INDIAN JOURNAL OF LEGAL REVIEW

VOLUME 4 AND ISSUE 1 OF 2024

INSTITUTE OF LEGAL EDUCATION

INDIAN JOURNAL OF LEGAL REVIEW

APIS – 3920 – 0001 | ISSN - 2583-2344

(Free and Open Access Journal)

Journal's Home Page – https://ijlr.iledu.in/

Journal's Editorial Page - https://ijlr.iledu.in/editorial-board/

Volume 4 and Issue 1 of 2024 (Access Full Issue on - https://ijlr.iledu.in/volume-4-and-issue-1-of-2024/)

Publisher

Prasanna S,

Chairman of Institute of Legal Education (Established by I.L.E. Educational Trust)

No. 08, Arul Nagar, Seera Thoppu,

Maudhanda Kurichi, Srirangam,

Tiruchirappalli – 620102

Phone : +91 94896 71437 - info@iledu.in / Chairman@iledu.in

INDIAN JOURNAL OF LEGAL REVIEW [IJLR]

VOLUME 4 AND ISSUE 1 OF 2024

APIS – 3920 - 0001 *(and)* ISSN - 2583-2344

Published by

Institute of Legal Education

https://iledu.in

EUTHANASIA AND ITS SOCIETAL IMPLICATIONS: A RESEARCH PAPER

AUTHOR - BLESSEN TOM CYRIAC, STUDENT AT SCHOOL OF LAW CHRIST DEEMED TO BE UNIVERSITY, BENGALURU

BEST CITATION – BLESSEN TOM CYRIAC, EUTHANASIA AND ITS SOCIETAL IMPLICATIONS: A RESEARCH PAPER, *INDIAN JOURNAL OF LEGAL REVIEW (IJLR)*, 4 (1) OF 2024, PG. 127-133, APIS – 3920 – 0001 & ISSN - 2583-2344.

Abstract

This paper examines the ethical issues surrounding euthanasia and assisted suicide, which have been widely debated by various stakeholders, such as physicians, legal experts, and the public. Through this paper, the author intends to provide an updated and comprehensive review of the relevant facts and arguments, as well as to clarify some common misconceptions and confusions. It adopts a narrative approach that follows the main line of reasoning that euthanasia is morally wrong and should not be legalized. It also discusses the potential risks and harms of legalizing euthanasia, and the alternative options that respect the dignity and autonomy of patients. The paper is intended for health-care professionals and general public who need to be well-informed and ethically competent in dealing with end-of-life decisions.

Keywords: Euthanasia, Physicians, Self-determination, Physician-assisted suicide

INTRODUCTION

Euthanasia is the medical practice of ending a person's life in order to alleviate the person's suffering due to some medical condition. Typically, the person in the case would be terminally sick or in excruciating pain and suffering. The literal term "euthanasia" is derived from the Greek words "eu" (good) and "thanatos" (death). Instead of subjecting someone or allowing someone to a lengthy, painful, or humiliating death, euthanasia allows the patient to have a comparatively “good” or less painful death.

Palliative care and sanctity of life difficulties in terminally ill patients such as final stage cancer and AIDS which has become a major concern for physicians in contemporary culture. Parallel to this worry, another contentious subject has emerged: euthanasia or "mercy killing" of terminally sick individuals. Champions of physician-assisted suicide (PAS) believe that a person's right to self-determination guarantees him a painless death. Opponents believe that a physician's involvement in a person's death contradicts a key premise of the medical world. Furthermore, untreated depression and the risk of societal 'coercion' in those seeking euthanasia call into doubt the ethical grounds driving such an act.

Types of euthanasia

There are generally nine types of euthanasia and the term "euthanasia" refers to a variety of techniques, they are Active euthanasia, Passive euthanasia, Voluntary euthanasia Involuntary euthanasia Self-administered euthanasia Other-administered euthanasia Assisted Mercy-killing Physician-assisted suicide

I. Active euthanasia: Execution of a patient using active means, such as injecting a deadly dosage of a medicine. Sometimes referred to as "aggressive" euthanasia.
II. Passive euthanasia: Allowing a patient to die on purpose by removing artificial life support such as a food supply or ventilator. Some ethicists differentiate between withholding and discontinuing

INDIAN JOURNAL OF LEGAL REVIEW [IJLR]

VOLUME 4 AND ISSUE 1 OF 2024

APIS – 3920 - 0001 *(and)* ISSN - 2583-2344

Published by

Institute of Legal Education

https://iledu.in

life support the patient is on life support but then removed from it.

