Law on Euthanasia in India

Life and death as concepts have invited many thinker, philosopher, writer and physician to define or describe them. **Swami Vivekananda** expects one to understand that life is the lamp that is constantly burning out and further suggests that if one wants to have life, one has to die every moment for it. One may like to compare life with constant restless moment spent in fear of extinction of a valued vapor; and another may sincerely believe that it is beyond any conceivable metaphor. Death is complicated and life is a phenomenon which possibly intends to keep away from negatives that try to attack the virtue and vigor of life from any arena. In spite of all the statements, references and utterances, be it mystical, philosophical or psychological, the fact remains, at least on the basis of conceptual majority, that people love to live – whether at eighty or eighteen – and do not, in actuality, intend to treat life like an—autumn leaf.

The perception is not always the same at every stage. There comes a phase in life when the spring of life is frozen, the rain of circulation becomes dry, the movement of body becomes motionless, the rainbow of life becomes colorless and the word life, which one calls a dance in space and time becomes still and blurred and the inevitable death comes near to hold it as an octopus gripping firmly with its tentacles so that the person shall rise up never.

The **ancient Greet philosopher, Epicurus,** has said, although in a different context:

> *Why should I fear death?*
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> *If I am, then death is not.*
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> *If death is, then I am not.*
>
> *Why should I fear that which can only exist when I do not?*

But there is a fallacy in the said proposition. It is because mere existence does not amount to presence. And sometimes, there is a feebleness of feeling of presence in semi-reality state when the idea of conceptual identity is lost, quality of life is sunk and the sanctity of life is destroyed and such destruction is denial of real living.

The society at large feels that a patient should be treated till he breathes his last breath.

Every doctor is supposed to take a specific oath that he will make every attempt to save the life of the patient whom he/she is treating and who is under his/her treatment. This oath, thus, puts a moral and professional duty upon a doctor to do everything possible, till the last attempt, to save the life of a patient.

The **Medical Council of India (MCI) Code of Ethics Regulations rejects Euthanasia** (deliberately ending a patient's life at his or her own request or at the request of close relatives). *"6.7* ***Euthanasia: Practicing euthanasia shall constitute unethical conduct****. However, on specific occasion, the question of withdrawing supporting devices to sustain cardiopulmonary function even after brain death, shall be decided only by a team of doctors and not merely by the treating physician alone. 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 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."*

While MCI Code of Ethics rejects euthanasia, it does not talk about **physician-assisted-suicide** (where a physician deliberately enables a patient to end his or her life by prescribing or providing medical substances with the sole intent of causing death. But practically, it is included in the same as both acts are contrary to the ethics of medicine and the role of the physician.

Medical scientists have been, relentlessly and continuously, experimenting and researching to find out better tools for not only curing the disease with which human beings suffer from time to time, noble attempt is to ensure that human life is prolonged and in the process of enhancing the expectancy of life, ailments and sufferings there from are reduced to the minimal. There is, thus, a fervent attempt to impress the quality of life.

It is this very advancement in the medical science which creates dilemma at that juncture when, in common perception, life of a person has virtually become unlivable but the medical doctors, bound by their **Hippocratic Oath and medical ethics** want to still spare efforts in the hope that there may still be a chance, even if it is very remote, to bring even such a person back to life.

The Hippocratic Oath taken by a doctor and the MCI Code of Ethics may make him feel that there has been

a failure on his part and sometimes also make him feel scared of various laws. There can be allegations against him for negligence or criminal culpability.

No physician should be forced to participate in euthanasia or assisted suicide, nor should any physician be obliged to make referrals to this end. However, **the right to decline medical treatment is a basic right of the patient.**

The physician does not act unethically in **respecting the patient's wish** to decline medical treatment, even if such a wish may result in the patient's death by allowing the natural dying process to unfold in the course of terminal phases of sickness.

A doctor has a crucial role to play in such situations as there is a very thin line between this ethical and unethical act.

Remember, it is the patient who has a right to deny the treatment and not the relatives. However, the patient must be in his or her sound state of mind to take any such decision.

There is a **distinction between the administration of lethal injection or certain medicines to cause painless death and non-administration of certain treatment,** which can prolong the life in cases where the process of dying that has commenced is not reversible or withdrawal of the treatment that has been given to the patient because of the absolute absence of possibility of saving the life. To explicate, the first part relates to an overt act whereas the second one would come within the sphere of informed consent and authorized omission. The omission of such a nature will not invite any criminal liability if such action is guided by certain safeguards. The concept is based on nonprolongation of life where there is no cure for the state the patient is in and he, under no circumstances, would have liked to have such a degrading state.

In the landmark judgment **Common Cause versus Union of India, 2018 (5) SCC 1, the Hon'ble Constitution Bench of 4 Judges of Supreme Court** held that **Euthanasia** is basically an intentional premature termination of another person's life either by direct intervention **(active euthanasia)** or by withholding life-prolonging measures and resources **(passive euthanasia)** either at the express or implied request of that person **(voluntary euthanasia)** or in the absence of such approval/consent **(non-voluntary euthanasia)**.

Active euthanasia also includes physician-assisted suicide, where the injection or drugs are supplied by the physician, but the act of administration is undertaken by the patient himself. Active euthanasia is not permissible in most countries.

