

EUTHANASIA

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INTRODUCTION

Euthanasia comes from the Greek words, 'eu' meaning 'good' and 'thanatos' meaning 'death'¹. Bringing these together, euthanasia means 'the good death'. On studying the works of ancient Greek and Roman philosophers, it is clear that they did not believe that life must be preserved at any cost and consequently were tolerant of 'suicide' when relief was no longer possible; or in the case of the Epicurean school of thought when a person no longer cared for his life. In his concept of a utopian society, Thomas More envisaged a community which would facilitate death when the lives became a burden on account of 'torture and lingering pain'.

According to MediLexicon's medical dictionary, Euthanasia is: "*A quiet, painless death.*" Or "*The intentional putting to death of a person with an incurable or painful disease intended as an act of mercy.*"²

Usually, 'euthanasia' is defined in a broad sense, encompassing all decisions (of doctors or others) intended to hasten or to bring about the death of a person (by act or omission) in order to prevent or to limit the suffering of that person (whether or not on his or her request)³.

Euthanasia is generally classified into two broad categories, active euthanasia and passive euthanasia, in simple terms the difference between them is the same as that between 'killing' and 'letting die'.⁴ The standard ways of distinguishing between the

¹ Hunt T, *Palliative Care for People with Cancer*, 1995: 11–22.

² www.medicalnewstoday.com/articles/182951.php , 19th Feb 2016

³ Sjeef Gevers , *Euthanasia: Law and practice in the Netherlands*

⁴ *Active Euthanasia*, (Feb 20th, 2016, 14:03)

http://www.bbc.co.uk/ethics/euthanasia/overview/activepassive_1.shtml

two are – act versus omission and the removal of ordinary care versus the removal of extraordinary care, respectively. Active euthanasia entails the use of lethal substances or forces to kill a person e.g. a lethal injection given to a person with terminal cancer who is in terrible agony⁵. Passive euthanasia entails withholding of medical treatment for continuance of life, e.g. withholding of antibiotics where without giving it a patient is likely to die, or removing the heart lung machine, from a patient in coma⁶. On the basis of consent of the patient and possibility of obtaining that consent, euthanasia can be divided into three types- Voluntary, Non-voluntary and Involuntary. Voluntary euthanasia encompasses those instances of euthanasia in which a clearly competent person makes a voluntary and enduring request to be helped to die or, by extension, when an authorised person makes a substituted judgment by choosing in the manner the no-longer-competent person would have chosen had he remained competent. A second key value is the competence of the person requesting assistance with dying⁷.

Non-voluntary euthanasia includes instances of euthanasia where a person is either not competent, or unable, at the time to express a wish about euthanasia and has not previously expressed a wish for it⁸. *Involuntary euthanasia* involves circumstances where a competent person's life is brought to an end despite an explicit expression of opposition to euthanasia⁹.

Physician Assisted Suicide has a close relation with the concept of euthanasia, and can be defined as follows, when a physician provides either equipment or medication or informs the patient of the most efficacious use of already available means for the purpose of assisting the patient to end his or her own life¹⁰.

⁵ Aruna Ramchandra Shaunbag v. Union of India 4 SCC 454 (2011)

⁶ Id.

⁷ Young, Robert, Voluntary Euthanasia, The Stanford Encyclopedia of Philosophy (Fall 2015 Edition) (Feb 20th, 2016, 15:00) <<http://plato.stanford.edu/archives/fall2015/entries/euthanasia-voluntary/>>.

⁸ Young Robert, *supra*.

⁹ Id

¹⁰ American Geriatrics Society, (AGS) 2007

There are four major arguments presented by opponents of euthanasia. Firstly, not all deaths are painful and the existence of this apparent pain cannot be used as a prime criterion to argue a case for euthanasia. Secondly, alternatives relating to hospice care, involving the use of effective pain relief are easily available with advances in modern medical technology and should be preferred over killing a person. Thirdly, the distinction between active and passive euthanasia is morally significant, as there is a difference between simply withdrawing treatment and actively causing a person to die. Lastly, legalising euthanasia will place society on a slippery slope – this talks about the possibility of the wrongful death by euthanasia of people who do not wish to die but are unable to communicate the same or people who do not satisfy the medical requisites, but are euthanized anyway.

Euthanasia is usually when a person receiving intensive treatments machines are turned off, providing they have no chance of recovery and are too ill to make the decision themselves, however in order for this to happen there must be a strong reason as to why the person would do this is they could make the decision themselves.

There have been many requests and cases around the world during the last few years to make euthanasia legalized. Most judges and governments believe it will turn in to a slippery slope and a bypass of murder if they were to change the law but there are many controversial opinions and concepts of this idea.

CHAPTER 2

PROS AND CONS OF EUTHANSIA

Pros of Euthanasia - Death with Dignity

Sometimes people mention in their wills, that if they ever get into such a situation where it seems hopeless or too much to bear, that the family should allow him/her to die. Here are some pros to this situation:

◆ An individual should have the liberty to choose induced death if he is suffering from an incurable disease where even the best treatment doesn't improve his quality of life.

◆ Legalizing euthanasia would help alleviate suffering in terminally ill patients. It would be inhuman and unfair to make them endure the unbearable pain.

◆ While killing someone in an attempt to defend 'self' is acceptable by law, mercy killing is seen as act that is highly immoral in nature. The motive of euthanasia is to 'aid-in-dying' painlessly and thus should be considered positively by the lawmakers.

◆ A doctor is expected to help treat the sick by prescribing medicines that will relieve the patient's suffering (at any cost) even if the medications potentially give rise to serious side effects. This means dealing with distress should be the priority even if it affects one's life expectancy. Euthanasia follows the same theory of dealing with torment in a way that it helps one die peacefully out of possible peril.

◆ Euthanasia should be a natural extension of patient's rights allowing him to decide the value of life and death. Maintaining life support system against the patient's wish

is considered unethical by law as well as medical philosophy. If the patient has the right to discontinue treatment, why would he not have the right to shorten his lifetime to escape the anguish? Isn't the pain of waiting for death more traumatic?

◆ Family heirs who would misuse euthanasia as a tool for wealth inheritance does not hold true. Reason being, the relatives can withdraw life support leading to early death of the said individual even in the absence of legalized euthanasia. Here they aren't actively causing death, but passively waiting for it without the patient's consent. This is passive involuntary euthanasia that is witnessed around us even without legal support.

◆ Health care expenditure is and will always be a concern for the family irrespective of the euthanasia laws, and only those who can afford a prolonged unproductive treatment will continue to do so. A section of those in support of mercy killing often ask whether it is rational to keep a person - who has no hopes of survival, alive on a support system when our medical infrastructure is already under immense pressure.

◆ It can thus be inferred that though euthanasia is banned worldwide, passive euthanasia has always been out there and moreover law doesn't prohibit it. Disrespect and overuse of (passive) euthanasia has always existed and will always be practiced by surrogates with false motives. These are the ones who don't need a law to take one's life. The existing legal restrictions leave both the incurable patients as well as pro-euthanasia activists helpless who approve euthanasia as a goodwill gesture for a patient's dignity.

Cons of Euthanasia - Respect the Sanctity of Life

Those against this practice most often resort to ethics and morality in their tirade against it. They argue that mercy killing is an unethical practice because killing a person - for whatsoever reason it is, cannot be justified. Here's giving you the cons of euthanasia and how people deal with the idea of it.

◆ Mercy killing is morally incorrect and should be forbidden by law. It is homicide and murdering another human cannot be rationalized under any circumstances.

◆ Human life deserves exceptional security and protection. Advanced medical technology has made it possible to enhance human life span and quality of life. Palliative care and rehabilitation centres are better alternatives to help disabled or patients approaching death live a pain-free and better life.

◆ Family members would take undue disadvantage if euthanasia was legalized by influencing the patient's decision into it for personal gains. Also, there is no way you can really be sure if the decision towards assisted suicide is voluntary or forced by others.

