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1. INTRODUCTION:

Euthanasia is defined as ***"a deliberate action conducted with the express goal of ending a life, to relieve persistent suffering."***[1] Whereas Assisted Suicide refers to the procedure when a physician offers a potentially fatal drug to a terminally ill patient at their request that can be taken at their preferred time. The terms ***"physician-aided suicide" and "physician-administered euthanasia"*** refer to the two types of assisted suicide. To commit physician-assisted suicide, a doctor prescribes a lethal dose of medication, which is subsequently taken by the patient. In physician-administered euthanasia, the doctor would give the patient a deadly dose of medication through a method like injection. In this context, only medical doctors are taken into account; no other professionals, including therapists, social workers, or even members of the patient's immediate family or circle of friends, are included. Perhaps the most well acknowledged justification for the desire for assisted suicide is the dread that folks have of a protracted and painful death, either their own or a loved one's death. It's something that advocates and opponents of assisted suicide can agree on: dying without suffering is essential. No one should have to die in suffering, and it should not happen with developments in palliative care.

One could argue that a doctor's primary duty is to alleviate pain and suffering whenever possible. As an apparent manifestation of distress, the avoidance of physical pain may explain why assisted dying would be both essential and appropriate for a doctor to offer it. The 'Double Effect Doctrine' in common law, a new school of thought, offers an answer to this issue.[2] It was ruled in this case that ***"a doctor is entitled to do anything correct and necessary to alleviate pain, even if life can be incidentally shortened by the steps he takes."*** This means that a treatment option for people with chronic pain is available.[3] As a matter of public opinion and public policy, the subject of whether and under what conditions terminally ill individuals should be able to receive life-ending medications with the assistance of a physician is garnering

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

significant attention. Medical professionals, patients, and their loved ones debate whether or not physician-assisted suicide should be legalised. Despite the fact that public opinion is divided and public policy issues include religious, ethical, and political concerns, there are some patients who want physician-assisted suicide, and the inconsistent legal landscape leaves a number of questions and difficulties for health care providers to address when dealing with patients who are contemplating or requesting physician-assisted suicide. Patients are unable to receive life-saving treatments and care because they are unable to bear the costs associated with them. Because of this, it is generally agreed that it is in the patient's best interest and consistent with the duty of care to safeguard that interest to withdraw life-sustaining treatment when it is determined that such treatment provides no benefit or creates an undue burden.

Another challenge for assisted dying would be determining whether or not patients seeking death were legally competent to make the decision. It is known that suicides are frequently the result of mental and psychological trauma or undiagnosed depression arising from overwhelming pain. If we accept the premise that assisted suicide is acceptable for relieving pain, loneliness, depression, or mental illness, we are effectively sanctioning its use to treat all forms of suffering. It might be difficult to make sense of the typical treatments for both terminal illness and mental depression. Indeed, there is evidence that between 25 % and 77 % of patients with terminal illness suffer from major depressive disorders. Prior to undergoing any assisted suicide procedure, a terminally ill patient must be determined to be in a ***"fit mental condition."*** Physician-assisted suicide has been openly practised in the Netherlands for more than 25 years and formally legalised since 2002.

Later a more restricted form of physician-assisted suicide was legalised in Oregon in 1997 and is subject of an annual report. The cultural, and socio-economic histories underlying the diverse perspectives on assisted suicide held by various segments of society have received inadequate consideration. There have been many debates over the right to die issue in India, where euthanasia is banned, and suicide is a crime resulting in imprisonment. Physician-assisted suicide is a controversial subject that has recently caught the focus of media, public, lawmakers, and the medical community. Although active euthanasia and Physician-assisted suicide are

banned in most parts of the world, except in Switzerland and the Netherlands. There is mounting pressure to legalise, which could have far-reaching consequences. As we live in cultural and religious affluent society, it is crucial to recognise the effects of these elements in the decision-making processes, especially in the domain of physician-assisted suicide.

