining permissible omissions widely, the law goes further than simply adopting a contested distinction. Both withholding and withdrawing medical treatment are considered to be omissions that may be necessary for a death, while it cannot be sufficient.

*Airedale NHS Trust v Bland*⁶⁴ concerned a declaration that the withdrawal of treatment would not be contrary to the criminal law. This required consideration of two linked issues of criminal law in the medical context: the differentiation between act and omission and the legal cause of death. The actus reus for murder is broadly the act of killing with the intent to kill or virtual certainty that the act will kill. The criminal law also imposes liability for an omission to act in circumstances where there is a duty on the defendant to care for the deceased.

⁶¹ J. Harris, *The Value of Life* 36 (Routledge and Kegan Paul, 1985)

⁶² J. Keown *Euthanasia, ethics, and public policy: an argument against legalisation* 14 (2002)

⁶³ *Ibid.*

⁶⁴ (1993) 1 All ER 821 at 867

On the issue of withdrawal of life sustaining treatment Lord Goff asked himself the question, why is it that the doctor who does so withdraw, and allows the patient to die, does not act unlawfully if there is no breach of duty to the patient? The answer lies in the fact, according to Lord Goff, that the doctor's conduct is an omission. The doctor is simply allowing nature to take its course and the patient to die from the pre-existing condition. An omission can still lead to criminal liability, but only if it is a breach of the doctor's duty.

Lord Browne-Wilkinson's opinion was that withdrawal of feeding would not be an act but an omission to treat. An omission cannot cause death, death is caused by underlying medical condition. The removal of the nasogastric tube would not have causative significance because on its own it did not keep Bland alive.

On application of the doctrine of causation or legal cause of death Lord Mustill criticised the withdrawal as not causative. He preferred a rather more realistic conclusion that the withdrawal of life support is factually causative, but because of the legal characterisation of the 'terminal regime' as acting in the best interests of the patient, that causative action has no legal consequence.

Switching off a ventilator and removing a feeding tube are acts that the law treats as omissions. They are interventions without which the patient would continue to live and they would be regarded as actions if performed by a passer-by rather than the doctor in charge of the patient's care. In effect, treating the medical withdrawal of life-sustaining support as a legal omission is little more than a "legal fiction" designed for the purpose of holding the line against actively killing a person. The distinction provides a useful guide. It gives doctors who cease treating patients the comfort of saying they did not kill their patients and also preserves the slippery slope argument. Even if not logical arguably, the distinction is said to be in accordance with many people's intuition.⁶⁵ McCall Smith has suggested⁶⁶ that despite its theoretical difficulties it provides a basis upon which many people think and act. Leaving aside cases where it is difficult to draw a distinction between an act and an omission, there are few cases where a killing is justified (it may be in self-defence, for example); whereas generally 'letting die' is permissible.

⁶⁵ James Rachels, *The End of Life: Euthanasia and Morality*. 112 (Oxford University Press; 1986)

⁶⁶ Mason and McCall Smith's, *Law and Medical Ethics* 1124(Oxford University Press, 7th edn., 2006)

5.10.3 Removal of artificial feeding tube and hydration: is it justifiable?

The difference between treatment and basic care?

Some commentators argue that there is a crucial distinction between medical treatment and basic care.⁶⁷ They argue that the artificial feeding and hydration cannot be the treatment. They take the view that although it may be legitimate to withdraw medical treatment from a patient, it is never permissible to withdraw basic care such as feeding or cleaning. The argument is that to deny basic care is undignified and inhumane, so although a patient has the right to refuse medical treatment, she or he does not have the right to refuse basic care.⁶⁸

The withdrawal of tube-feeding and hydration has been heavily criticized by some. In *Bland*,⁶⁹ their Lordships regarded tube-feeding as medical treatment, rather than basic personal care, and therefore that it could legitimately be withdrawn. Apart from this withdrawal of tube feeding is also considered as a part of medical treatment in “The medical treatment of terminally- ill patients (Protection of Patients and Medical practitioner) Bill, 2016. therefore, it can be withdrawn under the present ruling if it no longer promotes the best interests of the patient. Keown has argued that “although the insertion of the gastrostomy tube would have involved a medical procedure, the pouring of the food down it did not require medical skill and would be analogous to spooning food into someone’s mouth.” So, the artificial feeding and nutrition should consider as a ‘Basic Care’ not the ‘Medical Care’.⁷⁰

The distinction between basic and medical care is controversial. The argument that appeared to be accepted in *Bland* was that, even if it is appropriate to remove medication from a patient on the basis that that is in the patient's best interests, it is not appropriate to withdraw basic care, such as feeding or cleaning.⁷¹ The argument in favour of the distinction includes the suggestion that to permit death by starvation shows a serious lack of regard for the patient's comfort and dignity. Further, our society regards starvation as symbolically horrific. Even if there is no logical or moral basis for it, feeding the hungry is seen as a basic human obligation.

⁶⁷ J Keown *Euthanasia, ethics, and public policy: an argument against legalisation* 220 (2002)

⁶⁸ John Keown, *The Law and Ethics of the Medicine* 331 (Oxford University Press, 2012).

⁶⁹ *Airdale NHS Trust v Bland* (1993) 1 All ER 821

⁷⁰ *Ibid.*

⁷¹ Tom Beauchamp and James Childress, *Principles of Biomedical Ethics* 126 (Oxford University Press, New York, 2003)

Further there are also dangers that permitting the withdrawal of sustenance will lead to a slippery slope, because it will permit the death of a person, not from their illness, but from the lack of basic provision. In other words, non-dying patients could be left to starve to death. This is a very different thing from letting a patient die from the disease from which he or she is suffering.⁷²

Critics of the distinction argue that the difference between treatment and basic care is impossible to draw.⁷³ Take feeding, perhaps a classic example of basic care. If feeding is only possible through machinery or by the application of medical skill, does it become medical treatment? Certainly, to the House of Lords in *Bland* there was no distinction to be drawn between the provision of foods by artificial means and medical treatment. Whatever the difficulties in drawing the distinction, to many people there is an intuitive feeling that letting a patient starve to death cannot be seen as proper medical treatment.

There is also a concern that the emotive phrase ‘starve’ is misleading. Beauchamp and Childress state that: “Malnutrition is not identical with hunger; dehydration is not identical with thirst; and starvation is very different from acute dehydration in a medical setting.” It should also be noted that in a few cases artificial feeding and hydration can worsen a patient's medical condition.

5.10.4 Withdrawal of life sustaining treatment from PVS patients: Some Concerns

The diagnosis and management of Persistent vegetative state (PVS) patients is not only challenging and difficult task for the medical professional, relatives, and society but it is controversial as well. Persistent vegetative state is a chronic neurological disorder of consciousness, in which patients appear to be awake, but show no behavioural evidence of awareness. Thus, patients in PVS are not immobile and retain some cranial nerve and spinal reflexes, and these can include visual and auditory stimuli. The degree of responsiveness reflects the degree of vegetativeness. It can never be completely certain that the condition is permanent.⁷⁴

⁷² J Keown *Euthanasia, ethics, and public policy: an argument against legalisation* 220 (2002)

⁷³ Tom Beauchamp and James Childress, *Principles of Biomedical Ethics* 126 (Oxford University Press, New York, 2003)

⁷⁴ Jonathan Herring, *Medical Law and Ethics* 489(Oxford University Press, New York 3rd ed. 2010).

The current legal position is that the ‘Terminally illnesses includes PVS as per the medical norms and standards of treatment. Courts has declared PVS as sufficient cause for the withdrawal of life sustaining treatment in certain conditions.⁷⁵ PVS has also been included in terminal illness in “The medical treatment of terminally- ill patients (Protection of Patients and Medical practitioner) Bill, 2016.⁷⁶ Therefore switching off the life support machine by the concerned medical professional will be regarded omission. Although this omission may result in the patient’s death it will not amount to breach of duty by the concerned medical professional to the patient. So, the crime is not committed. It should be noted that if an application is made for withdrawal of life sustaining treatment to the High Court, a panel constituting three doctors- a neurologist, a psychiatrist and a physician would be consulted by the Bench to seek their opinion of the diagnosis and prognosis of PVS.⁷⁷

It is fact that patients in PVS cannot be diagnosed with certainty but misdiagnosis is very frequently. There are reports of misdiagnosis and even stories of remarkable recovery from the condition. Some claim that it is not justifiably to keep patients alive in the faint hope they may recover. For example, we do not, continue to search for those lost at sea even where there is a slight chance they may be recovered. However, It is considerable that recent progress in medicine, neuroimaging, and critical care management has made the patients able to survive from PVS which is caused after severe acute traumatic brain injury. Therefore, the recent positive results of studies related to neuroimaging technique has increased the possibility of survival and recovery of the patients suffering from PVS after traumatic brain injury. Thus, the rapid progress and advancement in medical technology has improved the life sustaining ability of such PVS patients. A relaxation of the criteria for the diagnosis of the permanent vegetative state (withdrawal of life support machine treatment) would a move towards quality of life standards rather than irrevocable and absolute loss of cognitive function. Therefore, the courts need to be more open and accept that

⁷⁵ House of Lords in *Airdale NHS Trust v Bland* and in India *Common cause (A registered society) v. Union of India and others* cases, the courts has recognised PVS patient as terminally ill patient.

⁷⁶ According to Section 2(m) (ii) of “The medical treatment of terminally- ill patients (Protection of Patients and Medical practitioner) Bill, 2016 “Terminal illness” means- (i) such illness, injury or degeneration of physical or mental condition which is causing extreme pain and suffering to the patients and which, according to reasonable medical opinion, will inevitably cause the ultimately death of the patient concerned, or (ii) which has caused a persistent and irreversible vegetative condition under which no meaningful existence of life is possible for patient.

⁷⁷ *Aruna Ramchandra Shanbaug V Union of India, AIR 2011 SC 1290*

the legal treatment of PVS patients is about sensible use of resources and ending the strain on families and friends which provide justice to that patients.

5.11 Physician Beneficent Responsibility to Patients:

One of the main arguments against PAS and euthanasia in the previous chapter is based on the societal standard of a physician's responsibility to her patient. The Hippocratic Oath denies that a physician can cause the death of her patient. However, Gregory Pence⁷⁸ points out in his book *Medical Ethics* that at the time of its creation, the 'Hippocratic Oath' only applied to a small number of physicians who belonged to an exclusive society. During this time there were many other doctors that morally permitted assisted suicide in their practice. In fact, it was common for a physician to assist in the death of a patient to ease their suffering and pain. In the same way that there were different standards of moral practice in ancient Greece, there are different standards of a physician's duty amongst Indian citizens today. There are citizens who believe it is equally as important for a doctor or medical staff to act on behalf of his patient's desires, whether that be to continue treatment or assist in end-of-life treatment.

In the article "Physicians, Assisted Suicide, and the Right to Live or Die" by Rosamond Rhodes, physician responsibility is not understood to strictly prevent death, but to act for the good of the patient⁷⁹. Rhodes considers the duty of beneficence to be the most important and morally binding aspect of a physician duty. He defines beneficence as the moral obligation to act for the good of someone else.

When it comes to the specific case of 'doctor-patient relationship', the duty of beneficence can mean different several things:

- i.** Doctors have an absolute duty to prevent pain and death to their patients.
- ii.** Doctors should do what is in the best interest for their patient while respecting their wishes.

⁷⁸, Gregory Pence, *Medical Ethics: Accounts of the Cases That Shaped and Diene Medical Ethics* Ch. 3(The McGraw-Hill Companies; New York, 2008).

⁷⁹ Rhodes, Rosamond, "Physicians, Assisted Suicide and the Right to Live or Die", *Physician Assisted Suicide: Expanding the Debate*, ed. Margaret P. Battin, Rosamond Rhodes, and Anita Silvers 170 (New York, Routledge, 1998)

Arguments similar to Rhodes introduce this second duty, which also considers respect for the patient as another important aspect of the doctor-patient relationship. Rhodes cites the American Medical Association's Principles of Ethics regarding these two duties, "A physician shall be dedicated to providing competent medical service with compassion and respect for human dignity."⁸⁰

In most medical cases patients and doctors do not have conflicting interests or desires. The standard situation or assumption is that an individual enters/stays in a hospital for medical treatment to get healthy. However, in the case of PAS and voluntary-passive or active euthanasia, a patient no longer desires life-sustaining treatment and care. This complicates matters in two ways:

- a. It calls into question what is considered when we talk about the patient's 'dignity'; and
- b. It raises questions about the amount of weight we should place on the duty of physicians to consider the 'dignity' of their patients when it opposes physician duty to medically treat a patient's illness.

Rhodes argues that if we assume that a physician's primary responsibility is beneficence and in that she must take into account the dignity of her patient, then a physician does not necessarily have two conflicting duties as it might first appear. Rhodes says that our medical care currently runs on a 'needs-based' system in that, "The more assistance a needy person requires, the greater the amount of assistance that must be given." His examples include the degree of assistance a sick person is given based on her need. When a patient needs medication yet has the abilities to take the medicine on her own, a doctor prescribes her a dosage and it is up to the individual to purchase and take the prescribed medication. When a patient is so sick, she/he no longer has the abilities to take the medication or capacity to administer proper treatment such as surgery or hospitalization, the physician must meet the increased demand of treatment.⁸¹

⁸⁰ *Ibid.*

⁸¹ Rhodes, Rosamond, "Physicians, Assisted Suicide and the Right to Live or Die", *Physician Assisted Suicide: Expanding the Debate*, ed. Margaret P. Battin, Rosamond Rhodes, and Anita Silvers 170 (New

Similar to when physicians have the moral and professional responsibility of beneficence to meet 'patients' needs for more extensive treatment due to pain and suffering, they are equally responsible under this duty to meet the needs of preserving patient dignity and/or respecting patient autonomy. Rhodes argues that physicians should fulfill these three needs based on the moral and professional obligation of beneficence. Therefore, both PAS and euthanasia are morally justifiable acts when there are no better options available to fulfill the need of dignity and autonomy.

For example, when a patient requires relief from suffering of a terminal illness such as late stage AIDS virus in order to maintain his autonomy and dignity in life but he requires the assistance from another because he alone is not capable of ending it himself, a physician is morally obligated to take on this assisting role. This responsibility falls more heavily on a physician because he has the ability i.e. medical equipment, the knowledge of how to use the equipment, and the relationship of a caretaker for the patient. Rhodes not only argues the moral justification of a physician to perform PAS or voluntary active and passive euthanasia, he says that if a doctor is aware of her patient's incurable suffering and her patient's desire to end life yet allows the suffering to continue, then she is in moral violation of her duty of beneficence.

Although Rhodes is an advocate for PAS and euthanasia, he also believes alternatives must be exhausted before the final decision can be made. Such alternatives are psychological treatment to make sure patients are not depressed with a skewed desire, or pain management options if that is the desired goal. With this said, it only furthers his reason why physicians are best fit to perform PAS and euthanasia; they are the most knowledgeable of medical history and alternatives for their patients.

Lastly, Rhodes argues that we must treat similar cases similarly when evaluating the moral acceptability of physician duty to their patient. Because physicians are allowed to cut into people to remove limbs and organs (surgery) out of their duty of beneficence or psychiatrists are allowed to physically confine people (psychiatric wards) out of their duty of beneficence and even provide potentially lethal dosages of drugs (medication) out of their duty of beneficence, physicians should be allowed to assist in end-of-life treatment (PAS and euthanasia) out of their

duty of beneficence.⁸² Rhodes applies the rule of universalizability to the case of PAS and voluntary passive and active euthanasia and does not accept the universal rule that all killing is wrong.

5.12 Intention/ foresight and doctrine of double effect:

The “principle (or doctrine) of double effect” was outlined in Chapter 2 and this chapter Specifies that it has some legal reliance. The principle has its origins in the moral theology of the Roman Catholic Church hold that an act that has two predicted consequences, one good and one bad can be morally permissible “Where me Intention is to achieve the good and the bad is as unchosen as it is unavoidable.”⁸³ It is a distinction between intention and foresight, between a chosen purpose and a foreseen but unchosen side effect.⁸⁴ According to Keown, it is best formulated so as to state that it is permissible to produce a bad consequence only if “the act one is engaged in is not itself bad”, “the bad consequence is not a means to the good consequence” the bad consequence is foreseen but not intended”, and there “is a sufficiently serious reason for allowing the bad consequence to occur”.⁸⁵ It is ethically controversial. Some reject its moral significance. It can be difficult to non-arbitrarily distinguish intended effects from unintended side-effects (double-effects) and it appears to depend on how the action is described.⁸⁶ It can also be difficult to determine whether a particular consequence was intended, both from a “first person” perspective (individuals can be unsure what they intend or do not intend) and from a “third person” perspective (we cannot directly enter another’s mind). Others reject these concerns arguing that the distinction is of moral significance, can be drawn without arbitrariness, is apparent from within a first-person perspective, and the evidential difficulties from a third person perspective are no more complex than those facing juries every day.⁸⁷

⁸² Rhodes, Rosamond, “Physicians, Assisted Suicide and the Right to Live or Die”, *Physician Assisted Suicide: Expanding the Debate*, ed. Margaret P. Battin, Rosamond Rhodes, and Anita Silvers 172-73 (New York, Routledge, 1998)

⁸³ Shaun D. Pattinson, *Medical Law and Ethics* 571 (Sweet and Maxwell, South Asian edn., 2013)

⁸⁴ J. Herring, *Medical Law and Ethics* 498 (Oxford University Press, 2010).

⁸⁵ J. Keown, *Euthanasia Ethics and Public Policy: An Argument Against Legalisation* 20 (Cambridge University Press, London, 2002)

⁸⁶ P. Singer, *The Rethinking Life and Death: The Collapse of Our Traditional Ethics* 209-210 (Oxford University Press, London 1995)

⁸⁷ Walton Report, House of Lords Select Committee 1994, para. 243

To some euthanasia only occurs where the actor intends to kill the patient. If, for example, a doctor provides a pain-relieving drug to a patient in order to reduce a patient's suffering, although she or he knows that the drug will also cause the death of a patient, this will not be euthanasia because there is no intent.⁸⁸ Other commentators reject a distinction between intention and foresight, and argue that if a doctor foresees that her or his treatment will lead to a patient's death, this is equivalent to intention.

Many who support the idea that euthanasia only occurs where there is an intention to kill, support the doctrine of double effect. In essence this doctrine holds that in some circumstances a person who is doing an act with the purpose of producing result A, but foreseeing that result B may well result from her or his actions, will be held to intend result A. The exact meaning of the doctrine is disputed. Known's version quotes four principles that render it permissible to do an act which produces a bad consequence:⁸⁹

- 1) the act one is engaged in is not itself bad,
- 2) the bad consequence is not a means to the good consequence,
- 3) the bad consequence is foreseen but not intended, and
- 4) there is sufficiently serious reason for allowing the bad consequence to occur.¹⁹³

Relying on this doctrine, its supporters are able to say that a doctor who gives her or his patient pain-relieving drugs for the purpose of pain relief, but foreseeing that they will also have the effect of killing the patient, will not be said to have intended to kill the patient.

5.12.1 Effects and double effects: Conceptual distinction and moral significance

There is a conceptual distinction between intending and merely foreseeing a virtually certain consequence of one's intended conduct. Harris, who rejects the moral significance of the distinction, accepts that a person can intend to get drunk without

⁸⁸ J. Keown, *Euthanasia Ethics and Public Policy: An Argument Against Legalisation* 20(Cambridge University Press, London, 2002)

⁸⁹ *Ibid.*

intending the hangover foreseen as a virtually certain consequence.⁹⁰ Finnis, who considers the distinction to hold significant moral weight, provides another example:

“The British climber in the Andes who, some years ago, finally cut the rope on which his friend was dangling, lest he himself be dragged over the precipice, and who later found (to his amazed delight) that the friend he had thought certain to be killed had fallen unscathed into deep snow, had no intent to bring, about death or any lesser harm.”⁹¹

Harris rejects its moral significance because he considers us to be morally responsible for all that we knowingly and voluntarily bring about, irrespective of whether we intend to bring about those consequences.⁹² I might not have intended my hangover but if I acted voluntarily knowing that that was a virtually certain consequence of my drinking, then I am responsible for it. Finnis refuses to accept this view of moral responsibility. He goes further and argues that the unintended side-effect need not be altogether unwanted, as hangovers are.⁹³ He declares that a war-time commander who orders the bombing of a factory is not morally responsible for civilian deaths if he does not intend them, even if he welcomes the “bonus” side-effect that killing civilian deaths will weaken enemy morale. According to Finnis, this side-effect is unintended if the war-time commander:

“has in no way calibrated or adjusted his plans so as to achieve civilian deaths not even as a secondary objective and if he stops the bombing as soon as the factory is destroyed”.⁹⁴

This is an extremely narrow interpretation of intention. To some extent the debate between Harris and Finnis turns on their underlying moral position. Harris rejects Finnis duty-based position in favour of one with distinctly utilitarian features.

⁹⁰ J. Harris “The Right to Die Lives: There is no Personhood Paradox” 13 *Medical Law Review* 37(2005)

⁹¹ J.M. Finnis, “Bland: Crossing the Rubicon?” 109 *LQR* 332(1993)

⁹² J. Harris “The Right to Die Lives: There is no Personhood Paradox” 13 *Medical Law Review* 66-73(2005)

⁹³ J.M. Finnis, “Bland: Crossing the Rubicon?” 109 *LQR* 63-64(1993)

⁹⁴ J.M. Finnis, “Bland: Crossing the Rubicon?” 109 *LQR* 63-64(1993)

5.13 Ordinary v. Extraordinary Means of Treatment:

In the last several decades two very important arguments and distinctions have developed based on the longevity of human life and the medical resources available: ordinary versus extraordinary medical treatments and physical pain versus psychological suffering.

To some commentators there is a fundamental distinction to be drawn between ordinary treatment which doctors are obliged to provide to their patients and extraordinary treatment which they are not obliged to provide. Behind this debate is an argument over the lengths to which a doctor need go to delay the death/prolong the life of the patient. This can be said to be justified as part of the need to protect the dignity of the patient: it is undignified for a patient to have every attempt made in a desperate bid to save their life.

In *Ms D v An NHS Trust Hospital*⁹⁵ Coldridge J made a declaration that doctors need not provide further life-saving treatments for a PVS patient. He held:

“In my judgment she should be allowed as dignified a passing as is achievable. Some might say that her dignity has already been severely compromised by the progress and incidence of this awful disease. To subject her body to further grossly invasive procedure can only further detract from her dignity.”⁹⁶

The distinction might also be justified as a reasonable allocation of resources. It would be foolish to expend substantial resources on treatment which has only a faint chance of saving the life of the patient. To some commentators, although the distinction is a useful one, the words ‘ordinary’ or ‘extraordinary’ are not particularly helpful. It is not whether the treatments are often used or not, it is rather whether the treatment is proportionate or beneficial to the patient. Gerald Kelly, in an oft-quoted statement, has suggested:⁹⁷

“Ordinary means are all medicine, treatments, and operations which offer a reasonable hope of benefit and which can be obtained and used without

⁹⁵ (2005) EWHC 2439 (Fam).

⁹⁶ President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioural Research (1983)

⁹⁷ Kelly (1951), Cited in J. Herring, *Medical Law and Ethics* 500 (Oxford University Press, 2010).

excessive expense, pain, or other inconvenience. Extraordinary means are all medicines, treatments, and operations, which cannot be obtained or used without excessive expense, pain, or other inconvenience, or which, if used, would not offer a reasonable hope of benefit.”

This interpretation suggests that the extraordinary/ordinary distinction is little more than a balancing of the benefits and disadvantages of the treatment, in which case it might be better to use different terminology. It is important to note the history of hospitals and medicine until the 1900's to see how these issues have developed. Hospitals used to be considered poor houses run by the church where people went to die and doctors were hardly ever seen there. Instead, physicians travelled around and treated patients in their homes. Surgeons did not find much work in the hospitals until the development of sanitation and antiseptic chemicals in the 1800's.

Needless to say, our standards of medical treatment and use of hospitals has drastically changed since then. Expectations play a large role in medical treatment today because hospitals and medical care are now capable of so much. The discussion on passive euthanasia has been limited so far because it is not the main focus for this chapter. However, researcher would like to address one argument in favour passive euthanasia. The standard of medical care is a sliding scale. Today, standard care includes treatments such as IVs, prescription medicine to cure illnesses such as the common flu, shots, check-ups, x-rays, MRIs, palliative-hospice care, and in-patient treatments. However, there is debate about whether certain types of available care are standard or extraordinary. In the debate of PAS and euthanasia, the main concern lies with passive euthanasia, which includes withholding and withdrawing life-sustaining treatment.

Proponents of passive euthanasia claim that life support by feeding tubes and breathing machines are extraordinary means of treatment that are not required of the physician to offer or for the patient to accept. This issue pertains mostly to those patients who would not survive unless supported by machines. Until recently there were laws that prohibited patients from withdrawing extraordinary means of treatment in order to end their lives.

When a patient's life is dependent on a machine to breath or to obtain nutrients, the quality-of-life can be diminished to the point where he no longer sees the point in living. Because such treatment artificially keeps a patient alive, it is considered extraordinary and not ordinary. Those who desire this extraordinary treatment have the right to it, but those who do not want it have an equal right to deny the treatment or withdraw it once they no longer find meaning for it. Therefore, there is a moral obligation for a physician to respond to the wants of her patient by either providing or withholding/withdrawing artificial life-sustaining treatment.

5.14 Physical Pain v. Psychological Suffering:

Many opponents of euthanasia make the claim that we have sufficient pain treatments with palliative-hospice care and other forms of medical care.⁹⁸ Morphine is a commonly used drug to treat severe physical pain,⁹⁹ however, opponents fail to recognize the difference between physical pain and psychological suffering. In chapter 4 of *Physician Assisted Dying: Oregon's legalisation* by Pence¹⁰⁰, he establishes two arguments regarding pain and suffering as sufficient reason for PAS and euthanasia. The first is that suffering can be both a physical and mental experience for a patient. It is also far more difficult to treat mental suffering compared to physical due to the limits of medication. Forms of mental suffering can include but are not limited to helplessness, stress, exhaustion, terror, and loss. These forms of mental suffering do not always mean that a patient is facing depression. This distinction is important to make because depression is not argued by any to be a reason for PAS or euthanasia. Since mental suffering is much more difficult to treat with medication than physical pain, it is should be reason enough for a patient to no longer wish to carry on.

The second argument by Pence for pain treatment, if it is physical, is when pain management goes too far. The known risk of morphine with patients facing excruciating amounts of pain is that it can induce a coma. Some patients would rather face death if their pain were so strong that it runs a high risk of putting them in a

⁹⁸ J. Herring, *Medical Law and Ethics* 542 (Oxford University Press, 2010).

⁹⁹ Morphine is a pain medication of the opiate family that is found naturally in a number of plants and animals, including humans. It acts directly on the central nervous system to decrease the feeling of pain. Available at, en.m.wikipedia.org/wiki/Morphine (last visited on Jan 7th, 2019)

¹⁰⁰ Gregory E. Pence, *Classic Cases in Medical Ethics Accounts* Ch. 4 (Trade paperback, 1999)

coma. There is no point to surviving in a vegetative state because the person has no brain function and cannot experience life like a human. Patients see PAS and euthanasia as a positive experience in this respect.

John Stuart Mill supports these two arguments presented by Pence with his discussion on autonomy. Mill says,¹⁰¹

“That the only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others. His own good, either physical or moral, is not sufficient warrant. The only part of the conduct of any one, for which he is amenable to society, is that which concern others. In the part which merely concerns himself, his independence is, of right, absolute. Over himself, over his own body and mind, the individual is sovereign.”

Mill’s perspective of autonomy allows for an individual to be her own sovereign, and thus places the greatest value on autonomy. As long as our actions do not infringe on the physical or psychological safety and comfort of others, we should be allowed to determine our own actions. Mill’s concept of autonomy is the basis for many who argue in favour of PAS and/or active euthanasia.

One such group that embodies Mill’s autonomy argument is the Hemlock Society. It is a nationally recognized euthanasia advocacy group led by a man named Derek Humphry. The Hemlock Society advocates both patient autonomy and the importance of pain and suffering when making a decision for end of life treatment. Just like the majority of Americans, the Hemlock Society does not believe in an emotional decision by a mentally unstable person to end her life; instead they believe in the “justifiable suicide”-that is, rational and planned ‘self- deliverance’.¹⁰² The Hemlock Society believes that suicide, what they refer to as ‘auto euthanasia’ and ‘euthanasia’, can be justified for two reasons:

- a. Advanced terminal illness that is causing unbearable suffering to the individual,
and

¹⁰¹ John Stuart Mill, *On Liberty* (1869), Ch. 5 (Apeton-Century-Crofts, New York, 1974).

¹⁰² Derek Humphry *The Case for Rational Suicide in Last Rights? Assisted Suicide and Euthanasia* Edited by Michael M Uhlmann 307.

- b.** grave physical handicap so restricting that the individual cannot, even after due consideration and training, tolerate such a limited existence.¹⁰³

The Hemlock Society does not believe just anyone can commit auto euthanasia or euthanasia. They have a specific set of ethical guidelines that qualify a suicide to be rational:

- i.** The person is a mature adult,
 - ii.** The person has clearly made a considered decision;
 - iii.** The decision has not be made at the first knowledge of the life-threatening illness, and reasonable medical help has been sought,
 - iv.** The treating physician has been informed, and his or her response has been taken into account;
 - v.** The person has made a will disposing of his or her worldly effects,
 - vi.** The person has made plans to exit this life that do not involve others in criminal liability,
 - vii.** The person leaves a note saying exactly why he or she is committing suicide.²⁵
- These guidelines differentiate suicide from ‘auto euthanasia’ because suicide is an emotional endeavour where ‘auto euthanasia’ is a rational decision.

The Society believes that these guidelines prevent any emotionally and mentally unstable individuals from making irrational decisions to end their lives. Additionally, Humphry provides a counter argument to those who believe in the legalizing euthanasia will lead to a slippery-slope. He states that the autonomous power given to the patient to end his life when he sees fit will make him live even longer if he did not have that option. Humphry reasons that many terminal patients feel stress because they do not know when their life will end and are anxious about the inevitable pain they will soon suffer. Instead, when they have the means of killing themselves, they not only can reevaluate where they stand in life, but they no longer have the stress that

¹⁰³Robert Young, *Medically Assisted Death*, 17 (Cambridge: Cambridge University Press, 2007),

causes them more sickness; Humphry says this is not an idea but a fact. He encountered many elderly and sickly individuals who expressed reasonable desires to end their lives before provided with medication or a means to end their lives. Yet once they obtained a means for ending their lives, they decided they could hold on longer. Humphry essentially argues that the right to end one's own life has the opposite affect that the slippery-slope assumes because the comfort and power of the choice will limit the amount of suicides.

Another famous example of patient autonomy is the case of Diane and her physician Timothy Quill. After Dr. Quill assisted in the death of Diane, he went on to write about the criteria necessary to regulate a health care system that performs PAS. Quill acknowledges that there are terminally ill patients who suffer regardless of palliative-hospice care treatments available to them; Quill also asserts the importance of patient dignity at the end of life. Quill says "Yet it is neither idiosyncratic, selfish, nor emblematic of a psychiatric disorder for a person with an incurable illness to want to have some control over how he leaves this world."¹⁰⁴ This statement makes it clear that Quill believes that terminally ill patients can reasonably decide how they wish to end their lives.

However, Quill is cautious about allowing patients to choose PAS as a final option. Patients must attempt other forms of comfort care and the approval must come from their primary-care physician who is most aware of the patients' medical history. Quill's criteria is as follows:

- a. The patient must, of his own free will and at his own initiative, clearly and repeatedly request to die rather than continue suffering,
- b. The patient's judgment must not be distorted,
- c. The patient must have a condition that is incurable, and associated with severe unrelenting, intolerable suffering,
- d. The physician must ensure that the patient's suffering and the request are not the result of inadequate comfort care,

¹⁰⁴ Timothy Quill, *Death and Dignity: B) Potential Clinical Criteria for Physician-Assisted Suicide in Last Rights? Assisted Suicide and Euthanasia Debate* Edited by Michael M Uhlmann, 327.

- e. Physician-assisted suicide should be carried out only in the context of a meaningful doctor-patient relationship,
- f. Consultation with another experienced physicians is required, and
- g. Clear documentation to support each condition above is required.¹⁰⁵

Requirement one does not allow for any room of uncertainty because death is *the* irreversible request. Requirement two means that a patient cannot be depressed and they must be fully aware of the consequences of ‘euthanasia and PAS’, review from a psychiatrist should be used to make certain that the patient is entirely rational when making the decision. Requirement four states that comfort care must be sought first and definitely strongly considered before any discussion of ‘euthanasia and PAS’. Although Quill believes PAS should be legally available to patients, it should be used with caution and as a last resort option to the terminally ill who demonstrate a reasonable request to end their lives.

The guidelines established above are very similar to what is set in place in Holland for the standard to carry out euthanasia which has been discussed in chapter 3.

What goes unstated in this set of guidelines for the Netherlands is the importance of the doctor-patient relationship because the medical system there is set up so a physician and her patient have a long-term relationship. This characteristic is very unlike the India and US system where primary-care physicians change with insurance coverage, and insurance can change depending on jobs. Relationships like that of Quill and his patient Diane are considered standard in Holland where in India it is scarcely found. With Quill’s hypothetical guidelines in place and the assumed personal doctor-patient relationship, the slippery-slope argument carries no weight. Physicians-assisted suicide and active euthanasia can be closely monitored to make sure it does not overstep moral boundaries that violate patient autonomy.

In summary, the arguments in favour of PAS and euthanasia are strongly based on the assumed importance of patient autonomy and the patient's evaluation for quality-of-life and dignity. Variables for this evaluation include physical pain,

¹⁰⁵ Timothy Quill, *Death and Dignity: B) Potential Clinical Criteria for Physician-Assisted Suicide in Last Rights? Assisted Suicide and Euthanasia Debate* Edited by Michael M Uhlmann, 330-332.

psychological suffering and expectations for medical treatment. The patient is regarded as the most important judge in end-of-life care while the physician is morally and professionally responsible-according to the beneficent role discussed by Rhodes-for assisting when needed. The role of religious doctrine has no place here because the patient is held responsible for an end-of-life decision instead of God or any other moral judge.

5.15 Doctor-patient relationship:

Some opponents of euthanasia claim that the possibility of euthanasia will undermine the relationship between doctor and patient and disrupt a doctor's healing role. It is noticeable that in Switzerland, where under certain circumstances assisted suicide is permitted, doctors play only a minimal role in the procedure, which is arranged by private clinics. The Hippocratic Oath states 'To please no one will I prescribe a deadly drug, nor give advice which may cause his death.'¹⁰⁶ The World Medical Association reaffirmed its strong belief that euthanasia conflicts with basic principles of good medical practice-¹⁰⁷ The British Medical Association, the Canadian Medical Association, and the American Medical Association have all voiced their objection to euthanasia. The root of the concern has been vividly expressed by Capron: I never want to have to wonder whether the physician coming into my hospital room is wearing the white coat of a healer-concerned only to relieve my pain and to restore me to health or the black hood of the executioner.¹⁰⁸

Hence it is argued that the knowledge that a doctor could kill the patient will undermine the trust that is at the heart of the doctor-patient relationship. Seeking advice from a physician who may be thinking "it would be best if I gave you a lethal injection and killed you is a frightening prospect." Although doctors will respect the autonomy rights of a patient this does not mean that a doctor must comply with every patient's request.¹⁰⁹

Supporters argue that on the contrary it will create a more open and equal relationship between doctor and patient, with the patient being more able to discuss

¹⁰⁶ G.E.R. Lloyd, *Hippocratic Writings*, trans. Chadwick and W.N. Mann, 13 (Penguin, New York, 1950)

¹⁰⁷ Available at, <https://www.wma.net/policies-post/wma-resolution-on-euthanasia/> (Last visited on Jan 7th,2019)

¹⁰⁸ Quoted in The British Medical Association (2004) p. 144

¹⁰⁹ J. Herring, *Medical Law and Ethics* 511(Oxford University Press, 2010).

her or his true feelings. The present law may discourage a patient from discussing her or his wish to die with her or his doctor for fear that it would put the doctor in a difficult position. On the other hand, if euthanasia were legal would people be deterred from discussing their pain for fear that the doctor may pressurize them into considering euthanasia? We should remember that at present doctors can give a lethal quantity of drugs so long as they are doing so with the intention of relieving pain, rather than killing. It appears the fact that doctors under the present law are arguably permitted to kill does not appear to undermine the trust between patient and doctor.¹¹⁰

5.16 Human rights: a right to die?

There are those who are adamant that there is a right to die in the manner of one's choosing. The heart of the argument was expressed by a Canadian judge, Cory J dissenting in *Rodriguez v A-G of British Columbia*.¹¹¹

“Dying is an integral part of living. It follows that the right to die with dignity should be as well protected as is any other aspect of the right to life. State prohibitions that would force a dreadful, painful death on a rational but incapacitated terminally ill patient are an affront to human dignity.”

In terms of the ECHR, the argument would be that the decision to end one's life is an essential aspect of the right to private and family life. As noted above, in fact the European Court in *Pretty v UK*¹¹² and the House of Lords in *R (Purdy) v DPP*¹¹³ have accepted that choosing the manner of one's death could be included as an aspect of the right to respect for private life,¹¹⁴ but held that the interests of the state and others justified an interference with that right.

It should not be thought that human rights arguments all point in favour of liberalizing the laws on suicide and euthanasia. The Committee of Legal Affairs and Human Rights,¹¹⁵ in a report generally negative towards euthanasia, emphasizes the

¹¹⁰ J. Herring, *Medical Law and Ethics* 512(Oxford University Press, 2010).

¹¹¹ (1994) 107 DLR (4th) 342, at 413.

¹¹² (2002) 2 FCR 97.

¹¹³ (2009) UKHL 45.

¹¹⁴ Mumby J in *R (Burke) v. GMC* (2004) EWHC(Admin) 1879 stated, at para 62, “Article 8 of human right convention embraces such matters as how one chooses to pass the closing days and moments of one's life and how one manages one's death”.

¹¹⁵ Council of Europe (2003)

right to life of the terminally ill. The European Assembly has asked members to uphold the prohibition against intentionally taking the life of terminally ill or dying persons.¹¹⁶ But some argue that the right to life means the right to a minimally decent life and if a person's life is intolerable their right to life, paradoxically, entitles them to a right to die.

