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Euthanasia: Ethical Challenges of Shift from "Right to Die" to "Objective Decision"

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Abstract

Euthanasia is mercy killing to alleviate the pain and misery of moribund persons. The thought in this regard is "Right to Life" includes "Right to Die." This paper examines the issue of euthanasia in advanced stage of terminal cases with no possibility of reversal and it has been argued that there is a case for lifting euthanasia from the domain of human rights "Right to Die," bringing the issue as a matter for professional opinion, a kind of medical advice/prescription. Guidelines need to be framed and criteria are laid down and notified under which euthanasia can be recommended. The decision is taken whether or not the criteria laid down are fulfilled in an objective manner. Like for other medical interventions "informed consent" is essential. In consideration of safeguards the decision is entrusted to a medical board and is subject to a legal prescrutiny. Professionally prescribed decision will to a great extent reduce emotive response surrounding euthanasia. The family may not have to face a difficult dilemma in deciding about euthanasia. There may not be a necessity of "living will," although it may still be useful. The change to treat euthanasia as a professional decision/medical advice will require making legal and administrative provisions to empower medical establishment to discharge responsibility of euthanasia. It is essential to legalize euthanasia with corresponding modifications of medical ethics and code of conduct prescribed by Medical Council of India, State Medical Councils, and other regulatory bodies. It is essential to identify the procedure for carrying out euthanasia and the personnel assigned to actually carry out. Injection of lethal substance in lethal dose may be a favored choice. Once final decision after legal prescrutiny is arrived for euthanasia, differentiating passive and active euthanasia is unnecessary. In one perspective, active euthanasia is less disturbing for the patient, family, and friends as withdrawal of supporting tubes leading to dehydration, wasting, and struggling for breath associated with passive euthanasia, which nullifies the basic tenet of euthanasia, can be avoided. There is a possibility of spill over benefit of "active euthanasia" in the form of opportunity to promote cadaveric organ transplantation. Caution has to be exercised for effective safeguards to prevent misuse. There is a case for consideration for brining decision-making process regarding euthanasia within medical professional assessment and implementation.

Keywords
- euthanasia
- active euthanasia
- human rights
- mercy killing
- peaceful death
- chronic vegetative state

Introduction

In the context of the present paper, the term "euthanasia" refers to "mercy killing" with a view to alleviate the misery and suffering of patients, their families, and society at large in cases of terminal stages of incurable disease with no hope of reversal and living, socially unproductive vegetative existence, that is, termination is considered a better

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option than continuation of life. The present paper attempts to explore the possibility of euthanasia to be a professional evaluation and decision, a kind of medical prescription.

There are two kinds of euthanasia, passive and active. Passive euthanasia is withholding interventions and active euthanasia involves taking specific steps. Both are intended to cause death. Euthanasia is administrated death which in common parlance is understood as murder and self-administrated as suicide. Both of these are criminal acts and any discussion on euthanasia has to address these concerns. Withdrawal of organ support system in "brain dead" or heart beating cadaver does not qualify as euthanasia as "brain dead" person is a dead person. This seemingly paradoxical situation is because of paradigm shift of definition of death from stoppage of heart beat and breathing to cessation of brain activity. Guidelines for declaration of brain death are included in the Act.[1] Functioning status of some organs may be preserved by use of technology but that should not be construed as life-support system or prolongation of life. The objective of provision of "brain death" is to determine end of life beyond which medical care of the patient is redundant. The opportunity thus offered for consideration of cadaveric organ transplantation program is incidental. Euthanasia is aimed to address issues of those who are living but the termination is considered a better option than continuation of life.

Current Focus

There are several issues surrounding the concept of euthanasia and are subject of public debate in many countries including India. The Honorable Supreme Court of India has opined that the High Courts may permit passive euthanasia on case–to-case basis till legal provision is enacted.[2] Law Ministry of Government of India has placed a draft of legislation on passive euthanasia in the pubic domain inviting public comments.[3] This draft bill deals only with passive euthanasia which in itself is a major short coming. A suggestion that the legislative exercise should include active euthanasia has been made.[4] Unfortunately, legislative process to enact a law on euthanasia has not been completed.

