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AN ANALYTICAL STUDY ON EUTHANASIA AND ITS POSSIBLE IMPACT IN INDIA; WITH SPECIAL REFERENCE TO RECENT APPROVAL OF PASSIVE EUTHANASIA

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Introduction

*Euthanasia, also known as assisted suicide, physician-assisted suicide (dying), doctor-assisted dying (suicide), and more loosely termed mercy killing, means to take a deliberate action with the express intention of ending a life to relieve intractable (persistent, unstoppable) suffering. Some interpret euthanasia as the practice of ending a life in a painless manner. According to MediLexicon's medical dictionary Euthanasia is:"A quiet, painless death." Or "The intentional putting to death of a person with an incurable or painful disease intended as an act of mercy."**Active euthanasia** is:"A mode of ending life in which the intent is to cause the patient's death in a single act (also called mercy killing)."**Passive euthanasia is**:"A mode of ending life in which a physician is given an option not to prescribe futile treatments for the hopelessly ill patient."Many disagree with this interpretation, because it needs to include a reference to intractable suffering. In the majority of countries euthanasia or assisted suicide is against the law.*

The Indian reality can be argued that in a country where the basic human rights of individuals are often left unaddressed, illiteracy is rampant, more than half the population is not having access to potable water, people die every day due to infections, and where medical assistance and care is less, for the few people, issues related to euthanasia and PAS are irrelevant. However, India is a country of diversities across religious groups, educational status, and cultures. In this background, the debate on euthanasia in India is more confusing as there is also a law in this land that punishes individuals who even try to commit suicide. The Medical Council of India, in a meeting of its ethics committee in February 2008 in relation to euthanasia opined: Practicing euthanasia shall constitute unethical conduct. However, on specific occasions, the question of withdrawing supporting devices to sustain cardio-pulmonary function even after brain death shall be decided only by a team of doctors and not merely by the treating physician alone. A team of doctors shall declare withdrawal of support system. Such team shall consist of the doctor in-charge of the patient, Chief Medical Officer / Medical Officer in-charge of the hospital, and a doctor nominated by the in-charge of the hospital from the hospital staff or in accordance with the provisions of the Transplantation of Human Organ Act, 1994. In India, euthanasia is a crime. Section 309 of the Indian Penal Code (IPC) deals with the attempt to commit suicide and Section 306 of the IPC deals with abetment of suicide – both actions are punishable. Only those who are brain dead can be taken off life support with the help of family members. Likewise, the Honorable Supreme Court is also of the view that that the right to life guaranteed by Article 21 of the constitution does not include the right to die. The court held that Article 21 is a provision guaranteeing protection of life and personal liberty and by no stretch of imagination can extinction of life be read into it. However, various pro-euthanasia organizations, the most prominent among them being the Death with Dignity Foundation, keep on fighting for legalization of an individual's right to choose his own death. A major development took place in this field on 7 March 2011. The Supreme Court, in a landmark judgment, allowed passive euthanasia. Refusing mercy killing of Aruna Shaunbag, lying in a vegetative state in a Mumbai Hospital for 37 years, a two-judge bench laid down a set of tough guidelines under which passive euthanasia can be legalized through a high-court monitored mechanism. The court further stated that parents, spouses, or close relatives of the patient can make such a plea to the high court. The chief justices of the high courts, on receipt of such a plea, would constitute a bench to decide it. The bench in turn would appoint a committee of at least three renowned doctors to advise them on the matter. Not all patients who seek a hastened death request assistance from their physicians. Rates of suicide among medically ill populations have been a topic of clinical concern and empirical research for many years prior to the emergence of the PAS debate. This research has generally concluded that depression and suicide among patients with medical illnesses are not particularly common but rather occur more often than in physically healthy populations. These suicide vulnerability factors in cancer and AIDS patients include poor prognosis and advanced disease, depression, hopelessness, loss of control, a sense of helplessness, delirium, fatigue and exhaustion of resources, pre-existing psychopathology, and previous suicide attempts. The role of psychiatric and psychosocial assessment and intervention has been well accepted as a critically important aspect of the care of patients with advanced cancer or AIDS.

