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Forensic Medicine & Toxicology

VOLUME 1



Recent Advances in Forensic Medicine & Toxicology

Good Practice Guidelines and Current Medicolegal Issues

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3

Euthanasia: Legal, Social and Humanitarian Aspects

Vijay Vasudev Pillay

'One has observed life poorly, if one has not also witnessed the hand that mercifully—kills.'
Friedrich Nietzsche (German philologist, philosopher and cultural critic)

ABSTRACT

Euthanasia refers to the practice of intentionally or deliberately causing a painless death of an individual suffering from hopelessly incurable and painful disease. Euthanasia is categorized in different ways, which include voluntary, nonvoluntary or involuntary. Voluntary euthanasia is legal in some countries. Non-voluntary euthanasia is illegal in most countries. Involuntary euthanasia is usually considered murder. Voluntary, nonvoluntary and involuntary euthanasia can all be further divided into passive or active variants. Passive euthanasia entails the withholding of common treatments necessary for the continuance of life. Active euthanasia entails the use of lethal substances or forces, such as administering a lethal injection to kill and is the most controversial means. Physician-assisted suicide (PAS), sometimes shortened to 'assisted suicide' is a new term for euthanasia committed by someone with assistance from a medically qualified person. There are different euthanasia laws in each country. PAS is legal in several countries, including Belgium, Luxembourg, the Netherlands, Switzerland and four American states (Oregon, Washington, Vermont and Montana). The Hippocratic Oath forbids physicians' participation in death, which has been interpreted by many to be a prohibition against PAS, euthanasia and involvement in executions. All forms of euthanasia are generally considered illegal in India, though there have been some recent developments which indicate liberalization of the concept, especially with regard to passive euthanasia.

Keywords: Mercy killing, aid-in-dying, self-deliverance, physician assisted suicide (PAS).

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INTRODUCTION

The word 'euthanasia' is derived from the Greek words 'eu' and 'thanotos' which literally means a 'good death', though it has undergone considerable distortion over a period of time to assume its present day meaning of 'mercy killing'.[1] History suggests that the word was used in the 17th century by Francis Bacon to refer to an easy and painless death, since it was the physician's duty and responsibility to alleviate the physical suffering of the patient.[1] Other synonyms include 'aid-in-dying' and 'self-deliverance'.

As far back as 300–400 BC, both Socrates and Plato accorded moral sanction to euthanasia and suggested that it was permissible in certain circumstances. But today, there is a raging controversy all over the world as to its legal standing, aside from the moral and ethical issues involved. It has been at the center of very heated debates for many years and is surrounded by religious, ethical and practical considerations. Euthanasia is the most active area of research in contemporary bioethics. There is paucity of information and confusion prevailing over the medicolegal status and ethical aspects of euthanasia in India and worldwide which led to the compilation of this chapter.

DEFINITIONS

- **Euthanasia:** The infliction of a painless death on an individual suffering from severe, intractable pain or discomfort, arising out of a terminal illness or condition.[2]
- **Physician-assisted suicide:** Physician-assisted suicide (PAS) is the physician prescribing a drug or other action to facilitate a patient taking his/her own life, with the committed action taken by the patient.[3]
- **Terminal illness:** Illness or injury or degeneration of physical or mental condition, causing extreme pain and which, according to medical opinion, will inevitably cause death or has caused persistent and irreversible vegetative condition.[1]
- **Palliative care:** The provision of reasonable medical and nursing procedures for the relief of physical pain, discomfort or emotional and psychological suffering as well as providing food and water.[1]

CLASSIFICATION

Euthanasia can be classified in different ways:[4]

1. *Voluntary euthanasia:* The dying individual consents to the act.
2. *Nonvoluntary euthanasia:* The person cannot make a decision or cannot make his wishes known. This includes cases where the person is:
   a. in a coma
   b. too young (for e.g., an infant)
   c. senile
   d. mentally deficient to a very severe extent
   e. severely brain damaged
   f. mentally disturbed in such a way that he/she should be protected from themselves
3. *Compulsory (involuntary) euthanasia:* Decision by society to terminate the life of an individual.
4. *Active euthanasia:* Inflicting painless death by an act of commission, for e.g., injection of a lethal dose of barbiturates.
5. *Passive euthanasia (negative euthanasia):* Inflicting painless death by an act of omission, i.e. when the patient dies because the medical professionals either do not do something necessary to keep the patient alive, or when they stop doing something that is keeping the patient alive, for e.g.:
   a. Switch off life-support machines
   b. Disconnect a feeding tube

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c. Do not carry out a life-extending operation
d. Do not give life-extending drugs

6. *Pediatric euthanasia:* Euthanasia administered to seriously sick or deformed infants.

   The *Groningen Protocol* was created in September 2004 by Eduard Verhagen, the medical director of the department of pediatrics at the University Medical Center Groningen (UMCG) in Groningen, the Netherlands.[5] It contains directives with criteria under which physicians can perform 'active ending of life on infants' who are seriously ill or suffer from significant birth defects (for e.g., newborns with spina bifida and hydrocephalus) without the fear of legal prosecution (*child euthanasia*—a form of nonvoluntary euthanasia). The protocol, made up after extensive consultation between physicians, lawyers, parents and the prosecution office, offers procedures and guidelines to achieve the correct decision and performance. The final decision about 'active ending of life of infant' is not in the hands of the physicians but with the parents, with physicians and social workers agreeing to it. Criteria are, amongst others, 'unbearable suffering' and 'unexpected quality of life'. Only the parents can start the procedure. The procedure is reported to be working well.

   However, the Groningen Protocol does not give physicians unassailable legal protection. Case law has so far protected physicians from prosecution as long as they act in accordance with the protocol, but no black-letter law exists in this area.

   Several studies have questioned the basis for the protocol and have recommended abandoning it.[6,7]

7. *Geriatric euthanasia:* Euthanasia administered to seriously sick, aged individuals.
8. *Battlefield euthanasia:* Euthanasia administered to severely wounded or handicapped individual.

HISTORY OF EUTHANASIA

A 20th century chronology of important events relating to voluntary euthanasia and PAS is presented in Table 3.1.[8] Prior to the beginning of the 20th century, the concept of euthanasia was rarely discussed as it was considered taboo and often equated with suicide, and thus deemed illegal.

Table 3.2 lists some of the important personalities around the world who have been campaigning for the legal acceptance and validation of euthanasia.

