CHAPTER III

MEDICO-LEGAL ASPECTS OF EUTHANASIA

3.1 INTRODUCTION:

From the sixteenth and seventeenth centuries science and technology began to place the means to control nature in human hands, and the elusive dream took on the air of reality.¹ The 20th century has witnessed a tremendous development in the medical technology, the doctor’s role of curing diseases and relieving pain has now changed into prolonging life via medications, transfusions, respirators, dialysis machines, artificial feeding, etc. One could argue that these medical changes have been, inter alia, fuelled the shift in values that now encourage patients and their families to actively participate in planning end-of-life care.²

The questions which arise due to these wondrously efficient medical facilities are, to what extent should medicine and physicians become the vehicles for individuals to have access to technologically promised benefits? How long to maintain life-sustaining medical intervention? And if such life support system requires termination, what would be the role of the doctors and is there a need to reconsider the elements involved in medical ethics followed by the medical profession? An attempt is made to answer these questions in the present Chapter.

To achieve the above objective this Chapter is divided into six segments. The first part explains the role of a doctor, medical ethics and the general issues related in pronouncing the death of a patient with examples. The second segment explains various artificial life support

systems used to prolong the natural span of life. Thereafter, the different life prolonging drugs administered to patients for keeping them alive are discussed. The third segment focuses on what amounts to terminal illness, various diseases leading to terminal illness and chances of recovery in such cases. The fourth segment of the chapter deals with the recent upcoming concept of hospice and palliative care for terminally ill patient as an alternate option for *euthanasia*. In the next segment of this Chapter an attempt is made to carve out a way to balance the medico-legal issue of *euthanasia* or physician assisted suicide by emphasising the importance of advance directive in this highly civilized society having dramatic changes in the field of medicine and hardly any changes made in the legal field to reciprocate with these changes of the medical world. The last segment contains a word of caution on legalization of *euthanasia*. Certain important unintended consequences are discussed to overcome the slippery slope arguments.³

### 3.1.1 EUTHANASIA AND MEDICAL ETHICS:

Doctors are looked upon by patients as a person next to God. When a doctor begins the treatment the patient’s attitude is full of trust in the doctor. The doctor’s involvement with his patient is thus very special but needs to be balanced. There has to be a specific outline which controls and declares guidelines for the doctor’s obligation and the patient’s rights, as medicine and law have been related from the earliest times.⁴

---

³ The ‘slippery slope’ argument in the *euthanasia* debate, concerns about the misuse of law allowing death with dignity. The possibility of misusing the law cannot be overlooked, hence the unintended consequences such as effect of *euthanasia* law on the weak and vulnerable, performance of *euthanasia* for economic interest, and the role of doctors performing *euthanasia* have been given due consideration.

The practice of medicine today is highly progressed as compared to the 17th or 18th century. The 20th century picture is, therefore, one of the rapidly advancing medical technology which is effected in a strongly research oriented environment and which exists within an increasingly hedonistic and materialistic society.\(^5\) Due to the dramatic advances new dilemmas are posed, and thus the legal intervention in medicine becomes inevitable. It is argued that public conscience, as embodied in law, provides a useful foundation for medical ethics. The crucial question, then, “is that of determining the extent to which medical decisions should be the object of legal scrutiny and control.”\(^6\)

Some people form the opinion\(^7\) that the medical decisions should be left to the doctors, while others\(^8\) state that it is important to have a lawful control over the medical practitioners as the doctors’ deal with issues such as life and death. To avoid encroachment on the patient’s right by the clinicians and in order to maintain professional standard it is necessary to have a particular code of conduct for doctors.\(^9\) This code of conduct for medical practitioners is based on the ‘medical ethics’. Medical law cannot be divorced from medical ethics.\(^10\) The relentless progress of medical science provokes new legal dilemmas just as legal scholars and moral philosophers\(^11\). The very success of medicine has made its practice morally complex. Naturally this has paved the way for various legal and ethical challenges.\(^12\)

\(^6\) Id., at 13.
\(^8\) Williams, Glanville, Text Book of Criminal law 281, 2\(^{nd}\) edn., Delhi: Universal Law Publication, 1983.
\(^10\) Ibid.
\(^11\) Ibid .
3.1.2 ETHICS AND THE ROLE OF DOCTOR IN THE LIGHT OF EUTHANASIA:

The term “ethics” can be generally defined as the principles governing moral behaviour. Owing to the prevailing influential social and economic factors, medical profession is increasingly being placed under legal and ethical regulations.

“Medical ethics” it is said, “will appeal to many temperaments: to the thinker and to the doer, to the philosopher and to the woman or man of action. It deals with some of the big moral questions: easing death and morality of killing…”

According to Aristotle, ethics when applied to medicine, it should be for the good of the patient. Conveying that, “[e]very art and every inquiry, and every action and pursuit, is thought to aim at some good and for this reason the good has been rightly declared to be that at which all things aim”.

A vital debate which has captured the imagination of people throughout the world is, how should one deal with the remarkable advances in medicine and human biology that bid fair to change the way in which human beings live. This debate is closely related to the role of law in medical practice and with the moral and legal contours of the doctor-patient relationship.

The concept of the legal role has proved largely unrealistic in the debate relating to euthanasia. Modern medical science creates new moral

---

13 Id., at 15.
14 Id., at 113.
choices, and challenges to the traditional views regarding reproductive technologies, cloning, exchange of organs from animals to human and the process of death.\textsuperscript{17} Medical law is catalysed by moral issues. The debate on \textit{euthanasia} is essentially an exposition of different moral views, yet in practice, it becomes one concerning what the law should be and not only what the law is.\textsuperscript{18} This requires engaging in moral evaluation which, in turn, raises the question how to identify what is right. The society is always confronted with a need to identify an ethical basis for the practice of medicine and its regulation by the law.

Many accounts of medical ethics are strangely silent to the importance of religious theories of medical ethics- the element of surprise stemming from the fact that medicine and religion have been intertwined from the earliest times, when priests were also recognised as physicians.\textsuperscript{19} It can be said that religious theories form the base of medical ethics. Religiously-based medical ethics has a clear sense of fundamental values.\textsuperscript{20} The debate of \textit{euthanasia} provides an instance of this in the form of the serious and persistent questioning provided by John Keown.\textsuperscript{21}

Medical ethics usually operates within an established framework of values which serves as reference from which to conduct the debate about the rightness or wrongness of an action. Ethically appropriate conduct is determined by reference to four key principles enlisted below which must be taken into account when reflecting on one’s behaviour towards others:\textsuperscript{22}

\begin{itemize}
\item \textit{Supra} note 15.
\item Mason, J.K., \textit{et. al., Law & Medical Ethics} 5, 6\textsuperscript{th} edn., London: Butterworths, 2002.
\item \textit{Ibid.}
\item \textit{Supra} note 19 at 6.
\end{itemize}
(i) the principle of respect for individual autonomy (i.e., individuals must be respected as independent moral agents with the ‘right’ to choose how to live their own lives);

(ii) the principle to beneficence (i.e., - one should strive to do good where ever possible);

(iii) the principle of non-maleficence (i.e., - one should avoid doing harm to others), and

(iv) the principle of justice (i.e., - people should be treated fairly, although this does not necessarily mean that everyone should be treated equally).23

At a broader level of abstraction, contemporary medical ethics can be seen as a tapestry in which arrays of philosophical theories interweave with one another.24 It is evident from the above four principles that utilitarian thought and the deontological theory are the basic strand of medical ethics. The utilitarian thought propounded by Bentham was based on promotion of good consequences i.e., pleasure and bad consequences i.e., pain.25 It is quite compatible with the principle of utility to recognise the fact that some kinds of pleasure are more desirable and more valuable than others.26

The liberal individualism is the corner stone of autonomy. Autonomy is by far the most significant value which has been promoted by contemporary medical ethics. Autonomy has indeed dominated medical ethics as it insists individual control over their own bodies, and right to make their own decisions relating to medical treatment. The fact that

23 Ibid.
24 Id., at 6-7.
25 Supra, Chapter I, p. 25.
every individual possesses right to autonomy points in the direction of allowing voluntary *euthanasia* or physician assisted suicide but at the same time moral and ethical questions remain unanswered.

Critics of utilitarianism have pointed out that the theory can be upheld and still permit an awful lot of wrong doing.\(^{27}\) It is argued that only autonomy should not be focused as the base of ethics, there are other ethical ideals- like individual rights, the sanctity of life, justice, purity and so on- which are universal in the required sense, and are, at least in some versions, incompatible with utilitarianism.\(^{28}\)

The second strand of deontological theories focus on the knowledge of right and wrong consequences of an act. This concern of consequences marks the moral acceptability of a particular act. Akin to the moral acceptability, Kant’s theory delivers a message of moral teaching that one should not use others but should respect their integrity as individuals. Kant’s doctrine would be absurd if it meant that the presence of a natural inclination to good actions (or even of a feeling of satisfaction in doing them) detracted from their moral worth.\(^{29}\) In a deontological theory actions of the kinds held to be virtuous are seen as being intrinsically obligatory or admirable, and goodness of character too may be seen as having intrinsic value.\(^{30}\) In addition actions and characters may have a merit of their own not wholly derived from what they bring out.\(^{31}\)

It has been observed that utilitarianism conceives the moral life in terms of intrinsic value and the means to produce this value. Deontologists, by contrast, argue that moral standards exist independently


of utilitarian ends and that the moral life should not be conceived in terms and ends.\textsuperscript{32} Referring to the weaknesses of the deontological theory, it does not specify as what is right at the time or to the virtues.

Autonomy emphasizes the importance of self-respect and self-determination. Medical ethics throughout the history\textsuperscript{33} has also respected the patient’s autonomy.

\textbf{3.1.2.1 MEDICAL ETHICS AND AUTONOMY:}

Autonomy means the capacity to think and decide freely and independently for one-self. As it gives a decision making authority which should also be followed by the medical professionals, it forms a pro-argument in the \textit{euthanasia} debate. It is in the assertion that the right to autonomous medical decision making is paramount consideration for medical ethics. A key feature of the principle of respect for autonomy has been developed in legal contexts, where ‘self-determination’ has a venerable history and is taken to be synonymous with autonomy.

Autonomy is the ability to understand one’s situation and pursue personal goals free from governing constraints.\textsuperscript{34} Respect for autonomy requires not only the health professionals but also others, including the patients family to help patients to take their own decisions, for \textit{e.g.}, by providing important information.\textsuperscript{35} At the same time the decision taken

\begin{itemize}
  \item \textsuperscript{34} Beauchamp, T.L., \& McCullough, L. B., \textit{Medical Ethics} 42, Englewood Cliffs: Prentice Hall, 1984.
  \item \textsuperscript{35} Hope, Tony, \textit{et. al.}, \textit{Medical Ethics and Law} 8, U.K: Churchill Livingstone, 2003.
\end{itemize}
by the patient should be respected and followed even when the health professional believes that the decision is wrong.\textsuperscript{36}

Thus, Medical ethics requires health care professional’s to respect the autonomy of their patients and to treat them with dignity.\textsuperscript{37} Within developed nations, there is increasing public \textit{debate} about apparent endorsement of the appropriateness of \textit{euthanasia} as an autonomous choice to die in the face of intolerable suffering.\textsuperscript{38}

Much of the debate surrounding the principle of autonomy concerns the right of the patient to refuse life-saving treatment.

\subsection*{3.1.2.2 MEDICAL ETHICS AND BENEFICENCE:}

Beneficence is the principle of medical ethics which promotes the patients best interest. This principle emphasizes the moral importance of doing good to patients in the medical context. This, in fact, raises the question of who should be the judge of what is best for the patient at a particular health condition and hence forms a base to argue in favour of \textit{euthanasia}. The terminally ill patients suffering from unbearable pain may consider a quick and painless death as their best interest rather than living with the distress hopelessly.

As per this principle of medical ethics, doctors are generally regarded as having a positive duty to do good. Whatever the case in general ethics, it is undoubtedly true that members of the medical profession undertake

\begin{flushright}
\textsuperscript{36} \textit{Ibid.}
\end{flushright}

\begin{flushright}
\end{flushright}

\begin{flushright}
\end{flushright}
to place the interests of their patients before their own in many circumstances.\textsuperscript{39}

Although an element of such self-interest undoubtedly exists in the practice of medicine and although the grandiose claim that interests of patients always come first is false as a description and undesirable as prescription, the medical profession nonetheless conceives itself, and is conceived by society, as having a duty of beneficence to sick in general and to its patient in particular.\textsuperscript{40} Gillon’s comments refer to the duty of the doctor as going beyond what can reasonably expected of everyone else. A main ingredient in a code of medical or other professional ethics consists of some generalised exhortations to care for patients, which can be summed up by saying that the medical and perhaps all the professionals are governed to much greater extent than other jobs by the principle of benevolence.\textsuperscript{41}

Apart from the doctor’s duty to care for his patients, beneficence is criticised by saying that the duties of doctors should not be regarded, as they are in tradition, as duties of benevolence, but rather as duties correlative to the rights of patients.

According to the Hippocratic Oath, the physician promises to follow that system of regimen which according to his/her ability and judgment he/she consider for the benefit of his/her patient. No where in the Hippocratic corpus there is any provision for the patient’s view of things.\textsuperscript{42}

\textsuperscript{40} Ibid.
It is very important to respect the patient’s view as the medical science exploded in 20th century and detonated in the 21st century has transformed medicine into a scientific and technical enterprise, where the modernized role of the physician overshadows the moral role. Considering the right to autonomy and self-determination of patients, the best interest of the patient should not be compromised at any cost.

3.1.2.3 MEDICAL ETHICS AND NON-MALEFICENCE:

Non-maleficence means not to cause harm or to avoid causing harm. This principle of medical ethics in its literal interpretation does not withstand in the euthanasia debate. However, the logical interpretation of ‘avoiding harm’ may include allowing or aiding a terminally ill patient die a peaceful and painless death.

The principle of non-maleficence is commonly known as the other side of the coin of the principle of beneficence. It is the prima facie duty of the doctor not to cause harm to his patient. The traditional duty to do good has been accompanied by the obligation to do no harm. Non-maleficence is a wider obligation than that of beneficence. The scope of non-maleficence is general, encompassing all other people whereas the scope of beneficence is more specific, applying only to some people not to harm them.

Thus, it can be accepted that everybody has a moral duty not to harm anybody else. If this duty conflicts with beneficence, which duty should be given priority over the other? For e.g., if administering euthanasia is in the best interest of the patient to relieve him from pain, the physician may act as per the principle of beneficence, but at the same time the act of

---

43 Supra note 35.
44 Supra note 39 at 81.
administering *euthanasia* takes away the life of the patient and forms a part of harm as per the principle of non-maleficence.

In such cases, this principle might, for *e.g.*, be used to justify the ‘acts and omissions’ distinction in law relating to *euthanasia*. In the case of a very seriously ill patient, a doctor may not be obliged to continue to treat that patient or he can withdraw or omit treatment, and remain within the confines of law. This is based on the reason that the treatment is not benefiting the patient. This act is consistent with the principle of beneficence because the doctor will say that the treatment is not, or would not, benefit the patient.

The omission to treat is acceptable, however the doctor is not legally permitted to give the patient a lethal injection to bring about death, even when natural death is very close, as it is argued, it would infringe the principle of non-maleficence. The intentional termination of life of a human being is contrary to the principles and policies for which the medical profession stands.45

The question of when to terminate life extending medical treatments is a thorny social issue which has given rise to public concern and has increased health care workers sensitivity and patient’s awareness of the issues involved.46 But at the same time it is arguable that the lethal injection would not be harmful as it might be the kindest way of treating a patient who is terminally ill and in great pain. Rather allowing a terminally ill patient to die by providing him means to do so, can be considered as doing justice with the patient’s health.

3.1.2.4 MEDICAL ETHICS AND JUSTICE:

The term ‘justice’ encompasses fairness, reasonableness, respect for law, distributive justice, equality, and the due process of law. As justice is one of the principles of medical ethics, it is pertinent to analyse whether it is achieved in case of terminally ill patients. In most of the countries, except a few, euthanasia or physician assisted suicide is legally prohibited. All the principles of medical ethics condemn any form of euthanasia. Is justice accomplished by making a terminally ill patient suffer with pain and agony? When there is no ray of hope for such patients to recover or even live without pain, is the law providing justice to them? It is commonly said that, ‘justice delayed is justice denied’. By delaying the death of terminally ill patients with the help of modern medical technology, they are unquestionably denied of the justice.

The principle of justice emphasises two points: first, that patients in similar situations should normally have access to the same health care. And second, that in determining what level of the healthcare should be available for one set of patients we must take into account the effect of such a use of resources on other patients.

The concept of ‘justice’ is no less an elusive concept, although its importance usually lies in the realm of politics, it can be relevant both to the wider issues of allocating health resources on national basis and when deciding which patients to treat when local resources are limited. Time and resources do not allow every patient to get the best possible

---

47 Article 14 of the Indian Constitution embodies the principles of fairness, reasonableness, distributive justice and equality. The ‘due process of law’ was recommended by a few members of the Constituent Assembly to be incorporated in Article 21, but was rejected by majority of members in 1948. However, the Apex Court of India has established through plethora of cases that procedure established by law has the same consequence as due process of law. Maneka Gandhi v. Union of India, AIR 1978 SC 597, Sunil Batra v. Delhi Administration, AIR 1978 SC 1675, infra, Chapter V, p. 364 to p. 367.

