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DYING WITH DIGNITY VIS-À-VIS EUTHANASIA: A SOCIO-LEGAL PERSPECTIVE

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The right to life means right to live a meaningful and dignified life. It does not mean mere animal existence, but a glowing vitality – the feeling of wholeness with a capacity for continuous intellectual and spiritual growth. But we must also remember that dying is an integral part of living. In fact it is the only certain thing in life. That is why, life is said to be a pilgrimage towards death which is the greatest mystery of life. Therefore, an important question arises that here is: Does right to live a meaningful and dignified life extend so far so as to include within its scope the right to die a dignified death by way of euthanasia or mercy killing? Should human dignity, freedom and autonomy be respected to such an extent we can even override the sanctity of sacred and precious life given to us by God? The conflict here is between sanctity of human life on the one hand and human dignity and right of personal autonomy and self-determination on the other. The paper aims to discuss the legal position of euthanasia in different countries of the world including India. In view of the recent developments of the concept in India in the light of the recent judgements of the Supreme Court and the Bill recommended by the Law Commission of India, there is an urgent need for a clear enunciation of law on this very sensitive and complex issue.

INTRODUCTION

In the global culture of human rights and freedoms, the true meaning of life and personal liberty of an individual can be ascertained only in the presence of his physical, psychological and social growth. The State endeavours to create such an environment by recognising and guaranteeing various fundamental rights and freedoms to individuals through the agency of law. But, since life is larger than law, the struggle for various civil rights and liberties is still going on in both developing and developed nations.

These rights and freedoms have evolved and developed since ages. However, the major shift took place in the period of renaissance and industrial revolution. Individual rights were recognised during and after the industrial revolution. The best example of this is the recognition and protection of labour rights and abolition of slavery throughout the world. Therefore, the acknowledgement of individual rights was a very significant step towards a whole culture of rights and freedoms.

Initially, the individual rights were limited to the protection of one's physical body and his belongings. Later on, the individual rights developed and grew in the form of State's recognition of one's control on his own body. But it was not an easy achievement. This State's recognition had to pass through the conflict between society's moral values and an individual's personal liberty. There were times when numerous personal liberties were treated as immoral and unethical and against religious sentiments. Gradually, after the inception of the principles of logic, reasoning, justice, fairness, equity and good conscience into the law, the State provided breathing space to the individuals.

But even today, there is disparity in different legal systems regarding one's right over his or her body, because, every society has its own parameters to decide moral, religious and decent values. An individual's behaviour can be disapproved by a society if it is considered immoral or indecent.

To explain the above point, initially, abortion was illegal as it was against religious principles. But, later on, medical termination of pregnancy was allowed under certain circumstances. Similarly, prostitution was also legalised in many legal systems of the world. Furthermore, the individual rights of lesbians, gays, bi-sexuals and transgenders (LGBT) got recognition in many civilised States. The practices of live in relationship, sex change, use of silicon in breast enhancement, tattoos and piercing on body, transplant of organs etc., also reflect legal recognition of one's right to have control over one's own body. The idea of 'surrogacy' is a very sensitive issue that has come up in the recent times, on which debate has started in many countries of the world including India.

Human beings are desirous of spending a happy life as long as they are alive. No one wants to be in pain and agony. But, sometimes the sufferings of life can grow to such an extent that even death becomes desirable and a man voluntarily hastens to it.[1] 'Right to die with dignity' is another very delicate and complex moral issue involving the right of personal autonomy and self-determination including the right to decide the time and manner of one's own death. The issue involves a variety of concepts like suicide, euthanasia (active and passive) and assisted suicide (including physician assisted suicide). The paper aims to deal with various social, ethical, moral and legal issues connected with euthanasia

(2). Euthanasia: Meaning and Concept

Euthanasia is one of the most perplexing issues which the courts and legislatures all over the world are facing today.[2] The term euthanasia is derived from the

Greek word "euthanatos", "eu" means both "well" and "easy" and "Thanatos" is death, thus meaning "good death".[3] The term has been defined as 'an act or practice of procuring, as an act of mercy, the easy and painless death of a patient who has an incurable and intractably painful and distressing disease.'[4] The term is often erroneously described as "mercy killing". Most forms of euthanasia are, indeed, motivated by mercy. Not so others.[5]

There are two kinds of euthanasia - active and passive. Active euthanasia is the 'intentional' killing of a terminally ill patient by a physician, or by someone, such as a nurse, who acts on the direction of the physician. It may be voluntary, non-voluntary, and involuntary. In voluntary active euthanasia the doctor intentionally kills the patient at the patient's request and so with the patient's consent. In non-voluntary active euthanasia the doctor intentionally kills the patient without the patient's request because the patient is unable to make a request or actively give his or her consent. In involuntary active euthanasia the doctor intentionally kills the patient without the patient's consent when patient consent is possible to get but is not sought. In passive euthanasia the doctor allows the patient to die, either by withholding treatment or by discontinuing treatment, where the relevant treatment is designed to keep a patient alive who is terminally ill. Like active euthanasia, it may also be voluntary, non-voluntary, and involuntary.[6]

Euthanasia is not a new subject as is evident from the references to it even in ancient Greece and Rome. The Hippocrates mentioned euthanasia in the Hippocratic Oath**.** The original Oath states:

I will not give a drug that is deadly to anyone if asked, nor will I suggest the way to such a counsel.[7]

