"EUTHANASIA AND RIGHT TO DIE WITH DIGNITY-A SOCIO-LEGAL STUDY"

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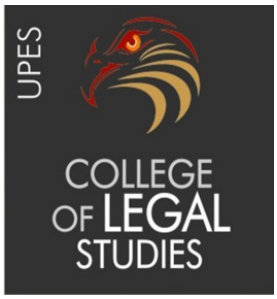
This dissertation is submitted in partial fulfillment of the degree of B.A., LL.B. (Hons.)/B.B.A., LL.B. (Hons)



College of Legal Studies

University of Petroleum and Energy Studies

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DECLARATION

I declare that the dissertation entitled "EUTHANASIA AND RIGHT TO DIE WITH DIGNITY-A SOCIO-LEGAL STUDY**"** is the outcome of my own work conducted under the supervision of Dr. SAROJ BOHRA, at College of Legal Studies, University of Petroleum and Energy Studies, Dehradun.

I declare that the dissertation comprises only of my original work and due acknowledgement has been made in the text to all other material used.

Aditya kumar Pandey

CERTIFICATE

This is to certify that the research work entitled **"** EUTHANASIA AND RIGHT TO DIE WITH DIGNITY-A SOCIO-LEGAL STUDY**"** is the work done by Aditya Kumar Pandey under my guidance and supervision for the partial fulfillment of the requirement of B.A., LL.B. (Hons.)/B.B.A., LL.B. (Hons) degree at College of Legal Studies, University of Petroleum and Energy Studies, Dehradun.

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INTRODUCTION

Life is a gift of nature to humankind and hence right to life is the most fundamental, natural human right. Article 3 of Universal Declaration of Human Rights (**UDHR**) 1948 declares, ‘‘everyone has right to life, liberty and security of person.’’ International Covenant on Civil and Political Rights (**ICCPR**) 1966 in Article 6 declares, “Every Human being has the inherent right to life. This right shall be protected by law. No one shall be arbitrarily deprived of his life.’’ Constitution of India too declares in Article 21, “No person shall be deprived of his life or personal liberty except according to procedure established by law.’’ But the question arises that does right to life brings with itself, the right to die? Euthanasia is one of the ways of exercising right to die.

Euthanasia is a deliberate act that causes death done by one person with the primary intention of ending the life of another person, to ease that person's suffering.

The word euthanasia is derived from the Greek words eu (good) and thanatos (death), meaning "good-death" or"dying well". But again the question arises that can death be good? We feel happy when a birth takes place but mourn on death. Every person wants to live a long life, so how can a death be good ?

For an mundane person,when life itself feels more throbbing and intolerable than death, then, one may accept death (Dayamaran or mercy killing or euthanasia).

However, for the great persons, death means a full stop to life after achieving the goals in life(meaning ‘Swachchanda Mrityu’. or Echchamaran or willful death).

In this dissertation the focus will not be wholly on legal grounds of right to die but also on the ethical,moral and emotional phase of it. All the fundamental rights guaranteed to its citizens reveals our desires,ambitions and it fixes a limit by not making it absolute which indirectly limits the desires and ambition of its citizens.

STATEMENT OF PROBLEM

Most of the countries are developing countries where there is lack of proper infrastructure, investment and research in Medical sciences. So whether make a law legalizing the use of euthanasia affect the Right guaranted under the constitution. The research will focus on lacunas the existing countries who have legalised the

euthanasia have on it citizens and the problem faced by India to make a law on euthanasia.

OBJECTIVE

The purpose of this dissertation is to identify and study the laws of countries that have legalized the euthanasia and how far are they able to meet the social and ethical standards. This dissertation would also focus on lacunas in the existing scenario of India where the apex court guidelines are regulating the euthanasia and no law has been passed by the parliament. So what are the problems faced by law makers to legalize the use of Euthanasia.

KEY RESEARCH QUESTIONS

1. What are the major issues in legalizing the Euthanasia and the social, ethical and moral status of a person after legalizing it?
2. What effect will legalizing euthanasia have on research conducted by medical sciences or is it indirectly leading towards underestimating medical sciences?
3. What effect Euthanasia will have on developing countries like India where their is a lack of proper infrastucture or is it better to invest in Palliative medicine as a middle way?

HYPOTHESIS

Developing countries like India lack proper investment and infrastructure to legalize euthanasia. Legalizing euthanasia by making a law will not cover all the aspect associated with Life.

RESEARCH METHODOLOGY

The nature of research is Non Doctrinal methodology to carry out study relying mainly on secondary data, which includes journals, articles, commentaries, textbooks, reference books, internet sources, e-books, committee and law commission reports and reliance is based on analytical study. Citation method used is Bluebook 19th Edition.

The methodology is adopted, as there are already voluminous literatures and research works available on the particular topic that could come handy in understanding the intention of lawmakers who have legalized the use of euthanasia.

For the mentioned purpose, the Researcher will analyze the existing legislative provisions, decided judgment, scholarly articles and comments on various areas connected with the issue. Researcher has collected materials from various sources i.e. primary as well as secondary sources available at the UPES Library and UPES online e-resources database.

LITERATURE REVIEW

1. Sujata Pawar, *Euthanasia: Indian Socio-Legal Perspectives,* Journal of Law, Policy and Globalization.

Even though, death is an inevitable incident, with the help of modern science and medicine, it may be prolonged to a considerable extent. In the light of this the author has given the origin of euthanasia from ancient times and analyzed the difference between Euthanasia, Assisted Suicide and Suicide.

2. B.Jyoti Kiran & Shiladitya Goswami, *Right to Die - Legal and Moral Aspects*

The author has analyzed how will legalizing right to die affect the society where we live. The author has focused on emotional aspect involved in euthanasia and morally how far if law is made it can suffice the needs of society.

3. Jenny ko*, Legalization Of Euthanasia Violates The Principles Of Competence, Autonomy, And Beneficence,* BC MEDICAL JOURNAL VOL. 52 NO. 2,2010

The article reflects that there are some aspects in Euthanasia which can neither be consistent nor standardized within legal sense. The used of Euthanasia violates the prinicple of self –determination and hence the claim that we have right to die contradicts itself. The author anlayzed that legalized euthanasia puts people who are suffering and vulnerable at risk, and no legal safeguard can prevent abuse against this group in the name of "a right to die."

4. Suresh Bada Math and Santosh K. Chaturvedi, *Euthanasia: Right to life vs right to die,*Indian Journal of Medical Research.

The article provides for arguments both in favour of Euthanasia and against it. The author examined that 'Right to life' has to become a reality and succeed before 'Right to death with dignity' and focussed on Palliative care which actually provides death with dignity.

5. Shreyans Kasliwa, *Should Euthanasia be Legalised in India?,*2003 PL WebJour 16, SCC Online

This article emphasized on various issues involved in India where still Euthanasia is illegal. How the liablity is fixed on doctors under IPC for negligence for suicide and how it will be different if law for euthanasia is passed in India.

6. Mrinal Satish, *Misadventures of the Supreme Court in Aruna Shanbaug v. Union of India.*

This article focus on case of Aruna Shaubaug which is a landmark case in India and apex court gave guidelines which are to be followed unless there is a law passed. The author has critically examined the judgment which fails to grapple adequately with the issues and also betrays faulty legal reasoning and an utter disregard for the law and the legal process. It gives short shrift to important constitutional issues, and is more concerned with foreign precedents than with Indian statutes, case law, rights and process.

7. Bruce Vodiga, *Euthanasia and the Right to Die - Moral, Ethical and Legal Perspectives*, Chicago-Kent Law Review Volume 51 | Issue 1

This article focussed on various issue as to Is euthanasia murder? Should steps be taken toward legalization? Is private regulation an effective method for control? The author has attempted to address what all problem country may face while making law and will that law be able to meet the needs of society or not.

CHAPTER 1

1. INTRODUCTION

" You matter because you are you,
You matter to the last moment of your life,
and we will do all we can,
not only to help you die peacefully,
but also to live until you die". … Dame Cicely Saunders, Founder of Hospice

DEFINITIONS

Euthanasia: "*A deliberate act undertaken by one person with the intention of either painlessly putting to death or failing to prevent death from natural causes in cases of terminal illness or irreversible coma of another person. The term comes from the Greek expression for "good death"*[1] .

Voluntary Euthanasia: The person who makes a request by himself or herself to get killed.

Non-Voluntary Euthanasia: It is just the opposite of Voluntary Euthanasia. In this the person makes no express request or consent for getting killed.

Assisted Suicide: It means when a person guides or provide any methods or information to a person who is willing to end his life. When any doctor provides such guidance or information or help it is know as Physician Assisted Suicide (PAS).

1.1 THE CONCEPT OF EUTHANASIA

The Euthanasia word has taken birth from the word "euthanatos" which is greek meaning "well death" and originally referred to intended mercy killing. In the cutting

[1] WHO Centre for Health Development Ageing and Health Technical Report Volume 5, available at <http://www.who.int/kobe_centre/ageing/ahp_vol5_glossary.pdf>,last accessed at JAN 31,2016.

edge setting Euthanasia is constrained to the executing of patients by specialist at the solicitation of the patient keeping in mind the end goal to free him of agonizing torment or from terminal sickness. At the point when medicinal advances made prolonging of the lives of kicking the bucket patients conceivable, the term Euthanasia was utilized to exclusion to stop passing[2].

Euthanasia can be classified as active or passive Euthanasia. Active Euthanasia means some steps are taken actively to put an end to patient life[3]. Passive euthanasia means the practice in which the doctor has not taken any steps actively to end the patient life.

In assisted suicide patients voluntarily bring about his own death with the help of another person. In this case, the doing is a suicide as he is himself active in causing his own death[4].

Survival is without a doubt beneficial however some time and in certain condition life gets to be excruciating and inconceivable in that stage observation appears like a condemnation or misuse. Killing is nothing else except for a grant or permits to the medicinal expert for completion the life of a man being referred to. Actually the idea is easily proven wrong. Here the key question is "what should be the ingredients of law which would legalize Euthanasia"? .

On of the main things that must be observed is that 'withdrawal of life supporting' to patients is very surprising structure killing and helped suicide. The subject of withdrawal of life backing to patients who are in a basic stage or under extreme lethargies for long stretches has pulled in the consideration of the officials in different nations. There are statues in a few nations."Euthanasia" is also called "mercy killing". In our country and in several countries euthanasia and assisted suicide are offences. The scope of the inquiry is therefore confined to examining the various legal concepts applicable to 'withdrawal of life support measures' and to suggest the manner and circumstances in which the medical profession could take decisions for withdrawal of life support if it in the 'best interest' of the patient. Further, address emerges as to in

[2] kasliwal,Shreyans,"*Should Euthanasia be Legalised in India*?", available at< http://www.ebc-india.com/lawyer/articles/592.htm> ,last accessed on Feb 1,2016
[3] Ibid

what circumstances a patient can decline to take treatment and request withdrawal or withholding of life bolster measure, in the event that it is an educated choice.

In that context, it will also become necessary to purpose sufficient safeguards to the 'patient' so that the procedure for doctors arriving at a decision for withdrawal of life support measures in not misused or abused by any body, including the patient, the relative of the patient or the doctors or the hospitals where the patient is under treatment.

The Law Commission in its 42nd report suggested the deletion of Section 309 of IPC which makes 'attempt to commit suicide' an offence and it has been decriminalized now.

1.2 HISTORICAL ASPECT

About 400 B.C. – The Hippocratic oath (By the "Father Of Medicine" Greek Physician Hippocrates)

"*I will give no deadly medicine to any one if asked, nor suggest ant such counsel*"[5]

14th through 20th century English Common Law(Excerpt is from the U.S. Supreme court ruling in the 1997 Washington v Glucksberg –opinion written by Chief Justice Rehnquist.)

"*More Specifically, for over 700 years, the Anglo American Common Law Tradition has punished or otherwise disapproved of both suicide and assisting suicide*."[6]

19th century United States (Excerpt is from the U.S. Supreme court ruling in the 1997 Washington v Glucksberg –opinion written by Chief Justice Rehnquist.)

Swift, in his early 19th century treatise on the laws of Connecticut stated that "*if one counsels other to commit suicide and other by reason of the advice kills himself the*

[5] "available at http://www.euthanasia.com/historyeuthanasia.html ,last accessed at Feb 5,2016"
[6] Ibid

advisor is guilty of murder as principle."[7] The consent of a homicide victim is "*wholly immaterial to the guilt of the person who caused the death and the prohibitions against assisting suicide never contained exceptions for those who were near death".* Rather "*the life of those to whom life had become a burden of those who were hopelessly diseased or fatally wounded, even the lives of criminals condemned to death, were under the protection of law equally as the lives of those who were in the full tide of life's enjoyment and anxious to continue to live*."

1828-Earliest American Statue explicitly to outlaw assisting suicide (Excerpt is from the U.S. Supreme court ruling in the 1997 Washington v Glucksberg – opinion written by Chief Justice Rehnquist.)

Between 1857 and 1865, a New York commission led by Dudley Field drafted a criminal code that prohibited 'aiding' a suicide and specifically, "*furnishing another person with any deadly weapon or poisonous drug knowing that such person intends to use such weapon or drug in taking his own life*"

20th Century United States (Excerpt is from the U. S. Supreme Court ruling in the 1997 Washington v. Glucksberg - opinion written by Chief Justice Rehnquist.)

Due to developments in medicine and technology, very few Americans today die in institutions, from chronic illnesses. "Public anxiety and democratic action are dedicated on how to protect dignity and independence at the end of life, with the consequence that there have been many substantial changes in state laws and in the approaches these laws reflect".

1920 The book "Permitting the Destruction of Life not Worthy of Life" was published.

[7] Ibid

In this book, Alfred Hoche, contended that "*patients who ask for death assistance should, under very carefully controlled conditions, be able to obtain it from a physician*".

1935 The Euthanasia Society of England was created to support euthanasia[8].

1939 Nazi Germany

In October 1939 at outbreak of war Hitler ordered widespread "mercy killing" of the sick and disabled. Code named "Aktion T 4," the Nazi euthanasia program to eradicate "life unworthy of life". The Nazi euthanasia program quickly expanded to include older disabled children and incurable adults, upon diagnosis of their condition, be given a mercy death.