III. Voluntary euthanasia: with the patient's permission

IV. Involuntary euthanasia: without the patient's agreement, such as if the patient is asleep and his or her intentions are unknown. Some ethicists differentiate between "involuntary" (against the patient's wants) and "nonvoluntary" (without the patient's permission but without knowledge of the patient's wishes) forms.

V. Self-administered euthanasia: The patient is the one who chooses the method of dying.

VI. Other-administered euthanasia: The method of death is administered by someone other than the sufferer.

VII. Assisted: The patient by himself administers the means of death with the help of another person, such as a physician.

There are several active combinations of the aforementioned sorts, and many forms of euthanasia are ethically questionable. Some kinds of euthanasia, including assisted death, are permitted in some nations.

Physician-assisted suicide: The term "physician-assisted suicide" refers to active, voluntarily aided euthanasia in which the patient is helped by a physician. A physician gives a mechanism for the patient suffering to murder himself or herself, such as enough drugs.

Some euthanasia cases are rather uncontroversial. For example, killing a patient against their choice (involuntary, aggressive/active, other-administered) is virtually unanimously condemned. During the late 1930s and early 1940s, Adolf Hitler who carried out a campaign in Germany to eliminate disabled children (with or even without their parents' approval) under the pretence of enhancing the Aryan "race" and lowering societal expenditures. Everyone today believes that euthanasia in the service of a eugenics agenda was manifestly immoral.

Some euthanasia cases are rather uncontroversial. For example, killing a patient against their choice (involuntary, aggressive/active, other-administered) is virtually unanimously condemned. During the late 1930s and early 1940s, Adolf Hitler who carried out a campaign in Germany to eliminate disabled children (with or even without their parents' approval) under the pretence of enhancing the Aryan "race" and lowering societal expenditures. Everyone today believes that euthanasia in the service of a eugenics agenda was manifestly immoral.

Physician-Assisted Suicide IN CLINICAL PRACTICE

Many surveys have been published which show the use of euthanasia and Physician-Assisted Suicide by medical practitioners. In a 1995 anonymous poll of Washington physicians, it was discovered that 26% of respondents got at a minimum of one request for PAS, with three-quarters of the medical practitioners granting such requests.[222]

Despite its unlawful status, these numbers imply that PAS is not an infrequent occurrence (it can also be taken into consideration that in spite of the anonymous and private nature of the survey conducted, some ph ysicians wh o had in fac t carrie d out thes e req uests w ere un willing to ac knowledge t heir actions for fe ar of rep ercussions).

A survey of AIDS-related physicians in the San Francisco area revealed even more startling findings Slome et al[223] showed that 98 percent of participants who responded had received PAS requests, and that more over fifty percent of all participating physicians had fulfilled PAS requests, with some physicians satisfying hundreds of them. Furthermore, nearly half of the respondents (48 percent) said they'd be

[222] Back AL, Wallace JI, Starks HE. Physician-assisted suicide and euthanasia in Washington state: Patient requests and physician responses. JAMA. 1996;275:919–25. [PubMed] [Google Scholar]

[223] Slome LR, Mitchell TF, Charlebois E, Benevedes JM, Abrams DI, et al. Physician-assisted suicide and patients with human immunodeficiency virus disease. N Engl J Med. 1997;336:417–21. [PubMed] [Google Scholar]

INDIAN JOURNAL OF LEGAL REVIEW [IJLR]

