Chapter-2
Euthanasia: Global and Indian Perspective

2.1 Introduction

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.
2.2 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.

2.2.1 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)\(^1\).

2.2.2 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 until I die." In the presence of his wife and doctor, he initiated the process that gave him a lethal drug injection². 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 August 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.
2.2.3 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 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 results of 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 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)\(^5\).

### 2.2.4 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. (Dick Sobsey, 1994)\(^6\).
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)\(^7\).

### 2.2.5 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, 1987.

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. 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)\textsuperscript{10}.

2.2.6 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 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)\textsuperscript{11}. To conclude, in Colombia a 1997 constitutional decision allowing euthanasia stands although no legislative follow up has taken place.

2.2.7 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).\textsuperscript{12}

\textbf{2.2.8 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)\textsuperscript{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.

\textbf{2.2.9 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)\(^{14}\).

"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, 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.
2.2.10 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).16

2.2.11 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 representing
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)\(^\text{17}\).

2.2.12 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. 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). It is worthwhile to mention that mercy killing legally forbidden in Italy.

2.2.13 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:

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)\(^\text{19}\).

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)\(^\text{20}\).
2.2.14 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)\textsuperscript{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.”

2.2.15 Luxembourg

The country’s parliament passed a bill legalizing euthanasia on 20\textsuperscript{th} February, 2008 in the first reading with 30 of 59 votes in favour. On 19\textsuperscript{th} March 2009, the bill passed the second reading, making Luxembourg the third European Union country, after the Netherlands and Belgium, to decriminalise euthanasia (Wikipedia, 2009)\textsuperscript{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)\textsuperscript{23}.

2.2.16 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 1\textsuperscript{st} 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 13\textsuperscript{th} April 2007 (Wikipedia, 2009)\textsuperscript{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.

\textbf{2.2.17 Netherlands}

According to Wikipedia the legal status of euthanasia and physician assisted suicide is as follows: \textit{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 patient's request for euthanasia must be voluntary and persist over time (the request cannot be granted when under the influence of others, psychological illness or drugs);
- The patient must be fully aware of his/her condition, prospects and options;
- There must be consultation with at least one other independent doctor who needs to confirm the conditions mentioned above;
The death must be carried out in a medically appropriate fashion by the doctor or patient, in which case the doctor must be present; and

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

The doctor must also report the cause of death to the municipal coroner in accordance with the relevant provisions of the Burial and Cremation Act. A regional review committee assesses whether a case of termination of life on request or assisted suicide complies with the due care criteria. Depending on its findings, the case will either be closed or, if the conditions are not met brought to the attention of the Public Prosecutor. Finally, the legislation offers an explicit recognition of the validity of a written declaration of will of the patient regarding euthanasia (a euthanasia directive). Such declarations can be used when a patient is in coma or otherwise unable to state if they wish to be euthanized.

Euthanasia remains a criminal offense in cases not meeting the law's specific conditions, with the exception of several situations that are not subject to the restrictions of the law at all, because they are considered normal medical practice:

- Stopping or not starting a medically useless (futile) treatment;
- Stopping or not starting a treatment at the patient's request; and
- Speeding up death as a side-effect of treatment necessary for alleviating serious suffering.

Euthanasia of children under the age of 12 remains technically illegal; however, Dr. Eduard Verhagen has documented several cases and, together with colleagues and prosecutors, has developed a protocol to be followed in those cases. Prosecutors will refrain from pressing charges if this Groningen Protocol is followed.
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 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).
- To monitor the process and be available to apply the combined procedure mentioned below, if necessary.

In two cases the doctor was reprimanded for not being present while the patient drank the potion. They said they had not realized that this was required. Forty-one cases were reported to combine the two procedures: usually in these cases the patient drinks the potion, but this does not cause death. After a few hours, or earlier in the case of vomiting, the muscle relaxant is administered to cause death. By far, most reported cases concerned cancer patients. Also, in most cases the procedure was applied at home.

A study in 2000 found that Dutch physicians who intend to provide assistance with suicide, sometimes end up administering a lethal medication themselves because of the patient’s inability to take the medication or because of problems with the completion of physician-assisted suicide. In February 2010 a citizens’ initiative called Out of Free Will further demanded that all Dutch people over 70 who feel tired of life should have
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)²⁵.

### 2.2.18 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)²⁶.

### 2.2.19 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)²⁷.

### 2.2.20 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 Rostov-on-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)

2.2.21 South 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*. 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 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)\textsuperscript{29}.

2.2.22 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. 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)\textsuperscript{30}.

2.2.23 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)\textsuperscript{31}.

**2.2.24 Switzerland**

Assisted suicide is not illegal in Switzerland and can have the involvement of non-doctors. 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)\textsuperscript{32}.

**2.2.22 Thailand**

Active euthanasia is illegal under Thai law. The National Health Act BE 2550 (2007), which into force on 20\textsuperscript{th} 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)\textsuperscript{33}.

**2.2.26 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 sanctity of life and respect for it. Euthanasia is legally forbidden in Turkey, 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, 1996).  

2.2.24 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). 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 intention is solely to alleviate pain, is not considered murder even if death is a potential or even likely outcome. (Margaret Otlowski, 1997).  

2.2.28 United States

The first instance of legal sanction 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 modern 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)\textsuperscript{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, dispensing physician) to also report to the Health Division (Death with Dignity Act, 1997)\textsuperscript{38}.
A similar act was passed in neighboring state of Washington in 2008. In Montana, a trial court affirmed the right to assisted suicide in 2008. The state Supreme Court confirmed this in 2009\(^3\). 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.

2.3 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.

2.3.1 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)\(^4\) 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 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 district Sikar of Rajasthan performed sati 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 now41.

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 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) 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 body” 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.\(^{43}\)

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 other 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 phenomenon. 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 fellow 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 vow45. 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.

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

2.3.2 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 character.

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 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 suffering (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 (1987)\textsuperscript{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)\textsuperscript{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 (R. K. Bansal, S. Das, P. Dayal, 2005)\textsuperscript{49}.

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)\textsuperscript{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:

(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-of-attorney 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 practitioner 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 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 thinks 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 writing the patient (if he is conscious), his parents or other relatives or guardian about the decision to withhold or withdraw such treatment in the patient’s best interests. 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 within 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 with prescribed procedure such medical practitioner is not debarred from administering palliative care.

(6) It is also to be noted that if a competent patient refuses medical treatment in circumstances mentioned above, 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.

(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 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)\textsuperscript{51} 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. 196\textsuperscript{th} and its recommendation for decriminalization of suicide report no. 210\textsuperscript{th}, 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)\textsuperscript{52} 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”.

Similarly, advocate Dhruv Desai (2008)\textsuperscript{53} 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 \textit{State of Maharashtra v. Maruti Shripati Dubal} \textsuperscript{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 \textit{P. Rathinam v. Union of India} \textsuperscript{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 \textit{Gian Kaur’s case} \textsuperscript{56}, that a five Judge Bench of the Supreme Court overruled \textit{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). 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”.

But any initiative for legalizing euthanasia and physician assisted suicide Tejshree M. Dusane (2009)57 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)58 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 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.

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.
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 in 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)\(^64\) 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 the issue of legalization of euthanasia in India duly supported with empirical evidences.

2.3 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 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 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.
Notes and References


42. VG Julia Rajan (1999) “Controversy: Better Off Dead?” *Hinduism Today*, 07th September,


45. Times of India (2011) “Voluntary Death has Religious Nod” Tuesday, 8th March, New Delhi, pp. 14.


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