THE NATIONAL UNIVERSITY OF ADVANCED LEGAL STUDIES, KOCHI

DISSERTATION

Submitted in partial fulfilment of the requirement for the award of the degree of

MASTER OF LAW (LL.M)

(2019-2020)

ON THE TOPIC

PHYSICIAN ASSISTED SUICIDE: ETHICAL AND LEGAL DIMENSIONS

Under the Guidance and Supervision of

Dr Liji Samuel

The National University of Advanced Legal Studies, Kochi

Submitted By:

Akhil Santhosh

Register No: LM0119019

LLM (CONSTITUTIONAL LAW AND ADMINISTRATIVE LAW)

CERTIFICATE

This is to certify that **Mr AKHIL SANTHOSH, REG NO: LM0119019** has submitted his Dissertation titled "**PHYSICIAN ASSISTED SUICIDE: ETHICAL AND LEGAL DIMENSIONS**" in partial fulfilment of the requirement for the award of Degree of Masters of Laws in Constitutional Law and Administrative Law to the National University of Advanced Legal Studies, Kochi under my guidance and supervision. It is also affirmed that the Dissertation submitted by him is original, bona fide, and genuine.

Dr Liji Samuel

Guide and Supervisor

NUALS, Kochi

Date: 12-10-2020

Place: Ernakulam

DECLARATION

I declare that this Dissertation titled "**PHYSICIAN ASSISTED SUICIDE: ETHICAL AND LEGAL DIMENSIONS**" is researched and submitted by me to the National University of Advanced Legal Studies, Kochi, in partial fulfilment of the requirement for the award of Degree of Master of Laws in Constitutional Law and Administrative Law, under the guidance and supervision of **Dr Liji Samuel**, Assistant Professor and is an original, bona fide and legitimate work. It has been pursued for academic interest. This work or any type thereof has not been submitted by me or anyone else for the award of another degree of either this University or any other University.

AKHIL SANTHOSH

REG NO: LM0119019

LL.M, Constitutional Law and Administrative Law

NUALS, KOCHI

Date: 12-10-2020

Place: Ernakulam

ACKNOWLEDGEMENT

I take this opportunity to express my profound respect and a deep sense of gratitude to **Dr Liji Samuel**, who guided me throughout my research. Her invaluable insights, thoughtful care, time, attention to detail and moral support have contributed immensely to my thesis. I cannot thank her enough for her generosity and encouragement.

I would like to extend my gratitude to the Vice-Chancellor **Prof. Dr K.C Sunny,** for his constant encouragement and support. I express my sincere thanks to **Prof. Dr Mini. S**, Director of Centre for Post Graduate Legal Studies for her support and encouragement extended during the course.

I would further extend my deep-felt gratitude to the faculty of **NUALS** for their constant encouragement. I convey my thanks to Mrs Jeeja V., Assistant librarian, **Mr Anil Kumar C**., **Miss Neenu** and **Mr Unnikrishnan KK**, Library Assistants for their timely assistance to carry out the work.

Words fall short of expressing love, appreciation and gratitude to my dear family and friends for their constant encouragement.

With genuine humility, I am thankful to The Almighty for all his uncountable bounties and blessings.

AKHIL SANTHOSH

ABBREVIATIONS

- PAS/E - physician Assisted Suicide and Euthanasia
- EOLOA - California's End of Life Option Act
- ODDA - Oregon Death with Dignity Act
- POLST - Physician Orders for Life-Sustaining Treatment
- PAD - Physician-Assisted Death
- BMJ - British Medical Journal
- HC - House of Commons
- NJ - Nederlandse Jurisprudence
- WLR - Weekly Law Reports
- QB - Queen's Bench
- All ER - All England Law Reports
- DPP - Director of Public Prosecutions
- MAID - Medical Assistance in Dying

LIST OF CASES

TABLE OF CONTENTS

CHAPTER 1

INTRODUCTION

Euthanasia is defined as "an intentional intervention undertaken with the express intention of ending a life, to relieve intractable suffering."[1] Whereas Physician-assisted Suicide refers to the practice where a physician provides a potentially lethal medication to a terminally ill patient at his/her request that he/she can take at a time of his/her choosing. Physician-assisted suicide encompasses two means of dying: physician-assisted suicide and physician-administered euthanasia. PAS requires a doctor prescribing medication with life-end drugs, who then administers the medicine himself. The doctor would prescribe the lethal drug to the patient, such as by injection, is physician-administered euthanasia. Physicians alone and no other practitioners, such as psychologists and social workers or family members and close associates of the patient, are considered here. Perhaps the most widely understood justification behind the call for assisted suicide is the apprehension that individuals have of a long and painful death, either their own or a loved one's death. Both supporters and critics of assisted suicide agree on the need for a pain-free death. No-one should have to die in pain, and it should not happen with advancements in palliative care.

It may be claimed that the primary responsibility of a doctor is to relieve types of distress in the patient's best interests. As an apparent manifestation of distress, the avoidance of physical pain may explain why assisted dying would be both essential and appropriate for a doctor to offer it. The emerging theory, known as the 'Double Effect Doctrine' in common law provides a solution to this problem.[2] This legal decision declared that "a doctor is entitled to do anything correct and necessary to alleviate pain, even though life can be incidentally shortened by the steps he takes." For people looking for an escape from chronic pain, this means that a procedure already exists.[3] As a matter of public opinion and public policy, the issue of whether

[1] Harris NM: *The Euthanasia Debate* J R Army Med Corps 2001
[2] R v Adams [1957] Crim LR 773.
[3] Morita T, Chihara S*: Effects of high dose opioids and sedatives on survival in terminally ill cancer patients*. J Pain Symptom Manage. 2001, 21 (4): 2

and under what conditions terminally ill patients should be able to access life-ending drugs with the assistance of a physician is attracting growing attention. For patients, ethicists, doctors, patients, and their families discuss whether physician-assisted suicide should be a legal choice. Although public opinion is fragmented and public policy issues include religious, ethical and political concerns, there is a desire among some patients for physician-assisted suicide, and the inconsistent legal landscape leaves a range of questions and difficulties for health care providers to address when confronted with patients contemplating or requesting physician-assisted suicide. It can be seen that the patients are unable to benefit from life-sustaining treatments and care because they find it burdensome. Consequently, when the life-sustaining treatment is defined as having no benefit or too much burden, the withdrawal of treatment is perceived to be in the patient's best interest and to be compatible with the duty of care to safeguard that interest.

Recognising whether patients seeking death were legally qualified to make the decision would be another obstacle for an assisted dying scheme. It is known that suicides are frequently the result of mental and psychological trauma or undiagnosed depression arising from overwhelming pain. If we support the general assumption that assisted suicide is an acceptable way to treat the suffering of individuals, we essentially sanction its use to mitigate all kinds of suffering, including pain, loneliness, depression or mental illness. The standard responses to terminal disease and psychiatric depression are arguably challenging to discern. Indeed, there is evidence that between 25 % and 77 % of patients with terminal illness suffer from major depressive disorders.[4] Any assisted Suicide procedure must first assess whether a terminal patient constitutes as a "fit mental condition."

Physician-assisted suicide has been openly practised in the Netherlands for more than 25 years and formally legalised since 2002. The practice has been analysed in four major national studies between 1990 and 2007. Later a more restricted form of physician-assisted suicide was legalised in Oregon in 1997 and is subject of an annual report.[5] The cultural, and socioeconomic history underlying the divergent opinions on assisted suicide held by various aspects of society have received inadequate attention.

[4] Fine R: *Depression, anxiety, and delirium in the terminally ill patient*. Proc (Bayl Univ Med Cent). 2001, 14 (2): 130-133.
[5] Timothy E. Quill: British Medical Journal, Vol 335, No. 7621 (Sep. 29, 2007), p. 625-626

There have been many debates over the right to die issue in India, where euthanasia is banned, and suicide is a crime resulting in imprisonment.[6]

Physician-assisted suicide is a controversial subject that has recently captured the interest of media, public, politicians, and the medical profession. Although active euthanasia and Physician-assisted suicide are illegal in most parts of the world, except in Switzerland and the Netherlands, there is a pressure to legalise which could affect many parts of the world. As we live in cultural and religious affluent society, it is essential to understand the effects of these factors in the decision-making processes, especially in the area of physician-assisted suicide.

STATEMENT OF PROBLEM

9 March 2018, passive euthanasia was adjudicated by the Indian Supreme Court of India, only amount to patients who are either in a vegetative state, patients who are in intolerable pain or suffrage due to a terminal illness cannot qualify for an End of Life Treatment in the current legislation unless the patient is in a vegetative state. The percentage of patients suffering from a disability or an illness is greater than those in a vegetative state. So, a need for an alternative End of Life Treatment is to be looked into. Aren't people who cannot commit suicide because they are physically incapable denied choices by criminalizing the act of assistance?

SCOPE OF STUDY

The research aims to explore the dilemmas with many ethical as well as legal issues facing healthcare practitioners in most countries worldwide now with the coming of Assisted or Hastening suicide. It aims to explore the practical considerations for healthcare practitioners associated with assisting suicide, including a focus on examining the concepts of autonomy for patients and healthcare practitioners.

The Netherlands is the first country to legalise euthanasia and assisted suicide. The Termination of Life and Assisted suicide (Review Procedures), Act 2002 legalised the act of euthanasia and assisted suicide. Oregon is of the few states in the USA where

[6] Barker K. Chicago Tribune: *Jain Leaders challenge law banning suicide in India* (2006), p.15

terminally ill patients if they wish, can legally end their own lives. The Oregon Death with Dignity Act requires a prescription for lethal drugs to be given to terminally ill patients, which they administer themselves during the consent process.

The Belgian Act on Euthanasia 2002 which legalised the use of Voluntary Euthanasia and Assisted suicide. However, the Act limits it with specific provisions like; competent adults and emancipated minors as well as having to reside in Belgium. In Oregon, physician-assisted suicide accounts for around one in 1000 deaths each year. All the patients have met the criteria necessary. There seems too much conversation about end of life options. Oregon is among the nation's leaders in the right end of life care, including deaths at home, opioid prescribing, and public awareness about end of life options.[7]

As per the survey conducted on Physician-assisted suicide by Dr Farooq Khan of Birmingham and Solihull Mental Health NHS Foundation Trust, Staffordshire University, the questionnaire answered by doctors (a total of 60 in which 28 are men and 32 women) in all 26.6% of them agreed that it could be an option for patients with motor neuron diseases, whereas 25% agreed with the idea of using it for patients with terminal cancer.[8]Indian Penal code 1860, provides for the legal status of Physician-assisted Suicide and euthanasia. According to the IPC active euthanasia is an offence under section 302 or even under section 304. As of March 2018, the supreme court of India declared Passive Euthanasia legal under the restriction that the patient must be in a permanent vegetative state. As for Physician-assisted Suicide as per the IPC, it comes under Abetment of suicide section 306. It was also construed that 309 does not violate Article 21 of the Constitution of India after the judgment by a Constitution Bench of the Supreme Court in the case of Gian Kaur v. State of Punjab, As per Article 21 of the Constitution, the right to life does not include the right to die or the right to be killed, and there is no basis to hold that Section 309 of the IPC is legally invalid.

[7] Lee MA, Tolle SW. *Oregon's assisted suicide vote: the silver lining*. Ann Intern Med 1996; 124:267·9

[8] Abbas Z, Macaden S. *Attitudes towards euthanasia and physician-assisted suicide among Pakistani and Indian doctors: A survey*. Indian J Palliat Care. 2008; 14:71–4.

RESEARCH QUESTIONS

1. Can the concept of physician-assisted suicide be legalised?
2. What are the legal issues faced by the patient when requesting assisted suicide?
3. Should doctors be prosecuted for assisting in the suicide of a terminally ill patient?
4. What are the safeguards and recommendations that can be listed for proper legalisation of PAS in India?

RESEARCH OBJECTIVES

1. To explore the concept of Physician-assisted Suicide legalised in various parts of the world and its scope in India.
2. To identify the legal raised by the patient when requesting assisted suicide?
3. Can a doctor be prosecuted for assisting in the suicide of a terminally ill patient?
4. To identify the safeguards put forth by various legislations of the world and recommend some more for its legalisation in India?

HYPOTHESIS

The law should respect an individual's autonomy, and right to die with dignity, by using the latest knowledge and medications that medical research has to offer, the law should encourage physicians to help their patients die in the least painful way.

METHODOLOGY

This research methodology used in this work is of the doctrinal method.

REVIEW OF LITERATURE

The research has depended on the primary sources, including the Constitution of India, various legislations, case laws. The research has also used secondary resources like books, commentaries for the proper understanding of the subject and analysing the various topics. The research is extensively depended on electronic resources like online databases, websites for gathering resources.

- **JOHN KEOWN: EUTHANASIA, ETHICS AND PUBLIC POLICY (CUP, 2002)**

The book talks against the legalisation of voluntary euthanasia and physician-assisted suicide on the basis that neither could be adequately regulated by statute, even though they were ethically defensible in some 'hard cases'. It claims that the legalisation experience in the Netherlands, Belgium and Oregon supports the two 'slippery slope' arguments against legalisation, the 'empirical' and the 'logical' arguments. The empirical argument questions the viability of sufficient protections against violence and abuse being drawn up and enforced; the logical argument demonstrates that accepting the euthanasia case in the case of suffering patients who logically request it means accepting euthanasia for suffering patients who are unable to request it, such as children and those with advanced dementia.

- **JENNIFER HARDES: LAW, IMMUNISATION AND THE RIGHT TO DIE (2016)**

The Constitution, Immunization and Right to Die focus on the immediate issue of legal appeals and assisted-death judicial decisions. It focuses on the problematic paternalism of legal rulings that currently deny assisted dying and asks whether the law does not accept what many define as "empathetic reasons" for assisted death, focusing on key cases from the United Kingdom and Canada.

- **CHOLBI M, VARELIUS J, NEW DIRECTIONS IN THE ETHICS OF ASSISTED SUICIDE AND EUTHANASIA (SPRINGER, 2015)**

This book presents new insights on assisted dying's ethical rationale. It reviews the role of patient autonomy and paternalistic motives, as well as the part, suggested in connexion with assisted dying for medical professionals and clinical

ethics consultation, relates the debate on assisted dying to concerns about organ donation and advances in medical technology, and shows the importance of experimental philosophy in assessing assisted dying issues. This book is perfect for advanced bioethics and health care ethics classes.

CHAPTERISATION

CHAPTER 2

THE SANCTITY OF LIFE AN ETHICAL DILEMMA

INTRODUCTION

Euthanasia and Physician-assisted suicide refer to deliberate action taken to alleviate ongoing suffering with the intention of ending a life. Active euthanasia is against the law in most countries, and it can bring a prison term. Euthanasia has long been a topic that is divisive and emotional. The recent high court case of Nicklinson v Ministry of Justice[9] has brought the contentious issue of assisted suicide to the public. The prospect of legalising euthanasia has fueled some of the most profound and controversial discussions into social[10], medical[11] , and legal[12] values in modern history, proving it to be a deeply divisive issue.

The debate between morality and legality of physician-assisted suicide (PAS) is not new. It has been a topic of heated discussions for hundreds of years and does not show any signs of cooling down. In Oregon, Washington, Vermont, Colorado, and Montana, physician-assisted suicide is officially legalised (2017). In the Netherlands, Belgium, Columbia, the UK, and Japan, it is legal around the world (although regulations differ considerably). In the Province of Quebec in Canada, it is also legal. It is important to remember that doctor-assisted suicide is a different issue from the right to withhold or remove life-sustaining measures or palliative sedation, about which there is far less debate and which are typically personal decisions rather than legal issues.

Physician-assisted suicide or aid in dying includes the right to seek and obtain a prescription drug to bring on their death to clinically capable adult patients with a terminal condition and a prognosis of six months or less. Most of the laws under review at the state level are modelled after the Death with Dignity Act of Oregon, which requires two doctors to confirm the residence of the patient, diagnosis,

[9] *Nicklinson v MoJ* [2012] EWHC 304 (QB)
[10] Smith S '*Evidence for the Practical Slippery Slope in the Debate on Physician-Assisted Suicide and Euthanasia'* Medical Law Review 2004
[11] P Bartlett *'The Consequences of Incapacity'* Blackstone Press Ltd 1997
[12] Keown J '*Euthanasia, ethics, and public policy: an argument against legalisation'* 2002 pp 58-59

prognosis, mental competence, and the request to die voluntarily. Two-year waiting periods are needed as well.

How we die, live, and are cared for at the end of life is essential, with implications for individuals, their families, and society. There has been a documented lack of or inadequate end-of-life care in the United States.[13] Medicine and society's focus on intervention and recovery has also come at the cost of good end-of-life care. Improper care at the end of life can be dangerous and draining for patients and their families, mentally, emotionally, and financially. Most individuals have thoughts about death. Some patients receive unnecessary treatment at the end of their lives; others do not receive the requisite care.[14]

Some end-of-life issues are outside the reach of medicine and should be dealt with in other ways. While medicine now has an unparalleled potential to cure disease and ease the dying process, it has not been done with the right treatment in the right place at the right time.

Physician-assisted suicide is medical aid in the deliberate act of a patient to end his or her own life (for example, a person taking a lethal dose of medicine prescribed for that purpose by a physician). It is ethically, morally, and clinically distinct from the denial of life-sustaining care by a patient by refusing or delaying therapy. Physician-assisted suicide contrasts from euthanasia, an act in which a patient's life (such as by lethal injection) is deliberately terminated by a doctor, the object of which is to alleviate pain or other sufferings.[15]

Dictionaries classify suicide as ending one's own life deliberately. The word is neither disparaging nor a judgement, despite cultural and historical connotations. Physician-assisted suicide terms, such as help in dying, medical aid in dying, physician-assisted suicide, and hastened suicide, together lump categories of behaviour, obscuring the

[13] Field MJ, Cassel CK. *Committee on Care at the End of Life Approaching Death: Improving Care at the End of Life*. Washington, DC National Academies 1997.
[14] Johnson, K. S. (2013). *Racial and ethnic disparities in palliative care. Journal of Palliative Medicine*, 16(11), 1329-1334.
[15] Snyder Sulmasy L; Ethics, *Professionalism and Human Rights Committee of the American College of Physicians. Ethics and the Legalization of Physician-Assisted Suicide*. 2017 Oct 17;167(8):576-578.

ethics of what is at stake and making it difficult to discuss meaningfully; therefore, clarity of language is essential.[16]

SANCTITY OF LIFE

In the bioethical literature nowadays, however, it is usually assumed that the doctrine of the sanctity of life is roughly the claim that all human life is of equal intrinsic value. Accordingly, except in cases of the legitimate defence of others' lives, it is always intrinsically wrong to take human life (though it may be permissible to let someone die).[17]

Keown D (Bioethicist, Department of History at the University of London and authority on Buddhist bioethics), Keown J (Senior Research Scholar, Rose F. Kennedy Professor of Christian Ethics) state that there is a frequent misrepresentation of the doctrine of the sanctity of life. However, their explanation of it is unfortunately not as straightforward as it might be, for they offer several, apparently logically distinct, formulations of it. These include:

(1) That as life is a gift from God, it is to be cherished.