VOLUME 4 AND ISSUE 1 OF 2024

APIS – 3920 - 0001 *(and)* ISSN - 2583-2344

Published by

Institute of Legal Education

https://iledu.in

likely to accept a hypothetical patients original request for PAS in reaction to a hypothetical scenario. Asch's study of nursing professionals was perhaps the most eye-opening investigation about the use of Physician-Assisted Suicide and euthanasia to date. According to the findings of this study, 17 percent of respondents said they had received a total one request for PAS, and 11 percent said they had accepted such a request [224]. Approximately 5% of responding nurses admitted to hastening a person to die at the physician's request, but without the patient's or family's consent (dubbed "nonvoluntary euthanasia" by some writers). Furthermore, 4.7 percent of the respondents admitted to hastening a patient's death alone without physician's knowledge or consent. In order to expedite death, many said they had ceased supportive care or increased pain medicine[225]. According to the accounts of responder nurses, these acts were taken in order to alleviate the patients' pain. These findings were based on the conventional role in nursing in pain management. It's also worth noting that Asch's divisive study drew a lot of attention, with many people claiming that methodological flaws including ambiguous question phrasing made the findings untrustworthy.[226]

While these statistics may not adequately reflect the real incidence of Physician-Assisted Suicide or more formallay called euthanasia, requests for aid in dying are definitely not uncommon, and physicians occasionally accept such pleas notwithstanding the legal restrictions. Furthermore, because physicians' capacity to confer with colleagues about how to respond to a request for PAS is limited by regulatory limitations, the reasonableness of patient plea and physician answers is uncertain.

Physician-Assisted Suicide in Netherlands

However, data on the frequency of requests for help in dying and the fraction of terminally sick person whose lives are ended in this manner are available in the Netherlands, where Physician-Assisted Suicide and euthanasia have been practised consistently for more than 20 years. After the Supreme Court of Netherland judgement in 1984, euthanasia was given its present status, provided that a number of requirements were satisfied. The patient's petition for Physician-Assisted Suicide must be free, aware, explicit, and persistent in nature. Both the medical practiitioner and the patient must concur that the patient's pain is severe and that all other options for treatment have been exhausted. A secondary practitioner must be contacted and must agree with the choice to help the patient terminate his or her life. Ultimately, each of these circumstances must be properly documented and submitted to the government agency in charge of overseeing euthanasia. Several studies have documented the proportion of fatalities in The Netherlands in which euthanasia and PAS are involved because to the availability of such information these estimated numbers were subjectet to adjustentment to account for lack of reporting of euthanasia which are acknowledged by many physicians in the Netherlands. Both the physician and the patient should accept that the patient's condition is unbearable, and other methods to alleviate the patient's suffering must have been taken. Van der Maas et al[227].used both government reports of euthanasia and replies to anonymous questionnaires to evaluate the frequency of euthanasia and Physician-Assisted Suicide when reflecting on euthanasia and Physician-Assisted Suicide practises in The Holland from 1990 to 1995. They found that euthanasia and Physician-Assisted Suicide were implicated in around 4.7 percent of

[224] Asch DA. The role of critical care nurses in euthanasia and assisted suicide. N Engl J Med. 1996;334:1374–9. [PubMed] [Google Scholar] [Ref list]

[225] Asch DA. The role of critical care nurses in euthanasia and assisted suicide. N Engl J Med. 1996;334:1374–9. [PubMed] [Google Scholar]

[226] Scanlon C. Euthanasia and nursing practice: Right question, wrong answer. N Engl J Med. 1996;334:1401–2. [PubMed] [Google Scholar]

[227] van der Maas PJ, van der Wal G, Haverkate Euthanasia, physician assisted suicide and other medical practices involving the end of life in the Netherlands, 1990-1995. N Engl J Med. 1996;335:1699–705. [PubMed] [Google Scholar]

INDIAN JOURNAL OF LEGAL REVIEW [IJLR]

VOLUME 4 AND ISSUE 1 OF 2024

APIS – 3920 - 0001 *(and)* ISSN - 2583-2344

Published by

Institute of Legal Education

https://iledu.in

the total deaths in the Netherlands in 1995, up from 2.7 percent in a 1991 survey[228].