In Judaism, Christianity, Buddhism, Hinduism, Sikhism and Islam, respect is shown to the principle of sanctity of life and euthanasia or suicide is opposed. Every life is valuable and precious to God. The person in Persistent vegetative State (PVS) is still valued and loved by God and hence is precious, even if no earthly person can relate to him or her.[8] However, in Christianity, the Declaration on Euthanasia, 1980, issued by the sacred Congregation for the Doctrine of the Faith, allows people to decline heroic, disproportionate or extraordinary medical treatment to prolong life when death is imminently inevitable. The Declaration rejects the inhuman implication that patients must always accept life-prolonging treatment, no matter how painful or costly such treatment may be.[9]

In the west, growing support for legalizing various forms of euthanasia is observed in recent times. The withdrawal of life support by the doctors is in law considered as an omission and not a positive step to terminate the life. The latter would be euthanasia, a criminal offence under the present law in UK, USA and India.[10] However, the general legal position all over the world seems to be that while active euthanasia is illegal unless there is legislation permitting it, passive euthanasia is legal even without legislation provided certain conditions and safeguards are maintained.[11]

Those favouring claim it as a civil right, whereas, for the opponents, it is a disastrous. Like abortion, euthanasia is also based on human mortality and compassion. A Federal Ninth Circuit Court Judge Stephen Reinhardt, in his historic 1996 decision on the right-to-die case *Compassion in Dying* v. *State of Washington*[12], opened his judgment with the following thoughtful words:

This debate requires us to confront the most basic of human concerns—the mortality of self and loved ones—and to balance the interest in preserving human life against the desire to die peacefully and with dignity. . . . This controversy . . . may touch more people more profoundly than any other issue the courts will face in the foreseeable future.[13]

(3) International Position on Right to Die and Euthanasia

The efforts to legalise euthanasia and assisted suicide were started in early twentieth century in various countries of the world. Euthanasia was first legalised in Netherlands. Many countries of the world followed its footsteps and legalised right to die in its different forms.

Various international documents like Universal Declaration of Human Rights (UDHR), 1948, International Covenant on Civil and Political Rights (ICCPR), 1966 and International Covenant on Economic, Social and Cultural Rights (ICESCR), 1966 recognize human dignity at the core of Human Rights Jurisprudence. Various nations have made laws which provide solution to this problem, having due regard human dignity and worth, right to personal autonomy and self-determination and have adopted different criteria for dealing with this sensitive issue. Some countries have legalised euthanasia, whereas others have legalised assisted suicide only. But, even in such countries right to die has not been granted absolutely. It has been made subject to certain conditions and restrictions to prevent its abuse. There are nations which have not legalised right to die in any of its forms.

In the Netherlands, euthanasia is regulated by the "Termination of Life on Request and Assisted Suicide (Review Procedures) Act", 2002.[14] It legalizes euthanasia and physician assisted suicide in very specific cases. The law allows a medical review board to suspend prosecution of doctors who performed euthanasia when certain conditions are fulfilled.[15] Following conditions are required to be fulfilled: The patient's suffering is unbearable with no prospect of improvement. The patient's request for euthanasia must be voluntary and persist over time (the request cannot be granted when under the influence of others, psychological illness, or drugs). The patient must be fully aware of his/her condition, prospects and options. There must be consultation with at least one other independent doctor who needs to confirm the conditions mentioned above. The death must be carried out in a medically appropriate fashion by the doctor or patient, in which case the doctor must be present. The patient is at least 12 years old (patients between 12 and 16 years of age require the consent of their parents). However, there are certain exceptional situations which are not subject to such restrictions of law as they are normal medical practice. These are (a) stopping or not starting a medically useless (futile) treatment, (b) stopping or not starting a treatment at the patient's request and (c) speeding up death as a side-effect of treatment necessary for alleviating serious suffering.[16]

Article 115 of the Swiss Penal Code considers assisting suicide a crime if, and only if, the motive is selfish, otherwise not. However, legally, active euthanasia is illegal in Switzerland. The Swiss law is unique because the recipient need not be a Swiss national and a physician need not be involved. Many persons from other countries, especially Germany, go to Switzerland to undergo euthanasia.[17]

Belgium became the second country in Europe after Netherlands to legalize the practice of euthanasia in September 2002, subject to certain conditions. Patients wishing to end their own lives must be conscious when the demand is made and repeat their request for euthanasia. They have to be under "constant and unbearable physical or psychological pain" resulting from an accident or incurable illness. Unlike the Dutch legislation, minors cannot seek assistance to die.[18]

In U.K., Spain, Austria, Italy, Germany and France euthanasia or physician assisted death is not legal.

Active Euthanasia is illegal in all states in U.S.A. But, Oregon was the first state in U.S.A. to legalize physician assisted death under Oregon Death with Dignity Act, in 1997. Under the Act, a person who sought physician-assisted suicide would have to meet certain criteria. Washington was the second state in U.S.A. which allowed the practice of physician assisted death in the year 2008 by passing the Washington Death with Dignity Act, 2008. Montana was the third state (after Oregon and Washington) in U.S.A. to legalize physician assisted deaths, but this was done by the State judiciary and not the legislature. On December 31, 2009, the Montana Supreme Court delivered its verdict in the case of *Baxter v. State of Montana*[19] permitting physicians to prescribe lethal indication.