5.17 Advance Refusal: Some Concerns

Advance refusals are more controversial than contemporaneous refusals.¹¹⁷ Advance refusals could be viewed as expressions of future oriented or "prospective" autonomy.¹¹⁸ They are made for a future situation when the patient is no longer able to competently make or express a refusal.¹¹⁹ Advance refusals can also be viewed as reassuring patients that they will not be treated unnecessarily in the future and as reducing the burden on others by relieving them of responsibility for making such decisions. Advance refusals can also be regarded as persuasive or binding in a similar way to contemporaneous refusals. Prospective refusals, however, lack the context, immediacy, and safeguards of contemporaneous refusals: They rely on hypothetical facts or best-guess predictions and, as Buchanan has argued:¹²⁰

"when the decision to forgo life-sustaining treatment is a remote and abstract possibility it is less likely to elicit the same protective responses that are provoked in family members and health care professionals when they are actually confronted with a human being who they believe can lead a meaningful life but who chooses to die."¹²¹

Prospective autonomy interests can conflict with contemporaneous welfare interests and, unlike contemporaneous decisions, an incompetent patient can no longer reconsider a decision. Some go further and argue that individuals can transfer their "personal identity", so that the individual who projects their autonomous choices into the future can be viewed as imposing those choices on a different (incompetent) individual.¹²² There is no

¹¹⁶ European parliamentary assembly (2003).

¹¹⁷ Michael Davies, *Medical Law* 358 (Oxford University Press, 2nd edn., 2009)

¹¹⁸ Shaun D. Pattinson, *Medical Law and Ethics* 577 (Sweet and Maxwell, South Asian edn., 2013).

¹¹⁹ *Ibid.*

¹²⁰ Allen, "Principal/Agent Theory and Decision Making in Healthcare", Vol. 2 Issue 4, *Bioethics* 279(1988)

¹²¹ *Ibid* at 280

¹²² *Ibid*

morally neutral position on whether advance refusals should be enforced or even enforceable. There is no reversing a patient's death and, as long as active measures to end life are prohibited, the effects of successfully administering unwanted life-saving treatment are irreversible.

5.18 Conclusion:

From the above discussion It is concluded that euthanasia is a complicated issue to. It has so many different arguments in favour and against. Both sides have its own justifications. No principle can be put in water tight compartment. Sanctity of life, quality of life is main justifications to acceptance or denial of euthanasia so as principle of personal autonomy. However, there is need to balance both the theory to make a qualified sanctity of life approach. There are some other concerns also involved in euthanasia debate. Application of voluntary passive euthanasia in case of contemporaneous refusal of withdrawal of treatment which is to be performed according to desire of patient, is not as challenging as advance refusal because situation may not be as someone think in future. Moreover, some practical difficulties appear in form of the informed consent and genuineness of advance directive. Coming back to non-voluntary passive euthanasia there are some extreme challenges seems to be crossroad. The emergence of novel medical technology, positive results of researches on PVS enabled the patient's recovery to some extent. Thus, PVS patients are not hopeless persons and needed to be carefully examined. Determining the best interest of the patient in also a daunting task, not easy as looking at surface. It should be considered not only medical factor but wholesome welfare of the patient. Concerns related to vulnerable persons and disabled also apparent from above discussion. At last it is concluded that feeding and nutrition is a basic human right and cannot be denied, even though it is artificial and requires feeding tube it should always be considered as a basic care of the terminal ill patients.



CHAPTER-VI
DATA ANALYSIS AND
INTERPRETATION



CHAPTER- VI

DATA ANALYSIS AND INTERPRETATION

“Everything is changeable, everything appears and disappears, and there is no blissful peace until one passes beyond the agony of life and death”.

- Lord Buddha

Euthanasia remains a controversial issue both among healthcare and legal professionals as well as general public. It contained many ideas and emotions by the general public, from murder to compassionate assistance in dying. The reason this is a controversial topic is due to the fact that there are situations within the family where people become very sick and are identified by the medical profession as terminally ill. Many of these people have chosen to find a means of ending their lives instead of living in a lot of pain or are physically incapacitated and do not wish to be a burden to others. Because of this thought process, the whole family is usually involved in the decision-making regarding the care of their terminally ill relative. Due to the variety of factors that influence people's ideals in our society, euthanasia has become a controversial issue not only locally but nationally as well.

Euthanasia is a very complicated topic that entails many different ideals and religious beliefs. This is a situation that could happen to any family, not necessarily to a family with an elderly person involved. Any age level can become a victim of circumstance due to an accident, disease, illness, etc. It becomes especially controversial when there is a child involved or someone who has lost the ability to make their own decisions regarding their lives or condition. Children don't have the maturity and capability of rationalizing the consequences of the possible actions; therefore, the decision-making has to be done by family members. This decision-making could involve parents, siblings, grandparents, etc. and could potentially divide families due to various beliefs within the family. Some people in the family unit will think that it is best to let someone go and others will want to hang on to the patient for emotional reasons, the possibility of a cure, a miraculous recovery, remission, etc. In any event, whether the patient is young or old, the decision is a difficult one to make.

Therefore, present study required a comprehensive opinion of the different section of population.

6.1 Research Methodology:

The research will consist of conducting a sample survey to the persons of different field above the age of 18 years through the method of questionnaire. It will be a convenience sampling. The sample survey will be conducted during the period of research with 400 individuals. The person below 18 years will be excluded from the study.

6.2 Universe of Study:

The following locations will be included for the distribution of questionnaire-

Sanjay Gandhi post graduate institute of medical sciences, King George medical University Lucknow, Students of different Universities like BBAU, RMLU, Lawyer of Lucknow High Court as well as civil court. The empirical study of the present research will comprise of views of various sections of public, which includes critical patients in coma and their families/ relative, doctors, nurses, lawyers, judges and is intended to be conducted in the city of Lucknow. Lucknow is the capital of Uttar Pradesh. The residents of the city are mostly a working class and are quite busy in their stressful professional life due to which they are unable to give sufficient time to their families, especially when both spouses are working. Therefore, it would be rather interesting to know their views on the concept of right to die with dignity i.e. euthanasia. Another reason to conduct the empirical study of the present research in this city is that in order to fulfil the multifarious needs of the patients, a large number of multi-specialty hospitals like KGMU and SGPGI have been constructed in the city where the patients in extremely pain and suffering also come from others cities. Therefore, the views of the doctors in these hospitals and terminally ill patients getting treatment from these hospitals as well as their families can be obtained through empirical study.

6.3 Data Analysis and Results:

1. Do you agree that a terminally ill and incurable patient with extreme physical mental suffering should have right to die peacefully when process of dying has already started?

Occupation * Question No.1 Crosstabulation

		Question No.1			Total	
		Yes	No	Neutral		
Occupation	Academicians	Count	36	2	12	50
		% within Occupation	72.0%	4.0%	24.0%	100.0%
		% within Question No.1	12.3%	5.3%	17.1%	12.5%
		% of Total	9.0%	0.5%	3.0%	12.5%
	Judges	Count	45	0	5	50
		% within Occupation	90.0%	0.0%	10.0%	100.0%
		% within Question No.1	15.4%	0.0%	7.1%	12.5%
		% of Total	11.2%	0.0%	1.2%	12.5%
	Lawyers	Count	42	0	8	50
		% within Occupation	84.0%	0.0%	16.0%	100.0%
		% within Question No.1	14.4%	0.0%	11.4%	12.5%
		% of Total	10.5%	0.0%	2.0%	12.5%
Total	Doctors	Count	40	4	6	50
		% within Occupation	80.0%	8.0%	12.0%	100.0%
		% within Question No.1	13.7%	10.5%	8.6%	12.5%
		% of Total	10.0%	1.0%	1.5%	12.5%
	Nurses	Count	36	6	8	50
		% within Occupation	72.0%	12.0%	16.0%	100.0%
		% within Question No.1	12.3%	15.8%	11.4%	12.5%
		% of Total	9.0%	1.5%	2.0%	12.5%
	Public	Count	61	16	23	100
		% within Occupation	61.0%	16.0%	23.0%	100.0%
		% within Question No.1	20.9%	42.1%	32.9%	25.0%
		% of Total	15.2%	4.0%	5.8%	25.0%
Patients Relatives	Count	32	10	8	50	
	% within Occupation	64.0%	20.0%	16.0%	100.0%	
	% within Question No.1	11.0%	26.3%	11.4%	12.5%	
	% of Total	8.0%	2.5%	2.0%	12.5%	
Total	Count	292	38	70	400	
	% within Occupation	73.0%	9.5%	17.5%	100.0%	
	% within Question No.1	100.0%	100.0%	100.0%	100.0%	
	% of Total	73.0%	9.5%	17.5%	100.0%	

Table 1

The demand of supporter of euthanasia finds its basis on ‘the right to die’. This right is being contentious in so many cases of apex court. Although the right to die with dignity has been declared the law of the land in the recent ‘common cause’ judgement, its important to know the opinion of the respondents in this regard. The Out of total 400 respondents, 73% thinks positive that a terminally ill and incurable patient with extreme physical mental suffering should have right to die peacefully when process of dying has already started. That shows the compassionate behaviour of the majority of people regarding the terminally ill patient with huge pain and suffering. Only 9.5% has declined such right. The reason maybe they think that life should be save in all cost. Moreover 17.5% respondents are remained neutral. See Table 1 and Figure 1

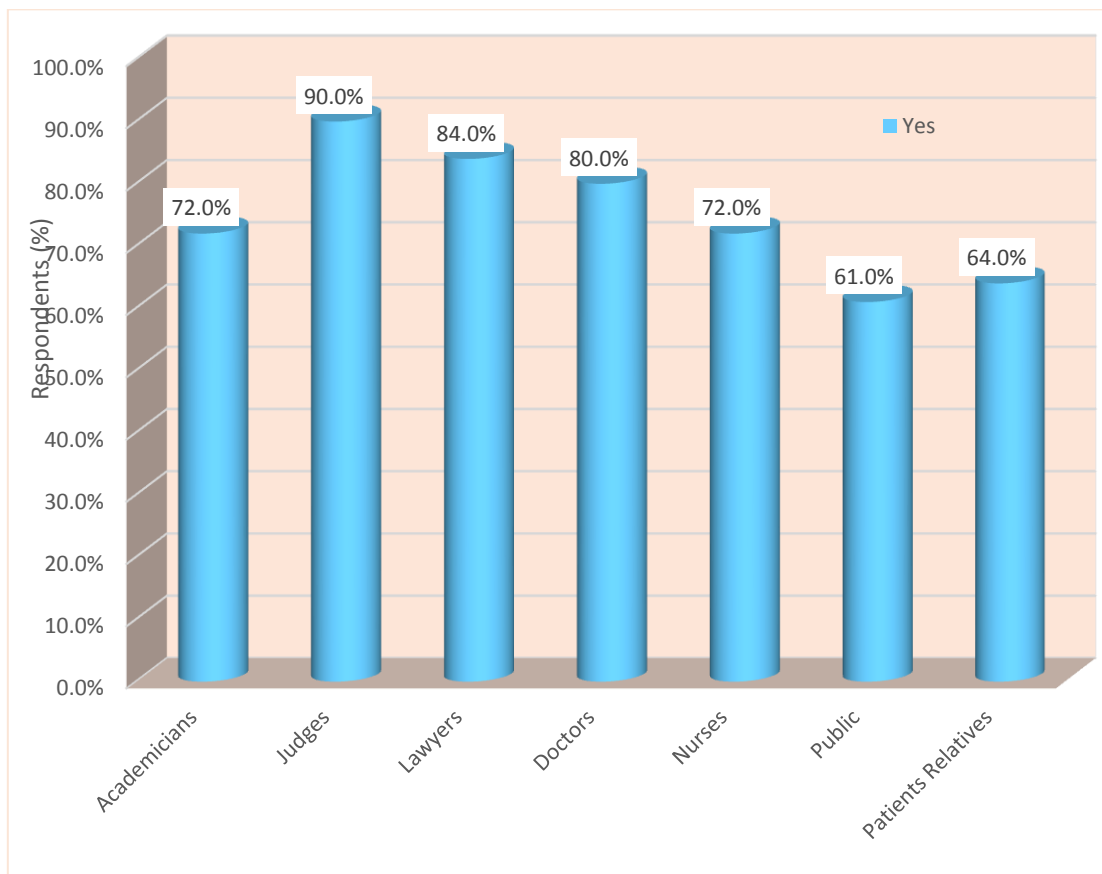


Figure 1

2. If a patient (close relative or loved one) is in huge pain and suffering, no prospects of recovery and close to death, requests consistently to you hasten death, would you accept his /her request.

Occupation * Question No.2 Crosstabulation

		Question No.2			Total
		Yes	No	Neutral	
Academicians	Count	26	10	14	50
	% within Occupation	52.0%	20.0%	28.0%	100.0%
	% within Question No.2	10.9%	10.6%	20.6%	12.5%
	% of Total	6.5%	2.5%	3.5%	12.5%
Judges	Count	31	14	5	50
	% within Occupation	62.0%	28.0%	10.0%	100.0%
	% within Question No.2	13.0%	14.9%	7.4%	12.5%
	% of Total	7.8%	3.5%	1.2%	12.5%
Lawyers	Count	27	10	13	50
	% within Occupation	54.0%	20.0%	26.0%	100.0%
	% within Question No.2	11.3%	10.6%	19.1%	12.5%
	% of Total	6.8%	2.5%	3.2%	12.5%
Doctors	Count	30	14	6	50
	% within Occupation	60.0%	28.0%	12.0%	100.0%
	% within Question No.2	12.6%	14.9%	8.8%	12.5%
	% of Total	7.5%	3.5%	1.5%	12.5%
Nurses	Count	29	17	4	50
	% within Occupation	58.0%	34.0%	8.0%	100.0%
	% within Question No.2	12.2%	18.1%	5.9%	12.5%
	% of Total	7.2%	4.2%	1.0%	12.5%
Public	Count	69	20	11	100
	% within Occupation	69.0%	20.0%	11.0%	100.0%
	% within Question No.2	29.0%	21.3%	16.2%	25.0%
	% of Total	17.2%	5.0%	2.8%	25.0%
Patients Relatives	Count	26	9	15	50
	% within Occupation	52.0%	18.0%	30.0%	100.0%
	% within Question No.2	10.9%	9.6%	22.1%	12.5%
	% of Total	6.5%	2.2%	3.8%	12.5%
Total	Count	238	94	68	400
	% within Occupation	59.5%	23.5%	17.0%	100.0%
	% within Question No.2	100.0%	100.0%	100.0%	100.0%
	% of Total	59.5%	23.5%	17.0%	100.0%

Table 2

There is growing demand for active voluntary euthanasia by terminally ill competent patients all over the world. The reason behind asking this question to find out the indication about active voluntary euthanasia. Out of total 400 respondents, 59.5 % agrees that If a patient (close relative or loved one) is in huge pain and suffering, no prospects of recovery and close to death requests consistently to hasten death, they would accept his /her request. However substantial number of respondents (23.5%) are disagree with the statement. Moreover, 17% of respondent are remain undecided. See Table 2 and Figure 2.

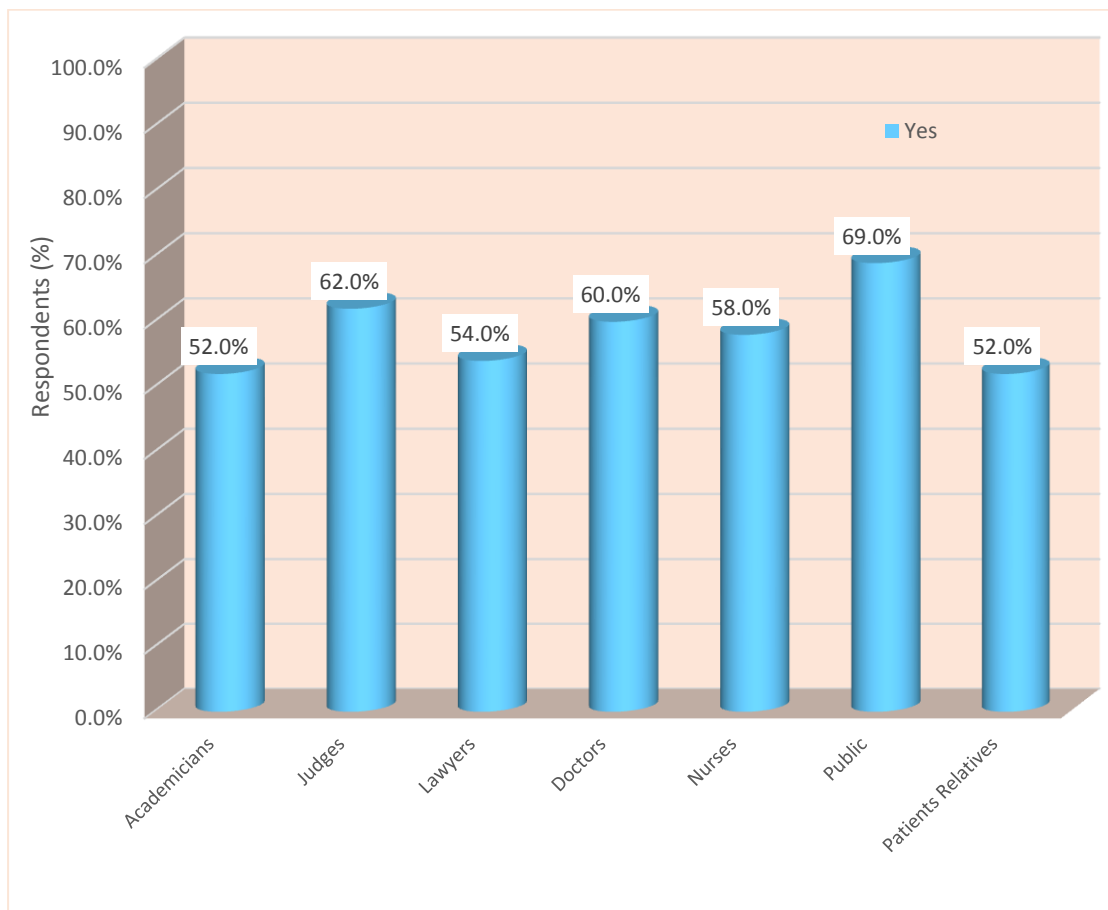


Figure 2

3. Do you think that personal autonomy and self-determination of your own body is the key aspect of human right of personal liberty?

Occupation * Question No.3 Crosstabulation

		Question No.3			Total
		Yes	No	Neutral	
Academicians	Count	33	6	11	50
	% within Occupation	66.0%	12.0%	22.0%	100.0%
	% within Question No.3	12.5%	16.2%	11.0%	12.5%
Judges	Count	41	3	6	50
	% within Occupation	82.0%	6.0%	12.0%	100.0%
	% within Question No.3	15.6%	8.1%	6.0%	12.5%
Lawyers	Count	35	6	9	50
	% within Occupation	70.0%	12.0%	18.0%	100.0%
	% within Question No.3	13.3%	16.2%	9.0%	12.5%
Doctors	Count	31	8	11	50
	% within Occupation	62.0%	16.0%	22.0%	100.0%
	% within Question No.3	11.8%	21.6%	11.0%	12.5%
Nurses	Count	27	5	18	50
	% within Occupation	54.0%	10.0%	36.0%	100.0%
	% within Question No.3	10.3%	13.5%	18.0%	12.5%
Public	Count	67	7	26	100
	% within Occupation	67.0%	7.0%	26.0%	100.0%
	% within Question No.3	25.5%	18.9%	26.0%	25.0%
Patients Relatives	Count	29	2	19	50
	% within Occupation	58.0%	4.0%	38.0%	100.0%
	% within Question No.3	11.0%	5.4%	19.0%	12.5%
Total	Count	263	37	100	400
	% within Occupation	65.8%	9.2%	25.0%	100.0%
	% within Question No.3	100.0%	100.0%	100.0%	100.0%
	% of Total	65.8%	9.2%	25.0%	100.0%

Table 3

Out of total 400 respondents, 65.8% answered in affirmative as compared to 9.2% who did not agree. However, a substantial proportion of population i.e. 25% are neutral. The reason maybe they think this depends upon facts and circumstances of each case to decide as to what extent a person can decide for himself or herself. The legal recognition of medical termination of pregnancy, prostitution, rights of lesbians, gays, bisexuals and transgenders (LGBT), practice of sex change, transplant of organs, the recognition of right to marry and live-in-relationships, surrogacy in various legal systems are various examples which show that a majority of people across the world support the right to have control over one's own body as a part and parcel of personal liberty. This shows that majority is in favour of the view that personal autonomy and self-determination of your own body is the key aspect of human right of personal liberty.

If we further categorize, 66% out of 50 academicians, 82% out of 50 judges and 70% out of 50 lawyers agreed that right to personal liberty includes right to personal autonomy and self-determination. This view is supported by a majority of medical professionals i.e. 54% out of 50 nurses and 62% out of 50 doctors. Similarly, the proportion of members of general public and patient's relatives supporting this view with 67% and 58% respectively. See Table 3 and Figure 3

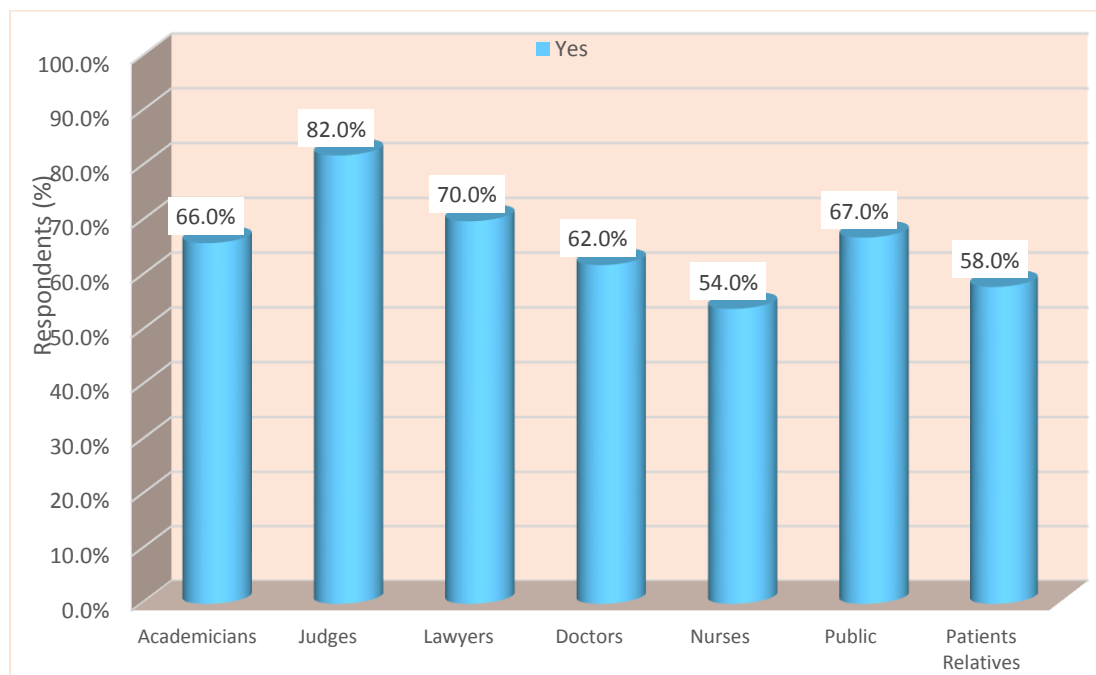


Figure 3

4. Right to personal autonomy and self-determination extends to demand euthanasia for those patients suffering for incurable disease and no chance of recovery.

Occupation * Question No.4 Crosstabulation

		Question No.4			Total		
		Yes	No	Neutral			
Occupation	Academicians	Count	33	5	12	50	
		% within Occupation	66.0%	10.0%	24.0%	100.0%	
		% within Question No.4	12.8%	17.2%	10.5%	12.5%	
		% of Total	8.2%	1.2%	3.0%	12.5%	
		Judges	Count	37	7	6	50
		% within Occupation	74.0%	14.0%	12.0%	100.0%	
		% within Question No.4	14.4%	24.1%	5.3%	12.5%	
		% of Total	9.2%	1.8%	1.5%	12.5%	
		Lawyers	Count	39	2	9	50
		% within Occupation	78.0%	4.0%	18.0%	100.0%	
		% within Question No.4	15.2%	6.9%	7.9%	12.5%	
		% of Total	9.8%	0.5%	2.2%	12.5%	
	Doctors	Count	31	3	16	50	
	% within Occupation	62.0%	6.0%	32.0%	100.0%		
	% within Question No.4	12.1%	10.3%	14.0%	12.5%		
	% of Total	7.8%	0.8%	4.0%	12.5%		
	Nurses	Count	31	3	16	50	
	% within Occupation	62.0%	6.0%	32.0%	100.0%		
	% within Question No.4	12.1%	10.3%	14.0%	12.5%		
	% of Total	7.8%	0.8%	4.0%	12.5%		
	Public	Count	52	6	42	100	
	% within Occupation	52.0%	6.0%	42.0%	100.0%		
	% within Question No.4	20.2%	20.7%	36.8%	25.0%		
	% of Total	13.0%	1.5%	10.5%	25.0%		
	Patients Relatives	Count	34	3	13	50	
	% within Occupation	68.0%	6.0%	26.0%	100.0%		
	% within Question No.4	13.2%	10.3%	11.4%	12.5%		
	% of Total	8.5%	0.8%	3.2%	12.5%		
Total		Count	257	29	114	400	
		% within Occupation	64.2%	7.2%	28.5%	100.0%	
		% within Question No.4	100.0%	100.0%	100.0%	100.0%	
	% of Total	64.2%	7.2%	28.5%	100.0%		

Table 4

It is often assumed that one of the strongest arguments in favour of legalizing euthanasia and assisted suicide is respect for patient autonomy, it might be argued that a patient's right to make decisions about her medical treatment should extend to being able to decide when and how she dies. To die quickly and painlessly, perhaps at home and with people we love, is obviously preferable to a lonely, protracted, and frightening death.

Out of total 400 respondents, 64.2% gives affirmative response that right to personal autonomy and self-determination extends to demand euthanasia for those patients suffering for incurable disease and no chance of recovery. The small portion of population does not accept the proposition. Moreover, substantial amount of population is showed neutral response.

If we analyse category wise data. It is submitted that 66% academicians are gave positive response, similarly respondents from legal field, 74% Judges and 78% Lawyers agree with the statement. Respondents related to the medical field, doctor and Nurses are equally positive with 62%. Patient relatives also think the same. However, it is notable that respondents belong to general public are less positive than the other profession respondents. Larger portion of population (general public) not sure with 42%. See Table 4 and Figure 4

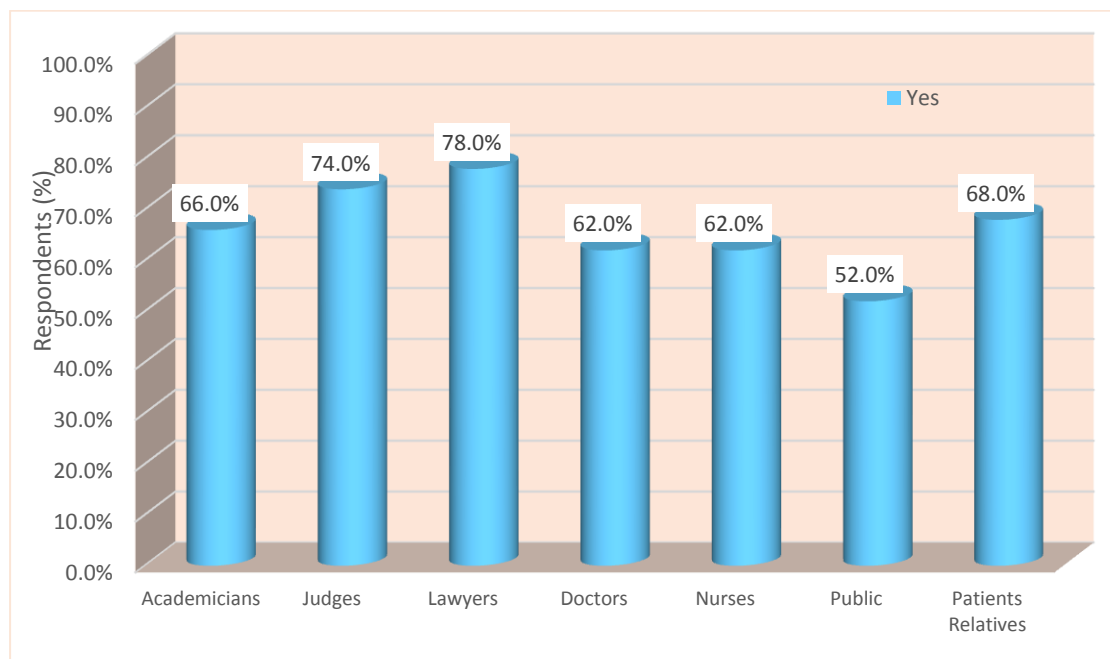


Figure 4

5. Do you know about euthanasia?

Occupation * Question No.5 Crosstabulation

		Question No.5			Total
		Yes	No	Neutral	
Academicians	Count	41	2	7	50
	% within Occupation	82.0%	4.0%	14.0%	100.0%
	% within Question No.5	14.4%	6.2%	8.3%	12.5%
Judges	Count	46	1	3	50
	% within Occupation	92.0%	2.0%	6.0%	100.0%
	% within Question No.5	16.2%	3.1%	3.6%	12.5%
Lawyers	Count	39	2	9	50
	% within Occupation	78.0%	4.0%	18.0%	100.0%
	% within Question No.5	13.7%	6.2%	10.7%	12.5%
Doctors	Count	33	5	12	50
	% within Occupation	66.0%	10.0%	24.0%	100.0%
	% within Question No.5	11.6%	15.6%	14.3%	12.5%
Nurses	Count	31	8	11	50
	% within Occupation	62.0%	16.0%	22.0%	100.0%
	% within Question No.5	10.9%	25.0%	13.1%	12.5%
Public	Count	59	9	32	100
	% within Occupation	59.0%	9.0%	32.0%	100.0%
	% within Question No.5	20.8%	28.1%	38.1%	25.0%
Patients Relatives	Count	35	5	10	50
	% within Occupation	70.0%	10.0%	20.0%	100.0%
	% within Question No.5	12.3%	15.6%	11.9%	12.5%
Total	Count	284	32	84	400
	% within Occupation	71.0%	8.0%	21.0%	100.0%
	% within Question No.5	100.0%	100.0%	100.0%	100.0%
	% of Total	71.0%	8.0%	21.0%	100.0%

Table 5

In research hypothesis the respondents were expected to know the meaning of the term 'euthanasia'. Out of total 400 respondents, 71% know about euthanasia. However small population is still unaware about this 'term', and 21% remained neutral. The respondents have fully satisfied that expectation by giving positive response to this question with overwhelming majority i.e. 82%, 92%, 78%, 66%, 62%, 59% and 70% respectively (category wise I to VII). Euthanasia is most commonly known in Indian society as mercy killing that is why the a few of respondents as shown in the table and figure might not be aware about the literal meaning of the term 'euthanasia'. But they understood the concept as explained by the researcher to them and have filled the questionnaire with a positive approach. See Table 5 and Figure 5.

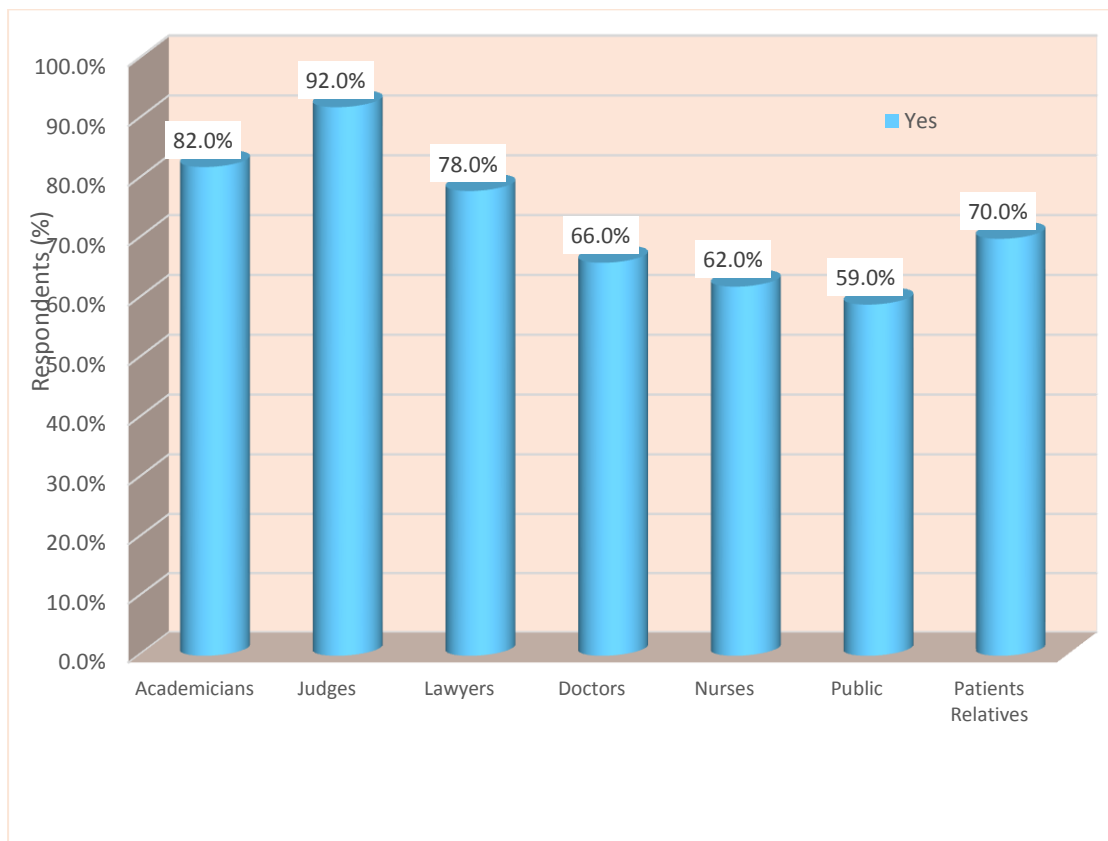


Figure 5

6. Do you agree that allowing euthanasia is justified to protect from undignified and distressing end to his/her life?

Occupation * Question No.6 Crosstabulation

		Question No.6			Total
		Yes	No	Neutral	
Academicians	Count	34	7	9	50
	% within Occupation	68.0%	14.0%	18.0%	100.0%
	% within Question No.6	12.4%	14.9%	11.4%	12.5%
	% of Total	8.5%	1.8%	2.2%	12.5%
Judges	Count	32	11	7	50
	% within Occupation	64.0%	22.0%	14.0%	100.0%
	% within Question No.6	11.7%	23.4%	8.9%	12.5%
	% of Total	8.0%	2.8%	1.8%	12.5%
Lawyers	Count	37	4	9	50
	% within Occupation	74.0%	8.0%	18.0%	100.0%
	% within Question No.6	13.5%	8.5%	11.4%	12.5%
	% of Total	9.2%	1.0%	2.2%	12.5%
Doctors	Count	31	6	13	50
	% within Occupation	62.0%	12.0%	26.0%	100.0%
	% within Question No.6	11.3%	12.8%	16.5%	12.5%
	% of Total	7.8%	1.5%	3.2%	12.5%
Nurses	Count	35	2	13	50
	% within Occupation	70.0%	4.0%	26.0%	100.0%
	% within Question No.6	12.8%	4.3%	16.5%	12.5%
	% of Total	8.8%	0.5%	3.2%	12.5%
Public	Count	76	6	18	100
	% within Occupation	76.0%	6.0%	18.0%	100.0%
	% within Question No.6	27.7%	12.8%	22.8%	25.0%
	% of Total	19.0%	1.5%	4.5%	25.0%
Patients Relatives	Count	29	11	10	50
	% within Occupation	58.0%	22.0%	20.0%	100.0%
	% within Question No.6	10.6%	23.4%	12.7%	12.5%
	% of Total	7.2%	2.8%	2.5%	12.5%
Total	Count	274	47	79	400
	% within Occupation	68.5%	11.8%	19.8%	100.0%
	% within Question No.6	100.0%	100.0%	100.0%	100.0%
	% of Total	68.5%	11.8%	19.8%	100.0%

Table 6

The proponents of euthanasia argue on the basis of dignity of life and death. Therefore, it becomes very important to recognize the perception of society towards it. Hence, with the purpose of examining the perception of individuals towards dignity of life and death the question was placed in the questionnaire. Out of total 400 respondents, 68.5% recognised euthanasia as a justification to protect from undignified and distressing end to his/her life. Small portion of respondents don't think so.