1995 Australia's Northern Territory approved a euthanasia bill.

1998 U.S. state of Oregon legalizes assisted suicide.

2000 The Netherlands legalizes euthanasia.

2002 Belgium legalizes euthanasia.

2008 U.S. state of Washington legalizes assisted suicide.

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[8] Supra Note 7

Mar. 2, 2014 - Belgium Legalizes Euthanasia for Terminally and Incurably Ill Children.

Belgium became the world's first country to lift all age restrictions on euthanasia

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Oct. 5, 2015 - California Becomes Legalize Physician-Assisted Suicide.

CHAPTER 2

2. ISSUES RELATED TO EUTHANASIA

2.1 LEGAL

The dispute regarding legalization of euthanasia in India can be well comprehended from two views:

(i) Reproduction from cultural and historical custom of India; and

(ii) To contemporary socio-medico-legal Growth.

Reproduction from Cultural and Historical Custom of India

Earlier social customs used to rule individual and social life. Social values lead human values. India is an example to this rule. Some Indian customs look like dictator and unjustified in modern era. Indian custom have created a hesitant environment for suicide and euthanasia. However suicidal actions were adored if done in guard of social values such as Sati, Jauhar, Saka[9].

Sati was a custom of self-sacrifice of a widowed woman by putting herself on the funeral fire of deceased husband. Varun Prabhat describes it as: "Sati is an ancient Sanskrit term, meaning a chaste woman who thinks of no other man than her own husband like Sati Savitri, Ahilya etc. none of them committed suicide, let alone being forcible burned. So how can we infer that they are Sati? 'Sati' means a pure woman and it should not be related with any suicide or murder. 'Pratha' was never used with Sati as Sati Pratha was a Christian Preacher creation"[10].

Regardless of the truth, the fact is that, Raja Ram Mohan Ray (1772-1833) had to start the movement against Sati Pratha and was finally eliminated by Lord William Benting (Governor General of East India Company) in the year 1829. Even after the abolition of such tradition there are people like Roop Kanwar in the village Deorala

[9] ""*Euthanasia:Global and Indian Perspective",* available at http://shodhganga.inflibnet.ac.in:8080/jspui/bitstream/10603/54434/7/07_chapter-2.pdf, last accessed at Feb 20,2015."
[10] Ibid

district Sikar of Rajasthan who still do sati. Many local people support her in the act and they believe that it helps to keep our hindu custom and traditions alive.

There is no denial of the fact that Custom is very difficult to stop but sati practices have become obsolete custom now. "Jauhar and Saka" means the deliberate deaths of men and women of the Rajput clan to evade arrest and dishonour from enemies. Mass self-sacrifice by women was known as Jauhar[11].

The knowledge about women and younger children were dead made them sad, occupied them with anger in the battle to the death called Saka.

In the year 2006 Nikhil Soni and his lawyers Madhav Mishra, who are Human Rights activists filed a public Interest Litigation (PIL) in the High Court of Rajasthan. The PIL argued about santhara being one of the social immoral act should be regarded as suicide and include all those who helped individuals in such act with abetting of suicide. However Indian Constitution's guarantees freedom of religion but for the Jains any such interference by the court would be the infringement of such freedom. The supporters of sallekhana or santhara contended that santhara has a religious background and not to be compared with suicide which are used in criminal perspective[12]. Form medical point suicide is result of deep psychological depression tailed by self-isolation. The act of suicide is prompt contrary to santhara in which the person takes oath to leave food or water and it is a gradual process. The basic intention behind the practice of Santhara is not to end life rather own karmas and to attain self cleansing and if he feels to resume his life he can break it[13].

Thus, santhara cannot be equated with suicide. Under sallekhana or santhara, death is hailed by a peaceful, calm way. On the issue of legality of such practice it can not be decided only on rationality and legal base alone. The custom of India suggests a cultural uncertainty towards suicide and euthanasia.

After the case of Venkatesh, a 25 year old who was having genetic neurological disorder and was on life-support but the court rejected to turn off life support as it would have amounted to euthanasia or mercy killing which was not legal in India.

[11] " available at http://www.euthanasia.com/historyeuthanasia.html ,last accessed at Feb 5,2016"
[12] Ibid
[13] Ibid

However there is urgent need to settle the issue with focus on to existing socio-medico-legal condition in India[14].

Contemporary Socio-Medico-Legal Growth

If we look at the present position of India we would have brisk cross currents of multi-dimensional processes of powers of social change. It is occupied in the course of development leading to modernization. Religion and caste will remain the guide to provide main background for modern India[15].

The majority of the population is still illiterate and they are still ruled by the old forbidden custom due to lack of basic necessities of life. The society experiences loss of basic values of our culture. India ranks 65thamong the most corrupt countries according to world audit corruption. Corruption is a virus, which degrades the flow of development and destroys organs of State. But its root is so deep that is very difficult to eradicate it and people have also accepted it as a way of life. There is immoral Relation between all the corrupt people sitting at all level from ground to[16]. The moral professions like teaching, medicine, and law have also given up their basic ethics for which they were known. Human rights have just become a theoretical concept which is there in book but cant be implemented. The difference between has and have nots is still not reduced and rich is getting richer and poor is getting poorer day by day. As regards the medical science it has made remarkable growth and now many of diseases like malaria, polio and smallpox are capable of being immunized[17]. Door to Door service of government for polio drops have helped to reduce the rate of polio patient substantially low which in return has controlled the annual death rate increasing the life expectancy of people. The medical science and technology are equipped with such life supporting system and medicines that will help to increase life for a long duration even after the majority of bodily functions are not being performed. Side by side these modifications the increase of upholding of human rights, autonomy and freedom of choice. These matters force the revision of many social morals and medical ethics.

[14] Supra note 9
[15] "Joshua, Samson Ayobami, "*Euthanasia: Socio-Medical and Legal Perspective*", available at < http://www.ijhssnet.com/journals/Vol_4_No_10_August_2014/30.pdf>, accessed at March 5,2016"
[16] Ibid
[17] Ibid

Most of the people are under a distress of using artificial life support for their living causing problems to family members also[18].

So here is the issue with legalizing of euthanasia in India that should a such a patient be given a right to choose the time and way of ending his own life? Answer to this issue will be dealt later in this dissertation by discussing the arguments of Medical Professionals who are for and against Euthanasia.

INDIAN PENAL CODE 1860 AND EUTHANASIA

"Abetment of a thing.—A person abets the doing of a thing, who—

1. Instigates any person to do that thing; or

2. Engages with one or more other person or persons in any conspiracy for the doing of that thing, if an act or illegal omission takes place in pursuance of that conspiracy, and in order to the doing of that thing; or

3. Intentionally aids, by any act or illegal omission, the doing of that thing.

Explanation 1.-A person who, by wilful misrepresentation, or by wilful concealment of a material fact which he is bound to disclose, voluntarily causes or procures, or attempts to cause or procure, a thing to be done, is said to instigate the doing of that thing.

Explanation 2.-Whoever, either prior to or at the time of the commission of an act, does anything in order to facilitate the commission of that act, and thereby facilitate the commission thereof, is said to aid the doing of that act"[19].

"Abetment of suicide.--If any person commits suicide, whoever abets the commission of such suicide, shall be punished with imprisonment of either description for a term which may extend to ten years, and shall also be liable to fine"[20].

"Attempt to commit suicide.--Whoever attempts to commit suicide and does any act towards the commission of such offence, shall be punished with simple imprisonment for a term which may extend to one year [or with fine, or with both"[21].

[18] Supra note 11
[19] SECTION 107
[20] SECTION 306

"*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 the 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 purpose of preventing or avoiding other harm to person or property. Explanation.-It is a question of fact 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"*[22].

" Act not intended and not known to be likely to cause death or grievous hurt, done by consent.-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"[23].

"Act not intended to cause death, done by consent in good faith for person's benefit-Nothing, which is not intented to cause death, is an offence by reason of any harm which it may cause, or be intended by the doer to cause, or be known by the doer to be likely to cause, to any person for whose benefit it is done in good faith, and who has given a consent, whether express or implied to suffer that harm, or to take the risk of that harm"[24].

"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

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[21] SECTION 309
[22] SECTION 81
[23] SECTION 87
[24] SECTION 88

Provisos.-First.-That this exception shall not extend to 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"[25].

2.2 ETHICAL PROBLEM SURROUNDING EUTHANASIA

2.2.1 PATIENT AUTONOMY

The stoutest contention for euthanasia is of autonomy, the principle of self-determination, uttered as the right of the individual to decide the timing and manner of their death. There is no denial to the fact that having done palliative care and assuring that patient is mentally competent, patients who request euthanasia will decline. It is unlikely to be because of pain. The research as to why people demand euthanasia shows the most common reason is psychosocial and existential factors. Patient desires are known to swing over time. What are we to do with this group of people. Suicidal thoughts are indication of depression. When a patient request for euthanasia foremost thing to be done is to evaluate and where apt treat him for depression. The rate of depression in cancer patients has been measured as high as 45%. From the available reports it is clear 1 out of 6 patients requesting for lethal prescription in Oregon 2004-2006 were clinically depressed. In contrary if there is any other group who urges for death it would alert a doctor for psychiatric analysis. Another thing to check is whether the patient aware of the rights they already have in terms of refusing life-prolonging treatment but knowledge of the right to refuse treatment would comfort many patients who fear being kept alive by artificial means against their desires. Finally, if the patient wants to avoid pain is by the reason of metaphysical or spiritual

[25] SECTION 92

concerns, then the psychological, religious, social and cultural anxieties needs to be focused.

Although there are still some people who request euthanasia, then how to move forward with such request? The concern is about legalizing euthanasia but not about whether euthanasia is right or wrong for individual cases. For some patients euthanasia is going to be ethically correct because for them their morality recognizes autonomy as a priority. So from the community scenario there is issue between those people who request euthanasia and the vulnerable people who are at risk of being given euthanasia against their wishes (Netherlands). Now we have conflict between Autonomy and Security. Is there a right to die that the government should support?

As Christians the belief would be that our bodies are not our own, legally, a man is free to end his life[26] . Many people say that when they are facing death they would want to be able to request euthanasia. The proportion of people actually requesting euthanasia when facing death is very different from the numbers of people would like the choice to request it.

A study done in Sydney has shown that after palliative care commenced, the number was reduced to less than 1% from 2.8% who requested euthanasia. Moreover, in practice, some will lose autonomy either path is chosen: if euthanasia is legalized, precedent shows that legally unprotected persons too often have their autonomy to choose life undermined; if illegal, Persons sincerely longing euthanasia lose their autonomy. The very small number of people demanding autonomy there is great responsibility on our society to care of them. Advocates of euthanasia bills will scrap this reasoning. They keep saying that it only affects patients and their carers, but this is just not true.

Autonomy as per Aruna Shaun Baug Case[27]

"Autonomy means the right to self-determination, where the informed patient has a right to choose the manner of his treatment. To be autonomous, the patient should be competent to make decision and choices. In the event that he is incompetent to make choices, his wishes expressed in advance in the form of a living will, or the wishes of

[26] Supra note 33

[27] Aruna Ramchandra Shanbaug vs Union Of India & Ors on 7 March, 2011

surrogates acting on his behalf (substituted judgment) are to be respected. The surrogate is expected to represent what the patient may have decided had she/she been competent, or to act in the patient's best interest"

2.2.2 INFORMED CHOICE AND CONSENT

Patient autonomy comprises the right to complete information the nature and progress of the terminal illness, the alternatives, the probable effects, and result of refusal of treatment.

People have life values that are important to them that doctors should not ignore. A good doctor should clarify the condition to his patient. For every process the patient should be given justification of the problem and possible answers, and then their consent asked. This is called informed consent.

ELEMENTS OF INFORMED CHOICE AND CONSENT

1. **Sufficient** information which is accurate, objective, relevant and culturally apt. This includes:

- efficiency of the suggested treatment or procedure
- the risks
- the probability of risk and effects if they eventuate
- other options, including the right to receive no care

The Code of Health and Disability Services Consumers' Rights 1996 states: "*Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive*". This is the so-called rights-based approach in that the consumer has the right to know what treatment demands in order to make a rational choice and consent[28]. In cases, patient do not want information the doctor should make a honest and sensible effort to get the consumer's real wishes.

[28] " "*Informed Consent and Informed Choice"*,available at < http://www.bioscience-bioethics.org/pdfs/CC_Intro_Bioethics_2nd_Ed_D_Medical_Ethics.pdf>, last accessed at Feb 20,2016"

The health professional must pass on information that is "material" to the patient. "Materiality" is a legal concept and in *Rogers v Whitaker* (Australia 1992), a risk is material if :

"In the circumstances of a particular case, a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it, or if the practitioner is or should be aware that the particular patient, if warned of the risk, would be likely to attach significance to it."

For example in case of ear operation involving a very slight risk of injury to the lingual nerve which is for sensation of taste. As the risk is so small,doctor would perhaps not usually warn every consumer[29]. Nevertheless, if the person is a cook then the risk becomes "material" and definitely be passed on[30].

INTERNATIONAL LAW

The basic principle of medical ethics is Informed consent. It is taken to be as the foundation of the "new ethos of patient autonomy", since the perception of autonomy has allowed and endowed patients to keep control of their lives.

Informed consent in legal term denotes a recognized directive of bio-law and human rights law. The bioethical and human rights methods to the life sciences have same base and morals i.e to guard human dignity and integrity.

INFORMED CONSENT IN INTERNATIONAL LEGAL INSTRUMENTS

In the outcome of the Nuremberg Trials international acknowledgment of patients' rights settled in the twentieth century stating duty of health-care providers and States responsibilities to the patient. In 1947, the Nuremberg Code declared that the voluntary approval of the human subject to medical research is needed in all conditions.

The first provisions of the Nuremberg Code stated: "*The voluntary consent of human subject is absolutely essential. This means the person involved should have legal capacity to give consent; should be so situated as to be able to exercise free power of choice, without the intervention of any element of force, fraud, deceit, duress,*

[29] Supra Note 28
[30] Ibid

overreaching or other ulterior form of constraint or coercion; and should have sufficient knowledge and comprehension of the element of the subject matter involved as to enable him to make an understanding and enlightened decision…"

The Declaration of Helsinki (1964) further advanced the Code principles and attached them to the ethical duties of physicians according to Declaration of Geneva (1948). In 1994, the World Health Organization Amsterdam Declaration on Patients' Rights needed informed consent as a condition for any medical interference which included the right to refuse or halt medical interference.

