EUTHANASIA-AN END TO TERMINAL SUFFERING: A MEDICO-LEGAL PERSPECTIVE

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Introduction

The essence of human life is to be able to live a dignified life; but if prevailing laws force us to live in intense pain and humiliation, they must be changed. Medical science and technology have made great advances in recent years. The medical profession today has more power over life and death than they would choose to have. They have power to prolong life where life seems to have lost its meaning and have power to terminate life without suffering. But none has got the right to prolong the life of one who is suffering, and has decided without any undue pressure that he would like to be put to rest. Obviously legalization of euthanasia should not include anyone aspiring to end his/her life at the flimsiest of excuses; but a patient should be allowed to choose when he has suffered enough, and the life has become one of unbearable pain and misery.

While arriving at the proper meaning and content of the right to life, the attempt of the court should always be to expand the reach and ambit of the fundamental right rather than to attenuate its meaning and content. A constitutional provision must be construed, not in a narrow and constricted sense, but in a wide and liberal manner so as to anticipate and take account of changing conditions and purposes so that the constitutional provision does not get atrophied or fossilized but remains flexible enough to meet the newly emerging problems and challenges. The fundamental right to life which is the most precious human right and which forms the ark of all other rights must therefore be interpreted in a broad and expansive spirit, so as to invest it with significance and vitality which may endure for years to come and enhance the dignity of the individual and the worth of the human person.[1]

The right to life enshrined in Article 21 of the Constitution of India, 1950 cannot be restricted to mere animal existence. It means something much more than just physical survival. Every limb or

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1 [527 C-D, 528 A-C] Weems v. U.S., 54 LAWYERS EDITION 801.

faculty through which life is enjoyed is thus protected by Article 21 and a fortiori; this would include the faculties of thinking and feeling.[2]

Every person is entitled to a quality of life consistent with his human personality. The right to live with human dignity is the fundamental right of every Indian citizen. Life is not mere living, but living in health. Health is not the absence of illness but a glowing vitality. The right to life including the right to live with human dignity would mean the existence of such a right up to the end of natural life. This also includes the right to a dignified life up to the point of death including a dignified procedure of death. In other words, this may include the right of a dying man to also die with dignity when his life is ebbing out.

An English writer, H. Romilly Fedden observed:

> "It seems a monstrous procedure to inflict further suffering on even a single individual who has already found life so unbearable, his chances of life so slender, that he has been willing to face pain and death in order to cease his living. That those for whom life is altogether bitter should be subjected to further bitterness and degradation seems perverse legislation."

In such circumstances where the state has perennially failed to discharge its obligation and we the people of India are unable to avail medical facilities. The parliament should think for legalizing euthanasia by coming up with proper measures that if a person, afflicted with terminal disease, should be given the right to refuse being put on life support system or to be administered with some medication to relieve him form intractable pain and suffering forever, after medical experts declare that he or she has reached a point of no return. In the present era, when the medical advancement has been able to control the conception and birth of child as per the ease of parents then why not trust be embodied in the same fraternity to do the best as per the patients wish at the end of life when it has lost its vitality.

Meaning of Euthanasia

The term "euthanasia" comes from two ancient Greek words: "eu" means "good", and "thantos" means "death"; so euthanasia means

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[2] Francis Coralie Mullin v. The Administrator, Union Territory of Delhi and Others, 1981 A.I.R. 746, 1981 S.C.R. (2) 516.