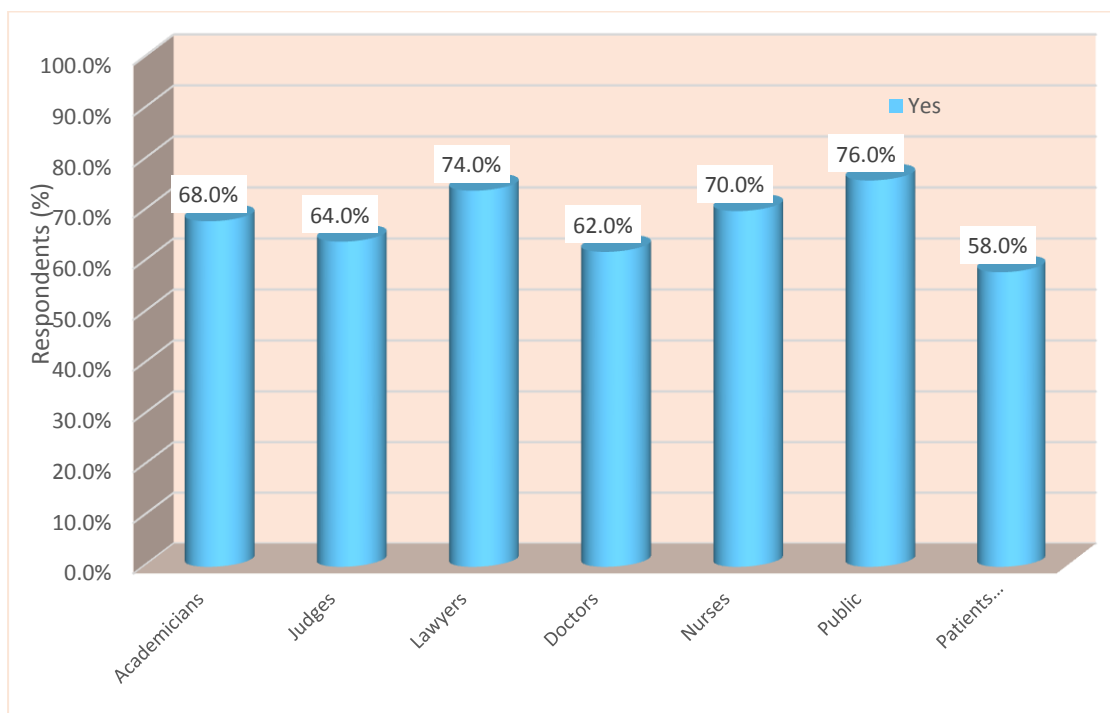


Figure 6

Because the euthanasia issue is surrounded by so many ethical, moral issue. That might be reason that some reasonable number people found them not sure about justification. In we analyse category wise data, the result shows that almost all the respondents have similar opinion. However, it is noted that category belongs to 'patient relative' are less positive than the other respondents. The reason might be the love and affection with the patient. So that they did not want leave the life of patient at any costs. See Table 6 and Figure 6

7. Euthanasia is necessary to protect right to privacy/ private life of the dying patient?

Occupation * Question No.7 Crosstabulation

		Question No.7			Total
		Yes	No	Neutral	
Academicians	Count	33	5	12	50
	% within Occupation	66.0%	10.0%	24.0%	100.0%
	% within Question No.7	12.9%	12.8%	11.3%	12.5%
	% of Total	8.2%	1.2%	3.0%	12.5%
Judges	Count	37	7	6	50
	% within Occupation	74.0%	14.0%	12.0%	100.0%
	% within Question No.7	14.5%	17.9%	5.7%	12.5%
	% of Total	9.2%	1.8%	1.5%	12.5%
Lawyers	Count	39	2	9	50
	% within Occupation	78.0%	4.0%	18.0%	100.0%
	% within Question No.7	15.3%	5.1%	8.5%	12.5%
	% of Total	9.8%	0.5%	2.2%	12.5%
Occupation Doctors	Count	31	3	16	50
	% within Occupation	62.0%	6.0%	32.0%	100.0%
	% within Question No.7	12.2%	7.7%	15.1%	12.5%
	% of Total	7.8%	0.8%	4.0%	12.5%
Nurses	Count	29	9	12	50
	% within Occupation	58.0%	18.0%	24.0%	100.0%
	% within Question No.7	11.4%	23.1%	11.3%	12.5%
	% of Total	7.2%	2.2%	3.0%	12.5%
Public	Count	52	10	38	100
	% within Occupation	52.0%	10.0%	38.0%	100.0%
	% within Question No.7	20.4%	25.6%	35.8%	25.0%
	% of Total	13.0%	2.5%	9.5%	25.0%
Patients Relatives	Count	34	3	13	50
	% within Occupation	68.0%	6.0%	26.0%	100.0%
	% within Question No.7	13.3%	7.7%	12.3%	12.5%
	% of Total	8.5%	0.8%	3.2%	12.5%
Total	Count	255	39	106	400
	% within Occupation	63.8%	9.8%	26.5%	100.0%
	% within Question No.7	100.0%	100.0%	100.0%	100.0%
	% of Total	63.8%	9.8%	26.5%	100.0%

Table 7

Although the Constitution of India does not explicitly mention the right of privacy, Supreme Court decisions have recognised that a right of personal privacy exists under Article 21 (Freedom of Life and Personal Liberty). Supporters of euthanasia are also

claim that unwanted treatment of a ‘dying patient’ (competent or incompetent) does the violation and deprivation of the right to privacy. They assert that in many of the cases of the terminally ill patient, the ‘medical procedure’ requires, which constitutes maximum bodily invasion and the chances of recovery and return to functioning life are very low. That weakens the individual right to privacy with the degree of increase of bodily invasion. It is evident that the patients in their last stage of life always put on life saving machines.

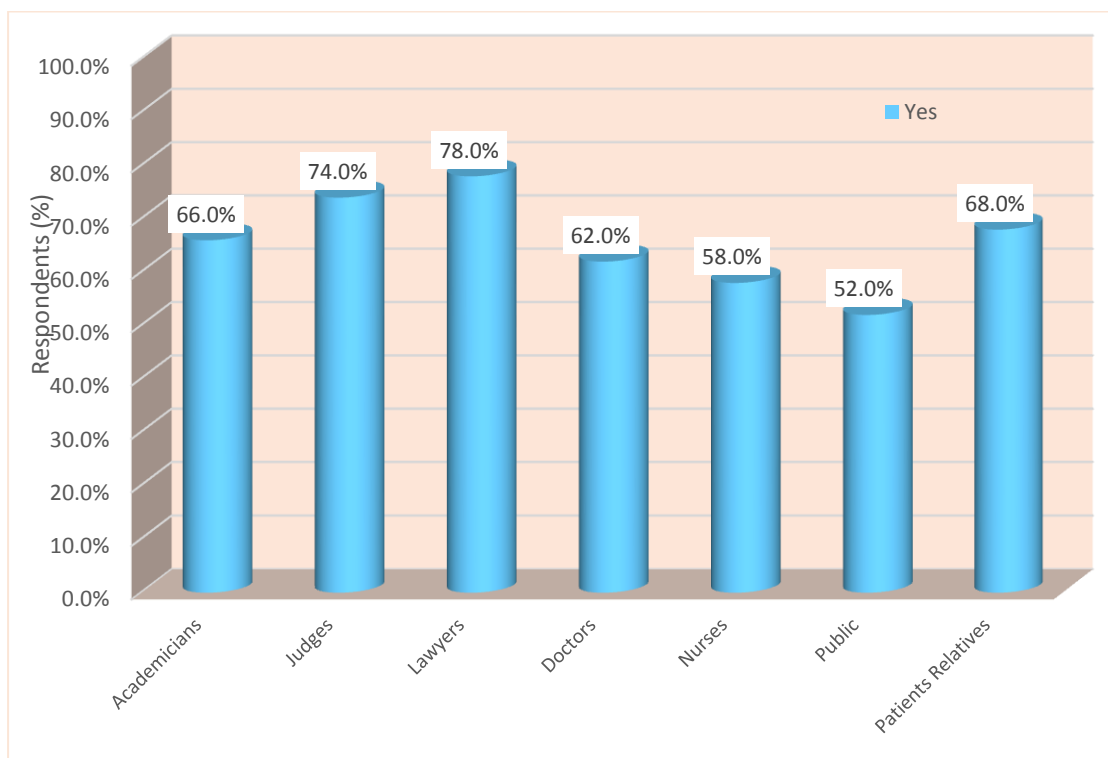


Figure 7

The question is asked to know the views in this regard. Out of total 400 respondents, 63.8% necessary to protect right to privacy/ private life of the dying patient. 9.8% are not agree with this statement. Moreover, one fourth of total respondents are remained neutral. As expected, the respondents belong to legal field is much positive than medical field. The data shows that general public has less positive response compare to other. The reason maybe they are not concerned of the right to privacy of dying patient. See Table 7 and Figure 7

8. Do you support voluntary euthanasia though the injection of lethal dose of some drug to a person in order to save that person from dying an unbearably painful death?

Occupation * Question No.8 Crosstabulation

		Question No.8			Total
		Yes	No	Neutral	
Academics	Count	29	5	16	50
	% within Occupation	58.0%	10.0%	32.0%	100.0%
	% within Question No.8	12.4%	7.6%	15.8%	12.5%
Judges	Count	25	15	10	50
	% within Occupation	50.0%	30.0%	20.0%	100.0%
	% within Question No.8	10.7%	22.7%	9.9%	12.5%
Lawyers	Count	29	9	12	50
	% within Occupation	58.0%	18.0%	24.0%	100.0%
	% within Question No.8	12.4%	13.6%	11.9%	12.5%
Doctors	Count	31	3	16	50
	% within Occupation	62.0%	6.0%	32.0%	100.0%
	% within Question No.8	13.3%	4.5%	15.8%	12.5%
Nurses	Count	34	8	8	50
	% within Occupation	68.0%	16.0%	16.0%	100.0%
	% within Question No.8	14.6%	12.1%	7.9%	12.5%
Public	Count	54	18	28	100
	% within Occupation	54.0%	18.0%	28.0%	100.0%
	% within Question No.8	23.2%	27.3%	27.7%	25.0%
Patients Relatives	Count	31	8	11	50
	% within Occupation	62.0%	16.0%	22.0%	100.0%
	% within Question No.8	13.3%	12.1%	10.9%	12.5%
Total	Count	233	66	101	400
	% within Occupation	58.2%	16.5%	25.2%	100.0%
	% within Question No.8	100.0%	100.0%	100.0%	100.0%
	% of Total	58.2%	16.5%	25.2%	100.0%

Table 8

Since last decades legalization of active voluntary euthanasia gained momentum all over the world. However, it was also by opposed by the thinkers as it would involve high risk of being misused. Supporters claims that the chances of being misused can be decreased with proper safeguards with law governing euthanasia. The data shows that there is growing support of voluntary euthanasia in India. Out of total 400 respondents, 58.2 % support voluntary euthanasia though the injection of lethal dose of some drug to a person in order to save that person from dying an unbearably

painful death. The respondents from all the categories have by a majority preferred option one as compares to option two given in this question. Starting from respondents from category I, 58% of them have answered positively while 10% have given negative response. Respondents from category II have also given a similar opinion i.e. 50% in favor and 30% in disfavor of legalization of active euthanasia in India. Respondents from category III are also very near to the above said two categories i.e. 58% have favoured and 18% have disfavoured such legalization. Respondents from Category IV are somehow different from the earlier three categories. They have given 62% response in favour and only 6% in disfavor of euthanasia. Category 6 has the lowest positive response and category six has highest positive response has been recorded.

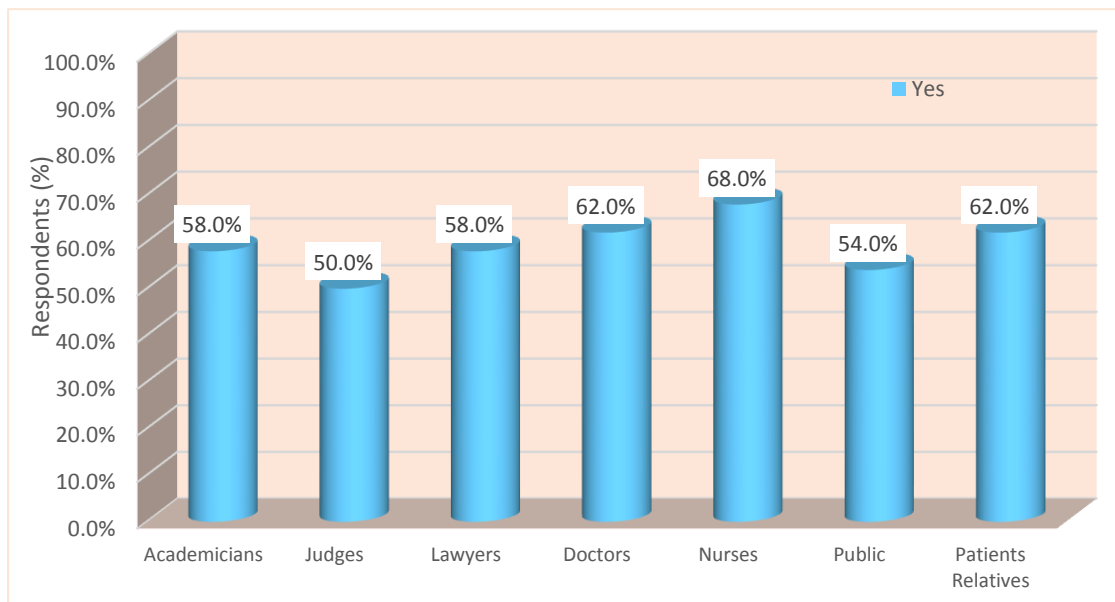


Figure 8

Moreover, substantial number of populations seems to be positive i.e. support voluntary euthanasia though the injection of lethal dose of some drug to a person in order to save that person from dying an unbearably painful death. However, it is noted that a reasonable number of respondents are showed either negative or neutral responses. This shows that respondents are aware about the problems which will accrue if active euthanasia will be legalized in India. The researcher has further left the scope for advocating reasons behind the answer to this question by the respondents. See Table 8 and Figure 8

9. Do you consider euthanasia not a crime but as a human right?

Occupation * Question No.9 Crosstabulation

		Question No.9			Total	
		Yes	No	Neutral		
Occupation	Academicians	Count	32	6	12	50
		% within Occupation	64.0%	12.0%	24.0%	100.0%
		% within Question No.9	12.1%	13.0%	13.3%	12.5%
		% of Total	8.0%	1.5%	3.0%	12.5%
	Judges	Count	29	16	5	50
		% within Occupation	58.0%	32.0%	10.0%	100.0%
		% within Question No.9	11.0%	34.8%	5.6%	12.5%
		% of Total	7.2%	4.0%	1.2%	12.5%
	Lawyers	Count	34	5	11	50
		% within Occupation	68.0%	10.0%	22.0%	100.0%
		% within Question No.9	12.9%	10.9%	12.2%	12.5%
		% of Total	8.5%	1.2%	2.8%	12.5%
	Doctors	Count	31	7	12	50
		% within Occupation	62.0%	14.0%	24.0%	100.0%
		% within Question No.9	11.7%	15.2%	13.3%	12.5%
		% of Total	7.8%	1.8%	3.0%	12.5%
	Nurses	Count	37	2	11	50
		% within Occupation	74.0%	4.0%	22.0%	100.0%
		% within Question No.9	14.0%	4.3%	12.2%	12.5%
		% of Total	9.2%	0.5%	2.8%	12.5%
	Public	Count	66	6	28	100
		% within Occupation	66.0%	6.0%	28.0%	100.0%
		% within Question No.9	25.0%	13.0%	31.1%	25.0%
		% of Total	16.5%	1.5%	7.0%	25.0%
	Patients Relatives	Count	35	4	11	50
		% within Occupation	70.0%	8.0%	22.0%	100.0%
		% within Question No.9	13.3%	8.7%	12.2%	12.5%
		% of Total	8.8%	1.0%	2.8%	12.5%
	Total	Count	264	46	90	400
		% within Occupation	66.0%	11.5%	22.5%	100.0%
% within Question No.9		100.0%	100.0%	100.0%	100.0%	
% of Total		66.0%	11.5%	22.5%	100.0%	

Table 9

The response to this question as shown in table no.9 is clearing the fact that a large majority of respondents do not consider euthanasia as a crime. The respondents of all categories have given almost a similar opinion regarding 'euthanasia not a crime but as a human right' except category II which have been given 32% negative response. Out of total 400 respondents, 66% consider euthanasia not a crime but as a human right. 11.5 showed negative response. However, a reasonable number of populations are not sure regarding euthanasia as a crime or human right. It is concluded from the above discussion that euthanasia is not a crime in the eyes of a large majority of population in India. Either they consider it help or a human right of a dying patient. See Table 9 and Figure 9

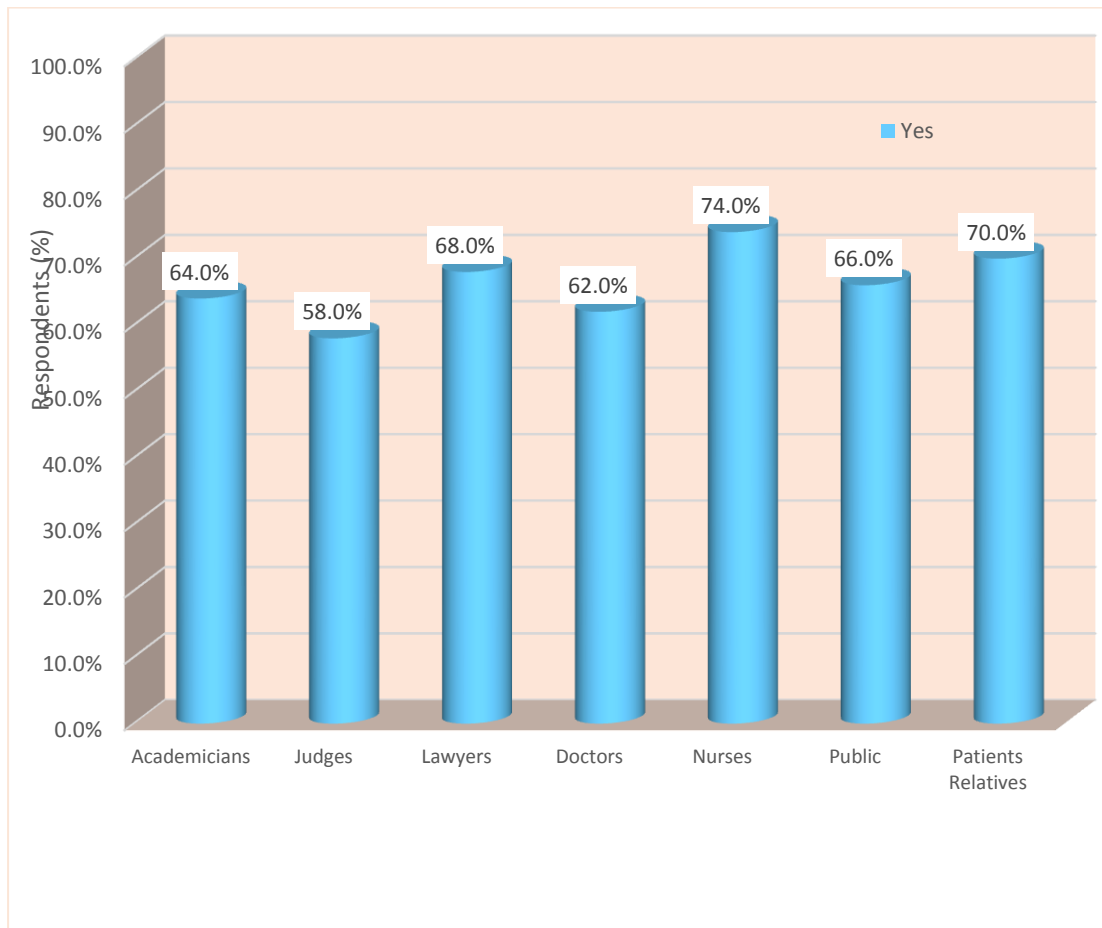


Figure 9

10. Do you agree that doctor has the duty to act in the best interests of all their patient competent and incompetent?

Occupation * Question No.10 Crosstabulation

		Question No.10			Total	
		Yes	No	Neutral		
Occupation	Academicians	Count	46	1	3	50
		% within Occupation	92.0%	2.0%	6.0%	100.0%
		% within Question No.10	15.3%	4.2%	3.9%	12.5%
		% of Total	11.5%	0.2%	0.8%	12.5%
	Judges	Count	48	1	1	50
		% within Occupation	96.0%	2.0%	2.0%	100.0%
		% within Question No.10	16.0%	4.2%	1.3%	12.5%
		% of Total	12.0%	0.2%	0.2%	12.5%
	Lawyers	Count	37	3	10	50
		% within Occupation	74.0%	6.0%	20.0%	100.0%
		% within Question No.10	12.3%	12.5%	13.2%	12.5%
		% of Total	9.2%	0.8%	2.5%	12.5%
	Doctors	Count	44	1	5	50
		% within Occupation	88.0%	2.0%	10.0%	100.0%
		% within Question No.10	14.7%	4.2%	6.6%	12.5%
		% of Total	11.0%	0.2%	1.2%	12.5%
	Nurses	Count	35	3	12	50
		% within Occupation	70.0%	6.0%	24.0%	100.0%
		% within Question No.10	11.7%	12.5%	15.8%	12.5%
		% of Total	8.8%	0.8%	3.0%	12.5%
	Public	Count	58	10	32	100
		% within Occupation	58.0%	10.0%	32.0%	100.0%
		% within Question No.10	19.3%	41.7%	42.1%	25.0%
		% of Total	14.5%	2.5%	8.0%	25.0%
Patients Relatives	Count	32	5	13	50	
	% within Occupation	64.0%	10.0%	26.0%	100.0%	
	% within Question No.10	10.7%	20.8%	17.1%	12.5%	
	% of Total	8.0%	1.2%	3.2%	12.5%	
Total	Count	300	24	76	400	
	% within Occupation	75.0%	6.0%	19.0%	100.0%	
	% within Question No.10	100.0%	100.0%	100.0%	100.0%	
	% of Total	75.0%	6.0%	19.0%	100.0%	

Table 10

It is well settled law that court's as well as medical professional's first and paramount consideration must be the best interest of the patient. An incompetent patient (patient in coma or persistent vegetative state) cannot give the informed consent regarding his treatment. Therefore, the doctor's role is very important to take decisions that how the reasonable treatment should be provided to the patient. It is also the primary duty of doctors to provide information of actual status of treatment with due care to the competent terminally ill patient.

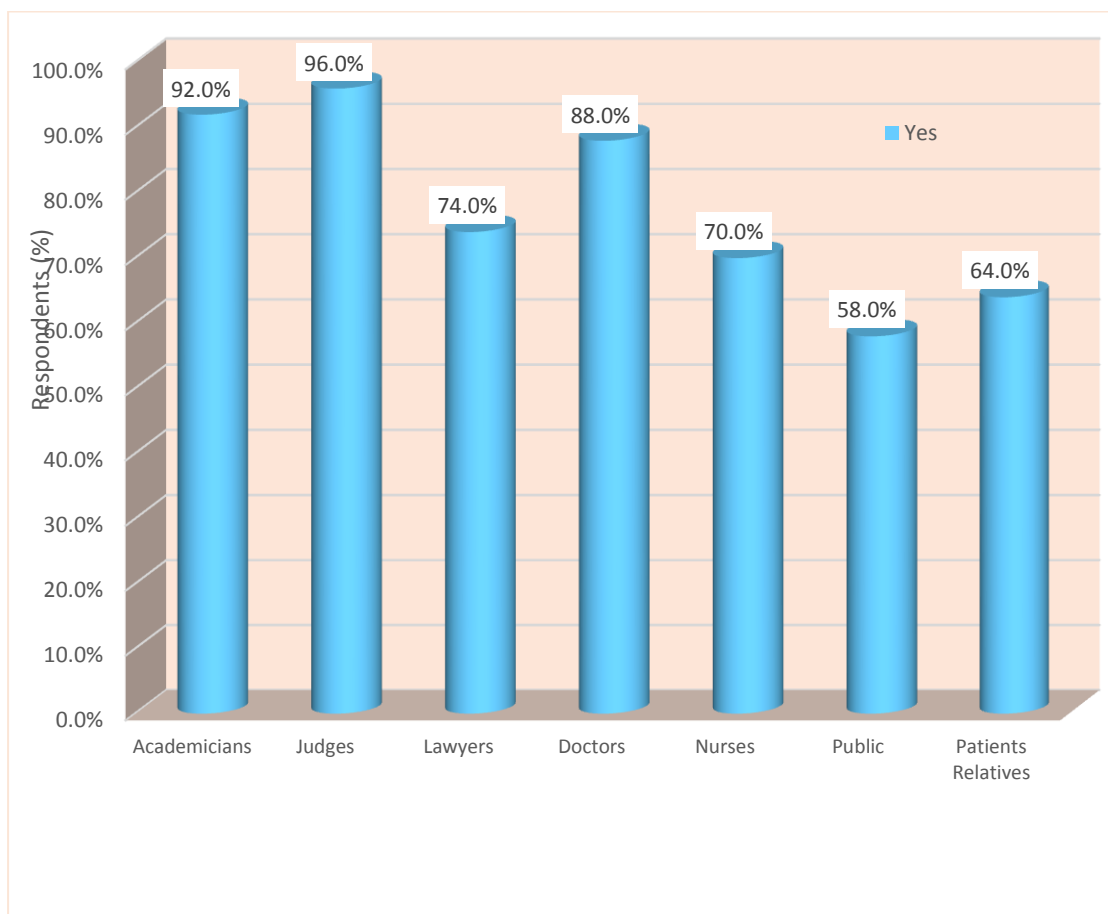


Figure 10

Out of total 400 respondents, 75% agree that doctor has the duty to act in the best interests of all their patient competent and incompetent. Only 6% respondents are don't think so. Moreover 19% has selected option 3. See Table 10 and Figure 10

11. Doctor's role is not only to save life but also a role to alleviate the suffering of the patients.

Occupation * Question No.11 Crosstabulation

		Question No.11			Total
		Yes	No	Neutral	
Academicians	Count	43	2	5	50
	% within Occupation	86.0%	4.0%	10.0%	100.0%
	% within Question No.11	14.8%	6.9%	6.2%	12.5%
Judges	Count	39	5	6	50
	% within Occupation	78.0%	10.0%	12.0%	100.0%
	% within Question No.11	13.4%	17.2%	7.4%	12.5%
Lawyers	Count	33	4	13	50
	% within Occupation	66.0%	8.0%	26.0%	100.0%
	% within Question No.11	11.4%	13.8%	16.0%	12.5%
Doctors	Count	45	2	3	50
	% within Occupation	90.0%	4.0%	6.0%	100.0%
	% within Question No.11	15.5%	6.9%	3.7%	12.5%
Nurses	Count	32	3	15	50
	% within Occupation	64.0%	6.0%	30.0%	100.0%
	% within Question No.11	11.0%	10.3%	18.5%	12.5%
Public	Count	60	11	29	100
	% within Occupation	60.0%	11.0%	29.0%	100.0%
	% within Question No.11	20.7%	37.9%	35.8%	25.0%
Patients Relatives	Count	38	2	10	50
	% within Occupation	76.0%	4.0%	20.0%	100.0%
	% within Question No.11	13.1%	6.9%	12.3%	12.5%
Total	Count	290	29	81	400
	% within Occupation	72.5%	7.2%	20.2%	100.0%
	% within Question No.11	100.0%	100.0%	100.0%	100.0%
	% of Total	72.5%	7.2%	20.2%	100.0%

Table 11

The Medical fraternity always face the moral-ethical and legal problems during the treatment of terminally ill patient. At one point they are expected to save or prolong life of patient for some time. On the other hand, they have the foremost duty to relieve the patient from extreme pain and suffering. Hence, keeping the above discussed point in his mind, the researcher has framed this question to ascertain the opinion of respondents on this issue. As expected, the response given is affirmative by majority of respondents from all seven categories. Out of total 400 respondents, 72.5% agree that Doctor's role is not only to save life but also a role to alleviate the suffering of the patients. Starting from category I to VII the percentage given is 86%, 78%, 66%, 90%, 64%, 60% and 76% respectively. See Table 11 and Figure 11

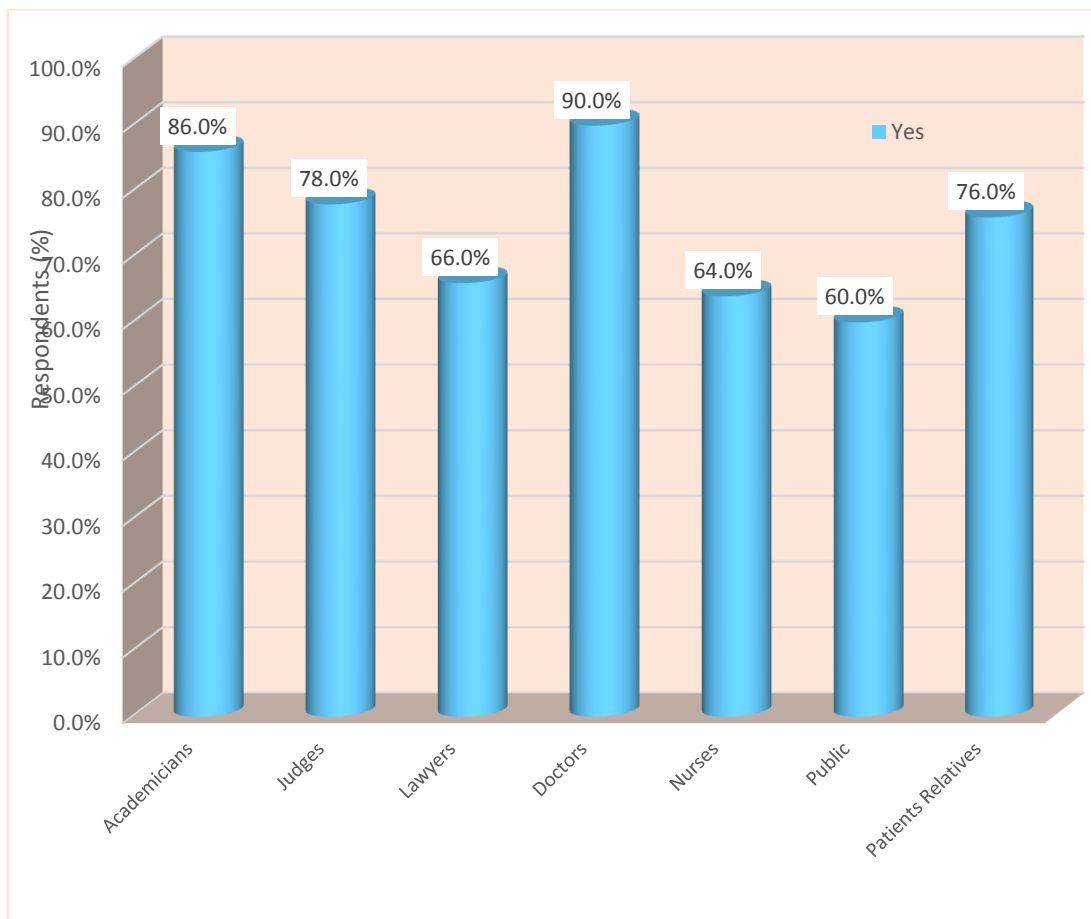


Figure 11

12. Do you agree that doctors should have special defence as to treatment of patient who is suffering from extreme and unbearable pain and also in terminally illness stage or incurable stage of treatment otherwise doctor may not treat patient with his best effort?

Occupation * Question No.12 Crosstabulation

		Question No.12			Total
		Yes	No	Neutral	
Academicians	Count	38	10	2	50
	% within Occupation	76.0%	20.0%	4.0%	100.0%
	% within Question No.12	13.1%	15.6%	4.3%	12.5%
	% of Total	9.5%	2.5%	0.5%	12.5%
Judges	Count	41	5	4	50
	% within Occupation	82.0%	10.0%	8.0%	100.0%
	% within Question No.12	14.2%	7.8%	8.5%	12.5%
	% of Total	10.2%	1.2%	1.0%	12.5%
Lawyers	Count	31	14	5	50
	% within Occupation	62.0%	28.0%	10.0%	100.0%
	% within Question No.12	10.7%	21.9%	10.6%	12.5%
	% of Total	7.8%	3.5%	1.2%	12.5%
Occupation Doctors	Count	47	1	2	50
	% within Occupation	94.0%	2.0%	4.0%	100.0%
	% within Question No.12	16.3%	1.6%	4.3%	12.5%
	% of Total	11.8%	0.2%	0.5%	12.5%
Nurses	Count	43	3	4	50
	% within Occupation	86.0%	6.0%	8.0%	100.0%
	% within Question No.12	14.9%	4.7%	8.5%	12.5%
	% of Total	10.8%	0.8%	1.0%	12.5%
Public	Count	64	14	22	100
	% within Occupation	64.0%	14.0%	22.0%	100.0%
	% within Question No.12	22.1%	21.9%	46.8%	25.0%
	% of Total	16.0%	3.5%	5.5%	25.0%
Patients Relatives	Count	25	17	8	50
	% within Occupation	50.0%	34.0%	16.0%	100.0%
	% within Question No.12	8.7%	26.6%	17.0%	12.5%
	% of Total	6.2%	4.2%	2.0%	12.5%
Total	Count	289	64	47	400
	% within Occupation	72.2%	16.0%	11.8%	100.0%
	% within Question No.12	100.0%	100.0%	100.0%	100.0%
	% of Total	72.2%	16.0%	11.8%	100.0%

Table 12

Out of total 400 respondents, 72.2% agree and 16% disagree that doctor should have special defence as to treatment of patient who is suffering from extreme and unbearable pain and also in terminally illness stage or incurable stage of treatment otherwise doctor may not treat patient with his best effort. Comparative analysis of data indicates that all the categories have given positive response. However, the data shows that lawyers, patient relatives and respondents belong to general public comparatively less sure to provide defence to doctor. See Table 12 and Figure 12

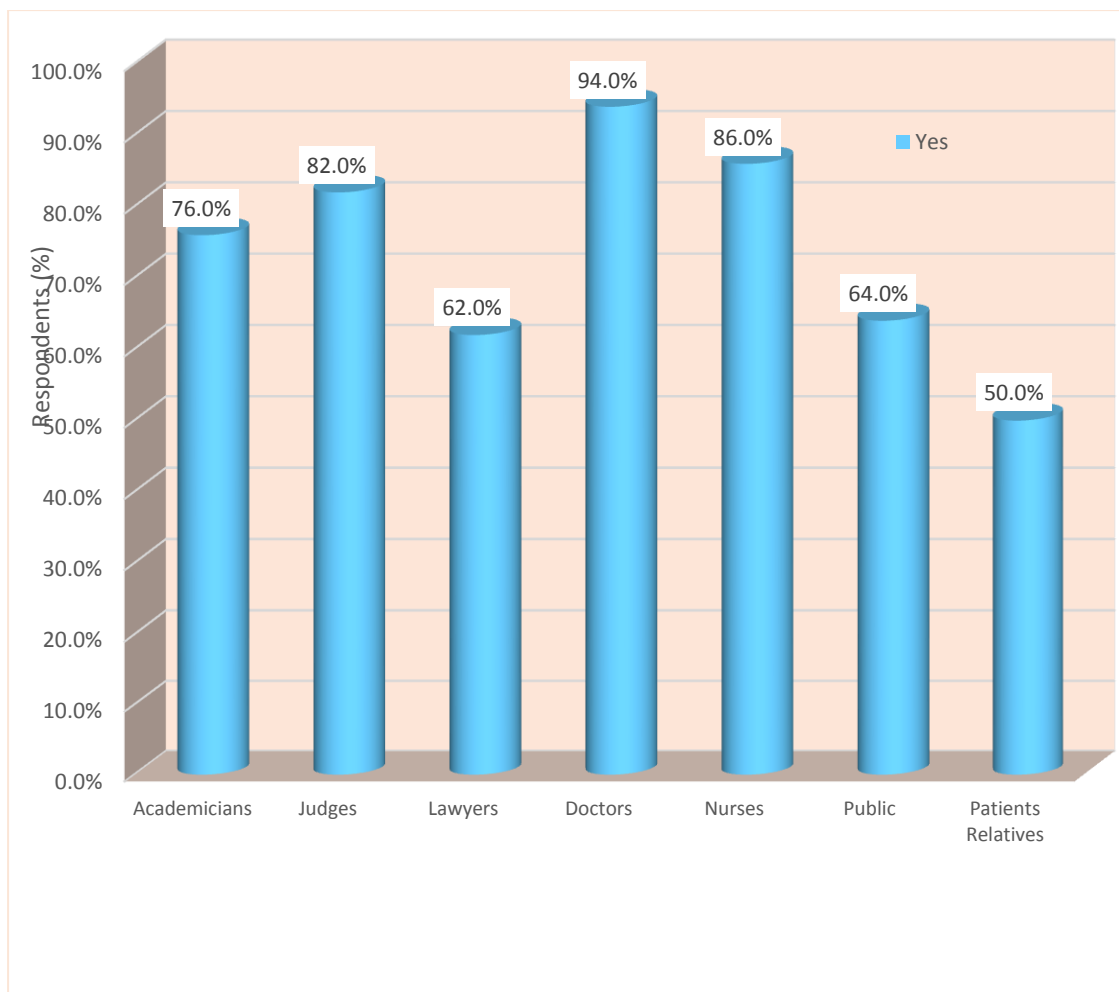


Figure 12

13. Do you know about the recent judgement of honourable Supreme Court of India recognised die with dignity, declared withdrawal of live support system and living will as legal?

Occupation * Question No.13 Crosstabulation

		Question No.13			Total	
		Yes	No	Neutral		
Occupation	Academicians	Count	46	2	2	50
	% within Occupation	92.0%	4.0%	4.0%	100.0%	
	% within Question No.13	16.0%	3.8%	3.4%	12.5%	
	% of Total	11.5%	0.5%	0.5%	12.5%	
	Judges	Count	49	0	1	50
	% within Occupation	98.0%	0.0%	2.0%	100.0%	
	% within Question No.13	17.0%	0.0%	1.7%	12.5%	
	% of Total	12.2%	0.0%	0.2%	12.5%	
	Lawyers	Count	39	6	5	50
	% within Occupation	78.0%	12.0%	10.0%	100.0%	
	% within Question No.13	13.5%	11.3%	8.5%	12.5%	
	% of Total	9.8%	1.5%	1.2%	12.5%	
	Doctors	Count	34	12	4	50
	% within Occupation	68.0%	24.0%	8.0%	100.0%	
	% within Question No.13	11.8%	22.6%	6.8%	12.5%	
	% of Total	8.5%	3.0%	1.0%	12.5%	
	Nurses	Count	26	14	10	50
	% within Occupation	52.0%	28.0%	20.0%	100.0%	
	% within Question No.13	9.0%	26.4%	16.9%	12.5%	
	% of Total	6.5%	3.5%	2.5%	12.5%	
	Public	Count	67	13	20	100
	% within Occupation	67.0%	13.0%	20.0%	100.0%	
	% within Question No.13	23.3%	24.5%	33.9%	25.0%	
	% of Total	16.8%	3.2%	5.0%	25.0%	
Patients Relatives	Count	27	6	17	50	
% within Occupation	54.0%	12.0%	34.0%	100.0%		
% within Question No.13	9.4%	11.3%	28.8%	12.5%		
% of Total	6.8%	1.5%	4.2%	12.5%		
Total	Count	288	53	59	400	
% within Occupation	72.0%	13.2%	14.8%	100.0%		
% within Question No.13	100.0%	100.0%	100.0%	100.0%		
% of Total	72.0%	13.2%	14.8%	100.0%		

Table 13

The supreme court of India in the case Common cause (A registered society) v. Union of India and others has legalized the ‘passive euthanasia’, right to die with dignity and living will or advance directive. The question before Constitution Bench on a petition by the NGO Common Cause was whether the right to live with dignity under Article 21 includes the right to die with dignity, and whether it’s time to allow ‘living wills’, or written authorizations containing instructions given by persons in a healthy state of mind to doctors that they need not be put on life-support systems or ventilators in the event of their going into a persistent vegetative state or state of terminal illness. Hence, keeping the above discussed point in his mind, the researcher has framed this question to ascertain the opinion of respondents on this issue. Out of total 400 respondents, 72% know about the recent judgement of honourable Supreme Court of India recognised die with dignity, declared withdrawal of live support system and living will as legal. 13.2% respondents were completely unaware about this important judgement. As expected, respondents belong to legal fraternity were much aware about judgement. See Table 13 and Figure 13.

