CHAPTER 9
CONCLUSION AND SUGGESTIONS

Life is larger than the law. Law is the essence extracted from the life and reinstilled into it for its purposeful invigoration, but it does not wholly cover the life. Life is comprised of elements which often travel far beyond the terrain of law and it is probably impossible to imprison life within four walls of law. It may be vain to hope to modulate the life invariably on the legal pattern, though law ever endeavours to keep it on its rails. It is however only a half measure and that too not always pleasant, to try to tame the man into the cage of law as a device of his construction.¹

Taking human suffering seriously and eliminating it is the foundation of ‘modern’ Human Rights Jurisprudence.² We must give new seriousness to life, insist upon absolute perfection, enhance the worth and dignity of man and of each individual, and his strong desire for love and happiness, increase man’s sensitiveness to dark and woe.³

Respect for human dignity and worth is the most important feature of any political system.⁴ But why man claims dignity? Man is a special type of animal.⁵ He appears to have not only more intelligence that the other animals, but also special kind of intelligence. That shows that he and he alone exhibits a series of special characteristics. The most striking among them is the capability to think completely different from other animals and to differentiate between right and wrong.⁶ These specialities grant him a certain dignity and power, which raise him above all other living creatures. He is the one who is also (and as it appears, he alone) conscious of his limitations, and above all, of his death.⁷ Thus, dignity denotes a quality of being worthy or honourable⁸, and consists in man’s ability to experience self-awareness and to think rationally.⁹

⁶ Id., at 82.
⁷ Id., at 87.
There is a continuous development in the field of medicine, in terms of technology and skills. New drugs and vaccinations are being developed, blood component therapy, genetic experiments, newer investigation techniques and organ transplantation are being researched into and are evolving. However, these new developments have created new moral and ethical questions as well as legal problems.\textsuperscript{10}

The doctor-patient relationship has undergone a drastic change. Earlier, doctors occupied the highest pedestal in society and their advice was accepted unconditionally by patients. Today, however, the old adage ‘doctor knows the best’, is no longer valid. Patients often seek opinions of different doctors for the same problem and then decide the course of treatment themselves. Moreover, a difference of opinion among doctors regarding treatment of same medical problem often causes confusion in the mind of the patient.\textsuperscript{11} The past few decades have witnessed an increase in the commercialization of various sectors including medical services. Not too long ago, medical care was mainly provided free. Gradually, the concept changed into service for a fee and now for most medical professionals, the focus seems to be primarily on profit. The cost of medical services is very high in private hospitals, nursing homes, private clinics and diagnostic centres, which are managed like commercial establishments. Medical profession has become more of a business these days. This change has occurred at a very rapid pace in India particularly.\textsuperscript{12}

Respect for human dignity means high regard for the inherent and intrinsic value of human life and individual autonomy. At the end of life, it signifies that dying should be attended by such degree of dignity that reflects the quality of the life lived till that time. Hence, the ability to govern one’s own conduct according to self-formulated rules and values should be upheld and personal choices endorsed, enabling people to control their own destinies. Modern medicine has got a solution to this problem. It has developed the ability to maintain life in the face of intractable illness, often at the cost of prolonging the dying process. But, sophisticated new medical and psychotherapeutic technology can pose a threat to the physical and intellectual integrity of the individual, thereby

\textsuperscript{10}Tapas Kumar Koley, Medical Negligence and the Law in India, xxii (2010).
\textsuperscript{11}Id., at 3, 4.
\textsuperscript{12}Id., at 4.
minimising the degree of control and choice he has over his own life. For a person who seeks a dignified death, overriding autonomy by insisting on utilising every available therapy is inherently destructive of human dignity and can compromise his quality of life. When medical technology prolongs dying, it does not do so unobtrusively. It does so with needles, tubes, pain and discomfort, accompanied by the bright lights, noise, odours and loss of privacy associated with institutional caring. In this environment death represents the ultimate form of patient’s resistance, where natural death is that point at which he refuses any further input of treatment. In contrast, the opportunity to die without the intrusion of medical technology and before experiencing loss of independence and control, appears to many to extend the promise of a death with dignity. As a result, euthanasia and death with dignity have become so closely linked. Concerns about excessive treatment have generated much of the debate about euthanasia. Fuelled by the increasing longevity of the population and the further development of medical expertise, the euthanasia debate is therefore gaining momentum. Moreover, proponents of voluntary euthanasia argue that by taking control when death is inevitable and avoiding the futile excesses offered by medicine, greater dignity can be achieved. For some, the possibility of choosing an alternative to becoming dependent upon medical carers and burdensome to family is fundamental to dignity in this context. Preserving dignity through the avoidance of dependency and the maintenance of autonomy, is of greater significance to them than was relief from pain. However, for others, dignity may amount to relief from pain and agony. The concepts of autonomy, self-determination and control at the end of life are therefore, key factors in dealing with the concepts of euthanasia and dignity.

Death and dying are the elements of life over which human beings can exercise only limited control. Death itself is not an experience that can be recounted or shared with others, but dying is an observable phenomenon whose contemplation shapes peoples’ perceptions of their own lives and their expectations for their own demise. Fear of dying, fear of the possible mode of dying, fear of death itself are part of the human

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15 Id., at 146-149.
condition and the combining of these fears with new anxieties about the excesses of inappropriate medical care has fostered the convergence of euthanasia and death with dignity that is now well established in various cultures of the world. Furthermore, it has been acknowledged that individual choice and self-determination are central to this debate.17

In the context of dying, the word dignity signifies a sense of serenity and powerfulness, accompanied by qualities of composure, calmness, restraint, reserve, and emotions or passions subdued and securely controlled without being negated or dissolved.18

Therefore, right to die with dignity should be protected as a part and parcel of the right to life. State regulations that would force a dreadful, painful death on a rational but incapacitated terminally ill patient are a violation of human dignity. But at the same time, the state has an interest in the protection and preservation of life of its members and the avoidance of any devaluation of human life which might result from permitting lives to be deliberately terminated, thereby resulting into abuse.19 Paradoxically therefore, opponents of euthanasia also speak of the centrality of dignity in dying but contend that there are alternative, more dignified, methods of achieving the same goal. In much the same way that euthanasia is preferred by its supporters as an alternative to traditional western medicine at the end of life, so the ‘good death’ ideal is revered by many ancient and eastern religions. As discussed in previous chapters, Buddhism, Jainism, and Hinduism, in particular, embrace the concept of the ‘good death’ as a means of achieving dignity and spiritual fulfilment at the end of life without resorting to artificially shortening its span. The modern hospice movement, founded in Britain, espouses a similar philosophy which emanates from a rather different environment.20

9.1 The Hospice Movement

The network of hospices was established by Dame Cicely Saunders in 1967 after an inspiring encounter with a terminally ill cancer patient. The patient shared Cicely

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20 Id., at 151-155.
Saunders’ vision of a caring environment for the dying and left £500 in his will so that
she could begin fund-raising to transform the vision into a reality. There are now in
excess of 200 hospices around the country, approximately 20 of which are dedicated to
the care of children. The hospice philosophy aims to provide a holistic approach to
terminal care in response to the depersonalisation of traditional medical techniques. They
treat total pain with total care in order to overcome the physical and psychological trauma
of terminal and incurable disease. Dying patients, and their families are treated as
individuals whose particular needs are related to their terminal condition rather than
simply as the recipients of symptomatic therapy. A positive attitude to the dying process
is encouraged.21

Cicely Saunders explains it thus:

To talk of accepting death when its approach has become
inevitable is not a mere resignation or feeble submission on
the part of the patient, nor is it defeatism or neglect on the
part of the doctor. For both of them it is the very opposite
of doing nothing. Our work . . . is to alter the character of
this inevitable process so that it is not seen as a defeat of
living but as a positive achievement in dying; an intensely
individual achievement for the patient.22

The development of the specialism of palliative medicine is directly attributable to the
hospice movement and hospices continue to carry out extensive research in the field of
palliative care and the relief of pain. Advocates of the hospice ideal are vociferous in
their defence of good palliative care for relief of the pain and distress associated with
terminal illness. Such therapy is invaluable in assuaging distressing symptoms and is
strongly defended as a means of achieving a good death, and as an alternative to
euthanasia.23

Research however indicates that the good death ideals of the hospice movement are
beginning to be subverted by its institutionalisation and the consequent encroachment of

22 Ibid.
23 Id., at 155.
mainstream medicine. The infiltration of hospice care by medical technology emphasising treatment and cure may result in failure to achieve the good death that those who advocate palliative care as an alternative to euthanasia seek. The methods employed by conventional medicine to give symptomatic control of pain usually involve sedation, and require a level of compliance which necessarily negates the patient’s control and choice. The intrusion of medical technology into terminal care is precisely what those pursuing death with dignity wish to escape and explains why some consider euthanasia to be an appropriate alternative. Were euthanasia to become a legitimate option, it should ideally be available in an environment where palliative care options could be exhausted first, not as an alternative to good palliative treatment. The current hospice philosophy, which denies that there might be a place for euthanasia, appears to preclude such an option. Against this, and despite the close association between euthanasia and death with