The Supreme Court has in a recent judgment legalized "passive euthanasia" and "living will" despite reservations by central government in recognizing living will on the ground that the patient may not be aware of the advancements in the treatment.[5] The concerns of the government are valid and hopefully the provision of medical board included in the judgment will address the issue. Major challenge is to identify and formulate practice guideline where termination is considered a better option than continuation of life. It is satisfying to note that euthanasia has been granted legal sanction though only passive euthanasia is covered. Differentiating passive and active euthanasia on the basis of mode of carrying out the decision does not appear to be logical or justifiable. Hopefully, legislation will address the issue of euthanasia in a comprehensive manner and include "passive" and "active" euthanasia on equal footing.

The current focus is to consider euthanasia under the doctrine of rights, such as "patient's right to die" as a follow-up of "patient's right to life." It has been argued to shift management of dying to the dying person as an expression of control including end–of-life decisions and euthanasia.[6] Exercising this right, a patient may opt for death instead of life of what he perceives life of misery, remorse, dependence on others for even tasks of daily living, and not worth living. The person may have expressed his desire/decision in favor of euthanasia to his family members, friends, well-wishers verbally, or in a written form, a kind of living will that is a statement of directions to be carried as per his/her wishes when he/she is not in a position to give directions directly but is still technically living, and the document has the same standing as a will and therefore is called living will ensuring wishes are performed.[7] As per court directive guidelines for living will are to be included in the proposed law on passive euthanasia.[8] There is a wide spread practice referred to as "Do Not Resuscitate" (DNR) followed when the process of natural death has started in a terminally ill patient so as not slow down or delay death.[9]

The situation may be complex in cases where the final event in the process of natural death has not started but the condition of patient is otherwise considered fit for euthanasia; termination is considered better option than continuation of life. The process of passive euthanasia consists of withholding food, water, medicines, and life-support system which may be a disturbing feature to witnessing the loved one in great misery slowly withering away, dehydrated, struggling for breath, particularly, so if it lingers on. Such a situation is against the spirit of euthanasia aimed at relieving miseries.

The patients, their family members, well-wishers, and caregivers may pray silently and hope for early death but still hesitate taking active steps for relief from miserable existence out of fear, training, cultivated mind set, social norms or behavior, and other reasons. In some cases, additional measures may be taken for the purpose of causing death. The relatives on request from the patient or otherwise provide information and substances to the patient thereby assisting and abetting suicide. Some persons wanting euthanasia may not be able to do final act for various reasons. Physician assisted suicide then assumes some important role in the context of euthanasia.[10] Involvement of medical persons is known to occur, though secretly. Some cases remain unreported.[11] Books offering practical suggestions are available to help persons desirous of euthanasia.[12] In absence of clearly defined law, it is not certain whether those involved in euthanasia are assured of protection against charges of wrong doing.

Taking an overall view when seen in context of human rights, euthanasia becomes an emotive issue with contradictory and irreconcilable ideological positions. Is there any alternative?

Alternate Approach

An alternate approach is to lift euthanasia from the domain of human rights and treat it as a professional decision. Euthanasia then becomes an objectively considered opinion and recommendation, a kind of medical prescription if one may like to call it, to terminate a life which has lost its purpose, is

meaningless and has no usefulness to the society. Like other professional decisions and recommendations/prescription/ advice suggestion of euthanasia will be subject to informed consent by the concerned person or legally valid representatives. The concept of informed consent in medical interventions is well accepted.[13] A living will is of immense values in this context.

If such a proposal of treating euthanasia as objective medical decision is accepted, multiple operative steps are required to be decided.