◆ Even doctors cannot firmly predict about the period of death and whether there is a possibility of remission with advanced treatment. So, implementing euthanasia would mean many unlawful deaths that could have well survived later. Legalizing euthanasia would be like empowering law abusers and increasing distrust of patients towards doctors.

◆ Mercy killing would lead to the 'slippery slope effect', which is when those who are unable to voice their desires, are put to death like the senile, or a baby or someone in a coma and so on. It would cause decline in health care and cause victimization of the most vulnerable sections of society. Perhaps, mercy killing would transform itself from the 'right to die' to 'right to kill'?

◆ Also, all the religions believe euthanasia to be an act of murder, with no one's right to end life or be the judge of what happens next. Apart from these reasons, there are certain aspects where there is a greater possibility of euthanasia being messed up with.

◆ How would one assess whether a disorder of mental nature qualifies mercy killing? What if one's pain threshold is below optimum and the patient perceives the circumstances to be not worthy of living? How would one know whether the wish to die is the result of an unbalanced thought process or a logical decision in mentally-ill patients? What if the individual chooses assisted suicide as an option and the family wouldn't agree?

CHAPTER -3

DIFFERENT THEORIES

Theories of recovery

When a medical expert fails to comply with a patient's will and has already provided unwanted treatment- the patient or his or her representatives may bring a civil action for damages under a variety of theories of recovery. The most common approaches are based either on the intentional tort of medical battery or the negligent tort of medical malpractice.

When their end-of-life instructions have been violated, and these claims have often been described as a new tort. At this point, however, it is essential only to recognize that 'wrongful living' is not an independent cause of action, but rather is simply a claim in tort for damages resulting from a negligent or intentional interference with one's right to refuse treatment when the treatment results in the unwanted extension of life. In the wrongful living context, the patient's recognized right to refuse care has been violated, leading to an injury, which is prolonged life itself¹¹.

According to the Restatement (Second) of Torts, a battery occurs when a person acts intending to cause harmful or offensive contact with another person and such harmful or offensive contact results, either directly or indirectly. Importantly, the requirement of intent does not implicate any personal hostility or require any physical injury, but speaks instead to whether the actor intended the very act that was not consented to; thus, battery is nothing more than the intentional tort of un-consented direct contact. Along the same lines, a physician who initiates treatment against a patient's wishes will be liable for battery, even if the treatment ultimately saves the patient's life or cures his condition as no consent was granted. When the physician makes an effort to obtain consent, but such consent is based on an incomplete or insufficient disclosure of the risks involved, the physician has failed to comply with the standard of care and may be subject to liability for negligence¹².

Suffering

¹¹ Mark Strasser, A Jurisprudence in Disarray: On Battery, Wrongful Living, and the Right to Bodily Integrity, 36 San Diego L. Rev. 997, 1021 (1999)

¹² Baltzell v. Van Buskirk, 752 S.W.2d 902, 906 (Mo. App. 1988)

According to rabbinical teaching, one should use suffering to examine one's deeds and return to God.' The pious person observes the commandments with love for God and accepts suffering with joy.¹³ The tradition of R. Israel Baal Shem Toy calls for the acceptance of whatever happens to one with love, so that he/she thereby acquires both the present and the future world.¹⁴ "Stem justice and human suffering is the body in relation to the soul, vitality and spirituality shining upon the human being ... and when he or she accepts suffering with love and joy this is the 'hieros gamos' between the body, contraction, and stern justice, on the one hand, and the soul, joy, vitality and spirituality, on the other hand."¹⁵

Nevertheless, rabbinical tradition reports that three extraordinary teachers of the third century, R. Chiya bar Abba, R. Yochanan and R. Elazar, all declared that they wanted neither suffering nor its reward.¹⁶

According to the interpretation of R. Loew of Prague, rejection of suffering was justified if the person knew he was unable to stand the pain and could not respond like Job.¹⁷ The interpretation of R. Moses

Teitelbaum (1759-1841) distinguishes between pains which are a punishment and those which are the expression of divine love. The former cannot be rejected, while the latter are within the discretion of the suffering person and may be rejected. Hence, if suffering is beyond the patient's ability to bear, there seems to be even rabbinical authority possibly justifying at least passive euthanasia, probably even more than that.

¹³ BT BT Sabbath 88b; Ta'anit 8a; Bava Metsia 85a; Sanhedrin 101a.

¹⁴ Quoted by R. Jacob Josef of Polnoye: Ben Porat Josef, 82b; Sefer Baal Shem Tov, Balaq 16.

¹⁵ Quoted in R. Jacob Josef: Toledot Jacob Josef, Egev, 180c; Sefer Baal Shem Toy, Bereshit 25.

¹⁶ BT Berakhot 5b.

¹⁷ R. Judah Loew of Prague: Netivot 'Olam, 2, 175.

CHAPTER 4

BELGIAN ACT

In Belgium, there is no relevant jurisprudence on euthanasia and no guidance is offered by self-regulation made up by the medical profession itself before or after the enactment of the act although some guidance may be derived from the advice on euthanasia of the Advisory Commission on Bioethics, mentioned below.

Thoughtful comments on the act are, understandably, lacking up to now while the discussions in parliament have been often unclear and even contradictory. In other words, the *law* on euthanasia in Belgium almost coincides with the *act* on euthanasia.

In this respect the situation in the Netherlands is totally different. The law on euthanasia is first of all governed by the "Termination of life on request and assisted suicide act" of 10 April, 2001 that entered into force on 1 April, 2002.

This act is generally considered as the codification of the norms and procedures that have governed the practice of euthanasia in the Netherlands for almost three decades. These norms and procedures have largely emerged from within the medical profession itself and were later adopted by the courts in the context of criminal prosecutions.' There also exists a very important legal doctrine that offers guidance in understanding this act. In other words, studying the law on euthanasia in the Netherlands is more than merely studying the act on euthanasia. The act is only the 'tip of the iceberg'.

While the Dutch act aims to *codify* existing practices, the Belgian act mainly aims to *modify* the behaviour of physicians when ending the life of their patients. It is hoped that a law that pretends to offer legal security to physicians and patients will stimulate

patients to express a voluntary and explicit request and that physicians will abandon their practice of ending the lives of patients without their request. Research indeed had pointed out that Belgian (or at least Flemish) physicians frequently 'forget' to obtain the patient's request before ending his life.¹⁸ It should be made clear from the outset that a comparison of the Belgian and the Dutch law regulating the practice of euthanasia is a hazardous undertaking.

Just comparing both acts - at first sight the Belgian act, although much more detailed, could be considered a 'clone' of the Dutch act - will lead to misleading and even incorrect results. Not only the acts, but also medical practice and legal practice (jurisprudence and doctrine) have to be considered when we try to compare the law on euthanasia in both countries. In this article I will make an attempt to do this. Lack of space requires omitting many details from the comparison.

1. The field of application of the Belgian and Dutch acts on euthanasia

1.1. Practices regulated

a) Euthanasia

Section 2 of the Belgian act defines euthanasia as intentionally terminating life by another person than the person concerned, at this person's request. This definition had been proposed in the recommendation of the Belgian Advisory Committee on Bioethics of 12 May, 1997.¹⁹ The great merit of this recommendation is that it ended the lack of clarity regarding the term 'euthanasia'. By offering a clear, strict and authoritative definition of euthanasia, the committee fulfilled one of the necessary conditions for a fruitful ethical and legal discussion regarding this matter.²⁰ The definition opted for in the recommendation and confirmed in section 2 of the act is commonly known as the 'Dutch' definition of euthanasia because it was also used by

¹⁸ Mortier, Freddy and Deliens, Luc, "The prospect of effective legal control of euthanasia in Belgium," in *Regulating physician-negotiated death*, ed. A. Klijn, M. Otlowski and M. Trappenburg (s' Gravenhage: Elsevier, 2001), p. 180.

