DISSERTATION TITLE

EUTHANASIA

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CHAPTER-1

INTRODUCTION

Euthanasia

"In ancient Greece and Rome, before the coming of Christianity, attitudes toward infanticide, active euthanasia, and suicide had tended to be tolerant. Many ancient Greeks and Romans had no cogently defined belief in the inherent value of individual human life, and pagan physicians likely performed frequent abortions as well as both voluntary and involuntary mercy killings. Although the Hippocratic Oath prohibited doctors from giving 'a deadly drug to anybody, not even if asked for,' or from suggesting such a course of action, few ancient Greek or Roman physicians followed the oath faithfully. Throughout classical antiquity, there was widespread support for voluntary death as opposed to prolonged agony, and physicians complied by often giving their patients the poisons they requested."

Euthanasia comes from the Greek words, Eu (good) and Thanatosis (death) and it means "Good Death, "Gentle and Easy Death." This word has come to be used for "mercy killing." In this sense euthanasia means the active death of the patient, or, inactive in the case of dehydration and starvation.

The first recorded use of the word euthanasia was by Suetonius, a Roman historian, in his De Vita Caesarum--Divus Augustus (The Lives of the Caesars--The Deified Augustus) to describe the death of Augustus Caesar:

"...while he was asking some newcomers from the city about the daughter of Drusus, who was ill, he suddenly passed away as he was kissing Livia, uttering these last words: "Live mindful of our wedlock, Livia, and farewell," thus blessed with an easy death and such a one as he had always longed for. For almost always, on hearing that anyone had died swiftly and painlessly, he prayed that he and his might have 1a like euthanasia, for that was the term he was wont to use. "

1 (Mishara, 1998)

Augustus' death while termed "a euthanasia" was not hastened by the actions of any other person.

Withdrawal or with-holding treatment was practiced in history, the correct term for this is **Orthothanasia**, which means 'passive death.' In this method, the actions of curing the patient are never applied and his death is made easy in a passive form. In **Orthothanasia**, the action of killing is not applied, but, passive actions are present in order to provide death.

The place of euthanasia in the history of medical ethics

The actions of easy death have been applied for hopeless patients who have been suffering extreme pain since ancient ages2.

These actions were forbidden from time to time. In Mesopotamia, Assyrian physicians forbade euthanasia. Again in the old times incurable patients were drowned in the River Ganges in India. In ancient Israel, some books wrote that frankincense was given to kill incurable patients.

Jewish society, following the teaching of the Bible and the sixth command "thou shall not kill", had rejected centuries ago every theory on shortening the life of handicapped or disadvantaged people. Judaism considered life to be sacred and equated suicide and euthanasia with murder. Dr Immanuel Jakobovits, former Chief Rabbi of England explained:

"Cripples and idiots, however incapacitated, enjoy the same human rights (though not necessarily legal competence) as normal persons... One human life is as precious as a million lives, for each is infinite in value..."

Statement of problems

2 (Chin, 1999)

1. A decision has to be taken to discontinue life support either by the parents or the spouse or other close relatives, 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.
2. Even if a decision is taken by the near relatives or doctors or next friend to withdraw life support, such a decision requires presence of two witness and countersigned by first class judicial magistrate, and should also be approved by a medical board set up by the hospital.3

RESEARCH QUESTION:

1. Whether Euthanasia has been abrogated or made non-operational partially?

2. If it has been abrogated or made non-operational is it constitutionally valid or not?

3. The procedure through which this change has been brought Does it qualify Constitutional validity?

4. Such change of law will have optimistic or pessimistic acceptance by the people of different regions of the country?

5. Its future implications and the judicial stand on the Lis Pendence.

6. Political influence of the change and on the change.

HYPOTHESIS

1. Researcher's hypothesis on Euthanasia to be non-operational partially and not abrogate.

2. Researchers hypothesis is yes this change is not constitutionally valid

3. Researchers hypothesis is the procedure of bringing the not constitutionally valid.4

4. Researcher's hypothesis is that such change all the region will adopt with optimistic approach.

3 (Chin, 1999)
4 (Kasimar, 1978)

Objective and scope of Euthanasia

Euthanasia, in its many forms, is an inherent right that should not be infringed upon through its not being legalized. Euthanasia refers to choosing a dignified death, rather than one set for the individual, and in a slow and painful manner at that. When palliative care is no longer an option and treatment has failed5 time and again, the option to choose "the good death" should remain open at all times. Despite slight possibilities in a lack of responsible actions taken in the name of euthanasia, the act itself will always be a personal choice, based on the amount of suffering one will allow oneself to go through before one must give in. Euthanasia will always be in existence, now it is merely a choice of making it "acceptable" or "unacceptable" as far as the government is concerned. After all, whose life is it?.

LIMITATIONS OF RESEARCH TOPIC

The limitation of the research is not restricted only up to the research from perspective of India and to the entire world except.

METHODOLOGY OF RESEARCH

The Research in this project is not only doctrinal but conceptual and theoretical in nature. This research project is a theoretical study ofthe historical background in detail and the study of landmark cases of Euthanasia. This project is doctrinal and6 an in-depth study of the research topic. The study is qualitative as well as analytical in nature.

5 (Cabe, 1904)
6 (Mishara, 1998)

CHAPTER-2

CONCEPT AND HISTORICAL BACKGROUND OF EUTHANASIA

In ancient Greece, suicide of the patient who was suffering extreme pain and had an incurable terminal illness was made easy and for this reason, the physician gave medicine (a poisoned drink) to him. Plato wrote: "Mentally and physically ill persons should be left to death; they do not have the right to live."

In Sparta, it was the common practice for each newborn male child to be examined for signs of disability or sickliness which, if found, led to his death. This practice was regarded as a way to protect the society from unnecessary burden, or as a way to 'save' the person from the burden of existence7.

Pythagoras and his pupils were completely against suicide due to their religious beliefs that the Gods place the man as the protector of the earthly life and he is not allowed to escape with his own will.

The first objection to euthanasia came from the Hippocratic Oath which says "I will not administer poison to anyone when asked to do so, nor suggest such a course."

In ancient Rome, euthanasia was a crime and this action was regarded as murder. However, history notes that sickly newborn babies were left outside, overnight, exposed to the elements8.

In the Middle Ages in Europe, Christian teaching opposed euthanasia for the same reason as Judaism. Christianity brought more respect to human beings. Accordingly, every individual has the right to live since God creates human beings and they belong to Him and not themselves. Death is for God to decree, not man. Like Judeo-Christian teaching, Islam also teaches that God is the only one who creates and the only one who may take life away.

2.1: 15th - 17th Centuries:

7 (Cicero., 1998)
8 (Cicero., 1998)

Sir Thomas More (1478-1535) is often quoted as being the first prominent Christian to recommend euthanasia in his book Utopia, where the Utopian priests encourage euthanasia when a patient was terminally ill and suffering pain (but this could only be done if the patient consented). "if a disease is not only distressing but also agonising without cessation, then the priests and public officials exhort this man...to free himself from this bitter life...or else to permit others to free him..." The problem with using this quote is that More, a devout Catholic, wrote Utopia as a work of satire.

The English philosopher, Francis Bacon (1561-1621), was the first to discuss prolongation of life as a new medical task, the third of three offices: Preservation of health, cure of disease and prolongation of life. Bacon also asserts that, 'They ought to acquire the skill and bestow the attention whereby the dying may pass more easily and quietly out of life.' Bacon refers to this as outward euthanasia, or the easy dying of the body, as opposed to the preparation of the soul. It appears unlikely he was advocating 'mercy killing', more likely he was promoting what we would term better 'palliative' care.

2.2: 18th - 19th Centuries

In Prussia, in the 18th century, 1st June 1794, a law was passed that reduced the punishment of a person who killed the patient with an incurable disease.

1828 - Earliest American statute explicitly to outlaw assisting suicide.

The earliest American statute explicitly to outlaw assisting suicide was enacted in New York in 1828, Act of Dec. 10, 1828, ch. 20, §4, 1828 N. Y. Laws 19 (codified at 2 N. Y. Rev. Stat. pt. 4, ch. 1, tit. 2, art. 1, §7, p. 661 (1829)), and many of the new States and Territories followed New York's example. Between 1857 and 1865, a New York commission led by Dudley Field drafted a criminal code that prohibited "aiding" a suicide and, specifically, "furnish[ing] another person with any deadly weapon or poisonous drug, knowing that such person intends to use such weapon or drug in taking his own life9."

Until the end of the nineteenth century, euthanasia was regarded as a peaceful death, and the art of its accomplishment. An often quoted nineteenth century

9 (Hume, 1929)

document is, 'De euthanasia medica prolusio,' the inaugural professorial lecture of Carl F. H. Marx, a medical graduate of Jena. 'It is man's lot to die' states Marx. He argued that death either occurs as a sudden accident or in stages, with mental incapacity preceding the physical. Philosophy and religion may offer information and comfort, but the Physician is the best judge of the patient's ailment, and administers alleviation of pain where cure is impossible.

Marx did not feel that that his form of euthanasia, which refers to palliative medicine without homicidal intention, was an issue until the nineteenth century.

The prevailing social conditions of the latter nineteenth century began to favour active euthanasia. Darwin's work and related theories of evolution had challenged the existence of a Creator God who alone had the right to determine life or death.

The first popular advocate of active euthanasia in the nineteenth century, was a schoolmaster, not a doctor. In 1870 Samuel Williams wrote the first paper to deal with the concept of 'medicalised' euthanasia. He stated:

"In all cases it should be the duty of the medical attendant, whenever so desired by the patient, to administer chloroform, or any other such anaesthetics as may by and by supersede chloroform, so as to destroy consciousness at once, and put the sufferer at once to a quick and painless death; precautions being adopted to prevent any possible abuse of such duty; and means being taken to establish beyond any possibility of doubt or question, that the remedy was applied at the express wish of the patient."

Though reprinted many times, the paper was seemingly ignored by the British medical profession, and in 1873 Lionel Tollemache took up his arguments in the Fortnightly Review. Writing under the clear influence of utilitarianism and social Darwinism, he described the incurable sick as a useless to society and burdensome to the healthy10.

10 (Gruman, 1973)

Although his views were simply dismissed as revolutionary, similar views were emerging with the new science of eugenics, as ideas of sterilising the mentally ill, those with hereditary disorders, and the disabled, became fashionable.

In 1889, the German philosopher, Nietsche, said that terminally ill patients are a burden to others and they should not have the right to live in this world.

In 1895, a German lawyer, Jost, prepared a book called "Killing Law." Jost stressed that only hopelessly ill patients who wanted death, must be let die. According to Jost, life sometimes goes down to zero in value. Thus, the value of the life of a patient with an incurable illness is very little.

2.3:The 20th Century

The efforts of legalization of euthanasia began in the USA in the first years of the 20th century. The New York State Medical Association recommended gentle and easy death. Even more active euthanasia proposals came to Ohio and Iowa state legislatures in 1906 and 1907 but these proposals were rejected.

In 1920, two German professors published a small book with the title 'Releasing the destruction of worthless animals' which advocated the killing of people whose lives were "devoid of value." This book was the base of involuntary euthanasia in the Third Reich.

In this book, authors Alfred Hoche, M.D., a professor of psychiatry at the University of Freiburg, and Karl Binding, a professor of law from the University of Leipzig, also argued that patients who ask for "death assistance" should, under very carefully controlled conditions, be able to obtain it from a physician.

Alfred Hoche also wrote an essay, which he published as "Permitting the Destruction of Life Not Worthy of Life." It embraced euthanasia as a proper and legal medical procedure to kill the weak and vulnerable so as not to taint the human gene.

The reduction of punishment in mercy killing was accepted in Criminal Law in 1922 in Russia. But this law was abolished after a short while.

A French physician, called Dr.E.Forgue. published an article, named "Easy death of incurable patients" in La Revue de Paris, in 1925, and pointed out that killing an incurable patient wasn't a legal condition. But, Liege Bar said that killing an incurable patient with his free consent had to be forgiven.

The laws that accept euthanasia as a legal condition are present in two countries of South America. According to Uruguay Penal Code, a Judge must not punish a person for mercy killing. A person must also be forgiven for this kind of killing in Colombia.

Adolf Hitler admired Hoche's writing and popularised and propagandised the idea. In 1935,the German Nazi Party accepted euthanasia for crippled children and "useless and unrehabilitive" patients.

Before 1933, every German doctor took the Hippocratic Oath, with its famous "do no harm" clause. The Oath required that a doctor's first duty is to his patient. The Nazis replaced the Hippocratic Oath with the Gesundheit, an oath to the health of the Nazi state. Thus a German doctor's first duty was now to promote the interests of the Reich.

Anyone in a state institution could be sent to the gas chambers if it was considered that he could not be rehabilitated for useful work. The mentally retarded, psychotics, epileptics, old people with chronic brain syndromes, people with Parkinson's disease,11 infantile paralysis, multiple sclerosis, brain tumours etc. were among those killed. The consent of the patient was absent in this type of euthanasia. This kind was applied by order.

Many people don't realise that, prior to the extermination of Jews by Nazi Germany, in the so-called "final solution," as many as 350,000 Germans were

11 (Gruman, 1973)

sterilized because their gene pool was deemed to be unsuitable to the Aryan race, many because of physical disability, mental deficiency or homosexuality.

In 1936 the Voluntary Euthanasia Society was founded in England. The next year the English Parliament (the House of Lords) rejected a proposal to legalise euthanasia. In opinion polls of those years, euthanasia supporters had around 60% of the votes.

According to a questionnaire in 1937, 53% of American physicians defended euthanasia. Approximately 2000 physicians and more than 50 religious ministers were among the members of the American Euthanasia Society. At that time, a majority of physicians in some American cites defended this subject.
In 1938, the Euthanasia Society of America was established in New York.

1939 Nazi Germany
"In October of 1939, amid the turmoil of the outbreak of war, Hitler ordered widespread "mercy killing" of the sick and disabled. Code named "Aktion T 4", the Nazi euthanasia program to eliminate "life unworthy of life" at first focused on newborns and very young children. Midwives and doctors were required to register children up to age three who showed symptoms of mental retardation, physical deformity, or other symptoms included on a questionnaire from the Reich Health Ministry."

"The Nazi euthanasia program quickly expanded to include older disabled children and adults. Hitler's decree of October, 1939, typed on his personal stationery and back dated to Sept. 1, enlarged 'the authority of certain physicians to be designated by name in such manner that persons who, according to human judgment, are incurable, can, upon a most careful diagnosis of their condition of sickness, be accorded a mercy death.'"

On August 3, 1941, the Catholic Bishop Clemens August Count of Galen, openly condemned the Nazi euthanasia programme in a sermon. This brought a temporary end to the programme. Read here

A law proposal that accepted euthanasia, was offered to the government in Great Britain in 1939. According to this proposal, a patient had to write his consent as a living will which must be witnessed by two persons. The will of the patient had to be accepted in the reports of two physicians. One of these physicians was the attending physician, the other one was the physician of the Ministry of Health. The will of the patient had to be applied after 7 days and most of the relatives of the patient had again to speak with him 3 days before the killing action. But this proposal wasn't accepted.

In 1973 Dr. Gertruida Postma, who gave her dying mother a lethal injection, received light sentence in the Netherlands. The case and its resulting controversy launched the euthanasia movement in that country.

The Dutch Voluntary Euthanasia Society (NVVE) launched its Members' Aid Service in 1975, to give advice to the dying. It received twenty-five requests for aid in the first year.

In 1976 Dr Tenrei Ota, upon formation of the Japan Euthanasia Society (now the Japan Society for Dying with Dignity), called for an international meeting of existing national right-to-die societies. Japan, Australia, the Netherlands, the United Kingdom, and the United States were all represented. This first meeting enabled those in attendance to learn from the experience of each other and to obtain a more international perspective on right to die issues12.

In 1978, Jean's Way was published in England by Derek Humphry, describing how he helped his terminally ill wife to die. The Hemlock Society was founded in 1980 in Santa Monica, California, by Derek Humphry. It advocated legal change and distributed how-to-die information. This launched the campaign for assisted dying in America. Hemlock's national membership grew to 50,000 within a decade. Right to die societies also formed the same year in Germany and Canada.

12 (Gruman, 1973)

The Society of Euthanasia assembled in Oxford in the last months of 1980, hosted by Exit, The Society for the Right to Die with Dignity. It consisted of 200 members represented 18 countries. Since its founding, the World Federation has come to include 38 right to die organisations, from around the world, and has held fifteen additional international conferences, each hosted by one of the member organisations.

On 5 May, 1980, the Catholic Church issued a Declaration on Euthanasia. Read here
In 1984, The Netherlands Supreme Court approved voluntary euthanasia under certain conditions.

In 1994, Oregon voters approved Measure 16, a Death With Dignity Act ballot initiative that would permit terminally ill patients, under proper safeguards, to obtain a physician's prescription to end life in a humane and dignified manner. The vote was 51-49 percent.

In 1995, Australia's Northern Territory approved a euthanasia bill. It went into effect in 1996 and was overturned by the Australian Parliament in 1997. Only four deaths took place under this law, all performed by Dr Philip Nitschke.

On 13 May, 1997, the Oregon House of Representatives voted 32-26 to return Measure 16 to the voters in November for repeal (H.B. 2954). On 10 June, the Senate votes 20-10 to pass H.B. 2954 and return Measure 16 to the voters for repeal. On 4 November 1997 the people of Oregon voted by a margin of 60-40 percent against Measure 51, which would have repealed the Oregon Death with Dignity Act, l994. The law officially took effect (ORS 127.800-897) on 27 October, l997.

In 1998, the Oregon Health Services Commission decided that payment for physician-assisted suicide could come from state funds under the Oregon Health Plan so that the poor would not be discriminated against.

In 1999, in the United States, Dr. Jack Kevorkian was sentenced to 10-25 years imprisonment for the 2nd degree murder of Thomas Youk after showing a video of his death, by lethal injection, on national television. Kervorkian's first appeal was rejected in 2001. Kevorkian helped a number of people die and even though he had been previously prosecuted, he remained free of criminal charges until 1999.

In 2000, The Netherlands approved voluntary euthanasia. The Dutch law allowing voluntary euthanasia and physician-assisted suicide took effect on the 1st of February, 2002. For 20 years previously, it had been permitted under guidelines.

2.4 Into The Third Millenium

In 2002 Belgium passed a similar law to the Dutch, allowing both voluntary euthanasia and physician-assisted suicide.

In New Zealand in March 2004 Lesley Martin was convicted of the attempted murder of her terminally ill mother. She served seven months of a fifteen-month prison sentence, before being released on a good behaviour bond, and subsequently failed, in two attempts, to appeal against the conviction.13

Switzerland, once known in the tourism business for its spectacular alpine landscape, the watches and chocolate, has a new claim to fame as the world's death Mecca. Physically and mentally vulnerable patients have been lining up for a one-way trip to Zurich.

In 2000 three foreigners committed suicide in Zurich. In 2001, the number of death tourists to Zurich rose to thirty-eight, plus twenty more in Bern. Most of the deaths occurred in an apartment rented by Dignitas, one of the four groups that have taken advantage of Switzerland's 1942 law on euthanasia to help the terminally ill die.

13 (Chin, 1999)

Dignitas has assisted the suicides of 146 people over the last four years. The Swiss parliament has been alarmed and there is a move to ban the 'suicide tourism' and to place tougher bans on assisted suicide.

When it was established in 1942, the Swiss euthanasia law was meant mainly to offer the opportunity for a dignified death to those with just two or three weeks to live.

In the past few years, though, it has been applied to patients with a range of ailments -- those with terminal illnesses or with acute mental disabilities, and even those suffering unbearable distress, such as a musician, for example, who has gone deaf.

There are several requirements under the Swiss law. People who opt for euthanasia must be rationally capable of making the decision to die. They must perform the final act -- usually the drinking of a lethal dose of barbiturates -- without assistance. And the event must be witnessed by a nurse or physician, and two other people.

2.5 Meaning And Definition

The word euthanasia translates from Greek roots as "good death." The Oxford English Dictionary states that the original meaning, "a gentle and easy death," has evolved to mean "the actions of inducing a gentle and easy death." This definition is consistent with contemporary use of the term. For example, the Canadian Senate Special Committee on Euthanasia and Assisted Suicide defined euthanasia as "the deliberate act undertaken by one person with the intention of ending the life of another person in order to relieve that person's suffering where that act is the cause of death" (Senate of Canada 1995, p. 15). Euthanasia is generally classified in terms of certain subcategories, depending upon whether or not the person who dies by euthanasia is considered to be competent or incompetent and whether or not the act of euthanasia is considered to be voluntary, non-voluntary, or involuntary.

Definitions of Euthanasia

Euthanasia is considered to be voluntary when it takes place in accordance with the wishes of a competent individual, whether these wishes have been made known personally or by a valid advance directive—that is, a written statement of the person's future desires in the event that he or she should be unable to communicate his or her intentions in the future. A person is considered to be competent if he or she is deemed capable of understanding the nature and consequences of the decisions to be made and capable of communicating this decision. An example of voluntary euthanasia is when a physician gives a lethal injection to a patient who is competent and suffering, at that patient's request.

Nonvoluntary euthanasia is done without the knowledge of the wishes of the patient either because the patient has always been incompetent, is now incompetent, or has left no advance directive. A person is considered incompetent when he or she is incapable of understanding the nature and consequences of the decision to be made and/or is not capable of communicating this decision. In the case of nonvoluntary euthanasia, the wishes of the patient are not known. An example of nonvoluntary euthanasia is when a doctor gives a lethal injection to an incompetent elderly man who is suffering greatly from an advanced terminal disease, but who did not make his wishes known to the physician when he was competent.14 Another example would be a father who asphyxiates with carbon monoxyde a congenitally handicapped child who was never considered to be competent.

Involuntary euthanasia is done against the wishes of a competent individual or against the wishes expressed in a valid advance directive. Examples of involuntary euthanasia include a son who gives a lethal overdose of medication to his father who is suffering from cancer, but the father does not want the overdose. Another example is a physician who, despite the advance directive of a patient indicating that he or she does not want any actions to hasten death, gives a lethal injection to the patient who is now unconscious and suffering from the final stages of a terminal illness15.

14 (Gruman, 1973)
15 (Gruman, 1973)

Although the above definitions may seem clear, there is much confusion in the words used to describe euthanasia and other actions that result in hastening death. The term "mercy killing" is often used to describe situations of nonvoluntary and involuntary euthanasia. In several European countries, for example the Netherlands, the difference between euthanasia, homicide, suicide, and assisted suicide appears to be relatively clear. However, in the United States and Canada there is much confusion concerning the use of the term assisted suicide and physician-assisted suicide.

2.6 : Definitions of Assisted Suicide

Assisted suicide is usually defined as a specific situation in which there is a suicide, that is, an act of killing oneself intentionally. Adding the word "assisted" to suicide implies that another person provided assistance by supplying the means (e.g., giving the person a gun or prescribing lethal medication), the knowledge (information about the use of the gun or how to take a lethal dose of medication), or both. In North America, assisted suicide has also been used in the media to refer to situations that appear to have been direct acts to end the life of a person intentionally initiated by another person. This is because assisted suicide has lesser legal sanctions than the act of killing another person even if the homicide is for the relief of pain and suffering in a terminally ill individual and can be called "euthanasia." For these reasons, Jack Kevorkian (the pathologist who made media headlines in the 1990s for his involvement in the deaths of over 130 individuals) claimed that his participation in the deaths of several patients was assisted suicide rather than euthanasia.

Sometimes there may be a fine line between what is considered assisted suicide and euthanasia. For example, during the period between July 1996 and March 1997, when euthanasia was legal in the Northern Territory of Australia, a machine was invented whereby a physician attached the patient to a computer-operated pump that contained lethal substances. Although the physician hooked up and turned on the apparatus, the lethal injection was only given after the patient responded to a question on the computer screen by pressing on a key.

Euthanasia is generally classified as either "active" or "passive", and as either "voluntary" or "involuntary". Similar to euthanasia is "assisted suicide".

2.7:Active vs Passive

"Passive euthanasia" is usually defined as withdrawing medical treatment with the deliberate intention of causing the patient's death. For example, if a patient requires kidney dialysis to survive, and the doctors disconnect the dialysis machine, the patient will presumably die fairly soon. Perhaps the classic example of passive euthanasia is a "do not resuscitate order". Normally if a patient has a heart attack or similar sudden interruption in life functions, medical staff will attempt to revive them. If they make no such effort but simply stand and watch as the patient dies, this is passive euthanasia.

"Active euthanasia" is taking specific steps to cause the patient's death, such as injecting the patient with poison. In practice, this is usually an overdose of pain-killers or sleeping pills.

In other words, the difference between "active" and "passive" is that in active euthanasia, something is *done* to end the patient's life; in passive euthanasia, something is *not done* that would have preserved the patient's life.

An important idea behind this distinction is that in "passive euthanasia" the doctors are not actively killing anyone, they are simply not saving him. While we would usually applaud someone who saves another person's life, we do not normally condemn someone for failing to do so. If you rush into a burning building and carry someone out to safety, you will probably be called a hero. But if you see a burning building and people screaming for help, and you stand on the sidelines -- whether out of fear for your own safety, the belief that an inexperienced and ill-equipped person like yourself would only get in the way of the professional firefighters, or whatever -- if you do nothing, few would judge you for your inaction. You would surely not be prosecuted for homicide. (At least, not unless you started the fire in the first place.) Thus, proponents of euthanasia say that while we can debate whether active euthanasia should be legal, there can be no debate about passive euthanasia: You cannot prosecute someone for failing to save a life. Even if you think it would be good for people to do X, you cannot make it illegal for people to *not* do X, or everyone in the country who did not do X today would have to be arrested.

In practice, though, the distinction can get hazy. It's like the old joke about the child who says to his teacher, "Do you think it's right to punish someone for something that he didn't do?" "Why, of course not," the teacher replies. "Good," the child says, "because I didn't do my homework."

In fact we have many laws that penalize people for what they didn't do. You cannot simply decide not to pay your income taxes, or not bother to send your children to school, or not to obey a policeman's order to put down your gun.

The most common method of euthanasia in the United States today is withholding food and fluids. In other words, the patient is starved to death. This is routinely classified as "passive euthanasia". But in other circumstances, if you locked someone in a room and kept all food away from him so that he starved to death, you could surely be prosecuted not just for kidnapping -- locking the person in the room -- but also for homicide. I sincerely doubt that a court would pay much attention to a defense based on the argument that you did not kill this person, you simply failed to save his life when he was starving.

2.8:Voluntary vs Involuntary

"Voluntary euthanasia" is when the patient requests that action be taken to end his life, or that life-saving treatment be stopped, with full knowledge that this will lead to his death.

"Involuntary euthanasia" is when a patient's life is ended without the patient's knowledge and consent. This may mean that the patient is kicking and screaming and begging for life, but in practice today it usually means that the patient is unconscious, unable to communicate, or is too sick and weak to be aware of what is happening or to take any action on his own behalf.

While this distinction appears clear - the patient willing agreed to euthanasia or he did not - it too is often made ambiguous in court cases and some public debate.

