7

Suggestions and Conclusion

The natural process of dying has changed due to the rapid and significant advancements in medical technology. Life can today be artificially maintained for days, months, and even years because of the capacity of various medical equipment. Such a prolonged death increases the agony of individuals who are terminally ill. A life filled with honour and dignity is guaranteed by and protected by the Constitution of India. Likewise, in the event of a terminal illness, everyone should have the same right to a dignified death. A patient with a terminal illness experiences excruciating pain and suffering. In such cases, the law must assist terminally ill patients in exercising their rights to liberty, justice, equality, self-determination, and autonomy to achieve a dignified and pain-free death.

7.1 Addressing the Research Questions

The first research question was, 'What are the historical roots of Euthanasia and how has the concept of euthanasia evolved over time?' The second chapter deals with the origin and historical development of Euthanasia. The origins of the idea of Euthanasia as a tool to achieve a dignified and painless death can be traced back to the ancient days of the Greek and Roman classical periods. As noted in Chapter 2, there was a practice of ending one's life when one achieved a certain age and felt that they have fulfilled their purpose in life and did not want to lead a life troubled by old age, disease, or infirmity. Such practices were in fact celebrated rather than being looked down upon. However, with the passage of time, particularly with the advent of Judeo-

Christian morals and values, the practice of euthanasia was no longer seen as desirable. Rather, it was condemned as interference in the domain of God. Life was deemed precious, even if filled with misery, and any attempt to extinguish a life was considered a criminal act. In the modern period, euthanasia was again advocated as a means to end the agony of a person who was suffering from an incurable illness. Francis Bacon used the term in its modern interpretation to mean a good death in the context of patients whose ailments had no cure. He advocated that it was the moral duty of the physicians to help such patients to end their lives as that was the only way to end their agony. In contemporary days, many nations have legalized Active or Passive Euthanasia or both. However, considering the negative connotation that the term euthanasia carries, various other terms have been used by various nations such as 'Medical assistance in Dying' in Canada, 'Physician Assisted Death' in the USA or 'Voluntary Assisted Dying' in Australia. In those countries which have legalized euthanasia in some form, there has been a progressive rise in acceptance of the practice.

The second research question was, 'How is the idea of dignity understood in the context of euthanasia and can euthanasia provide a dignified death?' Chapter 3 deals with the idea of human dignity from the perspective of various international instruments related to Human Rights as well as the Constitution of India. Dignity is an abstract idea that is difficult to define, yet we draw the meaning of our lives from the idea of a dignified existence. Dignity is usually understood from the point of view of autonomy and the right of self-determination. Therefore, what constitutes a dignified life to a person can be defined by that person only. Any legal provision intended to safeguard a dignified life must ensure that a person can have bodily autonomy and the right of self-determination. Discussions in the third chapter on euthanasia in the context of human dignity and human rights establish that a human life derives its meaning from the ability to guide the various facets of life according to one's own wishes. The idea of defining human dignity through bodily autonomy and self-determination must extend to the very end of life to determine what constitutes a dignified death. Chapter 4 of this thesis analyses various judgements of the Supreme Court of India. The Supreme Court has distinguished the right to die and the right to die with dignity. The Court, initially in the case of Gian Kaur and later in the case of Common Cause, has upheld this distinction and has held that individuals do not have

a ‘right to die’ in India and only the ‘right to die with dignity’ can be recognized in cases where an individual is suffering from an excruciating, incurable medical condition. The Supreme Court of India through its various judgements, has accepted that the right to life, as enshrined and protected in the Article 21 of the constitution of India, means a right to life with dignity and the right to a dignified death is also included in its ambit. Accordingly, a person cannot be forced to live an undignified life in pain. If a person, who has been diagnosed with an illness which can not be cured with the existing treatment modalities and all the ongoing treatments or life supports are merely extending a life of agony, and the person decides that such a life is not dignified, euthanasia can provide an escape from such undignified life through a painless death.