ARGUMENTS FAVORING EUTHANASIA

According to euthanasia expert Ezekiel Emanuel,[9] proponents of euthanasia invariably present four main arguments:

1. People have a right to self-determination, and thus should be allowed to choose their own fate.
2. Assisting a subject to die might be a better choice than requiring that he/she may continue to suffer.
3. The distinction between passive euthanasia which is often permitted, and active euthanasia which is not substantive (or that the underlying principle—the doctrine of double effect) is unreasonable or unsound.
4. Permitting euthanasia will not necessarily lead to unacceptable consequences.

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Table 3.1 Chronology of euthanasia (summary of important events from early 20th century)

Year	*Developments*
1906	First euthanasia bill drafted in the US (Ohio), but it does not succeed.
1935	World's first euthanasia society is founded in London.
1938	The Euthanasia Society of America is founded in New York.
1967	The first 'living will' is written by American attorney Louis Kutner.
1973	The American Hospital Association creates Patient Bill of Rights, which includes the right to refuse treatment.
1974	The Euthanasia Society in New York is renamed the Society for the Right to Die.
1976	The California Natural Death Act is passed which protects physicians from being sued for failing to treat incurable illnesses. Several other states of the US follow suit with similar legislation.
1976	First international meeting of 'Right to Die' groups.
1978	A Broadway play '*Whose life is it anyway?*' about a quadriplegic wanting to die is staged for the first time. It goes on to become a massive hit and is followed by its movie version in 1982.
1980	Pope John Paul II issues 'Declaration on Euthanasia' opposing mercy killing, but permitting the right to refuse extraordinary means for sustaining life.
1980	Hemlock Society (advocating euthanasia) is founded in California by journalist Derek Humphry.
1980	World Federation of Right to Die Societies is formed in Oxford, England.
1984	The Netherlands Supreme Court approves voluntary euthanasia under certain conditions.
1990	American Medical Association permits physicians to withhold or withdraw treatment from patients who are close to death.
1990	Dr Jack Kevorkian (Michigan, US), assists for the first time, in the death of a patient. Over the next 9 years he assists in a total of 130 deaths. He is tried 4 times before finally being convicted in his 5th trial in April 1999 for 2nd degree murder.
1991	Derek Humphry publishes 'Final Exit', a how-to book on self-deliverance. It quickly tops the US best-seller list and is subsequently translated into 12 languages.
1993	A political action committee Oregon Right to Die is founded to write and subsequently pass the Oregon Death with Dignity Act. The Act is in effect from 5th October 1997, after several unsuccessful attempts to scuttle it.
1996	The Northern Territory of Australia passes voluntary euthanasia law which was drafted the previous year. However, nine months later the Federal Parliament quashes it.
1999	Dr Kevorkian sentenced to 10–25 years in prison for 2nd degree murder of Thomas Youk suffering from motor neuron disease. The videotape of Youk's death had been telecast on national television, provoking public outrage.
2000	The Netherlands becomes the first country in the world to legalize physician-assisted suicide (PAS).

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Year	*Developments*
2000	The Switzerland-based Dignitas, a legal euthanasia center, begins its operations under the lax euthanasia laws of the country. However, a clear-cut law legalizing PAS has so far not been passed in Switzerland.
2002	Belgium becomes the second country to legalize PAS.
2007	Dr Jack Kevorkian is released from prison after serving 8 years.
2008	Luxembourg becomes the third country to legalize PAS.
2008	The Washington Initiative 1000 makes Washington the second US state to legalize PAS.
2009	Luxembourg becomes the third European Union country, after the Netherlands and Belgium, to decriminalize euthanasia.
2010	The Federal Court of Justice of Germany legalizes passive euthanasia with patient's consent.
2011	Kevorkian dies from a thrombosis on 3rd June, eight days after his 83rd birthday at William Beaumont Hospital in Royal Oak, Michigan, US.
2012	World's first mobile euthanasia unit begins to operate in the Netherlands. According to The Daily Mail in London, the units will be dispatched when family doctors refuse to administer lethal drugs on 'ethical' grounds.
2012	International Congress of World Federation of Right-to-Die Societies (WFRtDS), Zürich (Switzerland), hosted by 'EXIT Deutsche Schweiz' on behalf of their sister society ADMD Suisse Romande.
2013	Vermont becomes the first legislature in US to pass a PAS suicide law. Oregon and Washington had earlier passed their laws via citizen initiative vote; subsequently, Montana drafted a law through a court case.

Table 3.2 Some prominent *Right to Die* activists

Country	*Name*
Netherlands	Pieter Admiraal Marion Rookhuizen
Belgium	Wim Distelmans
Scotland	John Beloff
India	Buji Colabawalla
Australia	Lynda Cracknell Philip Nitschke
USA	Derek Humphry Jack Kevorkian
England	Ludovic Kennedy
Switzerland	Jeanne Marchig
Columbia	Clemencia Uribe

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Proeuthanasia activists often point to countries like the Netherlands and Belgium, and states like Oregon, where euthanasia has been legalized and is mostly unproblematic.

The medical ethos of the 'sanctity of life' implying the unqualified duty to preserve life at all costs has come under increasing challenge. There is a perceptibly growing movement away from a rigid obligation on the part of a doctor to preserve life 'at all costs', towards a more flexible duty to provide good palliative terminal care. Terminal illness is considered best treated by providing optimum conditions for death rather than by the use of increasingly invasive techniques to prolong some sort of existence. A conscious, dying patient can make his own decision, since patient's autonomy is today considered to be the cornerstone of ethical medical practice. To continue to treat in the face of contrary instructions can attract legal liabilities, though the exact position is still not clear-cut in India (*vide infra*).

In many Western countries, it is generally accepted that there is no moral obligation on the part of a doctor to preserve life at the expense of suffering, and if in the course of good terminal care, the use of drugs inadvertently hastens death, this is ethically acceptable within the concept of '*double effect*', i.e. an ill effect is morally acceptable as long as there is a greater, intended good effect from an action.[10] This concept was first given legal sanction in relation to euthanasia by Justice Devlin in the *Bodkin Adams case* (1957), when he remarked, 'The doctor is entitled to relieve pain and suffering even if the measures he takes may incidentally shorten life' (Box 3.1).[11]

Box 3.1 Case of Bodkin Adams

John Bodkin Adams (21st January 1899–4th July 1983) was an Irish-born British general practitioner (Fig. 3.1). Between the years 1946 and 1956, more than 160 of his patients died under suspicious circumstances. Of these, 132 left him money or items in their will. He was tried and acquitted for the murder of one patient in 1957. Another count of murder was withdrawn by the prosecution in what was later described as 'an abuse of process' by the presiding Judge Patrick Devlin, causing questions to be asked in Parliament about the prosecution's handling of events.