Legalizing Euthanasia

As a first and foremost preliminary step of euthanasia, without creating distinction between passive and active euthanasia, will have to be legalized, so that option of euthanasia is put on proper and sound footing. Working out further details will be relevant and meaningful only if euthanasia is accepted legally in principle and otherwise permissible. Legislative initiative must be comprehensive and include not only the concept and social acceptability but also address various concerns and critical issues, such as under what circumstances termination is considered an option, who decides, what methods to be used and who should carry out, dangers and safeguards, required changes in medical ethics and code of conduct, and administrative and other provisions to accommodate the change. The authors attempt to address some of these concerns and provide suggestions.

Task Force

A committee or "Task Force' should be constituted to examine different issues arising from the suggestion that euthanasia be considered as a part of professional decision instead of its being an issue in the domain of rights, "patient's right to die." The task force must be broad based group consisting of physicians dealing with advance incurable diseases, givers of end-of-life care, medical ethicists, legal profession, medical sociologist/anthropologists, human rights activists, social worker, political and religious leaders.

Key Issues

Indications for Euthanasia

Guidelines have to be framed that under what conditions and situations euthanasia may be considered as an option and recommendation. A statement on the lines like euthanasia may be considered when a patient is in chronic vegetative state, has lost meaningful existence, is suffering with miseries, etc., can best be taken as general principle but is not sufficient or of practical value. The guidelines must clearly identify to the extent possible the diseases/conditions and points in the progression and clinical profile at which termination is considered a better option than continuation of life. It is essential to define and lay down the criteria for expression "chronic vegetative state." Though difficult, it is most essential part of the exercise. Involvement of clinical disciplines and end-of-life caregivers is very useful in formulating these points. Special investigation for confirmation and objective decision making process may also be included.

Authorized Agency: Medical Board

Next major issue is to identify the agency authorized to take decision in respect of euthanasia establishing whether or not a particular patient fulfills the criteria laid down. The medical establishment is expected to discharge this responsibility and evaluate the patient's status on the relevant parameters. Being a sensitive issue the decision regarding euthanasia may not be entrusted to a single physician or a single unit. A system of shared responsibility needs to be put in place.

A Medical Board may be entrusted with this responsibility. The Board must have representation of social scientist, family counselor, medicosocial worker, in addition to medical team. The aim is to reduce subjective element and to gain confidence and acceptability by the society. Such a Board may be linked to an already existing committee like institutional ethics committee or be a separate stand-alone entity. The jurisdiction of the Board may be limited to one particular institution or may cover a group of institutions for logistic consideration and economic reasons. This aspect also will have to be examined by the task force.

There may be a situation when a patient is not admitted to a hospital but is being taken care of at home or a hospice, nursing home, etc., and the patient may have reached a stage which merits evaluation for euthanasia. There must be a provision to address this situation. A system of referral to an area wise designated Medical Board may be introduced. The treating physician or caregiver refers the case to the relevant Board with all the clinical notes and other information as is required. A specially designed format will help in recording of essential information and minimizing chances of omission. The Board will go through these documents and may elect to examine the patient independently and interact with family or well-wishers. The referring physician or caregiver from outside should also be available for clarification, if any is needed.

Legal Prescrutiny

In an effort to reduce errors in the judgment of the authorized agency, a system of built-in mechanism of legal prescrutiny may be put in place. The recommendations and notes of the Medical Board along with all documents are to be sent for scrutiny to a court designated for the purpose. The aim is to ensure that the criteria as laid down have been fulfilled, and there has been no extraneous consideration in arriving at conclusion by the Medical Board. The finality of the recommendations is reached only on confirmation by the court. Subsequent action is initiated after confirmation.

Administering Euthanasia

Medical technology will have to devise a humane method to carry out euthanasia which is less painful and faster. It may be noted that the basic idea behind mercy killing, euthanasia, is to reduce misery and not enhance it by such techniques as withholding respiratory support, tube feeding, intravenous

fluids, and medications, followed in passive euthanasia which is perceived as "safe method," though actually is against the spirit of euthanasia. As such passive and active euthanasia are directed to the same goal of causing death. The distinction between passive and active euthanasia is unnecessary.

