5

International Perspectives: A Comparative Analysis

The practice of Euthanasia is not uniform worldwide. Euthanasia's legal status differs from nation to nation. This could be caused by the various cultures, religions, and ethical perspectives present in the region. The discussion of euthanasia has gained in popularity during the past century. The laws of various nations represent the opinions of people who adhere to various cultures, philosophies, and socioeconomic conditions. It has been noted that the legal status of euthanasia is currently comparable in the majority of nations throughout the world. Many people logically decide to end their painful lives because they are not worth living. Therefore, it is crucial that all countries assess their legal systems. To understand this disparity, the chapter discusses the comparative research. The legal position of euthanasia legislation in a few selected countries is discussed in the current chapter. Additionally, a few remarkable decisions from other nations are mentioned. The legal status of the right to die, particularly that of euthanasia, has been a topic of discussion in several courts and parliamentary bodies across the world. Euthanasia's legality is still a hot button subject with several unresolved questions. Different courts have voiced a variety of different opinions. Therefore, this chapter emphasizes that it is important to comprehend the legislation and policy made by the courts in the nations where the law has grown, as the laws on the right to die with dignity in India are still in a very early stage. The law in numerous nations is studied to comprehend varied perspectives and ways since the development of the law has not been consistent across nations. This chapter begins by examining Australian law in order to give readers a context-rich understanding of the discussion because Australia was the first nation in the world to

establish legislation permitting a doctor to end the life of a terminally ill patient at the patient's request for a brief period of time on May 25, 1995. Consequently, the legislation permits both active voluntary euthanasia and physician-assisted suicide in specific circumstances. The next section of this chapter examines how American law has evolved and gives a brief account of the approach used by US courts. The major focus of this chapter is on those European countries that permit euthanasia, advance directives, and/or physician-assisted suicide. This chapter then offers a thorough overview of the law in the United Kingdom. The different judgements made by the House of Lords have greatly influenced the development of the law in the United Kingdom. This case law will be carefully examined. A comprehensive analysis of the law in the UK is presented because the majority of Indian laws were derived from British law, and Indian courts frequently consulted British court decisions when making decisions in individual cases. The most liberal country when it comes to issues with the right to die is Switzerland, which permits any adult, healthy or not, to have assistance with suicide, so the researcher took this country for her study. After that the Netherlands, Belgium, Luxembourg, Columbia, Canada and finally Spain are among these jurisdictions. Although they use a more controlled approach, the Netherlands and Belgium permit physician-assisted suicide and euthanasia. Euthanasia and physician suicide are only permitted in these two nations when a patient has a terminal disease. Luxembourg became the third nation in Europe to legalize assisted suicide as well as euthanasia. It is useful to have an awareness of how the law is applied and how it may be accepted in the Indian jurisdiction through the mechanisms and practices employed in these nations.

5.1 Australia

Australia became the first nation in the world to allow voluntary euthanasia when the Northern Territory Parliament enacted the Rights of the Terminally Ill Act, 1995,[382] in the early hours of May 24, 1995. This act allowed patients to choose how they wanted to get treatment and protected them against forceful treatments and procedures against their wishes. The Act specifies guidelines for physician-assisted dying and primarily focuses on the requirement for a decent and dignified death for the suffering patient. According to the Act, doctors may only think about accelerating a patient's death if

[382] The Rights of the Terminally Ill Act, 1995 (Northern Territory, Australia)

the patient has a terminal illness with little possibility of recovery and has voluntarily decided to do so. However, adequate time should be given for consideration before taking any actions that may invite death. The Act also imposes a responsibility on medical personnel to ensure that deaths are brought about humanely with minimal pain and suffering. This Act authorized and permitted physician-assisted death and voluntary euthanasia to be performed solely by medical experts to lessen the suffering of individuals with life-threatening diseases.[383]

Bob Dent was the first person to receive euthanasia under the NT Act.[384] He was in excruciating agony and suffering from prostate cancer for more than five years, which caused him to lose 25 kg of body weight, lose his testicles, develop a recurring hernia, and have his lung collapse. He had no chance of recovery or treatment for his illness. Bob decided to choose euthanasia at the age of 66 after getting exhausted from his physical and emotional anguish. He preferred to put an end to his own suffering as well as the suffering of his loved ones. Before passing away, Bob communicated to his wife in a letter that he had dictated that he had been going through months of anguish and suffering and that he would prefer to complete this journey by passing away. He said that people should not exercise the voluntary euthanasia option if they do not wish to, but they should not oppose anybody else's right to do so. Dr. Philip Nitschke,[385] Bob's physician and a well-known proponent of the individual's right to choose euthanasia, aided Bob in expressing his desire to pass away. Bob was attached to an automated syringe by Dr Philip Nitschke. When Bob gave the green signal to go-ahead, the syringe's effects started, and he passed away on September 22, 1996, surrounded by his family, in serenity and dignity.[386]

In the case of Christopher John Wake and Djiniyini Gondarra v. Northern Territory and Keith John Austin Asche,[387] this Northern Territory Rights of the

[383] The Rights of the Terminally Ill Act, 1995 (Northern Territory, Australia).
[384] Helen Davidson in Darwin "Philip Nitschke: how the face of the voluntary euthanasia campaign became its outcast*" The Guardian* ,22 Sep 2016, available at- https://www.theguardian.com/australia-news/2016/sep/22/philip-nitschke-how-the-face-of-the-voluntary-euthanasia-campaign-became-its-outcast// (last visited on September 25,2022)
[385] *Ibid.*
[386] Helen Davidson in Darwin "Philip Nitschke: how the face of the voluntary euthanasia campaign became its outcast*" The Guardian* ,22 Sep 2016, available at- https://www.theguardian.com/australia-news/2016/sep/22/philip-nitschke-how-the-face-of-the-voluntary-euthanasia-campaign-became-its-outcast// (last visited on September 25,2022)
[387] *Christopher John Wake and Djiniyini Gondarra v. Northern Territory and the Hon. Keith John Austin ASCHE AC QC The administrator of the Northern Territory Australia,* No. 112 of 1996.

Terminally Ill Act, 1995, was challenged before the Supreme Court of the Northern Territory. As a result of their disagreement with Dr Nitschke's assessment of the legality of the Rights of the Terminally Ill Act of 1995, Aboriginal Uniting Church minister Dr Djiniyinni Gondarra and the head of the AMA's Northern Territory branch appealed the Northern Territory Supreme Court's ruling to the High Court of Australia (NT). In anticipation of the Senate passing the Euthanasia Laws Act 1997 (Cth), the High Court postponed the application.[388] After a thorough hearing, the Supreme Court dismissed the Act's challenge. The Act did hold up against a legal challenge, but it was unable to do so because of Australia's federal democratic system. The Northern Territory Rights of Terminally Act, 1995 was repealed by the Federal Government in 1997, and the Northern Territory lost its authority to enact legislation pertaining to euthanasia.

5.1.1 Judicial Decisions in Australia

Australian courts have had a chance to decide on matters involving the right to die with dignity. The Australian Courts have established two fundamental principles. The acknowledgement of advance medical directives comes first, followed by the discontinuation of treatment when it is in the patient's best interest. Although there was no provincial statute governing such a directive at the time, the Supreme Court of New South Wales examined the legitimacy of an advanced directive signed by the patient in the case of Hunter and New England Area Health Service v. A.[389] The patient had made it clear in a directive that he did not want to undergo renal dialysis in the future. Mr A. was kept alive by life support equipment, such as artificial respiration and renal dialysis when he was taken to the hospital emergency room one year after giving the directive. A judicial pronouncement was sought to determine whether or not to carry out the advance directive to forego renal dialysis. The New South Wales Supreme Court found that an advance medical directive that has been signed by a competent adult and is unambiguous and relevant to the circumstances at hand should be honoured. An individual has the right to refuse treatment, and if the individual has made it clear that they do not want to be treated, their wishes should be

[388] *Christopher John Wake and Djiniyini Gondarra v. Northern Territory and the Hon. Keith John Austin ASCHE AC QC The administrator of the Northern Territory Australia,* No. 112 of 1996.
[389] *Hunter and New England Area Health Service v. A* [2009] NSWSC 761.

respected. In addition, the court determined that administering care to a patient against a clear advance directive to the contrary would constitute battery.[390]

An individual has the right to self-determination, and if they choose not to be treated, that choice should be honoured, according to the Supreme Court of Western Australia in the case of Brightware Care Group (Inc.) v. Rossiter.[391] The court was concerned about Mr Rossiter, a quadriplegic who was unable to do any fundamental human functions, including drinking or eating, anticipatory refusing treatment. Mr Rossiter had full mental capacity and wasn't in a vegetative or terminally ill state. He had made it abundantly obvious that he did not want to continue receiving care that, if stopped, would surely result in his death. The court decided that even if a person is not terminally ill or in a persistent vegetative state, they still have the right to self-determination and can choose whether or not to receive treatment. While Australian courts have consistently permitted the execution of advance directives, they have also made sure that fundamental safety precautions are upheld during the execution of such directives.

In the case of Australian Capital Territory v. JT,[392] the Supreme Court of Australian Capital Territory held that while advance directives should be followed, it is a basic requirement that the person making the directives be of sound mind and fully aware of their implications. In this particular case, the court determined that a person with paranoid schizophrenia, a mental disease, was unable to fully comprehend the effects of the advance directives that were given. The Court also stated, citing prior decisions, that the best interest of the patient requirement should be applied where a treatment is to be discontinued or terminated but no such directives are present. It must be determined if continuing the treatment would be in the patient's best interests if it were to prove futile. The patient's best interests should always come first when deciding whether to continue treatment or not, not the convenience of the hospital or the medical staff.[393]

Despite being the first nation to allow euthanasia in 1997, these developments in Australia show that the issue is still up for debate there. Even if the legislature has

[390] *Hunter and New England Area Health Service v. A* [2009] NSWSC 761.
[391] [2009] WASC 229; 40 WAR 84
[392] [2009] ACTSC 105; 4 ACTLR 68; 232 FLR 322
[393] *Ibid.*

been unable to agree on whether or not to permit any kind of euthanasia, it appears that the judiciary has more-or-less made it clear that advance directives submitted by a competent adult should be implemented.[394] It is obvious that the deciding factor in situations involving self-determination is mental capacity. The criterion of mental capacity would be a clear prerequisite since the right to self-determination implies the capability to make an educated decision about the future. After conducting a thorough analysis, Chief Justice Higgins correctly distinguished Auckland Area Health Board v. Attorney General,[395] in which a court similarly obligated to uphold the right to life and prohibition against cruel and degrading treatment determined that a patient in a persistent vegetative state could be released from futile treatment. He concurred with Howie J. in Messiha v. South East Health[396] that the best interests of the patient should always come first, not the convenience of medical services or their institutions when determining whether a therapy is futile.

5.1.2 Current Legal Status of Euthanasia in Australia

Although Australia's federal government does not permit euthanasia, the State of Victoria enacted a law allowing voluntary assisted death in 2017. Victoria's legislation defines VAD as the assistance provided by a medical practitioner to a person to end their life. This occurs either by a medical practitioner prescribing a VAD substance (i.e., VAD medication) to the person for self-administration or, in limited circumstances, through administration by that medical practitioner. Western Australia, Tasmania, South Australia, Queensland, and New South Wales have also passed legislations similar to Victoria which allow Voluntary assisted dying. These acts are –

1. Victoria – The Voluntary Assisted Dying Act 2017
2. Western Australia - The Voluntary Assisted Dying Act 2019
3. Tasmania - The End-of-Life Choices (Voluntary Assisted Dying) Act 2021
4. South Australia – The Voluntary Assisted Dying Act 2021
5. Queensland – The Voluntary Assisted Dying Act 2021

[394] Euthanasia - the Australian Law in an International Context, available at- https://www.aph.gov.au/about_parliament/parliamentary_departments/parliamentary_library/pubs/rp/rp9697/97rp4// (last visited on September 25, 2022)
[395] [1993] NZLR 235
[396] [2004] NSWSC 1061

6. New South Wales - The Voluntary Assisted Dying Act 2022

These Acts are more or less similar to each other, and their fundamental provisions are summarized below.

A. Eligibility Criteria of VAD

- The minimum age requirement to qualify for VAD in Victoria is 18 years old.
- Applicants must be Australian citizens or permanent residents who have been there for at least 12 months prior to submitting their first VAD request.
- The individual must be able to make decisions on voluntarily assisted dying.
- They must have been given a diagnosis of an incurable disease or illness that is advanced, progressive, and terminal.
- It is expected that the patient's illness would result in death within a few weeks or months, but no more than six. The eligibility period is prolonged by 12 months in cases of neuro-degenerative diseases (such as motor neuron disease); the patient's illness is giving them pain that cannot be treated in a way that they find tolerable.

The eligibility criteria for accessing VAD cannot be met only by a disability or mental disorder. Any criterion for eligibility must be met by a person who has a disability or a mental disorder. Unless it can be demonstrated differently, it is assumed that a person has the mental capacity to make a VAD decision.[397]

B. Person's Eligibility to Access VAD

- Two medical practitioners, a coordinating medical practitioner and a consulting medical practitioner, who have completed the required training, must independently determine a person's eligibility to use VAD.
- The coordinating physician will establish the patient's eligibility during the first evaluation, as well as if the patient knows what VAD entails,

[397] Voluntary Assisted Dying, available at-, https://www.health.vic.gov.au/patient-care/voluntary-assisted-dying// (last visited on November 27,2022)

has voluntarily chosen to access VAD, and has made an ongoing request for VAD.

- If the patient is eligible, the consultant physician must do an additional, independent evaluation.
- Other legal requirements must be followed, such as submitting a written declaration asking for access to VAD, making a final request for VAD in person to the coordinating medical practitioner, and naming a contact person, if that practitioner decides the applicant is qualified and the applicant wants to proceed.
- The coordinating medical professional will conduct a final review after receiving the patient's last request for VAD. This review will entail evaluating and filling out papers and confirming that the request and assessment processes have been finished.[398]

C. Administration of VAD

- The individual may apply for a VAD permission (a "self-administration permit") if the coordinating medical practitioner declares in a final review form that the request and assessment procedure is finished. The permit enables the coordinating physician to prescribe and provide the VAD medication to the patient for self-administration; the patient to obtain, possess, store, and administer the medication; and the contact person to possess, store, carry, transport, and return any unused or leftover VAD medication to the dispensing pharmacy after the patient passes away.
- If the patient is physically unable to self-administer or digest the medication, the coordinating physician may submit an application for a practitioner administration permit allowing them to administer the drug to the patient (for example, those with physical disabilities that limit their ability to self-administer).
- A person may use VAD when the Department of Health and Human Services has granted the coordinating physician permission.

[398]Voluntary Assisted Dying, available at-, https://www.health.vic.gov.au/patient-care/voluntary-assisted-dying// (last visited on November 27,2022)

- Most of the time, the patient will self-administer the VAD medication at a time and location of their choosing. If the participant so chooses, other persons (such as relatives and friends) may be present. A physician, another healthcare professional, or a witness is not required to be present.
- The patient has the option to refuse the drug at any moment.
- In situations requiring practitioner administration, the person will get the VAD medication from the coordinating medical professional (often intravenously or subcutaneously). The practitioner administration must be made in front of a witness who can attest that the individual making the request appeared to have the mental capacity to make that decision, that they were acting voluntarily and without coercion, and that their request appeared to be enduring. The witness must also confirm that the coordinating doctor gave the patient the VAD medicine. The person may also have anyone else with them while the practitioner administers the medication.
- Health professionals do have the option to decline VAD participation if they have a conscientious objection to it. They are not required to: educate someone about VAD; take part in any component of the VAD process, such as determining a person's eligibility; or provide, prescribe, administer, or be present before, during, or after the administration of a VAD medication.[399]

D. Medical professionals' choice regarding VAD

- Health professionals have the choice to decline VAD participation if they have a conscientious objection to it.
- They are not required to inform someone about VAD; take part in any component of the VAD process, such as determining a person's eligibility; or provide, prescribe, administer, or be present before, during, or after the administration of a VAD medication.

[399] Voluntary Assisted Dying, available at-, https://www.health.vic.gov.au/patient-care/voluntary-assisted-dying// (last visited on November 27,2022)

A registered healthcare professional may respond to a patient's request for information regarding VAD but may not initiate a discussion about VAD or propose VAD to a patient. As long as they also inform the patient about available treatment and palliative care choices, as well as their expected results, a doctor or nurse practitioner is permitted to open a dialogue or advise VAD. A registered health practitioner or another person who offers medical or professional care services is not allowed to start a conversation about VAD or suggest it, but they are allowed to give information about it upon request.[400]

E. Procedural Safeguards of VAD

- A number of safeguards are included in the Act, such as the need that a person submits at least three different VAD requests.
- A discussion about VAD cannot be initiated by health practitioners. This is done to make sure the request for VAD was made voluntarily.
- Additionally, no one's family member or caregiver may make a VAD request on their behalf.
- The diagnosis, prognosis, treatments that are available, palliative care options, and risks associated with administering the fatal medicine must all be explained to the patient.
- The person must also be informed that they can stop the VAD procedure at any moment.
- Without a permission allowing for either self- or practitioner-administration, VAD medicine cannot be taken.
- Prescription, dispensation, and disposal rules for drugs used to treat VADs. After dispensing, the VAD drug needs to be kept in a locked box. Any medicine left over after the individual who is using VAD passes away must be returned by the contact person they designated.
- Health professionals and employers must report suspected violations of the Act by other practitioners to the appropriate authorities.
- Collection and publication of de-identified statistical data on VAD users (i.e., their disease, illness or condition, and their age at the time of their death from VAD).

[400] Voluntary Assisted Dying, available at-, https://www.health.vic.gov.au/patient-care/voluntary-assisted-dying// (last visited on November 27,2022).

- Anyone who persuades another individual to ask for VAD or use the VAD prescription is guilty of offences, which are punished by up to 5 years in imprisonment.
- Medical professionals must successfully complete the certified training and possess the required knowledge and experience as described in the Act in order to offer VAD.

Monitoring, reporting, compliance, safety, and research tasks are handled by the Voluntary Assisted Dying Review Board.[401]

5.1.4 Execution of Living Will or Advance Directive in Australia

The laws covering advance medical directives are well established in Australia as well. Every state, excluding Tasmania, has a provision for advance directives. The advance directives as proposed by the various laws in each state of Australia vary in nature and their legal force, but each type's goal is still the preservation of the patient's autonomy.

Advance health care directives may become ineffective in a number of situations or with regard to specific provisions within. In Queensland, a directive fails to be effective if a medical professional determines that following it is contrary to good medical practice or if there has been a significant change in the environment, such as an advancement in technology, medicine, or medical practices, that makes following the directive inappropriate. The termination of an advance directive in the state of Victoria occurs when the patient's condition changes to the point where the condition for which the advance directive was given no longer exists. Furthermore, if a medical professional has reason to believe that a patient did not intend for a specific advance directive provision to apply in a given circumstance or that it would not accurately reflect the patient's current preferences, South Australia permits them to refuse to do so. In Western Australia, if a circumstance changes that the decision maker could not have foreseen when making the directive or that could cause a reasonable person in the decision maker's position to change his or her mind about the treatment decision, the directive's stated treatment decision is invalid. In the Northern Territory, an advance directive is disregarded if following it would cause the patient

[401] Voluntary Assisted Dying Act (Victoria), 2017 (Act No. 16 of 2017)

unacceptably great pain or suffering or if doing so would be so morally wrong that it would be more appropriate to disregard their desires. Additionally, the advance consent direction should not be followed if the medical professional believes that the patient would never have meant for it to apply in the given situation.[402] In accordance with Section 110Q of the Western Australia Guardianship and Administration Act, 1990, advance directives must be signed in the presence of two witnesses, one of whom must be a qualified witness under the relevant law, and both of whom must be at least 18 years old. The South Australia Advance Directives Act, 2013, Section 15 specifies the standards for acceptable witnesses. No one who is a medical expert in charge of the person who executed the advance directive's medical care has a direct or indirect interest in that person's estate or has been named as a substitute decision-maker under the advance directive may testify. According to section 110S of the Western Australia Guardianship and Administration Act of 1990, a treatment decision made in an advance directive is void if circumstances arise that the directive's maker could not have reasonably foreseen at the time the directive was made and that would have led a reasonable person in the maker's position to change her mind about the directive. The maker's age and the amount of time that has passed between the time the directive was formed and the circumstances that have arisen must be taken into consideration when deciding whether such circumstances have occurred and the directive's validity.[403] Under the provisions of sections 110V, 110W, 110X, 110Y, and 110Z of the Western Australia Guardianship and Administration Act, 1990, any person who, in the opinion of the state administrative tribunal, has a prior interest in the matter may apply to it for a declaration regarding the validity of an advance directive. Additionally, it has the authority to interpret the directive's provisions, issue instructions for implementing it, or reverse a treatment decision.[404]

5.2 United States of America

The first significant drive to legalize assisted suicide in the United States arose in the early twentieth century. Brown University historian Jacob M. Appel documented the intense political controversy around proposals to authorize physician-assisted death in Iowa and Ohio in 1906 in a 2004 essay published in the Bulletin of the History of

[402] *Common Cause (A Registered Society) v. Union of India,* (2018) 5 SCC 1
[403] *Ibid.*
[404] *Ibid.*

Medicine.[405] The campaign of heiress Anna Sophina Hall, whose mother had passed away from liver cancer after a protracted, gruelling illness, served as the impetus for the law in Ohio. Despite Hall's efforts, the Ohio legislature voted 79 to 23 to reject the bill.[406]

The Euthanasia Society of America was founded to promote the practice of euthanasia in 1938. They also wanted a proper piece of legislation. Although their movement gained considerable popularity and some public backing in America, they eventually failed to succeed in their mission there.[407] The right of a patient to refuse treatment was recognized by common law in the United States. Even if a patient was not in a terminal condition and might be healed with the correct medication, the common law in the USA acknowledged the patient's right to refuse treatment. The main tenets of this argument are the right to self-determination and the right to personal autonomy. It said that a person could refuse treatment if they are competent to make such decisions and are afflicted with a condition that cannot be cured. The right to refuse treatment for incompetent patients can be invoked through living wills or proxy decisions. The Federal Patient Self-determination Act of 1991 aims to promote the use of written intentions for supporting future healthcare preferences. Advanced directives can more effectively settle a dispute between doctors and eliminate any potential for future arguments among family members.

The discussion of euthanasia in America was rekindled in the 1970s due to a rise in human rights activism, a unique case involving Karen Ann Quinlan, and the right-to-die movement.

Karen Ann Quinlan Case[408]

This case, also known as the sleeping beauty case, emerged in 1975. A twenty-one-year-old woman named Karen Ann Quinlan accidentally overdosed on valium and alcohol, and as a result, she fell into a coma. However, a ventilator and other life-extending medications kept her alive. The entire country began to consider ways to

[405] Jacob. M. Appel, "A Duty to Kill? A Duty to Die? Rethinking the Euthanasia Controversy of 1906" 78 (3), *Bulletin of the History of Medicine*, 610–634, (2004).
[406] Ezekiel J Emanuel, "The History of Euthanasia Debates in the United States and Britain" 121 (10), *Annals of Internal Medicine*, 793–802, (1994).
[407] J. Pereira, "Legalizing euthanasia or assisted suicide: the illusion of safeguards and controls" 18(2) *Current Oncology*,38-35, (2011).
[408]I. M. Kennedy, "The Karen Quinlan case: problems and proposals" 2(1), Journal of Medical Ethics,3–7, (1976).

improve the patient's dreadful condition. Quinlan's case ultimately contributed to a redefining of the term "brain death" and the legal framework for both voluntary and involuntary decision-making in cases involving such brain-dead people. There was a petition submitted to the New Jersey Supreme Court requesting the removal of life support. The decision was made in 1976, and it permitted the withdrawal of life support on the grounds of her incurable condition and the surrogates' promise of her right to privacy. The court's approval of passive euthanasia fueled the push for the right to die. As a result of this decision, over 50 bills were presented by 38 legislatures the following year (1977) to pass laws authorizing living wills and expanding the power of attorney, among other issues. On the other hand, the American Medical Association increased its opposition to euthanasia. It was also suggested that passive euthanasia is ethically permissible, but only in a terminal illness where heroic or exceptional measures are needed to save a life in an uncomfortable and ineffective way for the patient. Until 1985, the right to refuse was widely accepted and protected by the due process clause of the American Constitution. The aforementioned provision allowed people to make judgments without unreasonable government interference.[409]

The Hemlock Society, founded in 1980, is a group of pro-euthanasia activists that began pushing for active euthanasia or physician-assisted death in 1990. They continued to promote the aforementioned procedures. The entire event resulted in the resurgence of the discussion surrounding the limitations on a person's right to die. The proponents of euthanasia make the case that administering a painless injection or fatal medication is considerably more compassionate and preferable than removing a feeding tube and allowing the patient to starve to death.[410] In 1991, the state of Washington attempted to implement a right to die through a voter initiative, but it eventually failed. California encountered the same issue the year after. The Oregon State enacted the Death with Dignity Act in 1994 through Measure I6, written by attorney Cheryl K. Smith, a former legal advisor for the Hemlock Society. This Act did not authorize euthanasia per se, but it did allow competent terminally ill individuals with a life expectancy of fewer than six months to seek drugs to terminate

[409]I. M. Kennedy, "The Karen Quinlan case: problems and proposals" 2(1), Journal of Medical Ethics,3–7, (1976).
[410] Robert Steinbrook, "Physician-assisted death—from Oregon to Washington State" 359(24), *The New England Journal of Medicine,* 2513–3515, (2008).

their lives. Consequently, Oregon became the first country in the world to approve physician-assisted suicide.[411] Nevertheless, Dr Jack Kevorkian, who became the public face of the right-to-die campaign in America, eclipsed this new statute.