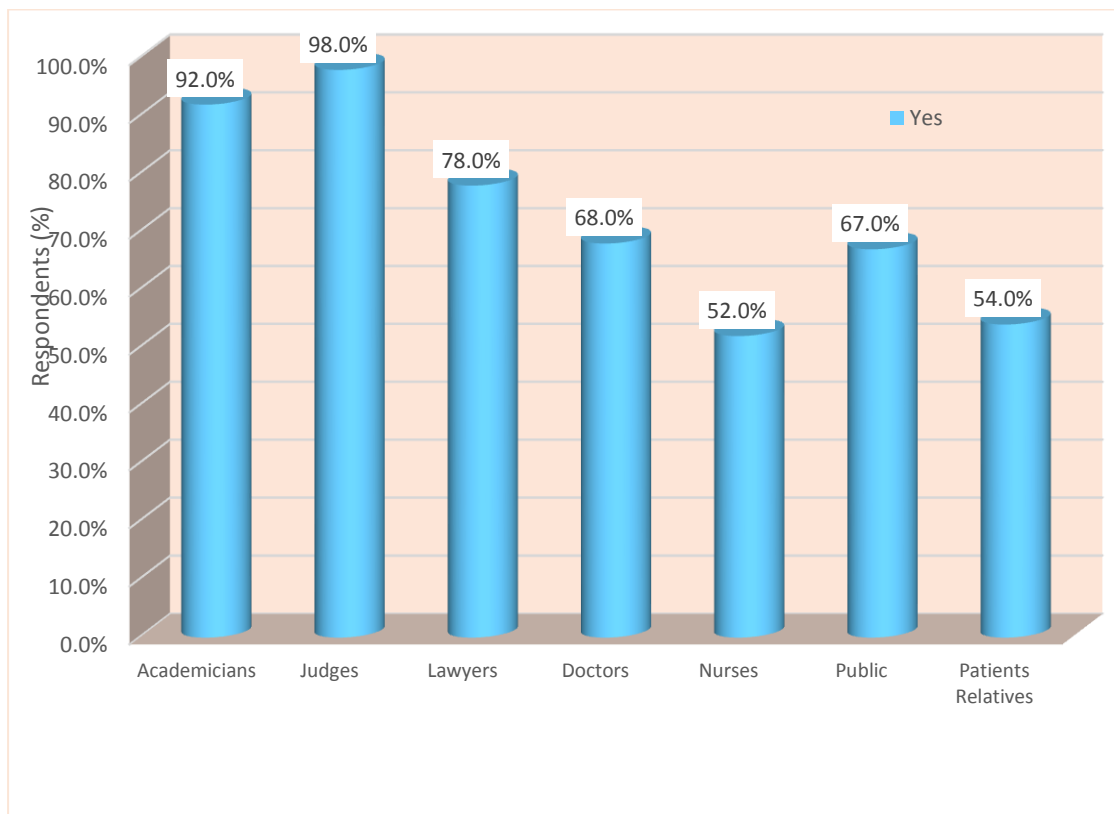


Figure 13

14. Do you support that withdrawal of life support system from terminally ill patients with huge pain and suffering so that they die with dignity in the ordinary course of nature?

Occupation * Question No.14 Crosstabulation

		Question No.14			Total	
		Yes	No	Neutral		
Occupation	Academics	Count	27	4	19	50
	% within Occupation	54.0%	8.0%	38.0%	100.0%	
	% within Question No.14	10.1%	6.3%	27.1%	12.5%	
	% of Total	6.8%	1.0%	4.8%	12.5%	
	Judges	Count	41	5	4	50
	% within Occupation	82.0%	10.0%	8.0%	100.0%	
	% within Question No.14	15.4%	7.9%	5.7%	12.5%	
	% of Total	10.2%	1.2%	1.0%	12.5%	
	Lawyers	Count	37	4	9	50
	% within Occupation	74.0%	8.0%	18.0%	100.0%	
	% within Question No.14	13.9%	6.3%	12.9%	12.5%	
	% of Total	9.2%	1.0%	2.2%	12.5%	
	Doctors	Count	43	2	5	50
	% within Occupation	86.0%	4.0%	10.0%	100.0%	
	% within Question No.14	16.1%	3.2%	7.1%	12.5%	
	% of Total	10.8%	0.5%	1.2%	12.5%	
	Nurses	Count	34	7	9	50
	% within Occupation	68.0%	14.0%	18.0%	100.0%	
	% within Question No.14	12.7%	11.1%	12.9%	12.5%	
	% of Total	8.5%	1.8%	2.2%	12.5%	
	Public	Count	61	27	12	100
	% within Occupation	61.0%	27.0%	12.0%	100.0%	
	% within Question No.14	22.8%	42.9%	17.1%	25.0%	
	% of Total	15.2%	6.8%	3.0%	25.0%	
	Patients Relatives	Count	24	14	12	50
	% within Occupation	48.0%	28.0%	24.0%	100.0%	
	% within Question No.14	9.0%	22.2%	17.1%	12.5%	
% of Total	6.0%	3.5%	3.0%	12.5%		
Total	Count	267	63	70	400	
% within Occupation	66.8%	15.8%	17.5%	100.0%		
% within Question No.14	100.0%	100.0%	100.0%	100.0%		

% of Total	66.8%	15.8%	17.5%	100.0%
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Table 14

Withdrawal of life support system from terminally ill patients with huge pain and suffering so that they die with dignity in the ordinary course of nature is a positive step towards the direction of saving medical resources for those who have good chances of recovery rather than wasting those on hopeless cases. ‘The Common Cause’ judgment is a first step in the direction of having a concrete law on the issue in hand. Hence, a proper law is required here to fill in the vacuum. The reason behind asking this question to find the consensus with the Supreme Court judgement allowing passive euthanasia. Concerning the passive euthanasia, it is important to know the view taken by various categories of respondents, especially doctors and patient’s relative. Out of total 400 respondents, 66.8% support that withdrawal of life support system from terminally ill patients with huge pain and suffering so that they die with dignity in the ordinary course of nature. While 15.8% were disagree with the judgement. As expected, the judgement finds much support from respondents belongs to category II, III, IV (Judges 82%, Lawyers 74%, Doctors 86%). However, researcher has surprised to see that judgement found less support from academician 54% and patient’s relatives 48%. Table 14 and Figure 14

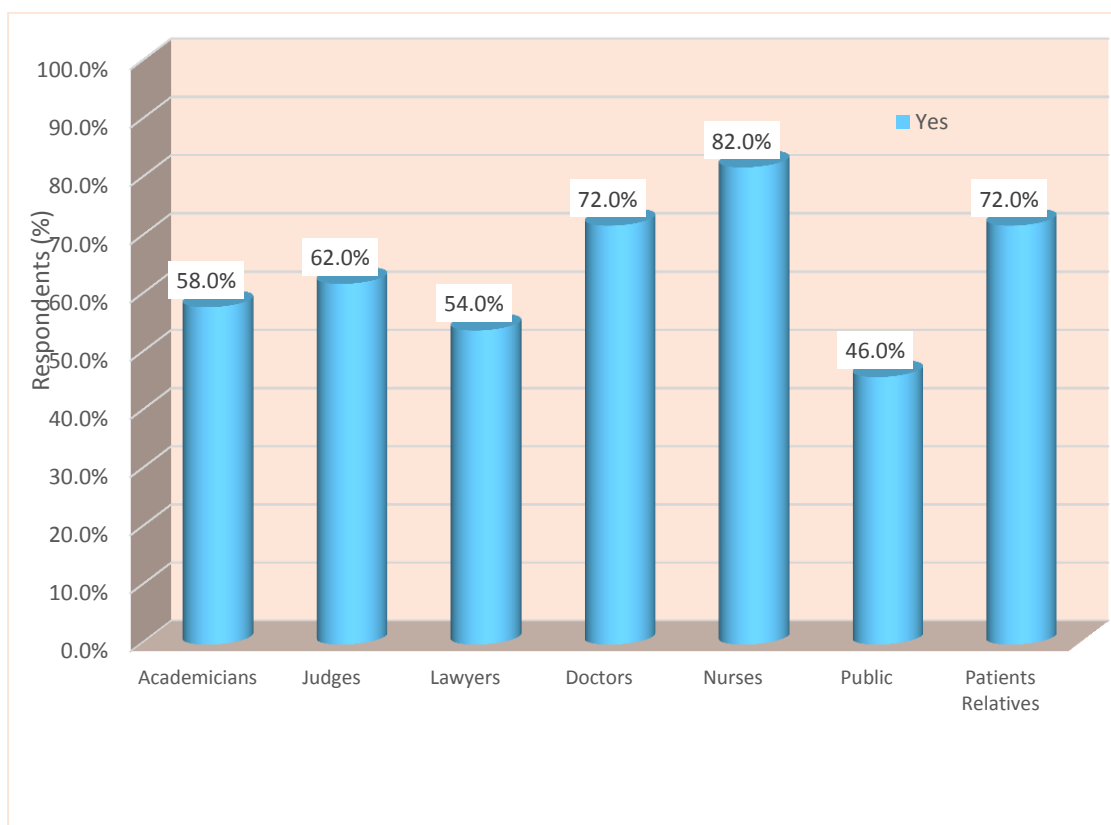


Figure 14

15. Do you support concept of living will or advance directives (a document containing instruction for future nontreatment decision in case of terminal illness or incurable disease).

Occupation * Question No.15 Crosstabulation

		Question No.15			Total	
		Yes	No	Neutral		
Occupation	Academicians	Count	29	12	9	50
	% within Occupation	58.0%	24.0%	18.0%	100.0%	
	% within Question No.15	11.8%	14.8%	12.3%	12.5%	
	% of Total	7.2%	3.0%	2.2%	12.5%	
	Judges	Count	31	8	11	50
	% within Occupation	62.0%	16.0%	22.0%	100.0%	
	% within Question No.15	12.6%	9.9%	15.1%	12.5%	
	% of Total	7.8%	2.0%	2.8%	12.5%	
	Lawyers	Count	27	11	12	50
% within Occupation	54.0%	22.0%	24.0%	100.0%		
% within Question No.15	11.0%	13.6%	16.4%	12.5%		
% of Total	6.8%	2.8%	3.0%	12.5%		

	Count	36	6	8	50
Doctors	% within Occupation	72.0%	12.0%	16.0%	100.0%
	% within Question No.15	14.6%	7.4%	11.0%	12.5%
	% of Total	9.0%	1.5%	2.0%	12.5%
	Count	41	4	5	50
Nurses	% within Occupation	82.0%	8.0%	10.0%	100.0%
	% within Question No.15	16.7%	4.9%	6.8%	12.5%
	% of Total	10.2%	1.0%	1.2%	12.5%
	Count	46	26	28	100
Public	% within Occupation	46.0%	26.0%	28.0%	100.0%
	% within Question No.15	18.7%	32.1%	38.4%	25.0%
	% of Total	11.5%	6.5%	7.0%	25.0%
	Count	36	14	0	50
Patients Relatives	% within Occupation	72.0%	28.0%	0.0%	100.0%
	% within Question No.15	14.6%	17.3%	0.0%	12.5%
	% of Total	9.0%	3.5%	0.0%	12.5%
	Count	246	81	73	400
Total	% within Occupation	61.5%	20.2%	18.2%	100.0%
	% within Question No.15	100.0%	100.0%	100.0%	100.0%
	% of Total	61.5%	20.2%	18.2%	100.0%

Table 15

The Respondents has been asked an interesting question regarding the application of living will or an advance directive in the Indian society. Living Will is a legal document through which a person when he/she is healthy can make an advance directive that if in future he/she will contract a terminal disease then euthanasia will be the appropriate option for himself/herself. Although in our country, such a legal document may lead to litigation still its importance cannot be ignored so far as the sufferings of a terminally ill patient are concerned.

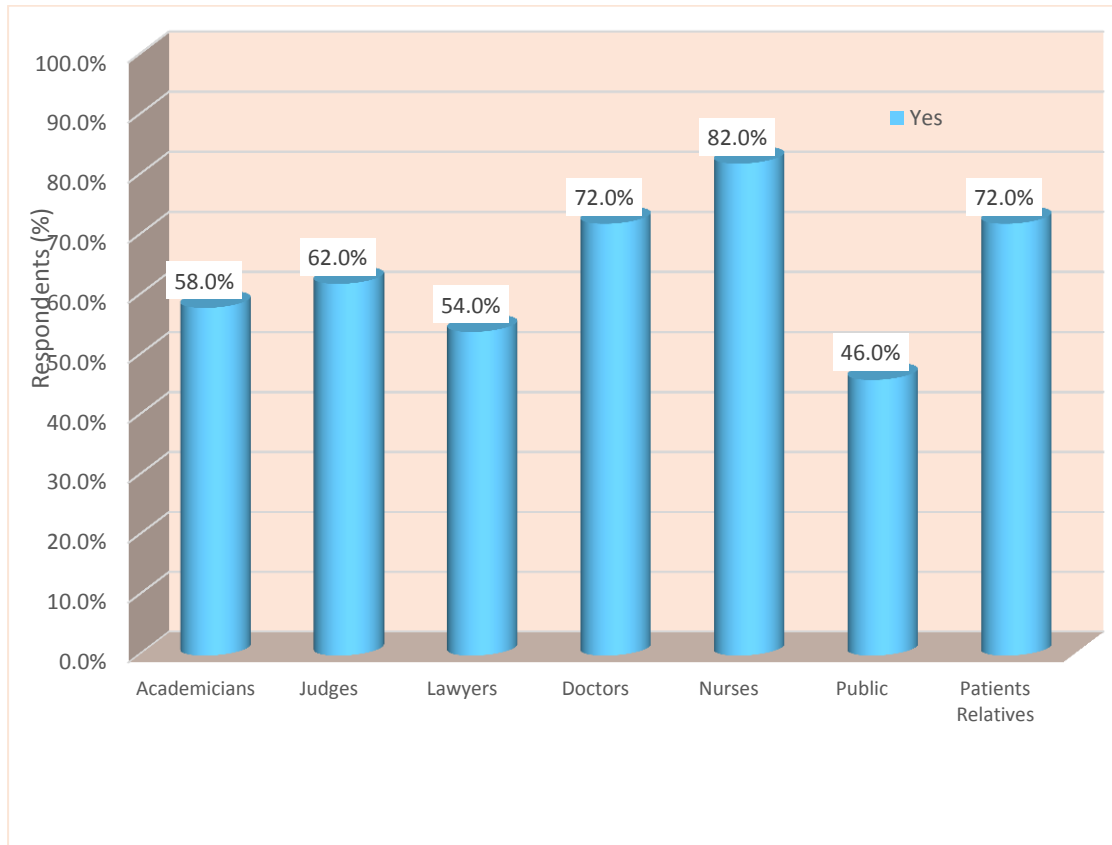


Figure 15

The response received from all categories is progressive towards the concept. Out of total 400 respondents, 61.5% support concept of living will or advance directives (a document containing instruction for future non-treatment decision in case of terminal illness or incurable disease). Category wise percentage of the response is 58%, 62%, 54% 72%,82% 46% and 72% respectively. The data shows that the concept of living will have not found much support from general public. To sum up, it can be said that a good percentage of respondents holds a positive view towards the concept of living will and its execution in India. See Table 15 and Figure 15.

16. In your view who should decide the best interest of the incompetent incurable patient suffering from terminal illness.

- A- A panel of doctors,
- B- Patients close relative or
- C- Court should decide?
- D- Any other

Occupation * Question No.16 Crosstabulation

	Question No.16	Total

		A panel of doctors	Patients close relative	Court should decide	
Occupation	Count	23	12	15	50
	Academicians				
	% within Occupation	46.0%	24.0%	30.0%	100.0%
	% within Question No.16	16.9%	10.4%	10.1%	12.5%
	% of Total	5.8%	3.0%	3.8%	12.5%
	Count	6	6	38	50
	Judges				
	% within Occupation	12.0%	12.0%	76.0%	100.0%
	% within Question No.16	4.4%	5.2%	25.5%	12.5%
	% of Total	1.5%	1.5%	9.5%	12.5%
	Count	6	5	39	50
	Lawyers				
	% within Occupation	12.0%	10.0%	78.0%	100.0%
	% within Question No.16	4.4%	4.3%	26.2%	12.5%
	% of Total	1.5%	1.2%	9.8%	12.5%
	Count	32	10	8	50
	Doctors				
	% within Occupation	64.0%	20.0%	16.0%	100.0%
	% within Question No.16	23.5%	8.7%	5.4%	12.5%
	% of Total	8.0%	2.5%	2.0%	12.5%
	Count	18	25	7	50
	Nurses				
	% within Occupation	36.0%	50.0%	14.0%	100.0%
	% within Question No.16	13.2%	21.7%	4.7%	12.5%
	% of Total	4.5%	6.2%	1.8%	12.5%
	Count	32	40	28	100
	Public				
	% within Occupation	32.0%	40.0%	28.0%	100.0%
	% within Question No.16	23.5%	34.8%	18.8%	25.0%
	% of Total	8.0%	10.0%	7.0%	25.0%
Count	19	17	14	50	
Patients Relatives					
% within Occupation	38.0%	34.0%	28.0%	100.0%	
% within Question No.16	14.0%	14.8%	9.4%	12.5%	
% of Total	4.8%	4.2%	3.5%	12.5%	
Count	136	115	149	400	
Total					
% within Occupation	34.0%	28.8%	37.2%	100.0%	
% within Question No.16	100.0%	100.0%	100.0%	100.0%	
% of Total	34.0%	28.8%	37.2%	100.0%	

Table 16

The data shows mix response from the respondents. Out of total 400 respondents, 37.2% opinion in favour of Court, 34% a panel of doctor and 28.8% patient's close relatives should decide the best interest of the incompetent incurable patient suffering from terminal illness. If we analyse category wise data. It indicated that there is an impact of respondent's profession upon the result as 76% Judges and 78% lawyers have selected option C. At the same time respondents belongs to medical field (Doctor 64% and Nurses 36%) are divided at this question. 50% nurses have selected option B. 50% Nurses is in favour of patient relative to decide the patient's best interests. The total number of data indicates that people are around equally divided upon in deciding best interest of incompetent patient as to withdrawal of life saving machine (mechanical ventilator or artificial feeding and nutrition). See Table 16 and Figure16

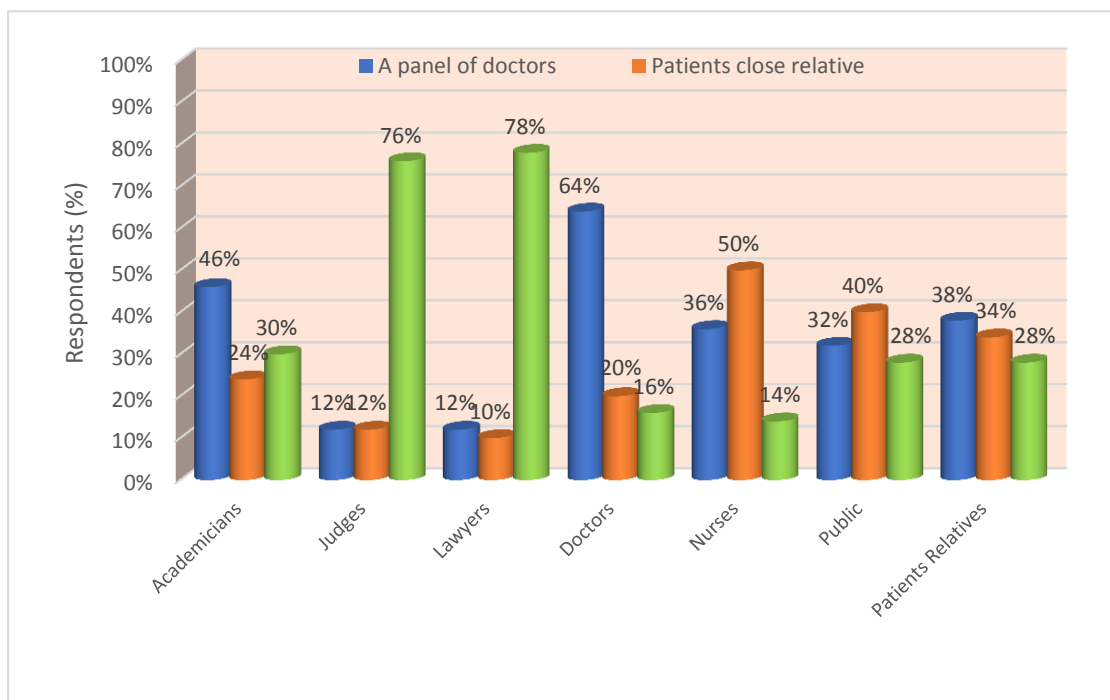


Figure 16

17. In your view which is the major factor to demand euthanasia?

- A- Unbearable pain and suffering,
- B- Depression and psychological factor,
- C- Lack of physical ability (person cannot get out of bed or provide self-care),
- D- Limited healthcare resources,

E- Financial condition of the family due to the high cost medical services.

Occupation * Question No.17 Crosstabulation

		Question No.17					Total	
		Unbearable pain and suffering	Depression and psychological factor	Lack of physical ability	Limited healthcare resources	Financial condition of the family due to the high cost medical services		
Occupation	Academicians	Count	25	1	4	8	12	50
		% within Occupation	50.0%	2.0%	8.0%	16.0%	24.0%	100.0%
		% within Question No.17	11.6%	3.3%	16.7%	19.0%	13.5%	12.5%
		% of Total	6.2%	0.2%	1.0%	2.0%	3.0%	12.5%
	Judges	Count	29	2	6	4	9	50
		% within Occupation	58.0%	4.0%	12.0%	8.0%	18.0%	100.0%
		% within Question No.17	13.5%	6.7%	25.0%	9.5%	10.1%	12.5%
		% of Total	7.2%	0.5%	1.5%	1.0%	2.2%	12.5%
	Lawyers	Count	28	4	2	3	13	50
		% within Occupation	56.0%	8.0%	4.0%	6.0%	26.0%	100.0%
		% within Question No.17	13.0%	13.3%	8.3%	7.1%	14.6%	12.5%
		% of Total	7.0%	1.0%	0.5%	0.8%	3.2%	12.5%
Doctors	Count	31	8	3	3	5	50	
	% within Occupation	62.0%	16.0%	6.0%	6.0%	10.0%	100.0%	
	% within Question No.17	14.4%	26.7%	12.5%	7.1%	5.6%	12.5%	
	% of Total	7.8%	2.0%	0.8%	0.8%	1.2%	12.5%	
Nurses	Count	29	9	2	6	4	50	
	% within Occupation	58.0%	18.0%	4.0%	12.0%	8.0%	100.0%	
	% within Question No.17	13.5%	30.0%	8.3%	14.3%	4.5%	12.5%	
	% of Total	7.2%	2.2%	0.5%	1.5%	1.0%	12.5%	
Public	Count	47	5	4	10	34	100	
	% within Occupation	47.0%	5.0%	4.0%	10.0%	34.0%	100.0%	
	% within Question No.17	21.9%	16.7%	16.7%	23.8%	38.2%	25.0%	

Total	% of Total	11.8%	1.2%	1.0%	2.5%	8.5%	25.0%
	Count	26	1	3	8	12	50
	% within Occupation	52.0%	2.0%	6.0%	16.0%	24.0%	100.0%
	% within Question No.17	12.1%	3.3%	12.5%	19.0%	13.5%	12.5%
	% of Total	6.5%	0.2%	0.8%	2.0%	3.0%	12.5%
	Count	215	30	24	42	89	400
	% within Occupation	53.8%	7.5%	6.0%	10.5%	22.2%	100.0%
	% within Question No.17	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	% of Total	53.8%	7.5%	6.0%	10.5%	22.2%	100.0%

Table17

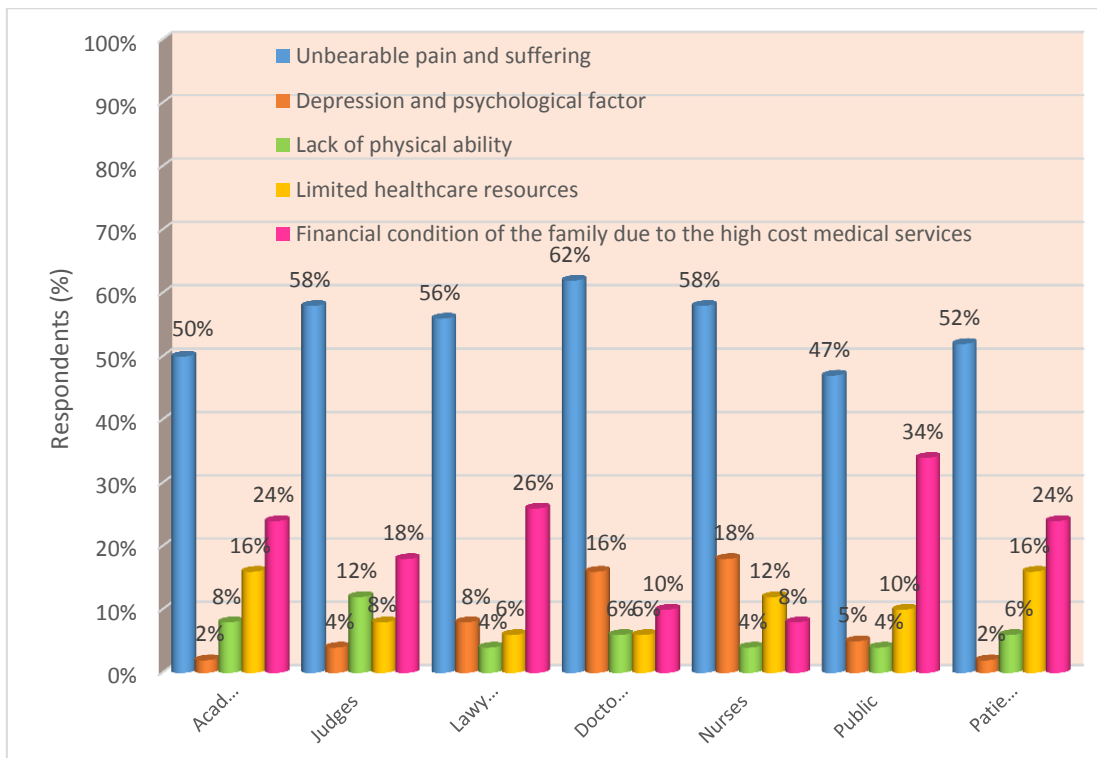


Figure 17

Out of total 400 respondents, 53.8% have selected option A (Pain and suffering) is the major factor to demand euthanasia compare to option C, 6% (Lack of physical ability). Other options are selected by the respondents that is option E, 22.2% (Financial condition of the family due to the high cost medical services), Option D, 10.5% (Limited healthcare resources), option B, 7.5% (Depression and

Psychological factor). Therefore, it is concluded that there is substantive number of gaps between pain and suffering factor than any other factor to demand of euthanasia. Comparatively speaking all the groups of our sample of the study exhibited approximately similar responses. See Table 17 and Figure 17

18. Which argument you feel most favourable to support legalisation of euthanasia.

- A- Elevate pain and suffering and empower Right to die with dignity,
- B- Individual autonomy and self-determination,
- C- End of quality of life and purpose
- D- Any other reason

Occupation * Question No.18 Crosstabulation

		Question No.18			Total	
		Elevate pain and suffering and empower Right to die with dignity	Individual autonomy and self-determination	End of quality of life and purpose		
Occupation	Academicians	Count	31	7	12	50
		% within Occupation	62.0%	14.0%	24.0%	100.0%
		% within Question No.18	10.5%	24.1%	15.6%	12.5%
		% of Total	7.8%	1.8%	3.0%	12.5%
	Judges	Count	36	4	10	50
		% within Occupation	72.0%	8.0%	20.0%	100.0%
		% within Question No.18	12.2%	13.8%	13.0%	12.5%
		% of Total	9.0%	1.0%	2.5%	12.5%
	Lawyers	Count	39	4	7	50
		% within Occupation	78.0%	8.0%	14.0%	100.0%
		% within Question No.18	13.3%	13.8%	9.1%	12.5%
		% of Total	9.8%	1.0%	1.8%	12.5%
Doctors	Count	35	5	10	50	

	% within Occupation	70.0%	10.0%	20.0%	100.0%
	% within Question No.18	11.9%	17.2%	13.0%	12.5%
	% of Total	8.8%	1.2%	2.5%	12.5%
	Count	40	2	8	50
Nurses	% within Occupation	80.0%	4.0%	16.0%	100.0%
	% within Question No.18	13.6%	6.9%	10.4%	12.5%
	% of Total	10.0%	0.5%	2.0%	12.5%
	Count	78	6	16	100
Public	% within Occupation	78.0%	6.0%	16.0%	100.0%
	% within Question No.18	26.5%	20.7%	20.8%	25.0%
	% of Total	19.5%	1.5%	4.0%	25.0%
	Count	35	1	14	50
Patients Relatives	% within Occupation	70.0%	2.0%	28.0%	100.0%
	% within Question No.18	11.9%	3.4%	18.2%	12.5%
	% of Total	8.8%	0.2%	3.5%	12.5%
	Count	294	29	77	400
Total	% within Occupation	73.5%	7.2%	19.2%	100.0%
	% within Question No.18	100.0%	100.0%	100.0%	100.0%
	% of Total	73.5%	7.2%	19.2%	100.0%

Table 18

While majority of respondents (73.5%) feel that option A (elevate pain and suffering and empower 'Right to die with Dignity') is the most favourable argument to support legalisation of euthanasia compare to option B, 7.2% (Individual autonomy and self-determination) and option C, 19.2% (End of quality of life and purpose). Therefore, it is concluded that the data shows huge difference of percentages between elevate pain and suffering factor and individual autonomy factor as favourable to support euthanasia. The responded data shows that all the groups of our sample of the study revealed almost similar responses. See Table 18 and Figure 18

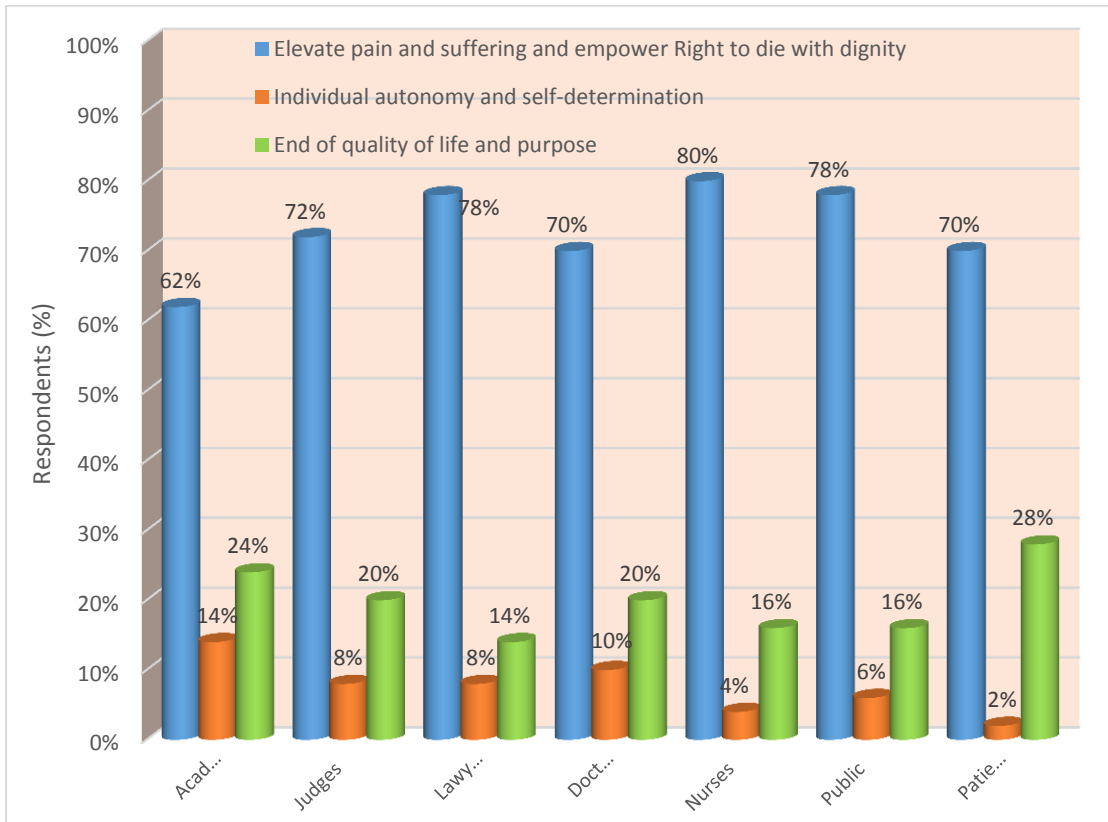


Figure 18

19. Which argument you fill most favourable to reject the legalization of euthanasia?

- A- Sanctity of life,
- B- Negative impact on vulnerable persons of the society,
- C- Public corruption and misuse of law,
- D- Effect on public trust upon doctor,
- E- Any other reason

Occupation * Question No.19 Crosstabulation

	Question No.19	Total
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		Sanctity of life	Negative impact on vulnerable persons of the society	Public corruption and misuse of law	Effect on public trust upon doctor		
Occupati on	Academicians	Count	7	9	29	5	50
		% within Occupation	14.0%	18.0%	58.0%	10.0%	100.0%
		% within Question No.19	9.3%	16.7%	13.6%	8.6%	12.5%
		% of Total	1.8%	2.2%	7.2%	1.2%	12.5%
	Judges	Count	9	11	27	3	50
		% within Occupation	18.0%	22.0%	54.0%	6.0%	100.0%
		% within Question No.19	12.0%	20.4%	12.7%	5.2%	12.5%
		% of Total	2.2%	2.8%	6.8%	0.8%	12.5%
	Lawyers	Count	7	8	30	5	50
		% within Occupation	14.0%	16.0%	60.0%	10.0%	100.0%
		% within Question No.19	9.3%	14.8%	14.1%	8.6%	12.5%
		% of Total	1.8%	2.0%	7.5%	1.2%	12.5%
Doctors	Count	13	4	25	8	50	
	% within Occupation	26.0%	8.0%	50.0%	16.0%	100.0%	
	% within Question No.19	17.3%	7.4%	11.7%	13.8%	12.5%	
	% of Total	3.2%	1.0%	6.2%	2.0%	12.5%	
Nurses	Count	10	5	22	13	50	
	% within Occupation	20.0%	10.0%	44.0%	26.0%	100.0%	
	% within Question No.19	13.3%	9.3%	10.3%	22.4%	12.5%	
	% of Total	2.5%	1.2%	5.5%	3.2%	12.5%	
Public	Count	17	11	59	13	100	
	% within Occupation	17.0%	11.0%	59.0%	13.0%	100.0%	
	% within Question No.19	22.7%	20.4%	27.7%	22.4%	25.0%	
	% of Total	4.2%	2.8%	14.8%	3.2%	25.0%	
Patients Relatives	Count	12	6	21	11	50	
	% within Occupation	24.0%	12.0%	42.0%	22.0%	100.0%	
	% within Question No.19	16.0%	11.1%	9.9%	19.0%	12.5%	
	% of Total	3.0%	1.5%	5.2%	2.8%	12.5%	

Total	Count	75	54	213	58	400
	% within Occupation	18.8%	13.5%	53.2%	14.5%	100.0%
	% within Question No.19	100.0%	100.0%	100.0%	100.0%	100.0%
	% of Total	18.8%	13.5%	53.2%	14.5%	100.0%

Table 19

There are several arguments presented against legalization of euthanasia by the opponents. So, it is interesting to know the views of respondents at this point. Out of total 400 majority of respondents (53.2%) consider public corruption and misuse of law most favourable to reject the legalization of euthanasia. Unexpectedly option A (The sanctity of life) has selected by only 18.8%. Similarly, option B 13.5% and option D 14.5% have selected by the respondents.

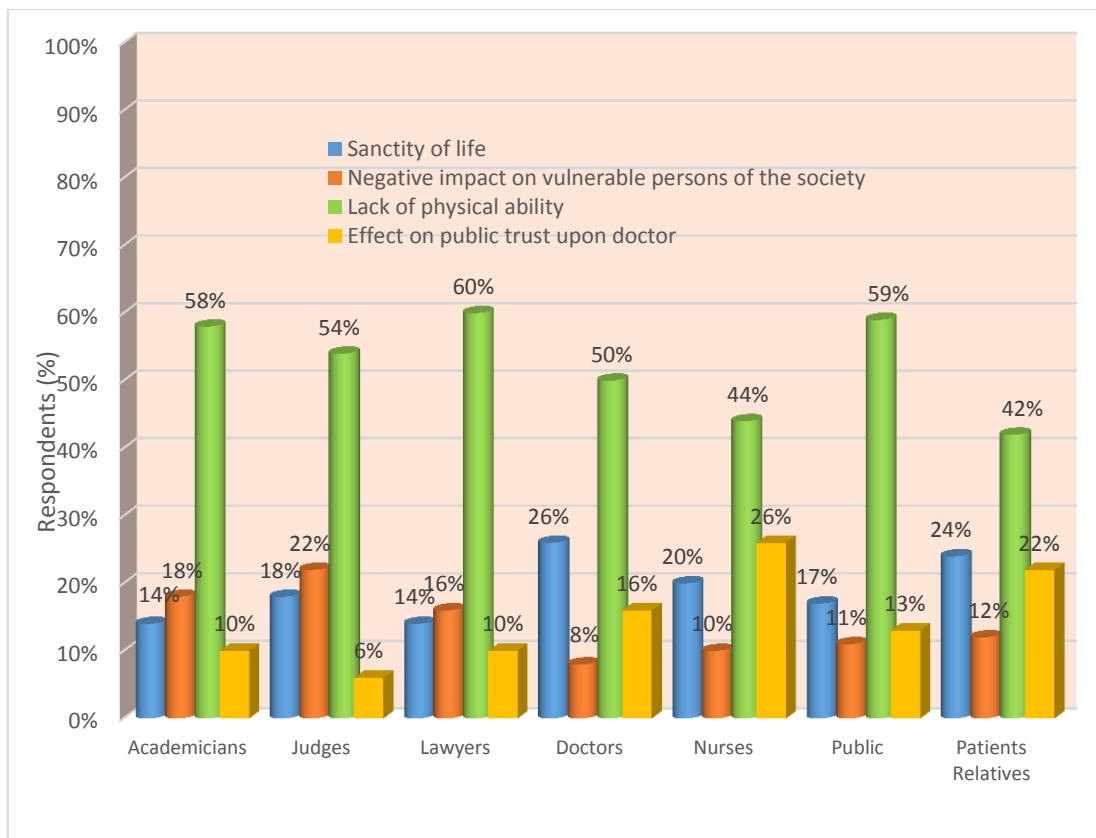


Figure 19

This result is a bit surprising to the researcher because the opponent of euthanasia always found their basis to deny legalisation of euthanasia in the traditional religious doctrine of sanctity of life. It indicates that the majority of population are

not supporter of saving life at the cost of quality of life but they very much concern about the actual social evil that is corruption and misuse of Law. This also indicates that public attitude towards life and death has changed since recent years. See Table 19 and Figure 1920. Euthanasia should be legalized only through law with adequate provision and strict procedure for the protection of interest of the patient and full proof safeguard against its misuse.

20. Euthanasia should be legalized only through law with adequate provision and strict procedure for the protection of interest of the patient and full proof safeguard against its misuse.