48 Ibid.

49 Ibid.
treatment. Health professionals have to decide how much time to spend with different patients and at various levels within a healthcare system, because of limited resources, decisions must be made about limitations on treatments that can be offered in various situations.\(^{50}\)

Proponents of *euthanasia* argue on this particular point, as the use of resources for a terminally ill patient would not benefit him in any case and hence in such cases physician assisted suicide shall be allowed in order to use those resources for the benefit of other patients who have a hope of recovery.

As per medical ethics it is undoubtedly a moral wrong to help a patient end his life in normal circumstances. In such a situation, if a physician conducts or aids in conducting *euthanasia*, it will be an unpardonable legal, moral and ethical error on his or her part.\(^ {51}\)

The inviolability-of-life principle would, to be sure, rule out cases where the doctor intends to kill his or her patient, and this would mean that current laws against physician assisted suicide and *euthanasia* largely should be retained.\(^ {52}\) The inviolability-of-life principle also parallels modern medical ethics, which has placed heavy emphasis on the double-effect principle in dealing with end life care issues.\(^ {53}\) Indeed, the inviolability-of-life principle affords what the strongest explanation may be why society has drawn the lines it has in the law and medical ethics of the end of life.\(^ {54}\) As well as the clearest, most consistent secular explanation and defence for our current regime that proscribes intentional

---

\(^{50}\) Supra note 35 at 9.

\(^{51}\) Supra note 12 at 71.


\(^{54}\) Ibid.
killings but does not seek to enforce any broader rule interfering with patient autonomy and choice.\textsuperscript{55}

Today, the question arises whether it is an equal ethical and moral wrong to help a patient end his life who is terminally ill or is in a persistent vegetative state for years together and has no hope of recovery? To answer such a question it becomes necessary to examine the circumstances in which a request for \textit{euthanasia} is put forth. Allowing \textit{euthanasia} for a healthy person or even a patient who is not suffering from terminal illness would definitely amount to violation of legal, ethical and moral norms in the society. And hence, this difference should be outlined by the medical practitioners in clinical discretion. At the same time, the law ought to recognise this difference and make suitable provisions to provide justice to the terminally ill patients.

Dr. Wolbarst, advocated \textit{euthanasia}, with reference to the history of man’s struggle for liberty and happiness and the tremendous advances in medical technology.\textsuperscript{56} Way back in 1939, he indicated that, \textit{euthanasia} aimed to advance humanitarian progress by easing the final passage when further suffering was useless and without purpose.\textsuperscript{57} According to him, to refuse terminal sufferers the release of death should be regarded as a denial of the physician’s solemn obligation to relieve pain and suffering.\textsuperscript{58}

A similar attempt was made by the Canadian Medical Association. In 1970 the General Council of the Canadian Medical Association took a significant step towards a more flexible stand on prolonging life when it approved a change in the code of ethics which stated, “[a]n ethical

\textsuperscript{55} Id., at 165.
\textsuperscript{57} \textit{Ibid}.
\textsuperscript{58} \textit{Ibid}.
physician will allow death to occur with dignity and comfort, when death of the body appears inevitable”.

The task of medical ethics and of medical law is to balance the two in a way which enhances individual dignity and autonomy but which does not inhibit the exercise of discretion in the marginal case. In any multicultural society objective scientific knowledge must co-exist with respect for individual’s deeply held beliefs.

The medical ethics followed worldwide are drafted under the influence of Hippocratic Oath which is considered of paramount importance in medical profession. However, the present state of affairs of this celebrated Hippocratic Oath is questioned on several issues and the most significant being abortion and **euthanasia**. The following segment reviews the Hippocratic Oath in light of the **euthanasia** debate.

### 3.1.2.5 MEDICAL ETHICS AND THE HIPPOCRATIC INFLUENCE:

Hippocrates remains the most famous figure in Greek philosophical medicine and the Hippocratic Oath stands as a **Magna Carta** for medical professionals. In Greece, by 500 BC, the strong influence of priests had waned, predominantly religious discipline had transformed the concepts of medicine through the process of thoughts, observation and deduction.

A standard of practice relevant to the new ideals was required and has indeed survived as Hippocratic Oath. The Oath lays down a number of guidelines, much of it relates to the medical etiquette. The Oath

---

59 Id., at 157.
60 Supra note 19 at 11.
62 See, Appendix A, Hippocratic Oath.
emphasizes the need for co-ordinated instruction and registration of
doctors, it also states that the doctor is for the benefit of his patients- he
should do nothing which will cause harm to the patient. Euthanasia and
abortion are officially forbidden, an undertaking is given not to take
advantage of the patient, and finally the Oath expresses the doctrine of
confidentiality.

Later on with the evolution of various medical universities a
modernised version of this Oath was introduced by the World Medical
Association as Declaration of Geneva, which was amended at Stockholm
in 1994 and provides the basis for an International Code of Medical
Ethics.63

A Code of Medical Ethics, 1972, was amended by the Indian
Parliament based on various reasons, such as, the influence of scientific
and technological developments in the processes of health care, misuse of
medical technology, public claims.64 At present, in India, Code of
Medical Ethics, 2002, is a codified law duly legislated by the Parliament
of India.65

In the 20th century the medical research begun with the renaissance,
which has hit the ceiling in the 21st century and since then new
dimensions are introduced by which new dilemmas are posed. The
progress of research with the advancing technology rapidly progressed
within an increasingly materialistic society. Society aiming towards
hedonism demanded more and more and thus encouraged medicine at all
levels. But the law, however, as compared to medicine and society

64 Supra note 12 at 41- 42.
21/2/2011].
changes very slowly. All this paves way for confrontation within the triangular relationship of medicine, society and the law.66

A similar problem arises in case of euthanasia. Most of the countries legally prohibit euthanasia as it amounts to taking someone’s life. Medicine has the capacity to keep a patient alive hopelessly for years together in such cases right to die with dignity is requested but as law prohibits the problem remains unsolved. However, in certain cases, the Courts are also willing to recognise their position in relation to the legislature in face of the speed of evolution of modern technology. As opined by Lord Browne Wilkinson, existing law may provide an acceptable answer to the new legal questions raised by the ability to sustain life artificially.67 Moreover, he examined the question whether judges should seek to develop a new law to meet a wholly new situation required society.68 Lord Browne Wilkinson was of the opinion that the practical problems should be voiced through the democratic expression in the Parliament, to reach its decision and then reflect those decisions in legislation- and, in this he was strongly supported by Lord Mustill.69 It can be stated that House of Lords was of the opinion that society as the policy decision maker, should take responsibility for the ethico-legal directions.

In R. v. Arthur,70 Farquharson J., commented that it was customary for a profession to agree on rules of conduct for its members but instructed the jury that it does not mean that any profession can set out a code of ethics and say that the law must accept it and take the notice of it, may be

68 Ibid.
69 Id., at 135.
70 Unreported, The Times, 6 Nov, 1981.
that in any particular feature the ethic is wrong.\textsuperscript{71} He added that whatever a profession may evolve as a system of standards of ethics, cannot stand on its own, and cannot survive if it is in conflict with the law.\textsuperscript{72} It would therefore be open to a jury to find a doctor guilty of murder even though they believed that he acted in accordance with the ethical standards currently accepted by the medical profession.\textsuperscript{73}

In 1954, Dr. Joseph Fletcher,\textsuperscript{74} influentially advocated legalization of \textit{euthanasia} in the United States. He noted that many of the problems faced by physicians today were never dreamt of in the times of Hippocrates- there are moral issues that should be decided on the basis of the present conditions.\textsuperscript{75} He further emphasized that the dimensions of our moral responsibility should expand with the advances made in medical science and medical technology.\textsuperscript{76} Consequently, the ethics of medical care should change, grow, and engage constantly in self-correction.\textsuperscript{77}

Does the Hippocratic Oath still apply to abortion and \textit{euthanasia} case needs to be ratified. It is evident by the abortion laws in different countries, that though the Hippocratic Oath condemned abortion it is legally accepted worldwide when the requisite conditions are fulfilled. The widespread performance of abortions strikes at a fundamental Hippocratic principle,\textsuperscript{78} which absolutely prohibits abortion. Nonetheless, abortion of foetus has become an observable fact in the society. Likewise, \textit{euthanasia} should also be considered at least in exceptional cases. Perhaps medical professionals, legal connoisseur,

\textsuperscript{72} \textit{Ibid.}
\textsuperscript{73} \textit{Ibid.}
\textsuperscript{74} Fletcher, J., \textit{Morals and Medicine}, Boston: Beacon Press, 1960, passim.
\textsuperscript{75} \textit{Supra} note 56 at 124.
\textsuperscript{76} \textit{Ibid.}
\textsuperscript{77} \textit{Ibid.}
policy makers and civilized people living in this world should take the time to read the Hippocratic Oath in its entirety and reflect on the fact that it was written over 2500 years ago.\textsuperscript{79} One could argue that our modern technology and our complex society have left the Oath’s ancient wisdom far behind, that worked twenty-five hundred years ago but cannot successfully work now.\textsuperscript{80}

Medical ethics as discussed above is undoubtedly the soul of medical profession to protect the patient’s right to autonomy and also to maintain the obligation of a doctor towards his patient, but at the same time as there is dramatic change in the medical technology there has to be an equal change in medical and legal field as well. The change is required especially when the natural meaning of death itself has undergone drastic changes due to the advent of modern medicine.

\textbf{3.1.2.6 EUTHANASIA AND ISSUES RELATED TO DEATH:}

The mode of dying in the early part of the twenty-first century argues that if one thinks that many years of incapacity and illness are generally to be avoided, then it is possible for death to come later than is ideal, and indeed that one of the drawbacks of the advance medicine is that death does often come later than is ideal.\textsuperscript{81}

Death is defined as the state of being dead or extinction or cessation of life. Death is also defined as a gradual process at the cellular level with tissues varying in their ability to withstand deprivation of oxygen.\textsuperscript{82}

\begin{footnotesize}
\textsuperscript{79} \url{http://www.arationaladvocate.com/abortion.htm}, [accessed on 15/3/2010].
\textsuperscript{82} \textit{Supra} note 5 at 209.
\end{footnotesize}
In the past, the cessation of spontaneous respiration, circulation, heart beats, brain function, etc., were entirely considered as the criteria for determining that a patient was dead. However, since four decades, advances in medical technology have made it possible to sustain brain function despite the absence of spontaneous respiration and circulation. It is even possible to maintain respiration and circulation when the brain is not functioning. Where only the higher regions of the brain have ceased to function, spontaneous respiration and circulation may continue for months or even years.  

Everyone generally accepts that when all respiratory, circulatory, and neurological activity has irreversibly ceased, the patient is dead, but can be put on a ventilator and then the patient is said to be alive. This creates disagreements between doctors which are not related to medical facts, but to broader ethical and social issues.

Nevertheless, for legal purposes it is necessary to make a sharp distinction between the living and the dead, as the application of various laws depends upon the individual being alive or dead, as yet, the law does not recognise any intermediate stage. The question whether someone has sustained brain death or cognitive death, is a technical medical issue. But it is important to note that even if it is established that the patient has sustained brain death, or cognitive death, can he be regarded as dead? This cannot be said to be a medical issue.

According to Skegg, the courts should approach the question of whether a body is that of a living human being, for the purpose of the particular rule of law, in the same way as they approach any other

---

83 Supra note 71 at 183.
84 Id., at 185.
85 Id., at 187.
question of whether a particular object comes within a category mentioned in a rule of law. In practice the courts will be very reluctant to take a different view from the adopted by the prominent members of the medical profession. But unless doctors can carry a wider public with them, if they wish to treat as corpses bodies which have hitherto been regarded as alive, the courts should not act as if the courts had no role to play in the resolution of the issue. In such situation it is wrong to consider the matter as simply a technical matter.

These developments have compelled one to rethink about the traditional criteria of defining death or declaring a patient dead. A patient whose brain function has irreversibly ceased but heart continues to beat because of artificial ventilation often is described as ‘brain dead’. The next segment of the present Chapter shall deal with the argument why euthanasia is advocated in cases of brain dead patients with an explanation of the phase known as ‘brain death’.

3.1.2.6.1 EUTHANASIA AND BRAIN DEATH:

The stage when a patient is declared brain dead is an important issue. In case of brain death, the patient’s all functions of the brain permanently and irreversibly cease, he loses the capacity of consciousness, and as a result he won’t be able to breathe. But if the patient is already on the ventilator, or if such facility is provided immediately, it is often possible to sustain bodily functions for a certain period after the occurrence of brain death. The Conference of Medical Royal Colleges has accepted

86 Ibid.
87 Ibid.
88 Ibid.
that brain death occurs when all functions of the brain have permanently and irreversibly ceased.\(^{90}\)

A brain-stem death is also defined under Section 2 (d) of *Transplantation of Human Organs Act, 1994*, in India.\(^{91}\) It is important to discuss the issue of brain death as this debate has resulted from the availability of artificial ventilation, which has the capacity to keep the body alive for years together.

In March 1981 the English Court of Appeal (Criminal Division) dealt with two cases which appeared to provide an excellent opportunity for authoritative judicial acceptance of the view that a person may be regarded as dead for legal purposes once brain death is established.\(^{92}\) In these cases,\(^{93}\) the assailants had both inflicted injuries which resulted in their victims being connected to ventilators. The victims were maintained on ventilators until doctors were of the opinion that brain death had occurred. Artificial ventilation was then terminated. As per the assailants there was evidence that the cause of death was the termination of artificial ventilation.\(^{94}\) The judge at Malcherek’s original trial was reported to have said, “[t]o have kept … [the patient] on the respirator would have been in effect, to ventilate a corpse”.\(^{95}\)

Such practical difficulties are increasing in the society as doctors keep patients on artificial ventilation even if the patient is brain dead, resulting in large number of ‘bodies being kept alive’ indefinitely. However in the United Kingdom many doctors were terminating the artificial ventilation


\(^{91}\) S. 2(d) reads: “the stage at which all functions of the brain-stem have permanently and irreversibly ceased and is so certified under subsection (6) of section 3”.

\(^{92}\) *Supra* note 71 at 195.


\(^{94}\) *Supra* note 71 at 196.

\(^{95}\) *Ibid.*
of severely brain-damaged patients long before it came to be accepted that at least many of these patients were already dead.\footnote{D. W. Evans and L. C. Lum, Letter, ‘Brain Death’ \textit{Lancet}, 1980, p. 1022. \url{http://www.proquest.unicom}, [accessed on 16/2/2010].} The proponents of \textit{euthanasia} go a step ahead in their argument in cases of brain dead patients. Their argument is not only to withdraw the life support system but to allow physician assisted suicide for such patients as keeping them alive adds to their suffering and pain.

The diagnosis of death is indeed a very important factor. The main difficulty in framing legislation is to allow for all modes of death- from the elementary obvious to the complex ventilator case, it would be absurd to demand that criteria designed for the latter be applied to the former.\footnote{Supra note 5 at 420.} A typical expression is to be found in the \textit{United States Uniform Determination of Death Act 1980}, which reads, “[a]n individual who has sustained either (1) irreversible cessation of circulatory and respiratory functions, or (2) irreversible cessation of all functions of the entire brain, including the brain stem, is dead. A determination of death must be made in accordance with accepted medical standards.”\footnote{Id., at 421.}

Medical facilities and expertise change very fast as compared to law, therefore the evaluation of diagnostic techniques remains in the hands of the medical profession. Apart from brain death and cognitive death, the last medical futility the ‘do not resuscitate’\footnote{‘Do not resuscitate’ (DNR) order is the last aspect of medical futility. The British Medical Association and the Royal College of Nursing have issued a set of guidelines for the DNR order. In certain cases when the medical treatment is ineffective, it is undesirable, to prolong the process of dying, in such cases the DNR order is followed to bring about the patients death. \url{http://www.resus.org.uk}, [accessed on 21/2/2011].} [here in after referred as DNR] order is of relevance to be discussed.
With the possibility of resuscitating otherwise dying patients, and of artificially maintaining the very seriously ill with the aid of machines which take over major body functions, many questions, both ethical and legal, began to present themselves.\textsuperscript{100} Does the law require that the patient be artificially maintained for ever? Should the patient be resuscitated repeatedly with the full knowledge that the task is hopeless? The answer certainly must be in the negative. It is undoubtedly, undesirable to prolong the process of dying- irrespective of the competence of the patient at that time. Most of the times, in case of incapacitated patient, our attitudes are already shaped in support of death, rather than fruitless treatment as a management option. This is the point when the line of reasoning may compel one to think whether the DNR option is a valid example of an exercise of the principle of futility? There is always a physical and moral demarcation between the incompetent patients and the patients who are reaching the end of life naturally, often in a state of diminished competence. In certain cases the DNR order is a matter of ethical importance. And such cases are the ones which should be meticulously considered for physician assisted suicide. In order to achieve this there is an urgent need for the society to go beyond even the questions of biological or brain death, to a recognition of psychological death- that is, death of the individual as a conscious person.\textsuperscript{101}

Dr. W.Spann of the Institute of Legal Medicine in Helsinki is quoted by Richard Restak, “[i]t is not the question of scientific boundary between life and death, but what is involved is a value judgment as to

\begin{footnotesize}
\begin{enumerate}
\item[101] Supra note 56 at 33-34.
\end{enumerate}
\end{footnotesize}
what is considered human life in its real sense. This kind of judgment is not a matter for the doctor on his own authority.\textsuperscript{102}

The three century old euthanasia debate has now gained momentum as never before. What may be the rationale for such impetus? People lived in the past and also faced their death, then, what is so special to discuss about the mode and manner of death? One of the reasons is the change in concept of death, and of more relevance is the modernization of the medicine which has revived the euthanasia debate. These radical changes have created far reaching dilemmas for human beings. The following segment provides an insight into how the modernization of medicine has invigorated the euthanasia debate.