There is a need to define process to administer euthanasia identifying the procedure and personnel to carry out the decision. The treating physician or team is best suited as a nodal point for coordinating and preparing the necessary papers for the Medical Board. The patients from outside who are brought to the institution empowered to evaluate for euthanasia will have to be admitted to the institution where evaluation is under taken. The referring physician or caregiver from outside should also be available for clarification, if any is needed by the Board.

There is also a necessity to identify the team who will actually carry out the procedure. The treating unit has an advantage of continuity and good rapport with the family that will lessen emotional and sentimental strain on the well-wishers. Association of team of intensive care unit (ICU) where patient is likely to be located will be useful. Participation by ICU team and anesthesiologists will have an added advantage in case cadaveric organ donation is contemplated. Creation of a special team may not be appropriate.

Apprehensions and Reservations

There are certain apprehensions and reservations before medical establishment in getting involved in the issue of euthanasia, particularly in carrying out the procedure, and these must be addressed adequately and satisfactorily.

There is moral dilemma for a physician, directly or indirectly, to be responsible for death. The training and mind set of physicians are tuned to do everything to preserve and prolong life, and nothing is done to harm the patient. The concept of euthanasia is in complete contrast to this dictum. There is a perceived danger of charges of violating the medical ethics and code of conduct prescribed by the Medical Council of India and State Medical Councils. Therefore, if the suggestion, made in this paper, is to gain ground, necessary modifications have to be effected in the norms of regulatory bodies.

Strategies to modify mind set will also have to be evolved to accept euthanasia as part of legitimate and acceptable professional activities, and it should be possible. In this context, reference to a similar situation may be made as an example. Abortion was banned before Medical Termination of Pregnancy (MTP) Act came into existence and induced abortions were called criminal abortion. Now with MTP Act, termination of pregnancy under certain conditions is part of practice of the relevant discipline. Therefore, it may not be out of place to conclude that a change in the mind set and norms of regulatory bodies are possible. The medical profession is likely to accept euthanasia as part of professional work.

Collateral Issues

Some issues which are not central to the concept of euthanasia or to the suggestion being placed in this paper are important and need attention. There is an issue of death certificate. The committee assisting legislative process must determine whether there is a need of mentioning the fact of euthanasia on the death certificate. In any case, it must be ensured that the death certificates remain valid, without controversy, for all purposes including insurance and medical bill reimbursement.

Permission for autopsy from the family may be sought as per normal practice as an exercise for continuing medical education. However, extra care should be taken to avoid giving an impression that autopsy is a precondition. There should not be any interference in the medicolegal postmortem.

Efforts should be made to counsel the family for organ donation in suitable cases to promote cadaveric organ transplantation. In this situation, extra care must be taken to dispel an impression that organ donation is a prerequisite. Cadaveric organ transplantation may be collateral side benefit but the central issue is addressing terminal illness. In this context, it is prudent to approach the topic only after the finalty is reached on confirmation by the designated court. If organ donation is agreed, the organ retrieval team is informed and the euthanasia is scheduled accordingly. Otherwise the timing is adjusted according to the convenience of family.

Care must be taken to ensure dignity and respect for religious sensitivities in handing over dead bodies to the relatives.

Dangers and Safeguards

There is a danger of overuse and misuse of provisions. It must be ensured that euthanasia is the last and not an alternate option in the end-of-life program. Loss of autonomy, degree of dependency, and family and physicians' support are significant factors in the evaluation for euthanasia.[14-16] The dignified death is gaining importance in consideration of issue of aging,[17] although the concept of euthanasia is not confined to old age but is concerned with terminal incurable disease in all age groups. It is important to distinguish between suitable and unsuitable candidates. The dividing line is thin, and it is essential to avoid errors. The risk of making errors is reportedly small.[18]

These dangers are inherent in the concept of euthanasia per se and not connected with the suggestion contained in this paper. There is additional danger is this proposal. There may be a vested interest in being extra liberal to promote cadaveric organ transplantation. This danger may be real or only imaginary and a theoretical possibility. Hopefully safe guards outlined earlier of constituting Medical Board for decision, informed consent, and built-in legal prescrutiny will address the safety concerns adequately.