good death. It is an act or practice of ending the life of an individual suffering from a terminal illness or in an incurable condition by injection or by suspending extra ordinary medical treatment in order to free him of intolerable pain or from terminal illness. Euthanasia is defined as an intentional killing by an act or omission of person whose life is felt is not to be worth living. It is also known as "mercy killing" which is an act where the individual who, is in an irremediable condition or has no chances of survival as he is suffering from painful life, ends his life in a painless manner. It is a gentle, easy and painless death. It implies the procuring of an individual's death, so as to avoid or end pain or suffering, especially of individuals suffering from incurable diseases. Oxford dictionary defines it as the painless killing of a person who has an incurable disease or who is in an irreversible coma. Thus it can be said that euthanasia is the deliberate and intentional killing of a human being by a direct action, such as lethal injection, or by the failure to perform even the most basic medical care or by withdrawing life support system in order to release that human being from painful life. It is basically to bring about the death of a terminally ill patient or a disabled. It is resorted to so that the last days of a patient who has been suffering from such an illness which is terminal in nature or which has disabled him can peacefully end up his life and which can also prove to be less painful for him. Thus the basic intention behind euthanasia is to ensure a less painful death to a person who is in any case going to die after a long period of suffering. Euthanasia is practiced so that a person can live as well as die with dignity. In brief, it means putting a person to painless death in case of incurable diseases or when life become purpose less or hopeless as a result of mental or physical handicap.

Types of Euthanasia

As euthanasia is a complex matter there are many different types of euthanasia. Euthanasia may be classified according to consent into 3 types:

1. **Voluntary euthanasia**-when the person who is killed has requested to be killed.
2. **Non-voluntary euthanasia**-when the person who is killed made no request and gave no consent. In other words, it is done when the person is unable to communicate his wishes, being in coma.
3. **Involuntary euthanasia**-euthanasia conducted against the will of the patient is termed involuntary euthanasia.

There is a debate within the medical and bioethics literature on whether or not the non-voluntary or involuntary killing of persons can be regarded as euthanasia, irrespective of consent. Beauchamp, Davidson and Wreen are of the opinion that the consent on the part of the patient is not considered to be one of the criteria. But others opine that consent is essential. The European Association of Palliative Care (EPAC) Ethics Task Force, 2003 came forward with an unambiguous statement that medical killing of a person without the consent of the person, whether non-voluntary (where the person is unable to give consent) or involuntary (against the will of the person) is not euthanasia; it is murder. Hence, euthanasia can be voluntary only. Euthanasia can be also divided into 2 types according to means of death.

1. **Active euthanasia**-it is also known as "positive euthanasia" or "aggressive euthanasia". It refers to causing intentional death of a human being by direct intervention, viz., by giving lethal dose of a drug or by giving a lethal injection. Active euthanasia is usually a quicker means of causing death.
2. **Passive euthanasia**-it is also known as "negative euthanasia" or "non-aggressive euthanasia". It is intentionally causing death by not providing essential, necessary and ordinary care or food and water. It implies to discontinuing, withdrawing or removing artificial life support system. Passive euthanasia is usually slower and more uncomfortable than active. Most forms of voluntary, passive and some instance of non-voluntary, passive euthanasia are legal.

There is no euthanasia unless the death is intentionally caused by what was done or not done. Thus, some medical actions often leveled as passive euthanasia are no form of euthanasia, since intention to take life is lacking. These acts include not commencing treatment that would not provide a benefit to the patient, withdrawing treatment that has been shown to be ineffective, too. Active euthanasia is taking specific steps to cause the patient's death, such as injecting the patient with some lethal substance, e.g., sodium pentothal which causes a person deep sleep in a few seconds, and the person instantaneously and painlessly dies in this deep sleep.

An important idea behind this distinction is that in passive euthanasia the doctors are not actively killing anyone; they are simply not saving him. While we usually applaud someone who saves another person's life, we do not normally condemn someone for failing to do so.

Thus, proponents of euthanasia say that while we can debate whether active euthanasia should be legal, there can be no debate about passive euthanasia. You cannot prosecute someone for failing to save a life which has become burdensome or is unwanted, and the giving of high doses of pain-killers that may endanger life, when they have been shown to be necessary. All those are part of good medical practice, endorsed by law, when they are properly carried out. At the heart of this distinction lies a theoretical question. Why is it that a doctor who gives his patient a lethal injection which kills him commits an unlawful act and indeed is guilty of murder, whereas a doctor, who by discontinuing life support, allows his patient to die, may not act unlawfully and will not do so, if he commits no breach of duty to his patient? Professor Glanville Williams has suggested that the reason is that what the doctor does when he switches off a life support machine 'is in substance not an act but an omission to struggle', and that 'the omission is not a breach of duty by the doctor because he is not obliged to continue in a hopeless case'.[3]

