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Understanding Euthanasia: Legal, Ethical and Practical Considerations in India

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Abstract—*Euthanasia, also known as the good death, is a means through which a patient can ease their pain and suffering when they have no hope of getting fully cured from their illness. A lot of patients world over opt for euthanasia as they don't want to continue living in a vegetative state. According to a 2001 study published in the Journal of the American Medical Association (JAMA), 60% of terminally ill patients are in favor of euthanasia (Emanuel, E.J, 2002).*

Due to its contestable nature, the debate over euthanasia has sparked controversy in the Indian healthcare system. The Indian supreme court took a decision to legalize passive euthanasia in 2011 after the Aruna Shaunbag case with an intent to alleviate the suffering of terminally ill patients (Center for law and policy research, 2023). However, passive euthanasia is hard to implement in India due to the legal ambiguities present in the legislation and the complexity of the steps involved to receive passive euthanasia.

This paper examines the flaws present in the current legislation, including the conflation of active and passive euthanasia, and withholding and withdrawing life support, complex procedures for advance directives, and delays in authorization process for passive euthanasia. These issues undermine patient autonomy and prolong patient suffering, highlighting the gap between the intent of legalizing passive euthanasia (to relieve suffering) and the practical application.

The paper then talks about how these issues can be resolved in the real world and make passive euthanasia an implementable process. Proposed improvements focus on prioritizing patient suffering over everything else, distinguishing between the different forms of euthanasia, streamlining the protocols for advance directives and authorization of passive euthanasia. By addressing these shortcomings and advocating for legislative reform, this paper aims to enhance the end-of-life care situation in India and uphold patient dignity.

Introduction

"To save a man's life against his will is the same as killing him" - Horace

Does this situation sound familiar? This is one of the most controversial topics in the healthcare system. Should doctors continue to keep a patient alive when they don't wish to live and undergo suffering?

Curing patient's diseases is one of the main purposes of the healthcare system, but, in the case of chronic diseases, which are illnesses that cannot be cured, the healthcare system aims to control the illness and prevent it from progressing (worsening) further (NCI Dictionary of Cancer Terms, n.d.). However, terminal illnesses cannot be cured or controlled, thus, in most cases, they are fatal. Terminal illnesses can cause a lot of pain and suffering, therefore, the only way to alleviate the discomfort is by providing the patient with an unnatural death. This is when the systems together answer the question above - "Should doctors continue to keep a patient alive when they don't wish to live and undergo suffering?". The healthcare system's and legal system's answer to this question was a no. But how can unnatural death be provided to a patient with a terminal illness? The answer is Euthanasia, which also means the good death, and emerges as a controversial yet compassionate option. Euthanasia is becoming a widely acceptable practice throughout the globe and more people are opting for it to earn a dignified and a good death. In Switzerland, the number of people who underwent euthanasia increased from 187 in 2003 to 965 in 2015 (McClure, T., 2022).

There are different forms of euthanasia that include active euthanasia, physician-assisted suicide (PAS), passive euthanasia and palliative care. Active Euthanasia and PAS are practiced with the intent of ending the patient's life for good to free them from pain and suffering. Broadly, active euthanasia is when the patient is provided with assistance to die and someone else takes the action, like by injecting lethal drugs (*Euthanasia - MU School of Medicine*., n.d.). PAS occurs when the healthcare professional prescribes drugs, and the patient takes it themselves to get rid of the suffering. In passive euthanasia, the medical interventions are **withheld** from a patient, for example, withholding of the ventilator, which leads to death, but a slow one compared to euthanasia and PAS (Sinha, V., Basu, S., & Sarkhel, S., 2012). Lastly, physician assisted support is given without the intention

of unnatural death, where medicines are prescribed to patients to alleviate their suffering and may hasten death. Different countries have legalized different methods of providing unnatural death to reduce the patient's suffering (Judgement, n.d.).