Fig. 3.1 Dr John Bodkin Adams

The trial had several important legal ramifications:

- It established the principle of 'double effect', whereby a doctor giving treatment with the aim of relieving pain may, as an unintentional result, shorten life.
- Secondly, due to the publicity surrounding Adams' committal hearing, the law was changed to allow defendants to ask for such hearings to be held in private.
- Finally, though a defendant had never been required to give evidence in his own defence, the Judge underlined in his summing-up that no prejudice should be attached by the Jury to Adams not doing so.

Adams was found guilty in a subsequent trial of 13 offences of prescription fraud, falsifying cremation forms, obstructing a police search and failing to keep dangerous drugs register. His name was removed from the Medical Register in 1957, but was reinstated in 1961.

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The possibility of maintaining 'physiological life', i.e. the continuation of the body functions by artificial means, while the patient remains unconscious over a period of months or years, has introduced a new dimension into the debate—'quality of life'. Clearly, the sustaining of physiological functions with no prospect of recovery of consciousness or contact with the patient's environment has led to considerable debate as to whether or not such support systems should be continued, and who should be responsible for the decision to turn off such systems.

Views vary widely, but there is a substantial proportion of population in countries, such as the US which favors the view that support systems can be switched off by attending doctors with consent from the victim's relatives, in certain cases.

The case of Karen Ann Quinlan (Fig. 3.2) is representative of this. Karen, a 21-year-old girl fell into a coma after imbibing an overdose of alcohol and drugs on 15th April, 1975. She passed into 'persistent vegetative state' from which recovery was extremely remote. Her parents, both devout Roman Catholics, were initially hopeful of a miracle, but as the months passed by they realized that this was only wishful thinking and that their daughter was never going to come back to meaningful existence. They requested that life support systems prolonging the futile ordeal be switched off. The doctors attending on the case refused, and the issue was taken to court. In 1976, the New Jersey Supreme Court delivered a verdict in favor of Karen's parents. However, while the support systems were subsequently switched off, artificial feeding was not stopped and Karen continued to 'live' for nearly 10 years before her heart finally stopped in 1985. The case, however, served to focus attention on a topic that had for decades been considered taboo.[12]

The Terri Schiavo case (another landmark case akin to the Quinlan case) that occurred in the US lasted from 1990–2005.[13] Terri Schiavo (Fig. 3.3) collapsed in her home in Florida due to sudden cardiac arrest, on 25th February 1990. She suffered massive brain damage due to lack of oxygen and after two and a half months in a coma, her diagnosis was changed to 'vegetative state'. For the next



Fig. 3.2 Karen Ann Quinlan



Fig. 3.3 Terry Schiavo

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few years, doctors attempted speech and physical therapy and other experimental therapy, hoping to return her to a state of awareness. In 1998, Schiavo's husband, Michael, petitioned the Court of Florida, to remove her feeding tube. He was opposed by Terri's parents, Robert and Mary Schindler, who argued that she was conscious. The court determined that she would not wish to continue life-prolonging measures, and on 24th April 2001, her feeding tube was removed for the first time, only to be reinserted several days later.

On 25th February 2005, a County Judge ordered the removal of Terri Schiavo's feeding tube. Several appeals and federal government intervention followed, which included US President George W Bush returning to Washington DC to sign legislation designed to keep her alive. After appeals through the Federal Court system upheld the original decision to remove the feeding tube, staff at the hospice facility where Terri was being cared for, disconnected the feeding tube on 18th March 2005 and she died on 31st March 2005.

The Schiavo case resulted in a big boost to the activism of prolife movement and disability rights groups. This case differed from the Quinlan case by involving settled law rather than breaking new legal ground on the right-to-die issue.

Today, not only in the case of terminally unconscious patients, but also in conscious patients (who are suffering from an intractable, painful, terminal illness), euthanasia is being increasingly considered as applicable, provided the patient concerned makes the request and he is judged to be of sound and rational mind. Withdrawing treatment and allowing a patient to die (passive euthanasia) is therefore not perceived as repugnant anymore in certain situations. In fact, in several Western countries, adult individuals over a specified age can execute a *living will* or *advance directive* which entitles him to refuse treatment any time in future in the event of a catastrophic accident or natural disease.[14] The usual phraseology in a living will is as follows:

"If I suffer an incurable, irreversible illness, disease or condition and my attending physician determines that my condition is terminal, I direct that life-sustaining measures that would serve only to prolong my dying be withheld or discontinued".

A related document is a specific type of power of attorney or *health care proxy*, in which the person authorizes someone (an agent) to make decisions on their behalf when they are incapacitated.

Similarly, a 'do-not-resuscitate' (DNR) order on a patient's files means that a doctor is required not to resuscitate if the heart stops functioning. DNR can be regarded as a form of passive euthanasia. They are not controversial, unless they are abused, since they are intended to prevent patient's unnecessary suffering.[3]

Other arguments that bolster the cause of euthanasia as an acceptable option in some situations include the high cost of medical treatment in prolonging life in certain terminal illnesses or medical conditions, especially if the 'extra lease of life' is of poor quality or associated with much suffering or pain. The economic and psychological burden on relatives in such cases can be substantial and sometimes debilitating. It is also a fact that medical science is not an infallible science and there are always limitations in curing certain diseases.

While passive euthanasia has been accorded some semblance of acceptance in certain situations by most people, active euthanasia is in the center of a heated (and often bitter) debate, with vociferous sections of the population in India and elsewhere either strongly advocating or condemning its practice. Despite

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its unresolved status, active euthanasia is being employed without serious legal difficulties in some countries, for e.g., in the US and Sweden.

ARGUMENTS AGAINST EUTHANASIA

Ezekiel Emanuel[9] argues that there are four major arguments presented by opponents of euthanasia:

1. Not all deaths are painful.
2. Alternatives, such as cessation of active treatment, combined with the use of effective pain relief are available.
3. The distinction between active and passive euthanasia is morally significant.
4. Legalizing euthanasia will place society on a slippery slope which will lead to unacceptable consequences.