N James, D Field, “The Routinisation of Hospice: Chrisma and Bureaucratisation”, (1992) 34 Social Science and Medicine 1363–1371. Until recently in Britain hospices have been run on a voluntary basis with minimal Governmental financial support. Even now, when they receive around 40,000 new patients a year and support approximately 56,000 in patient admissions, approximately 95 per cent of their funding is received from charitable donations and voluntary organisations. They offer terminal and respite care to those suffering from cancer, motor neurone disease and recently AIDS but hospice care is not universally available to terminally ill and incurable patients. People dying from a range of commonplace diseases like, multiple sclerosis and chronic heart or lung disease have until very recently not been eligible. Moreover, the availability of hospice places is constrained geographically because not all eligible patients reside in the immediate vicinity of a hospice. The provision of hospice care may offer death with dignity to its recipients, but its limited availability means that it is unable to negate the need for euthanasia felt by many people suffering from terminal and incurable illness. And, even if a perfect service existed there would still be those who would prefer to opt for a quick, or immediate death, rather than palliation of symptoms. B Farsides, “Palliative Care—a Euthanasia Free Zone?” (1998) 24 Journal of Medical Ethics 149–50 at 150. Furthermore, the nature of the hospice movement is changing as it is incorporated into mainstream medical services. The need for accountability and standardisation of care and services that has accompanied the growth of consumerism within health care and society in general has inevitably brought changes. Nicky James considers the implications of these changes at length. With growing professionalism comes careerism and professional development. Inevitable though these may be, they bring about a change in emphasis. The early hospice pioneers who believed in the importance of their mission took it up without any assurances for their futures. These pioneers are being, and will be replaced by those who, albeit committed to their specialist discipline, work in a now established specialism and look for peer credibility and recognition in pay, status research and career prospects. Traditionally the biomedical system emphasises the physical. Hospice services which initially strived for a balance of ‘total care’ may observe the primacy of physical interventions re-emerge. N James, “From Vision to System: the Maturing of the Hospice Movement”, in R Lee, D Morgan, Death Rites: Law and Ethics at the End of Life (London, Routledge, 1994) 102–130, at 117, 123. Similar concerns have long been expressed about the hospice movement in North America. E. K. Able, “The Hospice Movement: Institutionalising Innovation” (1986)16 International Journal of Health Services 71. Id., at 156-157.
dignity, the hospice movement is presently applauded for providing dignity in dying without deliberately ending life, that is, as an alternative to euthanasia.\textsuperscript{25}

That dignity can be applied with equal effect on either side of the euthanasia debate demonstrates the fluidity of the concept and how nebulous it can be in application. But, whether or not euthanasia can provide a dignified death requires a multifaceted analysis that depends largely on how euthanasia is performed in practice, both within present legal constraints and under any potential legal reforms.\textsuperscript{26} Yet, the debate is incomplete and inconclusive if this is the exclusive focus because the dignity of those who are, or might be, instrumental in performing euthanasia, and the wider implications for the dignity of society as a whole are also of great significance. Evidently some communities, notably Buddhists, Hindus and Jains, and many within contemporary society, favour different methods of attaining dignity in dying and consider euthanasia an insult to human dignity. But, as the discussion of the hospice ideal demonstrates, these too may provide an inadequate response to the perceived need for dignity in dying. The societal failure to endorse euthanasia as a legitimate option may be regarded as destructive of human dignity for those who want it, but if it were permitted, preserving the dignity of some may be achieved only by compromising the dignity of others, most notably carers who perform euthanasia.\textsuperscript{27}

For a person who seeks relief from the anguish of terminal or incurable disease active voluntary euthanasia may appear to be the most appropriate means of achieving death with dignity. A decision to this effect may be rational, reasoned and appear entirely appropriate in the circumstances. Thus, those caring for this patient are faced with a dilemma: how to respect the patient’s rational autonomous decision to die with dignity, without violating the law? Emotionally euthanasia might appear the best mechanism for achieving dignity in dying, and not only to the patient. Reason and emotion are both significant in treatment decisions, especially at the end of life where compassion is a natural response to appeals made on the basis of stifled self-determination.\textsuperscript{28}

\textsuperscript{25} Id., at 157.
\textsuperscript{26} Ibid.
\textsuperscript{27} Id., at 158.
\textsuperscript{28} Id., at 159.
While those who do find the courage to act suffer indignities associated with criminal and perhaps professional sanction, other carers may suffer the indignity of guilt, self-reproach, and remorse because they are unwilling or unable to perform the ultimate act of compassion. When a loved one or a respected patient professes to prefer the solace of euthanasia to enduring dependence, those who are unable to assist may suffer emotional turmoil which is destructive of their own dignity. Euthanasia is seen by many as an immoral act which is an affront to the sanctity of life and humanity. The fact that it is also an illegal act prevents many professional and emotional carers from performing it even if they perceive it as a compassionate and otherwise appropriate response.

Unlike active euthanasia, which exposes its practitioners to the potential indignity of criminal prosecution and sanction, passive euthanasia through selective non-treatment, can appear to preserve the dignity of the practitioner but perhaps at the expense of the patient’s dignity. To avoid a Hobson’s choice between the two some would argue that a death that results from double effect may be more dignified for all concerned. Hunt discusses the practice in the following terms:

The administration of sedatives for refractory symptoms and distress is common practice in terminal care. . . . It should be made clear that the treatment is likely to hasten death, the patient is less able to eat, drink, interact, mobilise, cough to clear secretions, and is prone to infections. . . . Terminal sedation which hastens death can be justified using the principle of double effect, or it can be regarded as slow euthanasia.

But to use double effect to legitimate a treatment regime whose predicted outcome is death, is to imply that the effects are not purely incidental or anticipated, they are desired, purposeful and therefore intended. Should a criminal prosecution be brought against a doctor in these circumstances she may confront not only the indignity of a

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29 Id., at 160.
30 Id., at 161.
31 Id., at 162.
criminal prosecution and trial but also a conviction for murder or manslaughter. Some of these indignities might be avoided if the law were reformed to permit voluntary euthanasia. Yet legal reform would also need to guard against other indignities and potential abuses in order to protect those who may fall victim to non-voluntary euthanasia in the guise of mercy killing. Relaxing the law too far in favour of euthanasia in order to protect practitioners might result in inadequate protection for vulnerable people and death with dignity would be equally illusive. Nevertheless the current legal approach to euthanasia serves nobody well, leaving many patients suffering against their expressed wishes and criminalizing those who provide assistance in disregard of the law.

Recent years have witnessed the further advancement of biotechnology and it seems clear that modern medicine’s technical success at maintaining life increasingly results in no more than prolonging death. Concerns about medicine’s ability to keep people alive inappropriately have been voiced as a result. The level of interest in advance directives in various countries demonstrates that most people would prefer not to be kept alive if they know they have no prospect of regaining their cognitive humanity. When faced with the reality of situations like this, most carers generally espouse similar sentiments, regarding the indefinite continuation of futile physical life as undignified. Doctors too appear apprehensive about merely postponing death in the face of terminal or incurable illnesses. Consequently, the law is frequently being called upon to reinterpret the boundaries between life and death.

Human dignity is challenging medical science in the courts, and in many countries (including India recently) the courts have consistently endorsed the primacy of dignity over rigid legalistic interpretation and allowed life to be terminated. Yet achieving the desired outcome has often required all the sophistry and sleight of hand the courts could muster. Creative manipulation of concepts like double effect and best interests has been required in order to tailor accepted legal arguments to unacceptable medical situations. In turn this has led to the incongruous position where those who can no longer experience pain or any kind of suffering, and cannot speak for themselves, now or in the future, are legitimately allowed to die, while those who actively court death to relieve their
continuing torment are not permitted the relief they desire. Aside from the well-known objections from those who advance arguments promoting the right to life in all circumstances, or others who fear a slippery slope to eugenics, public sympathy appears to support the outcomes of the Persistent Vegetative State cases. Scant attention is paid to the implications of how death will occur following the withdrawal of treatment.36

The ability to exercise choice, has been established as central to the concept of death with dignity, but the limitations on available choice in the current legal climate reveals a need for legal reform in favour of euthanasia. The shape and extent of any reform is largely dependent upon how euthanasia is defined and, what kind of conduct is accepted as proper medical care rather than clinical killing.37 As dying becomes more medicalised than ever, people continue to conflate euthanasia and death with dignity, resulting in a perceived need for permissive reform. The preservation of dignity through autonomous choice has in recent years been the stimulus for much interest in living wills, or advance directives in many countries. As a result, some jurisdictions have introduced legislation supporting the use of advance directives or living wills, confirming their legitimacy.38

Increased use of advance directives would certainly facilitate easier and more reliable terminal decision-making, especially where selective non-treatment or passive euthanasia was being considered, but they would be of little benefit to those who retain competence. The actions of clinicians accused of homicide following treatment withdrawal or double effect might be legitimated if the presentation of a valid living will were able to provide evidence of a patient’s intentions prior to becoming incapacitated, but no advance directive can sanction deliberate acts that lead to death. Perhaps more