Sociocultural Dimensions

The discussion on death and dying in general and euthanasia in particular are emotive issues and are surrounded by controversies. Some aspects of social science perspective of euthanasia have been dealt with elsewhere.[19] The present

paper deals with decisions-making process with a plea to lift euthanasia from the domain of "human rights" to bring it under professional evaluation and decision or a prescription, subject to informed consent. The proposition has wider sociocultural ramifications. Even if legally permitted, the medical persons are reluctant and feel uncomfortable in associating with the activities to cause death.[20]

In the doctrine of euthanasia as a "right," the patient or family member or caregiver perceives the need and seeks euthanasia which is decided by legal process on case-to-case basis. The patient may have given advance authorization by way of living will which may facilitate consideration, even then appropriate assessment by the authorized personnel, the medical team is needed to establish whether the patient's status fulfills the conditions of the living will. The family and well-wishers and caregivers may face a serious moral dilemma in deciding even in presence of living will.

Under the proposed decision-making process, the treating team recommends euthanasia as per guidelines. The recommendation is subject to informed consent like any other intervention assuring participation by the patient or family. The shift from "right" to "professional opinion" has wider social implications.

Criteria under what conditions euthanasia is considered are determined and notified. The given patient is assessed whether or not these are fulfilled and a system of legal prescrutiny before finalty provides further safeguard. The proposed decision-making process by professional assessment strengthens the confidence and acceptability of euthanasia by the society.

The patients and their representatives feel relieved on the knowledge that the decision is arrived at on the basis of competent assessment. The dilemma faced by the family in the difficult situation is resolved. However, the suggestion is not to endorse paternalist approach with patient occupying a passive role. The point is that euthanasia needs to be demystified and may be treated at par with other medical interventions that require informed consent. It is essential to appreciate need for laws to reduce unnecessary procedures for prolongation of life[21] which are not serving any useful purpose and actually delaying death only. Though curtailing unnecessary interventions may result in substantial savings, economic consideration should not become determining factor.

In many societies including India, high premium is attached to "peaceful death" and the prescription of active euthanasia by medical personnel offers such an opportunity. When the end comes, it is possible to organize the family members and friends to be at bed side of the patient which is highly valued sentiment. In a study of interaction in medical setting, it was observed complex hospital rules may be the cause of dehumanizing experience of modern medicine[22] which may be the case when the patient is in hospital or ICU with restrictions of entrance.

Among other debates concerning euthanasia there is continuing discussion on choice between passive and active euthanasia. If euthanasia is accepted in a given case, distinction is unnecessary. The process of passive euthanasia is disturbing to witness and may be prolonged. It may be recalled in case of Teri Schavio in the United States, it took 13 days for death after feeding tubes were withdrawn.[23] In this perspective, active euthanasia is a better option.

Euthanasia and active euthanasia by medical opinion may come in direct conflict with medical ethics and standard teaching or doctors restraining them from killing person. This uneasy feeling is further increased by participating in active euthanasia. Need for legalizing euthanasia and corresponding modifications of medical ethics and code of conduct are essential component of consideration for euthanasia. There is a felt need for education of physicians in end-of life-care palliative care programs[24] and euthanasia as a last resort may be included.

Conclusion

There is a strong case for shifting euthanasia from the domain of 'right to die' and bringing the issue within the fold of professional evaluation, and decision as per prescribed guidelines subject to informed consent and clearance by legal pre-scrutiny. Active euthanasia is a better option than passive euthanasia for alleviation of miseries and ensuring 'peaceful death' which are the primary objectives of mercy killing: euthanasia.

Conflict of Interest
None declared.

