ISSN: 0975-833X

Available online at http://www.journalcra.com

International Journal of Current Research
Vol. 9, Issue, 07, pp.55194-55198, July, 2017

INTERNATIONAL JOURNAL OF CURRENT RESEARCH

RESEARCH ARTICLE

EUTHANASIA: LEGAL ANALYSIS

***Mudit Bohara, A.**

Saveetha School of Law, Saveetha University, Chennai-600077

ARTICLE INFO

Article History:
Received 22nd April, 2017
Received in revised form
15th May, 2017
Accepted 26th June, 2017
Published online 31st July, 2017

Key words:

Euthanasia, PAS.

ABSTRACT

In our society, the analgesic care and quality of life issues in patients with fatal illnesses like advanced cancer and AIDS have become an important concern for clinicians. Similar to this concern has arisen another controversial issue-euthanasia or "mercy –killing" of terminally ill patients. Proponents of physician-assisted suicide (PAS) feel that an individual's right to independence automatically entitles him to choose a painless death. The opponents feel that a physician's role in the death of an individual violates the central precept of the medical profession. Moreover, undiagnosed sadness and possibility of social 'coercion' in people asking for euthanasia put a further question mark on the ethical principles underlying such an act. These concerns have led to strict guidelines for implementing PAS. Evaluation of the mental state of the person consenting to PAS becomes mandatory and here, the role of the psychiatrist becomes essential. Although considered illegal in our country, PAS has several advocates in the form of voluntary organizations like "death with dignity" foundation. This has got a stimulus in the recent Hon'ble Supreme Court of India Judgment in the ArunaShaunbag case. What remains to be seen is how long it takes before this sensitive issue rattles the Indian legislature.

Citation: Mudit Bohara, A. 2017. "Euthanasia: Legal analysis", *International Journal of Current Research*, 9, (07), 55194-55198.

INTRODUCTION

The phenomenal advances in medical science and technology have not been without a significant impact on society. They have brought into front issues that are altering the pattern of human living and societal values. Paripassu with these changes is the increase of affirmation of human rights, autonomy, and freedom of choice. These issues compel us to reconsider our concepts of societal and medical ethics and value systems. Amongst these issues, the analgesic care and quality of life issues in patients with fatal illnesses like advanced cancer and acquired immune deficiency syndrome (AIDS) have become an important area of clinical care and investigation. Important progress has been made in extending a palliative care/quality of life research agenda to the clinical problems of patients with cancer, including efforts that focus on mental health related issues such as Neuropsychiatric syndromes and psychological symptoms in patients with lethal medical illness. However, perhaps the most compelling and clinically relevant mental health issues in analgesic care today concern the desire for death and physician-assisted suicide (PAS) and their relationship to depression. The wish for death has been assumed as a construct that is central to a number of related issues or phenomenon, including suicide and suicidal ideation, interest in PAS/euthanasia, and request for PAS/euthanasia.

Corresponding author: **Mudit Bohara, A.**
Saveetha School of Law, Saveetha University, Chennai-600077

This construct, which was initially proposed by Brown and colleagues[1] and further developed by Chochinov et al. [2] focuses on the degree to which an individual wishes his or her life could end sooner. It ranges from suicidal aim (i.e., a desire to end one's life immediately) to a complete absence of any desire to die. Advocates demanding independence for patients regarding how and when they die have been increasingly voiced during recent years, sparked by the highly publicized cases of Drs Jack Kevorkian, Timothy Quill, and ArunaShanbaug. These cases have centered on the plight of dying patients with incurable illnesses. What has often been overlooked, however, in the political and legal intrigues, is the importance of medical, social, and psychological factors (e.g., depression) that may contribute to suicidal ideation, desire for hastened death, or requests for PAS by fatally ill patients.

Definition of Euthanasia and PAS

The English philosopher Sir Francis Bacon coined the phrase "euthanasia" early in the 17th century. Euthanasia is derived from the Greek word eu, meaning "good" and thantos meaning "death," and early on signified a "good" or "easy" death[3].