In November 2014, Brittany Maynard, 29, the young, terminally ill American cancer patient became the face of the controversial right to die movement. She ended her life in Oregon. She was diagnosed with a likely stage 4 glioblastoma, a kind of malignant brain tumour. Within weeks, in course of researching possible treatments and realizing it was futile, she became an advocate of a dignified death instead of undergoing endless rounds of debilitating chemotherapy and radiation, which was already proving useless in her case. She had moved from California to Portland, Oregon with her family, to take advantage of the State's physician assisted suicide laws.[20]

In Canada, physician assisted suicide is illegal under Section 241(b) of the Criminal Code of Canada. Moreover, the Canadian Supreme Court in *Sue Rodriguez* v. *British Columbia (Attorney General)*[21] rejected the plea of Rodriguez, a woman of 43, who was diagnosed with Amyotrophic Lateral Sclerosis (ALS) to allow someone to aid her in ending her life.

In some other countries the debate about its legalization is still going on.

(4) Indian Position on Right to Die and Euthanasia

The Preamble to Constitution of India ensures justice, equality, liberty, freedom of thought and expression. Article 14 strikes at Discrimination and Arbitrariness. Likewise Article 19 (1) (a) guarantees freedom of speech and expression and Article 21 guarantees personal autonomy and self-determination, right to refuse medical treatment, right to health etc. Similarly, Directive Principles of State Policy impose an obligation on the State to promote healthy lifestyle of its people.

The criminal law of India i.e. India Penal Code (IPC) does not recognize right to die. An attempt to commit suicide is punishable under section 309. And performing euthanasia would attract either Section 302 (i.e. punishment for murder) or section 304 (i.e. punishment for culpable homicide not amounting to murder). Hon'ble Supreme Court of India in *P. Rathinam's* case

struck down Section 309 of the Indian Penal Code punishing attempt to suicide terming it as unconstitutional.[22] However, in *Gian Kaur* Case[23] the Constitution Bench upheld that the right to live with dignity under Article 21 of the Constitution will be inclusive of right to die with dignity. It held that right to die with dignity at the end of life is not to be confused or equated with the right to die an unnatural death curtailing the natural span of life.[24] However, the decision did not arrive at a conclusion for validity of euthanasia, be it active or passive. Since then, courts have been facing pleas for mercy killing of such kind of incompetent patients.

Under such circumstances, the Law Commission of India in its Report in 2006 recommended the legalization of withdrawal of life supporting treatment/devices and drafted a Bill for that purpose. The draft bill provides for the protection of patients and medical practitioners from liability in the context of withholding or withdrawing medical treatment, including life support systems, from terminally ill patients. According to the provisions of the draft bill, every competent patient has a right to take a decision for withholding or withdrawing of medical treatment to himself or herself and to allow nature to take its own course, or for starting or continuing medical treatment to himself or herself. When a patient communicates the decision to the medical practitioner, such decision is binding on the practitioner, provided that the medical practitioner is satisfied that the patient has taken an informed decision based upon his or her free will.

However, in its landmark verdict[25] in 2011, the Supreme Court legalized passive euthanasia while rejecting the plea for mercy killing of Aruna Shanbaug who had been in a persistent vegetative state for the past so many years and laid down elaborate guidelines for carrying out passive euthanasia. It rejected the issue of active euthanasia and mooted decriminalisation of attempt to suicide. Since, Indian legal system does not recognise right to die, therefore, Supreme Court's guidelines become law until Parliament makes a law on the subject. Following guidelines were laid down by SC in *Aruna Shanbaug Case*:

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.[26]
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.[27]
3. When such an application is filed the Chief Justice of the High Court should constitute a Bench of at least two Judges who should decide to grant approval or not.[28]
4. A committee of three reputed doctors to be nominated by the Bench, 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 speedily at its earliest, assigning specific reasons in accordance with the principle of best interests of the patient.[29]

Considering Supreme Court's decision and guidelines laid down for performing euthanasia in *Aruna Shanbaug's* case, the Law Commission of India had a relook into the matter in 2012 and in its 241st Report, it recommended a following revised Bill[30] containing provisions and requirements for withdrawal of life supporting treatment.

5. **The Medical Treatment of Terminally-ill Patients (Protection of Patients and Medical Practitioners) Bill, 2012**

(a) Aim and Objective of the Bill

The Bill extends to the whole of India except the State of Jammu & Kashmir. It provides for the protection of patients and medical practitioners from liability in the context of withholding or withdrawing medical treatment including life support systems from patients who are terminally-ill.

As per section 2 (l) 'Patient' means a patient who is suffering from terminal illness. Further, according to Section 2 (m) 'terminal illness' means –

(i) such illness, injury or degeneration of physical or mental condition which is causing extreme pain and suffering to the patients and which, according to reasonable medical opinion, will inevitably cause the untimely death of the patient concerned, or

(ii) which has caused a persistent and irreversible vegetative condition under which no meaningful existence of life is possible for the patient.

(b) Competent Patient's Right to Refuse Medical Treatment

According to Section 2 (c) 'competent patient' means a patient who is not an incompetent patient. Section 2 (d)

defines 'incompetent patient' to means a patient who is a minor below the age of 16 years or person of unsound mind or a patient who is unable to –

(i) understand the information relevant to an informed decision about his or her medical treatment;

(ii) retain that information;

(iii) use or weigh that information as part of the process of making his or her informed decision;

(iv) make an informed decision because of impairment of or a disturbance in the functioning of his or her mind or brain; or

(v) communicate his or her informed decision (whether by speech, sign, language or any other mode) as to medical treatment.