(2) All human beings are to be valued, irrespective of age, sex, race, religion, social status or their potential for achievement.

(3) Except in self-defence or the lawful defence of others, the intentional taking of human life is prohibited.

(4) Human life is a necessary good as opposed to an instrumental good, a good itself rather than as a means to an end.[18]

Human beings are called as the most precious beings on the earth, and his reason dictates the law for this universe. Human beings are considered to be the most precious beings on earth, and its purpose determines the rule of this world. Each human being's privileged status grants him unique privileges over the universe. The

[16]BBC - Ethics - *Introduction to ethics: Ethics: a general introduction* Bbc.co.uk, http://www.bbc.co.uk/ethics/introduction/intro_1.shtml

[17] Glover J. *Causing death and saving lives. Harmondsworth*: Penguin, 1977; Kuhse H. The sanctity-of-life doctrine in medicine: a critique.

[18] Keown D, Keown J. Killing, *karma and caring: euthanasia in Buddhism and Christianity*. Journal of Medical Ethics 1995; 21: 265-9.

advent of science and technology made it more difficult as the conventional human values set out in our culture were seriously challenged. As the dignity of human life is a universal constant, the sanctity of life and the degree to which it has to be preserved can never be a domestic legal doctrine. It is true that when science deals with the rule, sanctity should not be an unforeseen issue. In the name of sanctity and religion, as natural lawyers contend at any moment, human reason will interfere with scientific developments. It is observed that:

"Faith and sanctity are indeed not very frequent, but yet they are not miracles, but brought to pass by education, discipline, correction and other natural ways by which God worketh them in his elect at such times as he thinketh fit."[19]

Despite religious ethics on the sanctity of life, the non-religious groups are a supporter of the doctrine because they found a method in it to obtain fair dignity for all human existence.[20] From the jurisprudence of natural law to contemporary legal theory, the meaning of life is seen as a positive and negative norm. The image of God in all living beings and that life has God's inherent worth is no longer the doctrine's legal justification. Terms, such as "equality of life," "purity of life" and so on, address the importance of human life interchangeably. Nevertheless, in order to make the law more severe, the word sanctity has its own quality.[21] The jurisprudence of this doctrine starts with natural law and that too with the Greek tradition. The Greek theologians considered the divine importance equally in all human lives, but the Sophists added that the principle of power is right.[22]

By the introduction of Scholasticism into the natural law jurisprudence, the concept of the divinity of life in all was also emerged. The scholastic school considered all man as part of the same spiritual humanity.[23] With Christian exposure, St. Thomas Aquinas (Italian philosopher) views on the current theory of natural law gave human life a fundamental sanctity. The Thomist version of natural law accepted that man created laws only to extend where the divine reason goes. The American Declaration of the

[19] Thomas Hobbes, Leviathan, William Collins Sons & Co. Ltd., London, 1972 p.287.
[20] Jonathan Herring, *Medical Law and Ethics*, (3rd Ed.), Oxford University Press, 2010, p.505.
[21] Eric Rakowski, "*The Sanctity of Life*", 103 Yale L.J. (1994) 2049,2050.
[22] Edgar Bodenheimer, *Jurisprudence: The Philosophy and Methods of Law*, Universal Law Publication Co. Pvt. Ltd., Delhi, (2006 Reprint), p. 6
[23] Costas Douzinas, The Human Rights and Empire: The Political Philosophy of Cosmopolitanism, Routledge Cavendish, Abingdon, 2007, p. 52

right to life, equality and pursuit of happiness as rights endowed by nature in 1776 was known as the spirit of the Thomist edition.[24]

From the current Catholic approach to science and technology, the ideals promoted by the Thomist school in the 13th century can also be identified. For a long time, after the developments made by St. Thomas Aquinas, the godly aspect in its entirety was not known. This resulted in natural law being secularised by new exponents. Hugo Grotius and Puffendorf began a new period of natural law with a secular edition. They have stated that even without the presence of any holy God, the natural law will remain the same. According to the reason or the rational habit of every human being make them more content.[25] To Grotius, there are many things in the nature that a man can dictate even without God on his part. Grotius said:

"Even if God did not exist, natural law would have the same content; and just as God cannot cause that two times two shall not be four, so he cannot cause the intrinsically evil to be not evil."[26]

It is believed that human dignity resides in its existence and that every individual's reasoning capacity is defined as the element that gives him that dignity.[27] A person's right to life is also well linked to the notion of integrity. The right to life is also protected by the right to equality under Article 21 of the Indian Constitution. Considering the right to dignity as a part of Art.21, the court interpreted the life under the said article as a broader right.[28] Krishna Iyer, J. opined that:

"Necessary conditions which must be fulfilled if everyone in the society is to be assured a life of basic human dignity and complete self-fulfilment, which is the objective and goal of human rights. I do not want any people just to survive. I want them to live a life of human dignity, and for that, they must have basic necessities for life, including food and health. This right is not merely lexical and legal, but expands as we conceptualise the dignity and divinity of the human personality."[29]

---

[24] J. W. Harris, *Legal Philosophies*, Butterworths, London, 1980, p.10
[25] id at p.11.
[26] Jon Miller, *Stanford encyclopaedia of philosophy, Hugo Grotius* (Metaphysics Research Lab) (2014).
[27] Eckart Klein, *The Concept of Human Dignity in Human Rights Discourse*, Kluwer Law International, The Hague, (2002), p.24.
[28] *Francis Coralie Mullin v. Administrator Delhi Territory of India*, (1981) 6 S.C.C. 608
[29] V. R. Krishna Iyer, *Social Justice- Sunset or Dawn*, Eastern Book Company, Lucknow, (1980), p.16

The sanctity of life doctrine is probably the most significant moral obstacle to legalising assisted dying. Many critics of assisted dying, such as Keown (Senior Research Scholar, Rose F. Kennedy Professor of Christian Ethics) and Finnis (John Mitchell Finnis, is an Australian legal philosopher), argue that primarily because of the belief that life is intrinsically precious and thus should be preserved.[30] The belief that life is inherently valuable can also be based on a religious view, but those who support this view insist that, regardless of religion, the intrinsic value of life is essential.[31] Lord Justice Ward put forward an insightful definition of the sanctity of life in the Re A, the conjoined twin's case:

"The sanctity of life doctrine holds that human life is created in the image of God and is therefore possessed of an intrinsic dignity which entitles it to protection from unjust attack. The 'right to life' is essentially a right not to be intentionally killed".[32]

One of the arguments put forward by those who oppose the legalisation of euthanasia is that the core principle of sanctity of life will be violated.[33] The principle serves to protect everyone's right to life, including the most vulnerable members of our society, stating that life is precious and must not be destroyed or limited under any circumstances.[34] If euthanasia were to be legalised, the question of whether this inviolable principle can be upheld to provide a safeguard for the vulnerable against involuntary euthanasia needs to be answered.

Grayling A.G (Vice-president, British Humanist Association) claims that the "right to life" means quite a rich life; withholding treatment with death as the result and giving treatment that causes death is indistinguishable, and death is the ultimate analgesic.[35]**Autonomy**, fidelity, and confidentiality are essential tenets of the legal and medical community.

AUTONOMY

[30] See, J Finnis, *Natural Law and Natural Rights*, 2nd Edition, (2011) Oxford University Press.
[31] See S Pattinson, *Medical Law and Ethics, London*: Thomson/Sweet and Maxwell (2006), p.18. See also C Paterson, *Assisted Suicide and Euthanasia*, (2008) Ashgate.
[32] *Re A children conjoined twins: surgical separation* [2000] 4 ALL ER 961 per Ward LJ at 999J-1000A and 1000G-H
[33] Donchiin A *'Autonomy interdependence and assisted suicide: respecting boundaries lines'* Bioethics 2000
[34] Suber P '*Against the Sanctity of Life'* Earlham College 1996
[35] Grayling AG. "*Right to die*." BMJ 2005; 330:799. (9 April.)

Autonomy is derived from the Greek word 'autos' meaning 'self', and 'nomos' meaning 'the rule of law'. In medicine, respect for autonomy is generally interpreted as granting a competent adult the right to make his or her own decisions about the medical care of that person. The principle that consideration must be given to patients' autonomous wishes was firmly founded in common law when Cardozo J claimed in Scloendorf v Society of New York Hospital in 1914: "Every human being of adult years and sound mind has a right to determine what shall be done with his own body"[36] Most recently, in England, Lord Scarman advocated individual autonomy in Sidaway v Board of Governors of the Bethlem Royal Hospital and Maudsley Hospital by arguing that "the right of the patient to make his own decision can be seen as a basic human right protected by common law."[37]

The views on the autonomy of the philosophers Immanuel Kant and John Stuart Mill have made a great contribution to the field of assisted suicide. Kant advocated the notion that there should be rational choices regulating autonomy.[38] Physicians and patients regularly discuss and negotiate care plans and priorities on a day-to-day basis. Equipped with their medical experience, doctors offer guidance and advice on options for treatment, including profit and risk standards. Patients are experts in their own lives, psychosocial well-being, and spiritual conditions, and therefore contribute to collective decision-making by voicing their personal interests, convictions, and values. Patients can veto prescribed, but unwanted care in a doctor-patient relationship and doctors can veto unnecessarily treatments and procedures that are dangerous, futile, or useless. A Kantian view of autonomy would support this partnership and relational decision-making model, which includes mutual choice, with an emphasis on rational choice, between doctors and patients, respect, dialogue, and reasoned negotiation.[39]

Unsurprisingly, the idea of autonomy (as defined by Beachamp and Childress[40]) holds a central place. Authors such as Young[41] and Gray[42] state that there should be no

[36] *Mary E. Schloendorff, v The Society of New York Hospital,* (1914) 105 NE 92
[37] *Sidaway v Board of Governers of the Bethlem Royal Hospital and Maudsley* Hospital [1985] AC 871.
[38] Kant I, Paton HJ. *The Moral Law*. London: Hutchinson; 1948 p 12-20
[39] Secker B. *The appearance of Kant's deontology in contemporary Kantianism: Concepts of patient autonomy in bioethics.* Journal of Medicine and Philosophy 1999; 24: 43–66
[40] Tom L Beauchamp, James F Childress, *Principles of Biomedical Ethics* (OUP, 2001) 12
[41] Robert Young, *'Existential Suffering and voluntary medically assisted dying'* (2014) 40 Journal of Medical Ethics 108-109

distinction, at least as far as the right to self-determination is concerned, between the multitude of acts that any given person may take in their everyday life in the name of autonomy and the act of planning and following through with an assisted Suicide. In this way, the topic of assisted suicide can be found in broader discussions regarding the boundaries of physical integrity and self-determination.[43]

Autonomy refers to the own moral norm of a person and their ability to rule themselves according to their sets of morals. One of the critical problems surrounding the assisted suicide dilemma has been autonomy. Essentially, the definition behind it states that if the moral compass of a person tells them that it is permissible for them to commit assisted suicide, then they have that right. To discourage anyone from engaging in it, the person also has the right to consider assisted suicide morally wrong. This is where the various autonomies of individuals compete with each other. At the heart of the assisted suicide crisis, this forms the core issue.[44]

The principle of respect for patient autonomy has taken a central role in health care in the last few decades. Indeed, most clinical codes of practise and even patient rights codes are now focused on respect for patients' self-determining decisions or interests.[45] The concern now is that fear during the dying phase of losing autonomy or dignity may cause some patients to request a hastened Suicide. In a study analysing physician thoughts and actions regarding end-of-life decisions that hastened suicide, the study discovered that respect for the autonomy of the patient was central in their decision-making.[46] Physicians who disagreed with the request for an assisted suicide of a patient acknowledged that the principle of autonomy was necessary but cited other reasons such as moral and professional considerations.[47]

---

[42] William Gray, *'Right to die or duty to live?*' (1999) 16 Journal of Applied Philosophy 19-32, 21

[43] Emma C. Bullock, *'Assisted Dying and the Proper Role of Patient Autonomy'* in M Cholbi, J Varelius (Eds.) *New Directions in the Ethics of Assisted Suicide and Euthanasia* (Springer, 2015) 13

[44] Andre, C & Valesquez, M. (2010). *Assisted Suicide: Right or Wrong?* Santa Clara University. Retrieved August 5, 2012 from http://www.scu.edu/ethics/publications/iie/v1n1/suicide.html

[45] Chisolm A, Askham J. A *review of professional codes and standards for doctors in the UK, USA and Canada.* London: Picker Institute Europe; 2006.

[46] Fried TR, Stein MD, O'Sullivan PS, *Brock DW, Novack DH Limits of patient autonomy. Physician attitudes and practices regarding life-sustaining treatments and euthanasi*a. Arch Intern Med. 1993 Mar 22; 153(6):722-8.

[47] Id n 21

Onora O'Neill (Philosopher and a crossbench member of the House of Lords)[48] state that an individual's right to lead himself to the desired end can already be found in the autonomous right to refuse care (even though it may lead to death) and thus there is nothing wrong with an individual making active decisions to speed up the end of life.

House of Lords Select Committee on the Assisted Dying for the Terminally Ill Bill, Harris argued that 'when we are denied control at the end of our lives, we are denied autonomy.'[49]

Evidently, the healthcare professional must also be treated as an autonomous entity by autonomy claims. Some have claimed that it is essential to respect medical practitioner autonomy that they should not, against their will, be forced to help patients die, an argument that allows some physicians to refer patients to someone else who can help them in achieving an assisted Suicide.

"The principle of patient autonomy is critical and must be respected, but it is not absolute and must be balanced with other ethical duties and principles. Physician-assisted suicide asks physicians to breach both the general duties of 'first, do no harm' (nonmaleficence) and to act in the patient's best interests (beneficence), and also the specific prohibition on physician-assisted suicide that has been a tenet of medical ethics since Hippocrates. Proponents of physician-assisted suicide have not offered strong enough arguments to change that."[50]

FIDELITY

Fidelity refers to being faithful or loyal. A physician has the duty to abide by the law and the Hippocratic Oath. He will also be faithful in following the laws that regulate assisted suicide in their particular region. The third field in which loyalty affects the issue of assisted suicide is that each person is faithful to their own autonomy. In the area of assisted suicide, confidentiality is also an issue. In the medical profession, an individual has a right to confidentiality. In the case of suicidal aid, however, there

[48] Onora O'Neill, *Rethinking informed consent in bioethics* (CUP, 2007) p.17
[49]Harris D, Richard B, Khanna P. *Assisted dying: the ongoing debate*. Postgrad Med J. 2006;82(970):479-482.
[50] Jack Ende, MD, *Hospitalists Weigh Ethical, Practical Impacts of Aid-in-Dying Laws*, 1 (2018).

might be family members who want to be present. Against the patient's wishes, family members can also attempt to stop suicide.[51]

HIPPORCRATIC OATH

The physician, because of his/her special status, acts for the good of the patient. The nature of the physician's job requires moral conduct and accountability. The concepts of ethics have been a result of religions, philosophies, and cultures.[52] The oaths or pledges that we take or swear allegiance to act as guidelines to a moral dilemma. The doctrines in the oaths allow doctors, patients, and families to generate a treatment plan without any conflict.[53]Many physicians have considered the commitment of the Hippocratic Oath about the administration of harmful drugs as the prohibition of euthanasia.[54]

The original Oath included, among other things, the following words:

"I will neither give a deadly drug to anybody who asked for it, nor will I suggest this effect."

As the world has changed since the time of Hippocrates, some feel that the original Oath is outdated. In some countries, an updated version is used, while in others, for example, Pakistan, doctors still adhere to the original. The Hippocratic Oath states "I will use treatments for the benefit of the ill in accordance with my ability and my judgment, but from what is to their harm and injustice I will keep them"[55], which offers a virtuous foundation for the ethical judgments of medical practitioners.

When it comes to euthanasia and assisted suicide, the Hippocratic Oath dispute ignores the fact that there has been no restriction of physician-assisted suicide in modern Greek medicine at the time of Hippocrates. According to Miles (Professor Emeritus of Medicine and Bioethics), neither the Hippocratic Oath nor the classical tradition offers a persuasive ethical or technical prohibition of physician-assisted

[51] Euthanasia.com (2012). *History of Assisted Suicide*. Retrieved August 5, 2020 from http://www.euthanasia.com/history.html
[52] The British Medical Journal, "*Hippocratic Oath*.", vol. 2, no. 4580, 1948, pp. 725–725. JSTOR, www.jstor.org/stable/25365228
[53] Bruce Alan Bob, *Do no harm* (B.A. Bob) (2000) p. 153
[54] Halperin EC. *Physician awareness of the contents of the Hippocratic Oath*. Journal of Medical Humanities 1989; 10(2): p. 107-114.
[55] Jones WHS *'The Doctors Oath'* Cambridge UP 1924

suicide; the word suicide did not even exist. In Ancient Greece, at the time that the Hippocratic Oath was allegedly written, the word suicide did not exist. It emerged years later, and even then, in order to avoid pain or disease, it did not apply to the end of one's life, nor to heroic death or to shame. He asserts that the urge to end one's life was considered a sign of depression in those days, similar to today.[56]

The Oath is not mandatory to be taken by physicians or medical students, but the rationale is that assisted dying is contradictory to the values of the profession and that doctors ought not to be involved in anything which does not save a life, their primary role being to help the ill or, at least, to do no harm.[57] Where practicable, medical training and ethos are aimed at enhancing and prolonging successful human life, not promoting its death, even though this is obviously not absolute as the profession has gone against those Hippocratic norms, specifically in regard to the termination of pregnancy. However, Kure[58] has put forward the other side of this claim, arguing that it is possible to deduce such a prohibition. In other words, the death of a patient brought about by a doctor may not be in line either with the Hippocratic Oath or even the Hippocratic tradition's spirit.

CONSTITUTIONAL AND LEGISLATIVE MEASURES IN INDIA FOR EUTHANASIA AND SUICIDE

ARTICLE 21 AND RIGHT TO DIE

The right to life is a fundamental natural right of human beings. It is a fundamental right guaranteed under Part-III (Article 21) of the Indian Constitution. Article 21 of the Indian Constitution states that – 'no person shall be deprived of his life or personal liberty except according to the procedure established by law.' The phraseology may be harmful, but it has conferred an obligation on the state to ensure good quality of life and dignified life to the people, which is the positive aspect of the article. The foreigners are also as much entitled to the right as the citizens.

---

[56] Miles SH. *The Hippocratic Oath and the ethics of medicine*. New York: Oxford University Press; 2004.
[57] W H S Jones *'Epidemics'* 1:11 in Hippocrates, vol 1, (1923).
[58] J Kure '*Good death within its historical context and as a contemporary challenge: a philosophical clarification of the concept of euthanasia'* (2011) in J Kure *Euthanasia - The 'Good Death' Controversy in Humans and Animals* (2011). p. 33

The Right to Die is a notion based on the view that a person is entitled to make certain decisions about ending his or her life (which often entails voluntary euthanasia). Possession of this right is also interpreted to mean that a person with a terminal illness should be able to end his or her own life or to reject life-prolonging care, or without the ability to continue living. The key issue that emerges is whether individuals should have the right to die and what the concept that explains such rights could be.[59]

The editors of Ratanlal and Dhirajlal's Law of Crimes, a leading and influential criminal law commentary asserted the following:

"As a normal rule, every human being has to live and continue to enjoy the fruits of life till nature intervenes to end it. Death is certain. It is a fact of life. Suicide is not a feature of normal life. It is an abnormal situation. However, if a person is seriously sick or having an incurable disease, it is improper as well as immoral to ask him to live a painful life and suffer agony. It is an insult to humanity. Right to life means the right to live peacefully as an ordinary human being. One can appreciate the theory that an individual may not be permitted to die with a view to avoiding his social obligations. He should perform all duties towards fellow citizens. At the same time, however, if he is suffering from unbearable physical ailments or mental imbalances, if he is unable to take normal care of his body or has lost all senses and if his real desire is to quit the world, he cannot be compelled to continue with torture and painful life. In such cases, it will indeed be cruel not to permit him to die."