Religious tolerance in India on the EUTHANASIA, AND PAS It has been pointed out that in Hinduism, the word for suicide, atma-gatha, has also the elements of intentionality. The intention to voluntarily kill oneself for selfish motives was condemned in Hinduism. Subjectively, the evil sprang from a product of ignorance and passion; objectively, the evil encompassed the karmic consequences which impeded the progress of liberation. It was in this context that the Dharmasutras vehemently prohibited suicide. Nevertheless, Hinduism venerated enlightened people who voluntarily decided their mode of death. Thus, the Pandavas eulogized “Mahaparasthana” or the great journey through their Himalayan sojourn when they

walked in pilgrimage, thriving on air and water till they left their bodies one after another. Crawford lists fasting, self-immolation, and drowning at holy places as other examples of such venerated deaths. Such deaths by enlightened persons have never been equated with the popular notion of suicide in the Indian tradition. It has been always considered that suicide increases the difficulties in subsequent lives. Can the Hindu stance as mentioned above be extended to the question of euthanasia? Here, the Indian attitude toward life and death needs special mention. In the Hindu tradition, death acts as a prefiguration and model, through which the ties that bind man's self or soul to cosmic impermanence can be completely broken and through which ultimate goals of immortality and freedom can be finally and definitely attained. Crawford considers "spiritual death" in the Indian context to be synonymous with a "good death," i.e., the individual must be in a state of calm and equipoise. Crawford surmises that to ensure such a noble death, the concept of active euthanasia would not be unacceptable to the Indian psyche. However, this view has been criticized by authors who claim that "spiritual death" or "iccha mrtu" can only be possible when the evolved soul chooses to abandon the body at will. It is also claimed that the evolving soul cannot be equated with mental tranquility as it is at a higher level of consciousness. Thus, though less dogmatic than other religions, Hindus would traditionally remain skeptic in their view about euthanasia. It has been proposed that a strong objection to euthanasia might arise from the Indian concept of Ahimsa. However, even in the Gandhian framework of Ahimsa, violence that is inevitable is not considered as sin.This emphasizes flexibility of the Indian mind. Hence, though a little skeptic, the Indian mind would not consider the thought of euthanasia and PAS as a sacrilege.

According to the National Health Service (NHS), UK, it is illegal to help somebody kill themselves, regardless of circumstances. Assisted suicide, or *voluntary euthanasia* carries a maximum sentence of 14 years in prison in the UK. In the USA the law varies in some states.There are two main classifications of euthanasia: **Voluntary euthanasia** - this is euthanasia conducted with consent. Since 2009 voluntary euthanasia has been legal in Belgium, Luxembourg, The Netherlands, Switzerland, and the states of Oregon (USA) and Washington (USA). **Involuntary euthanasia** - euthanasia is conducted without consent. The decision is made by another person because the patient is incapable to doing so himself/herself.

There are two procedural classifications of euthanasia:**Passive euthanasia** - this is when life-sustaining treatments are withheld. The definition of passive euthanasia is often not clear cut. For example, if a doctor prescribes increasing doses of opioid analgesia (strong painkilling medications) which may eventually be toxic for the patient, some may argue whether passive euthanasia is taking place - in most cases, the doctor's measure is seen as a passive one. Many claim that the term is wrong, because euthanasia has not taken place, because there is no intention to take life. **Active euthanasia** - lethal substances or forces are used to end the patient's life. Active euthanasia includes life-ending actions conducted by the patient or somebody else. Active euthanasia is a much more controversial subject than passive euthanasia. Individuals are torn by religious, moral, ethical and compassionate arguments surrounding the issue. Euthanasia has been a very controversial and emotive topic for a long time. The term *assisted suicide* has several different interpretations. Perhaps the most widely used and accepted is "the intentional hastening of death by a terminally ill patient with assistance from a doctor, relative, or another person." Some people will insist that something along the lines of "in order relieve intractable (persistent, unstoppable) suffering" needs to be added to the meaning, while others insist that "terminally ill patient" already includes that meaning.