The acceptance by 'hard' and 'soft' international legal instruments have significantly added to the informed consent as the fundamental principle of the developing international biomedical law. It is important to educe first, the WHO Declaration on the promotion of patients right in Europe of 1994 the Council of Europe's Convention on Human Right and Biomedicine of 1997and its Additional Protocols as well as the UNESCO Universal Declaration of Human Genome and Human rights 1997 and Bioethics and Human Rights 2005.

The informed consent as listed by Anand Grover, Special Rapporteur on the right to health and adoption, is as follows:

i. Admiration for legal capacity
ii. Admiration for personal autonomy
iii. Totality of information
iv. Right to health and informed consent

Competence – The Code of Rights states that "Every person is presumed to be competent to make an informed choice and give informed consent unless there are reasonable grounds for believing the consumer is not competent".

If individual is treated as incompetent then their autonomy is removed so it is desirable to improve the decision-making capacity of people having limited ability to give consent. It is important to determine the degree of capability i.e Children will differ in ability, people with mental disability also differ.

If a person is unable to give consent, then treatment will normally be provided or denied on the basis of "substituted judgement" or "the best interests of the person".

Absence of coercion – the person should act voluntarily and not be forced or have undue pressure or influence .

Consent should be free and voluntary without coercion. It is better that consent is recieved steadily or in periods so that the consumer has time to think about the information or discuss it

2.2.3 SANCTITY AND QUALITY OF LIFE

The sanctity-of-life proposition rests upon the religious argument that life is a gift or a loan from God and only he can take it back. So all those people who are seeking to finish life are, playing God.

Sanctity of life may claim biologically. Each human life marks the end product of millions of years of evolution. Each person is absolutely unique. However, as we see people are born with defective genes so it is clear that neither God or nature provides for us equally.

Sanctity of life may also be viewed sociologically whereby equal value is assigned automatically to each human life. So it turn out to be the duty and responsibility of society to defend the individual from "playing God". Efforts to defend a terminally ill individual from pursuing death can be viewed as an infringement by the state into individual human rights.

Modern medicine has been blamed of "playing God" by keeping alive those who would die. It is at this point that sanctity of life doctrine clashes with "quality of life" experiences.

DOCTRINE OF DOUBLE EFFECT

The Stanford Encyclopedia of Philosophy, in its July 28, 2004 record titled "Doctrine of Double Effect," elucidated:

"*The doctrine (or principle) of double effect is often invoked to explain the permissibility of an action that causes a serious harm, such as the death of a human*

being, as a side effect of promoting some good end. It is claimed that sometimes it is permissible to cause such a harm as a side effect (or 'double effect') of bringing about a good result even though it would not be permissible to cause such a harm as a means to bringing about the same good end. This reasoning is summarized with the claim that sometimes it is permissible to bring about as a merely foreseen side effect a harmful event that it would be impermissible to bring about intentionally. A doctor who intends to hasten the death of a terminally ill patient by injecting a large dose of morphine would act impermissibly because he intends to bring about the patient's death. However, a doctor who intended to relieve the patient's pain with that same dose and merely foresaw the hastening of the patient's death would act permissibly."

The British Broadcasting Corporation in the Religion & Ethics segment in an entry titled "The Doctrine of Double Effect" wrote:

"*This doctrine [of double effect] says that if doing something morally good has a morally bad side-effect it's ethically OK to do it providing the bad side-effect wasn't intended. 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 distressing symptoms even though he knows doing this may shorten the patient's life.*
This is because the doctor is not aiming directly at killing the patient - the bad result of the patient's death is a side-effect of the good result of reducing the patient's pain. 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

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 not be the means of achieving the good one. So if the only way the drug relieves the patient's pain is by killing him, the doctrine of double effect doesn't apply.

The action must be proportional to the cause: If I give a patient a dose of drugs so large that it is certain to kill them, and that is also far greater than the dose needed to control their pain, I can't use the Doctrine of Double Effect to say that what I did was right.

The action must be appropriate (a): I also have to give the patient the right medicine. If I give the patient a fatal dose of pain-killing drugs, it's no use saying that my intention was to relieve their symptoms of vomiting if the drug doesn't have any effect on vomiting.

The action must be appropriate (b): I also have to give the patient the right medicine for their symptoms. If I give the 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 wasn't suffering from pain but from breathlessness.

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

2.2.4 HOSPICE ALTERNATIVE

Hospice care provides care to the terminally ill patient to whom treatment is no longer needed or is no longer beneficial. It is constructed on palliative care framework to reduce pain by giving people apt symptom control help as symptom is associated with quality of life. They have inverse relationship with each other.

As per Sherman and Cheon:
"*In short, palliative care/hospice partnership creates a common sense allocation of health care resources as patients move across the illness trajectory and approach the end-of-life. With palliative and hospice care, the wishes and preferences of patients and families are respected, often with a desire to withdraw life-prolonging treatments and insure their comfort and dignity as death approaches."*

There is a genuine doubt in mind i.e. Are both Hospice care and Palliative Care same thing or is there any difference between them[31]. The answer is they are not same thing they differ in approach though they both provide care and reduce pain. The difference is:

In definition:

Palliative Care aims to focus on easing symptoms associated to chronic illnesses, such as cancer, cardiac disease etc. Palliative Care could be given at any point of illness.

Hospice gives palliative care by nature. It differs here that it is given when the symptoms have reached to such level where no cure is needed or if given it will not cure the illness. It comforts the patient and their relatives by aiming on reducing symptoms.

Treatment Differences:

The healing methods under palliative care are not limited. It can vary according to the symptoms of the patient from easy to harsh methods.

Under Hospice Care healing methods are narrow and effort is on palliation of signs of illness of patient. The objective is not to cure, but to promote ease.

Treatment Timing:

Palliative Care is given at any phase of the illness. There is not fixed time to give it.

Under Hospice Care, physician has to confirm about the fatal condition of patient and he will live for another six months or so.

Place of Treatment:

Hospice Care is given at Home where all the facilities giving hospice is available and there is nurse who will look into the health of the patient.

[31]" available at < http://palliativedoctors.org/faq>, last accessed at Feb 25,2016"

Palliative care can be given at home but most of the physician suggests to give it at hospital so that if any emergency service or care is needed it will be easy to get that in time[32].

Differences in Types of Services:

Palliative Care is delivered from experts, physicians and nursing .
Hospice Care services are wide-ranging. Hospice Care includes physician services, nursing services, social worker, spiritual care, bereavement care and volunteers and may include therapy services, as well as other counseling services to administer terminal signs and provide support.

2.2.5 KANTANIAN VS UTILITARIANISM OF EUTHANASIA

The most recognized ethicists are John Stuart Mill (1806-1873) and Immanuel Kant (1724-1804).The theories views the pros and cons of euthanasia.

John Stuart Mill, a British philosopher, supported the Utilitarianism view which is known as, "The Greatest Happiness" belief. He is in favor of Active Euthanasia, as it ends the suffering of the person and the choice to end life is the greatest happiness. The Utilitarian Theory embraces the pursuit of happiness. Mill believed in two classes of pleasure: higher pleasure and lower pleasure. Higher represents a person's intelligence and lower the body. When a person is towards the end of their life, it is said that we should agree that the absence of pain and the pride of the person should be taken into great consideration. When a terminally ill person is no longer capable of intellectual pursuits, it is a noble choice to end the anguish, therefor fulfilling the "absence of pain" principle (pain including one's inability to seek higher pleasure through intellectual pursuit). This leads me to construe that the intention to end suffering is more meaningful than euthanasia[33].

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[32]Ann,Villet-Lagomarsino, "*Hospice vs Palliative care*", available at < http://www.caregiverslibrary.org/caregivers-resources/grp-end-of-life-issues/hsgrp-hospice/hospice-vs-palliative-care-article.aspx>, last accessed at Feb 26,2016

[33]Konley,Jennifer,"kantanian vs utilitarianism of euthanasia", available at <http://wp4dying.blogspot.in/2010/04/kantian-vs-utilitarian-ethics-of.html> ,last accessed at Feb26,2016

Kant, has a very different viewpoint to believe. His theories on mortality are derived from the Greek "deontology," which means obligation. According to Kant's Ethics, "the more difficult the duty, the greater the moral value." This means that choosing to tough out the dying process naturally is more important than ending it at will. Kantian Ethics believe that the law should be followed to get more contentment in knowing that law is followed. Kant's theory on euthanasia is that if one feels it is okay to end the life of a "competent" terminally ill patient, then society might also feel that it their duty to decide the fate of "incompetent" people who may not contribute to society, are handicapped or elderly. Kant is against voluntary euthanasia as the person who is in pain and is tending to end life, is not doing his duty and is always immoral.

The act is moral "*if the unfortunate one, strong in mind, indignant at his fate rather than desponding or dejected, wishes for death, and yet preserves his life without loving it --- not from inclination or fear, but from duty, then his maxim has a moral worth*"

CHAPTER 3

3. RELIGIOUS VIEW ON EUTHANASIA

Every Religion deal with one most important aspect of life i.e death. All religion dictates meaning of death. Religion provides for rituals at the time of death, and ceremonies to be performed after the death of a person.

Religions regard dying as most important way to find the meaning in human life. Dying in every religion is seen as an occasion for getting powerful spiritual insights and preparing for afterlife to come.

3.1 HINDU

The common hindu belief is that soul and body to be divided by a natural way only so the doctor should not take the request of patient for euthanasia as it will disturb the karma.

Other Hindus view is that if euthanasia is allowed it is **ahimsa**. Although there are some Hindus who believe that by helping to put an end to persons pain is a good act and are doing their moral duties[34].

Background

Hindu religion is more focused on the effects of our deeds. They believe that culture and faith are complex.

Karma: They believe in the rebirth of the soul through many lives and fundamental aim of life is to attain moksha, liberty from the series of death and rebirth. Karma decides soul's next life, according to ones good or bad actions in previous lives. To attain moksha the person has to perform good karma.

Non-violence: It is the principle of ahimsa.

Dharma: It deals with their moral duties towards the other person.

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[34] ""Euthanasia and suicide", available at <http://www.bbc.co.uk/religion/religions/hinduism/hinduethics/euthanasia.shtml>, last accessed at Feb 27,2016."

Killing

In the hindu belief Killing be it in any way hinders with liberty of the killed soul. It also fetches bad karma to the person who is involved in the killing as it is against non-violence.

Euthanasia

Hindu views on euthanasia:

The person is doing a good act and meeting their moral duties by helping to finish a painful life. So a person is bothering the cycle of death and rebirth by his help and is a bad thing. Any person who is artificially alive on a life-support machine is not a good thing but as a brief method for healing is a good thing.

Suicide

Prayopavesa : It means fasting to death but it is not suicide. It a natural way and is done only when the body has fulfilled all its duties towards society. It is not a fast process but rather a steady process requiring time[35].

For prayopavesa religion has laid certain condition as to:

- Not able to do bodily cleansing
- Death is looming
- The choice is openly announced
- To be performed under community parameter

3.2 SIKH REASONING

Moral thinking

Guru Granth Sahib and Sikh Code of Conduct (the*Rehat Maryada*) is the source from where ethics is derived by Sikhs. They lay down general principles and provide a basic outline.

[35] Supra Note 34

Euthanasia

As a gift from God Sikhs give huge regard towards life. Most Sikhs are against euthanasia as it is upto God to decide the death of person. Every Person owe a duty to use life in a sensible way.

Care for others

Sikh response to conditions where people think about euthanasia is to give them best care and attention so that they don't think of euthanasia as better option to survive.

3.3 BUDDHISM MENTALITY

Euthanasia and suicide

Buddhists are not united about euthanasia, and the philosophies of the Buddha don't clearly deal with it. Most Buddhists are not in favour of involuntary euthanasia.

States of mind

The most common position is that voluntary euthanasia is wrong as it shows that one's mind is in a bad state and his physical suffering caused mental suffering. Use of prescribed meditation and pain killing drugs should enable a person to attain a stable mental state and not consider euthanasia or suicide[36].

Avoiding harm

They lay stress on non-harm, and on preventing the ending of life. The intentional ending of life is contrary to Buddhist teaching and voluntary euthanasia should be prohibited[37].

Karma

[36] Buddhism and Euthanasia ,available at < http://www.bbc.co.uk/religion/religions/buddhism/buddhistethics/euthanasiasuicide.shtml >, last accessed on Feb 28,2016
[37] Ibid

Death as a transition is what Buddhist regard. The dead person will be reborn to a new life according to the karma he did in his earlier life. This produces two problems. We don't have any idea as to how out next life would be and if it even worse than the life that the sick person is presently living it would clearly wrong to allow euthanasia. The second problem is that restriction on life affects with the working of karma, and changes the karmic balance accordingly.

Euthanasia as suicide

The Buddha himself showed tolerance of suicide by monks in two cases. The Japanese Buddhist tradition includes many stories of suicide by monks, and suicide was used as a political weapon by Buddhist monks during the Vietnam war.

In Buddhism, the manner in which the life ends has a deep impact on the way the new life will start. So a person's state of mind at the time of death is important. This proposes that suicide (and so euthanasia) is permitted for those people only who have attained enlightenment

3.4 CHRISTIAN VIEW

Most of the Christians are not is favor of euthanasia. Their belief is that God has given the life. Churches also stress the importance of not interfering with the natural course of death.

Life is a gift

All life is given by God and death is a part of the life, hence the society should respect it and therefore can't take the life of any person.

The process of dying is spiritually important

Many churches believe that the time just before the death of the person is the most spiritual time of life and any obstruction with death of the person would disrupt the course and manner in which his spirit moves to God.[38]

[38] "Christianity and Euthanasia, available at < http://www.bbc.co.uk/religion/religions/christianity/christianethics/euthanasia_1.shtml>, last accessed at Feb 28,2016"

All human lives are equally valuable

The inherent dignity and value of human lives indicates that the worth of each life is alike unaffected by any kind of intellect or triumphs.Treating all humans equal just because they are humans has inferences for thinking regarding euthanasia:

- The core value of patients in a persistent vegetative state remains the similar as anyone else's
- So to settle that they it would be better if they are dead is wrong.
- All patients are on equal platform as other humans.

Exceptions and omissions

On contrary this religion suggest that presence of some responsibilities go beside the view that euthanasia is not a good thing:

- Respect every human being
- It means to respect the decisions of person who is about to end their life
- It implies acceptance of patient decisions to decline treatment.

3.5 ISLAM

Euthanasia and suicide in Islam

Muslims are not in favor of euthanasia. They believe that Allah has given them life and hence it is sacred. No human is allowed to take the life of other person.