Advocates of Physician-Assisted Suicide cite statistics from the Dutch as proof that legalisation hasn't resulted in widespread euthanasia or PAS misuse or overuse. However, detractors argue that the 75 percent rise in deaths involving euthanasia or Physician-Assisted Suicide from 2.7 to 4.7 percent shows a growing trend toward their more frequent usage, and hence a higher proportion of possibly improper euthanasia instances. Those issues are reflected in a 1994 judgement by the Supreme Court of Netherlands, which expanded the right to euthanasia or Physician-Assisted Suicide to people with chronic conditions which are not incurable, particularly psychiatric illnesses such as depression, if the sickness is recalcitrant to medication and produces hardship and suffering. Although the great majority of petitions for physician-Assisted Suicide from mentally ill people have been refused, there have been occasional incidents when this court judgement has permitted mentally ill adults of the country to get Physician-Assisted Suicide or euthanasia.

One such case has been cited as evidence for the ripple effect argument, according to which legalising PAS will lead to a gradual expansion of the patient group eligible for this "intervention," some of whom may not be ideal choices, such as physically healthy but medically depressed people[229].

IMPORTANCE OF Mental ISSUES and the Rise of Euthanasia

Euthanasia petitions from both terminally sick and non-terminally ill people due to untreatable and excruciating pain can only be legally approved in Belgium, Luxembourg, and the Netherlands[230]. European counties such as Belgium and Luxembourg are the only countries in the world where the essence and source of suffering are explicitly defined as "physical and/or psychological suffering that could not be abated and consequences from a grievous and irremediable medical disease, caused by accident or illness" as a valid reason for requesting euthanasia[231]. Despite the fact that intolerable pain is clearly a key factor in legally granting a patient's request, a widely accepted definition of unbearable suffering – as well as a detailed account of the particular qualities of patients' perceptions that decide whether they are deemed unbearable – will still be in the works[232]. Due to the ambiguity of the phrase, the Belgian Federal Control and Evaluation Commission (FCEC), which was established to determine whether all legal requirements relating to the case had been met in order to determine whether the situation should allude to the Belgian public prosecutor, has mentioned (in previous reports) disagreement over how to comprehend and evaluate unbearable (mental) suffering[233]. In order to create the study agenda for developing this definition and exploring which aspects make psychiatric patients' suffering unbearable, our work provides and evaluates key qualitative data. This is important in order to increase physicians' skills to avoid, detect, understand, treat, and assess (possibly) intolerable suffering, as well as to improve physicians' capacity to inhibit, detect, understand, treat, and analyze the possibly unbearable suffering. This would also provide improved legal protection for both patients and doctors participating in euthanasia-related decision-making[234].

[228] van Der Maas PJ, van Delden JJ, Pijnenborg L. Euthanasia and other medical decisions concerning the end of life. Lancet. 1991;338:669–74. [PubMed] [Google Scholar]
[229] Hendin H, Rutenfrans C, Zylicz Z. Physician-assisted suicide in the Netherlands: Lessons from the Dutch. JAMA. 1997;277:1720–2. [PubMed] [Google Scholar]
[230] Steck N, Egger M, Maessen M, Reisch T, Zwahlen M. Euthanasia and assisted suicide in selected European countries and US states: systematic literature review. Med Care 2013; 51: 938–44. [PubMed] [Google Scholar]
[231] Naudts K, Ducatelle C, Kovacs J, Laurens K, van den Eynde F, van Heeringen C. Euthanasia: the role of the psychiatrist. Br J Psychiatry 2006; 188: 405–9. [PubMed] [Google Scholar]
[232] Dees M, Vernooij-Dassen M, Dekkers W, van Weel C. Unbearable suffering of patients with a request for euthanasia or physician-assisted suicide: an integrative review. Psychooncology 2010; 19: 339–52. [PubMed] [Google Scholar]
[233] Federal Control and Evaluation Committee on Euthanasia.
[234] Federal Control and Evaluation Committee on Euthanasia 2012

INDIAN JOURNAL OF LEGAL REVIEW [IJLR]

VOLUME 4 AND ISSUE 1 OF 2024

APIS – 3920 - 0001 *(and)* ISSN - 2583-2344

Published by

Institute of Legal Education

https://iledu.in

Disagreements and disputes in relation to euthanasia

Active euthanasia proponents often argue that the taking the lives the patients isn't any worse than allowing them down to die. according to proponents of voluntary euthanasia patients should have the freedom to do whatever they wish with their lives, according to proponents of voluntary euthanasia. Mercy killing proponents claim that allowing people in critical states with little or no chance of recovery to die peacefully spare future unnecessary and pointless treatment attempts. If the patients are in pain, terminating them will keep them from suffering any longer.