History of Euthanasia; The English medical word "euthanasia" comes from the Greek word eumeaning "good," and the Greek word thanatos meaning "death." Hippocrates (ca. 460 BC - ca. 370 BC) ;Euthanasia is mentioned in the Hippocratic Oath. The original oath states "To please no one will I prescribe a deadly drug nor give advice which may cause his death." Even so, the ancient Greeks and Romans were not strong advocates of preserving life at any cost, and were tolerant of suicide when no relief could be offered to the dying. The English philosopher Sir Francis Bacon coined the phrase "euthanasia" early in the 17th century. Euthanasia is derived from the Greek word eu, meaning "good" and thanatos meaning "death," and early on signified a "good" or "easy" death. Euthanasia is defined as the administration of a lethal agent by another person to a patient for the purpose of relieving the patient's intolerable and incurable suffering. Typically, the physician's motive is merciful and intended to end suffering. Euthanasia is performed by physicians and has been further defined as "active" or "passive." Active euthanasia refers to a physician deliberately acting in a way to end a patient's life. Passive euthanasia pertains to withholding or withdrawing treatment necessary to maintain life. There are three types of active euthanasia. Voluntary euthanasia is one form of active euthanasia which is performed at the request of the patient. Involuntary euthanasia, also known as "mercy killing," involves taking the life of a patient who has not requested for it, with the intent of relieving his pain and suffering. In nonvoluntary euthanasia, the process is carried out even though the patient is not in a position to give consent. PAS, on the other hand, involves a physician providing medications or advice to enable the patient

to end his or her own life. While theoretical and/or ethical distinctions between euthanasia and PAS may be subtle to some, the practical distinctions may be significant. Many terminally ill patients have access to potentially lethal medications, at times even upon request from their physicians, yet do not use these medications to end their own lives. Both euthanasia and PAS have been distinguished, legally and ethically, from the administration of high-dose pain medication meant to relieve a patient's pain that may hasten death (often referred to as the rule of double effect) or even the withdrawal of life support. The distinction between euthanasia/PAS and the administration of high-dose pain medications that may hasten death is premised on the intent behind the act. In euthanasia/PAS, the intent is to end the patient's life, while in the administration of pain medications that may also hasten death; the intent is to relieve suffering.Distinctions between withdrawal of life support and euthanasia/PAS are, in many ways, considerably clearer. Long-standing civil case law has supported the rights of patients to refuse any unwanted treatment, even though such treatment refusals may cause death.[8] On the other hand, patients have not had the converse right to demand treatments or interventions that they desire. This distinction has had the effect of allowing a patient on life support the ability to end his or her life on request, yet a patient who is not dependent on life support does not have such a right.

How it can be used and why it is normally used; Patients with a terminal or serious and progressive illness in most developed countries have several options, including: ***Palliative care ;***The World Health Organization (WHO) defines ***palliative care*** as: "An approach that improves the quality of life of patients and their families facing the problems associated with ***life-threatening illness,*** through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual". One goal of palliative care is for the patients and families to accept dying as a normal process. It seeks to provide relief from pain and uncomfortable symptoms while integrating psychological and spiritual features of patient care. Palliative care strives to offer a support system to help patients live their remaining time as actively as they can and to help families bereave and deal with the illness of a loved one. Since pain is the most visible sign of distress among patients receiving palliative care, affecting about 70% of cancer patients and 65% of patients dying from non-malignant diseases, opioids are a very common treatment option. These medicines form part of well-established treatment plans for managing pain as well as several other symptoms that patients encounter. Often, opioids are chosen during palliative care in spite of the side effects such as drowsiness, nausea, vomiting, and constipation. Some type of palliative care is given to about 1.2 million Americans and 45,000 new patients each year in England, Wales, and Northern Ireland. About 90% of these patients have cancer, while the remaining patients have heart disease, stroke,motor neuron disease, or multiple sclerosis. The providers of the palliative care include in-patient care, hospital support services, community care, day care and outpatient care.