The third research question is, ‘How have the Indian High Courts and Supreme Court dealt with the idea of the right to die with dignity and euthanasia?’ Various landmark cases related to euthanasia have been discussed in Chapter 4 to understand the legal reasoning behind the current legal situation in India. In the absence of legal recognition of active or passive euthanasia, any attempt by a person suffering from an incurable illness to end his suffering by ending his life was considered an attempted suicide, whereas, if any physician assisted such a person to end his life, it was considered abatement of suicide. Both these situations were illegal in India and attracted penal provisions. As such, the debates on euthanasia in India are deeply intertwined with the debate on decriminalizing suicide. Various High Courts and the Supreme Court of India have dealt with decriminalizing attempted suicide under section 309 of the IPC and abatement to suicide under section 306 of the IPC. The landmark cases of P. Rathinam and Gian Kaur have produced contradictory judgements where section 309 was considered ultra vires the Constitution in the former while it was pronounced constitutional in the latter. These cases also dealt with the issue of the ‘right to die’ as an extension of the ‘right to life’ under Article 21. In P. Rathinam, the Court held that a person had a right to die but in Gian Kaur, the Court opined that no such right exists. In Gian Kaur, however, the Court recognized that the right to life means the right to a life with dignity and that right also contains the ‘right to die with dignity’. These cases, however, did not deal with euthanasia directly. The case of Aruna Shanbaug dealt with the issue of Euthanasia directly. In its judgement, the constitutional bench of the Supreme Court of India refused to legislate

from the bench on the issue of euthanasia. They agreed with the opinion given in Gian Kaur and Airedale that only Parliament had the authority to bring in legislation on Euthanasia. The Court agreed that Article 21, which protects the right to life, guarantees a right to a dignified life which can be interpreted to contain in its ambit a right to a dignified death. The Common Cause judgement disagreed with the judgments of Gian Kaur and Aruna's cases that the Supreme Court cannot give a judgement on legalizing euthanasia. The five-judge bench in the Common Cause case, led by CJI Deepak Mishra, ruled that a person, under the existing laws, has the right to refuse treatment and therefore, can choose passive euthanasia in situations where the illness is incurable. The judgement also provided extensive guidelines to be followed for patients in PVS, who cannot express their wishes, in case the family members, next friend or the treating doctor decides that withdrawing treatment will be in the best interest of the patient. The Court also established the legal validity of advance directives and gave guidelines to make and implement advance directives. The Court, however, refused to legalize active euthanasia.

The fourth research question was, 'What are the legal provisions regulating the practice of euthanasia in those countries that have legalized it?' The fifth chapter deals with the legal provisions regulating euthanasia in various countries, viz., Australia, the United States of America, the Netherlands, Belgium, Switzerland, Luxembourg, Canada, New Zealand, Spain, Colombia, and the United Kingdom. In Australia, Voluntary Assisted Dying (VAD) has been legalized in all six federated states of Victoria, Western Australia, Tasmania, South Australia, Queensland and New South Wales through legislation. These legislations provide strictly defined eligibility criteria as well as procedural safeguards for access, dispensation, and administration of VAD drugs. Apart from these, there are well established laws governing advance medical directives in Australia. In the USA, the states of Oregon, Vermont, California, New Jersey, New Mexico, Colorado, the District of Columbia, Hawaii, Maine, and Washington have legalized Physician Assisted Suicide through legislation, whereas, in Montana, Aid-in-dying has been legalized through a state supreme court judgement. In the Netherlands, the Termination of Life on Request and Assisted Suicide (Review Procedures) Act legalized and laid down the procedures for performing euthanasia. 'Due Care Criteria' were established which were to be met by the physician, failing which the physician will be punishable by law. The Netherlands