This fundamental right confers a duty on the state to ensure that people, both citizens and others, have a good quality of life, livelihood, freedom and dignified life. The right to life has been interpreted by the Indian judiciary in different ways to include many new rights within its purview, such as the right to live with human dignity, the right to livelihood, the right to shelter, the right to privacy, the right to food, the right to education, the right to free air and water from pollution and some other rights that are very important for improving people's lives.

CONCEPT OF END OF LIFE CARE (EOLC)

The legal history of EOLC dates back to Aruna Shanbaug's case. In 2011, the SC had recognised passive euthanasia in Shanbaug's case and permitted withdrawal of life-

[59] Healthcare.gov. *Patient's Bill of Rights*. (2012). Retrieved August 5, 2020 from http://www.healthcare.gov/law/features/rights/bill-of-rights/index.html

sustaining treatment from patients not in a position to make an informed decision. The Centre had opposed recognition of living will and said the consent for removal of artificial support system given by a patient might not be an informed one and without being aware of medical advancements.[60]

In the words of Pipel (A lecturer of Philosophy at the University of Haifa and the Interdisciplinary Center Herzliya) and Amsel (Assistant Professor in Psychology, Columbia University)[61] Contemporary proponents of 'rational suicide' or the 'right to die' generally demand through 'rationality' that the decision to kill oneself be both the autonomous option of the agent desired through liberals, and 'the best option under the circumstances' choice desired by the stoics or utilitarian, as well as other natural circumstances such as secure choice, not an impulsive decision, not because of mentally desired choice.

Life and death are inseparable. Every moment our bodies changes, life is not disconnected from death. Dying is a part of the process of living."[62] On 9 March 2018, the Supreme Court (SC) in a landmark judgment declared the right to die with dignity as a fundamental right and passed an order allowing End of Life Care (EOLC), passive euthanasia in common parlance, in the country. The bench issued guidelines in recognition of the 'living will' made by terminally ill patients. The SC said that directions and guidelines laid down by it should remain in force till a legislation is brought on the issue.[63] The living will be signed in the presence of two attesting witnesses and counter-signed by the concerned Judicial Magistrate of First Class (JMFC). The judgment has provided some sanguinity to the high demand for the 'right to die.'[64]

R K Mani, an EOLC advocate and senior member of the Indian Society of Critical Care Medicine, which was also a party in the case in SC, says the judgement is quite clear that it is only possible to withdraw life-support care if the disease is terminal and there is no good treatment. The unfortunate duo is proposing active euthanasia in the

---

[60] *What ails the 'right' to die with dignity*? Downtoearth.org.in, https://www.downtoearth.org.in/news/health/what-ails-the-right-to-die-with-dignity--60052

[61] Pilpel Avital & Amsel Lawrence. (2011). *What is Wrong with Rational Suicide.* Philosophia. 39. 111-123.

[62] Justice D Y Chandrachud, *Common Cause (A Regd. Society) vs Union of India* writ petition (civil) No. 215 of 2005

[63] ANNADURAI, K., DANASEKARAN, R. AND MANI *'Euthanasia: Right to die with dignity'* 2000

[64] *DOES THE RIGHT TO LIFE INCLUDE THE RIGHT TO DIE…??* | LawLex.Org LawLex.Org, https://lawlex.org/lex-bulletin/does-the-right-to-life-include-the-right-to-die/1890

Kanpur case, which has been called strictly illegal in the judgement, although it is permissible in a few countries.[65]

"The process is so cumbersome that it is simply not workable. The fact that there is no deadline for all these boards further compounds the problems," says S Dhelia, general secretary of Mumbai-based organisation Society for Right to Die with Dignity. The complicated legal formalities have to be simplified if terminally ill patients are to be provided with the right to die with dignity and their caregivers the right to let their loved ones go with dignity.[66]

RIGHT TO DIE ARGUMENTS RAISED

The arguments in favour of giving patients the right to die and protecting healthcare providers who carry out those wishes: -

- The death of a patient brings the end of pain and misery for him or her.
- Patients have a chance to die with dignity, without fear that their physical or mental capacity will be lost.
- The total financial burden of healthcare on the family is minimised.
- Patients should make plans with loved ones for final farewells.
- Organs may be harvested and donated if envisaged in advance.
- Patients have a higher chance of witnessing a painless and less painful death (death with dignity) with physician assistants.
- When there is no hope for relief, patients should end their pain and suffering.
- Some claim the Hippocratic Oath is against assisted suicide with dignity; however, the phrase "first not hurt" can also be extended to help a patient achieve the ultimate relief from pain through death.

[65]KAUR, B. *What ails the 'right' to die with dignity?* Downtoearth.org.in, https://www.downtoearth.org.in/news/health/what-ails-the-right-to-die-with-dignity--60052 (last visited Oct 10, 2020)
[66] Id n 63

- Medical advancements have made life beyond what nature should have made, but with little hope of recovery, this is not always in the best interest of the suffering patient.[67]

While there are many excellent details to the emotionally-laden issue of physician-assisted suicide, this is broken into four points which frequently arise against its acceptance or legalisation. Furthermore, to every argument, there is a counter-argument: -

- **Improved Access to Hospice and Palliative Care**

  One claim against PAS is that since a model for quality end-of-life treatment is accessible through hospice and palliative care services, there should be no incentive for anyone to pursue PAS. The emphasis should not be on legalising PAS, but on improving access to hospice care in this context.[68]

- **Patient Autonomy Limits**

  It was determined in the opinion of Bouvia v. Superior Court (CA) that "the right to die is an integral part of our right to control our destinies so long as the rights of others are not affected."[69] This was a matter of autonomy for patients. PAS is not a totally autonomous act; it needs the support of another person.

  Physicians who are presented with a proposal to help end the life of a patient have the right, based on conscientious objection, to decline. Therefore, according to the Bouvia ruling, their rights are not affected.

  While recognising the importance of personal autonomy, many academics argue that once euthanasia in any form is legalised, "Patients will be coerced and exploited, the search for better or alternate therapies compromised and involuntary euthanasia will inevitably follow" as demonstrated by the unreported 2011 Dutch euthanasia case Of a 64-year old woman, suffering senile dementia, who was euthanised even though she unable to express a

[67] *Weighing the Benefits of Right-To-Die Legislation Verywell Health*, https://www.verywellhealth.com/arguments-in-favor-of-death-with-dignity-2614852
[68] WHO | WHO Definition of Palliative Care Who.int, https://www.who.int/cancer/palliative/definition/en/
[69] *Bouvia v. Superior Court* (Glenchur), 1986 Apr 16; 225:297-308.

desire to die.[70] As such, it is vital to consider the potential effectiveness of the safeguard of personal autonomy following any legalisation of euthanasia.

- **The "Slippery Slope" to Social Evil**

  Those in opposition to PAS are concerned that if assisted suicide is allowed, euthanasia will not be far behind. This view holds that it is a slippery slope towards the "mercy killing," without consent, of individuals with mental illness, physical handicap, elderly, demented, homeless, and anyone else society deems "useless."

  Our highly cultured societies are unlikely to allow this "slippery slope" to happen. [71]Cited examples include Adolf Hitler, Joseph Goebbels, and Joseph Mengele, who were defeated in their mission to "cleanse" Germany's gene pool.

- **Violation of the Hippocratic Oath**

  The Hippocratic Oath states that a physician's obligation is primum non-nocere, "first, do no harm." PAS directly contradicts that Oath, as deliberately killing a patient is regarded as harmful.

CRITICAL ROLE OF MENTAL HEALTH WORKERS

Although PAS has been legalised in those five US states, its support and cases have stalled in recent years, indicating severe ethical concerns, mostly because of multileveled challenges of combating and delineating cultural stereotypes, quantifying mental capacity, gauging the quality of life, and deciding where to situate psychiatrists in the PAS decision.

The position of the psychiatrist is under debate. Opponents in the United States take issue with the new PAS-legal state regulations on psychological tests. For instance,

[70] Smith W '*What's Choice Got to Do with Dutch Euthanasia'* National Right to Life News 2011
[71] J. David Velleman, "*Against the Right to Die*.", 1st ed., Open Book Publishers, 2015, pp. 5–20., www.jstor.org/stable/j.ctt17w8gwg.4.

Oregon only stipulates a referral to a psychiatrist in situations where a physician other than a psychiatrist assumes that the judgement of the patient is impaired. It is accepted that psychologists have the greatest range of skills to determine the experiences of a patient.

Other PAS-legal states require an assessment by a doctor or psychologist before making the decision. However, doctors have, sadly, rarely referred these patients to psychiatrists before offering PAS as an alternative.

PAS opponents target standards by which concepts like "quality of life" or "contributing member of society" are judged – specifically, that "unbearable suffering" and its ramifications are ill-defined – people whose lives are deemed "not worth living" (including the terminally ill) would be susceptible to "sympathetic death" via PAS that might result from PAS legalisation. Opponents also contend that accepting the "right" to commit suicide contradicts the fact that a large number of suicide attempts have mental illness and need assistance. They argue that legalising PAS will enable people with mental disabilities to perform an irreversible act based on their skewed views without providing them with the expected professional assistance.[72]

PHYSICIAN'S ETHICAL PARADOX

Physicians play a part in the process of assisted suicide and voluntary euthanasia, sometimes placing them at the forefront of the problem. (as evident in the name "physician-assisted suicide"). Assisting or hastening suicide is now a challenge facing healthcare professionals in most countries around the world with many legal as well as practical problems. Over time, numerous claims have been made for and against assisted dying, but the public call for euthanasia and assisted suicide to be allowed has never been greater.

With changes in healthcare practises, the role of the healthcare professional has obviously and unquestionably changed over time, but the duty of care has not changed. Thus, the dilemmas for healthcare professionals who have competent patients demanding assisted Suicide stretch well beyond working within the laws of a

[72] Clin Med (Lond). 2010 Aug; 10(4):323-5.

country as they go to the very heart of the practitioner-patient relationship. Although laws authorising or restricting assisted suicide are apparent in most jurisdictions around the world, the ethical aspects associated with them remain profoundly problematic.

For others, questions about the legitimacy and reliability of the consent of a patient to seek assistance to die, the potential for systematic exploitation of the most vulnerable people in society, and disagreement regarding the need for assisted suicide in light of other alternatives such as palliative or hospice care increase opposition to both the definition and practices of assisted suicide among some healthcare professionals.[73] However, some critics suggest that aid to hasten suicide is ethically appropriate because knowledgeable persons have the right to request and receive assisted suicide.[74]

Niall Dickson, the Chief Executive of the General Medical Council (UK), recently pointed out: "the issue of assisted suicide is complex and sensitive. We already have clear guidance for doctors that they must always act within the law, and assisting or encouraging suicide remains a criminal offence. This guidance will not in any way change the legal position for doctors. It is not our role to take a position on whether or not the law should be changed; that is a matter for the relevant legislature."[75]

The view that the job of a physician can legitimately involve helping patients to die in some situations strikes some as placing "the very soul of medicine on trial"[76] This view leads people to believe that physicians have a moral responsibility to protect the lives and welfare of their patients. Similarly, some argue that doctors are qualified not to take it but to save a life; their purpose must be to provide treatment rather than death.[77] However, other physicians and scholars have argued strenuously at the very same time that the role of the physician and other medical practitioners should extend to helping an eligible patient die when the life of that person has become intolerable

---

[73] Hendin H, Foley K *Physician-assisted suicide in Oregon: a medical perspective*. Mich Law Rev. 2008 Jun; 106(8):1613-40.
[74] Bartels L, Otlowski M A, *right to die? Euthanasia and the law in Australia*. J Law Med. 2010 Feb; 17(4):532-55.
[75] General Medical Council. *New guidance on dealing with complaints about assisting suicide*. 2011. http://www.gmc-uk.org/news/11532.asp.
[76] Gaylin W, Kass LR, Pellegrino ED, Siegler M, *Doctors must not kill'*. JAMA. 1988 Apr 8; 259(14):21,39-40.
[77] Randall F, Downie R, *Assisted suicide and voluntary euthanasia: role contradictions for physicians*. Clin Med (Lond). 2010 Aug; 10(4):323-5.

for them.[78]They also mentioned that this assistance must be a last-resort approach. Euthanasia and PAS, as last-resort approaches, constitute a view that others often defend.[79]

CONCLUSION

The main objective of this chapter is to construct an argumentative essay on the use of physician-assisted suicide as a last resort for people with terminal illnesses to ease their suffering and end their lives, thus taking into account the ethical opinions of opponents and proponents.

Like in the rest of the world, medical research is evolving in India, and so we currently have ideas that can artificially prolong life. This can prolong terminal suffering indirectly and can also prove to be very expensive for the family of the subject in question. In India, therefore, end-of-life questions are becoming important ethical issues in modern-day medical science. Euthanasia and PAS supporters and opponents are as active in India as in the rest of the world. The Indian legislature, however, does not seem to be receptive to these kinds of stuff. The historic decision of the Supreme Court has offered pro-euthanasia campaigners a big boost, even though it is a long way to go before it becomes a parliamentary statute. In addition, questions about its abuse remain a major problem that should be resolved before it becomes a rule in our country.

The complex physical, psychological, and social challenges associated with PAS and the difficulty in enforcing its laws necessitate more adept alternatives. Instead of conditionally legalising suicide, we should ease patient suffering with compassion and calibrated treatment.[80] Both mediaeval and modern oaths maintain the Hippocratic Oath's promise not to prescribe poisonous/deadly substances, which is close to the original. This is probably due to the influence of religion and Hippocratic / Galenic medicine during those times. It is not, however, possible to infer whether it applies to

[78] Wanzer SH, Adelstein SJ, *The physician's responsibility toward hopelessly ill patients*. A second look. N Engl J Med. 1989 Mar 30; 320(13):844-9.
[79] Ganzini L, Block S. *Physician-assisted death —A last resort?* New England Journal of Medicine. 2002;346(21):1663–1665.
[80] Always Care, *Never Kill: How Physician-Assisted Suicide Endangers the Weak, Corrupts Medicine, Compromises the Family, and Violates Human Dignity and Equality, Washington*: The Heritage Foundation, 2015.

euthanasia, assisted suicide or assassination. The dedication was generalised in contemporary times, and its meaning was often subject to the understanding of the reader. They contain words only in a few instances that explicitly state that they apply to active euthanasia and assisted suicide. Depending on the country, school and the idiosyncrasies of the student body, it would be advisable that medical oaths contain precise and relevant premises about this pledge, as the pledge loses its meaning when it is generalised and open to the interpretation.[81]

The premise of this study is that in communities where assisted suicide is seen as a response to the pain and distress that many feel as they reach the end of their lives, there are significant risks for people with disabilities. In that case, for most people, assisted suicide can be considered "merciful" because it relieves them of the physical and emotional pain they would otherwise have to undergo. However, for people with disabilities, "mercy" is often seen in terms of ending a life that is considered by others to be devoid of meaning because of the disability of the person, rather than being unbearable because of pain and misery for the individual.

In summary, as can be seen above, the simplistic yes / no essence of the debate masks major aspects. Although it is of little surprise that autonomy is at the core of a debate about allowing people to do something previously forbidden, the ways in which the existing body of work attempts to define the appropriate limits of autonomy are of particular interest. Any further work will need to set these limits for both, then balance this autonomy Finally, it should be remembered that the creation of a set of ethical principles that could be applicable to a reform in the law requires special attention. Any subsequent debate will be essentially moot without first determining this.

[81] Orr R, Pang N. *Use of the Hippocratic Oath: a review of twentieth century practice and a content analysis of oaths administered in medical schools in the U.S. and Canada in 1993*. Journal of Clinical Ethics 1997; 8(4): 377-388.

CHAPTER 3

ANALYSIS OF THE LAW OF ASSISTED SUICIDE IN OTHER JURISDICTIONS

(Netherlands, Oregon, Washington, Belgium, Luxembourg, Switzerland, Australia, New Zealand, And The UK)

INTRODUCTION

In western societies, life expectancy is high and non-communicable conditions such as cardiovascular diseases, and cancer are the leading causes of death. Patients with these diseases often deteriorate slowly and painfully. Medical interventions may prolong their suffering or keep them alive until they have lost their autonomy. Under these conditions, some people wish to hasten their death. When a patient explicitly asks a doctor to prescribe drugs that both know will end the patient's life, the result is an assisted suicide.[82]

Euthanasia, in reality, is not a concept of controversy throughout the world. It is discussed only in such countries which are economically and technologically developed. The issue of euthanasia does not arise if a country does not have the technological advancement in the medical field and a high economic standard for its citizenry.[83] Death was typically a normal occurrence just a few centuries ago: the body succumbed to a disease or accident, and that was it. With the emergence of modern industrialised medicine, particularly in recent decades, technical treatments, including a wide variety of medications (chemotherapy, anticonvulsants, painkillers, and many others), operations, transfusions, resuscitation, defibrillators, respirators, and feeding tubes, are more commonly associated with disability and death. As in

[82] McCormick AJ. *Self-determination, the right to die, and culture*: a literature review, 2011;56:119-128

[83] Aymond Whiting, *A natural right to die: twenty-three centuries debate*, 37 (1st ed. 2002)

chronic vegetative states, a body that would have died previously can now be kept going for days, weeks, or even years.[84]

Four European countries and three states have legalised euthanasia and Physician-assisted suicide. The Netherlands, Belgium, Luxembourg; and the states of Oregon and Washington explicitly legalised assisted dying. In contrast, Switzerland and Montana decided that Physician-assisted suicide was legal under existing laws.[85]

In the current legal stature, there seem to be three rough modes of regulations to cover assisted dying.

- In the Netherlands, Belgium, and Luxembourg, the decision to end life on request is based on the patient-doctor relationship. Patients must be suffering unbearably, with no prospect of improvement, to become eligible for euthanasia or physician-assisted suicide. The illness does not have to be terminal.
- In Switzerland, the relevant Article 115 dating from 1918. Although it was not intended to regulate Physician-assisted suicide, since the 1980s several right to die organisation have relied on it to justify their assistance efforts.[86]The Federal Supreme Court of Switzerland emphasised the responsibility of the physician in this process. However, physicians are generally not present when the patient takes the lethal dose, and a physician-patient relationship is not required. In addition to terminally ill persons, patients with mental disorders and other severely disabling illness have recourse to assisted suicide. Euthanasia is forbidden.
- The US states of Oregon, Washington, Montana allow assisted suicide but not euthanasia. In contrast to European countries, dignity acts and court rulings from Oregon, Washington, and Montana state that patients must have a terminally physical illness.