Objectives of this analytical study;

- Objective;I; to understand and clarify the concept of Euthanasia
- Objective ii; To analyse why India is Against Euthanasia
- Objective iii; to understand through analysis what are the positive and negative impacts that this dignified assisted medical death gives.
- Objective iv; to evaluate whether will it Suit Indian Sentiments

Review of Literature

A study of 100 psychiatric patients in Belgium reveals that those with depression and personality disorders were most likely to request help to die due to "unbearable suffering."English Common Law ; Suicide was a criminal act from the 1300s until the middle of the last century; this included assisting others to end their lives. Thomas More (1478-1535) An English lawyer, scholar, author and statesman; also recognized as a saint within the Catholic Church, once envisaged a utopian community as one that would facilitate the death of those whose lives had become burdensome as a result of*torturing and lingering pain*.

Study co-author Dr. Lieve Thienpont, of University Hospital Brussels in Belgium, and colleagues publish their findings in the journal *BMJ Open*. In Belgium, euthanasia - defined as a physician's "act of deliberately ending a patient's life at the latter's request" by giving them life-terminating drugs - has been legal since 2002.

According to Dr. Thienpont and colleagues, Belgium, the Netherlands and Luxembourg are the only countries in Europe where psychological suffering or distress is a valid legal basis for euthanasia. For their study, the team set out to determine whether patients with certain psychological disorders are at greater likelihood of submitting a euthanasia request. The researchers analyzed the euthanasia requests made by 100 individuals - 77 women and 23 men - on the grounds of unbearable suffering. All patients were receiving treatment for psychiatric disorders at outpatient clinics in Belgium between 2007 and 2011 and were followed-up until the end of 2012. Ninety-one of the patients had been referred for counseling, while 73 were classed as medically unfit to work and 59 lived alone, according to the study.

Dr. Thienpont and colleagues say their findings may inform the development of future guidelines in relation to euthanasia requests from patients with psychiatric illness, adding: "Unfortunately, there are no guidelines for the management of euthanasia requests on grounds of mental suffering in Belgium. Taking into account the ongoing fierce ethical debates, it is essential to develop such guidelines, and translate them into clear and detailed protocols that can be applied in practice." As such, they call for further studies to be conducted - particularly quantitative and qualitative studies - in order to gain a better understanding of euthanasia requests for unbearable suffering among mentally ill patients. "Furthermore, these studies could undertake systematic comparisons between groups of psychiatric and non-psychiatric patients, thereby exploring the risk factors for, and origins and degree of, unbearable suffering in both patient groups," they conclude. Earlier this year, *Medical News Today* reported on a study published in the *Journal of Medical Ethics*, which found 1 in 3 doctors in the Netherlands would consider helping a patient die if they were suffering from early dementia or mental illness.

Andreassen and colleagues Published in the journal *PLOS One*, the study found that workaholics were more likely to have anxiety, depression, obsessive-compulsive disorder (OCD), and attention deficit hyperactivity disorder (ADHD) than non-workaholics. According to the study authors - including Cecilie Schou Andreassen of the Department of Psychological Science at the University of Bergen, Norway - workaholism has been defined as "being overly concerned about work, driven by an uncontrollable work motivation, and to investing so much time and effort to work that it impairs other important life areas." With an increasing amount of Americans facing longer working hours and increasing job demands, workaholism is believed to be a common occurrence, with some studies estimating that it affects around 10 percent of the U.S. workforce.

Researchers say their results indicate that certain sociodemographic groups may be at increased risk of workaholism, and that workaholics may be more likely to have co-existing psychiatric conditions. Additionally, all participants were assessed for psychiatric symptoms through the Adult ADHD Self-Report Scale, the Obsession-Compulsive Inventory-Revised, and the Hospital Anxiety and Depression Scale.

A study, published this week in *Molecular Psychiatry*, finds the genetic basis of a poorly understood phenomenon. Mood and stress are known to contribute to shortened life spans, and researchers may now have identified the genes that are involved.