CHAPTER 2: THE SANCTITY OF LIFE AN ETHICAL DILEMMA:

On the other hand, in the contemporary bioethical literature, it is typically assumed that the theory of the sanctity of life is roughly equivalent to the argument that every human life has the same level of inherently valuable characteristics. As a consequence of this, it is always inherently wrong to take the life of another human being, with the exception of situations in which it is justifiable to defend the lives of others. Because the dignity of human life is a universal truth, the sanctity of life and the extent to which it has to be preserved can never be a matter of domestic legal doctrine. This is because the dignity of human life is a universal constant. When science discusses the law, sanctity is not something that ought to be a surprise problem. This is a fact. It is possible that natural lawyers will argue at any moment that human reason will interfere with the progress of scientific inquiry in order to protect sanctity and religion.[4]

The non-religious organisations are supporters of the doctrine in spite of the religion ethics on the sanctity of life because they found a technique in it to gain fair dignity for all human existences. This is the main reason for their support of the theory. The interpretation of the meaning of life as both a positive and negative norm can be found in the natural law jurisprudence as well as in contemporary legal theory. The legal justification for the doctrine is no longer that all living beings contain an image of God and that each life possesses the value that God gives it. However, in order to make the law more stringent, the word sanctity has its own quality. The jurisprudence of this doctrine originates with natural law and that too with the Greek tradition. Greek theologians considered the divine importance to be equally present

[4] Smith S 'Evidence for the Practical Slippery Slope in the Debate on Physician-Assisted Suicide and Euthanasia' Medical Law Review 2004.

in all human lives, but Sophists added that the principle of power is right. The sanctity of life doctrine is probably the most significant moral obstacle to legalising assisted dying. Many critics of assisted dying, such as Keown ***(Senior Research Scholar, Rose F. Kennedy Professor of Christian Ethics) and Finnis (John Mitchell Finnis, is an Australian legal philosopher),*** argue that primarily because of the belief that life is intrinsically precious and thus should be preserved. The belief that life is inherently valuable can also be based on a religious view, but those who support this view insist that, regardless of religion, the intrinsic value of life is essential. One of the arguments put forward by those who oppose the legalisation of euthanasia is that the core principle of sanctity of life will be violated. The principle serves to protect everyone's right to life, including the most vulnerable members of our society, stating that life is precious and must not be destroyed or limited under any circumstances. If euthanasia were to be legalised, the question of whether this inviolable principle can be upheld to provide a safeguard for the vulnerable against involuntary euthanasia needs to be answered.

2.1 AUTONOMY:

Greek words autos, meaning ***"self," and nomos, meaning "the rule of law,"*** combine to form the concept of autonomy. When discussing a patient's medical treatment, ***"autonomy"*** is typically understood to mean allowing the patient to make his or her own decisions as long as the adult is mentally capable of doing so. Cardozo J claimed in ***Scloendorf vs. Society of New York Hospital*** in 1914: ***"Every human being of adult years and sound mind has a right to determine what shall be done with his own body."***[5] More recently, in England, Lord Scarman advocated individual autonomy in ***Sidaway vs. Board of Governors of the Bethlem Royal Hospital and Maudsley Hospital*** by arguing that ***"the autonomy of the individual patient is a fundamental principle of the law."***[6] The opinions on the autonomy of the philosophers Immanuel Kant and John Stuart Mill have made a tremendous contribution to the topic of assisted suicide. Kant argued for the need for free will to be governed by reasoned options.[7] Physicians and patients regularly discuss and negotiate care plans and priorities on a day-to-day basis. Equipped with their medical experience, doctors offer guidance and advice on

[5] Mary E. Schloendorff, v The Society of New York Hospital, (1914) 105 NE 92
[6] Sidaway v Board of Governers of the Bethlem Royal Hospital and Maudsley Hospital [1985] AC 871.
[7] Kant I, Paton HJ. The Moral Law. London: Hutchinson; 1948 p 12-20

options for treatment, including profit and risk standards. The patient's perspective is invaluable in group decision making because of the patient's expertise in the patient's own life, psychological health, and spiritual condition. In a doctor-patient relationship, both parties have the right to object to any unnecessary treatments or procedures that pose a risk to the patient's health or well-being. This partnership and relational decision-making model between doctors and patients feature mutual choice, with an emphasis on rational choice, along with respect, dialogue, and reasoned negotiation, and would be supported by a Kantian view of autonomy.[8]

The principle of respect for patient autonomy has taken a central role in health care in the last few decades. In fact, the autonomy and autonomy-informed decision-making of patients is now at the centre of most clinical codes of practise and even patient rights codes. It is now feared that some terminally ill patients may request assisted suicide out of fear of losing their autonomy or dignity. Respect for the patient's autonomy was found to be central in the doctors' decision-making when faced with end-of-life decisions that facilitated suicide. Physicians who disagreed with the request for an assisted suicide of a patient acknowledged that the principle of autonomy was necessary but cited other reasons such as moral and professional considerations. Though fundamental, the principle of patient autonomy is not absolute and must be weighed against other ethical responsibilities and principles. The specific prohibition on physician-assisted suicide has been a tenet of medical ethics since Hippocrates, and allowing doctors to aid in a patient's suicide would require them to violate the general duties of ***"first, do no harm"*** (non-maleficence) and to act in the patient's best interests (beneficence). Proponents of physician-assisted suicide have not offered strong enough arguments to change that.