Life is sacred

From among the reasons acceptable for killing under Islam euthanasia and suicide are not included.

"Do not take life, which Allah made sacred, other than in the course of justice.
Qur'an" 17:33

"When their time comes they cannot delay it for a single hour nor can they bring it forward by a single hour".
Qur'an 16:61

"And no person can ever die except by Allah's leave and at an appointed term".
Qur'an 3:145

Suicide and euthanasia are clearly prohibited

"Destroy not yourselves. Surely Allah is ever merciful to you".
Qur'an 4:29

The Prophet said: "*Amongst the nations before you there was a man who got a wound, and growing impatient (with its pain), he took a knife and cut his hand with it and the blood did not stop till he died. Allah said, 'My Slave hurried to bring death upon himself so I have forbidden him (to enter) Paradise."*
Sahih Bukhari 4.56.669

End of life decisions and DNR orders

Most of the sincere Muslims think that Do Not Resuscitate (DNR) represent a lenient form of euthanasia which is stringently prohibited in Islam.
Nevertheless, the Islamic Code of Medical Ethics says "*it is futile to diligently keep the patient in a vegetative state by heroic means... It is the process of life that the doctor aims to maintain and not the process of dying*". Hence doctors can end trying to extend life where there is no chance of a treatment[39].
As per to the Islamic Medical Association of America (IMANA) "*When death becomes inevitable, as determined by physicians taking care of terminally ill patients, the patient should be allowed to die without unnecessary procedures*."
IMANA say that turnoff of life support is permitted of ill patient as they all are temporary measures. However accelerating death by use of pain-killing drugs is not permitted as this will link to euthanasia.

[39] "Islam and Medical Ethics, available at < http://www.bbc.co.uk/religion/religions/islam/islamethics/euthanasia.shtml>, last accessed at Feb 28,2016."

3.6 JUDAISM, EUTHANASIA AND SUICIDE

> ...The message of Judaism is that one must struggle until the last breath of life. Until the last moment, one has to live and rejoice and give thanks to the Creator...
>
> Dr Rachamim Melamed-Cohen, Jewsweek, March, 2002

The Jewish custom respects the human life and prohibits doing anything that lead to shortening of human life. Everyone life is of great value but there is a boundary to the responsibility of person to keep ill people alive. Doctors should not make the person grieve more by artificially prolonging death of person who is in serious pain[40].

Active euthanasia

Jewish are against active euthanasia and they equate it with murder and the wish of the person to die does not make any difference.

Shortening life

> The value of human life is infinite and beyond measure, so that any part of life - even if only an hour or a second - is of precisely the same worth as seventy years of it, just as any fraction of infinity, being indivisible, remains infinite.
>
> Lord Jakobovits, former UK Chief Rabbi

So in case if a person is a goses (someone started to die and will die in 72 hours), any act that would accelerate death is forbidden.

Passive euthanasia

Doctors have a obligation to preserve life. Although a doctor cannot do anything that hastens death but can remove anything that is stopping the person's soul from passing. So if a patient is kept alive only be the use of ventilator, it is allowed to switch off the ventilator.

[40] Ibid

CHAPTER 4

4. JUDICIAL APPROACH

In the year 2006 Law Commission of India made a broad study of the issue of medical treatment to terminally ill patient and made remarks as to how to protect patients rights etc. The Law Commission of India also attached a draft bill to the original report titled as "*Medical Treatment to terminally ill patient (Protection of Patients and Medical Practitioners) Bill, 2006*".

Certain Procedures which are to be followed in such conditions are laid down by the commission. For better understanding of legal procedure given by commission it is necessary to have a clear idea about three words:
first, the competent patient is that patient who is not incompetent;
Secondly, the incompetent patient denotes a person who is a minor, or of unsound mind or a person who is not able to - (a) realize the communication important to an informed decision about illness; (b) remember that communication; (c) to use that communication as a means to make a final decision; (d) make an informed decision or (e) speak the informed decision;
Thirdly, an informed decision implies the decision as to prolongation or stopping or removing of medical treatment which is acquired by a competent patient and being knowledgeable about (a) the type of illness, (b) any existing substitute treatment, (c) the effects of such form of treatment, and (d) the effects of staying without such treatment.

The major provisions in this regard have been given as under:
(1) If a capable patient makes himself an informed decision of medical treatment to continue or stop and permit natural course, or start treatment and speaks the decision to the medical practitioner. Then such choice of the patient is obligatory on the medical practitioner to abide save as patient is competent and made the decision without any coercion.

(2) Each medical directive (called living will) or medical power-of attorney effected by a person shall be invalid and shall not be compulsory on any medical practitioner.

(3) A medical practitioner to decide whether to suppress or remove the medical treatment(a) from a competent patient who has not provided any informed decision, or (b) from an incompetent patient.

Exceptions

(i) In the view of the Medical Practitioner in the interests of the patients medical treatment to be withdrawn ;

(ii) observe such guidelines delivered by the Medical Council of India (MCI)

(iii) discuss with the parents or relatives of the patient but shall not be bound by their decision.

The medical practitioner who decides to withheld or removes life support system has to abide by the the method laid down as :

(i) obtain view of the three medical practitioners selected for this issue by the Director General of Health services, for Union territories or Director of Health Services (or officer holding equivalent post) for states. The Commission has issued recommendations for the experts to prepare such a panel and provide it to all the medical institutes;

(ii) to keep a register in which he should have reasons about how he thought that: (a) the patient is competent or not; (b) the competent patient informed decision (c) reason of thinking that the act will be in best interest of patient. (d) data of the patient.

(iii) The medical practitioner to notify in written the patient or his parents or other relatives about the choice to withhold or withdraw such treatment is in the patient's best interests according to medical practitioner. However if the parents or relatives convey their intention to go to High Court, the medical practitioner shall delay fifteen days such treatment and if no order is received in the time specified then he may move forward with such treatment.

(4) A duplicate of the pages in the register regarding each such patient shall be lodged instantly and it should be kept personal.

(5) No medical practitioner is disqualified from dispensing palliative care regardless medical treatment has been withheld or withdrawn.

(6) Nothing in the Indian Penal Code or any other law for the time being in force (45 of 1860), make any patient guilty of any offence if he denies medical treatment ,

(7) The safeguard is offered to the medical practitioner also and any other person acting under his orders to withhold or withdraw medical treatment

(8) A High Court declaratory relief and orders is not a condition precedent to withholding or withdrawing medical treatment if the act is done according to the provisions of this act.

(9) Whenever a petition is filed under the act to the High Court, it should direct that the identity of the patient, medical practitioner, expert medical consultant who provided evidence, during the pendency of the petition and after its disposal, be personal and shall be referred only by the English alphabets as chosen or assign to each of them and shall be to be compulsory on all media. The violation will lead to contempt of court or prosecution in civil or criminal courts. Such communications to be made only in sealed covers and should be sent so that orders of the respective High court are understood and enforced in favor of patient.

(10) Medical Council of India compulsorily to prepare the panel of medical experts of at minimum twenty years experience to prepare and publish in official gazette and on website.

In the report no. 210th The Law Commission of India (2008) has suggested to government to scrap Sec 309 of Indian Penal Code, and in order to decriminalize attempt to suicide but keep Sec. 306 of the IPC i.e abetment to suicide that includes assistance to suicide. Hence the Modi government scrapped Section 309 of IPC after 18 states and 4 Union territories supported the recommendation of the Law Commission of India.

Parlika Jain (2008) has rightly spotted: *In the present scheme of criminal law it is not possible to interpret the sections to contain voluntary euthanasia exclusive of including non-voluntary and involuntary euthanasia. Parliament by a special legislation allow voluntary euthanasia while expressly outlawing non-voluntary and involuntary euthanasia.*

In State of Maharashtra v. Maruti Shripati Dubal[41], Bombay High Court held that, "*Everyone should have the freedom to dispose of his life as and when he desires*."

[41]" Maruti Ssripati Dubal v State of Maharshtra 1987 Cri LJ 743 Bom."

It was upheld by the Supreme Court P. Rathinam v. Union of India[42] and held, "A person cannot be forced to enjoy life to his detriment, disadvantage or disliking." But, the Supreme Court disallowed the plea that euthanasia (mercy killing) should be allowed by law as it needs third person either actively or passively.

Then in Gian Kaur's case[43], five Judge Bench of the Supreme Court overturned P. Rathinam's case and held, "*The 'right to life' under Article 21 of the Constitution of India does not include the 'right to die' or 'right to be killed'... the right to life would mean the existence of such a right up to the end of natural life. The Supreme Court also held that Article 21 of the Constitution of India does not include therein, the right to curtail the natural span of life."* Further stated that euthanasia and physician assisted suicide are not merely legal issues but individual, social and moral issues also.

"The contribution that law in India can make at this juncture is providing a procedural legal framework that would guide the practice of euthanasia in serving the interests of the contemporary and future society". But any initiative for legalizing euthanasia and physician assisted suicide Tejshree M. Dusane (2009) a Professor of Law in Pune, wrote: "*the legalization of euthanasia would be dangerous....all doctors with responsibility for the care of terminally ill patients should accept their duty to deliver this care at the known best standards, as they are legally obliged to do in other branches of medical practice. In this world of fast development and miracles, I staunchly believe that someday man would develop a mechanism to reduce pain to the minimum possible extent and make life less burdensome. The appropriate course of action would be to introduce proper care ethics ensuring a dignified existence rather than attempting to terminate one's life. The Kerala Law Reforms Commission (2009) has also suggested amendments in the Indian Penal Code (IPC), so as to legalizing euthanasia and to treat suicide attempts as a non-punishable offence".*

[42] "P.Rathinam vs Union Of India on 26 April, 1994."

[43] "Smt. Gian Kaur vs The State Of Punjab on 21 March, 1996."

"*Mortality is life's inevitability and death is deliverance from dreadful disease and intolerable torment. Life is sacred, but intense pain with no relief in sight is a torture, which negates the meaning of existence."*

The Commission Vice Chairman, Justice T V Ramakrishnan said : "*Many great minds have opted for euthanasia. The Indian Penal Code and its author Lord Macaulay are not the last word for the law reformer."*

The Kerala Law Reforms Commission proposals allow a ill person to end his life under direction and guidance of close relatives and medical practitioners. The draft bill in this respect is possibly the first of in Kerala and India.

4.1 EMPHASIS ON ARUNA RAMCHADRA CASE

The apex court of India in its landmark judgment on 8th March 2011 has allowed passive euthanasia including removal of life sustaining drugs and/or life support systems-for brain dead patients or in a persistent vegetative state (PVS), and doctors have lost chance of recovering after the use of most superior medical aid, but the court cleared that active euthanasia, including injecting a potent drug to increase patients death will remain a crime under Indian law.

The above judgment was given by Supreme Court bench of Justice Markandey Katju and Gyan Sudha Mishra in a PIL petition which Pinki Virani filed as a next friend of Aruna Shanbaug, a nurse in K.E.M. hospital Mumbai. Sohan Lal Valmiki, a ward boy at the hospital sexually assaulted Aruna Shanbaug when she was just 25 years old. Dog chain was used by him around her neck so that aruna can be throttled and it lead to cut off blood and oxygen to her mind, which lead her as paralysed and in a vegetative state. From that incident aruna is lying on bed for last 38 years.

The K.E.M. hospital staff and members take care of her in the best possible. Pinki Virani through PIL requested Supreme Court to stop Aruna's force feeding. The SC, dismissed Pinki Virani's petition and accepted K.E.M hospital prayer and viewed that it alone was legally, emotionally and circumstantially entitled to the position of Aruna's next friend. Sohan Lal Valmiki was convicted with attempted murder and robbing Aruna's earrings and was sentenced to seven years in jail.

The major procedure laid by supreme court in case of passive euthanasia are as under :

1. When patient is kept alive mechanically, when not only consciousness is lost, but person only able to sustain involuntary functioning through machines.

2. When there is no possibility of patient ever being able to come out of this. If there has been no alteration in patient's condition at least for a few years.
3. High Court can pass orders on plea filed by near relatives or next friend or doctor/hospital staff praying for permission to withdraw life support.
4. When such a plea is filed, the CJ of HC should constitute bench of at least two judges.
5. Bench should seek opinion of a panel of three reputed doctors preferably a neurologist, psychiatrist and physician.
6. HC should hear near relatives and state after giving them a copy of panel's report and make expeditious decision.
7. The HC would issue notice to parties concerned and give an expeditious judgment since delay could aggravate the mental agony of the relatives.

JUDGMENT

Rejecting mercy killing of Aruna Shanbaug, a two-judge bench of Supreme Court permitted "passive euthanasia" of withdrawing life support to patients in persistent vegetative state but disallowed active euthanasia by lethal doses. The Supreme court while framing the standards for passive euthanasia declared until Parliament legislates a law for this issue, it would now be the law of the land.
The bench urged Parliament to scrap Section 309 IPC (attempt to suicide) as it has become "anachronistic though it has become constitutionally valid." "A person attempts suicide in a depression, and hence he needs help, rather than punishment," Justice Katju writing the judgement said.
The Apex Court noted that though there is no statutory provision for withdrawing life support system from a person in PVS, it was of the view that "passive euthanasia" could be permissible in certain cases for which it laid down guidelines and cast the responsibility on high courts to take decisions on pleas for mercy killings.

GUIDELINES BY SC

"We are laying down the law in this connection which will continue to be the law until Parliament makes a law on the subject:

(i) *A decision has to be taken to discontinue life support either by the parent or the spouse or other close relative or in the absence of any of them, such a decision can be taken even by a person or a body of persons acting as a next friend. It can also be taken by the doctors attending the patient. However, the decision should be taken bona fide in the best interest of the patient. In the present case, we have already noted that Aruna Shanbaug's parents are dead and other close relatives are not interested in her ever since she had the unfortunate assault on her. As already noted above, it is the KEM Hospital staff, who have been amazingly caring for her day and night for so many long years, who really are her next friends, and not Ms. Pinki Virani who has only visited her on few occasions and written a book on her. Hence, it is for KEM Hospital staff to take that decision. KEM Hospital staff have clearly expressed their wish that Aruna Shanbaug should be allowed to live. However, assuming that the KEM Hospital staff at some future time changes its mind, in our opinion, in such a situation, KEM Hospital would have to apply to the Bombay High Court for approval of the decision to withdraw life support*.