Difference between Suicide and Euthanasia

There is a conceptual distinction between suicide and euthanasia. In a suicide a man voluntarily kills himself by stabbing, poisoning or by any other way. No doubt, in suicide one intentionally attempts to take his life. It is an act or instance of intentionally killing oneself mostly due to depression or various reasons such as frustration in love, failure in examinations or in getting a good job etc. On the other hand, in euthanasia there is an action of some other person to bring to an end the life of a third person. In euthanasia, a third person is either actively or passively involved i.e., he aids or abets the killing of another person. Mercy killing is not suicide and an attempt at mercy killing is not covered by the provisions of Section 309 of the Indian Penal Code, 1860 (I.P.C.).[4]

Euthanasia and Physician-Assisted Suicide

Some people mistakenly believe "physician-assisted suicide" and "euthanasia" are the same, and use the terms interchangeably. While the terms are arguably related by subject matter, the two actions are different and the distinctions are significant.

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[3] *See* GLANVILLE WILLIAMS, CRIMINAL LAW 282 (2nd ed., Steven and Sons, London 1983).

[4] Naresh Marotrao Sakhre v. Union of India, 1996(1) Bom. C.R. 92, 1995 Crim.L.J. 96.

Physician-assisted suicide involves a medical doctor who intentionally provides a patient with the means to kill him or herself, usually by an overdose of prescription medication. Assisting in a suicide is not necessarily an action limited to physicians. The term "assisted suicide" applies if a layperson provides the deadly means to the patient.

Euthanasia and Code of Medical Ethics

Over the past few decades a number of philosophers concerned with medical ethics have found it increasingly difficult to justify the blanket exclusion of taking life. Harris, in his influential work on medical ethics[5] talks of killing as being a caring thing to do (at least in some cases). Health care professionals have an inherent ethical delegation to respect the sanctity of life and to provide relief from suffering. Beneficence, autonomy and justice are accepted moral principles governing the behaviour of health care professionals within society. Technological and medical advances have created a conflict between application of these moral principles and use of certain types of medical treatment. Two of the cardinal principles of medical ethics are patient autonomy and beneficence.

1. **Autonomy**-means the right to self-determination, where the informed patient has a right to choose the manner of his treatment. To be autonomous the patient should be competent to make decisions and choices. In the event that he is incompetent to make choices, his wishes expressed in advance in the form of a living will, or the wishes of surrogates acting on his behalf ("substituted judgment") are to be respected. The surrogate is expected to represent what the patient may have decided had he/she been competent, or to act in the patient's best interest. It is expected that a surrogate acting in the patient's best interest follows a course of action because it is best for the patient, and is not influenced by personal convictions, motives or other considerations.

2. **Beneficence**-is acting in what is (or judged to be) in patient's best interest. Acting in the patient's best interest means following a course of action that is best for the patient, and is not influenced by personal convictions, motives or other considerations. In some cases, the doctor's expanded goals may include allowing the natural dying process (neither

5 J. HARRIS, THE VALUE OF LIFE (1985).

hastening nor delaying death, but 'letting nature take its course'), thus avoiding or reducing the sufferings of the patient and his family, and providing emotional support. This is not to be confused with euthanasia, which involves the doctor's deliberate and intentional act through administering a lethal injection to end the life of the patient.

Hippocratic Oath and International Code of Medical Ethics

Hippocratic Oath (*horkos*) and the International Code of Medical Ethics pose ethical contradiction for doctors. According to the Oath and the ethics, the doctor is to relieve the pain of his patient on one hand, and protect and prolong his life on the other. First is in favour of euthanasia and second counters the doctrine.

The principle of self-determination applies when a patient of sound mind requires that life support should be discontinued. The same principle applies where a patient's consent has been expressed at an earlier date before he became unconscious or otherwise incapable of communicating it as by a living will or by giving written authority to doctors in anticipation of his incompetent situation.