Dr Jack Kevorkian's Case

Dr Kevorkian,[412] sometimes referred to as Dr Death, first gained national attention in the 1990s. He helped over 130 people commit suicide while he was still a pathologist in retirement. In 1993, Michigan legislation prohibiting physician-assisted suicide jeopardized his profession. Nevertheless, Kevorkian received backing from the American Civil Liberties Union, and as a result of that support, he argued that a statute expressly barring the practice of active euthanasia amounts to a rejection of a person's freedom to choose the manner or time of their death. However, the discovery that many patients who sought his assistance were not genuinely terminally ill put an end to Kevorkian's argument. Dr Kevorkian did not express regret for his actions. Instead, he carried on practising medicine until a Michigan court found him guilty and sentenced him to jail in 1999 for the second-degree murder of Thomas Youk, a patient who had Lou Gehrig's illness.[413]

Washington vs Gluckberg Case

In the 1997 decision of **Washington v. Gluckberg**, the Supreme Court of the USA unanimously declined to rule in favour of legalising assisted suicide.[414] The **Roe v. Wade**[415] decision was applied to the current case by the court. According to Chief Justice William Rehnquist, those who were already in danger due to their age, poverty, or lack of access to adequate medical care could suffer significant harm from assisted suicide.

Quill vs Vacco Case

The Court in the **Vacco v. Quill case**[416] ruled that the right to refuse treatment is a crucial component of a person's autonomy and that this right has been recognized

[411] Lyon's, *Medical Jurisprudence and Toxicology,* (Delhi Law House,11th edn., 2007).
[412] *Nancy Beth Cruzan, by her Parents and Co-Guardians, Lester L. Cruzan, et ux., Petitioners v. Director, Missouri Department of Health, et al*. (1990) 497 U.S. 261
[413] Fred Charatan, "Dr Kevorkian found guilty of second-degree murder" 318(7189), 962, (1999).
[414] 521 U.S. 702 (1997)
[415] 410 U.S. 113 (1973)
[416] 521 U.S. 793 (1997)

both via common law and a previous USA Supreme Court decision. However, it would be incorrect to interpret a patient's freedom to refuse treatment as a desire to die sooner. No such right exists for the patient. Individual autonomy pertains to the freedom to refuse treatment, and if a patient were to exercise that right, nature would take its course, and the patient's life may end if they continued to refuse treatment. However, demanding a life-ending or death-hastening treatment is very different from this. When a person chooses not to get treatment, this request would be comparable to forcing them to pass away.[417] Both of these actions have distinct intentions; one would amount to a proactive measure to murder the individual, while the other might result in the person dying from the illness for which they have refused treatment.[418] The Court made it clear that while the right to refuse treatment is one that is acknowledged and cannot be taken away from a person, the right to want treatment that may hasten death or terminate one's life cannot be given.

Compassion in Dying v. State of Washington case[419]

The ninth circuit court, in this case, observed that the State of Washington had earlier allowed a competent patient who was close to death to direct the removal of life-supporting measures.[420] Furthermore, when dealing with competent people who are terminally ill, the state's interest in preventing suicide is lessened. The judge ruled that a terminally sick adult's decision to end his life while suffering from a serious degenerative condition that is incurable is not premature or senseless because it prevents him from experiencing crushing misery and a humiliating death.[421] Physician-assisted suicide remained a contentious topic at the state level far into the new millennium. The Supreme Court's ruling in the case of Washington v. Glucksberg recognized the power of state courts to decide whether to allow active euthanasia because the judges thought that each state had the right to protect its own

[417] Gillett Grant, "Euthanasia, Letting dies and the Pause" 14(2), *Journal of Medical Ethics*,61-68, (1988).
[418] H.M. Malm, "Killing, Letting Die, and Simple Conflicts" 18(3), *Philosophy & public Affairs*,238-258, (1989).
[419] 850 F. Supp. 1454 (W.D. Wash. 1994).
[420] *Compassion in Dying v. State of Washington* 49 F 3d 586.
[421] Supriyo Routh, "Right to Euthanasia: A Case Against Criminalization"112, Criminal Law Journal,193-194, (2006).

residents and that a federal decision would not be acceptable.[422] The Washington court's stance is similar to one adopted in a previous judgement on passive euthanasia.

Cruzan v. Director, Missouri Department of Health[423]

Anthony David Bland was placed in a persistent vegetative state in March 1993 and remained there for three years before being granted permission by the court to end his miserable life. The judges believed that he could have made a dignified exit years ago if he had had a living will.[424] The United States courts have discussed the validity and legality of such procedures in addition to the legislature's active efforts to regulate right-to-die practices. After an accident in Missouri in 1993, Nancy Cruzan spent several years in a lifelong vegetative state and was fed through tubes. The 30-year-old Nancy Cruzan was involved in a car accident that left her in a permanent vegetative state with little possibility of recovery. Her case was **Cruzan v. Missouri Department of Health.**[425] Her heart stopped working. Due to the lack of a living will, her servant could not provide her with a dignified farewell. However, after communicating her wishes to the servant, she passed away rather than staying half-dead. Cruzan's lack of a living will create a problem in this case, forcing the United States to confront the right to die for the first time. The patient's parents sought permission from the Missouri trial court to have their daughter's doctor remove life support equipment because they wanted to end the patient's suffering. The Missouri State Supreme Court overturned the lower court's verdict in favour of the parents. According to the appeal court, the Missouri legislation requires "clear and convincing proof" that the patient, although competent, has indicated a desire to have life support equipment turned off and be permitted to die peacefully. The Missouri legislation requires clear and convincing proof that the patient had previously indicated her desire to die in such a situation and her preference for having life support equipment removed, according to the United States Supreme Court in an appeal that upheld the State Supreme Court’s decision. The Court ruled that there could be no obligation on the treating physician to withdraw life-sustaining treatment because it was not clear from the evidence presented in this case that Nancy Cruzan would have preferred

[422]521 U.S. 702 (1997)
[423] 497 U.S. 261 (1990).
[424] John Keown*, Euthanasia, Ethics and Public Policy: An Argument Against Legalization,* 217-238(Georgetown University, Washington DC, Cambridge University Press,2nd edn.,2018).
[425] 497 U.S. 261 (1990)

death and would have preferred to die than remain in a permanent vegetative state.[426] The United States Supreme Court established several significant guidelines on the subject of individual consent in dealing with this Court. According to the court, every adult and competent person has the right to decide whether or not they want to undergo medical treatment. A medical expert who performs an operation without the patient's informed consent constitutes assault and is responsible for damages.[427] The Court recognized that each individual has the freedom to decide whether or not to accept medical care. The court acknowledged that a surrogate might exercise the right to refuse treatment on behalf of an incompetent person when that person is of unsound mind, in a coma, or otherwise unable to make an informed decision.

However, Missouri state law required an additional safeguard, requiring that the surrogate might refuse treatment if it could be demonstrated that the patient had made it very clear that she preferred to die. Nancy Cruzan's appeal was denied because no concrete evidence of her guilt could be presented, and this procedural requirement was not deemed prohibited by the Constitution.[428] In this decision, the Supreme Court made it clear that the State may prohibit the termination of treatment if there is no convincing proof of enduring consent on the part of the terminally ill patient. As a result of this decision, each state is free to choose the criteria that should be used for involuntary passive euthanasia. The majority of States supported and adhered to the precedents established in the Quinlan case to reach a workable, logical conclusion. In order to convince those who oppose euthanasia, proponents of physician-assisted suicide have voiced hope that ethical procedures in Oregon and the Netherlands will do so.[429] In conclusion, due to this decision, individual States now have tremendous power to decide how to carry out involuntary passive euthanasia inside their borders.

In the case of Brittany Maynard, brain cancer was detected. At 29, a woman who was actively planning her family with her spouse was unexpectedly surrounded by hospitals and nurses. The doctor only gave her six months. She went from California to Oregon to die peacefully after first choosing to get hospice care but then

[426] Robert, L. Schwartz, "Euthanasia, and the Right to Die: Nancy Cruzan and New Mexico" 20(3), *New Mexico Law Review*,676-699, (1990).
[427] *Ibid.*
[428] George J. Annas, "The Long Dying of Nancy Cruzan" 19(1), *Journal of Law, Medicine, and ethics*, (1991).
[429] *Ibid.*

changed her mind after considering how her family would be relieved if they did not have to watch her suffer. She maintained that choosing death does not constitute dying with dignity. She said it was her decision to die since she could not tolerate the anguish in her body. She campaigned for the legalization of end-of-life care. In the company of those she loved, she passed away on November 1st, 2014.[430]

Similar to the position in the UK, legislators in the United States have been unable to come to an agreement on a single legislation and policy that would regulate the country's right to die. While no federal law covers euthanasia and related acts nationwide, several states have passed legislation to control euthanasia within their own limits. Oregon was the first state in the US to authorize physicians to help patients in dying, which also created laws governing this practice.[431] Other states, such as Washington,[432] Vermont,[433] New Mexico,[434] and Montana,[435] have also legalized physician-assisted suicide; however, there are differences in how each state regulates the practices. Although each state's laws governing the right to die differ, they all rest on the same core concepts, including patient autonomy, informed consent, and the constitutional rights to privacy and personal liberty.[436]

5.2.1 Oregon

In November 1994, Oregon voters approved the citizen-sponsored Death with Dignity Act (DWDA) with 51% of the vote. The Ninth Circuit Court of Appeals lifted the legal injunction on October 27, 1997, after proceedings that included a petition that was denied by the United States Supreme Court. A proposal to repeal the Death with Dignity Act was put on the general election ballot in Oregon in November 1997. (Measure 51, authorized by Oregon House Bill 2954). By a 60% to 40% margin, voters rejected this proposal, keeping the Death with Dignity Act in place. The DWDA was renewed by voters in 1997, and Oregon was the first state to approve this practice. On November 6, 2001, United States Attorney General John Ashcroft

[430] Kevin M. Simmons, "Suicide and Death with Dignity" 5(2), *Journal of Law Bioscience*,436–439, (2018).
[431] Oregon Death with Dignity Act, 1997 (United States)
[432] Washington Death with Dignity Act, 2008 (United States)
[433] Vermont Patient Choice and Control at End-of-Life Act, 2013 (United States)
[434] New Mexico and Montana have allowed the practice of physician assisted suicide through case laws.
[435] *Ibid.*
[436] *Gonzales v. Oregon*, 546 U.S. 243 (2006) (United States Supreme Court)

released a new interpretation of the Restricted Medications Act, barring doctors from prescribing controlled substances for DWDA use. The Oregon DWDA was upheld after many hearings and appeals and is still in place today.[437]

Because of the Death with Dignity Act, physician-assisted suicide (PAS) is permitted there. The following conditions must be met: the patient must be in extreme pain; the patient must consistently request that a doctor give drugs to end his or her life; and the medications must be administered by the patient himself. The Oregon Hospice Association recognizes that palliative care and assisted dying may coexist in Oregon. It now takes a neutral position on this subject. Doctors must provide patients with all of their palliative care choices when they desire assisted suicide. To conduct and supervise the practice of PAS, the State has established stringent regulations. The State's Health Division must publish a yearly report on this practice. Thus, it may be concluded that a competent adult, who resides in Oregon, has a terminal illness, and wishes to willingly end his or her life is allowed to do so. The process is to submit a written request for medication with the intention of ending the person's life in a compassionate and dignified manner. The request for medication must be submitted using the specified form, and it must be signed and dated in the presence of the patient by a minimum of two witnesses who have attested to the patient's competence, free will, and lack of undue influence. The United States Supreme Court further strengthened the protections for doctors with its ruling in the following case.[438]

Gonzales v. Oregon[439]

The U.S. Supreme Court ruled in this case in 2006 that the Federal Controlled Substances Act does not give the U.S. Attorney General the authority to forbid doctors from prescribing controlled substances to be used in physician-assisted death as defined by Oregon law. Therefore, according to the strict procedure outlined by Oregon's PAS law, doctors are permitted to administer medications to patients who want to commit themselves.

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[437] Derek Humphry*, The Right to Die: Understanding euthanasia,* (The Hemlock Society, Eugene, Oregon, First Hemlock Society edn,1990).
[438] J. Donald Boudreau, Margaret. A. Somerville, "Euthanasia is not medical treatment" ,106(1), *British Medical Bulletin,*45–66, (2013).
[439] 546 US 243 (2006)

5.2.1.1 Eligibility criteria for the patient. Oregon citizens 18 and older who are mentally capable adults with a terminal disease and a prognosis of six months or fewer to live can make an oral request to a physician and acquire a fatal dose of medication to expedite their death. On March 29, 2022, Oregon stopped requiring residency. The Act requires a second opinion, written and oral requests, and other provisions.

5.2.1.2 Protocol of the physician

1. The treating physician must be licensed in the state where the patient resides.
2. The physician's diagnosis must include a terminal illness with a life expectancy of six months or less.
3. A consulting physician must certify the diagnosis, as well as that the patient is mentally competent to make and communicate health-care decisions.
4. If either doctor believes the patient's judgement is compromised, the patient must be referred for a psychological evaluation.
5. The attending physician must inform the patient of available options, such as palliative care, hospice, and pain management.
6. The attending physician must ask the patient to inform their next of kin about the prescription request.

5.2.2 Montana

Aid-in-dying is legal in Montana through a state supreme court decision. A decision issued by the Montana Supreme Court in the Baxter v. Montana case on December 31, 2009, allowed the practice in the state. In 2009 Robert Baxter, a 75 years old retired truck driver suffering from lymphocytic leukaemia, posthumously won his claim against the state of Montana that he had a right to die with dignity. According to the Montana Supreme Court, this should have extended to offering protection from liability under the state's homicide laws to a physician who prescribed him lethal medication.[440] In this instance, it was determined that doctors cannot be held accountable for helping their patients commit suicide. The rights provided by the state's living will law served as the foundation for this decision. The Montana Supreme Court rejected the state law's ruling by a vote of five to two despite the

[440] Emily Jackson and John Keown, *Debating Euthanasia*,2-4 (Hart Publishing, Oxford and Portland, Oregon,2012).

Attorney General of the state of Montana's request for an appeal. However, by not deciding whether the state's constitution guaranteed the right, the Court limited the reach of its ruling.[441] In Montana, the following conditions must be satisfied to qualify for PAS:

a. is a mentally competent adult;
b. is a resident of this state;
c. must be experiencing a terminal illness;
d. must have voluntarily expressed the desire to die;
e. submit an oral request and a written request to the attending physician;
f. reiterate the oral request after the necessary waiting period has passed; and
g. the patient's mental competency must be confirmed by two doctors (or referred to a mental health evaluation).

Two medical professionals must confirm that the patient has a terminal illness and has less than six months to live. The patient's demands must be made voluntarily, without compulsion, and supported by two doctors. All additional choices, including palliative and hospice care, must be explained to the patient. There is a 15-day waiting period between the original oral request and the written request. The time between the written request and the prescription's writing is 48 hours. Two witnesses, at least one of whom is neither linked to the patient nor employed by the healthcare facility, must sign the written request. The patient is urged to talk to their family members (not mandatory because of confidentiality laws). The patient has the freedom to alter their decision at any time and revoke the request. The patient's death certificate may be signed by the attending physician, and it must list the patient's underlying terminal illness as the cause of death.

In order to address the lack of official legislation, a bill to criminalize PAS was introduced in 2011. In the same month, a different bill that would have legalized and controlled PAS was introduced. The state Senate rejected both legislations. In 2013, two similar measures were introduced, but neither was successful. A bill to criminalize PAS was narrowly but successfully approved in the Montana House in

[441] Helena, "Mont. court: State law doesn't prevent assisted suicide", *The Spokesman-Review,* December 31, 2009.

March 2015, but it was again defeated in the Senate. Since there are no reporting requirements, there is no data on whether PAS has been implemented in the state.[442]

5.2.3 Vermont

The Vermont Legislature adopted the Patient Choice and Control at End-of-Life Act in May 2013.[443]

5.2.3.1 Eligibility criteria for the patients. Adults in Vermont who are mentally competent and have a terminal disease with a prognosis of six months or fewer to live may request verbally that a doctor give them a lethal dose of medication to accelerate their death. A second opinion, written and oral requests, and other requirements are stipulated in the Act.[444]

5.2.3.2 Protocol of the physician. The treating doctor needs to be authorized to practice in the patient's state. The medical professional's diagnosis must include a terminal illness with a prognosis of six months or less. A consultant physician must confirm the diagnosis and the patient's mental capacity to understand and communicate healthcare choices. A psychological evaluation of the patient is required if either doctor finds that the patient's judgement is impaired. The patient must be made aware of alternatives, such as palliative care, hospice care, and pain control choices, by the attending physician.[445]

5.2.4 California

The California End of Life Option Act, a bill that legalised the practise, was approved by the state legislature in September 2015, and Governor Jerry Brown signed it into law on October 5, 2015, making California the second state to do so through the legislature and the fifth state overall to permit medical aid in dying. The Act went into

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[442] Linda Ganzini, Heidi D. Nelson, et. al., "Physicians' Experiences with the Oregon Death with Dignity Act" 342(8), *New England Journal of Medicine*, 557-563, (2000)

[443] Vermont Legislature. (2013), title 18 health, V.S.A. Chapter 113 - Patient Choice at End of Life;Vermont Legislature. No. 39. (last visited on November 27, 2022)

[444] Terri Hallenbeck, "Vermont adjusts to new way of dying". *USA today* 6B–9B, (July 14, 2013), (last visited on December 7, 2022)

[445] Vermont Ethics Network "Medical Aid-In-Dying, Act 39: Patient Choice and Control at the End of Life, Advancing Health Care Ethics" available at- https://vtethicsnetwork.org/palliative-and-end-of-life-care/medical-aid-in-dying-act-39// (last visited on November 27, 2022)

effect on June 9, 2016.[446] The only difference between the Act and Oregon's is that doctors must possess a United States Drug Enforcement Administration certificate.[447] The process of passing the law was found to be unconstitutional in May 2018 by Judge Daniel A. Ottolia of the Superior Court of Riverside County, but the statute was reinstated the following month by a state appeals court[448].

5.2.4.1 Eligibility criteria for the patients. In order to request an oral deadly dose of medication from a doctor to speed up their death, California residents must be adults at least 18 years old with a terminal illness and a prognosis of six months or fewer to live. The Act requires the person to be physically and mentally capable of self-administering the aid-in-dying drug.

5.2.4.2 Protocol for the Physician. The attending physician must hold a current United States Drug Enforcement Administration (USDEA) certificate and be licensed in the same state as the patient. The medical professional's diagnosis must include a terminal illness with a prognosis of six months or less. A consultant physician must verify the diagnosis and the patient's mental capacity to understand and communicate medical decisions. A psychological evaluation of the patient is required if either doctor finds that the patient's judgement is impaired. The attending physician must inform the patient of alternatives, such as palliative care, hospice care, and pain management options.[449]

5.2.5 New Jersey

The Aid-in-dying for the Terminally Ill Act was submitted by state senator Nicolas Scutar in January 2018.[450] On March 25, 2019, the State Assembly approved the legislation, and on April 12, 2019, Governor Phil Murphy signed it into law, making

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[446] Patrick McGreevy, "After struggling, Jerry Brown makes assisted suicide legal in California," "Gov. Brown signs bill legalizing medically-assisted suicide for terminal patients",*Los Angeles Times*,(October 5, 2015). Available at- https://fox5sandiego.com/news/gov-brown-signs-bill-legalizing-medically-assisted-suicide-for-terminal-patients/ (last visited on November 9, 2022)

[447] Kerry Benefield, "Benefield: Some medical providers don't participate in California's End of Life Option Act. Here's why" *The Press Democrat*, July 14, 2022, available at - https://www.pressdemocrat.com/article/news/benefield-some-medical-providers-dont-participate-in-californias-end-of (last visited on November 9, 2022)

[448] John Rogers "State Appeals Court Reinstates California's Right-To-Die Law*", The Washington times* June 15, 2018.

[449] Wesley J. Smith, "California Assisted-Suicide Law Unconstitutionally Enacted" *National Review*, May 16, 2018

[450] Senate no. 1072 State of New Jersey,218th LEGISLATURE, January 22, 2018, available at- https://pub.njleg.gov/Bills/2018/S1500/1072_R1.HTM (last visited on November 9, 2022).

New Jersey the seventh state to permit assisted suicide. The legislation became operative on August 1, 2019.[451]

5.2.5.1 Eligibility criteria of the patients. Adults in New Jersey who are mentally competent and have a terminal illness with a prognosis of six months or less to live may make an oral request to a doctor for a fatal dose of medication to hasten their death. This request must be made in person. The Act stipulates requirements such as a second opinion, written and oral requests, and other clauses.

5.2.5.2 Physician Protocol. The treating physician must hold a license in the patient's state. The medical practitioner must include a terminal illness with a prognosis of six months or fewer in their diagnosis. A consultant physician must certify the diagnosis and the patient's capacity for communicating and making healthcare decisions. A psychological evaluation of the patient is required if either doctor finds that the patient's judgement is impaired. The attending physician must inform the patient of alternatives, such as palliative care, hospice care, and pain management options. The patient's next of kin should be informed of the prescription request, as advised by the attending physician.

5.2.6 New Mexico

In January 2014, a New Mexico court approved the procedure in Bernalillo County; however, this decision was overturned on August 11, 2015, upholding the state's ban on assisted suicide.[452] After being approved by the New Mexico Legislature, the Elizabeth Whitefield End-of-Life Options Act legalized assisted suicide in the state on April 8, 2021, when it was signed into law by Governor Michelle Lujan Grisham. The law permits patients with six months or fewer to live who are terminally ill to request lethal drugs. Two medical practitioners must concur on the patient's diagnosis and the patient must pass a mental competency test before lethal medications can be given to

[451] Julia Jacobo, "New Jersey governor signs law allowing terminally ill patients to end their lives",*abc NEWS,* April 14, 2019, available at- https://abcnews.go.com/US/jersey-governor-signs-law-allowing-terminally-ill-patients/story?id=62391589 (last visited on November 9, 2022).
[452] Valerie Richardson, "Assisted suicide New Mexico ruling struck by higher court" *The Washington Times*, August 11, 2015

the patient. The patient must take the drug themself following a 48-hour waiting period. The law became operative on June 18, 2021.[453]

5.2.6.1 Patient Eligibility. Adults in New Mexico who are mentally competent and have a terminal illness with a prognosis of six months or fewer to live may request in writing a lethal dose of medication from a doctor to expedite their death. These individuals must be 18 years of age or older.

5.2.6.2 Physician Protocol. The prescribing healthcare professional determines that the patient is able to make decisions about their own healthcare. The prescribing doctor certifies that the patient is either registered in a health - care facility or that another doctor has verified the patient's diagnosis and prognosis. The healthcare professional who prescribed the drug testifies that the patient is competent to self-administer the lethal medication. If the prescribing or consulting healthcare professional believes the patient's judgement is impaired, the patient undergoes a psychological assessment. The prescribing professional verifies that the patient's request was not made under duress or with undue influence from others. The prescribing healthcare professional informs the patient of viable alternatives to the medicine, including pain relief and comfort treatments. Before issuing the prescription, the prescribing practitioner gives the patient a chance to withdraw the request for an aid-in-dying drug.

5.2.6.3 Patient Request Timeline. The patient presents their healthcare professional with a written request signed in the presence of two competent adult witnesses. The particular form that the patient must use is provided by law.

5.2.7 Colorado

The Colorado House saw the introduction of an assisted suicide legislation in 2015 by Representatives Lois Court and Joann Ginal. In committee, the bill failed 8–5. Julie Selsberg and Jaren Ducker submitted an initiative to the secretary of state in April 2016 with the goal of getting medical aid-in-dying approved by voters in November

[453] Cedar Attanasio, "New Mexico latest state to adopt medically assisted suicide", *The Washington Times*, April 8, 2021.