(ii) *Hence, even if a decision is taken by the near relatives or doctors or next friend to withdraw life support, such a decision requires approval from the High Court concerned as laid down in Airedale case. In our opinion, this is even more necessary in our country as we cannot rule out the possibility of mischief being done by relatives or others for inheriting the property of the patient". In our opinion, if we leave solely to the patient's relatives or to the doctors or next friend to decide whether to withdraw the life support of an incompetent person, there is always a risk in our country that this may be misused by some unscrupulous person who wish to inherit or otherwise grab the property of the patient. "We cannot rule out the possibility that unscrupulous persons with the help of some unscrupulous doctors may fabricate material to show that it is a terminal case with no chance of recovery. In our opinion, while giving great weight to the wishes of the parents, spouse, or other close relatives or next friend of the incompetent patient and also giving due weight to the opinion of the attending doctors, we cannot leave it entirely to their discretion whether to discontinue the lift support or not. We agree with the decision of Lord Keith in Airedale case*

that the approval of the High Court should be taken in this connection. This is in the interest of the protection of the patient, protection of the doctors, relatives and next friend, and for reassurance of the patient's family as well as the public. This is also in consonance with the doctrine of parens patriae which is well-known principle of law".

(iii) Then Supreme Court explained the doctrine of 'Parens Patriae'. The Supreme Court then observed that Article 226 of the Constitution gives ample powers to the High Court to pass suitable orders on the application filed by the near relatives or next friend or the doctors/hospital staff seeking permission to withdraw the life support to an incompetent patient.

(iv) The procedure to be adopted by the High Court has been laid down in paragraph 134 (p. 522)as follows: "*When such an application is filed, the Chief Justice of the High Court should forthwith constitute a Bench of at least two Judges who should decide to grant approval or not. Before doing so the Bench should seek the opinion of a committee of three reputed doctors to be nominated by the Bench after consulting such medical authorities/medical practitioners as it may deem fit. Preferably one of the three doctors should be a neurologist, one should be a psychiatrist, and the third a physician. For this purpose a panel of doctors in every city may be prepared by the High Court in consultation with the State Government/Union Territory and their fees for this purpose may be fixed. The committee of three doctors nominated by the Bench should carefully examine the patient and also consult the record of the patient as well as taking the views of the hospital staff and submit its report to the High Court Bench. Simultaneously with appointing the committee of doctors, the High Court Bench shall also issue notice to the State and close relatives e.g. parents, spouse, brothers/sisters etc. of the patient, and in their absence his/her next friend, and supply a copy of the report of the doctor's committee to them as soon as it is available. After hearing them, the High Court bench should give its verdict. The above procedure should be followed all over India until Parliament makes legislation on this subject."*

PATH TO JUDGMENT

The Airedale case[44]

The facts of the case were that one 17 year old guy named Anthony Bland went to the Hillsborough Ground on 15th April 1989 to cheer up for his favorite football team i.e. Liverpool Football. While the match was going on there was huge rush of people who came to see the match and it resulted in disaster which is know as Hillsborough Disaster. Around 789 people were injured badly and anthony's lungs were crumpled and and the supply to his brain was interjected and he suffered "catastrophic and irreversible" damage to the brain. He was in a Persistent Vegetative State for last three years.

One of the judges on jury noted that it was 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. This extends to the situation where the person in anticipation of his entering into a condition such as PVS, gives clear instructions that in such an event he is not to be given medical care, including artificial feeding, designed to keep him alive. He observed that the principle of sanctity of life is not an absolute one. For instance, it does not compel the medical practitioner on pain of criminal sanction to treat a patient, who will die, if he does not, according to the express wish of the patient. It does not authorize forcible feeding of prisoners on hunger strike. It does not compel the temporary keeping alive of patients who are terminally ill where to do so would merely prolong their suffering. On the other hand, it forbids the taking of active measures to cut short the life of a terminally-ill patient (unless there is legislation which permits it).

Another judge of jury named Lord Keith observed "… *that although the decision whether or not the continued treatment and cure of a PVS patient confers any benefit on him is essentially one for the medical practitioners in charge of his case to decide, as a matter of routine the hospital/medical practitioner should apply to the Family Division of the High Court for endorsing or reversing the said decision. This is in the*

[44] "Airedale NHS Trust v Bland. [1993] 1 All ER 821 HL."

interest of the protection of the patient, doctors, and for the reassurance of the patient's family and the public".

Lord Goff observed: "*discontinuance of artificial feeding in such cases is not equivalent to cutting a mountaineer's rope, or severing the air pipe of a deep sea diver. The true question is not whether the doctor should take a course in which he will actively kill his patient, but rather whether he should continue to provide his patient with medical treatment or care which, if continued, will prolong his life*".

Lord Browne-Wilkinson observed: "*removing the nasogastric tube in the case of Anthony Bland cannot be regarded as a positive act causing the death. Its non removal itself does not cause the death since by itself, it does not sustain life. Hence removal of the tube would not constitute the actus reus of murder, since such an act would not cause the death*".

Lord Mustill observed: "…. *Anthony Bland's life should now end. The doctors have done all they can. Nothing will be gained by going on and much will be lost. The distress of the family will get steadily worse. The strain on the devotion of a medical staff charged with the care of a patient whose condition will never improve, who may live for years and who does not even recognize that he is being cared for, will continue to mount. The large resources of skill, labour and money now being devoted to Anthony Bland might in the opinion of many be more fruitfully employed in improving the condition of other patients, who if treated may have useful, healthy and enjoyable lives for years to come."*

Thus all the Judges of the House of Lords unanimously agreed that let Anthony Bland be permitted to die. The law in United Kingdom is well settled that in the condition where the patient is incompetent, if the doctors act on the basis of informed medical opinion, and withdraw the artificial life support system in the patient's best interest, then the act cannot be equated with a crime.

The Law Commission of India summarized Airedale's case as

"*The judgment of the House of Lords in Airedale lays down a crucial principle of law when it says that withholding or withdrawal of life support to a dying patient merely amounts to allowing the patient to die a natural death and that where death in the normal course is certain, withholding or withdrawal of life support is not an offence. 21 If a patient capable of giving informed consent refuses to give consent or has, in advance, refused such consent, the doctor cannot administer life support systems to continue his life even if the doctor thinks that it is in the patient's interest to administer such system. The patient's right of self-determination is absolute. But the duty of a doctor to save life of a patient is not absolute. He can desist from prolonging life by artificial means if it is in the best interests of the patient. Such an omission is not an offence. The doctor or the hospital may seek a declaration from the Court that such withholding, which is proposed, will be lawful."*

COURT AS PARENS PATRIAE:

Parens patriae means the authority which acts a protector to people who are unable to protect themselves. Now the issue is still unresolved as to who has the final say in what is patient best interest in persistent vegetative state. It is a norm that if a patient is in PVS then his blood relatives or friends be allowed to take a decision on his behalf but upto what extent will be considered vital[45].

The only reliable option the person is left with who will make a decision is Court who will act as parens patriae regarding the best interest of the patient, however the decision of all the other people has to be considered in delivering final decision for the patient.

As stated by J Balcombe[46] "*the Court as representative of the Sovereign as parens patriae will adopt the same standard which a reasonable and responsible parent would do".*

[45] "Chapter IV of the 196th Report of the Law Commission of India on Medical Treatment to Terminally ill Patients."
[46] "Balcombe LJ in Re J (a minor) (wardship: medical treatment) [1990] 3 All ER 930."

THE GLUCKSBERG AND THE VACCOV CASES:

The U.S. Supreme Court that addressed the concern whether there was a federal constitutional right to assisted suicide arose from challenges to State laws that banned physician assisted suicide (PAS) brought by terminally ill patients and their physicians.

In Glucksberg's case[47], the U.S. Supreme Court held:
"*The decision to commit suicide with the assistance of another may be just as personal and profound as the decision to refuse unwanted medical treatment, but it has never enjoyed similar legal protection. Indeed the two acts are widely and reasonably regarded as quite distinct."*
So it means any proclaimed right to help in committing suicide is not a fundamental liberty interest protected by the "*Due Process Clause"* of the Fourteenth Amendment

In Vacco's case[48], the U.S. Supreme Court again came across the similar issue between denying life saving medication and providing lethal medical treatment. The Court disagreed with the view of the Second Circuit Federal Court that ending or refusing lifesaving medical treatment is similar to and can be equated with assisted suicide.
The Court held that "*the distinction between letting a patient die and making that patient die is important, logical, rational, and well established*". The Court held that the State of New York could validly ban the latter.

THE CRUZAN CASE:

In Cruzan v. Director, Missouri Department of Health[49] decided by the U.S. Supreme Court. In that case, the petitioner Nancy Cruzan sustained injuries in an automobile accident and lay in a Missouri State Hospital in what has been referred to as a PVS, "*when a person is able to be awake, but is totally unaware. A person in a vegetative*

[47] "Washington v. Glucksberg (96-110) 521 U.S. 702 (1997)."
[48] "Vacco v. Quill, 521 U.S. 793 (1997)."
[49] "Cruzan v. Director, Missouri Department of Health. 497 U.S. 261(1990)."

state can no longer "think," reason, relate meaningfully with his/her environment, recognize the presence of loved ones, or "feel" emotions or discomfort. The higher levels of the brain are no longer functional. A vegetative state is called "persistent" if it lasts for more than four weeks".

The State of Missouri was bearing the expense of her medical treeatment. Her guardians approached the Court for consent to pull back her pipe, which was used to give her food and water and let nature take the course. While the trial Court allowed the removal of such pipe, the State Supreme Court of Missouri overturned the order, holding that under a statute in the State of Missouri it was important to demonstrate by clear and persuading proof that the individual had needed, while in sense, withdrawal of life bolster treatment in such a condition. At that time there was not enough substantial evidence to support the issue.

Chief Justice noted that in "*law even touching of one person by another without consent and without legal justification was a battery, and hence illegall"*. Such norm and practice has been imbibed in the informed consent when the patient is undergoing medical treatment.

As per Court of Appeals of New York *"Every human being of adult years and sound mind has a right to determine what shall be done with his own body, and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages*."
Thus the informed consent doctrine has become firmly entrenched in American Tort Law. This means the patient has been given full autonomy in the medical treatment case where he can allow or disallow any medication to be carried or abstained in future. No body can work contrary to such wish of the patient as it will be against law.

The Chief Justice observed: "*Not all incompetent patients will have loved ones available to serve as surrogate decision makers. And even where family members are present, there will be, of course, some unfortunate situations in which family members will not act to protect a patient. A State is entitled to guard against potential abuses in such situations."*

Further observed*: "An erroneous decision not to terminate results in maintenance of the status quo; the possibility of subsequent developments such as advancements in medical science, the discovery of new evidence regarding the patient's intent, changes in the law, or simply the unexpected death of the patient despite the administration of life-sustaining treatment, at least create the potential that a wrong decision will eventually be corrected or its impact mitigated. An erroneous decision to withdraw life-sustaining treatment, however, is not susceptible of correction."*

CONSENT IN PERSISTENT VEGETATIVE STATE:

RE QUINLAN CASE[50]:

The patient named Karen Quinlan received serious brain damage due to the anoxia, and was on PVS. Her father approached the court so that court could allow to remove the respirator from the Karen. The New Jersey Supreme Court approved the request of her father, holding that Karen had a right of privacy grounded in the U.S. Constitution to abstain or to stop treatment.

The Court concluded "*Karen's right to privacy could be exercised would be to allow her guardian and family to decide whether she would exercise it in the circumstances".*

RE CONROY CASE[51]:

In Conroys case, a 84 year old incompetent nursing home resident who had suffered irreversible mental and physical ailments, however, the New Jersey Supreme Court, contrary to its decision in Quinlan's case, decided to base its decision on the "*common law right to self determination and informed consent".*

An proxy person can practice this right in case of proof that such ill individual would have practiced it. Where such proof was deficient with regards to the Court held that an individual's privilege could in any case be summoned in specific circumstances under goal 'best advantage' measures. Where no dependable proof existed that the

[50] " Re Quinlan 70 N.J. 10, 355 A.2d 647 (NJ 1976)"
[51] " Re Conroy 98 NJ 321, 486 A.2d 1209 (1985)"

individual would have needed to end treatment, and a man's agony would make the organization of life maintaining treatment harsh, an impartial and prudent method could be utilized to end the treatment

It is important to note in Cruzan's case that there was a statute of the State of Missouri, unlike in Airedale's case, which required clear and convincing evidence that while the patient was competent she had desired that if she becomes incompetent and in a PVS her life support should be withdrawn.

The following pertinent observations made by the then Chairman of the Law Commission in the forwarding letter dated 28 August 2006 addressed to the Hon'ble Minister are extracted below:

"*A hundred years ago, when medicine and medical technology had not invented the artificial methods of keeping a terminally ill patient alive by medical treatment, including by means of ventilators and artificial feeding, such patients were meeting their death on account of natural causes. Today, it is accepted, a terminally ill person has a common law right to refuse modern medical procedures and allow nature to take its own course, as was done in good old times. It is well-settled law in all countries that a terminally ill patient who is conscious and is competent, can take an 'informed decision' to die a natural death and direct that he or she be not given medical treatment which may merely prolong life. There are currently a large number of such patients who have reached a stage in their illness when according to well-informed body of medical opinion, there are no chances of recovery. But modern medicine and technology may yet enable such patients to prolong life to no purpose and during such prolongation, patients could go through extreme pain and suffering. Several such patients prefer palliative care for reducing pain and suffering and do not want medical treatment which will merely prolong life or postpone death*[52]."

As Veerapaa Moily said," *Supreme Court is right that without a law you cannot resort this kind of decision with a juridical order and there is a need for a serious debate within the country."*

[52] "Law Commission of India: Passive Euthanasia- A Relook Report no.241, available at < http://lawcommissionofindia.nic.in/reports/report241.pdf>,last accessed at March 7,2016"

Harish Salve said : *"The Supreme Court judgment underscores the need for the government to enact a law on the subject*."

Iqbal Chagla said "*it strikes a very nice balance between the compassionate need of a terminally ill patient to end his or her life and to any abuse by relatives*."

In dissenting tone Dr. Samiran Nadi said: "*it will open the floodgates what if the relative wants the patients to die. There are several terminally illnesses which have no cure now. Does that mean the patient is put to sleep just because he or she is in pain*"?
Dr. Pragnya Pai: *"Birth, growing up and death are not optional but inevitable. Some people cannot decide if a person will live or die*."