Passive euthanasia is when medical practitioners do not provide life-sustaining treatment ((i.e., treatment necessary to keep a patient alive) or remove patients from life-sustaining treatment. This could include disconnecting life support machines or feeding tubes or not carrying out life-saving operations or providing life-extending drugs. In such cases, the omission by the medical practitioner is not treated as the cause of death; instead, the patient is understood to have died because of his underlying condition.

Further, in **Gian Kaur versus State of Punjab, (1996) 2 SCC 648**, the Hon'ble Constitution Bench of Apex Court expounded that the word **"life" in Article 21** has been construed as life with human dignity and it takes within its ambit the **"right to die with dignity"** being part of the **"right to live with dignity"**. As part of the right to die with dignity in case of a dying man who is terminally ill or in a persistent vegetative state, only passive euthanasia would come within the ambit of Article 21 and not the one which would fall within the description of active euthanasia in which positive steps are taken either by the treating physician or some other person. That is because the right to die with dignity is an intrinsic facet of Article 21.

In **Aruna Ramachandra Shanbaug versus Union of India, 2011 (15) SCC480**, Hon'ble Supreme Court has observed that **autonomy means the right to self-determination where the informed patient has a right to choose the manner of his treatment.** To be autonomous the patient should be competent to make decisions and choices. In the event that he is incompetent to make choices, his wishes expressed in advance in the form of a Living Will, or the wishes of surrogates acting on his behalf ('substituted judgment') are to be respected.

Thus, **all adults with the capacity to consent have the common law right to refuse medical treatment and the right of self-determination.** Doctors would be bound by the choice of self-determination made by the patient who is terminally ill and undergoing a prolonged medical treatment or is surviving on life support, subject to being satisfied that the illness of the patient is incurable and there is no hope of his being cured.

In "**Common Cause versus Union of India, 2018 (5) SCC 1** the Constitution Bench of Hon'ble Supreme Court held that **Advance Medical Directive** would serve as a fruitful means to facilitate the fructification of the sacrosanct right to life with dignity. The said

directive will dispel many a doubt at the relevant time of need during the course of treatment of the patient. That apart, it will strengthen the mind of the treating doctors as they will be in a position to ensure, after being satisfied, that they are acting in a lawful manner. However, Advance Medical Directive cannot operate in abstraction. The Hon'ble Court in the said judgment has enumerated various safeguards and procedure of advance medical derivatives and also in cases where there is no advance medical derivatives which will remain enforced till Parliament makes a law on Advance Medical Derivatives.

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Characterization of Risk Factors for Sudden Infant Deaths

Infants who sleep on a nonapproved sleep surface and use soft bedding are at a considerably high risk of explained suffocation, according to a study published online December 5, 2022 in the journal *Pediatrics*.[1]

This study sought to explore the risk factors for sleep-related suffocations and unexplained infant deaths (including deaths due to sudden infant death syndrome [SIDS]) together grouped as sudden infant deaths. For this, the researchers analyzed data from the Sudden Unexpected Infant Death (SUID) Case Registry of the Centers for Disease Control and Prevention (CDC) data, from 2016 to 2017. Live born infants from the Pregnancy Risk Assessment Monitoring System (PRAMS) constituted the control group. The age group of the infants included in the study was 2 to 9 months; 300 unexplained infant death cases with 1,200 age-matched controls and 112 sleep-related suffocation cases with 448 age-matched controls.

Among infants who did not share a room with their mother or caregiver, the risk of sleep-related suffocation was increased by almost nineteenfold with adjusted odds ratio (aOR) of 18.7. They were also nearly 8 times more at risk of unexplained death with aOR of 7.6 compared with infants who shared a room. Infants who shared their sleep area with their pet/toys or another person also doubled their risk of sleep-related suffocation or unexplained infant death with aORs of 2.5 and 2.1, respectively.

Infants who slept in a nonsupine (not on back) sleep position were nearly 2 times more likely to experience sleep-related suffocation and unexplained death with aORs of 1.9 and 1.6, respectively.

The risk of explained suffocation increased 16 times among infants who slept on a soft bedding such as loose bedding, stuffed toys and other objects close by (aOR 16.3) than in those who did not sleep on soft bedding. The risk of unexplained death was also increased among these infants (aOR 5.0). Infants who did not sleep in a crib, bassinet or portable crib were 4 times more at risk of explained suffocation death versus infants who slept on a firm and noninclined sleep surface (aOR 3.9). No such association was observed for unexplained sleep death in this group of infants (aOR 1.0).

This study has reiterated the association of unsafe infant sleep practices and sleep-related suffocation and unexplained infant death. It has also characterized the risk factors separately for sleep-related suffocation and unexplained infant death. Infants who slept alone were at the highest risk, almost 20 times higher, of sleep-related suffocation and unexplained infant death. Nonapproved sleep surface was strongly associated with explained suffocation, but not with unexplained sleep death. Use of soft bedding had a stronger association with suffocation than unexplained death.

In its updated 2022 recommendations for reducing infant deaths in the sleep environment, the American Academy of Pediatrics (AAP) recommends use of a firm, noninclined sleep surface, supine positioning, avoidance of soft bedding, room sharing without bed sharing and overheating.[2]

By highlighting the associated dangers, the findings of this study can be used by pediatricians to educate parents about safe sleep.

References

1. Parks SE, et al. Risk factors for suffocation and unexplained causes of infant deaths. Pediatrics. 2023;151(1):e2022057771.
2. Moon RY, et al. Sleep-related infant deaths: updated 2022 recommendations for reducing infant deaths in the sleep environment. Pediatrics. 2022;150(1):e2022057990.