Euthanasia: Should it be Lawful or Otherwise?

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The word euthanasia is derived from the Greek word "euthanatos" meaning "good death" and it refers to the practice of ending a life in a manner which relieves pain and suffering.

Based on whether a person gives informed consent or not, euthanasia may be classified into three types: voluntary, non-voluntary and involuntary. Voluntary, non-voluntary and involuntary euthanasia can all be further divided into passive or active variants.

Passive and Active Euthanasia

Passive euthanasia entails the withholding of common treatments, such as antibiotics, necessary for the continuance of life. Active euthanasia entails the use of lethal substances or forces to kill and is the most controversial means.

Voluntary, non-voluntary and involuntary euthanasia

Euthanasia conducted with the consent of the patient is termed voluntary euthanasia. Active voluntary euthanasia is legal in Belgium, Luxembourg and the Netherlands. Passive voluntary euthanasia is legal throughout the U.S. When the patient brings about his or her own death with the assistance of a physician, the term assisted suicide is often used instead. Assisted suicide is legal in Switzerland and the U.S. states of Oregon, Washington and Montana. Euthanasia conducted where the consent of the patient is unavailable is termed non- voluntary euthanasia. Examples include patients in a persistent vegetative state or coma who are unable to make an informed request for death. Euthanasia conducted against the will of the patient is termed involuntary euthanasia.

There is a debate within the medical and bioethics literature about whether or not the non-voluntary (and by extension, involuntary) killing of patients can be regarded as euthanasia, irrespective of intent or the patient's circumstances.

Legal Position

Passive euthanasia is legal in India. On 7 March 2011, the Supreme Court of India legalised passive euthanasia by means of the withdrawal of life support to patients in a permanent vegetative state. The decision was made as part of the verdict in a case involving Aruna Shanbaug, who has been in a vegetative state for 37 years at King Edward Memorial Hospital. The high court rejected active euthanasia by means of lethal injection. In the absence of a law regulating euthanasia in India, the court stated that its decision becomes the law of the land until the Indian parliament enacts a suitable law. Active euthanasia, including the administration of lethal compounds for the purpose of ending life, is still illegal in India.

As India had no law about euthanasia, the Supreme Court's guidelines are law until and unless Parliament passes legislation. The following guidelines were laid down:

1. A decision has to be taken to discontinue life support 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. It can also be taken by the doctors attending the patient. However, the decision should be taken bona fide in the best interest of the patient.
2. Even if a decision is taken by the near relatives or doctors or next friend to withdraw life support, such a decision requires approval from the High Court concerned.
3. When such an application is filed the Chief Justice of the High Court should forthwith constitute a Bench of at least two Judges who should decide to grant approval or not. The Bench will nominate a committee of three reputed doctors, who will give report regarding the condition of the patient. Before giving the verdict a notice regarding the report should be given to the close relatives and the State. After hearing the parties, the High Court can give its verdict.

Arguments for Legalising Euthanasia

Regarding euthanasia, at the present juncture, the debate largely revolves around active euthanasia and not passive euthanasia.

Supporters of euthanasia argue that society is obligated to acknowledge the rights of patients and to respect the decisions of those who select euthanasia. It is argued that euthanasia respects the individual's right to self-determination or his right of privacy. Interference with that right can only be justified if it is to protect essential social values, which is not the case where patients suffering unbearably at the end of their lives request euthanasia when no alternatives exist. Not allowing euthanasia would come down to forcing people to suffer against their will, which would be cruel and a negation of their human rights and dignity.

Every person has a right to live with at least a minimum dignity and when the state of his existence falls below even that minimum level then he must be allowed to end such tortuous existence. In such cases relief from suffering (rather than preserving life) should be the primary objective of health-care providers.

Supporters of active euthanasia contend that since society has acknowledged a patient's right to passive euthanasia (for example, by legally recognising refusal of life- sustaining treatment), active euthanasia should similarly be permitted. When arguing on behalf of legalising active euthanasia, proponents emphasise circumstances in which a condition has become overwhelmingly burdensome for the patient, pain management for the patient is inadequate, and only death seems capable of bringing relief. Moreover, in light of the increasing pressure on hospital and medical facilities, it is argued that the same facilities should be used for the benefit of other patients who have a better chance of recovery and to whom the said facilities would be of greater value. Thus, the argument runs, when one has to choose between a patient beyond recovery and one who may be saved, the latter should be preferred as the former will die in any ease.

It is not the case of the supporters of euthanasia that this right is not capable of exploitation. Rather they point out that almost any individual freedom involves some risk of abuse and argue that such risks can be kept to a minimum by using proper legal safeguards. Furthermore, merely because the risk of abuse of a right exists is no reason to deny a person the right itself.

Arguments against Legalising Euthanasia

The controversy over active euthanasia remains intense, in part because of opposition from religious groups and many members of the legal and medical professions. Opponents of euthanasia treat it as a euphemism for murder and maintain that euthanasia is not the right to die hut the right to kill.

They emphasise that the health-care providers have professional obligations that prohibit killing and maintain that euthanasia is inconsistent with the roles of nursing, earegiving, and healing. Instead, with the rapidly advancing medical science it is very much possible that those ill today may be cured tomorrow. Hence, the society has no right to kill them today and thereby deny them the chance of future recovery.