If the doctor acts on such consent there is no question of the patient committing suicide or of the doctor having aided or abetted him in doing so. It is simply that the patient, as he is entitled to do, declines to consent to treatment which might or would have the effect of prolonging his life and the doctor has in accordance with his duties complied with the patient's wishes. "Whilst this court has held that there is no right to die (suicide) under Article 21 of the Constitution and attempt to suicide is a crime *vide* Section 309 I.P.C., the court has held that the right to life includes the right to live with human dignity, and in the case of a dying person who is terminally ill or in a permanent vegetative state he may be permitted to terminate it by a premature extinction of his life in these circumstances and it is not a crime *vide* Gian Kaur's case."[6]

"If there is no hope of recovery for a patient, it is only humane to allow him to put an end to his pain and agony in a dignified manner," said Dr. B.K. Rao, Chairman of Sir Ganga Ram Hospital in New Delhi, "If it is established that the treatment is proving to be futile, euthanasia is a practical option for lessening the misery of patients."

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[6] Aruna Ramchandra Shanbaug v. Union of India and Ors., Writ Petition (Crim.) No. 115 of 2009; (2011) 4 S.C.C 454.

In United Kingdom (U.K.), the Mental Capacity Act, 2005 now makes provision relating to persons who lack capacity and to determine what is in their best interests and the power to make declaration by a special Court of Protection as to the lawfulness of any act done in relation to a patient.

Ethics in Patient Care Delivery

Two diverse ethical theories affect attitudes towards health care delivery and services:

- Utilitarian/Consequentiality view
- Formalist/Deontological view.

The utilitarian view point, expressed by John Stuart Mill[7] sees ethical decisions as those that produce the greatest positive balance of value over negative balance of value for all persons affected. The deontological view point of ethics, which was expressed by Immanuel Kant[8] states some acts are wrong and others are right independent of their consequence. American society highly values tolerance of conflicting moral values. It also values the right of the individual to control or govern himself or herself according to his or her own reasoning and ethical values.

In a *Discussion Paper on Treatment of Patients in Persistent Vegetative State* issued in September, 1992 by the Medical Ethics Committee of the British Medical Association certain safeguards were mentioned which should be observed before constituting life support for such patients:

> "(1) Every effort should be made at rehabilitation for at least six months after the injury;
> (2) The diagnosis of irreversible Persistent Vegetative State (PVS) should not be considered confirmed until at least 12 months after the injury, with the effect that any decision to withhold life prolonging treatment will be delayed for that period;
> (3) The diagnosis should be agreed by 2 other independent doctors; and
> (4) Generally, the wishes of the patient's immediate family will be given great weight."

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7 J.S. MILL, LIBERTY (W.W. Norton and Company, INC., New York, 1975).

8 C.J. FRIEDRICK, THE PHILOSOPHY OF KANT: INMANUAL KANTS MORAL AND POLITICAL WRITINGS (N.Y. 1977).

Law and Euthanasia

Active euthanasia is a crime all over the world except where permitted by legislation. In India active euthanasia is illegal and a crime under Section 302 or at least Section 304 I.P.C. Physician-assisted suicide is a crime under Section 306 I.P.C. (abetment to suicide). Section 87 of I.P.C. lays down that consent cannot be pleaded as defense in a case where the consent is given to cause death or grievous hurt. With regard to death, the restriction is absolute and unconditional though consent may have the effect of reducing the gravity of offence.

In India, suicide per se is not a crime, but attempted suicide is an offence under Section 309 of I.P.C. Exception 5 of Section 300 of I.P.C. protects a person who causes the death of another above the age of 18 with his/her consent. However this section has a limited scope. It only reduces the gravity of the offence and the person charged is made liable for culpable homicide not amounting to murder under Section 304 of I.P.C. Cases of non-voluntary and involuntary euthanasia would be struck by Proviso 1 to Section 92 of the I.P.C. and thus be rendered illegal.