As applied to the euthanasia debate, the slippery slope argument claims that the acceptance of certain practices, such as PAS or voluntary euthanasia, will invariably lead to the acceptance or practice of concepts which are currently deemed unacceptable, such as non-voluntary or involuntary euthanasia.[15] Thus, it is argued, in order to prevent these undesirable practices from occurring, we need to resist taking the first step.

The opponents of euthanasia (particularly *active euthanasia*) state that there are moral, religious and ethical objections which cannot be ignored. They argue that no one has the right to take away the life of an individual, not even the individual himself. The concept of 'sanctity of life' is inviolable and doctors having taken an oath (the Hippocratic Oath) 'to preserve life at all costs', cannot justify allowing a patient to die either through active or passive means.

It is also true that doctors are not omniscient; there have been several cases where a patient certified as terminally ill, has survived and led a reasonably fulfilling existence for several years with good palliative care.[16] Even if a patient does have only a few months to live, adequate medical care can in most cases serve to make him reasonably comfortable for the remaining period, till natural death supervenes. The emphasis therefore should be on improving palliative care, rather than improving methods of terminating life. Palliative sedation can be used for short periods with the plan to awaken the patient after a given time period, making terminal sedation a less correct term. The patient is sedated while symptom control is attempted, then the patient is awakened to see if symptom control is achieved. In some cases, palliative sedation is begun with the plan to not attempt to reawaken the patient. One such common example is a patient with an enlarging cancer in the throat that compresses the trachea who does not want intubation or a tracheostomy, so that eventually symptom control is impossible. Instead of experiencing death by suffocation, once symptoms are intolerable, some patients will request palliative sedation to ease their symptoms as death approaches. However, while the intent of palliative sedation is to eliminate pain and suffering, a significant minority of patients 'continue to experience pain, dysphoria, or nausea' that is commonly unknown to providers or families. The *Liverpool Care Pathway for the Dying Patient (LCP)* is a UK care pathway (excluding Wales) covering palliative care options for patients in the final days or hours of life.[17] It has been developed to help doctors and nurses provide quality end-of-life care. The LCP was developed by Royal Liverpool University Hospital

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and Liverpool's Marie Curie Hospice in the late 1990s for the care of terminally ill cancer patients. Since then, the scope of the LCP has been extended to include all patients deemed dying. While initial reception was positive, it was heavily criticized in the media in 2009 and 2012.[18,19] In July 2013, the Department of Health released a statement which stated that the Health Secretary was likely to recommend that the LCP is phased out over the next 6 to 12 months.[20]

The opponents of euthanasia also raise the issue of a possible cure being found over a period of time for illnesses or medical conditions that are considered incurable today. By terminating the life of a person diagnosed with what is deemed an 'incurable' condition, one may deprive that individual's chances of being cured by a new remedy that may be developed within the next few months or years. A disturbing feature that has come to light in those countries where PAS has been accorded legal sanction is the impatience (and sometimes greed) of the relatives of a dying patient who happens to be affluent, in pressing ahead with 'euthanasia' for their own selfish ends. In such cases the patient's 'right to die' is subtly converted to a 'duty to die', pressure being brought on the hapless victim to accede to the infliction of 'painless death'.[21]

RECENT DEVELOPMENTS

Organizations Advocating Legalization of Euthanasia

There are several nongovernmental organizations that have sprung up over a period of time around the world which advocate the legalization of euthanasia. The following are some of the more prominent organizations.

i. **Exit International:** It is an international registered nonprofit organization advocating legalization of euthanasia with offices in Sydney, Adelaide and Queensland. The average age of Exit members is 75 years. It was previously known as the Voluntary Euthanasia Research Foundation (VERF Inc.).[22] Exit International was founded by Dr Philip Nitschke (Fig. 3.4), a 'right to die' activist from Australia in 1997, after the over-turning of the world's first Voluntary Euthanasia law—the Rights of the Terminally Ill (ROTI) Act. During the ROTI Act, Dr Nitschke became the first physician in the world to administer a legal, lethal, voluntary injection. Recently, South Australian Board of the Medical Board of Australia has recommended suspending his medical license.

ii. **Dignitas:** This is a Swiss organization that helps those with terminal illness and severe physical and mental illnesses to die assisted by qualified doctors and nurses.[23] Additionally, they provide assisted suicide for people, provided that they are of sound judgment and submit to an in-depth medical report prepared by a psychiatrist that establishes the patient's condition, as required by Swiss courts.

Dignitas was founded in 1998 by Ludwig A Minelli, a Swiss lawyer (Fig. 3.5). Swiss laws provide that assistance to suicide is only illegal if it is motivated by self-interest. As a result, Dignitas seeks to ensure that it acts as a neutral party by proving that aside from nonrecurring fees, they have nothing to gain from the deaths of its clients. The person who wishes to die meets several Dignitas personnel, in addition to an independent doctor, for a private consultation. The independent doctor assesses the evidence provided by the patient

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Fig. 3.4 Dr Philip Nitschke



Fig. 3.5 Ludwig A Minelli

and is met on two separate occasions, with a time gap between each of the consultations. Legally admissible proof that the person wishes to die is also created, i.e. a signed affidavit and countersigned by independent witnesses. In cases where a person is physically unable to sign a document, a short video film of the person is made in which they are asked to confirm their identity, that they wish to die and that their decision is made of their own free will, without any form of coercion. This evidence of informed consent remains private and is preserved only for use in any possible legal dispute. Finally, a few minutes before the lethal overdose is provided, the person is once again reminded that taking the overdose will surely kill them. Additionally, they are asked several times whether they want to proceed, or take some time to consider the matter further. This gives the person the opportunity to stop the process. However, if at this point the person states that they are determined to proceed, a lethal overdose is provided.

In general, Dignitas uses the following protocol to assist suicides: an oral dose of an antiemetic drug, followed approximately 1 hour later by a lethal overdose of powdered pentobarbital dissolved in a glass of water or fruit juice. If necessary, the drugs can be ingested via a drinking straw. The pentobarbital overdose depresses the central nervous system, causing the person to become drowsy and fall asleep within 5 minutes of drinking it. Anesthesia progresses to coma as the person's breathing become shallower, followed by respiratory arrest and death which occurs within 30 minutes of ingesting the pentobarbital. In a few cases in 2008, Dignitas used breathing helium gas as a suicide method instead of a pentobarbital overdose. This avoids the need for medical supervision and prescription controlled drugs, and is therefore cheaper.