Dr. Farukh Udwadia ,medical practitioner said "*As doctor, our job is to relieve pain and suffering and not to take life in our own hands*."
People may argue about pros and cons of the judgment from their aspect but it cant be denied that this judgment has a far reaching effects and has ignited among various classes a thoughtful debate about the legalization of euthanasia in India.

RECENT DEVELOPMENT IN INDIA

The government has said it is ready to frame a statutory law on passive euthanasia, the act of withdrawing medical treatment with deliberate intention of causing the death of a terminally-ill patient. However, it said its "hands are stayed" because of a pending litigation in the Supreme Court on mercy killing.

The Ministry of Health and Family Welfare affidavit in the Supreme Court on January 28, 2016 delivers the clear vision into whether the Government considers euthanasia as manslaughter or an act of mercy.
The Ministry informed the Supreme Court that an expert panel has made changes and cleared the formulation of legislation on passive euthanasia after extensive debates, from July 2014 to June 2015.
The committee however refused on legalising 'active euthanasia' – an intentional act of putting to death a terminally-ill patient – on the grounds that this would lead to potential misuse and is practised in "very few countries worldwide".

The Health Ministry said "*it had consulted the Ministry of Law and Justice on the appropriateness of framing the euthanasia law when the issue is under the consideration of a Constitution Bench of the Supreme Court since February 2014*". At this point, the Health Ministry said it was "prudent to stay its hands".

The affidavit hints back to how the debate on legalising euthanasia began with a Lok Sabha private member's Bill – The Euthanasia (Regulation) Bill, 2002. The debate happened again after four years following the 196th Law Commission Report on euthanasia and the drafting of the Medical Treatment of Terminally Ill Patients (Protection of Patients and Medical Practitioners) Bill, 2006.
But the Ministry's experts under the Director General Health Services took a stand against euthanasia for reasons that it amounted to "intentional killing" and against the Hippocratic oath.

The affidavit said of how the Government even viewed euthanasia as an act against progressive medical science's objective to rehabilitate and treat patients. "*Death may be a fleeting desire arising out of transient depression*".

The Law Commission subsequently took full two years to draft a new law on the subject - The Medical Treatment of Terminally Ill Patients (Protection of Patients and Medical Practitioners) Bill. The Ministry had received the draft Bill in April 2014 and begun its task to fine-tune the law.

CHAPTER 5

5.INTERNATIONAL SCENARIO OF EUTHANASIA

5.1 DEFINITIONAL ISSUES

"In the absence of commonly accepted definition of 'euthanasia' it is important to be clear as to how to use the word in any particular situation. The price of not doing so is misunderstanding." Keown .

"It is positive to guess the development of common definitions as the diverse definitions reveal different fundamental moral assumptions whose resolutions is a precondition to definitional unanimity. Till we attain such an unanimity participants should be well-defined about which definition they are using and its reason." Keown

According to Brock:- Euthanasia is a "*deliberate killing of an innocent person*". If we take this definition then presumption that a late foetus is a human being, could point that there is marginal variation between euthanasia and abortion. The absence of such a universal definition is that not every "killing" is by virtue of its fact called as euthanasia.

Definition of euthanasia by Rosemary Firth (1981) is narrative. Euthanasia is (a) "*the medical use of drugs to ease a painful and protracted, but inevitable death", (b) "a deliberate attempt to bring about or to hasten one's own death in sickness or suffering", (c) "actively assisting an aged, sick or handicapped person to a merciful death".*

Assisted suicide, palliative care, the shortening of life comes under euthanasia. So such a wide-ranging explanation has to be made accurate.

In the year 1988 Michael Wreen tried to specify an analytical definition of euthanasia. According to "*someone must kill a live creature, or let her die, if euthanasia is to occur. The person A has committed euthanasia if and only if the following situations were fulfilled:*

1. *A killed B or let her die.*

2. *A had intention to kill B.*
3. *The intention was at least partial cause of the action .*
4. *The causal ride from the intention to the action is more or less according to A's plan of action.*
5. *A's act of killing of B is a voluntary act.*
6. *The motive for the act, the motive standing behind the intention is the good of the person killed and good includes the evading of evil.*

However this definition does take note of voluntary and active euthanasia. It also does not focus on as who and how the good of B is decided".

In 1990s and in early 2000s more specific definitions like "direct end of a capable patient's life at the patient's demand", "deliberate act to end life by someone other than, and at the demand of the patient" can be found (Quaghebeur).

Definition of euthanasia as started by Dutch and Belgian legislation is "*administration of lethal drugs by someone other than the person concerned with the explicit intention of ending a patient's life, at the latter's explicit request*" is being accepted my writers and scholars.

5.2 MEDICAL TREATMENT AND WILL OF THE PATIENT

Any person, who is not well and is suffering from some kind of illness, has the right to approach any medical practitioner and seek care and it will be duty of such physician to provide that person with such care and medicines to heel the illness. But there is one issue that giving patient the right to refuse the medication is causing difficulty. As per American national report, the autonomy of individual own body is protected and it includes the right to abstain from any such medication and this is norm which is continuing in common law. This also includes the discretion of the patient to put an end to any such method which is being used to stretch the life but this discretion does not mean to include the right to take decision of his death[53].

[53] "Groenhuijsen, Marc, "Euthanasia and the Criminal Justice System", available at < http://www.ejcl.org/113/article113-33.pdf>, last accessed at March 1,2016."

And, this discretion to abstain from medication or care is not absolute and there are some restrictions to it. In America many cases have come where state interests is invoked block the discretion of the patient and those are :

(a) the physician ethical code

(b) to safeguard the benefits of innocent third party

(c) the protection of life (sanctity of life); and

(d) the prevention of suicide.

However the gravity of effect of them are very less.

So to conclude : "*The result is that there is almost no set of circumstances where a competent individual will not have the right to refuse or discontinue any medical procedure, no matter how effective it promises to be, and no matter how drastic the consequences of declining it*."

In Germany, the Federal Court Of Justice in the "Kempten case" 1994 stated that the apparent will of the patient is considered equivalent to clear expression of the person's will. A request to let go medication has to be valued but on the opposite side the principle "in dubio pro vita" i.e. when in doubt prefer life has to be applied. However sometimes there is need for court order to stop such treatment[54].

The medical practitioner is not under any duty to stop the treatment when it is not useful for the patient on the request rather he has the discretion that he can exercise accordingly in his capacity.

In Israel Patients' Rights Law,1996 forms the principle administering the treatment and the patient's consent. When the life of patient is at risk such consent is not needed and medication can be commenced without such consent. If the patient life is at threat then medication can be given contrary to the desire of the patient, if an ethics board, after considering the patient, allows that the medication be run, given that some

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[54] Supra Note 53

legal needs are fulfilled, and there is a rational belief that after providing such medication the person would give his consent[55].

In 2004 Croatia approved the Protection of the Rights of the Patient Act. The right of patient to abstain from medication is not absolute and has some restriction in cases of undefeatable medical treatment whose failure to provide would risk the patient life.

The French Act of 22 July 2005 specifically provides the right to the patient to abstain from getting any further medication and the act extends to the limit if such refusal puts the life of patient at risk a reminder to that to the patient should be given, which later on will be stated in report which will be made[56].

In Greek national report, the condition in which the patient denies the medication or its furtherance is considered to be 'voluntary passive euthanasia'. In this case the right to abstain has been made unrestricted and it includes critical condition also because they think any action of the physician should not be done without or against the wishes of the patient.

In Italy according to Supreme Court judgment doctors have a strict professional responsibility to treat a patient and to save his life, irrespective of the patient's views. The discretion of patient to have medication is not of paramount value.

So the other issue is how to deduct the wish of the patient in situation where his consent in not being able to be taken or he not able to express it? So should physician take a advance consent in written form or his family members be allowed to make a call on his treatment?

In Germany, 'Kempten case' where a patient is in persistent vegetative state, the assumption that patient will not to continue with the medication can be conclusive. There is no law on legal nature of any previous written consent. There is also ambiguity in cases where there is no written consent or is just verbal, how far they will be treated as legally binding[57].

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[55] Ibid

[56] *Euthanasia A CARE briefing*", available at < http://www.care.org.uk/sites/default/files/Euthanasia_briefing.pdf>, last accessed at March 3,2016

[57] Ibid

As per Israeli Dying Patients Law the individual can tell his desires previously about the medication that should be given to him in case he is not in state to speak or provide explicit demand at that moment. The person may appoint a surrogate with a power of attorney and is binding for five years, with an choice for extension. The law also directs to have a record in which advance directives and powers of attorney shall be documented.

In the US both decisional and statutory law identify three ways for incompetent patients to decide their wishes[58].

The first one is explicit direction, by stating the condition in which a set standard of practice to be followed or avoided or they may also appoint any person who will take such decision with or without any conditions attached to it. In these situation it is presumed that condition being same as forecasted the patient would not have altered his thinking.

The second method is to make a choice in a way that traits the choice to the patient, i.e. by means of a "substituted judgement". This concerns the best judgement of the patient's guardian and family as to whether to discontinue treatment, which he or she believes the patient would have made under the situations. The disadvantage is that no matter how well the proxy decision-maker recognizes the patient, it is uncertain to what degree others can repeat the patient wishes.

The third method is founded "patient's best interest". Unexpectedly, this standard becomes less significant in circumstances where it is most desirable: where the ineffectiveness is the outcome of permanent unconsciousness or a persistent vegetative state[59].

The Greek national report states to issue as "one of the most crucial questions regarding passive euthanasia, i.e. what is the precise point in time at which the patient's will not to adopt life-saving measures must have been affirmed."

Greek criminal law does not recognize so-called "living wills". It is considered that consent can only be serious if it is imparted subsequent to the occurrence of the life-threatening situation. Hence in Greece, the will of a patient can be considered just to

[58] Supra Note 56
[59] Ibid

the event of life, never as a contention to legitimize ending it. In the Spanish legal literature, it is uncertain whether or not a "will in advance" can be associated with "express request". With respect to termination of medication, wills in advance can be considered to the extent they do not violate the law. In situations of irreversible coma, when treatment is of no use doctors are permitted to obey a wish by the patient's family and it is within law.

Belgian law has legalized euthanasia, defined as the "termination of life upon express request" and it include prior consent but only for one condition where the person is in coma and there are no chances of him being back to normal life and is valid for only .

As per Italian law, person has the authority to appoint any person in his behalf prior so that he can help the doctors and will be inclines towards him in case of incompetency. This substitution ("amministratore di sostegno") can always approve medical treatment, but it is uncertain to what scope he is also allowed to consent to any decision of medication. The Italian report describes the Terri Schiavo-like case of Ms Eluana Englaro, in which the court's approval to stop artificial nutrition and hydration was finally declined after many years. The report concludes: "The Englaro case shows how deep the legal uncertainty is in Italy in this field."

5.3 PALLIATIVE CARE

To palliate a patient is to make him relaxed by curing a person's signs from an illness. Hospice and palliative care help a person to be relaxed by focusing on issues causing pain. There is a special team of Hospice and palliative care in a hospital institute to give care. The main objective of palliative care is to enhance the value of a seriously ill person's.

According to the World Health Organization (WHO) the definition is,

"*palliative care is an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual."*

'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[60].

When we look at the definition of Palliative care by WHO it is evident that the definition does attract in any way any process which increase or delay the death of ill patient. Palliative care provides a means so that the ill patient in hospital forget their pain and live in a better way till they die. It is like providing them happy and calm end.
Its trend is growing and they are now part of hospital core team especially in Europe. However there are many concerns over when and how the palliative care be initiated and what are the basic features of such care.

Palliative care is not temporary or for any fixed period. It is given by team members till the death of the patient and is never found to be an effort which is in vain. The outcome of palliative care is so successful that it helps patient be relived from all aspects and he stops thinking about the pain[61].

However in case the patient is not relived by the palliative care and then he demand euthanasia, so drawing of such analogy that euthanasia is ultimate route when the palliative care is not effective. There is one model given by Belgium i.e Integral palliative Care which says that there is relationship between these two.

But the definition of palliative care does not fit in with the definition of Euthanasia as there is difference of intention. The World Health Organisation has specifically mentioned that Palliative Care does not accelerates or delays the death of the patient and this approach is followed by other palliative care givers. It has to seen by the Palliative care givers that the effort and value of such care is so effective so that patient do not think of euthanasia as an option and if any tacit intention is seen from the patient regarding euthanasia it should be addressed with immediate effect because

[60] "THE MEDICAL TREATMENT OF TERMINALLY-ILL PATIENTS (PROTECTION OF PATIENTS AND MEDICAL PRACTITIONERS) BILL"
[61] Supra Note 56

there is no denial to the fact that with all such excellent care there are chances that patient might ask for euthanasia or any drug which will increase the pace of his death.

Palliative sedation is defined as "*the monitored use of medications intended to induce a state of decreased or absent awareness (unconsciousness) in order to relieve the burden of otherwise intractable suffering in a manner that is ethically acceptable to the patient, family and healthcare providers*."[62]

When such Palliative sedation is used in proper condition they are appropriate and well within the ethical practice of medical practitioner. However there is a need of proper eye over the use of such sedation as any misuse or overuse can be against the health of patient illness. All the ethical aspect of such sedation should be seen beforehand and all the usage of it should be agreed to by the group members who are involved this proper and if possible it should also be agreed to by the relative of such patient.

But when we see the definition of palliative sedation the use of word Ethically acceptable is ambiguous. What may be ethical to one may not be ethical to someone else. This brings in subjectivity to the definition and can be thought of removing such ambiguity.

A bill in France on Palliative sedation is passed by its legislature according to which till the time of death the patient has right to ask for palliative sedation and the medical practitioner will not be able to reject such request if made by such patient. However the bill is struck down in June, 2015 by senate.

The basic difference between palliative Sedation and euthanasia has to be understood so that patient or its family members don't get confused. In the Palliative Sedation the physician tries to remove the pain or suffering by introducing in the body a drug which will press the illness symptoms and eventually will help eradicate such pain or symptoms[63]. However when the Euthanasia is used, the aim is to put an end to life of

[62] "Cherny NI and Radbruch L. European Association for Palliative Care (EAPC) recommended framework for the use of sedation in palliative care. Palliat Med 2009."
[63] Ibid

the patient which can be done by giving him dose which will let the patient die eventually. So we see that there is difference of intention under palliative sedation the intention is relive the patient of the pain he is suffering but in Euthanasia they want to put an end to life by any act.