The authors of the study conclude that "these studies uncover ANK3 and other genes in our dataset as biological links between mood, stress, and lifespan, that may be biomarkers for biological age as well as targets for personalized preventive or therapeutic interventions." Firstly, the team investigated the genetic changes mianserin made to *C. elegans*. The drug was found to affect 231 genes that were then cross-referenced to the human genome. In total, 347 corresponding, similar genes were identified in humans. These 347 genes were compared with the genomes of 3,577 older adults. Of these genes, 134 overlapped with depressive symptoms in humans. The researchers used a database containing genes already known to be involved in psychiatric disorders. They also used Niculescu lab's Convergent Functional Genomics approach to prioritize the genes in order of their involvement in mood and stress disorders.

Lead author Dr. Alexander B. Niculescu III After analyzing the genes further, Dr. Niculescu and his team found that the genes in question changed their rates of expression with age. When examining the genes of individuals who experienced significant stress or mood disorders - for instance, people who had committed suicide - they noticed shifts in the expression of these genes. The changes are of the type that would normally be associated with shorter life spans and premature aging.

Since early 1800s euthanasia has been a topic of debates and activism in the USA, Canada, Western Europe and Australasia. Ezekiel Emanuel (born 1957, USA), an American National Institutes of Health bioethicist said that the modern era of euthanasia was ushered in by the availability of anesthesia. An anti-euthanasia law was passed in the state of New York in 1828. It is the first known anti-euthanasia law in the USA. In subsequent years many other localities and states followed suit with similar laws. Several advocates, including doctors promoted euthanasia after the American Civil War. At the beginning of the 1900s support for euthanasia peaked in the USA, and then rose up again during the 1930s.

Swiss legislation Doctor assisted suicide became legalized in Switzerland in 1937, as long as the doctor ending the patient's life had nothing to gain.After the Second World War Glanville Williams (1911-1997, Wales. A legal professor) and Joseph Fletcher (1905-1991, USA. An Episcopal priest, he later identified himself as an atheist) emerged as proponents of euthanasia.

In Early 1960s During the 1960s advocacy for a right-to-die approach to euthanasia grew.Australia Rights of the Terminally Ill Act was passed in 1996 in the Northern Territory. Under the Act four patients died using a euthanasia device designed by Dr. Philip Nitschke. One year later the Act was overturned by the Federal Parliament. Dr. Nitschke responded by founding EXIT

International, a pro-euthanasia group. In 2009 a quadriplegic patient, Christian Rossiter (49) was granted the right to refuse nourishment and be allowed to die; Chief Justice Wayne Martin specified that Brightwater, his caregiver, would not be held criminally responsible for following his instructions. A chest infection eventually ended Rossiter's life. In **UK** Euthanasia is illegal in the whole of the United Kingdom (England, Wales, Northern Ireland and Scotland). However, as the matter is now under the Scottish parliament in Scotland, it is possible that varying laws may eventually apply in future within the UK.

Objective 1; In the Present Context; Some of Interesting cases for Our Analysis; Why euthanasia is sensitive; **Refusing treatment** In the USA, UK and many other countries a patient can refuse treatment that is recommended by a doctor or some other health care professional, as long as they have been properly informed and are *of sound mind*. In the UK, the Mental Health Act 1983 excludes children and people under the age of 18 years. According to the Department of Health, UK, nobody can give consent on behalf of an incompetent adult, such as one who is in a coma. Nevertheless, doctors take into account the best interests of the patient when deciding on treatment options. A patient's best interests are based on: What the patient wanted when he/she was competent, the patient's general state of health, the patient's spiritual and religious welfare. The British Voluntary Euthanasia Society (known today as EXIT) was founded by Dr. Killick Millard (1870-1952) and Lord Moynihan (1865-1936) in 1935. The society created *A Guide to Self Deliverance*, which included guidelines on how an individual could end his/her life. In 1980 the Voluntary Euthanasia Society of Scotland separated from the original society, and published *How to Die with Dignity*. The Voluntary Euthanasia Society of Scotland has been urging the UK to change the law so that terminally ill patients may have the option of ending their lives. Polls reveal that at least 80% of UK citizens and 64% of its GPs (general practitioners, primary care physicians) are in favor of the legalization of euthanasia (some polls give different results for health care professionals). However, Parliament has not passed any laws on this issue.