[84] Colby, W. H. (2006). *Unplugged: Reclaiming our right to die in America*. New York: Amacom
[85] Steck, Nicole. *"Euthanasia and Assisted Suicide in Selected European Countries and US States: Systematic Literature Review."* Medical Care, vol. 51, no. 10, 2013, pp. 938–944.
[86] Bosshard G. *Assisted suicide - medical, legal, and ethical aspects*. Praxis (Bern 1994). 2012; 101:183-18

All counties except Switzerland as well as the state of Montana have a notification obligation for assisted Suicides and regularly publish summary reports.[87]

LEGISLATIONS IN COUNTRIES LEGALISING ASSISTED-SUICIDE

Various countries around the world legalised the concept of Physician-Assisted suicide. Here we take a look at these countries and get familiar with their legal structures in this matter.

NETHERLANDS

The country is —*" a living laboratory of what happens when society accepts the legitimacy of physician-assisted suicide and euthanasia. You have got direct, empirical evidence of the consequences"* - Edmund Pellgrino[88]

Euthanasia and assisted suicide had been practised for a long time in the Netherlands. However, the Netherlands became the first country to legalise euthanasia through the enactment of law regarding the practice of euthanasia and assisted suicide on 1 April 2002. Over one hundred years, the Netherlands had legislation outlawing the practice of euthanasia. However, the post-second world war experience has been one in which euthanasia and assisted suicide came to be re-examined in the courts of law and public opinion.[89]

HISTORY OF ITS EVOLUTION

Articles 293 and 294 of the Dutch Penal Code make both euthanasia and assisted suicide illegal, even today. However, doctors who directly kill patients or help patients kill themselves will not be punished as long as they obey certain rules, as a result of numerous court cases. In addition to the current requirements that physicians report every euthanasia/assisted-suicide death to the local prosecutor and that the

[87] Id n 82.
[88] Lisa Yount*, Right to Die and Euthanasia*, 44(2nd ed. 2007) p. 20
[89] Jonathan T. Smies, *The Legalization of Euthanasia in the Netherlands*, (2004) p. 7-10

patient's death request must be enduring, the Rotterdam court in 1981 established the following guidelines:

- The patient must be experiencing unbearable pain.
- The patient must be conscious.
- The death request must be voluntary.
- The patient must have been given alternatives to euthanasia and time to consider these alternatives.
- There must be no other reasonable solutions to the problem.
- The patient's death cannot inflict unnecessary suffering on others.
- There must be more than one person involved in the euthanasia decision.
- Only a doctor can euthanise a patient.
- Great care must be taken in actually making the death decision.[90]

FALSIFIED DEATH CERTIFICATES

In the vast majority of cases of Dutch euthanasia, doctors—to escape further paperwork and scrutiny by local authorities—deliberately falsify death certificates for patients, claiming that the deaths occurred due to natural causes.[91]In reference to Dutch euthanasia guidelines and the requirement that physicians report all euthanasia and assisted-suicide deaths to local prosecutors, a government health inspector recently told the New York Times: "In the end, the system depends on the integrity of the physician, of what and how he reports. If the family doctor does not report a case of voluntary euthanasia or an assisted suicide, there is nothing to control."[92]

INADEQUATE PAIN CONTROL AND COMFORT CARE

In 1988, at the behest of British right-to-die advocates, the British Medical Association published the results of a report on Dutch euthanasia conducted. The

[90] Carlos Gomez*, Regulating Death* (New York: Free Press, 1991), p.32. Hereafter cited as Regulating Death.
[91] I.J. Keown, "*The Law and Practice of Euthanasia in the Netherlands*," The Law Quarterly Review (January 1992), pp. 67-68.
[92] Marlise Simons, "*Dutch Move to Enact Law Making Euthanasia Easier*," New York Times, 2/9/93, p.A1.

study found that palliative treatment (comfort care) services, with adequate pain management strategies and expertise, were poorly established, given the fact that medical care is offered to everyone in Holland.[93]

Since 1981, these guidelines have been interpreted by the Dutch courts and Royal Dutch Medical Association (KNMG) in ever-broadening terms. One example is the interpretation of the "unbearable pain" requirement reflected in the Hague Court of Appeal's 1986 decision. The court ruled that the pain guideline was not limited to physical pain, and that "psychic suffering" or "the potential disfigurement of personality" could also be grounds for euthanasia.[94]

The State Commission consulted a number of organisations, one of whom is the main Dutch doctors' organisation, the Royal Dutch Medical Association (KNMG).[95] Subsequently, although the KNMG adopted a neutral position on the question of whether euthanasia should be legalised, they played an important role in formulating the basis upon which assisted dying became permissible. The KNMG advised that any relaxation in the law should permit only physician-assisted dying (PAD), and a number of other requirements should be satisfied prior to any assisted Suicide; in relation to the patient, there must be a voluntary and well-considered request and 'unacceptable' suffering. Procedurally, a second doctor must be consulted, and the cause of death should be reported.

Subsequently, a significant development occurred in the case of Schoonheim (Supreme Court 1984),[96] when Dr Schoonheim was initially convicted for giving a lethal injection to his 95-year-old patient at her request. On appeal, the Dutch Supreme Court ruled that there had been an inadequate investigation into the conflict of duties faced by the defendant, and following consideration of the facts, the court applied the 'emergency' defence (noodtoestand), which is broadly equivalent to the defence of necessity in English law. This is a mitigating defence that exculpates conduct that would otherwise be illegal on the grounds that a person is compelled to behave in an emergency situation in order to escape a greater evil.

---

[93] Euthanasia: Report of the Working Party to Review the British Medical Association's Guidance on Euthanasia, British Medical Association, May 5, 1988, p. 49, no. 195.
[94] Id., p.39.
[95] Koninklijke Nederlandsche Maatschappij tot beverdering der Geneeskunst. (Royal Dutch Society for the Recovery of Medicine)
[96] Supreme Court of the Netherlands, Criminal Chamber, 27 November 1984, nr 77.091. Judges Moons, Bronkhorst, De Groot, De Waard, Haak [Nederlandse Jurisprudentie 1985, no. 106].

The strongest argument for Holland's euthanasia has always been the need for more patient autonomy — that patients are entitled to make their own end-of-life decisions. In the end, the Dutch practise of euthanasia has given more and more control to physicians, not to patients. The issue of whether a patient should be alive or dying is always determined solely by a doctor or a team of doctors.[97]

Thus, the foundations upon which Dutch assisted dying law rests were established. Over this time, a number of other cases were brought before the Dutch courts and, together with the KNMG's impact, a set of 'due care' standards were incrementally developed which served to exempt doctors from criminal liability in this regard. The public prosecutor's office then adopted the criteria as the guiding principles to determine whether to prosecute in cases involving euthanasia and assisted suicide.

In the case of Gerritsen Vs Chabot (Supreme Court 1994),[98] a psychiatrist complied with a woman's repeated requests for assistance in committing suicide, after terrible grief and unhappiness following the death of both her children, had left her irretrievably determined to end her life. The court agreed that situations that occur under which the necessity protection may be extended in the absence of terminal illness or intolerable physical distress, given, of course, that severe psychological distress could not be alleviated by other means.

Nonetheless, Dr Chabot was convicted because there was insufficient proof to prove that he had adhered to the provisions of due care for consulting another physician to ensure that the condition of the patient was adequately serious. Despite the conviction, no punishment was imposed, a decision which is reflective of Dutch Courts' reluctance to punish doctors convicted of breaching the law in this way.

The question of whether PAD (Physician-Assisted Suicide) might also be an appropriate means of relieving existential suffering was considered in the case of Sutorius.[99] Existential suffering is not a term that has been specifically described, but maybe interpreted as suffering that arises from social rather than psychiatric causes,

---

[97] H. Jochemsen, trans., "*Report of the Royal Dutch Society of Medicine on 'Life-Terminating Actions with Incompetent Patients, Part 1: Severely Handicapped Newborns.'"* Issues in Law & Medicine, vol. 7, no.3 (1991), p. 366.

[98] Nederlandse Jurisprudentie 1994 No.656, Supreme Court

[99] 3 See T Sheldon, '*Being 'Tired of Life' is Not Grounds for Euthanasia'*, (2003) 326 British Medical Journal Also; Griffiths et al, discussed at pp.35-39.

such that the subject feels tired or depressed of life in a situation that is increasingly dependent, socially alienated and generally 'hopeless.'

The Dijkhuis Committee, who use the term 'Suffering from life', describe people who suffer:

> "at the prospect of having to continue living in a manner in which there is no or only a deficient, perceived quality of life, giving rise to a persisting desire to die, even though the absence or deficiency in the quality of life cannot be explained in any or significant measure by an identifiable somatic or psychiatric condition."[100]

In 1998, Dr Sutorius assisted in the suicide of an 86-year-old man, Brongersma, on the grounds that he was suffering existentially as a consequence of a number of the side-effects of old age, which had rendered him feeling increasingly undignified and socially isolated. Sutorius had two independent experts evaluating and talking to Brongersma, both of whom supported the opinion that the ex-senator was experiencing his life as intolerable due to his physical degradation in the absence of depression.

At first instance, the court acknowledged the premise that the deceased's suffering could not have been remedied by other means, and so acquitted Sutorius on the grounds that necessity could be cited for such suffering.[101] The prosecution appealed on the grounds that the ruling would call for the presumption of an unqualified right to patient self-determination, while also raising concerns about the 'unbearable' nature of the suffering of Brongersma. After considering whether it should be part of the professional obligation of a doctor to relieve such non-medical existential suffering, the Dutch Court of Appeals ruled that this consideration would not apply to the provision of PAD, while doctors should be concerned about such suffering and should try to alleviate it.

---

[100] See KNMG position paper, *The Role of the Physician in the Voluntary Termination of Life* (2011) available at www.knmg.nl/voluntary-termination-of-life at p.14

[101] District Court Haarlem, 30 October 2001, no 15/035127-99; Tidjdschrift voor Gezondheidsrecht 2001/21.

Thus, Sutorius was found guilty, although no punishment was imposed. Sutorius appealed his conviction[102] , and in December 2002, the Supreme Court upheld Sutorius's conviction, reiterating that:

> "A doctor who assists in suicide in a case in which the patient's suffering is not predominantly due to a 'medically classified disease or disorder', but stems from the fact that life has become meaningless for him, acts outside the scope of his professional competence."[103]

At around the same time that the Brongersma case was unravelling, changes in the Dutch political landscape following the 1998 elections resulted in the adoption of a bill which became The Termination of Life on Request and Assisted Suicide (Review Procedures) Act, thereby completing the process of legalisation of PAD in the Netherlands.

As Griffiths (Faculty of Law, University of Groningen.), Weyers (Assistant Professor, Mental Health and Law, Groningen, Groningen) who co-authored Euthanasia and Law in the Netherlands, observed:

> "As far as the legality of euthanasia is concerned, the law of 2002 does little more than ratify what the State Commission, the Medical Association, the courts and the prosecutors had already accomplished. The only genuinely new provisions concern the legality of euthanasia pursuant to a prior written request by a person who has become incompetent, and the position of minors."[104]

Thus, the law of 2002 amended Articles 293 and 294 of the Criminal Code and came into force on 1 April 2002. Euthanasia and assisted suicide remain (potentially) unlawful[105] , but exceptions are introduced such that:

> "The act shall not be an offence if it is committed by a physician who fulfils the due care criteria set out in Section 2 of the Termination of Life on Request and Assisted Suicide (Review Procedures) Act, and if the physician notifies

[102] Nederlandse Jurisprudentie 2003, no 167.
[103] Griffiths, John, et al. Euthanasia and Law in the Netherlands. Amsterdam University Press, 1998. www.jstor.org/stable/j.ctt46mxn9. Accessed 10 Oct. 2020.
[104] id, p.33. With respect to the new provisions, the law of 2002 permits advance requests for euthanasia
[105] Under Articles 293(1) and 294(1).

the municipal pathologist of this act in accordance with the provisions of section 7, subsection 2 of the Burial and Cremation Act,"[106]

Under section 2 of the 2002 law, due care requires that a physician:

- Holds the conviction that the request by the patient was voluntary and well-considered;
- Holds the conviction that the patient's suffering was lasting and unbearable;
- Has informed the patient about the situation he was in and about his prospects;
- And the patient holds the conviction that there was no other reasonable solution for the situation he was in;
- Has consulted at least one other independent doctor who has seen the patient and has given his written opinion on the requirements of due care referred to in parts (a)-(d); and,
- Has terminated a life or assisted in suicide with due care.

THE DUTCH EXPERIENCE

Both Oregon and the Netherlands are understandably eager to refute the notion that their tightly controlled PAD model has fallen victim to slippage, and the worst fears of opponents have not occurred. Some recent findings in the Netherlands, however, indicate that the current standards of assisted dying are too restrictive, at least to some.[107] The strictly medical model, which permits only PAD might be seen to be under some strain as a consequence of a number of cases involving lay assistance. For example, in the case of Schellekens, in May 2009, the District Court in Almelo found Gerard Schellekens, the president of a Dutch right-to-die organisation, guilty of the offence of assisted suicide.[108]

[106] Articles 293(2) and 294(2).
[107] See, GK Kimsma, *'Euthanasia Drugs in the Netherlands' in DC Thomasma et al* (eds), *Asking to Die: Inside the Dutch Debate about Euthanasi*a, (1998) Kluwar Publishing.
[108] LJN: BI5890, Rechtbank Almelo, 08/750709-07

A Dutch government bill which has given statutory force to the guidelines permitting PAS was passed in the lower house of the Dutch Parliament in November 2000 and by the upper house in April 2001.[109] The Act provides:

- PAS must be performed in accordance with careful medical practice. Requests must be voluntary, well-considered, persistent, and emanate from patients who are experiencing unbearable suffering without hope of improvement, and the doctor and the patient must agree that PAS is the only reasonable option. At least one independent physician must be consulted, who must see the patient and give a written opinion on the case.
- All-cases must be reported to and evaluated by regional committees consisting of a lawyer, a doctor, an ethicist or another professional who is accustomed to dealing with ethical issues. (For each member there is a substitute member)
- PAS will not be punishable if performed by a doctor who has complied with the requirements listed in (1) and who has reported the case to the local medical examiner.
- The local medical examiner must send his or her report as well as the physician's report to the regional review committee. The medical examiner sends a form to the prosecutor informing the prosecutor about the case and seeking permission for burial or cremation. In the event of any serious infringement reported by the medical examiner or anyone else, the prosecutor will withhold permission for burial or cremation until the investigation has been conducted. The reports to the regional committee must demonstrate that all the requirements have been met.

In addition to these established criteria, the Act contains provisions concerning children and advance directives:

- A doctor may agree to a request for PAS by a child between 12 and 16 but only with the parents' consent. Requests by children aged 16-17 do not require parental consent, though parents should be involved in the decision-making process.

[109] See Henk Jochemsen, '*Legalizing Euthanasia in the Netherlands'* (1999) 5 Dignity: The Newsletter of the Center for Bioethics and Human Dignity

- Doctors may terminate the life of an incompetent patient who has made his or her request for PAS by way of a signed advance directive.

The guidelines contained in the new legislation seem no more precise and stricter than those laid down by the courts. Commenting on earlier legislative proposals, Professor Gevers, a professor of health law in the Netherlands and supporter of PAS, observed: 'It is impossible to delineate precisely the situations in which euthanasia should be allowed; therefore, a new law cannot add very much to what has already been developed by Courts, and will only partially reduce legal uncertainty.[110]

OREGON

The U.S. state of Oregon legalized Physician-assisted suicide (PAS) in 1998 following The Death with Dignity Act 1994. A decision of the Supreme Court in 1997 confirmed that although there could be no constitutional right to assisted suicide, the legalization of assisted suicide would not be unconstitutional.[111] This followed two narrowly unsuccessful attempts to legalize assisted dying in both Washington and California. By contrast, Oregon voters passed the first Bill in November 1994 by a majority of 52 %.

Just as this controversial law was about to be enacted, an injunction was issued on the grounds that the statute violated the Equal Protection Clause of the Fourteenth Amendment.[112] However, this injunction served only to delay matters as the court held that the plaintiffs lacked the necessary standing under the United States Constitution,[113] and, following a further vote which affirmed the measure by a 60 % majority, the Act was given the green light.

With respect to the parameters of the law, The Death with Dignity Act allows a physician to supply a prescription for lethal drugs under certain circumstances; these being upon the request of a competent adult who is suffering from a terminal illness from which they are expected to die within six months, and upon compliance with the following conditions:

---

[110] J.K.M. Gevers, '*Legal Developments concerning Active Euthanasia on Request in the Netherlands'* (1987) 1 Bioethics 156 at 162

[111] *Washington et al. v Glucksberg 117 SCt 2258* (1997) and Vacco v Quill 117 SCt 2293 (1997).

[112] *Lee v Oregon* (1995) F. Supp.1429, 1437 (D. Or.). See also, *Gonzales v Oregon* 546 US 243 (2006)

[113] Id, 107 F.3d 1382, 1392 (9th Cir.).

- The patient must make an oral request followed by a formal written request;
- The patient must repeat their oral request at least 15 days after the written request, and then a further 48 hours must elapse before the prescription can be provided;
- The patient's request must be witnessed by at least two other people besides the physician, at least one of whom must not be a relative, an heir or an employee of the medical institution in which the patient is receiving care;
- The patient must be asked to notify his/her family;
- A second doctor must confirm the patient's diagnosis and that the patient is competent and acting voluntarily;
- The patient must have received full information about diagnosis, prognosis and any alternative treatments such as pain control and hospice care;
- If there is any indication that the patient is depressed or has a psychiatric disorder, he/she must be referred to a psychiatrist or psychologist.

As in the Netherlands, there is no clear criterion for a PAS applicant to prove intolerable or unimaginable distress, although the terminal illness condition (with death anticipated within six months) is clearly an alternative way of deciding if PAS is justified. This issue may then be assessed via a system for monitoring and collecting information on PAS which is maintained by the Oregon Department of Human Services.

Information is gathered, including compliance reports from doctors and pharmacists, analyses of death certificates and follow-up interviews. The Department has adopted a neutral stance, and its position in monitoring PAS does not extend to any capacity for compliance.[114] This service allows access to the data emerging from the experience in Oregon in order that we might assess how society has responded to the option of legal PAS. Therefore, there were fifteen assisted suicides in Oregon in the year following the implementation of the Death with Dignity Act, representing 0.05 per cent of all deaths. The number subsequently increased although the annual figures remain small.

[114] F. Pakes, '*The legalisation of euthanasia and assisted suicide: A tale of two scenarios'*, International Journal of the Sociology of Law, 33 (2005) pp.71-84

For example, in 2007, there were 49 assisted suicides, which accounted for 0.15 of all deaths,[115] rising to 65 deaths in 2010.[116]

Unlike in the Netherlands, the final act of suicide is completely in the patient's hands as regards ingesting the drugs. Having this in mind, it is important to note that a small amount of those seeking a lethal prescription in Oregon chose not to take the medications, but rather to allow their terminal disease to run its course. It would appear that a large number of those who were sufficiently inspired by their plight to go to the trouble of pursuing the PAS option were able to continue their lives before death inevitably came. It implies that the choice of PAS is appropriate for certain patients so that if the patient has the ability to manage death, they can handle the final days, weeks or even months of life.

