A STUDY OF ETHICAL AND LEGAL CHALLENGES IN LEGALISING PASSIVE EUTHANASIA IN INDIA

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CANDIDATE'S DECLARATION

I hereby certify that the work which is being presented in the thesis, entitled **"A Study of Ethical and Legal Challenges in Legalising Passive Euthanasia in India"** in fulfilment of the requirements for the award of the degree of Doctor of Philosophy in Faculty and submitted in Galgotias University, Greater Noida is an authentic record of my own work carried out during a period from 2017-2022 under the supervision of Prof. (Dr.) Namita Singh Malik.

The matter embodied in this thesis has not been submitted by me for the award of any other degree of this or any other University/Institute.

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ABSTRACT

One of the controversial issues in the recent past has been the question of legalizing the right to die or Euthanasia. 'Right to life' includes the right to live with human dignity which would mean the existence of such right up to the end of natural life which includes the right of a dying man to die with dignity. But the 'right to die with dignity' is not to be confused with the 'right to die' an unnatural death curtailing the natural span of life. Hence, the concept of right to life is central to the debate on the issue of Euthanasia. Euthanasia is controversial since it involves the deliberate termination of human life. Patient suffering from terminal diseases is often faced with great deal of pain as the diseases gradually worsens until it kills them and this may be so frightening for them that they would rather end their life than suffering it. So the question remains whether people should be given assistance in killing themselves, or whether they should be left to suffer the pain caused by terminal illness. Passive euthanasia is when the patient dies due to non-performance of something necessary to keep the patient alive or when abstaining from doing something that is required in keeping the patient alive which includes switching off life-support system, withdrawal of feeding tube, not opting for life-extending operation or life-extending drugs. The Courts in India have time and again been grappled by the issue of permitting a person to die or not.

The answer to some extent came through the landmark judgement in Aruna Ramchandra Shanbaug where the Supreme Court of India responded to the plea for euthanasia filed by Aruna's friend journalist Pinki Virani, by setting up a medical panel to examine her. The three-member medical committee subsequently set up under the Supreme Court's directive, checked upon Aruna and concluded that she met "most of the criteria of being in a permanent vegetative state", but turned down the mercy killing petition. The Apex Court in its landmark judgement, however allowed passive euthanasia in India.

In Aruna Shanbaug and Gian Kaur cases, the Supreme Court has stated that the law currently only permits passive euthanasia. The administration of active euthanasia or assisted suicide would constitute attempts to commit or abet suicide under the Indian Penal Code, 1860. However, in both these judgments, the court stated explicitly that

assisted suicide was only illegal in the absence of a law permitting it. Therefore, assisted suicide could be legalised if legislation was passed by Parliament to that effect.

Earlier to the judgement, in 2006, the Law Commission of India laid down an act for *the medical treatment of terminally ill patients (protection of patients, medical practitioners)*. According to this bill, if a 'competent' patient who is afflicted by 'terminal illness' refuses treatment after being duly informed about all aspects of the disease and treatment, the doctor is bound to obey the same and withhold or withdraw treatment. However, when the patient is 'incompetent' (includes minor, person of unsound mind) and is unable to take decisions for end of life, the doctor has to take a decision in the 'best interests' of the patient based upon an informed body of medical opinion of experts. The law might not apply in situations where the parents/guardians insist on continuation of life support measures despite being explained the inevitable outcome of the same. However, health ministry had opted not to make any law on euthanasia then.

Even in *the 210th Report on Humanization and Decriminalization of Attempt to Suicide,* the Law Commission of India stated regarding the reduction of suffering that right to live would, however, mean right to live with human dignity up to the end of natural life. Thus, right to live would include right to die with dignity at the end of life and it should not be equated with right to die an unnatural death curtailing natural span of life.

Hence, a dying man who is terminally ill or in a persistent vegetative state can be permitted to terminate it by premature extinction of his life. In fact, these are not cases of extinguishing life but only of accelerating process of natural death which has already commenced. In such cases, causing of death would result in end of his suffering. But even such change, though desirable, is considered to be the function of the legislature which may enact a suitable law providing adequate safeguards to prevent any possible abuse.

In Aruna Shanbaug "right to die" case, the Supreme Court made a significant statement on attempted suicide. Observing that a person who takes his/her own life needs help more than punishment, it asked Parliament to consider decriminalising the attempt to

commit suicide. This would entail deletion of section 309 of the Indian Penal Code. The Supreme Court judgment in Aruna Shanbaug's case seems to have, in a broad sweep, sanctioned passive euthanasia for terminally ill patients in certain circumstances.

The Supreme Court in Aruna Shanbaugh case specified two irreversible conditions to permit Passive Euthanasia Law in 2011, i.e.:

- The brain-dead for whom the ventilator can be switched off;
- Those in a Persistent Vegetative State (PVS) for whom the feed can be tapered out and pain-managing palliatives be added, according to laid-down international specifications.

Following guidelines were laid down by the Supreme Court in Aruna Shanbaugh for carrying out passive euthanasia:

- Decision to discontinue life support needs to be taken either by the parents or the spouse or other close relatives, or in the absence of any of them, such a decision can be taken even by a person or a body of persons acting as a next friend.
- Such a decision can also be taken by the doctors attending the patient as bona fide in the best interest of the patient.
- Every such decision needs approval from concerned High Court.
- When a high court receives such application, the Chief Justice should constitute a Bench of at least two Judges who should decide to grant approval or not.
- This bench will nominate and need a report from a committee of three reputed doctors.

Again in August 2012, the Law Commission again proposed making legislation on passive euthanasia and prepared a draft bill called the Medical Treatment of Terminally Ill Patients (protection of patients and medical practitioners) Bill allowing conflicts in living will as advanced medical directives. Euthanasia is regarded as the only viable option when all end of life care mechanisms fall short of a better life for an individual who is terminally ill or in a vegetable-like state. Although a law on euthanasia is a prerequisite for people suffering from terminal illnesses, there was no legislation with

respect to euthanasia in India until now. The government of India has finally come up with a draft bill on passive euthanasia.

The Law Commission's 196th Report and the main features of legislation suggested by the Law Commission under the title *"Medical Treatment to Terminally ill Patients (Protection of Patients and Medical Practitioners) Bill 2006"*, it may be mentioned that the main difference between the recommendations of the Law Commission in 196th Report and the law laid down by the Supreme Court lies in the fact that the Law Commission suggested enactment of an enabling provision for seeking declaratory relief before the High Court whereas the Supreme Court made it mandatory to get clearance from the High Court to give effect to the decision to withdraw life support to an incompetent patient. The opinion of the Committee of experts should be obtained by the High Court, as per the Supreme Court's judgment whereas according to the Law Commission's recommendations, the attending medical practitioner will have to obtain the experts' opinion from an approved panel of medical experts before taking a decision to withdraw/withhold medical treatment to such patient. In such an event, it would be open to the patient, relations, etc. to approach the High Court for an appropriate declaratory relief. The Law Commission in its 241st Report mentioned that withdrawing life support for certain categories of people such as those in persistent vegetative state (PVS) or in irreversible coma or of unsound mind, who lack mental faculties to make decisions for themselves should be allowed.

The questions whether the patient who is in the state of irremediable condition with no chance of revival and recovery should be allowed to die, and if so in what circumstances and subject to what safeguards are of great social, ethical and religious significance and are questions on which widely differing beliefs and views are held often strongly as also perceived in Nikhil Soni's *Santhara* case. In a secular country like India, where most of the religion defies for any form of euthanasia except Jainism and Buddhism be it customary or in scriptures, allowing passive euthanasia legally will only remain as a judgement for the rich and for the poor and biased population, sufferings will still prevail. The Psychological factor grappled with religious sentiments, beliefs and

emotions will be a barrier in construing passive euthanasia in the form of withdrawal of life support system.

But question remains as to the legal validity of right to refuse treatment in regards to legalization of passive euthanasia through Common Cause judgement. As Passive Euthanasia is now legalized in India but allowing passive euthanasia has raised serious concerns in various laws and concepts. As mandated by the Apex Court, Right to life with dignity as enshrined under Article 21 of the Constitution of India also includes Right to die with dignity and as passive euthanasia in the form of withdrawal of life support system is legalized for terminally & PVS state patients is knocking the State's duty and as well as one of the Constitutional right i.e. right to health and whether Indian citizen has the right to refuse treatment. The concept of right to refuse treatment and its admissibility in regards to legal and ethical issues in consonance to passive euthanasia will be a legal challenge for future. It is evident that legalization of passive euthanasia has serious and threatening implications on right to health and widened the scope for transplantation of organ be it for the good or bad. Legalising passive euthanasia will surely put an end to growth of hospice and palliative care and tends to slippery slope towards active euthanasia.

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LIST OF ABBREVIATIONS

ACTSC	Australian Capital Territory Supreme Court
AIR	All India Reporter
ALL ER	All England Reporter
BMLR	Butterworths Medico-Legal Reports
Bom	Bombay
Bom LR	Bombay Law Reporter
Calif. L. Rev	California Law Review
CUP	Cambridge University Press
ECHR	European Convention on Human Rights
Edn	Edition
Eds	Editors
EWCA	England and Wales Court of Appeal
EWHC	England and Wales High Court
FCR	Family Court Reports
Guj	Gujarat
HC	High Court
HL	House of Lords
ICESR	International Covenant on Economic, Social and Cultural Rights
JMFC	Judicial Magistrate First Class
Kar	Karnataka
Monash ULR	Monash University Law Review
NEJM	The New England Journal of Medicine
NHS	National Health Service

NJ	New Jersey
NSWSC	New South Wales Supreme Court
NT News	Northern Territory News
NTLR	Northern Territory Law Reports (Australia)
NZLR	New Zealand Law Reports
OUP	Oxford University Press
PIL	Public Interest Litigation
PVS	Permanent Vegetative State
QB	Queens Bench
SC	Supreme Court
SCC	Supreme Court Cases
SCR	Supreme Court Reporter
UK	United Kingdom
UKHL	United Kingdom House of Lords
UKSC	United Kingdom Supreme Court
UN	United Nations
US / USA	United States
WASC	Western Australia Supreme Court
WLR	Weekly Law Reports

CHAPTER 1

INTRODUCTION

"You matter because you are you.
You matter to the last moment of your life,
and we will do what we can,
not only to help you die peacefully,
but also, to live until you die."[1]...

***-Dr. Dame Cicely Saunders** (1918–2005)*
Founder of Modern Palliative Care.

1.1 Introduction

There is a great deal of confusion regarding the responsibility families and doctors have when it comes to caring for their loved ones. A growing emphasis on patient autonomy has emerged in recent years, with informed permission being necessary before doctors may initiate medical procedures to terminate the lives of patients who are in excruciating pain or for whom further treatment looks useless, with a few exceptions when the patient is asleep. Euthanasia has long been linked to discussions about autonomy, mercy killing vs mercy euthanasia, as well as arguments against euthanasia being with a slippery slope or arbitrary limits.

When Pinki Virani, author of the book on Aruna Ramchandra Shanbaug, requested euthanasia for Aruna, the Supreme Court of India replied by setting up a medical team to evaluate her, and it was determined that Aruna satisfied "most of the requirements of being in a persistent vegetative state" by a three-member medical committee set up by the Supreme Court. However, the appeal for mercy killing, on the other hand, was rejected. However, a ground breaking ruling by the Supreme Court of India permitted passive euthanasia in the country.[2] The Court also established standards for passive euthanasia at the same time as well. To put it another way, these rules state that passive euthanasia is when a patient is taken off of life-supporting therapy or food. The case, on the other hand, irrevocably altered India's stance on euthanasia. Passive euthanasia

[1] Leiva René A., *Death, Suffering and Euthanasia* (Dec. 12, 2017, 06:00 PM), http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2902937/.
[2] Aruna Ramchandra Shanbaug v. Union of India and others, 2011 AIR (SC) 1290.

is permitted, but only if the conditions are right. If an irreversible coma occurs, other Indians can now argue for the right to refuse medical treatment, including removing a patient off a ventilator. When a person is in an irreversible vegetative condition or terminally sick, passive euthanasia is permitted, according to the Court's ruling. Nevertheless, it may be legal to withhold or discontinue life-sustaining medical care from a terminally sick patient under specified situations.

In the case of Common Cause (A Registered Society) v. Union of India,[3] Indian Supreme Court decided that the right to die with dignity is a basic fundamental right. The Bench also found that passive euthanasia for the sake of dying is legal. A patient's right to dignity extends to the ease with which he or she dies, whether they are terminally ill or in a chronic vegetative state. The legalisation of advance directives has occurred in certain jurisdictions by law and in some countries through judicial judgments, thus allowing for living wills.

Recently, after these two-landmark judgements, a hot-button subject has been the legalisation of euthanasia or assisted suicide, as human dignity is a part of the right to life and should be protected till the end of one's natural life. Even the right to die peacefully is included. Some people argue that the "right to die with dignity" should not be misconstrued as the right of an individual to die an unnatural death that reduces an individual's expected lifespan. As a result, the right to life is a significant issue in the Euthanasia debate. Considering that euthanasia is the purposeful termination of human life and it is contentious. Terminally sick patients are typically faced with excruciating agony as their condition progresses, and this may be so scary to them that they choose to terminate their lives rather than face it. So, the debate is whether people should be assisted in ending their lives or if they should be left to bear the agony of a fatal condition.

This study deals mainly with passive euthanasia. This method is often referred to as "Negative Euthanasia" or "Aggressive Non-Sanctioned Euthanasia." Not giving critical

[3] Common Cause (A Regd. Society) v. Union of India, (2018) 5 SCC 1.

medical care, necessary and routine care, or food and drink is a deliberate act of death. Removing or stopping artificial life support systems is what this means. Passive euthanasia is typically more painful and time-consuming than aggressive euthanasia. Non-voluntary passive euthanasia is legal in some cases, as are most kinds of euthanasia. There are some medical actions that are considered "passive euthanasia" since they lack the purpose of ending a person's life. Not starting therapy that will not help the patient is one of these acts, as is stopping treatment that has been proved to be unsuccessful, onerous, or undesirable. They are all recognised by law as legal and legitimate medical practices when done correctly.

The Medical Treatment to Terminally Ill Patients (Protection of Patients and Medical Practitioners) Bill, 2006 was addressed by the Law Commission of India in its 196th report in March 2006.[4] Terminally ill individuals (including those in a chronic vegetative state) who wish to suffer a natural death without the use of contemporary Life Support Measures such as artificial breathing and artificial food delivery are the focus of this research, stipulating, as stated at the beginning that euthanasia and assisted suicide to continue to be illegal and that the report will be dealing with a distinct subject involving the removal of life-sustaining measures from terminally ill patients, which is considered as 'lawful' in all nations.

Passive euthanasia was also the subject of the Law Commission of India's 241st report titled "Passive Euthanasia: A Relook" on the basis of Aruna Shanbaug's ruling on passive euthanasia.[5] After stating that it was not a case of euthanasia, the Shanbaug case made reference to the report in its decision on passive euthanasia, even though the report claimed that it was not about euthanasia. Accordingly, the Shanbaug judgement, which legalised passive euthanasia and established a set of guidelines for its implementation, was in line with the judiciary's views and catered to medical ethics and the duty of a doctor, the perspective of legalising euthanasia and changes were

[4] *Medical Treatment to Terminally Ill Patients (Protection of Patients and Medical Practitioners)*, Law Commission of India Report No. 196, March 2006, (Jan. 20, 2018, 07:10 PM), https://lawcommissionofindia.nic.in/reports/rep196.pdf.
[5] *Passive Euthanasia-A Relook*, Law Commission of India Report No. 241, August 2012, (Jan. 23, 2018, 08:15 PM), https://lawcommissionofindia.nic.in/reports/report241.pdf.

proposed in the draft Bill. It reaffirmed the Shanbaug judgment's position on the question of passive euthanasia and analysed the Supreme Court's findings and suggestions on the matter.

The issue of euthanasia cannot be tackled just from a legal and scientific standpoint; religious and moral factors must also be taken into account. An investigation of Indians' attitudes toward euthanasia is undertaken in this paper. The study also takes issue with past judgements regarding the right to die. Legalising euthanasia in India has been discussed at a different length.

1.2 Problem Statement

Despite the fact that pain and suffering are a part of everyday life in our society, society also seeks to preserve the sacredness of human life and the integrity of the medical profession. Advocates of assisted suicide claim that euthanasia can be permissible in cases when the individual's demand for human dignity and release from pain is the driving force behind the decision-making process. One would agree that in circumstances where death is unavoidable, prolonging life by artificial methods may result in undue suffering for both the patient and their families. Many of these individuals have been described as being "prisoners of technology" since they lack any ability to feel pleasure, sense or comprehend what is going on around them.

Considering the fact that euthanasia can help to alleviate the financial strain on the family of the sufferer. One of the tremendous pressures on society today is medical bills. It is very uncommon for some families to be left penniless and destitute after a loved one spends months in a nursing home or critical care unit before they are finally allowed to say goodbye.

There are already precautions in place following the Supreme Court's recent affirmation of passive euthanasia. To make a decision about a patient's life or death, the Court must be approached at significant expense, and the moral quandary of whether a patient should live or die is not resolved to have dilemmas with advanced medical directives and its relativity with concerning situations. The permission, next

friend, the role of the state, decision-making power, and palliative and end-of-life care all tend to create a pandora's box. Are not these patients entitled to a dignified and pain-free death if legislation is put in place? Will the patient's guardian allow for passive euthanasia if it is determined that it will address the problems and consequences?

1.3 Literature Review

1.3.1 *Euthanasia and Passive Euthanasia: Definitions, Types and Perspectives*

Every human being wants to live to the end of his or her life and enjoy the fruits of his or her labours. There are times when people want to die in a non-natural way. In circumstances where a person is suffering from chronic and incurable sickness, this tends to happen more frequently. It is the belief that when a person's life is no longer enjoyable or helpful, he or she should be euthanised or helped in euthanasia by a doctor or another person who is trained in the practice. Euthanasia, or mercy killing, is a word that refers to the purposeful end of a patient's life in such a scenario by an act or omission of medical treatment. In contemporary bioethics, this is the most active study field.[6]

The term "euthanasia" typically refers to the practice of actively assisting in the patient's death (mercy killing) rather than merely stopping the patient's care. Deliberately refusing life-prolonging measures and the use of painkillers are two distinct things that cannot be confused with euthanasia.[7] Euthanasia is an act in which a third party, often a doctor, either passively or actively terminates the life of a person. Stopping or delaying medical help to the patient allows them to die. The patient would die on their own if the ventilator assistance were removed. Another example is stopping dialysis. It is common to think of "passive euthanasia" as "letting a person to die" since when the physician removes the patient's supportive care, Patients die as a result of a life-threatening ailment or medical scenario that they were suffering from. As opposed

[6] Thomas Zachariah, *Euthanasia-A Study of Law, Policy and Ethics*, (Feb. 20, 2018, 10:32 PM), https://www.researchgate.net/publication/284791172_EUTHANASIA_-_A_STUDY_OF_LAW_POLICY_AND_ETHICS.

[7] Benjamin Gesundheit et al., *Euthanasia: An Overview and The Jewish Perspective*, Informa Healthcare, ISSN: 0735-7907, (Dec. 6, 2017, 10:00 AM), http://informahealthcare.com/doi/abs/10.1080/07357900600894898.

to active euthanasia, passive euthanasia deals with the omission of efforts that may have been taken to prolong life.[8] These "definitions" are clearly not comprehensive.

Euthanasia advocates have traditionally focused their attention on "voluntary" euthanasia, in which the patient actively asks for his life to be ended.[9] Unlike active euthanasia, when a purposeful act is performed in order to kill the patient, passive euthanasia is the deliberate failure to do an act in order to enable the patient to die.[10] Passive euthanasia refers to the practice of reducing a person's level of care and allowing nature to take its course. An example of this would be to cut off the respirator or medicine or to stop feeding or watering the patient so that they would dehydrate or starve to death. This includes giving patients enormous doses of morphine, even when it is likely to cause respiratory suppression and death earlier than otherwise would have occurred, as part of the practice of "passive euthanasia." Taking such high quantities of medicines has the dual effect of alleviating pain and speeding up the process of dying. In most countries and medical communities, administering such drugs is considered to be morally acceptable. In order to expedite the natural death of those who are terminally sick, specific treatments are used. People in a chronic vegetative state, such as those with severe brain injury or in a coma from which they are unlikely to wake up, are also frequently subjected to these procedures.[11]

According to **Somerville**,[12] the euthanasia discussion is bedevilled by ambiguity. There is a wide range of practical and theoretical issues that are affected by this misconception, which is both inadvertent and intentional. It is possible that creating misunderstanding is a strategy for promoting the legalisation of euthanasia. The term "euthanasia" is extraordinarily vague and challenging to define. 'Euthanasia' should be

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[8] George Zdenkowski, *Human Rights and Euthanasia, an Occasional Paper of the Human Rights and Equal Opportunity Commission*, December 1996, The Human Rights and Equal Opportunity Commission, Sydney, December 1996, (Dec. 8, 2017, 07:15 PM), www.hreoc.gov.au/pdf/human_rights/euthanasia.pdf.

[9] Tushar Kumar Biswas and Arnab Sengupta, *Euthanasia and its Legality and Legitimacy from Indian and International Human Rights Perspectives,* Asia-Pacific Journal on Human Rights and the Law, vol 11, issue 2 (2010) 18-30, ISSN: 1388-1906.

[10] M. Stauch et al.*,Text, Cases and Materials on Medical Law*, Cavendish, 3rd ed, *2006,* (Dec. 12, 2017, 07:00 AM), http://www.amazon.co.uk/Text-Cases-Materials-Medical-Law/dp/1859419348.

[11] *Euthanasia* (Dec. 6, 2017, 12:00 PM)*,* http://legal-dictionary.thefreedictionary.com/euthanasia.

[12] Margaret A. Somerville, *Euthanasia by Confusion*, 56 Advocate (Vancouver) 875 (1998).

defined as a purposeful act or omission that causes death, committed by one person with the primary aim of terminating the life of another person in order to alleviate that person's suffering for the sake of clarity. The most common example given is the administration of a fatal injection to a terminally ill individual who has requested and given informed permission for this. It should be noted, however, that neither informed permission nor terminal illness is mentioned in the definition that has been offered.

Thus, it encompasses non-voluntary euthanasia, in which the patient is unable to give or withdraw consent and involuntary euthanasia, in which the patient is able to give or withhold consent, but euthanasia is delivered without the patient's knowledge or agreement. This is in contrast to the Netherlands, where euthanasia is only permitted with "explicit permission." In the Netherlands, administering fatal injections to those who are unable to agree is not considered euthanasia. However, it is legal in some circumstances. The term "physician-assisted suicide" is also a source of misunderstanding. A typical example is euthanasia, in which the physician intervenes with the primary aim of killing the patient, most typically via fatal injection, which is homicide rather than suicide with the primary intention of killing the patient. Euthanasia and physician-assisted suicide are referred to as "physician-assisted death" in certain circles, which refers to a wide variety of treatments that physicians conduct and are under an ethical and legal responsibility to undertake to aid dying patients in their last days. The second type of medical help is something all want, but this does not imply whether one supports physician-assisted "suicide" or euthanasia in general.

This discussion is far too crucial to be based on a nebulous understanding of what constitutes euthanasia or what does not constitute it. For starters, one should discuss whether the legislation should be amended to enable physicians to administer fatal injections to terminally sick, mentally competent persons who desire and provide their informed consent to this procedure. There is a plethora of additional pertinent questions. For example, if we oppose euthanasia, should we permit physician-assisted suicide as a viable option? Alternatively, if we legalise euthanasia, should it be made available to those who are unable to make decisions for themselves? The fact that we should start

with the most obvious question should assist in clearing up the existing uncertainty, which is potentially hazardous whether we are for or against euthanasia?

Vincent Dep. Larkin[13] stated in the book review that John Ladd points out in his introduction that euthanasia once was taken to mean easy dying but now relates to the means taken to avoid an ugly, violent, or tortured death. He describes the role of philosophers as providing conceptual analysis to clarify concepts by way of logical analysis and argumentation to eschew appeals to authority. To the author, Philippa Foot considers the meaning of euthanasia and the relation of the concepts of good and evil to life and death in a closely reasoned exposition. She proposes that the virtue of charity can be as crucial to the patient as the rights derived from justice when active or passive euthanasia is contemplated. The author, Peter Singer, expounds his thoughts on the sanctity of human life. He finds no critical difference between severely and irreparably retarded humans and nonhuman primates and concludes there is no rational basis for treating them differently and, with Jonathan Swift, no moral objection "too fattening retarded infants for the table." In this connection, Michael Tooley explores the concept of the person in relation to decisions to terminate life. He distinguishes between the death of a biological organism and of a person. In his view, the only considerations that should be taken into account in deciding whether it is morally permissible to terminate the life of an organism are whether it is a person, whether it has a rational desire to die, and how expensive it is to keep the person alive, and whether it is technologically possible to restore consciousness. From this base, he considers morally acceptable euthanasia of mentally competent persons who desire it, abortion, infanticide (of healthy) infants and young children, and of comatose patients, where the cost of maintaining life is expensive.

There is an increasing number of possibilities for healthcare as medical knowledge and technology improve, according to the essay "End of Life Care: An Ethical Overview".[14]

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[13] Vincent Dep. Larkin, *Ethical Issues Relating to Life and Death*, Book Review, John Ladd, Editor, Oxford University Press, New York, 1979. 214 pp, (Dec. 8, 2017, 07:00 PM), www.ncbi.nlm.nih.gov/pmc/articles/.../bullnyacadmed00112-0081.pdf.

[14] *End of Life Care: An Ethical Overview*, Center for Bioethics, University of Minnesota, 2005, (Nov. 8, 2017, 11:15 PM), www.ahc.umn.edu/img/assets/26104/End_of_Life.pdf.

Decisions on the treatment of people who are nearing the end of their lives are fraught with complex ethical problems. Choosing the optimal treatment for a patient near the end of their life is a difficult decision for many. It may be essential to determine whether or not to stop a patient's therapy and allow their life to come to an end. People from all walks of life face difficult decisions whether it comes to their own health or that of a loved one who is dying. As a result of technological advancements, the barrier between life and death has grown increasingly blurred. Cardiopulmonary resuscitation (CPR) therapies and technology can restart and sustain heart and lung functioning at the site of an accident or in a hospital room. Because of the advancements in life support technology over the last century, a new type of patient has emerged - one who has lost the ability to think but whose heart and lungs are still beating normally. There has been much attention paid to enhancing the end of life and pushing for "good death" by many committed individuals and groups, as well as by researchers and policymakers. According to the Article, continuing to suffer might be worse than death for some people who are nearing the end of their life. Seeing a close friend or family member die may be devastating. In times of extreme suffering, the thought of physician-assisted suicide or euthanasia may seem like the only logical and humanitarian option left.

1.3.2 *Concept of Death with Dignity and Right to Die*

Popular among proponents of active euthanasia is the idea of "death with dignity" or the preservation of dignity as a person dies. The theory is based on the notion that dying for an extended period of time in a hospital is both unnatural and unworthy of respect. Thus, promoting dignity in dying helps those who desire to end undesirable or unproductive therapy for themselves or a loved one.[15]

Sujata Pawar[16] is of the view that the "right to die" appears to be derived from the rights to privacy, autonomy and self-determination, according to contemporary terminology. Suicide is a terrible act committed by a single person. Euthanasia and assisted suicide are not considered to be personal acts as it all comes down to allowing one individual to assist in the killing of another. Widespread public concern exists since

[15] *Supra* note 13.
[16] Sujata Pawar, *Euthanasia: Indian Socio-Legal Perspectives*, 15 J.L. Pol'y and Globalization 11 (2013).

this is a situation that has the potential to result in considerable abuse, exploitation, and worsening of care for the most vulnerable members of our society. The two categories of instances that are now causing concern are as follows:

- First and foremost, those who are able to articulate their intention to die. Patients suffering from a significant disease, or even for reasons unrelated to their sickness, who are profoundly unhappy and express a desire to die are known as suicidal patients. This group of people is no different from everyone else who has had suicidal thoughts-they simply have physical challenges in addition to their emotional or psychological troubles. Being a burden on one's family may be a cause of humiliation for specific individuals. The vast majority of people who speak about or attempt suicide are not sincerely motivated to die, according to social workers and psychologists who have frequently seen this phenomenon. They just get dissatisfied with their inability to lead the type of busy lives that they were accustomed to prior to their disease.
- Second, those who are unable to speak because they are in a coma, paralysed, or just too sick and feeble to make any meaningful conversation due to illness or injury. Euthanasia supporters claim that the "quality of life" of such people is so low that they would be better off dead and that they should be murdered by depriving them of food and fluids until they die of starvation as a result of their condition.

When one takes into account both the reasons in favour of and the arguments against euthanasia, one might come to the conclusion that the arguments against euthanasia exceed the arguments in favour of legalising euthanasia. The courts of other countries, as well as the courts of India, have reached differing conclusions on the legality of euthanasia and assisted suicide in their decisions.

Most of the discussion has centred around one central question: Is euthanasia indeed required for death with dignity? Is it possible that we are denying individuals their dignity if we murder them rather than care for them affectionately? In the debate over whether terminally sick persons or others should be allowed to seek aid in terminating their own life, and if so, under what conditions and subject to what protections, there is

a great deal of social, ethical, and religious importance. These are issues on which vastly divergent attitudes and points of view are held and frequently vehemently held. According to modern language, the "right to die" appears to be drawn from the rights to privacy, autonomy, and self-determination, among other things. In the case of voluntary euthanasia, the freedom to reject medical care is diametrically opposed to the right to request aid in dying. Ultimately, though, it is possible to decide that these reasons do not provide a compelling with enough rationale for society to relax its rule on deliberate killing. That restriction serves as the foundation of both the law and social interactions. Individuals are protected in an unbiased manner, embodying the principle that we are all equal, and so there should be no change in the law to allow for the practice of euthanasia. Generally speaking, it may be recognised that there are some situations in which euthanasia may be judged appropriate by some people. Individual cases, on the other hand, cannot possibly serve as the foundation for a policy that would have such substantial and widespread ramifications. Death is also a social phenomenon that affects many people at the same time. The death of a person has an impact on the lives of others around them, frequently in ways and to the extent that cannot be anticipated. It is impossible to separate the interests of the individual from the interests of society as a whole when it comes to the question of assisted suicide. Because of this, it is stated that in order to make a resolution to the debate over assisted suicide, the contradiction between the idea of life's sanctity and the rights to self-determination and the inherent dignity of a human being must be resolved. Euthanasia, on the other hand, may be permitted as a necessary exception only in the passive form in appropriate cases where the individual cannot give consent and the medical opinion is that death is imminent and inevitable, and withdrawing life support is in the patient's best interests, rather than being legalised as a general rule.

According to **Elizabeth Ogg**, there is no such thing as a right to die because no one chooses to be born. Considering that no one is selected to be born, it may be questioned if there is a right to live. There are many occasions in which patients or their families have asked the hospital to stop treatment, and the institution has refused to cooperate, according to this author's assertions about the legality of assisted death. Unnecessary

pain and suffering are experienced by the patient in these circumstances.[17] **Sprung** states that "the right to die is an integral part of our right to control our destinies so long as the rights of others are not affected."[18]

1.3.3 *Euthanasia: Ethical and Legal Perspectives*

In some instances, it may be challenging to determine whether a particular action or omission constitutes an act or an omission. The doctor, for example, understands that if a patient does not have access to life support, he will die. However, he must first turn off the ventilator. The Court ruled that shutting off the ventilator was an omission, not an act, for a layperson.

Active euthanasia is more humanitarian than passive euthanasia, according to **James Rachel**.[19] A terminally ill patient with throat cancer is in excruciating agony that can no longer be adequately eased. Even if the current therapy is continued, he will die within a few days, but he does not want to wait that long because the pain is intolerable. Because of this, he and his family begged the doctor to put a stop to it. Doctors are permitted to withhold treatment if they consent to it in accordance with traditional medical practice. Why does he do it? Because it would be morally immoral to prolong the patient's torment unnecessarily when the patient is already in excruciating pain. Because the patient may have to suffer longer in this situation, it may be preferable to use deadly injections rather than suggest withholding care. It is reasonable to believe that active euthanasia is preferable to passive euthanasia, rather than the reverse, once the decision has been made not to prolong his agony; otherwise, it would be counter-productive to endorse the option that would result in more suffering rather than less, which would be in violation of the humanitarian impulse that prompted the decision not to prolong his life in the first place. Lethal injections may be administered quickly and

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[17] Elizabeth Ogg (1980), *The Right to Die with Dignity*, N.Y: Public Affairs Committee, New York, (Dec. 13, 2017, 08:25 PM), www.getcited.org/pub/102098537.

[18] Charles L Sprung, *Is the Patient's Right to Die Evolving into a Duty to Die? Medical Decision-Making and Ethical Evaluations in Health Care*, Journal of Evaluation in Clinical Science, vol 3, Issue 1, February 1997, pp.69-75, (Dec. 31, 2017, 05:10 PM), http://onlinelibrary.wiley.com › ... › Journal Home › Vol 3 Issue 1.

[19] James Rachels, *Active and Passive Euthanasia*, The New England Journal of Medicine, vol. 292, January 9, 1975, pp. 78-80, (Feb. 10, 2017, 02: 45 PM), http://people.brandeis.edu/~teuber/Rachels_Euthanasia.pdf.

painlessly, but the process of "being let to die" might take a long time and be quite unpleasant.

True love would be to feel their suffering and let them leave since the delight of seeing them around is not greater than the anguish that they are going through.[20] If James Rachel's reasoning is correct, then passive euthanasia is no worse than active euthanasia; if this is the case, then active euthanasia is no worse than passive euthanasia. A fatal injection, on the other hand, is a reasonably speedy and painless method of death, according to James Rachel's assertion. Death by euthanasia has long been seen as an unethical and criminal practice; nevertheless, voluntary passive euthanasia may be justified as a moral one for those suffering from an incurable sickness. [21]

For **Kaplan**,[22] prior medical directives serve as a catalyst for talks regarding end-of-life care choices between patients and their doctors. Although this paradigm is often disregarded, the religious beliefs of the physician are a critical factor. Leaving out these viewpoints might have a significant impact on the therapeutic alternatives that are presented during these crucial sessions. Advance medical directives are designed to give patients the ability to specify their treatment preferences even if they lose the mental capacity to do so. Despite the fact that it is impossible to separate religious concerns from the medical care of a person nearing the end of his or her life, these concerns have the potential to undermine the effectiveness of advance medical directives by complicating their communication function and by introducing additional considerations, possibly pre-emptive, when family members have differing religious perspectives. Choosing a designated medical decision-maker can address specific religious concerns, but enforcement issues are more challenging to resolve and continue to limit the eventual use of advance medical directives, as well.

[20] Rosa Bowles, *Is Euthanasia Ethical*, (Jan. 4, 2018, 06:05 PM), http://people.brandeis.edu/~teuber/Rachels_Euthanasia.pdf.
[21] *Supra* note 17.
[22] Richard L. Kaplan, *Religion and Advance Medical Directives: Formulation and Enforcement Implications*, 2016 U. Ill. L. Rev. 1737 (2016).

Abortion and surrogacy, for example, were once viewed as morally repugnant practices.[23] According to **Bentham**, traditional religious doctrines did not fit with modern views. It took time for the state to allow some degree of freedom when logic, reasoning, justness and justice were included in the legal system. However, there is still a wide gap among countries when it comes to a person's freedom to control his or her own body. Because each civilisation sets its own criteria for determining moral and religious values, this is the reason. Good values are taken into account by every community. Societal members may reject a person's actions because of their perceived influence on moral standards.[24]

According to **Jordaan**,[25] Since the beginning of time, philosophers, theologians, ethicists, and lawyers have disputed whether or not a person has the right to choose whether or not to live or die. Although voluntary active euthanasia has been around for a long time, the moral and legality of this practice, in which a competent person makes a voluntarily request to a physician to be assisted in the execution of his or her death, has primarily been a phenomenon of the twentieth and twenty-first centuries. As medical technology progresses and the possibility of a protracted death in which a person may be mechanically sustained in perpetuity by mechanical respirators, food tubes, heart pumps, and antibiotics has increased, the subject of assisted dying has been pushed increasingly into the court arena. Although voluntary active euthanasia performed by physicians in accordance with specific due-care criteria has been recognised as lawful conduct in the Netherlands through the defence of necessity, the practice of voluntary active euthanasia as well as physician-assisted suicide has been regulated by legislation since 2001 in the Netherlands. Because palliative care has been recognised in the Netherlands for 25 years, the opinions of Dutch physicians on the subject of whether palliative care is always a viable alternative to euthanasia are relevant. According to a survey carried out in the Netherlands, in response to the

[23] *Abortion, Euthanasia and The Value of Human Life,* (Dec. 20, 2017, 10:40 AM), http://www.markedbyteachers.com/gcse/religious-studies-philosophy-and-ethics/abortion-euthanasia-and-the-value-of-human-life.html.
[24] Jeremy Bentham, *An Introduction to the Principles of Morals and Legislation* (1781), (Dec. 19, 2017, 11:28 PM), https://www.utilitarianism.com/jeremy-bentham/index.html.
[25] Louise Jordaan, *The Right to Die with Dignity: A Consideration of the Constitutional Arguments*, 72 THRHR 192 (2009).

statement that competent management of pain and final care renders euthanasia unnecessary, two-thirds of the physicians expressed disagreement. Having a religious conviction, working as a nursing home physician or clinical expert, and not desiring to conduct euthanasia were all mentioned as being associated with the opinion that competent treatment of pain and final care might render euthanasia unnecessary. According to the argument, the charge that the legalisation of assisted suicide will have the consequence of decreasing or even ceasing palliative care is entirely hypothetical and cannot be supported by evidence.

There are intriguing philosophical, legal and moral questions about the right to die and the right to prolong life posed by biomedical research and technology, according to **Gerald A. Laru** in his paper 'Euthanasia'[26] studying the moral, religious, societal, and legal elements of euthanasia is the most common way to grasp these new notions.

Most laypeople favour active euthanasia because they believe it is cruel to subject patients to unrelenting suffering or that it is cruel to keep them physiologically alive when they have "no life to live." Various doctors, however, do not take advantage of the many pain-relieving options that are now at their disposal. Physicians have learnt to oppose what one commentator terms merely onerous or demeaning medical additions to the miserable end of life despite advances in medicine that have made it feasible to, as one commentator put it, extend existence beyond all "natural boundaries." Because of this, the author's involvement in the euthanasia debate includes both hands-on involvement and an endeavour to stay objective while the debate moves forward. Many have established a distinction between terminating life support and guiding the patient to a death-causing drug, and the author does not necessarily agree with this and recognises that this distinction has become an essential part of medical law. To conclude, it does appear to be the compromise position our society has reached in its attempt to maintain as many traditional limitations against killing as we can while still taking a humanitarian approach to very ill patients. As much as a more idealistic

[26] Gerald A. Laru, *Euthanasia*, Humanism Today, http://www.humanismtoday.org/vol4/larue.pdf.

approach is desirable, there is doubt that most logicians or philosophers would agree, but it may still be a practical and justifiable way to resolve the argument.[27]

To die is a difficult task, and life is a phenomenon that may be meant to keep people away from the negativity that seeks to undermine the virtue and vigour of life from every angle. The fact remains, despite all of the statements, references, and utterances - whether mystical, philosophical, or psychological - that people love to live - whether they are eighty or eighteen - and do not, in actuality, intend to treat life as if it were an autumn leaf, at least on the basis of conceptual majority. The Hippocratic Oath sworn by a doctor, as well as the MCI Code of Ethics, may cause him to believe that he has failed his patients, and it may also cause him to be fearful of numerous regulations. It is possible that he may be accused of carelessness or criminal liability. The administration of a lethal injection or specific medications to cause a painless death should be distinguished from refraining from administering specific treatments that can prolong a patient's life in cases where the process of dying has begun and cannot be reversed or withdrawing treatment that has already been administered to the patient because there is no chance of saving the patient's life. Furthermore, the first half would be considered an overt act, whilst the second half would be classified as either informed consent or an approved omission, respectively. If certain safeguards are observed, an omission of this nature will not result in criminal liability for the culprit. According to this concept, life should not be prolonged when there is no cure for the scenario in which the patient is now, and the patient would have wanted to stay in this deteriorating state under any circumstances.[28]

The ethical and moral quandary surrounding euthanasia is well-known. Even at the patient's or a close relative's request, the World Medical Association deemed euthanasia immoral. In addition, the Medical Council of India (MCI) also declared euthanasia to be immoral. A doctor's oath states that he or she "should do no harm",

[27] Yale Kamisar, *Active v. Passive Euthanasia: Why Keep the Distinction?* Trial 29, no. 3 (1993): 32-4, 36-8.
[28] KK Aggarwal and Ira Gupta, *Law on Euthanasia in India*, Indian Journal of Clinical Practice, Vol. 29, No. 11, April 2019, (Oct. 02, 2019, 10:30 AM), https://ijcp.in/Admin/CMS/PDF/17.%20Medicolegal_IJCP_April2019.pdf.

but, in some cases, doctors may have to determine whether to remove a patient's support equipment. In the end, the definition of "damage" is the essential factor. One may be doing more damage than good by keeping a patient alive while they are in excruciating physical pain or emotional distress. It was stated that physician-assisted suicide was in line with the importance of personal liberty, human dignity and maybe a truly humanising act. Many people are worried that euthanasia, in any of its forms, may lead to the kind of harsh and inhumane actions that have sparked such a heated discussion about medical ethics in the past. When healthcare services, and hence the government, begin to murder its citizens, a line has been crossed that was never crossed in the first place. It is feared that a culture that accepts voluntary euthanasia would eventually accept non-voluntary euthanasia and eventually involuntary euthanasia as well. Such themes have previously been exploited in the past. Physicians must be aware of the risks associated with such techniques and ensure that adequate protections are in place. Despite the fact that euthanasia is banned, it is nonetheless done in many institutions in a passive manner. Technological advancements have made it possible to lengthen life even further artificially; yet, we must all acknowledge that budgetary limits are an essential concern in current healthcare systems. Finally, there is an ethical quandary in determining how to interpret the idea of a patient's right, or autonomy, in comparison to the rights and responsibilities of the doctor.[29]

The debate on death and dying in general, and euthanasia in particular, is a highly emotional topic that is fraught with ambiguity and controversy. Euthanasia should be taken from the area of "human rights," according to this argument, so that it can be subjected to professional assessment and decision, or prescription, with permission. The plan has a broader variety of societal ramifications than previously anticipated. Medical practitioners feel apprehensive and unhappy about participating in activities that have the potential to cause death, even if the actions are lawful and permitted by the government. When a patient, a family member, or a caregiver recognises the need for assisted suicide, they may petition the Court for euthanasia, which is then decided

[29] Ajay Kumar et al., *Euthanasia: A Debate—For and Against*, Journal of Postgraduate Medicine, Education and Research 2021;55(2):91–96, (Dec. 12, 2021, 10:30 PM), https://www.jpmer.com/doi/JPMER/pdf/10.5005/jp-journals-10028-1437.

through a legal process on a case-by-case basis. This is in contrast to the doctrine of assisted suicide, which is decided through a legal process on a general basis. Sometimes, the patient may have obtained advance authorisation in the form of a living will, which may make the decision-making process a little bit simpler. While a proper evaluation has been completed by authorised individuals, the medical team must still examine the patient's present state to decide whether or not it satisfies the criteria set forth in the living will. The family, well-wishers, and caregivers may be presented with a severe moral problem when making a choice, even if there is a living will in place to protect their interests. According to the suggested decision-making procedure, the treating team proposes euthanasia in accordance with established norms. The recommendation, like any other intervention, is subject to informed consent, which ensures that the patient or his or her family is included in the process. The transition from "right" to "professional opinion" has ramifications for the broader social community. Conclusion: Euthanasia should be removed from the sphere of the "right to die" and placed under the supervision of specialists who will make choices in accordance with defined rules after getting informed permission and receiving approval from legal pre-scrutiny, among other things. Active euthanasia is a superior option to passive euthanasia in terms of alleviating suffering and providing a "peaceful death," which are the fundamental goals of compassion killing: euthanasia. Active euthanasia is a superior option to passive euthanasia in terms of alleviating suffering and providing a "peaceful death."[30]

According to **Klemens Kappel's** *The Morality of Euthanasia*,[31] active euthanasia is ethically justified in certain circumstances and should be legalised. According to him, passive euthanasia is the most frequently approved method of ending the life of another, and passive euthanasia involves either delaying or withdrawing life-sustaining therapy or delivering medications that hasten death. There are three perspectives presented by the author on euthanasia, the most severe of which is that passive euthanasia and active

[30] Vivek R. Minocha and Arima Mishra, *Euthanasia: Ethical Challenges of Shift from "Right to Die" to "Objective Decision"*, Ann Natl Acad Med Sci (India) 2019;55:110–116, (Nov. 21, 2020, 11:00 PM), https://www.nams-india.in/anams/2019/NAMS55_2_article110-115.pdf.
[31] Klemens Kappel, *The Morality of Euthanasia*, University of Copenhagen, (Dec. 11, 2017, 07:20 PM), www.staff.hum.ku.dk/kappel/.../The%20morality%20of%20euthanasia.pdf.

euthanasia should never be legalised. The moderate position, where passive euthanasia is frequently ethically acceptable and should be legal, but aggressive euthanasia is not morally acceptable and should not be allowed. After that, he came to the conclusion that passive and active euthanasia may be ethically permissible in certain circumstances. This type of euthanasia should be permissible by doctors in these situations.

The subject of whether or not physicians and other health care providers should intentionally cause the death of a patient in specific situations and whether or not society should allow these practices is under growing criticism. The ramifications of these problems in terms of ethics, law, and public policy should be carefully considered. Euthanasia and assisted suicide are hotly debated morally, as is the option to refuse life-sustaining medicines. The ethical relevance of the intentions of persons who carry out these acts is at the centre of the discussion. Supporters of assisted suicide and euthanasia reject the idea that these actions are morally separate from refusing life-saving therapy. Euthanasia and assisted suicide, they argue, are in line with patients' constitutional freedom to make their own decisions about how and when they die. There are many who argue that only those who have a deadly underlying ailment should be allowed to die by euthanasia or assisted suicide because it is only those who have such an underlying disease that is responsible for mortality. On the other hand, a physician who conducts euthanasia or aids in a patient's suicide sees the patient's death as their primary goal. Individual autonomy is essential, but opponents of euthanasia and assisted suicide believe that the right to self-determination should not be accorded ultimate status in social policy on euthanasia and assisted suicide since it has its limits. Critics claim that the humane grounds for supporting euthanasia and assisted suicide cannot guarantee that euthanasia will only be available to those who desire it freely, despite the fact that euthanasia and assisted suicide are widely supported by the medical community. Anti-euthanasia advocates are also worried about a rise in the use and acceptance of private killings in society. To most observers, there is no substantive ethical difference between euthanasia and assisted suicide because both procedures involve someone actively aiding their patient's death. Concerns have been raised, however, regarding the potential for mistake, coercion, or abuse if doctors are the

ultimate actors in voluntary euthanasia. Debate rages on the issue of euthanasia and assisted suicide being called "medical" operations.[32]

As per **Menzel and Cramer**, when a person has dementia and loses the ability to make decisions about their own life, they have little control over how their lives end. An advance directive to withhold food and drink by mouth, on the other hand, may be used to ensure that a person does not have severe dementia for a lengthy period of time. The legality of such orders is debatable. When the present wishes and interests of an incompetent patient do not coincide with those expressed in her earlier directive, which should we follow? With the decline in a person's ability to create vital interests and enjoy life, it is fair to predict that the power of an advance directive to withhold food and drink or to deny necessary life-saving treatment will increase. When it comes to comfort feeding, the practice merely serves to contradict the concept that failing to give appropriate nourishment equates to neglecting to provide critical care and comfort.[33]

Euthanasia, because of its close association with "homicide" and the evident likelihood of "misuse," mercy-motivated killing, often known as "mercy killing," has remained a very contentious issue. One may argue that the practice of euthanasia is as old as civilisation itself, with origins that can be traced back to ancient Greek and Roman practices. The new interest in the subject has been sparked by the rapid advancements in life-sustaining medical technology. A doctor does an "act of commission" as opposed to an "act of omission" when he treats the patient who is required in the case of passive euthanasia. Doctors' unfettered ability to end patients' lives when they are in excruciating pain and suffering from an incurable disease is the focal point of the debate. Active euthanasia is a source of controversy because it allows patients to end their lives when they are in excruciating pain and suffering from an incurable disease. The issue of defining the word "terminal sickness" has proven to be a difficult one. As for Dr. Jack Koverkian, for people who are confronting a terminal disease, who are in irreversible agony and suffering, who desire to exercise their right to die with dignity,

[32] James V. Lavery et al., *Bioethics for clinicians: 11. Euthanasia and assisted suicide*, Can Med Assoc J, May 15, 1997; 156 (10).
[33] Paul T. Menzel and M. Colette Chandler-Cramer, *Advance Directives, Dementia, and Withholding Food and Water by Mouth*, The Hastings Center Report, Vol. 44, No. 3 (May-June 2014), pp. 23-37.

a system that should be accessible to them are the perfect word for a fitting ending. The sanctity of human life does not mean the continuance of a life spent in agony and suffering against one's will. Given that everyone has the right to live a dignified life, no one may be forced to live in a way that is detrimental to his or her well-being. If someone is suffering from an incurable sickness, it would be cruel to force him to endure a wretched existence. In order to do this, it is preferable to restrict euthanasia to terminally ill individuals alone. Although it is a broad phrase, medical professionals have unanimously agreed that it refers to and includes an illness that cannot be healed and for which there is no treatment or therapy. In reality, death is the ultimate solution. Death, being the sole means of respite from the awful anguish and unimaginable suffering associated with it, requires that criminal laws not be applied with excessive zeal. Only in cases where they can be demonstrated to be an acceptable and effective instrument in combating the aforementioned evil should they be employed. Another issue that has to be addressed is how the courts should interpret the phrase "right to life," which appears in Article 21 of the Constitution, to encompass the "right to die peacefully with medical aid for those who are terminally ill.[34]

The right to autonomy requires that a competent person's agreement to treatment be lawfully justified; at the same time, it requires that a capable person's refusal to consent be respected, regardless of how severe the consequences for the individual involved may be.[35]

1.3.4 *Euthanasia and Religion*

For **Kamble**,[36] according to Hinduism, every living being, including animals, is bestowed with a soul that has the ability to transmigrate from one lifetime to another. So, death is not considered to be the end of life but rather the transition between two continuous lives in two distinct bodies, which is completed through rebirth, rather than

[34] Tania Sebastian, *Legalization of Euthanasia in India with Specific Reference to the Terminally Ill: Problems and Perspectives*, 2 J. Indian L. and Soc'y 341 (2011).
[35] Paul Bowen, *Detained Patients and the Right to Refuse Treatment*, J. Mental Health L. 59 (2002).
[36] Shanmukh Kamble et al., *The acceptability among young Hindus and Muslims of actively ending the lives of newborns with genetic defects*, Journal of Medical Ethics, Vol. 40, No. 3 (March 2014), pp. 186-191.

the end of existence, according to these people. Life must be maintained at any cost, although this is not regarded as essential. The dying individual may be advised to fast until the time of death in some instances. The fact that there is no organised official institution, such as a church, to instruct individuals on the suitable method of thinking about the subject of death explains why people's positions on end-of-life decision-making vary. The capacity to take human life, according to particular academics, is reserved for God alone; the intervention of humans creates significant interruptions to the karmic cycle of existence. According to other authorities, it is morally acceptable for a dying person who is suffering greatly to hasten his or her death: Euthanasia ensures a merciful death because he can leave this life with consciousness unclouded by the stupor of drugs and without fear that some unexhausted cultural methodology was followed as closely as possible to its conclusion.

Other religious groups in India, such as the Jain, the Sikhs, and the Buddhists, have views that are diametrically opposed to those held by the Hindu majority. Researchers **Kamble** and colleagues discovered that the vast majority of Hindu students did not consistently oppose physician-assisted suicide for terminally sick adults and that the age of the patient was the most crucial factor in predicting approval. In keeping with the Hindu idea of reincarnation, it is suitable for a person to die when he or she is elderly so that the soul might transfer to a different body after completing one life cycle after another. Life in Islam is founded on the pursuit of transcendental ideals. Morality and truth are absolute, everlasting, and universal in their scope and application. They were established by God, not by human beings. Consequently, man has no justification for becoming irritated with them. Muslims believe that death is simply a transitory condition into eternal life with God and that God has decided the duration of each person's life in advance so that no one can die before his or her assigned time. As a result, killing an ailing patient, whether by active euthanasia or physician-assisted suicide, is considered a rebellion against the will of God. Because the patient's illness is causing them untreatable suffering, they are provided with food and drink till the end of their life, at which point they will die. While it is permitted to ease pain and postpone the withdrawal of life support with the goal of allowing a person to die, it is not

permissible to do so until mechanisms of consultation among all parties concerned with the well-being of the patient have been created.[37]

It was legal in ancient Greece and Rome to assist others in ending their life in certain circumstances. Lord Rama and his brothers are said to have taken 'Jal Samadhi' in the River Sarayu near Ayodhya, according to Hindu legend. Lord Buddha and Lord Mahavir, according to ancient Indian history, both sought death in order to achieve it.[38] According to ***Kaiser Mahmood***,[39] when it came to religious beliefs, a decent death did not always entail suicide in the medical sense for Greeks and Romans. Active voluntary euthanasia was acceptable as long as it was done for the right reasons, such as ending the pain of a terminal illness. Since birth and death are part of God's design, people should treat them with reverence, and no one has the ability to select the timing or method of their own, or another's death.

Euthanasia has been described as an example of the "culture of death" in western countries by the late Pope John Paul II, who was quoted by the author as saying that the Roman Catholic Church has been the most vocal opponent of the practice in the modern world.

> "Euthanasia is a grave violation of the law of God since it is the deliberate and morally unacceptable killing of a human person."
>
> *Pope John Paul II: Evangelium Vitae, 1995*

Judaism, like Christianity, believes that humans were made in the image of God and that sadness and suffering are not sufficient reasons for an individual to end his or her life. One thing separates Judaism and Christianity, however. Doctors are permitted to

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[37] Shanmukh Kamble et al., *The acceptability among young Hindus and Muslims of actively ending the lives of newborns with genetic defects*, Journal of Medical Ethics, Vol. 40, No. 3 (March 2014), pp. 186-191.

[38] *A Conspicuous Yet Nascent Debate on Euthanasia in our Country*, Reader Blogs on Legally India: Uncut (Jan. 16, 2018, 07:15 PM), http://www.legallyindia.com/Blogs/Entry/a-conspicuous-yet-nascent-debate-on-euthanasia-in-our-country-html.

[39] Kaiser Mahmood, *Difference Between Voluntary Active and Voluntary Passive Euthanasia: An Ethico-Legal Perspective,* Controversies in Clinical Practice, (Dec. 24, 2017, 04:30 PM), http://www.scopemed.org/mnstemps/27/27-1325419743.pdf.

remove “everything that prevents a soul from departing,” according to Jewish tradition. Jewish law allows a doctor to remove the object if it is obstructing the natural course of death and the patient only survives because of it. Islam, like Christianity and Judaism, regards human life as holy. In Islam, life is a gift from Allah, and Allah has the final say on how long a person lives. Islamic law explicitly prohibits euthanasia and suicide because Islam does not recognise any form of justification for the death of someone.

According to the article by **Mahmood**, Hinduism and Buddhism, two eastern religions, have had a significant impact on Western thinking about the right of an individual to terminate his or her own life. One of the two commentators on the works of Manu, Govardhana, said that if one is terminally sick or has suffered an enormous tragedy, then one can start on an end-of-life journey, as long as it is permitted by the scriptures and does not clash with Vedic rules that ban suicide. By starving themselves to death, ancient Indian hermits were thought to have ended their lives in style. Ascetics of the Jaina sect in ancient India believed that starving oneself to death was a noble deed. Suicide by monks has occurred in both Buddhism and other religions. Buddhist monks exploited suicide as a political weapon during the Vietnam War. Neither Hinduism nor Buddhism are unambiguous on the question of euthanasia, according to the author. The spirit and the body will be divided at an unnatural moment if a doctor accepts a patient’s request for euthanasia, according to one opinion. Karma (a good action) will be harmed, but the patient’s agony will be relieved, and the doctor will be fulfilling his moral commitment by bringing an end to the anguish. When a person refuses medical treatment, they are not taking their own lives, but instead, they are refusing to allow someone else to assist them in surviving. It is important to remember that mortality occurs as a result of a deadly disease spreading unchecked when treatment is refused. In light of these facts, it is apparent that euthanasia by choice is neither a kind of murder nor suicide.

Muslim jurists regard competent patients’ informed refusal to receive treatment or the ability for a person to die in circumstances when there is no medical justification for continuing treatment as legal, according to the author. A patient may be allowed to quit

therapy, however, when several medical specialists agree that the patient is terminal and there is no possibility of recovery, according to some sources.