The Suicide Act 1961 states that it is illegal to *"aid, abet, counsel or procure the suicide of another"* and sets a maximum prison sentence of 14 years. Doctors in the UK do often assist patients with their wishes by withholding treatment and reducing pain when death is a few days away and after consulting patients, relatives, and other health care professionals. **Inconsistency between illegality and prosecution** - even though 92 Britons have gone overseas for an assisted suicide, no relatives have ever been prosecuted for assisting them - some were charged, to later find that the charges were dropped. This discrepancy between the law and legal action prompted Debbie Purdy to launch a case to clarify whether her husband would be risking prosecution if he helped her travel to a clinic in Switzerland to die. On 30th August, 2009 a decision was made that the Director of Public Prosecutions had to clarify what the enforcement of the Suicide Act 1961 entailed.

Objective ii; To analyse why India is Against Euthanasia;
The expert committee, the Directorate General of Health Services (DGHS) has proposed formulation of legislation on passive euthanasia. The expert committee has further suggested certain changes in the draft bill. The committee has not agreed to active euthanasia since it has more potential for misuse and as on date it is prevalent in very few countries worldwide," the Centre said in its response to a petition filed by Common Cause, an NGO. The SC in Aruna Shanbaug case had in 2011 ruled in favour of passive euthanasia and the law ministry had opined that the SC's "directions should be followed". Reasons are many! But the fact remains the same. Euthanasia should be legalized. Not because it happens as a result of mercy but because it relieves the pain and initiates peaceful death. The death of Aruna Shanbaug has brought about the necessary revolution in Indian judiciary as passive Euthanasia is now legal in India. But does legalization of active Euthanasia call for another incident? Shanbaug died after being in a vegetative state for more than 40 years (after being raped in 1973). After the incident, she was abandoned by her family and friends and it was the KEM (King Edward memorial Hospital that had been taking care of her health and well being. Was her life worth living? She was an equivalent to lifeless animal lying on the bed, being fed mashed food, just for the sake of it. Does the Indian law require another eye-opener to allow mercy killing in the country? The answers to all these questions are still unknown. But, probably, every cloud has a silver lining!

Objective iii; to understand through analysis what are the positive and negative impacts that this dignified assisted medical death gives.
The arguments supporting legalization of euthanasia/PAS are substantial. Proponents perceive PAS as an act of humanity toward the terminally ill patient. They believe the patient and family should not be forced to suffer through a long and painful death, even if the only way to alleviate the suffering is through suicide. According to the proponents of PAS, it becomes ethical and justified when the quality of life of the terminally ill patient becomes so low that death remains the only justifiable means to relieve suffering. Lack of any justifiable means of recovery and the dying patient himself making the choice to end his life are conditions which make euthanasia more justifiable. To the advocate for PAS, legalization of PAS is a natural extension of patient's autonomy and the right to determine what treatments are accepted or refused. Arguments in favor of legalization of PAS are typically premised on the assumption that requests for PAS are “rational” decision, given the

circumstances of terminal illness, pain, increased disability, and fears of becoming (or continuing to be) a burden to family and friends.

Arguments opposing legalization of PAS/euthanasia Opposition to legalization of PAS and/or euthanasia has come from numerous different perspectives. As frequently noted in the editorial pages of various medical journals, the medical profession is guided by a desire to heal and extend life. This guideline is best exemplified in the Hippocratic Oath which states, "I will prescribe regimen for the good of my patients according to my ability and my judgment and never do harm to anyone. To please no one will I prescribe a deadly drug, nor give advice that may cause his death." Thus, the possibility that a physician may directly hasten the death of a patient – one whom the physician has been presumably treating in an effort to extend and improve life – contradicts the central tenet of the medical profession.