GONZALES V. OREGON[117]

In 1994, Oregon passed the Death with Dignity Act, the first state law permitting physicians to prescribe lethal doses of controlled substances to terminally ill patients. U.S. Attorney General John Ashcroft declared in 2001 that the Act violated the Controlled Substances Act of 1970, and threatened to revoke the medical licenses of physicians who engaged in physician-assisted suicide. Oregon sued the Attorney General in federal district court. The district court and the Ninth Circuit both held that Ashcroft's directive was illegal.

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

WASHINGTON

Based on Oregon's comprehensive and practically unblemished record, other States have been following. Its northern neighbour was the first state to mimic Oregon, In Washington. Washington State voters passed an initiative loosely modelled on Oregon's legislation in November 2008. Initiative 1000 passed by a margin of 58 to

[115] Oregon Department of Human Services, Tenth Annual Report on Oregon's Death with Dignity Act (2007), available at www.oregon.gov/DHS/ph/pas/docs/year10.pdf
[116] Id, year13
[117] *Gonzales v. Oregon* Docket # 04-623 Jan. 17, 2006

42 percent.[118] In early 2009, the Washington Death with Dignity Act became successful. Data from the annually published reports of Washington State indicate activity and use quite close to that in Oregon.[119]

WASHINGTON V. GLUCKSBERG[120]

Harold Glucksberg, MD, along with three other doctors, three gravely ill patients, and the nonprofit organization Compassion in Dying, brought a suit challenging the state of Washington's ban on physician-assisted suicide. The plaintiffs asserted that the Washington ban was unconstitutional, arguing that the existence of a liberty interest protected by the Fourteenth Amendment allows mentally competent, terminally ill adults to commit physician-assisted suicide. The District Court ruled that the ban was unconstitutional, and the Ninth Circuit affirmed.

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

OTHER NOTABLE EFFORTS TO ENACT PAS IN THE US

During the early 1990s, several cases in California and Michigan had sought a federal constitutional right to MAID (Medical Assistance in Dying). Nevertheless, the most important cases of civil rights were outside Washington and New York. In 1994, activists filed two federal cases questioning the constitutionality of legislation criminalising suicide aid in Washington and New York. The litigation in Washington and New York argued that the statutes of criminal assisted suicide represented denials of due process and equal protection as applied to terminally ill, qualified individuals voluntarily seeking support from licensed doctors. The New Jersey Assembly passed a MAID bill on a 41 to 28 vote in 2016.[121]

---

[118] Robert Steinbrook, *Physician-Assisted Death - From Oregon to Washington State*, 359 NEW ENG. J. MED. 2513, 2513 (2008).
[119] See Wash. State Dep't Of Health, Washington State 2016 Death with Dignity Act Report (Sept. 2017).
[120] *Washington v. Glucksberg* 521 U.S. 702 June 26, 1997
[121] Assemb. B. 2451, 217th Leg. (N.J. 2016).

VACCO V. QUILL[122]

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

The Supreme Court, in a 9-0 ruling, upheld the constitutionality of New York's ban on physician-assisted suicide.

IN RE QUINLAN[123]

In 1975, 21-year-old Karen Ann Quinlan was admitted to the hospital in a coma, and was later declared by doctors to be in a "persistent vegetative state." After five months on a ventilator, her parents requested that the ventilator be removed and that Ms Quinlan be allowed to die. After doctors refused, her parents brought the matter to court.

The New Jersey Superior Court denied her parents' request, but the New Jersey Supreme Court reversed and ruled that Quinlan's "right to privacy" included her right to be removed from the ventilator.

The Quinlan case has influenced U.S. law by providing the framework for deciding the difficult legal issues that continue to arise as advances in medical technology allow doctors to keep patients alive, even when they have little or no chance of returning to normal life. Nearly every judicial decision since Quinlan has recognized a patient's right to refuse life-sustaining medical treatments. Finally, the courts have agreed with Quinlan that where a patient is incompetent, the right to refuse such treatments may be asserted by the patient's family or guardian.[124]

---

[122] *Vacco v. Quill* 526 U.S. 793 June 26, 1997
[123] In *Re Quinlan* 70 N.J. 10; 355 A.2d 647 (1976)
[124] Stevens, M.L. Tina. 1996. "*The Quinlan Case Revisited: A History of the Cultural Politics of Medicine and the Law."* Journal of Health Politics, Policy and Law 21

BELGIUM

The Belgium Act on Euthanasia was passed on 28 May 2002 and came into force on 23 September 2002. Euthanasia is defined as the deliberate termination of life by someone other than the person concerned at the latter‘s request.[125] The patient should be a major or an emancipated minor(emancipated minor means that you are considered an adult before age 18, and are legally separated from your parents or legal guardians) who voluntarily makes a decision with regard to euthanasia and the patient should be suffering from incurable suffering that cannot be alleviated, and if the medical practitioner follows all the conditions given under the enacted statute, he will not be liable for punishment for practising euthanasia.[126]

Belgium legalized euthanasia in 2002 following in the footsteps of its Dutch neighbours, though retaining a legally ambiguous position on assisted suicide. Article 3.1 of the Law on Euthanasia provides that a doctor who performs euthanasia does not commit a crime if he or she ensures that:

‘The patient is in a medically hopeless situation of persistent and unbearable physical or mental suffering that cannot be alleviated, resulting from a serious and incurable disorder caused by illness or accident.’[127]

Accordingly, the Belgian Law on Euthanasia requires a practitioner to offer euthanasia under certain conditions; the patient must be over 18 years of age, qualified, conscious and in a 'medically impossible' state of constant and intolerable physical or mental pain, which cannot be alleviated as a result of a severe and incurable illness or accident. There must be a voluntary, well-considered and repeated request to die in the absence of any external pressure. In addition, the physician must inform the patient of his situation, discuss his request for euthanasia, discuss potential therapeutic and palliative options, and, if the physician agrees with the patient about the extent of his pain, and the request is long-lasting so that there are no appropriate solutions for the patient, the physician must consult another physician.[128]

[125] Section 2 of the Belgium Euthanasia Act, 2002
[126] Section 3(1) of the Belgium Euthanasia Act, 2002
[127] See p.312, Euthanasia and Law in Europe, J Griffiths, H Weyers and M Adams, Hart Publishing 2008
[128] see Griffiths et al, p.306

The second doctor must be competent to give an opinion on the condition in question and be independent of both the first and the patient. The second doctor must then study the medical record and assess the patient to ascertain the constant and intolerable distress of the patient, which cannot be alleviated by any means, before preparing a report for the doctor of the hospital who will then notify the hospital of the outcome of the examination.

Special precautions will be taken if there is no risk that the patient will die in the near future. Accordingly, the second doctor must be a physician or specialist of whatever condition affects the patient for those not imminently terminal patients, and there must be a time of at least one month between the admission of the patient and the euthanasia. There are also guidelines for patients to file advance euthanasia requests should they lose capacity. This is unsurprising that Belgium has taken a similar policy to the Netherlands given the closeness of the two nations and the presence of the Dutch-speaking community. Even more interesting is the fact that Belgium had no pre-statutory cases of legal euthanasia to draw on, unlike the Netherlands. Euthanasia was illegal until 2002.

The relationship between the Netherlands and Belgium is a strong illustration of a society adapting its legislation to morality changes shaped at least in part by the legalization and social acceptance of assisted dying in a neighbouring – and culturally similar – jurisdiction. The fact that Luxembourg has also legalized euthanasia provides further evidence of this contagion, and in the US, we see a similar phenomenon with Washington following Oregon, and other states looking likely to legislate.[129]While the UK does not share close cultural ties with any other European country, it seems that the increasing importance placed upon the right to self-determine issues of life and death is a phenomenon shared by a number of countries. As Biggs has observed,

> 'Throughout Europe, public support for assisted dying has been growing for many years in response to humanitarian concerns about the indignities associated with protracted dying.'[130]

[129] See '*Montana ruling bolsters doctor assisted suicide'* The New York Times, December 31 2009, available at http://www.nytimes.com/2010/01/01/us/01suicide.html
[130] H Biggs, '*The Assisted Dying for the Terminally Ill Bill 2004: Will English Law soon allow Patients the Choice to Die?'* (2005) European Journal of Health Law 12: 43-56

Moreover, the way that the drive to self-determine has developed in Switzerland, giving rise to the emergence of assisted suicide organizations such as Dignitas and Exit (whose doors are open to non-Swiss residents), has had repercussions beyond the Swiss border.

LUXEMBOURG

Luxembourg Parliament adopted the law decriminalizing euthanasia on 19 February 2008. It permits euthanasia in certain circumstances. The conditions are: the patient must be in a terminal condition, the patient must be in unbearable pain with no hope for improvement in their condition, the patient must make a voluntary request, and the patient's doctor must consult with another doctor.[131]

Euthanasia and physician-assisted Suicides are included in the Act. A doctor who assists in suicide must ensure that:[132]

1. At the date of his query, the patient is legally competent;
2. If the patient is between the ages of 16 and 18, the consent of his parents or legal guardian is available;
3. The request is voluntary, reflected and replicated and is not determined by various stress;
4. The individuals suffer from an incurable illness and are in severe physical or emotional pain that is unbearable.

SWITZERLAND

The continued practice of assisted suicide in Switzerland led communities to presume that, in the region, the practice was legalized. However, the key distinction between Switzerland's method of euthanasia and other countries such as the Netherlands and Belgium is that, in Switzerland, the legislation recognizes euthanasia or assisted suicide as medical treatment.

According to Swiss law[133], whoever, from selfish motives, induces another to commit suicide or assists him therein shall be punished. Thus, if the person assisting a suicide successfully claims that he is acting unselfishly, he is free from prosecution in

[131] See, http://www.station.lu/edito-9306-details-of-new-law-on-euthanasia.html
[132] Luxembourg: Right to Die with Dignity Loc.gov, https://www.loc.gov/law/foreign-news/article/luxembourg-right-to-die-with-dignity/ (last visited Oct 5, 2020)
[133] Article 115 of The Penal Code of Switzerland, 1937

Switzerland. This results in de facto legalization, i.e., assisted suicide is not per se legal, only not punishable, if the unselfish motive is proven. Thus, in Switzerland, euthanasia is illegal, and physician-assisted suicide is also not legalized, but it tolerates the practice based on the legal interpretation of the suicide law, 1918.[134]

Only Switzerland allows foreigners to make use of their clinics, which has given rise to the morbid industry of "death tourism" in the country. Swiss charity ―Dignitas" was founded in the year 1998 and has helped hundreds of people across Europe to commit suicide.[135] Dignitas is a suicide promoting organization, taking advantage of the liberal legislation on assisted suicide in Switzerland. Campaigners see the lack of a total ban on assisted suicides as tacit permission to proceed, while their position in Swiss courts has never been checked.

"Live with dignity, die with dignity" is the slogan of Dignitas. Dignitas revealed that they have assisted in the deaths of many persons who are not terminally sick. Dignitas believe that ―*we have owned our bodies, and thus, determining the time, manner, and method of our own deaths, for whatever reason, is a basic human right.*[136]

The Zurich Declaration delivered at the Bi-annual Convention of World Federation of Right to Die Societies in 1998 stated that: *"We believe that we have a major responsibility for ensuring that, it becomes legally possible for all competent adults, suffering severe and enduring distress, to receive medical help to die, if this is their persistent, voluntary and rational request. Such medical assistance is already permitted in the Netherlands, Switzerland and Oregon (USA). It should also be noted that one need not be dying or even sick to experience severe and enduring distress."*[137]

Thus, in Switzerland, the euthanasia lobby is becoming stronger, that they are no longer abiding by their traditional anthems of voluntary euthanasia for the competent and suffering. Now euthanasia is treated as a human right.

---

[134] Alex Schadenberg, ―*Troubling trends on euthanasia in Europe*. ‖ Available at www.theinterim.com /2008/June/15euthanasia.html

[135] Jenna Murphy, John Jalsevac, ―*Assisted Suicide Gains Ground in British Courts*, Available at‖ www.lifesitenews.com/ldn/2008/jun/08061304.html.

[136] Wesley J. Smith, ―*Right to Die Movement is really about Euthanasia, Not Compassion*. Available at ‖ www.Lifenews.com.

[137] Id, n 133

AUSTRALIA

The Northern Territory (NT) is a vast but sparsely populated area in Australia, occupying a sixth of the continent but with a population of Jess than 200,000. In 1995, its legislature of twenty-five enacted (by a small majority) the Rights of the Terminally ILL Act ("ROTTI').[138] The Act permitted both PAS and VAE (Voluntary Assisted Euthanasia).

The Act stated that it sought to confirm the right of a terminally ill person to request assistance from a medically qualified person to terminate his or her fife inhumane manner voluntarily; to allow for such assistance to be given in certain circumstances without legal impediment to the person rendering the assistance and to provide procedural protection against the possibility of abuse of the rights recognized by this Act'.

THE PATIENT'S REQUEST

Section 4 provided that a patient who 'in the course of terminal illness was experiencing pain, suffering or distress to an extent unacceptable to the patient' could request the patient's medical practitioner to assist the patient to terminate the patient's life. The Act defined terminal illness as an illness which in reasonable medical judgment will, in the normal course, without the application of extraordinary means of treatment the patient, result in the death of the patient It defined ‘assist’ to include 'the prescribing of a substance, the preparation of a substance and the giving of a substance to the patient for self-administration, and the administration of a substance to the patient. It is clear from the italicized words that the Act allowed not only PAS but also VAE.

THE FIRST DOCTOR'S OPINION

Section 5 stated that a medical practitioner who received such a request could if satisfied that certain conditions had been met, assist the patient to terminate the

[138] See John Fleming, *‘Death, Dying and Euthanasia: Australia versus the Northern Territory’* (2000) 15 Issues Law Med 291, Northern Territory of Australia, Act No. 12 of 1995

patient life in accordance with the Act. The conditions were laid down by section 7. First, the patient must have attained the age of 18. Secondly, the doctor must have been satisfied, on reasonable ground that:

- The patient was suffering from an illness that would, in the normal course and without the application of extraordinary measures, result in the death of the patient.
- In the reasonable medical judgment, there was no medical measure acceptable to the patient that could reasonably be undertaken in the hope of effecting a cure, and
- Any medical treatment reasonably available to the patient was confined to the relief of pain, suffering or distress with the object of allowing the patient to die a comfortable death.

THE SECOND AND THIRD DOCTORS OPINIONS

Thirdly, a second doctor (who was not a relative or employee of, or member of the same medical practice as, the first) who held a diploma of psychological medicine or its equivalent' must have examined the patient and confirmed:

- The first doctor's opinion as to the existence and seriousness of the illness; that the patient was likely to die as a result of the illness;
- The first doctor's prognosis; and
- That the patient was not suffering from a treatable clinical depression in respect of the illness.

One problem with this part of the Act was that there was no such qualification as a 'diploma of psychological medicine in the NT. Section 713) was therefore amended in 1996. The Act as amended required the patient to be examined by two other doctors, one a qualified psychiatrist, to confirm the final criterion, and the other a medical practitioner who held the prescribed qualification or had the prescribed experience in the treatment of the terminal illness from which the patient was suffering to confirm the first three.[139]

[139] Rights of the Terminally Ill Amendment Act 1996, Section 4(a)

OTHER CONDITIONS

The Act also required that certain other conditions be satisfied:

- The illness was causing the patient severe pain or suffering;
- The first doctor had informed the patient of the nature of the illness and its likely course, and the medical treatment, including palliative care, counselling and psychiatric support and extraordinary measures for keeping the patient alive which might have been available to the patient.[140] Where the doctor had no special qualifications in the field of palliative care, the information to be provided to the patient about the availability of palliative care was to be given by a doctor (who could be the second doctor with expertise in the patient's terminal illness[141] or any other doctor) who had such special qualifications as prescribed;[142]
- After being so informed, the patient indicated to the doctor that the patient had decided to end his or her life; • the doctor was satisfied that the patient had considered the possible implications of the decision to his or her family;
- The doctor was satisfied, on reasonable grounds that the patient was of sound mind and that the patient's decision had been made freely, voluntarily and after due consideration;
- The patient had, not earlier than seven days after indicating his or her decision to the doctor, signed a certificate of requests;
- The doctor had witnessed the patient's signature on the certificate and had completed and signed the relevant declaration on the certificates;
- The certificate of request had been signed in the presence of the patient and the first doctor by another doctor (who could be the second doctor referred to above with expertise in the patient's terminal illness) after that other doctor had discussed the case with the first doctor and the patient and was satisfied, on reasonable grounds, that the certificate was in order, that the patient was of sound mind and that the patient's decision to end his or her life had been made freely, voluntarily and after due consideration, and that the above conditions laid down by section 7 had been satisfied;

[140] Rights of the Terminally Ill Act, section 7(1) (e).
[141] Rights of the Terminally in Amendment Act 1996 section 4(c)
[142] Rights of the Terminally ill Act, section 7(3).

- The first doctor had no reason to believe that he or she; the countersigning doctor: or a close relative or associate of either of them, would gain a financial or another advantage (other than a reasonable payment for medical services) as a result of the patient's death;
- No less than 48 hours had elapsed since the signing of the completed certificate of request;
- At no time before the doctor-assisted the patient to end his or her life had the patient indicated a change of mind to the doctor;
- The doctor himself or herself provided the assistance and/or was and remained present while the assistance was given and until the death of the patient.

In view of ROTTI's manifold deficiencies, it is not surprising that a bill repeal it was introduced into the Federal Parliament. The Euthanasia Laws Bill, a private member's bill, was introduced by Kevin Andrews MP and sparked a nationwide debate, the bill was supported by those opposed to VAE in principle and to ROTTI's deficiencies in practice. It was opposed by supporters of VAE and opponents of federal intervention in state and territorial affairs. Having passed through the lower house, the bill was considered by the Senate, who referred it to the Senate's Legal and Constitutional Legislation Committee. By a majority, the Committee supported the bill.[143] By a narrow majority, so too did the Senate. The Euthanasia Laws Act repealed ROTTI in March 1997. However, carried forth the same provisions of the earlier Act with extra provisions for systematically supervising guidelines by medical practitioners.

NEW ZEALAND

While euthanasia is clearly illegal in New Zealand, as in many countries, the will and desire to prosecute and punish those who aid in the deaths of others for humanitarian reasons is quite weak.[144] An 87-year-old man in 1999 assisted his wife to die by helping her take sleeping pills and then placing a plastic bag over her mouth.

In this particular case, when the husband was being tried, instead of premeditated murder, he was charged with the low-level crime of manslaughter and eventually

[143] Legal and Constitutional Legislation Committee of the Australian Senate. Euthanasia Laws Bill 19961997

[144] Raymond Whiting, *A Natural Right to Die: Twenty-Three Centuries Debate*, 37 (1st ed. 2002)

obtained a sentence of only two years supervision. Prosecutors in the case were clearly affected by the fact that the wife of the defendant experienced intense suffering, and was clearly motivated by his willingness to display compassion.[145]

UK

There is no Suicide Act or equivalent. Prior to 1961, the rule of England and Wales was to view suicide as contrary to criminal law and as such could be prosecuted a person who unsuccessfully attempted suicide. Section 1 of the Suicide Act 1961 changed this to provide that suicide was not a criminal offence. However, section 2 (1) of the 1961 Act makes it an offence to encourage or assist the suicide or attempted suicide of another.