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36 Ibid.
37 Id., at 166.
38 In Britain, living wills have been discussed in a number of cases, (Airedale NHS Trust v. Bland [1993] 1 All ER 821, Re T (Adult: Refusal of Treatment) [1993] Fam 95, Re C (Adult Refusal of Treatment) [1994] 1 WLR 290) prompting the Law Commission to give careful consideration to their use in specific medical circumstances. Comprehensive recommendations have subsequently been made with regard to their potential operation and legal status. Law Commission Report 231, Mental Incapacity: Item 9 of the Fourth Programme of Law Reform: Mentally Incapacitated Adults (London, HMSO, 1995) at paras 5.1-5.39. Additionally, a Code of Practice has been formulated by the British Medical Association and the Royal College of Nursing, advising medical practitioners how to respond to patients with advance directives. The possibility of legislative intervention supporting the use of living wills has also been mooted however, with an opinion poll conducted in 1998 demonstrating a high level of public support for the potential enactment of legislation to give living wills the binding force of law. See C Dyer, “UK Public Calls for Legislation over Living Wills” (1998) 316 BMJ 9551. Cited in Ibid.
pressing then, is the need to safeguard the interests of those who still have capacity and seek voluntary euthanasia, while simultaneously protecting the medical professionals who assist them from criminal sanction. However, it is clear that without effective safeguards people who might already be vulnerable to abuse could be placed in greater jeopardy if the law were relaxed too far in favour of euthanasia. Opponents of euthanasia argue that no legislative framework could provide sufficient protection to save the vulnerable from abuse, or society from a decline into moral decay. For Cicely Saunders, concerns focus more on the dangers that particular groups within society might be exposed to if voluntary euthanasia were permitted and she argues that:

To make voluntary euthanasia lawful would be an irresponsible act, hindering help, pressuring the vulnerable, abrogating our true respect and responsibility to the frail and old, the disabled and the dying.

Regardless of the apparent dangers however, the need for dignity in dying continues to be expressed through the demands of patients for greater autonomy to select the time and method of dying. While the arguments for and against the legalisation of euthanasia are polarised on the basis of religion, ethics and politics, dignity in dying remains inexplicably linked with euthanasia in the public consciousness. Physical pain constitutes just one factor in the equation, with emotional pain assuming greater significance for those who wish to avoid dependence and therefore pursue death with dignity through euthanasia.

Alan Norrie has considered the limitations on the ability of the criminal justice system to deliver justice generally. He argues that the theoretical basis of the criminal justice system and the practicalities of modern life have diverged in such a way that the accepted rationale that crime deserves punishment may not always be legitimate. It may not always be appropriate simply to apportion blame and allocate punishment to the individuals involved in criminal conduct. Norrie argues that society as a whole may be required to shoulder some of the responsibility through what he describes as “relational...

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39 Id., at 167.
41 Ibid.
justice", where the social, moral and political context of the conduct in question is considered alongside its criminal definition. This conception of justice involves a sense of the particularity of human life, a sense of social engagement, and a sense of responsibility that is contextualised both in terms of looking at the wrongdoer’s past acts and their provenance, and to his relationship with a community that includes his victim.42 Thus, according to him euthanasia presents a perfect example of conduct that is decontextualised by the law in this way in some countries, and demonstrates the hesitance with which the law reflects and responds to the moral and political contexts within which changes in social attitudes occur.43

Recent technological advances have provided a context within which many ordinary people are calling for legal reform because they fear that they may be robbed of their autonomy and dignity as their lives draw to an end. In an age when people value their independence and strive to live independent and fulfilled lives it is important that life ends appropriately, that death keeps faith with the way we want to have lived.44 Here, Ronald Dworkin observes that death is not only the start of nothing but the end of everything and therefore, it should be accomplished in a manner compatible with the ideals sought during life. In many respects his interpretation reflects the good death ideal of the religious philosophies and those of the founders of the hospice movement (discussed earlier). Both are contrary to the kind of death often achieved through the practice of modern medicine and within the law, yet Dworkin’s proposals for immediate resolutions are more in accord with those of Derek Humphry and The Voluntary Euthanasia Society than with Buddhism and the Christian tradition of the hospice movement. A quick and certain death may be more dignified than a slow lingering one. The tensions inherent in Dworkin’s approach are also visible in society more generally, causing James to marvel at the fact that these quite distinct approaches have developed simultaneously. In his view,

It will be interesting to see how history interprets the morality of a society in which two contrasting groups, each

43 Ibid.
44 Id., at 179.
with deeply committed views on human dignity, develop in parallel.\(^{45}\)

Perhaps this diversity of opinions and approaches is due to the complex relationship between dignity and dying, which cannot be explained simply in terms of medical care or symptomatic relief. The dignity debate revolves around questions of how, where and when to die as much as to die or not to die. People fear a slow lingering death because such a death tends to be associated with a gradual loss of control and dignity. So some will respond by wishing for an immediate release in an effort to retain their dignity, while others consider the process of dying over an extended period of time as providing, “a chance to be able to come to terms with dying and with yourself, and other people, to sort things out in your life over a period of time; to round off your life”.\(^{46}\) Both may be dignity enhancing.\(^{47}\)

Of course, if euthanasia were available one could make dignified plans about the time and place of dying in advance, which in itself might facilitate the opportunity to make financial and emotional preparations for the inevitable death, as well as avoiding unwelcome suffering. Equally, one might find solace and dignity in resisting euthanasia, preferring to exercise choice by living every moment that life offers. It is the fluidity of the concept of human dignity that enables the hospice movement and the pro-euthanasia lobby to share the common goal of avoiding pointless pain and suffering at the end of life. The solutions they offer remain poles apart however, and euthanasia remains an intractable problem which apparently defies social or legal resolution. The need for individual dignity in dying is strongly felt within society but can be achieved in vastly different ways, depending on the medical, religious and philosophical imperatives of those concerned.\(^{48}\) Individualistic solutions however focus on the needs of the dying, often to the detriment of others who share the experience.\(^{49}\)

Sampaio concludes that whether or not euthanasia will ultimately gain legitimacy is likely to be determined mainly by economic imperatives. For him, in the industrialized

\(^{45}\) N. James, “From Vision to a System: the Maturing of the Hospice Movement”, in R. Lee and D. Morgan, Death Rites: Law and Ethics at the End of Life, 102-130 at 125 (1994).
\(^{47}\) Supra note 15 at 171.
\(^{48}\) Ibid.
\(^{49}\) Ibid.
part of the world there is the danger that as the economic problems worsen the powers that be might undergo an overnight ‘conversion’ and encourage the death of those who are not economically productive.\(^5\) Such a conversion is, he believes, likely to be informed by the kind of arguments made here and based upon notions of enhancing the dignity of the dying and protecting those who help others to die, but have a more sinister hidden agenda. With escalating costs placing market pressures on over extended healthcare services this concern is only too valid. Euthanasia could become a method of resource-led population control, in much the same way as infanticide has been practised in various societies throughout the ages.\(^5\)

Furthermore, Cicely Saunders is right in her assessment that the impact may well be greater on some groups within society than others. Life expectancy has increased and the numbers of people suffering disabling, chronic, and terminal disease is inevitably rising as the population ages. Cuts in welfare impact crucially upon the elderly who are now required to provide for more of their own care, either through contributions during their working lives or by the clawing back of their accumulated assets. The indignity of dependence coupled with the perceived financial burden to family and the state may be sufficient to encourage “the frail and old, the disabled and the dying” to consider euthanasia as an alternative.\(^5\)

If active euthanasia were to be permitted as a right, what is to prevent the endorsement of this right being translated into a social duty? How long will it be before those who seek euthanasia in order to avoid being a burden lose the right to continue living until the natural end of their lives? Despite these valid concerns the pressure to relax the law and permit euthanasia for individuals remains, while the ability of medicine to maintain life beyond what many perceive to be dignified bounds raises questions that go to the root of defining what kinds of human behaviour ought to be criminalised.\(^5\)

Killing is rightly proscribed but voluntary euthanasia may be slipping beyond the scope of the criminal law if society’s morality is no longer opposed to its practice. Yet

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2. Ibid.
3. Id., at 172-173.
4. For a discussion of some of the tensions present when one conduct is either criminal or legitimate depending on the context, see Jean Davies, “Raping and Making Love are Different Concepts; so are Killing and Euthanasia” (1988) 14 Journal of Medical Ethics 148–9. Cited in Id., at 173.
the law needs to protect the vulnerable at the same time as enabling the dying to exercise their autonomy through euthanasia.54