2016. Colorado voters approved Proposition 106 on November 8, 2016, legalizing assisted suicide for those suffering from a terminal illness.[454]

5.2.7.1 Patient Eligibility. Colorado residents who are 18 years of age or older, mentally competent individuals, and who have a terminal illness with a prognosis of six months or fewer to live may voluntarily make an oral request and acquire a lethal dose of medication from a doctor to speed up their demise.

5.2.7.2 Physician Protocol. The patient must have a terminal illness with a prognosis of six months or fewer, be mentally competent to make an informed decision and make the choice willingly, according to the doctor's diagnosis. The patient must provide proof of Colorado residency at the doctor's request. The patient must be sent to a consulting doctor to verify the diagnosis and competence. A medical diagnosis and prognosis of six months or less to live must be discussed with the patient, as well as any viable alternative or further treatments, hazards associated with using aid-in-dying drugs, and the potential that the patient may fill the prescription but decide not to use it. The patient must be referred by the physician to a licensed mental health professional. The doctor must request the patient's notification of their next of kin on the prescription request.

5.2.8 District of Columbia

The Death with Dignity Act of 2015 was proposed by Mary M. Cheh, a member of the D.C. Council, in January 2015.[455] The D.C. Committee on Health and Human Services passed the Death with Dignity Act on October 5, 2016, by a 3-2 vote. On November 1, the D.C. Council voted 11-2 to pass the Death with Dignity Act. After that, the mayor and the council had a second vote on it. The legislation was approved on December 23 by Mayor Bowser.[456] After the 30-day U.S. Congress review period required under the federal Home Rule Act, and after Congressional Republicans were

[454] Jennifer Brown, “Colorado passes medical aid-in-dying, joining five other states" *The Denver Post,* November 8, 2016
[455] Mike DeBonis, “Death with Dignity laws are proposed, bringing national debate to D.C. and Md" *The Washington Post,* January 16, 2015.
[456] Bradford Richardson, "'Death With Dignity Act' clears first hurdle as D.C. weighs physician-assisted suicide”, *The Washington Times,* October 5, 2016

unable to stop the legislation, the law became effective on February 18, 2017, making D.C. the seventh state or territory in the U.S. to allow this.[457]

5.2.8.1 Patient Eligibility criteria. A District of Columbia resident who is diagnosed with a terminal illness that will cause death within six months and who is capable of conveying their own health care preferences.

5.2.8.2 Physician Protocol. The attending doctor has to have a DC license. The doctor's diagnosis must include a terminal illness with a prognosis of six months or less. A consultant physician must validate the diagnosis and the patient's mental capacity to understand and convey medical decisions. A psychological evaluation of the patient is required if either doctor finds that the patient's judgement is compromised. The attending physician must inform the patient of alternatives, such as palliative care, hospice care, and pain control options.

5.2.9 Hawaii

Based on the models of Oregon and Washington states, assisted dying has been permitted in Hawaii since 2019. On April 5, 2018, Governor David Ige authorized medical assistance in dying.[458] The law includes safeguards to prevent abuse, such as the requirement that a patient's diagnosis, prognosis, ability to make decisions, and that the patient's request is voluntary be confirmed by two healthcare professionals, as well as the requirement that a counsellor determines that the patient does not have conditions that may impair decision-making, such as untreated depression. The patient must sign a written request attested by two persons, one of whom must be a family, and make two spoken requests for the life-ending drug, followed by a 20-day waiting period. Anyone who attempts to persuade someone to take medication that will terminate their life or tampers with the patient's request is subject to criminal punishment.[459]

5.2.9.1 Patient Eligibility. A person who lives in Hawaii, is at least 18 years old, is able to communicate their own health care needs, and has been identified as having a terminal illness that will cause death within six months.

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[457] Bradford Richardson "D.C. physician-assisted suicide law goes into effect", *The Washington Times*, November 15, 2016.
[458] Sophia Yan, "Medically assisted suicide becomes legal in Hawaii" *apnews.com.* April 6, 2018.
[459] *Ibid.*

5.2.9.2 Physician Protocol. A terminal disease with a prognosis of six months or less must be mentioned in the doctor's diagnosis. A consultant physician must verify the diagnosis and the patient's mental capacity to understand and communicate medical decisions. The patient's capacity and the absence of depression or other conditions that can impair their ability to make wise judgments must be confirmed by the counsellor. The attending physician must inform the patient of alternatives, such as palliative care, hospice care, and pain control options.

5.2.10 Maine

Representative Patricia Hymanson introduced the Maine Death with Dignity Act in the state assembly in 2019. The legislation was approved by the Senate 19 to 16 and the House 73 to 72. The Maine Death with Dignity Act was enacted on June 12, 2019, by Governor Janet Mills, making Maine the eighth state in the USA to legalize assisted suicide.[460] In a very tight vote in June 2019, the Maine Legislature approved a measure to allow assisted suicide. In the same month, the measure was approved by the governor of Maine.[461]

5.2.10.1 Patient Eligibility. The patient must have a terminal illness that will result in death within six months, be a resident of Maine, be 18 years of age or older, and be competent of communicating and making decisions about their own health care. They must be cognitively and physically able to self-administer the lethal drug.

5.2.10.2 Physician Protocol. The patient must have a terminal disease with a prognosis of six months or fewer, be mentally competent to make an informed decision and make the choice willingly, according to the doctor's diagnosis. The patient must provide documentation of Maine residency upon request from the doctor. To ensure that the patient is acting willingly and that the diagnosis and competency have been established, the patient must be referred to a consulting physician. A medical diagnosis and prognosis of six months or less to live must be discussed with the patient, as well as any viable alternative or further treatments, hazards associated with using aid-in-dying drugs, and the potential that the patient may fill the prescription but decide not to use it. The doctor must recommend the patient to a

[460] Governor Mills Signs Death with Dignity Act, June 12, 2019, available at-https://www.maine.gov/governor/mills/news/governor-mills-signs-death-dignity-act-2019-06-12// (last visited on November 9, 2022)
[461] Lydia Libby, "Governor Mills signs Death with Dignity bill", *News Center Maine*, June 12, 2019.

competent mental health professional if necessary. The doctor must advise the patient to let their kin know about the prescription request. The need to take the drug privately with a witness must be explained to the patient.

5.2.11 Washington

If terminally ill individuals should be permitted to obtain physician help in dying was the subject of a ballot question in 1991. With 46% of the vote, the initiative was defeated.[462] However, Washington voters adopted the Death with Dignity Act by a vote of 58% to 42% in the general election of November 2008. This law would grant civil immunity to terminally ill, competent adult Washington citizens who are expected to die within six months and who request and administer lethal drugs on their own. The legislation calls for a waiting time, physician confirmation of an informed patient decision, two oral and one written request, two diagnoses and determinations of the patient's competency from different doctors. Criminal and civil immunity would be granted to medical professionals, patients, and others acting in good faith compliance.[463]

5.2.11.1 Patient Eligibility. A Washington resident who is at least 18 years old, is competent to communicate their own health care needs, and has been given a terminal condition that will cause death within six months.

5.2.11.2 Physician Protocol. The treating physician must hold a license in the patient's state. The medical professional's diagnosis must include a terminal illness with a prognosis of six months or less. A consultant physician must validate the diagnosis and the patient's mental capacity to understand and convey medical decisions. A psychological evaluation of the patient is required if either doctor finds that the patient's judgement is impaired. The attending physician must inform the patient of all available options, including palliative care, hospice care, and pain management options. The patient's next of kin must be informed of the prescription request per the attending doctor's request.[464]

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[462] George J. Annas, "Death by Prescription" 331 (18), The New England Journal of Medicine, NEJM Groups, 1240–1243, (1994)
[463] The Washington Death with Dignity Act,2008
[464] States with Legal Medical Aid in Dying (MAID), available at- https://euthanasia.procon.org/states-with-legal-physician-assisted-suicide// (last visited on November 9, 2022)

5.2.12 Execution of Living Will or Advanced Directive in The United States of America

Advance medical directives are a notion that has evolved in many nations to address the issue of patients who cannot express their wishes when making a decision. The legal recognition of advanced medical directives has been established by legislation in several jurisdictions and judicial decisions in other nations. The great majority of US states have laws requiring doctors to carry out their patients' requests as stated in their advance directives. The first state to formally recognize living wills was California. In order to safeguard the core ideas of self-autonomy and self-determination, the US Congress passed the Patient Self Determination Act (PSDA) in 1990. The patient's right to accept or reject medical care was recognized by this statute. Following these, legislation allowing advance directives were passed in all 50 states. In addition, a few US states allow patients to choose a health care proxy which only takes effect when the patient cannot make decisions for themselves. Several directives have developed over time to deal with the complexities and difficulties related to a document as complicated as an advance directive. The "will to live," an alternative to a living will be created by the National Rights to Life Committee (NRLC) in the US, protects the lives of those who choose to accept life-sustaining care rather than refuse it. When the patient's will cannot be ascertained with confidence, and the courts order the discontinuation of life-sustaining care because they believe the patient's life is not valuable, this type of active declaration becomes more significant. Another measure for locating and gaining access to the patient's advance directive was the establishment of the US living will registry. According to this concept, the hospital administration was required to inquire about patients' advance directives before admitting them and to record that information on their medical records. The Ulysses Clause, which protects if a patient experiences a relapse in their condition—in this case, schizophrenia—and refuses treatment they otherwise would not have refused—was one of the unique powers of the advance directives that Virginia pioneered.

The Florida Department of Health developed the Do Not Resuscitate Order (DNRO), a sort of advance directive, to identify people who do not wish to be revived in the event of respiratory or cardiac arrest. When paramedics in Florida brought in an unconscious patient with the words "Do Not Resuscitate" tattooed on his chest, the doctors were not sure whether the message meant they should not give the patient any

medical care. Ultimately, the doctors decided against performing any medical procedures, and the patient died. In this case, the complexity of the issues illustrates the dynamics inherent in the concept of advance directives.[465]

5.3 The Netherlands

In 2002 the Netherlands was the first nation to have physician-assisted suicide (PAS) and euthanasia legal under certain circumstances.[466] Regarding right-to-die law, the Netherlands is one of the most progressive countries.[467] Two Articles of the Dutch Criminal Code expressly and apparently forbid euthanasia. Article 293 forbids the execution of a person who requests it. Article 294 prohibits aiding in suicide (suicide itself is not a crime in Dutch law). The courts have determined that article 40 of the Criminal Code allows a doctor prosecuted under Articles 293 or 294 to raise a defence of justification, despite the text of these clauses appearing to be prohibitive.

The first acquittal occurred in 1983, and the Dutch Supreme Court upheld it in the Schoon Heim case in 1984. The Supreme Court held that a doctor could invoke the justification due to necessity defence if, when faced with a choice between providing care as required by the Criminal Code and his duty to a patient whose suffering is "unbearable and hopeless," his decision was "objectively justified". The decision in Schoonheim sparked a series of judicial decisions in which the requirements and restrictions of the defence were gradually clarified.[468] Over time, the Netherlands' case law has established that the penalty and sanctions applied in euthanasia and assisted dying cases should be handled differently from cases of murder and culpable homicide. As a result, the punishment for euthanasia and assisted dying cases should be comparatively less severe.[469] The term "euthanasia" has a more limited meaning in The Netherlands; it only refers to the deliberate taking of a person's life at the request of another person (also known as active, voluntary

[465] Do Not Resuscitate Order, available at- https://www.floridahealth.gov/about/patient-rights-and-safety/do-not-resuscitate/index.html// (last visited on November 9, 2022)
[466] John Griffiths, Alex Bood, et.al., *Euthanasia and Law in the Netherlands*, (Amsterdam University Press, 1998).
[467] Nicole Steck, Matthias Egger, et. al, "Euthanasia and Assisted Suicide in Selected European Countries and US States: Systematic Literature Review" 51(10), *Medical Care*,938-944, (2013).
[468] John Griffiths, Alex Bood, et.al., *Euthanasia and Law in the Netherlands,* (Amsterdam University Press, 1998).
[469] Criminal Code of the Kingdom of Netherlands (1881, amended 2012), art. 293, 294

euthanasia).[470] The first euthanasia case was brought to a Dutch court in 1952. The Eindhoven doctor who administered medications and a morphine injection to his brother, who had serious TB, was found guilty of life termination on request, a crime punishable under criminal law. The doctor's brother had advanced TB, and when the discomfort grew terrible, he asked to be permitted a wish to die. Even though the doctor was found guilty of murder on the request in violation of Article 293, the court merely sentenced him to one year of probation, which for the first time indicated a lenient stance on the matter. He received a one-year conditional prison sentence.[471] In a different case, Mia Versluis, a 21-year-old woman who was comatose, was kept on artificial respiration in 1969. In this instance, the patient's father voiced his disapproval and argued for removing his daughter from the treatment. The Constitution of Appeal found the doctor guilty of removing the breathing tubes. He received a 1,000 pound fine from the court of appeal for his actions, which were detrimental to the healthcare profession.[472] Thereafter, the so-called Schoon Heim case—the first euthanasia case to make it to the Supreme Court—took place (1982). The procedure took five years to finish. In 1987, the Supreme Court made a ruling on this matter. The defence of necessity was successfully used in opposition to a charge of ending a life on request for the first time. A pragmatic tolerance policy was implemented toward euthanasia and PAS up to 1999 based on further legal precedent.

5.3.1 The Postma Case[473]

The Dutch Penal Code defines euthanasia as a crime. However, it is not classified as murder (as in some other countries) but is instead dealt with in a distinct section of the law. According to Article 293, anybody who takes another person's life at his express and sincere request would be penalized by imprisonment for a maximum of 12 years. A 1973 court case catalyzed the Dutch discussion over euthanasia (the same year in which the Dutch Society for Voluntary Euthanasia was formed). The Court of Leeuwarden in the Netherlands looked at the landmark Postma case, in which a

[470] Robert J M Dillmann, "Euthanasia in The Netherlands: The Role of the Dutch Medical Profession"5(1), Cambridge Quarterly of Healthcare Ethics,1996, Cambridge University Press, 100-106, (1996)
[471] Sjef Gevers, "Euthanasia: law and practice in The Netherlands" 52(2), British Medical Bulletin,326-333, University of Amsterdam, Amsterdam, The Netherlands, (1996).
[472] Ron LP Berghmans, Guy. A. M. Widdershoven, "Euthanasia in the Netherlands: Consultation and Review," 23(2), *King's law journal KLJ* ,109-120, (2012).
[473] Derek Humphry, *The Right to Die: Understanding euthanasia*, 170-180. (The Hemlock Society, Eugene, Oregon, First Hemlock Society edn,1990).

physician gave his mother, who was ill, a dosage of morphine.[474] According to reports, his mother had a brain haemorrhage, had speech impairment, nearly no hearing, and was permanently tethered to her wheelchair to prevent falls when walking or standing.[475] Postma's mother's health was deteriorating daily, and she frequently asked her children to assist her in ending her life. Andries Postma and his wife, both physicians, then gave their mother 200 milligrams of morphine by injection. Postma's wife administered the medication.[476] The Leeuwarden court found her guilty, not because she hastened the death of her mother (who was incurably ill and suffered excruciatingly), but rather because she killed her directly rather than increasing the doses of morphine, which would have had the additional effect of shortening the patient's life. She received a year of probation and a one-week suspended sentence from the court. The court found Postma guilty of murder, but instead of imposing the standard penalty of 12 years in prison, which would have applied in this case, the court gave Postma a week in imprisonment and a year on probation.[477] The court held that a doctor is not always required to keep a patient alive and should consider the patient's wishes and current level of suffering.[478] Many commentators have viewed this case as the foundation of a progressive legal system that respected an individual's right to self-determination and encouraged the values of a peaceful and dignified death in the Netherlands.[479] In later decisions, the courts no longer exclude the possibility that a doctor contributed directly to the patient's death, but they have expanded the standards set in the Leeuwarden decision and added some new requirements.

5.3.2 The Alkmaar Case

Nearly ten years after the Postma case, the Dutch Supreme Court delivered a significant decision in another crucial case in 1984. In this case, similar circumstances

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[474] Julie A DiCamillo, "A Comparative Analysis of the Right to Die in the Netherlands and the United States After Cruzan: Reassessing the Right of Self-Determination" 7(4), *American University International Law Review*, 807-842, (1992)

[475] Tony Sheldon, "Euthanasia Law Does not end Debate in The Netherlands" 307(6918), *British Medical Journal*, 1511-1512, (1993).
[476] Lukas Radbruch, Carlo Leget et. al., "Euthanasia and Physician-assisted Suicide: A White Paper from the European Association for Palliative Care" 30(2), *Palliative Medicine*,104-116, (2016).
[477] John Griffiths, Alex Bood, et.al., *Euthanasia and Law in the Netherlands*, 5 (Amsterdam University Press, 1998).
[478] *Ibid*.
[479] Margaret Otlowski, chapter 7, The Netherlands2000, p.no.391-455

forced the court to decide on the execution of euthanasia on a patient suffering from a terminal illness.[480] In this case, the doctor executed an 85-year-old patient whose condition was worsening and who had expressed that he wished to die in a dignified manner. In this case, the court deviated from the precedent set in the Postma case and determined that the doctor was innocent and not legally liable rather than condemning him and giving him a reduced sentence. Euthanasia is generally illegal and punished, but the court ruled that in this specific case, the "principle of necessity" must be given appropriate consideration.[481] The medical professional's duty to save the patient's life must be weighed against the patient's deteriorating health and the frequent and repeated requests for a dignified death. The Court acknowledged that doctors had to make judgments that could conflict with those required by the medical profession in this challenging situation. The Court stated that in certain circumstances, if there were reasonable objective justifications and if the doctors or medical experts acted out of necessity, then less severe punishment, or none at all, should be awarded.[482] The Court concluded that the conviction in this case by the lower courts was not supported by a thorough inquiry, and it did not consider whether a reasonable medical opinion would have concluded that the patient's euthanasia was necessary in this case. The patient's health status and repeated requests for a dignified death were taken into account by the Court of the Hague, which decided that the doctor acted out of necessity and was not criminally liable.[483] The verdict in the Alkmaar case had a significant impact on the Dutch debate about euthanasia. Following this decision, the Royal Dutch Medical Association released guidelines for all medical professionals to abide by in the event that their patients requested euthanasia. The practice of assisted suicide or euthanasia was permitted under the restrictions, but only if the guidelines were strictly followed.[484] According to the guidelines, a patient who is capable and fully aware of the consequences must willingly request euthanasia. The patient's health should be deteriorating, and the sufferer should be going through terrible, hopeless misery. The existence of any better medical alternatives than euthanasia to

[480] Jos V.M. Welie, "The Medical Exception: Physicians, Euthanasia and The Dutch Criminal law" 17(4), *The Journal of Medicine and Philosophy* ,419-437, (1992).
[481] John Keown, "Euthanasia in the Netherlands: Sliding down the Slippery Slope"9, *Notre Dame Journal of Ethics & Public Policy*,407, (1995).
[482] Sjef Gevers, "Euthanasia: law and practice in The Netherlands" 52(2), *British Medical Bulletin*,326-333, University of Amsterdam, Amsterdam, The Netherlands, (1996).
[483] *Ibid.*
[484] Sjef Gevers, "Euthanasia: law and practice in The Netherlands" 52(2), *British Medical Bulletin*,326-333, University of Amsterdam, Amsterdam, The Netherlands, (1996).

relieve suffering and give a dignified death should be investigated by independent medical professionals.[485]

5.3.3 The role of the End-of-Life Clinic

In 2012, the Netherlands association for voluntary euthanasia (NVVE) founded an independent 'End-of-Life Clinic 'for patients who had requested euthanasia.[486] The Society's key objective was to enhance freedom of choice at the end of life. It believed that the room the law offered for people who were suffering and wanted to end their life was not being utilized sufficiently by physicians[487]. The End-of-Life Clinic aimed to offer euthanasia—within the limits of the law—to people whose treating physician rejected their request for euthanasia or assisted suicide.[488] It had ambulant teams of physicians and nurses for this purpose. Their physicians were known to be less reticent regarding euthanasia in case of mental suffering than other Dutch physicians.[489] Because its primary goal was to grant a euthanasia request in cases of intolerable suffering without the chance of improvement, as allowed by the euthanasia statute, the End-of-Life Clinic appeared to reinforce and enhance the emphasis on the autonomous wish of the patient in euthanasia practice.[490] However, if care is considered in a broader context than just fulfilling the patient's autonomous wish to die, what fits into the law may not necessarily be the best possible care.

5.3.4 Self-help Method

Another striking trend in the Netherlands is the increasing publicity about self-help methods for people who wish to kill themselves. A movie directed by the psychiatrist Dr Chabot in 2012 described how someone could use helium to commit suicide. Chabot had advocated for self-administered euthanasia using techniques like

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[485] Agnes van der Heide, Bregje D Onwuteaka-Philipsen, et. al., "End-of-life Practices in the Netherlands Under the Euthanasia Act" 365(19), *New England Journal of Medicine*,1957-1965, (2007).
[486] John Wyatt, *Right to Die? Euthanasia, assisted suicide and end of life care*,40 (Inter- Varsity Press, England,2015).
[487] "The NVVE is committed to freedom of choice at the end of life", January 19, 2023, Over NVVE Organisatie. Nederlandse Vereniging voor een Vrijwillig Levenseinde. Available at- https://www.nvve.nl/over-nvve/organisatie// (last visited on November 25, 2022)
[488] Pauline S. C. Kouwenhoven, Ghislaine van Thiel, et.al., "Developments in euthanasia practice in the Netherlands: Balancing professional responsibility and the patient's autonomy" 25(1), *The European Journal of General Practice*,1-5, (2018)
[489] Marianne C Snijdewind, Dick L Willems, et. al., "A study of the first year of the end-of-life clinic for physician-assisted dying in the Netherlands" 175, *JAMA Intern Med*, 1633–1640, (2015).
[490] Dutch "Termination of Life on Request and Assisted Suicide (Review Procedures) Act", 2002.

gradually assembling a fatal mix of medications. However, he then released a film showing how inhaled helium could ensure rapid death from hypoxia.[491]

5.3.5 Discussions regarding the euthanasia law and completed life

In 2010, a public initiative arose to legalize assisted death for older people who considered their life completed. It was explicitly directed at the self-empowerment of the elderly.[492] Euthanasia or assisted suicide on the grounds of a completed life only, i.e., without serious illness, extends beyond the scope of the euthanasia law. In February 2016, an Advisory Committee on a Completed Life commissioned by the Ministry of Public Health published its report. The committee concluded that the current euthanasia law offers sufficient room to address most problems of older people who feel that their life is completed.[493] The government responded by stating that in order to give the elderly the ability to exercise autonomy over their death and to accommodate the (few) persons whose lives are complete and who prefer to pass away pain-free from any medical condition, a distinct legislative framework was desired.[494] These developments show a change in society in the direction of more self-empowerment and even towards a right to die. This change was confirmed in the latest Dutch evaluation of the euthanasia law.[495]

5.3.6 Legal position of doctors

Under current legislation, a doctor may end a patient's life provided they are confident that the patient's request was deliberate, thoughtful, and that the patient is experiencing "unremitting and excruciating" suffering. A firm conclusion that there is "no reasonable alternative" must have been made with the patient after the doctor

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[491] John Wyatt, *Right to Die? Euthanasia, assisted suicide and end of life care*,40 (Inter- Varsity Press, England,2015).
[492] Voluntarily Citizens' initiative Completed Life, The initiative,
Burgerinitiatief Voltooid Leven. Doel Uit Vrije Wil, Available at- www.uitvrijewil.nu. (last visited on November 25, 2022)
[493] Report of the Advisory Committee Completed Life. [Rapport Adviescommissie Voltooid Leven.] Den Haag: VWS; 2016, available at - https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6394318/ (last visited on November 25, 2022)
[494] Government's response and view on Completed Life [Kabinetsreactie en visie op Voltooid Leven] Letter from the ministers of Health [VWS] and Justice [Veiligheid en Justitie] to the Dutch parliament. Den Haag, available at - https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6394318/ (last visited on November 25, 2022)
[495] A van der Heide, B D Onwuteaka-Philipsen,et,al., [Fourth evaluation of the law on the review of termination of life on request and assisted suicide (Euthanasia Act)] 149(39), Ned Tijdschr Geneeskd, 2187-9,(2005),available at - https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6394318/ (last visited on November 25, 2022)

advised them of their clinical condition. The same diagnosis must have been reached after at least one more independent doctor examined the patient. The bill was approved by the Dutch Senate on April 10 by a vote of 46 to 28 to remove the last hurdle. Last October, the lower house's 2:1 vote in favour of decriminalization was viewed as a formality. Since Dutch physicians have been providing euthanasia to patients with terminal illnesses for at least 20 years, there will not be much difference in how things are done.