P A S proponents say that aiding a terminally sick or suffering patient is just supporting the patient in dying with dignity. People who oppose Euthanasia frequently claim that executing a person is always immoral, that nonvoluntary or forced death infringes a person's rights, or that doctor aided suicide breaches a duty of care and goes against the natural fiduciary relationship.

Killing vs letting die We would have come across a debate about whether executing a patient is truly worse than allowing the patient to die if both outcomes are the same.

In most cases, morality believes that allowing someone to die is not as evil as killing them. We may or may not condemn allowing an innocent person to die, but we never condone the murdering of an innocent person. In healthcare, the distinction between murdering and allowing for a slow painful death is contentious, with detractors claiming that the distinction has a solid moral foundation. They claim that murdering the aforesaid patient achieves the same result as letting him die. Others dispute, claiming that the nature of murdering differs from letting someone die in ways that would make it ethically reprehensible.

Ordinary vs extraordinary treatment Using a mechanical ventilator to assist a person to breathe and thus be alive is, nevertheless, sometimes seen as exceptional therapy or care. Some ethicists feel it is ethical to let a person die by withdrawing artificial care or treatment, but not conventional treatment or care. This viewpoint is divisive. Some argue that the line between regular and extraordinary therapy is arbitrary, constructed, ambiguous, or in flux as technology advances.

Death intended vs. anticipated Some moral philosophers feel that even if a person is suffering, the terminally ill patient dies as a result of getting pain-relieving drugs was meant or just expected, it makes no difference. It is immoral if indeed the killing was planned, but it may be ethically permissible if the deaths occurred were foreseeable. This logic is based on the idea of the twofold impact, which is a moral principle.

INDIAN PERSPECTIVE REALITY

It could be tried to argue that in a country under which basic human rights are frequently ignored, lack of education is widespread, more than 50 % of the population lacks access to clean drinking water, people die each day from infectious agents, and where medical assistance and care are scarce, issues like euthanasia and Physician assisted suicide are irrelevant. India, on the other hand, is a diverse country in terms of religious groupings, educational attainment, and culture. In this context, the argument about euthanasia in India seems to be more perplexing, given the country also has a legislation that punishes those who attempt suicide.

In February 2008, the Medical Council of India's ethics committee commented on euthanasia, saying: "Practicing euthanasia shall constitute unethical behaviour." However, on rare instances, the decision to remove life-sustaining equipment to maintain cardio-pulmonary function even after brain death should be made by a team of clinicians rather than just the treating physician. A group of doctors will make the decision to stop using the support system. The doctor in charge of the patient, the Chief Medical Officer / Medical

INDIAN JOURNAL OF LEGAL REVIEW [IJLR]

VOLUME 4 AND ISSUE 1 OF 2024

APIS – 3920 - 0001 *(and)* ISSN - 2583-2344

Published by

Institute of Legal Education

https://iledu.in

Officer in Charge of the Hospital, and a doctor selected by the in-charge of the hospital from the hospital staff or in compliance with the Transplantation of Human Organ Act, 1994 must make up such a team[235].

As of now Active Euthanasia is illegal in India. Suicide attempts are punishable under Section 309 of the Indian Penal Code (IPC), whereas suicide abetment is penalised under Section 306 of the IPC. Only people who are brain dead with the aid of family members can be turned off from life support system.

Similarly, the Honorable Supreme Court of India believes that Article 21 mentioned in the Constitution guarantees the right to live but rather does not include the right to die. The court futhure observed that Article 21 is a provision of the constitution which concentrates on ensuring preservation of life and liberty, and that no extinction of life can be read into it by any stretch of the imagination. Various pro-euthanasia organisations, the most well-known of which being the Death with Dignity Foundation, continue to campaign for the legalisation of a person's right to determine his or her own death.