But Yale Kamisar objected not only to hazards of abuse accompanying legalized hastenings of death, but also to eventual extensions of right to die to "far more objectionable practices." Kamisar primarily feared extension of physician assisted suicide to non-voluntary euthanasia (for patients who were not competent to make their own medical decisions) and to involuntary euthanasia (contrary to a competent patient's wishes or to the wishes of a surrogate representing a mentally incompetent patient). He cited the not-so-remote experience of Nazi Germany where the medical establishment had been enlisted in the performance of involuntary euthanasia first upon disabled citizens and later upon disfavored ethnic and political groups. Kamisar re-entered the fray and predicted that the purported boundaries would never hold up.55 Moreover, he also demonstrates how hastening of death may extend from terminally ill to chronically ill and from chronically ill to existentially unhappy.56 However, according to Peter Singer, there is little historical evidence to suggest that a permissive attitude towards the killing of one category of human beings leads to a breakdown of restrictions against killing other humans. For example, ancient Greeks regularly killed or exposed infants, but appear to have been at least as scrupulous about taking the lives of their fellow citizens. Similarly, in traditional Eskimo societies, it was the custom for a man to kill his elderly parents, but the murder of a normal healthy adult was almost unheard of. If societies like these could separate human beings into different categories without transferring their attitudes from one group to another, we with our more sophisticated legal systems and greater medical knowledge should be able to do the same.57

Advocate Bhaskarrao Avhad agrees that if a person is leading a life of misery with no hopes of recovery, a medical and social enquiry should be allowed. There should be a body to certify that the patient needs euthanasia. But legislators should make it absolutely foolproof as there is a great risk of bogus certificates being issued.58

54 Ibid.
56 Id. at 1818-1824.
57 Peter Singer, Practical Ethics, 217 (1993).
58 Lily Srivastava, Law and Medicine, 152 (2010).
Either a new offence or a new defence would require a legislative resolution which would be entirely dependent upon political will. An incremental approach, like that adopted in the Netherlands in recent years, would give the opportunity to determine how much sustained support there is for euthanasia in practice, beyond the purely theoretical endorsement it currently attracts. In this way a gradual relaxation of the present legal restrictions could facilitate a highly regulated system of allowing dying for those who require it, while providing a high level of protection for everybody.  

Now we can better answer the question of why people think what they do about death, and why they differ so dramatically. Whether it is in someone's best interests that his life end in one way rather than another depends on so much else that is special about him – about the shape and character of his life and his own sense of integrity and critical interests – that no uniform collective decision can possibly hope to serve everyone even decently. So we have that reason of beneficence, as well as reasons of autonomy, why the state should not impose some uniform, general view by way of sovereign law but should encourage people to make provision for their future care themselves, as best they can, and why if they have made no provision, the law should so far as possible leave decisions in the hands of their relatives and doctors whose sense of their best interests - shaped by intimate knowledge of everything that makes up where their best interests lie - is likely to be much sounder than some universal, theoretical, abstract judgment born in the stony halls where interest groups maneuver and political deals are done.

It is in the medical realm that many of the hardest decisions are being made. The issues are literally matters of life and death. The ethical discourse in this area is extremely important. We need to reflect on the ‘appropriateness’ of our behavior. There are options emerging which will create the brave new world. We are all required to participate in the conversation; the decisions that are being made may affect us all. Because of the entrenched nature of the debate, any change in the law in most countries would be difficult to achieve, as consensus on the issues involved seems very difficult to obtain.

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59 Supra note 15 at 173.
60 Supra note 4 at 213.
The main obstacle in implementing a law on euthanasia is that it is a twin-edged weapon. On one side, it can be used to relieve a patient from unbearable pain by giving him death, but on the other side, the corruption and the malafide or ulterior motives of doctors and relatives of patients may lead to its misuse. An uncertain death in a hospital would be covered by taking the plea of euthanasia. Relaxing the law by legalizing euthanasia would also promote illegal trade of human organs. This would also increase suicide rate in the society because anyone whose circumstances of life are not favorable would try to end up his life. A total chaos would be created in the society and it will make people more fragile. More so, Indian society and its families are closely bonded. Not providing medical aid or withholding medical aid or administering a lethal dose for the painless death of a family member is against their family values, the bond of love they share does not allow it and above all, being a God-fearing society, it is considered as a sin.63

Looking at the various aspects of euthanasia, it seems quite difficult to reach at a conclusion. There is nothing wrong in legalizing passive euthanasia in rare and genuine cases. Certainly, recognition of any right creates the possibility of its abuse. Therefore, an expert committee should be appointed to take into consideration the various aspects of the euthanasia, elaborate discussions should be held, a consensus should be drawn and stringent punishment should be imposed to punish the ones who put it to abuse. The law should be such which requires the doctors to come with enough evidence that the killing is in the best interests of the patient. A proper law with stringent provisions against its abuse would save a lot of people from dying a painful death and their families from financial crises.64

It is important to emphasise that it is practically not possible or desirable to legalise active euthanasia in India, as yet. Such a step would entail a complex policy debate regarding the availability of palliative and hospice care for terminally ill patients and necessitate stringent safeguards to protect vulnerable patients from unscrupulous relatives or doctors.65

63 Shree Ram, Insight Legal Essays, 204-205 (2010).
64 Id., at 205.
It is definitely time that we accept euthanasia though in a very restricted sense as it involves a high degree of moral responsibility. The need of the hour is to enact a suitable comprehensive legislation governing passive euthanasia with sufficient checks and balances. The statutory enactment would also ensure avoidance of different viewpoints or conflicts within members of judiciary while adjudicating such hypersensitive matters. At the outset, it can be concluded that although passive euthanasia has been granted judicial endorsement by the apex court under certain exigent circumstances, there is indeed a need for wider public debate on this vexed subject.

It should be noted that Aruna Shanbaug’s judgment has been criticized on various grounds. Firstly, the argument of the possibility of misuse cannot be a ground to oppose legalizing euthanasia. If misuse were to be the ground to do away with laws, the first provision to go would be the power of the police to arrest, as according to the National Police Commission approximately two-thirds of detentions in the country are unjustified. Secondly, the anguished pleas for euthanasia by persons suffering from terminally and debilitating diseases like muscular dystrophy and articulated as an issue of human dignity remain outside the scope of the present judgment. Not only this, the judgment in Suchita Srivastava vs. Chandigarh Administration, had categorically ruled that in deciding the ‘best interests’, the court should be guided by the interests of the patient alone, and not of others including guardians. The Aruna Shanbaug’s ruling seems to be solely based on the views of the nursing staff of the KEM Hospital, totally ignoring patient’s interests. The total denial of recognition of the right to autonomy and self-determination of a person incompetent to consent, and the usurpation by guardians or state as ‘Parens Patriae’ determining the best interests is a hazardous course of action.

Moreover, the debate on withdrawal of the life support system has also been seen in the context of the extreme commercialisation of the healthcare industry. Inflicting costly

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66 Supra note 58.
68 AIR 2011 SC 1290.
71 Supra note 68.
72 Supra note 69 at 12.
but totally ineffective treatment, unnecessary interventions by hospitals, and emotional blackmailing the bereaved family by refusing to release the body till payments are made are some prevalent practices. The argument that until medical treatment and services including palliative care is universally accessible, the issue of euthanasia should not be considered, shows that the apex court’s ruling ignores the important factor of affordability of treatment in regard to euthanasia. However, the present trend is towards privatization of healthcare with government hospitals too charging money for medical tests. In such a context, to deny individuals who are suffering from debilitating terminal diseases the option of euthanasia until healthcare is provided to all, seems unjust.73

Our Parliament in its wisdom as also bound under the Doctrine of Parens Patriae (Father of the country) ought to deliberate thoroughly on this topic involving all stakeholders before legislating over the issue as it is a matter concerning the precious life of terminally ill patients of the nation.74 Within the present legal system and the definitions it upholds, those who care might be compelled to kill in order to relieve suffering. All decisions concerning terminal medical care bring into sharp focus the divergence between the rights of patients and the responsibilities of doctors, and the fine distinctions between killing and caring are emphasised in this context. The demands now commonly made by patients and their relatives for death with dignity and the constraints imposed by the law diverge at the point where continuing medical care simply prolongs the dying process but doctors cannot lawfully participate in actions that curtail life. In practice it may not be possible to provide the kind of care required by a terminal or incurably ill patient without straying into territory policed by the criminal law, which means that doctors often have to deny patients the choice they seek.75

In recent years patients have been afforded greater involvement in treatment decisions through the development of the concepts of consent and patient autonomy. But, regardless of these advances, legal and ethical constraints prevent doctors from complying with requests for treatment options that will deliberately hasten death. Autonomy may be retained until the very end of life but, this choice is necessarily

73 Id., at 12-13.
74 Supra note 67 at 14.
75 Supra note 15 at 66.
limited. Those who are able to exercise their autonomy by refusing to accept life prolonging treatment may opt for death while those who are dependant upon institutional or emotional carers are denied choice. Here justice is denied to the patient who is prevented, by disease and the law, from exercising choice, as it may be to the practitioner or carer who flouts the law in order to compassionately comply with a person’s legitimate dying wishes. Greater use and recognition of advance directives would be valuable in the promotion of patients’ rights and choices at the end of life. Their usefulness can only be fully assessed however, through the careful analysis of individual consent, legal capacity and autonomy. In this environment care must be taken to avoid criminalising those whose motives are benevolent, particularly when they have simply responded to a request for mercy.