A law that required doctors to report any cases of assisted suicide to the authorities was adopted in 1994. If the doctor followed specific guidelines, the authorities would decide not to prosecute. Criminal laws still apply to assisted suicide and euthanasia. Three years in prison is the maximum sentence for assisted suicide while twelve years is the maximum term for euthanasia. As a result, a doctor is legally liable for prosecution.[496] Euthanasia is not a routine medical procedure, but doctors who carry out assisted suicide and euthanasia in a responsible manner will not be found guilty, according to recent judicial decisions. The Royal Dutch Medical Association welcomed the decision, saying it would end the "paradoxical legal position" and guarantee that medical professionals acting in good faith and with proper care would not be subjected to criminal prosecution. The "force majeure" that required the doctor to act serves as the legal basis for this judgement. The doctor must balance his or her responsibilities to the patient as a caregiver and the law as a civilian. Professional obligations compel the doctor to act against the letter of the law but in accordance with medical ethical principles and the express request of the patient who depends on him or her. When administering assisted suicide or euthanasia, a doctor must also adhere to ethical standards. These were made public by the Royal Dutch Medical Association's General Board in 1984, and court decisions have confirmed them. The following requirements must all be met in order to qualify: voluntary and persistent request; complete disclosure; unbearable and hopeless pain; absence of any other options; and consultation with another physician. In general, if a doctor follows these guidelines, they will not be penalized. In 1990, a notification procedure was decided upon by the Ministry of Justice and the Royal Dutch Medical Association. The doctor provides the medical examiner with a lengthy questionnaire

[496] Robert J M Dillmann, Johan Legemaate, “Euthanasia in the Netherlands: state of the legal debate”1, *European Journal of Health Law*, 81-87, (1994).

to demonstrate to them that natural death was not the cause of the death. The public prosecutor then decides whether or not to bring charges based on the information the medical examiner delivers to him or her.[497]

5.3.7 The Remmelink Report and the Van der Maas survey

The study by Han L J Van der Maas et al. was conducted at the request of the Remmelink committee, an inquiry committee that the government established in 1990 to look into medical decisions involving end-of-life care. Based on the committee's report, the administration published a new legislative proposal in November 1991, outlining its position towards upcoming legislation. The Lower House approved the plan on 9 February 1993, and the Senate approved it on 30 November 1993.[498] The new Act, which modified the Burial Act, was primarily procedural in nature. No changes were made to the penal code. The notification process for cases of assisted suicide and euthanasia, which was agreed upon in 1990, was outlined in regulations under the Burial Act and therefore received formal legal validity. The Act did not specifically address the need for careful medical practice concerning euthanasia. Since the legislator did not offer a canonical statement of these requirements, they must be derived from judicial decisions. Indirectly connected to the demands of careful medical practice, the regulations under the Burial Act will include an appendix with a questionnaire (to be completed by the doctor when reporting to the medical examiner).[499]

5.3.8 The Termination of Life on Request and Assisted Suicide (Review Procedures) Act, 2002[500]

Following judgements by the Dutch Supreme Court and recommendations from the Royal Dutch Medical Association, euthanasia became de facto authorized and permitted in the Netherlands. In 2001, the legislature approved a legislative statute recognizing euthanasia as a legitimate medical procedure. Euthanasia was approved and governed by the Termination of Life on Request and Assisted Suicide (Review

[497] Jacqui Wise, Bulletin of the World Health Organization, 79 (6), London, UK,2001.
[498] P J Van Der Maas, J J Van Delden et. al., "Euthanasia, and other medical decisions concerning the end of life" 338(8768), *Lancet*,669-674, (1991).
[499] Dr. Brian Pollard, "Euthanasia Practices in the Netherland", *Catholic Education Resource Center,* available at - https://www.catholiceducation.org/en/controversy/euthanasia-and-assisted-suicide/euthanasia-practices-in-the-netherlands.html// (last visited on November 25, 2022)
[500] Termination of Life on Request and Assisted Suicide (Review Procedures) Act,2002

Procedures) Act, 2001.[501] The "Termination of Life on Request and Assisted Suicide (Review Procedures) Act," sometimes known as "the euthanasia law," was introduced in 2002. Under this law, doctors who perform euthanasia are no longer punishable, provided they have followed the prescribed procedures and **due care criteria** and reported death by non-natural causes to the regional euthanasia review committee. The Act emphasizes the need to offer a dignified and respectful death and lays out the specific steps to be taken when euthanasia is administered. The Act also codified the guidelines that medical personnel must abide by and exempts them from criminal prosecution if they carry out euthanasia in accordance with those rules. The Dutch Penal Code was amended in response to the incorporation of this new law, and medical practitioners who carried out euthanasia in accordance with the new law were granted an exemption from prosecution.[502]

The new Act established stricter guidelines that must be followed while performing euthanasia. The new law's brief requirements were as follows:

- The patient must directly and voluntarily request euthanasia, free from any coercion.
- The patient must be in unbearable pain and have no chance or hope of recovery.
- The patient must be informed of the consequences of his or her request for euthanasia, and both the patient and the doctor must agree that there is no better alternative than to carry out the procedure. It is recommended to get an independent medical opinion before beginning any procedures, and this expert must conclude in writing that the patients' conditions require euthanasia after doing the appropriate medical examinations.[503]

Interestingly, Dutch law makes it essential for the patient's regular doctor to carry out any assisted suicide or euthanasia procedures. As the doctors in the Netherlands would not be their regular doctors, this indicates that persons from other jurisdictions cannot travel there to receive euthanasia.[504] The procedural report is another safety measure that has been put in place in the Dutch court system. The Act

[501] Termination of Life on Request and Assisted Suicide (Review Procedures) Act,2002.
[502] *Id.,* art. 20
[503] Jurriaan De Haan, "The new Dutch law on Euthanasia" 10(1), *Medical Law Review*, 57-75, (2002).
[504] Emily Jackson and John Keown, *Debating Euthanasia*,168 (Hart Publishing, Oxford and Portland, Oregon,2012).

establishes five regional review committees to oversee how assisted suicide and euthanasia are carried out across the nation. These panels are required to have one lawyer, one ethicist, and one physician on them.[505] A doctor, who has carried out euthanasia or assisted dying, has to provide a report to one of these committees once the life of the patient is terminated. Before choosing euthanasia or assisted suicide, the doctor must follow all the regulations outlined in the Act, and the committee's job is to determine if this was done. If the committee determines that all due care requirements have not been met and the Act's procedure has not been strictly followed, it will then submit a report and report with its findings to the Public Prosecutor's office. If the Public Prosecutor determines after careful consideration that a criminal wrong has been committed, they will conduct the required inquiries and then decide whether or not to charge the relevant doctor with a crime. According to the position in the Netherlands, the judiciary, the legislative, and the administration (in the shape of the Office of Public Prosecutor) have all significantly contributed to ensuring that a controlled form of euthanasia is permitted in the Netherlands. These organs of the state continue to ensure that the law is applied in accordance with its correct intent and that those who violate the law are duly prosecuted, tried, and punished.

5.3.9 Due Care Criteria

There are several so-called due care criteria in the Dutch euthanasia law. In the Netherlands, euthanasia and assisted suicide is punishable under Dutch criminal law unless a physician meets the criteria of due care stipulated by the Dutch euthanasia law. These are typically regarded as a summary of the case law because they have been codified after being established by the courts over the years.[506] The criteria of due care require that the physician

1) is convinced that the patient has made a voluntary and thoughtful request, and
2) is convinced that the patient is suffering excruciatingly with no hope of improvement, and
3) has informed the patient of his present circumstances and future prospects, and

[505] Termination of Life on Request and Assisted Suicide (Review Procedures) Act, 2001, art. 20
[506] Hilde Buiting, Johannes van Delden, et al., "Reporting of Euthanasia and Physician-Assisted Suicide in The Netherlands: Descriptive Study"10, *BMC Medical Ethics*, 18-24, (2009).

4) has jointly determined with the patient that there is no reasonable alternative solution to ease the patient's suffering, and
5) has consulted at least one independent physician, who visited the patient personally and has given a written assessment of the criteria of due care, and
6) has performed euthanasia or PAS with due medical care and attention.[507]

5.3.10 Execution of Advance Directive in the Netherlands

According to Article 2 of the Termination of Life on Request and Assisted Suicide (Review Procedures) Act, 2001, patients who are 16 years of age or older in the Netherlands may make advance directives. According to Article 7.450 of the Dutch Civil Code, an advance directive must be in writing, signed, and dated in order to be valid.[508] The Act accepts both oral requests and written directives (living wills) as valid. When a doctor decides to carry out a request for euthanasia when the patient can no longer communicate his wishes verbally, it is crucial to recognize written directives. In certain situations, a written directive is regarded as a well-reasoned request for euthanasia, but its existence never absolves the doctor of the responsibility to make his own judgement on the request in light of the statutory due care requirements. Any written directive must usually be given careful attention by the doctor. The only exception is if he has cause to suspect that the patient signed it without being able to assess his interests reasonably. The directive will not qualify as a request for euthanasia under the Act in that situation. If possible, the patient and doctor should go through the specifics of the instruction. The statutory provision for written directives enables patients to indicate in advance that they wish to have their lives ended if they eventually find themselves in circumstances that make it impossible for them to express their wishes personally, such as unbearable suffering with no hope of improvement. If a patient signed a directive while not being competent to make a rational analysis of his interests, the Act does not apply.[509] All people can access the Dutch healthcare system, ensuring complete insurance coverage for palliative and end-of-life care. Unfortunately, individuals receiving the best palliative care may still feel that their suffering is intolerable and ask their doctors to

[507] Termination of Life on Request and Assisted Suicide (Review Procedures) Act (2002)
[508] *Common Cause (A Registered Society) v. Union of India,* (2018) 5 SCC 1
[509] The Termination of Life on Request and Assisted Suicide (Review Procedures) Act,2002

end their lives. In certain situations, euthanasia might be a respectable way to end excellent palliative care.[510]

5.4 Belgium

After the Netherlands, Belgium became the second nation in Europe to approve euthanasia. Advance directives and voluntary euthanasia are both permitted under Belgium's Act on Euthanasia, which was established in 2002.[511] With the establishment of the Belgian Association for the Right to Die with Dignity (1981) and its Flemish counterpart Vereniging voor het right op waardig sterven (Association for the Right to Die with Dignity) (1983), organized campaigning for the legalization of euthanasia began in Belgium in the 1980s. Ten years later, the topic came up in parliament. Four members of parliament brought euthanasia bills to the Senate in the legislative session of 1995–1996. Euthanasia legalization has been hotly disputed since 1995 by the media, academics, the official Advisory Committee on Bioethics, and the Belgian Parliament.

In contrast to the Netherlands, Belgium did not have significant case laws influencing the legislation. Commentators contend that the goal of the law in Belgium was to influence how doctors behaved toward dying patients and those suffering when death was imminent. There was no specific law or set of guidelines to control patients in a permanent vegetative state in Belgium prior to the year 2002, even though many Belgian doctors believed it would be beneficial to remove the patient's feeding tubes under the doctrine of necessity. According to this doctrine, the doctor must choose between two evil practices: prolonging the patient's suffering by giving him medication even though he knows the treatment is ineffective or giving him a peaceful, dignified exit. The doctor who opts for the latter of the two evils may be exonerated of the crime.[512] The euthanasia law in Belgium was approved on May 28th, 2002, and it went into effect on September 23rd, 2002, following much debate over the submission of recommendations when the joint lawmaker proposal about the

[510] The Termination of Life on Request and Assisted Suicide (Review Procedures) Act,2002.
[511] The Belgian Act on Euthanasia, 2002.
[512] Jean-Louis Vincent, "End of Life practice in Belgium and the new euthanasia law"32(11) *Intensive Care Med*, 1908-11, (2006)

sensitive topic was submitted to the Belgium Senate. In Belgium, carrying out euthanasia under specific conditions does not constitute a criminal offence, if [513]

1. The patient requesting must be eighteen years and legally competent.

2. The patient must make a request under the circumstances beyond medical control, and he is in total psychological, physical and mental agony, and he must be in pain where all treatments are futile.

3. The request must not be under the influence of any external force and must be out of free will.

Before performing euthanasia, the doctor has several obligations to the patient:[514]

1. He must inform the patient about palliative care and, so far as practicable, discuss his health conditions thoroughly.

2. The patient and the doctor must conclude that there is no other alternative.

3. Over a reasonable period, the doctor and the patient should discuss the matter to ensure that the request is the last resort to give a peaceful exit to the patient.

4. The doctor must thoroughly discuss with his patient and his family. Only then could euthanasia be administered.

5. The doctor must consult his colleagues about the patient's request regarding euthanasia and his unbearable pain.

6. The request letter must bear the date and signature of the patient, or it must be written by someone competent to decide in the patient's best interest.

5.4.1 Advance Directive in Belgium

In 2002, Belgium passed laws on patient rights, palliative care, and the decriminalization of euthanasia. These laws have endorsed the patient's right to personal autonomy as well as the principle that everyone, including medical professionals, has the right to freedom of conscience. The expected declarations,

[513] Damas F, Damas P, Lamy M: "Euthanasia: a law in Belgium" 27, *Intensive Care Med* (2001).
[514] Belgian Act on Euthanasia, 2002

sometimes known as "living wills," that allow for both euthanasia and the patient's choice to decline medical care are now accepted legal documents.[515] The Act on Patients' Rights of August 22, 2002, and the Belgium Act on Euthanasia of May 28, 2002, both regulate advance directives in Belgium. It is only valid if done within five years of the state's inception and must be signed in the presence of two witnesses. Any individual or his members may declare under this in anticipation of a situation in which euthanasia would be the only practical alternative.[516]

The doctor preferring euthanasia must complete two documents-

1. Detailed report of the patient's illness.

2. Reasons for euthanasia and the method used.

The National Commission of Control and Evaluation, which consists of eight doctors, four law professors from Belgium University, and four people concerned with the care of the terminally ill, must receive these documents within four working days. Consequently, euthanasia is only carried out under observation and control. Open interactions with the patient's family are required before addressing matters as important as life and death. The Belgian Medical Association and the Belgian Society of Intensive Care Medicine support bioethical principles that defend autonomy and discourage the use of ineffective medications.[517]

The absence of legal guidelines does, however, pose some difficulties. One of these was the arrest of two doctors in Belgium for administering high dosages of morphine and thiopental to a patient who was 74 years old and had advanced pulmonary fibrosis. The case was reported to the police by the nurses, and the doctor asserted his argument that the patient and his family wished to pass away since they believed that he would be practically impossible to cure. One of the doctors was detained for five days before being granted bail and released. The court's ultimate decision indicated that the circumstances surrounding the person's euthanasia could not be ignored but that there should have been enough communication amongst

[515] Jacqueline Herremans, "Advance directives: the legal situation in Belgium" 3, Bull Soc Sci Med Grand Duche Luxemb,305-310, (2008).
[516] The Belgian Act on Euthanasia of May 28th 2002.
[517] Belgian Ministry of Justice, The Wet betreffende euthanasia (The Belgian Euthanasia Act) Belgian Law Gazette of June 22, 2002

hospital authorities and that it should only have been carried out with proper unanimity.[518]

5.4.2 The Belgium Euthanasia Act, 2002

The law outlines the conditions under which doctors may end the lives of patients who are terminally ill and experiencing intolerable suffering. To be eligible for euthanasia, potential patients must be Belgian citizens. Patients must be at least 18 years old and have made explicit, repeated requests to end their lives. Euthanasia and advance medical directives are both permitted under Belgian law. The Act lays out a specific process that must be followed in both cases and specifies the steps that doctors and other medical professionals should take when a patient expresses a desire to be put to death or when a patient has signed an advance directive. Euthanasia is defined as "actively terminating life by someone other than the individual concerned, upon the latter's request" in Section 2 of the Belgian Euthanasia Act.[519] The Act makes it clear that a patient must express a desire to be euthanized, and a doctor must carry it out. The Act stipulates that the patient must have a terminal, life-threatening condition that results in excruciating agony. The patient must be capable, have repeatedly expressed their desire to end their lives in an informed manner, and have at least made one written request before making the decision. Once a request has been made to the doctor, the treating doctor must explain to the patient any potential repercussions, available treatments, and palliative care options. The doctor should be convinced that the patient has made an informed decision free from coercion and that there is no reasonable medical treatment available for the patient before moving on with any procedure to end the patient's life. A second doctor should certify that the patient's condition is irreversible and incurable once they have written down their desire to be put to death.[520]

5.4.3 Execution of Advance Directives

The Belgian Euthanasia Act gives patients the option of advance directives.[521] Any competent adult can sign an advance directive saying they do not want to experience

[518] Belgian Ministry of Justice, The Wet betreffende euthanasia (The Belgian Euthanasia Act) Belgian Law Gazette of June 22, 2002.
[519] The Belgian Act on Euthanasia, 2002, s. 2
[520] *Id*., s 3
[521] *Id.*, s 4

agony and should be put to death if they develop a terminal illness. At least two witnesses must countersign the advance directive, at least one of whom cannot have a financial stake in the patient's demise. When a patient has given an advance directive, the process to be followed is similar to when the patient has stated a desire to be euthanized. The patient's condition must be determined by an independent medical opinion to be terminal and irreversible by the doctor. The patient's family or a friend who was selected in the advance directive must be consulted before the doctors make their choice. Notably, the law specifies that a written request must be made by the patient expressing their wish to die and that there must be a cooling-off period before the person is euthanized. This prevents hasty decisions and gives patients time to consider their options. So, while taking a liberal stance, Belgian law offers enough safeguards against legal abuse.[522]

5.4.4 Child Euthanasia in Belgium

In a highly contentious decision, the Belgian parliament permitted patients of all ages to be euthanized in 2014. There was much hostility to this law, notwithstanding the safeguards established to stop its abuse. A local society of paediatricians had opposed this bill, arguing that because palliative care procedures have progressed and could significantly reduce suffering, there was no urgent need for this regulation.[523] The proponents of this law countered that children in excruciating pain should not be exempted from the suffering process simply because they are minors. The case of 10-month-old Ella-Louise, who had a rare genetic disorder that slowly but surely deteriorated her neurological system and would finally kill her, significantly influenced public opinion in favour of child euthanasia.[524] Ella-Louise was in excruciating pain and helpless, but the doctors could not end her life because the law at the time mandated that the patient be at least 18 years old. Ella-Louise had to endure pain and wait for natural death to occur despite demands from her parents to allow her to pass away gently and cease her misery. Hospitalized, Ella-Louise died in

[522] Adams Maurice, Nys Herman, "Comparative Reflections on the Belgian Euthanasia Act 2002" 11(3), *Medical Law Review*,353-376, (2003).
[523] Editorial, 'Belgium's parliament votes through child euthanasia', *BBC News* ,13 February 2014. Available at- https://www.bbc.com/news/world-europe-26181615// (last visited on November 25, 2022)
[524] Nikhita Mendis, "Pulling the Plug: Euthanasia in Belgium", *Brown Political Review*, April 30, (2014).

agony.[525] Following this case, both the medical community and the general public supported giving children the option of euthanasia.[526] The Belgian parliament passed a law allowing the euthanasia of people of all ages, including minors, in February 2014.[527]

The law provides the following conditions before a child is euthanized[528]:

a. The patient should make a request that is voluntary and aware of the consequences.

b. The parents and medical team tendering to the patient must approve this decision.[529]

c. The patient must be suffering from a terminal illness.

d. The patient must be suffering from constant and unbearable pain with no recourse available to mitigate the suffering.[530]

e. That death is the most likely result in the short term. In cases where the minor is un-emancipated, a consultation with a child psychiatrist or a psychologist is mandatory, and the minor should be informed about the reasons for consultations and the possible consequences. The parents of the minor should also be made aware of such consultations and their outcomes.[531]

While some have claimed that this law might lead to infanticide and that it gives parents the option not to raise children who are ill, it has been utilized seldom and offers specific safeguards in the case of child euthanasia. Critics claim that this gives parents a simple way out of raising "perfect children" without taking into account the possibility that children with disabilities could also have healthy lives. Despite criticism, Belgian legislation permitting child euthanasia has been used, and

[525] Csilla Deak, Vassilis Saroglou, ‘’Terminating a Child’s Life? Religious, Moral, Cognitive, and Emotional Factors Underlying Non-Acceptance of Child Euthanasia” 57(1) *Journal of the Belgian Association for Psychological Science* 59–76 (2017).
[526] Diana Magnay, “Parents plead to be able to help terminally ill children die” *CNN News* ,27 November 2013.
[527] The Belgian Act on Euthanasia of May, 10 *European Journal of Health Law*, 329-335, (2003).
[528] *Ibid.*
[529] Hunter C. Leake, James Rachels et.al., “Case Studies in Bioethics: Active Euthanasia with Parental Consent” 9(5) *Hastings Center Report,* 9(5),19-21, (1979).
[530] *Ibid.*
[531] *Ibid.*

as of 2017, three children had been euthanized there. These three kids were all afflicted with severe, incurable illnesses.

5.4.4.1 Application of euthanasia laws to Belgium children. Belgium's euthanasia laws, based on the same presumptions as those for adults, were expanded to include kids in 2014. Due to their inexperience, it poses a serious risk to their lives. However, some requirements must be met:

1. Written opinion by the paediatrics team after careful perusal of the disease. It shall include a psychologist or psychiatrist.

2. The details of the sickness suffered mentioning that death is prone to take place soon.

3. The child must give in writing a request form to the doctor.

4. The next friend must give consent.

5. Obligation on the part of the physician

In conclusion, despite its controversial nature, Belgian law has been successfully employed to alleviate the agony and suffering of patients, including children, who have terminal illnesses. Citizens have repeatedly voted in favour of this law and supported it, saying that no one should have to endure intolerable suffering or pass away in an undignified manner. Similar to the law in the Netherlands, the law in Belgium establishes safeguards that must be followed before a patient is put to death or an advance directive is signed.[532] Significantly, the law stipulates that there must be a cooling-off period before euthanasia and that the patient must make a written request indicating their want to die. This helps patients think things out and avoids rash conclusions. Belgian law, therefore, affords sufficient protection against legal misuse while adopting a liberal approach.

5.5 Switzerland

Switzerland has taken one of the most unique viewpoints on the right to die. While the Swiss Criminal Code expressly prohibits taking a person's life at their own request,

[532] Johan Bilsen, Joachim Cohen, et. al., "Medical End-of-Life Practices Under the Euthanasia law in Belgium" 361(11) *New England Journal of Medicine,*1119-1121, (2009)

assisted suicide is legal. Euthanasia is against the law in Switzerland. However, assisted suicide has been legal and accepted in Switzerland since 1942. It is the only nation in the world to allow foreign nationals to visit and get assisted suicide at a clinic. Physicians and non-physicians can both assist in dying, unlike in other nations, including the Netherlands, Belgium, and the US state of Oregon. In general, decisions that result in a person's death are left in the hands of medical professionals, making this situation unusual. However, Switzerland enables anyone, including regular people, to help someone die as long as they do it out of altruistic motives.[533] According to Section 114 of the Swiss Penal Code, murder committed at the patient's request is considered less severe than murder committed without the victim's consent. The Swiss Penal Code's Article 115 exempts anyone who assists a suicide for altruistic reasons. A doctor's prescription is obtained when a lethal medication is needed, but patients are expected to give it themselves. The laws prohibit active euthanasia. The law permits voluntary organizations to assist individuals, including foreigners, in taking their own lives. However, the police are informed and are looking into all assisted suicide cases.[534] Article 115 of the Swiss Criminal Code states that abetting or assisting suicide for selfish motives is punishable.[535] This is perhaps the most liberal approach adopted in assisted suicide cases.[536] The only safeguard specified in the legislation is that assisted suicide cases must not have selfish motives. According to the law, the person assisting in death need not be a medical expert or a doctor. It's crucial to note that the law does not require the patient to have a terminal illness. Anybody of sound mind and body who desires to terminate their life may do so without being prosecuted if they ask for and get assistance. The reason for such a liberal stance is that suicide is not considered a criminal offence under Swiss law. It views suicide as a deliberate decision to end one's life. Therefore, it does not distinguish between a doctor and a non-doctor or between a patient who is terminally sick and a healthy person. It merely acknowledges that everyone can be

[533] Georg Bosshard., Esther Ulrich, et. al., "Assessment of Requests for Assisted Suicide by A Swiss Right-To-Die Society," 32(7), *Death Studies*,646-657, (2008).
[534] *Ibid.*

[535] The Swiss Criminal Code, 1937, art. 115, states: Inciting and assisting suicide: Any person who for selfish motives incite or assists another to commit or attempt to commit suicide shall, if that other person thereafter commits or attempts to commit suicide, be liable to a custodial sentence not exceeding five years or to a monetary penalty.
[536] Olivier Guillod, Aline Schmidt, "Assisted Suicide under Swiss law" 12(1), *European Journal of Health Law*,25-38, (2005).

helped to end their lives by excluding selfishness.[537] According to a decision by the Swiss Supreme Court, those with psychiatric disorders may also be assisted in dying if a psychiatrist provides a medical report establishing and confirming their diagnosis.[538] This verdict was challenged in front of the European Court of Human Rights, which decided that an individual's right to personal autonomy and the desire to end her life would be covered by the European Convention on Human Rights. The law also does not require the person receiving assistance in dying must be a citizen.[539] It enables the assistance of dying for both citizens and non-citizens.