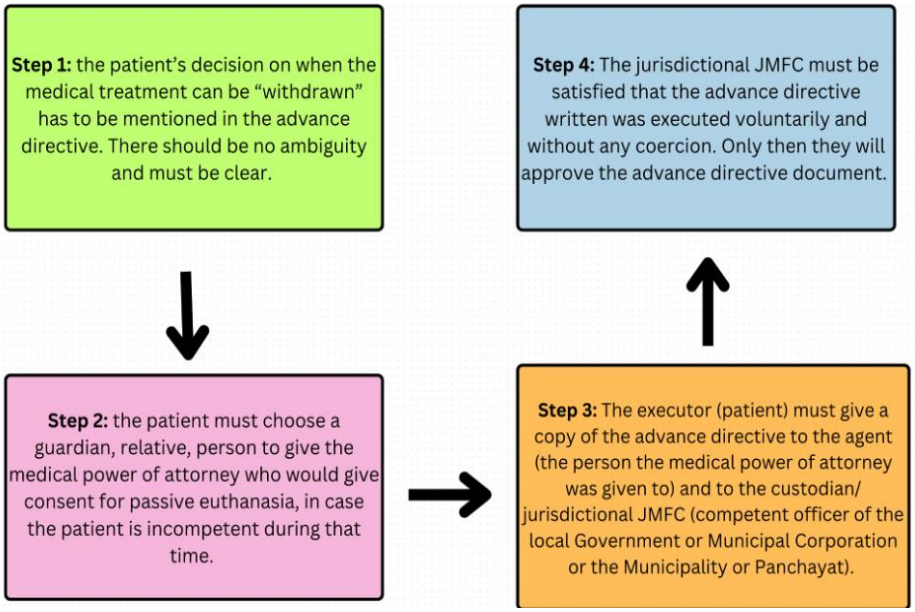
In 2011, India legalized passive euthanasia after the Aruna Shaunbag case. Although passive euthanasia is legal in India, there are significant flaws in the legislation that hinders its implementation.

The objective of this research paper is to delve into the problems present in the legislation that impede the effective implementation of passive euthanasia in India. It also aims to propose improvements that prioritize patient suffering and well-being, thereby enhancing the overall healthcare system for Indian citizens. The paper is divided into two sections. The first section explores the faults in the legislation pertaining to euthanasia. The second section delves into how these faults can be improved upon by the supreme court of India. The first section in this paper will talk about the legal aspect of euthanasia in India where the flaw of conflation of passive withholding and withdrawing life support and passive euthanasia will be discussed. Next, the practical aspects of euthanasia will be looked at with a focus on the process the patient has to undergo to have an advance directive document and administer themselves for passive euthanasia. Lastly, the first section talks about the ethical aspects of euthanasia and whether legalizing passive euthanasia was really the right choice. The subsections within the second section of the paper propose solutions to the above-mentioned issues in the verdict through suggesting the need to prioritize patient suffering, understanding the difference between the forms of euthanasia and refining the process of having an advance directive and undergoing for passive euthanasia.

Section 1: faults in the legislation

The first fault in the legislation is that the supreme court wasn't able to discern the difference between passive and active euthanasia and acts of withdrawing and withholding life support. After Aruna Shanbaug's case, who was in a vegetative state for almost 42 years due to a brutal assault, in 2011 the Indian supreme court decided to permit the use of passive euthanasia, allowing life support from a terminally ill patient to be withheld (removed) (Online, E., 2018). As mentioned before, passive euthanasia doesn't have an intention to "kill" the patient, but just fastens the process of natural death as the medical assistance is refused before starting the treatment or the assistance is not increased even if there is a need to increase it. On the other hand, active euthanasia has an intention to "kill" the patient and invites unnatural death as the medical assistance is removed during the course of the treatment due to which the patient is unable to live without life support (Misra, D., Khanwilkar, A. M., n.d.). For example, removing the access to a ventilator from a patient in the middle of an ongoing treatment.

Though blurry, there is also a difference between withdrawing and withholding medical assistance as withdrawing (removal) becomes active euthanasia as when life support is removed the patient won't be able to live for a long time without it. Whereas, withholding (refusal) is passive euthanasia as refusal of life support in the beginning of the treatment doesn't invite unnatural death, it just causes the natural death to prepone. However, the legislation says that the definition of passive euthanasia is withdrawing or withholding life support (anchini, V., Nardini, C., & Boniolo, G., 2014). So, as can be seen, the terms "withhold" and "withdraw" have been used interchangeably, even though there is a difference between the two and withdrawing is a form of active euthanasia. Clearly, as the verdict conflated between passive and active euthanasia and acts of withdrawing and withholding life support, the first fault in the verdict and the legal aspect of euthanasia can be seen.