¹⁹ See for the English text of the recommendation: Herman Nys, "Advice of the Federal Advisory Committee on Bioethics concerning legalisation of euthanasia," *European Journal of Health Law* 4(1997): pp. 389-393.

²⁰ Bert Broeckaert, "Belgium: towards a legal recognition of euthanasia," *European Journal of Health Law* 8(2001): p. 96.

the Dutch State Commission on euthanasia in 1985.²¹ Ironically, the Dutch act on euthanasia does not contain this definition and even the notion 'euthanasia' is not mentioned. This act always refers to 'the termination of life on request', without giving a definition of this notion. Because termination of life on request coincides with the activity labelled as euthanasia in the Belgian act, both acts have the same field of application in this respect.

b) Assisting suicide

The Belgian act is not applicable to assisted suicide, whereas the Dutch act treats termination of life on request and assisted suicide in exactly the same way. It defines assisted suicide as intentionally helping another person to commit suicide or providing them with the means to do so (section 1,b). The Belgian legislature deliberately left assisted suicide out of the field of application of the euthanasia act. In its recommendation the Belgian Council of State pointed at the fact that there is no principal difference between euthanasia and assisted suicide and recommended to include assisted suicide. Also, from within the parliamentary majority itself, different amendments have been proposed with the same purpose. By not approving these proposals, the legislature has clearly opted not to regulate assisted suicide. One can only speculate on their motives.

One motive could be that in the current state of Belgian law, assisted suicide is not expressly prohibited, whereas it has been in the Netherlands for many years (section 294 of the Dutch Criminal Code). Because assisted suicide was not a (separate) crime, whereas ending another person's life, even at their request, was (and still is) a crime, the legislature could limit himself to regulating euthanasia. However, this reasoning can easily be reversed: because assisted suicide is not a crime

²¹ This definition had been suggested already in 1977 by the late professor in health law, Leenen. See Henk J.J. Leenen, "The development of euthanasia in the Netherlands," *European Journal of Health Law* 8(2001): p. 127.

and the difference between euthanasia and assisted suicide is minimal, both have to be submitted to the same legal norms and procedures. Given that one of the motives for a change of the Belgian law has been the protection of patients against unrequested ending of life, one can even argue that the law should encourage physician-assisted suicide as a 'safer' alternative to euthanasia, because in the case of suicide it is the patient him/herself who has to act and this may be regarded as a stronger safeguard of autonomy. To sum up, I am not convinced that the Belgian legislature has left assisted suicide out of the euthanasia act because assisted suicide is actually not a crime. Moreover, and this complicates the matter, some argue that assisted suicide may be punishable as so-called "criminal negligence" or "failing to aid a person in grave danger" (section 422 *bis* of the Belgian criminal code). According to this argument, a patient with a suicide plan is for that very reason in grave danger. A physician has to offer him professional care, otherwise he commits criminal negligence. This is the case *a fortiori* when he not only fails to offer that help, but even provides his patient with the means to commit suicide. The problem with this argument is its supposition that

any person with a suicide plan is in grave danger. Moreover, until now no physician has been prosecuted in Belgium for offering a patient aid in committing suicide. That may be explained by the legal uncertainty but also by the uncompromising condemnation of physician-assisted suicide by the Belgian Order of Physicians. Indeed, section 95 of the code on professional ethics states that a physician is not allowed to help a patient commit suicide. It is noteworthy that this prohibition has been integrated into the code only since 1992: in the previous version assisted suicide was not even mentioned. So it might be the case that the main motive for the Belgian legislature not to regulate physician-assisted suicide is that there is no social need for it. Whatever the motives may be, in this respect the Belgian and the Dutch act differ fundamentally. One wonders whether the Belgian act is not making an unjustified discrimination and how the Belgian Constitutional Court would deal with a complaint in this respect.

1.2. Persons regulated

a) The physician

According to section 3 §1 and section 4 §2 of the Belgian euthanasia act, *the physician* who performs euthanasia "does not commit a criminal offence" when the norms and procedures prescribed by this act have been followed. Section 293 of the Dutch criminal code, amended by section 20 of the euthanasia act, provides that the act of terminating another person's life at that person's request is not a criminal offence if it is committed by *a physician* who fulfils the due care criteria set out in section 2 of the euthanasia act. Thus, in both Belgium and the Netherlands, euthanasia must be performed by a physician if it is to be legal. A remarkable difference between the Belgian and the Dutch act is that the former does not make explicit what criminal offence it is that a physician does not commit when he respects the norms and procedures, while the Dutch act does. This difference is all the more remarkable because the Belgian criminal code has never qualified killing someone at his own request as a separate offence, whereas the Dutch criminal code has done so for many decades. This raises the question: what exactly is the criminal offence that a physician in Belgium does not commit when he respects the norms and procedures provided for in the euthanasia act? Because killing someone at his request is not a separate offence, it could be qualified as manslaughter (art. 393), murder (art. 394) or poisoning (art. 397). This is pure speculation however, because until very recently there have been no prosecutions of physicians who terminated the life of a patient.²² Given the *nullum crimen sine lege* rule (no crime without a law), it is rather strange that a law explicitly considers an activity to be not a criminal offence under certain conditions, without referring to the offence that this activity would constitute if the conditions are not

²² Maurice Adams, "Euthanasia: the process of legal change in Belgium. Reflections on the parliamentary debate," in *Regulating physician-negotiated death*, ed. A. Klijn, M. Otłowski and M. Trappenburg ('S Gravenhage: Elsevier, 2001), pp. 30-31. Adams adds that very recently a few cases have been prosecuted without mentioning on what offence the prosecutions have been based. These prosecutions did up to now not turn out in punishments.

respected. At least in this respect, there is a marked difference between the act and more generally the law - governing euthanasia in Belgium and the Netherlands.

While under the Dutch law, a physician who kills a patient at this person's request and without respecting the due care criteria knows exactly what offence he commits and what sanctions he may expect, the Belgian law offers much less security to physicians in that respect. The original bill that formed the basis for the Belgian euthanasia act was very similar to the Dutch act. However, from within the parliamentary majority itself the explicit de-criminalization of euthanasia by changing the criminal code was severely criticized. For so-called psychological reasons, the authors of the bill decided to leave the criminal code unchanged. This resulted in the situation of uncertainty that I have described. Another interesting point of discussion is what conclusion can be drawn about the status of euthanasia from the requirement that euthanasia must be practised by a physician. In the Netherlands the majority of health-care lawyers believe that euthanasia is not a 'normal medical act', although it must be administered by a physician. There is no medical indication for euthanasia and there exists no professional medical standard for its permissibility. Whether euthanasia is to be allowed or not is a matter for society, not for the medical profession. The same is true of, say, non-therapeutic abortion. Moreover, if euthanasia were a normal medical act, the physician should in principle administer it. Nobody is of that opinion in the Netherlands.²³ In Belgium there seems to exist more discussion on the status of euthanasia. Some regard it as a normal medical act and the legal requirement that euthanasia be performed by a physician is used as an argument for this point of view. This argument is not very convincing: if euthanasia is a normal medical act, then the act governing the practice of medicine stipulates that only a physician may perform it. So the explicit requirement in the euthanasia act would have been superfluous in that case. This dispute masks a more fundamental discussion with

²³ Henk J.J. Leenen, "The development of euthanasia in the Netherlands," *European Journal of Health Law* 8(2001): p. 126

regard to the professional autonomy of hospital physicians and the competence of hospitals belonging to the Caritas Catholica network to place limits on this autonomy in the case of euthanasia. Although neither the Belgian nor the Dutch act requires additional conditions regarding the physician who performs euthanasia a difference in this respect may be that one of the due care criteria provided for in the Dutch law is that the physician has terminated the patient's life "with due medical care and attention".