It is not uncommon for courts to declare someone "legally incompetent". This does not mean that the person is stupid, but rather that the court believes that he is unable to make informed decisions and/or to communicate them to others. The judge then appoints a guardian to make decisions for this person. Usually this will

be a close relative, like a spouse, parents, or children. But if no such person is available, or if the judge believes that none of the relatives have this person's best interests at heart, then someone else may be appointed: a social worker, a lawyer, etc. Children are routinely considered legally incompetent, and their parents are expected to make decisions for them. No one asks a two-year-old whether or not he wants to go to the dentist: that decision is normally made for him by his parents. A judge may conclude that a person is senile, mentally retarded, suffering from delusions, or has some other psychological problem that makes it impossible for him to make truly informed, rational decisions. If someone is in a coma or is otherwise so sick that she is unable to communicate, then even if she is capable of making informed decisions, there is no way for anyone else to know what her decisions are.

When courts declare someone legally incompetent and appoint a guardian, any decisions that the guardian makes are, for legal purposes, considered to be decisions of the incompetent person. A little thought will show that this must be so for the system to work: there would be little point in saying that you are authorized to make decisions for this comatose person ... except that you do not have the authority to sign anything that would otherwise require his signature. That would exclude almost all important decisions. But it can also lead to legal statements that are very misleading: Suppose Nancy Smith convinces a court that her grandfather, Fred Jones, is senile, and she is appointed his guardian. Then she decides that she wants to have him euthanized. He objects but he is too old and sick to fight her in court herself, so he gets his other granddaughter, Mary Brown, to fight for him. Because Nancy Smith's decisions are legally considered to be Fred Jones's decisions, the case will be referred to as "Brown versus Jones", and court documents will routinely describe this as Fred Jones choosing euthanasia and Mary Brown attempting to overrule this decision. News reports on the court case may or may not make clear who actually made the euthanasia decision.

It is not uncommon for medical personnel to treat someone as legally incompetent without any official court decision. For example, if someone is in the operating room under anesthesia, and there is a sudden crisis and a life-altering decision must be made *now*, it is often not possible to sew the person back up, wait for them to wake up, and then discuss the matter. A spouse or other close relative will

be asked to make a decision on this person's behalf. Clearly under such circumstances it would be impractical to take this to court and hold hearings on the patient's competence and the suitability of the spouse as a guardian. But in euthanasia cases, the problem is often not that the patient is incapable of making and communicating a decision, but rather that those around her do not approve of her decision. Even when the legality of such actions is questionable, in real life the authorities are not going to intervene unless someone challenges it. And if the patient is weak, sick, and bed-ridden, she may not be capable of getting to court to protest. Unless there is another relative who disagrees with the decision to euthanize, the patient's wishes can simply be ignored.

2.9:Buddhism

There are many views among Buddhists on the issue of euthanasia, but many are critical of the procedure.

An important value of Buddhism teaching is compassion. Compassion is used by some Buddhists as a justification for euthanasia because the person suffering is relieved of pain.[1] However, it is still immoral "to embark on any course of action whose aim is to destroy human life, irrespective of the quality of the individual's motive."

In Theravada Buddhism a lay person daily recites the simple formula: "I undertake the precept to abstain from destroying living beings." For Buddhist monastics (bhikkhu) however the rules are more explicitly spelled out. For example, in the monastic code (Patimokkha), it states:

"Should any bhikkhu intentionally deprive a human being of life, or search for an assassin for him, or praise the advantages of death, or incite him to die (thus): 'My good man, what use is this wretched, miserable life to you? Death would be better for you than life,' or with such an idea in mind, such a purpose in mind, should in various ways praise the advantages of death or incite him to die, he also is defeated and no longer in communion."

2.10;Christianity

Catholicism

The Declaration on Euthanasia is the Church's official document on the topic of euthanasia, a statement that was issued by the Sacred Congregation for the Doctrine of the Faith in 1980.

Catholic teaching condemns euthanasia as a "crime against life" and a "crime against God". The teaching of the Catholic Church on euthanasia rests on several core principles of Catholic ethics, including the sanctity of human life, the dignity of the human person, concomitant human rights, due proportionality in casuistic remedies, the unavoidability of death, and the importance of charity.[16] It has been argued that these are relatively recent positions,[17] but whatever the position of individual Catholics, the Roman Catholic Church's viewpoint is unequivocal.

2.11:Protestantism

Protestant denominations vary widely on their approach to euthanasia and physician assisted death. Since the 1970s, Evangelical churches have worked with Roman Catholics on a sanctity of life approach, though some Evangelicals may be adopting a more exceptionless opposition. While liberal Protestant denominations have largely eschewed euthanasia, many individual advocates (such as Joseph Fletcher) and euthanasia society activists have been Protestant clergy and laity. As physician assisted dying has obtained greater legal support, some liberal Protestant denominations have offered religious arguments and support for limited forms of euthanasia.

2.11;Christians in support of euthanasia

Groups claiming to speak for Christians rather than the official viewpoints of the Christian clergy have sprung up in a number of countries.[18]

2.12:Hinduism

There are two Hindu points of view on euthanasia. By helping to end a painful life a person is performing a good deed and so fulfilling their moral obligations. On the other hand, by helping to end a life, even one filled with suffering, a person

16 Declaration on Euthanasia". Sacred Congregation for the Doctrine of the Faith. 5 May 1980.
17 McDougall H, It's popularly believed that Catholics are anti-euthanasia. Do Catholics believe we don't have the freedom to do as we like? The Guardian 27 August 2009
18 Australia: http://www.christiansforve.org.au/

is disturbing the timing of the cycle of death and rebirth. This is a bad thing to do, and those involved in the euthanasia will take on the remaining karma of the patient.[19]

It is clearly stated in the Vedas that man has only two trust worthy friends in life, the first is called Vidya (knowledge), and the 2nd is called Mrityu (Death). The former is something that is beneficial and a requirement in life, and the latter is something that is inevitable sometimes even unexpected. It is not the euthanasia that is the act of sin, but worldy attachment which causes euthanasia to be looked upon as an act of sin. Even a Sannyasin or Sannyasini if they decide to, are permitted to end his or her life with the hope of reaching moksha i.e. emancipation of the soul.

2.13:Islam

Muslims are against euthanasia.They believe that all humans life is sacred because it is given by Allah, and that Allah chooses how long each person lives. Human beings should not interfere in this.[20] It is forbidden for a Muslim[21] to plan, or come to know through self-will, the time of his own death in advance.[22]

2.14:Jainism

Jainism is based on the principle of non-violence (ahinsa) and is best known for it.[23] Jainism recommends voluntary death or sallekhana for both ascetics and srāvaka (householders) at the end of their life.[24] Sallekhana (also known as Santhara, Samadhi-marana) is made up of two words sal (meaning 'properly') and lekhana, which means to thin out. Properly thinning out of the passions and the body is sallekhana. A person is allowed to fast unto death or take the vow of sallekhana only when certain requirements are fulfilled. It is not considered suicide as the person observing it, must be in a state of full consciousness. When observing sallekhana, one must not have the desire to live or desire to die. Practitioner shouldn't recollect the pleasures enjoyed or, long for the enjoyment

19 "Religion & Ethics - Euthanasia". BBC. Retrieved 2009-02-14.
20 Translation of Sahih Bukhari, Book 71. University of Southern California. Hadith 7.71.670.
21 Translation of Sahih Muslim, Book 35. University of Southern California. Hadith 35.6485.
22 Translation of Sahih Muslim, Book 35. University of Southern California. Hadith 35.6480.
23 Kakar 2014, p. 175.
24 Jain 2011, p. 102.

of pleasures in the future. The process is still controversial in parts of India. Estimates for death by this means range from 100 to 240 a year. Preventing santhara invites social ostracism.

2.15:Judaism

Like the trend among Protestants, Jewish medical ethics have become divided, partly on denominational lines, over euthanasia and end of life treatment since the 1970s. Generally, Jewish thinkers oppose voluntary euthanasia, often vigorously, though there is some backing for voluntary passive euthanasia in limited circumstances. Likewise, within the Conservative Judaism movement, there has been increasing support for passive euthanasia (PAD) In Reform Judaism responsa, the preponderance of anti-euthanasia sentiment has shifted in recent years to increasing support for certain passive euthanasia options.[citation needed] Secular Judaism is a separate category with increasing support for euthanasia. A popular sympathiser for euthanasia is Rabbi Miriam Jerris.

A study performed in 2010 investigated elderly Jewish women who identified themselves as either Hasidic Orthodox, non-Hasidic Orthodox, or secularized Orthodox in their faith. The study found that all of the Hasidic Orthodox responders disapproved of voluntary euthanasia whereas a majority of the secularized Orthodox responders approved of it.

2.16:Shinto

In Japan, where the dominant religion is Shinto, 69% of the religious organisations agree with the act of voluntary passive euthanasia. The corresponding figure was 75% when the family asked for it. In Shinto, the prolongation of life using artificial means is a disgraceful act against life. Views on active euthanasia are mixed, with 25% Shinto and Buddhist organisations in Japan supporting voluntary active euthanasia.

2.17:Unitarian Universalism

The Unitarian Universalist Association (UUA) recommends observing the ethics and culture of the resident country when determining euthanasia. In 1988 the

UUA gathered to share a commitment to The Right to Die with Dignity document which included a resolution supporting self-determination in dying.

2.28:Influence of religious views

Religious views on euthanasia are both varied and complicated. While one's view on the matter doesn't necessarily connect directly to their religion, it often impacts a person's opinion. While the influence of religion on one's views toward palliative care do make a difference25, they often play a smaller role than one may think. An analysis of the connection between the religion of US adults and their view on26 euthanasia was done in order to see how they combine. The findings concluded that the religious affiliation one associates with does not necessarily connect with their stance on euthanasia. Research shows that while many belong to a specific religion, they may not always see every aspect as relevant to them.

Some metadata analysis has supported the hypothesis that nurses' attitudes towards euthanasia and physician assisted suicide are influenced by religion and world view. Attributing more importance to religion also seems to make agreement with euthanasia and physician assisted suicide less likely. A 1995 study of public opinion found that the tendency to see a distinction between active euthanasia and suicide was clearly affected by religious affiliation and education. In Australia, more doctors without formal religious affiliation were sympathetic to active voluntary euthanasia, and acknowledged that they had practised it, than were doctors who gave any religious affiliation. Of those identifying with a religion, those who reported a Protestant affiliation were intermediate in their attitudes and practices between the agnostic/atheist and the Catholic groups. Catholics recorded attitudes most opposed, but even so, 18 per cent of Catholic medical respondents who had been so requested, recorded that they had taken active steps to bring about the death of patients.

25 (Kasimar, 1978)
26 (Mishara, 1998)

CHAPTER-3

EUTHANASIA AND ITS TYPE, REASONS AND METHODS

Types of euthanasia, voluntary euthanasia, non-voluntary, Involuntary euthanasia

There are different types of euthanasia, voluntary euthanasia (euthanasia performed with the patient's consent), non-voluntary euthanasia (where the patient is unable to give their informed consent, for example child euthanasia).and Involuntary euthanasia (which performed on a patient against their will). In this essay, I will merely focus on voluntary euthanasia which is the only acceptable and sensible situation for carrying out euthanasia, as the other two options are not approved by the patient. The most crucial thing we have to consider and follow is the will of patient on grounds that people have no rights to determine others life.

I do not support any form of suicide for mental health or emotional reasons. But I do say that there is a second form of suicide -- justifiable suicide, that is, rational and planned self-deliverance from a painful and hopeless disease which will shortly end in death.

3.1:Legal-

Let me point out here for those who might not know it that suicide is no longer a crime anywhere in the English-speaking world. (It used to be, and was punishable by giving all the dead person's money and goods to the government.) Attempted suicide is no longer a crime, although under health laws a person can in most states be forcibly placed in a psychiatric hospital for three days for evaluation.

But giving assistance in suicide remains a crime, except in the Netherlands in recent times under certain conditions, and it has never been a crime in Switzerland, Germany, Norway and Uruguay. The rest of the world punishes assistance in suicide for both the mentally ill and the terminally ill, although the state of Oregon recently (Nov. l994) passed by ballot Measure 16 a limited

physician-assisted suicide law. At present (Feb. l995) this is held up in the law courts.27

Even if a hopelessly ill person is requesting assistance in dying for the most compassionate reasons, and the helper is acting from the most noble of motives, it remains a crime in the Anglo-American world. Punishments range from fines to fourteen years in prison. It is this catch- all prohibition which I and others wish to change. In a caring society, under the rule of law, we claim that there must be exceptions.

3.2:Case study

This paper concerns a deceased 77 year old married woman, who presented to the older adult services for the first time aged 70.

Mrs A initially presented to the local Accident and Emergency (A and E) services having been referred by her general practitioner (GP) with anxiety and threats of self harm after her long term diazepam was reduced from 5mg four times a day to 5 mg twice daily. There was also a history of a recent family bereavement. The reduction in the dose of diazepam was mandated by a central drive to reduce all benzodiazepine use in the locality.

The patient also had a medical history of a low grade vaginal prolapse and recto-vaginal fistula, back pain and arthritis.

She was initially offered a compromise of an interim increase of diazepam to 5mg three times a day, and discharged back to the GP with grief counselling to be arranged. She self-referred to the crisis team 2 days later, threatening to harm herself unless she was seen at home that day. When the crisis team indicated that they would have to get police involved as they could not immediately attend, she retracted the threats and informed them that she was going to attend the grief counselling session which was scheduled for the following day.

27 (Cicero., 1998)

At this point, she was referred to the older adult mental health services, who arranged a formal psychiatric review and allocated a care coordinator. As the older adult mental health team built up a relationship with her, it became clear that her behaviours were well established prior to contact with mental health services and that her first reported attempt of self harm happened in her twenties. She had married, raised her children and worked for about 15 years, apparently without being referred to services.

Reports from family members suggested that she was always focused on herself, and would engage in behaviour that brought her attention, even when inappropriate in the context. She was well known to the GP team, and would be very demanding of their time, often requesting appointments and home visits for what seemed to be spurious reasons28.

She was diagnosed with emotionally unstable personality disorder of the borderline type after an extensive period of assessment which included 2 periods of detention under Section 2 of the Mental Health Act. There was no evidence to support the presence of cognitive impairment, or recent personality change prior to contact with services.

Mrs A was poorly compliant with treatment modalities offered, including pharmacotherapy, behavioural therapy and psychotherapy. She refused to attend the grief counselling. She continued to engage with services and would phone, sometimes up to 20 times a day to speak to various team members. She also attended A and E regularly, even when she had been seen by the mental health team on the same day. She would phone the GP several times a day for various reasons such as back pain or the prolapse. She also phoned the ambulance services about 80 times in a 2 year period.

Her attitude to self harm seemed particularly challenging. She would threaten to drown herself and ask her husband to convey her in the family car to a suitable site, which she would then turn down as either too deep or too cold. On one occasion, she threatened to drown herself in the bath, and climbed out a few hours later because her husband had refused to call for help, and the bathwater had

28 (Kasimar, 1978)

turned cold. O n another occasion, she loudly counted out the paracetamol tablets she was taking as an overdose until she got to 16, whereupon she insisted that her husband took her to A and E to get help. She physically assaulted her husband on one occasion when he tried to reason with her demands to be taken to hospital. She agreed to have help for the vaginal prolapse, but sabotaged any attempts to have treatment, and then loudly insisted that she had seen so many doctors who had all told her it was untreatable. She would also describe, with a visible sense of enjoyment, how faecal matter would escape from the fistula, often in an attempt to derail any kind of discussion of her mental health needs.

It was difficult to understand the psychological drivers of her behaviour, but on one occasion when visited at home by her psychiatrist, she became very angry and insisted that she had a natural right to make any demands on her husband, as she was ill. She mentioned several friends of theirs who were similarly dependent on their husbands.

The OAMHS team adopted a pragmatic responsive approach which brought together GP, ambulance and the local A and E team. The management plan specified that she should have a psychiatric assessment whenever she presented to A and E, with a view to actively avoiding admission except where indicated under the Mental Health Act. It also specified that the dose of her diazepam (then 5mg twice daily) should not be altered, and no other psychotropics should be prescribed unless agreed with her core psychiatric team.

She was seen regularly in the community by her psychiatrist and CPN. Her unscheduled contacts with the various services seemed to stabilise for a few months. When she did not attend a scheduled outpatient review with her psychiatrist, the psychiatrist requested that active inquiry should be made by her care coordinator, to which the patient intimated that she and her husband had “a plan”. When this was fed back, her psychiatric consultant queried whether the allusion to “a plan” meant the possibility of suicide / homicide. Both the patient and her husband directly denied this.29

29 (Cicero., 1998)

Another appointment was arranged for a few weeks later. She did not attend. Her care coordinator contacted the family home to be informed that she had died in a European euthanasia facility the previous week.

3.3:In Child

Belgium, one of the very few countries where euthanasia is legal, is expected to take the unprecedented step this week of abolishing age restrictions on who can ask to be put to death — extending the right to children.

The legislation appears to have wide support in the largely liberal country. But it has also aroused intense opposition from foes — including a list of pediatricians — and everyday people who have staged noisy street protests, fearing that vulnerable children will be talked into making a final, irreversible choice.

Backers like Dr. Gerland van Berlaer, a prominent Brussels pediatrician, believe it is the merciful thing to do. The law will be specific enough that it will only apply to the handful of teenage boys and girls who are in advanced stages of cancer or other terminal illnesses and suffering unbearable pain, he said.

Under current law, they must let nature take its course or wait until they turn 18 and can ask to be euthanized.

“We are talking about children that are really at the end of their life. It's not that they have months or years to go. Their life will end anyway,” said Van Berlaer, chief of clinic in the pediatric critical care unit of University Hospital Brussels. “The question they ask us is: 'Don't make me go in a terrible, horrifying way, let me go now while I am still a human being and while I still have my dignity.'30”

The Netherlands already allows euthanasia for children as young as 12, providing their families agree.

The Belgian Senate voted 50-17 on Dec. 12 to amend the country's 2002 law on euthanasia so that it would apply to minors, but only under certain additional conditions. Those include parental consent and a requirement that any minor

30 (Mishara, 1998)

desiring euthanasia demonstrate a “capacity for discernment” to a psychiatrist and psychologist.

The House of Representatives, the other chamber of Parliament, is scheduled to debate on Wednesday whether to agree to the changes, and vote on them Thursday. Passage is widely expected.

King Philippe, Belgium's constitutional head of state, must sign the legislation for it to go into effect. So far, the 53-year-old monarch and father of four has not taken a public position, but spokesman Pierre De Bauw said that is not unusual. “We never give any comment on any piece of legislation being discussed in Parliament,” De Bauw said Tuesday.

Though one opinion poll found 75 percent of Belgians in favor, there has been a vocal opposition.

This week, an “open letter” carrying the names of 160 Belgian pediatricians was issued to argue against the new law, claiming there is no urgent need for it and that modern medicine is capable of soothing the pain of even the sickest children.

Van Berlaer, 45, was not one of the signatories. Very sick children who are surrounded by other ill and dying people are not like other youngsters, and mature quickly_too quickly, he said. They may look on as friends or neighbors in their ward die because they can no longer breathe or swallow, and come to realize what lies ahead for them.

In such cases, Van Berlaer said, a child may want to say goodbye to classmates and family, and ask if he or she can stop living.

“The thing is that it is an ultimate act of humanity and even love for the patients, minors in this case, that we at least listen to this question and think about why they would ask such a difficult thing,” Van Berlaer said. “And it will never be easy, even if the law changes now, things won't be easier.31”

Besides Belgium, the only other countries to have legalized euthanasia are two of its neighbors, the Netherlands and Luxembourg, said Kenneth Chambaere, a

31 (Battin, 1994)

sociologist and member of the End-of-Life Care research group at the Free University Brussels and University of Ghent.

In the Netherlands, children between 12 and 15 may be euthanized with parents' permission, while those who are 16 or 17 must notify their parents beforehand. Luxembourg limits the practice to legal adults 18 and older.

3.4:Reason for Euthanasia-

Advanced terminal illness that is causing unbearable suffering to the individual. This is the most common reason to seek an early end.

Grave physical handicap which is so restricting that the individual cannot, even after due consideration, counseling and re-training, tolerate such a limited existence. This is a fairly rare reason for suicide -- most impaired people cope remarkably well with their affliction -- but there are some who would, at a certain point, rather die.

1. People have the right to die.

Often, the discussion revolves around the right to life; anti-euthanasia proponents argue that euthanasia infringes on a person's fundamental right to live. What they fail to see is that our "life" as human beings implies death. Without death, we do not have "human life" by its very definition. Like black and white or two sides of a coin, human life cannot occur without death. Therefore for those that argue that every man has the fundamental right to live, they unknowingly also agree that every man has the fundamental right to die.

Because we can determine the course of our lives by our own will, we have the right to live our lives and determine our own course. Naturally it follows that the same self-determining capacity we have as human beings also gives us the fundamental right to determine how we die. It is also important to consider that the right to life has no say over the right to die. The right to live and the right to die are two separate, although related rights. They are also mutually exclusive in the sense that the right to live concerns itself only with self-determined life and

ends with the right to die. The right to die on the other hand begins where life ends in death. While you live, you exercise your right to life; when your life ends, you exercise your right to die. It is important to consider that we refer to self-determined or natural death and not death resulting from someone directly removing from you your life, thereby restricting your right to live. If such significant weight in this sense is given to our right to live, should we not also give equal weight to our right to die.

2. People have the explicit right to choose.

Beyond the philosophical implications of man's right to live or die lies man's explicit and fundamental right to choose. Everything is touched by this explicit right, from what you will have for breakfast to what you will believe, what your opinions are and what you do with your life. The society that man has built is founded on this very right, and evolves because our inherent nature is explored. Regardless of the outcome, no one can question our right to free will. The right to choose is fundamental and applies to all elements of "human life", which by the nature of human life, includes the right to choose how you die. As an example, a terminally ill individual who is currently under significant pain may choose to die with dignity, as is his right. To deny him this is to deny him his personal autonomy and is an act that is trespassing on his humanity. While concepts such as dignity are defined by social majority, an individual, possessing all the rights of a human being, may perceive a dignified death to be preferable to constant suffering. He may decide on euthanasia, and this choice should be available to him. Very simply, this is his right to choose, as equally as he made his choices when faced with circumstances in life. It cannot be questioned should he decide to act on it. In the case of euthanasia, we simply request assistance to facilitate this right of choosing how to exit this world.

3. Euthanasia is not immoral.

For something to be immoral, it would have to violate moral laws or norms. The argument of anti-euthanasia proponents is that euthanasia is immoral because life must be preserved and protected. The preservation of life is, however, subject to the self-determined choice of the person and not the choice of the physician. As

an example, murder infringes on a person's right to life by taking away the element of choice in the persons death. No infringement is done when it is the person who chooses how to die. For a physician to deny the person his right to die when under intense pain and suffering is effectively forcing them to live a life without what they believe is their dignity, a life of suffering and eventual death (in the case of terminally ill patients). While the intentions may be good, no person has the right to demand of another person to live a life of suffering, in fact, that is immoral as it removes their right to choose. Euthanasia facilitates the choice making it in fact the compassionate choice and sympathetic to that person's dignity. It is also important to note that those that argue to preserve life despite the patient being terminally ill and in extreme pain are usually not the patients themselves and therefore removed from the consequences of the decision.

4. Euthanasia protects self-hood and human dignity.

Self-determination is one of the key elements that make us human. It is the ability to determine our destiny as individuals and is facilitated by our ability to think for ourselves. Imagine a life where an illness has left you incapable of conducting the basics of life; you are unable to breathe, move or even think for yourself. You have effectively removed your ability to self-determine, arguably a significant element in being "human". Our sense of "self" is created as we progress through life. We grow our personalities as human beings by our choices and experiences. This sense of self is the foundation of our human dignity.

Now, go back to the example of the person who can no longer breathe, move or even think for himself, and add the element of extreme and constant pain to the point where they prefer death to living this way. Over time, because of this experience, the person will eventually lose sight of their "self", when they could move around, form opinions and self determine. This will all be a distant memory, and the most real thing to them will be the constant state of pain they are in. They won't even be able to cry out in pain despite the pain. Seem far-fetched? Consider Tony Nicklinson, whose bid for euthanasia was rejected multiple times. Tony Nicklinson was diagnosed with a disease that prevented him from moving any and all muscles in his body. After his bid was denied, he decided to starve himself to death, which took a week without food. Another example is Kelly Taylor who

starved herself for 19 days trying to die. Without the option of euthanasia, their quality of life will continue to deteriorate the same way Tony and Kelly had endured. They will eventually die, but in what state? Will they go out in a state of dignity? Euthanasia can provide them with the opportunity to finish their life keeping their human dignity intact.

5. Euthanasia does not harm to others.

Because people will naturally have different interests, it is not uncommon to have conflicts of interest. When conflicts arise, it is the goal of civilized society and the state to ensure the resolution of conflicts without the infringement of fundamental human rights. These rights are protected above all others and their infringement is punished severely. That being said, euthanasia as a choice infringes on no such fundamental rights. Death by its nature is a private affair. Assisted suicide (as is the case of euthanasia) involves direct harm and the termination of life only to the individual who has requested it. One cannot request euthanasia for another "competent" person. If this is the case, it will then be a question of murder instead. The process of euthanasia does not restrict or infringe on anyone's fundamental rights and therefore does no harm.

.6. Euthanasia is properly regulated.

Those who oppose euthanasia often cite the horror stories of patients being euthanized without consent or for unethical or impure reasons. Granted, the history of euthanasia is not without its fair share of horror stories and because of the gravity of its practice, it does need to be regulated. However, this is not reason enough to say that it cannot be properly regulated. Developed nations like the Netherlands have legalized euthanasia and have had only minor problems from its legalization. Any law or system can be abused, but that law and system can always be refined to prevent such abuse from happening. In the same way, it is possible to properly and effectively regulate euthanasia as various first world countries have done. More so because the process of euthanasia itself as it is being argued here, requires competent consent from the patient. It is important to consider the protection of both the physicians as well as the patients. The critical

element in the regulation of euthanasia will be determining the line between what is considered to be euthanasia and what is considered to be murder.

.7. Everyone has a right to a good death, therefore a good death must not be denied to those who want one.

Nobody thinks of their death and desires it to be extremely painful or horrible. Rational human beings desire a good, dignified end to an ideally long and fruitful life. Circumstance, like luck, may not always be in your favor. It may not even be a terminal disease, which is so frequently used in pro-euthanasia arguments. It can be as savage as a freak accident or as simple as falling down the stairs to put you in a world of excruciating pain. While this is never to be wished on anyone, for those that have had the misfortune of being diagnosed with a terminal or painfully debilitating disease must have a choice out of it. Do we, who so desire a good death, have the right to judge others' state when we know nothing of it? Do we have the right to compare their experiences day by day, having experienced none of them, and say that they don't deserve to die with dignity, the way they want to die? The answer is of course, no, we have no right to deny them the dignified death that we ourselves naturally desire. To do so would be selfish and we would effectively be imposing our own desires on that person, thereby restricting their freedom to self-determine even if it is in the most basic sense.