If a person deliberately helps others take their lives, they can be charged with murder or homicide in England and Wales and murder or culpable homicide in Scotland. That may entail a maximum sentence of up to 14 years in England.

Ironically, as Stark has pointed out, there is no such maximum penalty in Scotland so that the consequences may be much more severe.

The lack of relevant case law, particularly in Scotland, makes it difficult to establish how likely prosecution is to happen in any particular case. A particular public interest factor is the motivations of the suspect – for example, whether the suspect was wholly motivated by compassion or had sought to dissuade the deceased from taking the course of action that resulted in his or her suicide.

There have been many bills put forth. All three have been met with overwhelming opposition and have failed. However, there are examples where members of parliament have changed their mind. In 2006 Lord Rix voted against the legalization of euthanasia, but he has now pleaded for euthanasia to become legal after being diagnosed with a terminal condition. This example shows how people can change their opinion based on their health.

[145] 1999(1) NZLR 235

LEGAL PRECEDENT IN THE UK

Common law development is important, and its definitions allow us to fill in some of the complexities in an effort to understand current law about assisted dying in the UK. In recent years, there have been some landmark cases which suggest that the UK's legal status is now unclear. It is indicated not only by domestic law but also by the influences of the Court of Human Rights in the UK courts. Certain cases are upheld to show these facts.

DIANE PRETTY V DPP

One of the leading cases in the UK of assisted suicide is Pretty v United Kingdom (2002)[146]. The applicant, who was paralyzed and suffering from a degenerative and incurable illness (Motor Neuron Disease). She alleged that the Director of Public Prosecutions refusal to grant immunity to her husband from prosecution if he helped assist her in committing suicide infringed her human rights, under Article 2 and 8 European Convention on Human Rights (ECHR).

The facts of the case state that 'her life expectancy is very low, observable only in weeks or months,' and goes on to say, 'her intelligence and decision-making ability is unimpaired.' The claimant is terrified and distressed by the pain and indignity; it would mean if the disease continues its path. Motor neuron disorder does not have any therapy that may prevent the condition from progressing. It is necessary to remember that suicide under English law is not a crime, but the condition of Mrs Pretty prohibits her from committing suicide without assistance.

Ms Pretty then took her case to the European Court of Human Rights, challenging the domestic decisions under Article 2 (right to life) – she argued this included the right to self-determination in respect of life and death; Article 3 (freedom from inhumane and degrading treatment); Articles 8 and 9 (right to respect for private life and freedom of conscience); and Article 14 (freedom from discrimination) – she argued that a person without her disease might be physically able to end their lives whereas

[146] *R v Director of Public Prosecutions ex parte Diane Pretty & Secretary of State for the Home Department* (Interested Party) [2001] UKHL 61

her incapacity prevented her from doing so. The European Court of Human Rights ruled unanimously that the UK Government had not violated the Convention.

Ms Pretty's case was rejected due to no found violation of the convention. The court found that there is no right to die derived from Article 2 of the ECHR. In relation to the right to respect for private life under article 8, the court considered that the interference, in this case, might be justified as 'necessary in a democratic society' for the protection of the rights of others. Ms Pretty died ten days after the ruling.

DEBBIE PURDY V DPP[147]

Ms Purdy had multiple sclerosis, and she wanted to know from the DPP that her husband would be prosecuted under the current law if he accompanied her to Switzerland where she could be legally assisted in dying.

The DPP said he would not establish a clear policy for assisted suicide cases but would consider each case separately when determining whether to prosecute or not.

Ms Purdy sought judicial review of the DPP's refusal to create this policy, on the ground that her right under Article 8 of the Convention (right to respect for private life) had been violated. Article 8(2) requires any interference with the right of respect of one's private life to be 'in accordance with law'.[148]

On this basis, the five Lords of Court decided that in Article 8, the right to respect for private life was exercised in the case brought by Ms Purdy. Consequently, the Court directed the DPP to draw up a strategy immediately to specify which investigations should be pursued and not pursued, but its lords also ruled that Parliament should only vote on amendments to the legislation on assisted suicide.

[147] *R (Purdy) v DPP* (2009) UKHL 45.
[148] Article 8 of the ECHR provides that: 'There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law"

R (NICKLINSON) V MINISTRY OF JUSTICE (2012)[149]

Another important case in the UK in terms of assisted suicide is Nicklinson v Ministry of Justice 2012. The most relevant aspect of this case is the suicide legislation which is legal in the UK, so why should a mentally unstable and unable person be unable to commit suicide. This case is similar to the Pretty v UK case, as both cases were appealing against Article 8 of the ECHR and seeking clarification to whether the right to life was also the right to die.

The discussions are brought up to date with Mr Nicklinson, who suffered from locked-in syndrome. Again, the question was whether the courts could address his rights under Article 8 or whether this was a matter for (the Westminster) Parliament. Whilst the Supreme Court (SC) dismissed Mr Nicklinson's appeal by a majority of 7 to 2. Their Lordships were divided upon:

- Whether the SC had the constitutional authority to declare that the current law was not compatible with Article 8.
- Whether a Declaration of incompatibility should be made.

According to Article 8 ECHR, the applicant claimed that he would be able to end his life, and claimed that the legislation published by the DPP should define facts and circumstances with clarity as to whether anyone willing to assist him in committing suicide in Switzerland would know if they would face prosecution.[150]

Lord Neuberger provided four reasons why it would be institutionally inappropriate for the court to consider the issue:

- Modifying provisions of s 2 of the 1961 Act, 'raises difficult, controversial and sensitive issues' which justifies a cautious approach by the courts;
- Difficulties in identifying compatibility;
- Acknowledgement of its consideration in Westminster;
- Any action would be to reverse the H of L decision in Pretty.

[149] *R (Nicklinson) v Ministry of Justice* [2012] EWHC 2381 (Admin), [2012] MHLO 77
[150] Article 8 of the ECHR provides that: 'There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law"

Although this case was rejected, the law was again tested and may have made a bigger impact than Pretty v UK (2002). As this case had been appealed, through it made a bigger impact in terms of the legalization as the Supreme Court, the highest court in the UK, stated that they could not make laws regarding assisted suicide and that it is in fact up to parliament to make the law. It means that there is likely to be another bill put forward in parliament, which could be a success for the euthanasia and assisted suicide movement as the topic is again being discussed.

CONCLUSION

The aim of this chapter is to familiarize with the different legislations and cases that had happened in deciding the fate of Assisted suicide. We can see that the precedents set by these cases have provided a strong base for the need of Physicians assisted suicide and its use in the modern medical field. From the above, we can see that more than a quarter of the European states have recognized the need for such a method to provide an End of Life Care. All of the reasons for these laws encourage the patient to make the decision, while doctors must give all the other choices to the patients and provide a significant amount of proof that their diagnosis is right. A person has the right to not be in misery, agony, humiliation and suffering.

The laws in Oregon and Washington make it possible for patients to have a choice without legal consequences for their doctors or themselves. It is left to each state in the United States to decide whether or not one can legally end their own lives, without legal ramifications for doctors or others who can choose to assist the patient in ending their lives. In cases like Vacco v. Quill, it can be seen that even though there is no legislation in New York for PAS, the court has decided that if a case does arise like this, it can be accepted and will not be a violation of the constitution.

Dutch practise of euthanasia has given more and more control to physicians, not to patients. The issue of whether a patient should be alive or dying is always determined solely by a doctor or a team of doctors. The DPP (Director of Public Prosecutions) would not establish a specific policy for cases of assisted suicide, but would independently evaluate each case when deciding whether or not to prosecute.

Whether approached as assisted suicide or euthanasia, the 'right to die' question finds its most convincing moral claims in the act of compassion of allowing a person to die a dignified death that suffers an otherwise unbearable state of existence. This is a moral and legal dilemma that is challenging.

India is a long way in accepting the need for PAS and further in making legislation for its safeguard and protection of patients and physicians, respectively. However, these legislations and the understanding them can provide a nudge in the movement for the same.

CHAPTER 4

PAS IN INDIA AND SAFEGUARDS TO PREVENT ABUSE OF LAW

INTRODUCTION

This chapter will discuss a hypothetical scenario in which assisted suicide is allowed in India, exploring how it is possible to protect the most vulnerable members of our community and uphold our basic rights and freedoms. In particular, the focus of this investigation will be on whether the legalization of physician-assisted suicide, assisted suicide by a physician or medical professional, will lead to situations leading to the practice of assisted suicide and encouraging it.

Euthanasia or assisted suicide have been legalized in a handful of countries and states, and occasionally both. In all jurisdictions, to discourage exploitation and misuse of these procedures, regulations and protections have been placed in place. The preventive measures included, inter alia, the express consent of the individual seeking euthanasia, the compulsory documentation of all cases, the administration of doctors only (with the exception of Switzerland) and the consultation of a second doctor.

The legal status of PAS and euthanasia in India lies in the Indian Penal Code, which deals with the issues of euthanasia, both active and passive, and also PAS. Pursuant to The Indian Penal Code of 1860, Active euthanasia is a serious crime under Section 302 (punishment for murder) or at least under Section 304 (punishment for culpable homicide not amounting to murder) according to the Indian Penal Code of 1860.

The question is whether the procedure could lead to a type of involuntary euthanasia after the legalization of physician-assisted suicide and without sufficient protections in place; assisting the suicide of another without their permission. This chapter will investigate whether the legalization of physician-assisted suicide will contribute to the practice of involuntary euthanasia and how to safeguard against it by defining the main issues associated with the practice, examining possible protections for it and comparing and contrasting the precedent set by the Netherlands and other countries.

Definition of euthanasia is slightly different in different countries; however, it is generally defined as "a deliberate intervention undertaken with the express intention of ending a life, to relieve intractable suffering."[151] PAS is the practice of providing the patient with a prescription for drugs for the patient to use for the primary intention of taking his or her own life; the patient, directly or through a machine, will have to self-administer the medication.[152]

The cultural, religious, and socioeconomic backgrounds underlying the various views on assisted suicide held by different parts of society have received inadequate attention. Current research indicates that certain disparities linked to assisted suicide may account for cultural differences.[153] A survey quotes that was conducted to know that 60/100 (28 men, 32 women) Indian doctors answered a questionnaire. Of these doctors, 26 were Hindus, 23 Christians, and 10 Muslims, with a mean age of 35.4 years and a meaningful experience of 10.2 years. In all, 26.6% of them agreed that euthanasia could be an option for patients with motor neuron disease, whereas 25% agreed with the idea of using euthanasia for patients with cancer. Four Christian and 16 Hindu (eight male and eight female) doctors supported the concept of euthanasia.[154]

Jain leaders, a powerful group in India, say the constitution protects the fasts and people have the right to decide to die with dignity. This argument has led to a debate over the right-to-die issue in India, where euthanasia is banned, and suicide is a crime resulting in people attempting for suicide being imprisoned.[155]

There is a fear of possible misuse of PAS by some people if it is legalized true. However, before such laws are made, "systems" must be in place to adequately verify that there is no violation of the rule. This is where the task of professional judgement will come into play, and psychiatrists will be involved in assessing mental capacity, assessing mental wellbeing, and testing the individual's eligibility for PAS if the

---

[151] Supra, note 7, p. 367–70.
[152] Webster's, *Definition of physician assisted suicide*. New World Medical Dictionary. 3rd ed. Wiley Publishing, Inc; 2008. [Last accessed on Apr 10 2020]. http://www.medterms.com/script/main/art.asp?articlekey=32841. ISBN-10: 0470189282; ISBN-13: 978.0470189283.
[153] Clark JA, Potter DA, McKinlay JB. *Bringing social structure back into clinical decision making*. Soc Sci Med. 1991; 32:853–66.
[154] Supra note 10, p. 14:71–4.
[155] Barker K. *Jain leaders challenge law banning suicide in India*, Chicago Tribune: Publisher US; 2006.

courts decide to legalize it in India in the future. Other professional bodies can also be involved in the creation of such decisions, such as social workers, palliative care professionals, and psychologists.

INDIAN POSITION ON PHYSICIAN-ASSISTED SUICIDE

India is a healthy illustration of a variety of diverse cultures, traditions, and religions that have all retained their identities and blended with Indian historical ideologies and rituals as well. In the Indian context, disentangling faith and culture, customs and rituals, and values and attitudes is a Herculean task. At a professional and public level, a debate on PAS will face a range of complexities, such as people's moral beliefs, how religion and culture will play in people's minds, whether the strength of religiosity will overwhelm religion, and so on.

On this topic, India is not alone, and most countries have been trying to get decisions on this very subject. In comparison to the general population in the UK, a survey of 3733 UK doctors on the legalization of medically assisted dying found that most doctors opposed the legalization of PAS and that a deep religious conviction was directly related to opposition to assisted dying.[156] A survey conducted in Egypt found that it was the duty of physicians to determine if PAS should be regarded for religiosity rather than real faith. More religious physicians believed that, regardless of whether they were Christians or Muslims, PAS could not be considered because it would be against their set of beliefs.[157]

In a February 2008 meeting on Ethics Committee on Euthanasia, the Medical Council of India held the following opinion: the practice of euthanasia constitutes unethical behaviour. However, on particular occasions, only the team of physicians and not just the treating physician alone can determine whether to remove supportive devices to preserve cardio-pulmonary function even after brain death. A team of doctors shall declare withdrawal of support system. Such team shall consist of the doctor in charge of the patient, Chief Medical Officer / Medical Officer-in-charge of the hospital, and a

[156] Seale C. *Legalization of euthanasia or physician-assisted suicide: Survey of doctors' attitudes.* Palliat Med. 2009; 23:205–12.
[157] Tadros G, Rakhawy MY, Khan F. *Perception of physician-assisted suicide among Egyptian psychiatrists: Cultural perspective.* The Psychiatrist. 2011; 35:15–8.

doctor nominated by the in-charge of the hospital from the hospital staff or in accordance with the provisions of the Transplantation of Human Organ Act, 1994.[158]

Suicide is not an offence in India as a starting point, but attempted Suicide is protected by section 309 of the IPC.[159] In its study, the Indian Law Commission The 42nd Report recommended that this offence be repealed on the basis that it was harsh and unjustifiable to punish a person who had already found life so unbearable. The government approved the advice, and the bill was approved in 1978 by the Rajya Sabha and was pending in the Lok Sabha when it was disbanded in 1979, which resulted in the lapse of the bill. It has already been noted that abetting (or assisting) suicide is an offence under section 306 of IPC. So too is abetting attempted suicide by virtue of section 309 read with 107[160] of IPC. In support of these offences, the Supreme Court of India has observed that: "The arguments which are advanced to support the plea for not punishing a person who attempts to commit suicide do not avail for the benefit of another person assisting in the commission of suicide or in its attempt. The abettor is viewed differently, inasmuch as he abets the extinguishment of life of another person, and punishment of abetment is considered necessary to prevent abuse of the absence of such a penal provision."[161]

The difference between voluntary active euthanasia and assisting suicide is that the former, but not the latter, involves the accused performing an act, which directly causes the death of another. Apart from this, the similarities are that, for both activities, the accused intends for the other person to die, knowing that he or she consents to be killed. As far as cases of voluntary active euthanasia are concerned, some importance is granted to the consent of the deceased by making what could otherwise be the crime of murder the lesser offence of culpable homicide that does not amount to murder. The relevant provision is exception 5 to section 300 of IPC which

---

[158] Medical Council of India New Delhi. Minutes of the meeting of the Ethics Committee held on 12th and 13th February. 2008

[159] S. 309 reads: "Attempt to commit suicide – whoever attempts to commit suicide and does any act towards the commission of such offence, shall be punished with simple imprisonment for a term which may extend to one year or with fine, or with both."

[160] S. 107 reads: "A person abets the doing of a thing who —
(a) instigates any person to do that thing;
(b) engages with one or more other person or persons in any conspiracy for the doing of that thing, if an act or illegal omission takes place in pursuance of that conspiracy, and in order to the doing of that thing; or
(c) intentionally aids, by any act or illegal omission, the doing of that thing."

[161] *Gian Kaur v. State of Punjab*, AIR 1996 SC 1257 at para 37-38.

states that “culpable homicide is not murder when the person whose death is caused, being above the age of 18 years, suffers death or takes the risk of death with his own consent.”[162]

There has also been a lengthy debate on the topic of attempted suicide in India, and it is regarded as a punishable act by IPC Section 309. Section 309 of the IPC has, as in the case of P Rathinam v. India's Union,[163] been questioned on a range of occasions in the courts of law in India, the Supreme Court has held that the freedom to live referred to in Article 21 may be said to give rise to the freedom not to live a forced life, Article 21 is therefore infringed by section 309. However, then this decision was consequently overruled in Gian Kaur v. State of Punjab case[164] by a Constitution Bench of the Supreme Court, held that Article 21 could not be interpreted to contain within it the 'right to die' as part of the fundamental right guaranteed therein, it was therefore stated that it could not be lawfully argued that Article 21 was in violation of section 309.

THE CONSTITUTIONAL VALIDITY OF CRIMINALIZING PHYSICIAN-ASSISTED SUICIDE

Each individual is born with a fundamental shield of human rights, and the right to life is the most basic right among all such rights. It is the basic and fundamental right which states that each human being has the right to live and that another being cannot harm anyone. This right is the umbrella right under which other rights get their light and backing. This right is given to every citizen by Article 21 of the Constitution of India. Soon enough, the people of the state began to ask, "whether the right to live also means the right to die?”. In the Indian context, this began a major debate and discussions on the definition and its importance.

Those two cases, M.S. Dubal v. Maharashtra State (1986)[165] and Chenna Jagadeeswar v. AP State (1987)[166] discussed the positive and negative aspects of the rights granted to persons and, respectively, the violative existence of those laws. On the "Right to

[162] . See In *re: Kanaga Kosavan* (1931) 60 MLJ 616
[163] . AIR 1994 SC 1844.
[164] Supra note 157, para 13
[165] *M.S Dubal v. State of Maharastra*, CrLJ 549 AIR 1987
[166] *Chenna Jagadeeswar v. State of A.P*, CrLJ 549 AIR 1988

Life requires Right to Die" issue, both cases oppose each other. In the instance of M.S. Dubal v State of Maharashtra (1986), The dispute was regarding the negative and positive aspects of the rights given to individuals. The court ruled that Article 21 of the Right to Life also requires the right not to live. Chenna Jagadeeswar v. State of A.P is the decision by a Division Bench of the Andhra Pradesh High Court. The appeal of Section 309 IPC's constitutional validity was dismissed therein. The statement that the right to die is included in Article 21 was dismissed. Amareshwari. J also illustrated it. Speaking to the Division Bench, the courts have ample jurisdiction to ensure that unjustified cruel treatment or discrimination is not presented to those in need of care and consideration. The proposed breach of Article 14 was, therefore, adversely affected.[167]

The leading decision in Gian Kaur v. State of Punjab[168] which involved an appeal by the appellants against their convictions for abetting the commission of suicide by one Kulwant Kaur on the basis that the offence under section 306 was unconstitutional. The appeals were approached by a bench of five judges of the Supreme Court by first inquiring whether the closely related crime under section 309 of attempted suicide was in breach of the Constitution, the presumption being that section 306 would likewise not be if it were not. The court held unanimously that Section 309 and, subsequently, Section 306 were not in violation of Articles 14 and 21 of the Indian Constitution. With regard to Article 14, which affords equality before the law,16 the appellants argued, first, that it was infringed by section 309 of the offence because the lack of a plausible description of a suicide attempt made the offence arbitrary because it was not clear which attempts were severe and which were not. Second, by the same measure, section 309 handled all suicide attempts without referring to the circumstances in which the attempt was made. The court dismissed the first claim on the basis that the concept of suicide was capable of being narrowly defined and that it should be left to a court to determine whether or not the circumstances of a particular case included a suicide attempt. The court then dismissed the appellants' second claim by stating that section 309 requires a sentencing judge to change the sentence accordingly, taking into account the type, seriousness and duration of the suicide attempt.