Even though Dignitas is mainly meant for Swiss individuals, it is open to others from around the world to use its services. This has led to a controversial influx of tourists from other countries such as the UK, resulting in what is referred to by some as '*suicide tourism*'.[24]

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Euthanasia Devices

A *euthanasia device* is a machine designed and constructed to allow an individual to die quickly without pain. Early devices to help terminally ill people die without prolonged pain actually consisted of methods of administering lethal doses of drugs, such as barbiturates. These could be operated by the person wishing to die, or by another person, such as a physician. Subsequently, the method of inert gas asphyxiation using nitrogen or some other irrespirable gas via a mask became popular. It was only with the intervention of 'right to die' campaigners such as Dr Jack Kevorkian (Box 3.2)[25] that specialized devices began to be designed and constructed.

i. **Thanatron (Death Machine):** This device (Fig. 3.6) invented by Dr Jack Kevorkian, involved an individual pushing a button that released drugs or chemicals that would end his or her own life.[26] The drugs/chemicals would be delivered mechanically through an intravenous (IV) line. The device (named '*Thanatron*' by Kevorkian after the Greek God of death) had three canisters or bottles mounted on a metal frame, about 6 inches (150 mm) wide by 18 inches (460 mm) high. Each bottle had a syringe that connected to a single IV line in the person's arm. The first bottle contained normal saline, the second, a barbiturate (usually sodium thiopental), and the third a lethal mixture of potassium chloride which immediately stopped the heart, and pancuronium bromide, a muscle relaxant to prevent spasms during the dying process. In the limited number of cases that it was used, the usual procedure was for Kevorkian or an assistant to begin the saline solution flow, while the person who wants to die would have to deliver the barbiturates himself or herself by throwing a switch, pushing a button or pulling a string. After that, either a timer or a mechanical device triggered by the person's falling arm as the drugs take effect starts the lethal drug flowing. The idea is for the deadly chemicals to enter the bloodstream only after the person is asleep. Death usually occurred within 2–3 minutes.



Fig. 3.6 Thanatron

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ii. **Mercitron (Mercy Machine):** When Kevorkian found it difficult to continue using Thanatron, mainly because of relative inaccessibility to the drugs/chemicals required, he came up with another device that employed a gas mask fed by a canister of carbon monoxide which he called '*Mercitron*' (Fig. 3.7). This became necessary because Kevorkian's medical license had



Fig. 3.7 Mercitron

Box 3.2 Jack Kevorkian

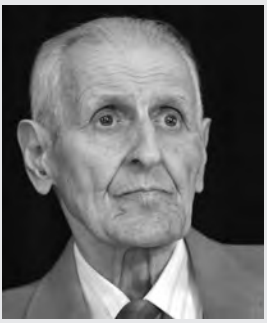

Fig. 3.8 Dr Jack Kevorkian

Jack Kevorkian (Fig. 3.8) was born in Pontiac, Michigan, US to Armenian immigrants. In 1945, he graduated from Pontiac Central High School with honors at the age of 17. In 1952, he graduated from the University of Michigan Medical School. He completed residency training in anatomical and clinical pathology and briefly conducted research on blood transfusion. Unable to function effectively as a hospital pathologist, Kevorkian left the active practice of medicine and for a time was even homeless.

As a pathologist at Pontiac General Hospital, Kevorkian experimented with transfusing blood from the recently deceased into live patients. He drew blood from dead bodies recently brought into the hospital and transferred it successfully into the bodies of hospital staff members. Kevorkian thought that the US military might be interested in using this technique to help wounded soldiers during a battle, but the Pentagon was not interested.

In the 1980s, Kevorkian wrote a series of articles for the German journal, Medicine and Law that laid out his thinking on the ethics of euthanasia. In 1987, Kevorkian started advertising in Detroit newspapers as a physician consultant for 'death counseling'. His first public assisted suicide of Janet Adkins, a 54-year-old woman diagnosed with Alzheimer's disease took place in 1990. Charges of murder were dropped on 13th December 1990, as there were, at that time, no laws in Michigan regarding assisted suicide. In 1991, however, the State of Michigan revoked Kevorkian's medical license and made it clear that given his actions, he was no longer permitted to practice medicine or to work with patients.

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According to his lawyer Geoffrey Fieger, Kevorkian assisted in the deaths of 130 terminally ill people between 1990 and 1998. In each of these cases, the individuals themselves allegedly took the final action which resulted in their own deaths. Kevorkian allegedly assisted only by attaching the individual to a euthanasia device '*Thanatron*' that he had devised and constructed. The individual then pushed a button which released the drugs or chemicals that would end his or her own life.

In Kevorkian's view, a patient did not have to be terminally ill to be assisted in committing suicide, but did need to be suffering. However, he has said that he declined four out of every five assisted suicide requests, on the grounds that the patient needed more treatment or medical records had to be checked. Kevorkian was tried 4 times for assisting suicides between May 1994 to June 1997. With the assistance of Fieger, he was acquitted 3 times. The 4th trial ended in a mistrial. The trials helped Kevorkian gain public support for his cause. On 22nd November 1998, Kevorkian allowed the airing of a videotape he made on 17th September 1998 which was broadcast on CBS News '60 Minutes'. It depicted the voluntary euthanasia of Thomas Youk, 52, who was in the final stages of amyotrophic lateral sclerosis. After Youk provided his full informed consent, Kevorkian himself administered him a lethal injection. This was highly significant, as all his earlier clients had reportedly completed the process themselves. During the videotape, Kevorkian dared the authorities to try to convict him or stop him from carrying out mercy killings. Youk's family described the lethal injection as humane, not murder.

On 26th March 1999, Kevorkian was charged with second-degree murder and the delivery of a controlled substance. Since Kevorkian's license to practice medicine had been revoked 8 years back, he was not legally allowed to possess the controlled substance. Kevorkian discharged his attorneys and proceeded through the trial representing himself, a decision he later regretted. Inexperienced in law but persisting in his efforts to represent himself, he encountered great difficulty in presenting his evidence and arguments. He was not able to call any witnesses to the stand as the Judge did not deem the testimony of any of his witnesses relevant. After a 2-day trial, the Jury found Kevorkian guilty of second-degree homicide. He was sentenced to 10–25 years in prison and was sent to a prison in Coldwater, Michigan. After his conviction, Kevorkian was denied parole repeatedly until 2007. Reportedly terminally ill with Hepatitis C which he contracted while doing research on blood transfusions, Kevorkian was expected to die within a year in May 2006. After applying for a pardon, he was finally paroled for good behavior on 1st June 2007. He had spent 8 years and 2½ months in prison.