The Belgian act does not contain such a prescription. It was debated in parliament but the majority considered it superfluous. If one looks at the way this due-care criterion has been applied in the Netherlands before the act on euthanasia codified it, one may doubt this. Due medical care and attention means that euthanasia should be carried out in a professionally responsible way and that the doctor should stay with the patient continuously, or be immediately available until the patient dies.⁸In the Netherlands the physician performing euthanasia should be a doctor who has "an established treatment relationship with the patient". This restriction is widely accepted.²⁴

In 70% of the cases of euthanasia in the Netherlands, it was the family doctor who administered it.²⁵ Everybody has a family doctor, most of the time in a long-standing relationship. In Belgium (Flanders) euthanasia is in most cases performed by a hospital doctor. Necessarily, this practical difference will also have consequences with regard to the relationship the physician has with the colleague he is required to consult.

b) The patient

The Belgian act requires the patient to be a person of age (i.e., over eighteen) or a so-called 'emancipated minor'. Emancipation of a minor is either the result of marriage

²⁴ Idem, 103 and note 41 where reference is made to so-called 'travelling euthanasia doctors' who made their services available to patients whose own doctors had failed to honour their requests. Given the fact that a large majority of Belgian physicians opposes the act and will not apply it and that the act does not contain a "due medical care" clause, one may expect that Belgian euthanasia practice will be more vulnerable to "specialised euthanasia physicians"

(which is not really exceptional) or of a decision by a judge to declare him competent to deal with his own affairs (which is exceptional). The overall exclusion of 'mature' minors from the application of the Belgian act may be explained by the fear that no majority would have supported the inclusion of mature minors, and that could threaten the very approval of the bill itself.

The Dutch act is in this respect totally different. If the patient is a minor aged between sixteen and eighteen and is deemed to be capable of making a reasonable appraisal of his own interests, the attending physician may comply with a request by this patient to terminate his life or provide assistance with suicide, after the parent or parents who has/have responsibility for him, or else his guardian, has or have been consulted (section 2.3). If the patient is a minor between twelve and sixteen and is deemed to be capable of making a reasonable appraisal of his own interests, the attending physician may comply with the patient's request if the parent or parents who has/have responsibility for him, or else his guardian, is/are able" to agree to the termination of life or to assisted suicide (section 2.4).

2. The current request

The Belgian act regulates in a very detailed way the substantive and formal requirements of a current request. A request has to be voluntary, considered and repeated, not resulting from any external pressure (section 3 § 1) and have a durable character (section 3 §2,20). Note that no explicit mention is made of a *well informed* request. The request has to be made up in writing. The document is drawn up, dated and signed by the patient himself. If the patient is not capable to do so, the document is made up by a major person, designated by the patient (section 3 §4). The request of the patient is kept in the medical file of the patient (section 3 §5). The patient can at any moment revoke his request, in which case it is taken out of his medical file and rendered to him (section 3 §4, last sentence). The Dutch act requires a voluntary and carefully considered request (section 2.1. a). There are no formal requirements. When

looking at the due care criteria developed in the jurisprudence and in self-regulation the Dutch euthanasia *law* is more developed. The request must be explicitly made by the person concerned; it must be voluntary (not the result of undue external influence); it must be well considered: informed, made after due deliberation and based on an enduring desire for the end of life (evidenced for instance by its having repeatedly been made over some period of time); the request should *preferably* be in writing or otherwise recorded.²⁵

2.1. The advance directive

Section 4 § 1 of the Belgian act regulates very detailed the formal requirements of an advance directive of will to obtain euthanasia when being incapable to express a current request. It is noteworthy that the many substantive requirements (voluntary etc...) a current request has to satisfy, are not repeated here. An advance directive can be written at each moment. It has to be made up in writing in front of two major witnesses, at least one of them having no material interest in the death of the patient and it has to be dated and signed by the drafter, both witnesses and, in case one or more person(s) of confidence have been appointed in the declaration, by this/these person(s). The role of this person of confidence is simply to inform the attending physician about the will of the patient. When a person who wants to make up an advance directive is in a permanent way physically incapable to write and sign a declaration, he can designate a major person, who has no material interest in his death, to draft an advance directive in front of two major witnesses, at least one of them having no material interest in the death of the patient.

The Crown determines the way an advance directive is drawn up, registered, confirmed, withdrawn and how it will be communicated to the physicians involved. This Royal decree has been enacted on April, 2, 2003. There is no legal obligation to

²⁵ John Griffiths, Alex Bood and Heleen Weyers, *Euthanasia and Law in the Netherlands* (Amsterdam: Amsterdam University Press, 1998), pp. 100-101.

follow the rules laid down in the decree. Also advance directives drawn up in another way will be valid.

With regard to the validity of an advance directive the act provides that it can only be taken into account when it has been drawn up or confirmed less than 5 years before the person involved could no longer express his will.

Section 2.2. of the Dutch act provides that in the case of a written declaration the due care criteria of section 2.1. apply *mutatis mutandis*, which means that the substantive requirements of voluntariness and careful consideration of the request are also applicable. As I have remarked earlier, this is not the case with the Belgian law and I consider this as an important difference between both acts. On the other hand, the Dutch law does not contain formal requirements, except that the advance directive has to be made up in writing. Up to now euthanasia after an advance directive is rather exceptional in the Netherlands because before the act doubts existed whether it was legal. Also after the enactment of the law it is expected to remain exceptional.²⁶ This may explain why in the jurisprudence and self-regulation no additional due care criteria can be found.

3. The health condition of the patient

Now, the second main substantive condition will be analysed, namely the health condition of the patient requesting for euthanasia. Again, a distinction will be made between a current request and an advance directive

3.1. In case of a current request

The Belgian act requires the patient who currently requests for euthanasia to be "in a medically hopeless condition of continuous and unbearable physical and mental

suffering that cannot be alleviated, and that is resulting from a serious and incurable disorder caused by illness or accident" (section 3 §1).

In this provision that has given rise to lengthy and confused debates in the Parliament, two elements, one objective and the other subjective, can be distinguished. The objective one is the serious and incurable disorder. Physicians have the knowledge and the skill to decide upon this condition. When a patient is not suffering from a disorder the Belgian act does not permit euthanasia. In the parliamentary discussion reference has been made to existential need. On the other hand the act covers both somatic and psychiatric diseases.

CHAPTER 5

THE PROPOSALS IN ENGLISH BILL

Three different ways of amending the law have been put forward. The Euthanasia societies favour a scheme of State authorized euthanasia, including appropriate safeguards. The English Bill of 1936 requires that the patient shall be twenty-one years old, of sound mind, and suffering from a fatal and incurable disease, accompanied by severe pain. A formal application is to be signed by the patient in the presence of two witnesses and submitted to the "Euthanasia Referee", an official appointed by the Minister of Health, together with two medical certificates, one from the attendant doctor and the other from a specially qualified practitioner. The referee is to conduct a personal interview of the patient and establish that he fully understands what he is doing. Euthanasia is to be administered by a licensed practitioner in the presence of an official witness, such as a minister of religion or justice of the peace. The Bill sponsored by the Euthanasia Society of America is very similar, but provides for application to the courts for a certificate, the court being empowered to appoint a committee of physicians and others to investigate the case.²⁷

This approach to euthanasia has been criticized as cold bloodedly formal and cumbrous, and D&Glanville Williams has suggested that a more acceptable proposal would be to provide that no medical practitioner should be guilty of any act done intentionally to accelerate the death of a seriously ill patient, "unless it is proved that the act was not done in good faith with the consent of the patient and for the purpose of saving him from severe pain in an illness believed to be of an incurable and fatal character". Discretion, as at present, would be left to the individual doctor, but if he killed a patient on request he would be protected by law. The proposal is also recommended by Dr Williams in that it substitutes for the question "Do you approve

²⁷ *New York University Law Review*, 31:1237 (1956).

of euthanasia?", the milder query, "Do you think euthanasia so clearly wrong that a doctor should be punished for administering euthanasia to end hopeless pain even though he thinks his act to be required by the most solemn duty of his profession?"²⁸ This, claims the writer, is to leave the subject to the individual conscience. A third line of approach is to rationalize existing practice, by providing lesser penalties for euthanasia, while still forbidding it by law. This, as Helen Silving has pointed out, may be achieved in two ways. 3 The legislature could classify different types of homicide, leaving it to the courts to assign particular cases to the various categories, or it could provide that punishment should be determined by motive. Reprehensible motives would lead to severe punishment, compassionate or humanitarian motives would provide grounds for more lenient treatment.