2.2 HIPPOCRATIC OATH:

The physician, because of his or her special status, acts for the good of the patient. The nature of the physician's job requires moral conduct and accountability. The concepts of ethics have

[8] 9 Secker B. The appearance of Kant's deontology in contemporary Kantianism: Concepts of patient autonomy in bioethics. Journal of Medicine and Philosophy 1999; 24: 43–66

been a result of religions, philosophies, and cultures.[9] The oaths or pledges that we take or swear allegiance to act as guidelines to a moral dilemma. The doctrines in the oaths allow doctors, patients, and families to generate a treatment plan without any conflict.[10] Many physicians have considered the commitment of the Hippocratic Oath about the administration of harmful drugs as the prohibition of euthanasia.[11]

The original Oath included, among other things, the following words: "I will neither give a deadly drug to anybody who asked for it, nor will I suggest this effect."

When it comes to euthanasia and assisted suicide, the Hippocratic Oath dispute ignores the fact that there has been no restriction of physician-assisted suicide in modern Greek medicine at the time of Hippocrates. ***The Oath is not mandatory to be taken by physicians or medical students, but the rationale is that assisted dying is contradictory to the values of the profession and that doctors ought not to be involved in anything which does not save a life, their primary role being to help the ill or, at least, to do no harm.*** Where practicable, medical training and ethos are aimed at enhancing and prolonging successful human life, not promoting its death, even though this is obviously not absolute as the profession has gone against those Hippocratic norms, specifically in regard to the termination of pregnancy. However, Kure58 has put forward the other side of this claim, arguing that it is possible to deduce such a prohibition. In other words, the death of a patient brought about by a doctor may not be in line either with the Hippocratic Oath or even the Hippocratic tradition's spirit.

2.3 PHYSICIAN'S ETHICAL PARADOX:

Assisting patients in dying on their own terms and performing euthanasia on their own volition are both processes in which doctors play a role. Healthcare providers in most countries now face the ethical, legal, and practical challenges of assisting or hastening a suicide. Over time, different claims have been made for and against assisted dying, but the popular desire for euthanasia and assisted suicide to be authorized has never been greater. Despite the undeniable fact that the role of the healthcare provider has evolved over time, the obligation to provide

[9] The British Medical Journal, "Hippocratic Oath.", vol. 2, no. 4580, 1948, pp. 725–725. JSTOR, www.jstor.org/stable/25365228

[10] Bruce Alan Bob, Do no harm (B.A. Bob) (2000) p. 153

[11] Halperin EC. Physician awareness of the contents of the Hippocratic Oath. Journal of Medical Humanities 1989; 10(2): p. 107-114.

adequate care remains unchanged. Consequently, the challenges for healthcare practitioners who have competent individuals wanting assisted Suicide reach well beyond working within the laws of a country as they go to the very core of the practitioner-patient relationship. Laws permitting or prohibiting assisted suicide are present in the majority of countries, but the ethical issues surrounding them are far from settled. For others, questions about the legitimacy and reliability of the consent of a patient to seek assistance to die, the potential for systematic exploitation of the most vulnerable people in society, and disagreement regarding the need for assisted suicide in light of other alternatives such as palliative or hospice care increase opposition to both the definition and practises of assisted suicide among some healthcare professionals.[12] However, there are those who argue that helping someone commit suicide is morally acceptable because adults should be allowed to make that choice for themselves.[13]

Some believe that doctors are qualified not to take it but to save a life; their objective must be to give therapy rather than death. However, other physicians and researchers have argued forcefully at the exact same time that the responsibility of the physician and other medical practitioners should extend to helping an eligible patient die when the life of that person has become intolerable for them. They also stressed the absolute necessity of this help being a very last resort.[14]

CHAPTER 3: ANALYSIS OF THE LAW OF ASSISTED SUICIDE IN OTHER JURISDICTION:

In western societies, life expectancy is high and non-communicable conditions such as cardiovascular diseases, and cancer are the leading causes of death. Patients with these diseases often deteriorate slowly and painfully. Medical interventions may prolong their suffering or keep them alive until they have lost their autonomy. Under these conditions, some people wish