Kevorkian gave a number of lectures upon his release at universities such as the University of Florida, Nova Southeastern University and the University of California and Los Angeles. 'You Don't Know Jack', a film based on Kevorkian's life, premiered in April 2010 on HBO, and at the Ziegfeld Theater in New York City. Kevorkian walked the red carpet alongside Al Pacino, who portrayed him in the film. Pacino received Emmy and Golden Globe awards for his portrayal and personally thanked Kevorkian, who was in the audience, upon receiving both of these awards. Kevorkian stated that both the film and Pacino's performance 'brought tears to my eyes—and I lived through it'.

Kevorkian was hospitalized on 18th May 2011 with kidney problems and pneumonia. His condition grew rapidly worse and he died from thrombosis on 3rd June 2011, eight days after his 83rd birthday at William Beaumont Hospital in Royal Oak, Michigan. There were no artificial attempts to keep him alive and his death was painless. He was buried in White Chapel Memorial Park Cemetery in Troy, Michigan. The epitaph on Kevorkian's tombstone reads, 'He sacrificed himself for everyone's rights'.

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been revoked after the first two deaths he had assisted and he could no longer have legal access to the substances required for the '*Thanatron*'. It was a rudimentary device consisting of a canister of carbon monoxide attached to a face mask with a tube. A valve had to be released to start the gas flowing. Depending on the person's disability, a makeshift handle was attached to the valve to make it easier to turn. In a few cases, with the valve in the 'open' position, a clip or clothespin would be clamped on the tubing. Pulling it off would allow the gas to flow. By Kevorkian's estimates, this method took 10 minutes or longer. Sometimes, he encouraged people to take sedatives or muscle relaxants to keep them calm as they breathed deeply of the gas.

iii. **Suicide Bag:** The basic principle of autoeuthanasia by anoxia, using a '*Suicide Bag*' was first described in a book Final Exit by Derek Humphry (Fig. 3.9) in 1991.[27] The original bag was devised using helium, by the NuTech group—engineers, physicians, divers and others, a small number of people first assembled in 1998 under the leadership of three 'right to die' activists—John Hofsess, Philip Nitschke and Derek Humphry. Inhalation of an enclosed inert gas is lethal because it flushes oxygen from the body, but released into the open air, it quickly disperses and hence is safe for others. It is neither flammable nor explosive. Exclusive inhalation of the gas is achieved in Humphry's book by enclosing the head in the suicide bag (nothing but a strong, clear plastic bag of dimensions 36 × 22 inches, secured around the neck by a strap) into which the inert gas is fed by plastic tubing. Later, a product available from the Canadian Right to Die Society called the 'Exit Bag' which has a sewn-in Velcro collar and fastened-in, flexible plastic tubing was substituted in place of the conventional 'suicide bag' (Figs 3.10A and B).[28]

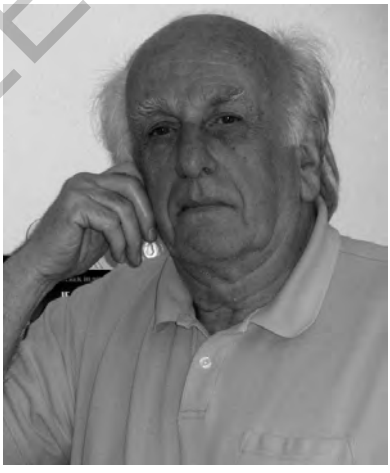

Fig. 3.9 Derek Humphry

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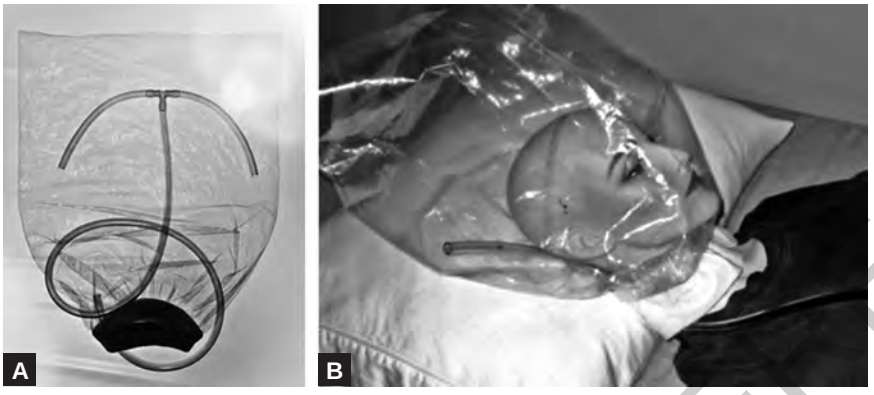

Figs 3.10A and B (A) Exit bag; (B) Exit bag *in situ*

iv. **Deliverance Machine:** This was invented by Dr Philip Nitschke. It consisted of a notebook computer and software titled '*Deliverance*' which would ask the patient a series of questions and automatically administers a lethal injection of barbiturates, if the correct answers are made.[29] Even if it would have been legally possible for a doctor to administer a lethal injection, Dr Nitschke preferred that the patient initiate the process. The machine also allowed a doctor to leave the patient with the family when the button was pushed. The machine was used legally under the Australian Northern Territory's Rights of the Terminally Ill (ROTI) Act 1995, which was later overturned.

v. **Exit International's Euthanasia Device:** The Exit International euthanasia device was invented by Dr Philip Nitschke in 2008. It used an ordinary barbecue gas bottle filled with nitrogen, a plastic suicide bag and some plastic tubing with one end attached to the gas canister and the other fixed inside the bag by a tie held by adhesive tape. In December 2008, Nitschke released details of the euthanasia device to the media. His new device/method was a modification of the 'Exit Bag plus helium' method described in *The Peaceful Pill Handbook*.[30] Instead of using a pre-packaged disposable cylinder of helium, he suggested filling purchased empty LPG cylinders (rated at 3300 kPa) with compressed nitrogen and then regulating this with a jet assembly to give a flow of around 10 liters per minute into the standard plastic 'Exit Bag'. Nitschke called it 'flawless' and 'undetectable', saying the new process uses ordinary household products available from hardware stores. Inhaling the pure nitrogen, patients lose consciousness immediately (in about 12 seconds) and die a few minutes later.