Finally, the author believes that voluntary passive euthanasia is more realistic, despite the fact that many notable Muslim scholars do not support or suggest this and connect this sort of euthanasia with suicide.[40] If we look at all of Prophet Muhammad's teachings and the jurists' interpretations of those teachings, it appears that Islam supports medicine. It is permitted, however, when medicine appears to have little benefit and should be discontinued. There are also many who believe that delaying or removing treatment does not constitute euthanasia, according to **Motlani**. As a medical, spiritual, and economic practice that some term 'passive euthanasia,' others believe it to be mainstream or customarily recognised practice. Instead of arguing that "active" euthanasia is distinct from "passive" euthanasia because it is a sort of assisted suicide, other researchers, such as **Craig and Putilo** believe that the lack of an overarching objective makes it impossible to distinguish between the two. For their part, Muslim thinkers like **Tantawi**, **Uthaymin**, and **Al-Qaradawi** think euthanasia may be divided into two categories: passive and active. When examining the views of Islamic scholars on medicine, **Yusuf al-Qaradawi** comes to the conclusion that active euthanasia is Islamically forbidden because it encompasses the positive role of the physician to end the life of the patient and hasten his death through lethal injection, electric shock, a sharp weapon or any other way.". According to Islam, killing is a severe evil and is thus banned.[41]

1.3.5 *Euthanasia, India and the World*

The idea of the right to die with dignity encompasses the right to die in peace and in one's own body, to select one's own fate and nature, as well as the manner and timing of one's own death. Article 21 of our Constitution expressly recognises the right to a dignified existence.[42] Even execution methods for death sentences should not be too

[40] *Supra* note 9.
[41] Mahmud Adesina Ayuba, *Euthanasia: A Muslim's Perspective*, Scriptura 115 (2016:1), pp. 1-13.
[42] Sandeepa Bhat and D Shyamala, *Euthanasia Regime: A Comparative Analysis of Dutch and Indian Positions*, NUJS Working Paper Series, (Dec. 21, 2017, 11:21 AM),

painful, barbaric, or cruel. That is why it needs to be definite. Every condemned prisoner's human dignity and humanity demands that he be executed quickly and painlessly without suffering any kind of torture or indignity. Standards of human decency and dignity must be taken into account when determining whether any form of execution of a death sentence is unfair, unjustifiably harsh or barbaric or inhuman. Article 21 of the Constitution ensures that a person's body, even after death, has the right to be treated with respect and dignity.[43]

"Right to die with dignity" refers to the right to manage one's own body, destiny, and nature, as well as the right to choose the time and method of one's own death. The right to a decent life is explicitly stated in Article 21 of our Constitution. To the extent that one's dignity is not up to this standard, one should be granted the option to terminate one's own life with dignity. Suicide, euthanasia, assisted suicide, and other forms of lethal self-harm are all included in the term. As a society, our views on mortality have evolved over the past few decades. The death of a loved one was formerly considered an inevitable part of life that had to be embraced.[44] However, because of advances in technology, we are now able to govern our own deaths better. There is much debate over how much control people should have over their or someone else's death, yet many people want a peaceful, quiet death. It is now up to medical experts to decide whether a patient on a ventilator and intravenous nutrition should be kept alive until the brain stem collapses or whether artificial support systems can be turned off if an informed body of medical experts believes that the patient has no hope of recovery. Legal, moral and ethical issues have arisen as a result of these developments. In such a case, might they face criminal charges of murder or aiding a suicide if they were doctors? Several nations have debated and resolved these issues, and basic principles have been established.

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http://www.nujs.edu/workingpapers/euthanasia- regime-a-comparative-analysis-of-dutch-and-indian-positions.pdf.

[43] K. I. Vibhute, *Right to Human Dignity of Convict Under 'Shadow Of Death' And Freedoms 'Behind The Bars' In India: A Reflective Perception*, Journal of the Indian Law Institute, Vol. 58, No. 1 (January - March 2016), pp. 15- 54.

[44] RK Mani and S. Balakrishnan, *The constitutional and legal provisions in Indian law for limiting life support*, Indian J Crit Care Med 2005; 9 (2):108-114.

The "removal of life support systems", sometimes known as "passive euthanasia", is legal in most countries because physicians or hospitals can perform it in certain rare circumstances. Several countries' courts provide pronouncements that such withholding or withdrawal is legal in particular instances.[45] The legalisation of artificial life-prolonging machines or artificial feeding and hydration has raised considerable concerns, however. These issues have come up in a variety of literary works.

In Gian Kaur, the Supreme Court was solely concerned with the criminalisation of suicide and not with euthanasia or living wills in their broadest sense. As a result, the proposition made in Gian Kaur with respect to the right to die with dignity must be recognised as obiter dictum, which means that it is obligatory in subordinate courts. In the case of Aruna Shanbaug, on the other hand, a two-judge panel of the Supreme Court was really concerned with a case in which active euthanasia was requested. Using Gian Kaur as precedent, the Court went on to find that "passive euthanasia" may be permissible under Indian law but that "active euthanasia" is not permissible. Furthermore, the Court went on to establish a procedure through which a high court might provide approval for passive euthanasia in the exercise of its authority under Article 226. It opposed the position taken by the then Attorney General of India, who stated that passive euthanasia in any form is not legal under Indian law. The three-judge Bench's interpretation of the term "conflict" between Gian Kaur and Aruna Shanbaug appears to be quite stretched in this regard. It is not as though the two conclusions are fundamentally incompatible with one another in any respect. One may argue that the two-judge Bench in Gian Kaur drew dubious conclusions from the obiter dicta in Gian Kaur, but this is a stretch.[46]

Despite the fact that medical technological improvements have saved the lives of some people, such "progress" has only served to prolong the agony of others. Doctors are reluctant to assist terminally ill patients in dying with dignity through physician-

[45] Caesar Ray, *Position of Euthanasia in India: An Analytical Study*, (Dec. 19, 2017, 11:45 PM), https://www.researchgate.net/publication/259485727_POSITION_OF_EUTHANASIA_IN_INDIA_-_AN_ANALYTICAL_STUDY.

[46] Alok Prasanna Kumar, *Tilting at the Windmills (Again): Should the Supreme Court Legalise 'Living Wills'?*,
Economic and Political Weekly, Vol. 49, No. 34 (August 23, 2014), pp. 10-12.

assisted suicide, despite the fact that some of these patients have made this request in the past. Those requests provide a physician with authority to prescribe a lethal quantity of medication for a terminally ill patient to administer to themselves or themselves. The right to physician-assisted suicide is not available to kids as it is to adults. A child's ability to "think, deliberate about, and make decisions" about their health care is assumed to be limited until the age of eighteen. When it comes to their children's health, parents are supposed to behave in their children's best interest. However, children, like adults, are concerned about their own physical well-being and want to be in charge of and in possession of their own bodies. A growing body of evidence suggests that terminally sick youngsters may grasp the facts of their condition, as well as the inevitability of death, which has been accepted by legal and medical professionals during the previous three decades. The right to select the time and location of our own death should be recognised as a fundamental human right regardless of age. When a kid is diagnosed with a fatal illness, it is essential to remember that they, too, have a desire to "own and control" their body. Children's freedom to die "without interference from others, but with support if they wish" from a physician is "the ultimate act of love, compassion, mercy" and civil liberties.[47]

As simple as it may sound, it is essential to remember that one's dignity should always be respected. A person's inherent and inalienable right to be treated with respect and equality, especially by those who are most vulnerable, is described by the term "dignity." Dedicated medical experts in the United States have long aimed to keep patients in a vegetative state as comfortable as possible. It is just exercising one's right to refuse treatment when one requests the withdrawal of a life-prolonging therapy, rather than making a complaint about how the patient is not being handled with respect. Making a personal decision to refuse treatment should not be confused with asserting one's right to dignified care. Although it appears to be a conflict with society's interest in safeguarding life, it may be incorrect to condition the right to die on a person's "dignity," as some have suggested. In any case, who, with the exception of the vegetative patient, can assert that death is anyway more honourable than life on a

[47] Sydni Katz, *A Minor's Right to Die with Dignity: The Ultimate Act of Love, Compassion, Mercy, and Civil Liberty*, 48 Cal. W. Int'l L.J. 219 (2018).

mechanical machine? Combining "the right to die" and the concept of "dignity" may be used to devalue a claim in order to outplay the importance of life preservation. This is because one almost certainly has a legitimate entitlement to dignified care. "The right to dignity" has been invoked as a justification for speculating that patients who are vegetative may reject being kept alive by machines, and we believe this has been misconstrued. The term 'to die with dignity' might be replaced with 'to die in peace'. There are a number of ways to prove that it is in the patient's best interest to die peacefully while they are still alive (even if they are just vegetative). There is a chance that dying is not the most incredible option for them, either. Patients with PVS should have their therapy stopped, or should the Court allow it? From a moral standpoint, the solution is elusive. Aside from moral considerations, we are only interested in the logic behind recent U.K. court judgements.[48] When it comes to moral and legal arguments around life and death issues, the phrase "dignity" has been used extensively. However, it has also been misused to stir emotional resistance to apparently "undignifying" treatment rather than stimulating critical examination of the issues involved. However, we have no objections to people being put to death in a PVS while they are asleep. Because the same conclusion needs a more solid foundation, it is just that. To put it simply, we believe that the courts in the United Kingdom should focus on the futility of therapy rather than the patient's best interests.

There were no euthanasia permits issued in this case due to the incredible and extraordinary devotion of medical personnel in caring for Aruna, which led to the Supreme Court dismissing the petition for euthanasia, but it opened the door for many others who desire to die in peace and with dignity now. Because it involves an issue of law that must be carefully examined by a Constitutional Court Bench for the benefit of all humankind from social, legal, medical, as well as constitutional aspects, the Court stated as much. Euthanasia was once again brought before the Supreme Court in the contemporary setting. The issue of physician-assisted suicide, sometimes known as euthanasia, is fraught with controversy and ambiguity. Even though it is frequently discussed in the media and scholarly press, it lacks a consistent set of ideas and

[48] Tak Kwong Chan and George Lim Tipoe, *The best interests of persistently vegetative patients: to die rather that to live?*, Journal of Medical Ethics, Vol. 40, No. 3 (March 2014), pp. 202-204.

definitions. Many euthanasia conversations end up being pointless and frustrating because of their faulty foundations and lack of focus. Good death as an existential, emotional, and ethically tricky debate is likely to continue to be a significant social and legal issue. Euthanasia decriminalisation is a matter of principle for both proponents and opponents alike; hence it is imperative that restrictive laws be halted at the same time as euthanasia is decriminalised.[49] Ultimately, autonomy and individual rights must be fostered so that individuals may make their own decisions regarding their own lives and deaths, but the right to life must be forcefully maintained. A multitude of unresolved questions, resulting in uncertainty, necessitates more investigation. As our country's timeless philosophy, culture, and natural and physical sensibilities are all intertwined with the idea of religion as a source of life, we urgently need a comprehensive law on this sensitive topic.

Rakesh Shukla, in his article "Is the 'Next Friend' the Best Friend?"[50] claimed that the Supreme Court's decision in the Aruna Shanbaug euthanasia case appears to be exclusively based on the views of the nursing staff of the Mumbai hospital who have been looking for her. When the patient's best interests are not considered, the legal term "next friend" is used. Shanbaug's "next buddy" was determined by the Court to be the nursing staff. Depriving an incompetent patient of his or her right to autonomy and self-determination, as well as entrusting the decision-making process to guardians or government agencies, is a dangerous course of action.

With an increase in the number of disabled people in both developed and developing countries, including India, there has been an increase in the number of requests for euthanasia. This is due to medical, psychosocial-emotional, socio-environmental and existential issues, as well as concerns about the potential misuse of the procedure. The Supreme Court, following the Aruna Shanbaug case, granted legal consent to passive euthanasia, but not active euthanasia. This legal approval will remain in force until

[49] Sanjeev Kumar Tiwari, *Concept of Euthanasia in India – A Socio- Legal analysis Concept of Euthanasia in India - A Socio-Legal Analysis*, International Journal of Law and Legal Jurisprudence Studies, (Jan. 01, 2018, 10:04 AM), http://ijlljs.in/wp-content/uploads/2015/04/AMBALIKA.pdf.
[50] Rakesh Shukla, *Is the 'Next Friend' the Best Friend?,* Economic and Political Weekly, vol XLVI No.18 April 30, 2011, (Dec. 15, 2017, 03: 00 PM),http://beta.epw.in/newsItem/comment/189840/.

Parliament introduces laws on the matter. When dealing with euthanasia requests, it is critical to recognise the complexity of the situation, individualise the palliative approach, and acknowledge the 'There is no alternative' or 'There is no solution' aspect, all of which are crucial factors.[51]

Additionally, the Common Cause decision contains a wealth of information that draws from other fields, including philosophy, ethics, and law, in order to support its diverse points of view. It is noteworthy to note that the idea of dignity lies at the heart of both proponents and opponents of the right to die arguments in this verdict. Other areas of the decision, however, are either problematic or lost chances. Since then, we have shown that the judgement is heavily informed by arguments in favour of euthanasia law and is generally uninfluenced by ethical considerations. It is important to note that while Justice Chandrachud devotes considerable time and space to explore various philosophical and ethical perspectives on the subject of assisted suicide and assisted suicide, his final section, like the others, concentrates on the constitutional framework used to support the permissibility of passive euthanasia but not the permissibility of active euthanasia.[52]

Because there is more than one course of behaviour that might be justified on numerous grounds, euthanasia is a difficult decision to make. Medical science has created methods of dealing with terrible pain and misery in the past. The orthodox-prolife proliferators passionately advocate for survival as the primary goal of human existence and are highly opposed to euthanasia because they think that life is a beautiful gift from God and that only God has the authority to take it away from anybody. The Hippocratic Oath also imposes an ethical duty on medical professionals to assist in the prolonging of life. A good decision was made, notwithstanding the fact that it failed to distinguish between active and passive euthanasia in its conclusion. It was also unable to address specific improvements in the healthcare system, and the mandated process for creating

[51] Skand Shekhar and Ashish Goel, *Euthanasia: India's Position in the Global Scenario,* (Dec. 15, 2018, 03:30 PM), https://journals.sagepub.com/doi/abs/10.1177/1049909112465941?journalCode=ajhb.
[52] Sunita VS Bandewar et al., *The Supreme Court of India on euthanasia: Too little, too late*, Indian Journal of Medical Ethics Vol III No 2 April-June 2018, (Dec. 15, 2018, 03:10 PM), https://palliumindia.org/wp-content/uploads/2020/05/The-supreme-Court-of-India-on-euthanasia-Too-little-too-late.pdf.

a living will is time-consuming due to the large number of actors involved. When compared to medical care, the engagement of nursing personnel in feeding was a source of controversy. The ruling was correct, despite the fact that it could not be considered a legal precedent. Despite the fact that the March 2018 judgement is not a flawless one on the matter, it is an essential first step in addressing a novel notion that has not been addressed previously.[53]

According to the opening remarks of the 196th Report of the Law Commission of India, the Commission was not dealing with "euthanasia" or "assisted suicide," which are both illegal in India, but instead with a different matter, namely, "withholding life-support measures from terminally ill patients, and such withdrawal is treated as lawful in all countries," which is legal everywhere. The Commission has repeatedly stated that withholding life-sustaining treatment from patients is fundamentally different from euthanasia and assisted suicide, a difference that has been brought into sharp relief in Aruna's case as well as in many other instances. "Passive euthanasia" was used in Aruna's case, which was seen to be more compendious. Those who are terminally sick and both competent and incompetent should be given the option of passive euthanasia, according to the 196th Law Commission of India report. The accompanying physician shall advise the patient and any other close relatives of the decision if a patient is found incompetent, and their views should be acquired from three medical experts whose names are on the approved panel Law Commission's 196th Report said that the right to refuse medical care, including discontinuation of life-sustaining measures, for a terminally sick but competent patient is enforceable on the doctor if the patient's decision is an "informed decision." Section 2(b) states that "best interests" include the best interests of both an incompetent patient and a competent patient who has not made an informed decision, and it should not be limited to the medical interests of the patient but should also include ethical, social, emotional, and other welfare considerations as well as medical interests of the patient. Countries throughout the world are debating whether or not to recognise and legalise euthanasia. Discussed here are the competing

[53] Rateesh Sareen, *India decides on Euthanasia: Is the Debate over?*, Health Care Current Reviews 7: 245, (Jan. 05, 2020, 11:25 PM), https://www.walshmedicalmedia.com/open-access/india-decides-on-euthanasia-is-the-debate-over.pdf.

philosophical, moral, ethical, and legal viewpoints. When a doctor makes a choice, he or she must adhere to two fundamental principles of medical ethics: autonomy and beneficence.[54]

As requested in its ruling, the Supreme Court urged the government to draft legislation to legalise assisted suicide. As a result, the Law Commission of India's 241st Report advocated legislation allowing passive euthanasia. For the sake of making an educated judgement, the Ministry of Health and Family Welfare released a draft law for public feedback in May of 2016. Indians are split on the question of assisted suicide. While some religious groups oppose it, the vast majority of scientists support it. Unlike Christians and Muslims, Hindus generally voice both pro and con euthanasia viewpoints, whereas Christians and Muslims have steadfastly opposed it. The Supreme Court's decision and the Law Commission's report allow the federal government of India to draught new regulations on passive euthanasia. Once euthanasia becomes legal in India, it will have a significant influence on the country's cultural, political, public, and medical realms.[55]

An important place in the history of medical jurisprudence has long been held by the right to get informed consent. One of the most contentious questions in contemporary health care is whether and when a patient has the right to refuse medical treatment, the foreseeable result of which will be death. In Indian legal circles, there has been a great deal of discussion on the concept of the ultimate autonomy of the patient. According to Article 25 of the Constitution, everyone has the right to exercise their conscience and religion freely. The Supreme Court recognised the freedom of patients to refuse treatment on the basis of their religious convictions. In a series of decisions, the Supreme Court concluded that a person has the right to refuse treatment on the basis of religious views, even if the observance of religious beliefs leads to the person's unavoidable death, regardless of the circumstances. Freedom of conscience is

[54] *Passive Euthanasia-A Relook*, Law Commission of India Report No. 241, August 2012, (Jan. 23, 2018, 08:15 PM), https://lawcommissionofindia.nic.in/reports/report241.pdf.
[55] Scaria Kanniyakonil, *New developments in India concerning the policy of passive euthanasia*, (Dec. 21, 2018, 03:20 PM), https://onlinelibrary.wiley.com/doi/epdf/10.1111/dewb.12187.

recognised as a corollary to the right to self-determination under common law as well as under international law. Depriving him of his freedom to refuse medical treatment would therefore constitute a breach of his constitutional right to free practice of conscience and religion, as guaranteed by Article 25 of the Constitution.[56]

As of 2011, the Medical Council of India recognised palliative care as a distinct field of medicine, clearing the path for more comprehensive training of healthcare professionals in India. Also, in 2012, the Ministry of Health and Family Affairs established a national palliative care policy, which was implemented in 2013. In recent years, India has made considerable strides in enhancing the provision of palliative care. Although the Drug Act has been revised, one of the most significant remaining hurdles to dignified end-of-life treatment in India has been removed.[57]

Even if the idea of legalising euthanasia is intriguing, many countries believe that it is an impossibility. Religious groups, medical organisations, politicians, and lawmakers have all taken a strong stance against legalisation. Fundamentalists and religious organisations are unlikely to shift their beliefs any time soon. They are based on the belief that "life is sacred". There is no need to regulate euthanasia because appropriate pain management and passive euthanasia are already ethically acceptable, according to religious and medical organisations. India is a secular country, and thus instead of thinking religiously or ethically, one should use logic and reason. However, euthanasia and assisted suicide are lacking in the commercialisation of medical therapy. The Supreme Court's decision in Aruna Shanbaug ignores the critical issue of India's prohibitively expensive and inaccessible medical care. The current tendency in healthcare is to privatise facilities such as government hospitals that charge patients much money for treatment and examinations. Extreme healthcare commercialisation undermines the fundamental principles of medical therapy. The rejection of euthanasia misuse cemented the notion of euthanasia as a choice and a good death.

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[56] Nishant Kumar Singh, *Does a Patient Have the Right to Refuse Medical Treatment*, 12 Student Advoc. 36 (2000).
[57] Zosia Kmietowicz, *Indian parliament votes to increase access to morphine*, BMJ: British Medical Journal, Vol. 348 (24 Feb 2014 - 02 Mar 2014).

However, the notion that euthanasia may be abused cannot be used to prevent its legalisation. As the "slippery slope" argument goes, the biggest concern of misuse is that voluntary euthanasia would turn into involuntary death of the insane and mentally incompetent over time. Based on the misuse of power that permeated the Nazi era, this worry is understandable. There are no signs of a slippery slope in the Netherlands after 30 years of experience. Assisted suicide and euthanasia may be legalised if the proper requirements are established. People who oppose the legalisation of physician-assisted suicide frequently use the issue of doctor and family abuse as a reason. Legitimate legislation may be crafted by the government to avoid abuse and defend the worth of life, as demonstrated by Oregon and Dutch laws. It is possible that the Dutch approach will not be helpful in India. Healthcare and social security are top priorities in the Netherlands, which is a welfare state. There is no necessity for a patient to request euthanasia because they cannot afford adequate medical treatment. As a result, everyone in the Netherlands has a long-term relationship with a single-family doctor. As a result of their long-term connection, these doctors and their patients have a unique understanding of one another. This means that the Dutch system will not be a good model for other nations to use as well.

Assisted suicide and euthanasia, on the other hand, deserve particular attention. Individual rights and religious extremists have more sway in India, which makes it more difficult for reform to occur. The development of a well-balanced comprehensive plan to replace conventional ethics requires further thinking and discussion. Despite the fact that suicide is illegal in India, euthanasia should be taken seriously. These facts cannot be ignored: 10% of the population is disabled, and 10% of the population is over the age of 65; developments in science and health care have made it possible to live longer and so increased the percentage of the elderly population. In the last few years of a person's life, more than 90% of the medical treatment he or she receives is related to physical and mental health issues. Those who are unable to work or are dying of terminal illness should be allowed to die an honourable death if that is what they choose and ask for. Additionally, there are a number of people in this category who are not only too elderly but also suffer from a number of debilitating illnesses such as asthma or diabetes. These folks are well aware of the fact that as time passes, their standard of

living will deteriorate much worse. Many of them are left to fend for themselves because they lack familial support. So, legal and official death may be a welcome alternative for individuals who do not want to be a burden on the younger generation or who do not have sympathetic carers. In addition to this, there are lengthy waiting lists for organs, including hearts, kidneys, livers, and other life-saving organs. Medically assisted suicide permits doctors to save vital organs for donation to others. Organs may deteriorate or stop working entirely if some illnesses are allowed to progress to their full extent. Euthanasia and assisted suicide deserve special attention in light of all of the above.[58]

Victoria Edwards[59] contemplated the instance of a newborn who was abandoned to die. Lethal medications are not permitted to be administered in the United States, despite the fact that physicians are permitted to withhold life-saving therapy in some circumstances. On the basis of James Rachels' study on active and passive euthanasia, Victoria Edwards claims that in some instances, an injection is ethically preferable to delaying treatment. One of the most common methods of euthanasia employed legally in the United States is to starve patients who reject food and fluids until they die. Instead of administering a deadly injection, the doctor who withholds meals from the patient is inactively doing the same procedure. Doctors are in the same moral position as those who administer deadly injections to patients if they choose to let them die for compassionate reasons, according to James Rachels. No matter whether an approach is chosen, it is not ethically preferable to the other because both active and passive euthanasia leads to a patient's death, which is the same regardless of how the doctor chooses to terminate the patient's life.

The suffering of terminal patients is not restricted to the physical plain, as horrible as that is; it involves helplessness, tension, tiredness, dread, loss, and other sensations that are impossible to conceive. Powerful drugs are sometimes the sole option for alleviation, but they often lead to a vegetative condition in which the patient has no

[58] Subhash Chandra Singh, *Euthanasia and Assisted Suicide: Revisiting the Sanctity of Life Principle*, Journal of the Indian Law Institute, 54 (2), 196–231.
[59] Victoria Edwards, *Baby Janie*, Germantown Academy, (Dec. 22, 2017, 08:35 PM), http://squirefoundation.org/documents/P2-Edwards.pdf.

further use for their life. According to the Hippocratic oath, doctors are obligated to practice and prescribe for the benefit of the sick, as well as to protect their patients from injury and injustice. Therefore, passive euthanasia is against the ethical practice of medicine that doctors must respect when patients request final relief from extreme pain and suffering. A patient's desire for physician-assisted suicide is often motivated by their mental misery, not their physical suffering. The examples of terminal sickness show that passive euthanasia is ethically worse than active because doctors have the resources to treat their patients but choose not to utilise them or are legally compelled not to, and hence the act of relieving the individual of their pain is considered as morally justified. For this reason, because both types of euthanasia end in the death of a patient who is suffering, neither kind should be considered ethically preferable to the other.

Incompetent patients, on the other hand, do not have the legal right to refuse medical treatment, but the competent adult patient does. A healthcare worker may have an obligation to treat an incompetent patient regardless of their wishes if they are in danger of harming themselves. Many organisations believe that the legalisation of physician-assisted suicide in Oregon is a reflection of the low quality of end-of-life care available in the US Physician-assisted suicide opponents believe that if patients wish to speed up death to avoid excessive suffering and loss of control, the health care system ought to do a better job of addressing these symptoms. In 1997, the Supreme Court of the United States considered issues addressing pain control, symptom management, and physician-assisted suicide. Both Washington v. Glucksberg and Vacco v. Quill support the concept that advancements for dying patients should be focused on pain management and palliative care rather than physician assisted suicide.[60]

While some nations have allowed euthanasia in the previous decade, there has been much controversy about whether or not to legalise it in other countries. Dutch euthanasia legislation was enacted in April 2001, making it the first country in the world to legislate on the subject. In the Netherlands, euthanasia was performed prior to 2001 without any legislative approval. Euthanasia was made legal in Belgium in September

[60] *Supra* note 13.

2002, making it the second country to do so. Suicide by physicians and individuals without medical expertise is permitted in Switzerland, although euthanasia is illegal. As of 1937, suicide is not a crime in Switzerland, and it is permitted to be helped for charitable purposes. Oregon became the first state in the United States to pass a physician-assisted suicide statute in November 1994. Terminally sick people who meet specific criteria can be prescribed fatal doses of drugs under this rule. So yet, no one has been able to overturn this statute. Legislation to allow terminally ill patients to be assisted to end their lives was recently vetoed by the House of Lords in Britain.

To put it another way, the Supreme Court of the United States explained why governments must deal with the problem. In Washington v. Glucksberg and Vacco v. Quill, the Supreme Court ruled that the states should conduct "serious, rigorous examinations of physician-assisted suicide," notwithstanding the federal government's stated interest in preventing assisted suicide. Prohibition of assisted suicide was first based on concerns about life preservation, suicide prevention, and medical ethics. One of those grounds for opposing assisted suicide at all costs was the slippery slope that may develop, in which more people seek out assisted suicide for less severe conditions in order to escape the slippery slope. The Supreme Court, on the other hand, did not outright ban assisted suicide, instead stating that the "right to die" is not guaranteed by the Constitution. Each state's legislature is entirely responsible for deciding whether or not to legalise marijuana. Laws prohibiting the use of assisted suicide in various states have been ruled to be legal. In the following states, assisted suicide is currently legal: Hawaii, the District of Columbia, Oregon, Vermont, California, Montana, and Colorado.[61]

A person's right to life has a wide range of protections that might be difficult to define. The presence or nonexistence of a purported "right to die with dignity" is one aspect of this issue. Despite being signatories to the European Convention on Human Rights, European countries take a diverse approach to this issue. When a person is suffering from an incurable condition and death is unavoidable, euthanasia can be defined as

[61] Zachary A. Feldman, *Suicide and Euthanasia: The International Perspective on the Right to Die*, 104 Cornell L. Rev. 715 (2019).

"planned killing conducted under the impulse of compassion in order to alleviate the physical miseries of a person." Since ancient times, euthanasia has been permitted or condemned, as it is now. Euthanasia and assisted suicide are both methods of ending one's life, but they differ in how they are carried out. A physician performing euthanasia provides the fatal drug to the patient. The patient administers the drug prescribed by the physician in the instance of assisted suicide. Although the right to die is not a part of the right to life, according to ECHR jurisprudence, governments are free to decide what sanctions they will apply to acts that violate this right, even though the right to die is not included in article 2 of the Convention. There are various discrepancies in the legal practices of governments and international organisations when it comes to human rights and euthanasia. The cause of this contradiction is the conflict that exists between the right to life and the right to religious freedom. This means that even if it puts his life in jeopardy, he can decline a life-saving therapy that is absolutely essential without fear of being compelled to do so, as could be the case with religious convictions. However, this demarche is prohibited if the person has made the free and intentional decision to end his or her life due to certain extraordinary circumstances. A right and a freedom that doctrine and jurisprudence had not yet agreed upon in the instance of euthanasia are at stake here. Assuming, of course, that theology and practice have made no connection between the "right to die" and freedom of conscience, this contrast should be taken into account to assess the constraints society places on individual freedom of choice.[62]

The right to determine what should be done with one's own body belongs to every adult human being of sound mind and mature years. A person's right to reject medical treatment under the common law was recognised in 1914 by the New York Court of Appeals, which wrote the phrase "refuse undesired medical treatment." The right, on the other hand, was restricted to those of "sound mind," thereby explicitly barring those suffering from mental illnesses. Because of the Boston Hospital case in 1979, that exclusion was eliminated in the United States, causing one writer in an academic publication to portray patients who used their right to refuse treatment as "rotting with

[62] Amelia Mihaela Diaconescu, *Euthanasia*, 4 Contemp. Readings L. and Soc. Just. 474 (2012).

their rights on." Soon afterwards, the psychiatric profession accepted the concept of "autonomy of choice" in regard to a patient's treatment, shifting focus away from the question of whether or not a patient has a "right" to refuse treatment and instead focusing on whether or not a patient has the "capacity" to make that decision.[63]

The recognition of the social right to health is a significant step forward in terms of allowing individuals to exert greater control over their social settings in the developing world. Individuals' social human rights acknowledge that the state is responsible for providing them with the fundamental social circumstances essential for them to live with human dignity. Despite the fact that the right to health offers some of the most challenging conceptual and practical challenges related to social human rights, ensuring that persons have the circumstances necessary for good health is critical to enable them to live with human dignity. Lastly, the experience with litigating social rights, such as the right to health, in India is discussed, as well as the implications of this experiment for the developing globe. Fortunately, the Indian judiciary has devised a legal system that may assist individuals in making social empowerment a reality for themselves. India has been able to offer the majority of its residents, who are impoverished or socially disadvantaged, the power to acquire control over and change their social settings as a result of public interest litigation. Individuals now have the procedural authority to enforce social rights and entitlements in Court, and the right to health has been substantively recognised as a legally enforceable entitlement by the courts as well. It is demonstrated by the Indian "experiment" that social rights may be rendered justiciable and utilised to alleviate human suffering in developing countries if they are approached with imagination and determination.[64]

Because of advancements in medical science, people can now be kept alive even if they do not wish to be kept alive under conditions when there is no hope of recovery, despite their wishes. Those with severe dementia are neither in significant acute physical discomfort nor are they terminally ill, as is the case with patients with mild dementia.

[63] Ronald B. Sklar, *The Capable Mental Health Patient's Right to Refuse Treatment*, 5 McGill J.L. and Health 291 (2011).
[64] Sheetal B. Shah, *Illuminating the Possible in the Developing World: Guaranteeing the Human Right to Health in India*, 32 Vand. J. Transnat'l L. 435 (1999).

Furthermore, they are unable to seek the discontinuation of life-sustaining treatment due to a lack of the ability to communicate themselves fully and rationally, as well as the inability to agree to such a choice, as described above. According to the findings of an international survey, the vast majority of nurses who care for patients with dementia believe that active euthanasia is immoral. The Working Party on the Ethics of Prolonged Life and Assisted Death of the Institute of Medical Ethics decided that it would be morally appropriate to remove mechanical nutrition and hydration from patients with severe, chronic brain failure who were in a vegetative state. This means that the diagnosis and prognosis must be conclusive, and they must be agreed upon by more than one expert doctor. According to the findings of the study, non-professional caregivers of dementia patients firmly accept passive euthanasia as a treatment option. The caretakers were able to distinguish between the various kinds of euthanasia and understand the differences between them. The question of passive euthanasia, as well as the repercussions it has on sufferers, caregivers, and professionals, needs to be explored in greater depth.[65]

The inconsistencies among various authors and articles regarding passive euthanasia and the issues raised on its impact on social, ethical, medical and legal aspects show the need for the study of this research.

1.4 Objectives

The objectives of this study are:

- To compare and analyse the concept of passive euthanasia.
- To understand whether passive euthanasia prevails in India.
- To contribute to the paucity of information on this topic in Indian literature and culture, including but not limited to legal, moral, ethical, religious, and cultural perspectives.
- To analyse the judgement of the Hon'ble Supreme Court of India in the landmark judgement in Common Cause and Aruna Ramchandra Shanbaug and its impact in comparison to the rest of the world.

[65] Emad Salib and George Tadros, *Passive Euthanasia in Dementia: Killing or Letting Die*, 41 Med. Sci. and L. 237 (2001).

- To critically analyse the "Treatment of Terminally Ill Patients Bill, 2016".
- To come up with suggestions as to facets of passive euthanasia and whether passive euthanasia, which has been legalised, is justified and to what extent.
- To draft and recommend a model bill on passive euthanasia.

1.5 Hypotheses

- H_1 - Passive euthanasia though legalised in India has ethical and legal challenges.
- H_2 - The concept of passive euthanasia as interpreted by Indian Judiciary tantamount to right to refuse treatment.
- H_3 – Indians repudiate passive euthanasia for emotional values and societal norms.

1.6 Research Questions

- What are the ethical and legal implications of passive euthanasia in India?
- What are the situations regarding the issues involved in passive euthanasia such as right to die with dignity, right to refuse treatment, end of life care, consent, advanced medical directives, living will, parens patriae in U.K., Netherlands, Belgium, State of Oregon and Australia?
- What are the existing legal provisions and concepts relating to passive euthanasia in India in the light of Common Cause and Aruna Shanbaug Judgement?

1.7 Scope of Research

The scope for studying this matter is vast and enormous as in every Indian state; there are terminally ill patients and their families as well as the organisations fighting for death with dignity and especially the medical professionals who determine such. Even the study has touched upon the constitutional safeguards, the Indian Penal Code, various other Indian and International Laws and Bills, and case laws of India and abroad can be analysed in this context.

1.8 Methodology and Tools

The study is chiefly based on doctrinal research with the help of empirical research to a small extent to verify the implications of passive euthanasia in India.

The study has been derived from primary sources such as the critical and landmark Judgements, Acts and pending Bills and Reports of various Commissions, and secondary sources such as authoritative books relating to criminal law, the Constitution of India, medical journals, and articles. The researcher has also taken the help of secondary sources such as the internet for articles, news etc.

In the empirical research, data has been collected with the help of a semi-structured interview method. Data has been analysed qualitatively on the basis of inferences collected from 30 respondents (total population), which includes Patients, Relatives of a patient, Doctors, Health Care providers, and Legal experts. Additionally, due to Covid situation, Survey Questionnaire from 200 respondents was analysed for supporting and verifying the interview data, relevant questions and statements.

1.9 Significance

The argument about euthanasia has gathered traction during the past few decades. People must know whether they grasp the phenomenon and why there have been requests to legalise passive euthanasia, which has resulted in its legalisation. This study aims to enhance awareness of the debate around passive euthanasia in India. Several studies have looked at the attitudes of the elderly on euthanasia and the role that culture plays in shaping these attitudes. This study also examined the first step toward euthanasia, Aruna Ramchandra Shanbaug v. Union of India and the most current case, Common Cause v. Union of India. If Indian society is ready for passive euthanasia, there has been a paucity of research; thus, this study is an attempt to fill in some of those gaps.

1.10 Limitations

There is a limit to the research since the subject matter is so wide-ranging and encompasses so many aspects of the terminally ill person and the Indian community. The research focused mainly on the Common Cause and Aruna Shanbaug rulings on passive euthanasia and similar instances. The research is focused on India, but examples from other jurisdictions will be used to show how the judicial tendencies in other

countries compare to those in India. Only a little amount of current research has been done in India on the topics of euthanasia and passive euthanasia. As a result of a time limitation, the researcher's findings may only be suggestive rather than definite. For legal and ethical considerations of euthanasia in India, the researcher must consult previous studies.

1.11 Scheme of the Study

The research study has the following chapters:

"Introduction" is the first chapter, and it provides an overview of what the research is about and how it will be conducted. Research questions and hypotheses are outlined in this section, along with the purpose of the study and any limitations it may have. It also includes an overview of the technique and instruments used to conduct the research, as well as any implications that may result from it.

The second chapter, **"Historical Background of Euthanasia: Constitutional and Jurisprudential",** explored the history behind euthanasia and its evolution through the passage of time, the justifications of typologies and the jurisprudential and constitutional reasoning behind them.

The third chapter, **"Passive Euthanasia: Philosophical, Religious and Ethical Perspectives",** narrowed down the study specifically to passive euthanasia by exploring and analysing the justification of passive euthanasia in regard to philosophical, religious and ethical aspects.

The fourth chapter, **"Passive Euthanasia in India: Concept and Provisions",** provides for the very concept of passive euthanasia, its definition and also the correlation with right to life, right to death, and suicide. This chapter further provides for the concept of passive euthanasia from the religious, ethical, legal and medical perspectives in India. Lastly, the chapter provides for the laws and provisions regarding passive euthanasia in India.

The fifth chapter, **"Passive Euthanasia in U.K., Netherlands, Belgium, State of Oregon and Australia",** provides and compares the concept and laws relating to passive euthanasia in the international arena. This chapter analyses the statutory and legal responses as well as the responses of the various international organisations.

The sixth chapter, **"Impact of Common Cause and Aruna Shanbaug's Case: An Analysis",** analyses the judgement of Common Cause and Aruna Shanbaug and its impact on society and the law. The chapter specially deals with issues concerning passive euthanasia, which are still within the veil.

The seventh chapter, **"Passive Euthanasia: An Empirical Study",** explored the real-world scenario attempting to come out with the issues of family opting for withdrawal of life support system, legal challenges as per legal experts and the obligations of the medical practitioners.

The eighth chapter and the last chapter, **"Conclusions and Suggestions",** dealt with the conclusion and suggestions to the issues that emerged from the judgment and the research.

CHAPTER 2

HISTORICAL BACKGROUND OF EUTHANASIA: CONSTITUTIONAL AND JURISPRUDENTIAL

2.1 Introduction

Until recently, euthanasia had not permeated such a wide spectrum of professions and sectors. Suicide and assisted suicide were common practices among the Greeks and Romans during this time period. At first, medicine was not seen as a dignified career choice. Autonomy and individual rights have their roots in ancient Greek and Roman thought, and this is the foundation on which the current fight for this topic is built.

The religious ideas of Christianity and Judaism were initially opposed to euthanasia throughout this historical period. Christian doctrine dictates that life is a gift from God, therefore we should cherish it and make the most of each moment. Not only Christians but even Muslims are against euthanasia, claiming that life is sacrosanct and that only Allah has the ability to decide how long someone may remain on this Earth.

Srutis, Smritis, Vedas and Upanishads, Puranas, Gita, Mahabharata and Ramayana, as well as other writings, provide moral standards, social responsibilities, and religious ideas that people are required to follow both during their lives and after they die in India. Suicide and self-liberation were strongly encouraged in Hinduism. In both the Manusmriti and the Upanishads, the concept of self-liberation in the face of terminal illness is mentioned.

Dharma, Arth, Karma, and Moksha are the four pillars upon which Hinduism is founded. Dharma, Arth, Karma, and Moksha (liberation). Practice of the first three beliefs in Hinduism leads to Moksha, the ultimate and most important belief in Hinduism (re-incarnation). A fresh body is all that is required for the soul to move on, according to the Hindu belief system. As a result, Hinduism holds that intentionally ending one's own life is permissible in certain circumstances. Jal Samadhi is said to have been found by Lakshman and Rama, but Mahavir is said to have perished in his pursuit of the fabled artifact and also began practicing Prayopavesa which is a type of fasting that lasts till one's death, as well. Even while Hinduism acknowledges the quest

of liberation as a worthy aim, there are limitations on when it can be achieved. For those who are terminally sick and cannot be saved, religions such as the Vedas advocate that they should be permitted to die as an alternative to the cycle of reincarnation.[66]

Suicide is permitted under certain conditions in the Indian religions of Buddhism and Jainism as well. This teaching was originally brought to the world by Buddha, also known as Siddhartha Gautama, in the 5th century BC. As Buddhists believe, he was one of the first to deliver this message to the world, which is that the ultimate aim of life is to be freed from the cycle of samsara (life and death). Jainism, which goes back to the 6th century BC and was popularized in India, also believes that reincarnation and eventual liberation are attainable.

2.2 Euthanasia: Definition and History

Death through euthanasia is the intentional killing of a person for the purpose of relieving them of their suffering or shielding them from further suffering. There are two Greek terms for "good death": eu (meaning well or good), and thanatos (meaning death).[67] It refers to the practice of ending one's life in a manner that minimizes the agony and suffering of the deceased. It is described by the International Euthanasia Society as "a purposeful intervention undertaken with the explicit objective of ending a life, in order to relieve intractable suffering." Deliberately killing someone in order to benefit or protect them from further pain is a kind of euthanasia.[68]

Voluntary, non-voluntary, and involuntary euthanasia are all based on the victim's informed consent; active, passive, or any mix of the two are all dependent on the technique utilized; and the third category is a hybrid of the two. Voluntary passive euthanasia, on the other hand, is widely considered non-criminal murder, even if the term "euthanasia" is often used to describe active euthanasia. It is said by those who

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[66] Shanmukh Kamble et al., *The acceptability among young Hindus and Muslims of actively ending the lives of newborns with genetic defects*, Journal of Medical Ethics, Vol. 40, No. 3 (March 2014), pp. 186-191.
[67] *Euthanasia and Assisted Suicide*, http://www.pages.drexel.edu/cp28/euth1.htm, accessed on 16.11.2017.
[68] Benjamin Gesundheit et al., *Euthanasia: An Overview and The Jewish Perspective*, Informa Healthcare, ISSN: 0735-7907, (Dec. 6, 2017, 10:00 AM), http://informahealthcare.com/doi/abs/10.1080/07357900600894898.

oppose euthanasia that it is either voluntary "suicide" or an involuntary "murder," with the former being more prevalent. A large number and a select few instances of non-voluntary passive euthanasia are legal in the United States. Medically killing someone without their consent, whether nonvoluntary (when the person is unable to consent) or involuntary (against their will), is not euthanasia but murder. Euthanasia is therefore limited to self-inflicted death. A patient's consent is required for euthanasia to be classified as voluntary.[69] Those who are incapable of understanding or expressing their own desires for continued existence are subjected to non-voluntary Euthanasia, which is the purposeful ending of their lives.

Involuntary euthanasia refers to euthanasia that is performed without the patient's consent. He or she gets slaughtered in spite of their desire to survive. Suicide via lethal injection is against the law. Commonly, this is considered an act of murder. But this isn't always the case. During a conflict, a shell explosion, for example, can rip apart a soldier's stomach. he shouts out in agony as he suffers severe pain. He pleads with the doctor to save his life as he expires. No matter what happens, the doctor knows he will die in ten minutes. Because he doesn't have any painkillers on him, he decides to shoot the soldier in the head to save his life.[70]

Suicide can be classified as passive or active euthanasia depending on whether it is chosen voluntarily or involuntarily.

The most controversial form of ending a person's life is active euthanasia, in which fatal drugs or physical force are used. Death was caused by the euthanasia performed on the patient, not by any other factor. Death can be hastened more quickly by active euthanasia than through other methods. The use of active euthanasia, in any form, is strictly banned.

One can die in a passive manner by postponing essential medical drugs, such as antibiotics, which are necessary for life to continue. As a poetic expression, "letting

[69] *Voluntary and Involuntary euthanasia*, BBC Ethics guide, (Jan. 20, 2018, 08:40 PM), http://www.bbc.co.uk/ethics/euthanasia/overview/volinvol.shtml.
[70] *Passive Euthanasia*, (Dec. 10, 2017, 11:10 AM), http://legal-dictionary.thefreedictionary.com/Euthanasia,+passive.

nature take its course" refers to euthanasia in which a patient is put to sleep. Compassionate care is not providing or discontinuing treatments that may reasonably be expected to keep the patient from dying, since death is seen as compassionate by the patient. Passive euthanasia is generally more painful and time-consuming than violent euthanasia. The majority of forms of voluntary passive euthanasia, as well as certain instances of non-voluntary passive euthanasia, are legal.

The act of hastening the death of a person by altering some form of aid and allowing nature to take its course is known as passive euthanasia. Some states have passed laws making it lawful. Refusing to resuscitate a person who is unconscious is one example of this. Passive euthanasia also includes the administration of a high dose of morphine to a patient in order to control pain, despite the knowledge that the painkiller is likely to depress respiration and hasten death. When used in large doses, drugs have the dual effect of reducing pain and accelerating death. The vast majority of countries and medical groups regard the use of such drugs to be ethical. These procedures are performed on terminally ill and suffering patients in an effort to expedite their natural death as much as possible. People in a long-term vegetative state, such as those who have experienced a severe brain damage or who are in a coma, are also commonly subjected to these procedures.

2.3 Typologies of Euthanasia

The practice of euthanasia has evolved into two distinct forms dependent on the method of execution:

Passive Euthanasia: It is described as the act of hastening death by withdrawing all life-sustaining measures and allowing the patient to expire naturally. In cases where the patient's prognosis is unknown, this procedure is used to allow the patient to die peacefully. As a result, removing life support systems, discontinuing food and drink, and permitting natural death from dehydration or not allowing CPR are all included in this strategy (cardio-pulmonary-resuscitation).

Active Euthanasia: It is an act of kindness meant to put an end to someone's misery or a life of agony and emptiness. A fatal injection, such as sodium pentothal, can be used in this manner to speed up the patient's death.

As a result of this classification, euthanasia may be divided into three types:

Voluntary Euthanasia: In this method of euthanasia, the patient makes the request. The patient requests euthanasia either verbally or in writing, stating that they would rather die than continue to suffer. As a result, both passive euthanasia and active euthanasia can be done under voluntary request.

Involuntary Euthanasia: A person is unable to consent to euthanasia if they fall under this category. As a result, people who are brain dead or in a coma can be tested using this procedure.

Non-voluntary Euthanasia: This sort of euthanasia occurs when a person is competent but does not agree with the choice to end their life. Direct murder is unquestionably the case here.

2.4 Concepts and Terminologies related to Euthanasia

In addition to euthanasia, there are a number of other phrases that should be mentioned:

Physician Assisted Suicide (PAS): When a patient requests euthanasia in the form of PAS, also known as aid-in-dying, a doctor administers the deadly dosage at the proper time and in the right dose. Self-injection or inhalation of a deadly amount is possible, but the dose must be made accessible to the sufferer first.

Permanent Vegetative State (PVS): To be vegetative indicates that a person is not capable of supporting himself or herself anymore and is dependent on a variety of life support systems or even other people (such as family members, relatives, doctors, and other medical professionals) to carry out the most fundamental human activities.

Terminal Illness: Medical professionals use the term "terminal illness" to describe a sickness or condition that has been medically diagnosed and is expected to result in death.

Advanced Medical Directive: People who are nearing the end of their lives may use this directive, known as a "living will," to say that they do not want life-sustaining medical care performed on them. For a directive to be valid, it must be given voluntarily, by someone with authority, and well in advance of when it is needed.

2.5 Euthanasia: Jurisprudence

Schools of Jurisprudence and Euthanasia

A study and theory of law can be done through jurisprudence. Consequently, it can be seen how law is seen differently by each individual, resulting in a unique interpretation of the law. Euthanasia is another topic that is treated differently by each legal school.

Natural school

The jurists who adhere to the natural law school are primarily concerned with morals and ethics. Each human being is born with certain natural rights, and they cannot be taken away from them by any human legislation. This is the premise of the natural law school of thought. Unlike the positive school of law, this view is moral in character and emphasizes that all legislation must be based on ethics and morals. Philosopher John Locke, one of the foremost champions of natural law, maintained that all people have some natural rights like the "right to life" and "right to liberty" that are independent of any made-up rules. Article 21 of India's Constitution includes these unalienable rights, which can be interpreted in a variety of ways. According to the natural school of law, there are fundamental moral truths that apply to all people regardless of where they are located or what agreements they have made.

To guarantee their right to life, liberty, and property, each individual gives part of their rights to the government in a conditional way, according to John Locke's notion of social contract. As a result, granting an individual the "right to die" by the Indian legislative would imply taking away their "right to life," which is provided to them by God and consequently outside the purview of the state and its legislature. Human life, according to John Locke, is a gift from God, and hence only God has the right to take it away from a person. Aristotle, in his discussion of the Universal Law, also contributed to this school of thinking. According to Aristotle, "Nature's rule is universal law. All

people are bound by a natural justice and injustice that applies to all people, including those who have no connection or agreement with one another, since everyone can sense to some degree ", it's a good idea to. It is therefore impossible for an individual to get active euthanasia since Aristotle felt that the "right to life" is universal and that even when an individual is in an incomprehensible situation due to disease or old age, the "right to live" was perfectly natural.[71]

Positive School

The positive school of thinking is in direct conflict with the natural school of thought's principles. Rather of focusing on what the law should be, as is the case with the natural school of thinking, the positive school places a greater emphasis on what the law really is. A key figure in the positive school of law, John Austin argued that "law is a command of the sovereign which must be obeyed as it is and reinforced by punishments for those who refuse to accept the law as it is". Positive philosopher Herbert Lionel Adolphus Hart says that as long as a law is established by a suitable and adequate mechanism, it must be regarded as an absolute. There are no exceptions in the positive school of law, which holds that judges can exercise their interpretative powers when rendering judgments based on the written law, which spells out the obligations and rights that residents of a country have under the law. In light of Austin and Hart's beliefs, judges cannot overturn a statute even if they consider it is morally repugnant.

In spite of the theoretical contradictions between the positive and natural schools of law, the conclusion drawn from the active euthanasia debate is the same for both schools. Indian Penal Code Sections 300 and 307, which govern the Indian Penal Code, state that attempted murder and murder are criminal offenses. For example, a person might be found guilty of murder under Section 307 if he or she does an act with "such purpose or knowledge and under such conditions" that if he or she caused death, "he or she would be guilty of murder." Article 21 of the Indian Constitution provides that "no individual shall be deprived of his life or personal liberty unless in accordance with procedure provided by law," which implies that the "right to life" in India does not include the "right to die". The positive school of law thus denies them permission to do

[71] Dr. N. V. Paranjape, Studies in Jurisprudence and Legal Theory, Central Law Agency (6th edition), 2012.

so, despite the fact that Indian judges and legislators feel that providing an individual the right to die is permissible within the current set of Indian laws.

In circumstances of serious passive vegetative states, the state has permitted individuals to possess the right to terminate their lives by approving passive euthanasia.[72]

Historical School

This school of law believes that "the law is the outcome of the powers and influence of the past." It is founded on the belief that the law is a product of the long-term progress made by the general population over the course of history.

Individuals' legal rights are grouped into four categories: immunity, privilege, authority, and claim, according to the historical school of law. The privilege of life cannot be given or taken away from anybody. State laws governing murder, homicide, culpable homicide, and self-defense, on the other hand, guarantee that one individual's right to life does not conflict with another individual's right to life. As a result, Active Euthanasia is now considered a "claim right," as the individual is seeking permission from the state to terminate his or her life. Passive euthanasia in India was legalized because the historical school of jurisprudence holds that legislation is established by people according to their evolving needs, habits, and customs. While the "right to die" and the "right to euthanasia" both fall under the purview of the country's inhabitants, they have not been categorized as such since passive euthanasia is only a "claim right."

Sociological School

The industrial revolution paved the way for the introduction of sociological legislation. The primary goal of the sociological method is to maintain a healthy equilibrium between the needs of the individual and the broader social good. It is not the objective of the sociological school of law to regulate the situations that develop as a result of legal procedures, but rather to deal with the morality and purpose of law. It is the primary goal of sociological school to safeguard the citizens of the state from the misuse and oppression of a single power in the state by the conventional understanding of law.

[72] *Ibid.*

By employing both legal and non-legal methods, sociologists hope to maintain social equilibrium.

Using the sociological school of law, it may be argued that the right to die should be recognized in cases when an individual is in a persistent vegetative state or suffering unbearably as a result of old age or illness, where improvement in condition is not possible. According to the current legal system, active euthanasia is not authorized under the sociological school of law, which places a greater focus on the welfare of the person and society.[73]

Utilitarianism and Euthanasia

One of the most prominent proponents of utilitarianism is Jeremy Bentham. Jeremy Bentham's basic assertion that nature has put people under the rule of two sovereign lords, pain and pleasure, is the basis for utilitarianism, a development of which is known as Benthamian utilitarianism. By 'the principle which approves or disapproves of every action', Bentham meant the propensity an action has to enhance or lessen the happiness of the party whose interest is in question, or the same, in other words, to provide or oppose' that enjoyment.

The ethical philosophy of utilitarianism holds that an action's moral worth is purely based on its contribution to the total utility. Thus, it is a kind of consequentialism, which states that the moral validity of an action is judged by its outcome-the goals justify the means. Utilitarianism is evaluating, acting, and enforcing norms based only on their benefits. A person's degree of well-being, according to this perspective, is exclusively defined by the amount of pleasure and misery they are exposed to. However, most utilitarians today believe that pleasure, even if interpreted as broadly as possible, is not the only thing desirable and pain is not the only thing bad in its own right. If you believe in utilitarianism, you may consider not just pleasure but also valuable information such as knowledge, friendship, personal liberty and success as things worth pursuing only for their own sake. As a result, many utilitarians now define utility as the fulfillment of desire or the satisfaction of preferences, with little limits on what the wants or preferences are for.

[73] M.P. Tandon, Jurisprudence Legal Theory, Allahabad Law Agency (7th Edn.) 2006.

In utilitarianism, two sorts of theories are distinguished: the act theory and the rule theory. Act utilitarian theory asserts that the utilitarian concept of utility should be applied to specific situations in everyday life. The net utility function of each potential course of action in this case must be determined. The appropriate course of action is thus defined as the one that provides the greatest net benefit over all other options. In act utilitarianism, each instance is evaluated on its own merits, with the computation of pain and pleasure consequences determining what should be done. A utilitarian approach would support active euthanasia over passive euthanasia because active euthanasia is less painful. However, even if the patient is pain-free, the anxious waiting of family members, the additional cost of drugs and nursing time, and the fact that a hospital bed cannot be used for another needy patient all need to be taken into consideration, adding additional support.

It is the goal of rule utilitarianism to establish broad principles that will lead to the greatest amount of happiness for the greatest number of people. It is only through adhering to societal norms that an individual's actions may be judged. We should not kill innocent individuals, which is a well-accepted societal guideline that contributes much to everyone's well-being. As a result, euthanasia methods that adhere to rule utilitarianism, or at the very least do not undermine it, will be considered. Because individual acts of active euthanasia may reduce pain better than passive or palliative care, rule utilitarianism would likely oppose the practice on the grounds that it will cause more misery in the long run if it is adopted widely as a medical routine in our hospitals and among the general public, and that gradual erosion of a good rule not to kill will lead to more unhappiness over time than it will bring happiness now, As a result of the popular belief that hospitals might become death houses rather than places of healing, there will be a widespread worry that the system is exploited and corrupted.[74]

Rule utilitarianism is wary of passive euthanasia as well because it fears that if the legislation is changed to allow it, widespread use of it will infect and erode people's willingness to adhere to the rule not to kill. Because utilitarians do not perceive any

[74] M.P. Tandon, Jurisprudence Legal Theory, Allahabad Law Agency (7th Edn.) 2006.

meaningful moral distinction between acts and omissions, between murdering and allowing to die, this concern becomes much more pressing. Because of this, act and rule utilitarianism are likely to differ on euthanasia in their respective approaches.

Euthanasia and Mercy Killing

A mercy killing is the act of intentionally terminating the life of a terminally sick individual. Voluntary euthanasia is the most common use of the word, which is often known as "right to die." However, non-voluntary and forced euthanasia are also included in its scope. Either passive or active euthanasia is a form of voluntary euthanasia. When a person refuses or withdraws their permission for life-saving medical assistance, it is considered passive voluntary euthanasia.[75] Euthanasia is popularly known as mercy killing.