Under Section 2 (i) 'medical treatment' means treatment intended to sustain, restore or replace vital functions which, when applied to a patient suffering from terminal illness, would serve only to prolong the process to dying and includes –

(i) life-sustaining treatment by way of surgical operation or the administration of medicine or the carrying out of any other medical procedure and

(ii) use of mechanical or artificial means such as ventilation, artificial nutrition and hydration and cardiopulmonary resuscitation.

According to section 3 of the Bill, every competent patient including minor aged above 16 years has a right to take a decision and express the desire to the medical practitioner attending on her or him:

(i) for withholding or withdrawing of medical treatment to herself or himself and to allow nature to take its own course, or

(ii) for starting or continuing medical treatment to herself or himself.

Such decision is binding on the medical practitioner. But the medical practitioner must be satisfied that:

(a) the patient is a competent patient, and

(b) that the patient has taken an informed decision based upon a free exercise of her or his free will. In the case of minor above 16 years of age, the consent has also been given by the major spouse and the parents.

It may be noted here that as per section 2 (e) 'informed decision' means the decision as to continuance or withholding or withdrawing medical treatment taken by a patient who is competent and who is, or has been informed about:

(i) the nature of his or her illness,

(ii) any alternative form of treatment that may be available,

(iii) the consequences of those forms of treatment, and

(iv) the consequences of remaining untreated.

Before proceeding further to give effect to the decision of the competent patient, the medical practitioner shall inform the spouse, parent or major son or daughter of the patient or in their absence any relative or other person regularly visiting the patient at the hospital about the need or otherwise of withholding or withdrawing treatment from the patient and shall desist from giving effect to the decision for a period of three days following the intimation given to the said patient's relations.

(c) Preparing a Panel of Experienced Medical Experts from various Fields

As per section 4, the Director-General of Health Services, Central Government and the Director of Medical Services (or officer holding equivalent post) in each State shall, prepare a panel of medical experts for the purposes of this Act. It is also provided that more than one panel may be notified to serve the needs of different areas. The panels shall include experienced medical experts in various branches such as medicine, surgery, critical care medicine or any other specialty as decided by the said authority.

The Director General of Health Services may consult the Directors of Medical Services or the equivalent rank officers in regard to the composition of panel in order to ensure uniformity, as far as practicable. Moreover, these panels shall be published in the respective websites of the said authorities and the panels may be reviewed and modified from time to time and such modifications shall also be published on the websites, as the case may be.

(d) Record to be maintained by the Medical Practitioner

Section 5 of the Bill provides that the medical practitioner attending on the patient shall maintain a record containing personal details of the patient such as age and full address, the nature of illness and the

treatment being given and the names of spouse, parent or major son or daughter, the request or decision if any communicated by the patient and his opinion whether it would be in the best interest of the patient to withdraw or withhold the treatment. According to section 2 (g) 'medical practitioner' means a medical practitioner who possesses any recognized medical qualification as defined in clause (h) of section 2 of the Indian Medical Council Act, 1956 (102 of 1956) and who is enrolled on a State Medical Register as defined in clause (k) of that section.

The medical practitioner shall inform the patient if conscious and the spouse, parent or major son or daughter of the patient or in their absence the persons regularly visiting the patient at the hospital about the need or otherwise of withholding or withdrawing treatment from the patient.

(e) Provision of Palliative Care

As per section 2 (k) 'palliative care' includes –

(i) the provision of reasonable medical and nursing procedures for the relief of physical pain, suffering, discomfort or emotional and psycho-social suffering,

(ii) the reasonable provision for food and water.

Therefore, as per section 6 of the Bill, even though medical treatment has been withheld or withdrawn by the medical practitioner in the case of competent patients and incompetent patients in accordance with the above provisions, such medical practitioner is not debarred from administering palliative care.

(f). Protection of Competent Patients from Criminal Action in Certain Circumstances

According to section 7, where a competent patient refuses medical treatment in circumstances mentioned in section 3 (mentioned above), notwithstanding anything contained in the Indian Penal Code (45 of 1860), such a patient shall be deemed to be not guilty of any offence under that Code or under any other law for the time being in force.

(g). Protection of Medical Practitioners from Legal Action

Section 8 further provides that where a medical practitioner or any other person acting under the direction of medical practitioner withholds or withdraws medical treatment in respect of a competent patient on the basis of the desire expressed by the patient which on the assessment of a medical practitioner is in her or his best interest, then, notwithstanding anything contained in any other law, such action of the medical practitioner or those acting under his direction and of the hospital concerned shall deemed to be lawful provided that the medical practitioner has complied with the requirements of Section 3 and 5.

(h). The Procedure to be followed

According to section 9, any near relative, next friend, legal guardian of patient, the medical practitioner or para-medical staff generally attending on the patient or the management of the hospital where the patient has been receiving treatment or any other person obtaining the leave of court, may apply to the High Court having territorial jurisdiction for granting permission for withholding or withdrawing medical treatment of an incompetent patient or a competent patient who has not taken informed decision.