In Switzerland, four leading organizations support patients as they approach death. These are Exit Deutsche Schweiz, Exit ADMD (Association pour le droit de mourir dans la dignité), Dignitas, and Exit international.[540] The primary objective of the non-profit member organization Dignitas, which is situated near Zurich, is to live with dignity and die with dignity. If a patient has no possibility of recovery and is suffering from a serious illness, a Swiss doctor may recommend assisted suicide; nevertheless, the illness need not be terminal. If the person wishes to pass away peacefully and is experiencing extreme pain and suffering, that is sufficient. It is important to remember that the person must submit a written request and give their free consent. Before assisting in suicide, these associations have established their own safeguards. Exit Deutsche Schweiz, for instance, only offers assistance to Swiss nationals and only very rarely to non-citizens, whereas Dignitas does not impose a citizenship restriction and offers suicide assistance to people of all countries. Numerous European countries have reportedly sent citizens to Switzerland to use these services. Up to 300 British nationals had gone to Switzerland as of August 2015 in order to receive assisted suicide.[541] A referendum was held in 2011 to prevent "suicide tourism" and not to assist foreigners in their death since local organizations opposed it. The referendum to prohibit assisted suicide and to stop offering such

[537] Olivier Guillod, Aline Schmidt, "Assisted Suicide under Swiss law" 12(1), *European Journal of Health Law*,25-38, (2005).
[538] Gross v. Switzerland, BGE 133 I 58 of November 3, 2006 (Swiss Federal Supreme Court)
[539] Gross v. Switzerland, No. 67810/10 of May 14, 2013 at 58, 60 (European Court of Human Rights),
[540] Susanne Fischer, C A Huber, at. al., "Suicide Assisted by Two Swiss Right-To-Die Organizations" 34(11), *Journal of Medical Ethics*,810-814, (2008).
[541] Jamie Doward, "One Person a Fortnight' Travels to Dignitas from Britain to End Their Lives" *The Guardian* ,15 August 2015,available at- https://www.theguardian.com/society/2015/aug/15/assisted-dying-britons-dignitas-risescampaigners-change-law (last visited on November 27, 2022).

services was voted down, and the public decided to keep doing so for both citizens and non-citizens.[542]

Switzerland has taken a unique and very liberal approach to assisted death that respects a person's freedom to choose death, in contrast to all other nations. The Swiss approach is apart from those of other nations since there are no strict guidelines or safeguards to be followed. It merely states that the intent behind assisted suicide cases must be determined and that if the intent is altruistic, no prosecution would be brought. Although it has been argued that relaxing laws governing death may encourage misuse, it cannot be proved that this has happened in Switzerland, where the restrictions have been relaxed. In fact, many people have stated that they would prefer to be free to choose death over suffering of any form or manner. [543]

5.5.1 Role of doctor in Switzerland

If a patient has no possibility of recovery and is suffering from a serious illness, a Swiss doctor may recommend assisted suicide; nevertheless, the illness need not be terminal. That is sufficient if the person wishes to pass away peacefully and is experiencing extreme pain and suffering. It is important to remember that the person must submit a written request and give their free consent.[544]

5.5.2 Advance Directives

Ethically, the right of a person to express his wishes in an advance directive for situations where he may be incapacitated is based on the principle of patient autonomy. This also includes the right of the individual to make decisions in his own interest based on personal values and concepts. As a result, unless it violates legal criteria or there are legitimate uncertainties about whether it was voluntary or reflects the patient's expected preferences, the physician must follow an advance directive. The possibility of drawing up an advance directive is open to all persons with capacity, including minors with capacity.

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[542] Andreas Frei, TA Schenker, et. al., “Assisted suicide as conducted by a "Right-to-Die"-society in Switzerland: A descriptive analysis of 43 consecutive cases” 131(25-26), Swiss medical weekly, 375-380. (2001).
[543] *Ibid.*
[544] *Ibid.*

A person drafting an advance directive must grasp the ramifications of the advance directive and, to the greatest extent feasible, anticipate what repercussions it would have in the event of a certain pathological condition. When the guidelines are adopted into the Code of the Swiss Medical Association (FMH), they become legally binding for all FMH members. According to article 16 of the Civil Code, a person has capacity if he or she does not lack the capacity to act rationally due to being under the age of majority or because of a mental disability, mental disorder, intoxication, or similar circumstances. It is presumed that whoever creates an advance directive has the capacity. However, in unusual cases when capacity may later be questioned, it is recommended that one's capacity be certified by an expert when the advance directive is being written.[545]

An advance directive must be drawn up voluntarily, i.e., without external pressure or force. Furthermore, an advance directive must not be made a requirement for admission to a long-term care facility or access to medical treatment and care. An advance directive should be written down, dated, and signed by the individual making it. In general, there is no temporal limit on how long an advance directive is binding; nevertheless, the advance directive should be reviewed/revised, dated, and signed at regular intervals. This is especially critical if the person's life condition or health has changed significantly. While advance directives which fail to meet formal requirements are invalid, they may serve as an indication of presumed wishes.[546]

5.6 Luxembourg

With the adoption of the law on euthanasia and assisted suicide on March 16, 2009, Luxembourg has also legalized euthanasia (Lux.) A bill to legalize assisted suicide in Luxembourg was defeated by one vote in 2003. A second referendum was successfully held in 2009 to legalize PAS and euthanasia after reforming the nation's parliamentary structure to lessen the monarch's power (who had placed a veto on the matter for religious concerns). The Netherlands' Law on the Right to Die with Dignity is similar to Luxembourg's; however, only adults who are 18 or older may ask for assisted death.[547] In the 2006 study on euthanasia acceptance, Luxembourg placed 6th

[545] Swiss Academy of Medical Sciences, "Advance directives" (May, 2019; Revised January 2013) available at - www.sams.ch/guidelines (last visited on November 27, 2022)
[546] *Ibid.*
[547] *Ibid.*

out of 33, indicating that the population favoured assisted dying even before it was legalized.[548] Since then, assisted suicide rates have remained low compared to those in the Netherlands and Belgium, making up just 0.003% of all deaths.[549]

Luxembourg became the third nation in Europe to legalize assisted suicide as well as euthanasia after the Netherlands and Belgium. The legislation was approved by parliament on February 19, 2008, and it became operative in April 2009. If a patient with a serious illness who has frequently expressed a desire to die is directly killed or assisted in committing suicide, doctors are legally protected from criminal and civil penalties. In order to confirm the patient's condition, the doctor must first consult with another doctor. Grand Duke Henri of Luxembourg had declined to sign the euthanasia bill into law, which was required under the country's constitution. Supporters of euthanasia in parliament were so determined to make it legal that a constitutional amendment was passed to do away with it and restrict the monarch's power.[550] The legislation was enacted simultaneously with another that offers paid leave and palliative care to family members of those who are terminally ill and in the final stages of life.[551]

The law covers both physician-assisted suicides and euthanasia. A doctor who performs assisted suicide or euthanasia must make sure that:

1. the patient is legally competent at the time of his request;
2. the patient has the authorization of his parents or legal guardian if he is between the ages of 16 and 18;
3. the request is voluntary, thought through, and repeated and does not result from external pressure;
4. the patient suffers from an incurable condition and is constantly in unbearable physical or mental pain; and

[548] Joachim Cohen, Isabelle Marcoux, et. al., "European public acceptance of euthanasia: Socio-demographic and cultural factors associated with the acceptance of euthanasia in 33 European countries" 63(3), *Social Science & Medicine*,743–756, (2006).
[549] *Ibid.*
[550] Luxembourg permits both euthanasia and assisted suicide, Patients' Rights Council, available at-patientsrightscouncil.org, (last visited on November 27, 2022).
[551] Associated Press in Luxembourg "Luxembourg to strip Duke of powers over euthanasia, *The Guardian*, December 3,2008, available at- https://www.reuters.com/article/us-luxembourg-duke-idUKTRE4B182220081202// (last visited on November 27, 2022).

5. the patient respects all the conditions and procedures prescribed by the Law.

The doctor must also discuss any possible therapeutic alternatives that are still available to the patient and their effects, including palliative care and the patient's current health and expected lifespan.[552]

From the patient's point of view, he must conclude that there are no other options. Additionally, he must confirm through several meetings with the patient that the psychological or physical pain is ongoing and that the patient has made repeated requests to end their life. He must consult with another specialist to confirm that the patient's illness is incurable. The death request must be made in writing. A living will may also include a request for euthanasia.[553]

A National Commission of Control and Evaluation is established by the Law to monitor and evaluate how the Law is being applied. A doctor who commits euthanasia is required to submit an official declaration to the Commission within four days. Last but not least, the Law specifies that no doctor is required to carry out euthanasia or assist in suicide.[554]

Anyone with an illness or injury that results in an incurable medical condition is eligible to request euthanasia or assisted suicide. Any terrible, incurable, and irreversible illness that causes intolerable physical or mental suffering qualifies as a qualifying condition for the patient who wishes to make end-of-life decisions to avoid having to confront a situation like this in the future. Patients with a GP (general practitioner) in Luxembourg who reside outside of Luxembourg may establish end-of-life decisions and have them documented in their medical records. However, the GP in question had to have treated the patient for a sufficient period of time and continuously. There are no residency or nationality requirements for having such information documented in one's medical file, or for any of the other essential and

[552] Atwill, Nicole, "Luxembourg: Right to Die with Dignity", 2008,available at-https://www.loc.gov/item/global-legal-monitor/2008-03-02/luxembourg-right-to-die-with-dignity/ (last visited on November 27, 2022).
[553] *Ibid.*
[554] *Ibid.*

formal conditions. However, the GP in question had to have treated the patient for a sufficient period of time and continuously.[555]

5.6.1 Due care criteria

The due care criteria for legal euthanasia and assisted suicide are mentioned in article 2 of this law.[556] The patient must:

1. be conscious at the time of the request;
2. be of legal age with the legal capacity to make their own decisions (i.e., they must not have been ruled incapable of making their own decisions by the court);
3. have made the decision without any outside pressure;
4. have an incurable medical condition, with no prospect of improvement, arising as a result of an accident or illness;
5. be undergoing constant and unbearable physical and/or mental suffering as a result of that condition, with no hope of improvement.

5.6.2 Eligibility Criteria for Requesting Euthanasia or Assisted Suicide

The patient making the request must be of legal age, have full legal capacity, be conscious at the time of application, and have a medical condition that satisfies all of the criteria for performing euthanasia. Direct requests from patients must be made in writing, include all relevant personal information, and be dated and signed. If the patient is physically permanently unable to write and sign the request (for example, due to paralysis), it may be formalized in writing by a person of legal age of the patient's choice, in the presence of the patient's GP, whose name must be on the document. The patient's designated representative must state in the document that the patient is physically unable to write the request themselves permanently, include a justification for this incapacity, and sign and date the request. The patient is always

[555] Atwill, Nicole, "Luxembourg: Right to Die with Dignity", 2008,available at- https://www.loc.gov/item/global-legal-monitor/2008-03-02/luxembourg-right-to-die-with-dignity/ (last visited on November 27, 2022).
[556] Euthanasia and assisted suicide Act (2009), available at - https://wfrtds.org/worldmap/luxembourg/ (last visited on November 27, 2022).

free to cancel their request. If so, it will be removed from their medical record and given back to the patient.[557]

5.6.3 Advance Request for Euthanasia or Assisted Suicide in The Form Of 'End-Of-Life Arrangements'/ Execution of Advance Directive

The phrase "end-of-life arrangements" describes a request for euthanasia made in advance if the patient might later find themselves in an irreversible unconscious state—which was regarded as irreversible at the time—or suffer from the incurable effects of a serious accident or illness—which was also regarded as irreversible at the time. Any person of legal age and full mental capacity may define in writing before the moment comes when they are unable to express their wishes, the circumstances and conditions under which they choose to have euthanasia as their end-of-life arrangements. A specific section describing the arrangements to be made for the declarant's burial, cremation, etc., and funeral service may also be included in the end-of-life provisions. Any person of legal age may designate a "person of trust" to assist them in creating their end-of-life plans. If the patient can no longer communicate their wishes, the "person of trust" will act as their representative. The 'person of trust' is responsible for communicating the patient's intentions to the doctor in accordance with their most recent statements, not for offering their personal opinion.[558]

5.6.3.1 Writing One's End-Of-Life Arrangements. Unless the patient is permanently physically incapable of writing and signing the declaration, the end-of-life arrangements must be stated in writing, dated, and signed by the patient in question. The end-of-life preferences of a person may be formalized by a person of legal age of their choice in front of two witnesses if that person is physically unable to do so in the near future. The end-of-life arrangements must then expressly state that the patient is unable to write and sign the agreement and explain why. End-of-life arrangements must be dated and signed by the individual who authored the declaration, the witnesses, and the ‘person of trust’, where applicable. A medical certificate certifying the patient's continued physical incapacity must be submitted with the arrangements for the patient's end of life.

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[557] Atwill, Nicole, “Luxembourg: Right to Die with Dignity”, 2008,available at-https://www.loc.gov/item/global-legal-monitor/2008-03-02/luxembourg-right-to-die-with-dignity/ (last visited on November 27, 2022).
[558] *Ibid.*

5.6.3.2 Changing One's End-Of-Life Arrangements. End-of-life plans can be updated, withdrawn, or restated at any moment. Such adjustments must be documented. However, the patient's final known requests are always given priority, and euthanasia must not be carried out if the doctor finds that the patient has changed their mind about receiving euthanasia after making the proper end-of-life arrangements.[559]

The National Control and Assessment Committee (Commission Nationale de contrôle et d'évaluation) must officially record the end-of-life arrangements and any changes. End-of-life arrangements are valid indefinitely, although the National Control and Assessment Committee is needed to certify the patient's wishes once every five years from the filing date.[560]

5.7 Canada

In Canada, euthanasia is known as medical assistance in dying (MAID), and it was made legal in June 2016 alongside assisted suicide to reduce the suffering of terminally ill patients. Active euthanasia is forbidden by law in Canada, and anyone who engages in it or assists someone in killing themselves is subject to punishment under the criminal code. The Supreme Court amended Sections 241(b) and 14 of the Criminal Code of Canada, which forbade assisted suicide, and concluded that it is up to the individual to choose whether to live or die with dignity. Compared to the United States, Canadian law is significantly more systematic, uniform, and consistent. A small number of provinces have drafted advanced directive laws. On the other hand, passive euthanasia is used since the country's Criminal Code does not permit doctors to force patients to receive medical treatment against their wishes, according to the Law Commission's opinion. In other words, the country's criminal code does not forbid discontinuing treatment if the situation suggests it is ineffective.[561] Death is unavoidable, but if force is used to coerce someone into receiving medical care over their objections, it could be considered an assault. In Canada, consent is a critical

[559] Atwill, Nicole, "Luxembourg: Right to Die with Dignity", 2008,available at-https://www.loc.gov/item/global-legal-monitor/2008-03-02/luxembourg-right-to-die-with-dignity/ (last visited on November 27, 2022).
[560] *Ibid.*
[561] Trudo Lemmens, "Towards the right to be killed? Treatment Refusal, assisted suicide and euthanasia in the United States and Canada" 52(2), *British Medical Bulletin*,341-353, (1996).

component. Before terminating or prescribing medication, the patient's informed permission is required.

The Supreme Court of Canada determined in Cater v. Canada (Attorney General)[562] that sections 14 and 241(b) of the Canadian Criminal Code, which forbid physician-assisted suicide, unjustly infringed upon the right to life, liberty, and security of the person guaranteed by Article 7 of the Charter of Rights and Freedoms of the Canadian Constitution. The supreme court ruled that the criminal code's infringing provisions are unconstitutional because they forbid physician-assisted suicide for a competent adult who, in addition to having a severe and incurable medical condition that causes unbearable suffering for the patient, also expressly consents to death. In reaction to the supreme court ruling, the Canadian government set up a special joint committee on physician-assisted suicide. Its task was to establish a framework for the federal government's response to physician-assisted suicide that would be consistent with the Canadian priorities, the Charter of Rights and Freedoms, and the Constitution. The Special joint Committee's report, which was published in February 2016, made several legislative recommendations to regulate medical assistance in dying by enacting both substantive and procedural safeguards.

5.7.1 Substantive safeguards

1. A grievous and irreparable medical condition (such as an illness, disease, or disability) is necessary;
2. Enduring suffering that is intolerable to the person in the circumstances of their condition is required;
3. Informed consent is required
4. Capacity to make an informed decision at the time of either the advance or contemporaneous request; and
5. Eligible individuals must be insured people who are qualified for publicly funded health care services in the state where they reside.

5.7.2 Procedural safeguards

1. Two independent doctors must conclude that a person is eligible;
2. A request must be in writing and witnessed by two independent witnesses;

[562] 2012 BCSC 886/ 2015 SCC 5

3. A waiting period is required based, in part, on the rapidity of progression and nature of the patient's medical condition as determined by the patient's attending physician.
4. Annual reports analyzing medical assistance in dying cases are to be tabled in Parliament;
5. Support and services, including culturally and spiritually appropriate end-of-life care services for indigenous patients, should be improved to ensure that request is based on free choice, particularly for vulnerable people.[563]

It also passed legislation to ensure that it was not abused because it dealt with people's lives and deaths. Euthanasia and assisted suicide are not permissible for minors, nor are they justified by terminal disease or any other condition that can be treated in due course. It is only made available to citizens eligible for Canadian medical services to prevent its misuse in the nation. Any official request for mercy killing is prohibited, and patients are not allowed to seek euthanasia in advance if their condition worsens in the future (such as in cases of Alzheimer's disease, where individuals wish to pass away once they have reached an advanced stage of illness and suffering).[564]

In a landmark decision on euthanasia, R v. Latimer,[565] the Canadian Court grappled with the question of whether the accused was genuinely guilty of taking the patient's life or had acted compassionately by sparing her from unending anguish and suffering. Robert Latimer had killed his physically disabled daughter Tracy with carbon monoxide in 1993. It was believed that she had been in a lot of agony. Her hip had had several surgeries, and another invasive procedure was planned. Robert Latimer "came to the conclusion that the life of his daughter was not worth living."[566] After being accused of first-degree murder, a jury found Mr Latimer guilty of second-degree murder. After numerous trials and appeals, the Supreme Court of Canada granted Mr Latimer permission to appeal on the grounds that the jury ought to have heard the necessity defence, that the trial judge ought to have informed the jury that Mr Latimer had the legal right to decide to end his daughter's life as her surrogate decision-maker and that the minimum sentence for murder violated the Charter by

[563] *Cater v. Canada*, 2012 BCSC 886/ 2015 SCC 5
[564] *Ibid.*
[565] (2001) 1SCR 3
[566] *R. v. Latimer*, [2001] 1 S.C.R. 3.

being a cruel and unusual punishment.[567] The Court upheld the conviction and sentence in January 2001.[568] However, it did mention that the royal prerogative of mercy is provided under Section 749 of the Criminal Code, which is a matter for the executive to decide rather than the courts. The National Parole Board's Appeal Division granted Mr Latimer day parole in February 2008, and he was released from prison with restrictions in March of that same year. In December 2007, the Board first turned down his request for parole. Mr Latimer was granted full parole in November 2010.

Another famous case was Rodriguez v. British Columbia,[569] which overturned section 241(b) of the code, which prohibits a terminally ill person from committing physician-assisted suicide. The court rejected the argument by stating that removing the prohibition would give vulnerable people access to a weapon that would be fatal to the community as a whole. The prosecution argued that the defendant should have the autonomy to choose when to die and the means by which it occurs. The court further declared that permitting physician-assisted suicide would undermine confidence in humanity.[570]

Brenda Barnes, 36, a resident of Nova Scotia, had diabetes, and her friend Mary Jane Fogarty assisted her in committing suicide because she believed she would profit from Barnes' $100,000 life insurance policy. By providing Barnes with a syringe so she could inject amphetamines, Mary Fogarty assisted Barnes in committing suicide. She also acknowledged composing the suicide note at Barnes' request, though she insisted she was unaware that it was a suicide note. After being found guilty, Mary Fogarty was given a three-year probationary period and 300 hours of community service. She became the first person in more than 30 years to be found guilty and the first person to be charged with breaching Section 241(b) of the Criminal Code.[571]

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[567] Section 12 of the Canadian Charter of Rights and Freedoms states that "Everyone has the right not to be subjected to any cruel and unusual treatment or punishment."
[568] *R. v. Latimer*, [2001] 1 S.C.R. 3.
[569] Rodriguez vs. British Columbia, [1993] 3 SCR 519
[570] Section 7 of the Canadian Charter of Rights and Freedoms states that "Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice."
[571] Jocelyn Downie, *A Case for Decriminalizing Euthanasia & Assisted Suicide in Canada*, 34, (University of Toronto Press, Toronto, 2004)

In the Sawatzky v. Riverview Health Centre Inc.[572] case, Dr Maurice Genereux was accused of administering medications to two gay patients with AIDS, although one of them survived. On May 30, 1997, he was accused of encouraging people to commit suicide and aiding or abetting their suicide. Dr Maurice confessed his guilt. Genereux's medical license was suspended, and he received a sentence of two years, one day in prison. He was the first doctor to be found guilty.

In Whitler v. Canada,[573] the court reevaluated its earlier decisions and determined that preventing physician-assisted suicide for those with disabilities is unjustified. They must endure the consequences of this prohibition for the rest of their lives, which is a burden and unacceptable.

It should be noted that Quebec, the country's capital, legalized euthanasia in its province in 2009. The majority of the Quebec Act, passed in June 2014 and relates to end-of-life care, went into effect on December 10, 2015. The Quebec Act establishes a framework for end-of-life care that includes "continuous palliative sedation" and "medical aid in dying," defined as the doctor's administration of medications to a patient who is towards the end of their life to lessen their suffering by hastening death. They carefully considered both sides before approving assisted suicide in the province. In order to ensure that the citizens' right to die is not being abused, they amended the criminal code, added clauses defining it, and demanded appropriate penalties. In order to interpret the right to die in accordance with established rules and regulations, the judiciary has also played a significant role.[574]

In order to be able to access medical aid in dying under the Quebec Act, a patient must:

1. Be an insured person within the meaning of the health insurance Act (chapter A29)
2. Be of full age and capable of giving consent to care;
3. Be at the end of life;
4. Suffer from a serious and incurable illness;
5. Be in an advanced state of irreversible decline in capability;

[572] (1998) 133 Man. R. (2d) 41 (QB)
[573] 2011 SCC 12
[574] *Common Cause (A Registered Society) v. Union of India,* (2018) 5 SCC 1

6. Experience consent and unbearable physical or psychological suffering;
7. Which cannot be relieved in a manner the patient deems tolerable;

Two doctors must sign the request for medical aid in dying. A commission on end-of-life care was also established by the Quebec Act to supervise and advise the minister of health and social services on applying the legislation governing such care.[575]

In Malette v. Shulman,[576] the Ontario Court of Appeal held the physician liable for battery after he gave blood transfusion to a Jehovah's witness despite having seen her written request not to accept blood. The right to refuse treatment if it is fruitless cannot be overridden by the state, despite the state's great interest in safeguarding life. Under Quebec's civil law, it is acceptable to refuse medical care. The patient cannot be given medication without his consent. The court said that the patient has the right to refuse any treatment, even in an emergency. The court ordered that the doctors must follow the patient's written instructions, even if doing so proves to be harmful to the patient's health. The court highlighted that the right to die is based on the principle that the public's will comes first.[577]

In Nancy B. v. Hotel - Dieu de Quebec,[578] Nancy B had requested that the respirator, on which she had become dependent, be disconnected, and her wish was granted. She had Guillain-Barre syndrome, a neurological disorder that rendered her entirely dependent on her respirator and left her helplessly paralyzed. The judge, in this case, believed that there had been a cessation of treatment rather than murder or homicide. It is impossible to compare refusing treatment and encouraging suicide. The doctor may stop the treatment, but death may not be accelerated. The court argued that the patient has the ultimate option to decide whether or not to continue receiving treatment. The principle that the patient's wishes must come first when determining which treatment method, the patient has approved was emphasized by the court once more. Additionally, it said that illness should run its course naturally and that unreasonable behaviour from the doctor's side would not be accepted.[579]

[575] *Common Cause (A Registered Society) v. Union of India,* (2018) 5 SCC 1
[576] 1990 CanLII 6868 (ON CA)
[577] Dom Law Rep.1990 March 30; 67:321-39
[578] 86 D.L.R. (4th) 385 (Que. S.C.)
[579] Dom Law Rep. 1992 Jan 6; 86: 385-95

5.7.4 Guidelines of Canadian Law

The legislation passed in Canada has proper guidelines so that this right cannot be abused and can only be used for the benefit of the patients. According to Canadian legislation, terminally ill patients must make a written request to the doctors explaining their want to pass away with medical assistance. Patients should be able to verify that the doctor is doing euthanasia without being forced or under pressure. Additionally, he must clarify that he is acting independently of anyone else and that none of his decisions has been influenced. The written communication must be completed and given to the doctor at least ten days before. The doctor and two other medical professionals will then examine the patient's condition and affirm that there is no other way to save the terminally ill patient and that the patient's health is not expected to improve in the near future. The medical staff will then inform the patient of all his options and allow him to withdraw his consent at any time, up until one minute before euthanasia is carried out.[580]

The British Columbia Supreme Court held in AG British Columbia V. Astaforoff[581] that the provincial prison authorities were not required to force-feed a person close to passing away from starvation. The court ruled that forcing food into a person who expresses his consent not to eat is inappropriate when recovery was deemed impossible based on medical reports. The Law Reform Commission clarified that the continuation of fragile treatment does not constitute acting in someone's best interest.