Euthanasia and Suicide

Suicide is an intentional act of ending one's own physical existence or self-murder in which a man of sound mind and maturity chooses to end his own life. Suicide is an act of taking one's own life deliberately or purposefully. The distinction between suicide and euthanasia or mercy killing is critical. Any attempt at ending one's own life with the help or support of another human being is, by definition, suicide. In contrast, euthanasia entails the involvement of another human agency in order to put an end to a person's life. Homicide, including euthanasia, is against the law unless an exception is made. A mercy-killing attempt is not the same as a suicide attempt.[76]

Taking one's own life is a form of suicide that is done voluntarily and consciously. Bombay High Court rules that mercy killing is not suicide in Maruti Shripati Dubal v. State of Maharashtra.[77] Similarly, in P. Rathinam v. Union of India,[78] the Supreme Court noted that the legal and other issues surrounding euthanasia varied significantly from those brought by suicide. As a result, the case for enabling people to take their own lives cannot be minimized or weakened in order to appease those who advocate

[75] *Mercy Killing*, Legal Information Institute, (Jan. 5, 2018, 07:32 PM), https://www.law.cornell.edu/wex/mercy_killing.
[76] *Humanization and Decriminalization of Attempt to Suicide*, the Law Commission of India, Report No. 210, October 2008, (Jan. 2, 2018, 09:20 PM), http://www.lawcommissionofindia.nic.in.
[77] Maruti Shripati Dubal v. State of Maharashtra, 1987 (1) BomCR 499.
[78] P. Rathinam v. Union of India, (1994) 3 SCC 394.

for laws allowing for mercy killings. The Supreme Court emphasized that self-inflicting harm is distinct from aiding someone else to commit suicide.[79]

On the other side, physician assisted suicide entails aiding a person in ending his or her own life. Physician-assisted suicide differs from euthanasia in that the patient is in total control of the process leading to death since the patient commits the act of suicide. There is no other individual involved in this process other than the physician, who provides the means to carry it out.[80]

Euthanasia and Homicide

Regardless of the circumstances, euthanasia or mercy killing is a kind of homicide.[81] Murder is defined as the purposeful killing of another person in an unlawful manner, and there are two types of murder. Secondarily, there are situations where a murderer does not have informed agreement of the person, he or she is committing a crime against. Because euthanasia is the act of ending a patient's life both at the patient's desire and at the request of the patient's family, it is equated to murder.[82]

An individual whose life depends on a respirator because their respiratory system and brain have failed completely and they have no chance of survival unless the respirator is disconnected as soon as possible is known to the doctor who administers the care, but the doctor cannot remove the treatment even if the patient's close family members insist on it because doing so would amount to murder or aiding murder.[83]

Assisted suicide, sometimes known as euthanasia, is the deliberate killing of an individual with the goal of alleviating their suffering. There are two Greek terms for "good death": eu (meaning "well or excellent") and thanatos (meaning "to die" (death). To put it another way, it refers to the technique of ending a life in a way that minimizes

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[79] Paranjape Prof. N.V., *Criminolgy and Penology*, Central Law Publications, 14th Edition, 2010, p. 272.
[80] *Euthanasia and assisted suicide*, (Jan. 2, 2018, 09:40 PM), http://www.pages.drexel.edu/~cp28/euth1.htm.
[81] Shreyans Kasliwal, *Should Euthanasia be Legalised in India?,* (2003) PL WebJour 16, Eastern Book Company, (Jan. 2, 2018, 10:15 PM), www.supremecourtcases.com/index2.php?option=com...5.pdf.
[82] Amandeep Kaur, *Legalisation of Euthanasia in India- a critical analysis*, (Jan. 2, 2018, 11:05 PM), http://lawherald.in/articlefull.php?id=13.
[83] N.V. Paranjape, *Criminolgy and Penology*, Central Law Publications, 14th Edition, 2010, p. 273.

pain and suffering. euthanasia is defined as "a intentional action made with the express goal of ending a life, to relieve persistent pain." The act of willfully causing someone's death with the goal of benefiting or protecting them from further pain is known as homicide.[84]

According to the method used, euthanasia can be classified as either active or passive, based on whether or not the patient has given their informed agreement, which can be voluntary, non-voluntary, or involuntary. Active euthanasia is what most people mean by the term "euthanasia," and it is deemed homicide in most jurisdictions; however, voluntary, passive euthanasia is not. One side of the debate revolves on the idea that assisted suicide and euthanasia are synonyms for "suicide" and "murder," respectively.

Euthanasia is directly responsible for the patient's death. Normal physical functions were all that was needed to carry out the deed (ex. the blood stream to carry the poisonous substance throughout the body). In the case of active euthanasia, the act of causing the patient's death is done out of pity for the patient (as opposed to Omission, not doing something). Death can be brought about more quickly if the method used is active. Active euthanasia in any form is strictly prohibited.

"Letting nature take its course" is a common poetic term for passive euthanasia. Essentially, this means that therapies that may plausibly avert the patient's death are not provided or discontinued because the patient's death is considered merciful (by whoever makes the choice). Because it relies on other circumstances to cause death, such as untreated pneumonia or the patient's inability to breathe properly without oxygen or respiratory help, this sort of euthanasia is more difficult to carry out successfully.

Voluntary and non-voluntary passive euthanasia are both legal methods of ending one's life. It is not euthanasia, but murder when a person is killed medically without their agreement, whether it is non-voluntary (when the person is unable to consent) or involuntary (against the person's will). Consequently, only those who choose to be

[84] *Euthanasia and Assisted Suicide*, (Jan. 3, 2018, 10:03 PM), http://www.pages.drexel.edu/cp28/euth1.htm.

euthanized can do so. Voluntary euthanasia is defined as euthanasia performed with the patient's permission. Involuntary euthanasia is defined as euthanasia performed against the patient's will. Involuntary euthanasia is always against the law.

Voluntary, non-voluntary, and involuntary euthanasia can all be split into passive and active varieties based on the technique used. The most contentious kind of euthanasia is active euthanasia, which involves the use of lethal chemicals or forces to kill. Euthanasia is directly responsible for the patient's death. Active euthanasia is typically a faster method of dying. Active euthanasia in any form is strictly prohibited. Active euthanasia, on the other hand, has been explicitly rejected by federal circuit court judgments in recent times. The withholding of life-sustaining medications like antibiotics, such as passive euthanasia, is a kind of active euthanasia. "Letting nature take its course" is a poetic term for this sort of euthanasia. Basically, it is not giving or ceasing therapy that would be fairly effective in avoiding the patient's death, because death is thought to be merciful to the patient. In comparison to active euthanasia, passive euthanasia often takes longer and is more painful. Voluntary and non-voluntary passive euthanasia are both allowed in most cases.

"Passive euthanasia" refers to a method of hastening someone's demise by removing or changing a life support system and then letting nature take its course. Refusing to revive a person after he or she has been dehydrated or starved to death is an example of a practice known as "denial of life." Passive euthanasia can also entail administering a high dose of morphine to a patient in order to alleviate their suffering despite the fact that doing so is likely to impair breathing and hasten their demise. These dosages of medications have the dual effect of alleviating pain and speeding up the patient's death. In most countries and medical systems, administering such drugs is considered to be morally acceptable. Patients who are nearing the end of their lives undergo these operations in order to speed up their natural death. These procedures are also often used on patients in a permanent vegetative state, such as those who have suffered severe brain injury or are in a coma and are unlikely to recover awareness. Passive tends to be slower and more painful than vigorous.

2.6 Euthanasia: Constitutional Aspect

A group called the Voluntary Euthanasia Legislation Society was formed in 1935 by C. Killick Millard and afterwards renamed Euthanasia Society. In 1935, this group began a campaign to make euthanasia legal. In 1936, the House of Lords rejected the Bill. Euthanasia's morality may be traced back to Plato, Aristotle, and the Stoics. Euthanasia was legalized in the Netherlands, Belgium, and Oregon, respectively, in 2001, 2002, and 1997. Since the primary goal of this procedure is to alleviate pain and suffering, it might be called a "good death," as opposed to just taking someone's life.[85] Only a few countries around the world recognize the "Right to Die," because the countries that have refused to grant their citizens the "Right to Die" believe that as people's minds change and become more pragmatic, more people will be killed in the name of Euthanasia, leading to violations of human rights. However, some countries that support euthanasia believe that a patient should not suffer and that the "Right to life" includes the "right to die with dignity" as part of that right. Both sides have valid points of view, but finding a medium ground is necessary if we are to achieve our goals as a society as a whole. As a further option, when a person's demise is imminent or they are in a vegetative state, it is permissible to remove their feeding tube or other life-sustaining equipment. Euthanasia in which a deadly injection or medicine is provided directly to the patient should not be permitted.

Is there a reason why individuals are not allowed to end their lives? Article 21 of the Indian Constitution of 1950 guarantees the right to life, but does it also include the right to die? What are the accepted standards for defining what it means to "live"? The term "life" has no established definition. Nobody is in favour of killing. The right to die should also exist for those who are in a life-threatening situation and are unable to withstand the anguish any longer. That pain should have lasted for a significant amount of time.

[85] Tushar Kumar Biswas and Arnab Sengupta, *Euthanasia and its Legality and Legitimacy from Indian and International Human Rights Perspectives,* Asia-Pacific Journal on Human Rights and the Law, vol 11, issue 2 (2010) 18-30, ISSN: 1388-1906.

Article 21 of the Indian Constitution is a depository for the right to life in the country. An individual's life and liberty cannot be taken from him or her unless in accordance with a lawful process established by the legislature. The fundamental significance of this constitutional clause, on the other hand, extends much beyond its explicit language. The Indian judiciary has been quite kind to Article 21.

India's court has only just begun to appreciate how important the right to life is on a fundamental level. The shift in judicial mindset may have been prompted by the sound idea that constitutional provisions should be interpreted broadly and liberally rather than narrowly and conservatively. Since its inception, the Supreme Court has often said that the court's goal should always be to extend rather than diminish the meaning and content of a fundamental right. It is because of this judicial approach that Article 21 of the constitution has been reduced to a collection of rights. In arguing that Article 21's definition of "life" includes more than just animal existence, the Supreme Court took a major step toward broadening the meaning of Article 21.

Using the term "life" in this context, something more than animal existence is intended. Resistance to its deprivation permeates all of our bodily functions. The amputation of an arm or limb is also prohibited under the law. The Indian Supreme Court has therefore widened the scope of Article 21 to include a wide range of possibilities. A wide range of substantive and procedural safeguards are now available to the people.

It is a belief that a human being has a fundamental right to life, which encompasses the minimum needs of existence such as enough nourishment and clothes; a roof over one's head; the ability to freely move and interact with others; and the ability to express oneself in many ways. Accordingly, it is maintained that every person has a life worth living, and that when a person's condition falls below even the bare minimum of that dignity, the individual should be left to end their gruesome plight. India's constitutional right to die has sparked a significant deal of legal discussion. This argument over euthanasia has centred on Article 21 of the Indian Constitution of India.

While privacy was the primary concern in the K.S. Puttaswamy case,[86] it has also been remarked that life is precious and worth living because of the freedoms that enable each individual to live life as it should be lived. Individuals are charged with making the finest judgments about how they choose to spend their lives. It is the social context in which an individual lives that continually shapes these concepts. States have an obligation to protect the individual's ability to make decisions, but not to dictate those decisions. It is also important to note that Article 21's definition of "life" does not limit it to the physical integrity of the human body. Full awareness of one's self can only be achieved through the right. To live is to live with honour and respect for one's self. A society based on constitutional ideals is one in which freedom and dignity are highly valued, according to the drafters of the Constitution. Part III's protection of individual rights is permeated by the concept of dignity, which is a foundational principle. The core of the basic rights is dignity since the fundamental rights attempt to provide each individual the dignity of existence. To one, his most prized property is his sense of self-worth and it was not lost throughout the process of death or after the death.

It is possible for a terminally sick man or one in a chronic vegetative state to have the "right to die with dignity" as part of the right to live with dignity. Since his intrinsic human right to freedom of choice is guaranteed by Article 21, no further law is required for it to take effect. It's true that the right cannot be unlimited, but it must be regulated by appropriate legislation with reasonable constraints and in the best interest of the general public. The court made it clear that, in the context of the issue at hand, Article 21 only covers passive euthanasia, not active euthanasia in which the treating physician or another person takes positive steps. So , the right to die with dignity is a fundamental part of Article 21. People with PVS who have little chance of recovery have the right to have their dying process made as painless as possible.

As the phrase "right to life" is interpreted in the Indian Constitution, this means that human life is protected. In order to fulfill this commitment, we need to provide 'food, safe drinking water, and health care,' as well as other necessities. Contrary to popular belief, most states have done little or nothing to help the terminally sick by giving

[86] K.S. Puttaswamy and another v. Union of India and others, (2017) 10 SCC 1.

access to hospital treatment. Most pro-euthanasia advocates will rethink their position if the government assumes responsibility for providing an acceptable level of health care. Our modern culture and public health system are not mature enough to deal with this complex subject, thus we should support the Supreme Court's judgment.[87]

However, this problem will need to be revisited in a few years to see how society and the public health sector have evolved in terms of providing health care for the poor and disabled. A new era in palliative care for terminally ill patients has begun with the Supreme Court's decision to postpone a verdict on this contentious topic. An attempt has been made to maintain societal cohesion when confronted with a difficult medical, social, and legal issue. According to the Law Commission's suggestion and the judgement in Aruna Shanbaug[88] and Common Cause,[89] legislation is needed to safeguard terminally ill people and their caregivers.

[87] Sujata Pawar, *Euthanasia: Indian Socio-Legal Perspectives*, 15 J.L. Pol'y and Globalization 11 (2013).
[88] Aruna Ramchandra Shanbaug v. Union of India and others, 2011 AIR (SC) 1290.
[89] Common Cause (A Regd. Society) v. Union of India, (2018) 5 SCC 1.

CHAPTER 3

PASSIVE EUTHANASIA: PHILOSOPHICAL, RELIGIOUS AND ETHICAL PERSPECTIVES

3.1 Introduction

Religious perspectives on euthanasia span a wide spectrum, making it impossible to classify any one of these viewpoints. One's religious views, even if they are not directly relevant to the topic, tend to impact one's perspective.

Palliative care is influenced by religious beliefs; however, this is less essential than one might imagine. A study of the association between American individuals' religious beliefs and their attitudes on euthanasia was done for this objective. No association was observed between religious affiliation and euthanasia attitudes by the researchers. Even if a person adheres to a certain religion, they may not see every aspect of it as appropriate for them. It's based on the facts. According to some recent study, nurses' views on euthanasia and physician-assisted suicide may be influenced by their religious and worldview convictions. Support for euthanasia and physician-assisted suicide tends to be negatively impacted by religious beliefs. In a 1995 poll, religious affiliation and educational level had a considerable impact on people's attitudes on euthanasia. More Australian doctors who had no official religious affiliation endorsed and executed active voluntary euthanasia than those who did. Somewhere in the midst between the atheist/agnostic and catholic camps, Protestants were found to have similar views and behaviors. According to a survey, Catholic physicians stated that they have tried in some way to expedite the deaths of patients.

Most religious leaders believe that the best way to help terminally ill people is to not allow them to choose death, but rather to accompany them through their pain and terror. Even the most traumatic events may teach us something worthwhile, they say. "There are some individuals in religious organizations who believe that having a dying person in the group is a benefit," said Bregman. Not only for that person, but for all of us, that person's end-of-life predicament serves as a reminder of what we shall all face at the conclusion of our lives.

According to religious authorities in favor of assisted suicide, people should be free to decide when and how they want to go out. The Unitarian Universalist Association has been working for the right of patients to make their own medical decisions for the past two decades. One cannot live an insignificant or pointless life. A physician-assisted death would be like saying that certain people's lives aren't worth living if assisted suicide was legalized at some point, according to Hill.[90]

Our religious beliefs influence our thinking, motivation, and societal frameworks when it comes to making decisions. As a person's personal schema develops, so does their capacity to perceive the world via the religious prism. Because we are social animals who rely on one another for our survival, religion gives us a feeling of community with which we can identify. We all have a desire to exert control over our surroundings, which is why we need religion to provide the necessary route and tools for accomplishing that goal. Using religion, one can find answers to life's most perplexing quandaries and govern some aspects of one's behavior to bring about the good things that God has promised. The idea that Jews and Muslims share comparable attitudes on euthanasia mitigation and involvement lends credence to Hood's method. According to Jewish and Muslim responses, one must tolerate a person's death when they are meant to. Although most Jews answered in the same way as other Jews, Muslims were more diverse in their responses. Religious beliefs play a crucial role in the choices people make, since Christians believe that one should not give up hope in life.

3.2 Passive Euthanasia: Philosophical Perspectives

Moral philosophy, commonly known as ethics, is the study of what is ethically good or evil and what is morally right or wrong. The phrase may also refer to a set of moral ideas or principles as a system or philosophy. Deontological, teleological, and virtue-based ethics are the three main types of ethical theories. Due to their emphasis on an individual's deeds, the first two are known as deontic or action-based theories of morality. Deontology is a philosophy that states that acts are either good or evil based

[90] K. I. Vibhute, *Right to Human Dignity of Convict Under 'Shadow Of Death' And Freedoms 'Behind The Bars' In India: A Reflective Perception*, Journal of the Indian Law Institute, Vol. 58, No. 1 (January - March 2016), pp. 15- 54.

on a set of predetermined criteria. The Greek word 'deon' meaning obligation, is the source of its name. Ethical activities are those that follow these guidelines, whereas unethical actions are those that do not. Immanuel Kant, a German philosopher, is best known for this ethical philosophy. It is not about the cause, but about the end, purpose, or aim, and that's what teleology or finality is all about.[91]

The utilitarian school of normative ethics is one of the most influential and effective in philosophical history. Proto-utilitarian viewpoints may be found throughout the history of ethical philosophy, even if they were not completely stated until the 19th century. Jeremy Bentham (1748–1832) published a systematic description of the notion. This realization is that acting in a way that is ethically just will not cause damage to others, but rather will raise their own contentment or 'utility.' Both Jeremy Bentham and John Stuart Mill, two classical utilitarians, believed in the hedonistic view of value that Epicurus espoused. Furthermore, they said that we should strive to achieve 'the greatest quantity of good for the largest number of people'.

Bentham and Mill, two Classical Utilitarians, were interested in legal and social change. For Classical Utilitarianism, if anything could be attributed to its growth, it would be a wish to see unnecessary, corrupt laws and social practices replaced. Normative ethical theory was an essential instrument in achieving this objective. What really constitutes a morally commendable or morally correct course of conduct or policy? It was also impacted by their strong beliefs about what was wrong in their society when they came up with the idea itself. For example, the belief that there are poor laws lead in an investigation into why those laws were problematic. They were also bad for Jeremy Bentham since they led to anguish and misery without any compensatory happiness, according to him. One cannot be good at anything if you do not do anything.[92]

[91] Tak Kwong Chan and George Lim Tipoe, *The best interests of persistently vegetative patients: to die rather that to live?*, Journal of Medical Ethics, Vol. 40, No. 3 (March 2014), pp. 202-204.
[92] Sanjeev Kumar Tiwari, *Concept of Euthanasia in India – A Socio- Legal analysis Concept of Euthanasia in India - A Socio-Legal Analysis*, International Journal of Law and Legal Jurisprudence Studies, (Jan. 01, 2018, 10:04 AM), http://ijlljs.in/wp-content/uploads/2015/04/AMBALIKA.pdf.

The purpose of Death with Dignity rules is to allow terminally ill individuals to speed up their inevitable and irreversible death. Rethinking certain beliefs has been made possible by modern medical knowledge, despite the fact that many religious traditions still adhere to old conventions and understandings of physical death.
What is the significance of my existence?" may become a question for dying persons under Death with Dignity laws. When it comes to spirituality, this is a question that can only be addressed privately in the comfort of one's own home, not in the midst of visits, therapy, or testing.

To ensure that patients' rights are protected during their final journey, the concept of "Death with Dignity" straddles the line between public policy and religion. In certain religious traditions, the practice of death with dignity has been encouraged, while others have seen it as a morally depraved practice.

Starting with the obvious: everyone has a duty to care for his or her own well-being, and it is the individual's obligation alone to do so. The act of killing oneself is likewise incompatible with nature. Because every human being constitutes a part of society, the second argument goes like this: As a result, everyone who attempts suicide does so at the expense of others. God gave every one of us the gift of life, and it's up to us to respect it. It would be a severe sin to tamper with God's design.

But Immanuel Kant, in his writings from 1785, argues the opposite "When morality is eradicated as a goal in and of itself, that is what is meant by destroying the subject of morality inside oneself. As a result, treating oneself as if you were nothing more than a tool to achieve a goal over which you have no say is humiliating.

Christian thinkers, as indicated by the aforementioned comments, have long seen suicide as a sin and a threat to society's well-being. One of the most important reasons to commit suicide is to eliminate one's ideals from the world. Discarding oneself in this manner is a depraved act of self-destruction that is morally unpleasant as well as ethically repulsive.

The Roman Catholic Church is fiercely opposed to suicide. In 1912, the Catholic Encyclopedia published an entry on suicide that explained that both of these notions were crimes against God's will and should be condemned as such. According to the stated statement, there are a number of reasons why this is the case:

When a person commits suicide, it implies that we are in charge of our bodies and that we have the freedom to do anything we want with them. Before one to be charitable to themselves, one must first be charitable to others. When these aspirations are pursued, they lead to moral and social disobedience that results in an inability to help others.

3.3 Passive Euthanasia: Religious Perspectives

Death is a topic that is frequently addressed in religious texts. All faiths deal with death and dying, and they all try to make sense of them. People who have lost a loved one might turn to their religion for rituals and memorial ceremonies. Religions provide comfort and understanding to those who are confronted with the reality of their own mortality. Religions think that in order to find meaning in one's life, one must understand death and dying. When it comes to preparing for eternity, many cultures see death as a chance to receive important spiritual insights. Suicide and euthanasia are contentious topics in many religions.

Most religions consider euthanasia to be wrong. Assisted suicide is strongly opposed by most religious traditions. In certain jurisdictions, it is strictly prohibited. The Roman Catholic Church is one of the most ardent opponents of euthanasia. End-of-life care rather than assisted suicide is preferred by practically all religions for those who have become vulnerable due to illness or disability. Several religious groups oppose euthanasia for a variety of reasons.

Since God created life, it should be protected and conserved under all circumstances. As a result, we should not obstruct God's plans by restricting the right to life of others. Human life has intrinsic value and dignity since we were made in God's image. A life taken, even one's own, is a violation of that particular value and dignity, regardless of how painful and difficult one's own life is.

Existence, or the concept that human life is sacred, has long been a frequent topic in religious debate. To put it another way, they usually claim that only God has the power to take someone's life. That's why it is important to handle our life with respect and care.

2.5 Religious Views

Religions have a lot to say about death, and it's one of the most essential topics they cover. Many people's supports for euthanasia is rooted on their religious convictions. Considering that religion is concerned with questions of life and death, purpose and virtue, it is essential to investigate the many religious perspectives on euthanasia.

2.5.1 Hinduism:

In Hinduism, euthanasia is seen in a variety of ways. According to Hinduism, euthanasia is not considered a path to moksha, or salvation. Euthanasia, according to most Hindus, would lead to the spirit and body being separated at an unnatural moment that is not set by nature. Doctors and patients' karma will be damaged as a result of this incident. Others in the Hindu community think that euthanasia is against the doctrine of ahimsa, and hence should not be allowed in the country.[93]

Others believe that assisting someone terminate a painful existence fulfills one's moral duty and hence counts as a good deed. The ideas of karma, moksha, and ahimsa underlie Hindu perspectives on euthanasia and suicide. "Karma" is the sum of a person's good and bad acts. One's previous actions have an impact on their reincarnation. A person's ultimate objective in Hinduism, moksha, or freedom from the cycle of reincarnation, is thwarted by an accumulation of negative karma. An important tenet of Hinduism and other Indian faiths is ahimsa, or nonviolence.

Suicide is widely discouraged in Hinduism because it disturbs the cycle of death and rebirth, which results in negative karma, and hence is discouraged. In Hinduism, suicide is discouraged since human life is a priceless gift that even the gods covet. It also has a

[93] S.S. Das, *Religious Postulates of Euthanasia in India*, The Legal Analyst, ISSN 2231-5594, Volume 1, 2011, pp. 118-122.

devastating effect on the soul's spiritual advancement. Suicide is not considered to be a path to heaven or hell in Hinduism, but rather a terrible spirit that wanders around the Earth until he or she reaches the end of his or her allotted life span. After that, he suffers much in hell. After completing his past karma, he returns to Earth and begins anew. When a person commits suicide, their spiritual clock goes backwards.

Prayopavesa, or fasting till death, is an exemption to the Hindu rule against suicide. Due to the fact that it's non-violent, and only appropriate for spiritually mature individuals under specific circumstances, Prayopavesa is not considered suicide.

According to BBC Religion,[94] the following is an illustration of prayopavesa: Sivaya Subramuniyaswami, an Indian Hindu guru born in California, committed himself in November 2001 via prayopavesa. after learning he had incurable intestinal cancer, the Satguru pondered for many days before deciding to accept only pain-killing therapy and to practice prayopavesa - ingesting water but not food. On the 32nd day of his self-imposed fast, he succumbed.

As a result, there are two competing Hindu perspectives on euthanasia: If you assist someone terminate their difficult existence, you are doing good deeds, and you will reap the benefits of that deed. Euthanasia, on the other hand, disrupts the timing of rebirth, and as a result, both the doctor and the patient will receive terrible karma.

Indian views on assisted suicide and euthanasia are tied together by karma, moksa, and ahimsa. A person's karma, which determines the attributes of their future incarnation, is influenced by their life's actions, both good and bad. If you keep accruing negative karma, Hinduism's ultimate goal is moksa, or liberation from the cycle of rebirth. Ahimsa, which means "do no damage," is a central principle of both Hinduism and Buddhism.

[94] *Euthanasia, assisted dying, and suicide*, BBC Religions, (Mar. 10, 2018, 11:45 PM), http://www.bbc.co.uk/religion/religions/hinduism/hinduethics/euthanasia.shtml.

Suicide is widely discouraged in Hinduism because it interferes with the cycle of death and rebirth, resulting in negative karma. It is forbidden in Hinduism to take one's own life in order to achieve a higher degree of reincarnation since even gods are jealous of this opportunity. It also has a devastating influence on the soul's spiritual growth.

People who commit suicide are reborn as an evil spirit who wanders aimlessly until their fixed and allotted lifespan ends, according to Hindus. If he dies, he will suffer even greater agony in hell for his crimes against humanity. He returns home and begins the procedure all over again at the end of the story. The compass of a person's soul is reset when he or she commits suicide.
The Law of Retribution governs Karma, which is based on the concept of retribution. That which we accomplish in this lifetime will determine how we are reborn and how far we move toward liberation or freedom, according to Hinduism. Everything we do has an equal and opposite response; and everything we do, in turn, has an equal and opposite outcome. It symbolizes the interplay between fate and free will. A fatalist, the belief that mankind are only puppets of the divine, does not exist among Hindus.

Each of us is born with karma that is unique to us since it is built up over many incarnations. Hindus turn to our longing for God, not the goods of this world, to achieve a high quality of life. The system of karma includes ramifications for transmigration that are both virtuous and immoral. It is also stated in the Upanishads of the Vedas that Hinduism differentiates between actions that lead to death and those that lead to life. With their knowledge of Hindu ethics, they are able to tackle bioethical issues from a Hindu viewpoint.

Death is a sin in Hinduism, which considers Euthanasia and Physician-Assisted Suicide to be crimes against humanity. It is common in Hinduism for a person's death to be violent, early, and uncontrollable. Euthanasia or physician-assisted suicide would be viewed as a horrific death by many.

When it comes down to it, Hinduism's primary belief is Sanatana Dharma or eternal religion. According to Hindu philosophy, dharma is crucial to the well-being of the

individual as well as the community. Law and religion can be found in the Dharma in this context. To strive for the finest possible existence is to follow this guiding tenet. People in Hinduism are guided by the moral commitments and responsibilities of their faith. Elderly members of the society, family, or even one's own family are required to be cared for by Hindus in line with Dharma.

According to this school of thought, if a patient's request for euthanasia is accepted, the soul and body will be separated at an unnatural time. The doctor's karma will suffer, as will the patients. According to Hinduism, killing oneself interferes with the natural cycle of death and rebirth, which results in negative karma. A person's spiritual growth also suffers greatly as a result. Murder and suicide are all acts of killing that hinder the soul's progress toward freedom or liberation. As a result of the killer's disrespect for nonviolence, it has a negative effect on him or her. As long as the soul's karma is present, it will continue to suffer in a new material or physical body. Using the same logic, it may be argued that prolonging someone's life artificially is a bad decision.

As a result, it is a problem for palliative care if it reduces the patient's awareness of Hinduism's perfect death. Since the reincarnation process relies on a person's final thoughts, the decision to end one's life by euthanasia may have ramifications.

However, the Autonomy Argument claims that a doctor's moral role is to help end a patient's suffering life, and so he is fulfilling his duty. Such behavior is ethically permissible. The freedom of an individual should not be curtailed.

According to Hinduism, taking one's own life is considered suicide. The compass of a person's soul is reset when he or she commits suicide. There is, nevertheless, a division in Hinduism.

In terms of wanting to die, there is a clear divide between selfish impulses and those that are more selfless or sympathetic. It is impossible for someone who conducts in this way to be freed from the cycle of life and death, which is the ultimate spiritual goal. Karmic punishment may also befall those who help in this suicide for breaching the ahimsa principle.

As a result, there are two distinct categories of persons who desire death for spiritual reasons. As a sign of enlightenment in the dying, caring about the well-being of others is at the core of the first. As a result, a patient may decide to cease therapy to avoid putting an unnecessary strain on their loved ones' shoulders. He or she may also decide to stop therapy in order to lessen the load on people close to him or her emotionally or financially.

2.5.2 Jainism:

The philosophy of Jainism emphasizes the importance of consciously choosing one's own death. Santhara, a Jain practice, encourages people to prepare for death through fasting. Death and life are viewed as enigmatic occurrences. If a person's soul has not already planned its future incarnation before passing away, it will be given the life (birth) that corresponds to the ideas that are going through his or her mind at the moment of death. Dharma or Shukla dhyana (higher varieties of dhyana, or excellent types of dhyana) gives birth to higher-class souls, whereas Raudra and Aarta dhyana (meditation) gives birth to lower-class souls.[95]

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2.5.3 Buddhism:

Buddhism does not have any monographs devoted to euthanasia. Relevant problems include the distinction between active and passive euthanasia, as well as the use of

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[95] Shanmukh Kamble et al., *The acceptability among young Hindus and Muslims of actively ending the lives of*
newborns with genetic defects, Journal of Medical Ethics, Vol. 40, No. 3 (March 2014), pp. 186-191.
[96] *Concept of Death in Jainism*, (Mar. 12, 2018, 10:22 PM), http://www.jinalaya.com/jainism/death.htm.

medications in palliative care to distort a patient's mental state and impede the process of death.[97] Compassion is a central principle of Buddhism. Some Buddhists argue that euthanasia is permissible because it relieves the suffering of the patient. As long as any action is taken with the goal of destroying human life, it is still morally wrong to engage in it.[98]

Kapleau's volume "The Wheel of Life and Death"[99]contains a short discussion of euthanasia in conjunction with suicide and it is suggested that Buddhism would reject the practice of either. Ethical considerations must be taken into account while considering euthanasia, because the process of dying is spiritually significant and should not be interrupted.

Death, according to Buddhism, is not the end of life but rather the beginning of another. Because the First Noble Truth plainly implies that death is one of the most basic characteristics of suffering and that it is therefore the issue rather than the solution, anybody who believes dying will put an end to their pain has misread the meaning of this statement.[100]

As far as religions go, Buddhism is often considered to be the most enlightening. Since death is an unavoidable part of life, Buddhists are better equipped than most to face it with dignity and calm.

A person may only determine a deed's morality in Buddhism if they understand its purpose. Ending all life by taking it means ending all life. Killing living animals is what this refers to. Non-philosophers use the word "living being" to refer to anything that can maintain life. As a result, the desire to kill everything that one views as having life,

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[97] *Supra* note 42, at 23.
[98] Keown Damien, *End of life: the Buddhist view*, (Mar. 13, 2018, 11:25 PM), http://www.thelancet.com/series/end-of-life.
[99] *Buddhism and Medical Ethics*, (Mar. 12, 2018, 11:53 PM), www.thaihealingalliance.com/.../Buddhism%20and%20Medical%20E.htm.
[100] *Euthanasia and Buddhism,* (Mar. 15, 2018, 09:45 PM), http://www.religionfacts.com/euthanasia/buddhism.htm.

whether expressed physically or verbally, is what is meant by the term “homicidal intent.”

It’s imperative that the most crucial part of patient care be brought to light. Buddhism forbids the willful attempt to terminate one’s own life, yet this does not entail that one must take extreme lengths to save one’s own life. People can survive without the use of life-support systems, such as ventilators, for example. It is not necessary to perform surgical treatments like organ transplants on patients in a chronic vegetative state. Buddhism has no problem with a doctor ending a patient’s treatment, despite the fact that each patient’s condition is unique.

It was either useless or extremely burdensome for the patient, despite the anticipated benefits. These ideas still hold true even if the patient’s death is hastened. Medicine’s fundamental aims are I the preservation and restoration of health (or a close approximation thereto) and (ii) the reduction of suffering. For those who have been in a vegetative state for an extended period of time, neither of these options is an option. Only those who are most likely to benefit from medical care should be given it.

Chronically vegetative individuals who have not been confirmed brainstem dead should have access to nutrition and fluids. Antibiotics, on the other hand, would not be required in the event of any subsequent complications, such as pneumonia or other infections. A patient may die if the infection is not treated, but all treatment options must be balanced against the possibility of a complete recovery. Accepting that a patient’s condition has progressed to the point that he or she is no longer amenable to medical intervention is sometimes the best course of action.

According to Buddhist teachings, all persons are deserving of compassion, regardless of their physical condition. Because Buddhism stresses the importance of universal rather than selective charity, it would be unfair and unjust to withhold this therapy to those who have been in a prolonged vegetative state. Compassion and care may be extended to those who are unconscious or in a vegetative condition. Despite their misery and suffering, others may offer them compassion as a sign of their goodwill and

sympathy. The care that these patients get is not a waste of time, but rather a way for friends to show their affection for one another. Accepting and forsaking them would be rejecting Buddhism's emphasis on universal compassion.

No one should find it difficult to care for a Buddhist patient's last needs, regardless of their religious views. Religiously affiliated patients would be excluded from this provision. Instead, they should not be placed in a mixed ward and instead treated by a physician of the same gender. This would ensure that they receive adequate treatment. Where medical resources are scarce, more and more doctors and nurses of the other gender are treating patients. As time goes on, this is becoming more and more prevalent among patients.

Buddhism emphasizes the significance of dying in order to have a better rebirth or start in the future, but it does so with an open mind. A small number of Buddhists are opposed to the use of sedatives or painkillers, and even those who aren't near death may prefer to remain alert rather than risk mental or sensory impairment by using analgesics.

The death of one's physical body does not end a person's worldly life, according to Buddhism, including any pain or suffering they have had. To put it another way, death signifies the end of a person's potential to do the best in the world and lower their karma before they die.

In Buddhism, both death and old age are viewed as symptoms of suffering (dukkha). Buddhist teachings emphasize that "everything has the character of emerging, has the nature of ending or cessation." Since all living things in the natural world are born as complete entities at a certain point in time, they all have the temperament of emerging because they are born as complete entities at that point in time. According to Buddhist doctrine, because they are composed beings, all composite beings inevitably melt or fall apart. A sense of discontent, or dukkha, is embodied in death because it symbolizes both the transience of human existence and the agony and sadness that accompany it.

Death serves as a model issue for Buddhists because it reflects all of the difficulties of reincarnation.

Buddhism's ultimate objective is enlightenment or nirvana, which is achieved via the practice of meditation. Ethics, meditation, and wisdom are the three pillars of a Buddhist's route to nirvana or enlightenment. According to the Dalai Lama, morality, like soil, is the basis and wellspring of all skillful dharmas (acts). Ethics and morality are well-documented in the literature of Buddhist schools. While the Ten Commandments serve as the cornerstone of all Buddhist ethics, they are not the only source of inspiration.

For a Buddhist to understand euthanasia, one must first understand the concepts of rebirth and karma. There is a strong belief in rebirth, also known as reincarnation, in Buddhism. Until enlightenment or nirvana, one's reincarnation cycle will come to an end, one believes, one will continue to live more lives.
One argument for opposing lethal injection or physician-assisted suicide is because of karma and the way of death. A deadly illness, according to Buddhists, is merely an unforeseen event. Chronic vegetative state patients are in the same category as those who are in a coma, according to medical experts. Buddhist philosophy and modern medical standards clearly show that the patients in this situation are still alive, despite some people's claims to the contrary. When given the correct nutrients, they are capable of surviving for many years. There is no need for life-support equipment for them.

According to the Buddhist view, a person in a persistent vegetative condition is a living human being who has had part of his or her body harmed. Therapy for such a patient should not differ from treatment for any other patient in the clinic or clinic setting. Buddhists believe that a lesion to a physical organ (the brain) causes sentiency (viana), or mental awareness (mano-viana), to stop working or operating in one of its essential modes. For Buddhists, permanent damage to the neo-cortex is no more significant than damage to any other organ in terms of therapeutic ethics.

Patients in a persistent vegetative state should not be denied the basic essentials of life since, according to the Buddhist perspective, all people are deserving of compassion and care, regardless of their physical condition. It is possible to show compassion and love to a patient even if they are completely unaware of it. People have an opportunity to show their support and kindness to them even in the most difficult of circumstances by administering benign therapy.

Euthanasia instances have been reported in accordance with the concept against the destruction or harm of human life (the third parajika; one of the four most serious offences in the monastic code that are punished by lifetime expulsion from the monastic community). A third of the more than 60 deaths in this category were the consequence of monastic medical intervention in some way (priests). Because the patient has had limbs amputated, it's safe to believe this is an instance of mercy killing.

The Buddha introduced this commandment in the monastic rule after noting that some monks had either murdered themselves or demanded that others kill them after developing a hatred for their bodies. The monks' argument that death was preferable to life led the Buddha to broaden the precept's scope.
If a monk is looking for a knife-bringer to help him end his life, or eulogizing death or urging someone to take their own life saying, "My excellent man, what need have you of this wretched, arduous life?"... he is also one who is vanquished [in the religious life]; he does not share in communion with God."

Because Buddhists believe in reincarnation, they accept that death is an unavoidable part of life, and that they will face it several times throughout their journey on earth. The Buddha's serene and attentive dying at the age of 80 was a paradigm for how to deal with death. There are no universally agreed-upon definitions of death, and clinicians should not assume that all Buddhists accept the idea of brain death. In particular, Japanese patients are likely to reject cadaver transplants (transplants from living donors should not pose a problem). However, there is no need to deal with extra issues for patients who are in a persistent vegetative state.

According to the majority of Buddhists, euthanasia is a violation of the First Precept, which prohibits the deliberate killing of one's own kind. This is true even if we are driven by an honest desire to make someone else's life better. The rejection of euthanasia in Buddhism does not imply vialism or the idea that life should be prolonged at any costs; rather, Buddhism conforms to the moderate path (majjhima patipada) stance. The center ground is here. As a result, cutting off medical care while a patient is on the verge of death is not considered unethical on moral grounds.

2.5.4 Islam:

Euthanasia is prohibited among Muslims. Human life is holy because Allah gives each individual a specific amount of time to live. This is something that should be left alone by humans. Euthanasia is prohibited in Islam because Muslims believe that both the body and the soul belong to God. In his Holy Quran digest, Masudal Hasan stated that Islam opposes suicide. Suicide, he argues, is an escape from God's will and demands. "Make not your own hands contribute to your downfall," says the next verse of the Quran. "Avoid self-destructive behavior. Allah is the one who gave you life, and Allah is the one who will take your life."[101]

Islam emphasizes the importance of life and states that one should devote one's life to serving oneself. According to the Quran, we have been given life so that we might serve one another. Quranic verse: "Whoever murders one person without any person being murdered or for causing troubles on earth, kills the whole human race; and one who protects an individual life from death, he saves the entire human race"[102]

The more we know about the role religion plays in society, the less likely a culture is to have a high suicide rate. As Western researchers have acknowledged, Muslims have the lowest suicide rates of any religious group, yet they rarely pin the blame on their faith in Islam. Suicide rates tend to be lower in Muslim countries, where there has been a long history of extreme condemnation of suicide under any circumstances. When it

[101] Kaiser Mahmood, *Difference Between Voluntary Active and Voluntary Passive Euthanasia: An Ethico-Legal Perspective,* Controversies in Clinical Practice, (Dec. 24, 2018, 05:20 PM), http://www.scopemed.org/mnstemps/27/27-1325419743.pdf.
[102] *Ibid.*

comes to managing one's own bio-behavior and internal diversity, religion often provides some sort of open conceptual concepts.

Euthanasia is a hot-button issue because of varying ethical and religious viewpoints. If a terminally ill patient is facing tremendous pain or other types of suffering, can it ever make sense to allow another person to take their life? Certain circumstances may warrant the use of euthanasia. The choice between allowing someone to die naturally and killing them presents a number of ethical concerns. There is a worldwide rush to solve the ethical and practical concerns surrounding euthanasia by developing legislation that does so. The solutions to these issues can be found in a range of philosophical and religious systems. Most Islamic countries, including Iran, have rules and regulations on euthanasia that are based on Islamic law, unlike secular ones that do not (sharia).

Such concerns are viewed as jurisprudential by experts in Iran and other Muslim countries, who look to Islamic law for guidance (Figh). Aside from specialists and authorities, the majority of people in these countries look to Islamic scholars for answers to these kinds of questions and rely on their jurisprudential nature. It is possible to trace Judaism's origins to one of four primary sources: The Koran and the Sunnah are the primary sources of Islamic law. As the Koran is the primary source of Islamic law, the Sunnah, or what the prophet said, did, or agreed to, is also observed. There are three sources: the Ijma, a consensus among Islamic scholars; Qiyas, which means reason or analogy.

Euthanasia in Islam may be found in at least three different Islamic sources: The Fatwas (religious rulings) of Muslim scholars, known as Mufti Al-Aazam in Sunni tradition and Ayatollah Al-Ozma in Shiite tradition, are the second most important source of Islamic judgment. Fatwas on bioethical concerns are important in Islamic society because of their legal nature. Islamic law is heavily influenced by these Fatwas, which are widely accepted by Muslims worldwide. To round things off, Islamic medical ethics guidelines have arisen as a result of discussions and consensus among Muslim doctors and intellectuals.

The Holy Koran, Fatwas, or religious rulings of Great Muslim scholars, and other documents including rules, regulations, and scientific publications are the main sources of this discovery.

There are two basic types of passages in the Koran: These lines highlight the sacredness of life. Only the lines "Do not kill life, which Allah made holy, other than in the pursuit of justice" are cited in connection with these passages. According to the Quran, verse 17:33: Unless the victim is committing murder or causing mischief, killing one person results in the death of the whole community.

Allah has decreed that no one can die unless he or she receives his or her final blessing. According to the grand mufti of Saudi Arabia, the practice of euthanasia or mercy killing (the removal of life-supporting equipment) is forbidden in Islam. According to Sheikh Bin Baz, the head of Saudi Arabian's top jurisprudence committee, the death sentence is against Sharia and should not be decided. In accordance with Islamic medical ethics, to protect life, a physician should recognize and not go beyond his or her limit, according to the Muslim Code of Medical Ethics, which was released during the First International Conference on Islamic Medicine in Kuwait in 1981. Deep-freezing a patient or keeping him or her alive in a vegetative state is pointless if the patient's life cannot be revived. Patients' lives should be extended as much as possible, not sped up. The doctor will not put the patient's life at risk no matter what he or she does. Two articles of "The Islamic Code for Medical and Health Ethics" deal with euthanasia and physician-assisted dying. It's now 61 paragraphs into the book. Islamic beliefs and the text of the law prohibit wasting a person's life. This is not a question for the medical community to address. It's against medical ethics for a doctor to actively participate in ending the life of a patient, no matter how severe the deformity is, how hopeless the disease is, or how excruciating the pain is. Even if the patient's guardian asks for it, a doctor should never actively participate in the death of a patient. The intentional demise of a person who voluntarily desires the termination of his or her life. One example of mercy murders is the purposeful death of newly born babies with deformities that might jeopardize their life.[103]

[103] Mahmud Adesina Ayuba, *Euthanasia: A Muslim's Perspective*, Scriptura 115 (2016:1), pp. 1-13.

Islamic law does not recognize a person's right to die voluntarily, based on a reliable reading of the Koran. It is possible to summarize Islam's position on euthanasia in two ways. Euthanasia and suicide are forbidden in Islam because Allah chooses how long each of us will live, as two texts make clear. According to Islamic teachings, a person's active or passive engagement in voluntary activities cannot bring about their demise. All Islamic scholars, Sunni or Shiite, agree that active euthanasia is forbidden (Haraam).

People should not try to hasten up or slow down the ajal (death), which is fully in the hands of Allah. The ban on life applies equally to acts of self-sufficiency, murder, and genocide. This is because of two things: a scarcity of personal agency and freedom to make one's own decisions. Taking a human life has far-reaching ramifications for the families involved, not to mention society at large. Freedom of choice is restricted when an individual's activities cause harm to others.

Mercy killing is a crime in Islam, hence proponents of euthanasia's viewpoint can't be defended by stating other factors like economics, resource considerations that may be used by other patients, or even dying with dignity. A brain-dead individual's life support system can, of course, be shut off in order to save the life of an actual person. Everything in life, according to Islam, belongs to Allah, thus the conclusion is obvious. Life and death can only be bestowed or taken away by God. Humans are unable to give or accept it. Muslims are against euthanasia. Every human life is revered by these people, who believe it is sacred since it is placed upon us by Allah, who also determines how long we live. There is no need for humans to become involved.

Passive assistance in permitting a terminally ill patient to die is permitted under Islamic law in the following two situations: one relieving pain and suffering, as well as withdrawing a futile treatment with the patient's informed consent (the patient's closest family members acting on medical experts in charge) to allow death to proceed naturally, are two common methods for dealing with pain and suffering.

If it is medically assumed that a patient has gone away due to brain death, it may be feasible to cut off the patient's life support equipment with adequate consultation and care. Transplanting organs and tissues are standard procedure in Iran and other Muslim nations. Islam teaches that those suffering from terminal dementia should be treated as entire human beings and their lives should not be terminated because of their fear of dying.[104]

2.5.5 Sikhism:

Sikhs hold life in great regard, considering it a gift from God. The time of birth and death should be left in God's hands, according to most Sikhs, who oppose euthanasia.[105]

The Sikh Gurus viewed suicide as an encroachment on God's purpose, and so condemned it. Eastern religions believe that human suffering is an inevitable part of karma and that it should be tolerated without complaint. This is not a given.

Even though life is given to us by God, Sikhism stresses the need of living responsibly and treating others with dignity. Euthanasia is something Sikhs must consider whether contemplating for themselves or someone else, and they must discern between putting someone out of their misery and not prolonging their suffering.

Secular practitioners of Sikhism who do not abide by the teachings of Guru Granth Sahib and Amrit are not regarded true Sikhs by the Sikh community. Meditation on God's name, hard labor, giving back to the community, and service to mankind are all part of Sikhism's path of self-sacrifice.

Sikhs believe that there is only one God, who is the source and creator of everything. The Guru Granth Sahib's descriptions of God's character qualities have inspired countless names for the Almighty. Waheguru is the name given to God among Sikhs. The term Waheguru is used here to convey thankfulness and gladness toward God and

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[104] *Ibid.*

[105] Shanmukh Kamble et al., *The acceptability among young Hindus and Muslims of actively ending the lives of newborns with genetic defects*, Journal of Medical Ethics, Vol. 40, No. 3 (March 2014), pp. 186-191.

His creation. Only one God, the everlasting truth and the originator, exists. He is fearless, devoid of malice or animosity, eternal, and self-existent in the divine spirit he embodies.

The relationship between the Creator and the created is one of love and affection. In spite of the fact that God does exist, the universe is only a temporary manifestation of His essence. It is God's expectation that all spiritual beings are completely in tune with and obedient to His will and commands.

It is forbidden in Sikhism to carry out acts of mercy killing or euthanasia. Pain management and medical care are important to address the problem. A doctor cannot end the life of an individual. If a physician is unable to treat an inoperable patient, they must not kill it. Suicide is strictly discouraged in the Sikh faith. We all have to learn to deal with the good and the bad that come with being human. Take these benefits from God with a smile on your face.

The Sikh moral code is built on these two texts (Rehat Maryada). Suicide and euthanasia were severely forbidden by the Sikh Gurus because they interfered with God's plans. Accepting this truth and moving on with one's life is the only way to go on. To put it simply, in Sikhism, euthanasia should be considered an unappealing choice for individuals who are terminally ill because of the involvement of loved ones and friends in the decision-making process.

In accordance with the preceding declaration, any kind of artificial death, including suicide, assisted suicide or euthanasia, is forbidden by all of the faiths mentioned. In the Sikh faith, life is regarded as a gift from God, and they respect it as such. Some Sikhs believe that the timing of one's birth and death should be left to God, and as a result, they are opposed to assisted suicide and euthanasia.

According to Sikhism, a person's time on earth should not be wasted on wicked deeds. Helping people who are oppressed and destitute should be its primary goal. In Amritsar, Punjab, the Bhagat Puran Singh orphanage cares for hundreds of disabled children

rather than putting an end to their lives. Sikhism teaches self-respect and dignity as a way to ensure that individuals who are less fortunate have a feeling of belonging and self-worth in their lives.

2.5.6 Christianity:

In general, Christians oppose assisted suicide and euthanasia because they believe that these practices violate God's holy boundaries of life and death and present additional ethical dilemmas.[106]

The purposeful choice to kill an innocent human being is always ethically wrong and can never be justified either as an end in itself or as a means to a better end. As a matter of fact, it is a severe act of disobedience toward the moral law and to God, the originator and guardian of that law, which opposes the essential virtues of justice and mercy.[107]

A dying person should be allowed to die peacefully, without the need for any unwanted or invasive treatment. The Church, on the other hand, deems it morally reprehensible since it is a deliberate act on the part of an individual to cause his or her own death or the death of another, when it otherwise would not have occurred.[108]

2.5.7 Judaism:

The preservation of human life is regarded as one of the highest moral virtues in Jewish tradition, and hence it is forbidden to do anything that can shorten it. However, this does not necessitate doctors to prolong the natural course of death.[109]

Religion and law have long thought that human life is precious and deserves to be protected and cherished in some way. The right to die or take one's own life is not a modern or novel concept. There are several faiths, such as Hinduism and Jainism, that support the practice of suicide in certain situations while condemning it in others. It is

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[106] *Euthanasia and Christianity: Christian Views of Euthanasia and Suicide*, (Mar. 16, 2018, 10:32 PM), http://www.religionfacts.com/euthanasia/christianity.htm.
[107] Chesterman Simon, *Last rights: euthanasia, the sanctity of life, and the law in the Netherlands and the Northern Territory of Australia*, International and Comparative Law Quarterly, 1998: Pope John Paul II, *On the Value and Inviolability of Human Life* (*Evangelium Vitae,* 25 Mar. 1995), para.57.
[108] Harakas Rev. Dr. Stanley S., *The Stand of the Orthodox Church on Controversial Issues*, (Mar. 16, 2018, 10:50 PM), http://www.goarch.org/ourfaith/ourfaith7101.
[109] *Supra* note 36, at 10.

unclear how Buddhists feel about death, although they have pushed people to take their own lives in the sake of religion and nation in the past. Both the Old and New Testaments do not clearly prohibit suicide. Suicide, in Christianity, is regarded as a murderous act. The Quran, on the other hand, considers it a crime worse than murder. The preservation of human life is regarded as one of the highest moral virtues in Jewish tradition, and hence it is forbidden to do anything that can shorten it. However, doctors are not required to prolong death over its natural timetable. Laws of Judaism
Because our lives are not ours to control, tradition holds that it is unlawful for anybody to shorten a human life; this is due to the fact that our lives are not ours to control. According to Jewish teachings, every human being is fashioned in the likeness of God, hence all life has incalculable worth, regardless matter how short or long it may be.
Judaism teaches that one must strive until one's final breath. As long as one has the ability, one should enjoy life to the fullest and give gratitude to God.

Euthanasia is illegal in Jewish law, which considers it a form of murder. Even if the individual in question desires to die, this rule does not change. It is morally wrong to cut a person's life short, even if it's just a few months away from death. It is impossible to put a value on human life since it is endless and indivisible, such that any part of it, even an hour or a second, has the same value as seventy years of it. Even if a patient expresses a desire for the doctor to end their life, Jewish law mandates that doctors do all in their power to keep their patients alive. There is still work to be done. Doctors have some latitude when treating patients who are nearing the end of their lives. Despite the fact that doctors cannot speed up death, they can remove "everything which is stopping the soul from going" from a patient who is nearing the end of their life.

If something constitutes an impediment to the natural process of dying and the patient only survives because of it, it is permissible under Jewish law to remove it. It is therefore permitted to turn off the ventilator if the patient is certain to die and is only being kept alive by a ventilator, as it is obstructing and becoming an impediment to the natural process of dying.

A dying patient should not be kept alive by artificial means if the therapy does not cure the sickness, but just extends the patient's life for a short period of time, and the patient suffers in extreme agony as a result. Pain medication can be administered even if it hastens death, provided the amount is not likely to kill and the purpose is not killing, but rather the alleviation of pain and discomfort. Because no one has the right to kill oneself, even a terminally sick person in excruciating suffering cannot hasten his or her own demise.

3.4 Passive Euthanasia: Ethical Perspectives

Ethicists use prayopavesa as a case study to demonstrate the concept. Indian Hindu guru Sivaya Subramuniyaswami, born in California, made a prayopavesa commitment in November 2001. A few days after learning he had an incurable kind of intestinal cancer, the Satguru decided to stop all other forms of treatment and begin the practice of prayopavesa, which entailed merely drinking water and abstaining from eating or drinking anything else. He had been on a 32-day fast when he died. Ultimately, there are two Hindu opinions on euthanasia: You will enjoy the rewards of your good deed or karma if you help someone end their terrible existence. On the other side, euthanasia interferes with the timing of reincarnation, which results in bad karma for both the doctor and patient.[110]

To put it another way, the name "euthanasia" is derived from the Greek terms "eu" for "good" and "thanos" for "death" and means "happy death" in English. Mercy killing, as it is commonly referred to, relates to the legal and medical meaning of 'terminating or ending the life of an individual who suffers from an incurable ailment or circumstance that is extremely unpleasant'. To use a popular phrase, euthanasia is the deliberate death of a human being whose life is judged to be useless as a result of some action or inaction.

Second, euthanasia has been classified into two categories based on the method of death:

[110] Achal Gupta, *Euthanasia: Indian View*, The SCC Online Blog, (Apr. 10, 2020, 10:50 PM), https://www.scconline.com/blog/post/2020/11/28/euthanasia-indian-view/.

Passive ways of euthanasia: It is referred to as "turning off the lights" and leaving the body to die on its own. Patients are put to sleep via the aforementioned method when there is minimal possibility of them being resurrected, and this is merely done to allow them to die quietly. When this method is used, discontinuing life support, stopping food and water, or allowing natural death from dehydration is not an option (cardio-pulmonary-resuscitation). Active Euthanasia refers to the practice of ending the life of a suffering individual who serves no use in this world. A lethal injection of sodium pentothal, for example, can be given to a patient to hasten their demise.[111]

There are three sorts of euthanasia based on whether or not the patient has given their consent:
This refers to circumstances in which the patient chooses to die on his or her own own. In order to end their suffering, the patient asks euthanasia either verbally or in writing. As a result, if the patient so desires, both passive and active euthanasia are permissible. In cases where the patient does not have the mental ability to consent, this type of euthanasia is carried out. This approach can also be used to test for HIV in patients who are in a coma or have died naturally.
Euthanasia is a form of non-voluntary euthanasia if a competent individual refuses to consent to the procedure. Without a doubt, this was an act of homicide.

In palliative care, a physician administers the appropriate dose of a lethal medication at the patient's request, prescribing or administering it as necessary. "Aid in Dying" is a term for this Injecting or inhaling the lethal dosage might be done by the individual, or the same can be delivered to the patient.

Patients who are in a "permanent" vegetative state are unable to perform fundamental human tasks on their own and necessitate the use of any or many life support equipment as well as the aid of other individuals, as defined by the phrase "permanent vegetative state" (such as family members, doctors or medical staff). An incurable and irreversible

[111] *Ibid.*

illness or condition that has been medically shown to lead to death is referred to as a "terminal disease."

People who are nearing the end of their lives and do not want any further medical treatment might leave instructions in their "living will," which is another name for this directive. If this teaching is to be taken seriously, it must be given by someone who is willing, competent, and knowledgeable.

However, the medical establishment as a whole is not unified in its opposition to euthanasia. Medical ethics and regulations are vehemently opposed to the practice. There are several medical ethics arguments to favor or oppose euthanasia, according to medical ethics. Whether or whether it's legal or practicable is still up in the air. Considering that doctors are ultimately in charge of providing a "dignified death," it is critical that medical ethics be thoroughly discussed.

These two ideas, "sanctity of life," "conception of death," and the current circumstances are mutually exclusive and incompatible. 'Sanctity of life' argues for the protection of life till natural death, regardless of situation. The "idea of death" has two sub concepts: one for the individual and the other for the organism. Death of an organism is different from death of an individual because the fundamental organs and systems of an organism fail to function together, which is in essence irreversible (respiratory, circulatory, immune, etc.).[112]

In India, euthanasia was also practiced in the nineteenth century. People like Veer Savarkar and Vinoba Bhave are well-known instances of those who chose to end their lives by refusing to eat. Mahatma Gandhi reportedly advocated for homicidal suicide. In other words, his actions, not his name, earned him the title of Mahatma Gandhi. A non-violent way of life, including fasting to purify one's soul and dying in service to a good cause were among his many beliefs for the remainder of his life. He utilized his own fasting-to-death habit as a means of self-promotion.

[112] Achal Gupta, *Euthanasia: Indian View*, The SCC Online Blog, (Apr. 10, 2020, 10:50 PM), https://www.scconline.com/blog/post/2020/11/28/euthanasia-indian-view/.

CHAPTER 4

PASSIVE EUTHANASIA IN INDIA: CONCEPT AND PROVISIONS

4.1 Introduction

When medicine and medical technology did not have the ability to artificially keep a terminally sick patient alive by medical care, including by means of ventilators and artificial nourishment, people in this condition were left to die of natural causes. This was the case one hundred years ago. As was the practice in bygone years, a terminally sick person has the common law right to refuse to have any further contemporary medical operations performed on them and instead let nature run its course, as was the case in earlier times. It is well-established law in every nation that a terminally ill patient who is conscious and is competent can make an "informed decision" to die a natural death and direct that he or she not be given medical treatment that may merely prolong life. This decision allows the patient to direct that he or she not be given treatment that could only serve to prolong life. There is now a significant number of patients who have progressed to the point in their sickness where, in the view of a knowledgeable group of medical professionals, there is no possibility that they will recover. However, advances in medical science and technology could one day make it possible for individuals in this situation to artificially extend their lives for no good reason; over this extended period of time, patients might be subjected to excruciating agony and anguish. A number of these individuals would to get palliative care for the purpose of alleviating their pain and suffering rather than receiving medical therapy that would only prolong their lives or put off death.