When you think about it, active euthanasia is the type of euthanasia that can alleviate a patient's suffering the quickest as a patient won't be able to last long without life support when they are already habitual to it. (Note: the content here is applicable only for terminally ill patients). However, the supreme court chose to legalize passive euthanasia instead of active euthanasia. Why is that you might ask? The primary reason behind this lies in the intention of both the acts. While both lead to the same outcome - death - active euthanasia is done with the intent of giving the patient unnatural death and "killing" the patient, whereas passive euthanasia is done with the intent of hastening the process of natural death (Misra, D., Khanwilkar, A. M., n.d). However, as the court believes withdrawing and withholding life support to be the same process, the court has indirectly permitted the use of active euthanasia when making end of life care decisions for terminally ill patients.

Let's think about a situation where a healthcare professional withdraws the life support of a terminally ill patient on a ventilator causing the patient to die and alleviating the patient's suffering (Of course, after the approval of the higher authorities). The intention of the healthcare provider now is to kill the patient. This is, indeed, a violation of the hippocratic oath that mandates "do no harm" and prohibits directly causing death (News-Medical, 2021). This poses certain ethical concerns as to whether active euthanasia should be allowed because though active euthanasia causes sudden death, it does free the patient from suffering quicker. Additionally, due to the conflation of passive euthanasia and active euthanasia and acts of withdrawing and withholding life support, the primary reason for the supreme court choosing passive euthanasia over active euthanasia gets defeated. This covers the legal aspect of euthanasia.

Laws on advance directives

The court believes that every patient has the right to choose the kind of medical treatment they want and, in case of terminally ill patients, if they want to undergo passive euthanasia. However, the criterion set by the court for the patients that can experience passive euthanasia is that they must be in a persistent vegetative state or are living by purely artificial means that prolong life. However, not all such patients are competent, which means that they may not have the ability to communicate what they wish for in the moment with regards to their medical treatment and if they want passive euthanasia. Therefore, to help such non-competent patients, the court introduced the concept of advance directives. An advance directive is a broad term given to any legal document that outlines the patient's desires on their medical treatment if they become non-competent in the future (Misra, D., Khanwilkar, A. M., n.d.). There are 2 kinds of advanced directives - a Living Will and a Medical Power of Attorney.

Living Will: it is a legal document prescribing a patient's wishes regarding the medical treatment the patient would want if they are unable to share their wishes with the healthcare provider (Misra, D., Khanwilkar, A. M., n.d.).

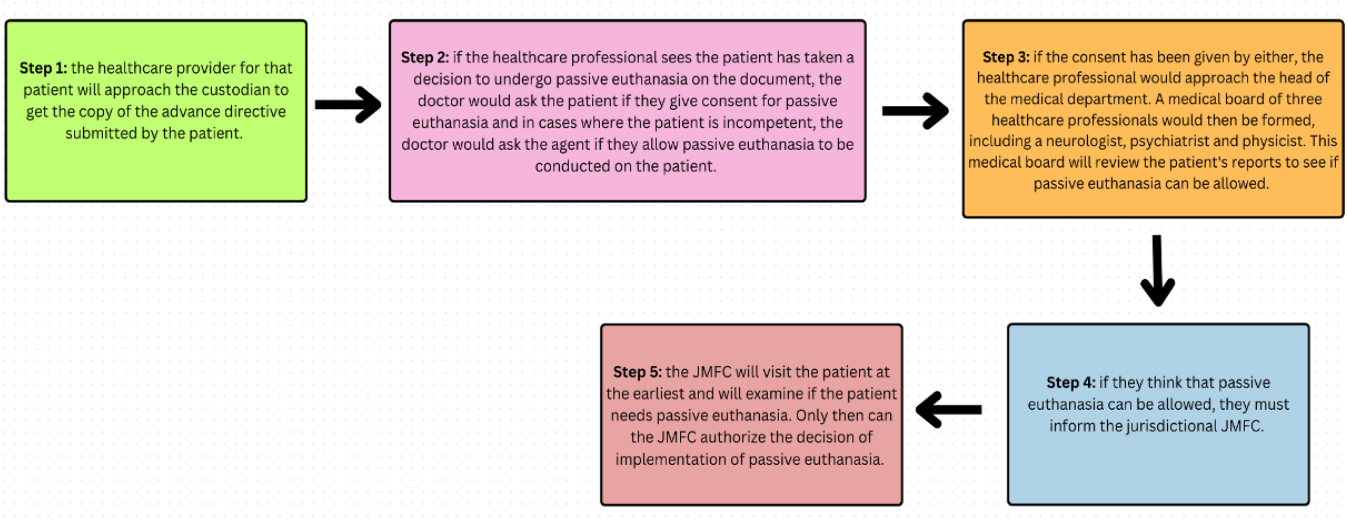
Medical Power of Attorney: It is a document which allows an individual (patient) to appoint a trusted person (agent) to make health care decisions when the principal is not able to take such decisions (Misra, D., Khanwilkar, A. M., n.d.).