GLOBAL SCENARIO

Some countries have virtually legalized active euthanasia if performed by a physician under strict guidelines *(physician-assisted suicide)*, for e.g., the Netherlands (Holland), Belgium and Luxembourg (Fig. 3.11).[31]

The Netherlands practices physician-assisted suicide (PAS) openly ever since the Royal Dutch Medical Association officially endorsed it in 1984 and the

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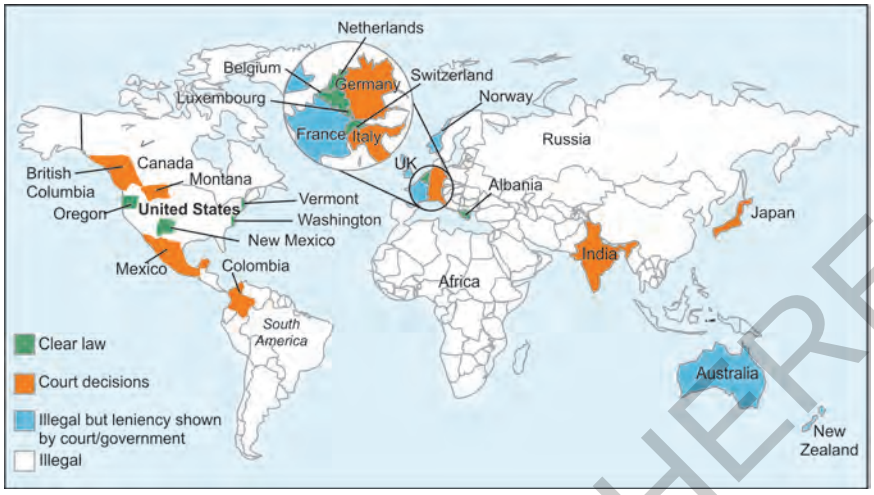

Fig. 3.11 Global status of euthanasia

Parliament approved the practice, provided it was done within a framework of specified guidelines. PAS is legal under specific circumstances and for children over the age of 12 years with parental consent (infants too can be euthanized, and that doctors will not be prosecuted if they act within the guidelines). It also allows doctors to euthanize dementia patients, if they believe the person is experiencing 'unbearable suffering,' although few cases are done practically.[32,33]

In Belgium, PAS is legal for people over the age of 18 years. About 80% of the cases involve terminally ill cancer patients and paraplegic or quadriplegic accident victims. In order to qualify for euthanasia, a patient must suffer from an incurable (not necessarily terminal) condition and experience unbearable physical or psychological pain. In the recent past, several cases of Belgians who were not terminally ill were euthanized—including 43-year-old deaf twins who were going blind, and a patient with childhood abuse and a failed sex-change operation. The government is further considering extending it to seriously ill children and adults with early dementia. Presently, people now can make a written declaration that they wish to be euthanized if their health deteriorates, but the request is only valid for 5 years and they must be in an irreversible coma. The new proposal would abolish the time limit and the requirement the patient be in a coma, whereby someone who is diagnosed with Alzheimer's can be put to death years later in the future.[34]

Elsewhere in Europe, euthanasia is only legal in Luxembourg. Assisted suicide is also allowed in Switzerland. In Mexico, laws allow the terminally ill to refuse further treatment and medication to extend life. France and Canada are also contemplating to legalize PAS for those suffering from an incurable or terminal illness.[32-34]

Some parts of the world have enacted legal statutes, for e.g., The Death with Dignity Act (1994) of the State of Oregon, US, and The Northern Territory of Australia which was however overturned by the Australian Senate in 1997. The state of Oregon accepts assisted suicide requests for residents aged 18 or

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over with a terminal illness. Initiative 1000 (I-1000) of 2008 established the US state of Washington's Death with Dignity Act which legalizes PAS with certain restrictions. Passage of this initiative made Washington the second US state to permit terminally ill patients to determine the time of their own death. In Montana, a physician can raise a defense of consent if charged with assisting suicide through a trial court ruling on 6th December 2009 in the case of *Baxter vs. Montana*.[35] The Attorney General of the state of Montana sought an appeal from the Montana Supreme Court, but the court, by a decision of five to two affirmed the lower court's ruling on the state law. The court did, however, limit the scope of the decision by not determining if the state's constitution protected the right. In May 2013, the Vermont Legislature passed the Patient Choice and Control at End of Life Act. The Governor signed it into law.[36] The law is based on, but is less restrictive than the Oregon model. In the rest of the US, actions that give the appearance of deliberate euthanasia rather than pain control will lead to criminal prosecution as a homicide, as well as loss of medical license. Some states have outlawed PAS specifically, whereas in others it would be pursued under negligent homicide or a variety of criminal charges.

CURRENT LEGAL STATUS IN INDIA

While euthanasia is not explicitly stated as a criminal offence in the Indian Penal Code (IPC), it is generally accepted that it is covered either under the offence of attempted suicide (Sec. 309 IPC), or abetment of suicide (Sec. 306 IPC).[1,37]

However, judicial opinion acknowledges that euthanasia is a 'gray area' in Indian criminal law. This unsettled status has been brought into stark focus in several past cases, for e.g., *P. Rathinam vs. Union of India* (1994), and *Smt. Gian Kaur vs. State of Punjab* (1996).[38,39] As per the Supreme Court's view, passive voluntary euthanasia can be visualized as a fundamental right protected by Article 21 which assures the right to privacy. Since such right to privacy can be said to encompass the right of a patient to refuse lifesaving medical treatment. In other words, the right to 'personal liberty' as guaranteed by Article 21 of the constitution includes the freedom to die with dignity.