In B v. Children's Aid Society of Metropolitan Toronto[582], the court dismissed the guardian's claims that the Canadian Charter of Rights' freedom of religion and liberty clauses gave them the right to decide what was best for their children since they were Jehovah's Witnesses. The Law Commission, which proposed making active euthanasia a crime, took a mild stance toward these doctors because their actions were driven by compassion. The Commission tried to approach this confusing topic sensibly and prudently. As a result, active euthanasia is not yet legal in Canada; instead, passive euthanasia and treatment refusal is the rule.[583] Assisted suicide is one

[580] Dom Law Rep. 1992 Jan 6; 86: 385-95
[581] (2004) 3 S.C.R. 657, 2004 SCC 78
[582] (1995) 1 S.C.R
[583] (1995) 1 S.C.R

of the social responses to the growing cost of medical treatment. The enormous financial burden on the caregivers is the main factor of assisted suicide or euthanasia. In Canada, euthanasia is a hot topic. The main argument against euthanasia revolves around the question of who has the right to die with the least amount of suffering, excluding excessive suffering and humiliation. Ron Siwicky, a musician in his 60s, is suspected of killing Betty Siwicky**,** who had fallen at her Winnipeg home and was unable to recover. He continued to give his mother water and drinks till she died on the floor with a blanket over her. It was argued that her son just followed her instructions because she refused medical assistance. Giving them a dignified exit is humane because they are terminally ill, but it is also much less expensive than keeping them alive. Ironically, dignified death is typically protected by the doctrine of necessity and is seen as a blessing in disguise.[584]

5.8 New Zealand

The End-of-Life Choice Act 2019 went into full effect on November 7, 2021, making euthanasia legal in New Zealand.[585] According to the BBC, New Zealand's vote to allow euthanasia in October 2020 was welcomed by activists as "a victory for compassion and kindness." The law allows individuals with less than six months to live who are terminally sick to request assisted suicide if two doctors agree. They must also be capable of making informed decisions. In November 2021, it went into effect.[586] One year after over two-thirds of New Zealanders voted in favour of it, the End-of-Life Choice Act went into effect. Supporters of the laws contend that they will provide choice, compassion, and dignity to New Zealanders who are "suffering terribly at the end of their life."

To request assisted suicide, a person must fulfil several requirements. These consist of the following:

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[584] Thomas Walkom, "Case of Winnipigman who let mother die highlights euthanasia debate," *InsideOttawaValley.com*, January 6, 2015, available at- https://www.insideottawavalley.com/opinion-story/5245198-case-of-winnipeg-man-who-let-mother-die-highlights-euthanasia-debate-walkom// (last visited on November 15, 2022)

[585] The End-of-Life Choice Act 2019, available at- https://www.health.govt.nz/our-work/life-stages/assisted-dying-service/about-assisted-dying-service/end-life-choice-act-2019// (last visited on November 15, 2022)

[586] *Ibid*

1. Suffering from a terminal illness that's likely to end their life within six months.
2. Showing a significant decline in physical capability.
3. Being able to make an informed decision about assisted dying.

If all requirements are completed, the law allows a doctor or nurse to prescribe or give a lethal dose of medication to be taken under their supervision. According to the law, a person cannot be refused assisted death based only on their advanced age, mental illness, or disability.[587]

5.9 Spain

Spain joined the Netherlands, Belgium, Luxembourg, Canada, and New Zealand as the sixth nation in the world to recognize the right to assisted death. In specific situations, it became legal to commit suicide in Spain in March 2021. Adults with "serious and incurable" diseases that result in "unbearable pain" are permitted to end their lives under the law. When making the request, which must be made twice in writing, the adult must be "fully aware and conscious" and a Spanish national or legal resident. Before the law's implementation, helping someone commit suicide in Spain carried a maximum sentence of ten years imprisonment.

In Spain, euthanasia is governed by the Organic Law for the Regulation of Euthanasia, enacted by the Cortes Generales in March 2021. The act of directly and deliberately causing someone's death by medical personnel, whether by giving a lethal chemical or by prescribing it so the individual can self-administer it, whether in a hospital or at home, is referred to as euthanasia in legal documents. In the context of a severe, chronic, and incurable illness that results in excruciating pain, an informed and persistent petition process must first be carried out over time. The entire process will be governed by and funded by the public health system, which is also required to provide this right to anybody who requests it and satisfies the requirements. For all

[587] Preeti Jha, "New Zealand euthanasia: Assisted dying to be legal for terminally ill people" *BBC NEWS*,30 October 2020, Available at - https://www.bbc.com/news/world-asia-54728717 (last visited on November 15, 2022)

intents and purposes, a death brought on by the provision of aid to die shall be deemed a natural death.[588]

Any medical professional may refuse to participate in the procedure out of "conscience." Five conditions must be met in order to seek this procedure, and they are stated as follows in the legal document:[589]

1. Applicants must be of legal age, possess Spanish nationality or be legally residing in Spain at the time of application.
2. To have in writing all pertinent information regarding the medical procedure, the various options and course of action, including how to obtain palliative care.
3. To have made two voluntary written requests with a minimum of fifteen calendar days in between each one. The responsible doctor may accept any shorter duration that they deem appropriate based on the current clinical conditions, which they must document in the patient's clinical history, if they believe that the requesting person's death or loss of capacity to give informed consent is imminent.
4. To have a severe, terminal illness or a severe, chronic, and incapacitating illness as defined by this legislation, as attested to by the responsible physician.
5. To give informed consent prior to receiving the aid to die. Said consent will be incorporated into the clinical history of the patient.

The individual may have previously designated a person to act on their behalf in an advance directive document. The health professional in charge of the case may, at some point during this procedure, conclude that the patient lacks the understanding or autonomy to make decisions without this having to imply a legal incapacity. In this case, the health professional must file a complaint with the appropriate evaluation commission in each autonomous community. Since there is no definition of this component in the law itself, there is a risk that euthanasia may be viewed as

[588] Mercedes Martínez-León, Jorge Feijoo Velaz, et. Al., "Medico legal study of the organic law of the regulation of euthanasia in Spain compared to the rest of the countries that regulate euthanasia and / or assisted suicide" 48(4) *Spanish Journal of Legal Medicine* 166-174 (2022)
[589] Euthanasia in Spain, Spanish National Health System, legal status,
"Proposición de Ley Orgánica de regulación de la eutanasia", available at - https://www.senado.es/legis14/publicaciones/pdf/senado/bocg/BOCG_D_14_141_1157.PDF (last visited on November 15, 2022)

complicity in suicide or even homicide if it is determined that the person has not been evaluated adequately.[590]

5.10 Colombia

According to a constitutional court's decision, Colombia became the first nation in Latin America to permit assisted medical suicide for patients under a doctor's supervision. The nation's highest court decided that a physician can assist a seriously ill patient in using a lethal drug to end their own life without running the risk of going to jail. Colombia currently permits euthanasia, in which a patient is given a medicine that ends their life by a physician. In 1997, Colombia became the first nation in Latin America to decriminalize euthanasia; the first such death occurred in 2015. In July 2021, a high court expanded this "right to dignified death" to those not suffering from a terminal illness. The Colombian Constitutional Court expanded the definition of non-terminal illnesses covered under the statute on assisted suicide and euthanasia in July 2021, "given that the patient is in extreme physical or psychological pain, arising from bodily injury or serious and incurable sickness."[591]

5.10.1 Resolución Número 1216 (Euthanasia in General) [592]

Resolución número 1216 was established in 2015. According to this resolution, adults who are nearing the end of their lives may be put to death through euthanasia. The family must record the patient's request for euthanasia if the patient is unconscious to show that they want to die. A health authority will assist the patient in finding another doctor if they are qualified for euthanasia, but the doctor refuses.

5.10.2 Three Lawsuits

5.10.2.1 Sentencia C-239/97. The Colombian Constitutional Court decided in 1997 that a patient who is terminally ill and has provided informed consent should be able to end their life on request. The Court urged the government to establish the

[590] Mercedes Martínez-León, Jorge Feijoo Velaz, et. Al., "Medico legal study of the organic law of the regulation of euthanasia in Spain compared to the rest of the countries that regulate euthanasia and / or assisted suicide" 48(4) *Spanish Journal of Legal Medicine* 166-174 (2022)
[591] Countries where euthanasia, assisted suicide is legal. Available at- https://www.wionews.com/photos/countries-where-euthanasia-assisted-suicide-is-legal-281943#colombia-478546// (Last visited on 15 Nov,2022)
[592] Colombia, legal situation,World federation right to die societies, available at - https://wfrtds.org/worldmap/colombia// (Last visited on 15 Nov,2022)

prerequisites for physicians to act responsibly to avoid court prosecution. The government did nothing for 18 years. Due to the uncertainty surrounding the effects, medical professionals hesitated to utilize euthanasia.

5.10.2.2 Sentencia T-970/14. The Constitutional Court reaffirmed in April 2014 that the right to assisted suicide could be valid. The judge gave the government a deadline. Resolution 1216 was a result of this decision.

5.10.2.3 Sentencia T-544/2017. In a different decision rendered in 2017, the Court mandated that the Department of Health and Social Protection produce a resolution that would guarantee children's and teenagers' right to a dignified death. Resolution 825/2018 resulted from this.

5.10.3 Resolución Número 825/2018 (Children)

Resolución número 825/2018 was issued by the Department of Health and Social Protection on March 9, 2018. With parental consent, this resolution permitted euthanasia for kids older than six. Before that age, children do not comprehend the concept of their own death, according to the Department. With their parents' consent, children between the ages of 7 and 12 may use euthanasia. Children between 12 and 14 are permitted access even if their parents object. If all conditions for euthanasia are met, parental involvement is not required after the age of 14.

5.10.4 Bill

A proposed bill to regulate euthanasia was presented to the Colombian Congress on August 27, 2019. Even though there is currently a Resolution, legislation will ease the treating physicians' concerns because they are frequently hesitant to use this treatment due to a lack of regulatory clarity. The bill lays out standards for applying euthanasia to individuals with terminal illnesses and those with chronic diseases that significantly impact their quality of life.

5.11 The United Kingdom

The UK parliament has considered several initiatives allowing assisted suicide and passive euthanasia. The earliest parliamentary discussions on this subject were triggered by the Voluntary Euthanasia (Legislation) Bill, which was introduced in

1936.[593] Even though the people paid close attention to this Bill during the debate, the Parliament rejected it. However, a motion for discussion on voluntary euthanasia was not submitted until 1950. The debate over euthanasia and the right to die persisted after this Bill was passed. However, this conversation could not happen because of resistance from many lawmakers.[594] In 1960, a wave of liberalism swept through the UK Parliament, decriminalizing abortion, homosexuality, and suicide while giving more importance to people's individual liberty.[595] It was intended that the freedom of choice framework would address concerns about this right while the new bill on the right to die was being created. In 1969, a second Bill was introduced to the Parliament that addressed similar rights to die with dignity, but it was ultimately rejected.[596] In 1997, a different law on the right to assisted suicide was introduced. This Bill sought to give terminally ill patients a dignified death by allowing them to request medical aid in suicide. The proceedings of this Bill are documented in the Hansard conversations, demonstrating how reluctant the house was to approve its passage. Only 89 people voted for this bill, and 234 people opposed it.[597]

Voluntary Euthanasia Society was established in 1935 (name changed to 'Dignity in Dying' in 2006) to advocate for the right of a mentally competent person to take the final decision whether to seek medical assistance for dying or for prolonging life, when diagnosed with a terminal illness.[598] The British Medical Association (BMA) had historically opposed euthanasia and physician-assisted dying. On 14th September, 2021 BMA changed its policy on a change in law on assisted dying from opposition to neutrality.[599] The Suicide Act of 1961 decriminalized suicide or attempted suicide but forbids assisted suicide in the United Kingdom.[600]

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[593] Isabel McArdle, "Strasbourg Rejects Right to Die Cases" UK Human Rights Blog,20 July 2015, available at- https://ukhumanrightsblog.com/2015/07/20/strasbourg-rejects-right-to-die-cases/ (Last visited on November 15, 2022)
[594] Margaret Otlowski, *Voluntary Euthanasia, and the Common Law* 269 (Oxford University Press,1st edn.,1997)
[595] *Ibid.*
[596] Sharon Young, *A Right to Die? Examining The Centrality of Human Rights Discourses to End of Life Policy and Debate in the UK* (2017) (Unpublished Ph.D. Thesis, Kingston University, London).
[597] Voluntary Euthanasia Bill, 1969 (United Kingdom)
[598] "Doctors Urge Mercy Death Be Legalized", Rochester Journal, Associated Press, 65 (1935), Available at- https://www.dignityindying.org.uk// (last visited on November 27, 2022).
[599] Physician-assisted dying, available at- https://www.bma.org.uk/advice-and-support/ethics/end-of-life/physician-assisted-dying// (last visited on November 27, 2022).
[600] Euthanasia and assisted suicide- N.H.S, available at- www.nhs.uk>pages>introduction// (last visited on November 27, 2022).

Since no legislation regarding physician-assisted suicide or passive euthanasia has been created, the Airedale case's guiding principles are now the only ones that apply in the UK.[601] The fundamental principle of acting in the "best interest of the patient," established by the House of Lords, is being observed and recognized with the rulings made in the Bolam case and currently via the Montgomery case. While many feel that these guidelines are restrictive and prevent many other patients with terminal illnesses and life-threatening conditions from passing away in a dignified and painless way. Commentators have claimed that because passive euthanasia and physician-assisted suicide are illegal in the UK, residents choose to move to countries like Switzerland and Belgium, where these practices are lawful.[602] Because the patient must terminate his or her life away from loved ones in an unfamiliar environment, this causes extra distress for both the patient and the family members.[603]

5.11.1 Judicial Decisions in the U.K

5.11.1.1 Dr John Bodkin Adams Case. In R V Adams, John Bodkin Adams was found guilty of murder for administering a lethal injection and other death-prompting medications to his 84-year-old patient. The patient was suffering from a grave illness when Dr Adams recommended a large quantity of opioids, and after receiving them, the patient passed away. Devlin J. informed the jury that any conduct that was intended to kill, and killed someone would be considered murder by the law, regardless of the victim's health or the accused's motivation. Additionally, he ruled that even if the first goal of medicine—the restoration of health—could no longer be accomplished, the doctor was still allowed to take all reasonable and necessary steps to alleviate pain and suffering, even if doing so might accidentally cause the patient's life to be cut short by hours or even longer. Thinking in terms of hours or months of life would make it impossible for the doctor to perform his duties while deciding whether or not to provide the medications. According to Dr Adams's defence, the therapy was intended to increase comfort, and if it was the legal and proper course of action, the fact that it resulted in a shorter lifespan did not make him guilty of murder. He can use every possible means to lessen suffering if the methods reduce life. He might not, however, have a particular defence. The doctor can take any action if any

[601] *Airedale NHS Trust v. Anthony Bland* [1993] 1 AER 821 (United Kingdom)
[602] Charlotte Naughton, "A trip to Switzerland in search of a good death: 'All this instead of just doing it in Brighton" *the Guardian*, 20 Nov 2021.
[603] Rimpi Gupta, (ed.), *C.M. Francis Medical Ethics*, (Jaypee Brothers, New Delhi,4th edn., 2020)

measures result in a person's life span being shortened. He will not have a particular defence for this. These defences could allow the doctor to avoid criminal responsibility. If the treatment is successful, the doctor cannot be held accountable for homicide, and it is acceptable to administer analgesic drugs like heroin and morphine.

5.11.1.2 Dr Leonard Arthur Case. The paediatrician Dr Leonard Arthur's trial, who was accused of killing a newborn with Down syndrome, ended in his acquittal.[604] His parents had rejected the child and told Dr Arthur that they did not want the infant to live. The baby should now solely receive "nursing care," according to a note that was later added to the baby's medical records. Instead of being fed, the baby was given powerful painkillers, allegedly to soothe his suffering. 3 years later, he passed away. The doctor claimed that the infant had Down syndrome and died naturally from that cause, but when additional serious congenital defects were also found, the allegation was changed to attempted murder. The jury was told that motive is unimportant in assessing the purpose and that doctors, like everyone else, must practice within the law, yet they could not find Dr Arthur guilty. This trend kept coming up during Dr Carr's trial.

5.11.1.3 Dr Carr Case. In the case of Dr Carr, his patient passed away after receiving a massive dose of phenobarbitone by injection (a barbiturate). The patient, who had incurable lung cancer, had asked to have his death hastened because he was in excruciating pain. The doctor was accused of attempting to murder. Dr Carr received an acquittal.[605]

5.11.1.4 R v. Cox Case. In this case, the doctor followed the dying and distressed patient's desires and deliberately gave her a lethal injection of potassium chloride, which kills but has no therapeutic use in this form. Soon after, she died. In this case, the jury had no choice but to find the defendant guilty because the death resulted from a willful, illegal killing, making it a homicide. Many of them openly sobbed as the judgement was delivered, demonstrating their profound reluctance to convict Nigel Cox. According to the patient's family, Dr Cox helped their elderly relative obtain a merciful release from the excruciating agony and misery she was going through so she could die with dignity. The case generated much public discussion and concern

[604] *R. vs. Arthur*, (1993) B.M.L.R.I
[605] Hazel Biggs, "Euthanasia and Death with Dignity: Still poised on the Fulcrum of Homicide,"12, *Criminal Law Review*, 878-888, (1996).

for the treating physician, the patient, her family, and others in a similar circumstance.[606]

5.11.1.5 Airedale NHS Trust v Anthony Bland case. The House of Lords in the United Kingdom has delivered one of the most critical judgments about the right to die in the case of Airedale NHS Trust v. Anthony Bland.[607] In this case, important principles that the House of Lords examined included the principles of individual autonomy and the due care owed by medical practitioners to their patients. In this case, the court reaffirmed the concept of acting in the "best interest of the patient." This decision is explored in length because it clarifies and explores several central concepts related to death with dignity in depth.

The case's facts brought up an interesting debate before the courts. Anthony Bland attended a football game at the Hillsborough stadium. Several individuals were hurt while evacuating the stadium, which was necessary. Bland suffered severe injuries due to the incident, including damage to his brain caused by a lack of blood supply. As a result, Bland entered a persistent vegetative state and lost the ability to move or feel anything on his own. Bland was kept alive by artificial means, and there was little prospect of his health ever improving. The treating medical personnel and the patient's parents believed it was necessary to stop all further medical care after two and a half years of being in this state and realizing the futility of any further treatment.

The British High Court was asked to issue a declaration allowing Bland to pass away peacefully and confirming that ceasing medical treatment in this situation would be legal and free of any criminal charges. The Court of Appeal upheld the family division's decision to grant the declaration. The Official Solicitor filed a second appeal with the House of Lords, claiming that cutting off life support would directly violate doctors' duty to exercise reasonable care for all patients and constitute a crime. After a thorough hearing, the House of Lords concluded that given the facts of the case, the medical staff's decision to remove Bland's life support would not constitute a criminal offence or a breach of their professional duty of care. Anthony Bland became the first person in English legal history to be euthanized and permitted

[606] (1992)12 B.M.L.R. 38.
[607] [1993] A.C. 789 House of Lords

to die due to this landmark decision. The Court considered several crucial factors, including the patient's best interests, the duty of care, procedural safeguards, etc., to come to this result.

Best Interest of the Patient

According to the Court, medical personnel are not always obligated to do all possible to extend their patient's life. The treating medical experts may determine whether or not to continue life-prolonging treatment when the patient is incompetent and unable to permit the continuation of medical care. If the medical professionals treating the patient believe that the current treatment is ineffective and does not enhance the patient's health, they may decide to stop giving the patient that medication. According to the Court's frame of thinking, medical personnel are not always obligated to do all possible to extend their patient's life. If such a decision is made and the treatment is discontinued, the action would not be illegal and would not constitute a breach of care. Before making such a decision, it is vital to seek the advice of unbiased medical professionals as a safeguard. Life-prolonging treatment may be discontinued if a responsible and qualified medical opinion determines that continuing medical treatment would be ineffective and not in the patient's best interests.[608] It is crucial to refer to a precedent-setting judgement made by the House of Lords in the case of Bolam v. Friern Hospital Management Committee,[609] which established that if a doctor's action is one that a responsible body of medical professionals would have followed, it is not considered to be unlawful. Therefore, it is crucial to seek the advice of qualified medical professionals before making any decisions about euthanasia or the right to die, even when such decisions are made. In his decision, Lord Goff stated that doctors must act in the patient's best interest, even if the patient lacks the capacity to provide consent, in accordance with the legislation established in the case of Re F. (Mental Patient: Sterilization).[610] Similarly, doctors must act in the patient's best interest and make sure that the patient's interests come first while discontinuing life-saving treatment for the patient. Further explaining this issue, Lord Browne Wilkinson says that if a responsible doctor determines intelligibly that continuing treatment is not in the patient's best interests and that decision is

[608] *Airedale NHS Trust v. Anthony Bland* [1993] 1 AER 821 (United Kingdom)
[609] (1957) 2 All ER 118 (QB) (United Kingdom)
[610] *F v. West Berkshire Health Authority* (1989) 2 All ER 545(HL) (United Kingdom)

supported by a responsible body of doctors, then treatment should completely stop and continued treatment would constitute a battery and trespass offence.[611]

Due care criteria

The Court also highlighted that the patient's best interests must be considered along with the principle of the medical experts' duty of care, which is not absolute. Even though the patient would likely pass away due to an underlying pre-existing disease or injury they have suffered, it would not constitute a breach of duty and would not bring criminal culpability if life-prolonging treatment was discontinued and the patient was euthanized in the best interest of the patient. According to Lord Goff, the medical expert's decision to stop the treatment would be considered an "omission" under the law and would not be considered illegal. Furthermore, it was made clear that this omission is distinct from a proactive step intended to end the patient's life. The term "positive act" refers to a behaviour that would result in death, such as administering a lethal injection or a high dosage of medicine. A positive action would indicate that the patient died due to the doctor's actions, but an omission would indicate that the patient died due to underlying medical issues. According to Lord Goff, because the doctor is acting in the patient's best interest, the law finds the doctor's omission to be in accordance with the doctor's duty of care.[612] Lord Keith also clarified the sanctity of life and its limitations in his judgment. Although extremely inclusive and broad, he claimed that the sanctity of life ethics could not be absolute. Withdrawing life-saving treatment from a patient who has been in a permanent vegetative state for longer than three years would not be against the sanctity of life principle. Continuing such treatment without the patient's consent would be intrusive. According to Lord Goff, a patient would lose their dignity due to such intrusive treatment. In most situations, it is almost probable that a patient in a vegetative state must depend on a third party, most likely a stranger, for their basic physical needs. According to Lord Goff, this not only results in a loss of dignity but also significantly harms the family's mental health. These circumstances and the ineffectiveness of the treatment should be taken into account when deciding what is in the patient's best interest.