Such application shall be treated as original petition and the Chief Justice of High Court shall assign the same to a Division Bench without any loss of time and the same shall be disposed of by the High Court as far as practicable within a month,

Further, a letter addressed to the Registrar-General or Judicial Registrar of the High Court by any of the persons above mentioned containing all the material particulars seeking the permission under sub-section (1) shall be placed before the Chief Justice without delay and the letter shall be treated as original petition.

The Division Bench of the High Court may, if deemed necessary, appoint an *amicus curiae* to assist the Court and where a patient is unrepresented, direct legal aid to be provided to such patient.

The High Court shall take necessary steps to obtain the expert medical opinion of three medical practitioners drawn from the panel prepared under Section 4 and any other expert medical practitioner if considered necessary and issue appropriate directions for the payment to be made towards the remuneration of the experts.

The High Court shall, having due regard to the report of panel of experts and the wishes of close relations, namely, spouse, parents, major children or in their absence such other persons whom the High Court deems fit to put on notice and on consideration of the best interests of the patient, pass orders granting or refusing permission or granting permission subject to any conditions.

As per section 2 (b), 'best interests' include the best interests of a patient:

(i) who is an incompetent patient, or

(ii) who is a competent patient but who has not taken an informed decision, and

are not limited to medical interests of the patient but include ethical, social, moral, emotional and other welfare considerations.

The medical practitioner or the hospital management or staff who in accordance with the order of High Court, withholds or withdraws medical treatment to the patient concerned shall, notwithstanding any other law in force, be absolved of any criminal or civil liability.

(i) Provision of Confidentiality of Identity of Patient, Relative, Doctors, Hospital etc

Section 10 further provides that the Division Bench of the High Court may, whenever a petition under Section 9 is filed, direct that the identity of the patient and of his or her parents or spouse, the identity of the medical practitioner and hospitals, the identity of the medical experts referred to in Section 4, or of other experts or witnesses consulted by the Court or who have given evidence in the Court, shall, during the pendency of the petition, and after its disposal, be kept confidential and shall be referred only by the English alphabets.

(j) Advance Medical Directives and Medical Power-of-Attorney to be void

As per Section 2 (a), advance medical directive' (called living will) means a directive given by a person that he or she, as the case may be, shall or shall not be given medical treatment in future when he or she becomes terminally ill. Further, Section 2 (h) defines 'medical power-of-attorney'. It means a document of decisions in future as to medical treatment which has to be given or not to be given to him or her if he or she becomes terminally ill and becomes an incompetent patient. Section 11 provides that every advance medical directive (called living will) or medical power-of-attorney executed by a person shall be void and of no effect and shall not be binding on any medical practitioner.

(k). Medical Council of India may issue Guidelines consistent with this Bill

Section 12 further provides that consistent with the provisions of this Bill, the Medical Council of India may prepare and issue guidelines, from time to time for the guidance of medical practitioners in the matter of withholding or withdrawing of medical treatment to competent or incompetent patients suffering from terminal illness.

The Medical Council of India may review and modify the guidelines from time to time. The guidelines and modifications thereto, if any, shall be published on the website and a press release may be issued to that effect.

6. Analysis of the Bill

The question before the Law Commission after *Aruna*'s case was whether parliament should enact a law on the subject permitting passive euthanasia in the case of terminally ill patients – both competent to express the desire and incompetent to express the wish or to take an informed decision. If so, what should be the provisions of such a legislation? Both the Supreme Court and Law Commission felt sufficient justification for allowing passive euthanasia in principle, falling in line with most of the countries in the world. The Supreme Court as well as the Commission considered it to be no crime and found no objection from legal or constitutional point of view. According to the Commission, rational and humane considerations fully justify the endorsement of passive euthanasia. Moral or philosophical notions and attitude towards passive euthanasia may vary but it can be safely said that the preponderance of view is that such considerations do not come in the way of relieving the dying man of his intractable suffering, lingering pain, anguish and misery. The principle of sanctity to human life which is an integral part of Article 21, the right to self-determination on a matter of life and death which is also an offshoot of Article 21, the right to privacy which is another facet of Article 21 and incidentally the duty of doctor in critical situations – all these considerations which may seem to clash with each other if a disintegrated view of Article 21 is taken – do arise. A fair balance has to be struck and a holistic approach has to be taken. As regards the procedure and safeguards to be adopted, the Commission inclined to follow substantially the opinion of the Supreme Court (in *Aruna's* case) in preference to the Law Commission's view in its 196th Report. However, many other provisions proposed by the Law Commission in its 196th Report have been usefully adopted.[31]

The Commission has very rightly recognized the right of the competent patient to refuse medical treatment while prescribing a certain procedure to be followed while withdrawing life support system of incompetent patient.

The Commission has defined various important words, phrases and expressions in order to avoid any kind of chaos and confusion in dealing with such matters. Moreover, it is commendable that a provision regarding

confidentiality is made under the Bill. The Bill also casts an obligation on the medical practitioner to maintain records to avoid chances of misuse. The Bill seeks to promote the idea of palliative care. It has also empowered the Medical Council of India to fill in the gaps by going into minute details in the matter of withholding or withdrawing of medical treatment.