From a mental health perspective, professional psychiatric and psychological training reinforces the view that suicide should be prevented at all costs. Several studies have supported this connection between mental disorder (e.g., depression) and interest in PAS, suggesting that suicidal ideation in terminally ill patients is a manifestation of undiagnosed, untreated mental illness.

In response to these concerns, legislators proposing guidelines for PAS have incorporated several mechanisms to minimize the risk that PAS, if legalized, will be misused. These guidelines include (1) a voluntarily request for assistance in dying on the part of the patient, (2) evidence of a terminal illness, and (3) documentation by the primary physician of the reason for the request and efforts made to optimize the patient's care. Opponents, however, suggest that these limitations are more arbitrary than scientific, and they argue that the legal and medical communities will eventually end up on a "slippery slope," where euthanasia is ultimately legalized as an acceptable practice for a wider patient population, including non-terminal, nonvoluntary patients. Opponents point to a similar evolution of euthanasia use in The Netherlands where regulations regarding PAS have gradually weakened over the 13 years since this practice was decriminalized. For example, in 1994, the Dutch Supreme Court accepted the argument that a chronic disease is an acceptable basis for euthanasia, even if not terminal, and more recent cases have extended this "right" even to patients without a physical illness.

Objective iv; to evaluate whether will it Suit Indian Sentiments

Let us firstly look at some of analytical studies done on Indian sub-continent, on the issue ; firstly let us first look at the attitude towards hastened death and palliative services and related psychiatric issues **;**Public interest has been spurred by media attention devoted to Drs. Kevorkian, Quill, Aruna Shanbaug, and others, as well as legal decision, state referenda, and the growing availability of life-extending medical treatments. As a result, both the public and the medical community have openly debated ethical issues relating to end-of-life options. While the US Supreme Court upheld the rights of individual states to prohibit PAS, its decision simultaneously opened the door for professionals to "experiment" with legalization of PAS, as has recently occurred in the state of Oregon.

The major factors that determined the attitude included deeply held moral values like role of physician is to preserve life, PAS would pressurize for improved palliative care, religious beliefs, and diversion of resources from palliative care. 60% believed that they would consider PAS on themselves in case of terminal suffering. The factors determining their decision to consider PAS would be pain in 70% cases, no hope of recovery in 50% cases, loss of mental faculties in 49% cases, inability to take care of self and poor quality of life in 35% cases each. 60% of the respondents believed that they would not be confident in diagnosing depression in the terminally ill patients during a single interview with the patients if they were called for giving an expert opinion. This is a surprising finding as it implies that more than expert knowledge, the moral principles and previous attitude regarding PAS may influence the judgments of the psychiatrists if they were act as a gatekeeper in the future. Another sample survey of 200 doctors carried out by the Society for the Right to Die with Dignity in Bombay also gave a glimpse of what views health professionals in our country held regarding euthanasia and PAS: Ninety percent stated they had the topic in mind and were concerned, while 78% argued that patients should have the right to choose in case of terminal illness; 74% believed that artificial life supports should not be extended when death is imminent, but only 65% stated that they would withdraw life supports; 41% argued that Living Will should be respected, and 31% had reservations about the issue.

Conclusion

A serious analytical study still needs to be done very seriously by the government since the democracy to have a dignified death shall become a legal voice for every citizen of this country, and also can take certain vital decisions that can save many families. It can very easily bring down suicides. Medical science is progressing in India as in the rest of the world, and hence currently we are having devises that can prolong life by artificial means. This may indirectly prolong terminal suffering and may also prove to be very costly for the families of the subject in question. Hence, end-of-life issues are becoming major

ethical considerations in the modern-day medical science in India. The proponents and the opponents of euthanasia and PAS are as active in India as in the rest of the world. However, the Indian legislature does not seem to be sensitive to these. The landmark Supreme Court judgment has provided a major boost to pro-euthanasia activists though it is a long way to go before it becomes a law in the parliament. Moreover, concerns for its misuse remain a major issue which ought to be addressed before it becomes a law in our country.

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