4.2 Passive Euthanasia: Definition and Concept in India

When patients and their families can no longer afford to continue life-prolonging therapy because of its high cost, passive euthanasia is becoming more commonplace at the county's hospitals. The commercial health industry in India would make a fortune

off the old and crippled if euthanasia is legalized, as many of them would otherwise die while waiting for expensive medical treatment.[113]

"Passive euthanasia" refers to the purposeful cessation of medical care in order to expedite a terminally ill patient's death, as the Supreme Court explained in its ruling on Aruna Shanbaug's case.[114]

In the words of several medical and legal dictionaries, the act of hastening the death of a terminally-ill patient by changing some type of support and allowing nature to take its course is known as passive euthanasia. There are several ways to passively euthanize a patient, including shutting off respirators, withdrawing medicines, and discontinuing food and drink. Even though morphine is known to cause deadly breathing issues, it is possible to provide high dosages of the painkiller as a form of passive euthanasia.[115]

4.3 Passive Euthanasia: Right to Life and Right to Die

Article 21 of the Indian Constitution ensures the right to life and liberty of every citizen. Individuals and citizens alike have the right to carry out their lives and maintain their personal freedom, until such rights are revoked through a legal process created or specified by law. This sentence's grammatical structure makes it look bad, but legal readings reveal that it expresses many of society's beneficial traits. It is strong. Article 21 of the Constitution has a plethora of basic rights, all of which are encouraged to grow, prosper, and thrive. It's important to look at these essential human rights in light of the Indian constitution's rules on human dignity and whether or not to take treatment. However, even though there is a substantial body of law supporting this, the idea that any act that interferes with or impedes the Constitutional Rights of Indian individuals has long been established.[116]

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[113] Airedale N.H.S. Trust v. Bland, (1993) 2 WLR 316.
[114] Aruna Ramchandra Shanbaug v. Union of India and others, 2011 AIR (SC) 1290.
[115] *What is passive euthanasia?* NDTV, (Jan. 25, 2019, 08:15 PM), https://www.ndtv.com/india-news/what-is-passive-euthanasia-449280.
[116] S Balakrishnan and RK Mani, The constitutional and legal provisions in Indian law for limiting life support, IJCCM 2005 Volume 9 (2) 108-114, (Apr. 01, 2019, 09:10 PM), http://www.ijccm.org/article.asp?issn=0972-5229;year=2005;volume=9;issue=2;spage=108;epage=114;aulast=Balakrishnan.

Article 21 of the United Nations Declaration of Human Rights outlines a basic inherent right: the right to live in safety and dignity. It is a process, the termination of life, the extinction of existence for individuals who choose suicide as a means of ending their lives. Suicide is incompatible and conflicting with this idea in terms of the concept of dignity, and the right to die concept together with dignity are relevant principles, even though the "right to life" involves not permitting suicide. It is the role of the state to ensure the health and well-being of its population while also improving the state's healthcare infrastructure.

4.4 Passive Euthanasia: Suicide

The practice of assisted suicide, often known as passive euthanasia, is legal in nearly every country. Most nations prohibit the practice of active involuntary euthanasia. Most nations consider active voluntary euthanasia to be criminal murder and so prohibit its use.[117]

4.5 Passive Euthanasia: Right to Refuse Treatment

There has been widespread recognition and acceptance in the past of the right of patients to refuse or reject treatment, but the acceptance of this even in official documents such as the Patient's Charter is still in its infancy. As much as it may be welcomed, the power to end the lives of patients through euthanasia should not be taken as license to murder them. Many contemporary medical law and ethics specialists tend to assume the polar opposite, making it seem as though arguing for what appears to be an obvious point is a waste of time.[118]

It is the role of the state to ensure the health and well-being of its population while also improving the state's healthcare infrastructure. However, physicians have an obligation to provide excellent medical treatment, but to avoid harming or neglecting patients at the same time. The right of a patient to cease, reject, or refuse medical treatment is an

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[117] *Passive Euthanasia-A Relook*, Law Commission of India Report No. 241, August 2012, (Jun. 23, 2019, 08:15 PM), https://lawcommissionofindia.nic.in/reports/report241.pdf.

[118] Susan L Lowe, The right to refuse treatment is not a right to be killed, Journal of Medical Ethics, 1997 23: 154-158, (Mar. 28, 2018, 05:45 PM), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1377341/pdf/jmedeth00308-0028.pdf.

important one in this situation. When it comes to life-saving and life-prolonging therapies, the freedom to reject or refuse medical treatment has been firmly established in the law for some time now. An example of someone who refuses treatment is someone with blood cancer who refuses chemotherapy or nasogastric tube feedings. By giving patients the option to decline or reject medical care, passive euthanasia has been made possible. For others, medical abortion before 16 weeks of pregnancy is also a type of active involuntary euthanasia, which is why it's legal.[119]

Patients who are in a life-threatening situation have the option to refuse or reject treatment because they have the right to do so. In the event of a witness, it is vital to obtain the patient's rejection. The witness must sign the document stating that they refused to testify. As refusing to consent to a life-saving procedure will invalidate the surgery or treatment, it is often in the patient's or authorized representative's best interest to inform the hospital administrator about the non-performance of the procedure and permit the administrator to take appropriate action. It is against the law to force an adult patient to remain in a hospital against his or her consent. There needs to be an official record of a patient's request to be discharged from the hospital regardless of medical advice, as well as his signature.[120]

4.6 Passive Euthanasia and Law Commission of India[121]

4.6.1 The 35th Report of the Law Commission on Capital Punishment, 1967:

In 1967, this report examined the question of capital punishment and recommended that the death sentence be retained in India. Lethal injection and some kind of euthanasia were suggested as execution methods by medical professionals.

4.6.2 The 42nd Report of the Law Commission on the Indian Penal Code, 1971:

[119] Suresh Bada Math and Santosh K. Chaturvedi, Euthanasia: Right to life vs right to die, IJMR 2012 Dec; 136(6): 899–902, (Mar. 20, 2019, 07:00 PM), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3612319.
[120] Ajay Kumar et. al., Consent and the Indian medical practitioner, IJA 2015 Volume 59 (11) 695-700, (Apr. 01, 2019, 09:10 PM), http://www.ijaweb.org/article.asp?issn=0019-5049;year=2015;volume=59;issue=11;spage=695;epage=700;aulast=Kumar.
[121] Law Commission of India, Ministry of Law and Justice, https://lawcommissionofindia.nic.in.

Questionnaire about the amendment of the Indian Penal Code regarding offenses affecting the body, in which it was asked: Should euthanasia, also known as mercy killing, be exempted from penalty either as murder or as abetment of suicide?

“Euthanasia” legalization has been a hot-button issue in recent years. This study, written in 1967, investigated the issue of capital punishment in India and recommended that it be maintained. Medical experts have recommended lethal injection and euthanasia as execution procedures, and the concept of “mercy killing” has piqued the interest of attorneys, moralists, medics, and the general public. Is responsible murder a crime if a person is put to death because he or she is in physical pain or because his or her existence has become pointless due of his or her physiological condition?

The overwhelming majority of responses to this topic express strong opposition to criminalizing euthanasia. Those who oppose legalizing euthanasia point out that in order to prevent misuse, it will be nearly hard to tell the difference between a true instance of compassion killing with agreement and a case of murder, and that these practical reasons must take precedence over humanitarian ones. Those in favour of exemption argue that a person in excruciating pain due to an incurable illness or another cause should not be compelled to suffer any longer. They believe that euthanasia should be legal if there are sufficient protections in place, such as certifications from two medical officials and the written agreement of the patient in front of witnesses.

It is not advised that euthanasia be legalized at this time. Research has led Commission to the conclusion that it is not advisable to include a clause that completely exempts euthanasia from criminal culpability, given the current climate of public opinion on the issue. The charge of murder has been downgraded to one of culpable homicide that does not amount to murder in the eyes of the law. A court may also impose short penalties when necessary for the second type of offense, because of the vast variety of punishments available for that particular infraction. As a result, the law is flexible and a complete immunity from responsibility is unlikely at this time. If public opinion shifts in favour of legalizing mercy killing, the issue may be revisited.

4.6.3 The 156th Report of the Law Commission on the Indian Penal Code, 1997:

The second session focuses on offences related to human body in which Andhra Pradesh's High Court Advocate Shri Pattabbi argued that the theft of human organs that results in death should be incorporated within S. 299 of the IPC at least to scare human organ thieves. To him, strengthening sentences under Section 304-A of the Indian Penal Code would be an injustice in a society where defendants are often found not guilty. S. 304-A IPC increase would be nothing more than a piece of paper, according to his argument. In his opinion, he observed that S. 498-A IPC was frequently used to persecute honest spouses, and that the provision should be renamed to better protect these men. On the basis that euthanasia (mercy killing) is not legal in India, he stated that S. 309 IPC should remain unchanged. As far as he was concerned, there is no need to change Section 306 of the IPC.

4.6.4 The 196th Report of the Law Commission on the Medical Treatment to Terminally Ill Patients (Protection of Patients and Medical Practitioners), 2006:

Indeed, almost everyone has wondered about whether or not this study intends to legalize "euthanasia or assisted suicide." As a consequence, in the first paragraph of Chapter 1, it has been written: Euthanasia, assisted suicide, or euthanasia are all terms that come to mind when reading the title of this report. Although euthanasia and assisted suicide continue to be illegal, this report is dealing with a separate subject 'withholding life-support measures' to patients who are terminally ill, which is considered uniformly in all nations as 'lawful'."

Assisted suicide differs from "euthanasia" in that it is performed by the patient with the help of a doctor, whereas "euthanasia" is performed by anybody, including doctors, who purposefully kills a dying patient by administering medications. According to our Supreme Court decision in Gian Kaur v. Punjab (1996 SCC 648) they are unlawful and will continue to be so.

Withdrawal of life support is not the same as euthanasia or assisted suicide, and should not be confused with such practices. First and foremost, "removal of life-support" is not the same as euthanasia or assisted suicide, which are both illegal in the United

States. The issue of removing life support from people who have been very ill or in a coma for an extended amount of time has piqued the interest of legislators throughout the world. In certain nations, there exist legislation, as well as guidelines issued by many medical councils and a considerable number of court decisions. Many law commissions have issued reports on the topic, and there is a plethora of information available.

S. 309 of the Indian Penal Code states that attempting to commit suicide is an offense, whereas S. 306 states that aiding or abetting suicide is an offense. S. 107 of the Penal Code defines "abetment" on its own.

For the purpose of alleviating the anguish of an incurable sickness, "euthanasia" refers to the act of murdering someone painlessly. The term "mercy-killing" is another term for this practice. In "assisted suicide," a doctor helps a patient end his or her life by administering medications at the patient's request when the patient is unable to bear the suffering on his or her own. "Euthanasia" and "assisted suicide" are illegal in the United States and many other nations (with a few notable exceptions).

Euthanasia and assisted suicide should remain criminal crimes in our country, according to this report. So, the scope of the investigation is limited to evaluating the different legal concepts applicable to "withdrawal of life-support measures" and suggesting how and when the medical profession may make choices about withdrawing life-support if it was in the patient's "best interests." A further dilemma emerges as to whether a patient might refuse treatment and ask for the withdrawal or denial of life-support measures, provided it is an educated choice. "The patient," in this context, must be given appropriate protection so that physicians' decision-making process is not exploited or manipulated by any party, including the patient, the patient's family members, or even the doctors or hospitals who are treating him or her. No guidelines seem to have been set by the Indian Medical Council. According to the Law Commission's 42nd Report, attempting to commit suicide should no longer be a crime.

Scientific and technological advancements and new ideas in the field of brain-stem death; and second, in India, euthanasia and assisted suicide are criminal offenses, while withholding or withdrawing life-supporting systems are not. Doctors are bound by adult patients' right to refuse treatment if they are making an informed decision. It is abuse or even murder to administer intrusive medical therapy against the will of a patient. Because the state has an interest in safeguarding life and upholding the ideal of human dignity, advance directives such as "living wills" and "durable powers of attorney" are not recognized in the United States. It is not an "attempt to commit suicide" to refuse medical care, and it is not a "abetment of suicide" for a doctor to withhold or remove treatment. Incompetent patients, "informed judgment" and "best interests" of patients, consultation with a group of three specialists before therapy is withheld or terminated. A court can give a declaration that invasive medical treatment is permissible under the facts of a particular instance, if the circumstances warrant it. The Court's pronouncement does not shield the doctor from civil or criminal action in any later lawsuit, civil or criminal. In certain situations, palliative care may have an unfavorable effect on a patient's health, yet it can be offered to alleviate pain and suffering. In collaboration with specialists and the Indian Society for Critical Care, the Medical Council of India has issued new guidelines for the treatment of critical illness.

Professional Conduct, Etiquette and Ethics of Indian Medical Councils (Regulations of 2002): Code of Medical Ethics where Regulation 1.1 deals with a physician's personal qualities and conduct. A physician, according to this code, is expected to protect the sanctity of the medical profession. In the medical field, the primary goal is to help people. Regulation 1.2 focuses on the need of maintaining high standards of medical care. It asserts that the basic tenet of a medical practitioner is to provide care to the public while upholding the dignity of both the profession and the individual. Patients put their trust in doctors, and doctors should repay that trust by providing unwavering service and commitment to their patients. Chapter 6 focuses on unethical behavior. "A physician shall not help or abet or conduct any of the following activities which shall be viewed as unethical," it adds. Regulation 6.7 states that "euthanasia" is morally wrong.

Euthanasia will be considered unethical behavior. However, a team of experts, not only the treating physician, will make the decision about whether to remove cardio-pulmonary support systems even after brain death in some circumstances. A medical team will formally announce the end of the patient's life support. According to the regulations of the Transplantation of Human Organ Act, 1994, "the team should include the patient's doctors, the Chief Medical Officer/Medical Officer In-charge of the hospital, and a doctor selected by the in-charge of the hospital staff."

There are many issues to consider when determining whether a patient is competent or incompetent, what is meant by "informed decision," what is meant by "best interests," and whether a patient's relatives, doctors, or hospitals can petition a court of law to declare that a doctor's actions are lawful, and whether such decisions will be binding on the parties and doctors, in future civil and criminal cases. If you refuse treatment, you may be charged with suicidal attempt, but you may also be charged with aiding and abetting, which does not amount to murder.

Patients who refuse medical assistance such as artificial feeding and hydration because they are terminally sick should be protected by law from being charged with the crime of "attempt to commit suicide" under Section 309 of the Indian Penal Code, 1860. Moreover, doctors (and those who act on their behalf) who follow the informed decision of a competent patient are also needed to be protected, as are those who decide that medical treatment should be withdrawn or withheld from incompetent patients or competent patients whose decisions are not informed decisions. So that medical professionals, including doctors, and those who work for them, can avoid charges of "abetment of suicide" under Indian Penal Code, 1860 Sections 305 and 306, as well as culpable homicide, which does not amount to murder under Section 299 read in conjunction with Section 304, as well as civil actions, it is necessary to declare such actions by doctors to be "lawful" by statute.

4.6.5 The 210th Report of the Law Commission on Humanisation and Decriminalisation of Attempt to Suicide, 2008:

The phrase “suicide” (felo de se) refers to the intentional killing of one’s own life by a man of legal drinking age and sound mind. Suicide is an act of taking one’s own life deliberately or purposefully. Euthanasia and compassion killing must be separated from suicide. For suicide to be considered a kind of self-destruction, it must be done without the aid or support from any other human being or entity. On the other hand, euthanasia entails the involvement of another human being in order to bring an end to the life. Homicide, including euthanasia, is against the law unless an exception is made. Attempts at mercy-killing are not suicide attempts, at least on the face of it.

Suicide happens at all ages, according to the Law Commission’s recommendation. A person’s life is a gift from God and only he can take it away from them. Any civilization would be outraged if it were terminated prematurely. However, it would be harsh and unreasonable to penalize a person who has attempted suicide because he or she has not succeeded in taking one’s own life. Attempting suicide is the only way he can cope with his terrible depression. Suicide attempts are more indicative of a mental illness that needs to be treated and cared for rather than punished. Inflicting extra-legal penalty on someone who has already endured misery and humiliation as a result of his failure to commit suicide would be unjust and unfair.

As a rule, criminal law should only be used when it can be proven to be an appropriate and effective tool for eradicating the desired evil. S. 309 of the Indian Penal Code imposes a twofold penalty on anybody who attempts to take their own life because they are tired of living it. For people who have tried suicide, S. 309 is an impediment to better access to medical care and the prevention of suicides. Inflicting punishment on a person who decides to commit suicide because of family strife, poverty, the death of a beloved relative, or any such reason is unjustified. People in this situation deserve sympathy, counseling and appropriate treatment, and not incarceration, in this scenario.

It does not matter if S. 309 is constitutional or unconstitutional; it’s a cruel provision that should be removed from the books. S. 309 of the Indian Penal Code should be repealed to save lives and alleviate the suffering of the afflicted. It is the Commission’s opinion that while urging or aiding another person to commit suicide should not go

unpunished, the offence of attempted suicide under S. 309 should be deleted from the Indian Penal Code.

4.6.6 The 241st Report of the Law Commission on Passive Euthanasia-A Relook, 2012:

The Supreme Court has legalized passive euthanasia, which is the withdrawal of life-sustaining measures, with the proviso that the High Court's authority must be obtained in the instance of an incompetent patient. The procedure for bringing a case to the Supreme Court has been established. The patient and his or her family members should be informed of the formation of an advisory committee of three medical professionals by the High Court. The Supreme Court has long been considered as the country's "parens patriae."

The Law Commission agrees with the previous Law Commission and the Supreme Court that passive euthanasia should be legalized under certain limits. Doctors who sincerely act in the best interests of terminally ill patients would be protected by a new rule. There is a consensus among the Law Commission members that the Supreme Court is right on the protections. As a result, we've adopted the 17th Law Commission's 196th Report suggestion on the structure and composition of the medical advisory panel. Legislators from the 17th Law Commission have produced a law named "The Medical Treatment of Terminally Ill People (Protection of Patients and Medical Practitioners) Bill 2006" while supporting the practice of removing life-sustaining measures from dying patients. Before shutting off life support equipment, attending clinicians have been advised by the Commission on the safeguards they should take. Patients who are capable of making their own decisions have the right to withdraw from medical treatment and doctors cannot force life support equipment on an unwilling patient, according to the Commission. The Supreme Court of India has ruled that refusing life-saving medical treatment is not against the law in India. The Aruna case, (2011) 4 SCC 454, dealt with non-voluntary passive euthanasia of a patient who was unable to make her own decisions, such as a coma or PVS. Airedale NHS Trust v. Bland, 1993 AC 789, a House of Lords case in which the "best interests" factor was awarded primacy over all other reasons, was prominently cited by the Law Commission (196th Report). In

view of Article 21 of the Constitution, there are further arguments for passive euthanasia.

When specific criteria and protections are met, passive euthanasia is permissible even without law (vide para 39 in Aruna case). To put it simply: in active euthanasia, something is done to bring about the patient's death but in passive euthanasia, nothing is done that may have saved the patient's life. This difference was made by the Supreme Court. As the learned Judge in the Aruna case put it, "the physicians are not deliberately murdering somebody; they are just not rescuing him". When it comes to saving another person's life, we typically acclaim the hero, but we don't normally blame the villain. Even though there is considerable discussion over whether active euthanasia should be lawful, the Supreme Court made it clear that passive euthanasia could not be questioned since "one cannot imprison someone for failing to preserve a life."

Non-voluntary and voluntary passive euthanasia are further subclassified. Voluntary euthanasia is a form of euthanasia in which the patient's permission is sought. Euthanasia that does not need the patient's agreement is known as "non-voluntary" euthanasia. The Supreme Court then stated, "although there is no legal difficulty in the instance of the former, the latter presents a number of issues, which we shall consider". Because the patient was in a coma, the Supreme Court was worried about a case of non-voluntary passive euthanasia.

The Law Commission and Supreme Court's views on "passive euthanasia"

Both terminally ill patients who are competent and those who are incompetent are supported by the Law Commission of India in its 196th Report. It is the responsibility of the attending physician to consult with three recognized medical experts whose names are on the panel before making a decision on an incompetent patient. Then, he must wait 15 days before stopping or reducing medical care, including life-support equipment, if necessary. By allowing the patient or his or her guardian, if present, 15 days to file an original petition with the High Court, a determination might be made about whether the medical practitioner's/plan hospital's to refuse treatment is legal or illegal. High Court rulings are binding on all parties and have the effect of shielding the

doctor or hospital from any civil or criminal culpability. Passive euthanasia has received the mark of approval from the Supreme Court in the Aruna case, subject to the restrictions outlined in the ruling. The Supreme Court's approach to safeguarding differs from that of the Law Commission. High Court authorization must be requested by close family members, friends, or doctors/hospital workers caring for incompetent patients, as stated in Aruna case of India's Supreme Court. After consulting with medical authorities, the High Court should ask a panel of three specialists to provide their view on such an application. It is up to the High Court to render its decision based on the report and the preferences of family members or friends in a similar position. As stated in paragraph 135, "the foregoing approach should be followed all throughout India until Parliament creates laws on this matter." "We are putting down the law in this connection which will continue to be the law until Parliament creates a legislation on the topic," the learned Judges declared.

Recommendations

There should be legal recognition for "passive euthanasia" in India, according to the 17th Law Commission of India and the Supreme Court decision in the Aruna Ramachandra case9. In legal and constitutional terms, it is not unacceptable. An adult patient who is capable of making his or her own decisions has the right to demand that he or she not be subjected to invasive medical treatment by way of artificial life-sustaining measures/therapy, provided that the doctor is satisfied that the patient has chosen a "informed decision." There will be no exception for patients under 16 years old, as long as one of the patient's parents or guardians has given their permission for the therapy to be halted. The doctor's or family' choice to withhold or remove medical care from an incompetent patient, such as a person in an irreversible coma or in a chronic vegetative state, is not final. The High Court must provide permission to the patient's immediate family, a close friend, or the hospital's administration before any life-sustaining treatment can be withdrawn or withheld.

4.7 Bills

4.7.1 The Medical Treatment of Terminally-ill Patients (Protection of Patients and Medical Practitioners) Bill, 2006

The Union of India has filed a rebuttal affidavit claiming, among other things, that considerable consideration has been given to regulating euthanasia. The Law Commission of India's 241st report and a private members bill were mentioned. Due to the following grounds, the Ministry of Health and Family Welfare was opposed to the passage of the Law Commission's recommendation on the Medical Treatment of Terminally Ill Patients (Protection of Patients and Medical Practitioners) Bill, 2006 as the Hippocratic oath prohibits doctors from murdering patients on purpose or voluntarily. There will be a setback in the advancement of medical research that aims to alleviate pain, suffering, rehabilitation, and the treatment of so-called ailments. A person may have a passing desire to die at some point in life, although it may merely be a transitory desire born of temporary despair. Suffering is a state of mind and a perspective that differs from person to person and is influenced by many environmental and social circumstances. Patients with cancer and other terminal illnesses can now benefit from improved pain management thanks to advances in medical technology. Euthanasia may not be necessary in the case of many spinal injury patients who benefit from therapy. A mentally ill patient's desire for euthanasia may be treated with adequate psychiatric therapy. Because societal constraints and conventions constantly change, it will be impossible to quantify pain.

Can doctors claim to have knowledge and experience to say that the disease is incurable and patient is permanently invalid? Defining of bed-ridden and requiring regular assistance is again not always medically possible. There might be psychological pressure and trauma to the medical officers who would be required to conduct euthanasia.

4.7.2 The Medical Treatment of Terminally-ill Patients (Protection of Patients and Medical Practitioners) Bill, 2016

The Medical Treatment of Terminally Ill Patients (Protection of Patients and Medical Practitioners) Bill, 2016, is scrutinized in this study. Improper drafting, such as imprecise language and provisions that contradict one another, failure to consider how the Mental Healthcare Bill, 2016, will interact with this legislation, and a refusal to recognize advance directives or medical powers of attorney are just a few of the

problems the bill has. These flaws together violate the basic concept of patient autonomy and the right to die with dignity established in Article 21 of the Indian Constitution. Because making decisions about the delaying or withdrawal of medical care near the end of life is such a difficult task, we began by laying out six guiding principles. Beyond the rights to autonomy and to die with dignity already mentioned, these principles demand that every effort be made to allow patients to exercise autonomy and make informed decisions, that decisions be guided by the best interests of patients when options for patient autonomy have been exhausted, and that communication and consultation between medical professionals, family and friends form the foundation of decision-making are all essential principles of these principles.

Many of these principles are violated by the Bill's provisions, according to our examination of them. Most fundamentally, Clause 11 of the Bill, which denies the legality of advance instructions, is in breach. This clause is a catalyst for other breaches of the guiding principles. Taking Clause 9 for example, it appears that the High Court must provide approval before any medical treatment is withheld or withdrawn from people who are unable to consent. Patients who are capable but have not made an informed decision are denied their right to autonomy under the Bill, which also requires medical practitioners to record their judgment on the need of withholding or discontinuing treatment even in the case of competent patients. Additionally, the bill contradicts itself by declaring that medical practitioners are bound by the choices of competent patients to withhold or withdraw treatment, while also exempting them from legal culpability for such withholding or withdrawal.[122]

4.7.3 The Treatment of Terminally-ill Patients Bill, 2016

Some experts have expressed concerns about the proposed legislation. In the measure, the idea of a living will is unclear. A significant development in 2018 was the Supreme Court's approval of the practice of creating living wills by the general public.

[122] Analysis of The Medical Treatment Of Terminally-Ill Patients (Protection of Patients And Medical Practitioners) Bill, 2016, Vidhi: Centre for Legal Policy, (Mar. 28, 2020, 05:45 PM), https://vidhilegalpolicy.in/wp-content/uploads/2019/05/AnalysisoftheMTTPBill_Vidhi.pdf.

In India, a person must be at least 18 years old in order to marry or sign a contract. This clause allows children between the ages of 16 and 17 to make this option about withholding or discontinuing therapy. A possible abuse of the bill's provisions is possible. For example, a doctor who is corrupt may create evidence to suggest that a patient has no hope of recovery, while in fact, there is hope. If a patient's loved ones are unable to give permission because of their own selfish motives, they might use the legislation to enable the patient to be killed, even if they are not doing so in the patient's best interest.

The bill's "terminal disease" definition, according to experts, is both subjective and ambiguous. An irreversible vegetative state in which it is impossible for the patient to lead a "meaningful life" is classified as terminal disease. Disabled persons may suffer from this definition as well.

4.7.4 The Euthanasia (Regulation) Bill, 2019

Active euthanasia and passive euthanasia are defined in this Bill, as well as the following provisions: allowing euthanasia for terminally-ill individuals who are facing acute suffering due to their illness; allowing euthanasia for individuals in a permanent vegetative state; establishing an Evaluation and Review Board to examine patients requiring active or passive euthanasia; and setting up a Commision on Euthanasia.

4.8 Judicial Response

Before the Aruna Shanbaug decision, euthanasia and the right to die were unlawful in India. As to Section 300 of the Indian Penal Code, 1860, attempting to murder a patient by a doctor is a crime punishable by death. The exception to this is voluntary euthanasia, which is covered under exception 5 to section 300 of the Indian Penal Code,1860 and so makes the doctor accountable for culpable homicide but not murder under section 304 of the Indian Penal Code,1860.

It was first argued in this case whether or not Article 21 included a right to die in *State of* Maharashtra v. Maruti Shripathi Dubal.[123] According to the Bombay High Court's decision, the right to live also includes the right to die, hence Section 309 was declared unconstitutional. In this case, the court said unequivocally that a person's right to die peacefully is not unnatural, but rather unusual and exceptional. In the case of P. Rathinam v. Union of India,[124] the Supreme Court affirmed this position. However, in the case Gian Kaur v. State of Punjab,[125] Those judgments were overturned, and the Supreme Court's five-judge panel found that Article 21's "right to life" did not encompass the "right to die." According to the court, Article 21 only provides the right to life and personal liberty, not a right to die, and this is plainly stated in the matter at hand.

In Gian Kaur v. State of Punjab,[126] Supreme Court's five-member Constitution Bench reverses 1994 rulings in P. Rathinam v. Union of India.[127] As a result of the Supreme Court's decision that S.309 was unconstitutional because it penalized an act that was nothing more than aiding someone in exercising his basic 'right to die' under Article 21, the Supreme Court upheld S.306, IPC, holding that the 'right to life' does not include the 'right to die.' It is not necessary to eliminate all life in order to protect it. In this decision, the Supreme Court debated whether or not a person's right to life included the freedom to die. Article 19 rights include the right to communicate one's thoughts, as well as the right not to speak, as well as the right to travel freely.

Article 21 of the Constitution does not apply to overt acts that a person must do in order to end his or her own life. The importance of life's purity as a concept should not be overlooked. Article 21 of the United Nations Charter does not protect life from extinction. Article 21 cannot be understood to contain the "right to die" as a fundamental right granted therein, regardless of one's position on suicide. As a result, even though Article 21 does not specifically specify that "suicide" is not authorized, it

[123] Maharashtra v. Maruti Shripathi Dubal 1987 (1) BomCR 499.
[124] P. Rathinam v. Union of India 1994 SCC (3) 394.
[125] Gian Kaur v. State of Punjab 1996 2 SCC 648.
[126] *Ibid.*

is nevertheless illegal to commit suicide. Article 21 declares that "the right to a life" is a basic human right, and an unnatural death, such as suicide, conflicts with this. Given the nature of other rights, such as the "freedom of expression," there is no basis for concluding that the "right to live" also incorporates the "right to die." P. Rathinam qua Article 21 is not supported by other fundamental rights instances in which the lack of pressure to exercise a right was found to be included in exercising that right.

S.309, IPC and S.306, IPC are within the constitutional limitations and are neither invalid or extra vires when it comes to an attempt to commit suicide under S.309, IPC or even aiding a suicide under S.306, IPC. There is no such thing as a "right to die," and there is no "right to life." A recent change to the code of medical ethics in India, which has been adopted in accordance with Section 20A read with Section 33(m) of Medical Council Act, 1956 with the prior consent of the Central Government acknowledged the act of euthanasia as an unethical practice of medicine.

Shri F.S. Nariman also submitted in Gian Kaur v. State of Punjab[128] that Article 21 cannot be interpreted to include within it the so-called "right to die" since Article 21 provides the preservation of life and liberty, not its annihilation. He argued that Article 14 isn't even violated by Section 309 since the provision of punishment therein offers considerable discretion to apply that provision with compassion to an unhappy victim of circumstances trying to take their own lives.

In Chenna Jagadeeswar and Anr. v. State of Andhra Pradesh,[129] Section 309 IPC's constitutionality was upheld in this case. There was no acceptance of the notion that Article 21 encompasses the "right to die." It was also pointed out by Amareshwari, J. arguing for the Division Bench, that courts have adequate power to ensure that persons in need of care and attention are not subjected to undue harsh treatment or discrimination. Another point made by the High Court was that in a nation like India, where the individual is exposed to a great deal of pressure, it is essential to be cautious. Human anguish and motivation would suffer if a person had a right to self-destruction

[128] Gian Kaur v. State of Punjab AIR 1994 SC 1844.
[129] Chenna Jagadeeswar and Anr. v. State of Andhra Pradesh 1988 Crl. L.J. 549.

and the courts were no longer able to investigate. It might lead to a number of anomalies, none of which should be permitted.

Even in circumstances where the patient is terminally sick, the right to die is incompatible with the right to life. The right to die peacefully should not be conflated with the right to die in a way that shortens one's natural life expectancy. Even if proponents of euthanasia argue that euthanasia implies eliminating a life that isn't worth living, the debate continues. However, the issue is how to determine whether or not a person's life is worth living anymore.

Regarding this topic from a legal standpoint, Article 21 clearly provides for the dignity of a person's life. People have the right to a life of at least minimal dignity, and if that standard is not being met, they should be granted the freedom to terminate their lives. The supporters of euthanasia further point out that since passive euthanasia has been permitted, thus active euthanasia must also be permitted. Only when a patient is in excruciating pain would he decide to terminate his life, preferring a painless death to the misery and suffering of a long and painful existence.

Thus, from a moral standpoint, it is preferable to let the patient to die peacefully when he or she understands that he or she will die from that fatal condition. It begs the question, though, why prolong his agony when he's already going to die anyway? Supporters of euthanasia also point out that a significant number of medical resources are being allocated to individuals who would die anyhow. In other words, they say, rather of wasting money on such patients, it's preferable to employ those resources for those who have even a slight prospect of recovery. This raises the question of who we want to save with these medical facilities: individuals who will die today or tomorrow regardless or those who have a decent chance of recovery. Euthanasia opponents frequently argue that granting the right of lethal self-injection to terminal patients will lead to abuse.

Due to advances in medical research and the increased danger of its bad usage, however, euthanasia's negative impact will only grow over time. Religious and

professional organisations, as well as those in the fields of law and medicine, have all voiced strong disapproval. To them it is not a right to die, but rather a right to kill. According to them, it's a violation of the medical code of ethics. Ethical guidelines in the field of medicine require that patients be cared for and not killed. Medical research is progressing rapidly in the modern era.

As a result, even the most dreadful illnesses are now treatable. The medical community should not advocate for a patient's suicide but rather urge them to face their difficult circumstances with bravery, both moral and physical. The patient's decision to request euthanasia is not the only one. Even the patient's own family plays a significant part in this process. As a result, it's quite possible that the patient feels pressured into taking such an extreme measure as terminating his life. When it comes to moral and psychological stress, it's considerably more powerful than physical pressure. In addition, there is the strain of the economy to consider. At some point, the patient begins to feel like a burden on his loved ones when they make this decision for him. Others argue that euthanasia should be prohibited as well since it is an extension of the ban on assisted suicide. When a person is depressed and no longer sees any reason to live, he or she will take his or her own life. People who want euthanasia are in a similar predicament. However, opponents argue that adequate care and encouragement can reduce this propensity. Opponents sometimes raise the issue of a "slippery slope."

In this view, the legalization of assisted suicide will inevitably lead to the legalization of other forms of euthanasia as well, including involuntary and non-voluntary. It's worth noting that the term "euthanasia" itself is unclear, as has been pointed up previously. There is no accepted definition of the word "terminally sick." As a result, not even the legal profession is certain who the terminally ill patients are. Euthanasia is thus only permitted in the most extreme of circumstances, according to opponents. Abuse will inevitably occur if this isn't done.

To assess whether Article 21's protection of the right to life includes the right to die, the court ruled that protagonism of euthanasia was of no assistance. Under Article 21, the right to life is defined as the right to live with human dignity to the end of one's

natural lifespan, which encompasses the right to a dignified existence to the point of death, as well as a dignified dying procedure. However, the right to die with dignity at the end of life should not be misunderstood or equated with the right to suffer an unnatural death that shortens the natural lifespan.

Suicide is, by definition, the deliberate and voluntary taking of one's own life without the assistance of another human being.

The Bombay High Court's ruling in Maruti Shripati Dubal v. State of Maharashtra[130] is worth mentioning in the perspective of suicide as an offense. By pouring kerosene over himself and attempting to light his clothes with a lighter, a police constable of Bombay City Police Force, who was suffering from mental illness and schizophrenia after a road accident in 1981 attempted to commit suicide outside the office of the Municipal Commissioner Bombay on April 27, 1985. Section 309 of the Indian Penal Code was used to arrest and prosecute him. When it comes to interpreting Article 21 of the Indian constitution, the Bombay High Court's JJ. Sawant and J. Kolse Patil held that a person has the right "to die or terminate one's life" without fear of punishment. Articles 14 and 21 of the Constitution were thereby violated by Section 309 of the IPC. Olga Tellis and others v. Bombay Municipal Corporation,[131] often known as the pavement Dweller's case, was relied upon by the Supreme Court, which ruled that the right to life includes the right to euthanasia, and hence Section 309 I.P.C would not apply to it.[132]

As mentioned above, there are many who believe that penalizing a person for making an attempt at suicide should be allowed, but there are also those who believe that euthanasia (also known as mercy killing) should be legal. We have no intention of addressing this issue since it is outside the scope of the current petitions and because euthanasia involves a third party who may be claimed to be complicit in the death of another person, either actively or passively. A difference should be drawn between a

[130] Maruti Shripati Dubal v. State of Maharashtra, 1987 (1) BomCR 499.
[131] Olga Tellis v. Bombay Municipal Corporation (1986 AIR 180.

person's attempt to terminate his or her own life and the actions of others to end the life of a third party. This differentiation is admissible theoretically as well as on principle.

Surjit Singh, a former Deputy Superintendent of Police, sought medical reimbursement in Surjit Singh v. State of Punjab. The appellant, who underwent a bye-pass surgery in London, sought compensation for the Rs. 3 lakhs he spent there. The State denied his claim for medical reimbursement. According to Article 21, the right to life is a basic, holy, priceless, and inviolable right, and the Supreme Court has ruled that self-preservation of one's own life is an essential concomitant of that right, which the Court deems to be a vital component.

In Maruti Shripati Dubal v. State of Maharashtra,[133] When it comes to interpreting Article 21, the Bombay High Court goes to great lengths. There should be no deprivation of life or liberty except in accordance with the method prescribed by law, according to Article 21.
The Supreme Court in Maneka Gandhi v. Union of India construed the term "process established by law" to imply equitable, fair, and reasonable procedure, rather than any method.

As stated in Sunil Batra v. Delhi Administration, Article 21 ensures the right to life and liberty, and this is clearly established in the case. In spite of its pejorative tone, it protects a basic human right to life and liberty. Art. 21 ensures the preservation of life and liberty. " The right to life and liberty is guaranteed, even if it is expressed in a negative manner. Because of the severe restrictions on a prisoner's personal freedom provided by S. 30's sub-section (2), a death row inmate's existence in solitary confinement is far harsher than a life sentence.

In Munn v. Illinois,[134] Using this definition, "life" implies something much more than just the existence of living organisms. The resistance to its loss extends to all of life's boundaries and capacities. All bodily parts that the soul uses to connect with its

[133] Maruti Shripati Dubal v. State of Maharashtra, 1987 (1) BomCR 499.
[134] Munn v. Illinois (1877) 94 US 113.

environment are explicitly prohibited, including amputations, eye removal, and mutilation, including amputation, and destruction, including amputation, destruction, and any other form of destruction."

Olge Tellis v. Bombay Municipal Corporation[135] held that "The sweep of the right to life provided by Art. 21 is vast and far-reaching. Life cannot be extinguished or taken away, for example, by the imposition and execution of the death penalty, unless the procedure set by law is followed. That's just one facet of the right to life, but... The right to a livelihood is an equally vital aspect of that right, since no one can survive without the means of earning a living. The easiest method to take away someone's right to life is to take away their means of subsistence, which is why the right to livelihood should be considered an integral aspect of the constitutional right to life. Not only would it be difficult to exist, but such deprivation would also rob life of its purpose and effectiveness. While this deprivation may not be required to be done in line with legislation, if it is not considered part of the right to life. This alone must be considered an essential part of the human right to life, even if we exclude what makes life bearable. If you take away someone's ability to earn a living, you've taken away their life. Because of these rulings, it's clear that Article 21 guarantees not just protection against the arbitrary loss of life and liberty, but also rights that let people lead decent lives. The existence of both positive and negative elements to the basic right is undeniable and cannot be seriously contested. There is a lot to be said about freedom of speech and expression that does not include the freedom to be silent. Freedom of association and migration encompasses the freedom to join no group and to go anywhere. A person's right to freedom of business and profession also includes the right to refrain from starting a new enterprise or to close an existing one. The Supreme Court's ruling in Excel Wear v. Union of India[136] provides the necessary evidence for his claim. If this is the case, then it follows that the right to life recognized by Art. 21 also includes a right not to live or not to be forced to live, logically. To put it another way, it would provide people the option to end their own lives.

[135] Olga Tellis v. Bombay Municipal Corporation 1986 AIR 180.
[136] Excel Wear v. Union of India 1979 AIR SC 25.

When it comes to the desire to die and hence the right to die, nothing is abnormal. The act of ending or terminating a person's life, regardless of the circumstances, is the act of that person. The act of life is all he has, and that is all he has to offer. Many people mistakenly believe that a desire to terminate one's life is irrational, whereas in fact, it is caused by the conditions in which one is forced or compelled to do so. It's important to distinguish between the wish to die and the cause of death that isn't natural. Unnatural methods of death, ranging from hunger to strangling, may be used to take one's own life. Even though a person's desire is not unnatural, he or she is not alone. It is possible that if the individual had not been subjected to torture or brutal treatment, he or she would still be alive today. In reality, the person's innate desire to terminate his or her own life was triggered by the therapy.

A human being's natural desire is to live and enjoy the pleasures of life until nature intervenes to bring it to an end. However, this is true for those who have their normal mental, intellectual, and physical faculties and go about their daily lives as regular mortals do. Attempting to commit suicide or taking your own life is not a natural part of life. It's an instance of something out of the ordinary, whether it's a bizarre circumstance or a peculiar aspect of one's personality. There is nothing unnatural about abnormality or uniqueness. Unbearable physical conditions that prevent a person from performing basic self-care and daily tasks; mental illness and mental imbalances; socially stigmatized diseases; a decline in physical health; the loss of all senses or a desire for pleasures of the senses; extremely cruel or unbearable conditions of life that make it painful to live; a sense of shame or disgrace; the need to defend one's honor; or simply the loss of one's sense of self. No matter the scenario, the community's reaction is not always the same and might range from condemnation to acclamation. All communities have not reacted or reacted in the same way at the same time. Society's various responses across time and space have been shaped in part by the moral and sociological practices that have been heavily impacted by organized faiths.

In modern society, the right to die or to end one's life is not a new or unheard of idea. Taking one's own life is permissible in Hinduism and Jainism under some conditions, while it is strictly prohibited in others. However, Buddhism's stance on suicide has

remained equivocal, despite the fact that it has supported it under specific conditions. Suicide is not clearly prohibited in either the Old or New Testaments. Christianity, on the other hand, considers suicide to be murder. According to the Quran, it is a crime even worse than murder. Knowing the conditions in which the Hindu Dharmashashtrakaras authorized or disapproved of the activities is interesting. As represented in the Dharmashastrakara literature, while suicide was generally discouraged, it was permitted, encouraged and even praised in specific cases depending on the individual and the unique circumstances. As a reminder, the circumstances in which the exceptions to the rule were formed are very much in line with those cited today as justifications for a suicide or attempted suicide. There is also no definitive proclamation as to why some religions and cultures consistently condemned suicides and attempted suicides, while others did so on a regular basis. Moral, religious, or ideological motivations and social or economic motivations are the two main schools of thought. The sacredness of life cannot be overstated. This gift is from God, and only He can remove it. In the afterlife, there is a full cycle of births for each unique soul, and they must complete it. Death by suicide or accidental death is a death that maintains the soul in the realm of spirits. That is a religious or ideological objection that doesn't make use of reasoning. At least in places where population growth must be checked and reduced rather than maintained or increased, the socioeconomic argument no longer holds water.

An essential question remains unresolved as a result of this. If attempting suicide is not a crime, then helping and abetting the attempt must also not be a crime, right? Right. In particular, it will open the door to euthanasia or mercy killing, as well as death-baiters in general. There is a misperception about the notions of "suicide" and "mercy-killing," which causes this dread, according to us. One of the most fundamental characteristics of suicide is that it is an act of self-destruction or self-killing, a decision to put an end to one's own life without the assistance of another human being. In contrast, the term "euthanasia" or "mercy killing" refers to the practice of ending a person's life with the assistance of another human being. Attempts at mercy-killing are not covered by the requirements of S. 309, as mercy-killing is not suicide. Legally and factually, the two notions are separate. Regardless of the circumstances, euthanasia or mercy-killing is

homicide. It is an offense unless one is explicitly exempted from that rule. In addition to homicide, our Penal Code punishes those who aid in the suicide of others. Abetment of suicide of any person is punishable under Section 306, whereas S. 305 punishes abetment of a young or crazy person by Section 305. Death-baiting threats can be dealt with under these statutes. S. 2 of the English Suicide Act of 1961, which criminalizes anybody who assists, abets, counsels, or procures the suicide of another or the attempted suicide of another, is an example of additional precautions that can be put in place. Not one single word in the Penal Code refers to suicide. As a result, attempts at suicide and the aiding and abetting of such attempts are rife with definitional ambiguities. Because of this, the issue is purely conceptual.

About one-third of those who commit suicide have been discovered to have a mental disorder that requires psychiatric care, according to estimates. A feeling of worthlessness, despair, and a desire to end one's life are common symptoms of depressive illness. The desire to end one's life differs even in this situation, though. In addition to being a significant mental condition, schizophrenia has a high suicide rate. Most of the others are unstable and fragile. Suicide is more likely to occur in those with violent inclinations. Suicides can be attributed to a variety of circumstances, including frustration, social isolation, and an inability to handle stress and strain. Other important factors, such as extreme mental and physical torture or cruelty, inhumane living conditions, poverty and unemployment, as well as the inability to make a living for oneself and the dependents, affection by incurable or socially dreaded diseases, physical incapacity to perform even bodily chores, and the need to protect one's honor or avoid social disgrace, are also important. In no way is this a comprehensive list of all the mental, physical, and social factors that might lead to suicide attempts; rather, it is designed to highlight the wide range of possibilities that exist. There isn't a single thing they have in common. To put it another way, they are all treated the same under Section 309.

In Naresh Marotrao Sakhre v. Union of India and Others,[137] If an attempt to commit suicide is not regarded a criminal, then helping in the attempted suicide is likewise not an infraction, which leaves the door open for euthanasia or mercy killing, in particular, and death-baiters. This anxiety is, in part, due to a misunderstanding of the terms "suicide" and "mercy-killing." For suicide to be a kind of suicide, it must be an act of self-destruction, an act of ending one's life without the assistance of another human being. In contrast, the term "euthanasia" or "mercy killing" refers to the practice of ending a person's life with the assistance of another human being. Attempts at mercy-killing are not covered by the restrictions of section 309, as mercy-killing is not suicide. Legally and factually, the two notions are separate. Regardless of the circumstances, euthanasia or mercy killing is a kind of homicide, regardless matter how it is carried out. It's an offense unless you're explicitly exempted from that rule. In addition to homicide, our Penal Code punishes those who aid in the suicide of others. Section 306 makes it a felony to aid in the suicide of anybody, whereas Section 305 makes it an offence to aid in the suicide of a child or an insane person and specifies separate punishments for the two. Death-baiting threats can be dealt with using these offerings. Section 2 of the English Suicide Act of 1961, for example, holds criminally accountable anybody who assists, abets, counsels, or procures the suicide of another person or an attempt by another to commit suicide if further precautions are required.

In C.A. Thomas Master and Etc. v. Union of India and Ors.,[138] he said that as death is the one certainty in life, anybody who feels they have lived long enough and is happy with their lot in life should be able to pick the time and location of their death, as well as the way they want to die by themselves. According to the petitioner, one's right to life is guaranteed by Article 21 of the Constitution, which includes the ability to select one's own means of dying. Because it was common to allow voluntary death in the ancient Indian and Chinese civilisations, the response should make measures to support voluntary death clinics. Despite the petitioner's prosperity and happiness in life, the petition states that he has the right to take his life willingly if he is unable to do so due to depression or other life-related difficulties.

[137]Naresh Marotrao Sakhre v. Union of India and Others, 1995 CriLJ 96.
[138] C.A. Thomas Master and Etc. v. Union of India and Ors. 2000 CriLJ 3729.

Finally, the petitioner pointed to the Supreme Court's ruling. In Gian Kaur v. State of Punjab,[139] It is to be regretted, according to the petitioner, that some High Court decisions on the subject fail to distinguish between what is commonly understood as suicide and the right of a person to decide whether or not to end his or her own life, which the petitioner claims is an inalienable part of the right to life. The petitioner, therefore, argues that despite the Supreme Court's ruling in Gian Kaur's case, the distinction between "suicide" as widely understood and the right to deliberately terminate one's life should be examined by this Court.

As in the case of the Gian Kaur case, a similar petition was filed by a second individual, who requested similar relief; the primary one being for the establishment of a "Mahaprasthana Kendra" (Voluntary Death Clinic) in order to ease the donation and transplantation of organs. Anyone who feels or believes they have been defeated in life may decide to take their own life, either spontaneously or after careful consideration, if they are feeling or believing they have been defeated in life. Another option is for a person, like as the petitioners before the Court, who is comfortable with his or her life and professes to be successful in life, to make the intentional decision to terminate it. Such a choice can be made after a careful review of the relevant evidence. It is said to be in one's best advantage to avoid any pain, or agony, or suffering in old age for oneself or one's dependents by making such a decision. A person who has claimed to be successful and content in their life may argue that committing suicide is not the same as killing oneself, but the word "suicide" has a broad definition that makes this argument challenging.

Section 309 of the IPC was found to be illegal by the Supreme Court in P. Rathinam v. Union of India[140] because it contravened Article 21 of the Indian Constitution. A person who aids another in committing suicide is only aiding in the enforcement of a fundamental right under Article 21 of the Constitution, and so Section 306, IPC, which penalizes assisted suicide, is also unconstitutional since it is a violation of Article 21.

[139] Gian Kaur v. State of Punjab, AIR 1996 SC 1257.
[140] P. Rathinam v. Union of India, 1994 AIR SCW 1764.

Indian euthanasia advocates argue that patients in a persistent vegetative state (PVS) are not entitled to the "right of life" or "the sanctity of life." The Supreme Court in Gian Kaur's case also addressed the issue of euthanasia. When it came to determining whether Article 21's protection of "right to life" also encompasses the "right to die," it was determined that euthanasia's proponents' opposition was of little use. "Right to life" in this context is defined as "the right to a dignified life up until the end of natural life," which includes "a dignified method of dying," says Article 21's Court of Appeal. In contrast to what some people believe, the "right to die with dignity" doesn't mean "the right to die an unnatural death" or "the right to a shorter natural life span." The Court disagreed with Rathinam's position and concluded that the reason Section 309 of the I.P.C. was determined to be violative of Article 21 did not hold up to judicial examination in this regard. As a result, it was determined that Article 21 of the Constitution was not violated by Section 309 of the I.P.C.

In light of the foregoing considerations, we are unable to accept the petitioners' assertion that, in the lack of an explicit definition in the I.P.C., voluntarily termination of one's life is not suicide. Assuming that the petitioners, who claim to have been successful in life, and had a comfortable existence, and claim that their mission in life is over, were to take their own lives for whatever reason, it would still constitute suicide under Sections 306 and 309 of the I.P.C. Suicide may be committed by anyone who feels disappointed or defeated in life, in our opinion. According to our perspective, the question of whether the suicide was spontaneous or deliberate is unimportant. Similar to the petitioners' decision to terminate one's life because one has had a successful life and the goal of his life has been accomplished, we believe that this constitutes suicide.

They have neglected the potential harm to society when a healthy individual chooses to terminate his or her life. It's possible that his wealth of life experience may benefit his family or society as a whole. It is impossible to rule out the prospect of such a privilege being abused or misused, as well as being exploited in this way. In the absence of law, and in light of the discussion surrounding Gian Kaur's case, we believe there is no difference between suicide as it is commonly understood and the petitioners' distinction

of the right to freely terminate one's life. As far as we are concerned, it would be suicide in any situation, and as a result it would be subject to both Sections 306 and 309 of I.P.C. If this is the correct legal position, then the petitioners' requests for relief will be denied.

For the first time, India's Supreme Court ruled that patients who are permanently vegetative can be taken off life support, but not those who can be killed by lethal injections.

There is no choice except to allow the death penalty to be used on future victims, as was the case with Aruna Shanbaug who has been in PVS for 37 years as a result of her sexual victimization. When the Supreme Court issued rules for passive euthanasia, it stated that it would now be the law of the nation until Parliament enacted laws to address the problem. Justice Katju and Justice Mishra, sitting as a two-judge panel, clarified and defined the two phrases. If medical treatment is withheld or removed from a terminally ill person, the result would be passive euthanasia." Patients who are given fatal injections or permitted to die in the presence of doctors are considered to be in active euthanasia, whilst those who are taken off life support are considered to be in passive. Both voluntary and non-voluntary passive euthanasia can be practiced If the patient wants mercy killing, it is completely up to them." Although the Supreme Court permitted passive euthanasia in rare cases, it made it plain that active euthanasia is against the law.

According to the Supreme Court, doctors, family members, and close friends must all agree on passive euthanasia before it may be performed. Those who are terminally sick but aren't in a vegetative state and don't want to burden their loved ones with the responsibility of their care can benefit from this. For sufferers like them, the verdict is a prayer granted by the Almighty. Without a question, the judiciary has done a remarkable job in light of the circumstances of such patients. Although some argued that the decision simply served to highlight a long-kept secret in the medical community, others felt the opposite.

CHAPTER 5

PASSIVE EUTHANASIA IN U.K., NETHERLANDS, BELGIUM, STATE OF OREGON AND AUSTRALIA

In the last chapter, we learned about the controversial topics of euthanasia and passive euthanasia in India, as well as the religious justifications for these practices. As a result, it is essential to be informed of the present status of passive euthanasia and its related difficulties across the world. The responses of various states and international organizations will be examined in this chapter, including the legislative and legal replies. This chapter will focus on the unique legal situations in different nations throughout the world addressing euthanasia, as this issue was already covered in the previous chapter.

5.1 Introduction

Euthanasia debates of today might be considered as a result of advances in biomedical science that allow terminally ill patients to be kept alive for as long as possible. Even the moral and legal elements of euthanasia are exceedingly difficult since experts distinguish between active and passive Euthanasia as well as voluntary or involuntary euthanasia. Many nations currently have groups that advocate for lawful euthanasia. The first effort to legalize mercy killing in England was undertaken in 1936, and it is worth noting.[141]

The legal position of Euthanasia and physician assisted suicide has been vigorously disputed by lawmakers and the judiciary in a number of nations, focused on either the legalization or the decriminalization of the actions. Some nations and some jurisdictions in the United States, despite the virtually universal rejection of euthanasia and assisted suicide, have or did allow either or both euthanasia and assisted suicide. Though it was illegal in the Netherlands until 2002, euthanasia and assisted suicide have been practiced for more than 30 years. Between 1973 and 2002, a variety of court judgements, government publications, and medical association directives shaped the

[141] Satpal Singh Makkar, "Euthanasia: A Betrayal of justice," Amritsar Law Journal, Vol.XII, 1985, p-65.

Dutch situation. Finally, everything ended up in a statute in 2002 which legalized Euthanasia and assisted suicide both. Hence, Netherlands became the first country in the world to legalize Euthanasia unavoidably.

In the United States and the United Kingdom, organizations for the legalization of euthanasia were created in 1935 and 1938, respectively. They had earned some popular support, but had so far been unable to achieve their aim in either nation. Western laws banning passive and voluntary euthanasia have been gradually relaxed over the last few decades, but substantial moral and legal concerns remain.[142] Certain kinds of euthanasia have been legalized as laws have developed from their basic religious foundations. Active Euthanasia and passive Euthanasia are often distinguished by regulations, which aim to distinguish between the two (generally associated with killing a person). Active euthanasia, on the other hand, is almost always against the law.[143]

5.2 Passive Euthanasia and United Kingdom

Activated euthanasia and passive euthanasia are distinct legal concepts in the United Kingdom. Since the Bland decision of 1993, "assisted suicide," which includes "omissions" that are largely the removal of life-saving therapy, is not legally forbidden. Contrary to this, it is illegal to carry out a person's death even if they have given their permission for the act to take place.

Making decisions about one's own demise has sparked a lot of discussion in the UK. The practice of euthanasia is outlawed in the UK. While it is still illegal to assist someone in taking their own life, as will be explained in further detail shortly, those who do so will not necessarily be charged for doing so.

On March 19, 2002, the European Court of Human Rights heard Diane Pretty's case. Ms. Pretty had got guarantees from the Director of Public Prosecutions (DPP) that her husband would not be prosecuted if he assisted her suicide. She was paralyzed from the neck down owing to a condition known as motor neurone disease. The House of Lords concluded that a Divisional Court judgement that dismissed her judicial review appeal

[142] M.D. Singh, "Euthanasia: How merciful is the Killing," Amritsar law Journal, Vol.X, 2001, p-54.
[143] Shreyans Kasliwal, "should Euthanasia be legalized in India", Criminal law journal, 2002, p-210.

was unlawful. She claimed that the European Convention on Human and Fundamental Rights Articles 2, 3, 8, 9, 14, 15, 16, 17, 18, 19 and 21 had been breached when the DPP declined to accept her request because the UK outlaws assisted suicide. The Court was unable to decide if any of the articles were violated.

An evaluation of Lord Joffe's assisted dying for terminally sick measure was set up after the House of Lord's passed the bill in November 2013. Patients must be terminally ill, doctors must have no reason to believe the patient is unable to consent to an assisted death, patients must be informed of their medical diagnosis and prognosis, and physicians must refer patients to a second consulting physician before allowing them to consent to an assisted death. Lord Joffe's measure allowed doctors to provide patients with the means to end their lives, but the Oregon model allowed doctors to do so for patients who could not. In comparison to Oregon's approach, this was a considerable divergence from the rulebook. While the Death with Dignity Act allowed a patient to request assisted suicide, the statute required a declaration in front of a lawyer who must determine the patient to be of sound mind and ensure that the patient knows what he or she is doing. The Assisted Dying for the Terminally Ill Bill has a clause that precludes doctors who have proclaimed their conscientious objection to participate in an assisted death from being obliged to comply with the law.

Several years ago, Debbie Purdy, a multiple sclerosis patient, revealed her decision to end her life with the aid of a Swiss hospital. Omar Puente, her husband, was reluctant to follow her to Switzerland because he feared prosecution in the UK. Specifically, she inquired about the DPP's official stance on assisted suicide and if it was legal for a British citizen to aid another person's suicide in Switzerland, where it is permitted.