[1] Brown JH, Henteleff P, Barakat S. Is it normal for terminally ill patients to desire death? Am J Psychiatry. 1986;143:208–11. [PubMed]
[2] Chochinov HM, Wilson KG, Enns M. Prevalence of depression in the terminally ill: Effects of diagnostic criteria and symptom threshold judgments. Am J Psychiatry. 1994;151:537–40. [PubMed]
[3] Nadeau R. Gentles, Euthanasia and Assisted Suicide: The Current Debate. Toronto: Stoddart Publishing Co. Limited; 1995. Charting the Legal

Euthanasia is defined as the administration of a toxic agent by another person to a patient for the purpose of releasing the patient's unbearable and incurable suffering.[4] Typically, the physician's motive is sympathetic and intended to end suffering. Euthanasia is performed by physicians and has been further defined as "active" or "passive." Active euthanasia refers to a physician deliberately acting in a way to end a patient's life. Passive euthanasia pertains to preserve or withdrawing treatment necessary to maintain life. There are three types of active euthanasia. Voluntary euthanasia is one form of active euthanasia which is performed at the request of the patient. Involuntary euthanasia, also known as "mercy killing," involves taking the life of a patient who has not requested for it, with the intent of relieving his pain and suffering. In non-voluntary euthanasia, the process is carried out even though the patient is not in a position to give consent.[5] PAS, on the other hand, involves a physician providing medications or advice to enable the patient to end his or her own life. While hypothetical and/or ethical distinctions between euthanasia and PAS may be delicate to some, the practical distinctions may be significant. Many terminally ill patients have access to potentially lethal medications, at times even upon request from their physicians, yet do not use these medications to end their own lives.

Both euthanasia and PAS have been distinguished, legally and ethically, from the administration of high-dose pain medication meant to relieve a patient's pain that may accelerate death (often referred to as the rule of double effect) or even the withdrawal of life support.[6] The distinction between euthanasia/PAS and the administration of high-dose pain medications that may hasten death is premised on the intent behind the act.[7] In euthanasia/PAS, the intent is to end the patient's life, while in the administration of pain medications that may also hasten death; the intent is to relieve suffering.

Arguments supporting legalization of PAS/Euthanasia

Regarding euthanasia, at the present juncture, the debate largely revolves around active euthanasia and not passive euthanasia. Supporters of euthanasia argue that society is obliged to acknowledge the rights of patients and to respect the decisions of those who choose euthanasia. It is argued that euthanasia respects the individual's right to self-determination or his right of privacy. Interference with that right can only be justified if it is to protect essential social values, which is not the case where patients suffering unbearably at the end of their lives request euthanasia when no alternatives exist. Not allowing euthanasia would come down to forcing people to suffer against their will, which would be cruel and a negation of their human rights and dignity. Every person has a right to live with at least a minimum dignity and when the state of his existence falls below even that minimum level then he must be allowed to end such tortuous existence. In such cases relief from suffering (rather than preserving life) should be the primary objective of health-care providers. Supporters of active euthanasia contend that since society has acknowledged a patient's right to passive euthanasia (for example, by legally recognizing refusal of life-sustaining treatment), active euthanasia should similarly be permitted. When arguing on behalf of legalizing active euthanasia, proponents emphasize circumstances in which a condition has become overwhelmingly burdensome for the patient, pain management for the patient is inadequate, and only death seems capable of bringing relief. Moreover, in light of the increasing pressure on hospital and medical facilities, it is argued that the same facilities should be used for the benefit of other patients who have a better chance of recovery and to whom the said facilities would be of greater value. Thus, the argument runs, when one has to choose between a patient beyond recovery and one who may be saved, the latter should be preferred as the former will die in any case. It is not the case of the supporters of euthanasia that this right is not capable of exploitation. Rather they point out that almost any individual freedom involves some risk of abuse and argue that such risks can be kept to a minimum by using proper legal safeguards. Furthermore, merely because the risk of abuse of a right exists is no reason to deny a person the right itself.[8]

Arguments against legalizing Euthanasia

The debate over active euthanasia remains intense, in part because of opposition from religious groups and many members of the legal and medical professions. Opponents of euthanasia treat it as a euphemism for murder and maintain that euthanasia is not the right to die but the right to kill. They accentuate that health-care providers have professional obligations that forbid killing and maintain that euthanasia is inconsistent with the roles of nursing, caregiving, and healing. Instead with the promptly advancing medical science it is very much possible that those ill today may be healed tomorrow. Hence, the society has no right to kill them today and thereby deny them the chance of future recovery. Further, it is not always that the patient wants to die. The family of the patient are also allowed to decide whether to let the patient live. In addition, even where the consent is that of the patient it may be one obtained by force. Use of physical force here is very improbable. But emotional and psychological pressures could become uncontrollable for depressed or dependent people. If the choice of euthanasia is considered as good as a decision to receive care, many people will feel guilty for not choosing death. Moreover, monetary considerations, added to the concern about "being a burden," could serve as a prevailing force that would lead a person to "choose" euthanasia or assisted suicide.