Further, the Bill rightly rejects Advance Medical Directives as to medical treatment (like living wills) and Medical Power-of-Attorney because there is always a chance of misuse if the same is allowed. People may show false and fabricated documents to prove the will of the incompetent patient. Moreover, it is very difficult to ascertain that in what context and in what state of mind the patient might have decided for himself or herself in the past.

Moreover, the period of one month provided for disposing of the application by the High Court is a welcome step, to avoid the unnecessary prolonging of the case. Likewise, the provision to provide legal aid to the patient if he or she is unrepresented plays a vital role in the administration of justice.

(6) *Aruna's* Case Challanged: *Common Cause (A Registered Society)* v. *Union of India*

In the aftermath of *Aruna Shanbaug'* judgment, the Supreme Court of India in *Common Cause (A Registered Society)* v. *Union of India*[32] on 25 February 2014 held that the Constitution Bench in *Gian Kaur*, did not express any binding view on the subject, rather reiterated that legislature would be the appropriate authority to bring the change. While hearing a PIL filed by NGO Common Cause, a three-judge bench of the Supreme Court of India said that the prior opinion in the *Aruna Shanubaug* case was based on a wrong interpretation of the Constitution Bench's opinion in *Gian Kaur*. The court also determined that the opinion was internally inconsistent because although it held that euthanasia can be allowed only by an act of the legislature, it then proceeded to judicially establish euthanasia guidelines. The bench headed by Chief Justice P. Sathasivam said that a five-judge Constitution Bench will review the judgment in the *Aruna Shanbaug* case. The five-judge Constitutional bench of Supreme Court on 15 July 2014 issued notices to the State governments and Union Territories (UTs) to submit their responses over legalizing passive euthanasia. The bench comprising of Chief Justice of India R.M. Lodha, and Justice J.S. Khehar, J. Chelameswar, A.K. Sikri and Rohinton F. Nariman reasoned that States and UTs must also be heard because the issue not only involves the Constitutionality of euthanasia but also involves morality, religion and medical science. The notice was issued by the SC bench on a PIL filed by Non-Governmental Organization (NGO) Common Cause. In the PIL Common Cause had reasoned that, if there is medical expert opinion that a person treatment is beyond from being curable has reached the point of no return, then the person should be given the right to refuse the treatment and die, if the person gives a living will. However, Attorney General of India contented that the issue of legality involved host of issues which needs to looked from multiple angle and hence it would be appropriate that legislature address the issue of legality of euthanasia. He further contended that legalizing euthanasia may give rise to misuse of it and there are many reasons for this.[33]

(7) Conclusion and Suggestions

The issue of right to die with dignity is global in character, because it deals with the matters of death, which is inevitable and comes to everyone. It is observed in hospitals that many people are unaware about their respective patients' state of physical and mental condition. In most of the cases, private hospitals misguide patient's relatives about the physical and mental condition of the patient and put the patient on unnecessary life supporting devices. It reflects that we do not have effective regulations and check over the hospital's administration. Unawareness regarding the fundamental rights and their enforceability still prevails in significant proportion of population in our country. At the same time, the degree of sense and practice of executing personal autonomy in Indian society is low.

1. Therefore, True and Value Education should be inculcated in the minds of people which would empower them to form their informed consent in their personal autonomous decisions. Right to health as a fundamental right should be implemented in its true sense.
2. Providing adequate medical facilities for the people is an essential part of the obligations undertaken by the government in a welfare state. The government discharges this obligation by running hospitals and health centres which provide medical care to the person seeking to avail those facilities. Article 21 imposes an obligation on the State to safeguard the right to life of every person. State is under an obligation to ensure that:

1. Adequate facilities are available at the Primary Health Centres where the patient can be given immediate primary treatment so as to stabilize his condition.

2. Hospitals at the district level and sub-divisional level are upgraded so that serious cases can be treated there.
3. Facilities for giving Specialist treatment are increased and are available at the hospitals at various levels having regard to the growing needs. For this, government should establish multi-specialty hospitals and medical institutions and employ highly qualified and experienced medical officers to deal with serious cases.
4. In order to ensure availability of bed in an emergency at state level hospitals, there is a centralized communication system so that the patient can be sent immediately to the hospital where bed is available in respect of the treatment which is required.
5. Proper arrangement for the ambulance is made in every hospital.
6. The ambulance is adequately provided with necessary equipment and medical personnel.[34]

1. Encouraging a healthy lifestyle (regular exercise and a good diet) has become a key part of secondary school education. If we can encourage people to live good, healthy lives, then everyone will win: the individuals will have healthier lives and society will have to spend less on medicine and on medical care of people following complex diseases. This is called Preventive Medicine Campaign.[35]
2. Hospice Care Program: A hospice is an organization whose purpose is to help terminally ill individuals die as peacefully as possible. A hospice program may be carried out in a facility where patients live in a homelike atmosphere, or it may simply be a way of organizing community services to help people to die in their own home or that of a family member. Many people can be helped through their last few weeks and months by the hospice concept. It can also be a tremendous help to the family of the dying person. Hospices are relatively new specialized health care programs which are autonomous but centrally administered.[36] The basic goals and principles of hospice care programs are to:

1. Help the terminally ill person live as full and comfortable a life as possible as a person rather than a helpless patient.
2. Keep the patient home as long as is appropriate.
3. Support the family as the unit of care and support them emotionally during the period of treatment and bereavement.
4. Supply medical, psychological, sociological and spiritual services as needed through a team approach.
5. Provide pain control without undue concern about narcotic addiction.
6. Provide services 24 hours a day, 7 days a week, under the supervision of a physician.
7. Supplement, not duplicate, existing services.
8. Keep costs down.
9. Accept patients on the basis of health needs rather than ability to pay.[37]