.8. Euthanasia does not shorten lifespans by as much as is portrayed.

Many arguments opposing euthanasia are based on the premise that the patient's life should be preserved because of the possibility of their recovery. Statistics however, paint a different picture. A Dutch survey conducted in 1991 showed that 86% of Euthanasia cases only shortened the life of the patient by a maximum of 1 week. The standard time it shortened their life was by a few hours only. This clearly shows that terminal illness is statistically terminal. Add in the fact that in the majority of these cases, the patients were in extreme agony, the numbers show you that terminally ill patients are using euthanasia to end the suffering where they would have had near impossible chances of recovery. This is not the same as

the ideal painted by opponents of euthanasia, wherein the patient may have a chance to survive and make a miraculous recovery. It is because the numbers are so heavily indicative of euthanasia as an out for terminally ill patients in terrible agony that it must be allowed as an option to end their suffering.

.9. Euthanasia saves lives.

Sound shocking? Consider this: a 2005 study of euthanasia in the Netherlands found that 0.4% of all euthanasia was done without consent from the patient. By the time this study was done, euthanasia had been legalized in the Netherlands. Now consider another study done in 1991 which was done before euthanasia was legalized which indicated that 0.8% of euthanasia done in the Netherlands was done without the patients consent. This shows that the legalization of euthanasia actually had the reverse of the expected effect and cut the unacceptable practice of no consent euthanasia in half. By these numbers, euthanasia has in fact saved lives since it now provides a protected and regulated framework with which doctors must first obtain explicit consent before conducting euthanasia. This same framework makes it more difficult and less grey for those seeking to perform euthanasia with impure or irresponsible intentions.

.10. The Hippocratic oath supports euthanasia.

Most people misinterpret the Hippocratic oath as being against euthanasia. The key element of the oath is that the physician must protect the wellbeing of their patient, hence the maxim "do no harm" commonly interpreted to be a summation of the oath. Most interpretations of the "harm" element are however taken to literally refer to the patient's life. It can be argued that harm in this case refers to the wellbeing of the patient, which includes his life. However in cases where it is a choice between intense suffering or death, it can be argued that the physician is doing more harm to the patient by not allowing them to die. While this argument can go either way, updated interpretations of the Hippocratic oath do include a segment that concerns taking life as well as preserving it:

"Most especially must I tread with care in matters of life and death. If it is given me to save a life, all thanks. But it may also be within my power to take a life; this

awesome responsibility must be faced with great humbleness and awareness of my own frailty.”

11. Avoid black market

If euthanasia were legalized in the United States, it would reduce the current number of deaths caused in a highly unprofessional manner because of the legality issues. Presently, many physicians aid in the suicides of terminally ill patients by giving them the drugs necessary to commit the act on their own. The physician will frequently list the cause of death as the actual illness, rather than (assisted) suicide. This is to prevent public delving into the patient's history and illness, and causing limitless pain for the patient's family. This is very unprofessional because though the intent is good, it is not a guaranteed method and could result in merely more pain for the patient and his or her relatives. Ronald Dworkin, an author of books about euthanasia and other ethical issues summarized this idea when he stated, "Patients might be better rather than less well protected if assisted suicide were legalized with appropriate safeguards" (Leone 36). The intent of this statement is to make it clear that safeguards could ensure the safety, rather than keeping it at the high risk it is at now. The issue of safeguarding euthanasia methods has many variations, and doesn't end with the legal and professional controversies.

The person is a mature adult. This is essential. The exact age will depend on the individual but the person should not be a minor who come under quite different laws.

The person has clearly made a considered decision. An individual has the ability nowadays to indicate this with a "Living Will" (which applies only to disconnection of life supports) and can also, in today's more open and tolerant climate about such actions, freely discuss the option of euthanasia with health professionals, family, lawyers, etc.

The euthanasia has not been carried out at the first knowledge of a life-threatening illness, and reasonable medical help has been sought to cure or at least slow down the terminal disease. I do not believe in giving up life the minute a

person is informed that he or she has a terminal illness. (This is a common misconception spread by our critics.) Life is precious, you only pass this way once, and is worth a fight. It is when the fight is clearly hopeless and the agony, physical and mental, is unbearable that a final exit is an option.

The person leaves a note saying exactly why he or she is taking their life. This statement in writing obviates the chance of subsequent misunderstandings or blame. It also demonstrates that the departing person is taking full responsibility for the action.

Case (commit suicide illegally)

3 .5:Sue Rodriguez

The most prominent case opposing this the law was that of Sue Rodriguez, who after being diagnosed with amyotrophic lateral sclerosis (ALS) requested that the Canadian Supreme Court allow someone to aid her in ending her life. Her request appealed to the principle of autonomy and respect for every person, which states that "everyone has the right to self-determination subject only to an unjust infringement on the equal and competing rights of others." 32

Her main argument for her assisted suicide, however, appealed to the principle of equality and justice which states that "everyone should be treated equally, and deviations from equality of treatment are permissible only to achieve equity and justice."33 The application of this principle to the case is as follows. Ms. Rodriquez's ALS would eventually lead her to lose her voluntary motor control. Therefore, this loss of motor control is a "handicap of ALS-sufferers" 34

Because suicide is not a crime, Ms. Rodriquez was being discriminated against in her option of deciding to commit suicide with the help of another person due to

32 Details of this policy can be found at http://www.cps.gov.uk/publications/prosecution/assisted_suicide.html [Accessed 26 July 2011].

33 Criminal Code, R.S.C. 1985, c. C-46.

34 Canada, Special Senate Committee on Euthanasia and Assisted Suicide, Of Life and Death – Final Report (Ottawa: Special Senate Committee on Euthanasia and Assisted Suicide, 1995), online: Senate of Canada <http://www.parl.gc.ca/Content/SEN/Committee/351/euth/rep/lad-e.htm>.Accessed 2 August 2011].

her disability, without the law "providing a compensatory and equitable relief" 35 Though in 1992, the Court refused her request, two years later, Sue Rodriquez, with the help of an unknown doctor ended her life despite the Court's decision. Due to her death, the Canadian medical profession issued a statement through Dr.Tom Perry and Dr.Peter Graff, who both said that they had assisted some of their patients in speeding up their death.

3.6:Robert Latimer

Robert Latimer is a Canadian canola and wheat farmer, who was convicted of second-degree murder in the death of his daughter Tracy (November 23, 1980 – October 24, 1993). This case sparked a national controversy on the definition and ethics of euthanasia as well as the rights of people with disabilities, and two Supreme Court decisions, R. v. Latimer (1997), on section 10 of the Canadian Charter of Rights and Freedoms, and later R. v. Latimer (2001), on cruel and unusual punishments under section 12 of the Charter.

3.7|:Methods of Euthanasia

Competent adult patients have the right to refuse medical treatment. Such refusals of treatments are morally and ethically different from euthanasia, and should remain legally different.

Dr Tricia Briscoe said at the 2004 Medical Law Conference:

"The right to refuse treatment flows from a right to inviolability - a right not to be touched, including by continuing treatment, without one's consent - not from a right to die. Withdrawal of treatment will mean death, but it will result from the patient's underlying illness." [36]

When, however, an action or medication is withheld from a patient for the *primary* purpose of causing or hastening death, this is passive, or indirect, euthanasia. These measures may include the with-holding or withdrawal of ordinary measures such as food, water (hydration) and oxygen.

35 Canadian Charter of Rights and Freedoms, Part I of the Constitution Act, 1982, being Schedule B to the Canada Act 1982 (U.K.), 1982, c.11.

36 www.nzma.org.nz

Examples of passive euthanasia are:

- when food and water is withheld from sick or disabled newborn babies who might otherwise have lived
- with-holding or withdrawing food and water from someone who is diagnosed as being in a 'persistent vegetative state,' has dementia, or who is not improving fast enough (e.g. from a stroke)
- 'do not resuscitate' orders written on patients' charts

3.8:Drugs

In Oregon, a doctor can write a prescription for drugs that are intended to kill the patient. When the prescription is filled, directions centre around making certain that the patient understands about taking all the pills in a single dose, dies after taking the prescription.

The lethal drugs are covered by some Oregon health insurance plans. They are paid for by the state Medicaid program under a funding category called "comfort care."

Research into euthanasia in the Netherlands claimed people awake from comas after taking supposedly fatal drug doses and suffer side effects such as vomiting and gasping.

To reduce the chances of the euthanasia drugs being vomited up, an anti-emetic must be given.

The study showed that when patients tried to kill themselves using drugs prescribed by a doctor, the medication did not work as expected in 16% of cases. In a further 7% of cases there were technical problems or unexpected side effects.

Problems surface so often that doctors felt compelled to intervene in 18% of cases, according to a report in the New England Journal of Medicine. Even when the doctor directly performed euthanasia, complications developed in 3% of the

attempts. Patients either took longer to die than expected or woke from a drug-induced coma that was supposed to be fatal in 6% of cases. [37]

3.9:Injections

In the Netherlands, the practice is an injection to render the patient comatose, followed by a second injection to stop the heart.

First a coma is induced by intravenous administration of barbiturates, followed by a muscle relaxant. The patient usually dies as the result of anoxemia caused by the muscle relaxant. When death is delayed, intravenous potassium chloride is also given to hasten cardiac arrest.

3.10:Starvation and Dehydration

Right-to-die activists often advocate the withdrawal of food and water in order to hasten death. This means of death is frequently approved when application is made to the courts. Proponents of euthanasia recommend the use of what is known as Terminal Sedation in combination with the withdrawal of food and water.

Terminal sedation allows for the measured use of sedatives and analgesics for the necessary control of symptoms such as intolerable pain, agitation, and anxiety, in order to relieve the distress of the patient and of family members.

If all food and fluids (nutrition and hydration) are removed from a person -- whether that person is a healthy Olympic athlete who takes food and fluids by mouth or a frail, disabled person who receives them by a feeding tube -- death is inevitable. That death will occur because of dehydration.

Dr. Helga Kuhse, a leading campaigner for euthanasia, said in 1984: "If we can get people to accept the removal of all treatment and care - especially the removal of food and fluids - they will see what a painful way this is to die and then, in the patient's best interest, they will accept the lethal injection." 38

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37 news.bbc.co.uk

38 Fifth Biennial Congress of Societies for the Right to Die, held in Nice, Sept. 1984

3.11:Gases, plastic bags and the 'peaceful pill'

This method, referred to as 'self deliverance,' is most commonly advocated by right-to-die activists such as Derek Humphry and Dr Philip Nitschke. In Humphry's book *Final Exit* describes the method and has been found in the possession of people who have used the method to commit suicide.

Dr Nitschke developed what he calls the 'CO Genie' - an apparatus that turns out lethal carbon monoxide that can be made at home. Nitschke has held workshops in Australia and New Zealand teaching people how to manufacture such devices for themselves.

Dr Nitschke's latest initiative is a barbiturate-based 'peaceful pill.' Nitschke's Peanut Project (named for an old street term for "Barbiturate") intends holding workshops for small groups of elderly and seriously ill Exit members from different countries to make their own Peaceful Pill.

OPERATING EUTHANASIA

3.12:Children Ages Three to Seven Years

Young children ages three to seven years have only a limited sense of time. They have not yet developed the ability to project ahead or conceptual time blocks in a way that helps them differentiate a day from a week, or a year. Without understanding the complexities of time they cannot understand that death is forever.

Because young children do not fully understand time, they cannot understand the permanence of death. Because they see themselves at the center of all that happens to them, they believe that they cause the bad things that happen. Children’s thoughts and momentary wishes about pets dying or running away are normal. Young children need huge quantities of repetitive reassurance before they fully understand that their private thoughts and wishes did not cause their pet’s injury, death or disappearance.

Television, with its frequently repeated episodes often shows familiar characters die only to be resurrected the following week in a rerun. Young children struggle to understand the difference between what is real and what is pretend. Think about how many times children watch cartoons where trucks flatten characters that magically reappear alive, only moments later. Most children have difficulty understanding that death is permanent. Some children will argue with adults that their dead pet will definitely be back because they have seen television characters come back after they "died" in a show.

3.13:Children Ages Eight to Twelve Years

Some older children, age eight to twelve years, are mature enough to be included in discussions about the medical options available for a sick or injured pet. Children need information to understand what is happening. They especially need to understand that what is happening to their pet is not their fault. Children should not be given any responsibility for making a decision about euthanasia.

Children do not have the perspective or life experience to weigh all the emotional, medical and financial factors that go into the heart wrenching decision to euthanize a pet. Asking children to weigh the financial realities of extensive surgery, expensive medications, or long hospitalizations would burden them unduly. Children have no power to affect family income nor spending priorities. Children need to trust their parents to make the big decisions about health care and family finances.

3.14: **Adolescents**

During the teen years maturity and ability to participate in decisions varies widely. Teens should only be asked to participate in the decision to euthanize a pet if they truly have a choice. If further medical care would only prolong suffering, or the family simply does not have the financial resources for extensive medical intervention, then parents should make the decision. Like younger children, teens need good information. They can handle more of the complexities inherent in the decision making process, and should be allowed a voice. Even into their teen years, children should not have primary responsibility for making a decision to euthanize a pet.

1. Ambivalent societal attitudes towards older people based on a variety of concerns:

• after retirement old people make no or little positive contribution to the economics of the country; worse still,

• the proportion of services they use especially in the health and social sectors are seen as a financial liability to society; worse still,

• They block the aspirations of younger people: e.g. by continuing to occupy jobs that could be handed on to younger workers. (Paradoxically, just ten years ago the Treasury was bewailing the probability that with the ageing of the workforce, there would not be enough people in the workplace to sustain New Zealand industry and the country's economy would sink under the weight of all the pensioners. So whatever happens, the elderly cop the blame.)

Although such notions can be largely refuted, -that is a discussion in itself- it is the perception rather than the facts that tends to rule people's reactions. The common factor in all this is that we in Western countries live in a society that largely values an individual on what he or she contributes as an economic unit. (How often nowadays do we hear people referred to as 'units'?) Depersonalisation is one factor that corrodes any expectation held by older people in society that they will not be harmed or, in extreme cases regarded as being expendable. Elder abuse (physical and psychological) is common the world over and in jurisdictions where euthanasia and PAS are legal, it may take that form. Older people are, by and large very sensitive to being thought to be a burden, and more likely than a young person to accede to more or less subtle suggestions that they have 'had a good innings.' Statistics from The Netherlands, where voluntary euthanasia is decriminalised, show that more than 30% of people requesting euthanasia do so on the grounds of not wishing to be 'a burden'. In such circumstances, one has to wonder how free freedom of choice really is.

Dr. Richard Fenigsen a Dutch cardiologist reported, in a paper on euthanasia in that country, that when the Dutch Parliament was considering making euthanasia

legal, a group of handicapped adults wrote to the Parliamentary Committee for Health Care and Justice in the following terms: .

"We feel our lives threatened…We realise that we cost the community a lot…Many people think we are useless…Often we notice that we are being talked into desiring death…We will find it extremely dangerous and frightening if the new medical legislation includes euthanasia."

2. Loss of control by older people over their destiny

Older people with disabilities lose the ability to control their environment (i.e. lose their autonomy) and are therefore at risk from those (nurses, doctors, pharmacists etc.) who assume that control and who have the power to do them harm – including to euthanase them even though they have not requested it – the so-called 'slippery slope' effect. In Holland the practice has moved in 30 years from euthanasia on request (legal voluntary euthanasia) to euthanasia of people who cannot request it, -including newborns) to euthanasia of people who could have but didn't request it; both of which are illegal. It is laughable that proponents of voluntary euthanasia declare it to be on the grounds of providing death with 'dignity.' In countries like The Netherlands and Belgium many more people suffer the ultimate loss of dignity by being euthanased without their consent than are euthanased on request. If voluntary euthanasia were to be legalised, older people would undoubtedly discover that the fear of dying that a minority have is replaced by a majority fear of being killed without their consent, – with the noblest intentions of course. They would not know who their enemy was: the smiling doctor who greets them twice a week on his ward round, the cheerful nurse who attends them so professionally on the evening shift. It is well recognised that legalising euthanasia throws up a cadre of euthanasia-friendly health professionals who can justify its use in virtually any circumstance – Dr. Nitschke is an example – and that eventually end-of life termination procedures run out of control no matter how tightly they are ostensibly regulated. Indeed, there are those euthanatics who argue that people who cannot make an informed decision in favour of euthanasia, are actually being unfairly discriminated against compared with people who are capable of making a decision so that the ethical thing to do is to euthanase them regardless. This is of course, murder, but to my knowledge

only one physician has ever been convicted in either The Ntherlands or Belgium and he was given a suspended sentence. The authorities turn a blind eye to the practice.

Dr. Herbert Hendin is a Professor of Psychiatry in New York and the author of a number of books on physician-assisted suicide and euthanasia. He has personally investigated the practice of euthanasia in The Netherlands. After doing so, he and others researching with him concluded that guidelines established by the Dutch for the practice of assisted suicide and euthanasia were consistently violated and could not be enforced. The guidelines specify that a competent patient who has unrelievable suffering must make a voluntary request for euthanasia to a physician. The physician, before actioning the request, must consult with another physician and must report the case to the authorities.

He notes that 'concern over charges of abuse led the Dutch government to undertake studies of the practice in 1990, 1995 and in 2001 in which physicians' anonymity was protected and they were given immunity for anything they revealed. Violations of the guidelines then became evident. Half of Dutch doctors felt free to suggest voluntary euthanasia to their patients, which compromises the voluntariness of the process. Fifty percent of cases were not reported, which made regulation impossible. The most alarming concern has been the discovery of several thousand cases a year in which patients who have not given their consent have had their lives ended by physicians. A quarter of physicians stated that they "terminated the lives of patients without an explicit request" from the patient. Another third of the physicians could conceive of doing so'. In other words, the most important thing we can learn from the Dutch experience over 30 years is that the practice of euthanasia cannot be controlled.

3.Modern Utilitarian philosophies about what constitutes a person worthy of care.

Bioethics has become a sounding board for utilitarian philosophers such as Peter Singer, John Harris and the late Joseph Fletcher. They contend that only beings that exercise personal awareness are capable of being classified as "persons" who

are worthy of respect by society. 39Thus the fetus, neonates and people with severe confusion / dementia – the majority of whom are elderly – are not, by their definition "persons'. Society is therefore justified in getting rid of them if they are an inconvenience: e.g. using scarce resources. This sort of philosophy is being taught in medical and nursing schools. As a philosophical stance it is not new: it was just such a viewpoint that, taken up nationally, was the theoretical basis underpinning the holocaust in Germany during the time of the Third Reich. In 1895 the German Adolf Jost enunciated the concepts of a "right to die" and "human worthlessness" in his book The Right to Die." His ideas were taken up and built on by Ernst Haeckel, Judge Karl Binding and above all, Psychiatry Professor Alfred Hoeche. Binding and Hoeche maintained in their book entitled: The Permission to Destroy Life Unworthy of Life, that there were people whose lives were "not worthy to be lived". They were to be found amongst the terminally ill, those in coma and psychiatric patients, especially those residing in hospitals. With regard to this last group, they emphasised the high financial cost to the German State incurred in their continuing treatment. Finally in 1922, Ernst Mann advocated euthanasia not only for the above groups, but also for children who were crippled or incurably ill. An officially endorsed euthanasia programme began in Germany in 1933 and became compulsory in 1939. It is estimated that 275 000 persons who had been in nursing homes, hospitals and asylums were killed in this programme prior to the onset of World War II. Hence what the world came to know as The Holocaust started with the forced euthanasia of disabled and mentally ill people. Proponents of legalised euthanasia are desperate to try to distance themselves from these unpalatable facts. But they are irrefutable. The only difference between Germany of the Third Reich and Holland today is that the Germans made the euthanasia programme compulsory. In The Netherlands it is still discretionary; at the discretion of the doctors.

4. Fraught family relationships

Experience overseas is that those who are less well-off, those who have no close family, and those who have fraught family relationships in older years have the most to fear. In this last case, younger members of families of long – lived elders,

39 (Chin, 1999)

may feel thwarted, believing that they could utilise their older relatives' resources better but being unable to access them while they are still alive. Or it may be that care-giving has become burdensome. Those of us who work in the sector know that these things happen and that is why every District Health Board in the country has an Elder Abuse team. What we see is probably only the surface of a deeper underlying problem because many older people are reluctant to complain about their care-givers' behaviour, especially if the family is involved, for fear of repercussions. Hence subtle and not so subtle pressure on older people to request euthanasia where it is available as an option for medical 'care' is not always because the family has the best interests of their ageing relative at heart. 'Choice' in such situations is not necessarily free choice.

5. Erroneous diagnoses

As we age, we are increasingly afflicted by disease, some of which may be readily corrected e.g. by wearing spectacles or taking medication, but some of which will likely be fatal. It is well recognised that all diagnoses, even in these days of high powered scanners and sophisticated blood tests etc. are a matter of probability. That is, there is a chance that the diagnosis is not correct. Clearly, the more diseases one has, the greater the likelihood that at least one diagnosis is not correct. On average one third of people aged 65 and over have three or more chronic (i.e. longstanding) disease entities, such as arthritis, high blood pressure, cancer, emphysema, Parkinson's disease etc. That doesn't include poor vision and hearing. The older one gets, the greater the number of chronic disorders. Moreover prognostication, i.e. determining how long a terminal illness will actually take to cause death is an even greater gamble. The annals of medicine abound with incorrect diagnoses and erroneous predictions of death. There are now many cases on record of people being euthanased by enthusiastic physicians where autopsies showed no evidence of fatal disease, and others being euthanased who may well have lived comfortably for months or years. In a recent Listener magazine, there is a story about septicaemia (bacterial blood poisoning). It includes a first-hand account by a woman who suffered from a severe episode of it, but recovered. The only part of her story that the magazine highlights is the following; "I had always

had an ambivalent attitude to voluntary euthanasia, but to my shock, I found myself vividly understanding the arguments in its favour." Now consider this: had she been sick in a country where voluntary euthanasia is legal, and had she expressed such sentiments to her doctors, and had they emphasised with her desire to be put out of her pain, she might well have been euthanased (voluntarily) in which case she would not have been here to tell her story. In my own years of practice, I can recall three examples of people diagnosed with terminal cancer by highly qualified teams of medical specialists, who, in the fullness of time proved not to have that disease. The problem is that if voluntary euthanasia had been legal, and if these people had requested it before time and the progress of events proved the diagnosis to be incorrect, an "innocent life" would have been lost, and, the error not discovered until the coroner's post-mortem (if such were ever held). Such a scenario did in fact occur in the case of Nancy Crick an Australian patient of Dr. Philip Nitschke's who killed herself whilst surrounded by advocates of voluntary euthanasia, on the basis of a diagnosis of bowel cancer. An autopsy revealed no evidence of cancer.

If as a nation we reject capital punishment on the grounds that one innocent person executed is one too many, why is it that the same standard is not applied to euthanasia?

6. Reduced access to palliative and terminal care

Killing sick people is cheap. Providing palliative and terminal care is a highly skilled, labour intensive and expensive enterprise. Despite the fact that the government funds only 60% of the cost of palliative care, we have a very good service in New Zealand. The majority of recipients of such care are old people. If euthanasia were to be legalised, it would not be logical to continue to make funding available for research and service provision in terminal care when there is a cheaper option. This may sound cynical: but I call your attention to the government's attitude to paying rest home carers a decent wage and the vigorous Ministry of Health led effort of recent years into devising formulas that will enable District Health Boards to shed people from their waiting lists because of insufficient funding. Incidentally, many of these rejects are old people without private health insurance. For some of them, especially those with life-restricting

disabilities and no assurance of reinstatement on hospital waiting lists, euthanasia must seem an attractive option.40

3.15:Who Should be Present When a Pet Dies

Some children may want to be present when their pet dies. In non-emergency situations the decision is best made carefully with advice from a veterinarian, and perhaps a minister or counselor. Attending the peaceful death of a cherished family pet can be healing for some children.

There is not one single correct way to handle death. No hard and fast wisdom about death applies. Never pressure a child to attend the moment of death nor to view or touch the pet after it has died. Offer children a choice. Respect and support their decisions. Help children understand that their choice is truly okay, whichever way they decide. Children's questions evolve over time, and they may require many repetitions of explanations before they can put the subject to rest. Feelings often emerge and re-emerge in cycles. Sometimes it may seem that your child is most upset when you, the parent, feel least resilient and most unable to cope with your own feelings.

3.16After the Pet Dies

Even anticipated deaths create painful feelings and require time and space for mourning. In the face of critical injury or catastrophic illness, parents may themselves experience grief of overwhelming proportion. Parents may not have the emotional stamina for children's repetitive questions; parents might also lack the perspective with which to offer children reassurance. Adults and children of all ages benefit from reminders that the pain of loss diminishes over time. Referral to a grief counselor, a family counselor, or a minister may help the family recover more quickly from the death of their pet. Books on the subject of pet deaths may also offer significant solace to some families.41

40 (Kasimar, 1978)
41 (Cicero., 1998)

CHAPTER-4

LEGAL ASPECTS OF EUTHANASIA

From the moment of his birth, a person is clothed with basic human rights. Right to life is one of the basic as well as fundamental right without which all rights cannot be enjoyed. Right to life means a human being has an essential right to live, particularly that such human being has the right not to be killed by another human being. But the question arises that if a person has a right to live, whether he has a right not to live i.e whether he has a right to die? Whiling giving this answer, the Indian courts expressed different opinions. In M.S Dubal vs. State of Maharastra, the Bombay High Court held that right to life under article 21 of the Indian Constitution includes 'right to die'. On the other hand in Chenna Jagadeeswar vs. State of AP, the AP High Court said that right to die is not a fundamental right under Article 21 of the Constitution. However in P. Rathinam's case Supreme Court of India observed that the 'right to live' includes 'right not to live' i.e right to die or to terminate one's life. But again in Gain Kaur vs State of Punjab, a five member bench overruled the P.Rathainam's case and held that right to life under Article 21 does not include Right to die or right to be killed.42

'Right to life' including the right to live with human dignity would mean the existence of such right up to the end of natural life. This may include the right of a dying man to die with dignity. But the 'right to die with dignity' is not to be confused with the 'right to die' an unnatural death curtailing the natural span of life. Thus the concept of right to life is central to the debate on the issue of Euthanasia. One of the controversial issues in the recent past has been the question of legalizing the right to die or Euthanasia. Euthanasia is controversial since it involves the deliberate termination of human life. Patient suffering from terminal diseases are often faced with great deal of pain as the diseases gradually worsens until it kills them and this may be so frightening for them that they would rather end their life than suffering it. So the question is whether people should be given

42 (Cicero., 1998)

assistance in killing themselves, or whether they should be left to suffer the pain cause by terminal illness.