[167] Supra, note 157
[168] Supra, note 157

A brief reference can be made to the case of Rodriguez v. British Columbia (Attorney-General)[169] of the Supreme Court of Canada because it broadly agrees with the Supreme Court of India's findings in Gian Kaur on the constitutional validity of the suicide offence. The truth was that the appellant died of a progressive and incurable motor neuron disorder and requested a decree that, when her situation became intolerable, she was entitled to assistance in committing suicide. The declaration was appropriate since suicide aid is an offence under the Canadian Criminal Code. The debate on this subject continued among people on different platforms, and soon in the path-breaking judgement in the Aruna Shaunbaug v. Union of India (2011)[170] case, the Supreme Court with its 5-judge bench noted the significance of the idea of euthanasia and the right to life could be interpreted as the right to a dignified and worthy life. This much-awaited verdict, which was a difficult fight in itself, helped to drive the consciousness quotient on this subject and thus entered our culture the debate for the legalization of passive euthanasia, albeit with the exception of it being performed only on terminally ill patients and by withdrawing medical life support. Aruna Shaunbaug's recent case has created a multitude of views and has also made us look at the status of the law in other countries and states that have legalized the practice.

In the 42nd Report in 1971[171], it was stated that after reviewing Manu's code and the law commentaries on it, it held that the commission of suicide was considered valid when the people were diseased and was living under miserable living conditions. It referred to the Vedic texts which upheld the values and importance of the persons who got rid of his own self as someone who would find salvation as they left the earthly pleasures. It considered the legal provisions of suicide as harsh and unjustifiable.

Later in 1997, the 156th Study of the Law Commission maintained the legitimacy of the criminalization of the suicide crime and awarded medical science and law credit. It accepted the judgement in the case of Gian Kaur and the legitimacy of the Penal Section and further supported the claim with the prevalent social evils such as drug and trafficking and the nature of terrorism and those who attempted suicide in the

[169] See further M. Dunsmuir and M. Tiedemann, "*Euthanasia and Assisted Suicide in Canada*" (1993) 107 DLR 4th 342. http://www.parl.gc.ca/information/library/prbpubs/919-e.htm#2thecriminal
[170] *Aruna Ramachandra Shanbaug v. Union of India,* (2011) 4 SCC 454 s 140
[171] Law Commission, Revision of Indian Penal code (Law Com No 42, 1971) page 111

background of these incidents.[172] In 2008, in its 210th report, the Law Commission recommended the decriminalization of the section punishing those who commit the crime of attempted suicide, which is Section 309 of the IPC. Amendments to the IPC were also suggested.[173]

The nation welcomed its Mental Healthcare Act in 2017, repealing the previous act and de-criminalizing the section on 'attempted suicide'. Section 115 of the act states:

"Notwithstanding anything contained in Section 309 of the IPC, any person who attempts to commit suicide shall be presumed to have severe stress and shall not be tried and punished under this Code; and the government is duty-bound to provide care, treatment and rehabilitation to such a person in order to reduce the risk of recurrence of attempt to commit suicide."[174]

The discussion regarding euthanasia, which means withdrawal of life support for terminally ill patients came to the public eye in 2000, with the case, Thomas Master v. Union of India.[175] The Court held that no distinction is ever made between suicide and the right to end one 's life voluntarily. Under the scope of Sections 306 and 309, IPC, voluntary termination of one's life for any cause will lead to suicide. There can be no difference between suicide committed by a person who is deeply suffering in life and that committed by an individual like a petitioner. It is pointless to ask whether suicide was committed impulsively or whether it was committed after lengthy deliberation.

SAFEGUARDS TO DECRIMINALIZE ASSISTED SUICIDE

Safeguards, criteria, and protocols were placed in place in jurisdictions to monitor the activities, ensure community monitoring, and avoid exploitation or misuse of euthanasia and PAS. There are similar requirements and procedures across jurisdictions; others differ from country to country. The degree to which these controls and protections have been able to regulate the practices and prevent violence merits closer scrutiny, particularly by jurisdictions considering the legalization of assisted suicide.

---

[172] Law Commission, Revision of Indian Penal code (Law Com No 156, 1997) page 123-134
[173] Law Commission, Humanization and Decriminalization of Attempt to Suicide (Law Com No 210, 2008) page 12-19
[174] The Mental Healthcare Act, 2017 (MHCA) § 115 (2017).
[175] *C.A. Thomas Master v Union of India* 252000 Cri LJ 3729

The components of a before-the-fact safeguards process might include some or all of the following:

- On the part of individuals and families, advance treatment preparation, either before the onset of a life-threatening illness or at the early stages.
- Obtaining second opinions at more advanced stages of illness, especially from clinicians highly qualified to prescribe medications (both curative and palliative) and predict results for the disease that the person has.
- Family conferences in which the best information available is revealed, the best interests and desires of the individual are addressed, and any technical or facility guidelines are taken into account.
- Referral of the situation to a hospital review committee or ethics committee that is responsible for ensuring the creation, distribution and follow-up of appropriate protocols.
- Appointment of an impartial advocate to work on behalf of the client, to ensure that the person is as well informed as possible about various options and their possible effects, that he or she knows what his or her rights are, both to receive medical care and to determine what care he or she wants to receive and also that the wishes and decisions of the client are articulated.
- Referral of the case to a court or other specialist tribunal, in particular where the appeal is for active action to be taken in order to reduce the life of the person, or where a replacement decision-maker demands that life-sustaining care be withheld or removed and does not have an individual advance directive to do so. Such a hearing may not be appropriate if the person has the capacity to personally refuse care that is needed to preserve life, or has provided specific prior instructions to that effect.

1. WRITTEN CONSENT

The petition for euthanasia or PAS must be voluntary, well-considered, educated, and continuous overtime in all jurisdictions. Explicit written consent must be given by the applicant and must be qualified at the time the request is made.

Despite those safeguards, more than 500 people in the Netherlands are euthanized involuntarily every year. In 2005, a total of 2410 deaths by euthanasia or pas were reported, representing 1.7% of all deaths in the Netherlands. More than 560 people (0.4% of all deaths) were administered lethal substances without having given explicit consent[176]. For every five people euthanized, one is euthanized without having given explicit consent. Attempts at bringing those cases to trial have failed, providing evidence that the judicial system has become more tolerant over time of such transgressions.[177]

Some supporters of assisted suicide claim that the statistics above are misrepresentative since many people might have shown a desire for or support for assisted suicide at some stage in their lives, although not formally. The counterargument is that if violence and misuse are to be prevented, the legal requirement of the explicit written consent is relevant. After all, in medical research, written consent has become necessary when patients are to be subjected to an operation, many of which present much lower risks of mortality. In the absence of clear, informed consent, modern history is full of instances of medical research abuse.[178]

2. MANDATORY REPORTING

In all jurisdictions, reporting is required, but this provision is sometimes overlooked.[179] Almost half of all cases of assisted suicide in Belgium are not reported to the Federal Commission for Monitoring and Evaluation.[180] In unreported cases, legal criteria were more often not met than in recorded cases: a formal order for assisted suicide was more often absent (88 % vs 18 %), doctors specializing in palliative care were less commonly consulted (55 % vs 98 %), and a nurse administered the medications more often (41 % vs 0 %). "Many of the unreported

[176] van der Heide A, Onwuteaka, et al. *End-of-life practices in the Netherlands under the Euthanasia Act*. N Engl J Med. 2007; 356:1957–65. doi: 10.1056/NEJMsa071143.
[177] Deliens L. *Euthanasia and other end of life decisions and care provided in final three months of life: nationwide retrospective study in Belgium*. BMJ. 2009;339: b2772.
[178] Mortier F, Deliens L. *Physician-assisted deaths under the euthanasia law in Belgium: a population-based survey*. CMAJ. 2010;182(9):895-901. doi:10.1503/cmaj.091876
[179] Onwuteaka–Philipsen BD. *The reporting rate of euthanasia and physicians-assisted suicide. A study of the trends*. Med Care. 2008; 46:1198–202.
[180] Muller MT, et al. *Dutch experience of monitoring euthanasia*. BMJ. 2005; 331:691–3.

cases (92 %) contained euthanasia, but the doctor did not interpret it as" euthanasia. At least 20 % of cases of euthanasia in the Netherlands go unreported. That figure is possibly conservative since it only reflects cases that can be traced; it can be as high as 40 %[181] of the actual number. Though reporting rates have risen since pre-legalization in 2001, 20 % accounts for several hundred individuals annually.

3. ONLY BY PHYSICIANS

The presence of nurses is a cause for alarm because, with the exception of Switzerland, all jurisdictions mandate that actions be carried out only by doctors. In a recent study in Belgium, 120 nurses announced that without specific request[182] they had taken care of a patient who received life-ending drugs. Nurses conducted euthanasia in 12 % of cases and without the prior consent in 45 % of cases. The doctors were absent in many cases. The nurse is a male working in a hospital, and the patient being over 80 years of age were factors greatly associated with a nurse prescribing the life-ending drugs.

4. SECOND OPINION AND CONSULTATION

Before continuing with euthanasia or pas, all jurisdictions except Switzerland require the consulting of a second doctor to ensure that all conditions have been fulfilled. In Belgium, if the individual's condition is assumed to be non-terminal, a third physician must examine the case. The consultant must be impartial (not related to the patient's treatment or to the provider of treatment) and must have an objective evaluation. There is, however, proof from Belgium, the Netherlands, and Oregon that there is no universal implementation of this method.[183] In the Netherlands, for example, 35 % of cases of involuntary euthanasia declined to seek consultation. 25 % of patients seeking euthanasia received psychiatric consultation in the Netherlands in 1998; none

[181] Id n 31
[182] Bilsen J, Mortier F, Deliens L. *The role of nurses in physician-assisted deaths in Belgium*. CMAJ. 2010; 182:905–10.
[183] Id n 178

received psychiatric consultation in 2010.[184] In addition, non-reporting tends to be related to a lack of consultation with a second physician.

In Oregon, 58 of 61 consecutive cases of patients obtaining pas in Oregon were advised by a physician member of a pro-assisted-suicide lobbying organization. This raises doubts about the objectivity of the procedure and the protection of the patients and raises questions about the effect of prejudice on the process on the part of these doctors.[185]

There are many ways in which safeguards can be classified against the violation of legalized physician-assisted suicide. For example, direct safeguards, such as the wording of the current law expressly designed to deter abuse, maybe the priority, as opposed to indirect safeguards, such as enhanced attention to research and advancement of clinical and palliative care therapies, so that it will be less likely to resort to physician-assisted Suicide.

A key question is whether safeguards should be completely delegated to the private context of physician-patient-family relationships, or whether there should still be intervention from an outside body, perhaps a judge, or a commission appointed by a hospital or government ministry.

A POSSIBLE MODEL: OREGON DEATH WITH DIGNITY ACT

A model that Indian legislators could seriously consider adopting is to be found in the State of Oregon on the west coast of the United States of America. By enacting the Oregon Death with Dignity Act in 1994,[186] Oregon became the first state in that country to enact a law legalising physician-assisted suicide. The opening provision spells out the essential details:

"An adult who is capable is a resident of Oregon, and has been determined by the attending physician and consulting physician to be suffering from a terminal disease, and who has voluntarily expressed his or her wish to die, may make a written request

[184] Hendin H. *Seduced by death: doctors, patients and the Dutch cure*. Law Med. 1994; 10:23-68.
[185] Supra note 69, p. 40.
[186] Dr Timothy Quill "*Death and Dignity: A Case of Individualised Decision*" 324 N Engl J Med 691 (1991).

for medication for the purpose of ending his or her life in a humane and dignified manner."[187]

In order to clarify, for a person to be entitled to obtain prescription medication for use in physician-assisted suicide, he or she must be an Oregon resident, be 18 years of age or older, and have been diagnosed by his or her attending physician as suffering from an incurable and terminal illness that will cause death within six months, within the fair medical judgement. The patient must have made both an oral and a written request and repeated the oral request not less than 15 days after making the first oral request to the attending physician.[188] The Act demands that the patient's prescription for medication be in a prescribed form, signed and dated by the patient and witnessed by at least two persons who testify, in the presence of the patient, that the patient is willing, acting willingly and not being forced to sign the prescription to the best of their understanding and belief. In addition, at least one of the witnesses must not be connected to the patient or be entitled to benefit from the estate of the patient, or be the owner, provider or employee of the health facility in which the patient receives care or is a resident.[189]

Detailed medical records of the procedure leading to the prescription must be maintained by the doctors involved, and these records are to be checked by the Human Services Department of Oregon.[190] The Act requires doctors to dispense a prescription for the medication required, but not to prescribe it. Physicians dispensing the medication must be licensed with both the Board of Medical Examiners of the State and the Federal Department of Drug Control. The Act makes it a serious offence for a physician who intentionally changes or forges a request for a prescription without the patient's consent, or conceals or ruins a rescission of that request with the intention or purpose of causing the death of the patient. It is also a serious crime for a doctor to coerce or exert undue control on a patient to ask for a prescription in order to end the life of the patient or to kill a rescission of such a request.[191]

---

[187] Oregon Death with Dignity Act in 1994 127.805 s. 2.01
[188] J. Keown, *Euthanasia, Ethics and Public Policy,* Ch. 15 (Cambridge: Cambridge University Press, 2002)
[189] K.L. Tucker "*Federalism in the context of assisted dying: Time for the laboratory to extend beyond Oregon to the Neighbouring State of California*" 41 Willamette L Rev 863 (2005)
[190] International Task Force on Euthanasia and Assisted Suicide, "*Seven Years of Assisted Suicide in Oregon*" available at http://www.internationaltaskforce.org/orrpt7.html (accessed 16th Aug2020).
[191] G. Tulloch*, Euthanasia – Choice and Death* 66 (Edinburgh: Edinburgh University Press, 2005).

The law does, however, have some drawbacks. One is that the patient does not have to endure any pain whatsoever, requiring only that the patient have a terminal condition that will cause death within six months. Arguably, physician-assisted suicide should be limited to situations where extreme suffering (which may or may not be physical)[192] adversely affects the quality of a patient's life. To support the patient's argument that he or she is not able to die with dignity, feeling such pain is appropriate. Another drawback of the law is that it is only important for the physicians involved to behave bona fide, which is a far lower standard than the "reasonable standard of care" needed for doctors involved in other types of medical treatment. Consequently, as long as he or she has behaved in good faith, a practitioner who has been incompetent in the course of assisted suicide will not be held liable.[193]

Two American researchers (R. Cohen-Almagor and M.G. Hartman) have introduced additional criteria that, if adopted, would greatly enhance the acceptable specifications of legislation in Oregon.[194] One is to prevent the doctor from recommending assisted suicide to the patient. Another is that, due to extreme pain, patients may have wanted to commit suicide; palliative care should be given to patients before receiving their requests for assisted suicide to prevent this. The researchers have suggested that a small committee of medical experts could review the petitions for physician-assisted suicide and select the consulting physician in order to prevent any collusion between the attending and consulting doctors. Another proposal was to require pharmacists to record all prescriptions for lethal drugs, thereby offering a further check on the documentation of the physicians.

LIST OF RECOMMENDATIONS

The report by Dr Jennifer Gibson & Maureen Taylor, in their publication Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying provides a key look into the needed recommendations for a safe practice of PAS.[195]

---

[192] J. Griffiths, H. Weyers, *I Euthanasia and Law in Europe* (Portland: Hart Publishing, 2008).
[193] Supra, note 41
[194] R. Cohen-Almagor and M.G. Hartman, "*The Oregon Death with Dignity Act: Review and Proposals for Improvement*" 27 J LEGIS 269 (2001) 293-298
[195] Dr Jennifer Gibson & Maureen Taylor, Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying (2015),

End-of-Life and Palliative Care:

A policy for palliative and end-of-life treatment, including physician-assisted dying, should ideally be developed and enforced in partnership with the government.

Collaboration and Coordination:

Collaborate and coordinate as soon as possible with all related organizations and institutions to ensure the smooth and effective implementation of physician-assisted death in India.

Critical Enablers of Access to Physician-Assisted Dying:

Rights to physician-assisted Suicide, for both doctor-administered and self-administered physician-assisted Suicide, should be guaranteed.

To maintain patient access to physician-assisted Suicides, all public health agencies should be mandated to have an appropriate publicly funded management system of treatment in place.

To expressly protect all health practitioners who provide supportive care during the provision of physician-assisted Suicide, the government could request that it amend the Criminal Code. This clarification will ensure that a team-based approach to the delivery of physician-assisted dying is feasible.

Health practitioners should be shielded from responsibility for actions or omissions carried out in good faith and without negligence in delivering or planning to provide physician-assisted dying. In order to require life insurance claims to be compensated for deaths resulting from physician-assisted dying, it should decide if legislative or regulatory changes are appropriate. Amendments can be made where appropriate to obtain the result.

Request and Documentation:

To ensure a patient declaration form is completed and witnessed by an impartial party, specifications should be defined.

In its revisions to the Criminal Code, the government could request that it make clear that at any time after the diagnosis of a grievous and irremediable illness, a request for

---

http://www.health.gov.on.ca/en/news/bulletin/2015/docs/eagreport_20151214_en.pdf (last visited Oct 10, 2020)

physician-assisted dying made by a legitimate patient declaration form may be met when suffering becomes unbearable.

A patient information form should be developed to collect demographic data on those seeking physician-assisted Suicides and the reasons for the request.

Data from the patient's initial request to the time of signing the death certificate and the completion of the patient's request should be gathered to facilitate case analysis and systematic review.

Assessment of Eligibility:

By enforcing arbitrary age restrictions, access to doctor-assisted Suicide should not be impeded. In its revisions to the Criminal Code, it should be proposed that the government make it clear that eligibility for physician-assisted dying is dependent on competence rather than age.

To ensure that requirements for access to physician-assisted dying have been met and procedural safeguards have been upheld, medical regulatory agencies should be requested to establish guidelines/tools for physicians.

Review:

The patient must be examined by medical professionals to ensure that all requirements are met.

If the availability of physicians is small, the government should facilitate virtual physician evaluations and visits using telemedicine services (or other video-based consultations) or, if necessary, transport doctors to the patient for a second examination.