has been one of the most progressive countries as far as the practice of euthanasia is concerned. It now allows older people, who are otherwise not suffering from terminal illness, to apply for assisted suicide if they feel that they have completed their lives and wished to have a painless death. The Belgium Euthanasia Act of 2002 legalized euthanasia in Belgium and established the procedures to be followed. In 2014, child euthanasia was also legalized under strict guidelines. Assisted suicide has been legal in Switzerland since 1942. Although euthanasia, i.e., a physician administering a lethal drug to the patient, is illegal in Switzerland, both physicians and non-physicians are allowed to assist in dying. There is no requirement for a person to be a Swiss citizen to apply for assisted death. Assisted suicide and euthanasia were legalized in Luxembourg in 2009. Medical assistance in dying was legalized in Canada in 2016. In New Zealand, euthanasia was legalized through the End-of-Life Choice Act 2019. In Spain, euthanasia is governed by the Organic Law for the Regulation of Euthanasia, enacted by the Cortes Generales in March 2021. Colombia became the first Latin American nation to decriminalize euthanasia in 1997.

7.2 Achieving the Objectives

The first objective was to trace the origin and historical development of euthanasia. The second chapter traced the origin of euthanasia in antiquity and its evolution through the medieval period as well as the modern period. The first objective was thus achieved.

The second objective was to critically analyze the role of the Indian Judiciary viz a viz euthanasia and the right to die with dignity. Chapter 4 deals with the various judgements of the high courts and the Supreme Court of India in dealing with the matter of euthanasia and the right to die with dignity. The second objective was, therefore, achieved.

The third objective was to critically analyze the Medical Treatment of Terminally-Ill Patients (Protection of Patients and Medical Practitioners) Bill, 2016 and to suggest on its loopholes. The sixth chapter analyzes the draft euthanasia bill critically and provides suggestions to remedy the shortcomings of the bill. Therefore, the third objective was achieved.

The fourth objective was to present a comparative analysis of the legislations and relevant case laws of nations where euthanasia or assisted suicide has been legalized. The fifth chapter provides an in-depth analysis of the various case laws and legislations that regulate the practice of euthanasia in the countries which have legalized it. The fourth objective was thus achieved.

7.3 Suggestions

The following suggestions are made by the researcher to facilitate upholding the right to die with dignity.

a) There must be a law that establishes procedures to regulate the practice of euthanasia. It must place a person's bodily autonomy at the forefront and provide simplified procedures that can be easily accessible to an ordinary citizen. It can be argued that legalizing only passive euthanasia defeats the purpose of the law, i.e., to uphold the right to a dignified death. Therefore, there must be provisions to allow active euthanasia with clearly established eligibility guidelines and safeguards.

b) There must be clearly defined eligibility criteria in the act. The person must be 18 years or older. There must be a diagnosis of a terminal illness with a prognosis of less than six months. The terminal nature of the illness and the prognosis must be certified in writing by two independent physicians. The person must be legally competent to make an application for euthanasia. If the person is not legally competent, the next friend can apply on the person's behalf. If there is an advanced directive available, then that can guide the decision-making if the patient becomes legally incompetent.

c) The role of the doctors who participate in the process must also be strictly defined in the act. The treating doctor must explain the nature of the disease, prognosis, and various treatment options, including palliative care to help the person or the family member make an informed decision. The treating doctor must take a second opinion regarding the diagnosis and prognosis. It must be recorded in writing in the patient's medical records. Assessment by a psychiatrist and psychologist must be mandatory to rule out any mental health condition like major depressive disorder that may influence the decision-making of the patient. Any doctor who agrees to participate in the process of euthanasia must undergo mandatory training. The National Medical Council can be tasked with preparing training modules for the

doctors. The participation, however, should be voluntary, and the doctor must be free to refuse participation in euthanasia and refer the patient to another doctor. The treating doctor must explain that the request for euthanasia can be withdrawn at any moment. Such withdrawal of request must also be recorded in the medical records. No healthcare provider must initiate a discussion on euthanasia with the patient or the family members. However, they must provide all the necessary information when the patient requests. Healthcare providers must be immune from prosecution if they follow the specified procedures. However, any procedural lapse must attract prosecution in a court of law. Penal provisions can be similar to those provided in instances of criminal negligence under the IPC. Re-training of doctors from time to time on the procedures to be followed must be organized.