The term Euthanasia comes from two Ancient Greek words: 'Eu' means 'Good', and 'thantos' means 'death', so Euthanasia means good death. It is an act or practice of ending the life of an individual suffering from a terminal illness or in an incurable condition by injection or by suspending extra ordinary medical treatment in order to free him of intolerable pain or from terminal illness.Euthanasia is defined as an intentional killing by an act or omission of person whose life is felt is not to be worth living. It is also known as 'Mercy Killing' which is an act where the individual who, is in an irremediable condition or has no chances of survival as he is suffering from painful life, ends his life in a painless manner. It is a gentle, easy and painless death. It implies the procuring of an individual's death, so as to avoid or end pain or suffering, especially of individuals suffering from incurable diseases. Oxford dictionary defines it as the painless killing of a person who has an incurable disease or who is in an irreversible coma. According to the House of Lords select Committee on Medical Ethics, it is "a deliberate intervention under taken with the express intention of ending life to relieve intractable suffering".Thus it can be said that Euthanasia is the deliberated and intentional killing of a human being by a direct action, such as lethal injection, or by the failure to perform even the most basic medical care or by withdrawing life support system in order to release that human being from painful life. It is basically to bring about the death of a terminally ill patient or a disabled. It is resorted to so that the last days of a patient who has been suffering from such an illness which is terminal in nature or which has disabled him can peacefully end up his life and which can also prove to be less painful for him. Thus the basic intention behind euthanasia is to ensure a less painful death to a person who is in any case going to die after a long period of suffering. Euthanasia is practiced so that a person can live as well as die with dignity. In brief, it means putting a person to painless death in case of incurable diseases or when life become purpose less or hopeless as a result of mental or physical handicap.

This research paper thus deals with one of the most debated subjects in the world, is euthanasia. The debate is regarding the legalization of euthanasia. This debate

is a continuing one as some people are of the view that life is sacred and no one has got the right to end it whereas on the other hand some say that life belongs to oneself and so each person has got the right to decide what he wants to do with it even if it amounts to dying.

In our day to day life we often come across terminally ill patients that are bedridden and are totally dependent on others. It actually hurts their sentiments. Looking at them we would say that death would be a better option for them rather than living such a painful life; which is painful physically as well as psychologically. But if on the other hand we look at the Netherlands where euthanasia is made legal, we will see that how it is abused there. So following its example, no one wants euthanasia to be legalized in India. But the question that lies before us is which will be a better option. In this paper, some basic issues regarding euthanasia are discussed and then it is left to the reader to decide which course would be better: legalizing or not legalizing euthanasia. Although the Supreme Court has already given its decision on this issue, yet some doubts persist on its execution.43

4.1:DIFFERENCE BETWEEN SUICIDE AND EUTHANASIA:

There is a conceptual distinction between suicide and euthanasia. In a suicide a man voluntarily kills himself by stabbing, poisoning or by any other way. No doubt in suicide one intentionally attempts to take his life. It is an act or instance of intentionally killing oneself mostly due to depression or various reasons such as frustration in love, failure in examinations or in getting a good job etc. on the other hand, in euthanasia there is an action of some other person to bring to an end the life of a third person. In euthanasia, a third person is either actively or passively involved i.e he aids or abets the killing of another person. It is important to mention in this context that there is also a difference between ‘assisted suicide’ and ‘euthanasia’. Assisted suicide is an act which intentionally helps another to commit suicide, for example by providing him with the means to do so. When it is a doctor who helps a patient to kill himself (by providing a prescription for

43 (Chin, 1999)

lethal medication) it is a 'physician assisted suicide'. Thus, in assisted suicide the patient is in complete control of the process that leads to death because he/she is the person who performs the act of suicide. The other person simply helps (for example, providing the means for carrying out the action). On the other hand euthanasia may be active such as when a doctor gives a lethal injection to a patient or passive such as when a doctor removes life support system of the patient.

4.2:Euthanasia is a complex matter; there are many different types of euthanasia. Euthanasia may be classified according to consent into three types.

1. Voluntary euthanasia- when the person who is killed has requested to be killed.
2. Non-voluntary euthanasia- when the person who is killed made no request and gave no consent. In other words, it is done when the person is unable to communicate his wishes, being in coma.

3. Involuntary euthanasia- when the person who is killed made an expressed wish to the contrary. In other words, it is involuntary when the person killed gives his consent not to die.

There is a debate within the medical and bioethics literature on whether or not the non-voluntary or involuntary killing of persons can be regarded as euthanasia,44 irrespective of consent. Some say that consent is not considered to be one of their criteria. However others see consent as essential. According to them killing of a person without the person's consent (non-voluntary or involuntary) is not euthanasia. It is murder and hence euthanasia can be voluntary only. Euthanasia can be also divided into two types according to means of death.

1. Active euthanasia- it is also known as 'Positive Euthanasia' or 'Aggressive Euthanasia'. It refers to causing intentional death of a human being by direct intervention. It is a direct action performed to end useless life and a meaningless existence. For example by giving lethal dose of a drug or by giving a lethal

44 (Battin, 1994)

injection. Active euthanasia is usually a quicker means of causing death and all forms of active euthanasia are illegal.

2. Passive euthanasia- it is also known as 'Negative Euthanasia' or 'Non-Aggressive Euthanasia'. It is intentionally causing death by not providing essential, necessary and ordinary care or food and water. It implies to discontinuing, withdrawing or removing artificial life support system. Passive euthanasia is usually slower and more uncomfortable than active. Most forms of voluntary, passive and some instance of non-voluntary, passive euthanasia are legal.

There is no euthanasia unless the death is intentionally caused by what was done or not done. Thus, some medical actions often levelled as 'Passive Euthanasia' are no form of euthanasia, since intention to take life is lacking. These acts include not commencing treatment that would not provide a benefit to the patient, withdrawing treatment that has been shown to be ineffective, too burdensome or is unwanted, and the giving of high doses of pain-killers that may endanger life, when they have been shown to be necessary. All those are part of good medical practice, endorsed by law, when they are properly carried out.

4.3:GLOBAL POSITION

In England, following a series of decisions of the House of Laws relating to euthanasia vary greatly and are constantly subject to changes as cultural values shift and better 'Palliative care' or treatments become available. In some countries it is legalised or in others, it is criminalized.

4.4:AUSTRALIA

The Northern Territory of Australia became the first country to legalize euthanasia by passing the Rights of the Terminally ILL Act, 1996. It was held to be legal in the case of Wake v. Northern Territory of Australia by the Supreme Court of Northern Territory of Australia. Subsequently the Euthanasia Laws Act, 1997 legalised it. Although it is a crime in most Australian states to assist euthanasia, prosecution have been rare. In 2002, the matter that the relatives and friends who provided moral support to an elder women to commit suicide was extensively

investigated by police, but no charges were made. In Tasmania in 2005, a nurse was convicted of assisting in the death of her mother and father who were both suffering from incurable illnesses. She was sentenced to two and half years in jail but the judge later suspended the conviction because he believed the community did not want the woman put behind bars. This sparked debate about decriminalization of euthanasia.

4.5:ALBANIA

Euthanasia was legalized in Albania in 1999, it was stated that any form of voluntary euthanasia was legal under the rights of the Terminally ILL act of 1995. Passive euthanasia is considered legal if three or more family members consent to the decisions.

4.6:BELGIUM

Euthanasia was made legal 2002. The Belgian Parliament had 45enacted the 'Belgium Act on Euthanasia' in September 2002, which defines euthanasia as "intentionally terminating life by someone other than the person concerned at the latter's request".Requirements for allowing euthanasia are very strict which includes the patient must be major, has made the request voluntary, well considered and repeated and he/she must be in a condition of consent and unbearable physical or mental suffering that can be alleviated. All these acts must be referred to the authorities before allowing in order to satisfying essential requirements.

4.7:NETHARLANDS

Netherlands is the first country in the world to legalise both euthanasia and assisted suicide in 2002. According to the penal code of the Netherlands killing a person on his request is punishable with twelve years of imprisonment or fine and also a assisting a person to commit suicide is also punishable by imprisonment up to three years or fine. In spite of this provision, the courts of Netherlands have come to interpret the law as providing a defence to charges of voluntary euthanasia and assisted suicide. The defence allowed is that of necessity. The

45 (Mishara, 1998)

criteria laid down by the courts to determine whether the defence of necessity applies in a given case of euthanasia, have been summarized by Mrs. Borst-Eilers as follows;

1. The request for euthanasia must come only from the patient and must be entirely free and voluntary.

2. The patient's request must be well considered, durable and persistent.

3. The patient must be experiencing intolerable (not necessarily physical) suffering, with no prospect of improvement.

4. Euthanasia must be the last resort. Other alternatives to alleviate the patient's situation must be considered and found wanting.

5. Euthanasia must be performed by a physician.

6. The physician must consult with an independent physician colleague who has experience in this field.

Thus, though active euthanasia is technically unlawful in the Netherlands, it is considered justified (not legally punishable) if the physician follows the guidelines.

In 2002, Netherlands legalised euthanasia. The law codified a 20 years old convention of not prosecuting doctors who have committed euthanasia in very specific cases, under very specific circumstances. It allows a doctor to end the life of a patient suffering unbearable pain from an incurable condition, if the patient so requests. The law requires a long standing doctor patient relationship, patient's awareness of other available medical options and that the patient must have obtained a second professional opinion.

4.8:CANADA

In Canada, patients have the right to refuse life sustaining treatments but they do not have the right to demand for euthanasia or assisted suicide. The Supreme Court of Canada in Rodriguez vs Attorney,1994 General for British Columbia

said that in the case of assisted suicide the interest of the state will prevail over individual's interest.

4.9:U.S.A

There is a distinction between passive euthanasia and active euthanasia. While active euthanasia is prohibited but physicians are not held liable if they withhold or withdraw the life sustaining treatment of the patient either on his request or at the request of patient's authorized representative. Euthanasia has been made totally illegal by the United States Supreme Court in the cases Washington v. Glucksberg and Vacco v. Quill. Only in Oregon, a state in America, physician assisted suicide has been legalized in 1994 under Death and Dignity Act. In April 2005, California State legislative committee approved a bill and has become 2nd state to legalise assisted suicide.

4.10:ENGLAND

Lords it is now settled that a person has a right to refuse life sustaining treatment as part of his rights of autonomy and self- determination. The House of Lords also permitted non voluntary euthanasia in case of patients in a persistent vegetative state. Moreover in a recent case, a British High Court has granted a woman, paralyzed from neck, the right to die by having life support system switched off[46].

4.11:THE UNITED KINGDOM

Euthanasia is illegal in United Kingdom but on November 5, 2006 Britain Royal College of obstructions and gynaecologists submitted a proposal to the Nuffield Counsel of Bioethics calling for consideration of permitting the euthanasia of disabled new-born.

4.12:SWITZERLAND

According to Article 115 of Swiss Penal Code, suicide is not a crime and assisting suicide is a crime if only if the motive is selfish. It does not require the involvement of physician nor is that the patient terminally ill. It only requires that the motive must be unselfish. In Switzerland, euthanasia is illegal but physician assisted suicide has been made legal. However decriminalizing euthanasia was

46 Dr. S.S Jaswal and S.C Baseen,civil and military law journal,p.g-90

tried in 1997 but it recommended where a non- physician helper would have to be prosecuted whereas the physician would not.

Death is not a right, it is the end of all rights and a fate that none of us can escape. The ultimate right we have as human beings is the right to life, an inalienable right not even the person who possesses it can never take that away. It is similar to the fact that our right to liberty does not give us the freedom to sell ourselves into slavery. In addition, this right to die does not equal a right to 'die with dignity.' Dying in a dignified manner relates to how one confronts death, not the manner in which one dies since history recounts many situations of individuals facing degrading deaths in a dignified way. Of course, what this objection really relates to is the supposed lack of dignity of forcing someone to endure suffering rather than allowing them to end their life. However better pain alleviation techniques are a more moral solution to this problem than killing those who are suffering. The question whether Article 21 includes right to die or not first came into consideration in the case State of Maharashtra v. Maruti Shripathi Dubal . It was held in this case by the Bombay High Court that 'right to life' also includes 'right to die' and Section 309 was struck down. The court clearly said in this case that right to die is not unnatural; it is just uncommon and abnormal. Also the court mentioned about many instances in which a person may want to end his life. This was upheld by the Supreme Court in the case P. Rathinam v. Union of India. However in the case Gian Kaur v. State of Punjab it was held by the five judge bench of the Supreme Court that the "right to life" guaranteed by Article 21 of the Constitution does not include the "right to die". The court clearly mentioned in this case that Article 21 only guarantees right to life and personal liberty and in no case can the right to die be included in it. In India, like almost in other countries, euthanasia has no legal aspect. In India there is no difference between active and passive euthanasia and no penal law yet introduced in I.P.C, which specifically deals with euthanasia. The every act of aiding and abetting the commission of suicide are punished under the section 306 of the I.P.C. Distinguishing euthanasia from suicide, Justice Lodha in Naresh Maratra Sakhee vs Union of India, observed that, "suicide by its nature is an act of self-killing or self-destruction, an act of terminating one's own act and without the aid or assistance of any other human agency. Euthanasia or Mercy killing on the other

hand means implies the intervention of other human agency to end the life. Mercy killing is thus not suicide and the provision of section 309 does not cover an attempt at mercy killing. The two concepts are both factually and legally distinct. Euthanasia or Mercy killing is nothing best homicide whatever the circumstances in which it is affected."

In case of physicians, there is an intention to cause death of patient, hence he can be charged under clause (1) of section 300 of I.P.C but where there is valid consent of the deceased, exception 5of section 300 is attracted and thus the act of the physician is considered as culpable homicide not amounting to murder under Part I of section 304. In case of non-voluntary and involuntary euthanasia, the act of physician can be fall under section 88 and 92 of IPC as there is an intention to causing death of a patient for his benefit. And other relatives who are aware of such intention either of the patient or of the physician can be charged under section 202 of IPC. The Supreme Court explained the position of Indian law on euthanasia 47in M.S.Dabal vs state of Maharashtra as under

"Mercy killing is nothing but homicide, whatever the circumstances in which it is affected. Unless it is specifically accepted it cannot be offences. Indian Penal Code further punishes not only abetment of homicide, but also abetment of suicide".

The followings are the arguments against euthanasia:

1. The human life is gift of God and taking life is wrong and immoral human beings cannot be given the right to play the part of God. The one who suffers pain is only due to one's karma. Thus euthanasia devalues human life.

2. It is totally against the medical ethics, morals and public policy. Medical ethics call for nursing, care giving and healing and not ending the life of the patient. In the present time, medical science is advancing at a great pace. Thus even the most incurable diseases are becoming curable today. Thus instead of encouraging a patient to end his life, the medical practitioners should encourage the patients to

47 (Gruman, 1973)

lead their painful life with strength which should be moral as well as physical. The decision to ask for euthanasia is not made solely by the patient. Even the relatives of the patient pay an important role in doing that. Hence, it is probable that the patient comes under pressure and takes such a drastic step of ending his life. Of course in such cases the pressure is not physical, it is rather moral and psychological which proves to be much stronger. The patient himself starts to feel that he is a burden on the relatives when they take such a decision for him and finally he also succumbs to it.

3. It is feared that if euthanasia is legalised then other groups of more vulnerable people will become at risk of feeling into taking that option themselves. Groups that represent disabled people are against the legalisation of euthanasia on the ground that such groups of vulnerable people would feel obliged to opt for euthanasia as they may see themselves as a burden to society.

4. It has a slippery slope effect, for example firstly it can be legalised only for terminally ill people but later on laws can be changed and then it may allow for non- voluntary or involuntary.

5. Acceptance of euthanasia as an option could exercise a detrimental effect a societal attitudes and on the doctor patient relationship. The doctor patient relationship is based on mutual trust, it is feared this trust may be lost if euthanasia is legalised.

6. When suicide is not allowed then euthanasia should also not be allowed. A person commits suicide when he goes into a state of depression and has no hope from the life. Similar is the situation when a person asks for euthanasia. But such tendency can be lessened by proper care of such patients and showing hope in them.

7. Patient would not be able to trust either doctors or their relatives as many of them were taking about patient's painless dignified death and it became a euphemism for assisted murder.

8. Miracles do happen in our society especially when it is a matter of life and death, there are examples of patients coming out of coma after years and we should not forget human life is all about hope.

Followings are the reasons to legalise euthanasia;

1. Euthanasia means ending the life a person who is suffering from some terminal illness which is making his life painful as well as miserable or in other words ending a life which is not worth living. But the problem is that how should one decide whether his life is any longer worth living or not. Thus, the term euthanasia is rather too ambiguous. This has been a topic for debate since a long time i.e. whether euthanasia should be allowed or not. At present, the debate is mainly regarding active euthanasia rather than passive euthanasia. The dispute is regarding the conflicts of interests: the interest of the society and that of the individual. Which out of these should prevail over the other? According to the supporters of euthanasia the decision of the patients should be accepted. If on the other hand we weigh the social values with the individual interest then we will clearly see that here the interest of the individual will outweigh the interest of the society. The society aims at interest of the individuals rather it is made with the purpose of assuring a dignified and a peaceful life to all. Now if the individual who is under unbearable pain is not able to decide for himself then it surely will hamper his interest. In that case it will surely be a negation of his dignity and human rights.

2. Euthanasia provides a way to relieve the intolerably extreme pain and suffering of an individual. It relieves the terminally ill people from a lingering death.

3. The essence of human life is to live a dignified life and to force the person to live in an undignified way is against the person's choice. Thus it expresses the choice of a person which is a fundamental principle.

4. In many developing and under developed countries like India, there is lack of funds. There is shortage of hospital space. So, the energy of doctors and hospital beds can be used for those people whose life can be saved instead of continuing

the life of those who want to die. Another important point on which the supporters of euthanasia emphasize is that a lot of medical facilities which amount a lot are being spent on these patients who are in any case going to die. Thus, they argue that rather than spending those on such patients, it will be much better to use such facilities for those who have even fair chances of recovery.

5. Article 21 of the Indian Constitution clearly provides for living with dignity. A person has a right to live a life with at least minimum dignity and if that standard is falling below that minimum level then a person should be given a right to end his life. Supporters of euthanasia also point out to the fact that as passive euthanasia has been allowed, similarly active euthanasia must also be allowed. A patient will wish to end his life only in cases of excessive agony and would prefer to die a painless death rather than living a miserable life with that agony and suffering. Thus, from a moral point of view it will be better to allow the patient die painlessly when in any case he knows that he is going to die because of that terminal illness.

6. Its aim is altruistic and beneficial as it is an act of painlessly putting to death to those persons who are suffering from painful and incurable diseases. So, the motive behind this is to help rather than harm.

7. It not only relives the unbearable pain of a patient but also relieves the relatives of a patient from the mental agony.

8. A point which is often raised against the supporters of euthanasia is that if such right will be granted to the terminally ill patients then there will be chances of abusing it. But the supporters argue that every right involves a risk of being abused but that doesn't mean that the right itself should be denied to the people. We should rather look at the brighter side of it than thinking of it being abused.

4.13:Arguments in Favor of Euthanasia

Arguments in favor of euthanasia are generally based upon beliefs concerning individual liberty, what constitutes a "good" or "appropriate" death, and certain life situations that are considered unacceptable. These arguments are generally

based upon moral or religious values as well as certain beliefs concerning the value and quality of human life. They also often suppose that people are capable of making rational decisions, even when they are suffering and terminally ill.

The good death. According to this view, certain ways of dying are better than others. Usually a good death is described ideally as drifting into death in a pleasing environment as one falls asleep. The ancient Roman orator and statesman Cicero said that a good death is the ideal way of respecting natural law and public order by departing from the earth with dignity and tranquility. Euthanasia can be seen as a way to assure that a person dies in a dignified and appropriate manner.48

Individual liberty. In his Essay on Suicide, the eighteenth-century Scottish philosopher David Hume stated that all individuals in a free society should be able to choose the manner of their death. Some people, for example, feel that this right must be tempered by the obligation to not cause harm to others.

Right to maintain human dignity. This argument is similar to the concept of the good death, except that the objective is to avoid a poor quality of life during the dying process rather than seek out a particular idealized way of dying the good death. There are great individual differences in what constitutes a dignified way to live and die. Commonly mentioned indignities to justify premature death include: being a burden to others, living a deteriorated state incapable of normal daily activities, having to be placed in a hospital or a nursing home, and being dependent upon intrusive medical apparatus to continue living or engaging in everyday tasks. The general public often assumes that certain chronic and terminal illnesses inevitably result in a poor quality of life. However, research suggests that the psychosocial environment determines quality of life as much or more than the nature of the illness, per se.

Reduction of suffering. In 1516 the English statesman and author Sir Thomas More described euthanasia to end suffering in his book Utopia as "those that are ill from incurable diseases they comfort by sitting and talking with them, and with all means available. But if the disease is not only incurable but also full of continuous pain and anguish, then the priests and magistrates exhort the patient

48 (Cicero., 1998)

saying that he has become . . . irksome to others and grievous to himself; that he ought to . . . dispatch himself out of that painful life as out of a prison or torture rack or else allow his life to be ended by others" (More 1964, pp. 186–187). In 1994 the philosophy professor Margaret Battin wrote that euthanasia to reduce suffering has two components: to avoid future pain and suffering and to end current pain and suffering. This definition generally assumes that the pain is not only intolerable but interminable.

Justice. Gerald Gruman described euthanasia in order to achieve "justice" in society as "thrift euthanasia," where decisions are made to end lives of certain patients in situations where there is competition for limited resources in medical care. When there is a scarcity of certain medical resources in a society, not all people who are ill can continue to live. In such situations, one can suggest that "less valuable" individuals should give up their places to persons who contribute more to society; if they are unwilling, others should decide who should live and who should die. An extreme example is the eugenics programs based upon Darwinian concepts, such as those proposed by the German biologist Ernst Haeckel in 1904. Haeckel proposed that in order to reduce 49welfare and medical costs "hundreds of thousands of incurable lunatics, lepers, people with cancer" be killed by means of morphine or some other "painless and rapid poison" (1904). This approach inspired the National Socialists led by Adolf Hitler in their eugenics program.

Even if one disagrees with any form of eugenics program for economic reasons, one may still consider the fact that social pressure often exists in situations where medical resources are limited. The concept of "distributive justice"involves looking at the collective good or general welfare as something to be shared among the total membership of society. When resources are limited, society may question, for example, if it is worth expending tremendous resources to maintain the life of one incurably ill individual in a vegetative unconscious state rather than using those resources to help cure those who have promising prognoses for recovery.

Avoiding botched suicides. Molloy states that if euthanasia remains illegal, some people will be forced to attempt suicide or try to kill loved ones without any help.

49 (Cabe, 1904)

He contends that in some instances unsuccessful suicide attempts and botched euthanasia by others may result in a life situation that is worse than before. It can be argued that legalization of euthanasia will avoid suffering from botched attempts and the prosecution of loved ones who are acting sincerely at the request of a family member.

Control of existing practices. In countries where euthanasia is illegal there are clandestine practices by physicians and family members regardless of the laws. Proponents of euthanasia50 in the Netherlands often state that as long as euthanasia remains illegal in a country, physicians and other citizens will camouflage those activities and there will be no monitoring or control of what occurs. An advantage to legalizing euthanasia would be to control existing practices and ensure that there are fewer abuses.

4.14:Arguments against Euthanasia

The arguments against euthanasia include religious and ethical beliefs about the sancitity of life as well as a number of arguments allowing for euthanasia that will inevitably lead to a situation where some individuals will risk having their deaths hastened against their will.

Sanctity of human life. This belief, based upon religious values, considers human life sacred and inviolable. No person may take the life of another. For example, St. Augustine interpreted the biblical prescript against killing as being absolute, even including the taking of one's own life. Another argument for the sanctity of human life is that this constitutes one of the pillars of social order that must be maintained to avoid social breakdown. For example, St. Thomas Aquinas condemned suicide because it goes against one's obligation to oneself, the community, and God.

Wrong diagnoses and new treatments. According to this point of view, where there is life there is hope. It is possible that a terminal diagnosis is in error; some people thought to be dying from an incurable disease are victims of a mistaken diagnosis or may miraculously continue to live. Also, because of the rapid pace of advances in medical science, there may soon be a cure for diseases that are at

50 (Cicero., 1998)

the time of the euthanasia considered to be incurable. Thus, euthanasia may be a mistake if there is a possibility, however slight, that the person is not really going to die. For example, it can be said that many persons with AIDS (acquired immunodeficiency syndrome) who ended their life prematurely because of impending death may have continued to live for a long time because of the development of new treatments for the disease.

The Wedge or Slippery Slope. This argument maintains that when one accepts killing upon demand in certain situations, despite the best controls and regulations, there is a risk of abuses. Furthermore, there is concern that once the door is opened to justify murder under some intolerable circumstances, there is the possibility of developing broader criteria and making euthanasia more widespread. For example, in the Netherlands euthanasia and assisted suicide was first only available to those who were terminally ill. Since 1998 the regulations for euthanasia have been used to permit access to euthanasia and assisted suicide to persons who are not terminally ill but who suffer hopelessly from chronic physical or even psychological illnesses.

Protection of the weak, incompetent, and disadvantaged. This argument is similar to the Wedge or Slippery Slope argument. The concerns with the Protection of the Weak argument are that people who may be unable to make informed choices concerning euthanasia may be forced to opt for a premature death or may become victims of non-voluntary or involuntary euthanasia.

The value of suffering. Suffering may be seen as good for the soul, a heroic act, or the price to pay for one's sins in order to guarantee a better life in the hereafter. Jesus' suffering on the cross may be considered an example of an appropriate way to die. If suffering is admirable, then seeking to end suffering by euthanasia cannot be condoned.

The option of suicide is always available. Because suicide is always available and not illegal in most countries, one can argue that legalization of euthanasia is not necessary because a person can always find some means of committing suicide. Because of the dangers in legalizing euthanasia, one might instead encourage people to commit suicide rather than involving others in their deaths. One may further argue that those who "do not have the courage" to end their own lives may be too ambivalent and should not be put to death by others.

The impossibility of competent and rational decision making. The seventeenth-century philosopher Spinoza felt that the desire to survive is such an essential part of human nature that humans may not rationally prefer not to survive and kill themselves. According to this view, anyone who wants to die may not be acting rationally. Furthermore, one may question if it is possible when experiencing pain and suffering to make a rational decision before the[51] pain and suffering is controlled. Finally, one may question whether or not most important human decision making is rational and why one should expect a person to be more rational when terminally ill. Major decisions such as choice of career, marriage partners, where to live, and whether or not to have children may be more emotional than rational. Also, there are no generally accepted criteria of what constitutes a rational argument in favor of euthanasia: What is logical and rational for one person may constitute reasons for continuing to fight against death in another person in a similar situation.

Choosing death for the wrong reasons. Many people consider euthanasia because they are experiencing pain and suffering. Ignorance of the availability of interventions to reduce pain and suffering may lead to a choice to end life. People involved in palliative care programs that focus upon reducing the suffering of terminally ill patients contend that better pain control and improvement of the psychosocial situation can alleviate a large proportion of the suffering and reduce the desire for euthanasia.