1. The Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002. (Code of Medical Ethics)[38]

Regulation 1.1 of the Regulations deals with character of the Physician. According to it, a physician should uphold the dignity and honour of his profession. The prime object of the medical profession is to render service to humanity. Regulation 1.2 deals with the need to maintain good medical practice. It states that the principle of the medical professional is to render service to humanity with full respect for the dignity of profession and man. Physicians should merit the confidence of patients entrusted to take their care, rendering to each a full measure of service and devotion.[39]

Similarly, Regulation 6.7 of the Regulations states that practicing euthanasia shall constitute unethical conduct. However on specific occasions, the question of withdrawing supporting devices to sustain cardio-pulmonary function even after brain death, shall be decided only by a team of doctors and not merely by the treating physician alone. A team of doctors shall declare withdrawal of support-system. Such team shall consist of the doctors in charge of the patient, Chief Medical Officer/Medical Officer In- charge of the hospital and a doctor nominated by the in-charge of the hospital staff in accordance with the provisions of the Transplantation of Human Organ Act, 1994.[40]

Likewise, as per Regulation 7.1, a physician, if he or she commits any violation of these regulations, shall be guilty of professional misconduct and liable for disciplinary action.[41]

1. The Ethics Committee of the Indian Society of Critical Care Medicines has made ‘Guidelines for limiting life prolonging interventions and providing palliative care towards the end of life in Indian Intensive care Units.[42]
2. Palliative care: It is the provision of active measures aimed at only alleviating pain and suffering, with no further attempt at resuscitation or providing organ support, when the underlying disease process is presumed to have reached a point of no return. The physician has a duty to disclose to the capable patient or family, the

patient's poor prognosis with honesty and clarity when further aggressive support appears non-beneficial. The physician should initiate discussions on the treatment options available including the option of no specific treatment. When the fully informed capable patient or family desires to consider palliative care, the physician should offer the available modalities of limiting life-prolonging interventions. The patient or family should be clearly made aware of the available options for the use of life-sustaining supports such as, Full support, Do not intubate (DNI) or Do not resuscitate(DNR status), Withholding of life support, Withdrawal of life support, Palliative care. The physician must discuss the implications of forgoing aggressive interventions through formal conferences with the capable patient or family, and work towards a shared decision-making process. Thus, he accepts patient's autonomy in making an informed choice of therapy, while fulfilling his/her obligation to provide beneficent care. The discussions leading up to the decision to withhold life-sustaining therapies should be clearly documented in the case records, to ensure transparency and to avoid future misunderstandings. Such documentation should mention the persons who participated in the decision making process and the treatments withheld or withdrawn. The overall responsibility for the decision rests with the attending physician/intensivist of the patient, who must ensure that all members of the caregiver team including the medical and nursing staff agree with and follow the same approach to the care of the patient. If the capable patient or family consistently desires that life support be withdrawn, in situations in which the physician considers aggressive treatment non-beneficial, the treating team is ethically bound to consider withdrawal within the limits of existing laws. In the event of withdrawal or withholding of support, it is the physician's obligation to provide compassionate and effective palliative care to the patient as well as attend to the emotional needs of the family.[43]

3. Aruna Shanbaug died on 18 May 2015.[44] But, it is suggested that in certain exceptional circumstances, where life has lost its meaning, where the difference between life and death has ceased to exist, where life has become miserable, painful, burdensome and full of agony, the principle of sanctity of life should give way to personal autonomy and self-determination.
4. There is an urgent need to make a law on the subject to allow euthanasia in case of an incompetent patient where there is point of no return i.e. irreversible medical condition of the patient) in passive form only i.e. withdrawal of artificial life sustaining measures.
5. The Definition of an incompetent patient (e.g. PVS or coma) is still unclear for the purposes of passive euthanasia in India. It needs to be interpreted through facts and circumstances of each case, i.e. fact oriented approach. The current position in India is weak in order to decipher the reversibility or irreversibility of the medical condition of the patient. There has to be differentiation of cases on the basis of illness.
6. Moreover, there is a paucity of literature in our country concerning this complex issue.
7. Moreover, the judgment does not provide for the definition of various other important terms and expressions like medical treatment, artificial life support, best interest of the patient etc.
8. If the law does not regulate and, fails to provide the uniform and effective mechanism, then, it would lead to be misused by both the state actors as well as non-state actors.
9. Since State always takes its economic incapacity as a defence, the unregulated mechanism of finding out the reversibility or irreversibility of the condition of the patient would instigate the state actors to escape from its responsibility to protect individuals' right to health and medical treatment.
10. Again, the clear cut guidelines are required in case of withholding of treatment or stop feeding, etc. of the incompetent patient.
11. For all these matters, it is also required that the doctors and care-givers should be well-qualified, trained and experienced and, should have the reputed and moral character. There is a need for a stronger healthcare system in India.
12. Strict and effective guidelines are required in case where the hospitals misguide the patients and their relatives about the medical condition of the patient.
13. Hospitals should not be allowed to act arbitrarily in putting the patients on life supporting devices.
14. Moreover, there is a need to strengthen the social solidarity and social harmony. Personal laws should be used for strengthening the family relations. It is not just a technical issue but involves the emotions of near and dear ones as well. It is hard for them too. The need is for quality of death. It is a question of people understanding each other. There is a need for counselling for patients, doctors, care-givers and relatives.
15. Keeping a patient on artificial life sustaining measures is a very costly affair. Therefore, it becomes the duty of State to provide for financial help to the relatives of such patients.