d) Strict procedural safeguards must also be in place to prevent any misuse of the law. The request for euthanasia must be in writing in a specified format. Such formats should be made available in all the official languages of India. The person must write the application himself/herself. If an otherwise competent person is not able to write, e.g., due to paralysis of the limbs, the doctor or next friend can write on their behalf with the reason being mentioned clearly. In the case of an incompetent person, the next friend can fill in the form. In all these scenarios, the application must be filled in in the presence of two witnesses, at least one of whom should not gain financially from the patient's death. The witnesses must certify that, to the best of their knowledge, the application is being made with free will, without any undue influence, and after understanding the nature and prognosis of the illness and alternative treatment options including palliative care. The request for euthanasia must be repeated, i.e., there must be two requests at least 15 days apart. There must be a cooling off period of at least 48 hours between application and approval; also, between approval and execution.

e) There must be a system for dispute redressal at various levels which should be easily accessible and should provide time-bound resolutions. There may be instances where a person in PVS does not have any next friend to take decisions on their behalf, or there may be a difference of opinion between the assessing doctors, the patient and the family members, or there may be suspicion of undue influence on the decision making. To deal with such situations, there must be ethics committees in all medical colleges, and district hospitals, as well as all government or private or charitable hospitals with ICU and/or 30 or more in-patient beds. These ethics committees should

comprise of a panel of at least three doctors with at least 5 years of experience. These committees must provide their recommendation within 48 hours. The institutional committees should also be tasked with dealing with disputes that may arise in smaller hospitals in a pre-defined jurisdiction. If a dispute is not resolved at the institutional level, the next level of committees should be at the district level. These district committees should comprise of the chief medical officer of the district with at least two other doctors with at least five years of experience. District committees must also provide their recommendations within 48 hours. At both the institutional and the district committees, the decision must be unanimous and their reasoning to accept or reject an application for euthanasia must be clearly documented and signed by all the members. The next level of committees should be under the supervision of the jurisdictional High Courts. These State level committees should comprise of at least five doctors with at least ten years of experience as well as a legal officer appointed from the office of the Advocate General of the state. This committee should also give their opinion within one week. This committee should also be tasked with compiling and publishing annual reports containing the details of the number of applications received for euthanasia in all the hospitals across the state, the numbers of applications accepted and rejected, reasons for rejection of applications, details of disputed cases and the final decision taken in those cases with detailed reasoning. Such reports will help in identifying any potential loopholes and drawbacks of the legal provisions and making appropriate amendments to the law.

f) A simplified procedure for living will is also needed. Every citizen of the Country, who has attained the age of majority, should be eligible to make a living will. The living will should be made in consultation with a legal and medical professional and be registered in the local sub-registrar's office. The document must be signed by the person, mentioning the date, time and place, in the presence of two witnesses. The witnesses should certify that the living will is being made without undue influence, threat, or inducement. The living will document the specific condition when it should come onto effect. The document should mention a person of trust, who may be a relative, friend or attorney, to keep a copy of the living will and present the same to the treating doctor when necessary. The person of trust should also sign the document. The living will should be consulted for decision-making only when the person cannot communicate their own decisions. When the person is conscious and legally competent, their decision will be accepted even if it differs from

any previous decisions that may have been recorded in a living will. A person should be able to change their living will at any moment without assigning any reason. Such change must be mentioned explicitly in the latter of the documents. A person should keep their living will frequently updated, ideally every five years, to reflect any change in their wishes and beliefs. When taking treatment decisions on behalf of an incompetent person, if more than one living wills are presented to the treating doctor, the latest of them should be considered. Ordinarily, the living will should guide the decision-making in case of an incompetent person. However, if the treating doctor concludes that newer treatment modalities have been developed since the living will has been made, which can potentially change the decision of any reasonable person, or suspects that the person had not fully understood the consequences of their decisions, the case must be referred to the ethics committee of the hospital/ district. The absence of a living will should not constitute a ground to refuse treatment to any person.

g) Apart from passing a law to address euthanasia and execution of living will, the Union and State Governments should also ensure that adequate healthcare infrastructure is built, including palliative care facilities, and human resources are appointed and trained to enable the patients to access the best possible care. The request for euthanasia should not result from a lack of access to healthcare.