In the United Kingdom, euthanasia does not have any legal standing. Those responsible for euthanasia face murder or manslaughter charges. Contrast this with "criminal liability" for participation in another's suicide in the 1961 Suicide Act.[144]

Euthanasia charges in the United Kingdom are unique from other examples of illegal killing in that the Attorney General's consent is an express requirement of the Act, and

[144] James Rachels, Active and Passive Euthanasia, The New England Journal of Medicine, vol. 292, January 9, 1975, pp. 78-80, http://people.brandeis.edu/~teuber/Rachels_Euthanasia.pdf.

punishment is modified by the sometimes tragic and horrible circumstances of specific cases.

Backbenchers in Parliament have often tried to change the Act, but little has changed since 1961.

Although the Human Rights Act of 1998 protects the right to die, others argue that present legislation breaches an individual's intrinsic dignity and "right to die" by depriving them of the opportunity to terminate their own life in the face of terrible agony.

Euthanasia is prohibited in the United Kingdom, hence no one is authorized to help another person end their suffering by taking their own life. A 14-year prison term awaits anybody who is found guilty of this offense. UK doctors frequently use "passive euthanasia" by turning off life-support machines when "nothing more they can do" despite the fact that actively taking the life of another person is illegal.

The End of Life Care Strategy, the first of its type in the United Kingdom, has been produced by the Ministry of Health. As a result of this scheme, people reaching the end of their life will be free to pick where they wish to live and die. Adults with an advanced or progressive condition are considered patients under this criterion.

According to Eve Richardson, CEO of the National Council for Palliative Care and member of the Dying Matters group, the quality of end-of-life care in the United Kingdom must be dramatically improved. Richardson is of the opinion that persons in need of terminal or end-of-life care do not have to be restricted to using hospice services. Hospice care can help relieve pain in terminally ill patients whose condition can be managed. Hospice care is not employed if the patient's suffering cannot be managed. The option of euthanasia should be addressed as part of this therapy. With the yearly death toll expected to climb, the government must prioritize the right to a good death.

Some doctors may already be using CDS, a type of "slow euthanasia," as a method of constant severe sedation. Dr. Nigel Sykes serves as the medical director. Comatose means someone is fully unaware of their surroundings, which is why severe sedation is

required. In recent years, the practice of euthanasia has given way to one of continuous, strong sedation, according to Rotterdam-based doctor Judith Rietjens.

End-of-life decisions are frequently made for people whose consent is either unavailable or problematic, whether they amount to euthanasia as it is typically understood in the United Kingdom, for example, as a positive act intended to result in a merciful death, or, more simply but no less certainly, decisions to withhold or withdraw treatment. Constricted space syndrome "According to the most recent developments, Tony Nicklinson, 58, of Melksham, Wiltshire, has the right to continue with his "right-to-die" plea. "On March 12th, a High Court judge issued his ruling on the issue.

Pain alleviation can lead to death as an unforeseen consequence, as demonstrated in R v. Cox. There are no criminal penalties for the desire of doctors to alleviate the pain of their patients in England's courts, according to this judgement. Due to the medicine used to ease pain and suffering, death is merely considered a "side effect" in the eyes of the law. Doctors, for example, are permitted to administer medications to cancer patients even if they know that doing so may shorten their lives. It's a well-known rule in the medical community. If the treatment is in the patient's best interest while he is still alive, it is lawful.[145]

If the basic purpose of medicine, the restoration of health, is no longer achievable, doctors are permitted to utilize techniques that may shorten lives in order to alleviate pain and suffering.

Patients who die after doctors give them medications because they asked for them will not always be protected by this legal idea from criminal responsibility. It is my understanding that this strategy is only applicable to people who are anticipated to die from a terminal illness. To make matters worse, a doctor cannot act with the intention of ending the life of a patient. The doctor will face criminal prosecution if the practitioner's primary objective in prescribing drugs is to hasten the patient's death. Painkiller overdoses, the doctor's failure to use a standard painkiller, and other deviations from established professional standards are more likely to be found in a

[145] Airedale NHS Trust v. Bland [1993] 2 WLR 316

doctor's treatment of a patient's pain, than than a doctor's treatment of the patient's condition. The case of R v. Cox[146] provides as an excellent example of how this legal norm is put into practice. A rheumatologist, Nigel Cox, was under investigation for his role in the death of a terminally ill patient, Lilian Boyes. Ms. Boyes, a 70-year-old patient of Dr. Cox's, had been a patient of his for 13 years. Her rheumatoid arthritis caused internal bleeding, gangrene, anemia, stomach ulcers, and pressure sores. As a result of the severe and ongoing agony, she was unable to find relief from her condition using over-the-counter pain relievers. As she neared the end of her life, she asked Dr. Cox again to end her suffering. His promise to her was that her dying days would be as painless and courteous as possible, and she accepted it. He injected her with a lethal dose of potassium chloride, a drug that has no recognized analgesic properties, into her system. She succumbed to the effects of the injection in a matter of minutes.

Dr. Cox was convicted of attempted murder and given a life sentence. On the basis of a jury verdict, he was sentenced to 12 months in prison, with credit for time served, at Winchester Crown Court.

Doctor Cox also faced disciplinary proceedings in the workplace. When the Professional Conduct Committee of the General Medical Council looked into Dr. Cox's conduct, they ruled that it was "both unlawful and utterly outside a doctor's professional responsibility to a patient." The Professional Conduct Committee did not suspend his registration or take any other action against him, but it expressed its 'great sympathy' for his situation. It was not until he satisfied certain conditions that Dr. Cox was permitted back to work by the health authority that employed him. One of them was a need for more palliative care training.

English law recognizes a 'exception,' allowing for the performance of potentially lethal procedures on patients if one or more of the following conditions are met:

This is the "Double effect" idea. This idea is heavily influenced by Roman Catholic moral theory. It's impossible to hold a doctor accountable for unintended negative consequences when they didn't want to cause damage in the first place (relieving pain) (killing the patient). You have a duty to behave in the patient's best interest as a doctor,

[146] (1992) 12 BMLR 38.

and that duty is broken if you act with the primary goal of killing. These rationales have been criticized as relying on 'illogical legal fictions' and 'fine and potentially unsustainable disparities'. In order to avoid acknowledging that many doctors who administer life-limiting pain therapy wish their patients to die, sophistry has been utilized. As a result, it has been suggested that both physicians (who cannot admit that they administer pain relief in many cases to hasten death as well as relieve pain) and society (which does not want criminal sanctions to apply to doctors who hasten their patients' deaths in this manner) are being hypocritical. In the end, the doctor's stated purpose is the deciding factor, according to one reviewer. As long as he follows the right verbal formula and records it in the patient's notes, he will be within the law. Culpability is no longer dependent solely on the actions taken or the events that transpire. As in the case of homicide, this is just unacceptable.

Noteworthy is the first and ultimately unsuccessful effort to legalize mercy killing in England in 1936. A similar motion was shot down in 1950 as well. There have been several attempts to make it legal in the past, but none have succeeded. Euthanasia would be considered murder under current English legislation. Due to the fact that the law does not accept the "victim's" consent for significant harm or death, the "victim" would have no bearing on culpability. Even the deliberate act of self-immolation was considered a crime.

As a result, euthanasia is illegal in the United Kingdom, and anyone found guilty of the act face a mandatory term of life in prison. While the courts in England have viewed mercy killings more liberally than in the United States, some of the defendants have been acquitted. According to the above-mentioned assertion, the following information will support it: -

The law of homicide compromises the right to die with dignity via euthanasia in England and other western jurisdictions. The criminal law does not recognize benign motivations when a person speeds up their own death in order to alleviate the pain of another. Rather of allowing the matter to be handled by physicians, it sees euthanasia as a kind of murder.

A number of incidents show that the criminal law of homicide does not sufficiently represent the motivations of those who aid persons in their care, in their final moments, to die peacefully. The following are some examples: Case of John Bodkin Adams Dr. Adams went on trial for the murder of an eighty-four-year-old patient who had listed him as a beneficiary in her will and seemed to value the treatment he gave. Dr. Adams had administered a lethal amount of drugs to the dying patient, and she died as a result of the medication. Judge Devlin told the jury that, regardless of the victim's condition or the accused's motivation, the law considers any conduct that had the intent to kill and really did kill to be murder. According to him, if a doctor can no longer fulfill medicine's fundamental goal — the restoration of health — he has the right to perform whatever actions are appropriate and necessary to alleviate pain and suffering, even if such treatments result in a reduction in human life expectancy. The jury rejected to convict after a seventeen-day trial. Dr. Adams was found not guilty after only 45 minutes of deliberation.[147]

Dr. Leonard Arthur, a doctor accused of murdering a newborn with Down's syndrome, was acquitted in his trial as well. Leonard Arthur Case, M.D., PhD Sadly, the child's parents had told Dr. Arthur that they did not want their child to live. It was noted in the baby's medical records that he or she should only be given "nursing care" after this incident. To alleviate the baby's agony, he was fed nothing but heavy painkillers. Three years later, he was pronounced dead. "Down's Syndrome" was blamed for the child's death, but proof of additional congenital problems lowered the charges to attempted murders when they emerged. After being told that doctors, like everyone else, must follow the law and that motive is unimportant in assessing intent, the jury failed to convict Dr. Arthur of any wrongdoing. Dr. Carr's trial followed the same trend. Using an extremely high dosage of Phenobaritone (an anesthetic barbiturate), he accidentally killed his patient. The doctor has been indicted on suspicion of attempted murder in this case. However, the patient had begged that his imminent death be accelerated because

[147] James Rachels, Active and Passive Euthanasia, The New England Journal of Medicine, vol. 292, January 9, 1975, pp. 78-80, http://people.brandeis.edu/~teuber/Rachels_Euthanasia.pdf.

he was suffering greatly from an incurable lung cancer. Dr. Carr was found not guilty of all charges against him. Arguments in the case of R against the City of Cox.[148]

To fulfill his dying patient's final request, the doctor injected powerful potassium chloride directly into her veins. This medication kills but has no therapeutic effect in this form. Soon after, she passed away. Due to the fact that the victim's death was the consequence of a premeditated, illegal killing, the jury had no alternative but to return a verdict of murder to the prosecution. Many of the jurors sobbed openly when the decision was read, demonstrating their passionate opposition to convicting Nigel Cox. Because of Dr. Cox, the elderly patient's family felt that she was able to be relieved of her agonizing agony and suffering and die in peace. Public debate and concern for the doctor, the woman, her family, and others in a similar scenario ensued as a result of the case. Certain instances back up Ognall J.'s statement that "prosecution is frequently justified in these circumstances": intentionally taking another person's life is a crime.

Airedale NHS Trust v. Bland

Medical attendants whose patients died as a result of "treatment" withdrawal sought a court ruling stating this was legal, so they might avoid criminal punishment. There was little hope of rehabilitation or progress in Anthony Blend's condition, therefore continuing a regimen of intrusive and costly therapy was futile. It is still possible that he might die if treatment is stopped, which would result in criminal liability. Euthanasia has been legalized for patients in a vegetative condition by the House of Lords.

Voluntary Euthanasia creates a medical-legal quandary that these stories illustrate. Medical ethics dictate that patients should not be subjected to unnecessarily painful treatments, but criminal law has a skewed approach to dealing with doctors who make life-threatening judgments. Euthanasia through the ruse of selective non-treatment and double impact, when helpful medication is provided in the understanding that death will occur as a side effect, has been tolerated, whereas publicly ending a patient's life out of compassion has been condemned.

[148] Gerald A Laru, Euthanasia, Humanism Today, http://www.humanismtoday.org/vol4/larue.pdf.

A British woman was paralyzed from the neck down in this instance. A year ago, she was paralyzed and unable to breathe on her own due to ruptured blood vessels in her neck. To put it another way, the hospital's physicians argued it was unethical to turn off the equipment that was keeping her alive. The lady, however, gained the "right to die" in this important judicial case.

An increasing number of patients have been calling for the right to die to take precedence over the rights of physicians and the law, and the Supreme Court has ruled in their favor. This is the first instance in British history that a patient deemed to have full mental capacity has requested that life support be turned off. Doctors have urged the courts to allow persons in a vegetative state to be turned off. England's "right to die" may be a first in contemporary English history, and it might serve as an example for the Indian Judiciary, which may authorize the execution of people in a vegetative condition who have given their agreement to be killed.

An Assisted Dying Bill was proposed in the House of Lords in November 2005, allowing a competent and terminally ill individual who is suffering severely to choose either assisted suicide or voluntary euthanasia. In order to qualify for the policy, a treating physician must determine that the patient would die within a few months from natural causes. In order for the patient to get the means to take his or her own life or, if the patient is physically unable to do so, to have his or her life terminated by voluntary Euthanasia, the patient must sign a written declaration of intent. There will be a medical panel that will examine all cases.[149]

Case of the United Kingdom v. Pretty

After a lengthy legal struggle for the right to die, Diana Pretty, a 43-year-old British woman with motor neurone disease, died in 2002. Even after her death, Brian Pretty, her husband, carried on the national Campaign for the legalization of euthanasia and handed the petition to British Prime Minister Tony Blair, as well as approaching the European Court of Human Right.

[149] James V. Lavery et al., Bioethics for clinicians: 11. Euthanasia and assisted suicide, Can Med Assoc J, May 15, 1997; 156 (10).

Bill of November 2005, which was briefly detailed only a few lines above, was introduced in response to this and the British High Court case stated above.

The purpose of the legislation was to make it easier for people who are nearing the end of their lives to get the help they need to die. However, the higher chamber of the British Parliament, the House of Lords, has obstructed the bill's progress. Around 1,000,000 anti-euthanasia protesters signed a petition, which they presented to parliament along with a large demonstration. An NGO called "Dignity in Dying," chaired by Mark Slattery, stated that- "the push to enact an assisted dying bill will continue in spite of obstacles."

Even though euthanasia is illegal in England, it has become increasingly accepted socially, despite the fact that the practice is still illegal. There is a sense of discord between law and societal morality in this region, and the criminal justice system in England is equivocal in its reaction to the circumstances at hand. Within this legal framework, it is the responsibility of the legislator to create a clear-cut statute allowing physicians to make medical decisions about the end of life of terminally-ill patients. Only in this way can the patient's right to autonomy be respected.

To address the issue of euthanasia being classified as murder, a new crime of compassion killing might be developed. Legal Euthanasia might be characterized as "mercy killing" or "legal euthanasia," and responsibility could be defined without consideration of the problem of causality or discriminating between acts and omissions. If the legislation were to be loosened too much in favor of Euthanasia, protection for people who may fall victim to non-voluntary Euthanasia under the pretense of mercy killing may become as impossible to secure.

An oral or written declaration made by an end-of-life patient during his or her healthy period that, in the event that the patient becomes unable to give an informed consent for withholding or withdrawing life-prolonging devices due to some terrible disease, the person named in the Will would be authorized to give such consent on behalf of such patient, is an easy way to explain what this is all about.

In order for a "Living Will" to take effect, the patient must be unable to freely communicate his or her wishes. Patients who are terminally sick and have fallen into a permanent coma are eligible for this treatment. It is up to him/her whether or not he/she want to accept or reject a certain medical procedure in advance.

A living will can only guarantee and approve acts that are otherwise lawful. Legally, the physician cannot be forced to do anything that is illegal. You can appoint any family member, close cousin, or next-door neighbor as a proxy. The role of the proxy person will be to assist the attending physician in obtaining a meaningful conclusion by providing a practical proposal or piece of advice.

A person creating a living will has a legal requirement to give a copy of the document to their doctor and legal counsel. To guarantee the legitimacy of the document, it must be properly executed and completed. In the British Law Commission Report 231, 68 "living wills" were given proper attention. An extensive review of previous decisions has led to this report. It has been addressed in detail in these decisions how the aforementioned will can be used in various medical situations. The report's suggestions on the legal status and functioning of living wills are thorough. Legal paperwork like this one will be used more frequently in the future, and it will help smooth the decision-making process for those patients who are in a persistent vegetative condition and need passive euthanasia after withdrawing or delaying undesirable medical assistance.

Finally, it may be concluded that an expert legal opinion should be sought in the preparation and interpretation of "living will" terms.

5.3 Passive Euthanasia and Netherlands

The Netherlands was the first country to legalize euthanasia, despite it being widely tolerated since the early 1970s. The Netherlands became the first country in the world to legalize euthanasia on April 1, 2001, when a controversial bill was passed into law (mercy killing). No legal consequences for doctors who perform euthanasia for the benefit of terminally ill patients in the United States if they adhere to strict rules. One

who is enduring terrible anguish because of a fatal illness is exempt from this strict restriction.[150]

The Netherlands is a wealthy country. There are several factors that contribute to the Netherlands' reputation as one of the world's happiest countries, including a high level of social solidarity and a universal health care system. In the decades following World War II, a new value orientation emerged that stresses individual liberty in making decisions about one's life path, including the option to terminate one's life in a compassionate manner (which in practice has meant, with the help of a doctor). Entrusting such an important and potentially life-altering duty to doctors has not appeared too risky to the Dutch. All of this, as well as a tradition of tolerance and a preference for openness over secrecy, provide the cultural soil for a public debate on euthanasia as well as the environment for the legal advancements and medical procedures discussed in the following pages.

Immediate implementation of the Assisted Suicide Review Procedures Act of 2002 was made possible by the passage of that statute.

The Netherlands became the first country in the world to legally legalize euthanasia through legislation. Even though 2002's law attracted international notice, it really reaffirmed decisions made by judges and medical organisations in the 1980s that had previously made a difference in the law in Holland. The bill's proponents in parliament said that it simply formalized already-existing practices. Legal developments from 1980 to 2002 are covered in this section of the chapter.

Between 1973 and 2002, a variety of court judgements, government publications, and medical association directives shaped the Dutch situation. When Postma, a doctor, was found guilty of the crime of euthanasia after killing her terminally sick mother in 1973, the legal discussion over euthanasia in the Netherlands started. If it weren't for Postma's demand that her acts be made public, the old woman's death would have gone unnoticed by authorities.

[150] Amelia Mihaela Diaconescu, Euthanasia, 4 Contemp. Readings L. and Soc. Just. 474 (2012).

She had been left partially paralyzed, deaf, and unable to talk after suffering a brain hemorrhage. She was restrained to a chair at the nursing home where she was housed in order to prevent her from collapsing. She asked her daughter constantly to take her own life. Postma finally admitted that she couldn't take it any longer after she saw her mother, a human ruin, hanging from the chair. She put her mother's life at danger by administering a lethal dose of morphine. As a result, the death was reported to the authorities by the facility's director. At the time, Postma was accused of mercy killing, which was a criminal offense in the Netherlands. Despite the fact that Postma was found guilty, she received just a one-week sentence with credit for time served and was placed on a year of probation.

The Royal Dutch Medical Association reevaluated its position on voluntary Euthanasia in the wake of the Postma tragedy. After years of unwavering support for the Hippocratic tradition that doctors should not help their patients in dying, the Royal Dutch Medical Association finally cracked up the door to assisted suicide in 1973. In spite of the fact that the group stated that voluntary Euthanasia should remain illegal, it urged that a court should examine if a doctor's decision to shorten the life of a terminally ill patient was justified due to a conflict of obligations. While deciding Pastma's case, the Dutch court turned significantly to medical inspector expert testimony, which outlined the circumstances under which a typical physician would believe Euthanasia to be appropriate. The inclusion of these requirements paved the way for the Netherlands' adoption of Euthanasia and assisted suicide.[151]

As part of their recommendations for future government policy on euthanasia and aiding suicide, the Netherlands' 15-member commission was established in 1982. The majority of the commission recommended that euthanasia be made available under specific conditions and performed only by a medical officer "using proper medical methods," and that a requirement for "penalty free Euthanasia" be instituted as well. Under the same circumstances, they considered physician-assisted suicide to be the

[151] Euthanasia, assisted suicide and non-resuscitation on request, Government of Netherlands, (Aug. 21, 2020, 08:42 PM) https://www.government.nl/topics/euthanasia/euthanasia-assisted-suicide-and-non-resuscitation-on-request.

same as lethal injection. When standard therapy fails to bring back a patient's lost consciousness, involuntary Euthanasia is advocated.

Killing a person on his or her request is punished by jail for a maximum of 12 years in the Netherlands under Article 293 of the criminal code, while helping someone in taking their own life is likewise punishable by imprisonment for up to three years.

Courts in Holland have interpreted the Code to provide a defense to charges of voluntary Euthanasia and aided suicide, despite its unambiguous phrasing. The justification of absolute necessity is used. There are two sorts of Dutch defense of necessity. "Psychological compulsion" is the first; "emergency" is the second. As long as the accused is committing an act of treason, this letter is applicable. 8 For the sake of clarity, the following are some relevant case laws:

Patients must be mentally competent before euthanasia may be carried out in a medically suitable way, and a second medical opinion must be sought. There are three medical professionals on the regional review committee to determine whether or not any action should be taken in the wake of the occurrence.

As euthanasia is not differentiated between voluntary and involuntary euthanasia in the Netherlands, "euthanasia" has no further meaning. To put an end to the patient's life, a doctor follows strict regulations and follows the patient's directives.

In the Netherlands, it's a crime to let someone die at the request of another person, and euthanasia was originally seen as a crime as well. In the Netherlands, euthanasia was legal, but those who committed it were not subject to punishment if they followed certain guidelines. Physicians have been accused of euthanasia, but have been absolved of culpability in various court trials. Each of the following requirements had to be completed in order for the transaction to proceed:[152]

- The sufferer must regularly state their want to die.

[152] Euthanasia, assisted suicide and non-resuscitation on request, Government of Netherlands, (Aug. 21, 2020, 08:42 PM) https://www.government.nl/topics/euthanasia/euthanasia-assisted-suicide-and-non-resuscitation-on-request.

- The three pillars of excellent patient decision-making are: informed, free, and long-lasting.
- It is necessary that the patient be in extreme physical or emotional pain with no reasonable prospect of recovery (but need not be terminally ill).
- Euthanasia is only an option if all other treatment options have been exhausted or if the patient has refused all other treatment alternatives.
- Euthanasia must be performed by a licensed physician.
- At least one other doctor must be consulted by the doctor (and may also consult other health care professionals).
- The doctor must notify the coroner of the euthanasia.

In the Netherlands, euthanasia instances were required to be reported in 1993. Although it didn't legalize euthanasia, doctors who followed a set of guidelines while carrying out the operation were protected from prosecution.

As a result of the highly publicized Chabot case, the Netherlands Supreme Court ruled that assisted suicide was technically permitted in 1994. As a result of a violent marriage, the loss of two children, and a deepening depression that had tormented him for 20 years, Hilly Bosscher, who was 50 years old, had lost the desire to live. In the end, Dr. Chabot determined that the greatest choice for his patient was to provide him with the tools he needed so that he could end his life with dignity.

Despite the absence of a physical illness, the Supreme Court recognized that assisted suicide may be lawful if the patient is experiencing great emotional or mental agony. But the Court found that Dr. Chabot had breached the rules of process. It was the Court's decision not to penalize Dr. Chabot for helping suicide as a means of alleviating non-somatic (non-physical) anguish that spared him from any penalty.

When the Termination of Life on Request Act went into force on April 1, 2002, it became law. Legal reasons for euthanasia or assisted suicide are not affected, but present requirements for providing appropriate care are clarified in greater detail. In order for a doctor to give a patient a lethal injection, he or she must be confident that the patient's request is voluntary and well-considered, that the patient's suffering is

unbearable and that there is no hope of improvement, and that the patient and the doctor have come to a joint decision that there is no other reasonable solution.

It ISa legal need to report incidents to a regional oversight agency. An inspector from the regional health care board and the Board of Procurators General are notified of the findings of this committee.

New law may enable children as young as 12 to request euthanasia or assisted suicide. Despite this, the Medical Treatment Contracts Act in the Netherlands requires parental consent for minors under the age of 16. Even though they are legally allowed to make their own decisions at the age of 16, 17-year-olds nevertheless need their parents' input and approval at all times.

Using "Deep Sedation," an alternative method that does not necessitate either euthanasia or suicide, has become more common in recent years in the Netherlands, according to experts. This occurs when a family doctor provides a consistent supply of medicine to an elderly patient. Many terminal cancer patients choose this treatment since it does not hasten their demise.

Euthanasia is illegal in the Netherlands, but an investigation into whether or not "seriously suffering" new-born babies should be allowed to die has been set up. When two members of a "professional help" organization were given prison sentences in the Netherlands, assisted suicide was still permitted. In March of 2008, researchers and psychiatrists announced the publication of a book with instructions on how to quickly and painlessly end one's life.

In any case, the United Nations Human Rights Committee is unsatisfied with the Dutch system's ability to prevent abuses such as pressure from patients. In the Netherlands, a doctor who spoke out on the matter said that "many terminally ill patients" find solace in mercy killing.

The term "euthanasia" is used in the Netherlands without the addition of qualifiers like "voluntary" or "involuntary." To put an end to the patient's life, a doctor follows strict regulations and follows the patient's directives. Euthanasia is illegal in the Netherlands,

and violators face up to 12 years in prison if they do it on the express request of another person.

Despite the fact that it is illegal, euthanasia is permitted in the Netherlands provided certain conditions are met. It came after a succession of trials in which doctors were accused of euthanasia and acquitted. A patient must meet all of the following criteria in order to be eligible for euthanasia: • the patient must express a clear and repeated desire to die; • the patient's decision must be well-informed, free, and enduring; • the patient must be suffering from severe physical or mental pain with no prospect of relief; and • all other options for care must have been exhausted or the patient must have refused other options.

It had previously been difficult to estimate the number of Dutch citizens who had chosen to end their lives. Euthanasia occurred in the Netherlands on an annual basis prior to September 1991, when 2,300 cases were registered. This represents 1.8% of all Dutch fatalities. There were more than 9,000 requests for euthanasia that year than there were actual executions (about 2,300). More than 70% of those seeking euthanasia were cancer patients nearing the end of their lives.

Euthanasia reporting legislation was enacted by the lower house of the Dutch Parliament in February 1993. Under the current law, physicians who use lethal injections to end the lives of terminally ill patients are immune from legal punishment if they comply to tight guidelines.

If there is no physical illness, but just intense emotional or mental suffering, assisted suicide may be permitted, according to the Supreme Court of the United States. Procedural norms were violated since none of the seven experts had examined Ms. Boscher personally; the Court remarked that such situations needed particular attention. The Court's decision not to penalize Dr. Chabot was based on his reluctance to face such a tough situation. When it comes to assisted suicide, non-somatic (or non-physical) pain is still a controversial topic.

In 1995, Dutch courts dealt with two cases in which doctors killed severely deformed children who were expected to die within a year of their birth. In both cases, the doctor followed the parents' instructions. However, even if they have the legal authority to

reject their child's care, which results in their child's approaching death, parents are unable to ease their child's pain throughout the dying process. When possible, these guidelines advocated for patients to give their own medications instead of those prescribed by their doctor. When selecting a second doctor, new guidelines mandate that the first and second doctors must have no professional or familial links to one other.

The Alkmaar Case

Doctors face an ethical dilemma between the Hippocratic Oath and the International Code of Medical Ethics because of the conflict. According to the oath, a doctor is obligated to balance the need to save as many lives as possible with the need to alleviate their patients' suffering. Those who take the second oath are in favor of euthanasia as a policy. In 1984, the Dutch High Court ruled on an important case known as the Alkmaar case, in which this conflict of obligations defense was applied. She had been unable to eat or drink, and had lost consciousness, in this situation. When she first regained consciousness, she begged her doctor multiple times to alleviate her pain.[153]

The doctor and his assistant doctors agreed that there was no hope for her recovery. Also, the doctor spoke to the patient's son, who backed his father's wish for euthanasia. When the patient's suffering became intolerable to the doctor, he made the difficult decision to put an end to her life. A mercy killing case was brought against him. Defending himself, the doctor stated that he had been forced to deal with an emergency. There was a contradiction between his responsibilities as a doctor and as a lawyer in trying to alleviate his patient's excruciating pain and prolong his life. Neither the lower court, nor the Court of Appeals, found merit in this argument. Convicted, but no sentence was handed down. An appeal was made to the High Court, and the court ruled that the Court of Appeals should have examined whether the doctor's claims of an emergency were true. According to the High Court, this case should be examined in light of "responsible medical opinion" as defined by current medical ethics norms. As a result of this ruling, doctors who comply with a patient's explicit, persistent, and well-

[153] Chesterman Simon, Last rights: euthanasia, the sanctity of life, and the law in the Netherlands and the Northern Territory of Australia, International and Comparative Law Quarterly, 1998: Pope John Paul II, On the Value and Inviolability of Human Life (Evangelium Vitae, 25 Mar. 1995), para.57.

informed request for Euthanasia when the patient is in an untreatable position and there is no other means to alleviate the patient's suffering are not violating the law. That's why this verdict in Alkmaar pushed the Dutch Judiciary Leagues to the top of the world rankings.

Dr. Chabot Case

In 1994, almost a decade later, another case known as Chabot case, was one step further to the Alkmaar's judgement since it considered the afflictions of the patient which were solely psychological by nature. In this historic case, it was declared by the Dutch Supreme Court that: "There is no reason, why the defense of necessity (pleaded by Dr. Chabot) may not apply if the patient's suffering is solely psychological".

Many improvements have been achieved in Netherlands in connection to the practice of euthanasia. But this case has been regularly utilized to find for the reasoning which lead to conflicting results. The after impact of the judgement may be observed by the fact that in September 1994, the prosecuting rules were updated by the Dutch government to conform with the verdict of the Supreme Court. Now, if a patient having psychiatric disorder makes a request to a physician for assisted suicide or active voluntary euthanasia, there is requirement under the relevant guidelines that such physician will arrange examination of such patient by at least two other independent doctors, one of whom must be a psychiatrist. The Government also dismissed 11 out of 15 outstanding proceedings in regard to situations where the patient was not in the terminal phase of a somatic condition as a reaction to the judgement of the same Court.

The opinion of some commentators emphasizes that once there will be a legislative permission to perform physician assisted suicide and active voluntary euthanasia with a strict and foolproof procedure in specific circumstances, the number and variety of patients who would be given benefit of such legal provision will categorically increase. Thus, it was alleged by them that this case is another step down the slippery slope towards a situation where euthanasia is permitted and provided in terrible circumstances even in those situations when patient has not made an express request.

On the other hand, some of the analysts regarded the Chabot case as a development in the Netherlands. They noticed that the Supreme Court's judgment had highlighted the conditions in which it is not appropriate as well as the circumstances in which it is allowed for a physician to enable a mental patient to commit suicide. Court has clearly down the idea of „defense of necessity" in Chabot's case.

More favorable rules were created by the Royal Dutch Medical Associations in establishing the right to die for the patient stated in the previous paragraph. A patient's suffering must be excruciating and without prospect of improvement to qualify for these requirements; they don't need to be in a terminal condition to qualify. In 1993, the Dutch Parliament finally enacted rules allowing Dutch doctors to assist terminally ill patients who had requested assistance in dying while simultaneously experiencing intolerable pain. Approximately 2,300 people in the Netherlands die each year as a consequence of voluntary euthanasia, according to a government-appointed commission of inquiry's study. In addition, there are about 400 cases per year in which doctors do not provide Euthanasia, but instead help their patients to commit suicide. 12

The Dutch government released a proposal to legally legalize them in the middle of August of 1999. Children as young as 12 and as old as 16 would be able to seek euthanasia and have their desires overruled by a physician with the doctor's approval under the proposed legislation. This has drawn international attention to the Netherlands." "Adults" are those who are at least 16 years old.

Astounding to the general public, this clause was. True, for years, the euthanasia of handicapped newborns in Holland had been widely known but joyfully overlooked. As a matter of fact in 1994, the Dutch Pediatric Association adopted recommendations allowing the treatment of death for infants who, while not terminally sick, had mental retardation or faced a long future with a chronic condition. Co-author of the association's instructions, Dr. Pieter Sauer says the regulations allow doctors to decide what is in the "best interests" of the child. When compared to the other case, however, this one was unique. In this case, it was not the doctor who made the final call. It was not a decision made by a parent. Would allow children and adolescents to legally request that their lives be ended by deadly overdoses of drugs if they so desired.

Guidelines for euthanasia that were drawn out in 1987 included requirements that family members be included in making choices about compassion killings. Even yet, the Dutch health council (an official government advisory body) recommended that family engagement be dropped from the Cabinet's recommendations. According to the Council, minors as young as 16 should be permitted to seek Euthanasia without the participation of their families. The Council said that the patient's suffering is "not more tolerable and curable" because he or she hasn't reached the age of 16.

retiree family doctor and chairman of the Dutch Association for Voluntary Euthanasia.

Law of 2002: Euthanasia and physician-assisted suicide

The legislation of 2002, which came into effect on April 10, 2002, governs the substantive and procedural criteria under which euthanasia can be conducted lawfully in the Netherlands since then. The legislation is divided into three sections: criminal, civil, and administrative. Prosecutors' duty is confined to situations in which the Regional Review Committees find the doctor "not cautious" under the first codification. A doctor's report is not required for cases that the committee deems to be outside their jurisdiction, such as when the doctor's actions are deemed "normal medical practice" or when the doctor's actions are brought to their attention by

It was formerly thought that euthanasia could only be performed by a doctor who was directly involved in the patient's care. The 2002 legislation does not include any such restriction as a requirement of due care. In the minds of the Regional Review Committees, the law and its legislative history presuppose that a doctor and patient have a medical treatment connection. There is no therapy connection if the only purpose of the interaction is to administer euthanasia. A therapeutic connection is no longer considered necessary by the Review Committees of 2005. A better test is whether or not „the doctor had such a connection with the patient as to permit him to develop a judgment regarding the standards of proper care.'

Other circumstances include a condition that requires the doctor to contact at least one other, independent physician, who visits the patient and writes a written report, among others. Only in extreme cases can the Review Committees decide that the doctor in

question exercised reasonable care notwithstanding the absence of a consultation. According to the studies, there are concerns about the consultant's independence, the consultant's knowledge and the timing and quality of the consultation, and if the consultant should agree with the consulting doctor's judgement.

After making a choice, "Due Medical Care and Attention" is the next prerequisite. When euthanasia was first legalized in 2002, doctors were often needed to be present throughout the patient's death. Guidelines for the medical profession and rulings of the Regional Review Committees have reiterated this need, which is now considered part of the necessary "appropriate medical care and attention."

Suicide help presents a unique set of challenges because to the need for a doctor's constant presence. Keeping an eye on the availability of euthanasia, ensuring that the suicide is compassionate and successful, and intervening with euthanasia if it is not are all apparent arguments for insisting on constant presence in these situations. As long as the doctor is promptly available, there are crucial grounds for not insisting on the doctor's attendance.

A condition of due care prior to the 2002 law was that of sufficient record-keeping. Common sense says that record keeping is a precondition for successful control, but the legislation of 2002 does not explicitly include it and rarely mentions it. A doctor may be asked by the Regional Review Committees to submit extra information, but they have never criticized a doctor's medical record-keeping practices.

In the case of a patient who has requested euthanasia, this requires extra attention since, aside from its typical duties (such as ensuring continuity and quality of care), good record keeping becomes the foundation for a later examination of whether the criteria of due care have been satisfied. It is feasible for a doctor to write a clear and accurate report about a patient's state and the grounds for his or her treatment if he or she maintains good records. For a doctor to falsely claim that a patient died of natural causes prior to 2002, it was a criminal offense, and that hasn't been amended. When a doctor who reports a euthanasia case is not the doctor who actually performed the procedure, the Regional Review Committees treat them as "reporting doctors" (who must meet

requirements of due care) and dispose of the case. However, in 2002, the Penal Code was amended to legalize euthanasia by a doctor who conforms to the requirements of due care and reports to a municipal pathologist as required by law on burial and cremation. Review Committees may only remark on the quality of reports they receive and seek further information if a report is unsatisfactory since they cannot observe non-reported cases. First for minors (patients younger than 18), the legislation of 2002 provides for particular measures that correspond to the age disparities in the law on medical treatment contract. Children as old as 12 who can be thought of as being competent to comprehend their own best interests and seek euthanasia may have their wishes honored by their doctor. Parents or guardians must consent to euthanasia for youngsters between the ages of 12 and 16. If a minor is under the age of 18, his or her parents or legal guardians must be included in the decision-making process, but it is not a requirement that they support euthanasia. Since 2002, the reporting and review procedures for children have been identical to those for adults.

To summarize, allowing physicians to legally execute their patients is a bad idea for the public good. First and foremost, the United Nations has declared that the Netherlands' euthanasia statute violates the UN Declaration on Human Rights. People's health and safety are in jeopardy as a result of this. Concerns have been raised by the United Nations that the process may not be able to identify and avoid circumstances in which euthanasia patients or doctors as the case may be are under excessive pressure to use or perform the procedure. As a result, the preventive measures will be circumvented.

5.4 Passive Euthanasia and Belgium

Euthanasia was legalized in Belgium in 2002, despite the absence of a sociological, medical, and legal preparing process equal to that in the Netherlands. In Belgium, euthanasia was prohibited until 2002. Euthanasia is also explicitly prohibited under the Belgian order of physicians' Deontological Code (Code of Medical ethics). Since no doctor had ever been convicted of committing euthanasia, there was no case law on the issue at the time of this writing. According to one Belgian court's reaction to a claim of justification by necessity, there was some legal confusion around the issue. When it came to assisted suicide, things got much more difficult. There was no case law on this,

therefore it was unclear if a doctor could safely provide such aid, despite the fact that on the surface, it was not prohibited. As a final point, it was agreed that doctors are not obligated to prolong medical therapy that no longer has any curative or therapeutic benefit, and that a possible shortening of life via the use of pain medication is permissible. The time period from 1980 to 1997 prior to legal reform.

Euthanasia was legalized in Belgium in the early 1980s, when the two organizations, the Dutch-speaking "Right to die with Dignity" and its French-speaking "Right to die with Dignity," were established. As a result, their impact was limited at that time since euthanasia had yet to become a major public or political issue, and both organizations were perceived as being anti-religious and liberal. In Belgium, where social Catholicism remained the dominant political ideology, their views were not well received by the general public. The Christian Democrats, the government's most powerful party since the 1950s, were adamantly opposed. Until the 1990s, Christian democrats resisted or obstructed Euthanasia legislation as a matter of Christian morality.[154]

The lack of progress in politics did not exclude social change. Euthanasia was a hot topic in the 1970s and 1980s, and it was frequently discussed in the media and in public debates. As an example, in 1971, the Belgian national broadcasting network staged a television discussion on the topic. Over half of Belgium's population speaks Dutch, so it's logical to assume that the Dutch experience with euthanasia had some impact there as well. Indirect proof of its impact, on the other hand, is few.

Both the French and Dutch-speaking Christian democratic parties softened their stance on the subject starting in the middle of the 1980s. Euthanasia and end-of-life decisions have typically become at least contentious as a result of technical advancements in medicine and biology. An investigation was launched in 1983 by a Christian Democrat from France to examine the ethical concerns involved. Many concerns were examined by the panel, including the tendency to prolong therapy even when it no longer benefits patients, the removal and transplanting of body parts, as well as issues pertaining to

[154] A v A Health Authority 2002 (1) FLR 481.

medical research. The commission's conclusions on the ineffectiveness of medical therapy prompted it to define "active" and "passive" Euthanasia. As long as it was accompanied with palliative care and intense counseling, the latter may be allowed, according to the commission.

Individual MPs from across the political spectrum, with the exception of Christian Democrats, began introducing legislation on Euthanasia and related concerns for the first time in the 1980s. There was no party support for any of them, as they were all put forth by independents. None of these ideas ever made it to the point of being addressed in Parliament in a meaningful manner. Euthanasia and other end-of-life options were rendered impossible by the government's inclusion of Christian Democrats.

A doctor would no longer be required to continue "treatment or reanimation" of a patient, with or without the patient's desire, if two clauses of the Penal Code had been included in the proposed measure. Belgian doctors have always been permitted to terminate useless medical treatment, and this proposition seemed unnecessary as a matter of legal principle. The primary goal of the idea was to give physicians a higher level of legal protection.

When a socialist French-speaking member of Parliament first introduced a draft law governing the doctor-terminally sick patient interaction, it was in the year of 1985. For example, a patient who requests information about his or her health should be entitled to receive it, and a patient who declines treatment should have the right to refuse it as well. A terminally sick patient might request euthanasia if pain management was no longer effective. It is recommended that the request be communicated in writing. The doctor might decline to meet the request, but he should then send the patient to another doctor. Clinically dead patients might potentially be terminated under this measure. There was no mention of assisted suicide or advance treatment instructions in the plan at all.

As a result, under Belgium's Euthanasia Act of 2002, individuals who are terminally ill can now opt for Euthanasia or assisted suicide. "Intentional end of life by someone other than the person involved at the latter's request" is defined as Euthanasia under the

Act. To be eligible for Euthanasia, a patient must be at least 18 years old, terminally sick, and in excruciating pain. There had to be at least a month's notice in writing before the request could be granted. Non-terminal patients who are in excruciating pain may also seek Euthanasia under certain circumstances. There was a "National commission" in charge of monitoring the practice, and requests were handled by a third-party specialist.

In Belgium, there is a connection between palliative care and lethal injection. The early proponents of palliative care in the United States held the belief that access to adequate palliative care was a precondition to the legalization of lethal injection. Both concepts have to be created at the same time. It's also worth noting that the Belgian model of integrated end-of-life care allows for euthanasia if palliative treatment fails to alleviate suffering. The majority of Belgians, palliative care workers, medical experts, and lawmakers agree with this assertion. It was for this reason that palliative care services in the country were stepped up prior to the passage of a legislation regulating euthanasia in 2002. Because of the public's faith in the healthcare system in place at the time, the aforementioned arrangement was made feasible. Both euthanasia and palliative care were supported by a large portion of the country's population. In addition, the Belgian model of end-of-life care is continually evolving and improving its processes. However, there are still flaws, gaps, and issues that need to be addressed, all of which necessitate a thorough examination and debate.

It is paradoxical that Belgium's hospitals, nursing homes, and day care centers do not receive enough funding to implement palliative care policies. Furthermore, it is vital to stress that euthanasia should be considered part of an integrated palliative care strategy, which necessitates an effective training program. There should be a thorough education of physicians on all elements of end-of-life care including the ability to bring about a peaceful death with no adverse effects. LEIF (Life End Information Forum) is currently the only organization in the country to offer this training.

Only at the Dutch-language Free University of Brussels may medical students take courses in both palliative care and physician-assisted suicide as part of their curriculum. – Since standard palliative care is taught at different medical institutions. The FPCF

(Federation Palliative Care Flanders) collaborates with the country's universities to offer a post-graduate education in the field. In Belgium, euthanasia can only be administered if the patient has adequate mental capacity at the time of the procedure. Advance instructions provided by a patient in writing who is completely asleep and that too irreparable, such as a brain damage, can be respected. Such advance directives cannot be supported by the courts if they are put up by patients who are aware of them. Patients who are suspected of not being completely competent to confirm their prior wish because of a brain tumor or comparable condition fall into this category.[155]

Palliative care and euthanasia should be provided to all Belgians, regardless of where they live or how they die, including in their own homes, according to the country's government. Since then the country has passed two sets of legislation on palliative care and assisted suicide. Both palliative care and euthanasia are options available when the patient refuses to receive it. However, in some circumstances in Belgium, where the patient has already decided that palliative care is a fruitless alternative, euthanasia is likely to be considered as well.

The Belgian approach of palliative care, despite its flaws, appears to be a successful experiment. Because of the country's long history of tolerance and compromise, this has become a trademark of Belgian society. As a Catholic nation, though, liberalism and secular humanism have found a place in many walks of life. These aspects make Belgium's approach to providing "help to die" unique, something that many other countries would like to have but cannot now afford.

Belgium's Euthanasia Law has been misused

There are many who believe that the statistics shown above is inaccurate since many persons may have previously stated a wish to use euthanasia in their life, even if they did not do so in writing. However, a valid counterpoint to this assertion is that euthanasia law requires an express written permission, which is critical if euthanasia misuse is to be prevented. Because of the numerous cases of medical research being

[155] Charles L Sprung, Is the Patient's Right to Die Evolving into a Duty to Die? Medical Decision-Making and Ethical Evaluations in Health Care, Journal of Evaluation in Clinical Science, vol 3, Issue 1, February 1997, pp. 69-75, http://onlinelibrary.wiley.com › ... › Journal Home › Vol 3 Issue 1.

misused due to the absence of a patient's express informed agreement, written consent is now an essential aspect of many medical research

Euthanasia consulting specialists in the Netherlands and Belgium have been joined together under the titles of the "Centre for Support and Consultation on Euthanasia in the Netherlands" and the "Life End Information Forum" respectively. Patients have been entrusted to these institutions with the duty of informing them of all available treatment options, including palliative care. The fact that most LEIF doctors attend a twenty-four-hour theoretical course and just three of those hours are devoted to palliative care is important. Those three hours are definitely insufficient to teach a LIEF member in palliative care needs. In order to become an expert in palliative care services, one must devote a significant amount of time. When it comes to palliative care, the United Kingdom requires a four-year degree program; in contrast, Australia and the United States provide three-year degrees in the field.

Many patients are using euthanasia and physician aided suicide despite the fact that they do not deserve it, as the safety precautions have proven ineffective. The most pressing issue is that lawbreakers aren't being penalized for breaking the rules. Such transgressions are tolerated because of a spirit of tolerance. It is hilarious to note that only 12% of all euthanasia cases in Belgium from 2002 to 2007 were referred to a palliative care specialist for a second view. Palliative care physicians were not consulted in 65 percent of euthanasia situations. Involvement in palliative care has been steadily declining. In 2002, only 19 percent of euthanasia cases included the use of palliative care services and the involvement of physicians in the final stages of dying, which serves as an example of the current state of affairs. However, by 2007, just 9% of instances had this type of participation. It is evident from the facts shown above that the country's palliative care system has not improved as a result of Belgium's euthanasia statute. Legalization of euthanasia or PAS has not been necessary or desired in other industrialized countries, such as the United Kingdom, Australia, France and Spain, where palliative care has progressed far more than in Belgium and the Netherlands.

Legislators in Belgium have proposed amending the euthanasia legislation to include children with impairments and those with dementia in an effort to prevent abuse of the law. With the expansion of euthanasia statute definitions, there will be fewer cases of people breaking the law.

According to the preceding lines, euthanasia cases have not been filed in Belgium, and the planned amendments to the Belgian euthanasia legislation, as well as the slight increase in the number of euthanasia deaths, indicate that the law has been expanded.[156]

5.5 Passive Euthanasia and State of Oregon

Early American laws made it illegal to assist someone in taking one's own life. New York challenged the practice in 1928 with an enactment. Within a decade, pro-euthanasia activists began clamoring for legislative protection for lethal dose reductions. It was founded in 1938 as the "Euthanasia Society of America" to advocate for euthanasia. They also called for appropriate legislation. Their cause gained some traction and support in the United States, but they eventually fell short of their goals in the country. 70 In the 1970s, however, the discussion about euthanasia in the United States was reignited due to a rising awareness of human rights, the case of Karen Ann Quinlan, and the "right to die" movement.[157]

Case of Karen Ann Quinlan

In 1975, this case was brought to light. After taking an accidental overdose of wine and valium, Karen Ann Quinlan, a twenty-one-year-old college student, died. She fell into a coma as a result of the overdose. But a ventilator and other life-prolonging medications kept her alive. The "sleeping beauty" case was another name for this case. The entire country began to brainstorm possible solutions to the patient's plight. This

[156] Ronald B. Sklar, The Capable Mental Health Patient's Right to Refuse Treatment, 5 McGill J.L. and Health 291 (2011).
[157] Oregon's Death with Dignity Act, Oregon Health Authority, https://www.oregon.gov/oha/ph/providerpartnerresources/evaluationresearch/deathwithdignityact/pages/index.aspx.

case contributed to re-define the phrase “brain death” and the foundation for decision-making processes in situations of brain-dead people, both voluntarily and unvoluntarily.

As long as the due process provision was in place, the concept of a “right of refuse” was widely accepted. Individuals have the right to make their own decisions without interference from the government under this provision.

A group known as the “Hemlock Society” (founded in 1980) began lobbying for physician-assisted suicide or active Euthanasia in 1990. In addition, they pushed for the same procedures as were previously mentioned. The whole affair resulted in a renewed discussion regarding the limits of an individual’s “right to die.”. Pro-euthanasia advocates argue that pulling a feeding tube and allowing a patient to starve to death is considerably crueler and more inhumane than administering a painless injection or fatal poison.

Doctors are surprisingly split on the morality of assisted suicide, a fact that may come as a surprise to some. Attempts in the state of Washington in 1991 to approve a “right to die” measure were unsuccessful. California was in the same predicament the following year. A unexpected measure enacted in Oregon in 1999, the Death with Dignity Act, was authored by Cheryl K. Smith, former legal counsel for Hemlock Society. However, euthanasia was not permitted under this law, which only enabled competent terminally ill individuals with a life expectancy of fewer than six months to seek drugs to terminate their lives. As a result, Oregon became the first state in the world to approve physician-assisted suicide.

However, Dr. Jack Kevorkian, who became the face of the “right to die” campaign in the United States, eclipsed this new statute.

The Case of Dr. Jack Kevorkian

Doctor Kevorkian, or “Dr. Death,” shot to fame in the 1990s. He was a retired pathologist who helped over 130 individuals commit suicide with the use of his services. This is the title of his book: Prescription for Medicine. In Michigan, a legislation against physician-assisted suicide was passed in 1993, and his practice was

challenged. And Kevorkian stated that an explicit legislation barring euthanasia equates to rejection of the individual's right to self-determination in regard to the manner or time of his/her death because of the American Civil Liberties Union's backing.

However, when it was found that a huge percentage of patients who received care from Kevorkian were actually not terminally sick, his argument suffered a defeat. Even Nevertheless, he showed no remorse for his actions toward a number of patients. Instead, he continued to practice until a Michigan court found him guilty of second-degree murder in 1999 and sentenced him to between 10 and 25 years in prison for the death of Thomas Youk, a patient with Lou Gehrig's disease. Finally, his conceit brought him to his knees. The tragedy of Thomas Youk's death was the subject of a 60-minute television special. In the end, Dr. Death was forced to face the repercussions of his illogical actions by the court.

Washington v. Gluck

Assistive suicide was rejected by the Supreme Court of the United States of America in 1997, voting unanimously to reject the matter. In this instance, the Supreme Court followed the decision in Roe v. Wade. Rehnquist observed that "assisted suicide constituted severe damage for persons already at danger because of their age, poverty, or lack of access to adequate medical treatment."

Quill v. Vacco

When the Second Circuit Court of Appeals ruled that assisted suicide is not a basic right, the New York Supreme Court heard the issue. As a result, the court ruled that New York's anti-assisted-suicide statutes are unconstitutional when applied to physicians treating terminally ill patients who are not attached to life-support systems. However, patients whose lives are supported by machines that might disconnect them from them and expedite their demise cannot exercise the same legal right to hasten their demise as those who are not. As a result, it violates the fundamental American concept of equality.

As a result, courts in the United States were generally opposed to the idea of assisted death. However, there was unequivocal support for passive euthanasia in the case of terminally ill individuals who were being kept alive by life-prolonging equipment. As previously said, the following case laws help to elucidate the situation: -

Dying v. Washington

State of Washington had already allowed competent terminally ill patients to direct for the withdrawal of life-sustaining measures in this case, the ninth circuit court remarked. Suicide prevention is less important to the state when dealing with terminally ill competent people. An adult with an incurable and terrible degenerative condition, who decides to die in order to prevent excruciating and humiliating anguish, is not "senseless and does not arrive too early," according to the court.

The physician-assisted suicide controversy raged on into the early 2000s at the state level. As a result of the justices' argument that each state has the right to protect its own inhabitants and that a federal ruling would be improper, the Supreme Court's decision in Washington vs. Glucksberg allowed state courts to decide whether active euthanasia should be legal. Passive Euthanasia was the subject of a previous judgement by the same court in Washington, D.C.

As the Supreme Court ruled in this case, a terminally sick patient's state might be prohibited from receiving any further treatment if there is no persuasive proof of his or her enduring consent. As a result of this ruling, each states now have the option to set their own guidelines for passively assisted suicide. In order to get at a sensible and acceptable judgment, the Quinlan precedents were followed and accepted by the vast majority of States. Oregon and the Netherlands have been cited by proponents of physician-assisted suicide as examples of appropriate euthanasia methods. States have been given enormous control over involuntary passive euthanasia in their jurisdictions as a result of this ruling.

State constitutions differ from the federal one in the United States of America. There is an exception to this rule in the state of Oregon, which has elected to do something different from the rest of the United States. The Death with Dignity Act makes

physician-assisted suicide (PAS) legal in that state. The patient must be in excruciating agony; the patient must have made an enduring request to a physician to prescribe medications to terminate his/her life; and the pills must be taken by the patient himself/herself. The prerequisites are as follows:

However, lethal injection and voluntary euthanasia, as well as mercy killing, remain illegal in California. The practice of PAS is regulated by the State and overseen by a team of experts. A yearly report on this practice must be issued by the State's Department of Health.

As a result, an Oregon resident who is legally competent and has a terminal illness is permitted to express his or her desire to die. To terminate his or her life in a humane and dignified way, the patient must submit a formal request for medicine in writing. The specified form must be signed and dated by the patient and at least two witnesses who, in the presence of the patient, sign such document after verifying that the patient is competent, acting willingly, and is not being forced or pressured to sign the request. The Supreme Court's ruling in the following case provides more protection for doctors.

Under Oregon's physician-assisted-suicide statute, the federal Controlled Substances Act does not provide the US attorney general the authority to prohibit doctors from prescribing restricted medicines to be used in the process. Patients who want to commit suicide can be prescribed medications by doctors who follow Oregon's PAS law's stringent prot

Assisted-suicide is now allowed in another American state. Montana's Supreme Court ruled in favor of legalizing the practice on December 31, 2009. After this verdict, the defense of a terminally ill patient's request for physician-assisted suicide has been established for physicians who comply. Non-physicians appear to be subject to Montana's present statute prohibiting assisted suicide.

According to the Montana Criminal Law Commission, it would be a crime of criminal homicide if an aided suicide resulted in the death of the patient. However, under Montana's homicide statutes, there is a consent defense. General murder rules in Montana, on the other hand, make it illegal to put an end to one's life. The subsequent

Montana Supreme Court ruling can help to better clarify the situation, as follows: 6.1 The Baxter v. Montana case 85 In 2009, the Montana Supreme Court ruled in favor of this outcome. In this instance, the judge held that doctors who assist their patients in committing suicide could not be penalized. Based on the state's "living will" statute, this decision was made. All of the following requirements must be met: To terminate their life, a patient must be a competent adult, a resident of the state, and have expressly declared their want to die by taking a drug that they will administer to themselves. Submit a written and verbal request to the physician in charge.

Two doctors must confirm that the patient is mentally competent (or referred to a mental health evaluation). Two doctors must certify that the patient has a life expectancy of fewer than six months and that the patient is terminally ill. Two doctors must verify the patient's demands, which must be made voluntarily and without compulsion. Palliative and hospice care should be discussed with the patient. After the initial oral request, there is a 15-day waiting period before submitting a written request. Prescriptions are written after a 48-hour waiting period following written request.

One of the witnesses must be unrelated to the patient or employed by the healthcare facility, and two witnesses must sign it. Patients are advised to speak with their loved ones about this (not required because of confidentiality laws).

The patient has the right to withdraw the request at any moment.

When a patient dies, the attending physician can sign the death certificate, which must indicate that the underlying terminal illness was the reason for the patient's death. To be eligible for assisted suicide in any of these states, the individual requesting it must first be a resident of that state. Only then may they submit an application.[158]

5.6 Passive Euthanasia and Australia

Over two decades after Australia decriminalized assisted suicide, a fifth Australian state legalized the practice for those who are terminally ill in 2021. In the Queensland

[158] Rosa Bowles, Is Euthanasia Ethical, dissertation submission, http://people.brandeis.edu/~teuber/Rachels_Euthanasia.pdf.

Parliament, 61 of the state's 93 legislators supported the bill. As far as individual states go, only the Australian state of New South Wales prohibits assisted suicide. Northern Territory and Australian Capital Territory are not states, and the Federal Parliament has prohibited them from implementing such laws.

As on January 1, 2023, a new law in Queensland permits anybody with a terminal disease or medical condition to have access to so-called voluntarily assisted dying. People with terminal illnesses, the ability to make their own decisions and not be pushed to continue treatment are required. Deputy Premier Steven Miles claims that the plan will ease suffering. The debate has been "thoughtful and challenging," Miles told Parliament. Because of palliative care funding shortages, the measure's critics claimed that some people might be forced to terminate their lives. Opposition members asked, "Will this government commit that people will have access to quality integrated palliative care services wherever they are in Queensland, wherever they get a terminal diagnosis, and not only in the final few months of life?". In contrast, Miles maintained that palliative care and voluntary assisted dying are complementing policies that provide terminally ill people additional alternatives.

In 1995, the Northern Territory became the first jurisdiction in the world to legalize physician-assisted suicide for terminally sick individuals. The Australian Parliament, however, removed the restriction in 1997 after four persons were aided to die.[159]

In June of this year, Victoria became the first state to legalize assisted suicide, despite the lack of federal oversight. A doctor-assisted suicide bill was defeated by a single vote in the New South Wales Parliament two weeks before it was enacted by the Victorian legislature.