Occupation * Question No.20 Crosstabulation

		Question No.20			Total	
		Yes	No	Neutral		
Occupation	Academicians	Count	34	7	9	50
	% within Occupation	68.0%	14.0%	18.0%	100.0%	
	% within Question No.20	12.4%	12.7%	12.7%	12.5%	
	% of Total	8.5%	1.8%	2.2%	12.5%	
	Judges	Count	41	6	3	50
	% within Occupation	82.0%	12.0%	6.0%	100.0%	
	% within Question No.20	15.0%	10.9%	4.2%	12.5%	
	% of Total	10.2%	1.5%	0.8%	12.5%	
	Lawyers	Count	37	7	6	50
	% within Occupation	74.0%	14.0%	12.0%	100.0%	
	% within Question No.20	13.5%	12.7%	8.5%	12.5%	
	% of Total	9.2%	1.8%	1.5%	12.5%	
	Doctors	Count	31	4	15	50
	% within Occupation	62.0%	8.0%	30.0%	100.0%	
	% within Question No.20	11.3%	7.3%	21.1%	12.5%	
	% of Total	7.8%	1.0%	3.8%	12.5%	
	Nurses	Count	27	11	12	50
	% within Occupation	54.0%	22.0%	24.0%	100.0%	
	% within Question No.20	9.9%	20.0%	16.9%	12.5%	
	% of Total	6.8%	2.8%	3.0%	12.5%	
Public	Count	66	14	20	100	
% within Occupation	66.0%	14.0%	20.0%	100.0%		
% within Question No.20	24.1%	25.5%	28.2%	25.0%		
% of Total	16.5%	3.5%	5.0%	25.0%		
Patients Relatives	Count	38	6	6	50	
% within Occupation	76.0%	12.0%	12.0%	100.0%		

Total	% within Question No.20	13.9%	10.9%	8.5%	12.5%
	% of Total	9.5%	1.5%	1.5%	12.5%
	Count	274	55	71	400
	% within Occupation	68.5%	13.8%	17.8%	100.0%
	% within Question No.20	100.0%	100.0%	100.0%	100.0%
	% of Total	68.5%	13.8%	17.8%	100.0%

Table 20

Out of total 400 respondents, majority of population (68.5%) agreed that Euthanasia should be legalized only through law with adequate provision and strict procedure for the protection of interest of the patient and full proof safeguard against its misuse. Since, in performing euthanasia, the roles of doctor and relatives are most important, therefore, it would be interesting to know their opinion on this question. 62% out of 50 doctors and 76% out of 50 relatives agreed that there should be some strict rules to perform and regulate euthanasia. See Table 20 and Figure 20

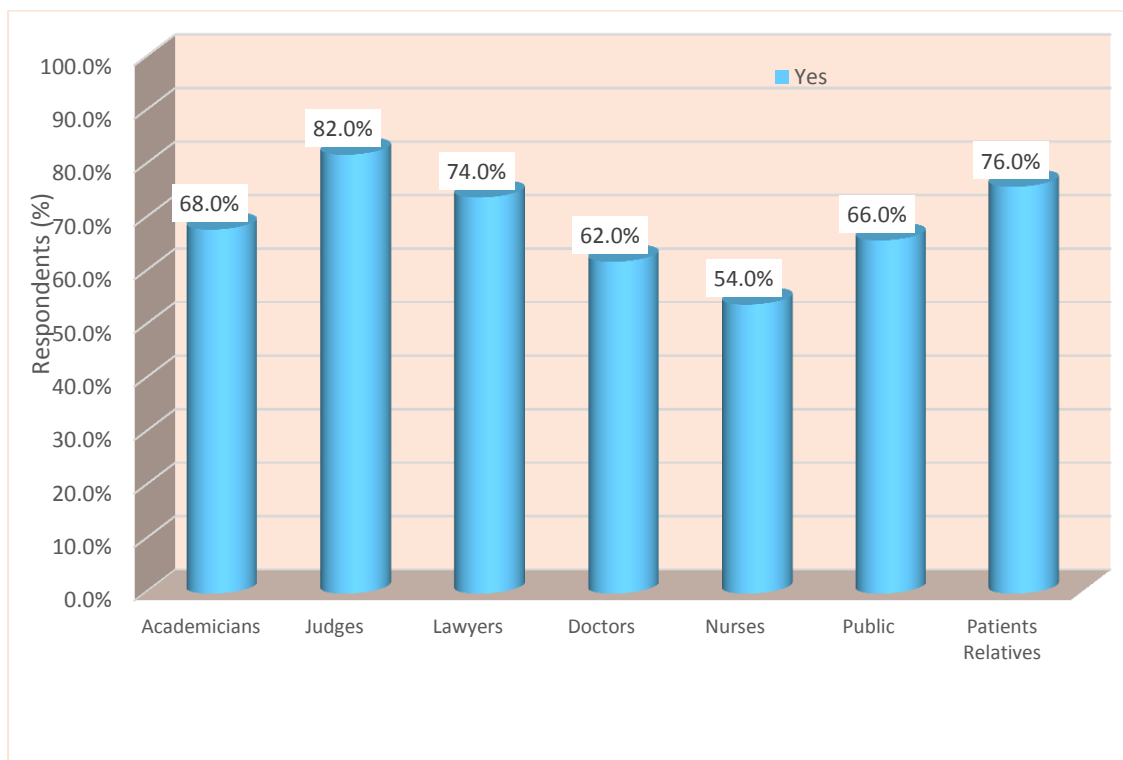


Figure 20

21. Do you agree that euthanasia in India involves major complex issues which need effective control and to be addressed with law made by the parliament?

Occupation * Question No.21 Crosstabulation

		Question No.21			Total
		Yes	No	Neutral	
Academics	Count	40	5	5	50
	% within Occupation	80.0%	10.0%	10.0%	100.0%
	% within Question No.21	14.3%	9.3%	7.5%	12.5%
	% of Total	10.0%	1.2%	1.2%	12.5%
Judges	Count	39	8	3	50
	% within Occupation	78.0%	16.0%	6.0%	100.0%
	% within Question No.21	14.0%	14.8%	4.5%	12.5%
	% of Total	9.8%	2.0%	0.8%	12.5%
Lawyers	Count	35	11	4	50
	% within Occupation	70.0%	22.0%	8.0%	100.0%
	% within Question No.21	12.5%	20.4%	6.0%	12.5%
	% of Total	8.8%	2.8%	1.0%	12.5%
Doctors	Count	34	3	13	50
	% within Occupation	68.0%	6.0%	26.0%	100.0%
	% within Question No.21	12.2%	5.6%	19.4%	12.5%
	% of Total	8.5%	0.8%	3.2%	12.5%
Nurses	Count	41	2	7	50
	% within Occupation	82.0%	4.0%	14.0%	100.0%
	% within Question No.21	14.7%	3.7%	10.4%	12.5%
	% of Total	10.2%	0.5%	1.8%	12.5%
Public	Count	58	18	24	100
	% within Occupation	58.0%	18.0%	24.0%	100.0%
	% within Question No.21	20.8%	33.3%	35.8%	25.0%
	% of Total	14.5%	4.5%	6.0%	25.0%
Patients Relatives	Count	32	7	11	50
	% within Occupation	64.0%	14.0%	22.0%	100.0%
	% within Question No.21	11.5%	13.0%	16.4%	12.5%
	% of Total	8.0%	1.8%	2.8%	12.5%
Total	Count	279	54	67	400
	% within Occupation	69.8%	13.5%	16.8%	100.0%
	% within Question No.21	100.0%	100.0%	100.0%	100.0%
	% of Total	69.8%	13.5%	16.8%	100.0%

Table 21

As already discussed in the previous chapters that Euthanasia is involves major socio-legal moral ethical, medical as well as political issue. The patient, doctors and patient relatives always face the dilemma of life and death. Very strong views are held on this

complex issue. The academic debate over legal and ethical issues is marked by heated exchanges where both sides feel that the other has misrepresented or failed to understand their arguments. Euthanasia and the related issues are topics that courts are struggled to deal with, and more than once the supreme court has called upon parliament to legislate on the area. Keeping above discussion in mind the question is asked to take views of respondents on need of effective control and the legislation made by the parliament that Out of total 400 respondents, 69.8% agree that euthanasia in India involves major complex issues which need effective control and to be addressed with law made by the parliament. Only 13.5% don't think so. Moreover 16.8% respondents remain neutral on above concern. If we analyse comparatively the all the category of respondents have given almost similar responses (Category I 80%, II 78%, III 70%, IV 68%, V 82%, VI 58% and VII 64% respectively). See Table 21 and Figure 21

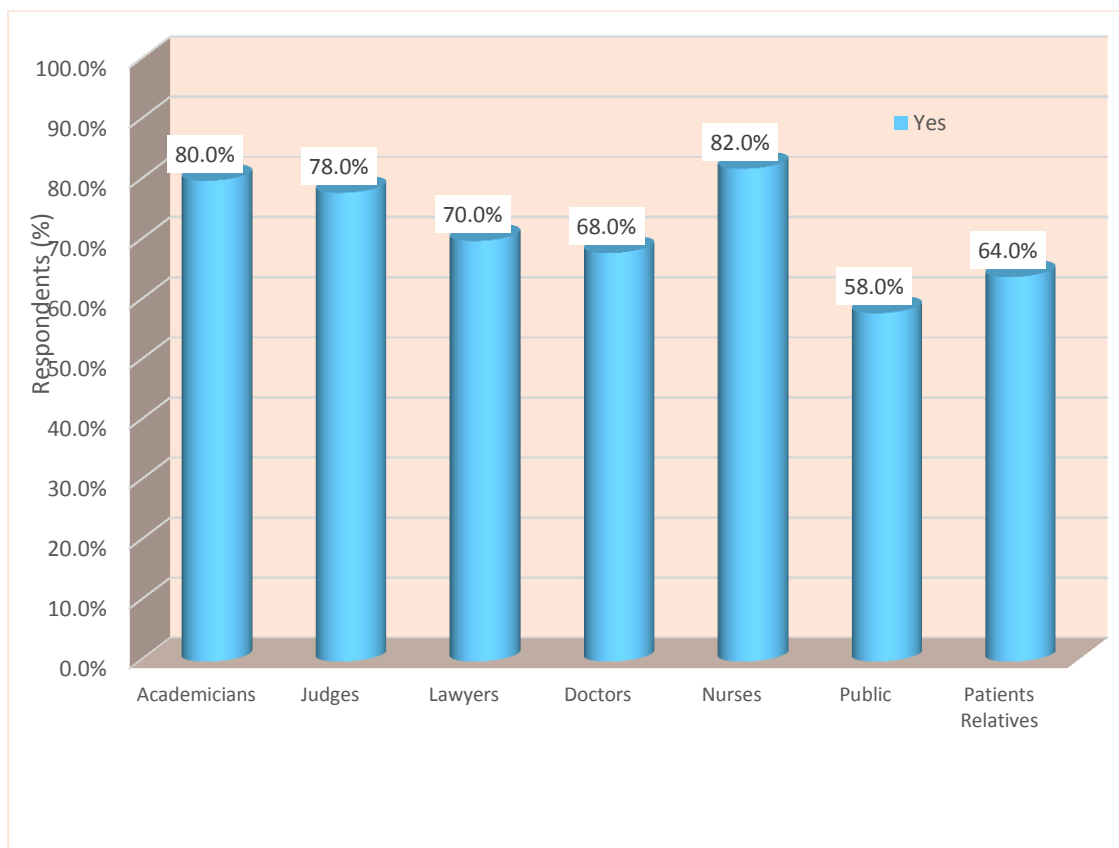


Figure 21

22. Do you agree that if euthanasia issue unregulated, patient's relatives would misuse euthanasia for economy, inheritance or other personal motives?

Occupation * Question No.22 Crosstabulation

		Question No.22			Total	
		Yes	No	Neutral		
Occupation	Academicians	Count	43	1	6	50
	% within Occupation	86.0%	2.0%	12.0%	100.0%	
	% within Question No.22	15.3%	2.9%	7.1%	12.5%	
	% of Total	10.8%	0.2%	1.5%	12.5%	
	Judges	Count	45	3	2	50
	% within Occupation	90.0%	6.0%	4.0%	100.0%	
	% within Question No.22	16.0%	8.6%	2.4%	12.5%	
	% of Total	11.2%	0.8%	0.5%	12.5%	
	Lawyers	Count	32	4	14	50
	% within Occupation	64.0%	8.0%	28.0%	100.0%	
	% within Question No.22	11.4%	11.4%	16.7%	12.5%	
	% of Total	8.0%	1.0%	3.5%	12.5%	
	Doctors	Count	39	4	7	50
	% within Occupation	78.0%	8.0%	14.0%	100.0%	
	% within Question No.22	13.9%	11.4%	8.3%	12.5%	
	% of Total	9.8%	1.0%	1.8%	12.5%	
	Nurses	Count	33	7	10	50
	% within Occupation	66.0%	14.0%	20.0%	100.0%	
	% within Question No.22	11.7%	20.0%	11.9%	12.5%	
	% of Total	8.2%	1.8%	2.5%	12.5%	
	Public	Count	62	7	31	100
	% within Occupation	62.0%	7.0%	31.0%	100.0%	
	% within Question No.22	22.1%	20.0%	36.9%	25.0%	
	% of Total	15.5%	1.8%	7.8%	25.0%	
	Patients	Count	27	9	14	50
	% within Occupation	54.0%	18.0%	28.0%	100.0%	
	Relatives	% within Question No.22	9.6%	25.7%	16.7%	12.5%
% of Total	6.8%	2.2%	3.5%	12.5%		
Total	Count	281	35	84	400	
% within Occupation	70.2%	8.8%	21.0%	100.0%		
% within Question No.22	100.0%	100.0%	100.0%	100.0%		
% of Total	70.2%	8.8%	21.0%	100.0%		

Table 22

In modern Indian society family values have undergone a change. In olden times joint family system was the unique feature of Indian society but now-a-days that system has lost its significance. Nuclear family system has successfully replaced joint family

system up to a large extent. Old persons in the family are generally considered as a burden by the younger ones. In this picture of Indian society, it is hard to expect sympathy and a feeling of moral responsibility from the family members of a terminally ill patient. Hence, keeping the above discussed point in his mind, the researcher has framed this question to ascertain the opinion of respondents on this issue. As expected, the response given is affirmative by majority of respondents from six categories. However, category VII has given less positive response (54%). Starting from category I to VI the percentage given is 86%, 90%, 64%, 78%, 66%, 62% and respectively. On the other hand, option two received 2%, 6%, 8% and 8%, 14%, 7% and 18% response from category I to VII respectively. Out of total 400 respondents, 70.2% favours the statement made in this question.

It can be concluded from the above data that in India, the majority of population is concerned about the fact that terminally ill patient may be forced by the family members to avail euthanasia even against his/her wish or if euthanasia issue unregulated, patient's relatives would misuse euthanasia for economy, inheritance or other personal motives. See Table 22 and Figure 22

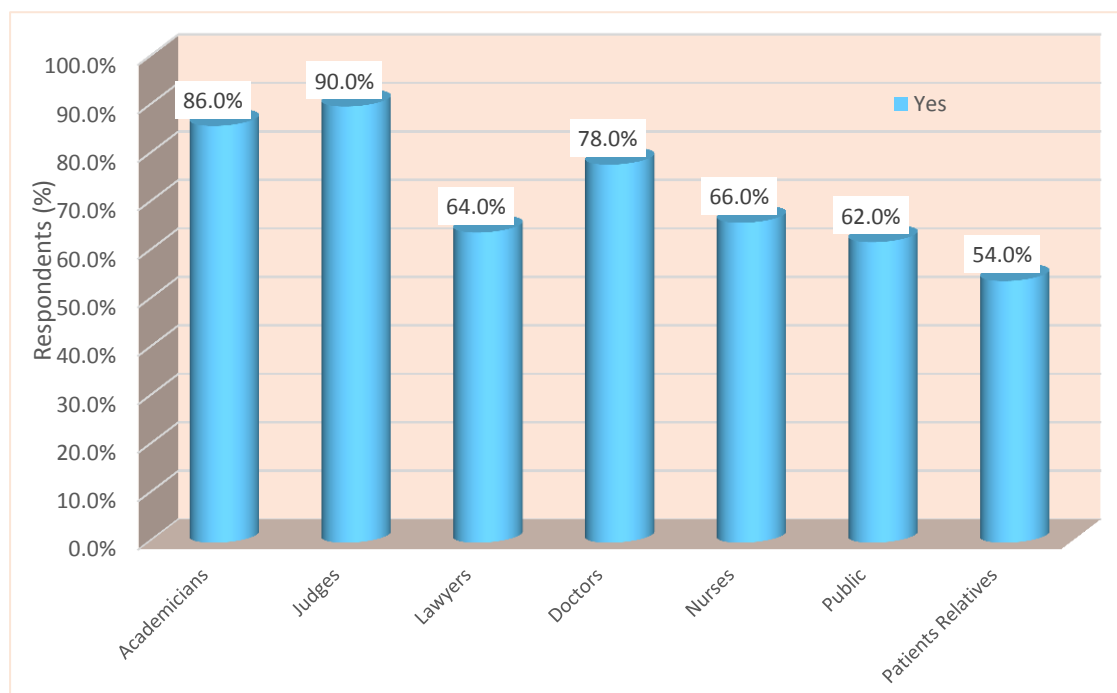


Figure 22

23. Do you think that if euthanasia issue unregulated it would be resulted into unethical medical practice?

Occupation * Question No.23 Crosstabulation

		Question No.23			Total
		Yes	No	Neutral	
Academicians	Count	35	1	14	50
	% within Occupation	70.0%	2.0%	28.0%	100.0%
	% within Question No.23	13.1%	2.8%	14.4%	12.5%
	% of Total	8.8%	0.2%	3.5%	12.5%
Judges	Count	41	4	5	50
	% within Occupation	82.0%	8.0%	10.0%	100.0%
	% within Question No.23	15.4%	11.1%	5.2%	12.5%
	% of Total	10.2%	1.0%	1.2%	12.5%
Lawyers	Count	37	3	10	50
	% within Occupation	74.0%	6.0%	20.0%	100.0%
	% within Question No.23	13.9%	8.3%	10.3%	12.5%
	% of Total	9.2%	0.8%	2.5%	12.5%
Doctors	Count	27	7	16	50
	% within Occupation	54.0%	14.0%	32.0%	100.0%
	% within Question No.23	10.1%	19.4%	16.5%	12.5%
	% of Total	6.8%	1.8%	4.0%	12.5%
Nurses	Count	21	11	18	50
	% within Occupation	42.0%	22.0%	36.0%	100.0%
	% within Question No.23	7.9%	30.6%	18.6%	12.5%
	% of Total	5.2%	2.8%	4.5%	12.5%
Public	Count	67	4	29	100
	% within Occupation	67.0%	4.0%	29.0%	100.0%
	% within Question No.23	25.1%	11.1%	29.9%	25.0%
	% of Total	16.8%	1.0%	7.2%	25.0%
Patients Relatives	Count	39	6	5	50
	% within Occupation	78.0%	12.0%	10.0%	100.0%
	% within Question No.23	14.6%	16.7%	5.2%	12.5%
	% of Total	9.8%	1.5%	1.2%	12.5%
Total	Count	267	36	97	400
	% within Occupation	66.8%	9.0%	24.2%	100.0%
	% within Question No.23	100.0%	100.0%	100.0%	100.0%
	% of Total	66.8%	9.0%	24.2%	100.0%

Table 23

Doctor patient relationship is most important thing in treatment of patients. Opponents of euthanasia think that unethical medical practice is the one the main reason for denial of euthanasia. They claim that if euthanasia is legalised it would have been

negative impact on doctor-patient relationship and at the same time the malpractices in the medical field would increase. This question has been asked to take the views of respondents in this regard. Out of total 400 respondents, 66.8% agree and only 9% disagree with the concern raised in this question. Moreover 24.2% respondent are not sure about the statement made in this question That if euthanasia issue unregulated it would be resulted into unethical medical practice That shows that response given is affirmative by majority of respondents. But it is surprising that nurses with 42% and doctors with 54% are not convinced with the afraid of other category responses.

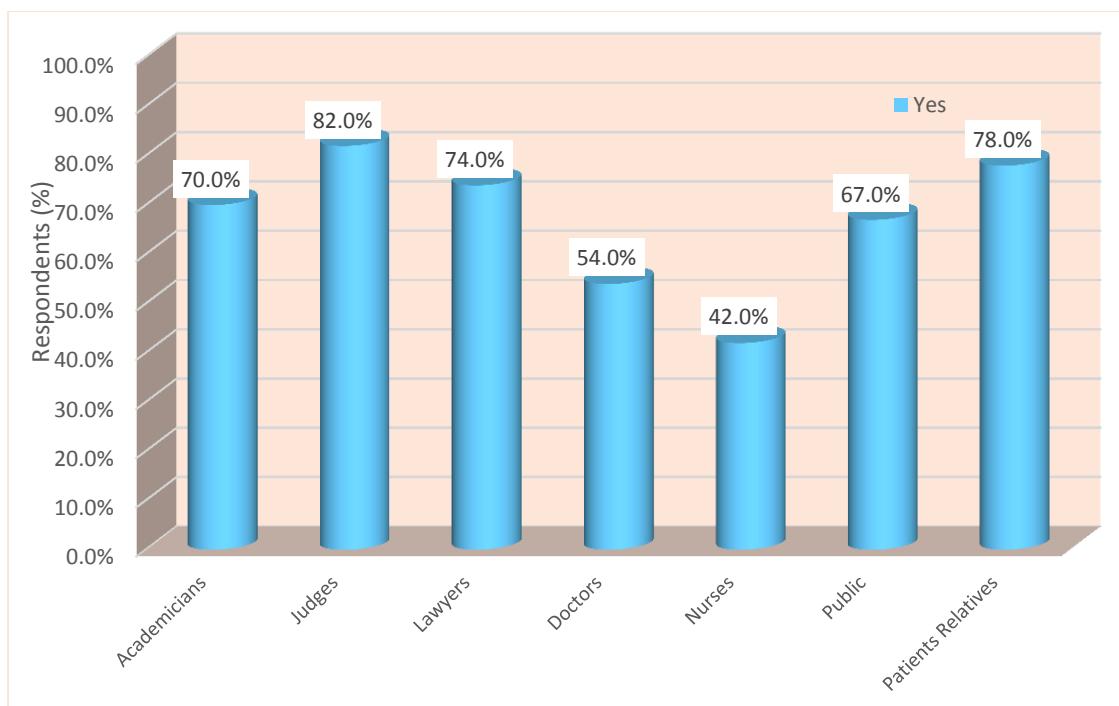


Figure 23

Starting from category I to VII the percentage given to option one is 68%, 64%, 45% and 80% respectively. On the other hand, option two received 70%, 82%, 74%, 54%, 42%, 67% and 78% respectively. It can be concluded from the above data that in India, larger people are of the view that if euthanasia issue unregulated it would be resulted into unethical medical practice. See Table 23 and Figure 23.

24. Do you think that unregulated euthanasia practices would negative effect on poor persons as they would be exploited by rich persons?

Occupation * Question No.24 Crosstabulation

		Question No.24			Total
		Yes	No	Neutral	
Academics	Count	43	4	3	50
	% within Occupation	86.0%	8.0%	6.0%	100.0%
	% within Question No.24	15.9%	8.3%	3.7%	12.5%
Judges	Count	39	7	4	50
	% within Occupation	78.0%	14.0%	8.0%	100.0%
	% within Question No.24	14.4%	14.6%	4.9%	12.5%
Lawyers	Count	28	8	14	50
	% within Occupation	56.0%	16.0%	28.0%	100.0%
	% within Question No.24	10.4%	16.7%	17.1%	12.5%
Doctors	Count	31	10	9	50
	% within Occupation	62.0%	20.0%	18.0%	100.0%
	% within Question No.24	11.5%	20.8%	11.0%	12.5%
Nurses	Count	36	2	12	50
	% within Occupation	72.0%	4.0%	24.0%	100.0%
	% within Question No.24	13.3%	4.2%	14.6%	12.5%
Public	Count	60	13	27	100
	% within Occupation	60.0%	13.0%	27.0%	100.0%
	% within Question No.24	22.2%	27.1%	32.9%	25.0%
Patients Relatives	Count	33	4	13	50
	% within Occupation	66.0%	8.0%	26.0%	100.0%
	% within Question No.24	12.2%	8.3%	15.9%	12.5%
Total	Count	270	48	82	400
	% within Occupation	67.5%	12.0%	20.5%	100.0%
	% within Question No.24	100.0%	100.0%	100.0%	100.0%
	% of Total	67.5%	12.0%	20.5%	100.0%

Table 24

India is a developing country. According to the 'United Nations Millennium Development Goals programme, 88 million population in India, lived below poverty line. Health resources, hospice and palliative care are limited in India. So that it is

being always a serious concern that if that unregulated euthanasia practices would negative effect on poor persons as they would be exploited by rich persons because poor don't have enough money to afford high cost life supporting machines and medicines. Therefore, it would be resulted into denial of right to treatment. Hence, keeping the above discussed point in his mind, the researcher has framed this question to ascertain the opinion of respondents on this issue. Out of total 400 respondents, 67.5% agree, 12% disagree and 20.5% showed neutral views. Starting from category I to VII the percentage given to option one is 86%, 78%, 56% and 62%, 72%, 60% and 66% respectively. On the other hand, option two received 8%, 14%, 16%, 20% 4%, 13% and 8% respectively. It can be concluded from the above data that in India, larger people are of the view that if euthanasia issue unregulated it would be resulted into unethical medical practice. See Table 24 and Figure 24

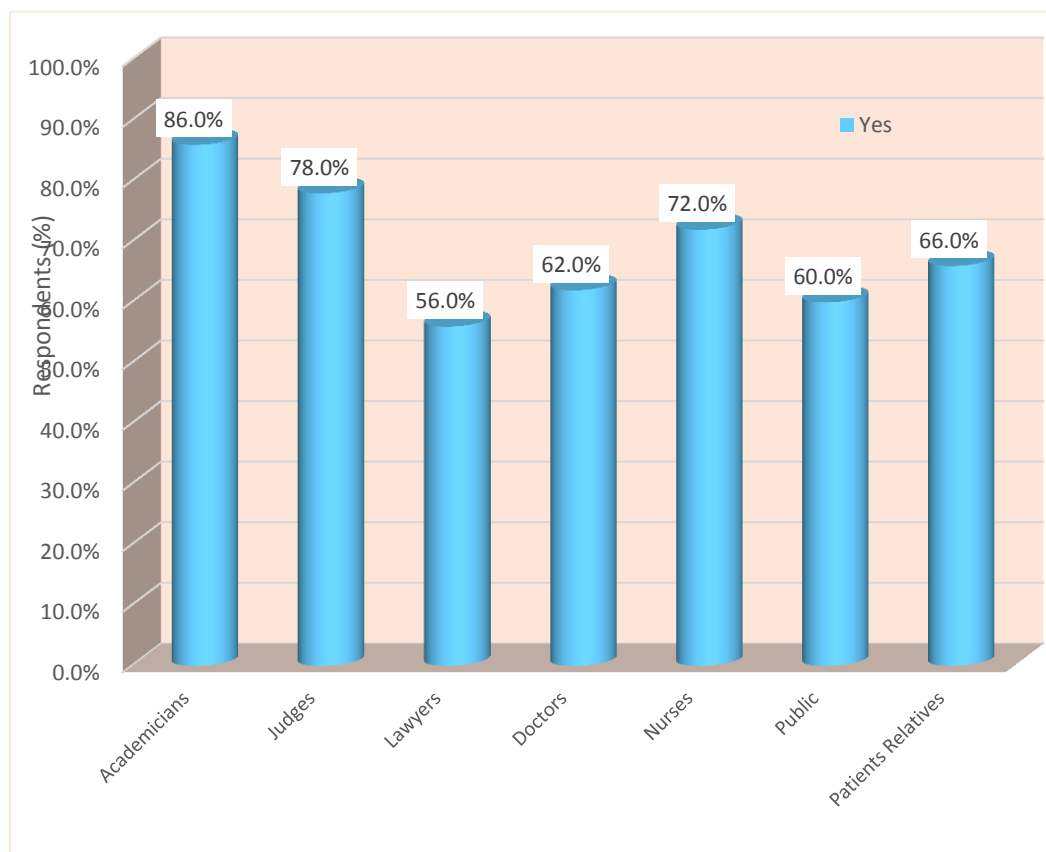


Figure 24

25. Do you agree that such law and regulation should make provision favouring defence of doctors who perform euthanasia in good-faith?

Occupation * Question No.25 Crosstabulation

		Question No.25			Total	
		Yes	No	Neutral		
Occupation	Academicians	Count	37	8	5	50
	% within Occupation	74.0%	16.0%	10.0%	100.0%	
	% within Question No.25	12.4%	20.0%	8.2%	12.5%	
	% of Total	9.2%	2.0%	1.2%	12.5%	
	Judges	Count	41	7	2	50
	% within Occupation	82.0%	14.0%	4.0%	100.0%	
	% within Question No.25	13.7%	17.5%	3.3%	12.5%	
	% of Total	10.2%	1.8%	0.5%	12.5%	
	Lawyers	Count	27	11	12	50
	% within Occupation	54.0%	22.0%	24.0%	100.0%	
	% within Question No.25	9.0%	27.5%	19.7%	12.5%	
	% of Total	6.8%	2.8%	3.0%	12.5%	
	Doctors	Count	48	0	2	50
	% within Occupation	96.0%	0.0%	4.0%	100.0%	
	% within Question No.25	16.1%	0.0%	3.3%	12.5%	
	% of Total	12.0%	0.0%	0.5%	12.5%	
	Nurses	Count	41	0	9	50
	% within Occupation	82.0%	0.0%	18.0%	100.0%	
	% within Question No.25	13.7%	0.0%	14.8%	12.5%	
	% of Total	10.2%	0.0%	2.2%	12.5%	
	Public	Count	64	10	26	100
	% within Occupation	64.0%	10.0%	26.0%	100.0%	
	% within Question No.25	21.4%	25.0%	42.6%	25.0%	
	% of Total	16.0%	2.5%	6.5%	25.0%	
	Patients Relatives	Count	41	4	5	50
	% within Occupation	82.0%	8.0%	10.0%	100.0%	
	% within Question No.25	13.7%	10.0%	8.2%	12.5%	
% of Total	10.2%	1.0%	1.2%	12.5%		
Total	Count	299	40	61	400	
% within Occupation	74.8%	10.0%	15.2%	100.0%		
% within Question No.25	100.0%	100.0%	100.0%	100.0%		
% of Total	74.8%	10.0%	15.2%	100.0%		

Table 25

Most doctors may have the fear of being prosecuted if they perform euthanasia. Therefore, the most important feature of such a law should be the incorporation of provision relating to the defence of doctors from prosecution if they perform

euthanasia as per the procedure. Out of total 400 respondents, 74.8% agree that such law and regulation should make provision favouring defence of doctors who perform euthanasia in good-faith. Only 10% respondents are disagreed. Moreover 15.2% remained uncertain with the statement. It is notable that Lawyers think less favourable regarding provision containing defence to the doctors than the other categories. They have selected response two with reasonable number with 22% See Table 25 and Figure 25.

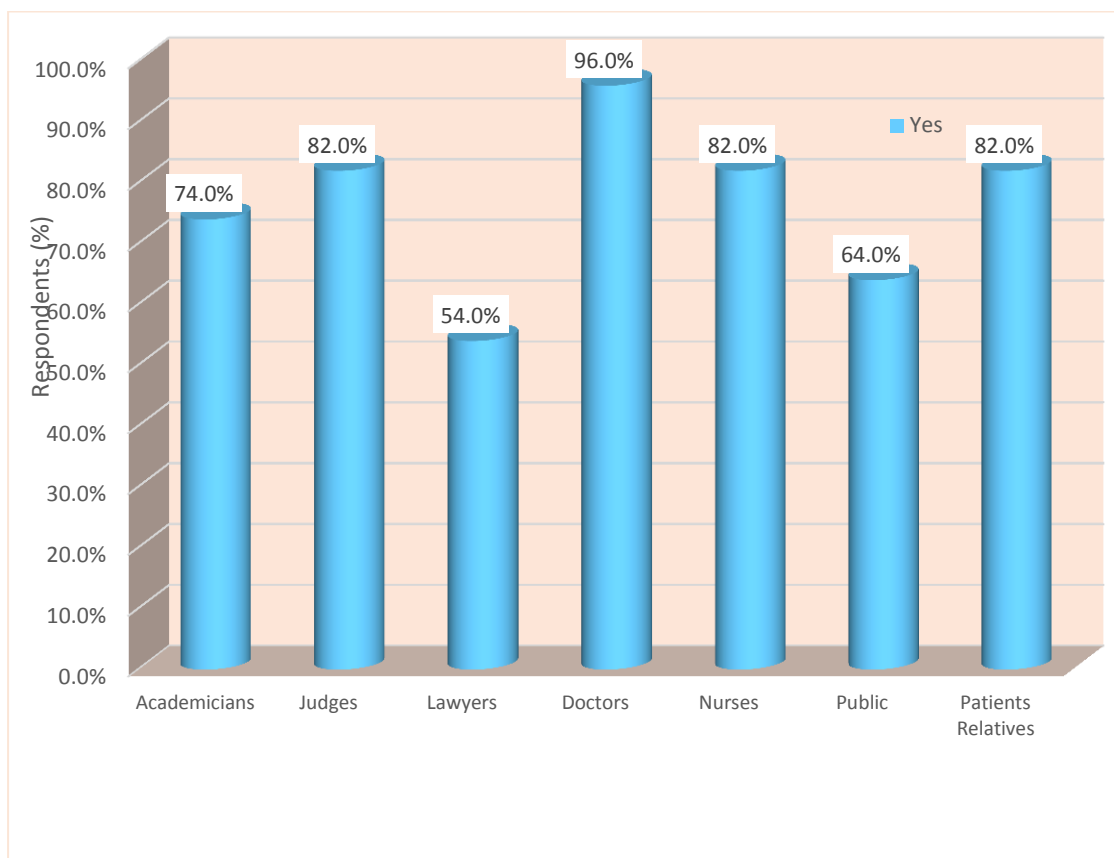


Figure 25

26. Do you agree that there should be rigorous punishment for those who misuse the Law on euthanasia?

Occupation * Question26 Crosstabulation

		Question26			Total	
		Yes	No	Neutral		
Occupation	Academicians	Count	46	0	4	50
	% within Occupation	92.0%	0.0%	8.0%	100.0%	
	% within Question26	14.1%	0.0%	8.3%	12.5%	
	% of Total	11.5%	0.0%	1.0%	12.5%	
	Judges	Count	47	2	1	50
	% within Occupation	94.0%	4.0%	2.0%	100.0%	
	% within Question26	14.4%	7.7%	2.1%	12.5%	
	% of Total	11.8%	0.5%	0.2%	12.5%	
	Lawyers	Count	43	4	3	50
	% within Occupation	86.0%	8.0%	6.0%	100.0%	
	% within Question26	13.2%	15.4%	6.2%	12.5%	
	% of Total	10.8%	1.0%	0.8%	12.5%	
	Doctors	Count	32	2	16	50
	% within Occupation	64.0%	4.0%	32.0%	100.0%	
	% within Question26	9.8%	7.7%	33.3%	12.5%	
	% of Total	8.0%	0.5%	4.0%	12.5%	
	Nurses	Count	36	11	3	50
	% within Occupation	72.0%	22.0%	6.0%	100.0%	
	% within Question26	11.0%	42.3%	6.2%	12.5%	
	% of Total	9.0%	2.8%	0.8%	12.5%	
	Public	Count	77	5	18	100
	% within Occupation	77.0%	5.0%	18.0%	100.0%	
	% within Question26	23.6%	19.2%	37.5%	25.0%	
	% of Total	19.2%	1.2%	4.5%	25.0%	
	Patients Relatives	Count	45	2	3	50
	% within Occupation	90.0%	4.0%	6.0%	100.0%	
	% within Question26	13.8%	7.7%	6.2%	12.5%	
% of Total	11.2%	0.5%	0.8%	12.5%		
Total	Count	326	26	48	400	
% within Occupation	81.5%	6.5%	12.0%	100.0%		
% within Question26	100.0%	100.0%	100.0%	100.0%		
% of Total	81.5%	6.5%	12.0%	100.0%		

Table 26

From the discussion and analysis of above questions, it is evident that people are very much concerned regarding misuse of euthanasia if it would be legalised. proper

safeguard cannot guarantee unless and until there is strict punishment to those who misuse the law. Hence, keeping the above discussed point in his mind, the researcher has framed this question to ascertain the opinion of respondents on this issue. Out of total 400 81.5% respondents, agree that there should be rigorous punishment for those who misuse the Law on euthanasia. All the categories of respondents from I to VII a have given affirmative response related to the question. See Table 26 and Figure 26

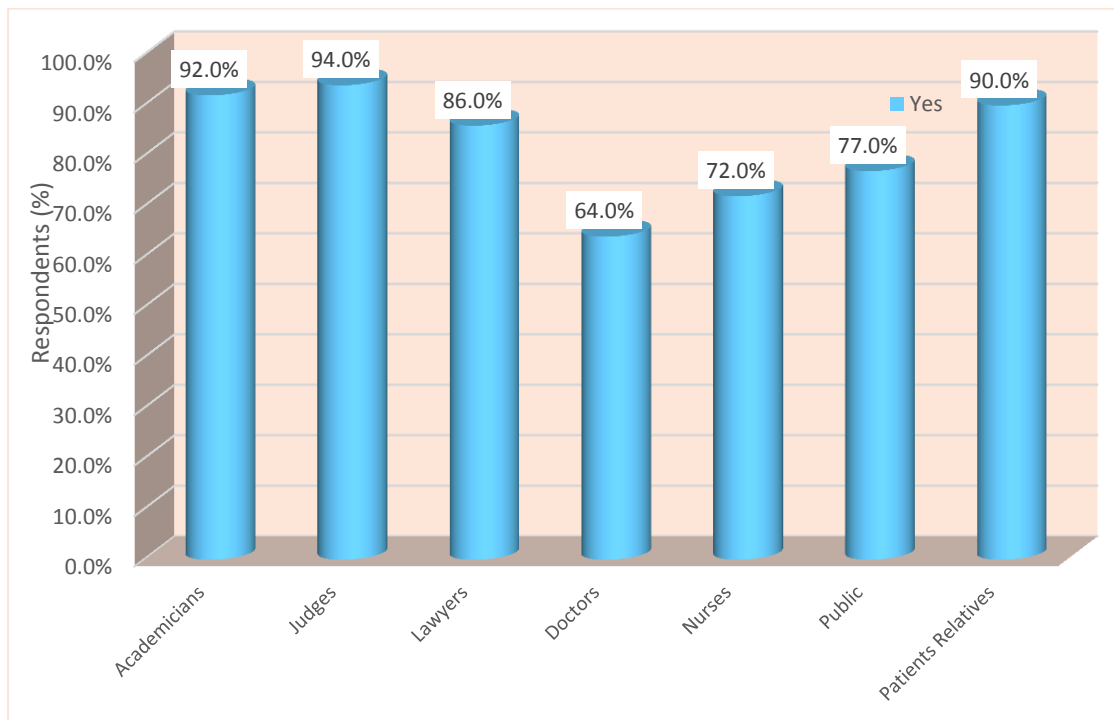


Figure 26

6.4 Major Findings

The major findings of this research are presented objective wise in the following manner:

- i. Euthanasia can be an answer to cases where a person is suffering from terminal illness or in coma or in persistent vegetative state or brain dead.**

As stated above the first objective of the present study was to explore and identify whether euthanasia can be an answer to cases where a person is suffering from terminal illness or in coma or in persistent vegetative state or brain dead. To achieve this objective, it is important to know the general attitudes of different stakeholders

(Academician, Judges, Lawyers, Doctors, Nurses Patient relatives and the general public) is important towards the issue of euthanasia in India. Their general attitudes towards legalizing euthanasia in India were elicited by constructing the items with reference to the patient's terminal illness, incurability and chances of recovery as well as the forms of euthanasia. The related questions were asked about right to die with dignity, personal autonomy and self-determination of your own body, right to privacy and euthanasia including direct question related to awareness and acceptance of euthanasia. The major findings related to this objective were as follows: a. The Academician included in this sample survey have shown positive attitude towards legalizing euthanasia in India, they don't think euthanasia as crime but as human rights or help of dying patient b. The legal fraternity (Judges and the lawyers) have also shown favorable attitude towards the issue of legalization of euthanasia and c. In the same way the medical fraternity (Doctors and Nurses) as well as general public also manifested the similar attitude towards euthanasia. Taking the sample as a whole, it can be concluded that in general, significant majority of the respondents of this study have taken euthanasia as a positive manner.

ii. To analyze various reasons giving rise to a debate over euthanasia:

The Second objective of the research was to analyze various reasons giving rise to a debate over euthanasia. The objective was further clarified by research hypothesis: "Legalization of euthanasia in India involves major complex issues which need to address with law". To achieve this objective the questions were asked about most favourable ground of opposing and justifying their stand on euthanasia. The search was led to the following major finding: Significant majority of academicians, Judges, lawyers, doctors, nurses, patient's relative and the general public opined that 'elevate intolerable pain and suffering and empowering right to death with dignity was the most favorable factor for euthanasia. One fourth of respondents were in favor of loss of 'quality of life and purpose' to justify euthanasia. However financial condition of the family due to the high cost medical services is also a factor to demand of euthanasia. On the other hand, physical disability, depression and psychological disorder and limited health resources are not a massive factor to ask for dignified death.