Aruna Ramchandra Shanbaug v. Union of India[236]

In this case, the court differentiated between active and passive euthanasia. Active euthanasia involves the intentional and direct termination of one's life by administering lethal substances. It is a criminal offence globally except where authorized by law. In India, active euthanasia violates Section 302 and Section 304 of the IPC. The High Court, under article 226, had the power to make decisions about the withdrawal of the life support system. The apex court laid down a proper procedure and guidelines for allowing passive euthanasia in the "rarest of rare circumstances" while dismissing the petition made by the petitioner. A bench was formed by the Chief Justice of the High Court upon receiving an application, before which a committee of three eminent doctors nominated was consulted. A comprehensive examination of the patient, state, and family members was carried out along with a notice issued by the bench.

Hence, in support of the "Parens Patriae" concept, the Supreme Court delegated the authority to decide the end of a person's life to the High Court to prevent any misuse. Consequently, in certain situations and with the High Court's approval after following the appropriate procedure, the Supreme Court sanctioned passive euthanasia. However, Supreme Court opined that passive euthanasia could be permitted in exceptional and rare cases with due consent from the patient's family members and doctors. Supreme Court maintained that it should be used sparingly and not become a means for undermining Article 21 of the Indian Consitution. Therefore, the court's evaluation of the medical report and the definition of brain death given in the Transplantation of Human Organs Act, 1994, clearly indicated that Ms Aruna's brain was not dead. Despite being in a Permanent Vegetative State, she had a stable state. She had sensations and could breathe without assistance. Therefore, ending her life was not justified.

Common Cause vs. Union of India[237]

The Supreme Court delivered a historic judgment on **9th March, 2018**, paving the way for passive euthanasia, also known as Physician Assisted Suicide (PAS). The Court reaffirmed that the right to die with dignity is a fundamental right, as previously established by its constitutional bench in Gian Kaur case[238], and ruled that an adult human being, having mental capacity, to take an informed decision, has right to refuse medical treatment including withdrawal from life saving devices. In the civil no. 215 of 2005 - Common Cause vs. Union of India and others, the Apex Court held that a

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

[236] Aruna Ramchandra Shanbaug v. Union of India (2011) 4 SCC 454

[237] Common Cause vs. Union of India (2018) 5 SCC 1, AIR 2018 SC 1665

[238] Gian Kaur V State of Punjab AIR 1962 SC 605

person of competent mental faculty is entitled to execute an advance medical directive. The judgment, spanning **538 pages**, was pronounced by the five-judges' constitutional bench consisting of the Chief Justice of India, Mr. Justice Dipak Misra, Mr. Justice, A.K. Sikri, Mr. Justice A.M. Khanwilkar, Mr. Justice D.Y. Chandrachud and Mr. Justice Ashok Bhushan. In 2005, an NGO, Common Cause had petitioned the Supreme Court seeking a declaration that the 'fundamental right to live with dignity' under Article 21 of the Constitution encompasses the 'right to die with dignity' and directions for adoption of appropriate procedure for implementing 'Living Wills', in which a person, while in sound mind and good health, may express his desire that he should not be kept alive by artificial means, such as ventilators, if doctors, at any point of his life, determine that he cannot survive without life support system. The judgment has enabled the terminally ill patients to opt for death through the passive euthanasia under a "living will".

CONCLUSION

The advancement of medical technology in India and around the world has enabled the artificial prolongation of life, but it also raises ethical dilemmas regarding the quality and cost of such life. This may inadvertently extend final pain and prove to be extremely costly for the subject's relatives. As a result, final issues have become important ethical concerns in India's contemporary medical science. Supporters and opponents of euthanasia and Physician assisted suicide are just as active in India as they are everywhere. The Indian legislature, on the other hand, does not appear to be concerned about these issues. The momentous Supreme Court decision has given pro-euthanasia supporters a big boost, albeit there is still a still far well before it becomes legislation in the legislature. Furthermore, fears of its abuse remain a key worry that must be resolved before that becomes legislation in our nation.