9.2 Important Findings of Data Analysis

(1) Unawareness regarding the fundamental rights and their enforceability still prevails in small proportion of population.

(2) Right to personal liberty includes right to personal autonomy and self-determination of human beings, including the right to have control over one’s own body and destiny.

(3) But right to personal liberty is not absolute and does not extend to a point where one can take one’s own life by committing suicide.

(4) Punishment for attempt to commit suicide aggravates the pain of accused. This means that though the majority respondents favour retention of attempt to commit suicide in the penal statute, yet they are against punishing the accused in such cases. Accused in such cases should rather be dealt with soft words and reformed.

(5) Physician assisted suicide should remain punishable under law.

(6) Patients suffering from incurable terminal disease or in coma or persistent vegetative state or brain dead do not live a meaningful and dignified life.

(7) Unremitting pain seems to be the major factor why patients or their relatives ask for a dignified death. However, majority of doctors opined that depression, hopelessness, general psychological distress, functional debility (patient has no pain but cannot get out

76 Id., at 67.
77 Ibid.
of bed or provide self-care, becomes dependent on others), meaningless and purposeless
life is the major factor.
(8) In case of ‘voluntary’ active euthanasia and ‘voluntary’ passive euthanasia, it is
the duty of the doctor to respect the decision of the patient provided he has given an
informed consent.
(9) Though a majority of population is against practicing euthanasia in any of its
forms in case of incompetent or unconscious patients, but the data shows that support for
passive euthanasia in case of incompetent or unconscious patients is found to be more as
compared to active euthanasia.
(10) The doctors should decide the best interests of the patient instead of any other
person.
(11) A desire or directive should be considered while determining an unconscious or
incapable patient’s best interests.
(12) There is an urgent need to make a law to regulate the practice of euthanasia in
India. Provisions should be made to consider Advance Directives and Living Wills.
(13) If not regulated, euthanasia would be misused by those involved in performing it
and it will have negative impact on people’s trust for doctors.
(14) Such law should make provision for the defence of doctors who perform
euthanasia in good-faith subject to prescribed guidelines.
(15) Limited hospital resources in India should be used for the treatment of those who
can be cured rather than the ones who do not have any chance of recovery.
(16) Government should establish highly specialized hospitals and medical institutions
to provide end of life care (e.g. Palliative care and hospice care) for patients suffering
from terminal illness.
(17) Misuse of provisions or safeguards for performing euthanasia should be
punishable under law.
(18) The general opinion is that there is a need for framing legislative policy legalizing
euthanasia prescribing sufficient guidelines for the purpose.
9.3 Suggestions

Immortality in terms of life on earth is an unreachable dream.\(^78\) Death is inevitable and we really need to accept the whole spectrum of life from birth to death. There is a great deal of accepting and coping necessary for each of the stages in our life.\(^79\) In accepting the inevitability of, we must encourage ourselves to live as good a life as we can until death is actually upon us.\(^80\)

A patient rarely gives up will to live. This is a universal fact, even a literate who is aware of the limitations of the medical science does not like to hasten his death although he knows well that medicine has failed to cure him.\(^81\) As death approaches, the world of the dying gradually shrinks. Hope generally remains until the final moments but its focus tends to shift.\(^82\) Consciousness in the dying sometimes undergoes qualitative changes. The crisis for the dying patient characteristically arrives when he stops ‘fighting’ to live. The period that follows is unlike any other experienced in life – the dying hour – when the dying person, accepting the lost struggle and the inevitable end, is relaxed and ready to depart, gradually distancing himself from life, turning away close friends and relatives, literally turning to the wall as he prepares himself to die.\(^83\)

And sometimes, at the hour of death, all kinds of memories of the past and projections of the future, merge with the present reality.\(^84\) The abandonment which dying patients fear can be as much emotional as literal. Nurses say that they do not become hardened to death and often dream about the death of their patients. As a result, they attempt to distance themselves from the dying by thinking of them as no longer quite there, referring to the care of unconscious patients as “watering the vegetables”. The terrible moment which demands that life-sustaining equipment be turned off is emotionally masked by the phrase, “pulling the plug”. The impulse to abandon the dying can become overwhelming. It is policy in most hospitals to move dying patients into single room as death approaches. And sometimes doctors, nurses and even the relatives

77 Id., at 107.
79 Id., at 108.
80 Id., at 108.
83 Id., at 269.
tend to find good reasons to stay out of the dying patient’s room. The pretense is that no one wants to ‘disturb’ the dying person while he is ‘resting’.85

Since doctors have taken the Hippocrates Oath, they continue to prolong the death of such patients by keeping them on costly life supporting measures till the end occurs in the hospital (fortunate for the patient and his relatives, if it is early). If the relatives of the patient cannot afford the costly medication, they discontinue the treatment and take the patient home against medical advice. For want of medical support, the patient succumbs eventually. This means that most of us are practicing passive euthanasia. From the doctor’s perspective avoiding surgery in advance cancer or keeping the oxygen concentration low or putting off the ventilator intentionally are some means by which this practice is being carried out since long. This is done taking into consideration the agony suffered by the patient and his relatives and also to make room or bed available for those patients who have a better chance of survival.86 Even when a doctor believes that a particular patient will not survive any longer, he is usually heard of saying in India, Isse dava ki nahi, dua ki zarurat hai.

Love has the patience to endure the fault we cannot cure. Society today tends to define love as a romantic expression for someone of the opposite sex. But it is possible to think of love in much broader terms: the basic feeling of goodwill for another, care for their health and well-being, and the desire to have only good come them. This includes our parents, siblings, friends and everyone. Sometimes when we think we love someone, we are actually loving what we think the other person may be able to give us. This can be an aspect of ‘conditional love’. Love at its highest demands nothing in return. Love is considered the great harmonizer and healer in life. According to Gandhiji, “a coward is incapable of exhibiting love; it is the prerogative of the brave”.87 Similarly, according to Ralph Waldo Emerson, “Love, which is the essence of God, is not for levity, but for the total worth of man”.88 In human relationships, we sometimes forget that true love is given

85 Supra note 82.
88 Id. at 6.
freely with no strings attached. Love is real. It works! It is gentle, yet undoubtedly one of the strongest tools to work with and brings the patience to handle every situation.89

In case of dying patients, family and friends may feel like staying away because they feel they don’t know what to say or how to act, but much can be done to give them emotional support. Expressions of affection and caring including touching, holding, hugging or very silently sitting beside the dying person, can help a lot. Profound speeches or insincere platitudes should be left unsaid. A few friendly words, talking about anything the patient may wish to bring up, or just holding hands for a while can be very helpful. For some, flowers, an appropriate book, or even tasteful humor are very welcome.90

Let us remember to do some positive things as we go through life rather than feel guilty later about not having done them. Let our loved ones and friends know that we love and care for them. One should not be afraid to show positive emotions in words and deeds. We should not let some minor or even major event put up a block between us and someone we care about. We should learn to forgive, learn to say thanks, and learn to accept others with their imperfections just as we want to be accepted. Let’s speak our eulogies while people can hear them rather than wait until they have left us forever.91

Medical science and technology have become so advanced that people can often be kept alive beyond the time when death would naturally overtake them. Artificial respiration, tube feeding, intravenous feeding and similar measures are clearly justified to help people who may be revived to live a life of some value, but to continue such measures for a person who for all other purposes is dead, is unkind and cruel.92 As stated earlier, a hospice is an organization whose purpose is to help terminally ill individuals die as peacefully as possible. A hospice program may be carried out in a facility where patients live in a homelike atmosphere, or it may simply be a way of organizing community services to help people to die in their own home or that of a family member. Many people can be helped through their last few weeks and months by the hospice concept. It can also be a tremendous help to the family of the dying person. Hospices are relatively new specialized health care programs which are autonomous but centrally

89 Ibid.
90 Supra note 78 at 109.
91 Id., at 111.
92 Id., at 109.
administered. Originally developed in England, they have now spread to many cities in America. The basic goals and principles of hospice care programs are to:

1. Help the terminally ill person live as full and comfortable a life as possible as a person rather than a helpless patient.
2. Keep the patient home as long as is appropriate.
3. Support the family as the unit of care and support them emotionally during the period of treatment and bereavement.
4. Supply medical, psychological, sociological and spiritual services as needed through a team approach.
5. Provide pain control without undue concern about narcotic addiction.
6. Provide services 24 hours a day, 7 days a week, under the supervision of a physician.
7. Supplement, not duplicate, existing services.
8. Keep costs down.
9. Accept patients on the basis of health needs rather than ability to pay.

People need to be educated to the point of approving it, just as they needed to understand the evil wrought by employing children in mines a hundred years ago or hanging for stealing a sheep and just as they need today to learn the necessity for sterilizing the grossly unfit, to save unborn children from the horrors of idiocy, blindness or other grave defects.