3.2. EUTHANASIA AND THE MODERNIZATION OF MEDICINE:

The practice of medicine is constantly evolving under the impetus of newly developed diagnostic and treatment techniques.\textsuperscript{103} It is alleged that with the modernization of medicine, medicine has substituted religion as the foremost institutional moulder of cultural death fears and immortality desires. This is in view of the fact that modern medicine, reminiscent of religion and law, seeks to discover, control and eradicate undesirable elements.\textsuperscript{104}

Breakthroughs of the past century have empowered doctors to battle acute infection successfully, thus transforming the hospital, from functioning essentially as a hospice, to an institution which provides medical, surgical and curative treatment for sick and injured.

\textsuperscript{102} Id., at 34.


Today, Medical profession is armed to battle against untimely deaths brought on by various organ failures. It has been reinforced that modern medicine has enhanced the average life span of human beings all over the world and has multiplied the chances of survival, but it equally harms human beings under the grab of service to mankind.\textsuperscript{105} The increasing prominence of degenerative diseases and terminal illness evidently has opened a new debate questioning the modernization of medicine. Artificial life support system is one of the focal facets of modernization of medicine. Artificial life support system has the capacity to sustain life boundlessly. And this creates an impediment in the process of a dignified death. The following segment features the problems generated by the artificial life support system which are of immense relevance in the \textit{euthanasia} debate.

\textbf{3.2.1 ARTIFICIAL LIFE-SUPPORT SYSTEM:}

Rationally any human being would desire to die a painless and easy death. No prudent person would wish to experience his last phase of life in the hospital, lying vulnerably with tubes inserted in his body awaiting his death. If given a preference every one would desire to die at home surrounded by their near and dear ones. The popular belief is that, \textit{“[i]t is far better to have a cup of tea on your last day than drips and tubes in every direction”}.\textsuperscript{106}

Traditionally, there was little scope for the physician at the deathbed. It was a frequent medical practice for physicians to withdraw their medical care from an incurable patient, leaving the dying in the


\textsuperscript{106} William, Thomas, \textit{Dictionary of Medical Ethics and Practice} 107, Bristol: John Wright \& Sons ltd, 1977.
trustworthy hands of the attending family, friends and the clergy.\textsuperscript{107} However, by early nineteenth century, the absence of the physician from the deathbed was no longer acceptable.\textsuperscript{108} As the years passed new inventions and research directed the medical profession towards an entire new era. The capacity to sustain human biological life by biomedical technology and artificial life support systems has reawakened debate on the ‘right to die’ and \textit{euthanasia}.\textsuperscript{109}

During the past century, advances in public health and medicine have led to dramatic changes in the health, life expectancy and death process. Social and legal conventions from earlier times have strained to respond to unprecedented and unforeseen developments.\textsuperscript{110} Therefore, the discussion about artificial life support system is a recent development, as it is the result of new technology emerged towards the end of 19\textsuperscript{th} and beginning of the 20\textsuperscript{th} century. Untold number of individuals can now be kept alive who would almost certainly have died much earlier in the past years. It is certainly not beyond reason to imagine a day in the near future when human life will be maintained artificially and indefinitely by medical means.\textsuperscript{111} In such situation our firm belief in the sanctity of human life is put to the supreme test in situations where the life of elderly or comatose patients is sustained by artificial producers developed through medical science and technology.\textsuperscript{112} But the issue of sustaining life by medical technology is complicated by uncertainty as to when

\begin{footnotes}
\item[108] Id., at 45.
\item[112] \texttt{http://www.ag.org/top/beliefs/contempissues_18_euthanasia.cfem}, [accessed on 20/1/2010].
\end{footnotes}
actually death occurs. Medical support can keep a body breathing after meaningful signs of human life have ceased.\textsuperscript{113} And this has become possible as, today, the hospital is a complex centre of activity- a vast assemblage of superbly trained and highly specialized talent and expensive equipments.\textsuperscript{114} This excellent set up of complicated equipments, sometimes make normal things more complicated.

As discussed above, a brain dead patient who would normally be declared dead is now put on a ventilator and said to be ‘alive’. When a patient is brain dead, but is maintained on an artificial ventilator, the cardio-vascular, gastro-intestinal, and urinary systems continue to function.\textsuperscript{115} The body is warm, consumes oxygen, and may react to painful stimuli.\textsuperscript{116} This technology has proved to be boon for patients who are young and are not victims of terminal illness, but it is a bane for patients suffering from terminal illness, living a life of agony waiting for death to take its recourse where this artificial life support does not allow it to happen. The problem becomes progressively more serious as medical science is able to keep a body “alive” almost indefinitely with a respirator, pacemaker, renal dialysis and artificial feedings- all this at the exorbitant expense of the family or society.

Current research, although limited, suggests that the desire for food and drink lessens in terminally ill patients and that artificial hydration neither prolongs survival nor alleviates symptoms.\textsuperscript{117} Further more, drips and nasogastric feeding tubes can cause unnecessary distress to patients.

\textsuperscript{113} Ibid.
\textsuperscript{115} Supra note 71 at 206.
\textsuperscript{116} Ibid.
and their relatives, and in such cases the withholding of these treatments is entirely appropriate as the intention is to save the patient from a treatment that has no medical benefit.¹¹⁸

Now that a man can be kept alive by these measures, it becomes extremely important, and indeed only just, for those who do not wish to be kept alive to have the legal right to die.¹¹⁹ Society and legal system have struggled to respond to this shifting paradigm of dying.¹²⁰ The growing demand for the resolution of such medical-ethical issues, coupled with a changing conception of the appropriate locus of medical policy making, have forced society to re-examine traditional methods of healthcare decision making.¹²¹

The modern technology has invented various life support systems which have the capacity to sustain human life artificially. The artificial life support system adds fuel to the fire of euthanasia debate. In order to understand the quandary tolerated by the terminally ill patient, it is important to be familiar with the various types of artificial life support systems. The upcoming segment itemises several artificial life support systems with its application in terminal illness.

### 3.2.1.1 TYPES OF ARTIFICIAL LIFE SUPPORT:

Artificial life support means a therapy or device designed to preserve someone’s life when an essential bodily system is not doing so. Life support may, for *e.g.*, involve enteric feeding (by a tube) or total

¹¹⁹ *Supra* note 56 at 3.
¹²⁰ *Supra* note 110 at 311.
parenteral nutrition, mechanical ventilation, dialysis, a pacemaker, defibrillator.

As a consequence of this advanced technology, it is difficult to declare whether a patient is dead or alive. Death, of course, is an irreversible cessation of life but the possibility of maintaining the heart and the lungs by artificial means has created new problems. In the light of these technologies it is imperative to find out answers to the questions like for e.g., what is the symptom of death? Can cessation of breathing be considered as the symptom? What about when the heart stops beating or when brain activity is no longer evident? It is very complicated to answer these questions as the natural activities of breathing, heart beats, or brain functioning may cease, but the patient can still be kept alive with the artificial life support systems. In such cases some patients can be resuscitated and kept alive with live support. A few patients may recover and return to normal life, where as others may be forced to live on the life support system against their wish awaiting death. Those patients who

122 Intravenous feeding that provides a patient with all of the fluid and the essential nutrients he needs, especially when the patient is unable to feed himself by mouth. http://www.medterms.com/script/main/art.asp?articlekey=19344, [accessed on 20/1/2010].


124 Dialysis is a procedure that is a substitute for many of the normal duties of kidneys. The kidneys are two organs located on either side of the back of the abdominal cavity. Dialysis helps the body by performing the functions of failed kidneys. http://www.medicinenet.com/dialysis/article.htm, [accessed on 20/1/2010].

125 A system that sends electrical impulses to the heart in order to set the heart rhythm is known as a pacemaker. There are different types of artificial pacemakers. All are designed to treat bradycardia, a heart rate that is too slow. A pacemaker can also be programmed to detect an overly long pause between heartbeats, and then stimulate the heart. With the advent of more complex devices such as the new biventricular pacemaker, there is an ever increasing burden on the patients as well as the doctors. http://www.medterms.com/script/main/art.asp?articlekey=11866, [accessed on 29/1/2010]. See, Datar, Rashmi, Critical Care 122, 1st edn., Hyderabad: Paras Medical Publisher, 2006.

126 The use of a carefully controlled electric shock, administered either through a device on the exterior of the chest wall or directly to the exposed heart muscle, to restart or normalize heart rhythms. http://www.medterms.com/script/main/art.asp?articlekey=11137, [accessed on 29/1/2010].

recover after resuscitation consider this advanced technology as a miracle. Unfortunately, such miracle is highly unachievable in case of terminally ill patients. Consequently, the same technology prolonging death is looked upon as a thorny problem by the terminally ill patients.

In such situations a few key questions evolve in search of materialistic answers. How long should the patient be kept alive hopelessly? Can the life support system reduce the pain and suffering of the patient? Is the quality of life maintained during this phase? When can a terminally ill patient be allowed to die? There are, ironically, no precise answers to these questions as the life support system only prolongs the natural death. There are times when a debilitating accident, a life-threatening illness at an advanced stage, or prolonged terminal illness without any hope of recovery compels a patient to say, “please allow me to die”. The request to die is not a sudden reaction of the patient but it is a result of torment faced during hospitalization. In course of terminal illness the patient undergoes a number of thoughts and experiences as the situation is worsened by the life prolonging technology. In fact, the patient becomes a victim of anxiety, anger, depression, helplessness, disengagement and rationalisation. Therefore, the proponents of euthanasia argue to release the patient from such intolerable suffering by helping him to die. The decision whether to use life-support technology or to refuse should be ultimately made by the patient whenever possible.

In critical life-and-death situations, the use or refusal of life support is at best a difficult decision. Such decisions differ from person to person. What is precise for one individual choosing or refusing life support may

---

129 Id., at 44.
not be right for another. Most of the countries now recognise an individual’s right to refuse treatment and also exempt doctors from criminal liability for withdrawal of treatment in exceptional cases. There is no ethical or legal distinction between withholding a pacemaker and deactivating one after it has been initiated. At the same time there is a widespread accepted practice of withdrawing life-sustaining interventions, (mechanical ventilation, haemodialysis, artificial hydration, nutrition from patients who are terminally ill). Moreover, it is an accepted practice, of switching off a mechanical support which is considered as an omission and is, therefore, both morally and legally acceptable.

In fact, the American Medical Association’s [hereinafter referred as AMA] decision to recognize that artificial feeding is a life-support mechanism and can be disconnected from hopelessly comatose patients is not only accepted but welcomed. The AMA’s pronouncement is all the more appreciated because it comes at a time when the benefits of some of our modern technologies are in danger of being ignored as the life-support machinery can create additional problems in the future.

There is plethora of cases where the courts have dealt with the issue of the patient’s right not be forced to live on artificial life support system. In Ms. B. v. An NHS Hospital Trust, the facts in brief were that Ms. B. was suffering from progressive paralysis due to a haemorrhage into her spinal cord and was maintained by the use of a ventilator. She had

---

130 For e.g., United Kingdom, United States of America, Canada, Australia, Netherlands, Belgium, and Switzerland.
133 Ibid.
134 2002 EWHC 429 (Fam).
135 Supra note 5 at 541.
already effected an advance directive and repeatedly asked that she be disconnected from her machine but the clinicians refused to do so. One of the issues before the Court was, whether Ms. B. had the legal capacity to accept or refuse the life sustaining treatment. The Court held through Butler-Sloss LJ, that irrespective of the best interests of the patient, Ms. B. had the legal capacity to refuse the treatment as no person can be forced to take treatment against his or her wish.\textsuperscript{136} Similarly, the Canadian Court, prior to Ms. B’s case had upheld the right to refuse life support system in \textit{Nancy B v. Hotel-Dieu de Quebe}\textsuperscript{137}. The facts in brief of this case were, Nancy B was suffering from the Guillain Barre Syndrome, and existed by virtue of ventilation. She sought to have her ventilator disconnected and was supported by her family and the hospital.\textsuperscript{138} One of the issues in the present case was can Nancy be removed from the ventilator which would certainly cause her death. Dufour J, of the Civil Code of Lower Canada, held, that Nancy B had a right to be made free from the slavery of the machine.\textsuperscript{139} In order to do this, a third person may help her to put off the ventilator as she was unable to do it herself and allow her to die a natural death.\textsuperscript{140}

Moreover, in \textit{Re Kathleen Farrell},\textsuperscript{141} a patient suffering from a motor neurone disease was not only allowed to be disconnected from the ventilator, but also the right to professional assistance during the agonal phase was upheld by the Court.\textsuperscript{142} It was also held that, in deciding what procedures are appropriate before termination of medical care for an incompetent patient, courts are torn between conflicting impulses. And to

\textsuperscript{136} \textit{Ibid.}\textsuperscript{137} 69 CCC (3d) (1992) 450.\textsuperscript{138} \textit{Supra} note 5 at 541.\textsuperscript{139} \textit{Ibid.}\textsuperscript{140} \textit{Ibid.}\textsuperscript{141} 529 A 2d 404 (NJ, 1987).\textsuperscript{142} \textit{Supra} note 5 at 542.
avoid this tension extensive judicial review of surrogate decision making to prevent the unjustified denial of medical care is required which would avoid the imposition of slow and emotional decisions.\textsuperscript{143}

A far reaching judgment was pronounced in Bouvia v. Superior Court of Los Angeles County\textsuperscript{144}. In this case the healthcare team was instructed to provide full facilities in order to ease the patient’s dying.\textsuperscript{145} The practical and theoretical distinction between refusal of treatment and physician assisted suicide was made clear in Quill’s case.\textsuperscript{146}

It is apparent from the cases discussed above that, patients are not supposed to be forced to live on artificial life support, as they are legally entitled to request removal of life support. The ambiguity arises in cases of incompetent or comatose patients. The competent patients can express their wish to discontinue the treatment but the incompetent patients are unable to put forth their wishes. And this is the grey area where the debate is continued without any solution.

However, presently people all over the world are not aware about the advance directive. As a result of this perplexity, the debate revolves around \textit{euthanasia}, in order to let the person die peacefully. The opponents of \textit{euthanasia} take advantage of the right to refusal granted by various courts, as one of their strong point. As per the opponents there is no need of physician’s assistance in dying as far as a patient may die naturally even if withdrawn from artificial ventilation. Nevertheless, it should be noted that, a doctor’s action to switch off the life-support is considered omission, the result of which is death of the patient, and physician’s assistance in dying is considered as an illegal act, the result of

\textsuperscript{143} Supra note 121 at 1654.
\textsuperscript{144} 225 Cal. Rptr. 297 (1986).
\textsuperscript{145} Ibid.
\textsuperscript{146} Vacco v. Quill. 138 L.Ed. 2 d 834 (1996).
which is death of the patient. Hence, legalization of physician assisted suicide is strongly advocated for the fact that in any case the terminally ill patient will die, so why not let him die a quick and painless death.

By means of respirators, oxygen tanks, heart-lung and kidney-dialysis machines, intravenous feeding, drainage tubes and other modern devices and medications terminally ill patients are forced to live, whereas factually they yearn to die. Due to the astounding success of medical science and technology, physicians are now able to keep the body functioning long past its natural span, long after the mind and the spirit have ceased to exist, sometimes almost indefinitely by artificial means. They can produce what some have called a living death, or, as David Hendin has said, “[d]ying is rendered obscene by technology”. This technological capacity is fuelled by physician’s inclination to exhaust all means available in heroic attempts to keep their patients alive.

Apart from the artificial life support system, what adjoins to the suffering of terminally ill patients are the advanced painkillers. These painkillers may reduce the pain for a certain period of time but do not have the capacity to completely relieve the patient’s pain. The opponents of right to die stress the importance of painkillers against the euthanasia debate. Undoubtedly, the advanced painkillers are a result of the relentless research and inventions by scientists. It is highly appreciated that such medicines are invented for reducing the pain of patients. However, in case of terminally ill patients, these painkillers alleviate the pain for a temporary phase. And the matter of concern is not only the provisional effect of medicine but also the consumption of the painkillers.

147 Supra note 56 at 16.
148 Id., at 15.
It may be in form of a tablet, or an injection, which ever form it is taken, it indeed burdens the patient. Hence in the debate of euthanasia the painkiller drugs fail to mitigate the agony of terminally ill patients. The subsequent segment features the short fall of painkillers for terminally ill patients and also examines the use of lethal dose as an option to relieve the patients permanently by euthanasia.

3.2.2 EUTHANASIA AND THE ADVANCED PAINKILLER DRUGS AND LETHAL DOSE:

The availability and equitable access to therapeutic drugs has never been more topical or eagerly debated than at present. Not only the medical equipments such as life support systems but also the pharmaceutical industry has witnessed radical changes in the last century. Today, the medicine has miraculous effects on human body. From slight problem of headache to any cumbersome disease, doctors are ready to prescribe medicines. But is the medicine always effective? Is it equally beneficial for terminally ill patients? Both the questions have the answers in the negative. Even with the incredible development of the medicinal drugs, it lacks the capacity to deracinate the pain of the terminally ill patients. Hence, the proponents of euthanasia contend to use a few drugs to allow a terminally ill patient die a quick and painless death.