Undiagnosed clinical depression. It may be considered appropriate for people who are dying to feel sad and unhappy. However, some terminally ill persons may suffer from a more severe and potentially treatable psychiatric syndrome of clinical depression. In some instances, the depression may be a side effect of treatment of the illness or may be related to the psychosocial environment of an institution. According to this view, accurate diagnosis and treatment with antidepressant medication and/or psychotherapy is a preferable option to euthanasia.

Erosion of confidence in physicians. According to this argument, if physicians are allowed to kill some terminally ill patients then confidence in physicians may be diminished. Medical practictioners and proponents of this argument have

51 (Cabe, 1904)

suggested that only "specialists" should practice euthanasia if it is legalized so that physicians can maintain their reputation as advocates in the fight against death and the reduction of pain and suffering.

Compromising the right to choose by involving others in one's death. Brian Mishara has argued that humans generally experience tremendous ambivalence about ending their lives by suicide, so much so that most highly suicidal people change their minds before an attempt and the vast majority of persons who initiate a suicide attempt do not die from their attempt. He questions whether the involvement of a physician in ending a person's life may create a social situation where there is tremendous pressure to complete the suicidal act and die rather than exercising the choice to continue to live. Once a physician has been convinced that euthanasia is acceptable and appropriate, it is not easy for a person to admit to the doctor that he or she is feeling ambivalent or scared and would like to put off the decision for a while. This analysis suggests that involving others in death can compromise people's rights to change their minds because of the social pressures to complete the act.

4.15:The Situation in the Netherlands

In the Netherlands, the practice of euthanasia and assisted suicide was legalized by legislative decree in November 2000. However, the practice of euthanasia has been tacitly condoned by jurisprudence since 1973. In 1973 a doctor was found guilty of giving her seventy-nine-year-old mother a lethal injection after repeated requests to end her suffering. The doctor was placed on probation for a year but this case generated considerable sympathy for the doctor and resulted in the Royal Dutch Medical Association producing a working paper on the topic. Furthermore, the Supreme Court of The Netherlands set out a number of considerations that would have to be met before an accused would be exonerated of euthanasia. Subsequently, the practice developed to not prosecute cases of euthanasia that respected those court guidelines. They include:

- The request for euthanasia must come from the patient and be completely voluntary, well considered, and persistent.
- The patient must have adequate information about his or her medical condition, the prognosis, and alternative treatments.52

52 (Cicero., 1998)

- There must be intolerable suffering with no prospect for improvement, although the patient need not be terminally ill.
- Other alternatives to alleviate the suffering must have been considered and found ineffective, unreasonable, and unacceptable to the patient.
- The euthanasia must be performed by a physician who has consulted an independent colleague.
- The physician must exercise due care, and there should be a written record of the case.
- The death must not be reported to the medical examiner as a natural death.

There is tremendous popular support in the Netherlands for the practice of euthanasia and the legal precedents have now been passed into law by Parliament. Several studies have been conducted on the nature of the practice of euthanasia and assisted suicide as well as possible abuses. Most cases of euthanasia occur among terminally ill persons in the advanced stages of their disease and it is rare that the criteria are not respected. However, in the Netherlands there are no monetary considerations concerning the cost of health care because there is a socialized medical program. Furthermore, the society in the Netherlands is very different from many other societies because of the strong emphasis upon individual freedom of choice and limited government control.

4.16:The Euthanasia Act in the Australian Northern Territories

The parliament of the Northern Territory in Australia passed the Rights of the Terminally Ill (ROTI) Act in May 1995, which was in effect for nine months from July 1, 1996, to March 25, 1997, when the act was repealed by legislation passed by the parliament of Australia. The ROTI Act allowed a terminally ill patient who was experiencing what he or she deemed to be unacceptable levels of pain, suffering, and/or distress to request the medical practitioner to end his or her life by euthanasia, if the requirements of the law were met. The law stipulated that besides suffering and being terminally ill, the patient must be at least eighteen years old, there must be no cure available, no other palliative care options to alleviate the suffering available, and a second opinion as well as a psychiatric

assessment to confirm that he or she is not suffering from a treatable clinical depression53.

After the law was passed, five persons who officially sought to use the act received extensive media attention. Although the intention of the law was to allow for a patient's personal physician to provide assistance to terminate life as part of their care, only one physician in the territory accepted to participate in euthanasia practices: Philip Nitschke. During the period that the act was in effect, seven cancer patients applied for euthanasia with Nitschke. Four of the seven died by euthanasia; one committed suicide; one died a natural death; and another died from the effects of pain relief sedation.

4.17:The Oregon Death with Dignity Act

In November 1994 the Death with Dignity Act was adopted by a referendum vote of Oregon residents of 51 percent against 49 percent. Soon after the act was passed, the act was contested on the grounds that it presumably threatened the lives of terminally ill persons and did not afford them equal protection. A judge granted an injunction on the grounds that the act put people at risk. However, in 1997, the injunction was lifted by the Ninth Court of Appeals, which dismissed the case. The law went into effect in 1997 after the U.S. Supreme Court declined to hear an appeal of the case. A second referendum in November 1997 found 60 percent in favor and 40 percent against this law. In November 2001 the U.S. Attorney General John Ashcroft issued a directive that would have prohibited doctors from prescribing lethal doses of controlled drugs to terminally ill patients. Immediately after issuing the directive, the U.S. District Court in Portland issued a temporary restraining order blocking Ashcroft from punishing physicians who wrote lethal prescriptions. In April 2002 the same court ruled that Ashcroft had over-stepped the authority of the Federal Controlled Substances Act when he declared that writing lethal prescriptions was not a legitimate medical purpose and threatened to revoke the license of physicians who wrote lethal-dose prescriptions to patients who requested one. This decision made the restraining order on Ashcroft permanent; however, as of this writing, the decision may be subject to appeal.

53 (Cabe, 1904)

According to this law there are four criteria necessary for an assisted suicide to be conducted in the state of Oregon: (1) the person must be at least eighteen years old, (2) a legal resident of Oregon, (3) able to communicate his or her decisions about medical care, and (4) in the terminal phase of an illness that is defined as having a life expectancy of less than six months. If the patient is eligible, the request must be made twice in less than fifteen days and the request must be made in writing to a physician who then establishes that all the conditions have been met. A second physician must be consulted, and the first physician must inform the patient of all alternatives available. The physician can request that the person inform 54family members about the request, but this is not obligatory. The physician may then prescribe a lethal medication, which he or she must declare to the Oregon Health Division. This physician has no obligation to participate in the assisted suicide and is protected against any criminal liability under this act.

During the first four years since the law was applied (1998–2000), 140 prescriptions for lethal doses of medication were written, mainly to cancer patients, and 91 persons died after taking these medications. This constitutes fewer than one-tenth of 1 percent of terminally ill Oregonians dying by physician-assisted suicide.

4.18:Legal Issues

The law on euthanasia have attracted considerable comment in both public and professional media(Howie,2005 ,Dowd 2005, Tonybee,2006) Legalising euthanasia would represent a major social development with a particular significance for health professional and patients .It is therefore essential that nurses are involved actively in the ongoing debate and that an informed nursing voice is evidenet whenever the issues are being discussed.

British law prohibits assisted dying .Practising active euthanasia would usually make an individual liable to be charged with murder (wainwright 1999) and in English criminal law assisting someone to die carries a sentence of up to 14 years imprisonment under the suicide act 1961

UK courts have consistently demonstrarted that actively hastening thee death of a patient with medical intervention is unlawful .For example in Cox 1992 ,a patient who was terminally ill and suffering from unrelievable pain,repeatedly requested

54 (Chin, 1999)

that Dr Cox should end her life .When Dr Cox administered a lethal dose of potassium chloride with the intention that this would kill the patient ,his actions were reported by a nurse and Dr cox eventullt received a one year suspended prison attempted murder (Ferguson,1997)

More recently ,the case of Diane Pretty highlighted the legal prohibition of assisted suicide .Mrs Pretty was terminall ill and claimed that "Right to life '' article 2 of the human rights Act 1998 ,included the right to die ,and to chose how and when to die ,She unsuccessfully sought assurance from the court that her husband would not be prosecuted if he were to help her to die at a time of her own choosing (Dyer 2001).Although there was a considerable support and sympathy for her plight ,English demonstrated its unwillingness to support assisted dying .The European Court of Human Rights ultimately rejected Mrs. Pretty's case(Dyer 2002).

The issues are sometimes muddled by the apparent inconsistency in the laws approach to medically assisted death .For example ,in 1999,a doctor, who openly advocated helping older patients to to die with dignity ,was acquitted on a charge of murder after he admitted giving a terminally ill patient a lethal dose of diamorphine with intention of relieving the pain rather than killing the patient (Wainwright 1999)55

In recent years ,changes to the law have been considered on a number of occasions .In 1993/1994,a house of lords select committee on medicl ethic reviewedthe law on euthanasia and concluded that it should not be legalized (House of lords1994)In 2003 ,Lord Joffie introduced a private members bill (House of lords 2003)That progressed only to a second reading .In 2004 and 2005 ,Lord Joffe introduced further bills ,both entitled assisted dying for the Terminally Ill Bill(House of Lords 2004,2005).The first of these sought to legalise physiscian – assisted suicide and voluntary euthanasia and was extensively examined by a selectcommittee.The 2005 bill was aimed solely at introducing legalization that would allow physician assisted suicide .It received its second reading in May 2006 when the lords voted (148to100) to delay a second reading by six months ,and it therefore failed to proceed to the next stage .Lord Jofee stated his intention to

55 (Hume, 1929)

reintroduce the bill in the next session of Parliament "I will continue to do so until a full debate through all the usual stages has been held(Lords Hansard 2006)

The Joffe bills were aimed at revising the law in Wales and England .In Scotland in 2005,Jermey Purvis MSP undertook a consultation which invited views on a draft proposal for a Scottish bill to 'allow capable adults with a terminal illness to access the means to die with dignity (Purvis 2005).He received more than 600 responses to his consultation and reported that 56 percent of the respondents were in general support of physician assisted suicide and a change in the law (Purvis 2005)

Parliamentary activity in England and Scotland has increased public awareness of euthanasia and assisted suicide .In addition ,widely publicized cases such as that of Mrs Pretty and the emergence of what has been termed "Death Tourism"(Revill 2002) have generated much public debate ,including calls for the law to reviewed to enable the individuals to exercise greater control over their own life and death (Annetts 2003) Whether or not public opinion is for or against changing the law is uncertain.In 2005,it was reported that "it is evident that there is much sympathy at a personal level for the concept of legally releasing those wishing to die from their pain and those who willing to help them from legal consequences "(House of Lords 2005)56

However ,it has been claimed that a lack of explanatory context undermines the findings of most surveys of public opinion on this issue ,They are generally based on the answers to "yes /no" or "either /or " questions without any explanatory context and without other opinions ,for example ,good quality palliative care being offered .Most people have little understanding of the complexities and dangers in changing the law in this way and opinion research consists therefore to a large extent of knee –jerk answers to emotive and often leading questions (Care Not Killing 2006) Given the complexity of the issues it is arguable whether a true measure of public attitudes to euthanasia has been developed .It is unrealistic simply to ask like are you in favour of legalizing euthanasia and expect to extrapolate a meaningful reflection reflection of public opinion from the responses received .To exposes the range and depth of opinons relevant ot such a sensitive e topic would necessitate a carefully considered empirical study that

56 (Battin, 1994)

investigated the personal values cultural and religious influences ,familiarity with the topic and personal experiences .It would be a challenging undertaking ,However uncertain the findings of surveys ,they undoubtedly influence the poltical agenda regarding euthanasia.Proponents of euthanasia generate prominent headlines (Evans 2006)although the dramatic emphasis given to some media reports can be mis leading for example in 2006, a survey of 857 UK doctors found that of 600,000 deaths in the UK in 2004 ,0.16percentage (936) were a result of voluntary euthanasia .Although the term was used to cover such events as with holding treatment in cases when it is supposedly in the best interest of the patient .Atotal of 0.33 %(1,930)of deaths involved non voluntary euthanasia.This was subsequently reported under the headline euthanasia:doctors aid 3,000deaths (Boseley 2006).However it is questionable whether any of the recorded deaths resulted from euthanasia in the sense that the doctor in question actively intervented to end the patients life.

Those who oppose a change in the law attract fewer headlines .Opponents of eythanasia often cite the slippery slope argument that legalizing voluntary euthanasia would inevitably lead to the legalization of other forms of euthanasia or that non voluntary or even involuntary euthanasia would start to occur under the guise of legalized voluntary euthanasia .According to Grayling (2001),The chief anti euthanasia viewpoint is exposed only when a change in the law is recommended ,either in parliament57 ,the media or at prominent professional gatherings(Hall 2006,Phillips 2006)

The debate can be particularly emotive .Campaigners frequently illustrate the possible benefits of legalising euthanasia with the accounts of people for whom the current law is unsatisfactory or for whom the law currentl offers protection .Although compelling ,such emotional appeals purposely exploit individual stories to promote a pro or anti-euthanasia viewpoint and may consequently serve to discourage a balanced ethical approach to these complex issues.It is vital that health professionals impartially examine such such emotionally charged and biased reports and make practical decisions that seek to acknowledge all points of view.

57 (Kasimar, 1978)

To promote critical and informed debate it is essential that both sides of the argument are carefully considered and understood .The two volume report of the 2004 House of Lords Select Committee(House of Lords 2005) that summarises the evidence given to the committee and sets out its recommendations ,provides a clear and comprehensive overview of the issues .The issues are also effectively exposed in the website of two prominent but opposing groups .The Care NOT Killing(www.carenotkilling.org.uk) seeks to promote more and better palliative care and to oppose moves to legalize euthanasia and the Pro euthanasia group dignity in dying formulated the voluntary euthanasia
society(www.dignityindying.org.uk) claims that a change in the law will give terminally ill people more control at the end of life and enable people to keep living longer than they might otherwise have done.

In general, the response of the health professions has been to oppose any change in the current law. If euthanasia were to be legalized it is clear that it would significantly affect the working lives of health professionals .In response to the Assisted Dying Bill 2004,the General Medical Council stated it had not developed a policy or issued guidance on euthanasia because :we believe that it is for society as a whole to determine ,though its democratic process ,How best to respond to the conflicting wishes of its citizens (House of Lords2005)58

58 (Gruman, 1973)

CHAPTER-5

HUMAN RIGHT AND EUTHANASIA

5.1:Euthanasia from the Human Rights Perspective

Euthanasia is often associated with "physician assisted dying" and it is also linked with "physician assisted suicide". In some contexts euthanasia simply means "assisted death", under which assisted suicide is also subsumed.The term euthanasia is divided into different types, as the table below illustrates:

Types and difinitions:

- Active euthanasia: A person, for example a doctor, causes the death of a patient directly and on purpose.
- Passive euthanasia: Euthanasia is carried out through the omission of life-preserving measures.
- Indirect euthanasia: The person is given treatment which first effect is to reduce the pain but which long-term effect is to terminate the life of the patient earlier.
- Involuntary euthanasia: The person who is killed does not want to die. This type is usually considered as murder.
- Non-voluntary euthanasia: The person is unable to ask directly for euthanasia, either because the person is unconscious, or mentally or emotionally incapable of making the decision, which includes children. This means that an appropriate person has to decide about the further medical treatment of the patient on their behalf. In this case a living will can be very helpful.
- Voluntary euthanasia: Occurs at the request of the person who dies.

There are many differing views, opinions and concepts that have been raised about euthanasia. While for some people euthanasia is a manifestation of individual autonomy; a right to self-determination, a compassionate response to someone's immense suffering or a clinical imperative to act in the patient's best interest, for other people euthanasia is 59tantamount to or merely a euphemism for murder,

59 (Hume, 1929)

the violation of human life and an infringement on the human right to life, contradicting the sanctity of life doctrine and facilitating the abuse of vulnerable persons.60

Upon closer inspection, this author considers euthanasia to be a violation and infringement on human life according to the 1948 Universal Declaration of Human Rights (UDHR). This Declaration states in its Preamble that "the foundation of freedom, justice and peace in the world" is the "recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family." More specifically, according to UDHR Article 6 "everyone has the right to life" and under UDHR Article 7 "all are equal before the law and are entitled without any discrimination to equal protection of the law."

The legally binding 1966 International Covenant on Civil and Political Rights (ICCPR) Article 6, further elaborates upon the rights in the UDHR, stating that: "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."

In some cases, if the pain is excruciating and the suffering severe and it is caused by chronic diseases, it may be argued that if the patient requests help from a doctor to end their life that they may be under the influence of pain, psychological pressures and the high cost of treatment. Further, this author maintains that patients with life-threatening illness often have a greatly impaired capacity to make rational judgments about complex matters. Although in court judges are often indulging in such cases, the international legal rules protecting the right to life are clear; under no circumstances, no matter how high the degree of suffering is, whether the illness is curable or not or whether the patient requested it, a doctor has no right to end a patient's life.

There are however, opposing arguments in favour of legalising euthanasia and assisted suicide, such as the increasing interest throughout many regions of the world regarding the right human beings have to determine the way they die and to ask for professional assistance in order to ease pain and suffering. Further, laws which permit euthanasia, in certain specified conditions, in the Netherlands and

60 (Mishara, 1998)

in the northern territory of Australia, along with the well-advertised accomplishments and publications of some scholars and physicians in the United States, also support the case for euthanasia.

The legal status of euthanasia is different in every country. In the majority of countries, active as well as passive euthanasia is forbidden but there are exceptions. Euthanasia is legal in Albania, Belgium, Luxembourg, the Netherlands, and Switzerland. The patient wanting to shorten his life has to be terminally ill and suffer under physical or emotional pain. The age from which a person can make use of the right to end his life earlier varies in each country as well. In 2013, Belgium decided that children are also allowed to use their right of ending their life earlier if they are responsible for their decision and if the wish was expressed voluntarily.

In the states of Oregon, Vermont, Washington and Montana (USA) physician aid in dying is allowed. The difference with euthanasia lies in the liberty to decide by oneself when and where to take the deadly drugs which were given to the terminally ill patient by a doctor and in the fact that the doctor is only involved in the process of providing the patient with the necessary drugs and is not actively killing a human. Only passive euthanasia was legalised in India, Ireland and parts of Mexico but the regulations which have to be fulfilled to end the life of the patient vary in each country. In Columbia and Japan the laws about the issue of euthanasia are unclear and contradictory. Columbia's court passed a law to legalise euthanasia in 1997 but the countries congress never ratified it. Japan itself has a law which clearly is against euthanasia, but in 1962, Japan passed six criteria that a doctor must meet before ending the life of his patient and not be accused of murder.61

5.2:Euthanasia And Law

There is always prevailing the rival claims of the society and the individual and the question lies that which claim should prevail. Mostly in the cases of health concerns, the claims of the society prevail over the individual claim. But it has to be kept in mind while deciding that which side should the balance bend that how

61 (Hume, 1929)

will this decision affect the society and the individual. In most of the health concerns, the whole society in gets affected, but here individual himself and affect family are getting more influenced by such a decision. Individual liberty is the hallmark of any free society. Thus, we should here consider the rights which accrue to the individual in such cases.

In India, euthanasia is absolutely illegal. If a doctor tries to kill a patient, the case will surely fall under Section 300 of Indian Penal Code, 1860. but this is only so in the case of voluntary euthanasia in which such cases will fall under the exception 5 to section 300 of Indian Penal Code,1860 and thus the doctor will be held liable under Section 304 of Indian Penal Code,1860 for culpable homicide not amounting to murder. Cases of non-voluntary and involuntary euthanasia would be struck by proviso one to Section 92 of the IPC and thus be rendered illegal. There has also been a confusion regarding the difference between suicide and euthanasia. It has been clearly differentiated in the case Naresh Marotrao Sakhre v. Union of India . J. Lodha clearly said in this case. "Suicide by its very nature is an act of self-killing or self-destruction, an act of terminating one's own act and without the aid or assistance of any other human agency. Euthanasia or mercy killing on the other hand means and implies the intervention of other human agency to end the life. Mercy killing thus is not suicide and an attempt at mercy killing is not covered by the provisions of Section 309. The two concepts are both factually and legally distinct. Euthanasia or mercy killing is nothing but homicide whatever the circumstances in which it is effected62."

The question whether Article 21 includes right to die or not first came into consideration in the case State of Maharashtra v. Maruti Shripathi Dubal . It was held in this case by the Bombay High Court that 'right to life' also includes 'right to die' and Section 309 was struck down. The court clearly said in this case that right to die is not unnatural; it is just uncommon and abnormal. Also the court mentioned about many instances in which a person may want to end his life. This was upheld by the Supreme Court in the case **P. Rathinam v. Union of India**. However in the case Gian Kaur v. State of Punjab it was held by the five judge

62 (Chin, 1999)

bench of the Supreme Court that the "right to life" guaranteed by Article 21 of the Constitution does not include the "right to die". The court clearly mentioned in this case that Article 21 only guarantees right to life and personal liberty and in no case can the right to die be included in it.63

5.3:The Debate Regarding Euthanasia

'In Favour' Euthanasia means killing a person rather ending the life a person who is suffering from some terminal illness which is making his life painful as well as miserable or in other words ending a life which is not worth living. But the problem lies that how should one decide whether the life is anymore worth living or not. Thus, the term euthanasia is rather too ambiguous. This has been a topic for debate since a long time i.e. whether euthanasia should be allowed or not. In the present time, the debate is mainly regarding active euthanasia rather than passive euthanasia. The dispute is regarding the conflicts of interests: the interest of the society and that of the individual. Which out of these should prevail over the other? According to the supporters of euthanasia the decision of the patients should be accepted. If on the other hand we weigh the social values with the individual interest then we will clearly see that here the interest of the individual will outweigh the interest of the society.

The society aims at interest of the individuals rather it is made with the purpose of assuring a dignified and a peaceful life to all. Now if the individual who is under unbearable pain is not able to decide for himself then it surely will hamper his interest. In that case it will surely be a negation of his dignity and human rights. Regarding this debate from legal point of view, Article 21 clearly provides for living with dignity. A person has a right to live a life with at least minimum dignity and if that standard is falling below that minimum level then a person should be given a right to end his life. Supporters of euthanasia also point out to the fact that as passive euthanasia has been allowed, similarly active euthanasia must also be allowed.

A patient will wish to end his life only in cases of excessive agony and would

63 (Cicero., 1998)

prefer to die a painless death rather than living a miserable life with that agony and suffering. Thus, from a moral point of view it will be better to allow the patient die painlessly when in any case he knows that he is going to die because of that terminal illness. So the question arises why to let increase that period of pain for him when in any case he is going to die.64

Another important point on which the supporters of euthanasia emphasize is that a lot of medical facilities which amount a lot are being spent on these patients which are in any case going to die. Thus, they argue that rather than spending those on such patients, it will be much better to use such facilities for those who have even fair chances of recovery. Thus, again the question lies that whom do we want to save using these medical facilities; those who are in any case going to die today or tomorrow or those who have fair chances of recovery. A point which is often raised against the supporters of euthanasia is that if such right will be granted to the terminally patients then there will be chances of abuse of it. But the supporters argue that every right involves a risk of being abused but that doesn't mean that the right itself should be denied to the people. We should rather look at the brighter side of it than thinking of it being abused.

5.4:'Against'

There is an intense opposition from the religious groups and people from the legal and medical profession. According to them its not granting 'right to die' rather it should be called 'right to kill'. According to them it is totally against the medical ethics. Medical ethics call for nursing, care giving and healing and not ending the life of the patient. In the present time, medical science is advancing at a great pace. Thus even the most incurable diseases are becoming curable today. Thus instead of encouraging a patient to end his life, the medical practitioners should encourage the patients to lead their painful life with strength which should be moral as well as physical.

The decision to ask for euthanasia is not made solely by the patient. Even the

64 (Cicero., 1998)

relatives of the patient pay an important role in doing that. Thus, it is probable that the patient comes under pressure and takes such a drastic step of ending his life. Of course in such cases the pressure is not physical, it is rather moral and psychological which proves to be much stronger. Also added to that is the economical pressure. The patient starts feeling him to be a burden on the relatives when they take such a decision for him and finally he also succumbs to it.65

Opponents also point out that when suicide is not allowed then euthanasia should also not be allowed. A person commits suicide when he goes into a state of depression and has no hope from the life. Similar is the situation when a person asks for euthanasia. But according to the opponents, such tendency can be lessened by proper care of such patients and showing hope in them. Another argument of the opponents is regarding the slippery slope. According to this argument, if voluntary euthanasia will be allowed, then surely it will lead to consequently allowing involuntary and non-voluntary euthanasia also. Also, as has been pointed out earlier, euthanasia in itself is an ambiguous term. The term 'terminally ill' has nowhere been properly defined. Thus even the medical fraternity is not clear as to who are the terminally ill patients, leave aside the legal practitioners. Thus, opponents strongly argue that euthanasia should be allowed only in rarest of the rare cases. If this is not done then surely it will lead to its abuse.

65 (Hume, 1929)

CHAPTER-6

COMPARATIVE STUDY OF EUTHANASIA

6.1:COMPARATIVE STUDY OF EUTHANASIA

The preceding chapter, the Context Origin of the Problem chosen for the study, its conceptual and theoretical framework, its objectives and research strategy have been properly and logically put forth. The chapter in hand aims to amplify the issue of legalization of euthanasia from an international as well as Indian perspective. The enormity of the issue can be understood by exploring the current status of euthanasia worldwide. It can be said at the very outset that euthanasia and physician assisted suicide are prohibited in most of countries in the world. However, the controversy about legalizing euthanasia and physician assisted suicide tends to occur more in North America, Europe and Australia then it does in Asia, Africa, South America and the middle East. Although there are exceptions to this trend.

The World Federation of Right-to-Die Societies claims that its member societies are spread all over the six continents. No two societies, however, are alike in their philosophy or practice. Nonetheless, all societies have the mission to attain a right for the individual to make a decision for himself towards the end of his/her life. In the same way there is a variety of theological and secular groups who oppose any attempt towards legalizing euthanasia in any form advocating the sanctity of life, the argument of slippery slope and the medical professional ethics. Out of this maze of warring ideological and ethical debate, it seems appropriate to take account of the status of euthanasia in various countries.

6.2:Euthanasia Worldwide

The following account displays the legal status of euthanasia and physician assisted suicide in countries around the world. It would be seen that the controversy over euthanasia differs from country to country, society to society and culture to culture. For the convenience, the major countries of the world have been placed alphabetically. Although, not exhaustive the list single out the

countries where the topic of euthanasia and physician assisted suicide are currently debated. In addition, it highlights the current events affecting the euthanasia debate in these selected countries.66

6.3:Albania

Euthanasia was legalized in Albania in 1999. It was stated that any form of voluntary euthanasia was legal under the rights of the terminally ill act of 1995. Passive euthanasia is considered legal should three or more family members agree to the decision. Albania's euthanasia policy has been controversial among life groups and the Catholic Church (Wikipedia, 2009)[1].