However in case the patient is not relived by the palliative care and then he demand euthanasia, so drawing of such analogy that euthanasia is ultimate route when the palliative care is not effective. There is one model given by Belgium i.e Integral palliative Care which says that there is relationship between these two.

The choice of using palliative Sedation should not be made by any individual as there is team which takes care of patient, so it has to be made after getting consensus from team members and the eye should be there to check such decision.

To recognize and value the each person as independent and exclusive as its basic feature is the aim of Palliative care. In ideal situation the patients has the right to take all the decision regarding his treatment and he has the right to protect it.

So if we look in between the lines of definition of Palliative care we would find that the crux of the definition is to provide help and avoidance of any pain and to enhance the life of the person he is living by giving him proper care and attention. So to attain such aim they have to focus on the independence of the patient i.e. Patient Autonomy. Palliative care has to be delivered in humble, frank and understanding way but the framework of such care has to be according to customs, heritage, religious belief etc of the country. The center of such care is only patient and his needs.
The Palliative care members should be trained in a such a way that they are able to understand the request of the patient regarding his needs and be in a position to have a communication with the patient and other required people involved in the care of the patient.

If the person makes a call to have euthanasia so if there is a well equipped palliative care method there are chances that such demand will be shifted towards palliative care. If there is enough communication about the availability of such care then it will provide support and faith to the patient and it will help to remove the worries which is

caused to the patient of his illness and he would not think about euthanasia but rather taking an alternative better care.

According to WHO palliative care :

"· *provides relief from pain and other distressing symptoms;*

· affirms life and regards dying as a normal process;

· intends neither to hasten or postpone death;

· integrates the psychological and spiritual aspects of patient care;

· offers a support system to help patients live as actively as possible until death;

· offers a support system to help the family cope during the patients illness and in their own bereavement;

· uses a team approach to address the needs of patients and their families, including bereavement counselling, if indicated:

· will enhance quality of life, and may also positively influence the course of illness;

· is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications.[64]"

5.4 PROCEDURAL ISSUES

Any Country Substantive and procedural law are always linked with each other or rather dependent one each other for providing justice. Same is the case or rather issue with Euthanasia as many countries don't have law on euthanasia and if they frame it they have to make cordial relation between substantive and procedural laws which is difficult as euthanasia is not just a legal topic but is includes within the ethics, culture, customs, belief etc. of the country.

The first issue is that how it can be proved that the doctor has not acted in interest of patient to save his life and how far is it correct to subject such doctor who worked all day long to trauma of criminal case[65]. So this raises serious concern that can legislature of country let the prosecutor decide that whether to proceed with the

[64] ""*Who Definition of Palliative care",* available at< http://www.who.int/cancer/palliative/definition/en/>, last accessed at March 5,2016."

[65] Ibid

prosecution or not? When we look laws of other country we find out that some country follow "legality principle" which means only those cases should be proceeded with where there is enough evidence on the issue[66]. Some countries follow "expediency Principle", in this the prosecutor of the case thinks not to commence with the case as it wont serve any public interest. As euthanasia in more than a legal issue the second principle seems to serve the purpose and will serve as a tool to eradicate any deficiency in substantive law of the country. It is very hard to accept but many reports of the country do not give the kind of criminal procedural law they follow. The court is comfortable with the fact the it is the duty of the prosecutor to bring any case where is complexity involved or is of grave nature. This system is called as German practice and is prevalent in Greece, Spain. However the expediency principle is called as French practice and is followed by Belgium, Netherlands.

The Second concern is how will the knowledge about the occurences of such practice will be received by Justice Department? There are two approaches for it now-

A) Is there a Fundamental obligation to communicate the cases of euthanasia and if the answer is positive then will such obligation include the obligation of physician who is involved in the act himself. This is followed in Belgium and Netherlands.
B) Can the medical practitioner be relieved from this duty to communicate such cases of euthanasia following the rule that no person should be compelled to the witness in his own cause or rather "self-incrimination"? This is followed in Greece and Spain.

Now the obligation to communicate such cases will itself bring such issues which needs to be addressed. The extent to which the medical practitioner will communicate the details of the case because as the case will proceed more evidences will be needed from the doctor and then it will be an legal matter which doctor cant escape. Now this is a subtle matter because if the doctor reveals all the personal and reliable data that will destroy the "doctor-patient privilege" clause.

[66] "Groenhuijsen, Marc, "Euthanasia and the Criminal Justice System", available at < http://www.ejcl.org/113/article113-33.pdf>, last accessed at March 1,2016."

The Belgium and Netherlands substantive law has clearly allowed euthanasia if due care criteria are satisfied. Now the questions arises what is the criteria of due care. The criteria involves to evaluate:

(1) The request made by patient is without any coercion,

(2) The pain is agonizing,

(3) The patient has the knowledge about his status,

(4) The rational options are not available,

(5) Consultation with another Physician,

(6) Best medical consideration should be given.

The medical practitioner has to submit a comprehensive detail about the procedure followed so that it is ensured that they are meeting the set criteria. There will be a body known as a Review committee who will evaluate the report and ensure that that they acted according to the set criteria and it may also involve giving additional notes on the case and communicate with other people involved.

The Belgian Euthanasia Act is generally parallel to Dutch Euthanasia Act but evaluation is done by one "multidisciplinary committee"[67].

The countries have established a comprehensive "notification procedure" subsequently when physician has done an act of euthanasia.

First, the Act of Euthanasia should be reported by the Physician. In The Netherlands the report is informed to the municipal coroner, in Belgium to the "Federal Commission on Control and Evaluation on Euthanasia ". The report should give a comprehensive listed action taken in the case and should be in such a way that the person who is scrutinizing it should be able to affirm whether the physician has met the "Due care criteria" or not. In Belgium FCCEE scrutinize the report, in Netherlands by "Regional review committees "[68].

It is very much evident that these bodies have been created to act as barrier amid the physician and prosecutor. This practice had goal of preventing the stigmatization of the physician and encouraging the inclination of the medical profession to inform cases of euthanasia and this is aided by the structure of the FCCEE and the RRCs.

[67] Supra Note 66

[68] Ibid

Both bodies comprise of medical professionals, lawyers and experts. When the organizing body decide that the due care has not been followed by the physician the matter will be directed for the Prosecution. And even then prosecution is not the automatic sequel. The Dutch example may serve to emphasize this point. Each matter is brought before the Board of the Prosecution Service. If the Board finds that there are sufficient details and evidence for the prosecution, it has to move the case to the competent court for a "judicial preliminary investigation" to be carried out by an examining magistrate.

After the investigation is complete, the consequences will again have to be evaluated by the Board. They can then decide to either drop the case or to start prosecution, but in either case, previous permission by the Minister of Justice is needed! It is clear that the logic behind this lengthy decision process is to shield the medical profession against the impulses or the personal preferences of individual prosecutors.

CHAPTER 6

6. ARGUMENTS FOR AND AGAINST EUTHANASIA

As the biological and medical sciences become more adept at prolonging life, we have been brought to consider the extent of a person's right, and ability, to choose, to accept, and to reject treatment for some treatable condition. Cases may become complicated by the mental state of the patient (e.g., depression, intellectual disability), by the effect of certain physical conditions on cognition, (e.g., kidney damage), by religious and cultural beliefs, by balancing the rights and welfare of an individual against those of the population, and by the practical costs and requirements of providing treatment and care.

Psychologists, by virtue of their knowledge and skills in dealing with mental states, cognitive abilities, beliefs, and individual characteristics, have a useful perspective to offer the debate on the rights of a terminally ill person to request assistance from a medically qualified person to voluntarily terminate his or her life. In the following section, we set out arguments, without endorsement, which are often advanced in favour of, and opposing, making euthanasia more accessible than it is now.

6.1Arguments for Euthanasia

Ethical/Moral

Patient autonomy

This argument rests on the ideal of being able at all times to exercise as much control over one's own life as is possible. This ideal is stated, for example, in Principle 6 of the Australian Council of the Ageing's "*Rights of the Elderly*": "*The right of individuals to consultation and participation in decisions affecting all aspects of their lives". The issue of self-control is the crux of such notions as "the right to die", and "the right to die with dignity*", which accept that agony persons have irrefutably the privilege to pick whether to live or to pass on, that the ethical operators is the torment individual. In the event that and when a sufferer chooses that life ought to end, lawful

willful extermination would give the way to closure it, securely, without setting someone else or gathering of persons in lawful danger[69].

Prefer "quality of life" above "sanctity of life"

Here it is argued that people have the right to decide whether quality of life or sanctity of life is most important to them. When a person is suffering severe pain or is severely restricted by illness, or when life depends, for example, on drugs which cloud consciousness and reduce control, those who value quality of life more highly may seek an end to life. Killing would permit them to do as such, without putting other individuals in lawful risk[70].

To end suffering

One argument in favour of making euthanasia a legal option for someone who is terminally or incurably ill or incapacitated, is suffering intolerably, and has expressed a wish to die, rests on the belief that suffering should be relieved or ended, that suffering harms the sufferers by robbing them of peace or pleasure, and demeans them. Another aspect, sometimes raised,concerns the suffering of carers: caring for or watching someone suffer, without any chance of relief or recovery, can become difficult to tolerate for the carers and watchers, both emotionally and physically, so that the carers' only prospect of relief resides in the death of the patient.

To lessen Dependence on Devices.

The cost of health care has increased greatly and shows every sign of continuing to increase. The perceived impropriety of making use of high technology and expensive medical procedures in cases where the only positive outcome is the temporary lengthening of life, without improvement in quality of life or prospect of recovery, is often seen as an argument for euthanasia. While it is ethically distasteful to ask for establishment of priorities for access to advanced medical technology, the issues of need and good outcome may make it imperative. If such priorities are at least implicit

[69] ""Pros of Euthanasia", available at < http://euthanasia.procon.org/view.resource.php?resourceID=000126>, last accessed at March 7,2016."
[70] Ibid

in, say, medical policy and hospital practice, then those priorities would, in fact, imply covert practice of euthanasia. Some form of legalisation would allow a more honest acknowledgment that euthanasia is an option.

To reduce risk of premature suicides

Some terminally ill patients who wish to end their suffering without incriminating loved ones take their own lives in secret, sometimes violently. Knowing that they will be physically unable to do so at a later stage, a few patients end their lives right off the bat into their disease[71].

Legal View

To lower the legal jeopardy

Euthanasia occurs now. Legally, a person who kills another or connives at the death of another, breaks the law and may be charged with a serious criminal offence (murder or manslaughter), and may be convicted and punished. That the killing resulted from requests from the sufferer, and that it was done from motives of empathy and compassion, will not necessarily alter the legal situation. If euthanasia were recognised as an option, and provided that accompanying regulations were observed, then a person who assists a person to die would be protected from prosecution or if nothing else have a protection[72].

To approve regulation vis-à-vis euthanasia procedure.

It is widely recognised that euthanasia does occur covertly. Overt recognition would allow regulations to be developed governing modes of request and consent, counselling for sufferers and families, decisions about modes of death, and so on.

[71] Supra Note 69
[72] Ibid

Public Attitude

Variations in professional and public attitudes

Surveys and polls over the past decade show that both professionals and the public are more ready to consider euthanasia as an alternative to sustaining a life of suffering . If it is believed that legislation should be responsive to public opinion, this would constitute an argument in favour of legislative change.

6.2 ARGUMENTS AGAINST EUTHANASIA

Ethical/moral

Absolute respect for human life

Certain sets of beliefs will remain totally inconsistent with a belief in the propriety of euthanasia, regardless of particular situations. Persons holding these beliefs and opinions deserve to have them recognised. In most societies there are strict bans against taking human life except under prescribed circumstances such as war or sometimes capital punishment. Survival of the species requests that life be ensured[73].

Probability of Undue force

Public recognition that euthanasia is available might lead to assaults on individual autonomy. People may be subjected to pressure to ask for their own death by being made to feel more guilty for the burden they impose on family and carers. Euthanasia may be offered as an option even when the patient had not previously raised it. Further, medical professionals (doctors, nurses) may be pressed into taking life against their own judgements.

[73] ""Anti –Euthanasia Arguments", available at < http://www.bbc.co.uk/ethics/euthanasia/against/against_1.shtml>, last accessed at March 8,2016."

Insignificant decision by the patient

A person's expression of a desire to end his or her life may be influenced by a state of depression, uncontrolled pain or dysphoria, conditions which may be relieved by proper treatment. If given such treatment, it is argued that the person may no longer desire to die. A man's ability to settle on an competent and skillful choice might be hard to find out[74].

Conflicts of interest

This applies only if others are empowered to make decisions on behalf of the individual. When carers are obliged to take a very large measure of responsibility for ill or incapacitated persons, it may be easy to assume total responsibility, even to the point of deciding when or whether the helpless person should die. When some advantage may accrue to the carer on the death of the helpless person (for example, independence, money, property), then there may be more motivation to make independent arbitrary decisions, without taking account of the helpless person's wishes. That is, the interest of the carer might clash with those of the sick individual[75].

Legal

Difficulty of enforcement and monitoring

It may be very difficult to discover, after a person's death, whether that death had occurred from "natural causes" or as a result of correctly (or incorrectly) carried out procedures of euthanasia. On the basis of a survey of medical practices in the Netherlands prior to 1993, Jochemsen (1994) found that 65-75% of physicians reported that, following euthanasia, they attributed the death to natural causes. It is clear that accurate establishment of the causes of death is difficult, although provision for inquests and autopsies may provide some safeguards. This concern exists now; it

[74] Supra Note 73
[75] Ibid

is not dependent on public or legal recognition of euthanasia. This worry exists now; it is not reliant on public or lawful acknowledgment of killing[76].

Technical

Failure to bring about an easy death

An accepted method of euthanasia may fail to kill the person within a reasonable time and may cause more suffering. The same procedures may produce different results in different people.

Diagnostic errors and medical advances

Diagnosis is not a perfect skill, art, nor science, and mistakes can occur in prediction about the outcome of any given medical or health condition. As knowledge expands, new drugs and new procedures and technologies are introduced, and a condition which may have been terminal at one time (or in one country) may respond to treatment at another time, or in another place. To acknowledge willful extermination might in this way deny individuals of continuation of life[77].

Reduction of efforts in diagnosis, treatment, and care

Availability of euthanasia may reduce efforts to provide, or to improve, diagnosis, treatment and care. If suffering persons are able to choose to die, and do so, their removal may reduce the motivation of financial sources to fund research, provision of caring facilities, training of carers, and maintenance of support systems. Economic considerations may motivate authorities to support euthanasia.