9.3.1 Preventive Medicine Campaign

It seems obvious that rather than wait for the symptoms of a potentially life-threatening disease to emerge, we should do everything we can to prevent it early. This has become a mantra in much public health policy in the western world. Encouraging a healthy lifestyle (regular exercise and a good diet) has become a key part of secondary school education. If we can encourage people to live good, healthy lives, then everyone will win: the individuals will have healthier lives and society will have to spend less on medicine on medical care of people following complex diseases. If certain developed

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93 Ibid.
94 Ibid.
95 C. Wcksteed Armstrong, Road to Happiness – A New Ideology, 84 (1951).
96 Ibid.
countries are advocating euthanasia, its high time India also adopts this policy for those incurable brain dead patients giving respite to them and their immediate relatives.\(^{97}\)

### 9.3.2 How to fight fear of Death? : The answer lies in Meditation

Taking the question of a terminally ill patient who sees no purpose to his life, what should we do with him or what should we advise him to do? He says, “I want to kill myself. I want the doctor to give me a shot to terminate my life.” We need an answer from a meditative point of view to someone who sees no further use to his body and is losing all hope. Through one’s spiritual power, one may gradually raise the level of consciousness so that even though the physical pain may increase, the mental suffering decreases. People should learn to separate physical pain from mental suffering by surrendering to the grace of God. One must learn that even if this body is stayed free from disease for a thousand years, sometime, somewhere, the moment of death has to come.\(^{98}\) The second chapter of the *Bhagavad Gita* is the most popular reading in India at the occasion of death. *Arjuna*, who is afraid of fighting and dying is advised to go into the battlefield. He is told to pick up his weapons. The fear is strong in him. The uncertainties baffle him.\(^{99}\)

Oh, Krishna, I cannot stand. This bow is slipping from my hands. My skin is burning, my head is going round and round. I will not fight.\(^{100}\)

He lets his bow slip and sits down on the back seat. Krishna looks at him and says:

What are you afraid of? What are your fears? Stand up! Fight! Fight without fear. Because O *Arjuna*, this body is made up of elements of matter. It is composed, so it has to decompose. Anything that at sometime was not, at some other time shall definitely cease to be. There was a time when this body was not, so the time has come when this body shall cease to be. And yet there is an entity of which there was never a time when it was not, for which there

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\(^{97}\) Supra note 82 at 82-83.

\(^{98}\) Supra note 84 at 38-39.

\(^{99}\) Id., at 40

\(^{100}\) Ibid.
shall never be a time when it shall not be. This spirit you are; there was never a time when this spirit was not. Just think of yourself going on and on into infinity, that there shall never be a time when this spirit shall cease to be. It will go on into infinity. So, what is this misery and fear in you?¹⁰¹

Such patient should be taught the art of meditation and through meditation he will find reduction in physical pain also. Even if he does not find reduction in physical pain, he will learn to accept it to a certain degree. This will alleviate a little of mental suffering, self-pity and resignation attached to it.¹⁰² Law must serve life: even the paramount law of the Constitution. To those who orthodoxly demand that laws must be slow to change, hon’ble Justice V.R. Krishna Iyer quotes Lincoln:

The dogmas of the quiet past are no longer adequate to the needs of the stormy present.¹⁰³

9.3.3 Obligation of State to provide adequate Medical Facilities

Providing adequate medical facilities for the people is an essential part of the obligations undertaken by the government in a welfare state. The government discharges this obligation by running hospitals and health centres which provide medical care to the person seeking to avail those facilities. Article 21 imposes an obligation on the State to safeguard the right to life of every person. Preservation of life is thus of paramount importance. The government hospitals run by the State and the medical officers employed therein are duty bound to extend medical facilities for preserving human life. Failure on the part of government hospital to provide timely medical treatment to a person in need of such treatment results in violation of his right to life guaranteed under Article 21.¹⁰⁴

In order that proper medical facilities are available, it must be ensured that:
1. Adequate facilities are available at the Primary Health Centres where the patient can be given immediate primary treatment so as to stabilize his condition.

¹⁰¹ ibid.
¹⁰² Id., at 41
2. Hospitals at the district level and sub-divisional level are upgraded so that serious cases can be treated there.

3. Facilities for giving Specialist treatment are increased and are available at the hospitals at various levels having regard to the growing needs. For this, government should establish multi-specialty hospitals and medical institutions and employ highly qualified and experienced medical officers to deal with serious cases.

4. In order to ensure availability of bed in an emergency at state level hospitals, there is a centralized communication system so that the patient can be sent immediately to the hospital where bed is available in respect of the treatment which is required.

5. Proper arrangement for the ambulance is made in every hospital.

6. The ambulance is adequately provided with necessary equipment and medical personnel.

9.3.4 Guidelines by Medical Council of India

The Medical Council of India in exercise of the powers conferred under section 20A read with section 33(m) of the Indian Medical Council Act, 1956, with the previous approval of the Central Government, has made Regulation relating to the Professional conduct, Etiquette and Ethics for medical practitioners, namely, The Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002.

Chapter I deals with Code of Medical Ethics. Regulation 1.1 deals with character of the Physician. According to it, a physician should uphold the dignity and honour of his profession. The prime object of the medical profession is to render service to humanity. Regulation 1.2 deals with the need to maintain good medical practice. It states that the principle of the medical professional is to render service to humanity with full respect for the dignity of profession and man. Physicians should merit the confidence of patients entrusted to take their care, rendering to each a full measure of service and devotion.

Chapter 6 deals with unethical acts. Regulation 6.7 declares ‘euthanasia’ as an unethical act. It reads as follows:

\[\text{id., at 324.}\]
\[\text{Available at www.mciindia.org/RulesandRegulations/CodeofMedicalEthicsRegulation. (Accessed on 23.12.13).}\]
\[\text{Ibid.}\]

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6.7 Euthanasia: Practicing euthanasia shall constitute unethical conduct. However on specific occasions, the question of withdrawing supporting devices to sustain cardio-pulmonary function even after brain death, shall be decided only by a team of doctors and not merely by the treating physician alone. A team of doctors shall declare withdrawal of support-system. Such team shall consist of the doctors 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 staff in accordance with the provisions of the Transplantation of Human Organ Act, 1994.  

As per Regulation 7.1, a physician, if he or she commits any violation of these regulations, shall be guilty of professional misconduct and liable for disciplinary action.

9.3.5 Guidelines as per Indian Society of Critical Care Medicines (ISCCM)

The Ethics Committee of the Indian Society of Critical Care Medicines has made ‘Guidelines for limiting life prolonging interventions and providing palliative care towards the end of life in Indian Intensive care Units.’ These guidelines are eight in number and read as follows:

1. The physician has a duty to disclose to the capable patient or family, the patient’s poor prognosis with honesty and clarity when further aggressive support appears non-beneficial. The physician should initiate discussions on the treatment options available including the option of no specific treatment.

2. When the fully informed capable patient or family desires to consider palliative care, the physician should offer the available modalities of limiting life-prolonging interventions. The patient or family should be clearly made aware of the available options for the use of life-sustaining supports such as, Full support, Do not intubate (DNI) or Do

108 Ibid.
109 Ibid.
not resuscitate (DNR status), Withholding of life support, Withdrawal of life support, Palliative care.111

Full support is the provision of all measures needed to support hemodynamics, metabolism, and ventilation; Full resuscitation (CPR): aggressive ICU management up to and including resuscitative attempts, in the event that cardio respiratory arrest occurs; DNI/DNR: aggressive ICU management up to, but not including endotracheal intubation (DNI) or attempts at CPR (DNR); Withholding of life support: this is a considered decision not to institute new treatment or to escalate existing treatments for life support (including, but not limited to, intubation, inotropes, vasopressors, mechanical ventilation, dialysis, antibiotics, intravenous fluids, enteral, or parenteral nutrition) with the understanding that the treatment has a higher potential to cause pain and suffering than resolution of organ failure; Withdrawal of life support: the cessation and removal of an ongoing life-supporting treatment while not substituting an equivalent alternative treatment, with the understanding that the treatment in question is causing pain and suffering and serves no purpose other than delaying death. It is anticipated that the patient will die following the change in therapy because of the natural progression of underlying disease conditions.112

Palliative care is the provision of active measures aimed at only alleviating pain and suffering, with no further attempt at resuscitation or providing organ support, when the underlying disease process is presumed to have reached a point of no return; This committee of the Indian society of critical care medicine emphasizes that 'euthanasia' and 'physician-assisted suicide' are illegal in India. Euthanasia is allowed in the Netherlands under certain strict regulations. Physician-assisted suicide (PAS) is legal only in the State of Oregon in the US. In India, requests for euthanasia have been turned down, and suicide and abetment to suicide are declared punishable by the Indian Penal Code. Indian Association for Palliative Care (IAPC) is the national organization for Palliative Care in India. It was formed in 1994 in consultation with World Health Organization (WHO) and Govt. of India to form a forum for activities aimed at the care of people with life limiting illness such as Cancer, AIDS and end-stage chronic medical disease. Its mission is to