The question whether Article 21 includes right to die or not first came into consideration in the case *State of Maharashtra v. Maruti Shripathi Dubal*[9]. It was held in this case by the Bombay High Court that "right to life" also includes "right to die" and Section 309 was struck down. The court clearly said that right to die is not unnatural; it is just uncommon and abnormal. Also the court mentioned about many instances in which a person may want to end his life. This was upheld by the Supreme Court in the case *P. Rathinam v. Union of India*[10]. However in the case *Gian Kaur v. State of Punjab*[11] it was held by the 5 judge bench of the Supreme Court that the right to life guaranteed by Article 21 of the Constitution does not include the right to die. The court clearly mentioned that Article 21 only guarantees right to life and personal liberty, and in no case can the right to die be included in it.

A landmark judgment was passed by Justice Markandey Katju and Gyan Sudha Mishra which tends to legalize passive euthanasia. During Aruna's case, the learned judges commented on deletion of the Section 309 of I.P.C. as it has become anachronistic. It was further held in Aruna's case that in case the patient is incompetent

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9 Cr.L.J. 549 A.I.R. 1987.
10 3 S.C.C. 394, A.I.R. 1994.
11 2 S.C.C. 648, A.I.R. 1996.

person to decide whether life support system should be discontinued, then in such situation the family member or close relatives, or in their absence doctors attending patient can decide in best interest of patient with the bonafide intention. However, such a decision requires approval from the concerned High Court. The Court laid a set of tough guidelines under which passive euthanasia can be legalized through High Court monitored mechanism. The judgement made it clear that passive euthanasia will "only be allowed in cases where the person is in PVS or terminally ill".[12] The apex court while framing the guidelines for passive euthanasia asserted that it would now become the law of the land until parliament enacts a suitable legislation to deal with the issue.

It must be remembered that the 17th Law Commission of India, then headed by Justice M. Jagannadha Rao, in its *196th Report* submitted in April, 2006 titled as *Medical Treatment to Terminally Ill Patients (Protection of Patients and Medical Practitioners)* had supported and made recommendations for drafting legislation on the passive euthanasia.

Legal Decisions across the Globe: The Airedale Case[13]

In this case the broad issue raised before the House of Lords was-in what circumstances, if ever, can those having a duty to feed an invalid lawfully stop doing so? This was precisely the question raised in the case of Aruna Shanbaug before the Supreme Court of India.[14]

In February, 1993 the British House of Lords determined that it was lawful to withdraw medical treatment and support, including nutrition and hydration from Anthony Bland, a patient in a PVS using the Bolam Principle which states that the decision to provide care should be based on a responsible body of medical opinion and that care is not required when a case is hopeless.[15] The House of Lords stated that the health professionals can act on what they believe is in the best interest of the patient, and thus may start or curtail treatment considered inappropriate. The bland decision, however, is not legally binding in United States of America (U.S.).[16] It would be worthwhile to discuss the landmark cases pertaining to the PVS.

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12 (2011) 4 S.C.C. 454.
13 Airedale N.H.S. Trust v. Bland, (1993)1 All E.R. 821.
14 Aruna Ramachandra Shanbaug v. Union of India, (2011) 4 S.C.C. 454.
15 (1957) 1 W.L.R. 582.
16 Brahamas D. - Persistent Vegetative State. Lancet 1993; 341: 428.

Helga Wanglie[17]: Helga Wanglie was 86 when she broke her hip in December, 1989 after falling on a rug in her Minneapolis home. She was treated and released from a local hospital and moved to a nursing home. In January, 1990 she was readmitted to the hospital and placed on a respirator, due to respiratory complications. Wanglie suffered a heart attack while under the care of this facility. Resuscitation efforts were successful, although she had been deprived of oxygen for several minutes, resulting in severe and irreversible brain damage. She was readmitted to the hospital on May 31, 1990 where she continued to use a respirator and was provided food and fluids through a tube implanted into her stomach. After repeated evaluations, she was diagnosed as PVS with the complication of permanent respirator dependency.

Wanglie had left no written record of her wishes in the form of a living will or advance directive, and was no longer in a position to indicate her preferences. Because of her prognosis, the medical staff suggested that the family re-evaluate continuing the extensive care required to prolong her existence. Relatives opposed termination of treatment. Doctors countered that in Wanglie's case, they would have to go beyond the limit of "reasonable care" to maintain her existence.