In 1936, a Bill was introduced before the British House of Lords, the purpose was to legalize medical euthanasia under certain conditions, and Lord Dawson presented before the House of Lords medical and social considerations opposing the legalization of euthanasia. Physicians, he believed, were ever more willing to alleviate the pain of the dying, even

---

151 Supra note 107 at 126.
when it involved the shortening of life. In his 1936 speech, he foresaw the emergence of a new medical practice that could be named “lethal dosing”.

In the early decades of the twentieth century this practice was widely accepted by medical practitioners. In 1988, for e.g., the AMA adopted the position that the administration of a drug necessary to ease the pain may be appropriate medical treatment even though the effect of the drug may shorten life. In fact, in 1997, Justice O’Connor of the Supreme Court of United States held that dying patients in Washington and New York could obtain palliative care, even when doing so it would hasten their death.

As a result of the ever increasing ability of the medical profession to prolong life, a growing number of people live to become the victims of degenerative diseases and senility. Though the medicinal drugs are invented to help human beings to cure diseases or reduce their pain, it is observed that the medicine also has an adverse effect on the human body. For e.g., use of narcotic analgesics in advanced cancer or the regular dose of diamorphine to maintain pain relief may prove harmful in future.

It is essential, while considering physician assisted suicide and euthanasia, to discuss the practice of “terminal sedation” or “slow

---

152 Ibid.
153 Ibid.
154 Id., at 127.
156 Supra note 56 at 5.
euthanasia”, which is knowingly performed in hospitals, nursing homes, hospices, and private homes throughout the world.

This is carried out under the doctrine loosely described as double effect, by which a doctor may lawfully give increasing doses of regular analgesic and sedative drugs that can hasten someone’s death as long as the declared intention is to ease pain and suffering.

The use of potent painkillers (especially opiates) can accelerate the moment of death, typically by depressing respiration or interfering with the gag reflex. With terminal sedation, narcotics (e.g., morphine), benzodiazepine sedative drug (e.g., valium) barbiturates (e.g., amobarbital) and/or major tranquilizing drugs (e.g., Haldol or Thorazine) are used to sedate the patient, and the sedation is maintained until the patient dies.

In 1993 the Select Committee of the House of Lords, while reconsidering England’s Suicide Act 1961, approved the distinction between the provisions of potentially lethal dosages of painkillers prescribed in response to pain and physician assisted suicide, and also expressed reference to the principle of double effect. If therapeutic drugs are given in large doses it may bring about the patient’s death. In such cases double effect can be misused to conceal its consequences. And

---

159 The terminally ill patient is beyond curative therapy and a large dose of medication is administered for the patient’s comfort which may bring about his death but the intention is not to kill the patient. This principle of double effect is invoked in the context, that an action which has a good objective may be performed despite the fact that the objective can only be achieved at the expense of a coincident harmful effect. Supra note 19 at 558. See, R. v. Adams [1957] Crim LR 365.
160 Supra note 158.
163 Supra note 52 at 68.
this may result in implied medical hypocrisy paving way to widespread practice of *euthanasia*. The doctors are authorized to do all that is necessary and possible to relieve the patient’s pain. It is also a common practice to use opiates or sedative drug in increasing doses. In some cases the patient may in consequences die sooner. And this is lawfully permitted as long as the doctor acts in accordance with the responsible medical practice with an objective of relieving pain and with no intention to kill the patient. The Select Committee rejected the charge that the doctors intention, and evaluation of the pain and distress suffered by the patient, are of crucial significance in judging double effect\textsuperscript{164}.

In *Washington v. Glucksberg*\textsuperscript{165}, the US Supreme Court, has accepted- and even endorsed- terminal sedation but rejected physician assisted suicide. The Court in this case has given physicians permission to employ a treatment that is essentially a form of *euthanasia*.\textsuperscript{166} Such terminal sedation serves fewer of the purpose of right to die law while posing a greater threat to patient’s welfare.

The appropriate use of strong opioid pain relief has been seriously hampered by an irrational fear of addiction in terminally ill patients, and by society's failure to distinguish between the legitimate and illegitimate uses of opioids. Obviously pain management includes the use of a full arsenal of many different drugs, doses, and means of delivery depending on the specific patient needs and reactions. Terminally ill patients rarely abuse pain medications, but tolerances to them develop and increases in pain means that for some patients larger doses are needed to control symptoms. When less potent or smaller doses of pain medications prove inadequate, physicians must feel free to use or to prescribe increasingly

\textsuperscript{164} Ibid.
\textsuperscript{165} Supra note 155.
\textsuperscript{166} Supra note 162 at 968.
higher doses of strong opioids like morphine.\textsuperscript{167}

The goal of relieving suffering is receiving increasing attention by health professionals, and informal strictures against the use of certain analgesics are being discarded as irrelevant in the case of dying patient.\textsuperscript{168}

The explosive growth of sophisticated medical techniques guarantees that large numbers of patients and physicians will face daily life support decisions with only insufficient legal guidelines defining their respective rights and responsibilities.\textsuperscript{169} On one side, the doctors are legally prohibited to prescribe lethal dose to terminally ill patients to end their life and on the other side, the widespread practice of terminal sedation or double effect, allows doctors to increase the medication which may prove fatal for the patient. Instead of having such bewildering situation, it is in the interest of terminally ill patient to have \textit{euthanasia} legalised.

What can be termed as the immediate reason to wish to die at the earliest? Is it the modern technology, the advanced medicine or the life support system which tempts one to die? Certainly, all these issues form a ground to die an early death, but what constitutes the backbone of \textit{euthanasia} debate is the “terminal illness”. There is need to deal with various diseases leading to terminal illness. The researcher intends to put forth the agony and suffering borne by the terminally ill patients which demonstrates an intensive requirement to legalize \textit{euthanasia}.


\textsuperscript{168} \textit{Supra} note 161.

3.3. TERMINAL ILLNESS: A PHASE AWAITING EUTHANASIA:

Terminal illness is a medical terminology popularized in the 20th century for an active and malignant disease which cannot be cured and is expected to lead to death. This term is more commonly used for progressive diseases such as cancer or advanced heart diseases than for trauma. A patient who has such illness may be referred to as a terminal patient or terminally ill. Terminal illness may be defined as illness in which the application of life-sustaining procedures serves only to postpone the moment of death of the patient. Terminal illness means active and progressive illness for which there is no cure and the prognosis is fatal.

Euthanasia activists refer terminal illness as, “hopelessly ill,” “desperately ill,” “incurably ill,” “hopeless condition”, and “meaningless life”. “Hopeless condition” was defined to include terminal illness, severe physical or psychological pain, physical or mental debilitation or deterioration, or quality of life that is no longer acceptable to the individual.

Although some critics assert that the phrase “terminally ill” is overtly vague, it can be defined for the purposes of legal analysis. A common definition restricts the group to those determined to have less than six months to live. Chronic illnesses that become terminal bring loss for

---

172 [Supra note 78 at 552.](http://international.westlaw.com)
both ill patients and their caretakers. In such conditions most patients would prefer a quick death instead of a prolonged and agonizing one.

There is a growing terminally ill population in the world. Physicians increasingly face a difficult request from their patients to have the physician assistance to die with dignity. National surveys suggest that one in five physicians in the United States have received at least one request to assist a terminally ill patient to die. And the basic reason for this is persons requesting and receiving assistance in dying are seriously ill with little time to live and a high burden of physical suffering.

Undoubtedly, patients suffering from terminal illness who are in the advanced stage of their illness undergo excruciating pain, but the situation further deteriorates in case of a patient in persistent vegetative state. What are the characteristics of patients in persistent vegetative state which prompt all the concerned to plead for *euthanasia* let us find out.

### 3.3.1 TERMINAL ILLNESS AND PERSISTENT VEGETATIVE STATE:

Persistent vegetative state medically means a condition in which the brain stem continues to function but the cortex is wholly destroyed. It is also described as a condition where the patient is unconscious or

---

181 Ibid.
182 Ibid.
183 Supra note 19 at 505.
comatose and is incapable of fulfilling his daily function and is totally dependant on others. This condition was first fully explored in 1972 by Jennet and Plum.\textsuperscript{184} Persistent vegetative state directly strikes at certain issues which are central to the euthanasia debate, such as, the quality of life, dignity of individual, right to refuse treatment and indeed request for right to die.\textsuperscript{185} Patients in persistent vegetative state are considered as terminally ill patients. Following are the criteria for the diagnosis of the vegetative state:\textsuperscript{186}

- No evidence of awareness of self or environment and an inability to interact with others;
- No evidence of sustained, reproducible, purposeful, or voluntary behavioural responses to visual, auditory, tactile, or noxious stimuli;
- No evidence of language comprehension or expression;
- Intermittent wakefulness manifested by the presence of sleep-wake cycles;
- Sufficiently preserved hypothalamic and brainstem autonomic functions to permit survival with medical and nursing care;
- Bowel and bladder incontinence;
- Variably preserved cranial-nerve and spinal reflexes.

From the above characteristics it is quite easy to visualize the unpleasant condition a PVS patient suffers. In this situation a request for

\textsuperscript{185} \textit{Supra} note 78 at 414.
euthanasia may be inevitably put forth to relieve the patient from unnecessary burden of life.

Apart from persistent vegetative state, there are various diseases which lead to terminal illness. Patients suffering from these diseases may in later stage enter the vegetative state as well.

### 3.3.2 DISEASES LEADING TO TERMINAL ILLNESS:

For the categorization of “terminally ill” the following criteria apply:

1. A clear definition of “terminal illness” so that almost all individuals may be classified correctly.

2. A reasonable survival period of persons who are categorised as “terminally ill”.

3. A period of terminal illness recognizable for most lethal chronic diseases.\(^{187}\)

It is of immense relevance in the euthanasia debate to discuss in detail the diseases leading to terminal illness. A request to die an easy and painless death is the outcome of atrocious and horrendous suffering borne due to such diseases in their advanced stage. By describing a few diseases in the present segment, the researcher makes an attempt to put forth the plight of terminally ill patients.

### 3.3.2.1 ALZHEIMER:

Alzheimer is an incurable, degenerative terminal illness which was first described by German psychiatrist and neuropathologist Alois Alzheimer in 1906 and was named after him.\(^{188}\)

Alzheimer is a disease which has a characteristic of disorder leading to a humiliating helpless condition at the later stage. It is one of the supreme ironies of the advanced medicine that there is no treatment that can completely cure or arrest the progress of this disease. Alzheimer disease is a common condition in old age with a prevalence of ten per cent among those aged seventy-five years and over and twenty per cent among those aged eighty-five years and above.\[^{189}\] For a common man this disease means loss of memory in old age. Tumours of the frontal or temporal lobes, chronic subdural haematoma, myxoedema and vitamin B\_12 deficiency can cause progressive mental deterioration with cognitive impairment as the main feature, although emotional characteristics and the personality are better preserved in the secondary dementias\[^{190}\] than in Alzheimer disease.\[^{191}\]

The stages in the progression of this disease become severe with the passage of time. In the initial stage for about two years, symptoms comprise of impairment of memory, waning of interest and gradual diminution of capacity for reasoning, calculation and abstract thought.\[^{192}\] In the second stage of three to four years, progressive intellectual impairment, personality deterioration and liability of emotions, followed by blunting and apathy, occur.\[^{193}\] During the later part of this stage, there is increased loosening in the cohesion of language and complexity in the


\[^{190}\] Ibid. Dementia is a progressive dysfunction which leads to gradually restricting daily activities. Most known type of dementia is Alzheimer. [http://www.alzheimers.treatment.org](http://www.alzheimers.treatment.org), [http://www.alz.org](http://www.alz.org), [accessed on 24/2/2011].

\[^{191}\] Id., at 270.

\[^{192}\] Id., at 271.

\[^{193}\] Ibid.
expression and comprehension of speech. Growing impoverishment and impediment in writing and reading reflect progressive devastation of certain parts of the brain which are concerned with storage, integration, and creative use of language, apraxia renders the patient dependent on others for daily courses and becomes incapable of feeding himself or even responding to requests or commands. Emotions, such as, pleasure, melancholy, irritation, anger, distress or affection, are all annihilated and only a profound and unvarying apathy prevails. High proportion of patients are bedridden, immobile, doubly incontinent, unable to recognise their relatives or friends or even their own reflection in the mirror and are totally unconscious of their humiliating and vulnerable condition.

Attempts to resuscitate such patients restore patients to an existence that is not a life in a real sense. The patients with Alzheimer’s disease who have reached the above mentioned feeble stage should be allowed to proceed to the end of life peacefully. In 2006, there were 26.6 million sufferers worldwide and the prevalence of Alzheimer’s is thought to reach approximately 107 million patients by 2050. In 2010, the number of Alzheimer’s patients worldwide having deterioration of memory and other cognitive domains has reached 35 million which was 26.6 million in 2006. As compared to the western countries, the situation in India may not be so alarming. But, at the same time it is of immediate concern, as the population of senior citizens in India according to the 2001 census

---

194 Ibid.
195 Apraxia is a neurological disorder characterized by loss of disability to execute skilled movements and gestures. [http://www.ninds.nih.gov](http://www.ninds.nih.gov), [accessed on 24/2/2011].
196 Supra note 189.
197 Ibid.
198 Id., at 273.
199 Ibid.
was seventy million.\textsuperscript{202} The danger of increase in Alzheimer patients in India cannot be refuted as people above sixty years of age are the common victims of this disease. In 2000, India had approximately 3.5 million Alzheimer patients.\textsuperscript{203} In spite of the multiplying number of senior citizens and presence of millions of Alzheimer patients, the research on Alzheimer disease is still in the initial stage in India. The patients who are already suffering from Alzheimer in India are forced bear intolerable pain.

The Alzheimer patients at the advanced stage experience a degrading and mortifying phase of life. If such patients plead for \textit{euthanasia} which would finally relieve the patient of his dreadful state of affairs, why does the law force them to live? A similar condition is faced by the patients of Muscular Dystrophy.

\textbf{3.3.2.2. MUSCULAR DYSTROPHY:}

The muscular dystrophies are a group of more than thirty genetic diseases characterized by progressive weakness and degeneration of the skeletal muscles that control movement.\textsuperscript{204} There are different types of muscular dystrophy.

\begin{itemize}
  \item [a)] Duchenne muscular dystrophy:\textsuperscript{205}
\end{itemize}

Duchenne muscular dystrophy is a severe recessive form of muscular dystrophy characterized by rapid progression of muscle degeneration, eventually leading to loss of ambulation and death.\textsuperscript{206} Symptoms usually appear in male children before the age of five. By the age of ten, braces

\textsuperscript{202} Mishra, Sailesh, “Rise of Alzheimer cases for seen in India too” \texttt{http://www.alzheimerdiseaseindia.com}, [accessed on 24/2/2011].
\textsuperscript{203} Ibid.
\textsuperscript{204} \texttt{http://www.ininds.nih.gov/disorders/md/md.htm}, [accessed on 29/1/2010].
may be required to aid in walking, but most patients become dependant
on the wheelchair by the age of twelve as progressive proximal muscle
weakens legs. Due to progressive deterioration of muscle, loss of
movement occurs eventually leading to paralysis.

b) Becker’s muscular dystrophy.207

Becker’s muscular dystrophy is a less severe variant of Duchenne
muscular dystrophy and is caused by the production of truncated, but
partially functional form of dystrophin.

c) Congenital muscular dystrophy.208

Congenital muscular dystrophy includes several disorders with a range of
symptoms, including muscle degeneration and muscle degenerated may
be paired with effects on the brain and other organ systems.

d) Distal muscular dystrophy.209

Distal muscular dystrophies develops between the age of twenty to sixty
years. Symptoms include weakness and wasting of muscles of hands,
forearms, and lower legs. The progress is slow and not life-threatening.

e) Emery-Dreifuss muscular dystrophy.210

Emery-Dreifuss muscular dystrophy develops during childhood to early
teens. Symptoms include upper arm, and shin muscles, joint deformities
are common and sudden death may occur from cardiac problems.

f) Facioscapulohumeral muscular dystrophy.211

---

207 Dastur, Rashna, S., et.al., “Becker’s Muscular Dystrophy in Indian patients: Analysis of
http://www.bioonline.org , [accessed on 24/2/2011].
210 Ibid.
Facioscapulohumeral muscular dystrophy initially affects muscles of the face, shoulders, and upper arms with progressive weakness. Some affected individuals become severely disabled.

g) Limb-girdle muscular dystrophy:212

Limb-girdle muscular dystrophy results in muscle weakness, affecting both upper arms and legs. Death from limb-girdle muscular dystrophy is usually due to cardiopulmonary complications.

h) Myotonic muscular dystrophy:213

Myotonic muscular dystrophy is the most common adult form of muscular dystrophy. It varies in severity and manifestations and affects many body systems in addition to skeleton muscles, including the heart, endocrine organs, eyes, and gastrointestinal tract.

i) Oculopharyngeal muscular dystrophy:214

Oculopharyngeal muscular dystrophy may develop during age forty to seventy years. Symptoms affect muscles of eyelids, face, and throat followed by pelvic and shoulder muscle weakness.

All the forms of muscular dystrophy finally lead to a terminal illness and there is no specific treatment to stop or reverse any form of muscular dystrophy. Basic treatment may include physical therapy,215 respiratory therapy,216 speech therapy,217 orthopaedic appliances used for support etc.