The "Slippery Slope" Argument

Several of the preceding arguments imply what has become known as the 'slippery slope' or 'precedent' argument. Mann (1995) argued that once traditional prohibitions

[76] Supra Note 73
[77] Ibid

and taboos are broken, society may be drawn down an unanticipated path towards acceptance of practices which, at the time of the initial breach, would be considered unacceptable. Similarly Helme (1993), in discussing the possibility of euthanasia becoming legal in some way, stated: "*if the law was to be changed, the balance of opinion would alter so that what would be intended as an extension of the rights of some, and possibly only a small minority, might result in the transference of an obligation to others. Once a legal precedent has been established, social endorsement of euthanasia might place undue pressure on patients to class themselves as a burden to others, and to submit to it rather than defend their individual interests*".

He suggested that some patients may make a request for euthanasia "in bad faith" in order to manipulate, threaten or exploit over-conscientious carers. Helme balanced these arguments by pointing out that other patients may enter their final illnesses reassured by the knowledge that euthanasia was available to them, even though they may never request it[78].

6.3 LEGALISING EUTHANASIA – BUT WHEN?

So why are we considering legalising euthanasia now, after our society has prohibited it for almost two millennia? It is true that the population is aging; modern medicine has extended our life span with the result that it is more likely now than in the past that we will die of chronic degenerative diseases, not acute ones. It is true also that many countries lack adequate palliative care. It is true that some physicians are ignorant about treatments for the relief of pain and suffering. And it is true that some of them either fail or refuse to provide them[79].

Medical practice, too, has also changed. A lifetime relationship with "the family doctor" is largely a relic of the past. And the isolation that people can experience in seeking help from health-care professionals is probably a reflection of the wider isolation that individuals and families experience. But the capacity to relieve pain and suffering has improved remarkably. Not one of the bottom-line conditions usually seen as linked with the call for euthanasia - that terminally ill people want to die and that we can kill them - is new. These factors have been part of the human condition

[78] ""*Slippery Slope Argument",* available at < http://euthanasia.procon.org/view.subissues.php?issueID=000416> , last accessed at March 10,2016."

[79] Ibid

for as long as humans have existed. Why, then, are we considering such a radically different response to this situation?

I suggest that the principal cause is not a change in the situation of individuals who seek euthanasia; rather, it is profound changes in our secular, Western, democratic societies. Some of these changes involve trends that have been emerging since the eighteenth century, but only recently have all co-existed and each overwhelmingly dominated its opposite, or countervailing, trend.

The factors that I single out here do not constitute a comprehensive list. They are not all of the same nature, so they are not all treated in the same way or depth. Indeed, I mention some very briefly. In any case, each requires a much more thorough examination. And my conclusions about their strength, causal link to euthanasia, or impact are clearly open to challenge. My aim is to provide a rough map - a somewhat impressionistic overview - of the societal and cultural factors giving rise to and influencing the movement to legalise euthanasia.

Individualism

Our society is based on "intense individualism" (much as we might regard this as perverted or distorted version of individualism as it was understood by the eighteenth-century founders of American democracy) - possibly, individualism to the exclusion of any real sense of community - even in connection with death and bereavement. If this highly individualistic approach is applied to euthanasia, especially in a society that gives pre-eminence to personal autonomy and self-determination, it is likely to result in the belief that euthanasia is acceptable.

There seems to be either a total lack of consciousness or a denial that this kind of individualism can undermine the intangible infrastructure on which society rests, the communal and cultural fabric. Individualism untempered by at least concern and perhaps the duty to protect and promote community will inevitably result in destruction of the community. Thus, although legalising euthanasia is a result of unbridled individualism, the latter would also promote it, at least in terms of balance between the individual and the community.

There is yet another sense in which "intense individualism" might give rise to calls for euthanasia. In Western societies, death is largely a medical event that takes place in a hospital or other institution and is perceived as occurring in great isolation - patients are alone, separated from those they love and the surrounding with which they are

familiar. Death has been institutionalised, depersonalised and dehumanized. "Intense individualism" and seeking to take control, especially through euthanasia, are predictable and even reasonable responses to the circumstances. To avoid legalising euthanasia, therefore, we must give death a more human scale and face[80].

Media

At first, we created our collective story in each other's physical presence. Later on, we had books and print media, which meant that we could do so at a physical distance from each other. Now, for the first time, we can do so through film, television and social media and, consequently, at a physical distance from - but still in sight of - each other no matter where we live on the planet.

We do not know how this will affect the stories we tell each other in order to create our shared story, our societal and cultural paradigm - the store of values, attitudes, beliefs, commitments and myths - that informs our collective life and through that our individual lives and helps to give them meaning. Creating a shared story through the mass media could alter the balance between the various components that make it up. In particular, we might engage in too much "death talk" and too little "life talk." We can be most attracted to that which we most fear, and the mass media provide an almost infinite number of opportunities to indulge our fear of, and attraction to, death.

Failure to take into account societal and cultural level issues related to euthanasia is connected with "mediatization" of our societal dialogues in general and the one about euthanasia in particular. We see these only as presented by the media, which introduces additional ethical issues - those of "media ethics." The arguments against euthanasia, based on the harm that it would do to society in both the present and the future, are very much more difficult to present in the mass media than arguments for euthanasia, which can make for dramatic, emotionally gripping television. Anti-euthanasia arguments do not make dramatic and compelling television. Visual images are difficult to find. Viewers do not personally identify with these arguments that come across as just abstractions or ideas in the same way that they do with those of dying people who seek euthanasia. Society cannot be interviewed on television and become a familiar, empathy-evoking figure to the viewing public.

[80] Supra note 78

Only if euthanasia were legalised and there were obvious abuses - such as proposals to use it on those who want to continue living - could we create comparably riveting and gripping images to communicate the case against euthanasia. Ironically, the most powerful way in which the case against euthanasia has been presented on television is probably through Jack Kevorkian's efforts to promote euthanasia and the revulsion they evoked in many viewers, including many of those who support euthanasia.

When it comes to euthanasia, it could be argued, people react one way in theory and another in practice. It is much easier to approve of euthanasia in theory than in practice, which probably reflects moral anxiety about euthanasia and an ethical intuition as to its dangers. That should send a deep warning, which should be heeded.

Denial and control of death and "death talk"

Ours is a death-denying, death-obsessed society. Those who no longer adhere to the practice of institutionalised religion, at any rate, have lost their main forum for engaging in "death talk." As humans, we need to engage in it if we are to accommodate the inevitable reality of death into the living of our lives. And we must do that if we are to live fully and well. Arguably, our extensive discussion of euthanasia in the media is an example of contemporary "death talk." Instead of being confined to an identifiable location and an hour a week, it has spilled out into our lives in general. This makes it more difficult to maintain the denial of death, because it makes the fear of death more present and "real."

One way to deal with this fear, is to believe that we have death under control. The availability of euthanasia could support that belief. Euthanasia moves us from chance to choice concerning death. (The same movement can also be seen at the very beginning of human life, when it results from the use of new reproductive and genetic technologies at conception or shortly thereafter.) Although we cannot make death optional, we can create an illusion that it is by making its timing and the conditions and ways in which it occurs a matter of choice.

Fear

We are frightened not only as individuals, however, but also as a society. Collectively, we express the fear of crime in our streets. But that fear, though factually based, might also be a manifestation of a powerful and free-floating fear of death in general. Calling for the legalisation of euthanasia could be a way of symbolically taming and

civilising death - reducing our fear of its random infliction through crime. If euthanasia were experienced as a way of converting death by chance to death by choice, it would offer a feeling of increased control over death and, therefore, decreased fear. We tend to use law as a response to fear, often in the misguided belief that this will increase our control of that which frightens us and hence augment our security[81].

Legalism

It is not surprising, therefore, that we have to varying degrees become a legalistic society. The reasons are complex and include the use of law as a means of ordering and governing a society of strangers, as compared with one of intimates. Matters such as euthanasia, which would once have been the topic of moral or religious discourse, are now explored in courts and legislatures - especially through concepts of individual human rights, civil rights and constitutional rights.

Man-made law (legal positivism), as compared with divinely ordained law or natural law, has a dominant role in establishing the values and symbols of a secular society. In the euthanasia debate, it does so through the judgements and legislation that result from the "death talk" that takes place in "secular cathedrals" - courts and legislatures. It is to be expected, therefore, that those trying to change society's values and symbols would see this debate as an opportunity to further their aims and, consequently, seek the legalisation of euthanasia

Mystery

Our society is very intolerant of mystery. We convert mysteries into problems. If we convert the mystery of death into the problem of death, euthanasia (or, even more basically, a lethal injection) can be seen as a solution. As can be seen in descriptions of death by euthanasia, euthanasia can function as a substitute for the loss of death rituals, which we have abandoned at least partly to avoid any sense of mystery.

A sense of mystery might be required also to "preserve ... room for hope," as C.S. Lewis put it. And, as Harry Moody suggested, euthanasia could be a response "based on a loss of faith in what life may still have in store for us. Perhaps, what is needed ... is a different kind of faith in life and in the community of caregivers." This is

[81] Supra note 78

especially true in situations of serious illness. If so, I postulate a complex relation between some degree of comfort with a sense of mystery and being able to elicit in others and experience ourselves hope and trust. This leads to a question: could the loss of mystery - and, therefore, of hope, faith and trust - be generating nihilism in both individuals and society? And could calls for the legalisation of euthanasia be one expression of it?

Scientific advances

Among the most important causes of our loss of the sacred is extraordinary scientific progress, especially insofar as science and religion are viewed as antithetical. New genetic discoveries and new reproductive technologies have given us a sense that we understand the origin and nature of human life and that, because we can, we may manipulate - or even "create" - life.

Transferring these sentiments to the other end of life would support the view that euthanasia is acceptable. Euthanasia would be seen as a correlative and consistent development with the new genetics; its acceptance, therefore, would be expected. According to this view, it is no accident that we are currently concerned with botheu-genics (good genetics: good at birth) and eu-thanasia (good death: good at death, of no trouble to anyone else). Yet another connection between genetics and euthanasia could arise from a new sense of our ability to ensure genetic immortality - seeing ourselves as an immortal gene - and, as a result, some reduction of anxiety about the annihilation presented by death.

The paradigms used to structure knowledge in general have been influenced by genetic theory. These paradigms have already been the bases for new schools of thought in areas well beyond genetics. They can challenge traditional concepts of what it means to be human and what is required to respect human life. For instance, evolutionary psychology, a sub-category of socio-biology, sees the characteristics usually identified as unique markers of being human - namely, our most intimate, humane, altruistic and moral impulses - as the product of our genes and their evolution. At a macro-genetic level, deep concern about overpopulation (as compared with earlier fears of extinction due to underpopulation) might, likewise, have diminished a sense of sacredness in relation to human life.

But countervailing trends, such as the environmental-protection movement, are beginning to emerge. A powerful recognition of innate dependence on the ecological

health of our planet has resurrected a sense of the "secular sacred" by re-identifying the absolute necessity of respectful human-earth relations.

Moreover, science can be linked with the sacred; it just depends on how we view it. Rather than assuming that the new genetics is a totally comprehensive explanation of life, for example, we can experience it as a way of deepening our sense of awe and wonder at that which we now know - but even more powerfully at that which, as a result of this new knowledge, we now know that we do not know. We can, in other words, see the new genetics and other sciences as only some of the lenses through which we are able to search for "the truth."

7. CONCLUSION

In contemporary world the death has become a debatable topic. It a circle of life which no one can escape and eventually every one has to die. Infact the only absolute truth is Death. By doing an act which causes the death of the person is like becoming God because whatever culture or religion we belong to there is no second thought about the universal truth that God has given us life and only he can take it. By fastening the process of death by doing an act is becoming God which is not acceptable. This also draws an argument that can the person be left to suffer the pain or something should be done to help that person to evade the pain. Each person has it own set of belief according to the religion he belongs. What might be ethical and moral for one person or group, might not be ethical and moral for other.

It is evident that euthanasia is a relatively a much sensitive issue in which there is a huge difference in the attitudes, values of people, irrespective of modernism or anything else.

Euthanasia is not just a legal issue which can be resolved by any legislation. The countries who have legislation are themselves very less and they themselves are facing problems in the legislation.

Euthanasia includes society norms, ethics, religion, legal aspect in total and medical practitioner ethics and moral are also included in this. The person who is in PVS and not able to give any consent who will decide for them what is better for them in their interest and if the proxy makes any decision how far doctor will be bound by it. The point of view of Doctor in patient best interest and that of proxy will clash. The immunity which doctor has while he is working in patient best interest and something wrong is done.

The issue in India is that we are mostly dependent on the cases of other cases. The Aruna shaunbagh judgment was given in the light of foreign judgments and they paved the way for the decision of the case. The need of the legislation can be understood by the fact that court in it decision specifically mentioned that until parliament legislates a law to this effect the guidelines of the court will be in operation.

There is a need of proper Hospice and Palliative Care center and it should be made mandatory for each hospital to have one department which will focus on this are. In India this practice is at a very early stage. Special Training is needed for this type of

care and due to lack of proper infrastructure and exposure special focus is needed in this area. This practice need a high level of compassion and effort.

There is a need of umbrella legislation to provide these areas a path and allow state to have a compulsory policy to protect the interest of its citizens. There is need to sign MOU with WHO and other international institutions so that we could have proper training and idea.

Legislation brings about the need of people, so that people are protected any ill-practice. So an ACT should not only be comprehensive but rather certain about the situation which may arise.

Passive euthanasia which is legalized in other countries, shall have legal recognition in our country , as recommended by the 17th Law Commission of India and as held by the Supreme Court in Arun Ramachandra's case. It is not objectionable from legal and constitutional point of view.

So to end here is the quote from Mirza Ghalib:

"Marte hain aarzoo mein marne ki
Maut aatee hai par naheen aatee"

RECOMMENDATIONS

• Efforts should be made to legislate a proper and comprehensive Act to promote collective good over individual good.

• The provision of considerate and care of the terminally ill and dying persons can be attained without killing them or tempt them for commit suicide. In modern era the notion of palliative care has been developed. Palliative care consists of group or a team in which there are people from different field and is based in holistic model of care.

• A segment of money should be spend by each hospitals on maintaining the infrastructure and training of the staff.

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