When the Northern Territory's Rights of the Terminally Ill Act passed in 1996, euthanasia became legal for the first time. Wake v. Northern Territory of Australia was upheld by the Supreme Court of the Northern Territory. It was made illegal again by the Euthanasia Laws Act of 1997, however. In February 1995, the Northern Territory's

[159] *Euthanasia - the Australian Law in an International Context*, Parliament of Australia, (Aug. 24, 2021, 07:12 PM), https://www.aph.gov.au/about_parliament/parliamentary_departments/parliamentary_library/pubs/rp/rp9697/97rp4.

chief minister filed a private member's bill named the Rights of the Terminally Ill Bill (1995) to the Northern Territory's parliamentary session (NT). When a patient is nearing the end of his or her life and is contemplating suicide, he or she may seek the assistance of a physician. For this purpose, the Legislative Assembly established a Select Committee on Euthanasia. After more than 50 amendments to the initial draft, the Legislative Assembly passed it by a vote of 15 to 10 in May 1995.[160]

The bill provoked a lot of controversy in Australia and throughout the world. It was confirmed by the Northern Territory administrator and rules were released in June 1995 and June 1996, despite calls for its repeal and for the Governor-General of Australia to condemn it. The Act came into effect on July 1, 1996, with these clauses included. The Northern Territory became the first jurisdiction in the world to legalize assisted suicide and euthanasia.

Between May 1995 and July 1996, the Northern Territory Legislative Assembly revised the Act once again, raising the number of physicians engaged from two to three, one of whom must be a qualified psychiatrist and another who is a specialist in the patient's illness. The changes were made. The 1995 Rights of the Terminally Ill Act incorporated several administrative safeguards and repeated references to therapy and "acceptable levels of suffering" for patients.

Northern Territory Medical Association President Dr. Christopher Wake, and Reverend Dr. Djiniyini Gondarra, an Aboriginal leader opposed the bill's legality in an effort to stop it being passed. There is an inherent "right to life" created in the democratic system and common law, and the legislative assembly's use of legislative authority is constrained by this obligation to protect it. The Supreme Court of Appeal of the Northern Territory affirmed the statute by a two-to-one majority, stating that the issue of whether it violated a fundamental right was "ethical or moral or political" rather than "legal."

A Darwin resident became the first to employ the updated bill's provisions, which had been criticized for their apparent inefficiency, and the issue erupted once more at the

[160] Ronald B. Sklar, The Capable Mental Health Patient's Right to Refuse Treatment, 5 McGill J.L. and Health 291 (2011).

end of September 1996. After being diagnosed with prostate cancer for five years, reports say the patient has been able to communicate with his family and loved ones via a laptop. Prior to the national parliament quickly rejecting the law, three additional people took use of its provisions.

Section 122 of Australia's constitution grants the Parliament the authority to override any territory law. In September 1996, a government backbencher proposed legislation to repeal the Northern Territory's euthanasia act. As of Dec. 9, 1996, and March 24, 1997, it was essentially terminated.

Euthanasia laws in the Northern Territory were abolished in 1997 when Senator Bob Brown introduced legislation to repeal the act in 2007. Senator Brown's lone pending legislation in the Senate is the Restoring Territory Rights (Voluntary Euthanasia Legislation) Bill 2010.

Euthanasia-related legislation has been a hot topic in state legislatures across the country in recent years, with the notable exception of Queensland. 32 Medically assisted suicide was proposed by Colleen Hartland in the Victorian Parliament in June 2008, but on September 10th, it was shot down. After being presented on May 20, 2010, a bill legalizing assisted suicide in Western Australia was never brought up for a second reading. 34 South Australia's lower house, the House of Assembly, proposed two legislation in 2010 that were adjourned at the 2nd reading; nevertheless, the Legislative Council introduced a replica of one of those proposals but was negative (i.e., did not pass). At the time of this writing, there has been no legislation approved in any other parliament.[161]

The Rights of the Terminally Ill Bill (1195), introduced by the Northern Territory Chief Minister in the Legislative Assembly in February 1995, was a Private Member's Bill. End-of-life care is now available to those with terminal illnesses who choose to end their own lives. Select Committee on Euthanasia established to investigate and report back to the Legislative Assembly on the proposed measure for assisted suicide. More than fifty changes to the original draft were made before it was adopted by the

[161] Skand Shekhar and Ashish Goel, Euthanasia: India's Position in the Global Scenario, https://journals.sagepub.com/doi/abs/10.1177/1049909112465941?journalCode=ajhb.

Legislative Assembly in May 1995 by a vote of 15 to 10. The Northern Territory became the first jurisdiction in the world to legalize assisted suicide and euthanasia.

In Australia and across the world, the bill aroused a lot of discussion. The Northern Territory Administrator, under the Northern Territory (Self Governance) Act, 1978, assented to the Act and its rules in June 1995 and June 1996 as a result of requests for their repeal and prohibition by the Governor-General of Australia. On July 1, 1996, the Act and these provisions went into effect. At least one of the three doctors employed by the Northern Territory's Legislative Assembly during this period had to be a certified psychiatrist.[162]

The 1995 Rights of the Terminally Ill Act incorporated several administrative safeguards and repeated references to therapy and "acceptable levels of suffering" for patients. Legislation's fundamental principles were summarized in Section 4.

End-of-life options are available to terminally ill patients if they are experiencing pain, suffering and/or grief at a level they find unbearable.

It was formerly said that a sickness was "terminal" if it didn't necessitate drastic measures or treatment that the patient couldn't bear. Patients who want assistance in terminating their lives from an authorized medical expert must follow all the measures stated in the laws in order for this assistance to be legal. It is possible that the assistance offered includes the prescription or preparation of medication for either self-administration by the patient or provision to the patient. As a result, the doctor may refuse to aid at any times and for any reason.[163]

Other prerequisites included: a minimum age of 18, no readily available palliative care options, and two nine-day "cooling off" periods between the original request for medical treatment and the actual assistance itself.

Aboriginal spiritual leader Reverend Dr. Gondarra, as well as Australian Medical Association branch president for Northern Territory, spoke against it in an effort to keep

[162] *Ibid.*
[163] Sydni Katz, A Minor's Right to Die with Dignity: The Ultimate Act of Love, Compassion, Mercy, and Civil Liberty, 48 Cal. W. Int'l L.J. 219 (2018).

it from becoming legislation. According to one of the grounds offered, legislative authority is obligated to protect an inherent "right to life," which is solidly entrenched in the democratic system of government and the common law. Because there was no constitutionally established Bill of Rights, a majority of the court concluded that the issue of whether the Act infringed any basic rights was "ethical, moral, or political" rather than "legal."

It was the end of September 1996, and despite critics' warnings that the new legislation was impractical, outrage erupted again when a Darwin man became the first person to successfully use it. Using a laptop computer that the patient had used to confirm his decision to die, doctors allegedly administered the lethal medicine to the patient after a five-year fight with prostate cancer The Act's provisions were used by three other people until the national parliament overturned it.

It is possible for Parliament to overrule any territory's legislation under Australian constitutional section 122. Overturning Northern Territory's Euthanasia Law via a Private Member's Bill It was first proposed in 1996 by Government Backbencher Kevin Andrews. The bill was passed by both the House of Representatives and the Senate on December 9th, 1996 and March 24th, 1997, respectively.

The Legislative Council of South Australia submitted a Voluntary Euthanasia Bill on November 8th, 1996. There were 13 votes in favor and 18 in opposition to the measure's consideration on July 9th, 1997, and the bill was sent to a Select Committee. It was also proposed that if the legislation was approved by both houses, a referendum be held before it became law.

This is a crucial feature that should not be overlooked:[164]

Eligible patients must have life-threatening conditions, such as permanent loss of consciousness or an irreversible reduction in quality of life, in order to be eligible for lethal injection.

[164] Zachary A. Feldman, Suicide and Euthanasia: The International Perspective on the Right to Die, 104 Cornell L. Rev. 715 (2019).

Requests may only be made by people who are in good health, and they can either be a Current Request or an Advancing Request, which takes effect when the individual is terminally sick.

Euthanasia could only be performed by a doctor, and a second doctor's opinion would be required. For this to happen, the patient must be cleared by both doctors as not having a diagnosable case of clinical depression. Any doctor or nurse can decline to engage in euthanasia if they so choose.

Before euthanasia may be performed, a request must be submitted 48 hours in advance. Plans for life insurance are not expected to be impacted.

Using a computer application that allowed terminally ill patients to input their order into a laptop computer and deliver a deadly dose of medications if suitable, the Northern Territory of Australia became the first jurisdiction in the world to legalize medically assisted suicide in 1996. The Act was, however, revoked by the Australian government in 1997. It has been slammed by religious, political, and indigenous leaders.

CHAPTER 6

IMPACT OF COMMON CAUSE AND ARUNA SHANBAUG CASE: AN ANALYSIS

6.1 Introduction

However, the Supreme Court of India has approved "passive euthanasia," in which patients in a permanently vegetative state are allowed to unplug their life support systems, but has rejected outright active euthanasia, in which patients are given lethal medications to die. Aruna Shanbaug, who has been in PVS for 37 years, was ordered to live in order to protect the safety of future rape victims. In accordance with the Supreme Court's directions, passive euthanasia is currently the rule of the land until Parliament develops a statute dealing with it.

the patient's parents or his spouse or other close relatives, or in cases when none of these people are present, the Supreme Court's Constitutional bench of India must make the decision to stop a patient's life support. This treatment can also be performed on a patient by a doctor. Only decisions that are made in good faith and with the patient's best interests in mind should be made about a patient's treatment. The Supreme Court underlined the authority afforded to Indian High Courts by Article 226 of the Indian Constitution and set a comprehensive protocol that each High Court had to follow when such a request to discontinue life support was submitted until Parliament approved legislation on the matter.

6.2 Aruna Ramachandra Shanbaug: Case Review

Aruna Ramachandra Shanbaug,[165] a 24-year-old registered nurse, worked at the King Edward Memorial (KEM) Hospital in Parel, Mumbai. On November 27th, 1973, she was assaulted by hospital cleaner Sohanlal Bhartha Walmiki. As part of the attack, Sohanlal chained up Aruna and hauled her back into a hospital basement room with the use of a dog collar. after learning she was pregnant, he tried to rape her but she wouldn't let him get close enough. He placed a chain around her neck and tightened it to keep her from fleeing.

[165] Aruna Ramchandra Shanbaug v. Union of India and others, 2011 AIR (SC) 1290.

A housekeeper discovered her unconscious and bloodied on November 28th, 1973, around 7:45 a.m., and he immediately called 911 for help. The dog chain strangulation caused damage to the brain by cutting off the oxygen supply to the brain. She had plantars extensors, which the hospital's Neurologist identified and suggested that she had had a brain damage. She also had a contusion of the brain stem and injury to the cervical chord.

When Aruna Ramachandra Shanbaug was 36 years old at the time of the incident, Pinky Virani asserts that she is now 60 years old. Frail bones were at risk of shattering since she was so light. After her period was through, her skin looked like a stretched-out sheet of papier mache. She had an issue with bed sores. Her wrists were twisted from the inside out. She was in constant pain because of her deteriorating teeth. Mashed food is all she can eat. At the time of her gulping down the dinner, she had no idea it was there. It was obvious that the meal was being absorbed without her active participation because she was unable to swallow any beverages. She continues to digest the mashed food in this manner as it passes through her digestive system Persistent vegetative state (p.v.s.): Aruna Ramachandra Shanbaug was effectively dead and had no awareness of her surroundings or functional brain. She is completely unable to see, hear, or express herself in any manner whatsoever. Her poop and feces were all over the place, including the bed. The cleaning crew came in and out, but she quickly reverted to her original condition of filthiness. If Aruna had not been fed the food that had been mashed into a fine powder, she would not have been alive at this point. Even if her health improved just a little bit, her corpse would still have lay at the KEM Hospital for the past 36 years like a dead animal. The petitioner has requested that the respondents stop feeding Aruna and allow her to die peacefully.

In response to Pinki Virani's appeal, Professor and Head of KEM Hospital, Dr. Amar Ramaji Pazare, filed a rebuttal affidavit on behalf of the Mumbai Municipal Corporation and Dean of KEM Hospital. Pinki Virani's words towards Aruna Shanbaug were unpopular with Pazare. Dr. Pazare's opinion is that: "While Aruna is unable to speak, she does communicate herself through facial expressions or noises when she is given instructions. When she receives her favorite foods, she beams with delight. She

relaxes to the sound of religious music playing in the background of her bedroom. To let medical staff know she's in trouble, she'll make noises to get their attention. No signs of misery or hardship may be seen on her face."

At Aruna's hearing before the Supreme Court, KEM Hospital's Dean, Dr. Sanjay Oak, spoke out against euthanasia. Dr. Oak stated the following: "She is well regarded at KEM Hospital. She likes listening to music and dancing around the house when she is on a liquid diet. We've never used an IV or a feeding tube to feed her. There have been no bed sores in all these years. When the persons who are accountable for her well-being are not experiencing any problems, an unrelated third party need not be concerned about her."

History of Procedural Actions

It is possible that Pinki Virani's petition was denied by the Bench without hearing from any of the parties present. Petitioners in India must establish that a fundamental right, including the right to life itself, has been violated under Article 32 of the country's constitution. There is no constitutional right to die, according to the decision in Gian Kaur vs State of Punjab, 1996(2) SCC 664, which held that an unnatural death shortening someone's lifespan is illegal.

According to the Bench, there was no violation of the petitioner's basic rights, and there was a precedent in the Gian Kaur case that may have dismissed the plea from the beginning.

India's Supreme Court began looking into the issue after Pinki Virani's petition and Dr. Pazare's counter affidavit included major discrepancies in terms of their assertions. A court-appointed medical team will conduct an evaluation of Aruna's physical and mental condition. T.R. Andhyarujina, a seasoned Senior Counsel, was also named by the court as an Amicus Curiae (friend of the court).

Before a health report on Aruna could be submitted, she had to undergo a thorough examination by a group of three renowned experts. Professor and Head of the Anesthesia Department at Tata Memorial Hospital, Mumbai's Dr J. V. Dvatia and Consultant Neurologist at P. D. Hinduja, Dr. Roop Gursahani, and Professor and Head of the Psychiatry Department at Lokmanya Tilak Municipal Corporation Medical College and General Hospital's Dr. Nilesh Shah were all present for the surgery.

Besides the required examination, this team extensively examined the 37-year case history and observations of the Dean and KEM Hospital medical and nursing staff. According to the medical team's findings:
Her non-progressive but irreversible brain damage from hypoxic-ischemic brain injury after strangling Aruna for so long made her the oldest survivor of this disease. It appeared that Aruna was neither brain dead nor in a coma, as far as we could discern. She, on the other hand, met most of the qualifications to join the PVS and was therefore eligible for membership. An excellent nursing staff might keep the patient alive for many years with the correct therapy if there was no danger to their health.

There was no treatment for the harm she'd sustained to her nervous system. All four of her hemispheres' primary neural circuits were confirmed to be intact. An examination failed to find solid evidence that any of the individuals were aware of any of the sensory inputs.

In accordance with the panel's conclusions, "Aruna is still alive, despite the use of artificial life support. She had no evidence of catatonia, rage, or violence at the time of the examination. Her life doesn't look to be full of agony because of this."

Issues

Medical ethics, the court said, is founded on two basic principles: patient autonomy and beneficence. According to Aruna's medical records, she had never expressed any preferences to any surrogate and was unable to do so now. Concerns regarding euthanasia and other sensitive issues were added to the Supreme Court's study into Aruna's case, as the court recognized the probable consequences of its judgment on the

larger community and the Indian judiciary. According to the Supreme Court, these were the issues in this case:

- Has the practice of withholding life-sustaining therapies (such feeding tubes) been deemed lawful by numerous authorities or is it only "not illegal"?
- Assuming the patient has already said that they do not intend to receive life-sustaining treatment in the case of futile care or a PVS, should their wishes be honored?
- As long as the patient's wishes have not been expressed, should family or heirs ask for life-sustaining therapies to be withheld or withdrawn?
- Aruna Shanbaug has been cared after by KEM Hospital employees since her family abandoned her 37 years ago. Who has the authority to make decisions on her behalf?

Analysis of the Judgment

According to the Supreme Court, Aruna Shanbaug had created an emotional bond with the KEM hospital staff, who in a way were her family. Aruna Shanbaug's "next friend," Pinki Virani, was not as close to the medical staff as she claimed to be, according to KEM hospital officials. The KEM hospital staff was referred to as Aruna Shanbaug's next pals rather than Pinki Virani by the court. When it comes to Aruna Shanbaug, the court noted that Pinki Virani had written to her and visited her, but that "she cannot claim the level of connection or bonding with Aruna that KEM hospital workers assert" - Pinki Virani v. KEM Hospital, Inc., a case from New York.

As the court observed, "In the history of American medical law, there has never been anything quite like this. Supporters of mercy killing are also on the increase across the country. Many terminally ill patients ask the courts to end their suffering by seeking death, but all of these pleas have been denied on the basis that the right to life is sacred."

Supreme Court Justice Pinki Virani submitted a writ petition claiming that Aruna Shanbaug is already dead, and hence, by not feeding her corpse any more, we would not be killing her. The judge questioned Pinki's claim that Aruna had died, asking, "When can a person be called dead?" When all functions of the brain, including the brain stem, were permanently terminated, a person was declared dead by the court.

However, this definition went beyond acknowledging consciousness and concluded that brain death differed from a persistent vegetative state, where the brain stem continued to work, and so some degree of reactions might occur, but the possibility of regaining consciousness was relatively remote; When someone is unconscious but still breathing and moving, they are not considered to be dead. He or she would be "alive" just by breathing, as the act of doing so would be mechanical. Consequently, "Aruna is not dead" was declared by the court. Further explanations were given by the court. "Petitioners are usually distant or blood relatives, but this case is unique since a person who is not related to Aruna, but who has been affected by her ongoing pain, has submitted this petition.

If a patient in a coma or on PVS is deemed incapacitated, it is unclear who has the ability to determine whether or not life support should be stopped." In light of this discrepancy, the Supreme Court issued a cautionary note "This is a critical question in India because of our society's poor ethical standards, pervasive commercialization, and endemic corruption. As a result, the court must use extreme caution in order to prevent those who desire to get someone else's property by dishonest means from doing so. A patient should not be called hopeless until there is no credible possibility of any improvement by any newly discovered medical treatment in the near future, according to medical professionals." In addition, the court held that medical experts, such as physicians, might evaluate whether a patient's chances of recovery were feasible in the near future due to a new medical discovery.

A set of standards for passive euthanasia has been established by the Supreme Court. The term "passive euthanasia" refers to the practice of depriving a patient of life-sustaining treatment or sustenance. To the extent that Parliament does not act on the Supreme Court's euthanasia rulings, they remain valid in India. Vivek Moily, Minister of Law and Justice of India, has called for serious political conversation. Rules and regulations were drafted and implemented.

A individual or group acting as a "next friend" must make the choice to remove the patient from life support if the patient's parents or other close family members are not available. It can also be used by medical personnel who are taking care of the patient.

In any case, the primary focus of the decision-making process should be on the patient's welfare.

The High Court of the country in which the patient is receiving medical attention must provide its approval before the decision to terminate life support can be made. In order to decide whether or not to give assent to such an application, the Chief Justice of the High Court should convene a bench of at least two justices as soon as possible. The patient's condition will be evaluated by a three-member panel of highly renowned doctors appointed by the Bench. Before a verdict is handed out, the victim's family and the state should be informed. Upon hearing from all sides, the High Court can make a ruling.

There are no laws in India governing euthanasia, thus the Supreme Court emphasized its authority under Article 226 of the Indian Constitution, which gives the High Courts this authority. In addition, it established a detailed procedure for each High Court to follow when it received a retry application. In court, a judge made the following statement: "The authorization of the High Court should be taken into account in this regard. Patients, doctors, patients' families, and the general public will all profit from this, which is in everyone's best interest. Parens patriae (father of the country), a well-known concept in law, is in agreement with this."

KEM Additionally, the Supreme Court lauded the hospital staff for their noble character and outstanding commitment to Aruna's treatment over the course of so many years. Court officials regarded Pinki Virani in high regard notwithstanding the court's rejection of her original petition, since she had taken up a cause she believed to be reasonable and ethical.

The Debates

Before making a decision on the issue, the Supreme Court considered the arguments of both sides. Furthermore, India's Attorney General and the authorized amicus curiae for the case were also in attendance. Shekhar Naphade, senior lawyer for the petitioner, cited the Supreme Court's 1988 (Supp) SCC 734 judgement in Vikram Deo Singh

Tomar against State of Bihar as a precedent and contended that Aruna should be allowed to die. In the counselor's opinion, this was the most crucial element. "A healthy lifestyle is more vital than merely making it to the other side of life. The absence of illness is merely one aspect of one's vitality; it also encompasses one's overall energy and vitality." However, this was not the case for Aruna.

On the issue of euthanasia, India's Attorney General, G.E.Vahanvati, said that the government had not accepted the conclusions of the Law Commission of India. According to him, "Indians don't send their parents to old age homes because they are a kind and compassionate people. If euthanasia is legalized, doctors and family members may conspire to murder a person in order to gain control of that person's possessions. Medical conditions that are today considered incurable may be treatable in the future."

T.R. Andhyarujina, the Amicus Curiae in the case, remarked, "In common law, people have a basic freedom to manage their bodies without interference from others. Those of sound mind and mature age have the right to make their own decisions about how their bodies are utilized." In his opinion, "Life support can be turned off as long as the patient is of sound mind, and he or she has the right to do so. Similar to a "living will" or a doctor's written authorization, a patient's consent may have been conveyed prior to his or her inability to communicate. When it comes to a patient's death, it is not about whether it is in his or her own best interest to die. There is a debate about whether or not the patient's life support therapy should be kept up." As opposed to the learned Attorney General, Andhyarujina favored passive euthanasia when medical practitioners made the choice to terminate life support.

According to Pallav Sisodia, the Dean of KEM Hospital, Pinki Virani had no legal right to submit a writ petition in this matter, and that only KEM Hospital staff could have done so, an official report was given. With Pallav Sisodia, T.R.Andhyarujina agreed on this matter.

Based on the arguments of the counsel, the Supreme Court recognized the distinction between murder and failing to save one's own life. As a result, the court made clear that euthanasia might be performed in two ways: actively or passively. This is what a judge defined as a violation of the law: "Passive euthanasia is the refusal of medical care in order to end the life of a person in need of aid, whereas active euthanasia entails the use of lethal substances or forces to kill a person. It's important to remember that doctors in passive euthanasia aren't actually killing anyone; they're just failing to rescue them." According to the court, euthanasia can be categorized as either voluntary or non-voluntary. The patient's consent was secured in the first instance, but not in the second.

Proponents of euthanasia say that while we can debate whether active euthanasia should be legal, there can be no debate over passive euthanasia," the court stated in response to this. The fact that someone saved another's life is celebrated is not generally punished, but the fact that they didn't is punished is "In its ruling, the court made its case. If you want to be a hero in a fire, you have to enter the flaming structure and save someone from damage. Few will hold someone accountable for their inactivity if they observe a burning building with people begging for rescue and do nothing. The reason for this might be because he fears for his personal safety or feels that a person like him, who is untrained and unequipped, will merely come in the way of the professional firefighter team. A person would almost definitely face charges of murder."
Many countries allow passive euthanasia, while most governments prohibit forceful euthanasia. Euthanasia was remained lawful in the United States despite the fact that euthanasia was prohibited in India. Furthermore, as of this writing, there is no regulatory structure in place to allow for the cessation of life support for an unconscious or otherwise disabled individual.

Community Implications of the Case

Fears of exploitation complicate the right to die. Family members and even suicidal patients may abuse the right to end their own lives. Some patients may be persuaded to end their lives due to misdiagnosis or misunderstanding of the facts. Medical professionals and their loved ones should not be allowed to murder a patient just because the patient does not wish to die. After the Aruna judgement was announced,

the story of two underprivileged boys with muscular dystrophy grabbed headlines. Seeing their children in pain is hard for their parents, who can't afford therapy. If these parents are denied permission to terminate the life of their children, then the state should foot the expense for their care, they argue in a new statement.

If a patient or her family cannot afford medical care, may they not demand free or subsidised medical care in lieu of their wish for mercy-killing? In a country where medical care, including palliative and hospice care, is inaccessible to a huge percentage of the population, the topic is pointless. When resources are very limited, some believe that money spent on artificially supporting patients should be better used to treat those who have a prospect of recovery, regardless of the severity.

On the right to die debate in India, Aruna Shanbaug has had a tremendous impact. As long as certain requirements and constraints are met, passive euthanasia for persons in a vegetative state is legal. The Supreme Court ruled that removing Aruna's feeding tube was an unjustified request.

Who decides what's best for a patient in a state of persistent vegetative state? According to Justice Katju, the Court has the ability to decide what is in the best interest of the patient as the "Parens Patriae."

Children and the mentally sick, for example, are protected by common law, which mandates that the state make judgements on their behalf to protect their best interests. When it comes to determining the 'Parents Patriae' jurisdiction for mentally incompetent persons, two standards have been developed: "Best Interests" and "Substituted Judgment." It is called "substituted judgement" when the court is forced to act in the place of an incompetent party and seek to render a decision that the party could not.

To determine if a pregnant woman with mental disability has the right to carry on, the Supreme Court relied on the "Parens Patriae" principle that embraces both of these situations. Since the woman was clearly intent on carrying her pregnancy to term, the

substituted judgment test was not necessary in this case. The Court determined that the 'Best Interests' test should solely be applied to the patient, rather than relying on the interests of the patient's guardians. As a result, the Court denied the patient's plea to end her pregnancy while upholding her rights.

When the Suchita three-judge court confirmed this "Substituted Judgment" threshold, it overlooked Aruna's case. A low standard of "best interests" that should be established by taking the wishes of parents and relatives into account was used in the House of Lords' Airedale judgment to enable passive euthanasia to be practiced.
Although the individual may be unsuited to consent, this judgment rejects all recognition of the individual's right to autonomy and self-determination. When it comes to their legal capacity, those who are mentally incompetent are no longer subject to "best interests" considerations. Surrogate decision-makers can only use this authority if there is clear evidence that the incapacitated person would have opted out of treatment, according to the Supreme Court of the United States in the Nancy Cruzan case. A court could only use this right if there was no evidence to support it under the "best interest" principles.

Because to the Aruna Shanbaug ruling, family members of terminally ill or elderly patients no longer have to evaluate whether or not the patient would have consented to their deaths being ended in this manner.[166] According to many, Aruna's degree of concern and devotion is the exception rather than the rule. Patients with similar problems are often turned away by hospitals. To free up a bed, Bombay Municipal Corporation requested that Aruna be moved outside of the hospital, but the nurses objected angrily even in Aruna's case.

On top of the emotional and psychological toll of losing a loved one to death, leaving a loved one in a nursing home or critical care unit for months at a time may leave some families destitute and impoverished. However, the Supreme Court confirmed the legality of passive euthanasia, which was controlled throughout the process. To judge

[166] *Who decides?* The Hindu, Online edition of India's National Newspaper, (Dec. 12, 2019, 07:00 PM),, http://www.hindu.com/mag/2018/03/20/stories/2018032050340600.htm.

whether or not a patient should live or die, the Court must be consulted, which incurs a hefty expense for the patient. There should be legislation in place to allow those who are dying in this manner to be able to die in peace and comfort.

As Narayana Hrudaylaya CEO and renowned cardiologist, Dr. Devi Shetty, has said "For my part, I'm totally against it. In my opinion, legalizing Shanbaug opens up Pandora's Box, and I don't want to open it. euthanasia will be exploited since it is neither controlled or supervised." Quite the contrary, in fact. Dr. Shetty believes that euthanasia should never be legalized under any circumstances. "India can't handle this. Another 20 to 30 years of preparation will be necessary for us to be ready." This was brought up by Dr. Shetty. "It will never happen. The Supreme Court has made a proposal, but it is not yet a law. A committee will be formed by the medical council and the health ministry."[167]

Dr. P Jagannath, a cancer expert, called it a "forward-thinking" move.
India has previously practiced "passive euthanasia," says Dr Nagaraj Huilgol, an advocate for "death with dignity" and a consultant radiologist.

'If a person is terminally ill, we would do nothing that would purposefully extend their life,' said Dr. Farokh Udwadia, one of India's finest medical academics. This implies that the patient's blood pressure and skin rashes wouldn't be a problem for the doctors. It is highly likely that a really ill patient would soon need a ventilator, and he would never be able to get out of it, therefore I would tell him that. The final decision would be made by the patient or a member of his immediate family. For Dr. Udwadia, euthanasia is opposed. Dr. Andrew Weil says, "As doctors, our mission is to relieve suffering, not to end life." A decision like this may not always be in the patient's best interest; thus, he opposes it.[168]

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[167] Ghose Priyanjali, *'India Not Mature Enough To Handle It',* Mid-Day, (Dec. 12, 2019, 08:50 PM),http://www.mid-day.com/news/2018/mar/090311-news-bangalore-pandoras-box-cardiologist-dr-devi-shetty-supreme-court.htm.
[168] Passive Euthanasia: Practice has existed in India (Mar. 08, 2020), http://articles.timesofindia.indiatimes.com/2018-03-08/india/28667713_1_passive-euthanasia-patient-doctors.

"If a patient on life support has a heart attack, we take the family's agreement to stop treatment," explains Dr. T V Divetia, chief of anaesthesia and critical care at Tata Memorial Hospital. To end one's life without the use of life-sustaining measures is known as "withdrawing life support," however that word is rarely used. A panel that includes Divetia was considering appointing Aruna Shanbaug to the Supreme Court. According to the Society for the Right to Die with Dignity in Mumbai, Dr. Nagraj G Huilgol welcomed the Supreme Court's decision to legalize passive euthanasia across the country. Patients who are seriously ill and have little prospect of recovery are encountered by every clinician. Physicians have hastened death by neglecting to deliver a certain course of treatment. To escape financial obligations or to harvest organs, "passive euthanasia" should not be an option.[169]

President Alex Schadenberg of the Euthanasia Prevention Coalition characterized the ruling as "mixed," saying that the Supreme Court rejected active euthanasia but allowing for passive euthanasia by removing essential food and water from an animal's system of support (via a feeding tube).[170]

Aruna Ramchandra Shanbaug against Union of India authorized passive euthanasia, according to Sushila Rao.[171] There is a tendency in legal reasoning to overemphasize the "sanctity of life" assumption when using an absolutist interpretation. To the extent that it no longer serves as a solid foundation, this fundamental principle has already been undermined. According to current legal and ethical framework, assisted suicide and euthanasia can be included in the right to die under certain circumstances. Patients who are unable to end their lives on their own are arbitrarily denied the right to death in its entire form.

[169] Nod for Passive Euthanasia Relieves Doctors Published, (Mar. 08, 2020), http://www.dnaindia.com/mumbai/report_nod-for-passive-euthanasia-relieves-doctors_1517052.
[170] Smith Peter, India Supreme Court Saves Woman's Life, But Rules Passive Euthanasia Legal (Mar. 08, 2020), http://www.lifesitenews.com/news/india-supreme-court-saves-womans-life-but-rules-passive-euthanasia-legal/
[171] The Moral Basis for a Right to Die by Sushila Rao, http://beta.epw.in/newsItem/comment/189816/

The degree of causation between a certain behavior and a person's mortality is denoted by the terms "active" and "passive." What is the difference between being active and silent in terms of morality? James Rachels says that no matter how active or passive you are, there is no moral distinction. The motivations, goals, and results of an action, according to him, are the most morally relevant components. Since both active and passive euthanasia are euthanasia, there are no moral differences to be made. The active/passive dichotomy isn't the only way to distinguish between different real-world circumstances.

Because active euthanasia eliminates any possibility of a miracle, is more closely related to murder than passive euthanasia, and does not need the patient to be as sick, some people who believe in miracles argue that there is a moral difference between active and passive euthanasia. It is possible to make exceptions to each of these points. Passive euthanasia advocates, however, contend that the right to privacy is a more basic one (especially protection from interference and bodily invasion). Patients have never had the right to demand particular treatments, which is why support for euthanasia stems from this weaker right.

When someone is helped to commit suicide, that individual is considered to have been assisted in their suicide. This means that the patient is in complete control of his or her own death because he or she is the one to carry it out. Health care providers who participate in assisted suicide or euthanasia may be viewed as less ethical than those who do not, as it undermines the core values of the profession. It's been suggested by some that one such objective should be the relieve of pain, and in rare cases, death is the only option to achieve this. Germany allows assisted suicide, but not euthanasia. This is in large part because of the issue of patient empowerment. If the patient committed the action that led to their death, it is more likely that they made a deliberate decision to die. As a result, there's less risk of something going wrong.

If the primary goal is to alleviate the patient's pain and suffering and guarantee that the patient's comfort is the primary focus, euthanasia and assisted suicide are not appropriate. They have a responsibility to reduce suffering and protect the dignity and autonomy of patients they care for. Some patients' misery and suffering can only be

relieved by prescribing a therapy that brings them closer to death. It is ethically permissible to provide a dose of medication that may have the side effect of hastening death as long as the intention is to alleviate or avoid suffering or anguish.

Medics have the right to reject treatment if it conflicts with their religious or moral beliefs. In any case, it's imperative that the duty is delegated to someone with at least the same level of expertise. In the event that no one can or will administer enough pain medicine, the patient should not be allowed to die. People may refuse pain medication for religious or philosophical reasons, however this isn't always the case.

It is the act of helping someone commit suicide. One of the most crucial differences between assisted suicide and euthanasia is that with the former, the patient has complete control over how and when they choose to die. The other party acts as a helping hand (for example, providing the means for carrying out the action).

Health care providers who participate in assisted suicide or euthanasia may be viewed as less ethical than those who do not, as it undermines the core values of the profession. It's been suggested by some that one such objective should be the relieve of pain, and in rare cases, death is the only option to achieve this. Germany allows assisted suicide, but not euthanasia. This is in large part because of the issue of patient empowerment. If the patient committed the action that led to their death, it is more likely that they made a deliberate decision to die. As a result, there's less risk of something going wrong.

Rather of alleviating their suffering, life-supporting measures have exacerbated it and prolonged their death. As a result of modern critical care's artificiality and removal of death from its natural context, we have lost our yearning for a peaceful dying surrounded by loved ones. Because of the necessity for long-term and pointless life support, patients and their families are likely to have been financially stretched to the limit.[172]

[172] End-of-Life Care in Critically Ill Patients : Indian Perspective, (Mar. 08, 2020), http://tmc.gov.in/clinicalguidelines/EBM/Vol5/final_critical_care_final/end-of-life_09.htm.

Painkiller availability, especially opioids, and the availability of carers were identified as the most crucial practical challenges by specialists in the field. According to the authors, hospice care financed by the state prioritized conventional therapy above palliative care. Patients rely heavily on charitable organizations, even in well-funded health systems, according to experts. "In many nations, end-of-life care is plagued by painkiller shortages and inadequate legislation. Too many people die in nations with world-class healthcare systems with average dying experiences, even when death is inescapable End-of-life care is likely to rise dramatically in many nations as life expectancy increases and the elderly population ages "the research team found.[173]

In cases when the malignancy is no longer under control, oncologists stop examining and treating patients. In spite of this, the patient's care is not done yet. The treatment's primary objective is to put the patient at ease. Prescription pain relievers and other treatments are available to help patients deal with their discomfort and other side effects. Several people may need to be hospitalized or otherwise cared for during this time period. Through a wide array of interventions, the medical, psychological and spiritual challenges that accompany dying can be alleviated. Hospices often provide these types of services.[174]

It is hardly a joke when patients in our intensive care units are humorously referred to as "cauliflowers." They're probably going to be like this for the remainder of their lives, if not forever. Neither the sender nor the recipient will be aware of their presence or the sentiments they share as they experience this outpouring of affection. The patient's brain lesion has rendered him entirely numb to the world around him.

Physicians continue to treat patients even though they know that their tests and assessments will never result in significant awareness for the patient. Pressure sores,

[173] 'India worst in end-of-life care', The Times of India, (Jul. 16, 2020, 03:30 PM), http://articles.timesofindia.indiatimes.com/2018-07-16/india/28299433_1_countries-rich-nations-end-of-life.
[174] End-of-Life Care: Questions and Answers, (Jul. 16, 2020, 04:30 PM), http://www.cancer.gov/cancertopics/factsheet/Support/end-of-life-care.

infections, and blood clots in the lower leg veins can occur as a result of coma and paralysis. Individuals who are unable to breathe on their own and must rely on machines to aid them are frequently seen in this category The cost of all of this medical care is prohibitive.

No one in the family would complain about making the sacrifice if the outcome was positive. Even the poorest households may afford care at institutions like the K. E. M. Hospital in Parel, Mumbai, even if they don't have a lot of money.

Whether or not to continue paying for expensive medical treatment is a decision that should be left to family members. A person's emotions typically take precedence over reason when facing the prospect of losing a loved one. In the words of a bereaved family member, "Doctor, please do everything you can," a doctor is asked to save the life of their loved one.

A few days or weeks after receiving therapy, the patient's family begins to doubt whether or not their money was well spent. Because no one can predict whether or not the patient will improve beyond this point, panic sets in. A person's life cannot be terminated at this stage by law; therefore, the sad drama will have to play out to its terrible conclusion.[175]

6.3 Common Cause: Case Review

Case Brief

Under Article 21, the right to live with dignity includes the right to die with dignity. Common Cause[176] filed this petition on behalf of its members. Those with deteriorating health or who are terminally ill should be able to sign Advance Medical Directives or Living Wills, according to the law.

[175] Sunil K Pandya, *Impact of life-prolonging technologies on end-of-life care in India*, Indian Journal of Medical Ethics.2005 Jul-Sep;2(3), (Aug. 05, 2020, 09:30 PM), http://www.issuesinmedicalethics.org/133ed02.html.
[176] Common Cause (A Regd. Society) v. Union of India, (2018) 5 SCC 1.

The Court looked at precedent from India and throughout the world, notably the case of K.S. Puttaswamy, and determined that Article 21 guarantees the right to die with dignity. Acknowledging that human autonomy can be protected by Advance Medical Directives, the Supreme Court affirmed their use. Privacy is a vital component of human dignity, and without it, liberty cannot be realized, the Supreme Court argued. A person's right to privacy was viewed as essential to the protection of their physical integrity, autonomy, and freedom of choice as inalienable human rights. The Court noted the US judgment in In Re Quinlan, which said that when physical integrity was compromised and the possibilities of recovery decreased, the right to privacy grew and the state interest decreased. This Court has recognized that a patient's right to bodily privacy and integrity, as well as their right to an informed consent-free treatment, is violated if treatment is continued against their desires.

Facts

Writ petitioners argued that the "right to die with dignity" was part of the "right to live with dignity" under Article 21, and that people in deteriorating health or who are terminally ill should be allowed to make living wills or advance medical directives.

Despite the fact that this issue was first brought to a three-judge bench, due to inconsistent precedents on the right to die in India, the Constitution Bench was asked to rule on the matter. In the matter of P. Rathinam, the Supreme Court's Division Bench found that Section 309 of the Indian Penal Code, 1860 (IPC), which criminalized suicide attempts, was unconstitutional because it violated Article 14 and 21 of the Constitution's basic rights. Previously, the Supreme Court had ruled that the freedom to die was part of the right to live. In Gian Kaur, a five-judge bench of the Supreme Court, ruled that Article 21 of the Constitution does not guarantee a person's right to die, and this was overruled. Aruna Ramachandra Shanbaug's death was approved due to unusual circumstances that met the court's rigorous standards for passive euthanasia.

Issue

Whether Article 21's guarantee of the right to live with dignity included the right to die with dignity as one of its essential rights.

Arguments

It was asserted by the Petitioner that the notion of individual autonomy's preservation was intrinsic to the right to privacy and also a part of the concept of freedom. Patients' autonomy and dignity were violated by maintaining them in a protracted vegetative state using modern medical techniques, it was said. That right to live and die with dignity is intertwined, the Petitioner asserted. A common law right to refuse medical treatment was asserted, as was the idea that no one could be forced to get treatment against their will, according to the argument made in the suit.

Euthanasia regulation was examined by the State but rejected by the Ministry of Health and Family Welfare, according to the Respondent-counter-affidavit. State's It was claimed by the Respondent that Article 21's protection of the right to a dignified life only included the right to food, housing, and health.

The "Society for the Right to Die with Dignity" was granted permission to file an intervention application. Adherence to the euthanasia concept and focus on the right to end one's life with dignity were emphasized in this affidavit. Also, it backed the notion of having a "living will" and submitted an example of one.

Decision

As stated by a Constitution Bench of the Supreme Court in the Gian Kaur case, the right to die with dignity is a fundamental right. Gian Kaur, however, did not develop the notion of passive euthanasia, according to the Court. Court addressed the distinction between active and passive euthanasia, where active euthanasia involves an overt action, but passive euthanasia is the act of withdrawing life support. – The Court Passive euthanasia could only be implemented through law, the court said in Aruna Shanbaug. This was deemed an error by the Supreme Court.

Living wills are a hot subject in this country, and the Supreme Court concluded that the notion of Advance Medical Directives is widely accepted. It went on to say that the right to make and carry out an Advance Medical Directive was a crucial step in safeguarding people's autonomy and physical integrity. A 'best interest' stance might

be applied to patients who were unable to make an educated choice, allowing a guardian to take this decision on their behalf.

There was a lot of discussion in this case on the right to privacy as it was articulated by Justice K.S. Puttaswamy and how it relates to individual autonomy and freedom. In this instance, the Court drew on passages from six different decisions. Other than Indian examples, the Court looked at judgements from other countries and considered the nexus between privacy and euthanasia.

The ruling was cited by the court. With regard to an individual's right to privacy in relation to their physical autonomy, in re Quinlan, the New Jersey Supreme Court found that the state's interest diminished as the patient's prognosis worsened. The individual's privacy may be protected by a guardian on their behalf if they were unable to do it themselves. Aside from the European Court of Human Rights decision in the Pretty vs. United Kingdom case, it also relied on the European Convention on Human Rights' Article 8(1) guarantee of the right to respect for private life, which states that an individual has the right to avoid what they consider an undignified and distressing end to their life.

Because the right to life and liberty guaranteed by the Constitution are intertwined with the fundamental right to privacy, the Court held that the protection of these rights was an emanation of the right to privacy, which mandated the preservation of the integrity of individual choice in matters of life and death.

CHAPTER 7

PASSIVE EUTHANASIA: AN EMPIRICAL STUDY

7.1 Introduction

Euthanasia continues to be a contentious subject, both among healthcare and legal experts, as well as the general population at large. Many different opinions and sentiments were expressed by members of the general public ranging from murder to sympathetic help in dying. Due to the fact that there are instances within the family where persons get very ill and are diagnosed by the medical establishment as terminally ill, this is a highly contentious subject to discuss. Numerous people have made the decision to find a way to terminate their life rather than continue to live in excruciating pain or they are physically disabled and do not desire to be a burden on their families or friends. This cognitive process results in the entire family being included in the decision-making process when it comes to the care of a terminally sick member. In our culture, euthanasia has become a contentious subject due to the wide range of elements that impact people's ideas. This is true not just locally but also nationwide.

Euthanasia is an extremely intricate subject that encompasses a wide range of ideas and religious beliefs from all over the world. Any family not just those with older members may find themselves in this scenario. A person of any age can become a victim of circumstance as a result of an accident, sickness, illness, or other occurrence. It becomes particularly contentious when a child is involved, as well as when someone has lost the ability to make decisions about their own life or medical conditions. Children lack the maturity and capacity to weigh the pros and drawbacks of many options; as a result, family members must make the final choice on whether or not to take action. This decision-making process might involve parents, siblings, grandparents, and other family members, and it has the potential to fracture families owing to differing religious beliefs within the family. Some members of the family unit will believe that it is better to let someone go, whilst others will believe that it is best to hold on to the patient for emotional reasons, the prospect of a cure, a miraculous recovery, remission, or other benefits, among other reasons. No matter how old or young the patient is, making the decision is a tough one, regardless of the circumstances.

As a result, the current study necessitated the participation of a diverse range of people from various backgrounds.

7.2 Methodology of Investigation

In the empirical research, data has been collected with the help of a semi-structured interview method. Data has been analysed qualitatively on the basis of inferences collected from 30 respondents (total population), which includes Patients, Relatives of a patient, Doctors, Health Care providers, and Legal experts. Additionally, due to Covid situation, Survey Questionnaire from 201 respondents was analysed for supporting and verifying the interview data, relevant questions and statements.

The research also consist of conducting a sample survey among adults over the age of 18 who work in a variety of fields. Survey Questionnaires are used for this survey. It will be a sampling for the sake of convenience. During the course of the research, a sample survey was performed with 201 participants. The participants who are under the age of 18 will be excluded from the research.

7.3 Research Universe

The distribution of questionnaires will be through google form for the Pandemic situation and will be circulated nation-wide. The interview data will be analysed quantitatively as well as qualitatively using inferences drawn from 30 respondents (whole population), including patients, patients' relatives, doctors, health care providers, and legal authorities. Survey Questionnaire from 201 respondents were evaluated for supporting and verifying interview data, pertinent questions and remarks owing to the Covid scenario is also a result. Patients in extreme pain and suffering who come to these hospitals from other cities are another reason for conducting the empirical study of the current research in this location. In order to acquire the perspectives of clinicians working in these hospitals, as well as terminally ill patients receiving treatment from these institutions and their families, empirical research is conducted.

7.4 Data Analysis and Results

Interview Response and Analysis

- Doctors are of the opinion that Passive euthanasia already is prevalent within the concept of right to refuse treatment entails through privacy an autonomy. The terminology of passive euthanasia is debatable.
- Respondents opined that right to health and healthcare is an important obligation on the state exchequer and should be declared a fundamental right.
- Economic condition is vital concern in terms of allowing euthanasia.
- Moral and ethical obligation in taking decision of end of life care be it through any kind of euthanasia or palliative care will always be a concern specifically in India due to our cultural upbringing and preaching.
- Religious sentiment in modern Indian is surely a concern and that has been an instance with Nikhil Soni's Santhara Judgement.
- Majority of respondents felt that doctors had an obligation to act in the best interests of all patients, competent and incompetent alike. The patient has an obligation to be informed and treated appropriately as part of this responsibility. They also agreed that a doctor's job extends beyond simply saving lives to alleviating the pain and suffering of his or her patients when therapy becomes ineffective or onerous.
- According to them, a panel of doctors and a patient's family should be involved in deciding whether or not the terminally ill patient should continue or stop receiving therapy.
- A sizable majority of those polled are in favour of living wills as a concept and as a legal document in India. Yet a sizable portion of the populace remains unconvinced by the notion of a living will.
- It has been also mentioned that even after taking decision for end of life care through passive euthanasia and approval granted, at the final moment, decision can change.

Survey Questionnaire Response and Analysis

The demand of those who favour euthanasia is founded on the concept of "the right to die." This right is being contested in a large number of cases before the Supreme Court. Despite the fact that the right to die with dignity has been recognised as the law of the nation in the recent "common cause" decision, it is necessary to know what the respondents think about this issue in order to understand their point of view. Out of a total of 201 respondents, 57.2% are law students, 13.9% are students, 11.9% are lawyers, 10% are academicians, 3% are doctors, 2% are professionals and rest 2% are others on the basis of occupation (Figure 1) and 100% of 201 respondents are above the age 18 (Figure 2).

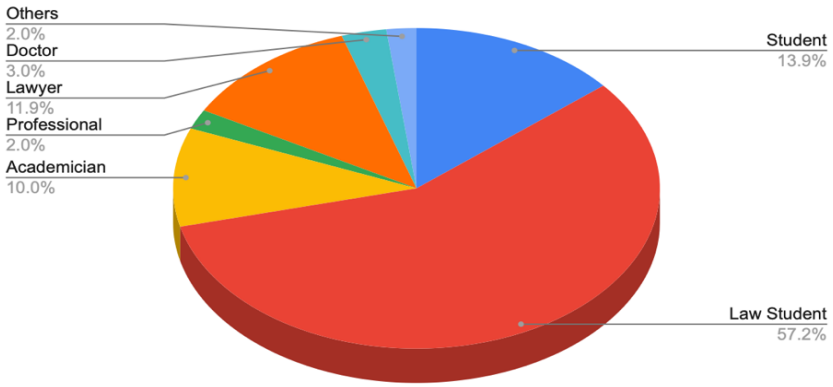

Figure 1: Occupation

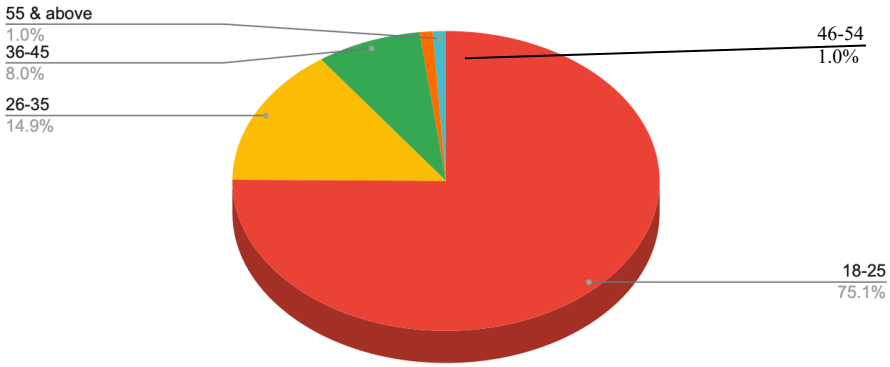

Figure 2: Age

Figure 3 and 4 deals with the very first question put to the respondents

1. Do you support Passive Euthanasia which is legalized in India in the form of withdrawal of life support system?

To which 65.2% has of total 201 respondents answered in affirmative, where 16.9% are No and 17.9% are May be. It is evident that more that 34% of the population are not supporting or in a dilemma on being of any opinion on the right conferred to us as passive euthanasia. Thus, in consonance to H_3-Indians repudiate passive euthanasia for emotional values and societal norms is partially negated as 65.2% supports passive euthanasia as allowed in India in the form of withdrawal of life support system with 17.9% who are in dilemma about this right.

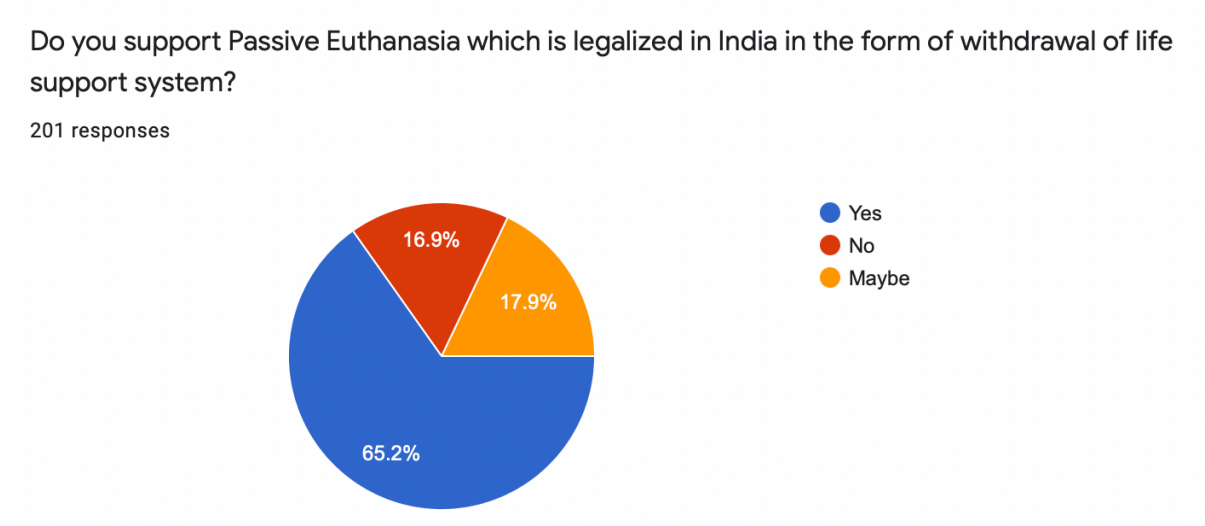

Figure 3

Even Figure 4 represents more than 50% acceptance towards passive euthanasia where only 66.7% of doctors fraternity are not is support of passive euthanasia which can be related to their Hippocratic Oath. 60.7% of students, 63.5% of law students, 90% of academicians, 75% of professionals, 66.7% of lawyers, 33.3% of doctors and 50% others are in support of passive euthanasia as legalised in India in the form of withdrawal of life support system.

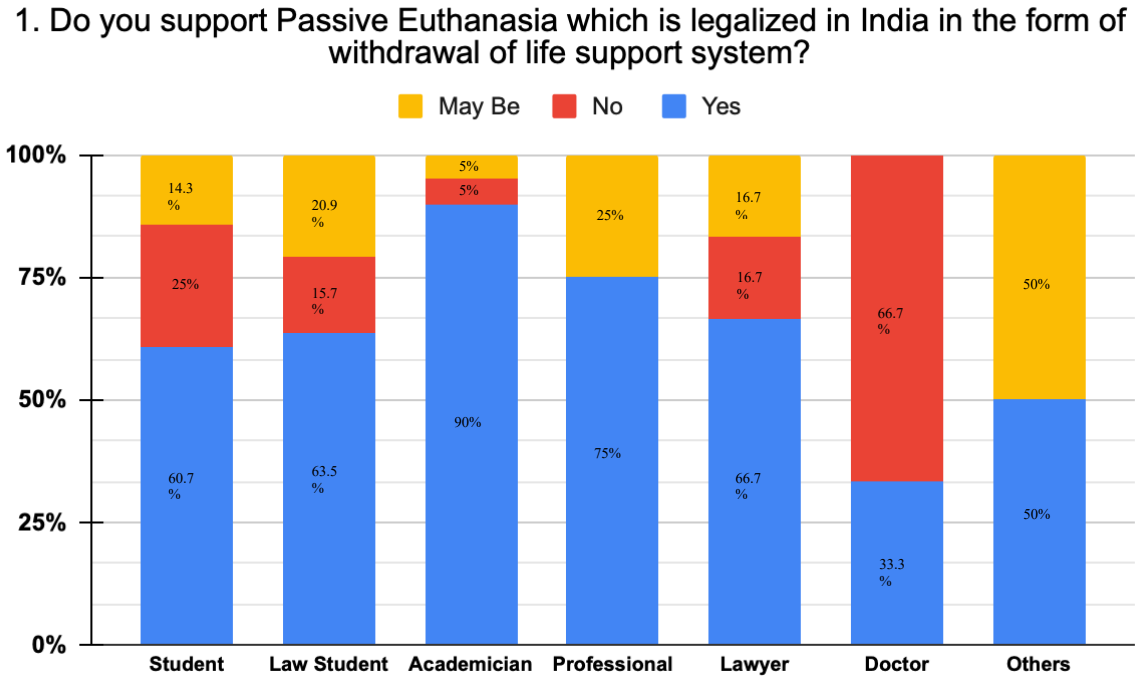

Figure 4

2. Are you aware of whether your religion allows for passive euthanasia?

After more than 65% of the respondents supported passive euthanasia in India in the last question, but in respect to religious permissibility or acknowledgement more than 45% of the respondents are unaware whether their religion allows passive euthanasia or not. 15.4% has opted May be and 39.3% of the population are aware of religious tolerance towards the option of passive euthanasia (Figure 5).

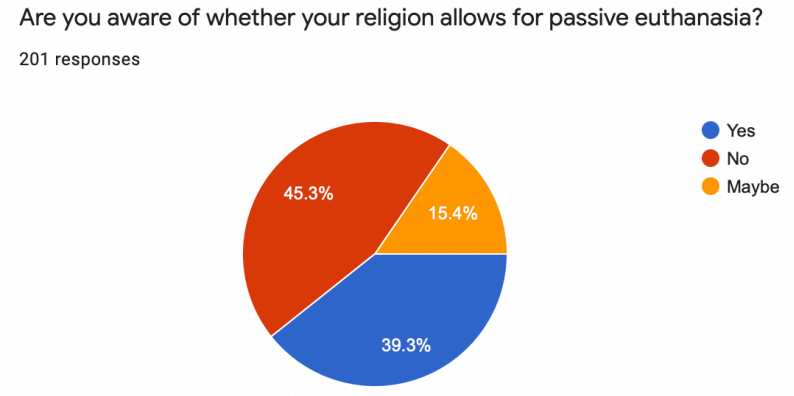

Figure 5

Figure 6 represents the data on the basis of religion where 42% from Hinduism, 62.5% from Islam, 50% from Christianity, 100% from Bhuddhism, 66.7% from Jainism and 55.6% of whom do not want disclose their religion are unaware whether their religion allows passive euthanasia or not. It is worthy to mention here that considerable percentage of answer in May be can be noticed in figure 6. Thus, it can be concluded that the population are not aware of religious perspectives of passive euthanasia as allowed in India.