[611] *Airedale NHS Trust v. Anthony Bland* [1993] 1 AER 821 (United Kingdom)
[612] *Ibid.*

Regarding family members' wishes, Lord Goff noted that it was recommended by the Committee and in a previous House of Lords decision that it is a good practice for medical experts to consider the patient's family members' opinions. However, family members' opinions cannot be the deciding factor in determining the nature and manner of treatment to be given to or withheld from the patient. While family members' opinions should be acknowledged, they cannot dictate what actions the medical professionals should take. Medical personnel must put the patient's best interests first. The doctors' actions should also fall within the guidelines of the Bolam test,[613] which states that they should be such that a responsible body of doctors would have performed the same action in the same circumstance. Another significant point made clear by the House of Lords, in this case, is the requirement that laws regarding the right to die be drafted by parliament following a thorough examination of all relevant factors and the effectiveness of the safeguards. Lord Browne-Wilkinson ruled that the courts should have a limited role in end-of-life decisions and should only be consulted in specific circumstances. According to Lord Goff, the courts should only get involved if there is a dispute or a conflict of opinion, such as when there is a dispute among the doctors, a dispute between family members and the doctors, a conflict of interest between the patient's family and the patient, a dispute among the family members, or when there are no family members present to give consent.

It is also important to note that the Supreme Court of the United Kingdom overruled the Bolam v. Friern Hospital Management Committee[614] judgment in the case of Montgomery v. Lanarkshire Health Board.[615] According to the UK Supreme Court, the Bolam test does not sufficiently require doctors to inform patients of all risks. Instead, the court established a new materiality standard, under which the doctor now must use reasonable care in informing the patient of all potential risks, making sure the patient is fully aware of all risks associated with a particular course of treatment and informed of any available alternatives or substitute treatments.[616] According to the new standard established in the Montgomery case, the doctor must inform the patient or the patient's family about the implications of discontinuing life-prolonging treatment and the available alternatives. Consequently, life-prolonging

[613] J. Warren Jones, "Law & Ethics: The Healthcare Professional and The Bolam Test" 188(5), *British Dental Journal*, 237-240, (2000).
[614] [1957] 1 WLR 582 (United Kingdom)
[615] [2015] 1 AC 1430 (United Kingdom)
[616] [2015] 1 AC 1430 (United Kingdom)

treatments can only be stopped, and patients can be put to death if doing so would be in their best interests and only after obtaining their consent or the approval of their family.

5.11.1.6 St. George's Healthcare NHS Trust v. S Case. In this case, the House of Lords ruled that the right to autonomy and self-determination extends to receiving life-sustaining care. The administration of artificial ventilation against the claimant's wishes constituted an unlawful trespass, the British High Court concluded in a historic decision.[617] In this case, a British woman was paralyzed from the neck down. She was paralyzed and unable to breathe on her own a year ago due to blood vessel ruptures in her neck. The hospital's doctors were using artificial measures to keep her alive and had stated that doing so would violate their ethical principles. However, the woman won in this famous judicial case by winning the right to die. The decision comes in response to a rising call from patients to prioritize their rights over those of doctors and the law and to make their own decisions about when to die. It was the first time in British history that a patient thought to be fully conscious had requested that life support be turned off in this way.[618]

5.11.1.7 UK: Post-Airedale Phase. Numerous cases identical to Airedale have been brought before UK courts in the aftermath of the historic House of Lords' judgment that acknowledged the patient's right to refuse treatment and the doctor's duty to continue it in the patient's best interest.

In the case of re B (Adult: Refusal of Medical Treatment), the Courts adopted the stance expressed in the case of Airedale.[619] Ms B was a talented woman whose spinal cavernoma left her paralyzed and dependent on a ventilator for continuous support with her breathing. She had little possibility of recovering her normalcy, but she might be able to have her pain managed with ongoing intensive care. She repeatedly asked for the ventilation to be turned off so that she could die naturally without the assistance of any machines. She was found to be competent and of sound mind after several tests. She asked the High Court to rule that she should be permitted

[617] (1998)3 All ER 673.
[618] Hazel Biggs, "Euthanasia and Death with Dignity: Still poised on the Fulcrum of Homicide,"12, Criminal Law Review, 878-888, (1996).
[619] Re B (Adult: Refusal of Medical Treatment) [2002] 2 AER 449

to decline treatment and die away with at least the bare minimum of human dignity.[620] Even if refusing medical care results in death, the Court recognised a patient's right to do so. In this case, a competent patient who needed a ventilator was permitted to refuse such care, resulting in the turnoff of the ventilator and artificial breathing support. This was the first case in which a UK court permitted a competent patient to choose her course of treatment, even though it would have resulted in death. The patient was free to decide how she would like to be treated because the court gave the autonomy of the patient a higher priority than the sanctity of life.[621] The Court's decision to allow turning off the ventilator was defended by some observers as a positive move. This act of turning off would be equivalent to active euthanasia. This comprehension might not be entirely accurate. In the Airedale case,[622] Lord Goff wrote that turning off the ventilator, discontinuing the medications, or removing any other life-saving treatment would constitute an omission because they are not the cause of the patient's condition. The patient's underlying medical condition was the cause of death in each instance. In this instance, the patient's underlying disease or condition—rather than an external event like a lethal injection—kills the patient.[623] In this instance, the doctors are not directly responsible for the patient's death; they are only stopping the treatment. As a result, this judgement, like the one before in the Airedale case, permits legal passive euthanasia.

Diane Pretty,[624] a British woman with terminal motor neuron disease whose muscles had shrivelled away and who, over time, would gradually lose control of her lungs and breathing system until they stopped functioning altogether. Her condition deteriorated over time, making it impossible for her to engage in any physical activity and affecting her speech skills. Her mental faculties, however, were normal. She needed her husband and nurses to assist her with basic daily tasks. She stated a desire to die and take her own life but would require assistance because she could not do so alone. Since aiding and abetting suicide is a crime in the UK, Diane requested a special declaration from the Public Prosecutor's office guaranteeing that her husband would not face charges if he assisted her in committing herself. Because of the

[620] M. Stauch, "Comment on Re B (Adult: Refusal of Medical Treatment) [2002] 2 All England Reports 449" 28(4), *Journal of Medical Ethics*,232-233, (2002).
[621] Hayden A Snow, Bill R Fleming, "Consent, Capacity and The Right to Say No" 201(8), *Medical Journal of Australia*, 486-488, (2014).
[622] *Airedale NHS Trust v. Anthony Bland* [1993] 1 AER 821 (United Kingdom)
[623] *Ibid.*
[624] *Pretty v. United Kingdom* (2002)2 F.C.R.97.

declaration's broader social implications, this declaration was rejected by the authorities and later by the courts. While many people believe that patient autonomy is important and should take precedence when resolving such matters, the House of Lords stated in R. (Pretty) v. Director of Public Prosecutions[625] that there is a potential for misuse in such cases. The family members and other interested parties are not always selfless in situations where the lives of terminally ill patients are at stake, and they may take advantage of their vulnerability. Despite noting her terrible situation, the court did not loosen its stance on prosecuting assisted suicide cases because it believed that any relaxation would be open to abuse. Diane filed an appeal with the European Court of Human Rights, saying that by rejecting a request from the UK authorities to drop all charges against her husband and enable him to assist in dying, her rights to life, dignity, privacy, and non-discrimination have been violated.[626] Her arguments were unique; she claimed that denying her access to assisted suicide was unfair because it prevented other terminally ill people from taking their own lives without assistance. She further contended that because her terminal illness is incurable and her physical condition is deteriorating daily, she would die in a dismal and undignified manner. Her appeal was denied, and the European Court ruled that while her condition calls for sympathy, the member state—in this case, the UK—must draft rules that consider the greater good of the entire populace. The defence's claims that legalizing assisted suicide could lead to abuse and jeopardize the interests of other terminally ill patients and their families were accepted by the court. As a result, the European Court ruled that it was legal for the UK to create laws and policies that protected the rights of society as a whole.[627] Diane, as she had feared while still alive, passed away in a hospital shortly after the European Court denied her appeal.[628]

Debbie Purdy's case is another significant one involving the UK's right to die. Ms Purdy had progressive multiple sclerosis, a terminal disease with no chance of recovery. She was entirely incapable of performing even the most basic tasks and was forced to use a wheelchair constantly. Ms Purdy believed that her life was getting

[625] (2002) 2 All ER 1
[626] *Pretty v. United Kingdom*, ECHR, (2002)2 F.C.R.97.
[627] John Keown, "European Court of Human Rights: Death in Strasbourg-Assisted Suicide, the Pretty Case, and the European Convention on Human Rights" 1(4), *International Journal of Constitutional Law*, (2003).
[628] Sandra Laville, "Diane Pretty Dies in the Way She Always Feared" *The Telegraph* ,13 May 2002, Available at-https://www.telegraph.co.uk/news/uknews/1394038/Diane-Pretty-dies-in-the-way-she-always-feared.html (last visited on November 27, 2022)

worse every day and that she would soon be unable to maintain a dignified standard of living. She wanted to visit a nation like Switzerland that permits active euthanasia to terminate her life there. She argued before the courts in the case R (Purdy) v. Director of Public Prosecutions[629] that there is no official statement from the government stating whether her husband, who assisted her travel to Switzerland, will be charged with aiding and encouraging suicide. She sought clarification on the criteria the Director of Public Prosecutions would apply in determining what constitutes encouraging and aiding suicide in such circumstances. The problem brought up in this case by Ms Purdy was serious since assisting and encouraging suicide might result in a criminal sentence of up to 14 years, and there was uncertainty over the criteria used to determine whether someone would be charged. In a unanimous decision, the House of Lords ruled in Ms Purdy's favour, holding that she had the right to choose how she wished to spend her final days. In addition, the law ought to be understandable and predictable, yet, the policy of encouraging and aiding suicide is unclear, and it is unclear which cases will and will not be prosecuted. The Court made it clear that while it is not its responsibility to create laws, it should be left to the parliament required to define laws and provide clarity where necessary.[630] The Director of Public Prosecution was consequently given a directive by the Court to establish criteria for what behaviours would constitute encouraging or helping suicide and be grounds for criminal prosecution. The Director of Public Prosecutions issued rules that will be used for prosecuting cases of assisting and encouraging suicide as a result of this judgment.[631] In response to the House of Lords' direction in the Purdy case, the Director of Public Prosecutions released guidelines that would be used for prosecuting crimes that instigate or facilitate suicide.[632] According to the prosecution department's policy for prosecutors in cases of promoting or helping suicide, a number of factors would be taken into account, with a heavy emphasis being placed on those relating to the public interest.[633] If there are enough reasons for public

[629] *R (Purdy) v. DPP* [2009] UKHL 45
[630] Afua Hirsch, "Debbie Purdy Wins 'Significant Legal Victory' on Assisted Suicide" *The Guardian*, 30 July 2009,available at- https://www.Theguardian.Com/Society/2009/Jul/30/Debbie-Purdy-Assisted-Suicide-Legal-Victory (last visited on November 27, 2022)
[631] Saimo Chahal, "Human Rights: Clarifying the Law on Assisted Suicide" *The Law Society Gazette*,20 August 2009, available at - https://www.lawgazette.co.uk/law/human-rights-clarifying-the-law-on-assisted-suicide/52048.article// (last visited on November 27, 2022)
[632] *R (Purdy) v DPP* [2009] UKHL 45
[633] The Director of Public Prosecutions, "Suicide: Policy for Prosecutors in Respect of Cases of Encouraging or Assisting Suicide" (February 2010), available at- https://www.cps.gov.uk/legal-

interest, the prosecution will not proceed. According to the policy, punishment is unlikely if a competent adult makes a fully informed decision and the assister solely acts out of sympathy. Additionally, the prosecution would often not proceed if the assister took steps to prevent the person from ending their life and made some attempts to prolong the person's life. If the person offered unwilling assistance, there are also fewer chances of prosecution.[634]

According to the policy, the probability of prosecution increases if the suicide victim is a minor, is incompetent when making the decision, and is capable of taking their own life without assistance. The likelihood of prosecution is also increased if the person who assisted the suicide had a history of violence or abuse toward the suicide victim, if there was no relationship of any kind between the assister and the person assisted, if the assister received payment for the assistance, or if the assister was acting in the capacity of a medical professional. The policy further stipulates that the authorities apply common sense and consider the entire situation when determining whether to prosecute the assister. According to the official data provided by the UK Crown Prosecution Service, 145 cases had been submitted by the police to the prosecution authorities as of the middle of 2018. Out of the 145 cases, 98 did not result in prosecution, and 28 had their cases withdrawn by the police. The prosecution authorities have successfully prosecuted three remaining cases, while two other cases are still pending. Seven other instances were transferred for prosecution as other serious crimes, while only one case was prosecuted and ended in acquittal.[635]

R (on the application of Nicklinson and others) v. Ministry of Justice[636] is one of the most recent cases involving the right to die to be heard by the UK Supreme Court. The euthanasia request of Tony Nicklinson,[637]54 years old British man who has suffered from locked-in syndrome since having a stroke in 2006. Tony Nicklinson of Melksham, Wiltshire, was supported by his wife and two daughters. The primary

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guidance/suicide-policy-prosecutors-respect-cases-encouraging-or-assisting-suicide (last visited on November 27, 2022).

[634] *Ibid.*

[635] The Director of Public Prosecutions, "Suicide: Policy for Prosecutors in Respect of Cases of Encouraging or Assisting Suicide" February 2010, available at - https://www.cps.gov.uk/legal-guidance/suicide-policy-prosecutors-respect-cases-encouraging-or-assisting-suicide (last visited on November 27, 2022).

[636] [2014] UKSC 38 (United Kingdom)

[637] Emily Jackson, John Keown, *Debating Euthanasia*,4-5 (Hart Publishing, Oxford and Portland, Oregon,2012).

appellant, Nicklinson, was in good mental health when he suffered a fatal stroke while visiting Athens on business. He lost all movement in his neck. He wanted to take his life because his situation was a "living nightmare," but he needed assistance from someone else in order to do so. Mr Nicklinson went to the court to ask for permission so that his doctor could honour his wishes and allow him to pass away peacefully. In a petition submitted to the London High Court, he begged the judge's assistance in not punishing the doctor, provided they assisted him in making a dignified exit. According to his strategy, the court's decision to deny him the right to life would subject him to torture and force him to continue living. Additionally, he asked the courts to rule that the current UK law prohibiting euthanasia and assisted dying was incompatible with his "right to respect for private life without interference" guaranteed by Article 8 of the European Convention on Human Rights if they did not grant his doctor permission to kill him (ECHR).[638] The High Court denied any of the reliefs requested by Mr Nicklinson. Mr Nicklinson chose to stop eating after being disappointed by the High Court's decision and soon passed away from pneumonia.[639] His wife continued the legal conflict, and gradually more appellants joined. The Court of Appeal denied the appeal made in this case, arguing that the necessity defence used by Nicklinson as the main reason for euthanasia could not be accepted since it may be abused. The UK Supreme Court then heard a second appeal in the case. However, out of the nine judges, three found that there was no incompatibility with the ECHR, and four decided that such matters are within the purview of the Parliament, despite the Court's decision that it had the constitutional authority to determine whether the UK's blanket ban on assisted suicide was incompatible with the rights granted in the ECHR. Only two judges concluded that the UK's current policy, which forbade assisted suicide in any situation, violated the ECHR. A second appeal was filed with the European Court of Human Rights after the majority decision dismissed the appeal. In

[638] The European Convention on Human Rights (ECHR) (formally the Convention for the Protection of Human Rights and Fundamental Freedoms), 1950, art. 8: Right to respect for private and family life
1. Everyone has the right to respect for his private and family life, his home and his correspondence.
2. There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others

[639] Editorial, "Right-to-die man Tony Nicklinson Dead After Refusing Food" *BBC News* ,22 August 2012, available at - https://www.bbc.co.uk/news/uk-england-19341722// (last visited on November 15, 2022)

Nicklinson and Lamb v. the United Kingdom,[640] the European Court unanimously dismissed the appeals. The Court ruled that the local parliament should consider all relevant legal, moral, and social concerns before passing legislation governing the right to die. The European Court should not become involved, according to the court.[641]

5.11.2 Execution of Living Will

Simply put, a living will is a written or verbal declaration made by a terminally ill patient while still in good health that, in the event the patient were to lose the capacity to consent to the withholding or withdrawal of life-prolonging devices due to a terrible disease, the person named in the will would be authorized to do so on the patient's behalf. It is important to remember that a Living Will only functions when the patient cannot express his assent freely.[642] This includes circumstances where the patient has developed a fatal illness and is permanently unconscious. They can say in advance whether they want to accept or refuse a specific medical treatment. A living will can only be used to guarantee and approve otherwise legal actions. The doctor cannot be forced to do any action that is against the law. Any family member, a close relative, or even a close friend might be designated as a proxy. That proxy person's role will be to assist the attending physician in reaching a meaningful decision by offering a useful recommendation or assistance. The maker of the living will is legally required to give copies of the document to both his or her doctor and attorney. To secure the document's authenticity through proper legal procedure, the document must be executed appropriately and finalized. In the British Law Commission Report 231, living wills have received adequate scrutiny. The aforementioned report was issued following a review of many judgments. The usage of the aforementioned will in particular medical circumstances has been elaborated upon in these judgements. A detailed list of recommendations regarding the functioning and legal standing of living wills is provided in the report. The usage of these types of legal agreements will undoubtedly grow in the future. It will go a long way toward making difficult

[640] Nicklinson and Lamb v. the United Kingdom (Applications nos. 2478/15 and 1787/15) available at- http://hudoc.echr.coe.int/eng?i=001-156476// (last visited on November 27,2022).
[641] Isabel McArdle, "Strasbourg Rejects Right to Die Cases" UK Human Rights Blog,20 July 2015, available at - https://ukhumanrightsblog.com/2015/07/20/strasbourg-rejects-right-to-die-cases// (Last visited on November 15, 2022)
[642] UK Guide on Ageing for Senior Citizens & Pensioners from Care Directions, available at- http://www.caredirections.co.uk/legal/comment-6.htm// (last visited on November 27,2022).

decisions about patients in a persistent vegetative state and requiring passive euthanasia after refusing or withdrawing the unwelcome medical treatment much easier.[643] In conclusion, it can be mentioned that a professional legal opinion should be sought regarding the formulation and application of the provisions listed in a living will.

5.12 Analysis of Different Foreign Judgments in The Context of India

Indian courts have always used the doctrine of stare-decisis in the absence of established law, and they have consulted foreign judgments to clarify the issue. Although these judgments are not legally binding, they have always helped reach valuable conclusions. In this section, the researcher has made an effort to evaluate and look at foreign judgments that are represented in numerous Indian judgments.

5.12.1 McKay v. Bergstedt[644]

In the case of P. Rathinam Nag Bhushan Patnaik v. Union of India,[645] this precedent was mentioned. Nevada's Supreme Court pronounced the decision on November 30, 1990. The case is related to Kenneth's application for removing the life-supporting equipment and administering a drug that causes a good death. At age 10, a swimming accident left Kenneth Bergstedt a quadriplegic (affected by or relating to paralysis of all four limbs). After twenty-one years, Kenneth decided that he wanted to be freed from a paralyzed life kept intact by a respirator's powers of survival. Kenneth was able to read, watch television, use a computer orally, and occasionally he found wheelchair ambulation to be somewhat enjoyable, but he feared the idea of living without his loving father's careful care and company. The Court only possessed a small number of documents, which indicated the significant evidence of events pertinent to the proceedings and a small number of materials to use to interpret the stated appeal's purpose. The documentation firstly consisted of a thorough neurosurgeon's certificate stating that Kenneth's quadriplegia is permanent. Second, a psychiatrist examined Kenneth and determined that he was competent and capable of comprehending the nature and repercussions of his decision. Thirdly, Kenneth made his decision after giving it serious thought. Fourthly, Kenneth's loving and dedicated

[643] UK Guide on Ageing for Senior Citizens & Pensioners from Care Directions, available at-http://www.caredirections.co.uk/legal/comment-6.htm// (last visited on November 27,2022).
[644] *McKay v. Bergstedt* ,801 P.2d 617 (1990).
[645] 1994 AIR 1844

father had unwillingly given his reluctant approval because he knew the reasons behind his son's decision. Fifth, Kenneth's quadriplegia was permanent; as long as he had artificial breathing, his condition was not terminal. In order to remove his respirator and alleviate the suffering that might otherwise cause his death, Kenneth petitioned the District Court as a non-terminal, competent adult quadriplegic. He also requested that a sedative be administered. Kenneth further wanted an injunction exempting anyone who provided the requested help from any civil or criminal liability. In addition, he asked the Court for a decision absolving him of suicide by turning off his life support. The court granted Kenneth's request for relief. The court also found that Kenneth was a mentally sound adult capable of deciding to forgo a respirator-connected life. The court also determined that he was aware that turning off his life support would quickly result in his death. As a result, the Court determined that Kenneth had a constitutional right to privacy that allowed him to stop receiving further medical treatment. The Court further decided that, even if Kenneth's disease were to receive legal recognition, it would not endanger the State's interest in protecting human life, have any negative effects on third parties, or compromise the credibility of doctors. Because the case "raises vast and important concerns of public policy which at the present time affect the rights of many persons in Nevada," the District Court ordered the State to appeal the decision to the Nevada Supreme Court.[646] The Legal Centre attempted to submit a brief on behalf of American Disabled for Access and Power Today (ADAPT) of Southern California, arguing that the Court should not participate in an erroneous campaign to support Mr Bergstedt's right to suicide when his right to independent living has neither been acknowledged nor encouraged.[647] Furthermore, if Mr Bergstedt had not been disabled, one would not have considered his decision to take his life to be logical. The amicus brief, therefore, claimed that Mr Bergstedt should be given a psychological evaluation, counselling, and information on rehabilitation, independent living, and peer group services by a specialist in suicide among people with disabilities. After receiving sedatives from his father and having his ventilator switched off, Mr Bergstedt passed away before the Nevada Supreme Court could issue a decision.[648] In the end, the Nevada Supreme Court upheld the District Court's decision to approve Kenneth's petition. The Supreme

[646] 1994 AIR 1844
[647] *Ibid*
[648] *Ibid*

Court established the right to cease treatment for competent adults suffering from physical and mental distress while being irreversibly sustained by artificial life support. In such cases, the patient's choice to reject or stop receiving life-sustaining care would take precedence over conflicting state interests in life preservation, and exercising that right would not constitute suicide.[649] In P. Rathinam Nag Bhushan Patnaik v. State of Maharashtra,[650] the Maharashtra High Court referred this matter under the principle of stare decisis because it was the first time the Court had ever been presented with such a question. Even though the facts differed, the cases dealt with the same issues; therefore, the court's decision to refer to it made sense. In its judgment, the Court expressed a similar viewpoint. It stated that the right to die was contained in the right to life.

5.12.2 R v. Cox[651]

Although unreported, this precedent was briefly cited in the case of Gian Kaur v. State of Punjab.[652] Dr Nigel Cox, a specialist rheumatologist, was found guilty in 1992 of attempting to kill Mrs Lillian Boyes, a patient of his. Mrs Boyes suffered from rheumatoid arthritis, septicemia, and limb sores and ulcers. She was terminally ill. Her lungs were failing, and her heart had hardened. She had many lumbar spine fractures in addition to gangrene. Mrs Boyes was, without a doubt, in excruciating pain. Dr Cox had attempted to alleviate her misery by giving her heroin, but to no avail. He gave her a potassium chloride injection, and she died shortly after. Many individuals applauded Dr Cox for his kind deed and voiced the hope that their doctors would treat them similarly if they were in the final stages of a terminal illness and experiencing similar levels of extreme agony. The fact that he was accused of murder and later found guilty of attempted murder, although the body had been cremated before a clear cause of death could be determined, indicates that the criminal law regards his behaviour very differently.[653]

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[649] Allen C. Snyder, "Competency to Refuse Lifesaving Treatment: Valuing the Non logical Aspects of a Person's Decisions"10(3) Issues Law Med,299-320, (1994).
[650] 1994 AIR 1844
[651] (1992)12 B.M.L.R. 38.
[652] 1996 AIR 946, 1996 SCC (2) 648
[653] Pamela R Ferguson, "Causing death or allowing to die? Developments in the law" 23, *Journal of Medical Ethics*,368-372, (1997).

Gian Kaur v. State of Punjab[654] overturned the precedent established in the case of P. Rathinam Nag Bhushan Patnaik v. State of Maharashtra.[655] In Gian Kaur's second ratio established in the aforementioned case, the Court considered the act of suicide, assisted suicide, and euthanasia as a criminal offence and stated that anyone abetting in such an act would be accountable for abetment for murder. The Court did mention that euthanasia may be made permissible by legislation, however.