But, again, facts and circumstances of each case should be taken into consideration.

16. Advance Directives like living wills and health care proxies should not be allowed because there is always a chance of misuse. Moreover, its genuineness or authenticity can be challenged.
17. Moreover, there is a need to incorporate a specific provision in the Indian Penal Code for the defence of doctors who would perform euthanasia subject to restriction prescribed by law made on the subject. There is also a need to put a redressal system in place to check its misuse. The consent of the patient is important and it has to be informed consent.
18. There is a need to mark boundaries between healthcare and ethics.
19. In the end, it is suggested that the Bill needs more discussion in public fora to get citizens acquainted with its implications. Considering the important question of law involved in the light of social, legal, ethical, medical and constitutional perspective, it becomes extremely important to have a clear enunciation of law for the benefit of humanity as a whole.

[1]Arthur Schopenhauer, "The Vanity and Suffering of Life", in Oswald Hanfling, (ed.), *Life and Meaning*, 97- 109 at 103 (1987).
[2] *Aruna Ramachandra Shanbaug v. Union of India.* AIR 2011 SC 1290 at 1292.
[3] Thomas L Beachamp, "The Justification of Physician Assisted Suicide", Ind. L Rev 29; 1173, 1175 (1996), cited in K.D. Gaur, *Criminal Law: Cases and Materials*, 266 (2005).
[4] *Butterworths Medical Dictionary*, 626 (1999).
[5] For details, see, "Euthanasia & The Right to Die", in Sam Vaknin, *Issues in Population and Bioethics*, (2002-05). Available at *http://www.authorsden.com/visit/viewArticle.asp%3Fid%3D24753 - 70k.* Also see, Sujata Pawar, "Right to Die, How far right? Judicial Responses", *Cri LJ*, (2010) 280-288 at 282.
[6] Jonathan Herring, *Medical Law and Ethics*, 437 (2006).
[7] Steven H. Miles, *The Hippocratic Oath and the Ethics of medicine*, 66 (2004).
[8] *Supra* note 6 at 468.
[9] Peter Singer, "Right to Die". Aavailable at *http.www.utilitarian.net/singer/by/200701*.
[10] *Supra* note 2 at 1309.
[11] *Id.*, at 1311.
[12] 79 F.3d 790 (9th Cir. 1996).
[13] R. Cohen Almagor, *Euthanasia in the Netherlands: The Policy and the practice of mercy killing*, 8 (2004).
[14] Visit *http://en.wikipedia.org/wiki/Euthanasia_in_the_Netherlands*
[15] *Ibid.*
[16] *Ibid.*
[17] Visit *http://en.wikipedia.org/wiki/Euthanasia_in_Switzerland.*
[18] For full text of the law visit *http://www.kuleuven.be/cbmer/viewpic.php%3FLAN%3DE%26TABLE%3_DDOCS%26ID%3D23*. Also see, R. Cohen Almagor, "Belgium Euthanasia Law: A Critical Analysis", 35 *Journal of Medical Ethics*, 436-439 at 436 (2009).
[19] No. ADV-2007-787 (Mont. 1st Jud. Dist. Ct 2000).
[20] "29 year old cancer patient, face of right to die, ends life", *The Tribune*, 1, 12 (4 November 2014).
[21] (1993) 3 SCR 519.
[22] *P.Rathinam* v. *Union of India* AIR 1994 SC 1844.
[23] *Gian Kaur* v. *State of Punjab* AIR 1996 SC 946.
[24] *Id.*, at 952.
[25] *Supra* note 2.
[26] *Id.*, at 1331.
[27] *Ibid.*
[28] *Id.*, at 1334.
[29] *Id.*, at 1334-35.
[30] Visit *www.lawcommissionofindia.nic.in/**reports**/**report**241.pdf.*
[31] *Ibid.*
[32] Writ Petition (Civil) No. 215 of 2005. Available at *www.supremecourtofindia.nic.in/outtoday/wc2152005.pdf.*
[33] Visit *www.jagranjosh.com/.../sc-asked-state-governments-and-uts-to-submit-re....* Also visit *https://en.wikipedia.org/wiki/Aruna_Shanbaug_case*.
[34] Justice Palok Basu, *Law relating to Protection of Human Rights*, 324 (2007).
[35] C. Wcksteed Armstrong, *Road to Happiness – A New Ideology*, 84 (1951).
[36] Joseph D. Alter, *Life after Death: Your Guide to Health and Happiness*, 109 (1982).
[37] *Ibid.*
[38] Available at *www.mciindia.org/RulesandRegulations/CodeofMedicalEthicsRegulation*.
[39] *Ibid.*
[40] *Ibid.*
[41] *Ibid.*
[42] Available at http://www.ijccm.org/article.asp?issn=0972-5229%3Byear=2012%3Bvolume=16%3Bissue=3%3Bspage=166%3Bepage=181%3Baulast=Mani.
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