6.4:Australia

Euthanasia was legalized in Australia's Northern Territory, by the rights of the Terminally Ill Act, 1995. The northern territory consists of about 1/6 the landmass of Australia but only has a population of about 168000 people. The law started as a private member's bill rights of the Terminally Ill Bill 1995, sponsored by Marshall Perron. It was opposed by the Australian Medical Association and a variety of Right-to-Life groups. The above act came into effect on July, 1996. It permitted active euthanasia, under careful controls, when certain prerequisites were met. Similar bills were introduced in other Australian states.

The first person was a carpenter, Bob Dent, who died on 22 Sept. 1996. He had moved to the Northern Territory as a Church of England (Episcopal, Anglican) missionary. He became disillusioned with politics within the church and left his calling to become a building estimator. He had been diagnosed with cancer in 1991 and converted to Buddhism shortly afterwards. He wrote a letter saying: "If you disagree with voluntary euthanasia, then don't use it, but please do not deny that right to me." He further said "no religious group should demand that I behave according to their rules and endure unnecessary intractable pain until some doctor in his omniscience decides that I have had enough and increases the morphine

66 (Cabe, 1904)

until I die." In the presence of his wife and doctor, he initiated the process that gave him a lethal drug injection[2].

Recently, to mark the anniversary of Bob Dents death, 200 people marched through Sydney calling on politicians to reintroduce Right-to-Die laws. Six months later, however, in March 1997, the Federal Government overturned the laws (Wikipedia, 2009)[3]. Nevertheless, in 67August 2009, the Supreme Court of Western Australia ruled that it was up to Christian Rossiter, 49 years old quadriplegic, to decide if he was to continue to receive medical care (tube feeding) and that his carer had to abide by his wishes. Chief Justice Wayne Martin also stipulated that his carers Brightwaters care, would not be held criminally responsible for following his instructions, Rossiter died on 21 September, 2009 following the chest infection. Thus, the Court of Australia decided to owner the right of a patient to determining what type of medical treatment he would like to choose (Wikipedia, 2009)[4].

It can, however, be concluded that both Euthanasia and Physician Assisted Suicide stand illegal in Australia.

6.5:Belgium

The Belgian Act on euthanasia was enacted on 28th May, 2002. It came into effect on 22 September after its publication in official Belgian gazette. The Belgian Law allowed doctors to help kill patients who during their terminal illness, express the wish to hasten their own death. Thus, the Belgian became the third jurisdiction after the Netherlands (April, 2002) and the state of Oregon USA (1997) to legalize euthanasia.

The Belgian euthanasia law laid down the strict legal conditions and procedure under which euthanasia and physician assisted suicide can be performed. The chapter 11 of the above act laid down the following conditions and procedures for euthanasia and physician assisted suicide:

(1) "The physician who performs euthanasia commits no criminal offence when he/she ensures that: (a) The patient has attained the age of majority or is an

67 (Chin, 1999)

emancipated minor, and is legally competent and conscious at the moment of making the request; (b) The request is voluntary, well considered and repeated, and is not the result of any external pressure; (c) The patient is in a medically futile condition of constant and unbearable physical or mental suffering that cannot be alleviated, resulting from a serious and incurable disorder caused by illness or accident; and when he/she has respected the conditions and procedures as provided in this act.

(2) Without prejudice to any additional condition imposed by the physician on his/her own action, before carrying out euthanasia he/she must in each case: (a) Inform the patient about his/her health condition and life expectancy, discuss with the patient his/her request for euthanasia and the possible therapeutic and palliative courses of action and their consequences. Together with the patient, the physician must come to the belief that there is no reasonable alternative to the patient's request is completely voluntary;

(b) Be certain of the patient's constant physical or mental suffering and the durable nature of his/her request. To this end, the physician has several conversations with the patient spared out over a reasonable period of time, taking into account the progress of the patient's condition; (c) Consult another physician about the serious and incurable character of the disorder and inform him/her about the reasons for this consultation. The physician consulted reviews the medical record, examines the patient and must be certain of the patient's constant and unbearable physical or mental suffering that cannot be alleviated. The physician consulted reports on his/her findings. The physician consulted must be independent of the patient as well as of the attending physician and must be competent to give an opinion about the disorder in question. The attending physician informs the patient about the result of this consultation; (d) If there is a nursing team that has regular contact with the patient discuss the request of the patient with the nursing team or its members; (e) If the patient so desires, discuss his/her request with relatives appointed by the patient; (f) Be certain that the patient has had the opportunity to discuss his/her request with the person that he/she wanted to meet.

(3) If the physician believes that the patient is clearly not expected to die in the near future, he/she must be also: (a) Consult a second physician who is a

psychiatrist or a specialist in the disorder in question and inform him/her of the reasons for such a consultation. The physician consulted reviews the medical record, examines the patient and must be certain of the consult and unbearable physical or mental suffering that cannot be alleviated and of the voluntary, well considered and repeated character of the euthanasia request. The physician consulted reports on his/her findings. The physician consulted must be independent of the patient as well as of the physician initially consulted. The physician informs the patient about the 68results69 70of his consultation; (b) Allow at least one month between the patient's written request and the act of euthanasia.

(4) The patient's request must be in written. The document is drawn up, dated and signed by the patient himself/herself. If the patient is not capable of doing this, the document is drawn up by a person designated by the patient. This person must have attained the age of majority and must not have any material interest in the death of the patient. The person indicates that the patient is incapable of formulating his/her request in writing and the reasons, why. In such a case the request is drafted in the presence of the physician whose name is mentioned on the document. This document must be annexed to the medical record. The patient may revoke his/her request at any time, in which case the document is removed from the medical record and returned to the patient.

(5) All the requests formulated by the patient, as well as any action by the attending physician and their results, including the report of the consulted physician, are regularly noted in the patient's medical record.

The act also contains a provision and procedure for the advance directive to be made by the patient suffering from incurable terminal illness or mental and physical pain. The law also requires that the full medical history of the person to be euthanized must contain full details regarding his mental history. The law also requires that the physician who has performed euthanasia is required to fill in the registration form, drawn up by the Federal Control and Evaluation Commission established by Section of this act and to deliver this document to the commission within four working days. The Constitution and functions of the Federal Control

68 (Kasimar, 1978)
69 (Cabe, 1904)
70 (Hume, 1929)

and Evaluation Commission are also detailed and prescribed under the act. It reviews each and every reported case of euthanasia and advises the Parliament on the matters concerning the euthanasia law after every two years. The Commission has also right to turn the case over to the public prosecutor of the jurisdiction in which the patient died, if in a decision taken with a two-thirds majority, the Commission is of the opinion that the conditions laid down in this act have not been fulfilled.

The passing of the above law on euthanasia in Belgium evoked mixed feeling by both its opponents and proponents. Belgian Bishops tried to explain why the Catholic Church opposes the law, saying: "It is based on the idea that the value and dignity of a human being is no longer linked to the fact of this existence, but rather to his so-called 'quality of life'. In future, the patients who are very ill are certain to face pressure (from relatives and hospital staff) to view themselves as a burden that should be eliminated. The Flemish Christian Democrats declared that they were going to challenge the law in the European court of human rights. The, proponents, on the other hand, stated that prior to the law, several thousand illegal acts of euthanasia had already been performed in Belgium each year. According to them, the legalization incorporated a complicated process, which can be called the establishment of bureaucracy of death" (Belgian Gazette, 2002)[5].

6.6:Canada

In Canada, it has been the subject of repeated discussions, including bills introduced to Parliament, Civil and Criminal Court cases, Law Reform Commission Reports and Medical Association resolutions. Each of these discussions has concluded that the dangers of permitting the willful destruction of human life and another human being far outweighs any benefits gained by legalization.

Canadian laws on living wills and passive euthanasia are a legal dilemma. Documents which set out guidelines for dealing with life-sustaining medical procedures are under the Provinces control. (Wikipedia, 2009).

6.7:China and Hong Kong

Euthanasia is not legal in China and Hong Kong. It is against the Chinese concepts of morality. According to the existing law of the country it is equivalent to murder. In 1986, however, a native to North Western Shanxi province, Wang Mingcheng involved in China's first official case of euthanasia after referred to as mercy killing. After his mother was diagnose with terminal, severe liver cirrhosis and advanced ascites, Wang then 32, and one of his sisters pleaded with doctors to give Xia Suwen a lethal injection. Wang and the principal physician, Pu Liansheng, were convicted of murder in September, 198771.

On April 6, 1991 Wang and Pu were granted a reprieve by local Hanzhong people's court ruling that as there were no laws dealing specifically with euthanasia, the decision required consideration. Wang died from stomach cancer in 2003. When he asked for help to end his life his request was rejected. According to a 2003 poll on euthanasia conducted by Shaohai Market Investigation Co. Ltd. 64.5% of respondent in Beijing accepted the controversial practice and believed the time was right for China to legalize it (China Daily News, 2007)[8].

In 2007, Pu's parents pleaded that their son be euthanazied as he was suffering from cerebral palsy and incurable disease which caused paralysis. On the ground that the treatment has been a constant economic burden on them. But their plea was ignored. Updating the legal status of euthanasia in China wikipedia status: "While active euthanasia remains illegal in China, it is gaining increasing acceptance along doctors and the general populace.[9] In Hong Kong, support for euthanasia along the general public is higher among those who put less importance on religious belief, those who are non-Christian, those who have higher family income, those who have more experience in taking care of terminally ill family members and those who are older" (Chong AM, Fok SY, 2004)[10].

6.8:Colombia

In Colombia, euthanasia became permissible in 1997 when the highest judicial body, the Constitutional Court, ruled that an individual may choose to end his life and that doctors cannot be prosecuted for their role in helping... Carlos Gaviria, the judge who wrote the court's majority ruling, is now a senator, and he plans to

71 (Cabe, 1904)

submit a bill to Congress to regulate the practice… Gaviria said, he will submit a bill to the present legislative session establishing guidelines similar to those in the Netherlands and Belgium, where doctors must seek second opinions, give patients rigorous mental tests before inducing death and have cases reviewed by government commissions... The issue has received little public attention in Colombia, but Gaviria's bill is expected to change that. Colombians are evenly split on the subject, with 45% in favor of inducing death in terminal cases and 46.9% against, according to a Yanhaas poll for RCN radio. The poll was released in March, 2005"(Kim Housego 2005)[11]. To conclude, in Colombia a 1997 constitutional decision allowing euthanasia stands although no legislative follow up has taken place.

6.9:Finland

In Finland law is silent on the issue of euthanasia and physician assisted suicide. Also there are no known or recorded cases of Finnish doctors practising euthanasia. (Subodh Verma, 2011).

6.10:France

Chantal Sebire's final days may trigger a change in French law. Her face horribly disfigured, she had fought in vain for the right to take a lethal dose of prescribed barbiturates, surrounded by her family at a time of her choosing. Refused by a court in Dijon the right to die under medical supervision, she was found dead at home. According to prosecutors, she had taken a ‘deadly dose’ of barbiturates. French law had already been changed after a mother and doctor were unsuccessfully prosecuted for ending the life of her tetraplegic son, Vincent Humbert, in his twenties. Under the "end of life" law, doctors are advised to avoid taking extreme measures to keep dying or brain-dead patients alive. Foreign Minister Bernard Kouchner (a former doctor) is one of a number of senior politicians who favour a legal right to euthanasia in rare cases. He argued it was wrong that Chantal Sebire should have to commit suicide in a clandestine way, which would cause suffering to everyone, especially her loved ones. (BBC News 2009)[13]. Thus contemporary status of euthanasia law in France can be that there

is no law banning assisted suicide. But government bans publications that advise on suicide. Active euthanasia, even patient's request, remains illegal.72

6.11:Germany

Euthanasia has long been a taboo subject in Germany because of the Nazi programme of so-called euthanasia, which targeted thousands of men, women and children considered handicapped or mentally ill. The law on assisted suicide is not clear. While no longer illegal, it cannot involve a doctor because that would violate the code of professional medical conduct and might contravene a doctor's legal duty to save life. Many of the clients who travel to Switzerland to seek help in suicide are Germans and, at one point, Dignitas suggested it might set up a German office in Hanover. Former Hamburg Justice Minister Roger Kusch, who left politics to campaign for the right to assisted suicide, has come up with his own way around German law. A patient would be attached to an intravenous drip with two syringes, one with an anesthetic and the other with a lethal substance. While a doctor would insert the needle, it would be up to the patient to take the fatal step of pressing the button. German medical professionals and church figures have criticized the idea. (BBC News, 2009).

"The decision by Dignitas, the Swiss assisted suicide organization, to open their first office abroad in Hanover, Lower Saxony, in September this year has provoked fierce controversy in Germany. The branch will provide information and advice to people wanting to commit suicide but will not actually provide any drugs for the purpose, unlike the organization's head office in Switzerland... Public and political reactions to the opening of a German branch of Dignitas have not been uniformly hostile. However, the German Society for Dying with Dignity, which has 35,000 members, welcomed Dignitas' decision to open a branch. Two opinion polls also showed that about a third of the German population was in favour of active euthanasia and assisted suicide in the case of terminal illness. An even greater proportion, more than half, wanted to see an improvement in palliative care and a strengthening of the hospice movement... German doctors, however, are uniformly opposed to the move by Dignitas." (Annette Tuffs, M. D,

72 (Cicero., 1998)

2005)[15]. To conclude, it can be stated that in Germany there is no penalty for suicide and assisted suicide, in June 2010, legalized passive euthanasia.73

6.12:Greece

Greece assumes a critical important in the heated debate over euthanasia as it is the land where the Hippocrates Oath by physicians took birth. In fact, medical physicians stand in the frontline of the debate as they are those who should decide to act or not to act when euthanasia is requested by a patient. In Greece the vast majority of people is against euthanasia as a result of tradition and religion. The influence of the Hippocratic philosophy and the humanistic teaching of the Christian Orthodox Church have made that doctors and people look at the issue of euthanasia with aversion. In addition, the law considers any such action as homicide and therefore as punishable. However, in Greece as in any democratic country, individual variations exist and the issue attracts increasing debate (Mavroforou A.; Michalodimitrakis E., 2001).

6.13:Israel

Euthanasia and Physician Assisted Suicide are not legal in Israel. "On December 15, 2006 after eight years of preparation and a year after it was approved by the Knesset, the law relating to dying patients will take effect, enabling people of all ages to submit forms to the Health Ministry declaring how they would like to be treated if they became terminally ill. The provisions of the law were approved by leading clergymen representing all major religions before it was approved… The law, initiated by the government on the basis of the recommendations of the Steinberg Committee which met for six years on the sensitive subject was passed on December 1, 2005. The recommendations were prepared by the 59 member public committee comprising physicians, scientists, medical ethicists, social workers, philosophers, nurses, lawyers, judges and clergymen representing74

73 (Cicero., 1998)
74 (Chin, 1999)

the main religions in Israel… Active euthanasia will continue to be forbidden. However, individuals will be able to set down in advance that they do not want to be attached to a respirator when they are dying or that, if a respirator is attached, it would include a delayed-response timer that can turn itself off automatically at a pre-set time."(Judy Siegel Itzkovich 2006).

6.14:Italy

Euthanasia is illegal, but Italian law upholds a patient's right to refuse care and the potential contradiction has resulted in several cases which have divided Italians. The debate is especially passionate in Italy, where the Roman Catholic Church, which is deeply opposed to euthanasia, still holds great sway. In 2006, Piergiorgio Welby, a terminally-ill man with a severe form of muscular dystrophy, died after a protracted legal dispute during which he described his life as torture. A judge had ruled that he did not have the right to have his respirator removed, and when anesthetist Mario Riccio switched off his life support he was investigated by a judge for "consensual homicide". He was eventually cleared and the judges involved called on politicians to change the law.

In July 2007 came the case of Giovanni Nuvoli, a 53 years old former football referee with advanced muscular dystrophy, who died after going on hunger strike because he was not allowed his request to die without suffering. Police prevented his doctor, Tommaso Ciacca, from switching off his respirator. Former Health Minister Livia Turco said at the time that it was time Italy had a law "which allows sick people to express their will.

Then in July 2008, a court in Milan awarded the father of Eluana Englaro, a 38 years old woman, who has been in a permanent vegetative state since a car crash in 1992, the right to disconnect her feeding tubes.

The judges ruled that doctors had proved Ms. Englaro’s coma was irreversible. They also accepted that, before the accident, she had expressed a preference for dying over being kept alive artificially.75

75 (Cicero., 1998)

Prime Minister Silvio Berlusconi tried to intervene after doctors at a private geriatric clinic began to withhold her food, issuing an emergency decree barring doctors halting nutrition to patients in a coma. However, President Giorgio Napolitano refused to sign it, and three days later, before the Senate could enact a new law barring doctors halting nutrition to patients in a coma, Ms. Englaro died. Following her death, senators agreed to expedite work on a draft law to clarify end-of-life issues (BBC News, 2009)[18]. It is worthwhile to mention that mercy killing legally forbidden in Italy.

6.15:Japan

The Japanese government has no official laws on the status of euthanasia and the Supreme Court of Japan has never ruled on the matter. Rather, to date, Japan's euthanasia policy has been decided by two local court cases, one in Nagoya in 1962 and another after an incident at Tokai University in 1995. The first case involved "passive euthanasia" (i.e., allowing a patient to die by turning off life support) and the latter case involved "active euthanasia" (e.g. through injection). The judgments in these cases set forth a legal framework and a set of conditions within which both passive and active euthanasia could be legal. Nevertheless, in both of these particular cases the doctors were found guilty of violating these conditions when taking the lives of their patients. Further, because the findings of these courts have yet to be upheld at the national level, these precedents are not necessarily binding. Nevertheless, at present, there is a tentative legal framework for implementing euthanasia in Japan.

In the case of passive euthanasia, three conditions must be met:

1. The patient must be suffering from an incurable disease, and in the final stages of the disease from which he/she/ is unlikely to make a recovery;
2. The patient must give express consent to stopping treatment, and this consent must be obtained and preserved prior to death. If the patient is not able to give clear consent, their consent may be determined from a pre-written document such as a living will or the testimony of the family;
3. The patient may be passively euthanized by stopping medical treatment, chemotherapy, dialysis, artificial respiration, blood transfusion, IV drip, etc.

For active euthanasia, four conditions must be met:76

1. The patient must be suffering from unbearable physical pain;
2. Death must be inevitable and drawing near;
3. The patient must give consent (unlike passive euthanasia, living wills and family consent will not suffice)
4. The physician must have (ineffectively) exhausted all other measures of pain relief (Wikipedia, 2009)[19].

Presently, Euthanasia and Physician-Assisted Suicide is illegal in the Japanese criminal code, but a 1962 court case, the 'Nagoya High Court Decision of 1962' ruled that one can legally end a patient's life if 6 specific conditions are fulfilled. "The Japan Society for Dying with Dignity is the largest right-to-die group in the world with more than 100,000 paid up members. Currently, the Society feels it wise to campaign only for passive euthanasia - good advance directives about terminal care, and no futile treatment. Voluntary euthanasia and assisted suicide are rarely talked about..." (Derek Humphry, 2007)[20].

6.16:Korea

South Koreans have also a favourable attitude towards euthanasia. Of course Korea has adopted guidelines for physician assisted suicide. There Parliament has not yet debated and enacted a sanctioning physician assisted suicide. But medical association and government have issued instructions that the doctors who assist voluntary and passive euthanasia will not be prosecuted. The Times of India (2010)[21] published a report which reads as follows: "A 77 years old brain dead woman died in January, 202 days after being taken off life support in the country's first case of legal euthanasia. The case fuelled debate in a country where some still oppose mercy killing because of deep rooted Confucianist beliefs ."

6.17:Luxembourg

The country's parliament passed a bill legalizing euthanasia on 20th February, 2008 in the first reading with 30 of 59 votes in favour. On 19th March 2009, the bill passed the second reading, making Luxembourg the third European Union country, after the Netherlands and Belgium, to decriminalise euthanasia

76 (Cabe, 1904)

(Wikipedia, 2009)[22]. Terminally ill people will be able to have their lives ended after receiving the approval of two doctors and a panel of experts. The above law was passed by 30 votes to 26. (Reuters 2008)[23].

6.18:Mexico

In Mexico, active euthanasia is illegal but since 7 January, 2008 the law allows the terminally ill or closest relatives, if unconscious to refuse medication or further medical treatment to extend life (also known as passive euthanasia) in Mexico City, in the central state of Aguascalientes (since 6 April 2009) and, since 1st September 2009 in the Western state of

Michoacán. A similar law extending the same provisions at the national level has been approved by the senate and an initiative decriminalizing active euthanasia has entered the same legislative chamber on 13th April 2007 (Wikipedia, 2009)[24]. Thus, so far only two provinces and Mexico City have law allowing terminal patients or closest family to refuse medication. Laws extending their measures to the whole country are under debate in its Parliament.77

6.19:Netherlands

According to Wikipedia the legal status of euthanasia and physician assisted suicide is as follows: *Termination of Life on Request and Assisted Suicide (Review Procedures) Act* took effect on April 1, 2002. It legalizes euthanasia and physician assisted suicide in very specific cases, under very specific circumstances. The law was proposed by Els Borst, the D66 minister of Health. The procedures codified in the law had been a convention of the Dutch medical community for over twenty years. The law allows medical review board to suspend prosecution of doctors who performed euthanasia when each of the following conditions is fulfilled:

- The patient's suffering is unbearable with no prospect of improvement;
- The death must be carried out in a medically appropriate fashion by the doctor or patient, in which case the doctor must be present;

In 2003, in the Netherlands, 1626 cases were officially reported of euthanasia in the sense of a physician assisting the death (1.2% of all deaths). Usually the

77 (Cicero., 1998)

sedative sodium thiopental is intravenously administered to induce a coma. Once it is certain that the patient is in a deep coma, typically after some minutes, Pancuronium is administered to stop the breathing and cause death.

Officially reported were also 148 cases of physician assisted dying (0.14% of all deaths), usually by drinking a strong (10 mg.) barbiturate poison. The doctor is required to be present for two given reasons:

To make sure the potion is not taken by a different person, by accident (or, theoretically, for 'unauthorized' suicide or perhaps even murder).

the right to professional help in ending it. The organization started collecting signatures in support of this proposed change in Dutch legislation. A number of prominent Dutch citizens supported the initiative, including former ministers and artists, legal scholars and physicians. Under current Dutch law, euthanasia by doctors is only legal in cases of *hopeless and unbearable* suffering. In practice this means that it is limited to those suffering from serious medical conditions and in considerable pain. Helping somebody to commit suicide without meeting the qualifications of the current Dutch euthanasia law is illegal (Wikipedia, 2009).

6.20:Norway

Under the contemporary law in Norway, assisted suicide attracts accessory to murder charge. But the consent of the victim was involved in such cases, Courts award lighter sentence (Subodh Verma, 2011).

6.21:Poland

Poland is a predominantly Catholic country and has strongly condemned euthanasia. In 2007, Poland's then Conservative Government argued that plans for a Europe-wide day of protest against the death penalty should be met with parallel condemnation of abortion and euthanasia. It also raised the prospect that the European Charter of Fundamental Rights which is a legally binding part of the Lisbon Treaty could pave the way for euthanasia (BBC News, 2009).

6.22:Russia

"In Russia, euthanasia is illegal. But courts have been sympathetic to people charged with helping others die. Two women in the southern city of Rostovon-

Don were found guilty last year of murdering Natalya Barranikova even though the court accepted that the paralyzed victim had asked them to kill her because the law is clear. But the defendants were given unexpectedly light sentences." (Peter Ford, 2005).

6.23South Africa

The country currently criminalizes physician assisted suicide. A survey by the Medical Association revealed that: (i) 12% of physicians had already helped terminally ill patients die; (ii) 60% had performed passive euthanasia by withholding a medication or procedure with the expectation of hastening death; (iii) 9% had engaged in physician-assisted suicide.

In 1997, April 15th: The *South African Law Commission* released a 100 pages discussion paper on titled *Euthanasia and the Artificial Preservation of Life*[78]. It included *a Draft Bill on the Rights of the Terminally Ill.* The bill discusses: (i) How mentally competent persons might refuse medical treatment and thereby hasten death; (ii) That physicians could administer pain control medication, even though it has a 'double effect' of killing pain and hastening death. This is a common practice that is currently in a legal limbo. (iii) That a competent person could obtain assistance in committing suicide from a physician under certain conditions. The patient would have to be suffering from a terminal illness, be in extreme pain that cannot be relieved, be over the age of 18, be mentally competent, and persistently request assistance in dying. Two doctors would have to agree; (iv) That a person could issue a living will in advance of need which would direct what medical treatment that they would prefer to avoid; (v) The conduct of medical personnel in withholding medical treatment. Doctors could refuse to participate in any of the above.

In 1999, March- 09: The *South Africa Medical Association* asked that the proposed legislation be put on hold.

In 1999, March-10: *Doctors for Life* is a group of 600 physicians who oppose choice in abortion and physician assisted suicide. They appealed to the South

78 (Hume, 1929)

African government and *Law Commission* to retain the status quo and to abandon any proposed legislation.

In 1999, Oct- 2: A bill was under active discussion in Parliament.

In 1999, Oct- 4: *Christians for Life* organized a demonstration to protest abortion access and physician assisted suicide.

In 1999, Oct-08 & 09: 40 African pro-life groups who form the *National Alliance for Life* (NAL) attended the *'Love them both'* conference in Amanzimtoti, South Africa. The conference linked the right of a pregnant woman to choose an abortion with the right for terminally-ill elderly persons in intractable pain who seek assistance in committing suicide. Albu van Eeden, the NAL Chairman, said: "Euthanasia is contrary to the very nature of medicine. It will destroy the trust that forms the basis of the doctor-patient relationship. Legalizing euthanasia is all about giving the doctor the right to kill, to be both judge and executioner."

Van Eeden appears to be opposed to involuntary euthanasia in which a person is killed without their informed consent. The law proposed for South Africa would prohibit this, and allow physician assisted suicide only after the individual has requested it. Dr. F. Kellerman, a member of Doctors for Life, said: "We are deeply grieved because of the situation in South Africa. Despite the thousands of people who stood up against abortion and against the legalizing of euthanasia, the government just continues to do what they have in mind to do. We get the impressions that irrespective of what the people say, irrespective of what scientific facts are put to the government, even in Parliament, there are some people who have set their minds on killing babies and bringing in euthanasia" (B. A. Robinson, 2009)[2979]. **Spain**

Euthanasia is a deeply divisive political and religious issue in Spain. Socialist Prime Minister Jose Luis Rodriguez Zapatero legalized same-sex marriage in his first term of office, but a campaign promised to set up a congressional committee on euthanasia was not followed through.

In 2007, the Socialists joined the opposition Popular Party in voting against the legalization of euthanasia as a way of ensuring the right to a dignified death.

79 (Mishara, 1998)

Although opinion polls suggest popular support for euthanasia, Spain has been rocked by a high-profile case involving allegations of sedation causing the premature deaths of 400 terminally ill patients. In 2005, Madrid anesthetist Luis Montes and several other doctors at a hospital in Leganes were placed under investigation by a regional health chief. It was not until early 2008 that all 15 doctors were cleared of any wrong doing, but the case is reported to have led many doctors to have shied away from sedating patients out of fear of court action (BBC News 2009).