THE UTILITARIAN VIEWPOINT

Utilitarians advocating euthanasia take as their basic premises that pain is an absolute evil. Accordingly, provision of euthanasia for the dying sufferer is not only morally permissible but mandatory.²⁹ The literature distributed in support of the cause stresses the horror of physical suffering, some may think to an excessive degree. The following is a typical piece of descriptive writing: "She was sodden with cancer; every nerve fibre responded hourly to pressure pain that sapped her strength and gave her relentless torment . . . 'Doctor,' she said, and reached her yellow hand to claw mine, 'the pain is dreadful and I am only a misery to my folks. Cannot Doctor put me out of my misery?' As it was, I could do little. Her look when I left her was one of reproach." A death of dignity and repose is demanded in place of the "shrieking, groaning and cursing" which is said to continue, "until breath fails". The pain caused to relatives, awaiting the end, is also emphasized.

²⁸ Ibid., p. 341.

²⁹ Glanville Williams, op. cit., p. 311.

This argument is supplemented by the postulation of a right to die, inherent in the individual. The notion that life is an absolute value is rejected as a metaphysical fantasy, the value of life being its quality, not its quantity. The assumption behind this view is clearly stated by Horace Kallen: "The human person ceases when awareness goes out and unawareness comes in, and awareness goes out when it becomes intolerable to itself. Death is only the lasting, as sleep, anaesthesia, and narcosis are the intermittent extinctions of consciousness." ³⁰ In place of the right to live, a criterion of the value of an individual life to the community is substituted. What social interest, asks Dr Williams, is there in preventing the sufferer from choosing to accelerate death?³⁰

These sentiments have been echoed by individual Christians. Supporters of voluntary euthanasia have included Dr W. R. Matthews, the Dean of St Paul's, Dr Norwood, the President of the Free Church Council, Joseph Fletcher, an episcopalian minister, and Canon Peter Green.³¹ The petition of the Protestant and Jewish ministers of New York states the principle clearly: "We believe in the sacredness of the human personality, but not in the worth of mere existence or 'length of days'. We no longer believe that God wills the prolongation of physical torture for the benefit of the soul of the sufferer. For one enduring continual and severe pain from an incurable disease, who is a burden to himself and his family, surely life has no value. We believe that such a sufferer has the right to die, and that society should grant this right showing the same mercy to human beings as to the sub-human animal kingdom. 'Blessed are the merciful'³²

³⁰ "Mercy Killing Legislation-A Reply", *Minnesota Law Review*, **43:1-12** (November, 1958).

³¹ Peter Green, *The Problem of Right Conduct*, London 1931. W. R. Matthews, *Voluntary Euthanasia: the Ethical Aspect*. Address delivered at the annual meeting of the Voluntary Euthanasia Society, May 2, 1950 (published by the Society). Joseph Fletcher, "Euthanasia", in *Morals and Medicine*, Princeton 1954.

³² I published by the Voluntary Euthanasia Society of America. Cf. Fletcher: "For the man of moral integrity and spiritual purpose, the mere fact of being alive is not as important as the terms of living. As every hero and every martyr knows, there are some conditions without which a man refuses to continue living. Surely among these conditions, along with loyalty to justice and brotherhood, we can include self-possession and moral integrity." **Op. cit.**, pp. 186-7

CHRISTIAN VIEWS

Whatever the opinions of some individuals, the overwhelming weight of Christian tradition and teaching condemns euthanasia. Much has been made by euthanasia supporters of the passage in Thomas More's *Utopia*, which states that those suffering from "torturing and lingering pain", would, with the consent of priests and magistrates, be allowed to take their own lives. To deduce from this that Thomas More advocated euthanasia is to ignore the whole purpose of his book and the context in which it was written. More's intention was to depict the institutions likely to exist in a community which lacked any assistance from Christian revelation. The purpose of the book was satirical and to show that some Christian societies were worse than heathen communities. Despite the popular connotation now inseparable from the word "Utopia", it was not intended to depict an "ideal" community, much less one which reflected More's own social views. The Roman Catholic Church has made clear its rejection of any form of euthanasia. In his encyclical, *Mystici Corporis*, Pius XII unequivocally condemned compulsory euthanasia. "Conscious of the obligations of our high office," said the Pope, "we deem it necessary to reiterate this grave statement today, when to our profound grief we see the bodily-deformed, the insane and those suffering from hereditary disease, at times deprived of their lives, as though they were a useless burden to society. And this procedure is hailed by some as a new discovery of human progress, and as something that is altogether justified by the common good. Yet what sane man does not recognize that this not only violates the natural and Divine law written in the hearts of every man, but flies in the face of every sensibility of civilized humanity? The blood of these victims all the dearer to Our Redeemer because deserving of greater pity 'cries to God from the earth'." Voluntary euthanasia has also been rejected by the Pope as contrary to Christian teaching. "It is never lawful to terminate human *life*," he said in an address to Italian doctors, "and only the hope of safeguarding some higher good, or of preserving or prolonging this same human

life, will justify exposing it to danger. Speaking in the House of Lords debate of 1936, the Archbishop of Canterbury denied that any man was entitled to take his own life.

His rejection of euthanasia was repeated by the Archbishop of York in the 1950 debate.³³ In 1950 the Church of England's Hospital Chaplains' Fellowship expressed its corporate condemnation of euthanasia.³⁴ The general secretary of the American Council of Christian Churches, representative of fundamentalist Protestants, has denounced the ministers who supported the voluntary euthanasia bill.³⁵ In 1952, the General Convention of the Episcopal Church in America passed a resolution opposing the legalizing of euthanasia "under any circumstances whatsoever".³⁶ Christians put forward three arguments for condemning euthanasia. The basis of the Christian position is not, as is sometimes stated, that life has an absolute value, but that the disposal of life is in God's hands. Man has no absolute control over life, but holds it in trust. He has the use of it, and therefore may prolong it, but he may not destroy it at will. A second point made by Christians is that no man has the right to take an innocent life. "The innocent and just man thou shalt not put to death", says *Exodus* (23: 7): "The innocent and just thou shalt not kill", is found in *Daniel* (13: 53).³⁷ The only occasion when a Christian may take the life of a human being, is when he is an unjust aggressor against an individual or the common good.

Suffering for the Christian is not an absolute evil, but has redeeming features. It may be an occasion for spiritual growth and an opportunity to make amends for sin. Lord Horder in the House of Lords debate in 1950 drew attention to this aspect of pain. To call the function of a doctor who helps a patient to achieve that degree of elevation of

³³ **3 103** H.L. Deb. (5th s.), **465-506** (936). 169 H.L. Deb. (5th s.), 551-76 (**1950**).

³⁴ *The Times*, May **30**, **1950**.

³⁵ Glanville Williams, *The Sanctity of Life and The Criminal Law*, New York 1957, P- 332.

³⁶ *Journal of the General Convention of the Protestant Episcopal Church*, 1952, **p. 216**. For a typical Protestant article condemning euthanasia, see W. Horder, "Reflections on Euthanasia", *Christianity and Crisis*, **10:45-6**, No. **6**, **1950**.