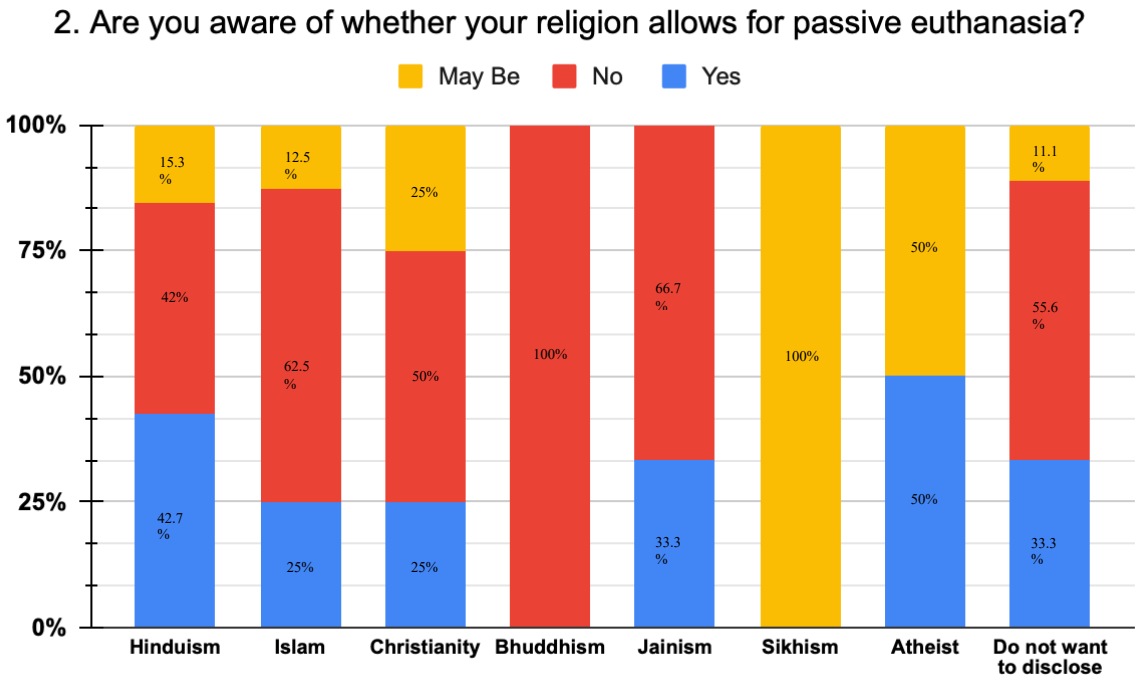

Figure 6

3. Do you realise that the right to life also includes the right to live with human dignity?

Figure 7 represents that 95% of 201 respondents realise that the right to life also includes the right live with human dignity.

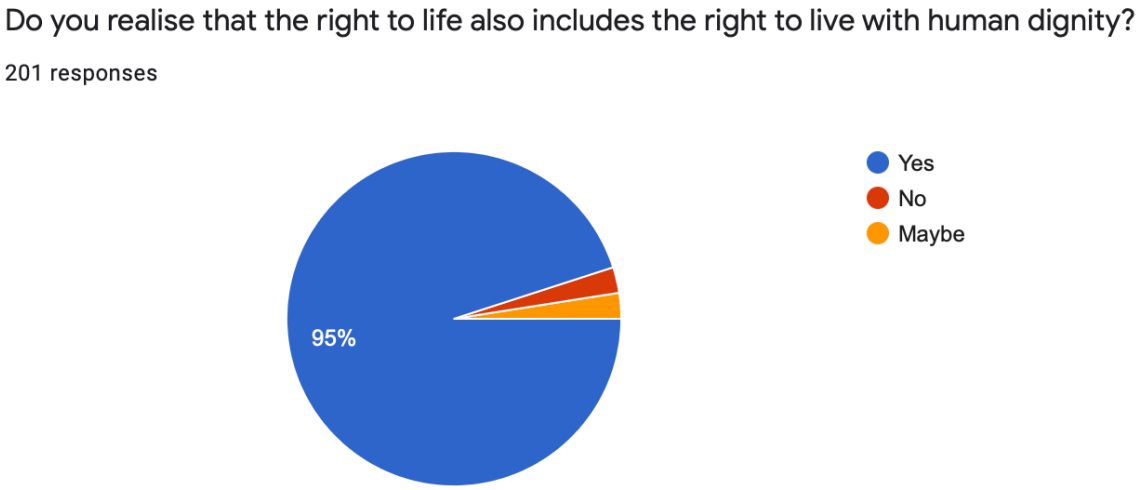

Figure 7

The concerned question has been further interpreted on the basis of gender where 92.7% male and 97.8% female are aware that right to life includes right to live with human dignity (Figure 8) which represents gender neutrality in realisation of the fundamental rights enshrined.

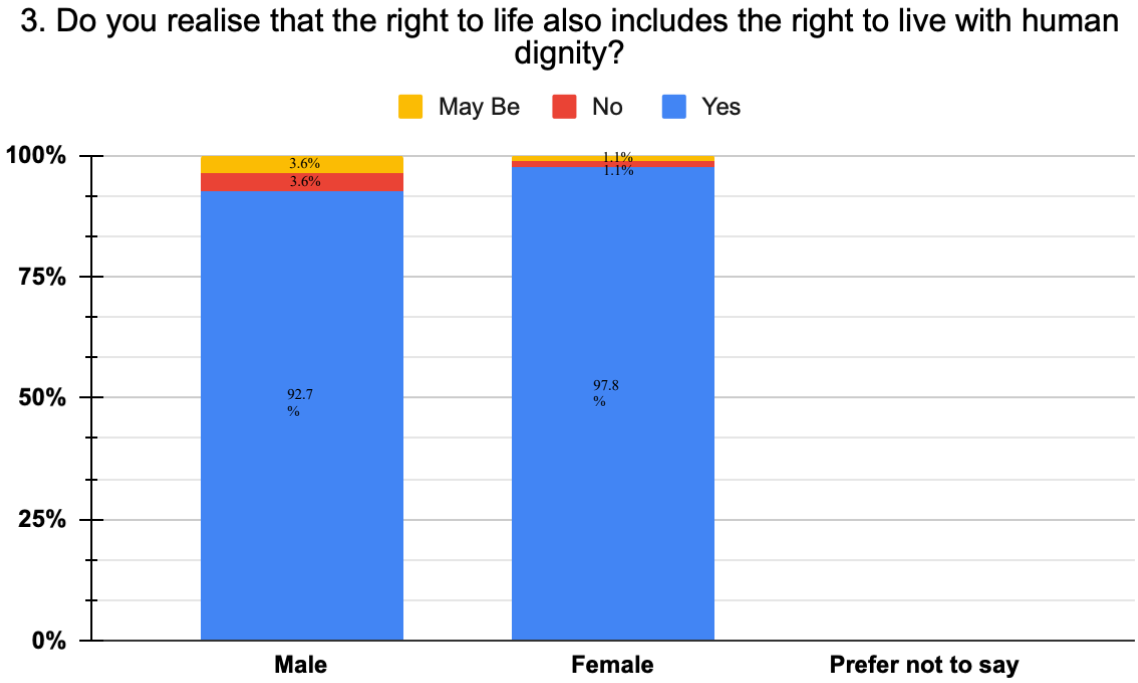

Figure 8

Figure 9 shows the representation of 53.8% male and 46.2% female from 201 respondents who participated in the survey questionnaire.

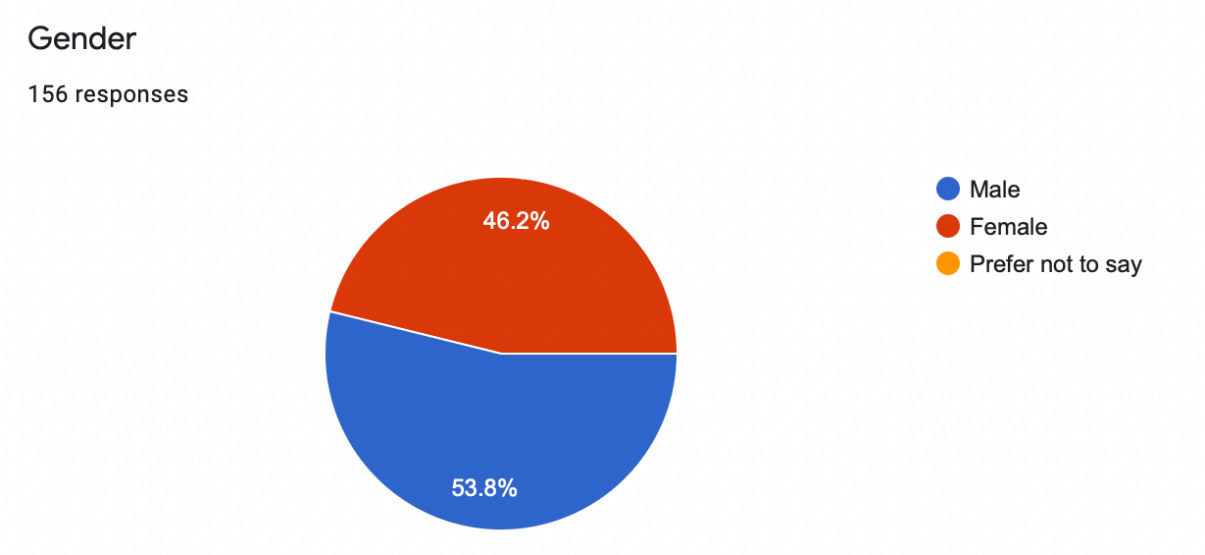

Figure 9

4. Whether right to life includes right to die?

To this question, 43.8% of the respondents are not aware of that right to life includes right to die whereas 40.3% are aware of and 15.9% are in doubt (figure 10).

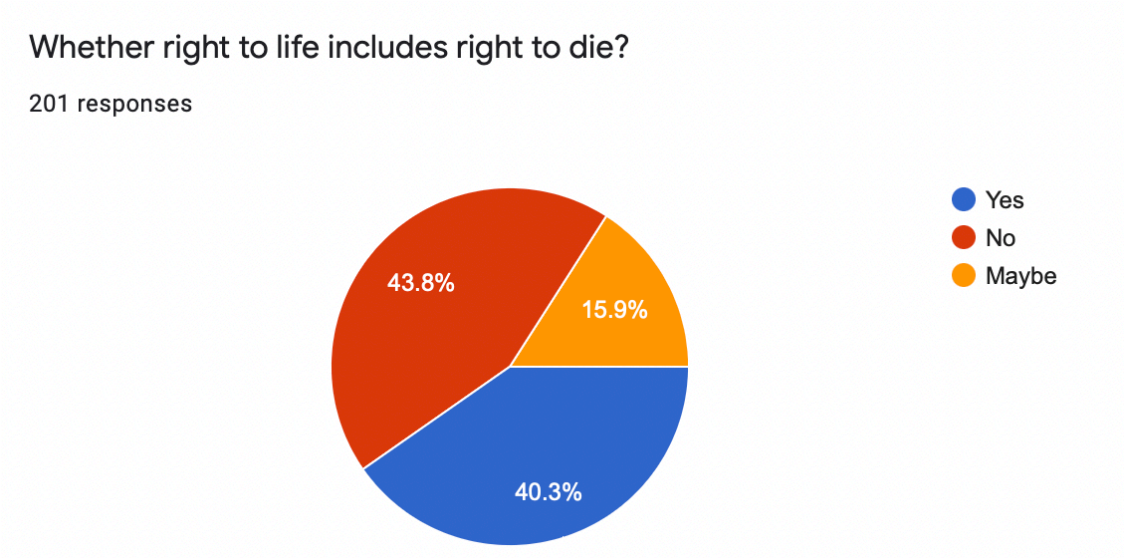

Figure 10

Figure 11 represents ratio to be almost 50-50 shift towards right to die as a right within right to life in support of 15.9% being with the answer may be. Hence, it can be

interpreted that half of the population are unaware of right to die as right and whether it falls within right to life as a negative right.

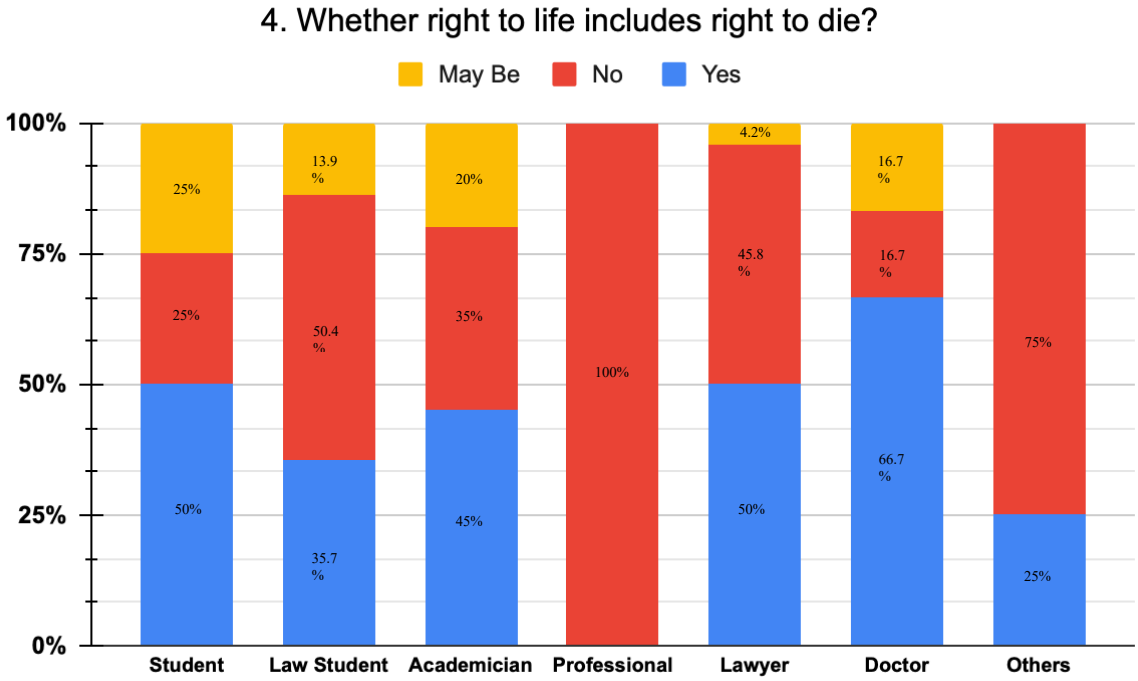

Figure 11

5. Do you know that Article 21 of the Indian Constitution guarantees the fundamental right to life and personal liberty as well as right to die with dignity?

To this question, more than 70% of the population has affirmed that Article 21 of the Indian Constitution guarantees the fundamental right to life and personal liberty as well as right to die with dignity which is certainly creates a deviation of the responses for question no. 4 that whether right to life includes right to die. It can be ascertained from question no. 4 and 5 that the earlier deals with the jurisprudence or philosophical aspect of right to life and die concept where the population has been almost divided into two, but in regard to the later question, right to die with dignity concept has been recognised since 2018 with the landmark decision in Common Cause and thereby the population is aware about the rights enshrined within Article 21.

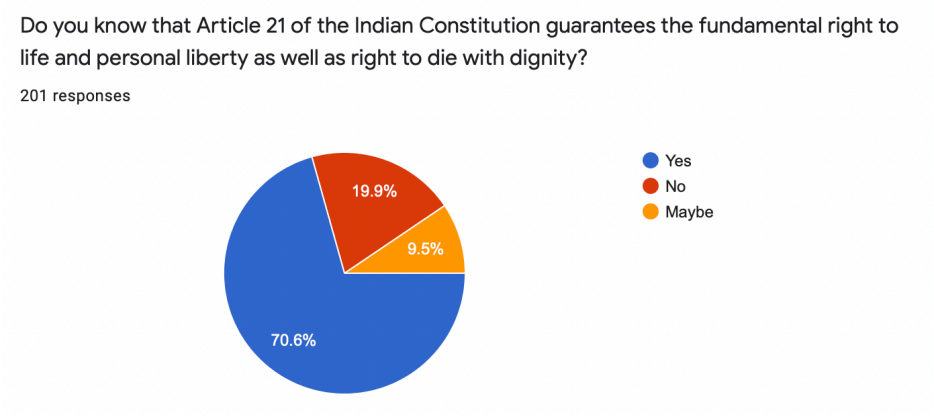

Figure 12

Figure 13 further classifies on the basis of occupation where 82.9% of students are of the view that Article 21 of the Indian Constitution guarantees the fundamental right to life and personal liberty as well as right to die with dignity which is further supported by 62.6% law students, 95% academicians, 100% professionals, 83.3% lawyers, 50% doctors and 25% others. It is important to mention the bar graph of doctor and others where 33.3% and 25% respectively negates and are unaware that right to die with dignity is enshrined in Article 21 of the Indian Constitution.

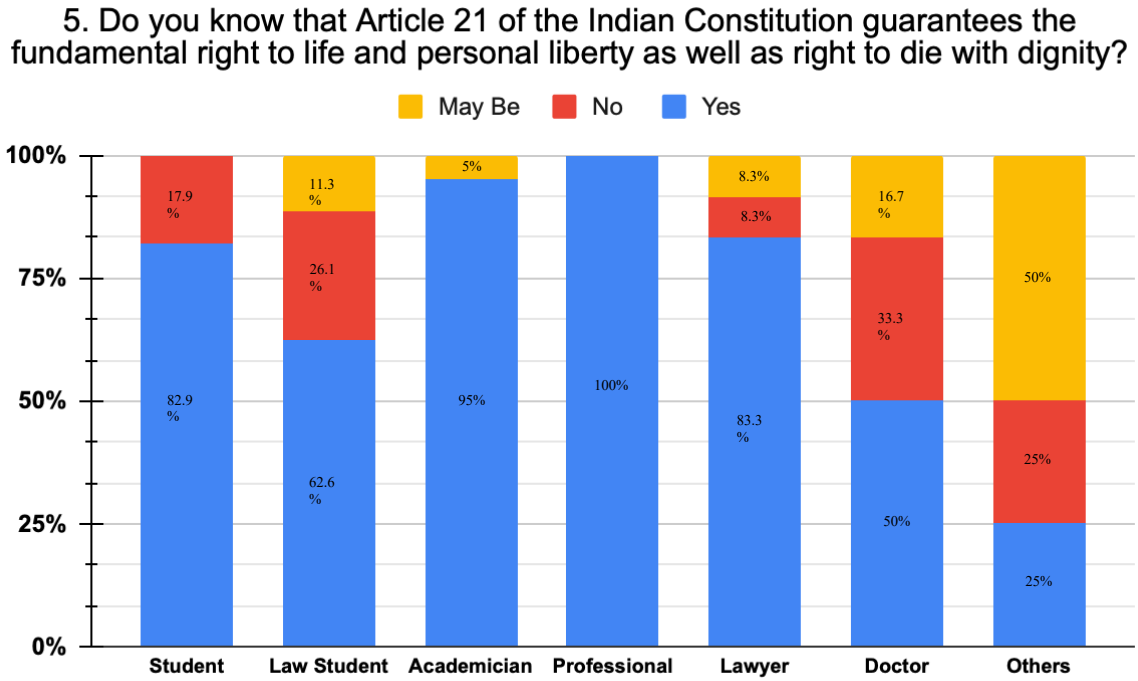

Figure 13

6. Do you believe that the right to personal autonomy and self-determination extends to the right to take one's own life?

To this question, the responses of the population is almost again into 50-50 ratio where 40.3% believes that the right to personal autonomy and self-determination extends to the right to take one's own life which is negated by 39.8% of the population and 19.9% are not certain.

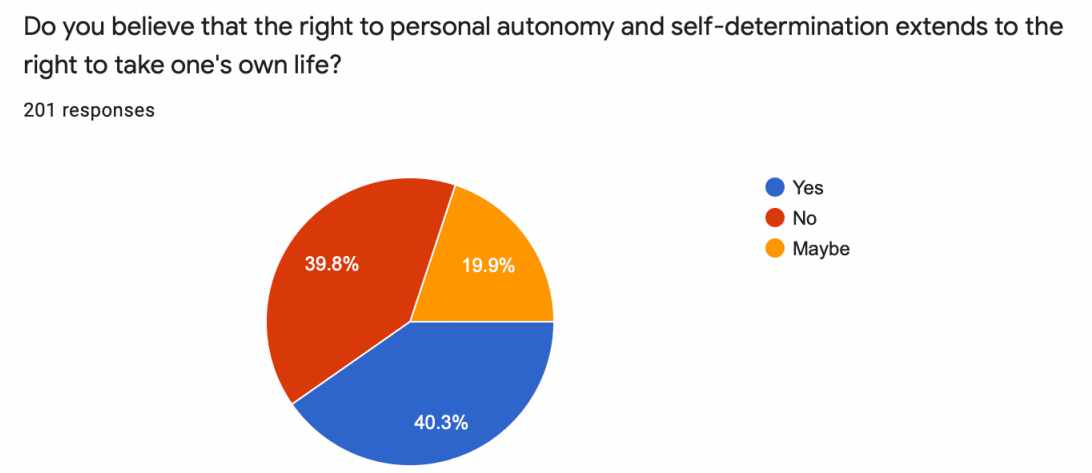

Figure 14

Figure 15 further represents with classification where it is pertinent to look into the bar graph of law student, lawyer, doctor and others where 41.7%, 54.2%, 50% and 50% respectively negates that the right to personal autonomy and self-determination does not extend to the right to take one's own life.

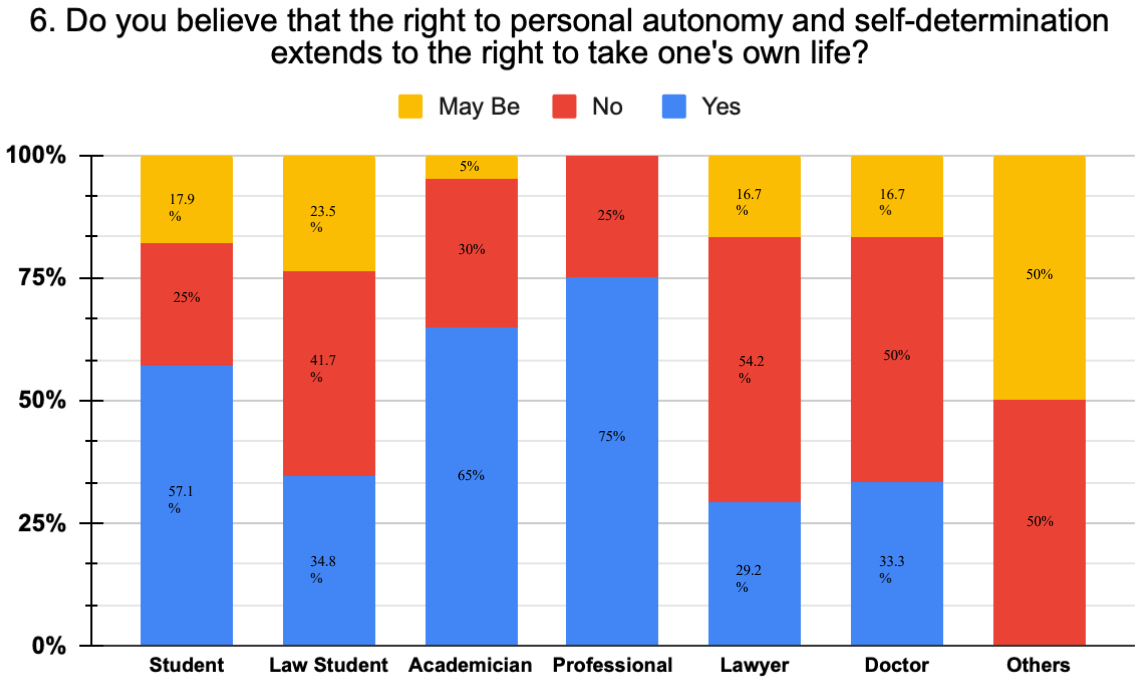

Figure 15

7. In your opinion, do terminally ill individuals who are diagnosed with incurable disease, coma, vegetative state, or brain dead also have a dignified life?

56.2% of the populations is of the opinion that terminally ill individuals who are diagnosed with incurable disease, coma, vegetative state, or brain dead also have a dignified life where 26.9% have responded in negative to the question and 16.9% are in dicey situation with may be as answer. Hence, it can be construed that majority is of the opinion that terminally ill patients have a dignified life.

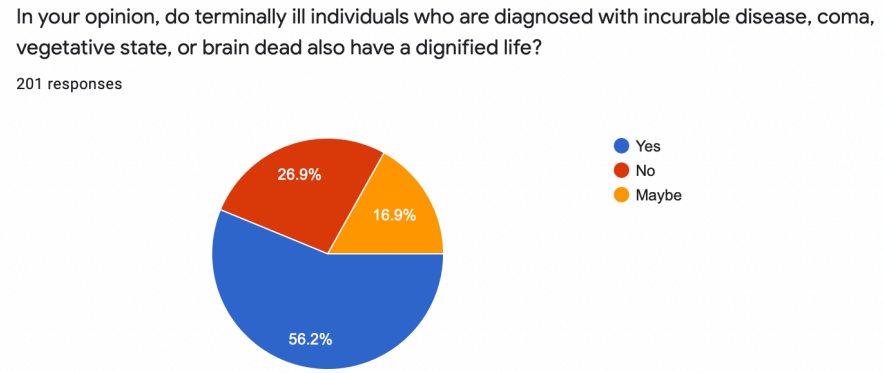

Figure 16

Figure 17 represents that 53.6% of students, 53.9% of law students, 65% academicians, 50% professionals, 70% lawyers, 33.3% doctors and 50% others responded in positive to the question asked where it is pertinent to mention here that 50% of professionals and 50% of doctors has also negated that terminally ill individuals who are diagnosed with incurable disease, coma, vegetative state, or brain dead also do not have a dignified life.

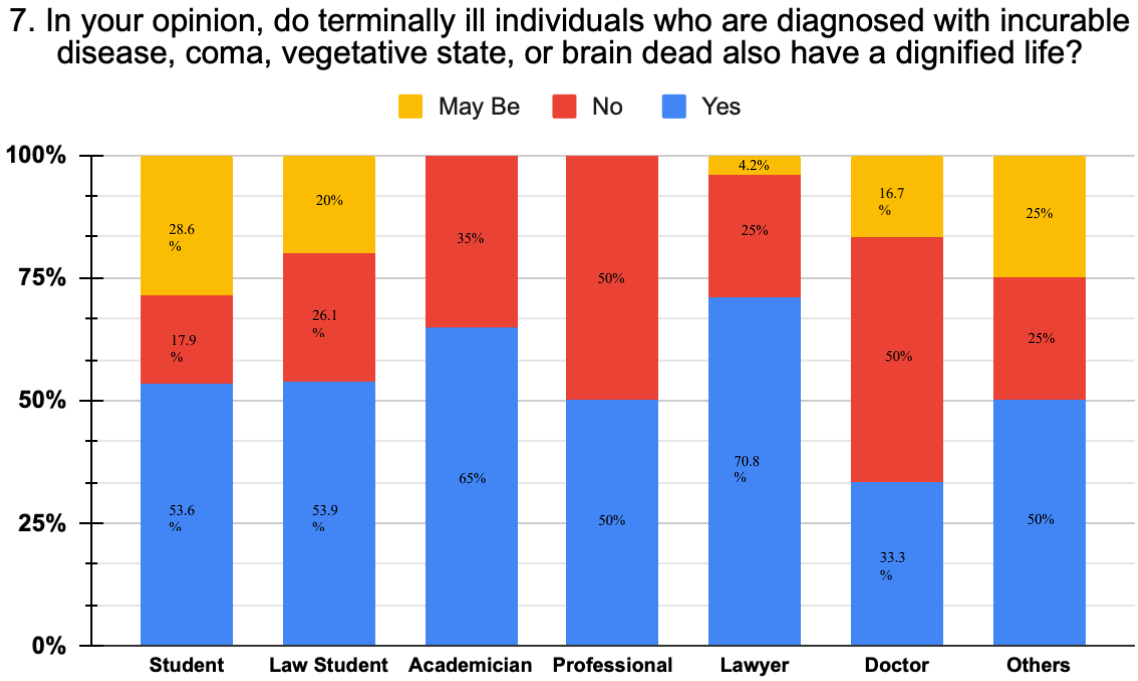

Figure 17

8. Do you support that patients on artificial life support system should be put to death with dignity by withdrawal of life support system?

Respondents with majority of 49.8% have supported that patients on artificial life support system should be put to death with dignity by withdrawal of life support system. 27.4% of the population do not support death with dignity by withdrawal of life support system and 22.9% has neither supported nor disapproved the question (Figure 18).

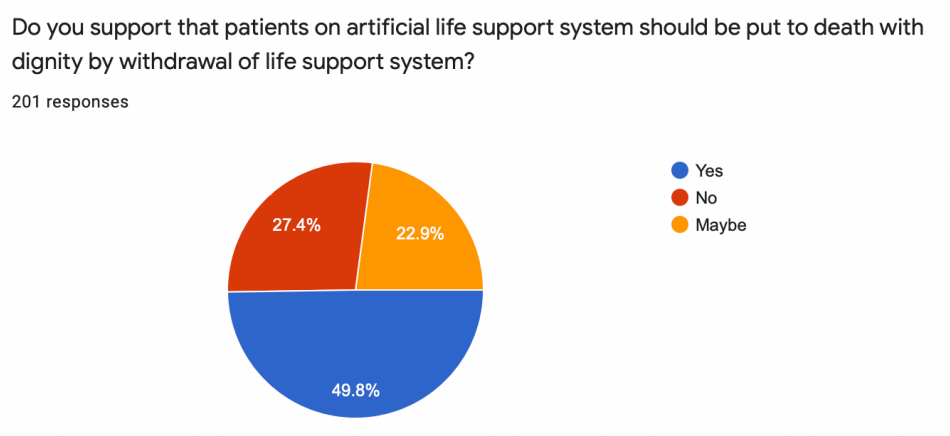

Figure 18

Figure 19 represents further where 57.1% students, 49.6% law students, 55% academicians, 75% professionals, 41.7% lawyers, 33.3% doctors and 25% others have supported that patients on artificial life support system should be put to death with dignity by withdrawal of life support system. It is important to mention here that 66.7% of doctors have not supported in favour of death with dignity by withdrawal of life support system. 75% others are have not decided to whether patients on artificial life support system should be put to death with dignity by withdrawal of life support system or not.

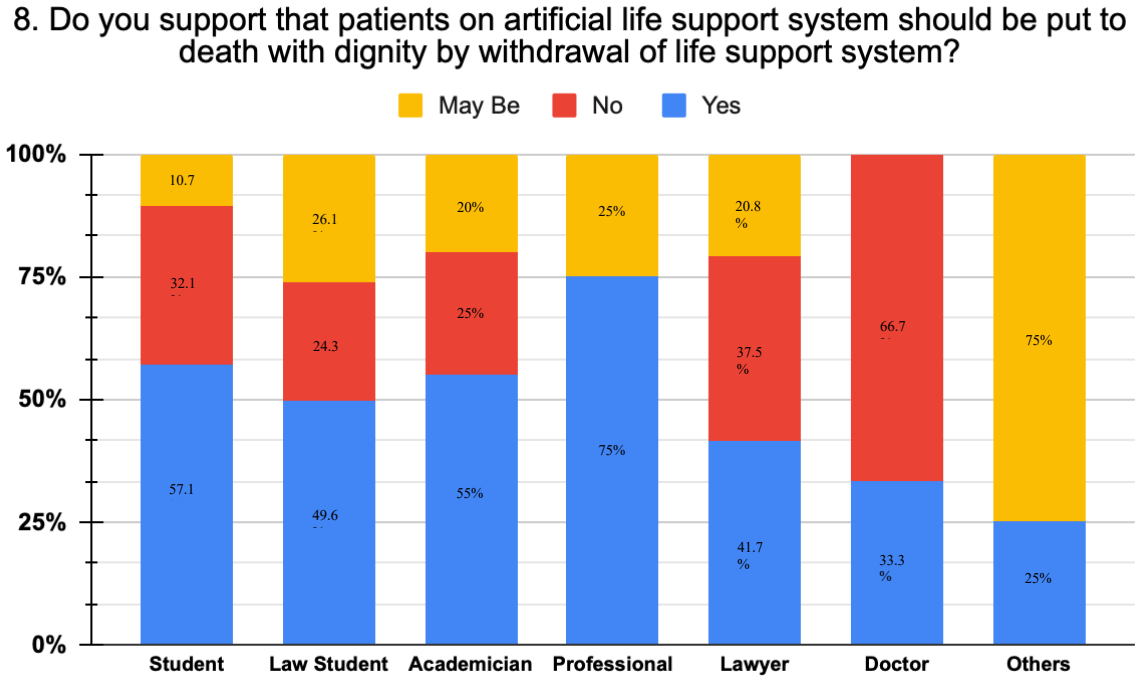

Figure 19

9. The concept of Right to Refuse Treatment is similar to withdrawal of life support system.

50.2% of the population is of the view that the concept of Right to Refuse Treatment is similar to withdrawal of life support system where 36.3% negates the statement and 13.4% of the population did not opt yes or no answered in may be.

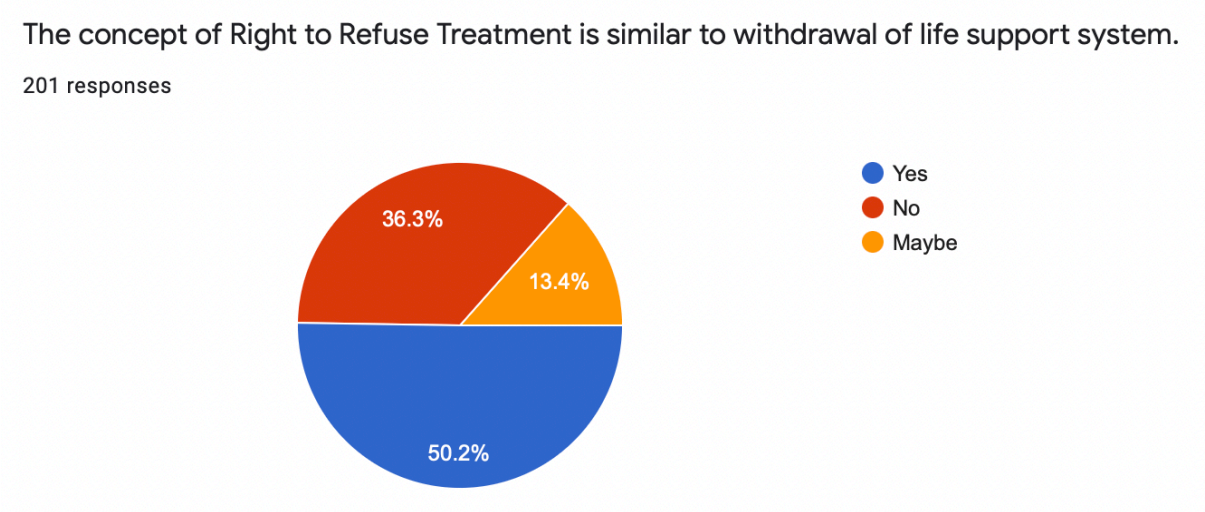

Figure 20

Figure 21 further analyses that 64.3% students, 47.8% law students, 60% academicians, 41.7% lawyers, 66.7% doctors and 50% others are of the view that the concept of Right to Refuse Treatment is similar to withdrawal of life support system. It is noteworthy to mention here that 75% professions negates the statement.

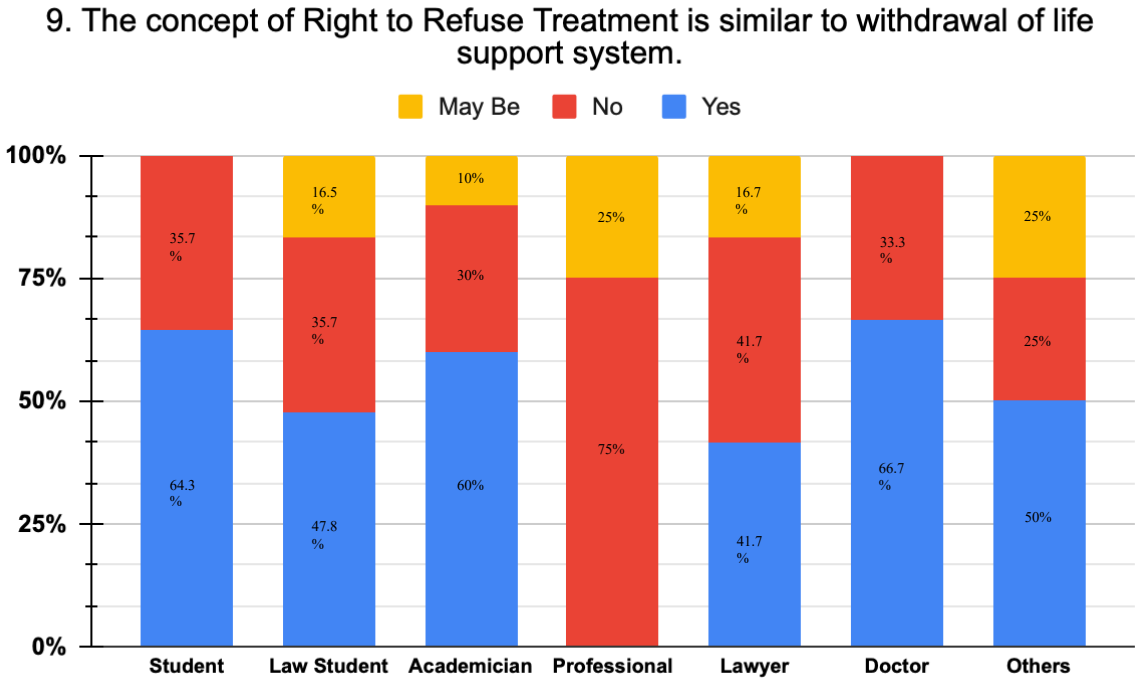

Figure 21

10. Are you aware of some of the guidelines to perform passive euthanasia in India?

63.2% of the population contends that they are aware of some of the guidelines to perform passive euthanasia in India. 27.4% are unaware and 9.5% are in dicey situation as they opted may be.

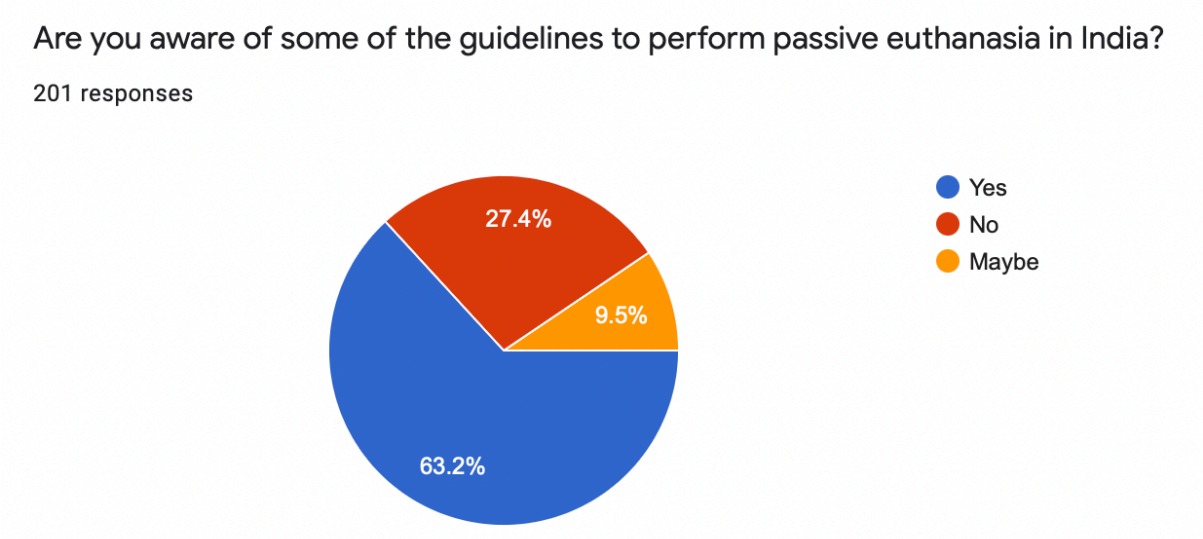

Figure 22

Figure 23 denotes that 57.1% students, 61.7% law students, 65% academicians, 75% professionals, 75% lawyers, 83.3% doctors are aware of some of the guidelines to perform passive euthanasia in India. In others, 25% are aware of the guidelines, 25% are unaware and 50% have opted may be.

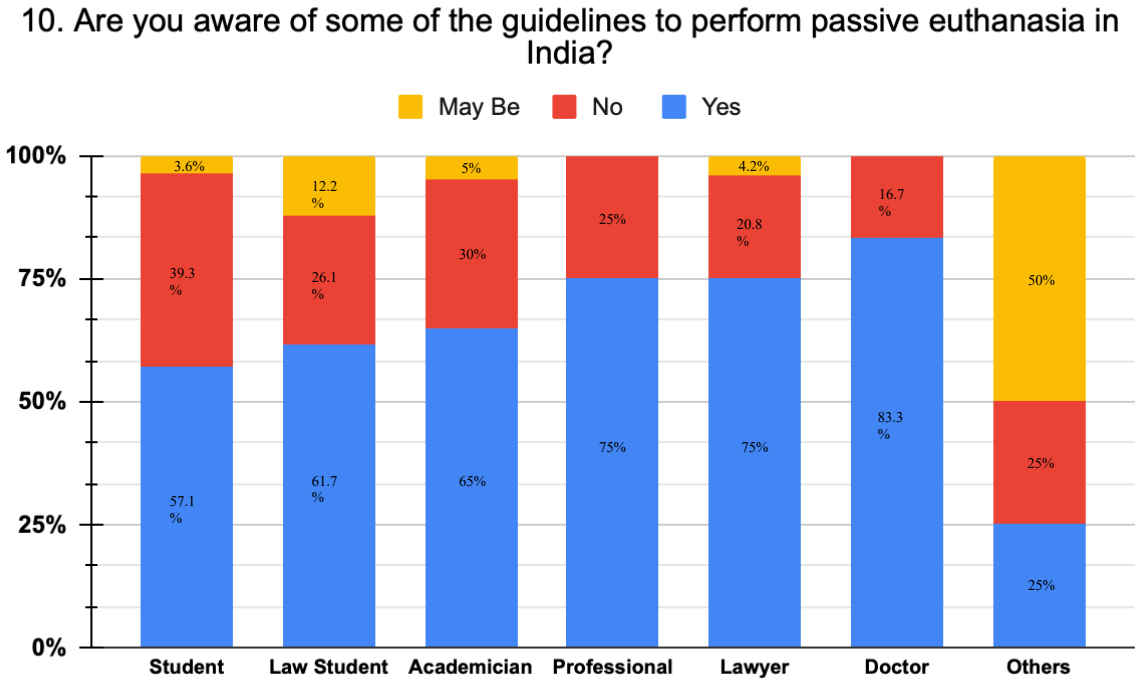

Figure 23

11. In your opinion, do you think that doctors or family members of the patient will mishandle euthanasia even in regulated environment?

Figure 24 represents that only 25.2% of the population are of the opinion that doctors or family members of the patient will not mishandle euthanasia even in regulated environment where rest 74.8% thinks that euthanasia will be mishandled by doctors or family members even in regulated environment in the nature of 27% to satisfy personal motives, 23.4% to get rid of medical expenses, 19.8% for financial benefit from organ transplantation. Remaining have also opined in favour of mishandling of euthanasia in combination of various reasons apart from the three specified ones.

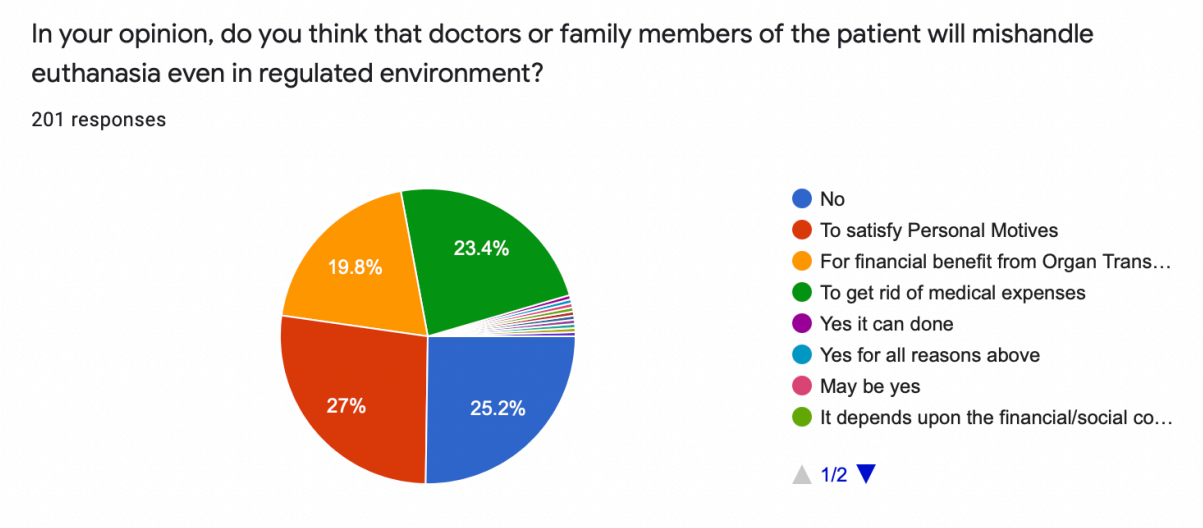

Figure 24

Figure 25 represents that regarding mishandling of euthanasia laws by doctors or family members have most chances in negative where 75% is distributed towards all the negative propositions.

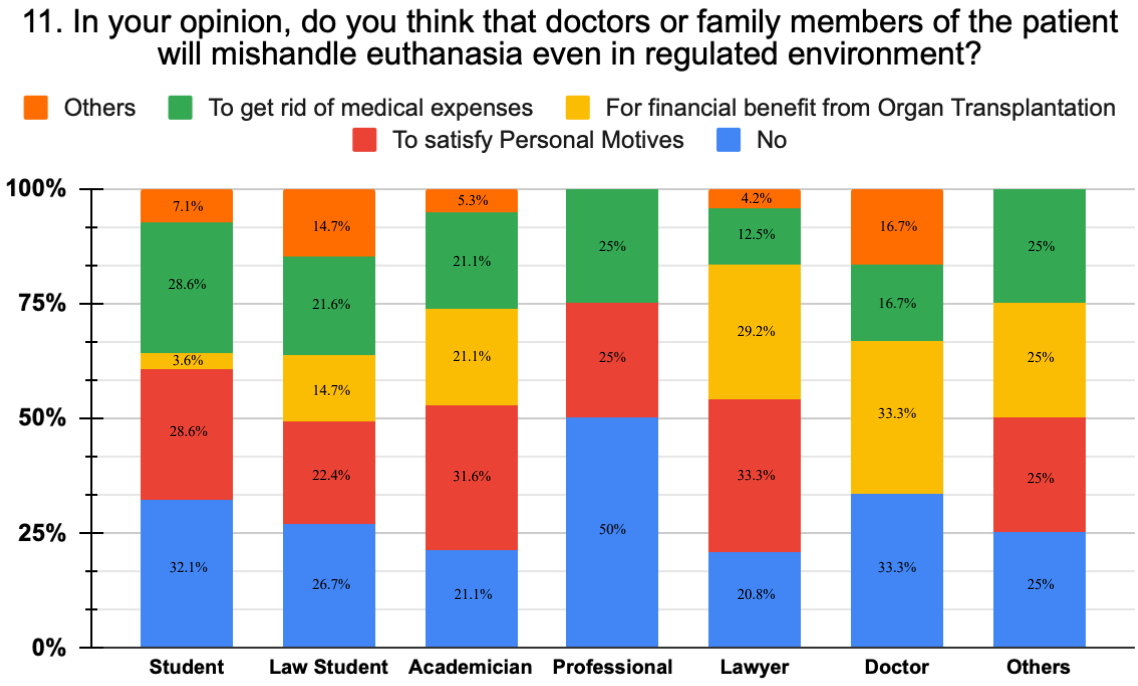

Figure 25

12. Are you aware of the concept related to Living will or advanced medical directives?

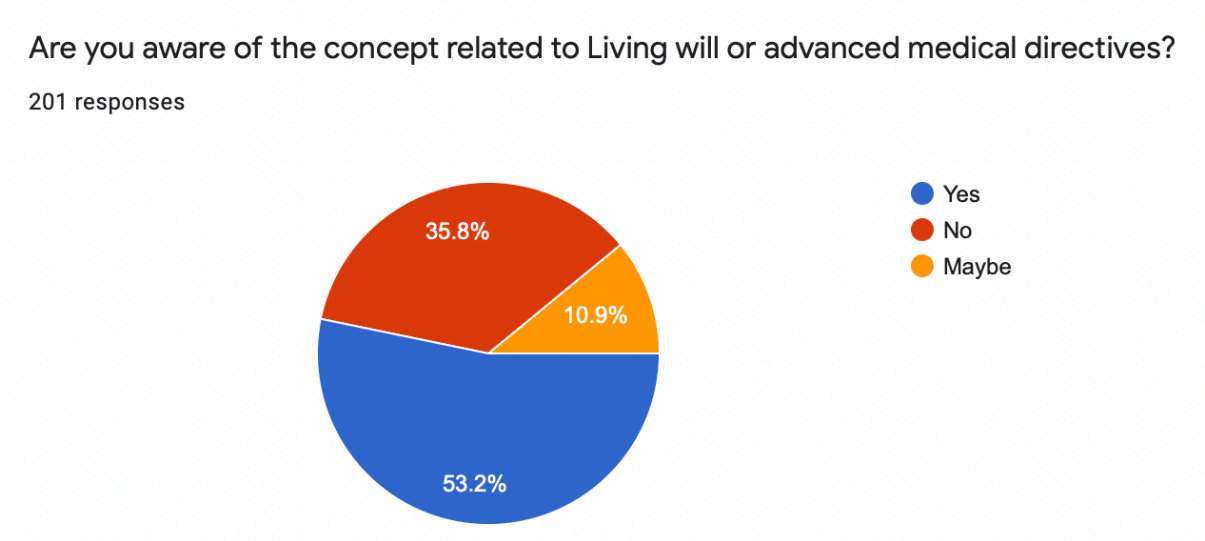

Figure 26

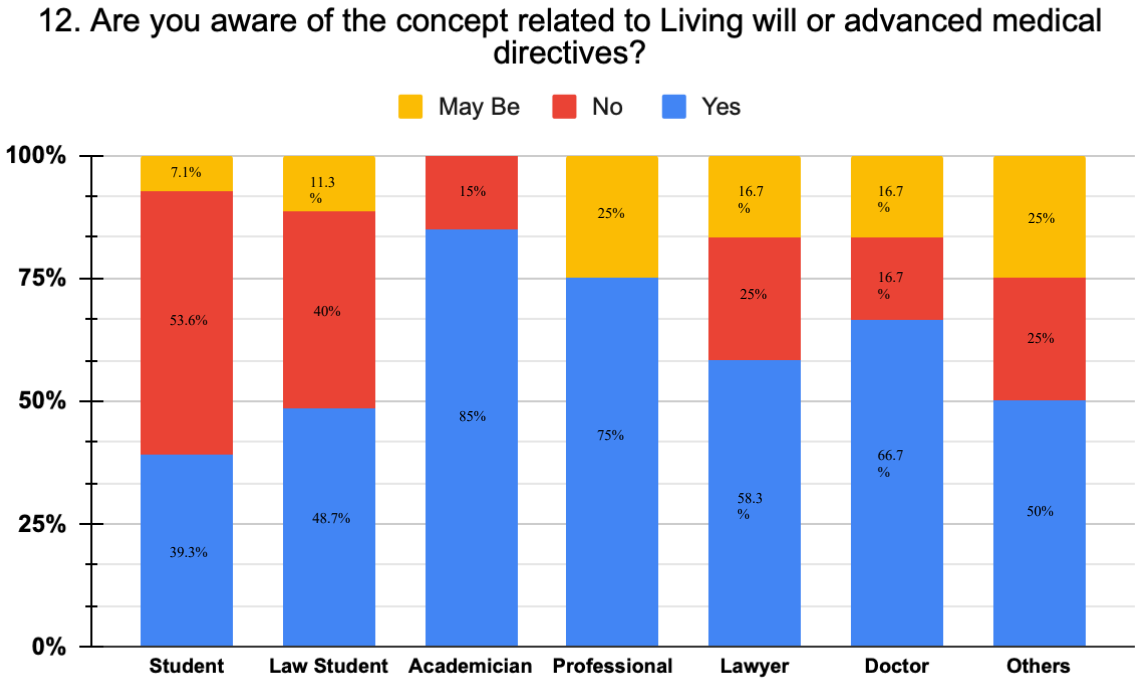

Figure 27

13. In your opinion, do you think people will not opt for passive euthanasia due to emotional values and societal norms?

In relation to H_3-Indians repudiate passive euthanasia for emotional values and societal norms which was partially answered in negative with Question No. 1 and to further analyse the next part of hypothesis, this particular question supports the hypothesis as 57.2% of the respondents agreed that people will not opt for passive euthanasia due to emotional values and societal norms taking also into consideration 31.3% of the respondents are in doubt. Only 11.4% of the respondents answered in negative. Thus, it can be concluded that H_3 is positive as Indians repudiate passive euthanasia for emotional values and societal norms.

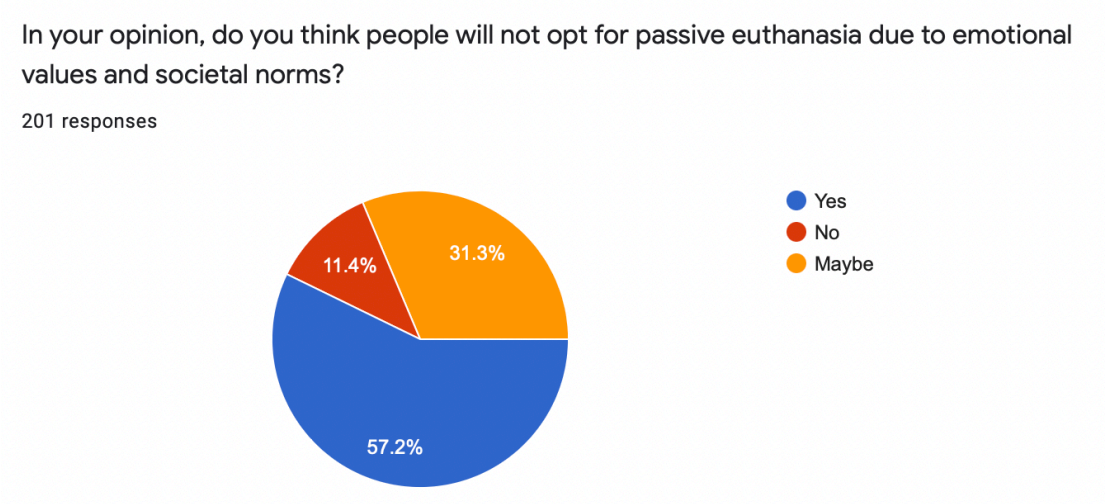

Figure 28

Figure 29 represents that that more than 50% of the respondents across occupational basis are in support of the question framed that Indians will repudiate passive euthanasia for emotional values and societal norms where 57.1% students, 52.2% law students, 65% academicians, 75% professionals, 62.5% lawyers, 100% doctors and 50% others have similar view that passive euthanasia will not considered for emotional values and societal norms.

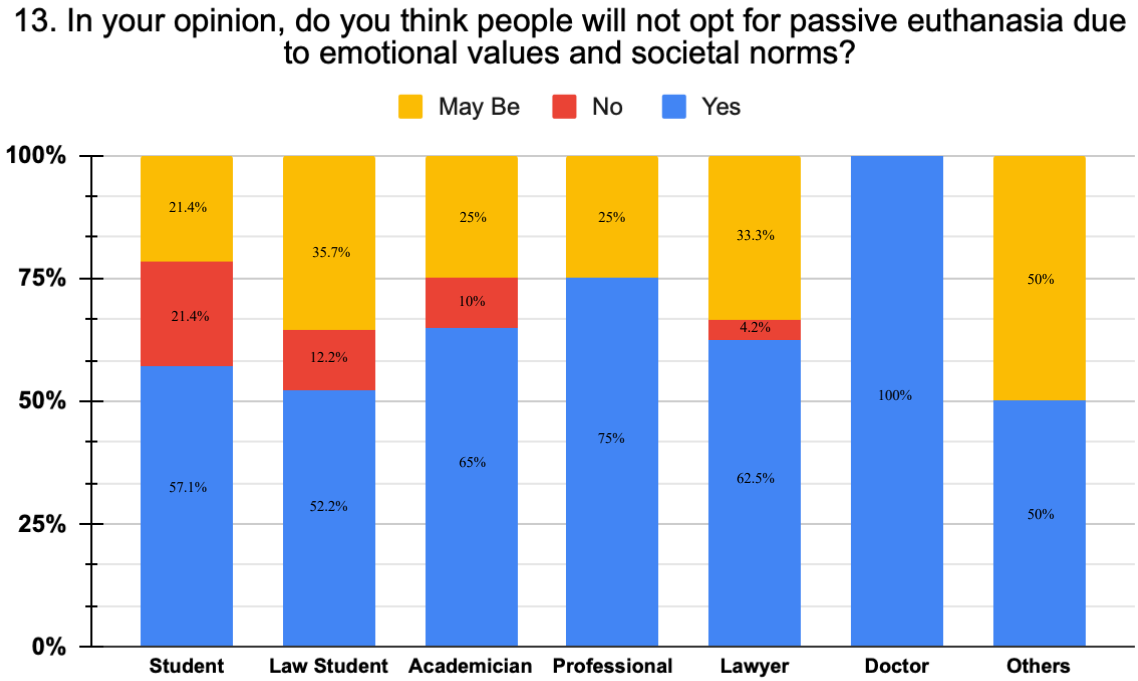

Figure 29

14. Do you think that allowing passive euthanasia in India will have slippery slope tendency in allowing active euthanasia in future?

52.7% of the respondents confirm that allowing passive euthanasia in India will have slippery slope tendency in further allowing active euthanasia in future. 33.8% are in doubt and only 13.4% negates the question asked (Figure 30).

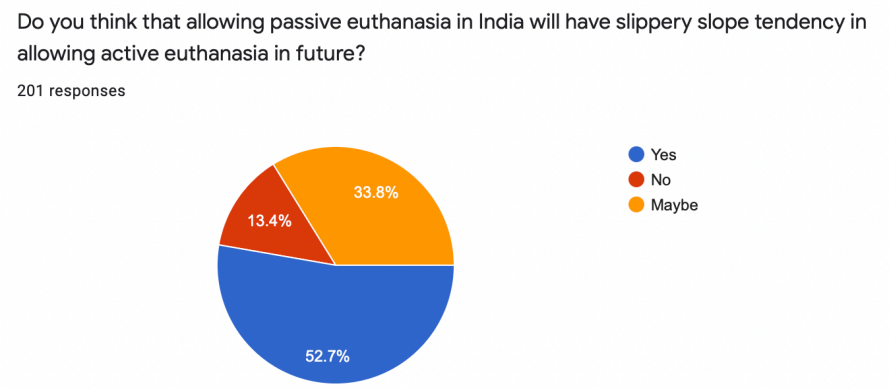

Figure 30

Figure 31 represents that 60.7% students, 47.8% law students, 50% academicians, 75% professionals, 62.5% lawyers, 66.7% doctors and 50% others is of the view that allowing passive euthanasia in India will have slippery slope tendency in allowing active euthanasia in future.