212 Ibid.
214 Ibid.
215 Physical therapy includes various muscle exercises to provide a temporary relief to the patient. http://www.clevelandclinic.org , [accessed on 24/2/2011].
217 The speech therapy is provided to enhance communication via expressions of ideas, desires and interpersonal interactions. http://www.brightots.com , [accessed on 24/2/2011].
Some patients may need assisted ventilation to treat respiratory muscle weakness and a pacemaker for cardiac abnormalities. Muscular dystrophy occurs worldwide, affects all races and some types of muscular dystrophy are more prevalent in certain countries and regions of the world. It is disappointing to state that there has been no survey conducted in India to find out the approximate number of patients suffering from muscular dystrophy in the country. In 2007, a letter was addressed to the Home Minister of India, Mr. P Chidambaram, pleading to include muscular dystrophy as one of the type of disability in the census of 2011. This letter was written on behalf of the fifteen hundred patients suffering from muscular dystrophy in Tamil Nadu which is a State of India. One can envisage that if there are fifteen hundred patients afflicted in one State of a highly populated country like India, what can be the number of patients all over the country? However, no action has been initiated by the Government of India for the patients of Muscular Dystrophy in response to the letter till date.

Out of more than thirty kinds of muscular dystrophy, nine types discussed in this part of the research acquaint us with the distress tolerated by the victims of muscular dystrophy. It should be noted that there is no cure for this disease and it is a fatal disease. Hence, patients suffering from muscular dystrophy in their advanced stage may be considered for euthanasia if desired by the patient.

---


3.3.2.3. MULTIPLE SCLEROSIS:

Multiple Sclerosis was first described in 1868 by Jean Martin Charcot. It is also known as disseminated sclerosis. It is a disease in which the axons of the brain and spinal cord are damaged, which affects the ability of the nerve cells in the brain and spinal cord to communicate with each other. Almost any neurological symptom such as, blurred vision, blindness,\textsuperscript{221} etc., can appear with the disease, and often progresses to physical and cognitive disability and neuropsychiatric disorder. There is no known cure for multiple sclerosis. As compared to the initial symptoms, the degree of disability increases as the time advances.\textsuperscript{222}

This disease occurs in young adults, and it is more common in females, it has a prevalence that ranges between two and one hundred per one lakh.\textsuperscript{223}

Multiple sclerosis affects more than a quarter of a million people in the United States. People of northern European heritage are more likely to be affected than people of other racial backgrounds, and multiple sclerosis rates are higher in the United States, Canada, and Northern Europe than in other parts of the world. Multiple sclerosis is very rare among Asians, North and South American, Indians, and Eskimos.\textsuperscript{224} However, in India, forty to fifty thousand people are affected with Multiple sclerosis.\textsuperscript{225} An approximate prevalence rate is 0.17 to 1.33 per one lakh population in India.\textsuperscript{226}

\textsuperscript{221} \url{http://www.multi.sclerosis.org}, [accessed on 24/2/2011].
\textsuperscript{222} \url{http://en.wikipedia.org/wiki/Multiple_sclerosis}, [accessed on 29/1/2010].
\textsuperscript{223} \url{http://wapedia.mobi/en/Multiple_sclerosis}, [accessed on 29/1/2010].
\textsuperscript{224} \url{http://www.answers.com/topic/multiple-sclerosis}, [accessed on 29/1/2010].
\textsuperscript{225} “Multiple Sclerosis- History and Prevalence” \url{http://www.kandmool.com}, [accessed on 24/2/2011].
Even in case of multiple sclerosis there is no medicinal cure available in any part of the world. The patients of this ailment at an advanced stage too face anguish resulting in inhuman and meaningless existence. Such exceptional cases after due consideration may be considered for *euthanasia*.

### 3.3.2.4. AIDS/HIV:

AIDS could be considered a terminal illness, but most patients with AIDS succumb to other illness due to their deficient immune system.\(^{227}\) It is reported that fifty per cent of patients with AIDS consider physician assisted suicide or *euthanasia*.\(^{228}\) In Netherlands, one-third of patients dying with AIDS receive *euthanasia* or physician assisted suicide.\(^{229}\) In India the first AIDS case was detected in 1986. And at present, there are 2.3 million people affected by AIDS in India.\(^{230}\)

AIDS patients can go through stages of neuropathy, the most common are those affecting brain. It also leads to changes of behaviour accompanied with symptoms of senility. But at the same time AIDS sufferers should not, until the very last stage of disease, be treated as terminally ill patients.\(^{231}\) AIDS resulting from infection with HIV may directly or indirectly affect any organ system.\(^{232}\) However, a recent research claims that a drug Viracept Generic Nelfinavir in combination


\(^{229}\) Ibid.


with Zidovudine, may treat AIDS patient.\textsuperscript{233} This drug can control the spreading of virus in the body.

A basic over-view of the most common afflictions of AIDS patients provides insight into choice of physician assisted suicide by many people suffering from the disease.\textsuperscript{234} The likelihood of impairment or incompetence in the course of HIV infection instils in many AIDS patients a fear of loosing control of their affairs, and raises serious concerns about the requisites for medically assisted suicide legislation.\textsuperscript{235}

However, patients suffering from AIDS are not terminally ill. AIDS patients are victimized not only by the physical ailment but also by psychological persecute. Hence such cases may not fall in the category to be considered for euthanasia. Euthanasia, if legalized should be considered in rarest of the rare cases in which the patient is beyond the scope of recovery and undergoes immense physical pain and agony.

3.3.2.5. IDEOPATHIC PULMONARY FIBROSIS:

Pulmonary Fibrosis is a disease inflicting the lung. Symptoms of the disease are shortness of breath, feeling of discomfort in the chest, loss of appetite, exhaustion, weariness and dry irritating cough. With the progression of time the fibrous tissue becomes denser, and prevents the transfer of oxygen into the bloodstream, leading to a terminal illness.

There is no specific treatment for the disease as the drugs are still in the experimental phase. Among the American community forty thousand

\textsuperscript{233} \url{http://www.medicalhealthforum.com}, [accessed on 24/2/2011].


\textsuperscript{235} \textit{Id.}, at 379.
people fall victims to this disease.\textsuperscript{236} There is no specific statistics available of patients suffering from this disease in India. But there are thousands of cases of idiopathic pulmonary fibrosis in India.\textsuperscript{237}

Patients suffering from idiopathic pulmonary fibrosis may be considered for \textit{euthanasia}. But only in the cases where the patient is in the final stage of the disease and life is unbearable due to the affliction of his physical condition.

\textbf{3.3.2.6 CANCER AND ITS DIFFERENT TYPES:}

Cancer is a class of diseases in which a group of cells display uncontrolled growth and invasion. Cancer is caused by the abnormalities in the genetic material of the transformed cells. Pain is one of the most common and feared symptoms by patients with cancer and is present in one third of patients increasing to two-thirds of patients who are terminally ill.\textsuperscript{238} It affects people at all ages with the risk for most types increasing with age. Cancer caused about thirteen per cent of all human deaths in 2007 (7.6 million) worldwide.\textsuperscript{239} In India three million people are affected by cancer.\textsuperscript{240}

Cardio-vascular diseases and cancer is the scourge of mankind today. Medicine is yet considerably less well alarmed against them.\textsuperscript{241} Cancer

\begin{itemize}
\item \textsuperscript{239} http://en.wikipedia.org/wiki/Cancer, [accessed on 29/1/2010].
\end{itemize}
patients generally are given chemotherapy which is a complex treatment. Chemotherapy may be given with an aim to prolong life or to palliate symptoms.\textsuperscript{242} Repeated attempts to cure the disease with traditional treatments have failed.\textsuperscript{243}

In recent years attitudes towards voluntary \textit{euthanasia} in certain cases such as terminal cancer appear to have become more liberal, and physicians are no longer necessarily expected to undertake all possible measures to sustain life in hopeless situations.\textsuperscript{244}

Types of cancer leading to terminal illness:

a. Lung Cancer: \textsuperscript{245}

Lung cancer is termed as another terminal illness, claiming the lives of millions of people across the world. The reason is because lung cancer, in contrast to other forms of cancer, cannot be treated with chemotherapy. It has a tendency to be diagnosed in its later stages, as a result people suffering from it have less chance of high life expectancy. When the cancer cells are not able to confine themselves to the lung, spread to other parts of the body patients enter the advanced stage of lung cancer. Treatments such as beam radiation, laser therapy, brachytherapy may help relieve some pain, however, do not cure lung cancer.\textsuperscript{246}

b. Acute Leukemia: \textsuperscript{247}

\begin{footnotes}
\item[246] \url{http://www.smallbusinessbible.org/types_terminalillnesses.html}, [accessed on 29/1/2010].
\item[247] \url{http://www.marrow.org}, \url{http://www.cancercompass.com}, [accessed on 24/2/2011].
\end{footnotes}
Acute leukaemia, sometimes is referred as acute lymphocytic leukaemia. It is a different form of cancer originating in the blood and bone marrow. The infected blood cells tend to increase with the time, and eventually destroy the healthy blood cells in the person. This results in reducing the resistance power which makes the patient more vulnerable to infectious sicknesses. At a later stage, lumps are formed in the lymph nodes of neck, underarm, and stomach.\(^{248}\)

c. Pancreatic Cancer: \(^{249}\)

Pancreatic cancer can be considered as one of the most fatal forms of cancer. There is a formation of tumour within the pancreas which prevents the release of the enzymes from the pancreas. This prevents the individual from digesting food resulting in loss of weight leading to inevitable death due to malnutrition. Although there is some preventive treatment for this type of disease, victim of this disease has little hope of living, hence it is termed as a terminal illness.

Cancer and AIDS are curable during the early stages. It is only when such diseases pass towards the last stage medicine cannot improve the patient’s condition. Recently a new therapeutic vaccine called ‘Provenge’ for terminal prostate cancer has been discovered.\(^{250}\) The fact that new medicine may change the fate of cancer patients should not be ignored in the euthanasia debate.

Cancer though is a terminal illness, all the patients do not fall in the category of incomparable cases. Cancer in this scientific era is not untreatable. There are different medicines and other medical treatment

\(^{248}\) Ibid.  
such as, chemotherapy, radiation, etc., available to curb the disease. However, patients in the final stage of cancer undergo immeasurable pain and loss of dignity. Only such cases may be considered for euthanasia or physician assisted suicide.

3.3.2.7. HEPATITIS B:

This disease is known as a disease which disrupts the function of the liver. Hepatitis B is hundred times more infectious as compared to the AIDS virus, and it destroys the liver for a permanent period of time, until inevitable death occurs. The disease can prove fatal if the immune system cannot fight off the disease, and may result in the evolving of the more serious disease such as liver cancer or cirrhosis, and finally death of the individual.

Approximately more than forty million Indians are affected with Hepatitis B and every year more than one lakh people die due to illness related to Hepatitis B in the country.

Today, diseases like Hepatitis B can be prevented by vaccination. Though it is preventable there are very rare chances of recovery as the virus transmits through blood which may cause irreparable damage to various organs of the human body. It is said that if diagnosed positive for this disease, in the developed stage, it is difficult to survive. Patients ailing at their advanced stage may be considered for euthanasia on voluntary request.

252 Supra note 246.
3.3.2.8. CROHN’S DISEASE: 254

Crohn’s disease is an autoimmune disease. In this disease the body’s immune system attacks the gastrointestinal tract, causing inflammation. It is classified as a type of inflammatory bowel disease. 255 Currently there is no cure for Crohn’s disease and remission may not be possible or prolonged.

Crohn’s disease is not very common as compared to AIDS or Cancer. However, during last decade cases of Crohn’s disease have been reported more frequently from different parts of India. 256 Though there is no specific data available for a definite figure of Crohn’s disease patients in India, it is reported that children are more victimized by this disease. 257 The victims of this disease face a situation of anguish and distress. As there is no cure available, patients suffering in the final stages may be considered for euthanasia.

3.3.2.9. CHRONIC SEVERE DISABLEMENT: 258

Chronic severe disablement covers a wide range of degenerative disorders, such as, Huntington’s disease or motor neurone disease. Patients suffering from these diseases in the late stage can be described as severely disabled and dependent for all their activities which may further lead to a persistent vegetative state. A few examples of chronic severe disability are paralytic condition of the patient, who is suffering from ‘locked-in-syndrome’, where there is total paralysis except for the ability

258  http://www.chroniccareindia.org , [accessed on 24/2/2011].
to move the eyes. Another rare phenomenon is the advanced case of Gullion-Barre syndrome in which there is total paralysis, but no mental impairment, yet termination of life may be sanctioned on the strength of the request made by the patient, who is unable to endure his totally helpless state.

There is no accurate statistic available of the number of patients suffering from chronic severe disability in India. However, it has been recorded that sixty per cent of deaths every year in India occur due to chronic severe disabilities.

There can be various types of chronic severe disablement, physical, mental, etc. In such cases severe unremitting pain would seem to be the most obvious reason to request euthanasia. Chronic severe disablement forms a strong base to argue for euthanasia as the patient suffers from intractable pain and the doctors are in a helpless position.

3.3.2.10. GERI PSYCHOSIS:

It is a psychosis of old age characterized by the deterioration of the brain tissue and progressive mental deterioration. Geri psychosis in later stages leads to loss of proper brain function resulting in dependent life with a terminal illness.

Exceptional cases depending on the condition of the patient may be considered for euthanasia.

---

260 Supra note 189 at 267.
261 http://www.who.int, [accessed on 24/2/2011].
The above mentioned diseases are commonly known as diseases leading to terminal illness, but the fact that unique researches propounding new medicines may make an irredeemable disease curable with the invention of new drugs, cannot be ignored. Medicines which may cure or reduce the pain and suffering of the terminally ill patient can bring a relief for such patients.

In an endeavour to solve the problem of patients, physicians should take into account the different aspects of suffering of patients such as, physical, psychological, recreational, social, and clinical who ask for euthanasia. Uncontrolled pain and other distressing symptoms are the primary concerns and greatest fears of patients facing serious illness. There is no medical treatment that can arrest the path of the disease towards an inevitable death, and medical treatment is limited to alleviate pain. It should be empathized that terminally ill patients who fail to mitigate their pain despite of all the medical therapies available are not comparable to the patients who are treated for seasonal allergies. And such patients should be allowed to end his or her life with dignity after having received every accessible type of curative and palliative care.

---


is also argued that, next to autonomy and mercifulness, “reciprocity” is a condition *sine qua non* for *euthanasia*.\textsuperscript{269}

The diseases and the symptoms discussed above are evident to prove the fact that living as a terminally ill patient is nastiest than dying. The plight of the terminally ill is an issue defined by the unending struggle between technology and the law. As medical technology has advanced, it has accomplished the capability both to prolong human life beyond its natural end point and to better define when that end point will occur.\textsuperscript{270}

It is argued on the principle of sanctity of life that under any circumstances *euthanasia* should not be legalized. The act of aiding or assisting the terminally ill patient to die directly violates the sanctity of life. However, does it mean that the terminally ill patient ought be forced to live an undignified life? Is there any ray of hope for such patients? Is there any way out which may substitutes *euthanasia* as a death with dignity? The opponents of *euthanasia* envisage the recently approaching concept of hospice and palliative care as an alternate to *euthanasia*. According to them hospice and palliative care provides an easy passage with dignity to the terminally ill patients. It is apt to critically evaluate the efficacy of hospice and palliative care in the debate of *euthanasia* at this point.

\begin{footnotesize}
\begin{enumerate}
\end{enumerate}
\end{footnotesize}
3.4. HOSPICE AND PALLIATIVE CARE: AN ALTERNATE FOR EUTHANASIA: A CRITICAL ANALYSIS

The word “hospice” is derived from the Latin Hospes, a word which served double-duty in referring both to guests and hosts. Hospice is a type of care and a philosophy of care which focuses on the palliation of a terminally ill patient’s symptoms which can be physical, emotional, spiritual or social in nature. The modern concept of hospice includes palliative care for the incurably ill given in such institutions as hospitals or nursing homes. The concept of hospice has been evolving since 11th century but the foundational principles by which modern hospice services operate were pioneered in the 1950’s by Dame Cicely Saunders.

It has been asserted that hope is an essential part of hospice care. Traditionally it is said, “[w]hile there’s life, there’s hope”, but as per Robert Twycross, “[w]here there is hope there is life”. He defines hope as an expectation greater than zero of achieving a goal, thus goal setting is an integral part of hospice care.

Through hospice, when high quality care is provided to those with advanced progressive incurable disease, the demand for euthanasia on grounds of compassion disappears. In fact, the hospice workers offer a humane alternative to the notion of physician assisted suicide. It is also argued that relieving pain, restoring dignity, quality of life and giving people back control over their lives is far better than fatal injections.
Hospice care can be provided in two ways. One type of hospice is attached to the hospital whereas the other is the in-home hospice care. The in-home hospice care can be provided in the house of the terminally ill patient. The time when continued attempts to cure are not compassionate, hospice care, helps by placing all efforts on making the patient’s remaining time comfortable.277

Despite the fact that hospice care makes an attempt to allow a comfortable passage, hospice has faced resistance springing from various factors, including professional or cultural taboos against open communication about death among physicians includes increase in new diseases, discomfort with unfamiliar medical techniques, and professional callousness towards the terminally ill.

A comparable provision to hospice is the concept of palliative care for terminally ill patients. Pain management in terminal illness can also be controlled and comforted by comprehensive palliative care.