Further, it is not always that the patient wants to die. The relatives of the patient are also allowed to decide whether to let the patient live. In addition, even where the consent is that of the patient it may be one obtained by force. Use of physical force here is highly unlikely. But emotional and psychological pressures could become overpowering for depressed or dependent people. If the choice of euthanasia is considered as good as a decision to receive care, many people will feel guilty for not choosing death. Moreover, financial considerations, added to the concern about "being a burden," could serve as a powerful force that would lead a person to "choose" euthanasia or assisted suicide.

Moreover, it is argued that when a healthy person is not allowed to commit suicide then why a diseased person should be allowed to do so. It is pointed out that suicide in a person who has been diagnosed with a terminal illness is no different than suicide for someone who is not considered terminally ill. Depression, family conflict, feelings of abandonment, hopelessness, etc. lead to suicide - regardless of one's physical condition.

Studies have shown that if pain and depression are adequately treated in a dying person as

they would be in a suicidal non-dying person the desire to commit suicide evaporates.

Suicide among the terminally ill, like suicide among the population in general, is a tragic event that cuts short the life of the victim and leaves survivors devastated.

In addition, it is also frequently pointed out that the legislation relating to euthanasia is full of vague and ambiguous terms which allows the provisions to be easily misused. For example, the term "terminally ill" is not subject to a fixed definition. Even within the medical fraternity (let alone the legal community) there is dispute about who is a terminally ill patient and thus the category could cover a very wide range of patients.

Another favourite argument is that of the "slippery slope". The slippery slope argument, in short, is that permitting voluntary euthanasia would over the years lead to a slide down the slippery slope and eventually we would end up permitting even non-voluntary and involuntary euthanasia.

Opponents also argue that permitting physicians to engage in active euthanasia creates intolerable risks of abuse and misuse of the power over life and death. They acknowledge that particular instances of active euthanasia may sometimes be morally justified. However, they maintain that sanctioning the practice of killing would, on balance, cause more harm than benefit.

Conclusion

A perusal of the arguments that have been summarised above tends to indicate that all the talk about sanctity of life notwithstanding, the opposition to euthanasia breeds from the fear of misuse of the right if it is permitted.

Here it is sought only to argue for the legalisation of voluntary (both active and passive) euthanasia. This is because though there may be some cases of non-voluntary or involuntary euthanasia where one may sympathise with the patient and in which one may agree that letting the patient die was the best possible option, yet it is believed that it would be very difficult to separate such eases from the other cases of non-voluntary or involuntary euthanasia. Thus, the potential of misuse of provisions allowing non-voluntary and involuntary euthanasia is far greater than that of the misuse of provisions seeking to permit voluntary euthanasia.

In the present scheme of criminal law it is not possible to construe the provisions so as to include voluntary euthanasia without including non-voluntary and involuntary euthanasia. Parliament should therefore, by a special legislation, legalise voluntary euthanasia while expressly prohibiting non-voluntary and involuntary euthanasia. Legalising euthanasia would not have any effect on the provisions relating to suicide and abetment thereof as euthanasia and suicide are two completely different acts.

Coming back to the argument that legalising voluntary euthanasia would lead to a misuse of the provisions, there could be a scheme by which such misuse could be minimised. It may be true that in Netherlands the provisions justifying voluntary active euthanasia may have been grossly misused but such misuse was possible because the procedure for investigating the validity of the death begins only after the death has taken place.

So a fairly practical scheme under which the investigation procedure would begin before the death is suggested and it is only after the investigation is complete that the doctor would be allowed to let the patient die.

A quasi-judicial officer be appointed by the appropriate authority under the proposed statute to supervise all cases of euthanasia within a feasible territory. Such officer must be reasonably well versed with the nuances of medical science. Any doctor who feels that his patient's request to die should be fulfilled would report such a case to the said supervising officer. The supervisor would then interview the patient to satisfy himself whether the request is free, voluntary and persistent. The supervisor would also then refer the case to a minimum of two other experienced doctors to get their opinion on the case. If both the doctors so referred feel that the patient is beyond recovery, that there is no alternate treatment available and that death would be a more suitable option for him then the supervisor would inform the patient's relatives about the patient's request and the doctor's opinion. Finally, the supervisor would issue a certificate allowing the doctor to let the patient die. Such certificate would also have to bear the signatures of the two doctors to whom the case was referred and of the legal guardian of the patient who would, after a talk with the patient, certify that the consent of the patient was not obtained by force.

Once such a certificate is obtained then the doctor would be allowed to let the patient die.

Though the procedure outlined above may seem cumbersome, such safeguards are necessary to minimise the chances of misuse of the right of euthanasia.

The only problematic issue that could arise is regarding the requirement that no other alternative to reduce the pain should be available. Problems could arise when it is required to decide what an alternative is. Thus, would a Rs 5 lakh treatment be an alternative for a person who earns Rs 5000 a year? Similarly, would a treatment available only in Delhi be an alternative for a person living in Port Blair and who cannot afford the passage to Delhi, even if he can afford the treatment? Also, would a doctor be held liable if he is ignorant of any new advancement in medical science? These are problematic issues and would require further extensive discussion. But one should not forget that in a country like India where there is tremendous pressure on the available medical facilities, euthanasia is all the more necessary for the maximum utilisation of the limited facilities. Euthanasia could be legalized, but the laws would have to be very stringent. Every case will have to be carefully monitored taking into consideration the point of views of the patient, the relatives and the doctors.

Author's Profile

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