Reporting:

Following the regulation of physician-assisted Suicide, to facilitate the review of each individual case, physicians should make a report with an advisory committee. This analysis will ensure accountability and confirm that current policies and procedures are being complied with.

The manner of death on medical death certificates across the territories should be listed as physician-assisted dying, and the name of the health condition that suited the patient for physician-assisted dying should then be listed as the cause of the death.

Duty to Inform:

It should be important to notify patients of all end-of-life choices, including physician-assisted suicide, regardless of their personal views, conscientiously by health care providers.

Health care professionals are required to notify their patients adequately of the facts and consequences of their conscientious opposition to physician-assisted dying. Any continuing care should be given to the patient in a non-discriminatory way.

Duty to Care for the Patient:

Health care practitioners should be able to either provide another healthcare professional with a referral or a direct transfer of care or contact the third party to transfer the information of the patient across the system.

Duties of Institutions:

Patients/residents should be expected to be informed of any institutional position on physician-assisted dying, including any and all limits to its provision.

Any requirement by institutions that patients give up the right to access physician-assisted Suicides as a condition of admission should be prohibited.

Duties of Non-Faith-based Institutions:

Non-faith institutions, whether publicly or privately funded, do not prohibit the provision of physician-assisted dying at their facilities.

Duties of Faith-based Institutions:

Faith-based institutions must either authorize physician-assisted Suicide inside the institution or plan for the secure and timely transfer of the patient for examination and probably the provision of physician-assisted Suicide to a non-objecting institution. The responsibility of treatment must be continuing and non-discriminatory.

Oversight:

In order to ensure compliance with applicable legislation and health professional regulatory requirements, transparency and accountability, a review committee scheme should be formed to review all cases of physician-assisted dying after the provision of the service.

A Commission on End-of-Life Treatment should be set up to provide system oversight and to report to the public.

Health Professional Education and Training:

In partnership with each other and with patient groups, professional associations, governmental authorities and colleges can develop relevant curricula and continuing education programme and training for students, doctors and health professionals related to the provision of physician-assisted Suicides.

Public Education and Engagement:

Public education on physician-assisted Suicide should be given, and best practices for public participation should be implemented to inform the continuing creation of end-of-life care legislation, policies, and practices.

CONCLUSION

Unfortunately, the published data from countries where assisted suicide is contrary to the law indicates that a continuation of the strict prohibition of physician-assisted Suicide would indeed put several citizens at risk. In fact, in jurisdictions where such behaviours are in breach of the law, persons could be much more likely to be helped to die, perhaps even without having demonstrated an intention to do so, than where they are not.[196] The medical profession, as an institution, remains more or less resolutely opposed to euthanasia and assisted suicide, but individual physicians are

[196] Kuhse, Helga, "*End-of-life decisions in Australian medical practice*" by The Medical Journal of Australia, 1997 http://www.mja.com.au/.

frequently prepared to take explicitly prohibited steps, both by law and by professional ethics, whether or not the laws are purely protective of human life.[197]

Many people claim, on professional, legal, religious or practical grounds, that preserving the centuries-old prohibition against intentional killing is the only effective safeguard since any other safeguard has been proved ineffective. Others are similarly adamant that what they (the patients) and their physicians consider certain interests to be, the only law that can be enforced is the best interests of patients.[198] It is not necessary to expect certain experiences to be free of distortion.

Among individuals who support and oppose the principle of euthanasia and PAS, there have always been and will always be reasons. People claim that hospitals should not pay attention to the wishes of patients, especially when they suffer from medical conditions that are terminally ill, debilitating, and non-responding. With the latest rules, which will be introduced if the PAS is legalized, this medical community is bound to change. When they need to deal with mental capacity problems all the time, this dilemma is becoming more and more important to psychiatrists. Empirical research on the perceptions and attitudes regarding euthanasia and PAS in India among large numbers of professionals and the general public is required to draw clear conclusions on the need or not to legalize euthanasia and PAS.

[197] See, Canadian Medical Association. Physician-assisted death [policy summary]. CMAJ 1995; 152:248A-B.
[198] Wolbring, Gregor. *Why Disability Rights Movements Do Not Support Euthanasia: Safeguards Broken Beyond Repair*. (Undated) (http://www.thalidomide.ca/gwolbring/why.html)

CHAPTER 5

CONCLUSION AND SUGGESTIONS

It can be argued that in a world where people's basic human rights are often left unaddressed, illiteracy is rampant, more than half the population does not have access to drinking water, people die every day from diseases, and where there is less medical assistance and treatment, euthanasia and PAS problems are insignificant for the few. India is, however, a nation of diversity through faith groups, educational status, and cultures. The debate on euthanasia in India is more confusing in this sense, as there is also a law in this country punishing people who even attempt to commit suicide.

It seems like a phase of evolution has sculpted the legal landscape, both with regard to end of life law and assisted dying, to the degree that the law permits or overlooks what might be thought of as assisted dying. This study discussed how the law was pressured by multiple factors to rethink its solution to end-of-life problems. Medical advancements have created dilemmas when it comes to health care practitioners about whether we should always artificially prolong life only because we can, or whether we should let certain patients die.

There are sound reasons to support the legalization of assisted suicide, but not active euthanasia. Any moral or ethical distinction between the two, of course, is open to dispute, but there are still reasonable reasons to differentiate between them. It also seems necessary to satisfy the demands of those who support legalization by legalising PAS but not euthanasia (for autonomy, the alleviation of suffering). Moreover, if there is to be any legal assisted dying, a line needs to be drawn somewhere to delineate justifiable action from that which is unjustifiable. Thus, we can contend that the present legal distinction between murder and assisted suicide presents a useful starting point for such a line. Admittedly, any line that is drawn might not be able to provide a boundary between the (morally) acceptable and unacceptable in a way that pleases everyone. Unlike the present legal position, however, it would at least determine a coherent, compassionate and rational stance that provides a clear legal position.

In this context, a variety of different legal, medical, ethical and circumstantial variables have combined to present a legal situation that may usually yield the required (or least bad) outcome, but would rarely do so in a logical, coherent or transparent manner. Although often a degree of fudging in the medical sense would be what the patient needs, most patients will prefer to take part in medical decision making. In view of the societal developments, the growing need to self-direct death seems likely to continue. Thus, end-of-life care and life and death decision making, whether or not it abbreviates life, should better reflect what the patient wants and not what the doctor - or even the doctor and the judge - think the patient deserves. The approach so advocated would enhance patient autonomy but not at the expense of legitimate competing concerns.[199]

The plan for the decriminalization of physician-assisted suicide should be viewed in isolation from the issue of whether it is also appropriate to legalize voluntary active euthanasia. Although it could be the next step after the legalization of physician-assisted suicide, it does not conclude at all that this must be taken. In the House of Lords decision in Purdy and the resulting prosecutorial strategy, the most important arguments in favour of law reform, self-determination and mercy/compassion were accepted as constitutionally determinative on the question of assisted suicide. For the time being at least, those advocating for formal legal reform will have to content themselves with the awareness that some of their demands have been met. Those opposed to legal reform should recognize that the ban has become largely illusory and accomplishes nothing in either upholding the values of sanctity or protecting the vulnerable.

India's economy has expanded at the beginning of the 21st century like never before, making an increasingly large portion of society able to both afford and seek medical care and life-long services. It will be a matter of time before the discussion on the prohibition of assisted suicide and voluntary active euthanasia by doctors spawns this societal phenomenon. This paper aims to encourage the discussion by debating that India is prepared to take the step of decriminalizing physician-assisted suicide carried

[199] See, Chapter 2, p 14

out in strict circumstances. Indeed, as previously noted, in Gian Kaur[200], the seed for the debate was sown by none other than the Supreme Court.

The termination of his or her own life by the patient differentiates it enough from voluntary active euthanasia, where the doctor terminates the life of the patient. This distinction is important because the decision of the patient to die at a time, location and method of his or her own choice is manifested not only in his or her request for support to commit suicide but also in his or her suicide act. On the other hand, only the former manifestation is present for voluntary active euthanasia, which, some may say, leaves the option of the patient to die less certain and is therefore open to greater violence because the practitioner is the one who administers the lethal drug. Therefore, lumping voluntary active euthanasia with physician-assisted suicide is apt and should be actively avoided to cloud the case for legalising physician-assisted suicide.

The best way to enact this plan, legislatively speaking, is to add a new clause in the IPC that acknowledges protection closely resembling the model found in the Oregon Death with Dignity Act.[201] The protection clause should also include amendments to the Act referred to in Part IV of this paper, such as the patient's need to suffer, as well as the additional protections proposed by two American researchers (R. Cohen-Almagor and M.G. Hartman).[202] The defence will refer to the crimes of suicide abetting, and suicide attempted abetting. Thus, these crimes will continue to act against suicide-assisting people who are not doctors. Physicians learned that exploiting their authority to support their patients in their suicide could also be accused of these offences as they would have refused to satisfy one or more of the strict protection requirements. In addition, a new crime against errant doctors, such as the one found in the Oregon Death with Dignity Act, may be added. Finally, in understanding the challenging position that doctors are called to play, those who may be negatively impacted by their experience of helping their patients commit suicide should be given a system of education, therapy and support.

Many improvements in behaviours, strategies, and behaviour would be needed to enhance treatment at the end of life. Such reforms will include a multitude of

[200] Supra, note 161
[201] See, chapter 4, p 69
[202] See, chapter 4, p 71.

individuals and organizations who have a role to play in making and enforcing patient care decisions or in structuring the systems in which such decisions are made and implemented. It is obviously important what patients and their families know, expect, and want. For patients at several levels, health care practitioners play vital roles in diagnosis, communication, instruction and direction, treatment, negotiation, and advocacy. Health plan managers, institutional leaders, and government officials' decisions influence and sometimes hinder patients, families, and clinicians' ability to develop a treatment plan that serves the dying person well.

Other seemingly intractable moral dilemmas, such as abortion or embryo research, have been resolved or at least moved forward by legal change, and it can only be a matter of time before we can say the same about physician-assisted suicide.

SUGGESTIONS FOR PROPER END OF LIFE CARE

People with advanced, potentially lethal diseases and those close to them should be able to expect effective, skilled, and compassionate treatment and receive it:

A vital responsibility of doctors, hospitals, hospices, support organizations, public services, and the media is to inform people about end-of-life treatment. In addition to diagnosis and prognosis, most patients and families need knowledge about what helps and what effects they should be able to expect accurately. For instance, they should not be permitted to assume that pain is inevitable or that supportive care is incompatible with continuing diagnostic and therapeutic efforts.

Doctors, nurses, social workers and other health practitioners must be committed to improving the treatment of patients who are dying and making efficient use of current expertise to avoid and alleviate pain and other symptoms:

To avoid and control the varying physical and psychological symptoms that follow advanced disease, most patients rely on health care professionals. Practitioners must keep themselves and their colleagues accountable for using current expertise and available strategies to evaluate, avoid, and alleviate physical and emotional suffering in order to fulfil their responsibilities to their patients. The most apparent issues that physicians can effectively prevent the vast majority of patients are unrelieved pain and other symptoms. However, communication difficulties, proper respect for patient

and family needs, and prompt referral to palliative care specialists or teams are other areas in need of improvement. Health practitioners have the duty as individuals and members of broader organizations to advocate for system reform when operational, financial or legal impediments hamper the good practice.

In order to gain a deeper understanding of the contemporary experience of dying, the choices available to dying patients and families, and the roles of societies towards those approaching death, continuing public discussion is important:

It is important to have individual discussions between clinicians and patients, but it cannot on its own provide a safe atmosphere for the behaviours and actions that make it possible for most people to die free of avoidable pain and to find the peace or sense that is important to them. Although attempts to minimize the focus of television and news media on violent or sensational death and unrealistic medical rescue have not been noticeably successful, thoughtful reviews, public forums, and other coverage of the health, emotional, and practical issues involved in end-of-life treatment have recently given a modicum of balance. The goal of enhancing treatment for those approaching death and addressing the obstacles to achieving that goal should not be allowed to disappear from public consciousness, regardless of how they present, widely discussed policy controversy on physician-assisted suicide is resolved. It is not with the media but with elected officials, professional associations, religious leaders, and community groups where much of the burden for keeping the public conversation going will rest.

Palliative care should at least become a specified field of knowledge, education, and study, if not a specialist medical field:

The aim is to establish a network of experts in palliative care whose numbers and skills are adequate to (a) provide expert consultation and role models for colleagues, students and other members of the health care team; (b) provide educational leadership and tools for undergraduate, graduate and continuing medical education that are scientifically informed and practically useful; and (c) coordinate and c More broadly, to include prevention as well as relief of symptoms, palliative care must be redefined. During the trajectory of illness, attention to symptoms should start at earlier points because early treatment may well lead to minimizing pain at the end of life.

BIBLIOGRAPHY

ARTICLES

1. David Leaf: British Medical Journal Vol. 345 No. 7865, "Safe laws on assisted dying are working worldwide."
2. Abbas SQ, Abbas Z, Macaden S. Attitudes towards euthanasia and physician-assisted suicide among Pakistani and Indian doctors: A survey. Indian J Palliat Care. 2008; 14:71–4
3. Lee MA, Tolle SW. Oregon's assisted suicide vote: the silver lining. Ann Intern Med 1996; 124:267·9.)
4. Morita T, Tsunoda J, Inoue S, Chihara S: Effects of high dose opioids and sedatives on survival in terminally ill cancer patients. J Pain Symptom Manage. 2001, 21 (4): 2
5. Thorns A, Sykes N: Opioid use in last week of life and implications for end-of-life decision-making. Lancet. 2000, 356
6. Bengoechea I, Onaindia M, Lopez J: Opioid use at the end of life and survival in a hospital at home unit. J Palliat Med. 2010, 100-168
7. Preston T, Patterson J: The rule of double effect. N Engl J Med. 1998, 338: 1389-1391.
8. Fine R: Depression, anxiety, and delirium in the terminally ill patient. Proc (Bayl Univ Med Cent). 2001, 14 (2): 130-133.
9. Field MJ, Cassel CK. Committee on Care at the End of Life Approaching Death: Improving Care at the End of Life. Washington, DC-National Academies 1997.
10. Johnson, K. S. (2013). Racial and ethnic disparities in palliative care. Journal of Palliative Medicine, 16(11), 1329-1334.
11. Snyder Sulmasy L; Ethics, Professionalism and Human Rights Committee of the American College of Physicians. Ethics and the Legalization of Physician-Assisted Suicide. 2017 Oct 17;167(8):576-578
12. Clark JA, Potter DA, McKinlay JB. Bringing social structure back into clinical decision making. Soc Sci Med. 1991; 32:853–66.

13. KEOWN, J, ‘Restoring moral and intellectual shape to the law after Bland’ (1997) Law Quarterly Review, 113, 482-503.
14. KEOWN, J, ‘Euthanasia in the Netherlands: Sliding down the Slippery Slope?’ in Keown (eds) Euthanasia Examined: Ethical, Clinical and Legal Perspectives, (1997) Cambridge University Press.
15. KEOWN, J, ‘Beyond Bland: a critique of the BMA guidance on withholding and withdrawing medical treatment’ (2000) 20(1) Legal Studies, 66.
16. KEOWN, J, ‘The case of Ms B: suicide’s slippery slope?’ (2002) Journal of Medical Ethics, 28, 238-239.
17. KEOWN, J, ‘A futile defence of Bland: a reply to Andrew McGee’ (2005) Medical Law Review, 13(3), 393-402.
18. KEOWN, J, ‘Restoring the sanctity of life and replacing the caricature: a reply to David Price’ (2006) 26(1) Legal Studies 109.
19. KEOWN, J, ‘Physician-Assisted Suicide: Lord Joffe’s Slippery Bill’ (2007) Medical Law Review, 15(1) 126-135.
20. KEOWN, J, ‘Dangerous Guidance’ (2009) 159 New Law Journal, 1718.

BOOKS

1. Timothy E. Quill: Physician-assisted death in vulnerable Populations.
2. Alexandra Mullock: The Assisted Dying Bill and the role of the physician.
3. Dworkin R. Life’s Dominion. An Argument about Abortion, Euthanasia, and Individual Freedom (1993)
4. Firth, Lisa. Euthanasia and Assisted Suicide. 1st ed. Cambridge: Educational Publishers, 2011
5. Humphry, Derek. Final Exit. 1st ed. Oregon: The Hemlock Society, 1991
6. JACOB, J M, Doctors and Rules, (1988) Routledge.
7. Keown J, Euthanasia, Ethics and Public Policy (CUP, 2002)
8. Manson N, O'Neill O, Rethinking informed consent in bioethics (CUP, 2007)
9. Cholbi M, Varelius J (Eds.) New Directions in the Ethics of Assisted Suicide and Euthanasia (Springer, 2015)
10. Schermer M, The Different Faces of Autonomy (Kluwer, 2002)

STATUTES

1. Dutch Termination of Life on Request and Assisted Suicide Act (2001)
2. European Convention on Human Rights (1950)
3. Lord Falconer's Assisted Dying Bill (2015)
4. Lord Joffe's Assisted Dying for the Terminally Ill Bill (2006)
5. Margo McDonald's End of Life Assistance Bill (2010)
6. Prosecution of Offences Act 1985
7. Mental Capacity Act (2005)
8. Oregon Death with Dignity Act (1997)
9. Suicide Act (1961)
10. Abortion Act 1967
11. The Constitution of India 1950
12. Indian Medical Council Regulations
13. Indian Penal Code 1860
14. Assisted Dying Bill 2013
15. Assisted Dying Bill 2014
16. Assistance for the Terminally Ill Bill 2004
17. Patient (Assisted Dying) Bill 2003
18. Belgium Act on Euthanasia 2002

REPORTS

1. House of Commons; the Adjournment debate in the House of Commons on January 29, 1951 (Hansard, HC vol.483, col. 679, paras 681-682).
2. House of Lords Select Committee on Medical Ethics, Report, HL Paper 21-I (Session 1993-1994) [20].
3. House of Lords, Assisted Dying for the Terminally Ill Committee, Assisted Dying for the Terminally Ill Bill – First Report (2005), 42.
4. Interim policy on assisted suicide, available at http://www.cps.gov.uk/news/press_releases/144_09/
5. DutchNews.nl, 16 June 2010, and, LJN: BI5890, Rechtbank Almelo, 08/750709-07.

6. Treatment and Care Towards the End of Life: Good Practice in Decision-Making (GMC: London, Aug 2010)
7. ‘Do not go gentle... into legalised assisted suicide’, The Telegraph, 8 April 2010.
8. ‘Euthanasia cases in Holland rise by 13 per cent in a year’ The telegraph, 20 June 2010.

APPENDIX

THE NATIONAL UNIVERSITY OF ADVANCED LEGAL STUDIES

Kalamassery, Kochi – 683 503, Kerala, India

CERTIFICATE ON PLAGIARISM CHECK

1.	Name of the Candidate	
2.	Title of Thesis/Dissertation	
3.	Name of the Supervisor	
4.	Similar Content (%) Identified	
5.	Acceptable Maximum Limit (%)	
6.	Software Used	
7.	Date of Verification	

**Report on plagiarism check, specifying included/excluded items with % of similarity to be attached in the Appendix*

Checked By (Name, Designation & Signature) :

Name and Signature of the Candidate :

Name & Signature of the Supervisor :