111 Ibid.
112 Ibid.
promote affordable and quality palliative care across the country through networking and support to palliative care institutions.\(^\text{113}\)

3. The physician must discuss the implications of forgoing aggressive interventions through formal conferences with the capable patient or family, and work towards a shared decision-making process. Thus, he accepts patient’s autonomy in making an informed choice of therapy, while fulfilling his/her obligation to provide beneficent care.\(^\text{114}\)

4. Pending consensus decisions or in the event of conflicts between the physician’s recommendations and he family’s wishes, all existing supportive interventions should continue. The physician however, is not morally obliged to institute new therapies against his/her better clinical judgment.\(^\text{115}\)

5. The discussions leading up to the decision to withhold life-sustaining therapies should be clearly documented in the case records, to ensure transparency and to avoid future misunderstandings. Such documentation should mention the persons who participated in the decision making process and the treatments withheld or withdrawn.\(^\text{116}\)

6. The overall responsibility for the decision rests with the attending physician/intensivist of the patient, who must ensure that all members of the caregiver team including the medical and nursing staff agree with and follow the same approach to the care of the patient.\(^\text{117}\)

7. If the capable patient or family consistently desires that life support be withdrawn, in situations in which the physician considers aggressive treatment non-beneficial, the treating team is ethically bound to consider withdrawal within the limits of existing laws.\(^\text{118}\)

8. In the event of withdrawal or withholding of support, it is the physician’s obligation to provide compassionate and effective palliative care to the patient as well as attend to the emotional needs of the family.\(^\text{119}\)

9.3.6 Recommendations of the Law Commission of India

9.3.6.1 Recommendations of the 17th Law Commission, 2006

\(^{113}\) Ibid.
\(^{114}\) Ibid.
\(^{115}\) Ibid.
\(^{116}\) Ibid.
\(^{117}\) Ibid.
\(^{118}\) Ibid.
\(^{119}\) Ibid.
The Law Commission of India its 196th Report on Medical Treatment to Terminally Ill Patients (Protection to Patients and Medical Practitioners), held the view that there is need to have a law to protect patients who are terminally ill, when they take decisions to refuse medical treatment, including artificial nutrition and hydration, so that they may not be considered guilty of the offence of ‘attempt to commit suicide’ under section 309 of the Indian Penal Code, 1860.120

It is also necessary to protect doctors (and those who act under their directions) who obey the competent patient’s informed decision or who, in the case of (i) incompetent patients or (ii) competent patients whose decisions are not informed decisions, and decide that in the best interests of such patients, the medical treatment needs to be withheld or withdrawn as it is not likely to serve any purpose.121

Parliament is competent to make such a law under Entry 26 of List III of the Seventh Schedule of the Constitution of India in regard to patients and medical practitioners. The proposed law, should be called ‘The Medical Treatment of Terminally Ill Patients (Protection of Patients, Medical Practitioners) Act.122 The Bill is provided in Annexure I

9.3.6.2 Recommendations of the Law Commission, 2012

The earnest effort of the Commission at this juncture, was only to reinforce the reasoning adopted by the Supreme Court in Aruna’s case123 and the previous Law Commission. On taking stock of the pros and cons, this Commission restated the propriety and of legality of passive euthanasia rather than putting the clock back in the medico-legal history of this country.124 The Commission recommended that passive euthanasia, which is allowed in many countries, shall have legal recognition in our country too subject to certain safeguards, as suggested by the 17th Law Commission of India and as held by the Supreme Court in Aruna Ramachandra’s case125. It is not objectionable from legal and constitutional point of view.126 A competent adult patient

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120 Law Commission of India, 196th Report on Medical Treatment to Terminally Ill Patients (Protection to Patients and Medical Practitioners), 205 (2006).
121 Ibid.
122 Ibid.
123 Supra note 68.
125 Supra note 68.
126 Supra note 124 at 40-41.
has the right to insist that there should be no invasive medical treatment by way of artificial life sustaining measures/treatment and such decision is binding on the doctors/hospital attending on such patient provided that the doctor is satisfied that the patient has taken an ‘informed decision’ based on free exercise of his or her will.\textsuperscript{127} As regards an incompetent patient such as a person in irreversible coma or in Persistent Vegetative State and a competent patient who has not taken an ‘informed decision’, the doctor’s or relatives’ decision to withhold or withdraw the medical treatment is not final. The relatives, next friend, or the doctors concerned/hospital management shall get the clearance from the High Court for withdrawing or withholding the life sustaining treatment. In this respect, the recommendations of Law Commission in 196th report is somewhat different. The Law Commission earlier proposed an enabling provision to move the High Court.\textsuperscript{128} The High Court shall take a decision after obtaining the opinion of a panel of three medical experts and after ascertaining the wishes of the relatives of the patient. The High Court, as \textit{parens patriae} will take an appropriate decision having regard to the best interests of the patient.\textsuperscript{129}

Provisions are introduced for protection of medical practitioners and others who act according to the wishes of the competent patient or the order of the High Court from criminal or civil action.\textsuperscript{130} The Governments have to devise schemes for palliative care at affordable cost to terminally ill patients undergoing intractable suffering.\textsuperscript{131} The Medical Council of India is required issue guidelines in the matter of withholding or withdrawing of medical treatment to competent or incompetent patients suffering from terminal illness.\textsuperscript{132}

Accordingly, the Medical Treatment of Terminally Ill Patients (Protection of Patients and Medical Practitioners) Bill, 2006, drafted by the 17th Law Commission in the 196th Report has been modified and the revised Bill is practically an amalgamation of

\textsuperscript{127} \textit{id.}, at 41. 
\textsuperscript{128} \textit{ibid.} 
\textsuperscript{129} \textit{ibid.} 
\textsuperscript{130} \textit{ibid.} 
\textsuperscript{131} \textit{id.}, at 42. 
\textsuperscript{132} \textit{id.}, at 42.
the earlier recommendations of the Law Commission and the views and directions of the Supreme Court in *Aruna Shanbaug’s* case. The revised Bill is at Annexure II.

9.3.7 Role of Courts

A stage has come for the judiciary to abnegate its role as an umpire and enter the playground assuming the role of a salutary player to protect human rights.

Certain recommendations were given by Supreme Court in *Aruna Shanbaug’s* case on various issues concerning euthanasia. According to it, experts like medical practitioners could decide whether there was any reasonable possibility of a new medical discovery which could enable such a patient to revive in the near future. It laid down the guidelines for withdrawal of life support system which will continue to be the law until Parliament made a law on the subject. A decision to discontinue life support could be taken either by the parents or the spouse or other close relatives, or in the absence of any of them, such a decision could be taken even by a person or a body of persons acting as a next friend, the doctors attending the patient. However, the decision should be taken bona fide in the best interest of the patient. Such a decision required approval from the High Court concerned. The Chief Justice of the High Court should constitute a Bench of at least two Judges who should decide to grant approval or not. Before doing so the Bench should seek the opinion of a committee of three reputed doctors, preferably a neurologist, a psychiatrist and a physician, to be nominated by it after consulting such medical authorities/medical practitioners as it may deem fit. For that purpose, a panel of doctors in every city may be prepared by the High Court in consultation with the State Government/Union Territory and their fees for this purpose may be fixed. The committee of doctors should carefully examine the patient and also consult the record of the patient as well as taking the views of the hospital staff and submit its report to the High Court Bench. The High Court Bench shall also issue notice to the State and close relatives e.g. parents, spouse, brothers/sisters etc. of the patient, and in their absence his/her next friend, and supply a copy of the report of the doctor’s committee to them as soon as it was

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133 *Supra* note 68.
134 *Supra* note 104 at 324.
135 *Supra* note 68.
136 *Id.,* at 1327.
137 *Id.,* at 1331-32.
138 *Id.,* at 1334.
available. After hearing them, the High Court bench should give its verdict\textsuperscript{139} speedily at the earliest, assigning specific reasons in accordance with the principle of ‘best interest of the patient’, since delay in the matter might result in causing great mental agony to the relatives and persons close to the patient. The views of the near relatives and committee of doctors should be given due weight by the High Court before pronouncing a final verdict which shall not be summary in nature.\textsuperscript{140}

9.3.8 A Universal Declaration of Human Rights by the Hindus\textsuperscript{141}

Article 1 of the Declaration states that all human beings have the right to be treated as human beings and have the duty to treat everyone as a human being. Moreover, Article 3 (2) states that everyone has the right to life, longevity and liveability and the right to food, clothing and shelter required to sustain them. Likewise, everyone has the duty to support and sustain the life, longevity and liveability of all. Article 5 states that no one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment, inflicted either physically or mentally, whether on secular or religious grounds, inside the home or outside it. No one shall subject anybody to such treatment. Article 25 states that everyone has the right to health and to universal medical insurance. It is the duty of the state or society to provide it. Article 32 states that everyone has the right over his or her body and mind to use it in any manner one wishes. Everyone has the duty to use his or her body and mind to further the well-being of all. One’s body and mind possess the right not to be abused by oneself as the right of the part against the whole. It is one’s duty to cultivate one’s body and mind.\textsuperscript{142}