[12] Hendin H, Foley K Physician-assisted suicide in Oregon: a medical perspective. Mich Law Rev. 2008 Jun; 106(8):1613-40.
[13] Bartels L, Otlowski M A, right to die? Euthanasia and the law in Australia. J Law Med. 2010 Feb; 17(4):532-55.
[14] Randall F, Downie R, Assisted suicide and voluntary euthanasia: role contradictions for physicians. Clin Med (Lond). 2010 Aug; 10(4):323-5.

to hasten their death. When a patient explicitly asks a doctor to prescribe drugs that both know will end the patient's life, the result is an assisted suicide.[15] Four European countries and three states have legalised euthanasia and Physician-assisted suicide. ***The Netherlands, Belgium, Luxembourg; and the states of Oregon and Washington explicitly legalised assisted dying.*** *In contrast,* ***Switzerland and Montana decided that Physician-assisted suicide was legal under existing laws.***[16]

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

- ***In the Netherlands, Belgium, and Luxembourg, the decision to end life on request is based on the patient-doctor relationship.*** Patients must be suffering unbearably, with no prospect of improvement, to become eligible for euthanasia or physician-assisted suicide. The illness does not have to be terminal.
- ***In Switzerland, the relevant Article 115 dating from 1918. Although it was not intended to regulate Physician-assisted suicide, since the 1980s several right to die organisation have relied on it to justify their assistance efforts***.[17] The Federal Supreme Court of Switzerland emphasised the responsibility of the physician in this process. However, physicians are generally not present when the patient takes the lethal dose, and a physician-patient relationship is not required. ***In addition to terminally ill persons, patients with mental disorders and other severely disabling illness have recourse to assisted suicide. Euthanasia is forbidden.***
- ***The US states of Oregon, Washington, Montana allow assisted suicide but not euthanasia.*** In contrast to European countries, Dignity acts and court rulings from Oregon, Washington, and Montana state that patients must have a terminally physical illness.

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

Various countries around the world legalised the concept of Physician-Assisted suicide:

[15] 2 McCormick AJ. Self-determination, the right to die, and culture: a literature review, 2011;56:119- 128
[16] Steck, Nicole. "Euthanasia and Assisted Suicide in Selected European Countries and US States: Systematic Literature Review." Medical Care, vol. 51, no. 10, 2013, pp. 938–944.
[17] Bosshard G. Assisted suicide - medical, legal, and ethical aspects. Praxis (Bern 1994). 2012; 101:183-18

1. ***Netherlands became the first country to legalise euthanasia through the enactment of law*** regarding the practice of euthanasia and assisted suicide on 1 April 2002.
2. ***The U.S. state of Oregon legalized Physician-assisted suicide (PAS) in 1998 following The Death with Dignity Act 1994.*** A decision of the Supreme Court in 1997 confirmed that although there could be no constitutional right to assisted suicide, the legalization of assisted suicide would not be unconstitutional.[18] ***The Death with Dignity Act allows a physician to supply a prescription for lethal drugs under certain circumstances;*** these being upon the request of a competent adult who is suffering from a terminal illness from which they are expected to die within six months, and upon compliance with the certain conditions.
3. ***Washington was the first state to mimic Oregon.*** Washington State voters passed an initiative loosely modeled on Oregon's legislation in November 2008.[19] In early 2009, the Washington Death with Dignity Act became successful.
4. ***The Belgium Act on Euthanasia was passed on 28 May 2002*** and came into force on 23 September 2002. Article 3.1 of the Law on Euthanasia provides that a doctor who performs euthanasia does not commit a crime if he or she ensures that: 'The patient is in a medically hopeless situation of persistent and unbearable physical or mental suffering that cannot be alleviated, resulting from a serious and incurable disorder caused by illness or accident.'
5. ***Luxembourg Parliament adopted the law decriminalizing euthanasia on 19 February 2008.*** It permits euthanasia in certain circumstances. Euthanasia and physician-assisted Suicides are included in the Act.[20]
6. ***The continued practice of assisted suicide in Switzerland led communities to presume that, in the region, the practice was legalized.*** According to Swiss law,[21] if the person assisting a suicide successfully claims that he is acting unselfishly, he is free from prosecution in Switzerland. This results in de facto legalization, i.e., assisted suicide is not per se legal, only not punishable, if the unselfish motive is proven. Thus, in

[18] Washington et al. v Glucksberg 117 SCt 2258 (1997) and Vacco v Quill 117 SCt 2293 (1997).
[19] See Wash. State Dep't Of Health, Washington State 2016 Death with Dignity Act Report (Sept. 2017).
[20] 1 See, http://www.station.lu/edito-9306-details-of-new-law-on-euthanasia.html
[21] Article 115 of The Penal Code of Switzerland, 1937