Palliative care is the stipulation of therapy or drugs which intends to relieve pain and make the patient comfortable until death occurs.278 Palliative care is needed by all those suffering from advanced progressive incurable disease.279 The definition which was adopted in 1987, when palliative medicine was recognised in Britain as a medical speciality, states that “palliative medicine is the study and management of patients with active, progressive, far-advanced disease for whom the prognosis is limited and the focus of care is the quality of life”.280

280 Ibid.
The most recent World Health Organisation definition describes palliative care as an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, such as, physical, psychological and spiritual. On the whole palliative medicine facilitates the process of farewell to life without speeding up death.

The palliative care concept derives from the acceptance that at some point of chronic illness, the medical response must turn from curing the patient already beyond cure to caring for and relieving the patient’s pain and other symptoms. The goal is to relieve suffering and provide the best possible quality of life for patients and their families. It also is an imperative to improve the terminal quality of life so that prolonged suffering can be prevented. Palliative care neither hastens nor prolongs death, primarily it aims at alleviating suffering and improving quality of life for the patients and their families. Likewise, palliative medicine is to ensure that a person’s physical and emotional distress is controlled or reduced as much as possible. Palliative care is the medical speciality focused on relief of the pain, stress and other debilitating symptoms of serious illness.

---


283 Supra note 167 at 256.


Palliative care is not completely the same as hospice care. Palliative care may be provided at any time during a person’s illness, even from the time of diagnosis, and, it may be given at the same time as curative treatment. Whereas hospice care is focused on terminally ill patients who no longer seek treatment to cure them and who are expected to live for about six months or less.\textsuperscript{288}

Some medical professionals are of the opinion that doctors should not advocate \textit{euthanasia} only because their patients have unbearable suffering. On the contrary, they should seek assistance from a multidisciplinary team experienced in the management of terminal illness through expertise in palliative care. As it may not be possible to cure or reverse advanced disease, but it is never impossible to care. Palliative care experts also believe that the number of patients with unavoidable and intolerable pain is very small.\textsuperscript{289} Doctors against \textit{euthanasia}, claim that \textit{euthanasia} will encourage poor medical practice, and as a result the principles of palliative care will be lost and there will be no professional pride in the skilful palliation of symptoms and the support of patients and their families through terminal illness.\textsuperscript{290}

Similarly the opponents of \textit{euthanasia} fear that the elderly and vulnerable may feel pressure to request for \textit{euthanasia} if it is legalized. At the same time, legalization of \textit{euthanasia} entails the infinitesimal moral and ethical concerns of patient’s right to request and receive \textit{euthanasia} or physician assisted suicide may take precedence over the

\textsuperscript{288} \textit{Ibid.}
\textsuperscript{290} \textit{Supra} note 228 at para 4.2.
immeasurable moral and ethical concern for the autonomy of others in society.\(^{291}\)

The antagonists of *euthanasia* project palliative care as the appropriate treatment for terminally ill patients. It has also been observed through various survey’s and reports\(^{292}\) that appropriate and multidisciplinary palliative care greatly reduces requests for physician assisted suicide. A report from the Mildmay Mission Hospice in London, states that there were one thousand eight hundred admissions over a three year period but only one requested for *euthanasia*, also in one report in which palliative care was an option, eighty-six per cent of respondents chose palliative care, nine per cent physician assisted suicide, and five per cent *euthanasia*.\(^{293}\)

As Netherlands is the first country to legalize *euthanasia*, it is critically analyzed that, palliative care is hardly known to Dutch doctors and medical students. In fact, medical students are trained in how to practice *euthanasia* but not in the diagnosis and treatment of symptoms in terminal care.\(^{294}\) Most physicians in the Netherlands are not convinced that palliative care can always alleviate all suffering at the end of life and believe that *euthanasia* could be appropriate in some cases.\(^{295}\)

A further argument which has been advanced against legalization of active voluntary *euthanasia* is that it would discourage the search for new cures and progress in palliative care.\(^{296}\) In evaluating these arguments it is

\(^{291}\) *Id.*, at para 4.3.

\(^{292}\) *Supra* note 228 at para 2.4 and 8.6.

\(^{293}\) *Ibid.*

\(^{294}\) *Id.*, at para 5.14.


important to note that mixed views are held in respect of active voluntary *euthanasia* amongst those involved in the provision of palliative care.²⁹⁷

The palliative care approach attaches great importance to the avoidance of intrusive medical interventions, unless improved quality of life is clearly likely to result.²⁹⁸ In fact it is argued that comprehensive and multidisciplinary palliative care can effectively relieve much of the suffering of the terminally ill which is presently cited as a justification for *euthanasia* or physician assisted suicide.

With regard to palliative care there is an urgent need for professional education about the management of patients with advanced disease including acknowledgement of the vital role of the multidisciplinary aspects of palliative care²⁹⁹-

- Palliative care should be an integral part of the management of the patients with advanced diseases and not geographically or ideologically separated from mainstream medicine.
- The public need to be educated about what palliative care can offer.
- There needs to be universal access to expert multidisciplinary palliative care.³⁰⁰

---

²⁹⁸ Supra note 279 at 303.
²⁹⁹ Supra note 228 at para 10.3.
³⁰⁰ It is disappointing to state that, in India the access to palliative care can be equated to a dream which never becomes a reality. Palliative care can be provided universally only when the State is equipped with proper medical facilities. Otherwise, a very number of patients, who can afford to pay heavy bills of the doctors, will avail the benefit of palliative care. And the maximum number of patients, for want of money will await their death with pain and agony. And this may happen as fifty percent of Indian population do not have access to basic medical facilities. Over 700 million Indians live in rural areas for such people basic medical facilities are unavailable, hence palliative care in the last phase of life is impossible. Moreover, sixty-nine percent of Indians do not have access to adequate sanitation, thus when the State is unable to provide basic medical facilities and sanitation, will the State provide palliative care to terminally ill patients? This is the practical situation in India at present. See, Sujata, Manohar, “Human Rights Agenda: A Perspective For Development” *JILI*, vol. 45, no. 2, April-June 2003, p. 219- 220.
According to the challengers of euthanasia, allowing dying or assisting in dying is not the solution for a patient in terminal illness. Similarly, supporters of hospice and palliative care claim that the uncontrolled suffering in a dying patient is a medical emergency, and not an allusion for euthanasia. 301 It is also advocated that more than ninety per cent of the pain associated with severe illness can be relieved if physician adheres to well-established guidelines and seeks help, when necessary, from experts in pain management or palliative care. 302

The provision of appropriate palliative and hospice care for terminally ill patients is now increasingly being seen as part of mainstream medicine. 303 It is also said that intolerable suffering should be treated with a holistic approach of care to diminish distress and enhance a sense of positive-ness by proper hospice care and effective palliative care. A good standard of medical care includes conscientious assessment, through professional attention, competent and considerate management, appropriate and prompt action and readiness to consult professional colleagues. 304

A major step towards the development of hospice and palliative was taken by Dr. Magno. In 1984, Dr. Josefina Magno, who had been instrumental in forming the American Academy of Hospice and Palliative Medicine, founded the International Hospice Institute, which later became the International Association for Hospice and Palliative Care. There are more than eight thousand hospice and palliative services established in more than hundred countries. 305 Standards for palliative

301 Supra note 228 at para 2.1.
302 Supra note 265.
303 Supra note 297 at 294.
305 Ibid.
and hospice care have been developed in a number of countries around the world, including Australia, Canada, Hungary, Italy, Japan, Moldova, Norway, Poland, Romania, Spain, Switzerland, Africa, Zimbabwe, Harare, Nairobi, Kenya, South Africa, Uganda, Poland, India, China, Hong Kong, Russia, Taiwan, the United Kingdom and the United States. The first American hospice, the Connecticut Hospice, opened in Branford in March 1974 with funding from the National Cancer Institute.  

Compassionate counselling and assistance, such as that provided in many hospices, together with medical and psychological care, provided alternative to euthanasia among those who have terminal illness.

The opponents of euthanasia foresee the developments of hospice and palliative care as a better and lawful way to die peacefully than voluntary euthanasia or physician assisted suicide. Supporters of hospice and palliative care do not accept physician assisted suicide as a choice over care in terminal illness. As per their view the rising tide of public opinion in favour of euthanasia or physician assisted suicide is based on fear and a lack of medical knowledge. According to them with the developments in medical technology, there are no clinical situations necessitating the legalisation of euthanasia or physician assisted suicide.

On grounds of hospice and palliative care there is some relief for patients in terminal illness for comfort regardless of the impact on his or

her lifespan.\textsuperscript{308} It is also opined that the modern medicines that can reduce pain and make a dying patient reasonably comfortable should negate a common fear that anticipated pain will be so severe that suicide or \textit{euthanasia} are better alternatives.\textsuperscript{309} It is suggested that, systematic approaches, including team care are needed to adequately manage chronic diseases and co-ordinate care.\textsuperscript{310} Expert medical, legal and political opinion from around the world except a few countries\textsuperscript{311} suggests that \textit{euthanasia} cannot be controlled by anything less than complete prohibition. Opponents fear that, once legalised, \textit{euthanasia} will be increasingly performed on those with increasingly less severe pain, distress or disability.

The advocates of \textit{euthanasia}, rightly, disagree with this opinion as the palliative care and hospice provide comfort to the patient but fail to uproot the agony of terminally ill patients. Margaret Battin argues in support of \textit{euthanasia}, according to her if a patient has reached the end stages of fatal diseases, for \textit{e.g.}, Alzheimer, or chronic severe disability, though palliable, is ultimately untreatable, and sure to disrupt the cognitive functioning- then in such harsh circumstances the most trustworthy and dignified way to treat such patient is to support him in a choice that may be truly his own about how his life shall end.\textsuperscript{312}

In support of this there are survey reports which reveal the fact that even if terminally ill patients are under palliative or hospice care, most of them prefer \textit{euthanasia}, for \textit{e.g.}, in Oregon seventy-eight per cent persons

\begin{flushleft}
\textsuperscript{309} \url{http://www.ag.org/top/beleifs/contempissues_18_euthanasia.cfm}, [accessed on 20/1/2010].
\textsuperscript{311} For \textit{e.g.}, Netherlands, Belgium, Luxembourg, and Switzerland are the countries where physician assisted suicide is legalized.
\textsuperscript{312} Battin, Margaret, \textit{The Ethics and The Way We Die} 112, New York: Oxford University Press, 2005.
\end{flushleft}
of the ninety-one persons died by physician assisted suicide between 1998 and 2001 although they were enrolled in hospice programmes.\textsuperscript{313}

Euthanasia has generally been rejected as an unnecessary and unacceptable option by many organizations and individuals involved in the delivery of hospice and palliative care.\textsuperscript{314} Even than, there is a constant demand to legalize euthanasia. This demand of euthanasia reflects a changed attitude not only among terminally ill patients but also within the medical profession. This changed attitude in favour of euthanasia may thereby encourage greater acceptance of voluntary euthanasia within the health care professionals.\textsuperscript{315}

The concept of palliative care and hospice has not proved successful in consoling the terminally ill patients. Even in affluent western nations, terminally ill patients, despite palliative care, still die in immense pain and distress.\textsuperscript{316} On the contrary, in India, the concept of hospice and palliative care is still in the initial stage of development. Hospice and palliative care centres in India are woefully inadequate as there are only 55 such centres, and those are located only in major cities, viz., Mumbai, Delhi, Chennai, Calcutta.\textsuperscript{317} A total number of beds provided by these centres are approximately two thousand, whereas the number of terminally ill patients in India is in millions.\textsuperscript{318} Therefore, it is of


\textsuperscript{314} Supra note 273 at 141.

\textsuperscript{315} Supra note 297 at 294-295.

\textsuperscript{316} Keown, John, Euthanasia, Ethics and Public Policy 1, Cambridge: Cambridge University Press, 2002.


\textsuperscript{318} Ibid.
immense concern to examine that how many terminally ill patients will be benefited in India by palliative care and hospice.

It is a disappointing fact that in a developing country like India, sixty-nine per cent of Indians do not have access to basic medical facilities. While patients are deprived of their basic right to health, is it practically possible for terminally ill patients in India to expect any comfort from hospice or palliative care? When a terminally ill patient reaches a stage where he cannot tolerate the pain, the only desire he has, is to die a painless and easy death. But, in the present state, will the law permit to do so for Indians? Can there be any legal document to express the patient’s last wish? And if, there is any such document, can it be legally recognised and made binding? Can terminally ill patients exercise their right to dignity in this crucial phase?

Certainly, the terminally ill patients should have a right to make an advance directive about their health care provisions. The tension between the medical and legal discipline results in denial of the right to die. The doctors are lawfully restricted to assist a patient to die. The law is voiceless on this critical issue as it directly takes away the life of an individual. But, if there is a written document, duly signed by the patient expressing his wish about the healthcare in case of any terminal illness, it may act as a catalyst between the law and medicine. The next segment provides an avenue to resolve the conflict between law and medicine which also materializes support for the legalization of euthanasia.

---

319 Almost one million Indians die due to inadequate basic healthcare facilities and seven million Indians have no access to specialist health care facilities. It should be noted that terminally ill patients need special healthcare facilities. That means, a huge number of patients die and will continue to die in absence of both- derisory medical facilities and death with dignity law in India. [http://www.healthindia.com](http://www.healthindia.com), [accessed on 1/3/2011].
3.5. NEED FOR A MEDICO-LEGAL BALANCE PAVING WAY FOR LEGALIZING EUTHANASIA:

The dramatic advance in medical technology and pharmacology which has been made in the course of this century has made it possible to sustain lives of terminally ill or hopelessly ill patients for indefinite period. As a result the medical practitioners, whose decisions to use or not to use life support treatment, have posed legal, moral and ethical questions. Legally and ethically the doctors are not permitted to use their discretion in deciding the life and death of the patient. As discussed earlier, euthanasia is a demand on grounds of autonomy and principle of self-determination, at the same time great difficulties are witnessed for the legalization of euthanasia.

Except a few countries, physician assisted suicide or any form of euthanasia is considered equivalent to the offence of homicide. Though the options of hospice and palliative care are developing throughout the world, the proponents of euthanasia argue on the point, why the law forces an individual to live, when life is not worth living? And in support of their argument the advance directive forms a legal basis to allow the doctor to perform his duty without any fear of legal accountability.

It is well established that, an act of any individual to make a will is respected and legally followed after his or her death. In fact, the law makes it mandatory to follow the last wish of the person expressed in the will.\(^{320}\) However, it is surprising to note that the law does not allow a person to legally implement his living will, which can be the most important document for a terminally ill patient, to declare his wish during the last phase of life. Does a remedy lie in making an advance directive?

---

\(^{320}\) For e.g., see, S. 66, Indian Succession Act, 1925. See also, S. 100, Indian Evidence Act, 1872.
This takes us to the question what exactly is this and how best it serves as a remedy? Let us find out?

3.5.1 ADVANCE DIRECTIVE A PLATFORM FOR LEGAL REQUEST FOR EUTHANASIA:

The ethical and legal problems accompanying the provision of life-sustaining treatment revolve around the medical decision making capacity of an individual. Since the law is one of the chief agency through which society translates its fundamental ethical concerns and central values into rules and regulation of human conduct, these principles form the framework for the legal regulation of decision on death and dying.321

There is a general consensus among medical ethicists that favours patients being able to make their own decisions about health care, a consensus reflected by law, but the practicality of how to ensure this in law is sometimes far from clear. Advance directive is an attempt to implement this interest to refuse medical treatments not only for competent patients but also for incompetent patients.322

The term “Advance Directive” refers to treatment preferences and the designation of a surrogate decision-maker in the event that a person should become unable to make medical decisions on her or his own behalf.323 Legislation and litigation on issues of advanced directive and withholding or discontinuing life-supporting or life-sustaining treatment

321 Supra note 278 at 201
have begun to set the framework within which these choices are made by and for the terminally ill.\textsuperscript{324}

Advance directive is based on the right to self-determination and autonomy. As Professor Ian Kennedy states that, “[t]o abide by the refusal may be difficult for the doctor, but it is required by law, the principle of self-determination overruling any notion that the doctor knows best”.\textsuperscript{325}

Advance directive is a written instruction regarding one’s medical care preferences to be opted in future. Advance directive is meant to represent a demented patient’s desire even when the patient has lost the ability to participate in decisions regarding healthcare and medical treatment.\textsuperscript{326}

In health care advanced directive includes directions given by individuals specifying what actions should be taken for their health in the event that they are no longer able to make decisions due to illness or physical or mental incapacity. Statutorily recognised advance directive is a legislative response to public demand for a mechanism by which an individual can prospectively exercise the right to make health care decisions during a subsequent period of decisional incapacity.\textsuperscript{327}

Thus, advance directive occupies a significant place in the debate about the limits of patient autonomy, the right to refuse life-saving medical treatment and euthanasia.\textsuperscript{328} Such directive can be written and

\begin{thebibliography}{9}
\end{thebibliography}
signed by any person of eighteen years of age and above. Advance
directive includes Living Will, Medical Power of Attorney, Do Not
Resuscitate Order.

A living will is one of the forms of advance directive, leaving
instructions for treatment. A written form of refusing life prolonging
treatment signed by the individual in advance is formally called a living
will.