³⁷ The prohibition applies only to human life. See *Genesis* i, **26** and **29**. It may be carried out under divine inspiration, *Genesis* xxii, **1a**, Abraham and *Isaac*; *Exodus* xii, **29**, the slaying of the firstborn of **Egypt**.

spirit an intolerable burden-as the euthanasia advocate is apt to call it-seems to me to be disparaging one of the very important duties that a doctor has to perform."³⁸ At the same time the Christian recognizes suffering as an evil in the natural order, and is under a duty to relieve it where possible, although not at any price. Some writers have represented the Christian attitude towards suffering as sadistic, but how far this is from the truth is indicated in a passage from Pius XII's address to the Italian anaesthetists. He points out that there is no obligation for the sick and dying to endure physical suffering. "Now the growth in the love of God and in abandonment to His will does not come from the sufferings themselves," said the Pope, "which are accepted, but from the intention in the will, supported by grace. This intention, in many of the dying, can be strengthened and become more active if their sufferings are eased, for these sufferings increase the state of weakness and physical exhaustion, check the ardour of soul and sap the moral powers instead of sustaining them. On the other hand, the suppression of pain removes any tension in body and mind, renders prayer easy, and makes possible a more generous gift of self. If some dying persons accept their suffering as a means of expiation and a source of merits in order to go forward in the love of God and in abandonment to His will, do not force anaesthetics on them. They should rather be aided to follow their own way. Where the situation is entirely different, it would be inadvisable to suggest to dying persons the ascetical considerations set out above, and it is to be remembered that instead of assisting towards expiation and merit, suffering can also furnish occasion for new faults."

CHAPTER 6

³⁸ *House of Lords Debates* (5th series), 169:568 (1950).

DIFFERENT LAWS AROUND THE WORLD

I. USA

Euthanasia is illegal in most states in the USA. There are some states, however, which allow terminally ill patients to end their lives as per their own free will, with assistance from a physician. Physician Assisted Death is legal in some states. However, in states where there are no laws pertaining to active or passive euthanasia, or physician assisted death, the patient may elect to have all life sustaining measures terminated by means of a Living Will. A Living Will is a document prepared to indicate the manner in which a terminally ill patient wishes to end his or her life. This document serves as consent from the patient to the withdrawal of life support, in case he or she is incompetent to give his or her express consent at the time of withdrawal. It must be noted that the concept of living wills is entirely different from that of euthanasia.

Death with Dignity Laws of some States in the USA:

Oregon:

On October 27, 1997, the Death with Dignity Act was passed in Oregon, which allows terminally ill patients to end their lives voluntarily, should they be in incurable and unbearable pain.

The case which led to the passing of this legislation is *Gonzales v. Oregon*³⁹.

As prescribed by the Act, there are certain duties that a medical practitioner must fulfil before administration of euthanasia to a patient. They are:

- 1) An initial duty to determine whether the person has a terminal illness.
The physician also must determine whether or not the patient is competent to give consent and take rational decisions. Further, it is the

³⁹*Gonzales v. Oregon* 546 U.S. 243 (2006)

doctor's responsibility to ensure that the patient has made his decision voluntarily, and with no undue influence from any third parties.

- 2) Secondly, the medical practitioner must ask for proof from the patient, of his residency in the state of Oregon.
- 3) So that the patient can arrive at an informed decision, the practitioner must inform him/ her about:
 - His or her exact medical diagnosis and prognosis
 - The risks inherent to consuming the medication prescribed
 - The predicted result of taking the medicines suggested
 - All the possible alternative treatments available, such as hospice care and pain control.
- 4) The medical practitioner must also consult a second physician who will confirm the diagnosis, and also affirm that the patient is able to take a rational decision, and is doing so absolutely freely.
- 5) If necessary, the physician must also ensure that the patient gets appropriate counselling.
- 6) The doctor must suggest to the patient that his close family, friends be informed.
- 7) The doctor must advise the patient on the importance of another person's presence at the time of administration of the drug. Further, the patient has to be advised to not administer the medicine in a public place.
- 8) The patient must be informed that he/ she may rescind the request at any time, and in any way that he/ she sees fit.
- 9) The patient must be given a chance to refuse administration of the drug on expiry of the 15 day waiting period prescribed.
- 10) The doctor must duly complete all formalities pertaining to the documents of the patient needed in the process.

- 11) The doctor must do everything in his/ her power to ensure that the patient ultimately dies a dignified, peaceful death.

Only after all the above requisites are fulfilled, may active euthanasia be availed of by a patient. The patient must be of major age, have at most six months to live, and should have made three requests, at intervals of at least fifteen days (two oral and one written) in order to confirm the decision. Therefore, in Oregon, physician assisted death is legal, unlike in India.

California:

In 2015, the End of Life option Act was passed in California. It allows medical practitioners to prescribe lethal life-terminating drugs in particular cases of terminal illness. The Law in California bears resemblance to the Death with Dignity Act passed in Oregon, Washington, etc. Patients who have at most six months to live may be allowed to avail of physician assisted death if they are fully aware of their medical condition, and taking the same into due consideration have given their free, absolute and unconditional consent. The patients are also required to request three times to avail of this method of termination, so that it is confirmed by the doctor that the patient has not changed his or her mind. Two oral requests need to be made by the patient, after an interval of at least a fortnight. A written request confirming the same also needs to be submitted by the patient. The minimum age to avail of Physician Assisted Suicide is 18 years.

Montana:

Both active and passive euthanasia are illegal in Montana. However, physician assisted death is legal in the State. The laws governing Physician Assisted Death are laid down in the Rights of the Terminally Ill Act, the scope of which was broadened to include Physician Assisted Death, after the Montana Supreme Court decision in the landmark case of *Baxter v. Montana*⁴⁰. The case was filed by four physicians and Mr. Robert Baxter, a seventy six year old truck driver suffering from lymphocytic leukaemia. His death was imminent. The

⁴⁰*Baxter v. Montana* 2009 MT 449

plaintiffs contended before the Supreme Court of Montana that the right to receive and provide aid in dying be made a Constitutional right. In turn, the State argued that the Constitution did not confer any right to aid in terminating one's existence, but there was also no provision in the Constitution, or any precedent expressly denying the right to give and receive aid in taking one's life. Also, the Constitutional rights of individual privacy and human dignity bestow upon any terminally ill patient the power to die with dignity. The Court thus ruled in favour of the plaintiffs. Mr. Baxter passed away on the same day.

Other Countries

II. Netherlands:

In the Netherlands, Euthanasia is governed by the provisions laid down under the "Termination of Life on Request and Assisted Suicide (Review Procedures) Act, 2002.

At this point, it is worth making a distinction between euthanasia and Physician Assisted Suicide. The main distinction between the two concepts is that, in case of euthanasia, the measures are taken by the physician, acting upon the consent of the patient. In case of Physician Assisted Suicide, the patient follows the instructions of the doctor, to end his life. Thus, the doer of the act is the doctor, when it comes to euthanasia, and the patient, as per the instructions given by the doctor, in case of Physician Assisted Suicide.

According to the legislation mentioned above, euthanasia and Physician Assisted Suicide are legal, subject to certain conditions of "due care." They are:

- a) The patient in question should have given his/her free consent.
- b) The patient is at least 12 years old. In case of children between the ages of 12 and 16, the consent of their parents or guardians is required
- c) The patient should be in unbearable and hopeless pain

- d) The patient should be well informed about the process, his/her condition, and any kind of alternative treatments, to be able to make an informed decision.
- e) There should be no alternative treatment available.
- f) At least one other independent medical practitioner should be consulted to reaffirm that the patient is of sound mind, capable of making rational decisions, and that he/ she is not acting under pressure while giving a decision. The doctor must also authenticate that the patient is indeed in unceasing, incurable pain.
- g) The death must be carried out in a medically approved manner by the physician, in case of euthanasia, and by the patient in case of Physician Assisted Suicide. In case of Assisted Suicide, the physician must be physically present at the time of doing the Act.

Should a physician practice euthanasia or assisted suicide when any of these terms are not complied with, he/ she will be prosecuted.

The physician is also required to report a case to a Review Committee, when all the aforementioned criteria are met. The committee then decides, after investigation, whether the measure may be taken.

When a person is unable to give express consent, a document called a euthanasia directive may serve as evidence of his/her consent to euthanasia. It is recognised by the law, as a document expressing a person's intention and willingness to be euthanised.