Passive euthanasia is now *legal* in India. On 7th March 2011, the Supreme Court of India legalized passive euthanasia by means of the withdrawal of life support to patients in a permanent vegetative state provided the High Court's permission is obtained in case of incompetent patient. For incompetent patients, the Supreme Court has mandated the High Court to provide sanction after seeking assistance from a committee of three medical experts and consult the close relations or the next friend of the patient and the State. Hence, the role of a High Court is described as that of '*parens patriae*' (Latin, 'parent of the nation').[40] The decision was made as part of the verdict in a case involving Aruna Shanbaug (Box 3.3), who has been in a vegetative state for 37 years at King Edward Memorial Hospital, Mumbai.[41] The Court rejected active euthanasia by means of lethal injection. In the absence of a law regulating euthanasia in India, the court stated that its decision becomes the law of the land until the Indian Parliament enacts a suitable law. Active euthanasia (voluntary or otherwise) is unambiguously viewed as a crime under Sec. 302 (murder) or 304 (culpable homicide not amounting to murder) of the IPC, along with PAS under Sec. 306 IPC, though convictions have

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Box 3.3 Case of Aruna Shanbaug

Aruna Shanbaug (Fig. 3.12) from Haldipur, Uttara Kannada, Karnataka was working as a nurse at King Edward Memorial Hospital, Parel, Mumbai. She was planning to get married to a junior doctor in the hospital. On the night of 27th November 1973, she was sexually assaulted by a ward boy while she was changing clothes in the hospital basement. He choked her with a dog chain and sodomized her. The asphyxiation cut off oxygen supply to her brain, resulting in brainstem contusion injury and cervical cord injury apart from leaving her cortically blind. The police case was registered as a case of robbery and attempted murder on account of the concealment of anal intercourse by the doctors under the instructions of the Dean of KEM, perhaps to avoid the social rejection of the victim and her impending marriage. The perpetrator was caught and convicted and served two concurrent 7-year sentences for assault and robbery, neither for rape or sexual molestation, nor for the 'unnatural sexual offence' (which could have got him a 10-year sentence by itself).



Fig. 3.12 Aruna Shanbaug

Since the assault, she has been in a vegetative state. On 17th December 2010, the Supreme Court of India (SC) while admitting the plea to end the life made by journalist Pinki Virani, sought a report on her medical condition from the hospital in Mumbai and the Government of Maharashtra. On 24th January 2011, after she had been in this status for 37 years, the SC responded to the plea for euthanasia filed by Pinki Virani, by setting up a medical panel to examine her. The three-member medical committee subsequently checked upon Aruna and concluded that she met 'most of the criteria of being in a permanent vegetative state'. On 7th March 2011, the SC in its landmark judgment turned down the mercy killing petition, but allowed passive euthanasia under 'exceptional circumstances' and laid down guidelines for it. According to these guidelines, passive euthanasia involves the withdrawing of treatment or food that would allow the patient to live.

not been brought so far against any individual in India for the commission of such an 'offence'.[1]

The Law Commission made recommendation to the government for a 'separate legislation' to deal with withdrawal of life support to those terminally ill and had the right to refuse treatment. The Commission prepared a draft '*Medical Treatment of Terminally-ill Patients (Protection of Patients and Medical Practitioners) Bill, 2006*' for the government's consideration which has not yet been passed. The Commission is of the view that 'competent' adult patient who can take an informed decision, has the right to insist that there should be no invasive medical treatment by way of artificial life sustaining measures. If a patient communicates his/her decision to the doctor concerned, it would be binding on the doctor. But the doctor has to be satisfied that the patient has taken an informed decision based upon his/her free will. However, if the patient is not in a position to take healthcare decisions due to an irreversible coma or is in a persistent vegetative state, the doctors or relatives should get the clearance from the High Court for withdrawing or withholding the life sustaining treatment. The Commission's proposals also include protection from prosecution for both patient's relatives and their doctors. The Commission said those below 16 years

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of age are 'incompetent' to take a decision without the permission of an adult next of kin. It suggested provisions for protection of medical practitioners and others who act according to the wishes of the competent patient or the order of the High Court from criminal or civil action. The recommendation is part of the Commission's latest report in which it changed some of the provisions of a draft bill that dealt with this issue.[1,42]

Recently, however, the government dropped plans for the implementation of the Bill because it is not in favor of 'mercy killings'. The government is of the opinion that effective pain management and treatment of patients with cancer and other terminal illnesses is now possible and so is rehabilitation of patients with spinal injuries, hence withdrawal of life support is not required. Suffering is a state of mind that varied from person to person and depended on various environmental and social factors, and therefore it is difficult to quantify. Moreover, it would be impossible for doctors to certify with certainty that the disease was incurable and the patient would remain permanently an invalid.[43]

RECOMMENDATIONS

The following is a list of current trends and some important recommendations:

i. Euthanasia must be considered as a separate and distinct entity, and must never be confused with suicide. The right terminology may be 'end-of-life decisions' and not euthanasia. Terms such as 'physician-assisted suicide' which can be misleading must be substituted with more acceptable terminology, for e.g., physician-assisted euthanasia. In the debate revolving around euthanasia, religion and moral tenets must not be allowed to take center stage. The issue must be debated purely on ethical, psychological and scientific lines.
ii. Euthanasia must, as far as possible, be discussed from the actual sufferer's point of view taking into consideration today's emphasis on patient's rights as being superior to physician's rights or society's beliefs. The person should have the right to die with dignity and to die without suffering, just as people have the right to live with dignity.
iii. The time honored conviction of the importance of preserving life at all costs must make way for the emerging view that 'quality of life' is an issue that must be incorporated in all cases where the life of a person is prolonged indefinitely by artificial means.
iv. To force a patient to be kept alive in a vegetative state when medical opinion is certain that there is no chance of recovery, is cruel both on the patient and on his/her family and friends. The law must, therefore, clearly allow for euthanasia—both active and passive—in such situations. There must, however, be very strict safeguards to ensure that the provision is not misused by people, who may benefit from the death of the patient.

CONCLUSION

Death must be viewed as the inevitable consequence of life and hence there is no point in prolonging it using artificial life-support systems. A competent adult patient should have the right to voice his/her decision for withdrawing of artificial

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life-sustaining measures/treatment and such decision should be 'informed decision' based on free exercise of his/her will.

Although, the Supreme Court has legalized passive euthanasia—withdrawing or withholding life support in the context of incurable illness, the government is not in favor of legalizing any form of euthanasia, assisted suicide or hastening of death through withdrawal of treatment or life support.

While the debate on euthanasia is bound to rage for some more time, and there will always be proponents and opponents, it is desirable for physicians to understand current concepts and rectify certain well entrenched misconceptions. This is especially true for a country such as India which is composed of diverse religions, communities, traditions, customs and beliefs. It is high time that India legalizes PAS and be a part of the handful of nations that allows euthanasia on grounds of compassion and maintaining the dignity of the individual.

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