Even though these efforts help the patient have control over their medical treatment, the verdict hasn't completely respected the patient's autonomy. This is because the law states that if a competent patient wants to undergo passive euthanasia, the healthcare provider must have a conversation with the patient and the advance directive regarding the possibilities of it. But, if the patient is competent, what is the need to have a conversation with the advance directive as no one else has the right to decide what is right for the patient in a given situation?

When thought about, advance directives could also be harmful for the patient as the patient is trusting whoever they are giving their medical power of attorney to and they might take decisions the patient might not have wanted if they were competent. Therefore, to prevent the misuse of advance directives, the court has laid down strict guidelines with respect to having an advance directive (Misra, D., Khanwilkar, A. M., n.d.).

However, this procedure, even though it seems very short and condensed as it's only written in 4 steps, can be a very overwhelming one for patients, especially when they are ill. This is because writing an advance directive itself is a tedious task, especially when such less citizens in India can afford to take help from a lawyer for guidance on how to write the advance directive document. Approximately 65% of India's population lives in rural areas (World Bank, 2021), where access to government offices and services is limited due to distance and lack of transportation infrastructure (World Bank, 2021). Due to this reason as well, meeting the custodian becomes a time-consuming process. Additionally, the law says the custodian must ensure that the content in the advance directive hasn't been written under pressure and compulsion. However, it doesn't talk about how the custodian would know it – is there a criterion to check if the advance directive is genuine? Additionally, over 180,000 cases have been pending for more than 30 years in district and high courts, exhibiting the low possibility of them checking if the advance directive has been written voluntarily and approve it (JOSEPH, K. M. & Indian Society of Critical Care Medicine, 2019). Looking at these points, realistically making an advance directive document, especially for the patients who live in rural areas is a time consuming and energy draining process and cannot be practical particularly when they are ill. This also indicates the low importance given by the verdict to the patient suffering because this process of administering an advance directive only puts more strain on the patient.

Process to undergo passive euthanasia:



The process to allow passive euthanasia to be conducted also has various steps involved in it, making it unimplementable.

But, if at any step passive euthanasia is denied, the patient (if competent) or the agent (if the patient is incompetent) can approach the high court. The law says that the high court must render its decision at the earliest (Misra, D., Khanwilkar, A. M, n.d.).

However, there are some faults in the law:

1. The verdict said that the JMFC and the high court shall give their decision on whether to allow passive euthanasia at the earliest. But the law should have been more specific and should have added a particular time frame within which the decision has to be shared, for example, within 3 weeks. Without having any timeframe, the decision might take months to come out and this will only increase the patient suffering. Thereby, highlighting that the court did not consider patient suffering again.
2. The verdict didn't mention in what situations can passive euthanasia be declined - if the eligibility of undergoing passive euthanasia is not met, i.e., the patient should be in a persistent vegetative state? It is important to emphasize on this point because if the patient is in a vegetative state and needs passive euthanasia to end this suffering, a refusal by the JMFC or medical board means suffering for the patient for more years, where they are merely existing. Therefore, it is important to set a list of criteria to check if passive euthanasia can be allowed, ensuring that no patient has to go through unneeded suffering.