7.4 Conclusion

The practice of Euthanasia can be traced back to the Greek and Classical Roman periods when it was a socially acceptable, even desirable, practice to end a person's life in a dignified manner. It was considered morally acceptable. With time the idea of the sanctity of life became the dominant narrative prohibiting human interventions in matters of life and death, a domain solely left to the will of God. However, there have been many philosophers and thinkers who advocated for euthanasia, particularly for those suffering from terminal illnesses causing immense suffering.

The idea of a dignified life has been the dominant discourse that has guided the debates and discussions concerning Euthanasia. The right to life has been interpreted as the right to a dignified life by the Supreme Court of India. The Supreme Court of India has even accepted the right to die with dignity to be a part of the right to life with dignity. The right to bodily autonomy is foundational to understanding the

concept of a dignified life. Accordingly, a person must have the right to choose the treatment they want to receive in case of any illness. They must also have the right not to receive treatment or withdraw treatment. This right to bodily autonomy must extend to the very end of life if a person wishes to die instead of prolonging their suffering when facing a terminal illness which is causing excruciating agony. Euthanasia can provide a dignified death in such a scenario.

The various high courts and the Supreme Court of India have, through various judgements, recognized the right to die with dignity. In the Common Cause judgement, the Supreme Court has legalized passive euthanasia and advance directives. However, the Supreme Court has refused to legalize active euthanasia and has opined that it can be legalized by Parliament only. However, it can be argued that legalizing only passive euthanasia does not adequately deal with the right to die with dignity. Passive euthanasia does not always result in a painless death without suffering. In many instances, patients who had their ventilators turned off and their life-supporting medications withdrawn would choke to death, wait until their bodies decomposed, or starve to death, resulting in a painful death and negating the very point of dying with dignity. Therefore, passive euthanasia might result in instances when death does not happen in a compassionate manner and instead enhances the patient's suffering and misery during their final moments. If medical professionals could actively intervene to hasten death in circumstances where a patient is in agony and has little chance of recovery, rather than letting nature take its course and waiting for death to happen, the wait time and, subsequently, the length of suffering and pain may be decreased. This might be done through a regulated system that would ensure the use of such a procedure is kept to a minimum and restricted to situations when passive euthanasia would result in more misery and anguish. There are precedents of various Supreme Courts in various countries, as discussed in Chapter 5, allowing active euthanasia before legislation is passed. Therefore, the Supreme Court of India should lead the path to genuinely upholding the right to die with dignity by allowing active euthanasia. Moreover, the guidelines laid out to execute advance directives and to withdraw life-sustaining treatment in person in PVS are procedurally too complex and are likely to be out of the reach of ordinary citizens.

Many countries have passed laws that allow Euthanasia under strictly defined yet procedurally simplified guidelines which protect the interests of the patients and

their family members and shield the healthcare professionals from unnecessary lawsuits. There is a dire need for legislation that can provide simplified procedures to regulate the practice of euthanasia and the execution of advance directives. Debates and discussions must be encouraged involving various stakeholders to lead to a future where the right to die with dignity is truly upheld.

The right to die with dignity needs to be discussed and debated widely. Such debates will increase awareness among policymakers and ordinary citizens, which should lead us to a law that will facilitate the practice of passive and, hopefully, active euthanasia. Increasing awareness of advance directives and simplifying the procedures to make and execute such directives is also the need of the hour. Wider adoption of advance directives will improve the decision makings at the final days of a person and protect the family members and the treating doctors from moral dilemmas. Legalizing both active and passive euthanasia, with appropriate safeguards to protect from abuse, can give the option of a dignified exit to a person suffering from an incurable condition and will eventually lead to a truly dignified life culminating in a dignified death.