In 1967, an attorney named Luis Kutner suggested the first living will.
Kutner’s goal was to facilitate “the rights of dying people to control
decisions about their own medical care”. Legally the execution of
‘will’ is always after the death of the person executed it. But in case of
Living Will it should be executed during the life time in relation to the
health care, hence it is called as a living will. A living will consists of
specific directives about the course of treatment that is to be followed by
the doctors or health care providers. Living will can be used only when
the individual is incapable of conveying his desire directly by words or
through any other form of expression. Sometimes a living will can be
very specific or general, for e.g., a living will may include a statement-
“If I suffer an incurable, irreversible illness, disease, or condition and my
attending physician determines that my condition is terminal, I request
that life-sustaining measures that would serve only to prolong my dying

Living will is a document which expresses a request not to prolong life by artificial means in case
the person enters an irrecoverable health condition. Living will lacks legal force.
Medical power of attorney means a power vested in another person to make healthcare and
medical treatment choices for an individual, in case he has lapsed into incompetence. However,
such power of attorney does not carry any legal force. In fact, the common law under, S. 3 (1) of
the Enduring Powers of Attorney Act, 1985, does not legitimately include healthcare decisions.
See, supra note 17 at 303.

Supra note 99. See, Mayo Clinic staff, “Living wills and advance directives for medical decisions”,
http://www.mayoclinic.com/health/living-wills/HA00014, [accessed on 23/2/2010]. All the fifty
States in The United States of America Have legalized durable-power of Attorney Statute for
future medical treatment in case of incompetence of the patient. “West Encyclopaedia of American
Appendix C Living Will.
be withheld or discontinued."\textsuperscript{334} Whereas a more specific living will may include detailed information regarding an individual’s desire for such services including the medicines pain relief drugs, hydration, feeding, use of ventilators, \textit{etc.}

The demand and development of advance directive is a result of the increasing medical technology which has the capacity to keep a person alive for indefinite period irrespective of any recovery in the patient. Frequently, death in health care facilities-where eighty per cent of all deaths occur- is unnecessarily prolonged, painful, expensive, and emotionally burdensome to both patients and their families.\textsuperscript{335} In America, for \textit{e.g.}, aggressive medical intervention leaves nearly two million Americans confined to nursing homes, and over 1.4 million Americans remain so frail as to survive only through the use of feeding tubes, and thirty thousand persons are kept alive in comatose and permanently vegetative states.\textsuperscript{336} The ruling in the \textit{Cruzan}\textsuperscript{337} has triggered a flood of requests for legislative action providing right to living will.\textsuperscript{338} In support of living wills Professor Dworkin has said that every State in the United States recognises some form of advance directive. And this advance directive stipulates that specified medical procedures should not be forced on the patient in certain circumstances. Through the advance directive a person may appoint someone else to make life and death decisions when the person himself is not in a condition to do so.\textsuperscript{339}

\begin{thebibliography}{99}
\footnotesize
\item \textsuperscript{334} Supra note 56 at 296.
\item \textsuperscript{335} \url{http://en.wikipedia.org/wiki/Advance_health_care_directive}, [accessed on 23/2/2010].
\item \textsuperscript{336} Ibid.
\item \textsuperscript{337} \textit{Cruzan v. Director, Missouri Dept of Health}, 111 L.Ed.2d 224, 110 S.Ct. 2841, 58 U.S., June 1990.
\end{thebibliography}
Following *Karen Quinlan*, California, in 1976 became the first State to pass legislation that directly addressed decision making on behalf of incompetent patients. This idea was substantially developed in the United States in the highly debated case of *Cruzan v. Director*, in which the 14th Amendment was interpreted by the Supreme Court to imply that a competent person has a constitutionally protected liberty interest rather than a fundamental right in refusing unwanted medical treatment. *The Patient Self-Determination Act* [hereinafter referred as PSDA] was brought into force in December 1991, and it required health care providers to give patients information about their rights to make advance directive under State law while the substance of the law governing advance directive is left to the States.

The concept of living will has gained momentum in a few countries. On July 28, 2009, Barack Obama became the first United States President to announce publicly that he had a living will and also encouraged others to do the same. To protect individual autonomy, most States in the United States of America have enacted living will or right to die legislation as a process to prospectively reject life-sustaining measures in the event of a terminal medical condition.

Developments in the medical technology over the past fifty years have dramatically altered the dying process and, in this respect the western

---

341 Liberty interest is a right recognised by the *Constitution* in the wider sense of right and the liberty interest is subject to State regulation. According to Hohfled’s analysis of right, liberty is a species of right. Supra, Chapter II, p. 133.
342 A fundamental right is granted by the *Constitution* and fundamental right has its reasonable restrictions enumerated in the *Constitution* itself. See, Justice Rehnquist’s opinion on liberty right and fundamental right discussed in *Roe v. Wade*, supra, Chapter II, p. 148 to p. 149.
343 Supra note 337.
344 Supra note 322 at 182.
345 Ibid.
346 Forty-two States out of the fifty States in the United States have legalized living will for future medical treatment in case of incompetence of the patient. “West Encyclopaedia of American Law”… supra note 331.
347 Supra note 234 at 371.
society is radically different from the one contemplated by Locke whose ideas have nevertheless so heavily influenced the western social structures to this day.\textsuperscript{348} However, Locke’s ideas do not prevail over the Indian society. In India, till date, there is no initiative taken to legalize any form of advance directive. Some countries have intended to accommodate within existing law rather than tackling from scratch the question of \textit{euthanasia} and dying.\textsuperscript{349}

Innumerable difficulties are expected to arise with prolongation of life beyond expectation. In such a situation need of a document authorizing the health care professionals to end the treatment arises.

In the light of \textit{euthanasia} debate, legally the living will supports passive \textit{euthanasia} but cannot be considered for physician assisted suicide or any form of active \textit{euthanasia}. Apart from a few countries which have legalised \textit{euthanasia}, a request from a person even in a form of a living will is not considered a valid defence for taking some one’s life.

At this juncture, it is pertinent to examine the position of law regarding advance directive in several countries world over. Can advance directive be legally enforced for administering \textit{euthanasia}? Which form of advance directive is lawfully accepted? What is the consequence of legal advance directive? Are there any adverse effects of the advance directive? Should India make an attempt to legalize any form of advance directive? Which may be a suitable form for India? The next part of the thesis provides the answers for all these questions associated with advance directive in the debate of \textit{euthanasia}.

\textsuperscript{348} Russell, B., \textit{History of Western Philosophy} 628-72, London: George Allen & Unwin, 1940.
\textsuperscript{349} \textit{Supra} note 322 at 180.
3.5.1.1 ADVANCE DIRECTIVE IN NETHERLANDS:

Netherlands is the first country in the world to legalize euthanasia.\textsuperscript{350} The patients can specify the circumstances under which they would want euthanasia for themselves by signing a euthanasia directive.\textsuperscript{351} It can be executed only if the patient is terminally or hopelessly ill as verified by two physicians.\textsuperscript{352}

3.5.1.2 ADVANCE DIRECTIVE IN SWITZERLAND:

\textit{Euthanasia} is also legalised in Switzerland, in fact it is the only country which allows \textit{euthanasia} to non-citizens as well.\textsuperscript{353} A living will is signed by the patient declaring that in case of permanent loss of judgment for e.g., inability to communicate, PVS, or in case of severe brain damage, all means of prolonging life shall be stopped. At present, such a document is merely viewed as representing the supposed will of the person with incapability. However, a revision of the \textit{Swiss Civil Code} aims to change this situation\textsuperscript{354} by making the patient living will a legally binding document.\textsuperscript{355} In Switzerland, \textit{euthanasia} in form of physician assisted suicide is legally allowed even in absence of a living will.\textsuperscript{356}


\textsuperscript{352} Ian, Ireland, “The Netherlands Euthanasia Legislation” \url{http://www.aph.gov.aw}, [accessed on 27/05/2011].


\textsuperscript{354} Art. 360, \textit{Swiss Civil Code}.


\textsuperscript{356} “Death Tourism- Euthanasia Holidays” \url{http://www.life.org.nz}, [accessed on 27/05/2011].
3.5.1.3 ADVANCE DIRECTIVE IN GERMANY:

On 18 June 2009, the Bundestag passed a law on advance directive, applicable since 1 September 2009. Such law, based on the principle of the right of self-determination, provides for assistance of a fiduciary and of the physician.\(^{357}\) Nine Million Germans have signed their advance directive. However, the law allows only medical treatment preferences and withdrawal of life support system. Physician assisted suicide is illegal in Germany.\(^ {358}\)

3.5.1.4 ADVANCE DIRECTIVE IN ENGLAND AND WALES:

In England and Wales, people are allowed to make an advance directive or appoint a proxy under the Mental Capacity Act, 2005. This advance directive is applicable only for refusal of treatment. It may be enforced only when the person lacks mental capacity and will be considered valid and applicable by the medical staff. However, United Kingdom has no legislative framework giving effect to advance directives or defining their legal scope for physician assisted suicide.\(^ {359}\) The common law has always recognised the basic liberty of a person to refuse touching the body. In Sidaway v. Board of Governors of the Bethlem Royal hospital\(^ {360}\), Lord Scarman described the existence of a patient’s right to make his own decisions about treatment as ‘a basic human right protected by common law.’\(^ {361}\) Nonetheless, the common law does not recognise any form of advance directive allowing euthanasia or physician’s assistance in dying in case of terminal illness.


\(^{358}\) “Living Will law passed by Germans- Bundestag” [http://www.dw-world.de](http://www.dw-world.de), [accessed on 27/05/2011].

\(^{359}\) Supra note 328 at 298.

\(^{360}\) (1985) A.C. 871 at 882.

\(^{361}\) Supra note 328 at 299.
3.5.1.5 ADVANCE DIRECTIVE IN UNITED STATES:

In the United States, majority of States recognize living wills or the designation of a health care proxy, for e.g., California does not recognize a living will but instead uses an Advanced Health Care Directive. Surveys show that one-third of Americans think that they should make decisions about end-of-life care. In surveys conducted between the years 2000 to 2006, it was analysed that patients who had prepared advance directive received care that was strongly-associated with their preferences. The United States of America, thus, recognizes advance directive for preferences of treatment, refusal of treatment but does not authorize physician assisted suicide. The State of Oregon and Washington which allow physician assisted suicide consider not only the advance directive made by the terminally ill patient but also the health condition, chances of recovery and the suffering of the patient.

Though living wills form a strong base for arguing in favour of euthanasia, it has a few advantages as well as disadvantages. It is very incumbent to examine both aspects of living will as an advance directive.

3.5.1.6 ADVANTAGES OF LIVING WILL AS AN ADVANCE DIRECTIVE:

- Living Will as an Advance Directive provides for protection and recognition of patient’s autonomy. It has been established by various landmark judgments, that the patient’s right to autonomy

---

362 Mayo Clinic Staff... supra note 331 and 346.
should be protected.\textsuperscript{365} Every individual by making a living will for health care will be enforcing his right to self-determination. Living will enables terminally ill and incompetent patients to exercise their right to autonomy.

- It reassures the patient from the fear of application of life-sustaining treatment. As the medical technology has the capacity to prolong life indefinitely, terminally ill patients worry about the end phase of their life. The living will can avoid this frightful situation by allowing patients to refuse life sustaining treatment.

- It also provides guidance and legal protection to doctors or health care professionals. Most of the countries neither have legalized living will nor allow any form of euthanasia. However, in case of hopelessly terminally ill patients passive euthanasia by way of withdrawal of treatment is widely practiced. In such circumstances it is of imminent importance to have living will, which not only provides guidance for the patient’s healthcare but also protects the health care professionals from legal liability.

- Moreover, it relieves the relatives by reducing the emotional anguish to make life and death decision. Irrespective of the age and health condition of a patient, the near and dear ones always wish to continue the medical treatment. However, in certain exceptional cases of incurable terminal illness, the patient is burdened by the fruitless treatment. The relatives of the patient may not be in a position to take a decision whether to continue the treatment as an outcome of their love or discontinue the treatment as an effect of

\textsuperscript{365} Supra, Chapter II, p. 76 to p. 87.
sympathy for the patient. In such poignant situation, living will provides relatives with the correct solution.

- Helps in avoiding ambiguity, by knowing the patient’s wishes in precise details. In case of incompetent health condition it is very difficult to know what the patient desires regarding his treatment. Living will provides what the patient wants through the request expressed in the living will.

**DISADVANTAGES OF LIVING WILL AS AN ADVANCE DIRECTIVE:**

- Life is considered sacred and inviolable. The principle of sanctity of life opposes any form of taking life. If a living will expresses a request for physician’s assistance in dying, it violates the principle of sanctity of life. Active euthanasia contravenes the sanctity of life. Even in *Bland*,\(^\text{366}\) the House of Lords made clear that active euthanasia remained unlawful\(^\text{367}\). In the absence of statutory intervention, therefore, any request in an advance directive for positive steps to be taken to hasten death would be completely unenforceable, indeed would amount to an incitement to murder.\(^\text{368}\) At the same time, even if individuals might make suicidal or unethical choices the law should none the less respect them- this ignores the law’s interest in upholding and preserving human life.\(^\text{369}\)

- A living will is a document which expresses the wish of individual to be followed on occurrence of a particular situation in the future.

---

\(^{366}\) *Supra* note 67.  
\(^{367}\) *Supra* 328 at 303.  
\(^{368}\) *Id.* at 304.  
\(^{369}\) *Id.*, at 306.
It is highly improbable for any human being to predict what may happen in the future. Hence living will may prove harmful for the person who has made it.

- It is evident from the development of science and medical technology in the past fifty years, that there can be new inventions in the medical treatment at any time. A disease incurable in the year 2011 may become curable in the year 2020 by the discovery of new medicines. Hence, it is alleged, the living will may fail to satisfy its cause.

- Patient may change his mind due to any other circumstances. Human thoughts, desires and emotions constantly undergo changes according to the changing circumstances. A patient due to depression may make a living will requesting to terminate life support system, but the patient may desire to continue his treatment when he actually enters that phase of life. In such situation the living will may adversely affect the patient.

- Relatives may take undue advantage of the living will. Practically, this possibility cannot be denied. The relatives who are aware of the fact that the patient has made a living will either to terminate life-support system or to allow a peaceful death by *euthanasia*, may implement it even if there are chances of recovery of that patient.

- The difficulty in identification and interpretation of ‘terminal illnesses, for *e.g.*, terminal condition, persistent vegetative state, brain damage, dementia, advanced degenerative or malignant

---

370 Relatives can misuse the living will of the terminally ill patient to bring about his death for different reasons, such as, financial interest in property of the patient, personal differences with the patient, or desire to take over the patient’s position in life.
disease, stroke and paralysis, serious toxic condition, no reasonable prospect of recovery of faculties, no reasonable prospect of worthwhile life or independent life,\textsuperscript{371} are elements that discourage to have Living Will as an advance directive.

Apart from this a major area of concern is the understanding capacity of an average person about what a living will is? For e.g., in a country like India even in the 21\textsuperscript{st} century, three hundred and fifty million people are illiterate, \textsuperscript{372} how can one expect them to sign a living will? A certain class of population, it is apprehended, may not get any benefit from such provisions.

The proponents of euthanasia may have high hopes about advance directive but the legal position of such directive in countries which have given statutory status to living wills, deals only with refusal to continue life-sustaining treatment and does not accept or allow a request to administer a lethal dose in order to die a quick and peaceful death under any circumstances.

After discussing the advantages and disadvantages of the advance directive a basic question needs to be answered is should advance directive be given complete legal recognition in case India legalizes euthanasia.

The most important benefit of having legal advance directive aims at solving a few problems, such as, avoiding burdensome and unnecessary treatment for patients and better understanding to the doctors to proceed or not to proceed with their treatment within the legal framework. It is unfortunate that arguments on this advance directive issue have left the


realm of dispassionate consideration of constitutional rights and entitlements of patients and practitioners alike and has entered the politics, and like many issues of biotechnology and bioethics, have become core subjects of electioneering campaigns especially in the western world.\(^{373}\)

According to the current trend in law and medical field, the issue of advance directive must be dealt considering the medical, social, ethical, legal and policy implications of any form of advance directive. It is regrettable that neither the legislation nor the courts have laid down proper guidelines for the advance directive to address the problems which deal with most valuable aspect of life-and-death in countries where euthanasia is legalized.

However, in India the situation is completely different as compared to the western countries. There have been no attempts made in the country to legalize any form of euthanasia in the past. There is no legislation allowing any form of advance directive in the country. There is, therefore, cause of concern that whether debate over advance directive, opens up the Pandora’s Box \(^{374}\) in India too.

The proponents emphasize the need to enact a separate legislation legalizing euthanasia and also to make provision in the law for advance directive. If, advance directive legally permits euthanasia, is there any possibility of misuse of the advance directive? Undoubtedly, the fear of misuse of law governing euthanasia cannot be overruled. But, surely, the fear of misuse can always be prevented by incorporating appropriate safeguards in the legislation. Apart from the anticipated consequences there is a possibility of confronting some unintended consequences in

\(^{373}\) *Supra* note 37 at 375.

\(^{374}\) *Supra* note 328 at 311.
realistic application of legalized euthanasia. Hence, there is need to discuss a few unintended consequences which may result in on legalizing euthanasia.

3.6. EUTHANASIA AND THE UNINTENDED CONSEQUENCES:

With the increase in public opinion in favour of euthanasia, as recorded by the data of various polls conducted in different countries\(^\text{375}\) there is a possibility of having a legislative progress towards euthanasia. The demand to legalize euthanasia is not only encouraged in the western countries but has also been appealed in India in a number of cases.\(^\text{376}\) However, opponents of euthanasia project hospice and palliative care as an alternative to physician assisted suicide for pain management. But, the advance directive supports the right to autonomy of the patients, whereas exponents of euthanasia emphasize the need of physician assisted suicide for a permanent relief from suffering.