5.12.3 Cruzan v. Director, Missouri Department of Health[656]

It is crucial to investigate this issue because it was extensively discussed in the decision in Aruna Shanbaug v. Union of India.[657] However, in the Cruzan v. Director case, the burden of proof requirements for demonstrating a person's intent concerning a life-threatening situation is the main topic of discussion. This type of situation, where a person wishes that her life be left to natural processes, must be separated from assisted suicide cases, where a doctor will actively work to hasten a person's death.[658]

Nancy Cruzan was in an automobile accident that caused her to be in a "permanent vegetative state," which was the actual circumstance in this case. On January 11, 1983, Nancy Cruzan, a 25-year-old woman, was involved in a car accident after losing control of the vehicle. She was thrown 35 feet from the vehicle onto a desolate field, landing face-first and losing consciousness for almost 15 minutes (an absence of oxygen). When the paramedics arrived on the scene of the accident, they were able to revive the heartbeat. She was described as being in a "permanent vegetative state" because the damage to her cerebral cortex, which controls awareness and thought, was irreparable. Surgeons put a feeding tube inside her to feed her and speed up her recovery. Cruzan's parents ordered hospital staff to stop performing life support measures after it became clear that Cruzan had little prospect of recovering. She had expressed her desire to avoid passing away terribly on a hospital bed to her housekeeper. Thus, it stands to reason that she would also prefer not to live in this condition. Employees at the State hospital declined to comply with

[654] 1994 AIR 1844
[655] 1996 AIR 946, 1996 SCC (2) 648
[656] *Nancy Beth Cruzan, by her Parents and Co-Guardians, Lester L. Cruzan, et ux., Petitioners v. Director, Missouri Department of Health, et al*. (1990) 497 U.S. 261
[657] (2011) 4 SCC 454
[658] *Nancy Beth Cruzan, by her Parents and Co-Guardians, Lester L. Cruzan, et ux., Petitioners v. Director, Missouri Department of Health, et al*. (1990) 497 U.S. 261

this request without a court order. As a result, they presented a petition to the Trial Court. Nancy's parents, Joyce and Lester Cruzan were granted permission by the Missouri Trial Court to stop providing Nancy with artificial nutrition and hydration. In order to appeal to the Missouri Supreme Court, guardian ad litem[659] was appointed by the State and the Court. The Missouri Supreme Court declined to compel the life support to be turned off following the trial because there was insufficient, convincing evidence that Cruzan would have opted to forego treatment. Nancy Cruzan did not leave a living will. Her parents argued that she would want to pass away rather than be kept alive indefinitely by artificial methods with little chance of recovery. The State Constitution does not include a right to privacy, which would support a person's decision to refuse medical treatment, the Missouri Supreme Court underlined. Despite the fact that the right to privacy had been recognized by the U.S. Supreme Court in instances like Roe v. Wade[660] and Griswold v. Connecticut[661], this right did not encompass obtaining food and liquids. The U.S. Supreme Court's Roe v. Wade ruling, however, made clear that the court had previously refused to recognize an unfettered right of this nature. The Court rejected their petition, claiming they had not presented them with clear and persuasive evidence. The Supreme Court acknowledged this right but stated that Missouri may prevent the Cruzans from depriving their daughter of food and water unless there was "clear and persuasive" proof that she would have chosen to die. Cruzan's parents were not allowed to order the end of her medical care, and the court rejected that claim, concluding that "no one can presume that choice for an incompetent in the absence of the formalities needed under Missouri's Living Will regulations or the clear and persuasive, inherently reliable evidence absent here."[662] In a new petition, the parents claimed that their daughter would have opted to die rather than be kept alive indefinitely by artificial methods with little chance of recovery.[663] In support of their assertion, they highlighted verbal remarks she had made. The Cruzans referenced new information in their most recent appeal, including "three

[659] Guardian ad litem is a guardian appointed by a court to protect the interests of a minor or incompetent in a particular matter.
[660] 410 U.S. 113 (1973).
[661] 381 U.S. 479 (1965)
[662] *Nancy Beth Cruzan, by her Parents and Co-Guardians, Lester L. Cruzan, et ux., Petitioners v. Director, Missouri Department of Health, et al*. (1990) 497 U.S. 261
[663] Don Colburn, "Another Chapter In The Case Of Nancy Cruzan", Oct 16,1990, *The Washington post, Democracy dies in Darkness*, available at - https://www.washingtonpost.com/archive/lifestyle/wellness/1990/10/16/another-chapter-in-the-case-of-nancy-cruzan/ebd1bb95-8f53-4636-a78a-6c45eb142252/ (last visited on 29 Nov,2022).

witnesses" who "came forward who had detailed discussions with Nancy regarding her desires about life-sustaining medical treatment." The Cruzans testified that the evidence was "extremely compelling" and "more than fulfils" the state's "clear and convincing" standard, which was upheld by the Supreme Court when combined with comments already made at the first trial in 1988. A terminally ill individual in a "permanent vegetative state" has a constitutional right to refuse life-sustaining treatment, the Supreme Court decided in 1990.[664] A higher legal burden may be placed on a family to demonstrate that a patient has genuinely agreed by "clear and compelling evidence," according to Chief Justice William H. Rehnquist's judgment, which made it plain that "right was not absolute."[665] The decision sent Nancy Cruzan's case back to Missouri State Court, which ultimately decided the comatose woman had expressed a desire to die. In that case, five of the nine justices still supported the Court.[666]

5.12.4 Airedale NHS Trust v. Bland[667]

This judgement was mentioned in the **Aruna Shanbaug v. Union of India[668]** case. Because the State in both cases did not acknowledge the right to die as a constitutional right, the case received greater attention than that of Aruna Shanbaug.

Tony Bland, a young Liverpool fan, was 18 years old. He sustained injuries due to the mayhem at Hillsborough football stadium, including smashed ribs and two pierced lungs. His brain's oxygen supply was cut off, resulting in catastrophic and irreparable damage and putting him in a persistent vegetative state. He could not perceive anything, hear it, feel it, or speak it. The brain stem, which manages the body's basic processes like breathing, digestion, and heartbeat, persisted in functioning. As long as the brain stem is still functioning, a person is not considered clinically dead in the eyes of both the medical community and the law.[669] He spent three years in this condition. Tony Bland needed to be tube-fed in order to survive in

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[664] Don Colburn, "Another Chapter In The Case Of Nancy Cruzan", Oct 16,1990, *The Washington post, Democracy dies in Darkness*, available at - https://www.washingtonpost.com/archive/lifestyle/wellness/1990/10/16/another-chapter-in-the-case-of-nancy-cruzan/ebd1bb95-8f53-4636-a78a-6c45eb142252/ (last visited on 29 Nov,2022).
[665] *Ibid.*
[666] Editorial, "Justice' earlier comments on right to life", *nbc news*, March 24, 2005, available at - https://www.nbcnews.com/id/wbna7278229#.WSz_IpKGPIU// (last visited on 29 Nov,2022).
[667] *Airedale NHS Trust v. Anthony Bland* [1993] 1 AER 821 (United Kingdom)
[668] (2011) 4 SCC 454
[669] *Airedale NHS Trust v. Anthony Bland* [1993] 1 AER 821 (United Kingdom)

his current state. All medical experts agreed that Tony Bland would never fully recover from his current state but would live for many years as long as he received medical care.[670] The doctors in charge of Tony Bland concluded that Tony Bland's medical treatment was unnecessary, and his parents agreed. They determined that stopping artificial feeding and other life-extension techniques was appropriate. In other words, Tony Bland had no benefit from being kept alive. However, because there were questions about whether this may be considered a crime, Bland's caretakers at the Airedale NHS Trust turned to the High Courts of Justice for advice. As a result, declarations along the requested lines were approved by the Family Division President's decision on November 19, 1992.[671] On December 9th, 1992, the Court of Appeal upheld the decision (Sir Thomas Bingham M.R., Butler-Sloss, and Hoffman L.JJ.).[672] The declarations stated that, despite the defendant's inability to give his or her consent, the plaintiff and the responsible attending physicians may lawfully discontinue all life-sustaining treatment and medical supportive measures intended to keep the defendant alive in his or her current persistent vegetative state, including the termination of ventilation, nutrition, and hydration by artificial means; and may lawfully discontinue and thereafter need not furnish medical care for the defendant.[673] In a subsequent appeal to the House of Lords, Lord Keith of Kinkel stated that the aim of medical treatment is to benefit the patient and that the Court thought that administering therapy against the patient's will would be considered criminal assault and battery. Such a person can refuse treatment, even if death is certain. This also applies when a person desires to avoid such treatment if he or she enters a persistent vegetative state. Additionally, if the patient's consent is unavailable due to an accident or other unforeseen circumstance, the medical professional may withdraw or postpone treatment while acting in the patient's best interest. The Court further affirmed that a doctor is not required to continue a patient's treatment if most other doctors believe that doing so will not be in the patient's best interests. The Coram, made up of Lord Keith of Kinkel, Lord Goff of Chieveley, Lord Lowry, Lord Browne Wilkinson, and Lord Mustill, decided that in certain situations, treatment might be terminated legally since the patient's best interests did not require that he be kept alive at all costs. According to Lord Keith, such withdrawal is not considered a criminal offence under

[670] *Airedale NHS Trust v. Anthony Bland* [1993] 1 AER 821 (United Kingdom).
[671] *Ibid.*
[672] *Ibid.*
[673] *Ibid.*

the laws of other nations, including the USA. Additionally, he added that it is somewhat comforting to know that in common law jurisdictions, especially in the United States where there are numerous cases on the subject, the Courts have nearly unanimously determined that discontinuing medical treatment and care, including artificial feeding of PVS patients and in other similar circumstances, is not illegal.[674] According to Lord Browne Wilkinson, judges should apply the values that society chooses via the democratic process in this area of the law rather than imposing their own standards on it. If Parliament does not take action, judge-made law will be forced to offer a legal response to each new matter as it arises through a slow and unpredictable process. But in his opinion, that was not the best course of action. In these instances, the Court's role is to decide this particular case in line with the law as it already stands, rather than to create new rules for the legal system. Parliament should address the larger issues that the case brings up and establish basic legal rules that apply to the removal of life support systems.[675] Lord Browne Wilkinson and Lord Mustill stated that "It is imperative that the moral, social and legal issues of the present case should be considered by Parliament"[676] While distinguishing between euthanasia, which can only be legalized by legislation, and "withdrawal of life support," the Supreme Court in **Aruna Shanbaug v. Union of India**[677] appears to agree with the House of Lords that "withdrawal of life support is permissible in respect of a patient in a persistent vegetative state as it is no longer beneficial to the patient that "artificial measures" be started or continued merely for "continuance of life". The Court further noted that the concept of the "sanctity of life," which is the State's concern, was "not an absolute one." Although this course of action is motivated by a humanitarian desire to end his suffering, the Court made it clear that it was illegal for the doctor to administer drugs to his patient in order to cause his death. This is true even if the act of causing death may be intended to prevent or end the patient's suffering. It was decided that euthanasia was illegal under all circumstances under common law.

[674] *Airedale NHS Trust v. Anthony Bland* [1993] 1 AER 821 (United Kingdom)
[675] *Ibid.*
[676] *Ibid.*
[677] (2011) 4 SCC 454

Cruzan v. Director, Missouri Department of Health[678] and **Airedale NHS Trust v. Bland**[679] were the cases that served as the foundation for the famous judgment in **Aruna Shanbaug v. Union of India.**[680] The Court placed heavy reliance on both cases.

After analyzing several judgments, the researcher noticed that euthanasia is typically considered by the Indian judiciary in the context of the crime of attempted suicide, with the case of Aruna Shanbaug being the first to have the verdict provided completely and only in the context of euthanasia. Even though many of the instances mentioned above do not specifically address euthanasia, it was crucial to thoroughly study them since they directly impacted the Right to life and Human dignity.

5.13 Comparative Analysis Among the Countries

Although different nations have chosen different strategies, practically all of them have implemented safeguards to ensure that legal misuse is stopped. These safeguards mainly make sure that the liberties and privileges guaranteed by the law are utilized for their intended purposes and not for any ulterior motives. Euthanasia and physician-assisted suicide are only to be used in rare circumstances when the patient is suffering from a painful terminal illness with no chance of recovery, which is a resemblance that is evident throughout jurisdictions. When deciding whether to permit euthanasia or physician-assisted suicide, jurisdictions must take the patient's agony into account and the patient's right to a dignified death. The requirement that patients actively express their desire to die is another crucial safety measure initially outlined in the law of the Northern Territory of Australia and is currently outlined in the laws of Oregon, the Netherlands, and Belgium. This safety measure ensures that the patient is deciding to terminate his suffering and misery voluntarily and is not being forced to.

In almost all jurisdictions, there is also a standard safeguard known as a "waiting period" or "cooling period" between the moment a patient expresses a desire to die and the time the patient is actually put to rest. This waiting period ensures the

[678] *Nancy Beth Cruzan, by her Parents and Co-Guardians, Lester L. Cruzan, et ux., Petitioners v. Director, Missouri Department of Health, et al*. (1990) 497 U.S. 261
[679] [1993] A.C. 789
[680] *Nancy Beth Cruzan, by her Parents and Co-Guardians, Lester L. Cruzan, et ux., Petitioners v. Director, Missouri Department of Health, et al*. (1990) 497 U.S. 261

patient is not laid to rest if they have changed their minds or do not want to carry out their desire to die. Theoretically, this prevents the patient from being euthanized or assisted in suicide in the interim period if there is a new medical advancement or if there is a new means to ensure that the patient's agony and suffering are significantly lessened.

Along with these, a well-known safeguard that can be found in all jurisdictions is that before any actions are taken to assist a patient to commit suicide or to end their life, a medical professional's independent opinion should be obtained to confirm that the patient has a terminal illness for which there is no prospect of a cure in the near future. In order to ensure that the medical professionals caring for the patient have come to the correct conclusion and are not acting under the influence of a false impression, it is imperative to seek an independent medical opinion. An independent medical opinion also determines whether treating physicians are subject to any pressure or bias, and if they are, such actions can be avoided.

The British courts have often established important principles. The well-known "concept of the best interest of the patient," which permits doctors to take action even if the patient cannot provide consent, was established in the Airedale case, which made it famous. Before acting in the patient's best interest, doctors must seek an outside medical opinion and tell the patient or the patient's family of all potential consequences. In previous cases, the UK's courts have established important principles of individual autonomy and the patient's right to refuse treatment. The courts in Australia and the United States have acknowledged similar concepts about the patient's right to refuse treatment, even if doing so could result in the patient's death. The courts have also outlined the principles of informed consent, stating that if the patient is competent, the doctor should only proceed with the procedure with the patient's consent. If the patient is not competent, the consent of the patient's next friend or legal guardian should be acquired. As a result, the Courts have also established essential safeguards that must be followed before making decisions that will impact the patient's life. As a result, it is clear that while there are disparities between how law and policy have evolved in various jurisdictions, there appear to be some common characteristics present in the majority of jurisdictions.

5.14 Summary

According to the analysis of laws and policies established in various nations discussed above, there is no consistency in how the legislation governing the right to die has evolved in different nations. The courts have taken a proactive stance in several nations, like the United Kingdom and the United States, and have, on various occasions, interpreted the law. Although the Courts have ruled that the legislature should draft appropriate laws and that they do not have the authority to do so, their guidance has sparked discussions and debates. Other nations, like the Netherlands and Victoria Province in Australia, have legislative bodies that take action after cases are heard in court and judgments are made. These regions' legislative bodies have passed legislation regulating physician-assisted suicide and euthanasia. While there have not been many case laws in other nations like Belgium and Switzerland, and the courts have not had a chance to discuss these issues fully, the parliament in those nations passed relevant laws that allowed patients to pass away peacefully and with dignity after taking the socio-cultural context of the region into account. The most vulnerable patients in Belgium, such as those with dementia or other mental incapacity, infants, and kids, should receive extra care. Detailing the requirements for euthanasia is necessary to prevent misunderstandings that can result in abuse. Palliative care is promoted in Australia, but as assisted suicide is forbidden, doctors often give patients dosages of medication, which unquestionably hastens death. Due to numerous laws and disputes, the law is largely obscure. According to the study, there are no established justifications for euthanasia in the Netherlands. Due to improper citation of the causes, any cause—including mental depression, terminal sickness, or other types of depression—can justify suicide. Unwanted deaths have been caused by the law, and there is no effective way to stop these tendencies. As the study noted, it lacks an effective law in many ways because the doctor can make all the decisions. The defence of necessity is abused in that one can simply choose active euthanasia in the nation under the pretext of this defence. If a physician reports an illness while keeping to the standards of care in him, he can easily escape criminal prosecution. The lack of provisions to examine whether the condition is met is a flaw in the legislation. Even young children, who typically lack the maturity and aptitude to exercise rational judgement, can make judgments when their guardians are present. Euthanasia is legal in Switzerland for foreigners as long as they are not swayed by any other factors.

Altruistic motivation can be quite challenging to evaluate, and it can be challenging to scrutinize. It is essential to underline that in Switzerland, the choice to end one's life must only be made with the doctor's help. According to the researcher, a patient's decision should be made by the doctor who is treating them and must be made necessary because he is the best person to determine the patient's condition. However, the patient's interest is also to be seen. One study found that half of the 2,400 armies expressed interest in hastening the death of a loved one who had requested euthanasia due to extreme suffering. Eighty-two per cent of the 1,000 respondents in a 1999 survey of the Swiss public agreed that if a person has a terminal illness and is experiencing severe physical and mental suffering, he has the right to ask for death and to seek assistance for that purpose. Sixty-eight per cent thought a doctor's help was necessary, while 37 per cent thought the family and 22 per cent thought the right-to-die societies and 7% believed that religious organizations ought to be able to meet their request. However, it should be highlighted that no information was available to determine if the patient would embrace the hotly debated topic. In other words, no statistics or opinions from the general public could be used to determine how they felt about this practice method.[681] Additionally, Canadian law distinguishes between active and passive euthanasia, but this distinction is purely cosmetic and does little to illustrate how abuse may be stopped. In actuality, the patients' suffering would worsen for no valid reason. How long can a patient be kept alive without treatment that seems crueller and more inhumane than simply giving him an injection to end his life peacefully? Since Canadian law is uniform and systematic, the researcher's observations highlight cases when if the distinction between active and passive euthanasia had been made, it could have been more logical and systematic. Although there are numerous international legal frameworks, Canada will still need to create its comprehensive legislation to guarantee fair, moral, and suitable access to assisted suicide.

The law in Switzerland is an exception to these basic principles. The essence of Swiss law is unique and takes a very liberal stance. According to Swiss legislation, it is not necessary for the individual receiving assistance with suicide to have a terminal illness. The topic of a "waiting period" or getting an impartial medical

[681] Derek Humphry, *Dying with dignity: Understanding euthanasia*, (Carol Publishing Group, New York, 1992)

opinion does not arise because Swiss law does not require the person assisting in suicide to be a medical professional. The diverse sociocultural context that resulted in the development of this policy in Switzerland, where there have been no reports of abuse, may be responsible for the liberal approach of the country's legal system. It has been suggested that local factors must be considered when legalizing a specific activity and that a direct export from another country is unlikely to succeed.[682] Therefore, every jurisdiction that legalizes euthanasia and/or physician-assisted suicide must do so while considering the local context and current circumstances. Furthermore, much media attention and worry have been focused on the Zurich-based right-to-die society, which provides assisted suicide to non-resident foreigners, but a significant change from Switzerland's unique position on this topic seems improbable. In Belgium, euthanasia is out of hand and skyrocketing. More cases beyond those with a prognosis of death are likely to be covered by the law. Without hesitation, cases of women between the ages of forty-four and sixty-four who suffered from chronic anorexia and chronic depression were injected, drastically changing society in that region. Although a second doctor checks patients before harsh measures are taken, Belgium is a small country, making it easy to obtain. Society was abandoning moral principles and looking on the bright side of unnatural deaths. The irony is that a doctor may inject a family's mother with a lethal drug without adequately informing the kids. Drugs are used to hasten death without even the patients' consent. Euthanasia administration became considerably simpler in such countries because doctor certification is the prerequisite and only resource. According to reports, euthanasia was delivered to people with personality disorders or psychological illnesses who were not terminally ill. In total, 67 cases of euthanasia justified by neuropsychological disorder were found in Belgium.

Now coming towards India, In India, the question of whether one should consider the conditions endured by patients or patients' family members has not been settled by most parliamentarians. There can be no justifications for why a rigorous monitoring system cannot reduce euthanasia. For instance, even though stealing is against the law, evil people nonetheless do it. Since death is a personal matter, the government should not get involved. In the 196th report, the 17th law commission of

[682]Emily Jackson, John Keown, *Debating Euthanasia*, (Hart Publishing, Oxford and Portland, Oregon,2012).

India distinguished between assisted suicide and euthanasia and had a lengthy discussion on withdrawing life support measures that lead to passive euthanasia. Every person has a right to die just as they have a right to live in society. The law commission noted a few things about informed consent and passive euthanasia for the first time in India. However, the idea of informed consent was exclusively applied in doctor-patient relationships. The commission decided to examine the topic at the Indian Society of Critical Care Medicine's request. The commission rejected active euthanasia and assisted suicide in favour of focusing solely on the legal implications of turning off life support. When a terminally ill patient is found to be incompetent, the treating physician should inform the patient's family after seeking the opinions of three medical professionals. The treatment might be stopped after waiting fifteen days, and in the interim, the family could file a petition with the High Court for declaratory relief. The patient, hospital, and family members would be bound by the High Court's decision. However, the Supreme Court first used the term passive euthanasia in 2011, which was five years later. Both the High Court and the Supreme Court determined that from a legal and constitutional perspective, stopping the treatment would not be harmful. The Supreme Court's recommendations issued in 2011 made the High Court's clearance certificate necessary for discontinuing treatment, but the Law Commission merely saw the High Court's function as one of declaratory relief. The commission added that a doctor is not held criminally liable even under the Indian Penal Code's general exception. In its 241st report, the Law Commission outlined specific actions doctors must take while making decisions. It allowed passive euthanasia for both patients who were competent and those who were not. The Commission, led by P.V. Reddi, acknowledged the withdrawal of life support for terminally ill patients, including those who were mentally ill. It happened in response to the country's Supreme Court decision in March 2011. By distinguishing between active and passive euthanasia, it made it possible to stop treatment when medicines are ineffective. According to some, the judgement in Shanbaug's case was rendered on the wrong premises. The 241st report supported the argument made by Lord Brown Wilkinson in the case of Airedale. It made it evident that prolonging a patient's life while in a permanent vegetative state was not always in their best interests. Only the Supreme Court of India in 2018 recognized the advanced directive. A living will include directions from a patient to the doctor and caregivers on what should be done and what should be avoided regarding the patient's health due to

incapacity or a terminal illness. The patient's death should not be equated with an advanced directive. It is acknowledged in the United States, Canada, Australia, and many other European nations. Most people in India are unaware of living wills, and those who exist only prepare for death through the maker's terminal illness. Individuals are given preference to ensure the patient's autonomy; however, this cannot be employed in India due to the high possibility of abuse. Luis Kutner was the first to propose advance directives as a corollary to property law. A person may manage property concerns under it, but Indians could not make sensible decisions. The public was asked for recommendations about the Medical Treatment of Terminally Ill Patients (Protection of Patients and Medical Practitioners) Bill. The Ministry of Health and Family Welfare provided it. A patient may decide while they are ill but not beforehand. The doctor should not feel obligated to offer care endlessly and prolong life even though it is disrespectful. The Constitution guarantees the right to life; however, it should be recognized that no constitution supersedes humanity. It is not harmful to allow people to write down their wishes in advance because it cannot be used as a simple method of suicide, and there is very little chance of being exploited by another person. The researcher believes that because most Indians are unfamiliar with the process, adopting living wills will not harm the populace.

In the Airedale judgement, Lord Mustill[683] offered an insightful and controversial opinion that is extremely helpful to a developing nation like India. Even though he agreed with the majority's view that life support measures could be stopped if they are not in the patient's best interests, he added that it is also essential to consider if continuing life support would be advantageous to the larger community. He believed that maintaining life by life support systems, even when there is little chance of recovery, would not provide any beneficial effects and would more likely harm the patient's immediate family and the medical team caring for them. Additionally, Anthony Bland and other patients in a permanent vegetative state are treated with tremendous resources. According to Lord Mustill, the resources allocated to meet the needs of this patient, who has no prospect of recovering, may instead be used for other patients who, with prompt treatment and care, could live long and healthy lives. The Court did not express it very clearly, but it did suggest that a cost-benefit analysis could be employed in some situations to determine whether the

[683] *Airedale NHS Trust v. Anthony Bland* [1993] 1 AER 821 (United Kingdom)

expense of maintaining a patient in a persistent vegetative state alive is justified. The advantage in these situations is almost nonexistent, as the patient's health does not significantly improve. Therefore, if we follow Lord Mustill's logic, the expense should not be placed on patients who are in a permanent vegetative state, but rather it should be placed on patients who can be treated and who may have a better life. Lord Mustill's analysis is flawed since it attempts to balance the costs and benefits of living a human life. Even though keeping a patient alive carries a high expense in terms of money, labour, skill, etc., this should not be considered when deciding whether to let the patient pass away. It is asserted that the state must allocate adequate funds so that people can obtain essential medical care. When deciding whether to stop life-prolonging treatment, it should not be taken into account because the state cannot afford to offer enough resources to its citizens.