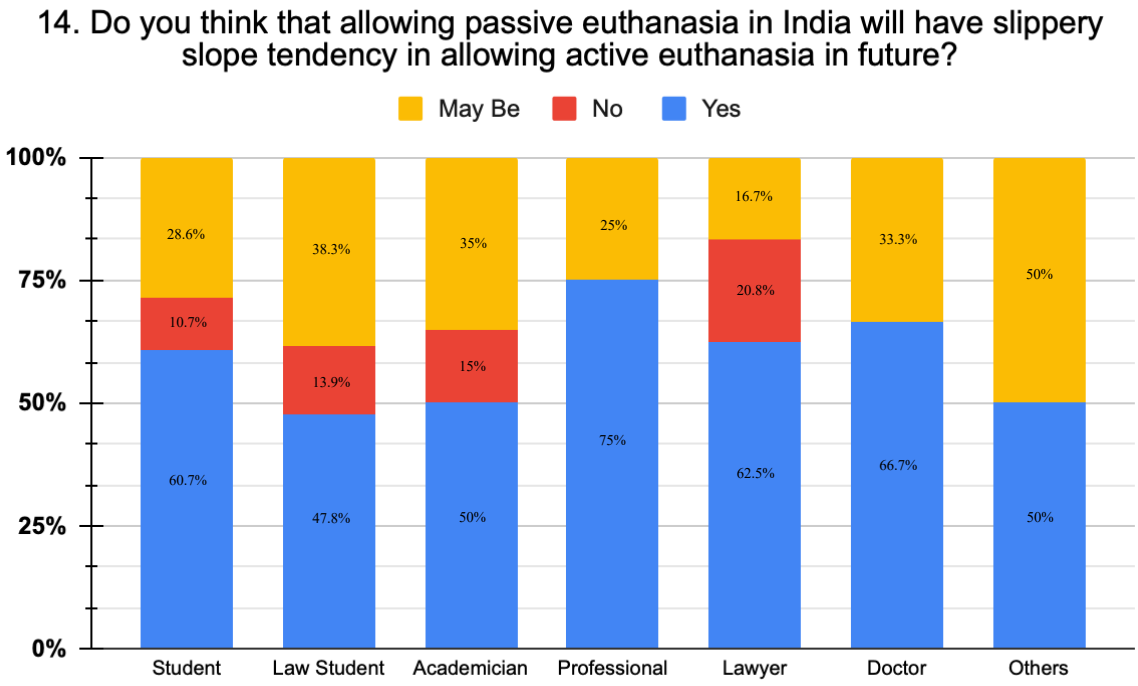

Figure 31

CHAPTER 8

CONCLUSIONS AND SUGGESTIONS

8.1 Introduction

Euthanasia is the best illustration of individual freedom of choice since it has sparked a wide range of debates both for and against it. However, although some people feel that euthanasia is an effective way to end a person's suffering, those who are opposed to it argue that it diminishes human life and should be avoided at all costs. Choosing life over death is a tough decision, and society has endeavored to accept this radical transformation, not only with the support of the law, but also by bringing about a shift in their own mentality, which is more prominent in older generations.

Finally, via a series of judgements, the Judiciary recognized the right to die as an essential component of the right to life and also ruled right to die with dignity as a fundamental right. A terminally sick patient should not be forced to endure all of the pain, sorrow, and suffering on his or her own. Respecting one's own choices and freedom to make judgments in one's own best interests is at the heart of this.

The Supreme Court has declared that passive euthanasia is permissible for patients who are in a prolonged vegetative state and would not be able to recover. Furthermore, the court looked at how mercy killings are viewed legally in other nations. There was no disagreement among the judges that a person's dignity is the foundation upon which their integrity rests, and that a man should have the freedom to accept or reject medical care.

People in India invented the concept of a Living Will to guarantee that no one abuses their position and that the law is correctly implemented. They have used living will to protect the patient's interests, so no one can take advantage of them. In Canada, euthanasia was legalized a few years ago, and a thorough piece of legislation has been developed to support the law. Many precautions have been implemented to ensure that the necessary procedure is followed and that the right is utilized to its fullest extent.

Taking someone's life by executing them in cold blood but harboring feelings of compassion? This is referred to as "mercy killing" for a reason. A terminally sick patient's wish for death serves as a calm path to life. Invoking the expression "mercy killing" suggests a human desire to end the suffering of a terminally sick individual, evoking a human emotion of mercy. What happens when two persons with opposing viewpoints live together for a long period of time? Ethics, law, morality, humanity, and society are all affected by the usage of these words in the same way. The issue at hand is not whether or not killing is moral. It is, however, an issue of whether this kindness is moral, ethical, and legal. If so, how much mercy is good and when it crosses the line into being evil, i.e., when such killing provides a peaceful death and when it becomes murder in the eyes of the law? One can then wonder if the activities are not being abused and being overdone. And if such laws are even required.

Throughout history, people have been captivated by the mystery of death. Because of an incurable sickness, the choice between life and death is incredibly tough, even if the life is not worth living. Mercy killing, on the other hand, refers to the act of aiding another person who is suffering to die peacefully. Many perspectives and ideas are being woven into the fabric of the idea. Those who are unfamiliar with it may find it difficult to accept. It has always been a top priority because to the direct connection between the suffering individual's life and death. Everyone has a hard time deciding between these two options.

The idea that a terminally ill patient has a right to die or a right to mercy killing is rapidly affecting the way people think about living. Patients who are near death or whose lives cannot be saved by any means other than death often ask for mercy killings. In the face of extreme anguish, it is hard to understand that a person's life may be ended peacefully. On the other hand, it's hard to deny the reality of those who are terminally sick and in excruciating agony. Euthanasia should be made legal in order to stop the suffering of patients who cannot bear to wait for their natural death to occur, or if they should be allowed to die peacefully in order to end their misery.

The notion of euthanasia is neither universally accepted or rejected throughout nations and civilizations. That is the reason it is referred to be a contentious subject. Both

socially and legally, the concepts “mercy” and “killing” are difficult to hold together. As a result, people’s views on mercy killing vary greatly depending on the environment in which they find themselves. Various viewpoints, such as theosophical, medical, legal, and the social acceptance of it by people on Earth, may be linked back to it.

Aruna Shanbaug’s case has opened the door to hope for brain-dead patients who are dependent on life support machines, thus the purpose of this research work is to inform the actual practice of mercy killing at international level in various countries and whether it should really be practiced in India in comparison to nations that are tolerable to this concept, along with discussion on the famous case of Aruna Ramachandra Shanbaug (2011) and further reiterated by Common Cause (2018).

8.2 Research Questions

1. **What are the ethical and legal implications of passive euthanasia in India?**

The phrase “right to life” encompasses the idea that a person has the right to be treated with respect and dignity throughout his or her life, including the right to die peacefully at the end of it. But the ‘right to die with dignity’ is not to be confused with the ‘right to die’ an unnatural death that shortens one’s life span. As a result, the discussion over euthanasia revolves upon the idea of the right to life. Euthanasia has been contentious since it entails the intentional terminations of life. Terminally sick patients are typically subjected to excruciating pain as their condition progresses, and this may be so scary to them that they choose to terminate their lives rather than endure the agony any longer. Even yet, it’s still debatable whether or not terminally sick patients should be assisted in ending their lives or allowed to suffer in silence. While the landmark Aruna Ramchandra Shanbaug verdict makes it plain that passive euthanasia would only be permitted in circumstances when the patient is in a chronic vegetative state or terminal illness, it does provide some insight into the situation. A terminally sick patient may, however, be allowed to be denied or withheld life-sustaining medical care provided certain requirements are met. The Supreme Court issued an important remark on attempted suicide in the “right to die” case of Aruna Shanbaug before it. Observing that a person who commits suicide needs aid more than punishment, it encouraged

Parliament to consider decriminalizing the attempt to commit suicide. Indian Penal Code section 309 would be struck off the list. While the Supreme Court's ruling on Aruna Shanbaug's case appears to have sanctioned passive euthanasia for terminally ill patients in broad strokes, it is being reiterated in a broader context in Common Cause's Case, which recognizes and declares the right to die with dignity as a fundamental human right consistent with the right to life guaranteed by Article 21 of the Indian Constitution. Nikhil Soni's "Santhara" case has sparked debate over the legality of passive euthanasia, which has set the way for legal challenges in the areas of right to health, hospice and palliative care, and organ transplantation.

2. **What are the situations regarding the issues involved in passive euthanasia such as right to die with dignity, right to refuse treatment, end of life care, consent, advanced medical directives, living will, parens patriae in U.K., Netherlands, Belgium, State of Oregon and Australia ?**

It appears that a patient has the right to refuse treatment, but the denial of treatment and the life support system, which entails passive euthanasia, present severe problems. When confronted with the most difficult questions: Is it permissible to withhold life-sustaining measures even if the system is being treated in line with medical directives? The legality of a person exercising his or her right to commit suicide with knowledge or via parens patriae is a matter of affirmative error.

Neither of these matters has a clear Indian legal position established on it. Legislative regulation of life-support measures must first be established if a specialized professional body has a view on the matter. This is crucial since there is no relevant case law in the nation. Passive Euthanasia and the right to decline processing are still unresolved issues, despite the landmark rulings in the Aruna Shanbaug and Common Cause cases on the assimilation of Law Commission of India reports. The freedom to refuse treatment has long been viewed as a hindrance to the state's ability to provide adequate health care and as a form of passive euthanasia that is permitted despite the right to refuse it. As a legal punishment to limit their financial resources, the judgement looks to benefit society's upper classes, while giving little attention to how those with disabilities and those in the public health sector will be served by healthcare services.

It has always been an option for the poor to deny treatment and allow for passive euthanasia to continue infringing on their rights to better healthcare in the country.

Even after the two most important judgments about the end of life, Indian law neglects to stress the realms of medical and legal problems. No one knows for sure if someone is entitled to refuse treatment in this situation because suicide rules only deal with a person's determination to kill themselves in the absence of any ailment. Rejecting or withdrawing life support is morally equivalent, according to the Supreme Court's reading of Articles 21 and 14. To stop counterproductive interventions, such as death by enabling it to occur via treatment or euthanasia, they both use a new understanding of privacy legislation in the context of terminal health and medical treatments. Receiving palliative care is a must for everyone on life support. When it comes to palliative care, physicians have the primary obligation of relieving pain and suffering. It's worth noting that in India, the concept of the right to refuse and passive euthanasia is the other side of the coin, but both stand for terminally ill patients' right to self-determination.

Unlike the legislation in industrialized countries, the Judicial approach to this thorny issue has taken some strides toward a new age of healthcare and medicine for people with terminal illnesses, as the Supreme Court established rulings to the decision by permitting passive euthanasia. The penalties imposed in a community facing a complex medical, social, and legal problem in medical-legal ethics are aimed at preserving social cohesion. End-of-life patients and physicians must be protected by legislation in accordance with the Law Commission Recommendation. New legislations are needed in the areas of Right to Refuse Treatment or Informed Refusal of Treatment, Withdrawal or withholding of Life Sustaining Treatment, right to Palliative Care and in the absence the intervene in these areas.

3. **What are the existing legal provisions and concepts relating to passive euthanasia in India in the light of Common Cause and Aruna Shanbaug Judgement?**

When the Supreme Court of India ruled in the case of Aruna Shanbaug on March 9, 2018, it permitted passive euthanasia by disconnecting life support from patients in a vegetative state, as part of the ruling. To be sure, it did not order the removal of medical assistance for Mrs. Shanbaug. Despite this fact, the court did explore the subject of assisted suicide and concluded that the prevention of feeding for an unconscious person was believed to be an act of passive suicide.

In the landmark case of Common Cause (A Registered Society) v. Union of India, 2018, an appeal was made for a strong mechanism for Passive euthanasia and acknowledgement of the 'living will' of an individual. "Life and death are interwoven," Justice D.Y. Chandrachud wrote in the decision. Our bodies undergo transformation at all times... life and death are inextricably linked. Dying is an inevitable part of life." The court ruled that euthanasia is the sole viable option when all other life-saving efforts fail or fall short of providing a better life for a terminally sick or vegetative patient.

Supreme Court of India acknowledged the existence of a living will. Other rights recognized by the court as essential include the "Right to Die with Dignity," the "Right to Self-Determination," and the "Right to Autonomy."

In India, euthanasia can be misunderstood and overused. As a result of rampant corruption, it is not uncommon for Indian hospital administrators to take payments from cold-blooded family members in order to execute patients who are not qualified for mercy killings or euthanasia. As a result of euthanasia, organ trafficking is encouraged and the legality of organ sale is questioned (organs black market). "Dowry death," one of many horrific crimes in India, is one such instance where euthanasia is used. These kinds of instances tend to occur at institutions that place a high importance on profits and affluence over the lives of patients. It is therefore necessary to have a regulatory body overseeing euthanasia in India. In order to prevent the abuse of the notion of euthanasia, adequate norms and legislation should be devised and a governing authority formed by the Government of India.

Because of a patient's suffering and the value of a peaceful death, euthanasia was approved by the Supreme Court. Article 21 of the Constitution's guarantee of the right to life is strengthened if the right to die with dignity becomes a reality. With the help of Parliament, this issue may now be addressed as fast as possible by drafting laws and making suggestions.

8.3 Hypotheses

H1 - Passive euthanasia though legalized in India has ethical and legal challenges.

It was widely agreed that the most important aspect for euthanasia was to "elevate intolerable agony and suffering and empower the right to dying with dignity," according to a wide range of academicians and legal experts. More over a quarter of those polled supported euthanasia because of a lack of "quality of life and purpose," according to the results. However, the family's financial situation, exacerbated by the exorbitant expense of medical care, plays a role in the decision to seek euthanasia. A person's physical or mental incapacity, or any of the accompanying disorders such as depression or psychosis, isn't a compelling reason to ask for a dignified death. It was also asked if there was any evidence to support the claim that euthanasia should remain illegal. Corruption and misuse of law, sacredness of life, influence on public faith in doctors and bad effects on vulnerable people in society are among the reasons cited by them in order of importance.

The primary motivation for legalizing euthanasia, as indicated by our respondents, is to alleviate suffering and empower the individual's "right to die with dignity" rather than allow them to continue to suffer from an incurable and agonizing condition for the rest of their lives. However, individual liberty is not sufficient on its own; it must complement the "elevate pain and suffering and empower death with dignity" goal. Unfavourable attitudes are a result of public corruption and law enforcement abuse. The research hypotheses also state that euthanasia concerns must be addressed legally in order to limit the danger of misuse and abuse. Euthanasia should have specific provisions in the law, so questions about the doctor's duty to provide informed consent, provisions for deciding best interests and safeguarding medical professions are also

asked. Provisions related to the acceptance of living wills and punishment for those who misuse the law are also asked. Majority of respondents felt that doctors had an obligation to act in the best interests of all patients, competent and incompetent alike. The patient has an obligation to be informed and treated appropriately as part of this responsibility. They also agreed that a doctor's job extends beyond simply saving lives to alleviating the pain and suffering of his or her patients when therapy becomes ineffective or onerous. According to them, a panel of doctors and a patient's family should be involved in deciding whether or not the terminally ill patient should continue or stop receiving therapy. A sizable majority of those polled are in favour of living wills as a concept and as a legal document in India. Yet a sizable portion of the populace remains unconvinced by the notion of a living will. Euthanasia advocates also argue that doctors who follow established rules and carry out euthanasia in good faith should be protected from legal repercussions.

H2 - The concept of passive euthanasia as interpreted by Indian Judiciary tantamount to right to refuse treatment.

Medical and legal issues are not given sufficient attention in Indian law even after the first and second most important decisions about the end of life have been made. As long as suicide laws are in place, it is unclear if a patient has the right to refuse treatment because the latter only pertains to a deliberate decision to hurt oneself in the absence of any sickness. As the Supreme Court has interpreted Articles 21 and 14, there is no moral difference between refusing and discontinuing life-support. For example, permitting death to occur through treatment or euthanasia using an updated concept of privacy in the context of terminal health and medical treatments is both fruitless and harmful. It is vitally essential to receive palliative care prior to using life support. One of a physician's core duties is providing palliative care, which aims to reduce pain and suffering. While India's right to refusal and passive euthanasia laws are opposites, they both represent terminally ill patients' freedom to self-determination, and this helps alleviate their mental and psychological agony.

Unlike the legislation in industrialized nations, the Supreme Court has taken some steps toward a new era of healthcare and medicine for terminally ill patients by permitting

passive euthanasia on the tough issue of euthanasia, as it has established conclusions to the decision. It's not uncommon for sentences to be issued in the face of a complex medical, social, and legal problem in medical-legal ethics. It is clear that new laws are needed to protect patients and physicians' rights, as stated in the Law Commission Recommendation, because the right to refuse treatment or informed refusal of treatment, withdrawal or withholding of life-sustaining treatment and the right to palliative care cannot be delayed any longer.

H3 – Indians repudiate passive euthanasia for emotional values and societal norms.

According to a comparison between each individual category within our research sample, it has emerged that euthanasia and the removal of life support systems are popular with patients' loved ones and the broader population, respectively. However, passive euthanasia was favored over active volunteer euthanasia by this group. Of course, the extent of their agreement varied from one another, and there were statistical discrepancies amongst them. According to the results of this survey, a large majority of respondents support the legalization of euthanasia in India. The vast majority of those who took part in our survey agreed that legalizing euthanasia in India carries a considerable danger, both when compared to other respondents and when looking at the sample as a whole. No correlation was found between the characteristics of their occupation and their opinions regarding euthanasia. Over 18% of respondents, on average, choose the "neutral" option, according to the results. There might be two possible explanations for this. There is a chance that some people have not given the topic considerable consideration to emotional values and societal norms.

8.4 Conclusions

Euthanasia is legal in India, although there are two opposing views on the issue. A pro-euthanasia stance and an anti-euthanasia opinion exist. It is possible to sum up the arguments of both sides as follows:

8.4.1 Arguments in Favour of the Legalization of Euthanasia

Despite the fact that euthanasia is now illegal, the following are some arguments in favor of decriminalizing it. To see if euthanasia can be implemented in the Indian context, researchers also looked at that country's legal structure. The following are argued in an effort to achieve this goal:

Interpreting Article 21

Article 21 ensures the right to life and freedom of expression. Article 19's negative connotations were cited in P. Rathinam case as support for the conclusion that this "right to life" also includes the right not to live. However, as Gian Kaur's case demonstrated, such inference was based on incorrect assumptions. According to Article 19, the right to freedom of speech and expression includes the freedom to speak, but it excludes the freedom to slit one's own throat, which would be a complete erasure of the right. As a result, the "right to life" does not include the "right to die," which is the complete erasure of one's rights.

However, there is another way to view Article 21. Besides "right to life," this Article includes "personal liberty," as well. Let's consider liberty in the context of life as a continuous sequence of events from birth to death. The moment a person is born, he or she loses all freedom. When he can't make a decision, he uses his freedom. He is free to live the way he chooses. He has the freedom to become a sage or a killer. He is free to engage in any and all illegal activities, and the state may only intervene once they have been completed (except in certain situations where state can intervene as preventive measure). Under Article 25 of the Constitution, however, a sage has the basic right to practice and preach his faith without restriction. As long as the person is using his "personal liberty" of shaping his life as he sees fit, if one wants to take Samadhi (meditation till death) to attain salvation, which is not harming the society at large, can the state prohibit his Samadhi? (Which would abridge his fundamental right of freedom of religion under Article 25). If one can disregard the "religiosity" of the deed, the sage's Samadhi is nothing more than an exercise in personal sovereignty.

When a person is terminally sick, in a chronic vegetative condition, or when his cerebral cortex has ceased to function, does he not have the right to decide whether or not to end his life? In this case, can he not take control of his own life?

As part of the ongoing discussion, it is important to keep in mind that a person's prudence and intelligence are lost when the "brain cortex" fails to function; respiration and circulation continue until the "brain-stem" is dead. Patient's position worsens to "beast existence" for terminally ill patients. A person's right to life is not a matter of "mere animal existence," as the courts have previously concluded. The right to life protects more than just the survival of animals; it also protects everything that gives life meaning and purpose. This basic right of "dignified life" may not be exercisable by someone in a chronic vegetative condition; neither can the state enforce it, so why not read Article 21 so as to enable both the patient and those caring for him a dignified death, free of pain?

Right to Privacy

While the state is preventing a terminally sick patient who chooses to die from ending his life, he is also violating his right to privacy. The right to privacy is a deciding element in many circumstances, as has been held by US courts and recognized by the common law. Invasion of one's personal space has been made a point of discussion in India as well. Individuals are responsible for determining when they are able to allow others to enter/operate their bodies, not the government. This may also be applied to the interaction between a doctor and a patient. A patient has the right to request that no one, including the doctor, be allowed to enter/operate his or her body beyond a specified period of time. Even if the doctor (or anybody else) follows this directive, entering/operating the patient's body would be a civil wrong, giving rise to a trespass on person tort case for damages. Self-discrimination and autonomy are at the heart of respecting someone's privacy.

Right to Autonomy

India through the Transplantation of Human Organs and Tissues Act, 1994 and the Transplantation of Human Organs (Amendment) Act, 2011 has recently allowed people

to donate their kidneys and other essential organs, including their eyes, while they are still alive and after their death, for the benefit of others whose organs have failed. Legally, the right to donate body parts is a powerful and significant one in the modern world. Vital organ transplantation is a risky procedure that might result in death. Although the government has allowed it, donors may die as a result of the donation during or after the process.

How therefore could a person's right to self-determination, which includes the freedom from pain and suffering for the sake of others, not extend to relieving oneself or herself from a similar condition? An individual's right to self-determination is demonstrated or acknowledged when they provide their informed agreement to undergo treatment or surgery. The right to self-determination or autonomy has been at the heart of several Euthanasia debates in the Western world. To give therapy against a patient's requests is plainly against the doctor's legal obligation, hence there is no need for him to do so. It's possible that he owes it to the patient to explain the ramifications of his rejection.

Medical practitioners can terminate a pregnancy in accordance with Section 3 of the Medical Termination of Pregnancy Act, 1972. It allows for the termination of a pregnancy if the mother's life or the health of her unborn child would be in grave danger if the pregnancy continued, or if there is a significant chance that the child would be born with severe physical or mental disabilities. This law established a legal justification for the death of a fetus in order to protect the mother's health or mental well-being. The Act exclusively acknowledges the mother's consent in this matter. Why should not Indian law allow "putting an end to one's own life to relieve another person from agony, misery, or a pointless vegetative state?"

It is well-established in medical jurisprudence that a physician must use caution while ending his or her care for a patient who is about to be euthanized. For as long as the patient is in need of treatment, he must supply it. Even if he learns that his illness is incurable, he should not stop therapy. He should only stop treatment if the patient agrees to it, among other things. As a result, if the patient consents to the discontinuation of therapy, the doctor will not be held liable. As a result of this examination, it is obvious

that euthanasia may be lawful in India, depending on how the rules are interpreted and construed.

Lack of Medical Facilities in India

As a developing country like India experiences a growing strain on its hospitals and medical facilities, it seems more reasonable to utilize the same resources to help other patients who have a better chance of recovery and whose recovery would be more valuable to the country. When faced with a choice between an unrecoverable patient and a patient who can be rescued, the latter should be chosen because the former is certain to die.

Proper Legal Safeguards can minimize misuse of the Right

Furthermore, the proponents of euthanasia do not claim that this privilege cannot be used. Rather, they contend that effective legal protections can reduce the likelihood of misuse of any individual freedom. In this context, the practice that is prevalent in the Netherlands is particularly significant. Following a set of standards, Dutch doctors who execute active Euthanasia are not penalized. There must be no mistake about the patient's decision to die, the patient's mental and physical suffering is well-informed and free, and there are no alternative choices for the patient remaining. Furthermore, the mere possibility of a right's wrongful use does not justify denying access to anybody.

It is becoming more common for people to rely on "living wills," which allow their designated representatives to request the removal of life-sustaining equipment if they become terminally sick. Many groups and people have declared the "right to die" as of late. Increasing numbers of "Right to Die" Societies are being formed, and living wills are becoming more and more common.

Public Policy-A Variable Concept

While considering the legalization of euthanasia, it is important to analyze the country's policies in this respect. This was a national policy in the Netherlands. Is it possible for India to achieve the same results as the United States?

Proponents of legalizing euthanasia are of the view that public policy is a nebulous, shifting, and unpredictable term. In the context of legal rights, the term "public policy" is a vague and unsatisfactory term that can be interpreted in a variety of ways. In its ordinary sense, "political expedience" or "what is best for the common good of the community," it can be understood to mean anything from "political expediency" to "what is best for the common good," and in that sense, there may be a wide range of opinions based on one's education, habits, talents, and dispositions.

In order for public policy to change, it must. It can vary not just from one century to the next, but even within a single generation as well. Although public policy is not always easy to describe, it changes throughout time as people's habits, attitudes and well-being shift. Consequently, the notion of public policy is always evolving, and it differs from one culture and person to the next. Because Euthanasia should be adopted as public policy, it must be borne in mind that the "terminally ill" patient is not being killed by the physician; rather, he is freed of the misery and pointless existence he is suffering.

Death Penalty vis-a-vis Euthanasia

After that, proponents say, if society can authorize the death sentence, why can't it also condone euthanasia? In both circumstances, a person's life is cut short. In the first case, a person is murdered for his wrongdoing, but in the second, he is slain to save him from a miserable and pointless existence.

Euthanasia is letting Die - Not Killing

To euthanize someone is to allow them to die, not to murder them. The goal is to benefit others rather than to do damage. As a result, it is a different crime from murder.

8.4.2 Arguments against Euthanasia as a Humane Option

It is unavoidable that euthanasia is a deliberate act intended to end the life of the patient. The pro-life movement opposes the use of artificial techniques to extend human life. Opponents of active methods like deadly drugs to shorten a person's natural lifespan, on the other hand, reject this approach.

Not right to die but right to kill

Anti-euthanasia critics view euthanasia as a permission to kill patients. Because they claim that it is not a right to die but a right to kill, they're equating it with murder. Because of the widespread corruption and malpractices in the medical field, they say that granting doctors the ability of active euthanasia would result in a severe misuse of their authority. However, they acknowledge that in some cases, active euthanasia may be morally acceptable. In light of the foregoing, the following are some of the arguments against euthanasia legislation: There is less trust between the doctor and patient.

If doctors are allowed to take the life of a terminally sick patient, the delicate and trusting connection between patient and doctor would suffer. People have a trusting connection with their physicians because they believe they are committed to helping them live long and healthy lives. The Hippocratic Oath's roots may be traced back to this kind of connection. It's an unbreakable law that no doctor, no matter how beseeched, will ever murder a patient. After the legalization of euthanasia, the medical profession will become engaged in the killing procedure. Legalized terminators would be applied to the doctors. Furthermore, if legalized, it will give doctors greater control over their patients' health than it already does. Victimization of the patients will occur, and their vulnerability will not be adequately safeguarded.

A duty to kill presupposes the existence of a right to die

Every right has a duty that must be fulfilled. If euthanasia is made legal in India, the responsibility to kill would follow as a natural consequence of the right to die. People will be able to assert their right to die in such a scenario by filing a lawsuit against the

government, which will obligate it to protect that right. Doctors may be sued for breaching someone's right to life by deciding not to kill him. In the future, they may begin to get malpractice insurance to protect themselves from such lawsuits brought by patients.

Euthanasia Misuse Concerns

In a society where the elderly and impoverished are already seen as a burden and have no social structure to help them, opponents of euthanasia protested the authorization of the practice. Lawbreakers may take use of this law for their own selfish motives. As a means of inheriting ancestral property, a person can simply kill his predecessor with the aid of a doctor under the guise of mercy killing, and this would further wreak havoc in the family. Due to the availability of mercy killing, there will be an increase in the number of lawsuits over the inheritance of the deceased's property. Non-voluntary Euthanasia of undesired relatives will grow dramatically as a result of this "Slippery Slope."

As a result of the previously described situation being reversed, we now face the following issue:

In the event that euthanasia is made legal in India, a clause in the Hindu Succession Act of 1956 (Section 25) will stand in the way of its execution. According to Section 25, murderers are ineligible: If an heir kills or aids in the murder of the person whose property he would otherwise be entitled to receive, that heir forfeits his or her inheritance rights. It was done to ensure the succession of power. Due to his or her illegal actions, an heir is barred from inheriting property from someone else's estate.

In such circumstances, it is standard practice to regard the assassin as if he or she did not exist and not as a potential ancestor. It is clear that the patient's heirs will be reluctant to take use of the euthanasia provisions since, under the Indian Penal Code, it would constitute murder or aiding and abetting murder, which would result in the patient's heirs losing their property. So, the application of Euthanasia regulations would be further complicated by these contradictory provisions. It will be necessary to make

significant revisions and repeals to various laws in order to keep them all in effect at the same time.

Death Penalty different from Mercy Killing

To harden a criminal who poses a major danger to society's ability to maintain law and order, the death penalty is used. It is a penalty. Mercy killing, on the other hand, is not a punishment meted out to someone for their sins. In contrast to hardened criminals, terminally sick people represent little threat to society. Furthermore, Amnesty International, a London-based nongovernmental group, has begun a global campaign to abolish the death sentence. A number of UN resolutions have also said that eliminating the death penalty is in the best interests of the whole world.

Euthanasia is morally repugnant as well as unconstitutional

For pro-lifers, allowing euthanasia or physician-assisted suicide is morally indefensible since it degrades the sacredness of human life. It's also against public policy, according to them, because it's against saving human lives. Humans were created by God and given the gift of life. Taking another person's life in an unnatural manner is an act of cruelty. Therefore, no one can be granted the position of God if they are the incorrect person. A prevalent idea is that if a person is in agony, it is because of his or her own Karma.

Euthanasia, on the other hand, diminishes the worth of life. Medical ethics, morality, and public policy are plainly at odds with this. Medical ethics require that patients be cared for, nursed, and treated, rather than put to death. Medical breakthroughs have made previously inconceivable things attainable. It's now possible to cure even the most dreadful diseases, such as cancer. It is preferable to urge the patient to persevere through the rest of his life with courage and patience rather than prepare him to terminate it prematurely. Furthermore, the decision to request euthanasia is not simply based on the patient's preferences. In addition to the patient, the patient's family should be considered before making such a decision. In order to make such a decision, the patient is likely to be subjected to excessive influence and psychological pressure. The patient may feel that he is a burden on his family at times.

If suicide is considered a crime in India, euthanasia should be deemed a criminal as well. Suicide occurs when a person is depressed and has given up all prospect of a comfortable life. In some ways, the individual seeking euthanasia is in the same situation as the one described above. It is possible to reverse this tendency by giving compassion and encouragement to those who are experiencing it. Several individuals have been brought out of comas after long periods of time in various parts of the world. Furthermore, human existence is predicated on the concept of hope, which should not be overlooked.

Terminal Illness: Ambiguity

Pro-lifers say that terminally ill patients should have access to palliative care and hospice services instead of allowing them to exercise their legal "right to choose death" through physician-assisted or non-physician-assisted means. Palliative care policies in India are in the early stages of development, and there is no law in the country to govern them. The quality of life must be improved without being halted. There's a problem with how we define the word "terminally sick" or "terminal illness".

Euthanasia law, on the other hand, is full of imprecise and confusing wording that make it easy for the rules to be misunderstood. For example, the word "terminally ill or sick" does not have a defined meaning. A wide range of individuals might fall under this umbrella phrase, even among the medical community (much alone the legal profession) because there is disagreement on what constitutes a terminally ill patient.

While it may be possible to support the idea that euthanasia should be legalized, there are still some issues that must be addressed: In the first place, who will decide if a person is terminally ill? In the case of a licensed physician, however, it is impossible to rule out the possibility of misuse. Medical malpractice stories are becoming more and more prevalent. Even if a person is diagnosed as terminally sick in one location, they may find respite in another. A medical practitioner with such power might use it to their advantage financially. Secondly, how can one expect a person who is terminally sick to offer free, reasonable, and fair permission if this privilege is only granted to them?

Parents, guardians, or relatives who have given their approval in addition to the doctor's cannot rule out abuse.

If euthanasia is legalized, the crime of responsible but non-murderous homicide must be abolished, and the resulting consequences may easily be anticipated.

Slippery Slope Argument

Slippery slope is another popular argument. Prohibiting voluntary endangers even non-voluntary and involuntary lethal injection, the slippery slope argument states. Opponents of euthanasia use the following two instances to demonstrate how the slippery slope works: For patients in a prolonged vegetative state, the House of Lords in Airedale NHA Trust case permitted non-voluntary euthanasia. The Supreme Court of Ireland enlarged the persistent vegetative state to encompass circumstances in which the patient had minimal cognitive skills. In 1984, the Dutch Supreme Court ruled that euthanasia may only be justified in the case of terminal physical sickness. When Chabot's case came to light, the court ruled that it may even apply to those with mental illness.

This practice sends out the incorrect message. There is an incorrect message that certain lives are not worth living if euthanasia is permitted in India. "To address the problems of the suffering by murdering them does not help the suffering person...it sends messages of hopelessness and helplessness," says a clinical intensive care physician. To acknowledge that "some lives may not be worth defending," it lowers the social rule against killing.

Few patients want euthanasia at this time, but that may change in the future, given the current condition of events. The problem is that once it is made legal, there will be an obligation placed on those who use it because it is legal. Patients may even begin to believe that they owe it to themselves to be murdered. After the legalization of euthanasia, some people may be forced to choose between life and death. A rule of this nature will undoubtedly have a negative impact on the lives of those who are most vulnerable.

8.4.3 Settling the Debate on Euthanasia

Many ethical and legal issues arise during the course of a doctor's work. Doubts about what to do and what not to do in the care of a patient might occur at any time. A physician's ability to make sound decisions is obviously impaired when confronted with such a conundrum. Irritability in the mind can induce feelings of sadness and lack of motivation. It is quite tough to pick between two options in the medical field. There is a chance that both sides of a debate have valid points. Patients and their loved ones are often unaware of the bigger picture when it comes to the challenges they are dealing with.

The doctor, although being able to predict the disease's course and weigh its benefits and drawbacks, cannot be considered ethically or legally competent to make a choice. Numerous more compelling factors, some of which may have socioeconomic underpinnings, come into play while making a decision. Many insolvencies in India are caused by expensive and long-term medical treatment for patients who are already in their last days. Aruna Shanbaug Case is a step forward in India's efforts to establish clear standards on the problem of delaying or withdrawing life-support equipment and medical care.

When a terminally sick patient has an incurable condition, it is extremely difficult to provide ongoing care. The carers may find it difficult. Deciding whether or not to continue therapy is a difficult decision. If you believe that therapy should be halted in the face of an incurable and dismal situation, you're being irrational. One may argue that such a measure is both ineffective and unethical because of its potential for harm. Pro-life activists may mistakenly believe it to be the same as euthanasia, which it most certainly is not. However, family members of the patient, who is in a persistent vegetative state, have legitimate concerns. If the therapy is stopped, what are the reactions of the patient's loved ones and the rest of society? They will probably respond, "Let's keep going with the therapy anyhow, maybe a miracle will happen."

An advocate for the patient who is unable of speaking for himself or herself may challenge the necessity and duty of extending death and interfering with the natural

process of dying. Why employ artificial technologies to lengthen the time of suffering, anguish, and torment in the first place? What's the point of depriving a dying patient of their due respect? Medicine's primary goal is to alleviate suffering and promote health, not the inverse. To sum up, one has reached his last stage and this ailment is untreatable, meaning that all therapeutic options have been explored.

As there are so many arguments for and against withdrawing therapy, there is no clear-cut answer. Since the introduction of artificial life-support systems, this has been a contentious subject in the medical community. Numerous medical conundrums arose, most likely, in the late nineteenth century and forward. Solving these conundrums has been a priority for the previous two decades. Guidelines are quite popular in today's world. In order to discover a solution to a difficult problem, scientific principles such as these must be followed. When it comes to questions of end-of-life care, it is impossible to formulate uniform recommendations. People in different cultures and ethnic groups have diverse views on these topics that are not only regionally particular but also culturally and religiously specific.

Certain Indian Societies have also made continual efforts in India. India's critical care society has developed national standards for patients nearing the end of life. Hospice care for patients who are nearing their final days in critical care units has long been a goal of the Society for the Study of End-of-Life Care (SOLC). The plan also included the creation of realistic procedural guidelines aimed at curbing medical treatments that only serve to extend life. As a result of this choice, a viable solution has been found for the issue at hand. It was not until 2012 that the Indian Society of Critical Care Medicine (ISCCM) released updated versions of its 2005 EOLC guidelines.

Another Indian organization, the Indian Association of Palliative Care (IAPC), has also made attempts to build national EOLC policy. EOLC policy for the dying has just been released in a consensus statement by the group. For the purpose of assembling an expert panel, representatives from ISCCM and IAPC were solicited. An EOLC policy for terminally ill patients was launched with the help of such a committee. A thorough review of both national and international guiding principles as well as current procedural procedures was conducted by the members of the committee. The

committee's unified policy incorporated socio-cultural, ethical, and legal considerations while also taking India's specific circumstances into account.

Suggestions to remove the shortcomings of the Draft Bill 2016

An important contribution from this researcher is a set of legal principles-based ideas for improving the Bill's flaws so that it may better serve both the interests of medical and legal fraternity while also catering only to terminally ill patients. Certain irregularities must be resolved before the government can complete the work of enacting laws on this Bill. In order to make it a more complete law, certain additions must be made. Accordingly, a researcher is eager to provide the following recommendations: -

Age of consent is commonly set at 18 in India, according to a number of well-known regulations. Many people, in the general public as well as on social media, were still calling for an age reduction for minors from 18 to 16 even after the Delhi rape ruling. That wish was not met in the new Act on juvenile delinquency, however, as the expert committee made an exemption in favor of the age group between 16 and 18 that the magistrate may consider them to be major, taking into account their maturity and knowledge. As a result of the above, anyone under the age of 18 who causes bodily harm to another is still regarded as a minor, with the exemption noted above. If this individual decides to terminate his or her own life in accordance with the proposed Bill, he or she will be a competent person who has the maturity to make an educated choice about it. Contrary to Indian Majority Act of 1857, Indian Contract Act of 1872, Hindu Matrimony Act of 1955 and other well-established legal precedents. As a result, it is recommended that the age of a competent patient be raised from 16 to 18 years old, rather than the current 16 years and beyond. For those patients who are over the age of 16, but not yet 18, their primary spouse or parents/guardians will also be notified of the patient's decision and their permission taken in addition to the patient's own. This requirement in and of itself implies that anyone under the age of sixteen is unable to make an educated decision for themselves. Thus, an appropriate change to the relevant provisions of the proposed Bill is needed to address this anomaly.

In contrast to India, western countries have a far more established idea of informed consent. A few examples of landmark cases have already been explored in the preceding pages of this chapter in the development of this idea. Preconditions for informed consent can be deduced from judicial statements in these cases, such as complete disclosure of serious risks and an alternative therapy that includes all of its advantages and drawbacks. It indicates that it's not only a formality, but it's the doctor's responsibility to inform the patient of all the hazards that might affect their decision-making. Despite this, it is common for doctors to place a lot of trust on the judgment of the patient's attending physician when it comes to determining the patient's best interests. Medical paternalism and the patient's right to self-determination may conflict here. The doctor-patient connection must be based on trust. Otherwise, the number of lawsuits alleging medical malpractice would rise unnecessarily. That this notion is not examined by the courts in India to the same extent as in western nations is a sad fact. Throughout a nutshell, the notion of informed consent must be developed and understood in India. The proposed Bill's concept of informed decision has to be clarified by appropriate change, according to the authors.

There must be quasi-judicial entities for the preparation of the medical penalty and the preparatory authority. There is a need for an alternative, and that is probably the development of a Euthanasia Tribunal in each state, in order to relieve the load on the state judiciary to examine each case of euthanasia and then issue orders appropriately.

Additions needed in The Bill of 2016

To ensure that the Bill of 2016 is complete and thorough, the following amendments have been proposed: The following are some definitions: The following terms should be included in the 2016 legislative proposal:

- The practice of assisted suicide or euthanasia: Intentional killing is defined as the act or omission of a person whose life is deemed unworthy of live.
- It is worth noting that the aforementioned attribution, as stated, applies to everyone who has suicidal thoughts. It's also important to note that the term "person" doesn't just refer to "patients." Legalizing the above will lead to

nothing but pandemonium, according to my opinion. As a result, the meaning of "person" must be specified in order for a person to qualify for euthanasia.

- Euthanasia via lethal injection: Positive euthanasia is another term for this practice. It refers to a positive act of mercy intended to put an end to pointless suffering and a life without purpose. In a sense, it's a "commission." One of the more contentious methods for euthanasia is providing a fatal injection, which involves the use of lethal drugs or forces. There is no doubt that this was a murder.

This is the opposite of active euthanasia. It is sometimes referred to as allowing oneself to die or aiding oneself in death. It entails stopping or halting the use of life-prolonging measures. Some of these include a failure to resuscitate a someone who is terminally or disabled. Disconnecting a feeding tube, forgoing a life-prolonging procedure, or withholding life-extending medications are all options. In the medical context, to "let die" implies to allow an outgoing inner-organismic disintegration process to take place without sustaining or substituting essential processes. As a result, extubation (the withdrawal of a patient from a ventilator) is not killing, even if it is a physical activity that leads to death. Death is not caused by extubation; it just delays its onset by a short period of time.

The term "brain death" refers to the permanent loss of all brain functioning, including the brain-stem. If the person's brain stem is no longer functioning, they are declared dead. It signifies death that cannot be averted. In order to deal with euthanasia cases at the state level, a provision should be inserted to create a Euthanasia Tribunal. We need a quasi-judicial body consisting of one or two medical practitioners and one or two social workers with experience in the relevant issues. When it comes to euthanasia law, the Euthanasia Tribunal is the best option. The active euthanasia of any terminally ill patient should be prohibited under any circumstances. Relatives and doctors implicated in euthanasia must be punished severely, as must the doctor or doctors have involved. It must be a cognizable and non-bailable offense of culpable homicide that does not constitute murder. Patients who are brain dead or in a lifelong vegetative condition should be given the option of passive euthanasia if the protocol is followed precisely.

In light of the Supreme Court's decision in Aruna's case, it is necessary to make a legislative provision for the same.

To summarize the findings, it can be argued that the debate over euthanasia in India is picking up steam in light of recent international events, including legislation and court rulings. Both of these issues are very contentious, and it is difficult to come to a consensus on them. It's a topic that divides people based on their own values and social context. Despite the fact that the notion of a joint family is long gone, the contemporary nuclear family is an important part of Indian culture today. Modern young people view their elderly parents as a burden. The surge in the number of senior living facilities in our country is proof of this. Furthermore, in today's culture, ideals like compassion and a desire to help the elderly in their time of need have diminished in importance. It's hard to think that the children of an elderly, terminally sick patient would put their own comfort ahead of their parents in such a scenario. As a result, they choose to use active euthanasia in order to save both time and money. Furthermore, they may be able to seize the property of a patient at the earliest possible opportunity. The foregoing conclusions are backed up by India's social reality. Particularly in rural regions, heirs do not hesitate to use the thumb impression of a deceased illiterate parent on property paperwork.

The issue is becoming worse because of the widespread corruption throughout the entire system. Medical professionals who practice ethical medicine aren't exempt from this need. Female foeticide is one egregious example of medical professionals engaging in unethical behavior for personal benefit.

India appears to be an ideal environment for the practice of passive euthanasia. When there are only a limited number of life-saving resources available in India, it's imperative that they're not wasted on hopeless situations. As a further measure to prevent the abuse of passive euthanasia, only allowing it in situations of brain death and persistent vegetative state (PVS) should be allowed. The Apex Court developed a comprehensive method to cover the circumstance, further guaranteeing that it would not be misused in any way. It has also taken a lot of effort from the Law Commission to come up with a Bill that would allow terminally ill individuals to be taken off of their

medical care. In the real world, both have the same goal: to alleviate the patient of their excruciating suffering to the point where further therapy is no longer possible. However, this Bill just represents a first step. There are still a lot of things that need to be done to make things clearer.

To summarize, a large majority of legal responders oppose India's adoption of state-sponsored assisted suicide, for the reasons outlined above in this chapter and elsewhere. On the other side, they have backed the Supreme Court's ruling in favor of Aruna Shanbaug's passive euthanasia. With a huge majority, they have endorsed passive euthanasia for people who are brain-dead or in a coma. In addition, a majority of them supported the retention of Section 309 of the IPC and said that the freedom to commit suicide cannot be given to Indians because of the unique socioeconomic conditions of the country. "Euthanasia is no longer viewed as a criminal by the majority of the legal community, but rather as a human right for a terminally ill patient. The permission of the patient, if he or she is competent of doing so, has been accorded top priority by the legal respondents. The concern is that it will be misused by unscrupulous relatives of the terminally sick patient for their own profit. Finally, they have endorsed the idea of "living will" in India with a large majority. However perilous it may be, many people still see it as an option in the case of a terminally sick patient who is unable of making their own decisions due to their illness. They've also proposed a flawless system for putting such a law into effect in India. All legal responders have given the court a central role in such a procedure. India's Supreme Court has taken a key step toward the prospect of passive euthanasia by carving out the right to die with dignity for Gian Kaur and Aruna, respectively, in Gian Kaur's case and Aruna's case. Both of the Apex Court's recent judgements have been widely endorsed by the legal community.

In terms of the general public, even if they are not experts, the people who responded showed enough maturity to grasp the concept and provide thoughtful comments. The ultimate beneficiaries of such legislation will be society, and society is made up of the general people, which is why the researcher recruited them to participate in a survey in which they were asked to answer questions on the proposed legislation. As many of them believe in the right to die, they've expressed a range of opinions on the subject. As a general rule, most people believe that the right to die should not be granted to

humans since it would result in the deaths of many people. Furthermore, unlike legal replies, the majority of them saw euthanasia as a kind of assistance rather than a criminal act. They have voted overwhelmingly in favor of legalizing euthanasia in India. They have, however, raised concern that, in the event of an emergency, doctors would be unable to provide the best treatment possible to a terminally ill patient. They're worried that a legislation like this may be abused by the patient's family members working with the physicians to seize the patient's belongings. This rule would be misused in India since moral standards have eroded greatly in society. Patients with terminal illnesses should be given specific palliative care centers funded by the government, according to the responses of the general public. When making a choice on euthanasia, patients' rights to self-determination and autonomy have been elevated by most respondents. Many of them also considered the social consequences of euthanasia. Proposals for legislation on euthanasia have been made, however they have not yet been implemented due to lack of support from the public. It's their opinion the practice should only be used in the most extreme instances, and not as a normal practice.

Last but not least, physicians have also contributed their thoughts on the matter at hand, as they are the ones who will ultimately carry out euthanasia. Medics in India will bear a heavy burden if euthanasia becomes legal in the country. Like the other two types of responders, the majority of doctors who took the survey saw it as helpful. They, too, support the legalization of both active and passive euthanasia, as well as assisted suicide. A law of this nature would offer doctors with explicit instructions on how to apply it to the most appropriate patients. As a result, there would be no more ambiguity surrounding the choice to take the life of a terminally sick patient. The majority of those polled also recognized that some medical practitioners would utilize such a law for financial gain. It indicates that they are aware of the corruption and malpractices that are common in the profession. Because of this, they have shifted the burden of establishing a patient's fitness for euthanasia onto the shoulders of the patient's family and a panel of judicial specialists. Some of them have proposed drafting a clause for prosecuting people who commit such malpractices and corruption when conducting euthanasia. Many of them are willing to carry out euthanasia if the legislation permits it. Patients' pain is the sole motivator. To avoid the matter being politicized, just a

handful have opted to leave it to doctor-patient interactions. Surprisingly, the majority of doctors polled preferred that such a patient's final care be provided by members of the patient's family rather than in a terminal care hospital. In other words, they are well-aware of India's medical infrastructure's shortcomings, especially the dire state of the country's palliative care policy. According to this group of experts, physicians and judges should organize a high-level committee to approve euthanasia if the patient's informed agreement has been obtained. There should be a legislation that allows terminally ill individuals who are in intense pain to take use of this option, but only if there is a particular condition. In order for a doctor to administer euthanasia to a patient in accordance with such a legislation, he or she must be protected from harm.

Legal and general responses support passive euthanasia with a significant majority, although doctors support both active and passive euthanasia. In India, palliative care policies are in a state of disrepair, and everyone is aware of this. As a result, they have chosen to have the patient die in the care of his or her loved ones rather than at a hospice or other facility providing terminal care. According to the arguments presented above, a complete law on the issue is required in order to remove any doubts that members of the medical and legal communities as well as the general public may have. In order for the Bill to become a comprehensive law on euthanasia, it will need to be reworked extensively as indicated by the researcher in the earlier pages of this chapter. As a result, we urgently want a solid, thorough, and practical piece of legislation.

8.5 Suggestions

- Legislation on euthanasia must be enacted quickly in order to ensure that the right to die in the country is preserved. Due to the legislature's continual failure to fulfill its duties, the judiciary was forced to step in and legalize it in order to alleviate the suffering of those who are in a permanent vegetative state.
- A number of experts have argued that our country should follow the lead set by other nations that have legalized euthanasia. If we had laws like these, we would know exactly what we should do and what we should avoid in our daily lives. If the country's legislative body adopts the right legislation, legalizing euthanasia can be done in an effective manner.

- In order to administer euthanasia, proper rules, including the technique to be used, must be devised. For anyone stuck between life and death in a life-or-death scenario, the rules set by the Supreme Court are not clear enough to assure that this right will not be a disaster. Ineffective execution of the operation raises the risk that others may exploit it for their own gain. An application must be approved within a certain time frame, but the standards are vague and do not identify any preventative measures to guarantee that sufficient care and prudence are employed in the application's creation.
- To rely only on the doctor's judgment in administering Euthanasia is dangerous since the doctor might misuse his authority, putting a person's life in danger. Historically, the Court has scrutinized medical professionals' actions in considerable detail to make sure there was no proof of carelessness on their behalf. According to this, the only component that matters in the execution of mercy killing is one, and that one aspect alone has the ability to have lethal consequences.
- For the sake of avoiding any surprises down the road, the court must appoint a medical expert to review the doctor's euthanasia decision. After an expert review, it should be presented to the appropriate High Court for approval.
- Because of the legalization of euthanasia, who or what variables would establish the criterion of pain in order to terminate an individual's suffering if it is enacted? Putting exclusive authority in the hands of a doctor or a family member is a dangerous notion since it is not always clear whether they're acting in the best interest of the patient or not.
- What should you do if you find yourself in this predicament? It is vital to develop a Proper Redress Mechanism that deals solely with the issue of euthanasia in order to put an end to this situation. There should be a committee of two or more members, with one member representing the judiciary and the other two members representing senior and experienced doctors who would not be biased in their decision and would weigh all of the advantages and disadvantages before they allowed euthanasia to be performed. Any party that feels wronged might bypass the courts and go straight to this committee in order to expedite the process. A lengthy euthanasia process would just make things

worse for individuals who were euthanized because the judiciary is already swamped with other matters.

- Preventing the doctor or family from misusing their position and making the procedure as clear as possible should be a requirement following the administration of euthanasia. An autopsy should be performed after the surgery is completed and the patient has passed away in order to ascertain the facts of the case and to take necessary measures to punish the offenders if any violations or misuse have been detected.
- Because illiterate people are more emotional than literate people, who are more practical, the determining decision cannot be decided only on the basis of feelings and emotions, the second most populous country in the world, India, has a greater percentage of illiterates than literates. Euthanasia's overall transparency is hampered by the fact that literate people are more inclined to engage in corruption than illiterate people. Even in the healthcare industry, corruption is a termite that eats away at every part of the infrastructure and puts the health and well-being of people at risk because of its destructive behavior. Consequently, we should defer to the courts so that the interests of the whole community can be protected. Moreover, Indians must show maturity in dealing with such a sensitive issue by carefully assessing its merits and cons.

Proposed Bill

THE PASSIVE EUTHANASIA (REGULATION) BILL, 2022

A
BILL

to regulate termination of life of persons who are in a permanent vegetative state or terminally ill and facing unbearable suffering and for mattersconnected therewith or incidental thereto.

BE it enacted by Parliament in the Seventy Fifth Year of the Republic of India as follows:—

1. (*1*) This Act may be called the Passive Euthanasia (Regulation) Act, 2022.

(*2*) It extends to the whole of India except the State of Jammu and Kashmir.

(*3*) It shall come into force on such date as the Central Government may, by notification in the Official Gazette, appoint.

2. In this Act, unless the context otherwise requires, —
(*a*) "active euthanasia" means termination of life of a person who is terminally ill and facing unbearable suffering by administration of lethal drugs;

(*b*) "Board" means the Evaluation and Review Board constituted under section 3;

(*c*) "Committee" means the Committee constituted by the Chief Medical Officer of a Government Hospital under section 8;

(*d*) "passive euthanasia" means termination of life of a person who is in a permanent vegetative state for not less than six months by withdrawal of life support system;

(*e*) "physician" means a medical practitioner registered with the Medical Council of India; and

(*f*) "prescribed" means prescribed by rules made under this Act.

3. (*1*) The Central Government shall, by notification in the Official Gazette, constitute a Board to be known as the Evaluation and Review Board.

(*2*) The Board shall consist of—

(*a*) Director General of Health Services in the Union Ministry of Health and Family Welfare, who shall be *ex-officio* Chairperson of the Board;
(*b*) two eminent physicians;
(*c*) a jurist of repute; and
(*d*) an eminent person having experience in ethics or social work, to be appointed by the Central Government in such manner, as may be prescribed, as members of the Board.

4. (*1*) The Board shall have such officers and employees as may be necessary for the efficient discharge of its functions.

(*2*) The term and other conditions of service of officers and employees of the Board shall be such as may be prescribed.

5. The Board shall examine applications of active euthanasia and passive euthanasia made under sections 7 and 8, respectively and give its opinion thereon:

Provided that in examining an application of euthanasia in respect of a child below the 25 age of eighteen years, the Board shall associate a paediatrician if neither of the physician in
the Board is a paediatrician.

Provided further that in respect of an application of active euthanasia, the opinion of the Board shall be given within three weeks of the receipt of such application.

6. Notwithstanding anything contained in the Indian Penal Code, 1860 or any other law for the time being in force,—

(*a*) a physician shall not be deemed to have committed any offence for performing an act of termination of life through active euthanasia or passive euthanasia in accordance with the provisions of this Act and the rules made thereunder;

(*b*) no person applying for termination of life through active euthanasia or 35 passive euthanasia either for himself or for a person in respect of whom he is so authorised under this Act shall be deemed to have committed any offence.

7. An application for termination of life through active euthanasia shall be made to the Board by that person himself or where that person, by reason of his illness, lack of mental faculties or age or such other reasons, as may be prescribed, is unable to express his 40 consent, by his parents or spouse or children or siblings or legal guardian.

8. (*1*) An application for termination of life through passive euthanasia shall be made to the Chief Medical Officer of a Government hospital by the parents or spouse or children or siblings or legal guardian of that person.

(*2*) On receipt of an application under sub-section (*1*), the Chief Medical Officer shall constitute a Committee consisting of three physicians for examining the person in respect of whom an application has been made and giving its opinion thereon.

(*3*) Notwithstanding anything in sub-section (*2*), where the application made under sub-section (*1*) is in respect of a person, whose any organ is to be transplanted to another person, or a girl child, the Chief Medical Officer shall forward that application to the Board.

9. If the Board or the Committee, after examining the person in respect of whom an application has been made is of the opinion that the life of that person requires to be

terminated by active euthanasia or passive euthanasia, as the case may be, it shall issue a certificate to that effect containing therein the reasons for such opinion.

10. No person shall be administered active euthanasia or passive euthanasia under this Act unless he makes an application in a Court of Session and such Court permits the application of euthanasia.

11. (*1*) On receipt of an application of euthanasia under section 10, the Court shall appoint a team of lawyers to investigate and enquire as to whether the patient, actually and without any extraneous influence of any kind, desires to terminate his life through euthanasia and make a report thereon.

(*2*) If the Court is satisfied with the report, it shall grant permission for euthanasia in the prescribed form under its seal and signature.

12. (*1*) On production of permission from the Court of Session, the Civil Surgeon or Chief Medical Officer of a Government hospital shall fix a date for euthanasia.

(*2*) On the date so fixed, steps shall be taken to put the life of the patient to a gentle and painless end in the presence of the members of the family of the patient and a representative of the Court of Session.

13. If any difficulty arises in giving effect to the provisions of this Act, the Central Government may, by order published in the Official Gazette, make such provisions, not inconsistent with the provisions of this Act, as appear to it to be necessary or expedient for removing that difficulty:

- Issuance of certificate of euthanasia.
- Permission for euthanasia by the Court of Session.
- Investigation of application of euthanasia by the Court.
- Euthanasia of the patient.
- Power to remove difficulties.
- Act to have overriding effect.
- Power to make rules.

14. The Provisions of this Act shall have effect notwithstanding anything inconsistent therewith contained in any other law for the time being in force or in any instrument having effect by virtue of any law other than this Act.

15. The Central Government may, by notification in the Official Gazette, make rules for carrying out the purposes of this Act.

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Annexure I: Questionnaire