The question was also asked regarding argument they find most favourable to reject the legalization of euthanasia. They have professed the following reason in order of priority: Public corruption and misuse of Law, sanctity of life, effect on public trust upon doctor and negative impact on vulnerable persons of the society.

Summative conclude, it may be stated that the major reason for favoring legalizing euthanasia, as professed by our respondents could be identify as follows: to alleviate pain and suffering and empowering the individual 'right to die with dignity' rather than go on suffering from an incurable and painful disease. The principle of individual autonomy cannot be a sole and adequate factor but it can only play a supportive role to the 'alleviate pain and suffering and empowering death with dignity'. Whereas the reason for unfavorable attitude were identified as Public corruption and misuse of law.

iii. Practical Concerns of Misuse of the Law of Euthanasia if Legalized:

The above-mentioned objective of the present study was also included some specific questions related to real concerns raised by opponent and even by the supporters of euthanasia. The objective was further clarified by research hypothesis: "people are now very much aware about euthanasia and its socio-legal implications". The questions were asked as: if euthanasia issue unregulated it would be resulted into unethical medical practice? patient's relatives would misuse euthanasia for economy, inheritance or other personal motives? And euthanasia practices would negative effect on poor persons as they would be exploited by rich persons. The major findings which emerge out of the data gathered from the respondents were as follows: It is interesting to mention that in a very significant majority all the respondents belonging to 7 sub-categories of our sample i.e. Academicians, Judges, Lawyers, Doctors, Nurses patient's relatives and general public have agreed with the risk involved in legalization of euthanasia without proper safeguards. The observed data have clearly indicated that in the opinion of more than significant majority (sixty five percent) of the respondents, the unregulated legalization of euthanasia would increase the chances of its abuse or misuse the patient's relatives, the medical professionals. They have also agreed that the following might be reasons for motivating them for such abuse and misuse: economy, inheritance weariness and vested interest. It is concluded that(i) A more than sixty out of hundred respondents have highlighted the fact that the

prevailing socio-political conditions are not yet ripe enough to legalize euthanasia because the Indian society was still afflicted by a large number of poor people and public corruption. In other words, they have opined that the present conditions in India were not friendly for legalizing euthanasia because of its chances of misused (ii) The respondents of the present study were further found to be in agreement with the view that euthanasia and if legalized in India, would open the door for the exploitation of the poor by the rich. Because there existed a vast class-cleavage in the existing social structure in India. (iii) Lastly, a very significant majority of 7 subgroups of respondents assessed that the prevailing medical scenario was also not favorable for undertaking euthanasia legalization because there was no dearth of unethical medical practice.

iv. The Issue of euthanasia need to be addressed with Law:

The Hypothesis of the research also mention that the issues of euthanasia need to be address with law so that risk of misuse and abuse can be minimize. This law should include detailed provisions related to euthanasia, therefore specific questions are also asked to take the views of respondence about the doctor's duty to provide informed consent, provisions deciding best interests, provisions related to safeguard of medical professions, acceptance of living will, and punishment to those who misuse of law. The Data showed that majority of respondence agreed that Doctors have the duty to act in the best interests of all their patient competent and incompetent. This duty includes to provide reasonable information and treatment to the patient. They also agreed that When the treatment will become futile and burdensome then doctor's role is not only limited to save life but also a role to alleviate the suffering of the patients. In addition, they also in opinion that Court should decide the best interest of a terminal ill patient's best interests regarding to continue or withdrawal the treatment with consensus of a panel of doctors and consent of patient's relatives. A good percentage of respondents holds a positive view towards the concept of living will and its execution in India. However substantial number of populations still not convinced with the concept of living will. They also believe that euthanasia law should have the provision for the defense of doctors who perform euthanasia in good-faith subject to prescribed guidelines. Lastly, three fourth majority of respondents are in favour of rigorous punishment to those who misuse of law on euthanasia.

Comparatively speaking all the sub groups of our sample of the study i.e. Academician, Judges, Lawyers, Doctors, Nurses Patient relatives and the general public have exhibited positive attitude towards legalizing euthanasia as well as withdrawal of life support system. However, they more preferred passive euthanasia than active voluntary euthanasia. Of course, their agreement differed vis-a-vis each other in magnitude, statistical differences did exist among them. Summative speaking it can be concluded that the significant majority of the respondents have exhibited a positive attitude for legalizing euthanasia in India. A significant majority of our respondents both comparatively vis-a-vis each other and summative for the sample as a whole have opined that there was definite risk involved in legalizing euthanasia in India and they also in favour of strict law. As regards the association between the variables of their profession, attitudes towards legalization of euthanasia no relationship did emerge. Finely, it is found that in average over 18% respondents select neutral option. There may be the two reasons for this. Some may not have given the issue much thought and importance. Others may have had an opinion but found that response alternatives did not allow them to express their views.

6.5 Inferences and Implications:

Keeping the views in the sample of respondents as a whole. The major inferences and implications are as follows:

- Terminally ill and incurable patient with extreme physical mental suffering should have right to die peacefully i.e. death with dignity.
- There is enough support is rising for voluntary euthanasia (whether active or passive) in India. However, it is limited to terminally ill and incurable patient with extreme physical mental suffering.
- Substantial number of populations either not convinced or undecided the with the concept of euthanasia.
- Personal autonomy and self-determination of your own body is an important part of human right of personal liberty. But this right is not absolute and it can be only extended to take own life or demand euthanasia to the terminally ill and incurable patient who is suffering from unbearable pain and suffering.

-
- People are very much aware about euthanasia. However small portion of population still unaware about this concept.
 - Allowing euthanasia is justified to protect from undignified and distressing end to his/her life.
 - Euthanasia is essential to protect right to privacy/ private life of the dying patient. undesirable treatment and bodily invasion of a 'dying patient' (competent or incompetent) does the violation of the right to privacy.
 - In comparison there is much support of passive euthanasia than active euthanasia.
 - Euthanasia is not a crime in the eyes of a large majority of population in India. Either they consider it help or a human right of a dying patient.
 - Doctors have the duty to act in the best interests of all their patient competent and incompetent. This duty includes to provide reasonable information and treatment to the patient.
 - When the treatment will become futile and burdensome then doctor's role is not only limited to save life but also a role to alleviate the suffering of the patients.
 - Doctors should have special defence as to treatment of patient who is suffering from extreme and unbearable pain and also in terminally illness stage or incurable stage of treatment.
 - People are very much aware about recent judgement of honourable Supreme Court of India recognised die with dignity (declared withdrawal of live support system and living will as legal) and supported the same.
 - A good percentage of respondents holds a positive view towards the concept of living will and its execution in India. However substantial number of populations still not convinced with the concept of living will.
 - Court should decide the best interest of a terminal ill patient's best interests regarding to continue or withdrawal the treatment with consensus of a panel of doctors and consent of patient's relatives.
 - Intolerable pain and suffering seem to be the most favorable factor for patients or their relatives ask for a dignified death. However financial condition of the family due to the high cost medical services is also a factor to demand of euthanasia. On

the other hand, physical disability, depression and psychological disorder and limited health resources are not a massive factor to ask for dignified death.

- Personal autonomy is not most favourable argument to support legalisation of euthanasia but it is a patient's deteriorate condition is the most favourable argument to demand death with dignity.
- Public corruption and misuse of law is the most favorable argument against legalisation of euthanasia than any other ground. That shows that people are aware about socio-legal implications and concerns of euthanasia after legalisation.
- There is concern of people occur that if euthanasia not regulated, euthanasia would be misused by patient's relatives for economy, inheritance or other personal motives, resulted into unethical medical practice, negative effect poor persons as they would be exploited by rich persons
- To resolve these concerns there is an urgent need to make a law made by the parliament with strict provision and safeguards to regulate the practice of euthanasia in India.
- Such law should make provision for the defence of doctors who perform euthanasia in good-faith subject to prescribed guidelines.
- Misuse of provisions or safeguards for performing euthanasia should be punishable with rigorous imprisonment under the law.

6.6 Suggestions for further Research:

During the survey and analysis of collected data it was realized that there existed certain gaps in euthanasia research. Indirectly the gaps pointed out the limitations of the present research exercise. It is true that a systematic effort has been initiated in this direction but much more is needed to be done. The following suggestions are made where a systematic research should be undertaken on priority bases so as to enable the concerned authorities to formulate a sound national policy on legalization of euthanasia:

- a) The present study presents a small survey of professionals of legal and medical field, patient's relatives as well as general public without including a

demographical (Age, religion, people status of living and dividing professionals into subgroups) survey. A large-scale survey of a cross section of society including Religion, socio-economic status, level of education, occupation, rural and urban background and political affiliation. should be made to elicit people's views on legalization of euthanasia.

- b)** The present study did not make any distinction among the various categories of doctors e.g. their field of specialization in medical practice. It may be fruitful to know the views of doctors towards legalization of euthanasia on the basis of their specialty i.e. general physician, Psychiatrists, Oncologists, Neurologists. There are medical areas which usually deal with such terminal illness like cancer and AIDS. It would be fruitful to examine their attitudes to the problem under investigation.
- c)** Lastly, this research study has been done in limited area and only in Lucknow region. The National Sample Survey type studies should be undertaken in different parts of the country in order to arrive at a right decision on the problem of legalization of euthanasia in India.

While summarizing the present study admits that a logical effort in any field of study is a continuing process. The present study in its own modest way has achieved all the objectives which were set before it and made some contributions towards filling up the gap which existed in area of euthanasia research. This study, however, does not propose to claim any finality in regard to either facts gathered or to the inferences drawn. If it succeeds in provoking further research in the field of euthanasia, its effort would naturally be fructified.



CHAPTER-VII
CONCLUSION AND
SUGGESTIONS



CHAPTER-VII

CONCLUSION AND SUGGESTIONS

“Let death be as beautiful as the autumn leaves and life is as beautiful as the summer flowers”.

-Rabindranath Tagore

In the previous chapters, the researcher tried to study and examine the issue of euthanasia in the light of Conceptual analysis including Historical Backgrounds, Religious concepts, operational concepts, dignified life and death, comparative analysis of different countries in different continents including Medical Ethics, Human and Constitutional Rights, Legislative Frame-works, Judicial response around the world regarding different aspects of euthanasia. The researcher after analysing the issue in the light of the above-mentioned areas felt a need of drawing social perspectives on euthanasia. Therefore, drew a sample of 400 random individuals from the universe of Lucknow area categorizing different professionals including general public individuals above the age group of 18 years. The data was collected through structured questionnaire method. The out-come of the empirical study is has already mentioned in the previous chapter.

The present chapter is divided into three parts

1. Conclusion- deals with the detailed conclusion of the research analysed and examined with reference to various backgrounds that tested with the hypothesis.
2. Suggestions- deals with the suggestions.
3. Suggested draft bill.

1. Conclusion of the Study:

The good death in the 21st Century from the perspective of those who seek legal recognition of a right to die as well as from the perspective of those who oppose it, is all about making one's own choices about one's last days. That may be a reasonable

conclusion in light of the many attempts that have been made in recent times to legalize assisted suicide and active voluntary euthanasia and the belief held by many, captured in the quote immediately above, that one's death ought to be a fitting end to one's life and in keeping with one's own values. But is it analysis of the situation correct? If it is, should this attitude be officially accommodated in some way? If it is not, then what is the actual situation with regard to the shape of death in the 21st Century and, are our institutions responding in an adequate manner to contemporary views of death and dying? If not, should we change our approach? The answers to these questions are of pressing importance in light of predictions that, by 2056, the number of old people in the world (65 or older) will exceed the number of young people (16 years and younger) for the first time in history and, among the old, the fastest growing number will be the 'old, old' (people aged 85 or older). These changing demographics arguably suggest that the pressure for greater control over the process of dying, which finds expression in the right to die movement, will increase in the future as more people are terminally ill at any one time.

Accordingly, in this thesis, researcher focus on changing sensibilities to death and dying in the context of contemporary debates as to whether 'euthanasia' should be legalized. Researcher mainly concerned with the adequacy of the legal regulation of, and the medical response to, these changing sensibilities. However, in examining the legal regulation of euthanasia and the medical response to the right to die movement, one must recognize that these discourses are limited in their ability to provide a clear resolution to the debate. Further, community sentiment in relation to death and dying has shifted over time and remains unsettled. So, there is no clear consensus on whether either or both of these practices should be legalized.

We as a society try to dissociate ourselves and even disillusion ourselves from the fact that we are all eventually going to die. Death is not something that we must fear but embrace. There is no magic potion which is going to make us live forever. For this reason, we must talk openly about our deaths, when this topic is often brought up it is pushed to the wayside for a later day. When should we want to talk about it, when were on our death bed waiting to die? The answer to this difficult question is 'now'. We must talk about it 'now' since it leads to our needing to talk about our rights as human beings. We should have the right to decide if we believe euthanasia or

assisted suicide is an option that one could take. The idea of euthanasia or assisted suicide is a touchy subject for most people because they have reservations as to who, when, where and under what conditions. We must now decide if euthanasia and assisted suicide is morally sound and if we accept these ideas. Some prominent arguments set forward about euthanasia and assisted suicide is that they are killing and letting the person die. We must then ask ourselves is there a moral difference between killing and letting die and the answer is no. There is no moral difference between euthanasia and assisted suicide. We not only need to talk about the moral aspects affecting these topics but also to consider the complexity of the topic. There are many other considerations to make each of which has a substantial affect that ultimately affect our decision making such as mental aspects, physical aspects and our human rights. The relevance of the morals surrounding euthanasia and assisted suicide debate play important roles in making policies affecting euthanasia and assisted suicide. Morals are the foundation in which we live our lives from obeying the law to walking down the street to the way in which we interact with one another. When looking at the moral differences between killing and letting die we must realize that this is a very complicated and highly debated subject.

To understand which approach of killing and letting die are morally just we must embrace the old saying stating that there are exceptions to every rule. To fully appreciate why this saying holds true let us look at the example provided by Rachels in which two cases are put forward one in which “Smith stands to gain a large inheritance if anything should happen to his six-year-old cousin.” Smith drowns his cousin, and then disguises it as an accident. The article continues on to show that Smith was found to have murdered his “six-year-old cousin.” The second case involves the same scenario, except, when Jones goes in to kill his cousin the child has fallen and is face down in the tub. Jones does not save the child; he merely lets him die. In summary Smith did the actual act of killing whereas Jones simply let the child die. Such examples are used to endless means to try to justify that killing and letting die are morally equal, if under highly extreme conditions could they ever have the same weight?

Since everyone has different standards and morals, we have to look at more than one’s morals in deciding what is the most morally superior answer, especially

given the examples put forward. If one was to pick Jones over Smith or Smith over Jones which decision would be ethically unsound due to the extreme conditions knowing what we know about morals and values.

The Jones and Smith examples are not the only cases in which killing and assisted suicides are justifiable in terms of ethics. For instance, in a circumstance like the one where you are out hiking and your loved one's safety line breaks and he/she falls off the face of the mountain that you were escalading. This person now in intense amounts of pain asks you to help them put an end to the pain and suffering and you are put in the position of ending the love one's life to help them escape a long and painful end. There are many things that need to be considered before terminating the life. There are at hand other ways to look at this debate as to say that killing and letting die may have the same end result death, but if the end result is the same then how can there be a difference. It is the actions that dignify the difference.

When looking at the subject of ethics and the impact it has on killing and letting die there are other impacts or differences that need to be addressed such the mental stresses that have implications on effect not only on the patient but the family and the ever-popular doctor. Killing and letting die are important issue that should be addressed in cases such as ill patients. In the case of dealing with terminally ill patients the idea of ending one's suffering may play a large part of the mental stability that the patient has. As we pass through our lives we hear of people dying everyday either it be a loved one, a friend or acquaintance if we hear that the person died in their sleep then we say that they died a good death and even to the point where we include ourselves saying "I hope to have a peaceful death like that one". The reason no-one says that same line when someone is suffering through a degenerative disease such as cancer or aids is to facilitate the ease of their conscious, because it is understood that it wasn't an easy death. Letting someone die is seen as a more humane and better way in letting someone come to life's end. What if letting someone die is worse off than the individual having their life terminated for their own good. If the final end is death the only difference between killing and letting die is that we let nature take its course. If we let everything take nature's course, we would be back in the Stone Age as opposed to the living arrangements we currently enjoy. We as humans have the tendency of disrupting the natural way so in that regard why is it that

terminating a fellow human's life who is under their own judgement and that there is no way that they would recover so difficult.

The most powerful example set forward in the mental battle is dignity, the dignity that the person wants to uphold in their mind. To be killed or to slowly let die in a haze of painkillers where the patient is unaware of the surroundings and is simply there in body but not in mind. The notion of letting die as opposed to killing "reflects not just a fear of experiencing substantial suffering when dying, but a desire to retain dignity and control during this last period of life." (Brock) Death is the here and end all of our existence. It is better to go off with dignity than have no dignity at all.

Morals are what our society is based on, the laws in which we follow are all based on morals from the laws against stealing to the laws against forgery. Laws are not the only ways in which ethics play a part in our life's religions base their fundamentals on morals for example in Christianity there are the Ten Commandments, the Islamic people follow the Koran and Jews follow The Old Testament. Since morals play such a powerful role in our everyday lives it is just to talk about the relevancy of morals in relation to policies on euthanasia and physician assisted suicide. Euthanasia can be simplified into the termination of life by painless means for the purpose of ending severe physical suffering. Euthanasia can be broken down into three categories the first of these is passive euthanasia. Passive euthanasia is the action of withdrawing or withholding the means of maintaining or prolonging life; for example, removing a respirator from a patient who cannot breathe without assistance. Another type of euthanasia is called voluntary active euthanasia. Voluntary active euthanasia is mercy killing administered to the patient who has requested it of their own free will and understands the implications of the consequences. The final kind of euthanasia is involuntary active euthanasia. Involuntary active euthanasia is mercy killing administered to the patient without their informed consent; for example, babies and incapable adults. In the debate over the righteousness of euthanasia assisted suicide must be addressed. Assisted suicide is someone, usually a doctor, and a member of the family or close friend, will provide the patient with the knowledge and means to take his or her own life. The life-ending procedure is then carried out under that person's guidance. Also, there is something called physician assisted suicide which is when a doctor acts directly to cause the death of a terminally ill

patient, most commonly by lethal injection or asphyxiation. In euthanasia morals are used to ease the pain of the patient as with assisted suicide. The relevance of the moral status used for euthanasia and assisted suicide is deep rooted into our societies from coast to coast euthanasia and assisted suicide are looked at differently due to the cultural differences for example in the United States it is unlawful to commit euthanasia but “allowing to die is the only legally protected alternative to maximal treatment.” Conversely in the Netherlands laws against are less constrictive it is not to say that the morals of one country are better than the other one it is simply that the relationship between doctor and patient are different. In the United States as well as Canada the patient doctor relationship is not as extent as in the Netherlands. Morals are not different murdering someone out of hate is still an immoral thing as opposed to ending a dying person’s life out of compassion and duty to uphold one’s dignity and last wishes.

Physicians-assisted suicide and euthanasia are clearly commonly discussed topics in the medical ethics field. Technological advances in medical care and major causes of death in the world and India too are big factors in why patients live longer and suffer more in the end stages of life than they did in the past. With these developing ethical problems, our medical ethics need to be reevaluated to better deal with these recent changes. The United States state of Oregon has made important moral reconsiderations by legalizing PAS with strict legal safeguards, but that is only the first step. More states need to allow their residents the autonomous decision of how to end their lives and Oregon legislature should be aware of the moral equality of PAS and euthanasia.

Researcher propose that the moral values we place on the physical actions of PAS and euthanasia are misdirected and that focus should instead be targeted at the reason for the action and the intended result of the action. All the while, physicians are morally responsible to respect patient autonomy through their guiding professional principle of beneficence. Physicians also need to ensure that patients are capable, aware agents of their own decision to end life and act freely and rationally. With the proper legal and moral safeguards for PAS and euthanasia, there is no need to be concerned that society is going to fall down the slippery slope that will force the elderly, disabled or anyone unable to meet the standards of an agent to kill

themselves. Physicians-assisted suicide and voluntary-active euthanasia are practiced out of a physician's professional concern for the wellbeing of his patient, and there are circumstances where ending life can be in the patient's best interest. My argument is not that patients should kill themselves, but that it is morally right they have the option to end their lives or seek the best alternative to end-of-life care; this makes PAS and euthanasia morally permissible in medical practice.

In India from Lord Rama's Jal Samadhi and Bhishma Pitamah's self-willed death, Vinoba Bhave's fast till death proves that euthanasia existed in Indian society. Judiciary has also viewed euthanasia from a compassionate approach which is apparent for the reflection of the various judgments dealing with 'euthanasia' or 'right to die with dignity'.

Though there is risk factor and fear of misuse involved, this could be resolved with suitable and strict safeguards and specific guidelines. We have the examples of other countries where euthanasia is in practice with strict safeguards which have been already discussed in the previous chapters.

The concept of public policy is however illusive, varying and uncertain. Policy is an ever-changing concept and it varies from society to society and people to people. Therefore, there is no harm in adapting euthanasia as a matter of public policy and in doing so it has to be kept in mind that the 'terminally ill' patient is being killed by the physician. Rather he is relieved of the pain and meaningless life he is bearing.

We are living in progressive society. Those who support the 'absolute sanctity of life' may agree that sanctity of life should not be kept at the all cost i.e. undignified death with extreme mental and physical suffering of others and thereby threaten irreparably their social wellbeing. In view of the fact that time is a saleable commodity it may not be possible the patient's dependents to spare much of it for the patient. If we study exception V of Sects 300, Section 88 and Section 92, of Indian Penal Code it is find that these provisions make an act like euthanasia less punishable or completely justifiable. In spite of a great development of technologies observed since the last century still there are many patients who die in great pain and suffering. Such patients often ask their doctors to end their lives either by killing them or by helping them to kill, many countries of the world, the doctor who obey such a request commits the crime.

Centuries ago, when there was not so much medical development and so many supporting machines were not developed, people died a natural death. Today |a person must have the right to meet a natural death. There are many patient's illness cannot be recovered, but the modern life prolonging machines extend their lives, though they suffer with a great pain. Some of them, instead of prolonging their lives want to have natural death, so refuse modern medical treatments which are used to extend life. Almost everywhere, terminally ill patients, who are conscious and competent, have a right to take an informed decision for their natural death and refuse the treatments which might extend their lives. But modern technologies enable such patients to extend their lives using machines like ventilators and such machines which may cause them a great pain and sufferings. Such patients mostly prefer palliative care and do not want to extend their life through life prolonging medical treatments. Euthanasia helps the patient to be painlessly die without any sufferings.

Each and every person who is terminally ill has a right to withdraw medical treatment 'Withdrawal of Medical Treatment' is legal in almost every country but not "Euthanasia and Assisted Suicide". In our country also withdrawal of medical treatment is not treated as a crime but "euthanasia and assisted suicide" are unlawful as held by the Indian Supreme Court in Common Cause case.

This shows that most countries rely on withdrawing of medical treatment in almost every country of the world, withdrawing medical treatment is not offence but euthanasia is. Most countries consider euthanasia as murder or suicide. Almost no country, leaving one or two countries, permits euthanasia but they do permit withdrawing of medical treatment.

They don't think letting die is same as to kill. The difference between killing and letting die is that in cases of killing we assign primary causal responsibility for a person's death to an agent's intervention in the person's life, whereas, in cases of letting die, primary responsibility for the death is attributed to factors other than intervention by the agent. It has to be conceded, of course, that there are analyses of the concept of causation that allow that the failure to prevent a death can count as the cause of the death.

In *Maruti Shripati Dubal vs. State of Maharashtra*¹, the court observed: “There is nothing unnatural about the desire to die and hence the right to die. The circumstances which induce a person to end or terminate his or her life the act of termination of life is the act of that individual. It is no less than his act of living.” The court seems to associate the desire to live with the desire to die and locate the origin of both in the free - will of the individual. The Court treats the suicidal action as a natural and freely - willed action of the personal concerned. Accepting such a comprehensive application of the free -will concept, particularly in the context of suicidal situations which, in a majority of cases, are the product of convincing obliging factors that positively negate the possibility of free-will. People think euthanasia is just like suicide However both are different concept and issues.

The problem of suicide is not of controvertible nature, the question that whether the person is free for euthanasia or not created a debate since a long time. The decisions of Supreme Court show that life is considered more precious and everyone should preserve it. The court in the immediate case made it clear that the right to life means the existence of such right up to the end of natural lite. This also includes the right to a dignified life up to the point of death including a dignified procedure of death. Supreme Court further told that the right to life under Art. 21 of the constitution did not include “right to die” or “right to be killed” and this kept its earlier judgment given in P. Rathinam case.

As far as destroying of Section 309 IPC from the Statute is concerned, the provision should remain unbroken because destroying it will create more problem and people may choose to these activities to threaten the family members even on unimportant issues. But the court must see the circumstances of each case. There may be various causes which lead people to commit suicide. These can be mental disease, unbearable pain etc. On the basis of circumstances of each case, the court must decide them.

The arguments are based upon various aspects such as medical ethics, morals, religion, legality and the possibility of being misused by the society. The very interesting question on which the researcher pondered upon was *‘whether it is a*

¹ 1987 CrL LJ 743

problem, a controversy, or a controversial problem'. If euthanasia is an act of aiding or helping a person suffering from incurable pain to attain a good death or a process of relieving pain of a patient, how can that be a sin?

The researcher in chapter 2 of this work has made many references to the historical concept - the ancient, medieval period as well as the present times. It has been observed and concluded that the epics of the globe have always echoed heroic act of aiding such painless and merciful death. Drowning incurable patients in the Ganges in India, self-willed death of Pitamah Bhishma, are few of the examples for the same. Whether it is survival of the fittest philosophy of the Nazi movement or drinking hemlock in order to have a good death in classical Greece and Roman antiquity, all suggests the acceptability of euthanasia in the ancient and medieval times. It was only in the Hippocratic Oath, where Hippocrates described it as a sin for the medical practice and stated that one should not help or aid or administer his patient any drug that hastens his death.

The euthanasia debate sparked up since the 19th century, which geared up euthanasia battle, many attempts were made to legalize euthanasia, many associations, and societies were formed that struggled to set up a regime for dignified death. Many of the countries have successfully legalized it while many of the countries are still struggling for the right.

As far as India is concerned, the issue got lime light from the case of *Aruna Shanbaugh v. Union of India*², where the Supreme Court legalized passive euthanasia, provided an elaborate guidelines and procedure for its practice. However, the matter decided by the Supreme Court of India in Shanbaug case is not the first case where an application expressing a desire for legalizing euthanasia in India. It is argued several times in many different petitions that if the disease is incurable and if the death of the patient is inevitable, it is not immoral in helping him get a dignified and painless death and the law must change its attitude towards holding it illegal. There has been series of applications made to the High Court, Supreme Court and the President for mercy killing. The reasons behind asking for mercy killing was however not only the incurable illness but also due to many other factors.

²(2011) 4 SCC 454.

Many legislative attempts were made to legalize euthanasia, in chapter 3 in the segment of the comparative analysis including India, a timeline of the attempts made for legislation in various countries is exhibited by the researcher to demonstrate the efforts that are put in the death with dignity movement. Judiciary has also many times made passing comments about making a legislation on euthanasia. After years of debate and legal battles, a draft bill on passive euthanasia titled '*Terminally Ill Patients (Protection Of Patients And Medical Practitioners) Bill, 2016*', that gives patients the right to "withhold or withdraw medical treatment at his choice" and "allow nature to take its own course" has been drafted. Hence, all these references make it clear about the necessity of euthanasia law in the present times. The above-mentioned bill however only legalizes passive euthanasia and totally ignores the need of active euthanasia and physician assisted suicide, continuing them a penal offence.

The researcher while working on chapter 4 found that the bill is just a model of the guidelines provided in the *Aruna Shanbaugh case*. After going through various legislations globally has humbly suggested a modal bill on the issue.

The researcher in this work has tried to find out purpose of life and pursuit of happiness and in the beginning of the study. He has acknowledged that right to life include right die with dignity and living a forced life infringes the dignity of a human and the same is substantiate in the case of *Common Cause- A Registered society v. Union of India*³, where the Court held "*The right to life and liberty as envisaged under Article 21 of the Constitution is meaningless unless it encompasses within its sphere individual dignity. With the passage of time, this Court has expanded the spectrum of Article 21 to include within its sphere individual dignity. With the passage of time, this Court has expanded the spectrum of Article 21 to include within it the right to live with dignity as component of right to life and liberty.*"

It was also observed by LJ. Dr. D. Y. Chandrachud "*Life is precious in itself. But life is worth living because of the freedoms which enable each individual to live life as it should be lived. The best decisions on how life should be lived are entrusted to the individual. They are continuously shaped by the social milieu in which individuals exist. The duty of the State is to safeguard the ability to take decisions —*

³ *Common cause (A registered society) v. Union of India and Others* (2018) 5 SSC 1W.P. Writ petition (Civil) NO. 215 Of 2005

the autonomy of the individual — and not to dictate those decisions. —Life within the meaning of Article 21 is not confined to the integrity of the physical body. The right comprehends one's being in its fullest sense. That which facilitates the fulfilment of life is as much within the protection of the guarantee of life. To live is to live with dignity. The draftsmen of the Constitution defined their vision of the society in which constitutional values would be attained by emphasizing, among other freedoms, liberty and dignity. So fundamental is dignity that it permeates the core of the rights guaranteed to the individual by Part III. Dignity is the core which unites the fundamental rights because the fundamental rights seek to achieve for each individual the dignity of existence. Privacy with its attendant values assures dignity to the individual and it is only when life can be enjoyed with dignity can liberty be of true substance. Privacy ensures the fulfilment of dignity and is a core value which the protection of life and liberty is intended to achieve.” The same has been challenged as well as validated in many of the cases, where the Courts have clarified that right to life is a life full of dignity and not just a mere animal existence and many other rights that provide dignity to human life are included within the purview of Article 21 of the Constitution of India. Life and death are indeed inseparable. However, the quest of each individual to find meaning in life reflects a human urge to find fulfilment in the pursuit of happiness. The pursuit of happiness is nurtured in creative pleasures and deal with fundamental things as the freedom to think, express and believe, the right to self-determination, the liberty to follow a distinctive way of life, the ability to decide whether or not to conform and the expression of identity. Dying is an inevitable part of life that cannot be controlled however the suffering at the time death can be controlled or at least minimized.

Humans are more concerned with the dignity of our existence. The process through which we die bears upon that dignity. A dignified existence requires that the days of our lives which lead up to death must be lived in dignity; that the stages through which life leads to death should be free of suffering; and that the integrity of our minds and bodies should survive so long as life subsists. The fear of an uncertain future confronts these aspirations of a dignified life. The fear is compounded by the fact that as we age, we lose control over our faculties and over our ability to take decisions on the course of our future.

The researcher in this work has tried to cover the religious norms and medical ethics too along with the juridical aspects because the researcher believes that religion and ethics play a vital role in the making of the law. From the comparative study of all the religions counting Hinduism, Islam, Buddhism, Jainism, Sikhism and Christianity, the researcher can conclude that Hinduism, Buddhism and Jainism has sanctioned euthanasia to some extent, though not in the sense in which it is desired in the present time.

Hinduism as interpreted through the religious texts gives the privilege of choosing one's time of death oneself as it believes in rebirth and immortality of soul. The reference to Bhagwat Gita, Mahabharata as well as Max Mullars interpretation on Mahaprasthanas clearly shows that passive euthanasia does not have much opposition as per the religious text as there are catena of incidents where Rishis have starved themselves to death in order to attain salvation. There are two Hindu views on euthanasia, one that believes in compassion, equating an act of helping a person get rid of painful life as an act of compassion while the other view states that by helping a person to end a life, even when it is filled with pain and suffering, one is disturbing the timing of the cycle of death and rebirth, which adds to the bad karma and those, involved in the euthanasia, will take on the remaining karma of the patient. The same argument suggests that keeping a person alive by artificial means also is a bad thing to do. However, the use of life support system as a part of temporary attempt for healing will not be considered bad. The ideal death in Hinduism is a conscious death because the thoughts of the person during his final exist also plays a big role in his rebirth. Consequently, the palliative care will create a problem if it reduces mental alternates of the patient. The religion allows taking away of the life but only for the religious purpose where it allows sages to take mahaprastana to meet the divine.

Jainism condemns euthanasia however allows Santhara/Sallekhana to attain salvation. Santhara is again a form of taking away life but for the religious purpose. The only difference between the concept of taking away life or Jeevan Tyag as per the religious notions of Hinduism and Jainism is that while in Hinduism, choosing the time of death is available to the seers and the spiritually elevated people but in Jainism it is the mean to elevate one's soul and is available for common man also. Jainism is the only religion, which advocates 'Ichcha Mrityu' in the most explicit

terms. It is still prevalent among the community and being practiced, while Hindus do not practice the concept presently and it remains only in the religious texts. Jains consider it as a 'Dharmic Mahotsav' and a pledge taken in order to get salvation.

Sikhs condemn it in totality as it is against the teachings of 'Guru Granth Saheb'. They consider life as a gift from god and by taking it away in whatever circumstances is discourteous act towards god.

Buddhist ideology believes in love and compassion and allows self-willed death in certain exceptional circumstances. However, it prohibits taking life due to physical pain and agony. However, the views of lamas in this context can be considered rational one when Dalai Lama states that life is precious; consequently, euthanasia should not be practiced. However, he has also stated that it should be decided on the individual basis. While Buddhism strongly upholds respect for life, it also recognizes that death is an integral and indivisible part of life and thus that death needs to be respected too. One way we can respect life is to accept when it has become so filled with pain and stripped of dignity that an individual or their loved ones may wish to end it. To respect death means to gracefully recognize when its time has come and allow it to take place according to nature. Thus, from the Buddhist perspective, Passive Voluntary Euthanasia and Passive Non voluntary Euthanasia would not be breaking the first Precept of Buddhism and in fact might even be an act of compassion. However, it strictly prohibits active euthanasia.

While Islam and Christianity condemn it in totally, the traces of acceptance of passive euthanasia can be construed from the fatwas and few of the verses of bible respectively. Islam and Christianity have strictly forbidden it. Christianity, whose basis is the service of people, and Islam has denied euthanasia but slowly seems to be diverting towards the passive euthanasia. The reason for which may be to keep in terms with the pace of the modern times. However, in the process of trying to keep in pace with the modern needs and aspirations, the mandate from the two religions does not forget to put stress on the religious verdict against it.

Therefore, from the religious experiences it can be said that the religions are to an extend not in disfavor of passive euthanasia but none of the religion permits actively taking away of life or active euthanasia or physician assisted suicide. Moral

or philosophical notions and attitude towards passive euthanasia may vary but it can be safely said that the preponderance of view is that such considerations do not come in the way of relieving the dying man of his intractable suffering, lingering pain, anguish and misery.

For a long time, the Courts have been continuously rejecting all pleas of euthanasia citing legal, moral and ethical reasons. However, pleas have been raised repeatedly in the court about what is the actual state of patients who are brain dead or those who are permanently bound on life support system. The advocates of euthanasia state that it prolongs sufferings of the terminally ill patient and is in a manner morally right to end a life of suffering. They claim that by bringing about an early death, the pain and sufferings are reduced both of the person who is in a vegetative state surviving on a life support as well as of their near relatives and friends who undergo mental and emotional trauma, watching their loved one suffer. However, euthanasia has been criticized on a number of social, theological, moral and ethical grounds. In a country like India, where the morals of the individuals are sinking, the older members of the family might be considered as a burden and the greedy relatives might take the path of euthanasia to get rid of them. Euthanasia might be misused for ending the lives against the will of the patients are few of the arguments disfavoring euthanasia.

The researcher believes that life has an intrinsic value; however, this should not override the quality of life, at least in case of terminally ill patients. Many times, the questions are raised on the grounds of morals. The answer to the moral confusion surrounding euthanasia is frustratingly out of reach since the tolerance under pain is inextinguishable by both the comforting sayings of moral and religions.