6.24:Sweden

Passive euthanasia is now possible in Sweden because of new medical guidelines which allow doctors to halt life-extending treatment if a patient asks. Swedish law says that doctors should respect the will of patients and should not kill them. Doctors had previously interpreted that as banning them from withholding treatment. But the rules were reassessed after a 35 year old man who had spent years on a respirator, was unable to persuade doctors to turn off his life-support and travelled to Switzerland to end his life. The Swedish Society of Medicine now advises doctors to respect the wishes of patients who are capable of making their own decisions, well-informed and aware of all the alternatives. Swedish doctors are not generally in favour of euthanasia. A recent survey suggested that 84% of them would never consider helping a patient die, even if the patient asked for it and it was legal (BBC News 2009).

6.25:Switzerland

Assisted suicide is not illegal in Switzerland and can have the involvement of non-physicians. Hundreds of Europeans have travelled to Zurich to end their lives because of Dignitas, an organization set up in 1998, to help people with terminal illnesses. They are provided with a lethal dose of barbiturates which they have to take themselves. But Dignitas was forced to move from the flat it was using because of opposition from residents in the area. At one point, those using its services were told to use hotel rooms and, according to one report, one man decided to die in his car. According to Swiss law, a person can be prosecuted only if helping someone commits suicide out of self-interested motivation. Dignitas' staffs work as volunteers (BBC News, 2009)[32].

6.26:Thailand

Active euthanasia is illegal under Thai law. The National Health Act BE 2550 (2007), which into force on 20th March 2007, provides for the right to specify advance health care directives, which may include refusal of treatment in terminal cases (passive euthanasia) (Wikipedia, 2009)[33].

6.27:Turkey

The concept of euthanasia entered the agenda in Turkey in 1975. It has become an important problem in Turkey in the last decade, as the result of technological and medical developments. Turkish law is established from the principle of the 80sanctity of life and respect for it. Euthanasia is legally forbidden in Turkey81, and is regarded as homicide. As one of the main elements of the crime which is called 'bad intention' does not exist in euthanasia, there is a dilemma. There has been no law suit about euthanasia in Turkey, so the jurists' interpretations are not clear (N. Yasemin Oguz, 1 996)[34].

.6.28:The United Kingdom

Euthanasia is illegal in the United Kingdom. Any person found to be assisting suicide is breaking the law and can be convicted of assisting suicide or attempting to do so (e.g. if a doctor gives a patient in great pain a bottle of morphine to take (to commit suicide) when the pain gets too great), Ursula Smartt (2009)[35]. Although two thirds of Britons think it should be legal, in 2004 the 'Assisted Dying for the Terminally-Ill Bill' was rejected in the lower political chamber, the House of Commons, by a 4-1 margin. Currently, Dr Nigel Cox is the only British doctor to have been convicted of attempted euthanasia. He was given a 12 months suspended sentence in 1992. The principle of double effect is however firmly established. In 1957 Judge Devlin in the trial of Dr John Bodkin Adams ruled that causing death through the administration of lethal drugs to a patient, if the

80 (Chin, 1999)
81 (Gruman, 1973)

intention is solely to alleviate pain, is not considered murder even if death is a potential or even likely outcome. (Margaret Otlowski, 1 997)[36].

6.29:United States

The first instance of legal saction to euthanasia took place in Oregon, a northwestern state in the United States. In 1994, the state adopted the Oregon Death with Dignity Act that allowed people who had been diagnosed with terminal illness and had six months to live, to take a lethal dose of prescribed medication and die voluntarily. Since the passage of the Act, 401 people have adopted this measure, most of them over 80 years of age and suffering from cancer. In 2006, the United States Supreme Court upheld the law despite President Bush's opposition. The provision of "Death with Dignity Act" deserves special attention as the Act was first of its kind to be enacted in morden times. It is also to be noted that it was a citizen's initiative that legalized PAS in Oregon (A. E. Chin et. al., 1999) [37]. It allows terminally-ill patients to obtain a prescription for lethal medication from an Oregon physician. Euthanasia, in which a physician directly administers a lethal medication, is not permitted. Patients eligible to use the Act must: (a) be 18 years of age or older; (b) be an Oregon resident; (c) be capable of making and communicating health-care decisions; (d) have a terminal illness with<6 months to live; and (e) voluntarily request a prescription. The patient must make one written and two verbal requests (separated by at least 15 days) of their physician. The prescribing physician and a consultant physician are required to confirm the terminal diagnosis and prognosis, determine that the patient is capable and acting voluntarily, and refer the patient for counseling if either believes that the patient's judgment is impaired by a psychiatric or psychological disorder. The prescribing physician must also inform the patient of feasible alternatives, such as comfort care, hospice care and pain control options. The law mandates that the Oregon Health Division, monitor the Act's implementation. To be in legal compliance with the law, physicians are required to report the writing of all prescription for lethal medications to the Health Division. The statute has been amended to include a requirement for health-care providers dispensing lethal medication (e.g., pharmacists, dispending physician) to also report to the Health Division (Death with Dignity Act, 1997).

A similar act was passed in neighboring state of Washington in 2008. In Montana, a trail court affirmed the right to assisted suicide in 2008. The state Supreme Court confirmed this in 2009[39]. Thus it can be concluded in the basis of the above discussion that euthanasia law has evolved in United States out the legal battle in various state as well as US Supreme Court. Active euthanasia, however, remains illegal there. Voluntary euthanasia however, has legalized in Oregon, Washington and Montana in some form or the other.82

6.30:Euthanasia: Indian Perspective

The issue of legalization of euthanasia in India can be better understood from two points of view: (i) Reflection from cultural and historical heritage of India; and (ii) To contemporary socio-medico-legal scenario.83

6.31:Reflection from Cultural and Historical Heritage of India

In almost all societies individual and social life was governed by social customs during the ancient and medieval ages. Social value preceded human values. India is no exception to this rule. India had too remained under the rule of customs, how so ever; some of them might appear as tyrant and unjustify today. Indian culture seems to create an ambivalent attitude towards suicide and euthanasia, on the one hand sanctity of life was taken to be the highest value and the violation of it including suicide was considered the highest sin. But on the other hand suicidal acts were glorified if they occurred in defense of social values. The customs of *Sati, Jauhar, Saka (Keseria)* may be taken as evidences of providing the above arguments. Sati stood for a custom of self-immolation of a widowed woman by setting on the funeral pyre of her deceased husband. Although, there is scholar like Varun Prabhat (2006)[40] who argued that Sati was not an ancient custom but its modern connotation was invented by Christian Missionaries. Varun Prabhat writes: *"Sati* is an ancient Sanskrit term, meaning a chaste woman who thinks of no other man than her own husband. The famous examples are Sati Anusuiya, Savitri, Ahilya etc. none of them committed suicide, let alone being forcible burned. So how is that, that they are called Sati? The word *'Sati'* means a chaste woman and it has no co-relation with either suicide or murder. The term *Sati* was

82 (Mishara, 1998)
83 (Chin, 1999)

never accompanied by *'Pratha'*. The phrase, *'Sati Pratha'* was a Christian Missionary invention. Sati was taken from the above quoted source and *'Pratha'* was taken from the practice of *Jauhar,* (by distorting its meaning 'Suicide' to 'Murder') and the myth of *'Sati Pratha'* was born to haunt Hindus forever".

Whatsoever might had been the truth, the fact remains that, even at the dawn of the modern age, Raja Ram Mohan Ray (1772-1833) had to initiate the movement against Sati Pratha and did not relaxed till the horrible custom was abolished in 1829 by Lord William Benting, the then Governor General of East India Company. Even in recent times a woman Roop Kanwar in the village Deorala 84district Sikar of Rajasthan performed s*ati* on the burning pyre of her husband. There were many local people who supported her and asked everyone to do what she had done so bravely and uphold the Hindu traditions and long followed customs of the village. Customs indeed, do die hard *sati pratha* of course and obsolete custom now.

About *Jauhar* and *Saka* Wikipedia informs us: "Jauhar and Saka refer to the voluntary deaths of men and women of the Rajput clan in order to avoid capture and dishonour at the hands of their enemies. This was done sometimes by Hindu and Sikh women in *Mugal* times and are recorded incidences of this on a much smaller scale during the partition in 1947, when women preferred death then to being raped by enemies or, turned into a slave or being forced in to a marriage and to take their enemy's religion". *Jauhar* was originally the voluntary death on a funeral pyre of the queens of the royal women folk of defeated *Rajput* Kingdoms. The term is extended to describe the occasional practice of mass suicide carried out in medieval times of Rajput women and men. Mass self-immolation by women was called Jauhar. This was usually done before or at the same time their husband, brother, father and sons rode out in a charge to meet their attackers and certain death. The upset caused by knowledge that their women and younger children were dead, no doubt filled them with rage in this fight to the death called Saka.

Besides, Sati, Jauhar and Saka which were performed in defense of social values and customs, there are umpteen stories in Purans and Vedas in which both men

84 (Chin, 1999)

and women voluntarily accepted death by immolating their mortal bodies by various means, including fire. The power of yoga makes them oblivious of the pain of the decay of the mortal body. V.G. Julie Rajan (1999)[42] aptly writes : "Hinduism does provide a means to end one's own life when faced with incurable illness and great pain that is fasting to death prayopavesa, under strict community guidelines. Gandhi's associate, Vinoba Bhave, died in this manner, as did recently Swami Nirmalanand of Kerala. It is generally thought of as a practice of yogis, but is acceptable for all persons. Prayopavesa is a rare option, one which the family and community must support to be sure this is the desire of the person involved and not a result of untoward pressures.

Thus, Hinduism made the provision of self-willed death also. In his book 'Merging with Siva' *Satguru Sivaya Subramuniyaswami* wrote about Hindu view of death in the following words: "Pain is not part of the process of death. That is the process of life, which results in death. Death itself is blissful. You did not need any counselling. You intuitively know what's going to happen. Death is like a meditation, a *Samadhi*. That's way it is called *Maha* (Great) *Samadhi".*

Jains, a leading religious and business community of India, claim same, or some time more antiquity as Hinduism. They have an ancient custom called *sallekhana* or *santhara,* according to this custom a person can take a vow not to drink or eat food till his last breath. Even in modern India, it is reported that Jain resort to santhara in a sizable number. Gujrat, Rajasthan, Maharashtra and Karnataka account for most santharas in the country. It is also to be maintained that *santhara* is not the preserve of jain monks who have renounced worldly affairs. According to Jitendra Shah, Director of L D Institute of Indology "In fact, more ordinary Jains take up *santhara* than monks. Another common misconception is that only people suffering from illness embrace the practice. That's not true. *Santhara* is taken up with a view to sacrifying attachments, including one's boby" Becides, women-men ratio of *santhara* practitioners stands at 60 : 40, perhaps because women are generally more strong willed and have a religious bent of mind.

The cultural tradition of *santhara* among Jains is not an exception to its critics or opponents who claim to be rationalists and humanists. In 2006 Human Rights activists Nikhil Soni and his lawyers Madhav Mishra file a public Interest

Litigation (PIL) with the High Court of Rajasthan[44]. The PIL claimed that *santhara* was a social evil and should be cosidered to be suicide under Indian legal statute. It also extended to those who facililated individuals taking the vow of with aiding and abetting an act of suicide. For the Jains, however, the courts or any 85other agency intervention in such case would be a clear violation of the Indian Constitution's guarantee of religion freedom. This landmark case sparked dabate in India, where bioethics is a relatively new phenomenan. The defenders of *sallekhana* or *santhara* argued that *santhara* has a religious context, where as suicide, and abetment to suicide fall in criminal context. Moreover, hunger strikes are a common form of protest in India but often end with forced hospitalization and criminal charges. Besides, the suicide is itself contentious, since it would punish only an unsuccessful attempt at suicide, also punishable how far this provides deterrence is questionable. Lastly, suicide is usually and outcome of acute mental depression followed by self-isolation a person may leave a suicide note also. The act of suicide is instantaneous and not a prolonged ritual, where as in *santhara* the person takes a vow not to have food or water and it is a slow process which takes place admits the dear ones and other fallow co-religionists. *Santhara* is not practiced with an intention to end one's life but to end his own karmas and to achieve self purification through act of renunciation of all worldly actions including food and water. In addition to it if an individual feels he can continue or has a desire to live, an individual can break a vow[45]. Thus, santhara can not be in any way considered as suicide. With sallekhana or santhara, death is welcomed through a peaceful, tranquil process providing peace of mind for everyone involved. In fact philosophically santhara can be rationalized by many angles and Jain philosophers and religious leaders have actually done so. As regards the question of its legality, it can be stated that like all religious practices the question cannot be decided on the bases of rationality and law alone. At present it is not clear on what grounds and statistics, santhara is to be held illegal.86

Thus, the cultural heritage of Indian reflects a cultural ambivalence towards suicide and euthanasia. In fact, it is important to make two observations here:

85 (Chin, 1999)
86 (Mishara, 1998)

First, that Sati, Jauhar or Saka or Maha Samadhi by yogis or santhara among Jains is certainly more different than euthanasia used in the modern sense. All societies including advance and developing societies glorify the killing of enemies in a war and; secondly, the controversy over euthanasia is of recent origin due to advancement of medical science and technology and longevity. It is the product of almost last three or four decades. In India the controversy gained momentum after the case of Venkatesh in 2004. In reality it is related to medical context and socio-legal setting. Voluntary euthanasia and physician assisted suicide have become the focal points. There appears no need of justifying them or rationalizing or legalizing them on support of cultural history of India. Since the controversy on legalizing euthanasia in India is of recent origin, it has to be resolved and settled with reference to contemporary socio-medico-legal situation in India.

6.32:Contemporary Socio-Medico-Legal Scenario

If one looks at the contemporary Indian Society, one may certainly find it undergoing the powerful and rapid cross currents of multi-dimensional processes of powers of social change. It is engrossed in the process of development and modernization. Although it is a fact that its solid edifice founded on age-old traditions of caste and religion is crumbling in the whirlpool of change, yet it appears to be still strong enough to hold on. Religion and caste still continue to provide main context for understanding contemporary India. Society in India continues to be structured on the principle of social hierarchy and precedent of group over the individual. In fact, contemporary Indian society appears to be existing at multi level stage of civilization development simultaneously. At its apex there is a layer advanced cosmopolitan and modern India. The elites of this layer dominate most of the areas of social life i.e., political, industrial and beaurocratic.

Then there is a second layer of developing India compromising of thousands of urbanizing and back word villages reflecting the feudal systems still holding on caste community and religion. The last layer may be identified as surviving at primitive level. There are millions of people still illiterate. Stricken by abject poverty deprived of food, cloth and shelter, they are still governed by the forces of customs. These layers are not interwoven in a smooth social fabric. There exist

a great hiatus among them reflecting an imbalanced kaleidoscopic scene. The holistic reality of Indian society appears to be dismal. The society faces with a crisis of degenerating values and character87.

The body of Indian polity is suffering from many threatening viruses. India is 87th ranked among the corrupt nations. (Wikipedia, 2010)[46]. The virus of corruption is eating the vitals of institutional organs of socio-political India. It is most unfortunate that the corruption is being accepted as a part of the game and becoming a component of people's mentality. Moreover, there is criminalization of politics and politicization of crime. There is nefarious nexus of corrupt politicians unethical beaurocrates debased capitalists and mafias. Self-centered individualism and materialism have become the courts of social conduct. The noble professionals like teaching, medicine, and law have lost the ethical values of their profession. Individual autonomy and human rights have become a verbose to be talked of in public, not to be practiced in personal life.

It is important to note that the post-independence Indian society has made glaring achievements in the field of socio-economic development. The rate of economic growth during the last sixty years has been appreciable but the fruits of progress have not trickled down to the bottom of Indian society. The rich and powerful layer has become richer and more powerful.

As regards the medical and health scenario of Indian society, it can be said that there has been an impressive progress, the medical science and technology have made considerable achievements. The process of immunization has contributed towards a lot in control of many diseases like malaria, polio and smallpox which were considered to be deadly in the past. Hence the annual death rate has been reduced and controlled. Medical facilities have increased. The life expectancy (70 years) has also increased accordingly. The social problem of the aged has emerged as an important problem. The medical science and technology in India have now acquired life supporting system and medications to extend life artificially for a long period even after the loss of brain activities and the control of bodily functions. It has brought into relief issues which are altering the pattern of human living and societal values. Pari passu with these changes is the upsurge of

87 (Cicero., 1998)

affirmation of human rights, autonomy and freedom of choice. These issues compel the revaluation of many social values and medical ethics. One of these issues is that of dignified death and the related matter of legalization of euthanasia. Many people have a fear today of being kept alive artificially by life support system with consequent sufferings and distress to them and members of their family. They may wish to request the doctor to withhold or withdraw such treatment so that they may die with dignity among their dear ones (voluntary passive euthanasia) or may request the doctor to give a lethal dose to end their 88suffering (active euthanasia). Herein lies the origin of debate over the issue of legalizing euthanasia in India. Should a terminal patient be granted a right to decide the time and manner of ending his life? Pleading for the case voluntary medical euthanasia the urologist B. N. Colabwala (1 987)[47] have argued : "The prime duty of the medical professional is to relieve suffering and voluntary euthanasia should be viewed in that context. Indeed, it is the duty of the physician to treat, heal and offer an acceptable quality of life to a patient. But above all is the relief of suffering by all means available to him. An end of point is often reached when death via the medium of voluntary euthanasia is the only good medicine. Moreover, the financial implications of a futile treatment have serious implications for the patient and his relatives to for maintaining and unmaintainable life." Dr. Mukesh Yadav (2006)[48] however, argued that voluntary withdrawal of life support system by terminally ill patient should neither be treated as passive euthanasia nor an attempt to suicide. As every medical intervention requires the consent of the patient, he reserves the right to refuse treatment, even if it is to his detriment.

Opponents of euthanasia however, argue that Hippocratic Oath and International Code of Medical Ethics insist that a doctor should alleviate the suffering and pain of his patients at all costs. It does not make sense to consider ending the suffering of a person by putting an end to the sufferer. The treatment of the severe headache is not the removal of the head but in seeking ways of relieving the pain while keeping the head intact. Moreover, the disease which is incurable today might become curable tomorrow[89].

88 (Chin, 1999)

89 R. K. Bansal, S. Das, P. Dayal, 2005

Thus, the medical situation in India does not provide an easy ground for resolution of the issue of legalization of euthanasia. The rampant corruption in India and widening gap between rich and poor and their accessibility of medical services make the problem more enigmatic.

Now it is time to see the current legal status of euthanasia in India. As already pointed out in chapter one that euthanasia and assisted suicide continue to be unlawful under the existing law. But the Law Commission of India (2006)[50] has made a comprehensive study of the problem of medical treatment to terminally ill patient. It has made valuable recommendation to protect the rights of patients and the medical practitioners in such cases. The Commission also annexed a draft bill to its report entitled as "Medical Treatment to terminally ill patient (Protection of Patients and Medical Practitioners) Bill, 2006". The major provisions of the Bill relate to the withholding or withdrawing life support system like ventilation, artificial supply of food and hydration from a patient who is terminally ill. It has also laid down the specific procedure to be followed in such cases. To understand the legal protocol prescribed by the Commission, it is better to clarify three terms used by the Commission in this context : first, the competent patient is one who is not incompetent; Secondly, the incompetent patient refers to a patient who is a minor, or a person of unsound mind or a person who is unable to - (a) understand the information relevant to an informed decision about his or her illness or its treatment; (b) retain that information; (c) use or weigh that information as part of the process of making his or her informed decision; (d) make an informed decision because of impairment of or a disturbance in the functioning of his or her mind or brain; or (e) communicate his or her informed decision (whether by speech, sign, language or any other mode) as to medical treatment. Thirdly, an informed decision means the decision as to continuance or withholding or withdrawing medical treatment taken by a patient who is competent and who is, or has been informed about (a) the nature of his or her illness, (b) any alternative form of treatment that may be available, (c) the consequences of those form of treatment, and (d) the consequences of remaining untreated. The major provisions in this regard have been given as under :90

90 (Hume, 1929)

(1) If a competent patient takes an informed decision for withholding or withdrawing of medical treatment to himself or herself and to allow nature to take its own course, or for starting or continuing medical treatment to himself or herself, and communicates his or her decision to the medical practitioner. Such decision is binding on the medical practitioner. Provided that the medical practitioner is satisfied that the patient is a competent patient and that the patient has taken an informed decision based upon a free exercise of his or her free will.

(2) Every medical directive (called living will) or medical power-ofattorney executed by a person shall be void and of no effect and shall not be binding on any medical practitioner.

(3) A medical practitioner may also take a decision to withhold or withdrawn medical treatment (a) from a competent patient who has not taken an informed decision, or (b) from an incompetent patient. Provided that : (i) the Medical Practitioner is of the opinion that the medical treatment has to be withheld or withdraw in the best interests of the patients; (ii) adhere to such guidelines as might have been issued by the Medical Council of India (MCI) in relation to the circumstances under which medical treatment to a patient in respect of the particular illness could be withheld or withdrawn and (iii) consult the parents or relatives (if any) of the patient but shall not be bound by their views. The commission has also provided directions for the above purpose. The medical practitioner91 who makes a decision to withheld or withdraws life support system from a patient in the two situations mentioned above has to follow the procedure which is laid down as follows : (i) he must obtain opinion of the three medical practitioners selected a panel of medical experts appointed for this purpose by the Director General of Health services, in the case of Union territories or Director of Health Services (or officer holding equivalent post) in case of states as the case may be as to where the patient is being treated. The Commission has issued guidelines for the above

91 (Cicero., 1998)

authorities to prepare such a panel and issue it to all the medical institutions in their respective jurisdiction. In case of differences of opinion among medical experts refer to above the majority decision will prevail; (ii) the medical practitioner has to maintain a register wherein he should record as to why he is satisfied that: (a) the patient is competent or incompetent; (b) the competent patient has or has not taken an informed decision about withholding or withdrawing or starting or continuance of medical treatment; (c) why he things that withholding or withdrawing life support system from a patient is in his or her best interest. (d) the age, sex, address and other particulars of the patient. (iii) Before withholding or withdrawing medical treatment, the medical practitioner shall inform in written the patient (if he is conscious), his parents or other relatives or guardian about the decision to withhold or withdraw such treatment in the patient's best interests. In case the patient, parents or relatives inform the medical practitioners of their intention to move the High Court, the medical practitioner shall postpone such withholding or withdrawing by fifteen days. If no orders are received from the High Court with that period, he may proceed to implement his decision.

(4) A photocopy of the pages in the register with regard to each such patient shall be lodged immediately, as a matter of information, on the same date, with the Director General of Health Services, or Director of Health Services of the Union territory or State, as the case may be, in which the medical treatment is being given or is proposed or is proposed to be withheld or withdrawn and acknowledgement obtained. The medical practitioner is also required to keep the register as confidential and not to reveal it to public or media. The same obligation of confidentiality is binding on the relevant authorities who have been informed about such cases and they are also required to maintain the copies of the information sent by the medical practitioners in their office.

(5) It is worthy being highlighted that even though medical treatment has been withheld or withdrawn by the medical practitioner in the case of competent patient and incompetent in accordance procedure such medical practitioner is

not administering palliative care.92

(6) It is also to be noted that if a competent patient treatment in circumstances mentioned above, with prescribed debarred from refuses medical notwithstanding anything contained in the Indian Penal Code (45 of 1860), such a patient shall be deemed to be not guilty of any offence under that code or under any other law for the time being in force.

(7) The same protection is provided to the medical practitioner and any other person acting under his direction to withhold or withdraw medical treatment, (a) In respect of a competent patient, on the basis of the informed decision of such patient communicated to the medical practitioner for such withholding or withdrawal, or (b) (i) in respect of a competent patient who has not taken an informed decision, or (ii) in respect of an incompetent patient, and the medical practitioner take a decision in the best interest of the patient for withholding or withdrawal of such treatment, and complies with all the requests of the law as discussed above. In other words, their action to withhold or withdraw the medical treatment shall be deemed to be lawful.

(8) As mentioned above, an opportunity recourse to the High Court has been provided to any patient or his or her parents or his or her relatives or next friend or medical practitioner or the hospital authority for seeking any interim or final direction from the said court as they may deem fit. But it has also been provided that such a recourse to High Court declaratory relief and direction is not a condition precedent to withholding or withdrawing medical treatment if such withdrawal or withholding is done in accordance with the provisions of this act.93

(9) The condition of confidentiality mentioned above has been extended to the appellate High Court also. The division bench of the High Court shall, whenever a petition is filed under the proposed act, direct that the identify of the patient, medical practitioner, expert medical consultant or their relative or next friend or who have given evidence in the court, shall, during the pendency of the petition and after its disposal, be kept confidential and shall be referred only by the English alphabets as chosen or assign to each

92 (Cicero., 1998)
93 (Chin, 1999)

of them by the division bench of High Court. The same direction of the High Court shall be deemed to be binding on all media. The violation of the confidentiality would attract not only contempt of court but they may be prosecuted against in civil or criminal courts. In case, however, the declarations or directions given by the High Court have to be communicated to the patient, parents, medical practitioner, hospital or experts concerned, it shall be permissible to refer to the true identity of the patient. Person or hospital and such communications shall be made in sealed covers to be delivered to these addresses so that the declarations or directions made by the High Court are understood and implemented as being with reference to the particular patient.

(10) The proposed bill also makes it mandatory for Medical Council of India to prepare the panel of medical experts of good standing and at least of twenty years experience to prepare and publish in official gazette of India and on its website. The Medical Council of India, of course, has also been empowered to modify or review and publish the same in the gazette.

It is worthy to recall that in its subsequent report no. 210th The Law Commission of India (2008) has recommended to government to initiate steps for repeal of the anachronistic law contained in Sec 309 of Indian Penal Code, and to decriminalized attempt to suicide as a punishable offence. But the Commission, however, also recommended to retain Sec. 306 of the IPC which relates to abetment to suicide which covers assistance to suicide also. It is also worthy to note here that the Commission's draft bill on Medical Treatment of Terminally ill Patient (Protection of Patient and Medical Practitioner) report no. 196th and its recommendation for decriminalization of suicide report no. 210th, mentioned above have not yet been considered and adopted by the Indian Parliament. Hence, voluntary euthanasia or withholding or withdrawing life support of a terminally ill patient or physician assisted suicide continues to be illegal in India. As such the debate on these issues goes on both among legal scholars and jurists.