Moreover, these two issues will automatically be solved when the verdict prioritizes the patient's suffering over everything else. The verdict said the reason why the high court mustn't delay submitting its decision on whether to allow passive euthanasia is "since delay in the matter may result in causing great mental agony to the relatives and persons close to the patient." There is not even a single mention of the patient's pain (Misra, D., Khanwilkar, A. M, n.d.).

Is passive euthanasia really the right choice?

As mentioned before, passive euthanasia hastens the process of natural death, but this doesn't mean that the pain and suffering of the patient has reduced during the journey to death. In fact, the patient's suffering increases due to having no medical support. But, is it really worth worsening the patient's suffering simply because we don't want to have the intention of "killing" patients, hence passive euthanasia is permitted? The physician has the obligation and responsibility to ease the patient's physical pain. Passive euthanasia, however, does not ease the patient's physical pain (Judgment, n.d.).

Additionally, it is predicted that if euthanasia is legalized the government may decrease the amount of funds provided to the healthcare sector. This is because the expenses for long term care would be cut down, particularly for terminally ill patients. For instance, in Holland, legalizing euthanasia has led to a decline in the quality of care for the terminally ill patients due to the funding they get from the welfare state (Math, S. B., & Chaturvedi, S. K., 2012).

Next, not everyone in India has access to healthcare and life support for chronic illnesses. In June 2021 NITI Aayog launched a report on 'Health Insurance for India's Missing Middle' claiming that 30% of the population are devoid of any financial protection for health (Sheth, V., 2022). Moreover, India has one of the lowest expenditures on healthcare: the Indian government spent only 2.6% of the country's GDP on healthcare in 2023 (*Economic Survey 2023, 2023)*. Due to this, a lot of patients don't

cannot have treatments and life support. Therefore, they don't have a choice to reduce their suffering and are practically already undergoing passive euthanasia as patients who are terminally ill don't have access to artificial machines to keep them alive and are suffering (*Is the Right to Die an Issue for the Poor?*, n.d.).

However, the judicial system didn't fully consider the healthcare gap present in Indian society and its implications that certain patients are already subjected to passive euthanasia. The court overlooked this as the focus has been on the legal and ethical dimensions of euthanasia, rather than the practical aspects. This highlights the need to have a more holistic approach to form the healthcare policies and euthanasia. Addressing these fundamental issues is crucial for ensuring that all individuals, regardless of their economic status, have the right to quality healthcare and the dignity of a well-supported life, even in the face of chronic and terminal illnesses.

In conclusion, passive euthanasia may not seem like a good option when patient suffering is prioritized over patient life, especially where healthcare is all about alleviating one's suffering. There may also be situations where the government may further reduce the funds provided to the healthcare sector if euthanasia is implemented but there can be some pros as well.

Section 2: Improvements to the existing legislation

Prioritizing patient suffering

Firstly, the main improvement that would help address all the faults in the verdict would be to prioritize patient suffering over everything else. This is because when the patient suffering is placed on the highest pedestal, faults like the time-consuming nature of processes like getting an advance directive and actually undergoing passive euthanasia gets solved. Additionally, every action the court will take would be in the interest of the patient. For instance, legalizing passive euthanasia causes the patients to experience more suffering, hence, if alleviating patient suffering was a priority, perhaps another means of euthanasia would be legalized.

There are certain ways through which the court can ensure that there is minimized patient suffering. However, the court mainly has to take into consideration the practical and ethical aspects of euthanasia to reduce patient suffering. This is because, when thought about, it isn't ethical to make a patient who is already ill run around so much just for an advance directive document, which can be made a simple procedure. Some of the ways patient suffering can be prioritized include:

1. Improving the processes regarding advanced directives and administering for passive euthanasia: By reducing the number of steps involved in in these two processes or the complexity of the steps, there will be reduced pressure and stress on the patient. This will also lead to more people owning advance directives as it would be a more viable and implementable option. This will be talked about in more detail in the later paragraphs.
2. Improve the access to palliative care: palliative care focuses on reducing the patient's pain and improving the quality of their journey to recovery. However, not every patient has access to palliative care in India. Therefore, improving the number of people who can receive support from palliative care can lead to a decreased patient suffering as the quality of their treatment will improve. This will also be discussed in more detail in the later paragraphs.
3. Establishing clear legal guidelines: having a clear understanding on what are the types of euthanasia and what impact they have on the patient suffering is a vital step in establishing guidelines on euthanasia. Thus, post having this understanding, the members of the court must sit and discuss what form of euthanasia would be most appropriate for the citizens of India. Also, taking into account the religious beliefs of citizens all across India. The best outcome would stem from the members of the court placing themselves in the shoes of different stakeholders, i.e., the patient, the healthcare provider, the patient's family, and understanding what they would really want at that moment.
4. Promote research and innovation: the government should provide more funds for research in the healthcare sector in order to come up with methods that could reduce patient suffering, especially for those with progressive chronic illnesses. India's total expenditure on Research and Development (R&D) has been around 0.6-0.7% of its Gross Domestic Product (GDP). This is significantly lower than countries like the United States, China, and South Korea, which spend more than 2% of their GDP on R&D (Ratan P. Watal, Satpathy, B. N., Mohan, S., Raghavan, K. V., Mitra, A., & Mohapatra, J. B., 2019). Additionally, with Artificial Intelligence on the rise treatments can be made more effective and early diagnosis of problems can be done if sufficient funds are provided for research. For instance, Alzheimer's Disease is a chronic neurodegenerative disease and is the most common cause of dementia. Because a patient has to take several MRI scans of the brain for a period of time, diagnosing Alzheimer's Disease becomes an expensive, stressful and time-consuming procedure. Due to this, about 90% of the patients with Alzheimer's Disease in India remain undiagnosed (World Alzheimer's Day, n.d.). Therefore, it is imperative we come up with solutions to treat such problems. AI can be a promising solution for this as researchers in the US are trying to diagnose Alzheimer's Disease through just one retinal eye scan using Artificial Intelligence (Ashayeri, H., Jafarizadeh, A., Yousefi, M., Farhadi, F., & Javadzadeh, A., 2024). As a result, diagnosing Alzheimer's Disease can be a

much quicker and cheaper process, being accessible to everyone in Indian society. This would also lead to an early diagnosis of Alzheimer's Disease, allowing the patient to get access to the right treatment before it is too late and can save them from intense suffering and pain. Hence, with adequate funds provided to research in India, AI can be applied to the diagnosis of other diseases as well, reducing suffering for patients and their families.

Process improvements

Understanding the difference between active euthanasia and passive euthanasia and acts of withdrawing and withholding life support. As mentioned before, withdrawing life support comes within active euthanasia as one is aware that through removing the existing life support, the patient will die as they won't be able to live without artificial resources. Hence, the intention becomes to invite unnatural death. But, withholding life support is an example of passive euthanasia as it is refusal of providing life support before the treatment has even begun or not increasing the life support, which causes the existing life support to be inadequate for the patient. As a result of passive euthanasia, the process of natural death fastens. Thus, even though it doesn't have the intention of directly "killing" the patient as it doesn't cause unnatural death but does increase the patient's suffering till the time natural death doesn't come to the patient. Hence, with first having this understanding, the court must decide if they want to legalize passive euthanasia or active euthanasia because due to the continuous inter-changing of the terms withdrawing and withholding of life support under passive euthanasia, the court indirectly allows both passive and active euthanasia. Therefore, if the court cares more about alleviating the patient's suffering, withdrawing life support under active euthanasia should be legalized. However, if the court cares more about the intention of the doctor's act and the societal perception of active euthanasia equating to killing, withholding medical assistance under passive euthanasia should be legalized.

Now, depending on what the choice the court makes, there can be changes in the further laws. This is because if the court chooses to allow withholding life support, then there may be cases where an advance directive is not needed at all because the patient might refuse to live with the help of life support in the very beginning of the treatment. Hence, here there's no role of the medical team, thus, no advance directive needed. Moreover, if the court chooses patient suffering and legalizes active euthanasia, more laws will have to be made on injecting lethal drugs or withdrawing (removing) life support, such as a ventilator.

Thus, the first improvement to the law would be to really go into depth and understand the different forms of euthanasia, how they are performed, their impact on the patients and the intention behind conducting these acts of euthanasia.