The researcher believes that either life is not created by religion or by reasons of faith; though it is believed that god created it, there is no scientific proof of it. Moreover, religious perspectives are contradictory in nature. Different religions have different perspectives as well as approach of a similar religion is different in different circumstances. Undue devotion and importance to religious feelings may become a hedge in the pursuit of scientific alleviation of pain and suffering. Life is a practical experience and death is natural extinction though mode may vary. Accordingly, the researcher believes that quality of life should be given priority over sanctity of life.

After analyzing the medical ethics and the accepted principles, the researcher submits that medical ethics have always emphasized on the need of preservation of human life in addition, has always rejected the act of taking away of life. Therefore, making intentional termination of life of a human being is contrary to the principles of medical profession. However, the very foundation on which these principles are based is an ancient document, which barely has any relevance in the present times. The society and its needs have changed with the changing times and medical ethics too have never been static. Ethics have been undergoing changes. Therefore, now the primary responsibility of the medical professional is to relieve human suffering. Duty of the medical practitioner is to treat, to heal and offer an acceptable quality of life to an ailing patient. According to the researcher, when a patient has reached to such an extent of life where the only possible alternative available is only death, death by nature or via the medium of voluntary euthanasia becomes immaterial.

The medical practitioner has to respect the other principles of the medical ethics, which provide the right to refuse the treatment and the principle to do good to the patient as well not to harm the patient. When it is clear when the situation is such that the death is inevitable, prolonging it will only do harm to the patient, mentally, physically as well as psychologically. Therefore, if the medical practitioner is respecting these rights of refusal of medical treatment or providing a dose of lethal drug to terminate his suffering, or at times using doses of pain killer drugs, which may shorten the life - a physician is not transgressing any ethical bounds. Added to this the patient's voluntary and informed consent to accept treatment also forms all the legal and ethical basis for offering any form of treatment, be it a conservative line of treatment for prolonging life or means of painless termination of life under the banner of euthanasia. Therefore, researcher humbly submits, if a medical practitioner, acting in good conscience and in good faith, he is ethically justified in assisting death, which relieves intense and unnecessary pain or distress caused by an incurable illness. Because the ultimate, responsibility vested on the medical practitioners is to relieve pain and sufferings of his patients. This applies to patients whose wishes on this matter are known to the doctor be respected and considered as more significant than any contrary opinions.

The fundamental right of 'Right to Life' under Article 21 of the Constitution of India is a guaranteed right. The meaning of the word 'life' was given a broader interpretation in many of the cases and it is not confined to mere physical existence of a person, hence life is a life of dignity. The question of whether right to life includes right to die has been raised several times in the High Courts and the Supreme Courts of India. The authority conferred to live is no doubt an inalienable and inherent right however, it has always been argued that this power does not permit to terminate one's life.

In *Maruti Shripati Dubal v. State of Maharashtra*⁴, the court was convinced with the pleas of the petitioner and based on that stated, they should not be penalized on the contrary treated as they try to commit suicide. One commits such acts due to mental instability that requires healing measures and not a penal action. Therefore, in the case the Bombay High Court held that 'Everyone should have a freedom to dispose of his life as and when he desires.'

In the case of *P. Rathinam v. Union of India*⁵, upheld this decision, where the Supreme Court held that a person could not be forced to enjoy life to his detriment, disadvantage and disliking. It was held that Article 21 of the Constitution of India includes right to die. It was also held that Article 21 has a positive content and not just the negative content. The Court after observing various ratios laid down by several courts concluded that the term life does not mean 'mere animal existence' but a right to live with human dignity embracing quality of life. However, the Court rejected the plea that euthanasia should be permitted by law because act of suicide is an act of self-destruction or self-killing while in euthanasia, a third person is actively or passively involved, which can be considered as aiding or abetting a person in the act of killing.

In *Gian Kaur v. State of Punjab*, the five judge bench of the Supreme Court over-ruled the ratio laid down in the case of *P. Rathinam Nagbhusan Patnaik v. Union of India*⁶ and held that 'Right to life does not include Right to die or Right to be killed' under Article 21 of the Constitution of India. Right to life would mean the

⁴ 1987 (1) BomCR : (1986) 88 BOMLR 589

⁵ 1994 AIR 1844

⁶ 1994 AIR 1844

existence of such right up to the end of one's natural life. This also includes the right to a dignified life up to the point of death including a dignified procedure of death. Thus, the right does not give a right to curtail one's natural span of life. The non-acceptance of euthanasia in India is based on the case of *Gian Kaur v. State of Punjab*⁷, where it was held that right to life does not include right to die. However, it is interesting to note that the case pertains to abetment to suicide where the arguments were raised which indicated that right to life includes right to die. It was also argued that since right to die is a fundamental right consequently the abetment to suicide cannot be criminalized and in response to this the court laid down that ratio which stated right to life does not include right to die. This, case nowhere concerns about euthanasia or physician assisted suicide.

All these issues were resolved by the historic verdict on the issue i.e *Aruna Shanbaugh v. Union of India*⁸. In this case, the court took an overview about the subject in detail. Since, there are very few judgements on the issue the court studied catena foreign judgements on the issue and came with the detailed conclusions. The patient possesses a right to refuse the medical treatment as per the principle of patient's autonomy which is one of the most essential principle of medical ethics was approved in the case of *Aruna Shanbaugh v. Union of India*. After the judgement of *Aruna Shanbaugh v. Union of India*, if a person consciously and voluntarily refuses to take lifesaving medical treatment it is not a crime, but active euthanasia and physician-assisted suicide is still a penal offence. The researcher, while analyzing this case found that it was a flawed judgement where the court did not go to decide whether right to life includes right to die but it simply allowed 'withdrawal or withholding of medical treatment' in the case of patients in persistent vegetative state. The court however, totally ignored the scope of living will in India whereby a person can make an advance medical directives or authority authorization when he is in fit state of mind and body about his choice of the treatment in future.

Prior to the judgement of *Aruna Shanbaugh v. Union of India*⁹, pleas for mercy killing were raised in the case of *C.A. Thomas v. Union of India*¹⁰ and *K.*

⁷ 1996 AIR 946, 1996 SCC (2) 648

⁸ (2011) 4 SCC 454

⁹ (2011) 4 SCC 454

¹⁰ 2000 CriLJ 3729

*Venkatesh*¹¹. However, those petitions were straight away rejected keeping in mind the precedents set in the case of *Gian Kaur v. Union of India*¹².

Thereafter, in the case of *Common Cause- A Registered Society v. Union of India*¹³ clarified that the Constitution Bench in *Gian Kaur*'s case held that the "right to life: including right to live with human dignity" would only mean the existence of such right up to the end of natural life, which also includes the right to a dignified life up to the point of death including a dignified procedure of death. The abovementioned right was held to be part of the fundamental right enshrined under Article 21 of the Constitution which was also reiterate in the present case. The Court in the said verdict, permitted passive euthanasia however blatantly rejected to include active euthanasia or physician assisted suicide within the purview of dignified procedure of death. The researcher in chapter 4 has discussed the judicial response including few landmark cases pertaining to euthanasia in different countries and has tried to draw inference regarding euthanasia from judicial reasoning's of different jurisdictions. In most of the cases discussed in the judicial trends the plea to die was made by terminally ill patients. The cases are real life instances and not hypothetical examples. These pleas clearly show the real need for humane and merciful termination of life. Many terminal patients who wish to die with dignity are forced to resort to gruesome alternatives because of the unavailability of physician assisted euthanasia. Life should unquestionably be protected but it should not be forced on a person in such a manner that it becomes a burden. When a person faces unbearable pain or disability with a life full of suffering, it cannot be deemed to be a dignified life. It will be a noble act, if the State grants him with a right to choose the mode of this death or a right that allows him or her to hasten the death. Right to life may not permit forced exit but at the same time, it cannot entail forced existence, which will equate to a mere animal existence, which will certainly not be a dignified life. Therefore, in exceptional circumstances, terminally ill patients should be allowed to die with dignity. The researcher also found it really frustrating where the judgements have a long history of the law prohibiting assisted suicide and active euthanasia. History is interesting to know the reasons pertaining to which active euthanasia and physician-assisted suicide is a crime, but

¹¹ WRIT PETITION No. 31023 of 2014 available at <https://indiankanoon.org/doc/180434817/> retrieved on 02/21/2018.

¹² 1996 AIR 946, 1996 SCC (2) 648

¹³ (2018) 5 SSC 1W.P. Writ petition (Civil) NO. 215 Of 2005

citing the long legal history does not justify the ancient statute. Law should be dynamic and if the age-old laws are followed, the society will never change and remain stagnant. There has been interesting discussion of human rights with relation to euthanasia in many case laws of European Courts on Human Rights, which have been discussed in chapter 4. The plea in all cases was to relieve the pain of the person and considered such right as a fundamental human right.

The human dignity in the true worth means life worth living. The dignity of a human being is violated when he is living a dependent life or living on the mercy of others on account of his illness and suffering. Every patient has the right to careful care, the treatments that he receives must be proportionate to his medical situation; they must also aim to alleviate his pain. In this regard, one cannot overemphasize the importance of making better known and further developing medical services and palliative care, which have as their purpose of medical, psychological and spiritual adding of the sick person, in the most dignified way possible. By allowing euthanasia to a person who is terminally ill and suffering from an incurable disease one will only relieve suffering of the person. When a person knows that, the death is near and there are no chances of recovery and is living, aimlessly waiting for death for his final exists and all he thinks of is to have a painless death and by allowing him such one is respecting his dignity.

The right of personal autonomy and self-determination which includes right to decide for oneself. When this right is granted, it gives authority to a person to decide what he wants to do to his body. Again, arguments can be raised that this right is not an absolute one. For example, the right of self-determination does not give a right to a person to sell his organs. The reason behind imposing such restriction is these acts are against public policy. However, euthanasia is not of such kind; in fact, it will help in the social welfare of the society. Imposing medical treatment on a person is actually intruding privacy of a person as well as inhumane or cruel treatment of a person. As discussed earlier, the vital aim of the human rights is to respect human dignity and the freedoms provided to an individual. It also states that that the individual interest should also be kept as priority to the interest of the society. Though allowing euthanasia will not hamper the interest of the society, the argument opposing it is also ascended that legalizing euthanasia will affect the societal interest. People will misuse

the right provided but if the reference is made to the countries where it is allowed there are hardly any signs of misuse. The human right provision also declares that while using medical technology minimum harm and the maximum benefit should be done to an individual.

Again, sanctity of human life does not imply the forced continuation of life in pain and suffering. Under Article 21 of the Indian Constitution, everyone has the right to life, which means not mere animal existence, but a dignified life. Given that a person has the right to lead a dignified life, he cannot be forced to live to his detriment. The essence of human life lies in the fact that a person is able to live a dignified life but when law forces one to live in intense suffering, pain and agony then there is a serious need to think about this issue.

Right to life means right to live peacefully as a human being. If a person is unable to take normal care of his body or has lost all the senses and if his real desire is to quit the world, he should not be compelled to continue with his painful life enduring torture and pangs of death. Euthanasia, in all its forms as conceived today is only giving aid to a person unwilling to live and craving to die.

The lives of all persons do not have the same pattern. One person's life may be filled with happiness and he may like to live on until it becomes impossible to live any further. Another's life may be full of such agony, psychological or physiological as it generally is and living for him may become a curse and he may not prefer to live any longer. The law along with medical ethics has to cater for both kinds of people. Living with dignity means the right to live a meaningful and non-vegetative life. The fundamental purpose of euthanasia is to save an individual from suffering severe physical and psychological torture caused by incurable terminal illness. Article 21 of the Indian Constitution states that every person has right to live with human dignity but if the living standard of person falls below that dignity and his life becomes a bane or curse for him, he should be given the right to put an end to his unending sufferings. Article 21 also speaks about the autonomy, consent and individual responsibility. It also states that individuals and groups of special vulnerability should be protected and the personal integrity of such individuals respected. Terminally ill patients fall under this category therefore their right to dignified death should be protected. At last but not the least, it declares that states should not deny any person or group of such right.

The human rights jurisprudence no doubt supports completely that life of a person shall have to be preserved, protected, and even in the most difficult situation, it indirectly opposes termination of natural life of a person. One should not forget that human life is of paramount importance and it should be respected and protected. However, the human life should be such that respects physical, mental and moral integrity. It should not be subject to any kind of cruel or inhuman treatment. In the endeavor to protect life, there cannot be a command for mere living without dignity. When a person is suffering from an unbearable pain and there is no hope of recovery, the person cannot be forced to go through that agony in the name of morals, ethics and religion. Almost all the Human Rights Conventions emphasize on the right to life and dignity and clarify that every person has an equal right to dignity and dignified life but when a patient is bed ridden for a long period in a vegetative state is it truly dignified life? Ignoring the plight of a terminally ill patient would in fact be a gross violation of fundamental rights and human rights.

The researcher would also like to submit that ancient wisdom of India taught people not to fear death but to aspire for deathlessness and conceive it as — Mahaprasthan. In the modern times, the State interest should not over-weigh the individual interest in the sphere of a desire to die a peaceful death which basically conveys refusal of treatment or by any other means when the condition of the individual suffering from a disease is irreversible. This can indeed be considered as a liberal and humanitarian approach. The researcher during writing this work has observed that two interpretations can be made of the provisions of these instruments and if the liberal, humanitarian and utilitarian interpretation is made, it can be concluded that right to die is a human right of self-determination and it would create more benefit than harm, by putting to end a life that is unworthy or undignified. It is believed that whenever individual autonomy is threatened, it would result in the destruction of human dignity as well; whenever a restriction to individual choice may occur, it would encroach upon human rights as well. Hence, it gives much importance to human autonomy and declares that suppression of such will be suppression of his human rights. The researcher has observed that the International Human Rights instruments though do not touch the issue directly but that does not mean that euthanasia would be inconsistent with the International Human Rights legal regime. The primary aim of the human rights law is to protect and guarantee human rights

internationally, thus one should consider the quality of life and not the quantity of life. If they do not do so, it is a blatant violation of the 'right to live with dignity'.

Law has changed as society continues to evolve. Abortion, that was forbidden by Hippocrates in ancient times, is now legalized through a legislation seeing the needs of the ever-changing society. If abortion is allowed in certain circumstances, similarly death with dignity should also be allowed for the terminally ill patients. The researcher believes that legalizing euthanasia is a need of the hour to provide a dignified death to a human being at this juncture, the researcher has also related the concept of death with dignity with the utilitarian theory of jurisprudence and has emphasized more on the interpretation of John Mill.

According to Jeremy Bentham, "*Nature had placed mankind under the governance of two sovereign masters, pain and pleasure. It is for them alone to point out what we ought to do, as well as to determine, what we should do.*"¹⁴ He further adds, "*By the principle of utility is meant that principles which approves or disapproves of every action, whatsoever according to the tendency. Which it appears to have to augment or diminish the happiness of the party whose interest is in question, or what is the same thing in other words, to promote or to oppose happiness.*"¹⁵

By utility, it is meant that property in any object, whereby it tends to produce benefit, advantage, pleasure, good or happiness or to prevent the happening of mischief, pain, evil or unhappiness to the party whose interest are considered; if that party be the community in general, then the happiness of the community; if a particular individual, then the happiness of that individual. Consequently, this theory emphasizes on addition of happiness and subtraction of pain, be it for the individual or for the society. Bentham in his theory of pleasure and pain has enumerated many kinds of pleasures, one of them being the pleasure of benevolence and the malevolence, which are also the fundamental principles of medical ethics.

The other utilitarian interpretation is of John Stuart Mill. According to John Stuart Mill, "*the greatest happiness is the greatest of the happiness of all the*

¹⁴ Jeremy Bentham, *An Introduction to the Principles of Morals and legislations* p.1

¹⁵ *Ibid.*

persons.” Mill also remarks “according to the greatest happiness principle, the ultimate end, with reference to end for the sake of which all other things are desirable, is an existence exempt as far as possible from pain, and as rich as possible in enjoyment, both in point of quantity and quality.”¹⁶

According to Mill’s theory of utilitarianism, morality is based on the consequences of the action. If an act brings good consequence, then it is a utilitarian act.¹⁷ According to his views, good consequences brings pleasure and eliminate or reduces pain. Thus, to act morally greatest amount of action should be brought to greatest number of people. John Stuart Mill argued that individuals are, ultimately, the best judges and guardians of their own interests. In a famous example, he says, “if you see people crossing a bridge you know to be unsafe, you may forcibly stop them in order to inform them of the risk that the bridge may collapse under them, but if they decide to continue, you must stand aside and let them cross, for only they know the importance to them of crossing, and only they know how to balance that against the possible loss of their lives.”¹⁸ Therefore, it is also believed by utilitarian that one has complete authority over one's body and should have an authority to make decision about it and no other person should have the authority. If a person volunteers to die in his own will, then it is their right to make his decision and people, even the government, has no right to interfere.

Therefore, it has been suggested by John Stuart Mill, “A good death is happy death” this opinion is supported by Jeremy Bentham when he says; “A good death is a painless death.” Then, if a person who is sick and disabled, unable to die, by his own appeals pathetically to terminate his life. When the medicine is available to do so but the medical ethics should not be hesitant, State should not stunt the situation with a silence and the law should not lead to ambiguous suspense. At this point, is it appropriate to let a person suffer despite of mental and physical oddities? The right to die is not a pleasant right but a painful claim sandwiched between legality and humanity. The interconnectivity and interdependence between individuality, State and Society has to be dealt with in a manner that provides maximum benefit to an individual.

¹⁶ John Stuart Mill, *Utilitarianism* 17(Longmans Green and Co. London, 7th edn., 1879).

¹⁷ *Ibid.* at 88

¹⁸ John Stuart Mill, *On Liberty*, Chapter 5. (First published 1869, Various editions)

The researcher at the end of her study believes that there is no moral difference between active euthanasia, physician assisted suicide and passive euthanasia. The motive, intention and consequences decide morals. Killings are considered as a harmful act because it harms the individual as well as the society but the intention behind practicing euthanasia and killings is not the same. The intention behind all the form of voluntary euthanasia is to relieve pain and suffering of a patient suffering from a terminal illness. The same is validated by Justice Dr. D. Y. Chandrachud in his judgement where he observed that the correctness of this precept may be questioned by pointing out that there is a qualitative difference between a positive medical intervention (such as a lethal injection) which terminates life and a decision to not put a patient on artificial life support, which will not artificially prolong life. The former brings a premature extinction of life. The latter does not delay the end of life beyond its natural end point. However, if the decision to proceed with euthanasia is the right one based on compassion and the humanitarian impulse to reduce pain and suffering, then the method used is not in itself important. Moreover, it is argued that passive euthanasia often involves more suffering since simply withholding treatment means that the patient may take longer to die and thus suffer more. Passive euthanasia may become questionable where the withholding or withdrawal of medical intervention may lead to a condition of pain and suffering, often a lingering and cruel death. The avoidance of suffering, which is the object and purpose of euthanasia, may hence not be the result of passive euthanasia and the converse may result. If it is said that the duty of the medical practitioners to not do harm to his patient, allowing a patient die withdrawing or withholding artificial support indeed causes more pain to the patient, so if the circumstances are such when withdrawal or withholding of artificial mechanism leads to suffering, active means should be taken to relieve the pain and suffering of the patient.

As far as, judicial trends are concerned the judiciary has always been generous enough to accept passive euthanasia i.e. the right to withdrawal and withhold of medical treatment as a fundamental right of every human. The similar experience is of India and the nations elsewhere but judiciary has always straight away rejected the applications for physician assisted suicide and active euthanasia because of the lack of legislation in this regard. However, in many of the cases that the researcher has discussed in this work, the court has also remarked that it can be legalized through

legislations. In the case, where a person has assisted and aided another person in willful death due to severe medical conditions, considering the intention behind aiding a person with lethal drug the court has sometimes taken a liberal approach towards the physicians in cases of physician-assisted suicides where the person has no vested interest in the death of the person.

As far as legislative framework is concerned, in chapter 3 the researcher has examined the legislations of various countries including Australia, Belgium, Netherlands, Oregon, Switzerland, and United Kingdom and other nations before analyzing the road map towards the legislative framework of India. The researcher believes that a legislation permitting both euthanasia in active and passive form is the need of the hour. The researcher has come to the conclusion that there is a need of a detailed law with proper provision for giving recognition to genuine 'Advanced Medical Directives' or 'Living Will'. The researcher strongly believes that legalization in this regard will not only protect the interest of the patient but will also protect the interest of the family, attending doctors and other relatives attending to the patient. If the patient has specifically expressed his wish, there will should be no dilemma for the family members but an obligation to respect it.

Presently, India does not have any legislation allowing euthanasia but a flawed judgment based on the wrong premise, which permits passive euthanasia under certain exceptional circumstances. The researcher strongly feels that we should look into and study thoroughly the experiences of other countries where euthanasia has been legalized. The conditions in other countries are surely not similar to India and the approach towards the value of life is quite different but legislation cannot be drafted in isolation. The best example for this is the Constitution of India, which was drafted after studying functioning Constitutions from across the world. The researcher has therefore examined the legislative framework of different countries of this work and has attempted to draft a model bill that can be considered for legalizing euthanasia. The researcher believes that it is high time to consider the legalization of both passive as well as voluntary active euthanasia.

Finally, life does not mean that we are having sufficient flesh and blood to live and we are living. Life is always full of dignity and honour. If a person cannot live like that, he should be given the right to practice euthanasia. Right to death should

also be seen as the other rights. Therefore, there should be euthanasia legalized for the people only who are terminally ill to allow such people to die with dignity and honour.

Summary of the Conclusions:

- a. After learning and comparing the approach towards euthanasia of major religions, the researcher found that only Hinduism and Jainism has sanctioned euthanasia, though not in the sense in which it is desired in the present time. The approach of Buddhism is quite flexible on the issue. Sikhism, have strictly forbidden it. Islam and Christianity though condemns but slowly seems to be diverting towards the passive euthanasia. The reason for which may be to keep in terms with the pace of the modern times. However, in the process of trying to keep in pace with the modern needs and aspirations, the mandate from the two religions do not forget to put stress on the religious verdict against it.
- b. Right to die with dignity form the basis for legalizing euthanasia.
- c. The quality of life should be upheld in order to protect dignity of the patients.
- d. Life should be protected but it should not be imposed.
- e. The principles of autotomy and beneficence should be respected.
- f. Rules of Medical ethics should be changed according to the best interest of patients.
- g. Judiciary should interpret the laws in order to provide justice to terminally patients.
- h. Law allows abortion under certain circumstance in the same way death with dignity should be allowed.
- i. Laws should be made in keeping with the global legislations in mind.

- j. 'Active voluntary euthanasia' and 'passive euthanasia' should be allowed in rarest of rare case.
- k. The strict and proper procedure must be applied to.
- l. The stringent procedure should be followed to avoid misuse of the law on euthanasia.

2. Suggestions:

1. The patient who is demanding euthanasia, his situation should be regarded as incurable with no hope of recovery, and death should be imminent,
2. The patient must be suffering from unbearable and severe pain that cannot be relieved,
3. The act of killing should be undertaken with the intention of alleviating the patient's pain,
4. If it is possible, the act should be done only if the patient himself or herself makes an explicit request,
5. The euthanasia should be carried out by a physician, although if that is not possible, special situations will be admitted for receiving some other person's assistance,
6. The euthanasia must be carried out using ethically acceptable methods,
7. One should review a few basic facts about euthanasia. There is no law that recognizes passive or active euthanasia. However Supreme Court of India has legalised passive euthanasia in recent judgements. In case of active voluntary euthanasia, the following four conditions should need to be filled that,
 - The patient's death is inevitable and imminent,
 - The patient is suffering from unbearable physical pain,
 - The doctor has already done everything possible to remove the pain,
 - The wish of the patient to die has been made clear.

8. The family's role and consent are also very important along with the patient. The traditional importance and authority of the family in medical decision-making is illuminated by the fact that they should also be informed of a terminal diagnosis. The family also should be informed about the terminally ill patient's request to practice euthanasia.
9. There should be 'with-holding Life-Support Measures' to patients terminally ill. But there should be restrictions also for practicing euthanasia or with-holding life support measures so that there are no malpractices regarding assisted suicide.
10. Incompetent patients and also competent patients who have informed decisions, the doctor can take a decision to withhold medical treatment, if that is in the 'best interests' of the patients based on the opinion of a body of medical experts. Therefore patient's 'best interest' should be protected at all cost.
11. It is suggested that a virtual - judicial officer be appointed appropriate authority under the proposed bill to supervise all cases of euthanasia within a possible territory as a beginning. Such officer should have the reasonable knowledge of medical science with the degrees. Any doctor who feels that his patient's request to die should be fulfilled would report such a case to the said supervising officer. If the officer so mentioned feels that the patient would not be able to recover and he has no other option than death, then the supervisor should issue a certificate allowing the doctor involve in the treatment to let the patient die.
12. If euthanasia is legalized in India, a section should be inserted after Section 88 of Indian Penal Code, but the provision should be limited to adults. Taking a person's life, even in case of serious illness is an issue must be decided by that very person, the decision should not be left parents or to the doctor. In short, the provision may be to the effect that it is not an offence for a physician, with the concurrence of another physician, to accelerate, by any merciful means, the death of a person is seriously ill, provided the act is done in good faith with the consent the patient.'

- 13.** There is need to have a law to protect the patient who are terminal when they take decision to refuse medical treatment, so that they may not be considered guilty of the offence of the attempt to commit suicide 309, IPC. Though, section 115 of the Mental Healthcare Act, 2018 has weakened the provision of punishment to commit suicide (Section 309 IPC) this provision still exists.
- 14.** Parliament should enact specific laws for the patients, doctors and should define some technical words like it is given in the ‘proposed bill’. There must be a council to observe practicing euthanasia for competent incompetent patients.
- 15.** In case of incompetent patients whose decisions are not informed once, in respect of whom the doctor is entitled to take a decision for withholding or withdrawing medical treatment provided it is in the best interest of patient. In these cases, appropriate decisions should be taken and it should not be abused. In this case the doctor should not withhold or withdraw medical treatment until it is permitted by high ranking medical authorities’ panel and if there is a difference opinion in these authorities, then majority opinion should prevail. This panel should consist of the parents or close relatives and they should be consulted with. But it is not necessary that the medical panel should be bound with their consent.
- 16.** It is suggested that panel of experts must be prepared and published by the director general of health service, Central Government for purposes of the Union Territories and by the directors of medicine in the states. The panel must contain name of medical expert in different field who can take decisions on withholding or withdrawing medical treatment and also one member of the panel must be retired high court judge. Panel should maintain a written record in which about all the proceedings should be written like all the details of the patient, whether he is competent or incompetent, consent etc. and this record should be like a public document.

7.4 Suggested Draft legislation i.e. “Treatment of Terminally Ill Patients and Dignified Death Bill”, 2020.” on Euthanasia:

The researcher in chapter third have studied and analysed the legislations of different countries permitting euthanasia. Therefore, on the basis of the understanding of the study and analysis, the researcher in the has proposed a draft bill for regarding physician assisted suicide and active euthanasia and provides the procedure for its execution. “Treatment of Terminally Ill Patients and Death with Dignity Bill”, 2020.”

Preamble

A bill to provide a right to death with dignity to terminally ill patients and protecting medical practitioners from criminal liability arising from withdrawal or withholding the treatment, assisting, aiding in the process of guided suicide and administering lethal drug to end the life of a terminally ill patient.

Be it enacted by the Parliament in the seventy-second year of the Republic of India as:

Section 1:

1. This act shall be called as “Treatment of Terminally Ill Patients and Death with Dignity Act.”
2. It shall be extended to the whole of India.
3. It shall come into force on such date as the Central Government may, by notification in the official Gazette appoint.

Section 2:

In this Act, unless the context otherwise requires, -

- a. ‘Adult’ means and includes an individual who has completed the age of eighteen years on the date of making an expressed request;
- b. ‘Patient’ any person who is suffering from terminal illness;

c. 'Competent Patient' means and includes any person who is not incompetent as per the provisions of the act;

d. 'Incompetent Patient' means and includes -

- i. Any person, who is a minor i.e. a person below the age of eighteen years on the day of making an expressed request,
- ii. Any person, who is an adult and not physically, mentally and psychologically able to understand, retain and communicate the information, who is not able to weigh the consequences of the decision made and who is incapable giving informed consent for the treatment,
- iii. Any person who is in a persistent vegetative state,

e. 'Persistent Vegetative State' means and includes the severe brain damage and state of partial arousal but not full awareness for more than 32 weeks;

f. 'Terminal Illness' means and includes

- i. the illness of severe nature that affects the mental, physical and psychological well-being of the patient and has been confirmed by the medical practitioner that it will soon result in the persistent and irreversible condition,
- ii. an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgement, cause death within one year; or
- iii. which has caused a persistent and irreversible vegetative condition under which no meaningful existence of life is possible for the patient;

g. 'Informed Decision' means a decision by a competent patient, to request withholding or withdrawing of medical treatment, request and obtain a prescription to end his life in a humane and dignified manner as well as a request to terminate his life in a humane and dignified manner, that is based on an appreciation of the relevant facts and after being fully informed by the attending medical practitioner of—

- i. his medical diagnosis;
- ii. his prognosis;
- iii. the consequences of remaining untreated;

- iv. the potential risks associated with taking the medication to be prescribed;
 - v. the probable result of taking the medication to be prescribed; and
 - vi. the feasible alternatives, including, but not limited to, palliative care, hospice care and pain control.
- h. ‘Expressed Consent’ means a consent given by a competent patient;
- i. ‘Expressed request’ means the written request made by the competent patient;
- j. ‘Medical Treatment’ means treatment intended to sustain, restore or replace vital functions which, when applied to a patient suffering from terminal illness, would serve only to prolong the process of dying and includes-
- i. life-sustaining treatment by way of surgical operation or the administration of medicine or the carrying out of any other medical procedure; and
 - ii. use of mechanical or artificial means such as ventilation, artificial nutrition and hydration and cardiopulmonary resuscitation;
- k. ‘Medical Treatment’ includes all the treatments that are required to sustain, restore or replace vital functions which includes ventilation, artificial nutrition and hydration, cardiopulmonary resuscitation etc. which, when applied to a terminally ill patient, would only serve to prolong the process of dying;
- l. ‘Medically Confirmed’ means the opinion and reports of attending medical practitioner and independent medical practitioner is confirmed by the panel of medical practitioners;
- m. ‘Living Will’ means a directive given by a competent person where he voluntarily expresses that he shall or shall not be given medical treatment in future when he becomes terminally-ill;
- n. ‘Attending Medical Practitioner’ means and includes the physician who has a primary responsibility for the treatment of the patient;
- o. ‘Independent Medical Practitioner’ means and includes a physician who has been consulted by the attending medical practitioners to give an opinion on the intention to terminate life on request or to provide assistance with suicide;

- p. 'Panel of Medical Practitioners' includes the Panel of 3 Medical Practitioners including 'a physician, a neurologist, a psychologist' appointed by the District Euthanasia Commission in consultation with the Medical Council of India;
- q. 'Active Euthanasia' means and includes every act that a medical practitioner does on expressed willingness of the patient through his expressed consent or living will to end his life through active involvement;
- r. 'Passive Euthanasia' means and includes the act of withdrawing or withholding the medical treatment of the terminally ill patient with his or his authorized attorney's consent;
- s. 'Physician Assisted Suicide' means and includes every act of aiding a terminally ill patient in wilful ending of his life;
- t. 'Palliative Care' includes the provision of reasonable medical and nursing procedures for the relief of physical pain, suffering, discomfort or emotional and psycho-social suffering and reasonable provision for the nutritional requirement;
- u. 'Parent' includes biological parents,
- v. 'Near relative' means and includes siblings, spouse, parents and relationships of affinity and
- w. 'Next friend' means and includes anyone who takes care of the patient in absence of near relative.

Section 3: Establishment of District Euthanasia Commission

There shall be a District Euthanasia Commission at every district of the country where the act applies.

Section 4: Constitution of District Euthanasia Commission

The District Euthanasia Commission shall include a committee of five members including

- i. two retired High Court Judge,

- ii. a medical practitioner having minimum experience of 15 years,
- iii. a legal expert with reasonable knowledge of medical science, having minimum experience of 15 years and
- iv. a distinguish person who is an expert on social, moral or ethical issues in such manner as may be prescribed.

Section 5: Refusal of Medical Treatment, Active Euthanasia and Physician Assisted Suicide

1. Every patient who is or above the age of eighteen years shall have the right to take a decision and express his desire to the attending medical practitioner attending to him
 - i. for withholding or withdrawing of medical treatment to himself; or
 - ii. to administer him any drug which may relieve the patient from extreme pain and suffering or will end his life peacefully; or
 - iii. to intentionally assist him to commit suicide by providing him with the means to do so,

Explanation-1 The Right provide in this section only covered those patients who is in terminally ill stage with extreme physical and mental suffering and have no prospectus of recovery.

Explanation-2 The right mentioned in this section does not covered any patient who is mentally ill or physically disabled.

2. In case of incompetent patient who has not executed a living-will
 - i. the decision of the family member and near friends should be considered,
 - ii. if family members are not available, the decision of the next friend should be considered,
 - iii. in case no one is available the opinion of a panel of doctors shall be taken into consideration,
3. Every competent patient has to communicate his decision through two written requests with a gap of twenty days to the attending medical practitioner, and in case of incompetent patient who has executed a living will single request shall be considered,

4. When a patient referred to in sub-section (1) and (3) communicates his decision to the attending medical practitioner, the medical practitioner should inform him about the consequences of the decision and also inform about the alternative treatment available, in case the medical practitioner feels that the patient is not in a proper psychological frame of mind may also refer the patient to a psychologist for the consultation,
5. In case of the patient referred in sub-section (2) the decision of the parents, next relative or friend has to be communicated to the doctor in writing,
6. All the requests are to be addressed to the panel of doctors,
7. After obtaining the report of the panel of doctors the reports should be presented before the District Euthanasia Commission for approval,
8. The applicant should be disposed of within ninety of filing of such application.

Section 6: Procedure for filing an Application On completion of conditions laid down under the Act,

- i. Parent
- ii. any near relative,
- iii. next friend,
- iv. the attending medical practitioner

may apply to District Euthanasia Commission having territorial jurisdiction for granting permission to the attending medical practitioner for withholding or withdrawing of medical treatment to the patient or assist in suicide or administering a lethal drug to an incompetent patient or a competent patient who has not taken an informed decision.

Section 7: Decision of the District Euthanasia Commission Shall Be Binding-

The decision of the District Euthanasia Commission shall be binding on the medical practitioner on fulfilment of the following condition:

- i. in case of competent patient, the attending medical practitioner is satisfied that the patient is a competent, the decision is through his free will and without any

force or coercion, the patient is terminally ill, the opinion of the attending medical practitioner is confirmed by the independent medical practitioner as well as the panel of medical practitioners and the District Euthanasia Commission has approved it,

- ii. In case of incompetent patient, the living will which expressly states about passive or active euthanasia in absence of living will the wishes of the parent, next relative, next friend or attending doctor, the condition being terminal confirmed by the panel of doctors and approval of district euthanasia Commission, iii. In case of incompetency due to age or the expressed wish of the minor should be backed by the wishes of the parent, next relative, next friend or attending doctor along with the confirmation from the panel of doctors and approval of the district euthanasia Commission.

Section 8: Duty of the Attending Medical Practitioner

- i. The duties of the attending medical practitioner include-
- ii. Maintaining a record of the medical condition of the patient,
- iii. Obtaining the report of the independent medical practitioner,
- iv. Referring the case to the panel of medical practitioners,
- v. to wait for at least for seven days after the approval of the district Commission.
- vi. to inform the patient as well as family members that he can rescind the decision any time and in any manner before execution, failing which medical practitioner can be held criminally liable.

Section 9: Living Will

- a) Advance Directive can be executed only by an adult who is of a sound and healthy state of mind and in a position to communicate, relate and comprehend the purpose and consequences of executing the document, It must be voluntarily executed and without any coercion or inducement or compulsion and after having full knowledge or information, It should have characteristics

of an informed consent given without any undue influence or constraint, It shall be in writing clearly stating as to when medical treatment may be withdrawn or no specific medical treatment shall be given which will only have the effect of delaying the process of death that may otherwise cause him/her pain, anguish and suffering and further put him/her in a state of indignity.

- b)** It should clearly indicate the decision relating to the circumstances in which withholding or withdrawal of medical treatment can be resorted to, It should be in specific terms and the instructions must be absolutely clear and unambiguous, It should mention that the executor may revoke the instructions/authority at any time, It should disclose that the executor has understood the consequences of executing such a document, It should specify the name of a guardian or close relative who, in the event of the executor becoming incapable of taking decision at the relevant time, will be authorized to give consent to refuse or withdraw medical treatment in a manner consistent with the Advance Directive, In the event that there is more than one valid Advance Directive, none of which have been revoked, the most recently signed Advance Directive will be considered as the last expression of the patient's wishes and will be given effect to.
- c)** Every living will executed by a person in presence and attested by two witnesses and one advocate registered at the District Euthanasia Commission shall be binding on the attending medical practitioner during the course of medical treatment of the patient.
- d)** The District Euthanasia Commission should preserve one copy of the document in his office, in addition to keeping it in digital format.
- e)** An individual may withdraw or alter the Advance Directive at any time when he/she has the capacity to do so and by following the same procedure as provided for recording of Advance Directive. Withdrawal or revocation of an Advance Directive must be in writing.

Section 10: Appeal from District Euthanasia Commission

The appeal from the order of the District Euthanasia Commission shall lie to the High Court having territorial jurisdiction and the appeal from the order of the High Court shall lie to the Supreme Court within 60 days from the order.

Section 11: Protection to the Competent Patient from Criminal Liability

Notwithstanding anything contained in the Indian Penal Code, 1860, a patient seeking action under section 5 shall not be deemed guilty of any offence under the Indian Penal Code or any other law for the time being in force.

Section 12: Protection to the Medical Practitioner

Any action of the attending medical practitioner or any other person acting under the direction of the attending medical practitioner on the express desire of a patient under section 5, and by the order of the District Euthanasia Commission under section 7 shall be deemed to be a lawful action.

Section 13: Criminal Liability of the Medical Practitioner

The medical practitioner shall be punished with an imprisonment up to the seven years for failing to fulfil the necessary compliance under the act.



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ANNEXURE



23. Do you think that if euthanasia issue unregulated it would be resulted into unethical medical practice?

- A Yes
- B No
- C Neutral

24. Do you think that unregulated euthanasia practices would negative effect on poor persons as they would be exploited by rich persons?

- A Yes
- B No
- C Neutral

25. Do you agree that such law and regulation should make provision favouring defence of doctors who perform euthanasia in good-faith?