Parlika Jain (2008) has aptly observed: it is submitted that in the present scheme of criminal law it is not possible to construe the provisions so as to include voluntary euthanasia without including non-voluntary and involuntary euthanasia. Parliament should, therefore, by a special legislation legalize voluntary euthanasia

while expressly prohibiting non-voluntary and involuntary euthanasia. Legalizing euthanasia would not have any effect on the provisions relating to suicide and abetment thereof as euthanasia and suicides are two completely different acts".94

Similarly,95 advocate Dhruv Desai (2008) took an overview of euthanasia and suicide and discussed in the case law of the following words: "In india the contention whether the 'right to life' includes within its ambit the 'right to die' came for consideration for the first time in the year 1987. It was in the case of *State of Maharashtra v. Maruti Shripati Dubal* [54], wherein the Bombay High Court held that, "Everyone should have the freedom to dispose of his life as and when he desires." The said decision of the Bombay High Court was upheld by the Supreme Court of India in the Case of *P. Rathinam v. Union of India* [55], where the supreme Court held, "A person cannot be forced to enjoy life to his detriment, disadvantage or disliking." However, the Supreme Court rejected the plea that euthanasia (mercy killing) should be permitted by law, because in euthanasia, a third person is either actively or passively involved; about whom it may be said that he aids or abets the killing of another person. It was in *Gian Kaur's case*, that a five Judge Bench of the Supreme Court overruled *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. This also includes the right to a dignified life up to the point of death including a dignified procedure of death." 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." He concluded that the euthanasia and physician assisted suicide are not simply legal issues alone; and by terminating them so, we may be missing the crux of the matter. They are individual, social and moral issues also. He further argued "In spite of every day discoveries in science and medicine or a possibility of a miracle cure, the patient suffering from Aids, Cancer, Motor Neuron disease or Persistent Vegetative State, would rather prefer to exercise the option of euthanasia and physician assisted suicide. The issue in hand is, thus related to cases of the terminally ill (like the right to decide about life sustaining treatment and right to respect for autonomy).

94 (Gruman, 1973)
95 (Gruman, 1973)

Moreover, it is certain that the world of today or hopefully tomorrow would be governing by the law. 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 the best possible way) in serving the interests of the contemporary and future society".96

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. The Commissions following words are not only relevant but critical also at this juncture: "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 has drafted a tentative Bill which would hopefully receive deeper consideration in the state assembly. The Commission Vice-Chairman, Justice T V Ramakrishnan has aptly remarked : "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 102 recommendations permit a terminally person to end his life under supervision and advice of his close relatives and medical practitioners. Detailed provisions have been incorporated in the draft bill to impose strict conditions and safeguards in the matter of assisting terminally ill persons without reasonable prospect of continuing life to put an end

96 (Hume, 1929)

of their unbearable pain and pitiable existence. The draft bill in this regard is perhaps the first of its kind in Kerala and India.

Recently, however, the Supreme Court of India in its historic judgment on 8th March (2011) has allowed passive euthanasia involving withdrawal of life sustaining drugs and/or life support systems-for patients who are brain dead or in a permanent vegetative state (PVS), and whom doctors have lost hope of reviving even with the most advanced medical aid the court, however classified that active euthanasia, involving injecting a potent drug to advance the death of such patients, remained a crime under law.97

The above landmark judgment was delivered by the two judges Supreme Court bench of Justice Markandey Katju and Gyan Sudha Mishra in a PIL petition filed by Pinki Virani as a next friend of Aruna Shanbaug a nurse in K.E.M. hospital Mumbai. Shanbaug, 63 was brutally sexually assaulted by a ward boy Sohan Lal Valmiki when she was 25 years old. Sohan Lal used a dog chain to throttle her which cut off blood and oxygen supply to her mind, leaving Aruna paralysed and in a vegetative state. Since then Aruna lied on bed for 38 years. The staff of the K.E.M. hospital continued to care her as a real family. Pinki Virani moved the Supreme Court seeking Aruna's force feeding to be stopped. The honorable bench of SC, however, dismissed Pinki Virani's petition while praising her effort. The Court accepted the prayer of K.E.M hospital staff and viewed that it alone was legally, emotionally and circumstantially entitled to the position of Aruna's next friend and clarified that it wanted her to live till her natural death. It would not be out of place to mention here that Sohan Lal Valmiki was charged with attempted murder and for robbing Aruna's earrings. The Court awarded Valmiki seven years in jail. Although, the Supreme Court rejected the petition of Pinki Virani for withdrawal of life support to Shanbaug, yet it allowed passive euthanasia in the manner discussed above. Further, the Supreme Court has laid down the procedure to be followed in cases of passive euthanasia. The major provisions 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.

97 (Hume, 1929)

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.

Other highlights of the judgment may be noted as follows :

1. Active euthanasia, involving injecting a potent drug to advance the death of such patients would remain a crime under law.
2. The judgment would have to hold good until Parliament enacts a law on this issue.
3. While giving great weight to the wishes of the parents, spouses or other close relatives or next friends of the patient and also giving due weight to the opinion of the attending doctors, the SC has not left the decision entirely to their discretion whether to discontinue the life support or not. Instead it has laid down the detailed procedure to be followed and a due order of the High Court should be obtained before taking any step towards passive euthanasia. SC has clarified that even if K.E.M hospital staff change their mind and in future want euthanasia for Aruna, for this they have to apply to Bombay High Court for approval of the decision of withdraw life support system.
4. Thus, entrusting the High Court to take final passive euthanasia call, the Supreme Court has served two purposes : first, to provide protection of the interest of the patient and the doctors; and second, to provide safeguards against absence or misuse of the law of unscrupulous vested interest.
5. The Supreme Court also observed that it was time to decriminalize suicide and delete the provision for punishment for attempted suicide, under

> Section 309 of IPC and asked Parliament to examine it. Although Section 309 of IPC (attempt to suicide) has been held to be constitutionally valid 98in Gian Kaur's v/s State of Punjab (1996)[60] case by Supreme Court, the time has come when it should be deleted by parliament as it has become anachronistic.

With the delivering of the aforesaid order by Supreme Court, can one come to a conclusion that the controversy over the legalization of euthanasia and PAS has been settled? Certainly the answer would be in negative. As Veerapaa Moily the Union Law Minister (2011)[61] said, while reacting the apex court order, " Supreme Court is right that without a law you cannot resort this kind of decision with a juridical order. He further added, "there is a need for a serious debate within the country." Similarly, Harish Salve (2011)[62] Solicitor General and senior counsel said : "The Supreme Court judgment underscores the need for the government to enact a law on the subject." Iqbal Chagla (2011)[63] has also taken a positive view of the Supreme Court judgment; he observed that, "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." The judgment has raised the voices of dissent also. Dr. Samiran Nadi (2011) 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"? In the same way Dr. Pragnya Pai (2011)[65] opposed the judgment by stating: "Birth, growing up and death are not optional but inevitable. Some people cannot decide if a person will live or die." Taking a view based on professional ethics of a medical practitioner Dr. Farukh Udwadia (2011)[66] said "As doctor, our job is to relieve pain and suffering and not to take life in our own hands." Thus, in spite of arguments for and against the SC judgment it can be said that it is defiantly a progressive juridical order. It has also underlined a need for a serious debate over

98 (Cabe, 1904)

the issue of legalization of euthanasia in India duly supported with empirical evidences.

6.34 Emergent Views

Having made a global and Indian assessment on the present status of euthanasia law the following trends may be identified : (i) the issue of legalizing euthanasia is hotly debated in many countries of the world including India; (ii) the countries which have legalized voluntary euthanasia and physician suicide are : Albania, Belgium, Germany, Luxemburg, Netherlands, Switzerland, and USA (only in state of Oregon, Washington and Montana); (iii) the countries which have guidelines provided by courts regarding euthanasia and PAS but no national law on the subject, are: Colombia, Japan and India; (iv) the countries which have specific laws for binding euthanasia and PAS are : Australia, Canada, China & Hong Kong, Greece, Israel, Poland, Russia, Spain, South Africa and UK; (v) the voluntary refusal to medical treatment has been legally permitted in the countries: Italy, Mexico (two province and Mexico City only), Sweden, Thailand and South Korea; (vi) the trends also suggest that active euthanasia is practically opposed in most of the countries whereas voluntary withdrawal of treatment and voluntary PAS are favoured and legalized in some countries; (vii) it can also [99]be observed that the controversy over legalization of euthanasia and PAS erupted during last two or three decades of the 20th century. The first step towards its legalization was formalized in Oregon (USA) 1997; (viii) in many western countries assisted suicide even though illegal formally, are dealt with leniently by judiciary and minimal or suspended sentences are given to doctors assisting in death, after thorough scrutiny; (ix) attempts to pass laws decriminalizing euthanasia have been rejected in many countries or provinces recently, including Scotland, Canada, Western and Southern Australia, Hawaii, New Hampshire, Israel and France; (x) the passive euthanasia have been legalized very recently in India

99 (Kasimar, 1978)

through SC judgment in Aruna Shanbaug's case. But Supreme Court has itself urged the Indian Parliament to enact a law in this direction. When the Indian Parliament will take action, no time limit has been set. Hence, the controversy over the issue goes on unresolved.

CHAPTER-7

JUDICIAL TRENDS REGARDING ETHUNASIA IN INDIA

7.1:Common Cause (A Regd. Society) vs Union Of India on 9 March, 2018[100]

We, therefore, proceed now to consider the question of constitutional validity with reference to Articles 14 and 21 of the Constitution. Any further reference to the global debate on the desirability of retaining a penal provision to punish attempted suicide is unnecessary for the purpose of this decision. Undue emphasis on that aspect and particularly the reference to euthanasia cases tends to befog the real issue of the constitutionality of the provision and the crux of the matter which is determinative of the issue.‖

22. In view of the aforesaid analysis and taking into consideration various other aspects, the Constitution Bench declared Section 309 IPC as constitutional.

23. The Court held that the "right to live with human dignity" cannot be construed to include within its ambit the right to terminate natural life, at least before the commencement of the process of certain natural death. It then examined the question of validity of Section 306 IPC. It accepted the submission that Section 306 is constitutional. While adverting to the decision in Airedale N.H.S. Trust v. Bland11, the Court at the outset made it clear that it was not called upon to deal with the issue of physician-assisted suicide or euthanasia cases. The decision in Airedale‘s case (supra), was relating to the withdrawal of artificial measures for continuance of life by a physician. In the context of existence in the persistent vegetative state of no benefit to the patient, the principle of sanctity of life, which is the concern of the State, was stated to be not an absolute one. To bring home the distinction between active and passive euthanasia, an illustration was noted in the context of administering lethal drug actively to101 bring the patient's life to an 102end. The significant dictum in that decision has been extracted in Gian Kaur (supra) wherein it is observed that it is not lawful for a doctor to administer a drug

100 215 OF 2005

101 (Gruman, 1973)
102 (Hume, 1929)

to his patient to bring about (1993) 2 WLR 316: (1993) 1 All ER 821, HL his death even though that course is promoted by a humanitarian desire to end his suffering and however great that suffering may be. Further, to act so is to cross the rubicon which runs between the care of the living patient on one hand and euthanasia - actively causing his death to avoid or to end his suffering on the other hand. It has been noticed in Airedale that euthanasia is not lawful at common law. In the light of the demand of responsible members of the society who believe that euthanasia should be made lawful, it has been observed in that decision that the same can be achieved by legislation. The Constitution Bench has merely noted this aspect in paragraph 41 with reference to the dictum in Airedale case.

It can be argued that in a country where the basic human rights of individuals are often left unaddressed, illiteracy is rampant, more than half the population is not having access to potable water, people die every day due to infections, and where medical assistance and care is less, for the few people, issues related to euthanasia and PAS are irrelevant. However, India is a country of diversities across religious groups, educational status, and cultures. In this background, the debate on euthanasia in India is more confusing as there is also a law in this land that punishes individuals who even try to commit suicide.

The Medical Council of India, in a meeting of its ethics committee in February 2008 in relation to euthanasia opined: Practicing euthanasia shall constitute unethical conduct. However, on specific occasions, the question of withdrawing supporting devices to sustain cardio-pulmonary function even after brain death shall be decided only by a team of doctors and not merely by the treating physician alone. A team of doctors shall declare withdrawal of support system. Such team shall consist of the doctor in-charge of the patient, Chief Medical Officer / Medical Officer in-charge of the hospital, and a doctor nominated by the in-charge of the hospital from the hospital staff or in accordance with the provisions of the Transplantation of Human Organ Act, 1994.[103]

In India, euthanasia is a crime. Section 309 of the Indian Penal Code (IPC) deals with the attempt to commit suicide and Section 306 of the IPC deals with abetment

103 Medical Council of India New Delhi. Minutes of the meeting of the Ethics Committee held on 12th and 13th February. 2008

of suicide – both actions are punishable. Only those who are brain dead can be taken off life support with the help of family members. Likewise, the Honorable Supreme Court is also of the view that that the right to life guaranteed by Article 21 of the constitution does not include the right to die. The court held that Article 21 is a provision guaranteeing protection of life and personal liberty and by no stretch of imagination can extinction of life be read into it. However, various pro-euthanasia organizations, the most prominent among them being the Death with Dignity Foundation, keep on fighting for legalization of an individual's right to choose his own death.

A major development took place in this field on 7 March 2011. The Supreme Court, in a landmark judgment, allowed passive euthanasia. Refusing mercy killing of Aruna Shaunbag, lying in a vegetative state in a Mumbai Hospital for 37 years, a two-judge bench laid down a set of tough guidelines under which passive euthanasia can be legalized through a high-court monitored mechanism. The court further stated that parents, spouses, or close relatives of the patient can make such a plea to the high court. The chief justices of the high courts, on receipt of such a plea, would constitute a bench to decide it. The bench in turn would appoint a committee of at least three renowned doctors to advise them on the matter.[104]

7.2:NEW DIMENSION IN INDIAN HISTORY- ARUNA's CASE

Aruna Shanbaug, who was working as a nurse at KEM Hospital, was assaulted on the night of November 27, 1973 by a ward boy. He sodomised Aruna after strangling her with a dog chain. The attack left Aruna blind, paralysed and speechless and she went into a coma from which she has never come out. She is cared for by KEM hospital nurses and doctors. The woman does not want to live any more. The doctors have told her that there is no chance of any improvement in her state. Her next friend (a legal term used for a person speaking on behalf of someone who is incapacitated) describes Shanbaug: "her bones are brittle. Her skin is like 'Paper Mache' stretched over a skeleton. Her wrists are twisted inwards; her fingers are bent and fisted towards her palms, resulting in growing

104 The Telegraph. 2011 Mar 6th;

nails tearing into the flesh very often. Her teeth are decayed and giving her immense pain. Food is completely mashed and given to her in semisolid form. She chokes on liquids and is in a persistent vegetative state." So, she, through her 'next friend' Pinki Virani, decided to move the SC with a plea to direct the KEM Hospital not to force feed her. And on 16th December 2009, the Supreme Court of India admitted the woman's plea to end her life. The Supreme Court bench compromising Chief Justice K G Balakrishnan and Justices A K Ganguly and B S Chauhan agreed to examine the merits of the petition and sought responses from the Union Government, Commissioner of Mumbai Police and Dean of KEM Hospital.

On 24th January 2011, the Supreme Court of India responded to the plea for euthanasia filed by Aruna's friend journalist Pinki Virani, by setting up a medical panel to examine her. The three-member medical committee subsequently set up under the Supreme Court's directive, checked upon Aruna and concluded that she met "most of the criteria of being in a permanent vegetative state". However, it turned down the mercy killing petition on 7th March, 2011. The court, in its landmark judgement, however allowed passive euthanasia in India. While rejecting Pinki Virani's plea for Aruna Shanbaug's euthanasia, the court laid out guidelines for passive euthanasia. According to these guidelines, passive euthanasia involves the withdrawing of treatment or food that would allow the patient to live105.

Ms Shanbaug has, however, changed forever India's approach to the contentious issue of euthanasia. The verdict on her case today allows passive euthanasia contingent upon circumstances. So other Indians can now argue in court for the right to withhold medical treatment - take a patient off a ventilator, for example, in the case of an irreversible coma. Today's judgement makes it clear that passive euthanasia will "only be allowed in cases where the person is in persistent vegetative state or terminally ill."

Recently in November 2007, a member of Indian parliament who belongs to the Communist Party of India introduced a bill to legalize euthanasia to the Lok

105 (Mishara, 1998)

Sabha, the lower house of representatives in the Indian parliament. C.K. Chandrappan, a representative from Trichur, Kerala, introduced a Euthanasia Permission and Regulation Bill that would allow the legal killing of any patient who is bedridden or deemed incurable. The legislation would also permit any person who cannot carry out daily chores without assistance to be euthanized.

"If there is no hope of recovery for a patient, it is only humane to allow him to put an end to his pain and agony in a dignified manner," said Dr. B. K. Rao, chairman of Sir Ganga Ram Hospital in New Delhi. "If it is established that the treatment is proving to be futile, euthanasia is a practical option for lessening the miseryofpatients."

Euthanasia is totally different from suicide and homicide. Under the Indian penal code, attempt to commit suicide is punishable under section 309 of IPC and also abetment to suicide is punishable under section 306 of IPC. A person commits suicide for various reasons like marital discord, dejection of love, failure in the examination, unemployment etc. but in euthanasia these reasons are not present. Euthanasia means putting a person to painless death in case of incurable diseases or when life became purposeless or hopeless as a result of mental or physical handicap. It is also differs from homicide. In murder, the murderer has the intention to cause harm or cause death in his mind. But in euthanasia although there is an intention to cause death, such intention is in good faith. A doctor apply euthanasia when the patient, suffering from a terminal disease, is in an irremediable conditions or has no chance to recover or survival as he suffering from a painful life or the patient has been in coma for 20/30 years like Aruna Shanbaug.106

Therefore it is suggested that penal provision regarding attempts to commit suicide and abetment to suicide should be preserved in the interests of the society as a general rule but euthanasia (voluntary) should be permitted in certain circumstances as an exception to the general rule. Thus Indian Parliament should enact a law regarding euthanasia which enables a doctor to end the painful life of a patient suffering from an incurable disease with the consent of the patient.

106 (Kasimar, 1978)

Parliament should lay down some circumstances under which euthanasia will be lawful as bellow;

A) consent of the patient must be obtained.

B) Failure of all medical treatments or when the patient, suffering from a terminal disease, is in an irremediable conditions or has no chance to recover or survival as he suffering from a painful life or the patient has been in coma for 20/30years.
C) The economic or financial condition of the patient or his family is very low,

D) Intention of the doctor must not be to cause harm,

E) Proper safeguard must be taken to avoid abuse of it by doctors,

F) Any other circumstances relevant to the particular case

Thus, Euthanasia could be legalized, but the laws would have to be very stringent. Every case will have to be carefully monitored taking into consideration the point of views of the patient, the relatives and the doctors. But whether Indian society is mature enough to face this, as it is a matter of life and death, is yet to be seen.

If we carefully examine the opposition to the legalization of euthanasia, we can conclude that the most important point that the opponents raise is that it will lead to its misuse by the doctors. Thus, it is submitted that when a patient or his relatives can willingly put his life in the hands of the doctor trusting him, then why can't a doctor be given such discretion to decide what will be in favour of his patient. Another doubt that is often raised is that if the doctors will be given discretion to practice voluntary euthanasia then surely it will gradually lead to asking for involuntary or non-voluntary euthanasia. But it is humbly submitted that a separate legislation should be made allowing only voluntary euthanasia and not involuntary or non-voluntary euthanasia. As has already been pointed out107 earlier, we also have to keep in mind the limited medical facilities available in108 India and the number of patients. This question still lies open that who should be provided with those facilities; a terminally ill patient or to the patient who has fair

107 (Hume, 1929)
108 (Chin, 1999)

chances of recovery. As the patient himself out of his pain and agony is asking for death, doctor should not increasing that pain of his should allow euthanasia. It has been ruled in the Gian Kaur case that Article 21 does not include right to die by the Supreme Court. But one may try to read it as is evident in the rights of privacy, autonomy and self-determination, which is what has been done by the Courts of United State and England. Thus, we can see that as the said right has been included in the ambit of Article 21, so this can also be included in Article 21. This question was not raised in the case earlier. Again the point that remains unanswered is regarding the abuse of this right by the doctors. But relevant safeguards can be put on this right and thus its abuse can be avoided. One of the safeguards can be that a proper quasi-judicial authority having a proper knowledge in the medical field can be appointed to look into the request of the patient and the steps taken by the doctor. To make it more full proof some two or three assistant officials including one from the legal field can also be appointed. This will avoid any abuse of this right granted to the terminally ill patients. Here, we have to regard the painful situation in which the patient is and top priority should be lessening his pain. Now when we already know that he is anyways going to die today or tomorrow and he himself is asking for death, there is no point that he should be denied with this right of at least leading a life with minimum dignity and willingly. Otherwise his life will be no better in that situation. Thus, considering the financial and medical facilities also, the question still lies open that what will be better-allowing euthanasia or not allowing euthanasia.

7.3:JUDGEMENT

The Hon'ble Division Bench of the Supreme Court of India, comprising Justice Markandey Katju and Justice Gyan Sudha Mishra, delivered this historic judgment on March 7, 2011. The Court opined that based on the doctors' report and the definition of brain death under the Transplantation of Human Organs Act, 1994, Aruna was not brain dead. She could breathe without a support machine, had feelings and produced necessary stimulus. Though she is in a PVS, her condition was been stable. So, terminating her life was unjustified.

Further, the right to take decision on her behalf vested with the management and staff of KEM Hospital and not Pinki Virani. The life saving technique was the

mashed food, because of which she was surviving. The removal of life saving technique in this case would have meant not feeding her. The Indian law in no way advocated not giving food to a person. Removal of ventilators and discontinuation of food could not be equated. Allowing of euthanasia to Aruna would mean reversing the efforts taken by the nurses of KEM Hospital over the years.

Moreover, in furtherance of the parens patriae principle, the Court to prevent any misuse in the vested the power to determine the termination of life of person in the High Court. Thus, the Supreme Court allowed passive euthanasia in certain conditions, subject to the approval by the High Court following the due procedure. When an application for passive euthanasia 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. 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.

However, Aruna Shanbaug was denied euthanasia as the court opined that the matter was not fit for the same. If at any time in the future, the staff of KEM109 hospital or the management felt a need for the same, they could approach the High Court under the procedure prescribed.110

This case clarified the issues revolving around euthanasia and also laid down guidelines with regard to massive euthanasia. Alongside, the court also made a recommendation to repeal Section 309 of the Indian Penal Code. This case is a

109 (Mishara, 1998)
110 (Hume, 1929)

landmark case as it prescribed the procedure to be followed in an area that has not been legislated upon.

CONCLUSION& SUGGESTION

8.1:Conclusion

Arguments for or against active euthanasia that are based upon moral or religious beliefs are impossible to resolve on the basis of empirical facts or logical arguments; these arguments are related to cultural values and practices. However, values and practices can change over time. Some practices that were considered barbaric at one time in history have become acceptable in the twenty-first century. The practice of euthanasia, its legalization, and acceptance in various societies is also influenced by public debate and media reports. With the increased acceptance and legalization of euthanasia in different societies, researchers are gaining more information about the practice of euthanasia and its effects. One of the central issues in the acceptance of euthanasia is weighing society's obligations to provide an easier access to death against society's obligations to provide the means for diminishing pain and suffering among those who may want to die prematurely by euthanasia.

Euthanasia, in its many forms, is an inherent right that should not be infringed upon through its not being legalized. Euthanasia refers to choosing a dignified death, rather than one set for the individual, and in a slow and painful manner at that. When palliative care is no longer an option and treatment has failed time and again, the option to choose "the good death" should remain open at all times. Despite slight possibilities in a lack of responsible actions taken in the name of euthanasia, the act itself will always be a personal choice, based on the amount of suffering one will allow oneself to go through before one must give in. Euthanasia will always be in existence, now it is merely a choice of making it "acceptable" or "unacceptable" as far as the government is concerned. After all, whose life is it?.111

If we carefully examine the opposition to the legalization of euthanasia, we can conclude that the most important point that the opponents112 raise is that

111 (Chin, 1999)
112 (Kasimar, 1978)

it will lead to its misuse by the doctors. Thus, it is humbly submitted that when a patient or his relatives can willingly put his life in the hands of the doctor trusting him, then why can't a doctor be given such discretion to decide what will be in favour of his patient. Another doubt that is often raised is that if the doctors will be given discretion to practice voluntary euthanasia then surely it will gradually lead to asking for involuntary or non-voluntary euthanasia. But it is humbly submitted that a separate legislation should be made allowing only voluntary euthanasia and not involuntary or non-voluntary euthanasia. As has already been pointed out earlier, we also have to keep in mind the limited medical facilities available in India and the number of patients.

This question still lies open that who should be provided with those facilities; a terminally ill patient or to the patient who has fair chances of recovery. As the patient himself out of his pain and agony is asking for death, doctor should not increasing that pain of his should allow euthanasia. It has been ruled in the Gian Kaur case that Article 21 does not include right to die by the Supreme Court.

But one may try to read it as is evident in the rights of privacy, autonomy and self-determination, which is what has been done by the Courts of United State and England. Thus, we can see that as the said right has been included in the ambit of Article 21, so this can also be included in Article 21. This question was not raised in the case earlier. Again the point that remains unanswered is regarding the abuse of this right by the doctors. But relevant safeguards can be put on this right and thus its abuse can be avoided.

One of the safeguards can be that a proper quasi-judicial authority having a proper knowledge in the medical field can be appointed to look into the request of the patient and the steps taken by the doctor. To make it more foolproof some two or three assistant officials including one from the legal field can also be appointed. This will avoid any abuse of this right granted to the terminally ill patients. Here, we have to regard the painful situation in which the patient is and top priority should be lessening his pain. Now when we already know that he is anyways going to die today or tomorrow and he himself is asking for death, there is no point that he should be denied with this right of at least leading a life with minimum dignity and willingly. Otherwise his life will be no better in that

situation. Thus, considering the financial and medical facilities also, the question still lies open that what will be better-allowing euthanasia or not allowing euthanasia.

8.2:Suggestion

The biggest debate in India in the coming weeks will be over the legality of euthanasia (mercy killing). Some argue that it should be made legal in India while some argue that making it legal will lead to biased decisions on the lives of unfortunate individuals, who in most cases will not have an opinion of their own. Some people oppose it as they are totally against any form of taking lives.

I see a point in all these arguments. While taking one's life is not desirable (although medically assisted), at least in some cases I have felt the need for an intervention for the good of the patients and their relatives. In a corrupt country such as India, all kinds of manipulations and foul plays can happen in any system. So before considering to making it legal, it is of paramount importance to consider the legal, medical, and social aspects of euthanasia.

In my opinion, euthanasia should be allowed legally in India subject to certain clauses. The clauses are needed to arrive at a practice that is safe and free from the possibility of manipulation. First, the patient should be suffering from an extremely bad, rare, painful, or unconscious condition which is incurable. Second, at least three specialist hospitals should certify that the condition of the patient is irrevocable and that the patient cannot live (or return to) a normal life. It goes without saying that the doctors judging the health condition of the patient should have adequate experience and reputation. Third, the referred case should be studied by an executive committee constituted by experts from the Indian Medical Association, National Human Rights Commission, National Commission for Women, and at least one retired judge of the Supreme Court. The committee should consider aspects such as the patient's age, family, social status, legal and financial commitments, and health condition, and recommend whether[113] to

113 (Hume, 1929)

grant euthanasia or not. All these should come under the union ministry of law and justice. 114

114 (Mishara, 1998)

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