Switzerland, euthanasia is illegal, and physician-assisted suicide is also not legalized, but it tolerates the practice based on the legal interpretation of the suicide law, 1918.[22]

7. ***Australia****:* The Northern Territory (NT) is a vast but sparsely populated area in Australia, occupying a sixth of the continent but with a population of Jess than 200,000. In 1995, its legislature by a small majority enacted, ***the Rights of the Terminally ILL Act. The Act permitted both PAS and VAE (Voluntary Assisted Euthanasia)***. The Act stated that it sought to confirm the right of a terminally ill person to request assistance from a medically qualified person to terminate his or her fife inhumane manner voluntarily; to allow for such assistance to be given in certain circumstances without legal impediment to the person rendering the assistance and to provide procedural protection against the possibility of abuse of the rights recognized by this Act'.
8. While ***euthanasia is clearly illegal in New Zealand***, as in many countries, the will and desire to prosecute and punish those who aid in the deaths of others for humanitarian reasons is quite weak.

CHAPTER 4: ASSISTED SUICIDE IN INDIA AND SAFEGUARDS TO PREVENT ABUSE OF LAW:

This chapter will discuss a hypothetical scenario in which assisted suicide is allowed in India, exploring how it is possible to protect the most vulnerable members of our community and uphold our basic rights and freedoms. In particular, the focus of this investigation will be on whether the legalization of assisted suicide by a physician or medical professional, will lead to situations leading to the practice of assisted suicide and encouraging it. The legal status of assisted suicide and euthanasia in India lies in the Indian Penal Code, which deals with the issues of euthanasia, both active and passive, and also assisted suicide. ***Pursuant to The Indian Penal Code of 1860, active euthanasia is a serious crime under section 302 (punishment for murder) or at least under section 304 (punishment for culpable homicide not amounting to murder)*** according to the Indian Penal Code of 1860. Definition of euthanasia is slightly

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

different in different countries; however, it is generally defined as ***"a deliberate intervention undertaken with the express intention of ending a life, to relieve intractable suffering."*** Assisted Suicide is the practice of providing the patient with a prescription for drugs for the patient to use for the primary intention of taking his or her own life; the patient, directly or through a machine, will have to self-administer the medication.[23] India is a healthy illustration of a variety of diverse cultures, traditions, and religions that have all retained their identities and blended with Indian historical ideologies and rituals as well. In the Indian context, disentangling faith and culture, customs and rituals, and values and attitudes is a Herculean task. At a professional and public level, a debate on assisted suicide will face a range of complexities, such as people's moral beliefs, how religion and culture will play in people's minds, whether the strength of religiosity will overwhelm religion, and so on. On this topic, India is not alone, and most countries have been trying to get decisions on this very subject.

In comparison to the general population in the UK, a survey of 3733 UK doctors on the legalization of medically assisted dying found that most doctors opposed the legalization of assisted suicide and that a deep religious conviction was directly related to opposition to assisted dying.[24] A survey conducted in Egypt found that it was the duty of physicians to determine if assisted suicide should be regarded for religiosity rather than real faith. More religious physicians believed that, regardless of whether they were Christians or Muslims, assisted suicide could not be considered because it would be against their set of beliefs.[25] ***In a February 2008 meeting on Ethics Committee on Euthanasia, the Medical Council of India held the following opinion: the practice of euthanasia constitutes unethical behaviour.*** However, on particular occasions, only the team of physicians and not just the treating physician alone can determine whether to remove supportive devices to preserve cardio-pulmonary function even after brain death. A team of doctors shall declare withdrawal of

[23] Webster's, Definition of physician assisted suicide. New World Medical Dictionary. 3rd ed. Wiley Publishing, Inc; 2008. [Last accessed on Apr 10 2020].
[24] Seale C. Legalization of euthanasia or physician-assisted suicide: Survey of doctors' attitudes. Palliat Med. 2009; 23:205–12.
[25] 7 Tadros G, Rakhawy MY, Khan F. Perception of physician-assisted suicide among Egyptian psychiatrists: Cultural perspective. The Psychiatrist. 2011; 35:15–8.

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. ***Suicide is not an offence in India as a starting point, but attempted Suicide is protected by section 309 of the IPC***.[26] In its study, the Indian Law Commission The 42nd Report recommended that this offence be repealed on the basis that it was harsh and unjustifiable to punish a person who had already found life so unbearable. The government approved the advice, and the bill was approved in 1978 by the Rajya Sabha and was pending in the Lok Sabha when it was disbanded in 1979, which resulted in the lapse of the bill.