The debate about Euthanasia began in the Netherlands with the landmark Postma case. The facts were that a doctor helped his wife, also a doctor, administer euthanasia to her mother, who was handicapped. She had suffered a brain haemorrhage, was deaf, and could not speak easily. Further, she had to be tied to a chair in her nursing home, to avoid falling. She incessantly pleaded with her daughter that her life be

terminated. The daughter agreed, and administered morphine in an excessive quantity, leading to her mother's demise. The daughter faced criminal charges, as did her husband, for assisting her in administering euthanasia, for at the time, euthanasia was not legal in the Netherlands. Two years after this case, in 1973, the Act came to be passed, and her punishment was reduced, from 12 years in jail to a week in jail, as the terms mentioned in the legislation subject to which euthanasia was legal were not complied with.

Euthanasia remains a criminal offence in situations which do not come under the specific terms established by law.

In India, active euthanasia continues to be illegal, and so does Physician Assisted Suicide. In the Netherlands, both active and passive euthanasia, as well as Physician Assisted suicide are legal, subject to certain limitations, as has been discussed above.

III. Canada

Carter V Canada

Carter v Canada (AG) is a landmark Supreme Court of Canada decision where the prohibition of assisted suicide was challenged as contrary to the Canadian Charter of Rights and Freedoms by several parties,

In a unanimous decision on February 6, 2015, the Court struck down the provision in the Criminal Code of Canada, giving Canadian adults who are mentally competent and suffering intolerably and enduringly the right to a doctor's help in dying.^[2] The court suspended its ruling for 12 months, with the decision taking effect in 2016, giving the government enough time to amend its laws

The judgment said as follows: -

Section 7 did not promise that the state would *never* interfere with a person's life,

liberty or security of the person, it *did* promise that the state would not do so in violation of the principles of fundamental justice. The court also rejected the the “slippery slope” argument: that without an absolute prohibition on assisted dying, Canada would descend into a situation in which euthanasia was permitted and murder condoned. The court said “Section 241 (b) and s 14 of the *Criminal Code* unjustifiably infringe section 7 of the *Charter* and are of no force or effect to the extent that they prohibit physician-assisted death for a competent adult person who (1) clearly consents to the termination of life and (2) has a grievous and irremediable medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition”⁴¹

IV. Belgium

This country took euthanasia one step forward. It is the only country that allows this option to be availed by children.

In December 2013, the Belgian Senate voted in favour of extending its euthanasia law to terminally ill children. Conditions imposed on children seeking euthanasia are that "the patient must be conscious of their decision and understand the meaning of euthanasia", "the request must have been approved by the child's parents and medical team", "their illness must be terminal" and "they must be in great pain, with no available treatment to alleviate their distress"⁴²

But the main issue comes in here. What happens when a country becomes too free about the law? Belgium recently permitted a 24 years old health women to be euthanized because she had suicidal thoughts.⁴³ She did have a terminal disease. This

⁴¹ <http://www.lawandreligionuk.com/2015/02/10/physician-assisted-death-in-canada-carter-v-canada-ag/>

⁴² "Belgian Senate votes to extend euthanasia to children". BBC News. 13 December 2013.

⁴³ <http://www.dailymail.co.uk/news/article-3141564/Belgian-doctors-healthy-woman-green-light-die-euthanasia-suicidal-thoughts.html>

is why this law is highly debated on because there will reach a point where it could turn into murder.

For this reason, it is hard to frame laws. It is hard to understand where the line is to be drawn or how to decide if it okay for someone to die.

V. India

In the landmark case of Aruna Shanbaug⁴⁴, it was held that according to Ms. Shanbaug's medical reports, she shows no sign of any life- limiting condition, such as, for example, brain death. She was in a permanent vegetative state, but her brain was alive, and she also showed slight response to stimuli. Thus, this was not a case of one being in such agony that death would be preferred to life. Neither active nor passive euthanasia was granted. She was allowed to succumb naturally.

In India, active euthanasia is a crime, punishable under Section 302 of the Indian Penal Code. Passive euthanasia may be granted if:

- a) The patient desires it: The desire to end all life- sustaining measures may be given by a patient if he is competent to do so, or by means of a living will. A living will is a document prepared by a terminally ill patient, of sound mind, who knows that he/she has at most six months to live, indicating how he/ she wants to die.

If the patient is incompetent, and there is no living will to refer to, the close friends and family of the patient will be consulted. The friends and family should act in the patient's best interests, and not for their own interest. It is assumed that had the patient in question been competent to take a decision, it would have been the same as what is taken by his/ her near and dear ones. The decision is made by the close relatives of the patient in consultation with the

⁴⁴*Aruna Ramchandra Shanbaug v. Union of India and Others* 2011 Indlaw SC 148

doctors of the patient in question. Should the patient not have a close family or friends, the Court shall decide on the matter.

- b) There is no scope of recovery or alternative mode of treatment available.

CHAPTER 7

CONCLUSION

Euthanasia has been a highly debated topic for the simple reason that it is not black and white. There have been numerous cases that have been seen as exceptions in various countries around the world. The main problem for law makers is that this decision is not black and white. Each is case sensitive. Each case must be looked at differently. I do not believe that there can be a universal law with regard to Euthanasia. To prevent a situation like that in Belgium (24 year women permitted to euthanasia because of suicidal thoughts), it is important to look at it case wise rather than have a law in place.

Personally, I believe that Euthanasia should not be allowed because of the number of medical miracles seen over the years. It will further, give patients a less of incentive to fight. However, the current generation believes in legalizing euthanasia.

Miscellaneous cases

Baxter V Montana⁴⁵ [Dec. 31, 2009]

In the case, Baxter V Montana, On Dec. 31, 2009, the Montana Supreme Court ruled in favor of Baxter. It stated that, while the state's Constitution did not guarantee a right to physician-assisted suicide, there was "nothing in Montana Supreme Court precedent or Montana statutes indicating that physician aid in dying is against public policy." This did not turn into a law.

In re Quinlan⁴⁶ [Mar. 31, 1976]

In 1975, 21-year-old Karen Ann Quinlan was admitted to the hospital in a coma, and was later declared by doctors to be in a "persistent vegetative state." After five months

⁴⁵ 224 P.3d 1211 (2009)

⁴⁶ 70 N.J. 10

on a ventilator, her parents requested that the ventilator be removed and that Ms. Quinlan be allowed to die. After doctors refused, her parents brought the matter to court. The New Jersey Superior Court denied her parents' request, but the New Jersey Supreme Court reversed and ruled that Quinlan's "right to privacy" included her right to be removed from the ventilator.

Cruzan v. Director, Missouri Dept. of Health⁴⁷ [June 25, 1990]

Nancy Beth Cruzan was involved in an automobile accident that left her in a "persistent vegetative state." After being sustained for several weeks by artificial feedings, her parents attempted to end life-support, but state hospital officials refused to do so without court approval.

A state trial court authorized the termination of feeding, but the Missouri Supreme Court reversed. In a 5-4 decision, the U.S. Supreme Court upheld the ruling of the Missouri Supreme Court, finding that the State of Missouri's actions to preserve human life were constitutional in the absence of "clear and convincing evidence" that Cruzan desired treatment to be withdrawn.

Washington v. Glucksberg⁴⁸ [June 26, 1997]

Harold Glucksberg, MD, along with three other doctors, three gravely ill patients, and the nonprofit organization Compassion in Dying, brought a suit challenging the state of Washington's ban on physician-assisted suicide.

The plaintiffs asserted that the Washington ban was unconstitutional, arguing that the existence of a liberty interest protected by the Fourteenth Amendment allows mentally competent, terminally ill adults to commit physician-assisted suicide. The

⁴⁷ 497 U.S. 261

⁴⁸ **521 U.S. 702**

District Court ruled that the ban was unconstitutional, and the Ninth Circuit affirmed.

The Supreme Court, in a 9-0 decision, reversed, finding that the ban on physician-assisted suicide does not violate the Fourteenth Amendment.