It is essential to consider a situation if euthanasia or physician assisted suicide is legalised, what problems may emerge in the future as a result of such legalisation. Given the infinite elasticity of legal definition of suffering, what began as a practice of allowing euthanasia in rare and medically definite cases of patients with severe physical pain not susceptible to relief has been increasingly applied to non-terminally ill patients on the grounds of much less objective criteria.\(^\text{377}\) Legalised euthanasia raises the “potential for a profoundly dangerous situation for

\(^{375}\) Infra, Chapter IV Comparative History of Euthanasia, p. 263 to p.265.
\(^{376}\) Requests made by terminally ill patients in India, supra, Chapter II, p. 102.
doctors if a seriously ill or disabled person “chooses” to die rather than receive long-term care.”

Once society authorizes physician assisted suicide for competent, terminally ill patients experiencing un-relievable suffering, it will be difficult, if not impossible, to contain the option to such a limited group.

The major concern of abuse is the ‘slippery slope’ argument. Society clearly has some risk of sliding down these slopes toward more permissive policies, extending access to physician assisted suicide to those beyond the narrowly defined categories which now proposed and perhaps may lead even towards sanctioning euthanasia. Following are the major areas of concern as the unintended consequences of euthanasia.

3.6.1 EUTHANASIA AND ITS EFFECT ON WEAK AND VULNERABLE:

The first and the foremost effect of legalization of euthanasia may be lack of confidence and trust of patients they have in their concerned medical professionals. Emotional and psychological pressures could become overpowering for depressed or dependant patients. If the procedure is to sign a living will as an advance directive, the elderly patients may be forced to sign the paper even if it is not needed. There is a maximum possibility of misuse of such provisions. In most of the countries, the medical associations considering these facts have argued against legalising euthanasia.

379 Supra note 289 at 210.
380 Slippery slope argument indicates the fear of misuse or abuse of euthanasia after its legalization. See, John, Keown, “Euthanasia in the Netherlands: sliding down the slippery slope?” in Euthanasia Examined, supra note 21 at 261-263.
The patients in coma or persistent vegetative state may be administered *euthanasia* even if they had a desire to struggle for their existence. This issue is surrounded by a variety of ethical, philosophical, legal and religious views. Officially sanctioning *euthanasia* might also provide an excuse for those wanting to spend less money and efforts to treat severely and terminally ill patients, such as patients with acquired immunodeficiency syndrome (AIDS) or Alzheimer.\(^\text{382}\) The British House of Lords Committee on Medical Ethics, after lengthy hearings, reached much the same conclusion, recommending against legalization out of concern. The Committee alleged that the vulnerable people, such as, the elderly, lonely, sick or distressed may request an early death due to certain pressure. In fact, it is the duty of the society to assure the vulnerable and disadvantaged people care and supporting life.\(^\text{383}\)

If *euthanasia* is legalized on request of a competent person, under court precedents that have already been set, someone who is not competent could be made a victim at the direction of that person’s guardian even though the incompetent patient had never expressed a desire to die.\(^\text{384}\) Even some enthusiastic advocates of legalization acknowledge that the comprehensive regime of health care in the Netherlands helps mitigate the incidence of abuse or coercion in *euthanasia*.\(^\text{385}\) It is an admitted fact that the American health care system, where many people are uninsured or underinsured, carries with it a far greater risk that patients will be forced into accepting *euthanasia* as a result of pressure, abuse, coercion, or general economic forces.\(^\text{386}\)

---

382 Supra note 52 at 127.
383 Ibid.
385 Supra note 297 at 452.
386 Ibid.
Apart, from the effect on the weak and vulnerable, *euthanasia* may, it is apprehended, misused for economic interest of family members. Let us identify such possibilities.

**3.6.2 EUTHANASIA AND THE ECONOMIC INTEREST:**

Legalizing physician assisted suicide or *euthanasia* would represent a radical change in the end-of-life laws and ethics, it would undoubtedly carry with it other consequences for medicine, law, and social norms that cannot be easily predicted or foreseen.\(^{387}\) The end-of-life health care world wide is highly expensive and by giving people an alternative to die instead of being on life support as a legitimate medical response to their terminal illness may discourage people from the end-of-life care. A 1988 study strongly suggested that the lack of adequate palliative medicines in the Netherlands has, in fact, contributed to the number of requests made for physician assisted suicide in the country.\(^{388}\) Providing physician assisted suicide or *euthanasia* may result in discouraging the new concept of palliative care and hospice care. At the same time, it may also result in disinterest of the medical fraternity to discover new methods and drugs to treat the terminally ill patients. Instead of innovative research for advanced new medicines to safeguard healthcare, the medical professional may get accustomed to prescribe *euthanasia*.

Griffiths, while defending the Dutch *euthanasia* regime, expressly acknowledges that, there have been occasional indications that the economic considerations have played a role in the administration of physician assisted suicide in the Netherlands.\(^{389}\) In fact, twelve percent of the doctors and fifteen percent of the prosecuting officials interviewed in

\(^{387}\) Supra note 52 at 128.
\(^{388}\) Ibid.
1995 expected that drastic budget-cutting in the health-care system could lead to increased pressure on doctors to engage in life-shortening practices. Apart from concepts of sanctity of life which still play a part in the legal debate, fears of abuse in any scheme for voluntary euthanasia, this can be one of the reasons why many jurisdictions are reluctant to follow the example of the Netherlands. Such potential for abuse undermines the public health and patient safety.

Margaret Otlowski, contends that it is misleading to view the legalization of physician assisted suicide or euthanasia as likely to detract from medical research and the dissemination of palliative care because proponents of legalization only wish to expand the options of dying available to patients. However, Otlowski’s argument does not draw a clear line between the intention and the consequences. It also fails to address the possibility of economic disincentives to research and palliative care after the legalization of physician assisted suicide. A few other authors are silent or perhaps ignore the economic issue, for e.g., Derek Humphry, the co-founder of the Hemlock Society, terms it as “unspoken argument” in favour of legalizing euthanasia. Economic interest in cases where terminally ill person has mass property or high yielding business may become the reason to hasten his death once physician assisted suicide is legalized. In such cases if the patient is not willing to request for physician assisted suicide but he has made such a request earlier in his living will, and later becomes incompetent to make the changes, such patients shall be in a helpless position and shall be

390 Ibid.
393 Supra note 297 at 248.
394 Supra note 132.
forced to die by relatives who have a keen interest in the property owned by the patient.

In the euthanasia debate, the fear of economic interest indeed needs to be carefully handled in order to avoid such consequences. Another matter of concern is the change in the doctor’s role. Medical professional is the most trustworthy person in case of health care of terminally ill patients. If doctors are legally authorized to administer euthanasia, will the patients have faith in the doctor? Can there be instances of doctors misusing physician assisted suicide? In the following paras, the researcher has attempted to examine the unintended consequences of the doctor’s role if euthanasia is legalized.

3.6.3 EUTHANASIA AND THE CHANGE IN DOCTOR’S ROLE:

Even if the economic factor is legally taken care of in physician assisted suicide, it cannot be ignored that euthanasia or physician assisted suicide may become a part of the doctor’s duty in professional life. In fact, training doctors for physician assisted suicide will be a part of the medical course. If euthanasia becomes an acceptable form of medical treatment in a society, it would be but a small political and logical step to permit family members to decide whether to kill their relatives without the patient’s consent- that is to commit non-voluntary euthanasia.\textsuperscript{395}

Otlowski, a strong supporter of euthanasia, recognizes the possibility of such a result in America and considers it a distinct problem.\textsuperscript{396} She states that, euthanasia should be legalised only in cases where the patient

\textsuperscript{395} Supra note 52 at 130.
\textsuperscript{396} Supra note 297 at 224.
expressly and voluntarily consents, but she also accepts that it may lead to “most plausible slippery slope concern”.

An example of misuse of *euthanasia* is the case of Dr. Jack Kevorkian, who has caused fear and repugnance by this unethical method of offering *euthanasia* to all and sundry who requested it.

Margaret Battin argues that one can kill incompetent only when they provide express directives before becoming incompetent. Patricia Mann sheds a vivid light on some cultural consequences on legalization of physician assisted suicide for the medical profession. According to Mann, if physician assisted suicide is legalized it may gradually be incorporated as a cost-efficient death. Doctors may shift in favour of physician assisted suicide. Medical students will also learn about physician assisted suicide as a part of their curriculum from the beginning of their training. It can be expected in the future that a growing proportion of doctors may find physician assisted suicide as a good practice for terminally ill patients and may comfortably recommend it to their patients.

As per Mann, now many people react strongly against physician assisted suicide, but if it is legalised it will become a part of our daily life. In fact, even doctors will look upon physician assisted suicide as a convenient and cost efficient method to end lives of terminally ill patients.

---

397 *Id.*, at 482, 483.
398 [http://members.tripod.com/Amis_Lee/fallingtree/eu.html](http://members.tripod.com/Amis_Lee/fallingtree/eu.html), [accessed on 19/3/2010].
399 *Supra* note 312.
401 *Id.*, at 22.
Mann’s views of rapid changes in doctors’ role and economic forces in the society, can be supported by the example of sterilization and use of contraceptives to control population growth and have a small and happy family. Similarly, women working outside the house was also initially opposed but later become a regular practice in society as it helped the economy. Likewise, if physician assisted suicide is legalised people will react to it as a part of life and not as something shocking as it is looked upon today.

Another major concern is the legalization of physician assisted suicide may result in increase in demands to the medical professionals, but as per the statistics from Netherlands and Oregon it is evident that the number of deaths by assisted suicides has not increased over the years.\(^{402}\)

Griffith and Helga Kuhse also influentially establish their contradictory instinctive hypothesis that decriminalization does not encourage more cases of voluntary and non voluntary *euthanasia* or physician assisted suicide.\(^{403}\) At this point, it can be possibly, argued that legalization would ostensibly authorize the State to regulate the practice of physician assisted suicide or *euthanasia*. The legalization would mechanically result in providing appropriate safeguards to administer *euthanasia* and will definitely curb the illegal practices of physician assisted suicide carried out secretly in the society.\(^{404}\)

Considering the effect on weak and vulnerable, the economic interest and the duty of medical professionals, cautions that the legalization of *euthanasia* may bring with it unintended and unwanted consequences as well.

\(^{402}\) *Infra*, Chapter IV, p. 288 to p. 289, and p. 301 to 305. Statistics of number of deaths by physician assisted suicide in Netherlands and Oregon.

\(^{403}\) *Supra* note 52 at 132- 137.

\(^{404}\) *Id.*, at 137.
Utilitarians, such as, Glanville Williams and Yale Kamisar strongly argue in favour of legalisation of *euthanasia* based on personal autonomy. According to the proponents doctors can provide standard medical treatments to keep dying people alive, but it is unclear whether these treatments do any real good, perhaps, like blistering, they do more harm than good.\(^{405}\) Margaret Battin argues the problem on different standard, acknowledging that if voluntary *euthanasia* is legalised, it may lead to non voluntary *euthanasia*. Such practice may result in ignoring the welfare and would encourage corrupt practices in the society.\(^{406}\)

As per Battin’s opinion the incommensurability problem- the individual rights and the societal interest, sets up a conflict. According to her the right to protect the people who may be wrongly killed as a result of legalized *euthanasia*, is more important than the desire to die a peaceful death of a terminally ill patients.\(^{407}\) She suggests that society’s traditional willingness to protect one innocent man even at the expense of letting ten guilty men go free, is based on the fact that doing so imposes no “harm” on the guilty men. By contrast, Battin observes, preventing persons from seeking physician assistance in dying does impose real harms on them.\(^{408}\)

As per the maxim in the context of homicide, it would definitely be wrong even if one innocent person is killed as a result of malpractice or carelessness by the medical professionals in case of *euthanasia*. On legalization of physician assisted suicide, innocent persons may be forced


\(^{407}\) Ibid.

\(^{408}\) Ibid.
to forgo the opportunity to obtain *euthanasia* or physician assisted suicide, which may result has a gross misuse of the provision.\(^{409}\)

The possibility of undesirable consequences in legalizing *euthanasia* cannot be overlooked, but other utilitarians like, Joel Feinberg, argue that, reasonable mistakes should be considered in a legalized voluntary *euthanasia* scheme to be “the inevitable by-products” of efforts to deliver human beings, at their own requests, from intolerable suffering, elaborate and expensive prolongations of death.\(^{410}\)

Glanville Williams also accepts that legalization of physician assisted suicide may carry with it certain abuse or mistakes. He says, “[i]t may be allowed that mistakes are always possible, but this is so in any of the affairs of life”.\(^{411}\)

Based on the double effect doctrine\(^{412}\), William adds, “[d]istinguishing between “mistakes” or other unintended consequences associated with legalization, and those consequences that are intended- is distinctly at odds with the vociferous attack on the principle elsewhere”.\(^{413}\)

Although the utilitarians emphasize the importance of intended consequences than the unintended ones, the unintended consequences cannot be outweighed as there is a possibility of abuse of physician assisted suicide even if there is an appropriate legislation enacted for this purpose. For example, it has been observed that even after the legalisation of *euthanasia* in Netherlands the guidelines established by Dutch Courts have not been followed. As a result, the practice of *euthanasia* has moved

\(^{409}\) Supra note 52 at 140.


\(^{412}\) Supra note 159.

\(^{413}\) Williams, Glanville, *Text Book on Criminal Law* 37, 2nd edn., London: Stevens, 1983,
from terminally ill to chronically ill, from cases of untreatable physical illness to cases of treatable psychological distress, and from voluntary *euthanasia* to involuntary *euthanasia*.

Those who argue in favour of legalizing *euthanasia* inevitably base their case on one or two extreme situations, but, if *euthanasia* is legalized, the ripple effect will result not only in administering *euthanasia* even in less extreme situations but also radically changing the doctor patient relationship.

Proponents argue that without fearing abuse, intolerably suffering patients should be permitted the right to exert this ultimate autonomy in choosing the manner of their dying.

Opponents fear that the movement from voluntary *euthanasia* to involuntary *euthanasia* would be like the movement of abortion from ‘only the life or health of the mother’ to in numerous female feticides in the society.

Indeed, no health care professional association has unequivocally endorsed its member’s participation in physician assisted suicide. The balance between the benefits and risks is likely to result from legalization of physician assisted suicide is extremely different from a similar balancing in the context of decisions to refuse medical treatment.

---


417 Abortion is legally permitted under the prescribed condition as a liberty right of women. However, the reality is diverse, and the reason is the gross misuse of medical technology and law. Female foeticide is a nefarious crime on this earth. At least 100 million female foetuses have been aborted to date in this world. India is not an exception to this, and the number of female foeticide is almost 35 to 40 million. All these figures are based on the male female ratio. [http://www.orthodoxwiki.org](http://www.orthodoxwiki.org), [http://www.unicef.org](http://www.unicef.org), [http://www.iheu.org](http://www.iheu.org), [accessed on 1/3/2011].


419 *Supra* note 289 at 198.
Unquestionably, there are dangers that go along with legalizing physician assisted suicide, just as there are dangers that accompany other constitutional rights. The legislature can positively regulate physician assisted suicide and find solutions to alleviate the dangers involved.\textsuperscript{420} The individual interest in allowing patients to exercise their right to autonomy versus the interest in preventing non-consensual killing of innocent persons remains a fundamentally unresolved debate.

Nonetheless, it is an inevitable requirement for terminally ill patients to legalize \textit{euthanasia} in the changing state of affairs. Even in a country like India, the materialistic interests have overshadowed the moral and cultural values of caring for elders and terminally ill patients. The fact that Indian Parliament has enacted a law for the rights of senior citizens in the country,\textsuperscript{421} demonstrates the change of mind set of younger generation towards the elder generation in India. In the present scenario, caring for terminally ill patient, often, is looked upon as a burden by the family members. This attitude of the dear ones kills the ailing patient emotionally. So, instead of forcing the terminally ill patients experience indignity and torture at the fag end of their lives, they should be allowed to die peacefully with honour.

As discussed above the unintended consequences on legalization of \textit{euthanasia} cannot be ignored. However, the misuse of \textit{euthanasia} can be certainly combated with proper safeguards. The countries which have legalized \textit{euthanasia} can be looked upon as an exemplar for drafting the


\textsuperscript{421} The \textit{Maintenance and Welfare of Parents and Senior Citizens Act}, 2007. This Act seeks to make a legal obligation on children to take care of Parents. S. 125 of the \textit{Criminal Procedure Code, 1973}, also has been amended for a similar purpose. \textit{The Criminal Procedure Code (Amendment) Act}, 2008, S. 125, includes the maintenance and welfare of senior citizens in India.
model law for India. The researcher has made an attempt to incorporate adequate measures to deal with the unintended consequences in the fifth chapter of the present research work where a model law is coined for legalizing *euthanasia* in India.

Considering the fact that terminally ill patient undergo a difficult passage as *euthanasia* is legally prohibited in most of the countries including India. Probably, the legislators are apprehensive about the unintended consequences which may occur in future. However, it should be acknowledged that four countries, the Netherlands, Switzerland, Belgium and Luxembourg and two States from the US, Oregon and Washington have successfully legalised *euthanasia* by allowing physician assisted suicide. The next chapter thoroughly deals with a comparative analysis of laws governing *euthanasia* in different countries.