It has already been noted that ***abetting (or assisting) suicide is an offence under section 306 of IPC***.[27] So too is ***abetting attempted suicide by virtue of section 309 read with 107 of IPC.*** In support of these offences, the Supreme Court of India has observed that: "The arguments which are advanced to support the plea for not punishing a person who attempts to commit suicide do not avail for the benefit of another person assisting in the commission of suicide or in its attempt. The abettor is viewed differently, inasmuch as he abets the extinguishment of life of another person, and punishment of abetment is considered necessary to prevent abuse of the absence of such a penal provision."[28] ***The difference between voluntary active euthanasia and assisting suicide is that the former, but not the latter, involves the accused performing an act, which directly causes the death of another.*** Apart from this, the similarities are that, for both activities, the accused intends for the other person to die, knowing that he or she consents to be killed. As far as cases of ***voluntary active euthanasia are concerned, some importance is granted to the consent of the deceased*** by making what could otherwise be the

[26] S. 309 reads: "Attempt to commit suicide – whoever attempts to commit suicide and does any act towards the commission of such offence, shall be punished with simple imprisonment for a term which may extend to one year or with fine, or with both."
[27] S. 107 reads: "A person abets the doing of a thing who — (a) instigates any person to do that thing; (b) engages with one or more other person or persons in any conspiracy for the doing of that thing, if an act or illegal omission takes place in pursuance of that conspiracy, and in order to the doing of that thing; or (c) intentionally aids, by any act or illegal omission, the doing of that thing."
[28] Gian Kaur v. State of Punjab, AIR 1996 SC 1257 at para 37-38.

crime of murder the lesser offence of culpable homicide that does not amount to murder. The relevant provision is ***exception 5 to section 300 of IPC*** which states that ***"culpable homicide is not murder when the person whose death is caused, being above the age of 18 years, suffers death or takes the risk of death with his own consent."***

There has also been a lengthy debate on the topic of attempted suicide in India, and it is regarded as a punishable act by IPC Section 309. Section 309 of the IPC has, as in the case of ***P Rathinam vs. India's Union***,[29] been questioned on a range of occasions in the courts of law in India, the Supreme Court has held that the freedom to live referred to in Article 21 may be said to give rise to the freedom not to live a forced life, Article 21 is therefore infringed by section 309. However, then this decision was consequently overruled in ***Gian Kaur vs. State of Punjab*** case by a Constitution Bench of the Supreme Court, held that Article 21 could not be interpreted to contain within it the 'right to die' as part of the fundamental right guaranteed therein, it was therefore stated that it could not be lawfully argued that section 309 was in violation of Article 21.

SAFEGUARDS TO DECRIMINALIZE ASSISTED SUICIDE:

Safeguards, criteria, and protocols were placed in place in jurisdictions to monitor the activities, ensure community monitoring, and avoid exploitation or misuse of euthanasia and Assisted Suicide. There are similar requirements and procedures across jurisdictions; others differ from country to country. The degree to which these controls and protections have been able to regulate the practices and prevent violence merits closer scrutiny, particularly by jurisdictions considering the legalization of assisted suicide. ***The components of a before-the-fact safeguards process might include some or all of the following:***

- *On the part of individuals and families, advance treatment preparation, either before the onset of a life-threatening illness or at the early stages.*
- *Obtaining second opinions at more advanced stages of illness, especially from clinicians highly qualified to prescribe medications (both curative and palliative) and predict results for the disease that the person has.*

[29] AIR 1994 SC 1844.

- *Family conferences in which the best information available is revealed, the best interests and desires of the individual are addressed, and any technical or facility guidelines are taken into account.*
- *Referral of the situation to a hospital review committee or ethics committee that is responsible for ensuring the creation, distribution and follow-up of appropriate protocols.*
- *Appointment of an impartial advocate to work on behalf of the client, to ensure that the person is as well informed as possible about various options and their possible effects, that he or she knows what his or her rights are, both to receive medical care and to determine what care he or she wants to receive and also that the wishes and decisions of the client are articulated.*
- *Referral of the case to a court or other specialist tribunal, in particular where the appeal is for active action to be taken in order to reduce the life of the person, or where a replacement decision-maker demands that life-sustaining care be withheld or removed and does not have an individual advance directive to do so. Such a hearing may not be appropriate if the person has the capacity to personally refuse care that is needed to preserve life, or has provided specific prior instructions to that effect.*

Written Consent:

The petition for euthanasia or PAS must be voluntary, well-considered, educated, and continuous overtime in all jurisdictions. Explicit written consent must be given by the

Mandatory Reporting:

In all jurisdictions, reporting is required, but this provision is sometimes overlooked.