Vacco v. Quill⁴⁹ [June 26, 1997]

Timothy Quill, MD, along with two other physicians and three gravely ill patients, challenged the constitutionality of New York state's ban on physician-assisted suicide. The plaintiffs argued that New York's ban violated the Equal Protection Clause of the Fourteenth Amendment, as the law allowed for patients to refuse life-sustaining treatment, but not for them to receive assistance in suicide.

The District Court ruled in favor of the State of New York, and the Second Circuit reversed in favor of Dr. Quill. The Supreme Court, in a 9-0 ruling, upheld the constitutionality of New York's ban on physician-assisted suicide.

People v. Kevorkian⁵⁰ [Nov. 20, 2001]

Fifty-two year old Thomas Youk was suffering from Lou Gehrig's disease when, upon Youk's request, Jack Kevorkian, MD, administered a lethal drug to Youk, who died as a result.

Dr. Kevorkian filmed Youk's death and the trial court jury, who saw the videotapes in court, convicted Kevorkian of second-degree murder, despite his claims that he had committed a "mercy killing." The Michigan Court of Appeals affirmed the conviction.

⁴⁹ 526 U.S. 793

⁵⁰ 639 N.W.2d 291

Bush v. Schiavo⁵¹ [Sep. 23, 2004]

Theresa Schiavo had been in a persistent vegetative state since 1990. The Second District Court of Florida allowed for the removal of her nutrition and hydration tube on Oct. 15, 2003.

On Oct. 21, 2003, the Florida Legislature enacted chapter 2003-418, and Governor Jeb Bush signed the Act into law, issuing executive order No. 03-201 to stay the continued withholding of nutrition and hydration from Theresa.

Michael Schiavo, Theresa's husband and guardian, challenged the Act in circuit court, and the circuit court ruled in his favor, finding the Act unconstitutional. The Florida Supreme Court affirmed.

Gonzales v. Oregon⁵²

Jan. 17, 2006

In 1994, Oregon passed the Death with Dignity Act, the first state law permitting physicians to prescribe lethal doses of controlled substances to terminally ill patients. U.S. Attorney General John Ashcroft declared in 2001 that the Act violated the Controlled Substances Act of 1970, and threatened to revoke the medical licenses of physicians who engaged in physician-assisted suicide.

Oregon sued the Attorney General in federal district court. The district court and the Ninth Circuit both held that Ashcroft's directive was illegal.

The U.S. Supreme Court, in a 6-3 opinion, also held that the Controlled Substances Act did not authorize the Attorney General to ban the use of controlled substances for

⁵¹ No. SC04-925

⁵² 546 U.S. 243

physician-assisted suicide.

The Indian Perspective

In India, the sanctity of life has been placed on the highest pedestal. "The right to life" under Article 21 of the Constitution has received the widest possible interpretation under the able hands of the judiciary and rightly so.

This right is inalienable and is inherent in us. It cannot and is not conferred upon us. This vital point seems to elude all those who keep on clamoring for the "Right to Die." The stance taken by the judiciary in this regard is unquestionable.

In **Gian Kaur vs. State of Punjab**⁵³, a five judge Constitutional Bench held that the "right to life" is inherently inconsistent with the "right to die" as is "death" with "life".

In furtherance, the right to life, which includes right to live with human dignity, would mean the existence of such a right up to the natural end of life. It may further include "death with dignity" but such existence should not be confused with unnatural extinction of life curtailing natural span of life. In progression of the above, the constitutionality of Section 309 of the I.P.C, which makes "attempt to suicide" an offence, was upheld, overruling the judgment in **P. Rathinam's case**⁵⁴. The factor of immense significance to be noted here is that suicide, euthanasia, mercy killing and the like amount to unnatural ebbing of life. This decision thereby overruling P. Rathinam's case establishes that the "Right to life" not only precludes the "right to die" but also the right to kill."

Interestingly in P. Rathinam's case, even when a Division bench affirmed the view in **M.S Dubal v. State of Maharashtra**⁵⁵ that the "right to life" provided by the Constitution may be said to bring into its purview, the right not to live a forced life, the plea that euthanasia be legalized was discarded. It was held that as euthanasia

⁵³ 1996 AIR 946

⁵⁴ 1994 SCC (3) 394

⁵⁵ 1987 (1) BomCR 499

involves the intervention of a third person, it would indirectly amount to a person aiding or abetting the killing of another, which would be inviting Section 306 of the I.P.C.

In **Naresh Marotrao Sakhre v. Union of India**⁵⁶, Lodha J. affirmed that "Euthanasia or mercy killing is nothing but homicide whatever the circumstances in which it is effected."

The above inferences lead to one irresistible conclusion i.e. any form that involves unnatural termination of life, whether an attempt to suicide, abetment to suicide/assisted suicide or euthanasia, is illegal.

The fact that even an attempt to suicide is punishable goes to show the extent of credibility accorded to the sanctity of life and the right to life as a whole. This apart, the decriminalization of euthanasia is unworkable in the Indian perspective, even on humanitarian grounds, as it involves a third person.

Though, there has been no legislation pertaining to euthanasia in India, the term keeps on coming back for public approval like a recurring decimal.

However, the **Aruna Shanbaug V Union of India**⁵⁷ case was a landmark judgment in laying down guidelines to passive euthanasia.

A panel had concluded that Ms Shanbaug met "most of the criteria of being in a permanent vegetative state".

While the Supreme Court turned down the mercy killing petition on 7 March 2011, the court, in a landmark decision, allowed passive euthanasia in India. While rejecting Pinki Virani's plea for Shanbaug's euthanasia, the court laid out guidelines for passive euthanasia. According to these guidelines, passive euthanasia involves the

⁵⁶ 1996 (1) BomCR 92

⁵⁷ (2011) 4 SCC 454

withdrawing of treatment or food that would allow the patient to continue living

RECOMMENDATIONS

There are a number of recommendations I would like to suggest for policy makers once euthanasia has been legalized or look at it case-wise:

1. The educational and law-making impact of the review committees could be improved by efforts to keep their website with anonymous judgments up-to-date. In addition, their conceptualization of key issues in the legal requirements should be clarified. This could be done by presenting important cases in medical journals. Further, the review committees or another organization should develop a clear 'code of practice' that includes an up-to-date overview of their conceptualization of key issues in the requirements of due care.
2. The requirement concerning due medical care when performing euthanasia or assisting in suicide should be assessed outside the context of criminal law. If review committees assess a case as non-compliant with regard to this requirement, the case should be handed over to the Health Care Inspectorate.
3. The Criminal Code should include an explicit statement that termination of life does not include the indicated and proportional use of medication to relieve suffering, even if such medication hastens death.
4. In due time, the practice of termination of life in the context of the End-of-life Clinic should be independently evaluated, in order to assess the relationship between this Clinic and the legal requirements. Such a study may also evaluate other initiatives to address the issue of physicians who are unwilling to grant requests for euthanasia or assistance in suicide.

5. The official blueprint for medical training should include a clear understanding of different end-of-life practices as an outcome. Training programs for (future) physicians should pay attention to the distinction between termination of life on the one hand and palliative sedation and the use of opioids in the last phase of life on the other.
6. Whereas this study has demonstrated that the practice of end-of-life decision making is still developing and changing, the tradition of five-yearly studies to monitor these practices should be continued.
7. Authoritative organizations in pediatrics should take the initiative to set up an organization that can give professional advice and support about assistance in dying for children.
8. Professional medical and nursing organizations should develop a guideline about the role and responsibilities of physicians and nurses in cases where patients voluntarily stop eating and drinking with the aim of ending their life.
9. The report model for physicians who have terminated a patient's life should be complemented with clear questions about how patients were informed of their situation and prospects, and about the availability of alternative treatment options.
10. The consistency of the review system should be enhanced by further conceptualization of norms based on 'case law', themed meetings and meetings of the lawyers, physicians and ethicists of the committees, and by more efficient communication between the committees about special or controversial cases.