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References

1 The transplantation of human organs Act, 1994. Available at: https://mohfw.gov.in/sites/default/files/Act%201994.pdf. Accessed April 2017
2 Desikan P. Supreme Court delivers historic judgment on Aruna Shanbaug case. Natl Med J India 2011;24(3):190–191
3 Govt. of India, Ministry of Law. Formulation of law on passive euthanasia and a draft bill "Terminally patients (protection of patients and medical practioners). Available at: http://Law Commission of India.nic.in/reports. Accessed November 2016
4 Minocha VR, Mishra A. Comments on formulation of law on passive euthanasia and its draft bill 'terminally ill patients (protection of patients and medical practitioners).' MAMC J Med Sci 2017;3:174–175
5 Sinha B. Dying with dignity—a right (SC ruling). The Hindustan Times, Delhi Edition. March 10, 2018
6 Howarth G, Jefferys M. Euthanasia: sociological perspectives. Br Med Bull 1996;52(2):376–385
7 Higgs R. Living wills and treatment refusal. Br Med J (Clin Res Ed) 1987;295(6608):1221–1222
8 Anonymous. Times of India, Delhi Edition. January 30, 2016
9 Do Not Resuscitate (DNR). Available at http://wikipedia.org/wiki/Do Not Resuscitate. Accessed May 2017
10 Southern Cross Bioethics Institute. Euthanasia and physician assisted suicide: a four monthly report prepared for the

protection of unborn children. Available at www.supc.org.uk. Accessed July 2014
11 Smets T, Bilsen J, Cohen J, Rurup ML, Mortier F, Deliens L. Reporting of euthanasia in medical practice in Flanders, Belgium: cross sectional analysis of reported and unreported cases. BMJ 2010;341:c5174
12 Humphry D, Final Exit: The Practicalities of Self-Deliverance and Assisted Suicide for the Dying. 3rd ed. New York, NY: Delta Trade Paperback; 2002
13 Minocha AA, The socio-cultural context of informed consent in medical practice. In: Baviskar BS, Patel T, eds. Understanding Indian Society: Past and Present. Delhi, India: Orient Black Swan; 2010 259–279
14 Seale C, Addington-Hall J. Euthanasia: why people want to die earlier. Soc Sci Med 1994;39(5):647–654
15 Seale C, Addington-Hall J. Euthanasia: the role of good care. Soc Sci Med 1995a;40(5):581–587
16 Seale C, Addington-Hall J. Dying at the best time. Soc Sci Med 1995b;40(5):589–595
17 Duttagupta C. Dying with dignity. In: Chatterjee SC, Patnaik P, Chariar V, eds. Discourses on Ageing and Dying. Delhi, India: Sage Publication; 2006
18 Norgrady B. Little evidence of slippery slope with euthanasia or physician-assisted suicide. Clinical Neurology News JAMA 2016;316:79–90
19 Minocha AA, Mishra A, Minocha VR, Euthanasia: a social science perspective Economic and Political Weekly 2011;46(49)
20 Zitter JN. Should I help my patient to die?. New York Times. Available at: http://www.nytimes.com.2017/08/05/opinion/sunday/dying-doctors-pallative-medicine.html. Accessed August 8, 2017
21 Mani RK, Simha N, Gursahani R. Let's talk about death-euthanasia debate must focus on how we compassionately care for the dying. Available at: https://timesofindia.indiatimes.com/blogs/toi-editorials/lets-talk-about-death-euthanasia-debate-must-focus-on-how-we-compassionately-care-for-the-dying/. Accessed September 09, 2019
22 Minocha AA. (1996). Perceptions and interactions in a medical setting. New Delhi, India. Hindustan Publishing House
23 Teri Schiavo case. Available at: https://en.wikipedia.org/wiki/Terri_Schiavo_case. Accessed May 2017
24 Dey SK. Education of physician on end of life care: Indian perspective. Indian Pediatr 2000;37(10):1047–1050