Only By Physicians:

The presence of nurses is a cause for alarm because, with the exception of Switzerland, all jurisdictions mandate that actions be carried out only by doctors.

Second Opinion And Consultation:

Before continuing with euthanasia or pas, all jurisdictions except Switzerland require the consulting of a second doctor to ensure that all conditions have been fulfilled. The consultant

must be impartial ***(not related to the patient's treatment or to the provider of treatment)*** and must have an objective evaluation.

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

A POSSIBLE MODEL: OREGON DEATH WITH DIGNITY ACT:

A model that Indian legislators could seriously consider adopting is to be found in the State of Oregon on the west coast of the United States of America. By enacting the Oregon Death with Dignity Act in 1994[30], Oregon became the first state in that country to enact a law legalizing physician-assisted suicide.

The opening provision spells out the essential details: *"An adult who is capable is a resident of Oregon, and has been determined by the attending physician and consulting physician to be suffering from a terminal disease, and who has voluntarily expressed his or her wish to die, may make a written request for medication for the purpose of ending his or her life in a humane and dignified manner[31]."*

In order to clarify, for a person to be entitled to obtain prescription medication for use in physician-assisted suicide, he or she must be an Oregon resident, be 18 years of age or older, and have been diagnosed by his or her attending physician as suffering from an incurable and terminal illness that will cause death within six months, within the fair medical judgment. The patient must have made both an oral and a written request and repeated the oral request not less than 15 days after making the first oral request to the attending physician[32]. The Act demands that the patient's prescription for medication be in a prescribed form, signed and dated by the patient and witnessed by at least two persons who testify, in the presence of the patient, that the patient is willing, acting willingly and not being forced to sign the prescription to the best of their understanding and belief. In addition, at least one of the witnesses must not be

[30] Dr Timothy Quill "Death and Dignity: A Case of Individualized Decision" 324 N Engl J Med 691 (1991)
[31] Oregon Death with Dignity Act in 1994 127.805 s. 2.01
[32] J. Keown, Euthanasia, Ethics and Public Policy, Ch. 15 (Cambridge: Cambridge University Press, 2002)

connected to the patient or be entitled to benefit from the estate of the patient, or be the owner, provider or employee of the health facility in which the patient receives care or is a resident[33]. Detailed medical records of the procedure leading to the prescription must be maintained by the doctors involved, and these records are to be checked by the Human Services Department of Oregon.[34] The Act makes it a serious offence for a physician who intentionally changes or forges a request for a prescription without the patient's consent, or conceals or ruins a rescission of that request with the intention or purpose of causing the death of the patient. It is also a serious crime for a doctor to coerce or exert undue control on a patient to ask for a prescription in order to end the life of the patient or to kill a rescission of such a request.[35]

Two American researchers ***(R. Cohen-Almagor and M.G. Hartman)*** have introduced additional criteria that, if adopted, would greatly enhance the acceptable specifications of legislation in Oregon.[36] One is to prevent the doctor from recommending assisted suicide to the patient. Another is that, due to extreme pain, patients may have wanted to commit suicide; palliative care should be given to patients before receiving their requests for assisted suicide to prevent this. The researchers have suggested that a small committee of medical experts could review the petitions for physician-assisted suicide and select the consulting physician in order to prevent any collusion between the attending and consulting doctors. Another proposal was to require pharmacists to record all prescriptions for lethal drugs, thereby offering a further check on the documentation of the physicians.

CHAPTER 5: CONCLUSION:

Euthanasia and assisted suicide may seem like minor issues in a world where people's basic human rights are frequently ignored, illiteracy is widespread, more than half the population does not have access to drinking water, people die every day from diseases, and medical care is scarce. However, India is a multicultural country with many different religions, educational