Shobha Ram Sharma, in her article titled “Euthanasia and Assisted Suicide: Need to change the Law”\textsuperscript{143}, suggested that mercy killing could be considered in cases where death is only salvation and preservation of life would be medically impossible and visited with insufferable physical or mental pain. To check the misuse of euthanasia, proper procedure may be incorporated by law. In this regard, some suggestions are as follows:

\textsuperscript{139} Ibid.
\textsuperscript{140} Id., at 1334-35.
\textsuperscript{141} Composed by Prof. G.C. Pande, at the International Symposium on Indian Studies, held at Kovalam in Kerela from 28 November to 2 December, 1994.
(a) A euthanasia request should come from a patient suffering from unbearable pain from an incurable condition.\textsuperscript{144}

(b) The physician must follow certain due care criterion. He must:
   i. Be convinced that request was voluntary, well considered and lasting.
   ii. Be convinced that the patient was facing unremitting and unbearable suffering.
   iii. Have informed the patient about his situation and prospects.
   iv. Have reached the firm conclusion with the patient that there was no reasonable alternative solution.\textsuperscript{145}

(c) Mercy killing should be carried out with the written sanction of three state recognised doctors certifying that the patient under consideration is a fit case for euthanasia.\textsuperscript{146}

(d) Termination of life should be in a medically appropriate fashion. Like that the practice is to administer an injection to render the patient comatose, followed by a second injection to stop heart.\textsuperscript{147}

(e) The person who is going to die:
   i. Must completely understand what will happen.
   ii. Must know about all other kind of treatment.
   iii. Must freely repeat his/her wish to die over a period of time.
   iv. Must be suffering from something that will not stop or go away.\textsuperscript{148}

(f) All case history should be put up before the district judge level officer and after his prior consent euthanasia should be performed.\textsuperscript{149}

(g) After patient has died, the doctor who performed euthanasia must complete a long questionnaire.\textsuperscript{150}

When the patient is dead, a coroner must look at the body and check the facts of the case. If case is not found for euthanasia, penal proceedings may be initiated.\textsuperscript{151}

\textsuperscript{144} Ibid., at 50.
\textsuperscript{145} Ibid.
\textsuperscript{146} Ibid.
\textsuperscript{147} Ibid., at 50-51.
\textsuperscript{148} Ibid., at 51.
\textsuperscript{149} Ibid.
\textsuperscript{150} Ibid.
\textsuperscript{151} Ibid.
Researcher emphasises that law must keep pace with the changing society. If a law is not able to cater to the changing needs of society, then it becomes a bad law. Law has to provide an answer to every problem that arises in the real life and comes up before the courts and specifically those which relate to life and death because death is universal and it must come. So, apart from the above suggestions, viewpoints and recommendations, the researcher suggests that the principle of sanctity of life is supreme because life is sacred; it is a gift of God. At the same time, there is another very important right i.e. right of personal autonomy and self-determination. Therefore, it is suggested that in certain exceptional circumstances, where life has lost its meaning, where the difference between life and death has ceased to exist, where life has become miserable, painful, burdensome and full of agony, the principle of sanctity of life should give way to personal autonomy and self-determination.

Thus, in researcher’s view, there is an urgent need to make a law on the subject to allow euthanasia in case of brain death in passive form only i.e. withdrawal of artificial life sustaining measures. Here comes the relevance of difference between killing and letting die. If a patient is killed by giving lethal injection or dose (active euthanasia), it may amount to shortening the life, because then the doctor is intervening in the natural span of life. Whereas, in case of passive euthanasia, by withdrawing artificial life sustaining measures, the doctor is just letting the patient die i.e. death comes in its normal course and there is no intervention in the natural span of life, there is no shortening of human life.

It is further suggested by the researcher that euthanasia should not be allowed in case of coma or persistent vegetative state (PVS), whether reversible or irreversible. The reason is that even the doctors are not the final authority to decide or determine whether a particular case of come or PVS can be reversed. The possibility of miracles cannot be ruled out.

It is well established position of law, that the requests of competent patients as to treatment or withdrawal of treatment must be respected, provided the consent is informed consent. Since, brain dead patients cannot make a request because they are artificially kept alive. It is an artificial existence, where life has lost its relevance. Therefore, in such
cases, the principle of best interest of the patient should be followed as is followed by English courts.

Researcher emphasizes that keeping a patient on artificial life sustaining measures is a very costly affair. Therefore, it becomes the duty of State to provide for financial help to the relatives of such patients. But, again, facts and circumstances of each case should be taken into consideration.

The researcher suggests that a panel of reputed doctors should be constituted in every town or city. The panel should consist of doctors (other than the one attending the patient) belonging to various specialisations like a psychiatrist, a neurologist and a general physician. This panel should decide whether the case is fit for euthanasia. The whole process should be undertaken under the supervision, guidance and direction of the High Court concerned which shall take decision in the best interest of the patient. The decision should be taken by the High Court as expeditiously as possible. But, it is suggested that opportunity of being heard should be given to all the concerned parties.

Request for withdrawal may be made by parent(s) or spouse or next friend of the patient. Advance Directives like living wills and health care proxies should not be allowed because there is always a chance of misuse. Moreover, it genuineness or authenticity can be challenged.

It is further suggested by the researcher that there is a need to incorporate provision in the law for fixing time limit within which such cases should be decided by the High Court, because sometimes, such cases linger for so long that the mental pain and agony of relatives of such patients increases manifold. Moreover, there is a need to incorporate a specific provision in the Indian Penal Code for the defence of doctors who would perform euthanasia subject to restriction prescribed by law made on the subject.

Researcher emphasises on the views of hon’ble Justice V.R. Krishna Iyer at this juncture. According to him, the right to life is a fundamental right and embraces every dimension of life with dignity, divinity, accessibility to the highest material-spiritual ascent and ability to terminate life if it loses its basic value of pursuit of happiness.152

He quoted Darwin, who demonstrated dialectically and verifiably that Man has evolved from animal species. The superlative element that marks out a human being from his animal ancestors is the power of intelligent judgment and free faculty of choice and development. It follows inevitably that human life forfeits its relevance when, by acute agony or incurable disease, the reality of dignified existence disappears. In such exceptional situations, the capacity to continue terrestrially, using the senses and faculties, becomes *non est*, nougat and the distinction between life and death ceases, being merely a matter of breath and heart-beat. To be or not to be, is a decision that then belongs to the individual who owns his right to life and, therefore, has also the concomitant right to disown it by giving it up as no longer worth keeping. This is a supreme freedom inalienably implicit in the fundamental right to life.153

According to him, our penal laws in both hemispheres are rooted in obsolete values, barbaric criteria and obdurate obscurantisms. That is why taking away life by him who owns it even in selective freedom and grave crisis is condemned as suicide by intolerant provisions of law. This is jejune jurisprudence, cultural myopia and noetic nonsense. On the contrary, euthanasia, which confers plenitude of precious enlightenment on the creative spark which dwells in every person, is a most sensitive expression of human liberty.154

The hon’ble Justice looks at the event of death as transformation, not termination. Once the horror of body burke or disappearance is shown to be a sham, taking life by oneself for just causes ceases to be a sin or crime, not arbitrary suicide but sensible, sensitive farewell to suffering and purposeful survival of *Atman*. When a sage, whose tenure of *Karma* is over, takes to solemn *Samadhi* in non-violent merger with the infinite, no humanist castigates it as obnoxious barbarity. Our epics are rife with instances of voluntary quittance by avatars.155

Euthanasia, according to him, is finding acceptance as a fair process among enlightened sensitive, as a gentle, just excuse of a fundamental right to rid life of an...
incurable, intolerable, poignant pain or distress.\textsuperscript{156} Life is dear and cannot be taken even by the judicial brethren except under compelling circumstances.\textsuperscript{157} Lastly to quote him,

\begin{quote}
We must always have the brooding thought that there is a divinity in every man and that none is beyond redemption.\textsuperscript{158}
\end{quote}

To conclude in the words of Ronald Dworkin\textsuperscript{159}:

\begin{quote}
Any of these developments, or any of dozens of others that may leap from science fiction to medical routine, would force us to confront the issues we have been exploring – about the relative importance of the natural and the human contributions to the sanctity of life – in very different terms, and it would be absurd even to speculate about how those issues would best be defined, let alone resolved, then. But if people retain the self-consciousness and self-respect that is the greatest achievement of our species, they will struggle to express, in the laws they make as citizens and the choices they make as people, the best understanding they can reach of why human life is sacred, and of the proper place of freedom in its dominion.\textsuperscript{160}
\end{quote}

\textsuperscript{156} Ibid.
\textsuperscript{158} \textit{Id.}, at 144.
\textsuperscript{159} Ronald Dworkin, \textit{Life’s Dominion} (1994).
\textsuperscript{160} \textit{Id.} at 240-241.