Moreover, it is argued that when a healthy person is not allowed to commit suicide then why a diseased person should be allowed to do so. It is pointed out that suicide in a person who has been diagnosed with a terminal illness is no different than suicide for someone who is not considered terminally ill. Depression, family conflict, feelings of abandonment, hopelessness, etc. lead to suicide — regardless of one's physical condition. Studies have shown that if pain and depression are effectively treated in a dying person — as they would be in a suicidal non-dying person — the desire to commit suicide fades. Suicide among the terminally ill, like suicide among the population in general, is a tragic event that

Trends; p. 727

[4] Decisions near the end of life. Council on Ethical and Judicial Affairs: American Medical Association. JAMA. 1992;267:2229–33. [PubMed]

[5] Yount L. Physician-assisted suicide and euthanasia. New York: Facts On File, Inc; 2000.

[6] Emanuel EJ. Ethics of treatment: Palliative and terminal care. In: Holland J, editor. Psycho-oncology. New York: Oxford University Press; 1988. pp. 1096–111.

[7] When Death Is Sought: Assisted Suicide and Euthanasia in the Medical Context. New York: Health Research Inc; 1994. New York State Task Force on Life and the Law.

[8] http://www.ebc-india.com/lawyer/articles/592.html.

cuts short the life of the victim and leaves survivors overwhelmed. In addition, it is also frequently pointed out that the legislation relating to euthanasia is full of indefinite and unclear terms which allow the provisions to be easily misused. For example, the term "terminally ill" is not subject to a fixed definition. Even within the medical fraternity (let alone the legal community) there is dispute about who is a terminally ill patient and thus the category could cover a very wide range of patients.

Another favourite argument is that of the "slippery slope". The slippery slope argument, in short, is that authorizing voluntary euthanasia would over the years lead to a slide down the slippery slope and eventually we would end up authorizing even non-voluntary and involuntary euthanasia. The opponents of euthanasia point out the following two examples to display the working of the slippery slope:

1. In England, the House of Lords in *Airedale NHS Trust* v. *Bland*[9] permitted non-voluntary euthanasia in case of patients in a persistent vegetative state. Subsequently, the Supreme Court of Ireland in *Re A Ward of Court*[10] expanded the persistent vegetative state to include cases where the patient possessed limited cognitive faculties.
2. In Netherlands, the Supreme Court in a 1984 ruling had held that euthanasia could be lawful only in cases of physical illness. However, a decade down the line, the Supreme Court in *Chabot's case*held that it could even extend to cases of mental illness.[11]

Opponents also argue that authorizing physicians to engage in active euthanasia creates intolerable risks of misuse of the power over life and death. They admit that particular instances of active euthanasia may sometimes be morally justified. However, they maintain that sanctioning the practice of killing would, on balance, because more harm than benefit.

Attitude towards Hastened Death and PAS: Importance of Psychiatric Issues

Public interest has been spurred by media attention devoted to Drs. Kevorkian, Quill, ArunaShanbaug, and others, as well as legal decision, state referenda, and the growing availability of life-extending medical treatments. As a result, both the public and the medical community have openly debated moral issues relating to end-of-life options. While the US Supreme Court sustained the rights of individual states to prohibit PAS, its decision simultaneously opened the door for professionals to "experiment" with legalization of PAS [12] as has recently occurred in the state of Oregon.[13] Clearly, if PAS is legalized, mental health professionals must play an important role in the evaluation of patients at the end of life who request PAS[14]Despite the apparent importance of a mental professional's evaluation in assessing requests for PAS, little research has been conducted that has focused on the basis for patients′ interest in hastened death. In their study of physician response to request for PAS/euthanasia, Meier *et al*.[15] found that physicians required mental health consultation for only 2% of their patients who requested PAS or euthanasia. Furthermore, a study by Ganzini *et al*[16] indicated that only 6% of Oregon psychiatrists felt "confident" in their ability to assess whether a psychiatric disorder was impairing the judgment of a patient requesting PAS, despite overwhelming support from psychiatrists for legalization.

Reasons for seeking Hastened Death and PAS

A growing body of writings has emerged indicating the types of physical and psychological concerns that may give rise to a desire for hastened death and requests for PAS. Although this work has not always been dependable, a growing accord has supported many of the assumptions put forth by the initial advocates and opponents of legalization. Specifically, the issues that have received the broadest realistic support are pain, depression, social support, and cognitive dysfunction.