[33] K.L. Tucker "Federalism in the context of assisted dying: Time for the laboratory to extend beyond Oregon to the Neighbouring State of California" 41 Willamette L Rev 863 (2005)
[34] International Task Force on Euthanasia and Assisted Suicide, "Seven Years of Assisted Suicide in Oregon" available at http://www.internationaltaskforce.org/orrpt7.html (accessed 16th Aug2020).
[35] 1 G. Tulloch, Euthanasia – Choice and Death 66 (Edinburgh: Edinburgh University Press, 2005).
[36] R. Cohen-Almagor and M.G. Hartman, "The Oregon Death with Dignity Act: Review and Proposals for Improvement" 27 J LEGIS 269 (2001) 293-298

levels, and ways of life. India's euthanasia debate is even more perplexing in this regard because of the country's law that criminalises suicide attempts. It seems like a phase of evolution has sculpted the legal landscape, both with regard to end of life law and assisted dying, to the degree that the law permits or overlooks what might be thought of as assisted dying. This article discussed the various forces that prompted legal reform regarding issues of terminal illness. This newfound ability to artificially prolong life raises ethical questions for doctors, who must decide whether or not to do so for every patient. Assisted suicide, but not active euthanasia, has strong arguments in its favour. Of course, there can be debate over whether or not there is a moral or ethical difference between the two, but there are still good reasons to do so. Also, it appears inevitable that, in order to appease proponents of legalisation, assisted suicide but not euthanasia will need to be made legal. Furthermore, a line needs to be drawn somewhere to separate justifiable action from unjustifiable action if assisted dying is to be legalised at all. Consequently, we can argue that the current judicial split between murder and assisted suicide provides a good foundation for such a line. It's true that it's possible no agreed-upon line could adequately separate the ***(morally)*** acceptable from the unacceptable. In contrast to the current legal position, this one would establish a consistent, compassionate, and rational stance that makes one's legal position crystal clear.

A number of factors, including those of the law, medicine, ethics, and context, have come together to create a legal situation that may typically produce the desired ***(or least bad)*** outcome, but which would rarely do so in a logical, coherent, or transparent manner. Although it is often in the best interest of the patient to ***"fudge"*** the truth a little bit in the medical sense, most patients will still want to be involved in making decisions about their care. In view of the socioeconomic trends, the growing demand to self-direct death seems likely to continue. Whether or not it shortens a person's life, end-of-life care and life-and-death decision making should be based on the person's wishes, not on what the doctor or the judge thinks the person deserves. The approach so advocated would enhance patient autonomy but not at the expense of legitimate competing concerns. The question of whether or not it is also suitable to legalise voluntary active euthanasia should be considered separately from the idea to decriminalised physician-assisted suicide. Legalizing physician-assisted suicide is a possible next step, but this

does not imply that it must be taken. Proponents of formal legal reform will have to be satisfied, at least temporarily, with the knowledge that some of their demands have been met. Those who oppose legal reform should acknowledge that the ban is mostly symbolic at this point and serves neither the values of sanctity nor the protection of the weak. Beginning in the first decade of the 21st century, India's economy grew at an unprecedented rate, allowing a larger percentage of the population to afford and access healthcare and other long-term services. As long as people are debating whether or not doctors should be allowed to aid in suicide or perform active euthanasia on their patients, this trend will continue to grow in popularity. The purpose of this paper is to spark conversation by arguing that India is ready to legalise physician-assisted suicide under certain conditions. The Supreme Court themselves planted the initial seed for the Gian Kaur case controversy. The patient's decision to end his or her own life is a significant distinction from voluntary active euthanasia, in which the doctor makes the decision for the patient. Finally, in understanding the tough position that doctors are asked to play, individuals who may be negatively influenced by their experience of aiding their patients commit suicide should be given a system of education, treatment and support.

Adding a new clause in the IPC recognising protection very similar to the model found in the Oregon Death with Dignity Act is the most effective legislative means of enacting this plan. The patient's need to suffer and the other amendments to the Act discussed in Section IV of this paper proposed by two American researchers should also be included in the protection clause ***(R. CohenAlmagor and M.G. Hartman)***. 202 The defence will raise the charges of aiding in the suicide or an attempt to commit suicide. Therefore, violence against non-medical suicide counsellors will persist. By refusing to meet one or more of the stringent protection standards, doctors who exploited their authority to promote their patients' suicides could potentially be accused of these crimes. In addition, a new crime against errant doctors, such as the one found in the Oregon Death with Dignity Act, may be added. Finally, in recognising the difficult role that doctors are called to play, a system of education, therapy, and support should be made available to those who may be negatively impacted by their experience of helping patients commit suicide. There is a great deal of room for behavioural and strategic changes that could improve end-of-life care. Many different people and institutions will be involved in

these changes, all of which will have some say in how patient care decisions are made and enforced. What patients and their loved ones understand, anticipate, and desire is crucial. Medical professionals play crucial roles for patients in the areas of assessment, conversation, guidance, treatment, negotiation, and advocacy. The ability of patients, families, and clinicians to come up with a treatment plan that serves the dying person well is influenced and sometimes hampered by the decisions of health plan managers, institutional leaders, and government officials.