- A Yes
- B No
- C Neutral

26. Do you agree that there should be rigorous punishment for those who misuse the Law on euthanasia?

- A Yes
- B No
- C Neutral

27. Suggestions, if any.

ANNEXURE 2

THE MEDICAL TREATMENT OF TERMINALLY-ILL PATIENTS (PROTECTION OF PATIENTS AND MEDICAL PRACTITIONERS) BILL, 2006

A Bill to provide for the protection of patients and medical practitioners from liability in the context of withholding or withdrawing medical treatment including life support systems from patients who are terminally ill.

Be it enacted in the Fifty Seventh Year of the Republic of India as follows:

1. Short title, extent and commencement: (1) This Act may be called the Medical Treatment of Terminally ill Patients (Protection of Patients and Medical Practitioners) Act, 2006.

(2) It extends to the whole of India except the State of Jammu and Kashmir.

(3) It shall come into force on such date as the Central Government may, by notification in the Official Gazette, appoint.

2. Definitions: unless the context otherwise requires,

(a) 'advance medical directive' (called living will) means a directive given by a person that he or she, as the case may be, shall or shall not be given medical treatment in future when he or she becomes terminally ill.

(b) 'best interests' include the best interests of a patient (i) who is an incompetent patient, or (ii) who is a competent patient but who has not taken an informed decision, and are not limited to medical interests of the patient but include ethical, social, moral, emotional and other welfare considerations.

(c) 'competent patient' means a patient who is not an incompetent patient.

(d) 'incompetent patient' means a patient who is a minor or person of unsound mind or a patient who is unable to (i) understand the information relevant to an informed decision about his or her medical treatment; (ii) retain that information; (iii) use or weigh that information as part of the process of making his or her informed decision; (iv) make an informed decision because of impairment of or a disturbance in the functioning of his or

her mind or brain; or (v) communicate his or her informed decision (whether by speech, sign, language or any other mode) as to medical treatment.

(e) 'informed decision' means the decision as to continuance or withholding or withdrawing medical treatment taken by a patient who is competent and who is, or has been informed about (i) the nature of his or her illness, (ii) any alternative form of treatment that may be available, (iii) the consequences of those forms of treatment, and (iv) the consequences of remaining untreated.

(f) 'Medical Council of India' means the Medical Council of India constituted under the Indian Medical Council Act, 1956 (102 of 1956).

(g) 'medical practitioner' means a medical practitioner who possesses any recognized medical qualification as defined in clause (h) of section 2 of the Indian Medical Council Act, 1956 (102 of 1956) and who is enrolled on a State Medical Register as defined in clause (k) of that section.

(h) 'medical power-of-attorney' means a document executed by a person delegating to another person (called a surrogate), the authority to take decisions in future as to medical treatment which has to be given or not to be given to him or her if he or she becomes terminally ill and becomes an incompetent patient.

(i) 'medical treatment' means treatment intended to sustain, restore or replace vital functions which, when applied to a patient suffering from terminal illness, would serve only to prolong the process of dying and includes (i) life-sustaining treatment by way of surgical operation or the administration of medicine or the carrying out of any other medical procedure and (ii) use of mechanical or artificial means such as ventilation, artificial nutrition and hydration and cardiopulmonary resuscitation.

(j) 'minor' means a person who, under the provisions of an Indian Majority Act, 1875 (4 of 1875) is to be deemed not to have attained majority.

(k) 'palliative care' includes (i) the provision of reasonable medical and nursing procedures for the relief of physical pain, suffering, discomfort or emotional and psychosocial suffering. (ii) the reasonable provision for food and water.

(l) 'Patient' means a patient who is suffering from terminal illness.

(m) 'terminal illness' means (i) such illness, injury or degeneration of physical or mental condition which is causing extreme pain and suffering to the patients and which,

according to reasonable medical opinion, will inevitably cause the untimely death of the patient concerned, or (ii) which has caused a persistent and irreversible vegetative condition under which no meaningful existence of life is possible for the patient.

3. Refusal of medical treatment by a competent patient and its binding nature on medical practitioners:

(1) Every competent patient has a right to take a decision (i) for withholding or withdrawing of medical treatment to himself or herself and to allow nature to take its own course, or (ii) for starting or continuing medical treatment to himself or herself. (2) When a patient referred to in subsection (1) communicates his or her decision to the medical practitioner, such decision is binding on the medical practitioner Provided that the medical practitioner is satisfied that the patient is a competent patient and that the patient has taken an informed decision based upon a free exercise of his or her free will.

4. Advance Medical Directives as to medical treatment and Medical Power of Attorney to be void and not binding on medical practitioner:

Every advance medical directive (called living will) or medical power-of-attorney executed by a person shall be void and of no effect and shall not be binding on any medical practitioner.

5. Withholding or withdrawing of medical treatment by medical practitioner in relation to a competent patient who has not taken an informed decision and in relation to an incompetent patient:

(1) Subject to compliance of the provisions of section 6, a medical practitioner may take a decision to withhold or withdraw medical treatment (a) from a competent patient who has not taken an informed decision, or (b) from an incompetent patient, provided that the medical practitioner is of the opinion that the medical treatment has to be withheld or withdrawn in the best interests of the patient. (2) The medical practitioner shall, while taking a decision under subsection (1), (a) adhere to such guidelines as might have been issued by the Medical Council of India under section 14 in relation to the circumstances under which medical treatment to a patient in respect of the particular illness could be

withheld or withdrawn, and (b) consult the parents or relatives (if any) of the patient but shall not be bound by their views.

6. Expert medical opinion to be obtained by medical practitioner for purposes of section 5:

(1) No decision to withhold or withdraw medical treatment in respect of patients referred to in section 5 shall be taken by any medical practitioner unless such medical practitioner has consulted and obtained the opinion in writing of three medical practitioners selected by him from the panel of medical experts referred to in section 7, who are experts in relation to the illness of the patient and unless the majority opinion of the experts is in favour of withholding or withdrawing the medical treatment. (2) Where there is difference in the opinion of the three medical experts, the majority opinion shall prevail.

7. Authority to prepare panel of medical experts for purposes of section 6:

(1) The Director General of Health Services, Central Government and the Director of Medical Services (or officer holding equivalent post) in each State shall, prepare a panel of medical experts for purposes of section 6. (2) The panels referred to in subsection (1) shall include medical experts in various branches of medicine, surgery and critical care medicine. (3) The medical experts referred to in subsection (1) shall be experts with not less than twenty years experience. (4) While empanelling medical experts on the panels, the authorities mentioned in subsection (1) shall keep in mind the reputation of the expert and shall exclude from the panel, experts against whom disciplinary proceedings are pending with the State Medical Council concerned or the Medical Council of India and those experts who have been found guilty of professional misconduct.

(5) The panels prepared under subsection (1) shall be published in the Official Gazette of the Central Government or the Official Gazette of the State, as the case may be, and on the respective websites of the said authorities and the panels may be reviewed and modified by the authorities specified in subsection (1) from time to time and such modifications shall also be published in the Gazettes as aforesaid, or on the websites, as the case may be. (6) The relevant panel for selection of experts will be the panel for the

State or Union Territory in which the medical treatment is being given or is proposed or is proposed to be withheld or withdrawn.

8. Medical Practitioner to maintain register and inform patient, parents etc:

(1) The medical practitioner who is bound to follow the decision of a competent patient given under section 3 or who takes a decision under section 5, shall maintain a record in a register as to why he is satisfied that (a) the patient is competent or incompetent; (b) the competent patient has or has not taken an informed decision about withholding or withdrawing or starting or continuance of medical treatment; (c) the best interests of an incompetent patient or of a competent patient who has not taken an informed decision, require medical treatment to be withheld or withdrawn; and shall maintain record of age, sex, address and other particulars of the patient and as to the expert advice received by him under section 6 from the three experts selected by him out of the panel referred to in section 7. (2) Before withholding or withdrawing medical treatment under sec 5, the medical practitioner shall inform in writing the patient (if he is conscious), his parents or other relatives or guardian about the decision to withhold or withdraw such treatment in the patient's best interests. (3) Where the patient, parents or relatives stated in subsection (2) inform the medical practitioner of their intention to move the High Court under sec 14, the medical practitioner shall postpone such withholding or withdrawal by fifteen days and if no orders are received from the High within that period, he may proceed with the withholding or withdrawing of the medical treatment.

(4) A photocopy of the pages in the register with regard to each such patient shall be lodged immediately, as a matter of information, on the same date, with the Director General of Health Services or the Director of Medical Services of the Union Territory or State, as the case may be, in which the medical treatment is being given or is proposed or is proposed to be withheld or withdrawn and acknowledgement obtained and the contents of the register shall be kept confidential by the medical practitioner and not revealed to the public or media.

(5) The authorities referred to in subsection (2) shall on receipt of such photo copies, maintain the said photocopies in a register in the offices of the said authorities and shall keep the information confidential and shall not reveal the same to the public or the media.

(6) The said Authorities may make Rules for the purposes of sections 7 and 8 and publish the said Rules in the appropriate Gazette or on their websites.

9. Palliative care for competent and incompetent patients:

Even though medical treatment has been withheld or withdrawn by the medical practitioner in the case of competent patients and incompetent patients in accordance with the provisions of sections 3, 5 and 6, such medical practitioner is not debarred from administering palliative care.

10. Protection of competent patients from criminal action in certain circumstances:

Where a competent patient refuses medical treatment in circumstances mentioned in section 3, notwithstanding anything contained in the Indian Penal Code (45 of 1860), such a patient shall be deemed to be not guilty of any offence under that Code or under any other law for the time being in force.

11. Protection of medical practitioners and others acting under their direction, in relation to competent and incompetent patients:

Where a medical practitioner or any other person acting under the direction of the medical practitioner withholds or withdraws medical treatment, (a) in respect of a competent patient, on the basis of the informed decision of such patient communicated to the medical practitioner for such withholding or withdrawal, or (b) (i) in respect of a competent patient who has not taken an informed decision, or (ii) in respect of an incompetent patient, and the medical practitioner takes a decision in the best interests of the patient for withholding or withdrawal of such treatment, such action of the medical practitioner or those acting under his direction, and of the hospital concerned, shall be deemed to be lawful, provided only where the medical practitioner has complied with the of sections 5, 6 and 8.

12. Enabling provision for seeking declaratory relief before a Division Bench of the High Court:

(1) Any patient or his or her parents or his or her relatives or next friend may move an original petition before a Division Bench of the High Court seeking a declaration that any act or omission or proposed act or omission by the medical practitioner or a hospital in respect of withholding or withdrawing medical treatment from a patient is lawful or unlawful and seeking such interim or final directions from the said Court as they may deem fit.

Explanation: 'High Court' in this section and section 13 means the High Court within whose territorial jurisdiction the treatment is being given or is proposed or proposed to be withheld or withdrawn. (2) Any medical practitioner or a hospital may move an original petition before a Division Bench of the High Court seeking a declaration that any act or omission or proposed act or omission by the medical practitioner or the hospital in respect of withholding or withdrawing medical treatment from a patient is lawful and seek such interim or final directions from the said Court as he or it may deem fit. (3) The Division Bench of the High Court may, wherever it deems it necessary, appoint an amicus curiae to assist the Court and where a patient is unrepresented, direct legal aid to be provided to such patients. (4) The Division Bench of the High Court shall dispose of such petitions in the light of the provisions of this Act, after hearing the patient if he or she is competent or hearing his or her parents or relatives or next friend or guardian-ad-litem, the medical practitioners or the hospital authorities treating the patient and the amicus curiae, if any, and after receiving, wherever necessary or appropriate, such further evidence of witnesses including expert medical practitioners. (5) Such original petitions shall be disposed of expeditiously and, at any rate, within a period of thirty days from the date of filing of the original petition.

(6) Where the High Court is of the view that interim or final directions have to be passed and implemented urgently, it may pass such operational orders initially and follow up the same by giving its reasons therefor, soon thereafter. (7) Any declarations or final directions given by the Division Bench of the High Court in a petition filed under subsection (1) or (2) shall be binding in all other actions civil or criminal against the medical practitioner or the hospital, in relation to the said act or omission of the medical practitioner or the hospital, in relation to the said patient. (8) Recourse to the High Court for a declaratory relief and for directions under this section is not a condition precedent

for withholding or withdrawing medical treatment if such withdrawal or withholding is done in accordance with the provisions of this Act.

13. Confidentiality for purposes of sections 12 and 13:

(1)(i) The Division Bench of the High Court shall, whenever a petition under section 12 is filed, direct that the identity of the patient and of his or her parents, the identity of the medical practitioner and hospitals, the identity of the medical experts, referred to in section 6, or of other experts or witnesses consulted by the Court or who have given evidence in the Court, shall, during the pendency of the petition, and after its disposal, be kept confidential and shall be referred only by the English alphabets as stated in clause (ii)..

(ii) As soon as the original petition is filed, the Division Bench of the High Court shall make an order choosing English alphabets for identifying the patient, parents, doctors, hospitals or experts or other witnesses referred to in sub clause (i) or other persons connected with the medical treatment and shall direct that in the further proceedings of the Court or in any publications in the law reports or in the print or electronic media or audio-visual media, during and after disposal of the petition, those alphabets alone shall be used to refer to the particular patient, person or hospital and that the identity of the patient, person or hospital shall not be disclosed and the High Court may, where necessary, hold all or any part of the hearing in camera.

(iii) It shall not be lawful for any person or body to refer to the identity of the patient, person or hospital or other particulars or matters referred to in sub clause (i) and (ii) in any law-report or publication in the print or electronic or audio-visual media, and the alphabets designated by the Division Bench of the High Court under subsection (2) alone shall be referred to while publishing the proceedings of the Court, during the pendency of the petition and after its disposal.

(iv) Any person or body acting in violation of the provisions of sub clause (iii) may be held liable for contempt of Court for violation of the orders of Court under sub clause (ii) and be dealt with accordingly.

(v) Notwithstanding the provision of clauses (i) to (iv), when the declarations or directions given by the High Court have to be communicated to the patient, parents,

medical practitioner, hospital or experts concerned, it shall be permissible to refer to the true identity of the patient, persons or hospital and such communications shall be made in sealed covers to be delivered to these addresses so that the declarations or directions made by the High Court are understood and implemented as being with reference to the particular patient.

(vi) The High Court may make Rules of Procedure for the implementation of provisions of section 12 and this section.

(2) No person or body including media shall, in cases which have not gone to the High Court under subsection (1), publish the names of the patients or other information which may disclose the identity of the patient, relatives, doctor, hospital or experts and if these provisions are violated, may be proceeded against by way of a civil or criminal action in accordance with law.

14. Medical Council of India to issue Guidelines:

(1) Consistent with the provisions of this Act, the Medical Council of India shall prepare and issue guidelines, from time to time for the guidance of medical practitioners in the matter of withholding or withdrawing of medical treatment to competent or incompetent patients suffering from terminal illness.

(2) While preparing such guidelines, the Medical Council of India may consult medical experts or bodies consisting of medical practitioners who have expertise in relation to withholding or withdrawing medical treatment to patients or experts or bodies having experience in critical care medicine.

(3) The Medical Council of India may review and modify the guidelines from time to time.

(4) The guidelines and modifications thereto, if any, shall be published in the Official Gazette of India and on its website.

ANNEXURE 3

THE MEDICAL TREATMENT OF TERMINALLY-ILL PATIENTS (PROTECTION OF PATIENTS AND MEDICAL PRACTITIONERS) BILL, 2012

A Bill to provide for the protection of patients and medical practitioners from liability in the context of withholding or withdrawing medical treatment including life support systems from patients who are terminally-ill.

BE it enacted in the Sixty Second Year of the Republic of India as follows:-

1. Short title, extent and commencement. – (1) This Act may be called the Medical Treatment of Terminally-ill Patients (Protection of Patients and Medical Practitioners) Act.

(2) It extends to the whole of India except the State of Jammu & Kashmir.

(3) It shall come into force on such date as the Central Government may, by notification in the Official Gazette, appoint.

2. Definitions. – Unless, the context otherwise requires –

(a) ‘advance medical directive’ (called living will) means a directive given by a person that he or she, as the case may be, shall or shall not be given medical treatment in future when he or she becomes terminally ill.

(b) ‘best interests’ include the best interests of a patient :

(i) who is an incompetent patient, or

(ii) who is a competent patient but who has not taken an informed decision, and are not limited to medical interests of the patient but include ethical, social, moral, emotional and other welfare considerations.

(c) ‘competent patient’ means a patient who is not an incompetent patient.

(d) ‘incompetent patient’ means a patient who is a minor below the age of 16 years or person of unsound mind or a patient who is unable to –

(i) understand the information relevant to an informed decision about his or her medical treatment;

- (ii) retain that information;
 - (iii) use or weigh that information as part of the process of making his or her informed decision;
 - (iv) make an informed decision because of impairment of or a disturbance in the functioning of his or her mind or brain; or
 - (v) communicate his or her informed decision (whether by speech, sign, language or any other mode) as to medical treatment.
- (e) 'informed decision' means the decision as to continuance or withholding or withdrawing medical treatment taken by a patient who is competent and who is, or has been informed about :-
- (i) the nature of his or her illness,
 - (ii) any alternative form of treatment that may be available,
 - (iii) the consequences of those forms of treatment, and
 - (iv) the consequences of remaining untreated.
- (f) 'Medical Council of India' means the Medical Council of India constituted under the Indian Medical Council Act, 1956 (102 of 1956).
- (g) 'medical practitioner' means a medical practitioner who possesses any recognized medical qualification as defined in clause (h) of section 2 of the Indian Medical Council Act, 1956 (102 of 1956) and who is enrolled on a State Medical Register as defined in clause (k) of that section.
- (h) 'medical power-of-attorney' means a document of decisions in future as to medical treatment which has to be given or not to be given to him or her if he or she becomes terminally ill and becomes an incompetent patient.
- (i) 'medical treatment' means treatment intended to sustain, restore or replace vital functions which, when applied to a patient suffering from terminal illness, would serve only to prolong the process to dying and includes –
- (i) life-sustaining treatment by way of surgical operation or the administration of medicine or the carrying out of any other medical procedure and (ii) use of mechanical or artificial means such as ventilation, artificial nutrition and hydration and cardiopulmonary resuscitation.

(j) 'minor' means a person who, under the provisions of an Indian Majority Act, 1875 (4 of 1875) is to be deemed not to have attained majority.

(k) 'palliative care' includes –

(i) the provision of reasonable medical and nursing procedures for the relief of physical pain, suffering, discomfort or emotional and psycho-social suffering,

(ii) the reasonable provision for food and water.

(l) 'Patient' means a patient who is suffering from terminal illness.

(m) 'terminal illness' means –

(i) such illness, injury or degeneration of physical or mental condition which is causing extreme pain and suffering to the patients and which, according to reasonable medical opinion, will inevitably cause the untimely death of the patient concerned, or

(ii) which has caused a persistent and irreversible vegetative condition under which no meaningful existence of life is possible for the patient.

3. Refusal of medical treatment by a competent patient and its binding nature on medical practitioners. – (1) Every competent patient including minor aged above 16 years has a right to take a decision and express the desire to the medical practitioner attending on her or him:-

(i) for withholding or withdrawing of medical treatment to herself or himself and to allow nature to take its own course, or

(ii) for starting or continuing medical treatment to herself or himself.

(2) When a patient referred to in sub-section (1) communicates her or his decision to the medical practitioner, such decision is binding on the medical practitioner,

Provided that the medical practitioner is satisfied that the patient is a competent patient and that the patient has taken an informed decision based upon a free exercise of her or his free will and,

Provided further that in the case of minor above 16 years of age, the consent has also been given by the major spouse and the parents.

(3) Before proceeding further to give effect to the decision of the competent patient, the medical practitioner shall inform the spouse, parent or major son or daughter of the patient or in their absence any relative or other person regularly visiting the patient at the

hospital about the need or otherwise of withholding or withdrawing treatment from the patient and shall desist from giving effect to the decision for a period of three days following the intimation given to the said patient's relations.

4. Authority to prepare panel of medical experts. (1) The Director-General of Health Services, Central Government and the Director of Medical Services (or officer holding equivalent post) in each State shall, prepare a panel of medical experts for purposes of this Act and more than one panel may be notified to serve the needs of different areas.

(2) The panels referred to in sub-section(1) shall include experienced medical experts in various branches such as medicine, surgery, critical care medicine or any other specialty as decided by the said authority.

(3) The Director General of Health Services may consult the Directors of Medical Services or the equivalent rank officers in regard to the composition of panel in order to ensure uniformity, as far as practicable.

(4) The panels prepared under sub-section (1) shall be published in the respective websites of the said authorities and the panels may be reviewed and modified by the authorities specified in sub-section (1) from time to time and such modifications shall also be published on the websites, as the case may be.

5. Medical Practitioner to maintain record and inform patient, parent etc. The medical practitioner attending on the patient shall maintain a record containing personal details of the patient such as age and full address, the nature of illness and the treatment being given and the names of spouse, parent or major son or daughter, the request or decision if any communicated by the patient and his opinion whether it would be in the best interest of the patient to withdraw or withhold the treatment. The medical practitioner shall inform the patient if conscious and the spouse, parent or major son or daughter of the patient or in their absence the persons regularly visiting the patient at the hospital about the need or otherwise of withholding or withdrawing treatment from the patient.

6. Palliative care for competent and incompetent patients. – Even though medical treatment has been withheld or withdrawn by the medical practitioner in the case of

competent patients and incompetent patients in accordance with the foregoing provisions, such medical practitioner is not debarred from administering palliative care.

7. Protection of competent patients from criminal action in certain circumstances. – Where a competent patient refuses medical treatment in circumstances mentioned in section 3, notwithstanding anything contained in the Indian Penal Code (45 of 1860), such a patient shall be deemed to be not guilty of any offence under that Code or under any other law for the time being in force.

8. Protection of medical practitioners and other acting under their direction, in relation to competent and incompetent patients. – Where a medical practitioner or any other person acting under the direction of medical practitioner withholds or withdraws medical treatment in respect of a competent patient on the basis of the desire expressed by the patient which on the assessment of a medical practitioner is in her or his best interest, then, notwithstanding anything contained in any other law, such action of the medical practitioner or those acting under his direction and of the hospital concerned shall be deemed to be lawful provided that the medical practitioner has complied with the requirements of Section 3 and 5.

9. Permission to be obtained from High Court and the procedure. - (1) Any near relative, next friend, legal guardian of patient, the medical practitioner or para-medical staff generally attending on the patient or the management of the hospital where the patient has been receiving treatment or any other person obtaining the leave of court, may apply to the High Court having territorial jurisdiction for granting permission for withholding or withdrawing medical treatment of an incompetent patient or a competent patient who has not taken informed decision.

(2) Such application shall be treated as original petition and the Chief Justice of High Court shall assign the same to a Division Bench without any loss of time and the same shall be disposed of by the High Court as far as practicable within a month,

Provided that a letter addressed to the Registrar-General or Judicial Registrar of the High Court by any of the persons above mentioned containing all the material particulars

seeking the permission under sub-section (1) shall be placed before the Chief Justice without delay and the letter shall be treated as original petition.

(3) The Division Bench of the High Court may, if deemed necessary, appoint an amicus curiae to assist the Court and where a patient is unrepresented, direct legal aid to be provided to such patient.

(4) The High Court shall take necessary steps to obtain the expert medical opinion of three medical practitioners drawn from the panel prepared under Section 4 and any other expert medical practitioner if considered necessary and issue appropriate directions for the payment to be made towards the remuneration of the experts.

(5) The High Court shall, having due regard to the report of panel of experts and the wishes of close relations, namely, spouse, parents, major children or in their absence such other persons whom the High Court deems fit to put on notice and on consideration of the best interests of the patient, pass orders granting or refusing permission or granting permission subject to any conditions.

(6) The medical practitioner or the hospital management or staff who in accordance with the order of High Court, withholds or withdraws medical treatment to the patient concerned shall, notwithstanding any other law in force, be absolved of any criminal or civil liability.

10. Confidentiality for purposes of section 9. – The Division Bench of the High Court may, whenever a petition under Section 9 is filed, direct that the identity of the patient and of his or her parents or spouse, the identity of the medical practitioner and hospitals, the identity of the medical experts referred to in Section 4, or of other experts or witnesses consulted by the Court or who have given evidence in the Court, shall, during the pendency of the petition, and after its disposal, be kept confidential and shall be referred only by the English alphabets.

11. Advance Medical Directives as to medical treatment and Medical Power-of-Attorney to be void and not binding on medical practitioners. –

Every advance medical directive (called living will) or medical power-of-attorney executed by a person shall be void and of no effect and shall not be binding on any medical practitioner.

12. Medical Council of India to issue Guidelines. – (1) Consistent with the provisions of this Act, the Medical Council of India may prepare and issue guidelines, from time to time for the guidance of medical practitioners in the matter of withholding or withdrawing of medical treatment to competent or incompetent patients suffering from terminal illness.

(2) The Medical Council of India may review and modify the guidelines from time to time.

(3) The guidelines and modifications thereto, if any, shall be published on the website and a press release may be issued to that effect.

AS INTRODUCED IN THE RAJYA SABHA
ON THE 5TH AUGUST, 2016

Bill No. XXVII of 2016

THE MEDICAL TREATMENT OF TERMINALLY-ILL PATIENTS
(PROTECTION OF PATIENTS AND MEDICAL PRACTITIONERS)
BILL, 2016

A

BILL

to provide for the protection of patients and medical practitioners from liability in the context of withholding or withdrawing medical treatment including life support systems from patients who are terminally-ill and for matters connected therewith and incidental thereto

BE it enacted in the Sixty-seventh Year of the Republic of India as follows:—

1. (1) This Act may be called the Medical Treatment of Terminally-ill Patients (Protection of Patients and Medical Practitioners) Act, 2016.

Short title,
extent and
commencement.

(2) It extends to the whole of India except the State of Jammu & Kashmir.

5 (3) It shall come into force on such date as the Central Government may, by notifications in the official gazette, appoint.

Definitions.

2. Unless, the context otherwise requires,—

(a) "advance medical directive" (also called living will) means a directive given by a person that he or she, as the case may be, shall or shall not be given medical treatment in future when he or she becomes terminally ill and becomes an incompetent patient. 5

(b) "appropriate Government" means in the case of a State the Government of that State and in other cases the Central Government.

'best interests' include the best interests of a patient,—

(i) who is an incompetent patient, or

(ii) who is a competent patient but who has not taken an informed decision, and are not limited to medical interests of the patient but include ethical, social, moral, emotional and other welfare considerations." 10

(c) 'competent patient' means a patient who is not an incompetent patient.

(d) 'incompetent patient' means a patient who is a minor below the age of sixteen years or person of unsound mind or a patient who is unable to,— 15

(i) understand the information relevant to an informed decision about the medical treatment;

(ii) retain that information;

(iii) use or weigh that information as part of the process of making the informed decision; 20

(iv) make an informed decision because of impairment of or a disturbance in the functioning of his mind or brain; or

(v) communicate the informed decision, whether by speech, sign, language or any other mode, as to medical treatment."

(e) 'informed decision' means the decision as to continuance or withholding or withdrawing medical treatment taken by a patient who is competent and who is or has been informed by the attending medical practitioner about:— 25

(i) the nature of the illness,

(ii) any alternative form of treatment that may be available,

(iii) the consequences of those forms of treatment, and 30

(iv) the consequences of remaining untreated.

(f) 'Medical Council of India' means the Medical Council of India constituted under the Indian Medical Council Act, 1956. 102 of 1956.

(g) 'medical practitioner' means a medical practitioner who possesses any recognized medical qualification as defined in clause (h) of section 2 of the Indian Medical Council Act, 1956 and who is enrolled on a State Medical Register as defined in clause (k) of that section. 35 102 of 1956.

(h) 'medical power-of-attorney' means a document of decisions in future as to medical treatment which has to be given or not to be given to him if he becomes terminally ill and becomes an incompetent patient. 40

(i) 'medical treatment' means treatment intended to sustain, restore or replace vital functions which, when applied to a patient suffering from terminal illness, will serve only to prolong the process of dying and includes,—

(i) life-sustaining treatment by way of surgical operation or the administration of medicine or the carrying out of any other medical procedure; and 45

(ii) use of mechanical or artificial means such as ventilation, artificial nutrition and hydration and cardiopulmonary resuscitation; and

(iii) but does not include palliative care."

4 of 1875. 5 (j) 'minor' means a person who, under the provisions of an Indian Majority Act, 1875 is to be deemed not to have attained majority.

(k) 'palliative care' includes,—

(i) the provision of reasonable medical and nursing procedures for the relief of physical pain, suffering, discomfort or emotional and psycho-social suffering; and

10 (ii) the reasonable provision for food and water."

(l) 'patient' means a patient who is suffering from terminal illness.

(m) 'terminal illness' means,—

15 (i) such illness, injury or degeneration of physical or mental condition which is causing extreme pain and suffering to the patient and which, according to reasonable medical opinion, will inevitably cause the untimely death of the patient concerned, or

(ii) which has caused a persistent and irreversible vegetative condition under which no meaningful existence of life is possible for the patient."

20 3. (1) Every competent patient including minor aged above sixteen years shall have a right to take an informed decision and to express the desire to the medical practitioner attending on her or him:—

Refusal of medical treatment by a competent patient.

(i) for withholding or withdrawing of his medical treatment and to allow nature to take its own course, or

(ii) for starting or continuing his medical treatment.

25 (2) When a patient referred to in sub-section (1) communicates an informed decision to the medical practitioner, such decision shall be binding on the medical practitioner:

Provided that the medical practitioner is satisfied that the patient is a competent patient and that the patient has taken an informed decision based upon a free exercise of his free will and:

30 Provided further that in the case of minor above sixteen years of age, the consent has also been given by the parents, or legal guardian or any next of friends.

35 (3) Before proceeding further to give effect to the decision of the competent patient, the medical practitioner shall inform the patient, if conscious, or the spouse or parent or major son or daughter of the patient or in their absence any relative or other person regularly visiting the patient at the hospital about the informed decision of the competent patient and his own opinion on that decision including the need or otherwise of withholding or withdrawing treatment from the patient and shall desist from giving effect to the decision for a period of three days following the intimation given to the said patient's relations.

40 4. (1) The medical practitioner attending on the patient shall maintain a record containing personal details of the patient such as age and full address, the nature of illness and the treatment being given and the names of spouse, parent or major son or daughter, the request or decision, if any, communicated by the patient and his opinion whether it would be in the best interest of the patient to withdraw or withhold the treatment.

Maintenance of record of Terminally-ill patient.

45 (2) The patient, spouse, parent or major son or daughter of a patient shall be entitled to receive a copy of the records maintained by the medical practitioner under this section and the medical practitioner shall furnish such records upon request without delay.

Palliative care for terminally ill patients.	5. Notwithstanding that medical treatment has been withheld or withdrawn by the medical practitioner in the case of a competent patient or an incompetent patient in accordance with the foregoing provisions, palliative care shall be administered to such patients by the medical practitioner attending on them.	
Protection of competent patients.	6. Where a competent patient refuses medical treatment in circumstances mentioned in section 3, notwithstanding anything contained in the Indian Penal Code 1860, such a patient shall not be deemed guilty of any offence under the Code or under any other law for the time being in force.	5 45 of 1860
Protection of medical practitioners.	7. Where a medical practitioner or any other person acting under the direction of medical practitioner withholds or withdraws medical treatment in respect of a competent patient on the basis of the desire expressed by the patient which on the assessment of a medical practitioner is in his best interest, then, notwithstanding anything contained in any other law for the time being in force, such action of the medical practitioner or those acting under his direction and of the hospital concerned shall be deemed to be lawful provided that the medical practitioner has complied with the requirement of sections 3 and 5 and followed the guidelines laid down by the Medical Council of India in this regard under section 12 of this Act.	10 15
Panel of medical experts.	8. (1) The appropriate Government in consultations with The Director-General of Health Services and the Director of Medical Services (or officer holding equivalent post) in each State, as the case may be, shall prepare a panel of medical experts for every state and union territory for the purposes of this Act and more than one panel may be notified to serve the needs of different areas. (2) The panels referred to in sub-section (1) shall include medical experts with an experience of at least fifteen years in various branches such as medicine, surgery critical care medicine or any other specialty as prescribed by Central Government. (3) The panels prepared under sub-section (1) shall be published in the respective websites of the said authorities specified in sub-section (1) from time to time and such modifications shall also be published in the website, as the case may be.	20 25
Permission for withholding/withdrawing medical treatment from High Court.	9. (1) Any parent, spouse, any near relative, next friend, legal guardian of patient, the medical practitioner or para-medical staff generally attending on the patient obtaining the leave of court, may apply to the High Court having territorial jurisdiction for granting permission for withholding or withdrawing medical treatment of an incompetent patient or a competent patient who is incompetent to take informed decision. <i>Explanation.</i> —'High Court' in this section and section 11 means the High Court within whose territorial jurisdiction the treatment is being given or is proposed or proposed to be withheld or withdrawn. (2) Such application shall be treated as original petition and the Chief Justice of High Court shall assign the same to a Division Bench without any loss of time and the same shall be disposed of by the High Court within thirty days: Provided that a letter addressed to the Registrar-General or Judicial Registrar of the High Court by any of the above mentioned persons and containing therein all the material particulars seeking the permission under sub-section (1) shall be placed before the Chief Justice without delay and the letter shall be treated as original petition. (3) The Division Bench of the High Court may, if deemed necessary, appoint an <i>amicus curiae</i> to assist the Court and where a patient is unrepresented, direct legal aid to be provided to such patient. (4) The High Court shall obtain the expert medical opinion of three medical practitioners drawn from the panel prepared under section 8 and any other expert medical practitioner if, considered necessary and issue appropriate directions for the payment to be made towards the remuneration of the experts:	30 35 40 45 50

Provided that as far as practicable, one doctor each on the panel shall be a neurosurgeon, a psychologist and a physician.

(5) The expert panel shall follow the guidelines laid down by the Medical Council of India with regard to withholding or withdrawing of medical treatment to competent or incompetent patients suffering from terminal illness under section 12 of this Act.

(6) The High Court shall, having due regard to the report of panel of experts and the wishes of close relations, namely, spouse, parents, major children or in their absence such other persons whom the High Court deems fit to put on notice and on consideration of the best interests of the patient, pass orders granting or refusing permission or granting permission subject to any conditions.

(7) The parent, spouse, any near relative, next friend, legal guardian of patient who consents to, and the medical practitioner or the hospital management or staff who in accordance with the order of High Court, withholds or withdraw medical treatment to the patient concerned shall, notwithstanding any other law in force, be absolved of any criminal or civil liability with regard to the action taken in accordance with the order or High Court.

10. (1) It shall be open to the party applying for the order of High Court as prescribed in section 9 to withdraw the application anytime before the final decision of the High Court is delivered:

Withdrawing or contesting the application.

Provided that such party shall submit an application to this effect highlighting the reasons and new facts, if any, and the High Court may accept or reject the application of withdrawal.

(2) Parent, spouse, any near relative, next friend, legal guardian of patient, the medical practitioner generally attending on the patient obtaining the leave of the court, may contest the application submitted under section 9 and petition the High Court not to entertain the application or reject the application filed under Section 9, anytime before the final order of the High Court is delivered:

Provided that such party shall submit an application to this effect highlighting the reasons and all relevant facts and the High Court may accept or reject the application:

Provided further that where the High Court accepts this application, the party applying for the order of the High Court under section 9 and the party contesting the application shall be permitted to tender all the relevant evidence and the High Court shall finally dispose of the application along with contesting application within thirty days from the date on which contesting application was received.

(3) The party applying for order of High Court under section 9 shall submit a compliance report to the High Court within thirty days from the date on which the order of the High Court was delivered:

Provided that if, the party fails to comply with the decision of the High Court or if, new facts emerge, such party may apply to the High Court citing the reasons for such non-compliance and the High Court may pass such orders as deemed appropriate.

11. The Division Bench of the High Court may, whenever a petition under section 9 is filed, direct that the identity of the patient and of his or her parents or spouse, the identity of the medical practitioner and hospitals, the identity of the medical experts referred to in section 4, or of other experts or witnesses consulted by the Court or who have given evidence in the Court, shall, during the pendency of the petition, and after its disposal, be kept confidential and shall be referred only by the English alphabets.

Confidentiality.

12. (1) Consistent with the provisions of this Act, the Medical Council of India may prepare and issue guidelines, from time to time, for the guidance of medical practitioners in the matter of withholding or withdrawing of medical treatment to competent or incompetent patients suffering from terminal illness.

Medical Council of India to frame guidelines.

(2) The Medical Council of India may review and modify the guidelines from time to time.

(3) The guidelines and modifications thereto, if any, shall be published on the website and a press release may be issued to that effect.

Advance
medical
directives and
medical power
of attorney.

13. Every advance medical directive (also called living will) or medical Power-of- 5
Attorney executed by a person shall be taken into consideration in matter of withholding or
withdrawing of medical treatment but it shall not be binding on any medical practitioner.

Power to
make rules.

14. The Central Government may, by notification in the official gazette, make rules for
carrying out at the purposes of this Act.

STATEMENT OF OBJECTS AND REASONS

Following the landmark judgment of the Hon'ble Supreme Court in Aruna Ramchandra Shaunbag vs. Union of India, Law Commission of India in its 241st Report in August, 2012 advocated for legalising passive euthanasia. Passive Euthanasia, also called as negative euthanasia involves withholding of medical treatment or life support system for continuance of life. As opposed to active euthanasia which requires doing something to end a life and which is a crime in India, passive euthanasia involves not doing something which would have preserved a patient's life. These decisions are taken on humanitarian grounds in the best interest of the patient allowing a patient to die a natural death thereby upholding their dignity in death.

The Hon'ble Supreme Court legalised passive euthanasia in the above mentioned judgment and in its wisdom appointed the High Court as *parens patriae* in such cases where a terminally ill patient is unable to give his/her consent and the parents, spouse, relative, friend or medical practitioner attending on him/her applies to the court for withdrawing the treatment. The Bill provides for detailed procedures which can be followed in this regard providing adequate safeguards for the patient and excludes criminal liability of their relatives and medical practitioners who withhold the treatment following the order of the court.

Passive euthanasia today is legalised in many countries and India is no exception. Our Constitution acknowledges the right to life of every person which includes in it the right to live this life with dignity. Legalising passive euthanasia will permit terminally ill patients to live their final days in dignity where any kind of intrusive medical treatment with its attendant side effects is only likely to prolong death and not avert it altogether.

Hence this Bill.

HUSAIN DALWAI

MEMORANDUM REGARDING DELEGATED LEGISLATION

Clause 14 of the Bill empowers the Central Government to make rules for carrying out the purposes of the Bill. The rules will relate to matters of details only.

The delegation of legislative power is of normal character.

RAJYA SABHA

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BILL

to provide for the protection of patients and medical practitioners from liability in the context of withholding or withdrawing medical treatment including life support systems from patients who are terminally-ill and for matters connected therewith and incidental thereto.

(Shri Husain Dalwai, M.P.)