The matter was referred to court. In a ruling issued on July 1, 1991 Judge rejected the hospital's position and turned over full guardianship to Oliver Wanglie, Helga's 87 year old husband. Helga Wanglie died of multi system organ failure on July 4, 1991.

Karen Ann Quinlan[18]: In 1975, after consuming alcohol and tranquilizers at a party, Quinlan collapsed into an irreversible coma that left her unable to breathe without a respirator or eat without a feeding tube. Her parents asked that she be removed from the respirator, but her doctors objected. The New Jersey Supreme Court case that ruled the case was the first to bring the issue of euthanasia into the public eye. In 1976 the court allowed Quinlan's parents to have the respirator removed. Although Quinlan lived for another 9 years (her parents did not want her feeding tube removed), the case set a precedent for a patient's right to refuse unwanted medical treatment.[19] This case led to the legalization of euthanasia in California.

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17 *In re* Helga Wanglie, Fourth Judicial District (Dist. Ct., Probate Ct. Div.) PX-91-283, Minnesota, Hennepin County.

18 *In re* Quinlan, 70 N.J. 10, 355 A.2d 647(1976).

19 B.D. COLEN, KAREN ANN QUINLAN: DYING IN THE AGE OF ETERNAL LIFE (New York: Nash, 1976).

Nancy Cruzan[20]: Cruzan had gone into an irreversible coma in 1983 after a severe car crash, and her parents wanted the machine that was keeping her alive removed. However, in this case the machine consisted of intravenous feeding tubes that provided Cruzan with hydration and nutrition. Her parents viewed the removal of the machine as the termination of unwanted treatment. However, the State of Missouri argued that to remove the feeding tubes would be to intentionally kill Cruzan through starvation. The Cruzan family appealed this decision to the U.S. Supreme Court, which, in June 1990 issued a decision that recognized the existence of a right to die, but qualified that finding by arguing that it was entirely appropriate for the states to set "reasonable" standards to guide the exercise of that right. The State of Missouri was asking that "clear and convincing evidence" of a patient's wishes be produced before allowing the Cruzans' whishes to be honored. Consequently, the U.S. Supreme Court sided with the state and remanded the case back to Missouri.

Subsequently several of Nancy's friends, doctors came forward to testify before Judge Teel about conversations they had remembered having with Nancy regarding her preferences in matters such as this. On December 14, the Jaspar County Court ruled that there was, indeed, sufficient evidence that Nancy would not wish to be kept alive while hopelessly ill. On December 15 the feeding tube that had sustained Nancy for nearly 8 years was removed, and 11 days later she died.

The 2 most significant cases of the U.S. Supreme Court that addressed the issue whether there was a federal constitutional right to assisted suicide arose from challenges to state laws banning physician-assisted suicide brought by terminally ill patients and their physicians. These were:

Glucksberg's Case[21]: In here the U.S. Supreme Court held that the asserted right to assistance in committing suicide is not a fundamental liberty interest protected by the "due process clause" of the 14th Amendment. The Court observed:

> "The decision to commit suicide with the assistance of another may be just as personal and profound as the decision to refuse unwanted medical treatment, but it has never enjoyed similar

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20 Cruzan v. Director, Missouri Department of Health, 497 U.S. 261 (1990).
21 Washington v. Glucksberg, 521 U.S. 702 (1997).

legal protection. Indeed the two acts are widely and reasonably regarded as quite distinct."

Vacco's Case[22]: In here the U.S. Supreme Court again recognized the distinction between refusing life saving medical treatment and giving lethal medication. The Court disagreed with the view of the 2nd Circuit Federal Court that ending or refusing lifesaving medical treatment is nothing more nor less than assisted suicide. The Court held that: "The distinction between letting a patient die and making that patient die is important, logical, rational, and well established". The Court held that the State of New York could validly ban the latter.