Hinduism- Suicide, Euthanasia and PAS

It has been pointed out that in Hinduism, the word for suicide, *atma-gatha*, has also the elements of intentionality.[17] The intention to voluntarily kill oneself for selfish motives was condemned in Hinduism. Subjectively, the evil sprang from a product of ignorance and passion; objectively, the evil embraced the karmic consequences which delayed the progress of liberation. It was in this context that the Dharmasutras vehemently prohibited suicide.[18] Nevertheless, Hinduism respected enlightened people who voluntarily decided their mode of death. Thus, the Pandavaspraised "Mahaparasthana" or the great journey through their Himalayan stopover when they walked in pilgrimage, thriving on air and water till they left their bodies one after another. Crawford[19] lists fasting, self-immolation, and drowning at holy places as other examples of such recognized deaths. Such deaths by rational persons have never been equated with the popular notion of suicide in the Indian tradition. It has been always considered that suicide increases the difficulties in subsequent lives. Can the Hindu stance as mentioned above be extended to the question of euthanasia? Here, the Indian attitude toward life and death needs special mention. In the Hindu tradition, death acts as a prefiguration and model, through which the ties that bind man's self or soul to cosmic evanescence can be completely broken and through which ultimate goals of immortality and freedom can be finally and definitely attained. [20]Crawford, considers "spiritual death" in the Indian context to be synonymous with a "good death," i.e., the individual must be in a state of calm and equipoise. Crawford inferences that to ensure such a noble death, the concept of active euthanasia would not be unacceptable to the Indian psyche. However, this

[9]*Airedale NHS Trust* v. *Bland*, (1993) 1 All ER 821.
[10](1995) 2 ILRM 401.
[11]John Keown, *Physician Assisted Suicide and the Dutch Supreme Court*, (1995) 111 *LQR* 394.
[12]Quill TE. Death and Dignity: Making choices and taking Charge. New York: WW Norton; 1993. pp. 156–7
[13]Oregon State Supreme Court. ORS127-885, 4.01
[14] Chochinov HM, Wilson KG. The euthanasia debate: Attitudes, practices and psychiatric considerations. Can J Psychiatry. 1995;40:593–602
[15]Meier DE, Emmons CA, Wallenstein S. A national survey of physician-assisted suicide and euthanasia in the United States. N Engl J Med. 1998;338:1193–201.
[16]Ganzini L, Fenn OS, Lee ML. Attitudes of Oregon psychiatrists toward physician-assisted suicide. Am J Psychiatry. 1996;153:1469–75.
[17]Young K. Euthanasia: Traditional Hindu views and the contemporary debate. Hindu ethics: Purity, abortion and euthanasia.
[18]Crawford SC. Dilemmas of life and death: Hindu ethics in a North American context. Albany, New York, USA: State University of New York Press; 1995. p. 113.
[19]Crawford SC. Dilemmas of life and death: Hindu ethics in a North American context. Albany, New York, USA: State University of New York Press; 1995. p. 113.
[20]Young K. Euthanasia: Traditional Hindu views and the contemporary debate. Hindu ethics: Purity, abortion and euthanasia.

view has been criticized by authors[21] who claim that "spiritual death" or "icchamrtu" can only be possible when the evolved soul chooses to abandon the body at will. It is also claimed that the evolving soul cannot be compared with mental tranquility as it is at a higher level of perception. Thus, though less inflexible than other religions, Hindus would traditionally remain skeptic in their view about euthanasia. It has been proposed that a strong objection to euthanasia might arise from the Indian concept of Ahimsa. However, even in the Gandhian framework of Ahimsa, violence that is inevitable is not considered as sin. This emphasizes flexibility of the Indian mind. Hence, though a little cynic, the Indian mind would not consider the thought of euthanasia and PAS as a violation.

The Indian Veracity

It can be argued that in a country where the basic human rights of individuals are often left unaddressed, illiteracy is widespread, more than half the population is not having access to filtered 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 extraneous. 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 removing 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.[22] 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 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 ArunaShaunbag, 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.[23]

Conclusion

Medical science is advancing in India as in whatever is left of the world, and henceforth as of now we are having devices that can draw out life by manufactured means. This may by implication draw out terminal enduring and may likewise end up being exorbitant for the groups of the subject being referred to. Consequently, end-of-life issues are getting to be noticeably major moral contemplations in the advanced medicinal science in India. The advocates and the rivals of willful extermination and PAS are as dynamic in India as in whatever is left of the world. Be that as it may, the Indian governing body does not appear to be delicate to these. The point of interest Supreme Court judgment has given a noteworthy lift to ace willful extermination activists however it is far to go under the steady gaze of it turns into a law in the parliament. Additionally, uncertainties for its abuse remain a noteworthy issue which should be inclined to under the watchful eye of it turns into a law in our nation.

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