There must be some changes made to the existing laws, especially the processes of having an advance directive and undergoing the act of euthanasia.

To address the issue of writing an advance directive document becoming overwhelming for patients, especially for ones who don't have access to enough consulting and support, the hospital can perhaps have a consulting team for patients that help them write advance directive documents. This will ensure that there is no ambiguity in the advance directive document, and in the future while making decisions with the JMFC and medical board regarding allowing euthanasia for the patient, everything that the patient had desired while writing the advance directive comes through properly in the document. It will also reduce the time it takes to write the advance directive document, enabling the patient to focus on their treatment.

One thing to also note within this is that the government must invest more into the healthcare sector to ensure everyone has access to good medical treatment, especially the ones who live in rural areas. Only then can the laws related to consulting departments within hospitals or local aging agencies in societies be decided on.

Secondly, the other improvement to the advance directive law that can be made is that meeting the custodian is a time-consuming process as it is hard to take the appointments, again causing unnecessary stress on the patient. Therefore, there can be another department made for cases of euthanasia because these are high priority cases as a delay may cause one to bear unnecessary health consequences. This would allow the patient to easily submit a copy of their advance directive to that department and get it approved as soon as possible.

Currently, few people make advance directive documents due to the complex and time-consuming process they need to follow. However, making these 2 improvements to the laws pertaining to the advance directive document can make the process implementable and more people would form it and opt for euthanasia to prevent continuous suffering.

Moreover, within the law regarding the process of authorizing passive euthanasia for a patient, some improvements can be made. As mentioned before in the research paper, there should be a defined time frame in which the medical board, the JMFC and the high court should submit their decision. For example, the law should say that the decision should be submitted within 3 weeks or so to prevent the patient from undergoing any more suffering. Additionally, a clear criterion should be established to check if the patient is eligible for euthanasia. This would ensure that a patient who was eligible for euthanasia isn't denied for it as there would be clear factors to check and examine. So, it would promote fairness and ensure no one has to go through pain and suffering if they don't wish to.

Palliative Care & Psychiatric Support

Many patients opt for euthanasia because their grief often transitions into depression, thus, they want to end their life and suffering. However, for competent patients this depression can be resolved, thereby, enabling them to accept their illness and continue living with it. This comes under palliative care, which aims at optimizing quality of life and mitigating suffering for terminally ill patients and their family. However, the number of people who get access to palliative care is devastating. Only 1-2% of the estimated 7-10 million people in India who need palliative care have access to it (*Palliative care in India*, n.d.). If more patients have the access to palliative care, they might be able to handle the emotional turmoil they face during their treatment better and might, therefore, opt out of euthanasia. Therefore, it is imperative that the gap is bridged through making systematic changes.

The government should firstly give more funds to palliative care programs as currently no separate budget is allocated for the National Palliative Care Program. Giving fundings would allow more programs like these to be integrated in the healthcare settings with a greater patient reach. Additionally, the funds must also go into the training of the conductors of palliative care, so they are able to treat and help the patients in terms of their mental wellbeing.

There must also be some moderation to the policies regarding palliative care in India, wherein, the government mandates the inclusion of palliative care in all healthcare settings, ensuring every patient has access to it. The government policies should also incentivize healthcare institutions to have Palliative Care programs and train their staff to smoothly host those programs.

These changes can make the patient's journey a little less stressful and might give them a hope to live. (This can mostly be done with competent patients only).

Conclusion: How can we make euthanasia a reality?

All the Improvements in the law explained above would help make euthanasia an implementable process. However, to make these improvements reach to the government and the court, few methods can be adopted:

1. petitions: write petitions to urge the government to incorporate the improvements mentioned above to the verdict on Euthanasia.
2. Campaigns: Start awareness campaigns to educate the public on what euthanasia is, what kinds of euthanasia can one opt for and what are the consequences for each kind of euthanasia. Allow the audience/ public to form an opinion on what kind of euthanasia works best for them and is suitable for all.
3. Advocacy movements: create societal groups who think passive or active euthanasia might be good for India as a whole, including people from rural areas. Start a movement to urge the government to legalize that kind of euthanasia.

By implementing these techniques, we would be able to bring about a change in the verdict pertaining to euthanasia and promote equal access to healthcare!

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