Gonzales Case[23]: On January 17, 2006 the Supreme Court ruled that the 1970 Controlled Substances Act (CSA) does not give the U.S. attorney general the authority to prohibit Oregon doctors from prescribing lethal doses of drugs to certain terminally ill patients who want to end their own lives. The court's decision in *Gonzales v. Oregon* resolves a conflict between the state's Death With Dignity Act (DWDA) and the attorney general's interpretation of the federal drug statute. Oregon is currently the only state that has an assisted-suicide law.

Baxter's Case[24]: On December 31, 2009 the Montana Supreme Court issued a landmark ruling in the case of *Baxter v. State of Montana*, upholding the right of terminally ill Montanans to seek aid in dying from their physicians without the fear that the doctors could be criminally prosecuted for assisting them. Montana thus joined Oregon and Washington as the only states recognizing such a right, but it is the only state that has done so through the judicial process rather than by the ballot. The Supreme Court's decision was based upon Montana public policy as embodied in state statutes and court decisions. It stated that while the state's Constitution did not guarantee a right to physician-assisted suicide, there was "nothing in Montana Supreme Court precedent or Montana statutes indicating that physician aid in dying is against public policy".

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22 Vacco v. Quill, 521 U.S. 793 (1997).
23 Gonzales v. Oregon 546 U.S. 243 (2006).
24 *In* Baxter v. Montana, (2009) 224 P.3d 1211, 2009, WL 5155363 (Mont).

Conclusion

Regarding euthanasia, at the present juncture, the debate largely revolves around active euthanasia and not passive euthanasia. Euthanasia, both in active and passive form, should be allowed in every society.

> "The objections to legalizing active euthanasia are based on religious principles, professional and ethical aspects and the fear of misuse. But, it cannot be forgotten that it was by overruling similar objections that abortion was legalized and later raised as an ingredient of the right to privacy. It is submitted that just like abortion, the modern societies demand the right to assisted suicide."[25]

It should be legalized owing to the amount of pain an individual goes through due to the fatal disease or disorder for a long period of time. Having a patient suffer endlessly is not giving him a better quality of life. The kind of quality of life is defined by the patient, not the doctor or government. Consequently, when the patient feels he is not getting the quality of life he wants the doctors can insist upon Physician-Assisted Death (PAD). Supporters of active euthanasia contend that since society has acknowledged a patient's right to passive euthanasia (e.g., by legally recognizing refusal of life-sustaining treatment), active euthanasia should similarly be permitted. Court needs to lay reasonable grounds as to why there is a refusal in the first place to grant euthanasia; be it active or passive. When arguing on behalf of legalizing active euthanasia, proponents emphasize circumstances in which a condition has become overwhelmingly burdensome for the patient, pain management for the patient is inadequate, and only death seems capable of bringing relief. In a liberal democracy like India where fundamental rights are given highest significance over any other substantial law, right to die should be treated at par with the fundamentals of the Constitution. It is argued that euthanasia respects the individual's right to self-determination or his right of privacy. Interference with that right can only be justified if it is to protect essential social values, which is not the case where patients suffering unbearably at the end of their lives request euthanasia when no alternatives exist.

The debate regarding euthanasia has going on from very long time but only recently euthanasia gained massive importance. After the

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[25] Law Commission of India, *Passive Euthanasia-A Relook Report No. 241* (August 2012).

landmark judgment passed by the Indian court in Aruna's case it's clear that passive euthanasia is now allowed in India. But still there is some ambiguity with regard to euthanasia. Hence there has been an urgent need to pass legislation on euthanasia. Law on euthanasia is the need of the hour. As has already been pointed out earlier, we also have to keep in mind the limited medical facilities available in India and the number of patients. This question still lies open that who should be provided with those facilities; a terminally ill patient or to the patient who has fair chances of recovery. It has been ruled in the Gian Kaur case that Article 21 of the Constitution of India does not include right to die by the Supreme Court. But one may try to read it as is evident in the rights of privacy, autonomy and self-determination, which is what has been done by the courts of United State and England, which issue was not raised in an earlier case. Thus, considering all aspects, the balance tilts towards the legalization of euthanasia by appropriate legislation.