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Introduction to euthanasia

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Abstract
One of the most hotly contested ethical topics in modern medicine and law is euthanasia, also known as "mercy killing." This study investigates the ethical, legal, and social ramifications of euthanasia from the viewpoints of human rights, medical ethics, and religious traditions. It emphasizes the differences between voluntary and involuntary acts, active and passive euthanasia, and the different legal statuses of euthanasia in various nations. In contrast to opposing viewpoints that stress the sanctity of life and the possibility of abuse, the study examines the arguments in favour of euthanasia as a manifestation of individual autonomy and compassion. This paper seeks to contribute to the ongoing international conversation on end-of-life decision-making by offering a balanced understanding of the complexities of euthanasia through an analysis of case studies, legal frameworks, and ethical theories. The psychiatrist's participation becomes crucial in this situation as it becomes necessary to assess the mental health of the individual giving their assent to PAS. Despite being illegal in our nation, PAS has a number of supporters in the form of nonprofits like the "death with dignity" foundation. The recent ruling in the Aruna Shaunbag case by the Honourable Supreme Court has given this a boost. How long it takes for this delicate matter to shake the Indian legislative is yet to be seen.

Keywords: Euthanasia, mercy killing, human rights, ramifications, sanctity of life, individual autonomy, legal framework, ethical theories

Introduction

The remarkable developments in medical science and technology have had a profound effect on society. They have raised issues that are changing societal norms and the way people live. As a result of these developments, human rights, autonomy, and freedom of choice are increasingly being affirmed. These problems force us to reconsider our conceptions of value systems and societal and medical ethics.

Palliative care and quality of life concerns in patients with terminal illnesses, such as advanced cancer and acquired immune deficiency syndrome (AIDS), have emerged as a significant area of clinical care and research. Extending a palliative care/quality of life research agenda to the clinical issues of cancer patients has advanced significantly, including initiatives that concentrate on mental health-related problems like neuropsychiatric syndromes and psychological symptoms in patients with terminal illness. However, the desire for death and physician-assisted suicide (PAS) and its connection to depression are arguably the most compelling and clinically important mental health issues in palliative care today.

Many associated difficulties or phenomena, such as suicide and suicidal ideation, interest in PAS/euthanasia, and requests for PAS/euthanasia, have been linked to the concept of desire for death. The degree to which a person desires their life may end sooner is the emphasis of this construct, which was first put forth by Brown and colleagues [1] and then expanded upon by Chochinov *et al.* [2]. It can range from a total lack of want to die to suicidal purpose, which is the intention to terminate one's life right away.

Due to the well reported examples of Drs. Jack Kevorkian, Timothy Quill, and Aruna Shanbaug, advocates for patient autonomy over how and when they pass away have become more vociferous in recent years. The suffering of terminally sick people has been at the focus of many cases. However, the significance of medical, social, and psychological elements (such as depression) that may contribute to suicidal ideation, a desire for an accelerated death, or requests for PAS by terminally ill patients has frequently been disregarded in the political and legal machinations.

Definition of Euthanasia and Pas

The term "euthanasia" was first used in the early 17th century by the English philosopher Sir Francis Bacon. Euthanasia, which originally denoted a "good" or "easy" death, is derived from the Greek words eu, which means "good," and thanatos, which means "death." [3] The administering of a fatal agent to a patient by another individual in order to alleviate the patient's unbearable and irreversible suffering is known as euthanasia. [4] The doctor's motivation is usually compassionate and meant to alleviate pain. Physicians carry out euthanasia, which is further classified as "passive" or "active." When a doctor intentionally ends a patient's life, this is referred to as active euthanasia. Withholding or stopping life-sustaining treatment is known as passive euthanasia. Active euthanasia comes in three different forms. One type of active euthanasia that is carried out at the patient's desire is voluntary euthanasia. Involuntary euthanasia, sometimes referred to as "mercy killing," is the taking of a patient's life without their consent in order to alleviate their suffering. In nonvoluntary euthanasia, the procedure is carried out notwithstanding the patient's incapacity to give consent. [5]

In contrast, PAS entails a doctor giving a patient drugs or guidance so they can take their own life. The practical differences between PAS and euthanasia may be substantial, even though the theoretical and/or ethical differences may seem minor to some. Despite having access to potentially fatal drugs—sometimes even at their doctors' request—many terminally ill people choose not to take these drugs to end their own lives [1].

Both PAS and euthanasia have been legally and morally separated from the removal of life support or the use of high-dose painkillers intended to alleviate a patient's suffering that could expedite death (commonly referred to as the law of double effect). [6, 7] The distinction between high-dose painkillers that may accelerate death and euthanasia/PAS is based on the purpose of the act. While the goal of administering painkillers, which may also hasten death, is to alleviate suffering, the goal of euthanasia/PAS is to end the patient's life.

Egalization of Pas and Euthanasia

1. Arguments supporting legalization of PAS/euthanasia

There are strong arguments in favour of legalizing PAS and euthanasia. PAS is seen by supporters as a humanitarian gesture toward patients who are near death. Even if suicide is the only way to end the agony, they feel that the patient and their family shouldn't have to endure a protracted and agonizing death. PAS proponents contend that when a terminally sick patient's quality of life declines to the point where death is the only acceptable way to end their suffering, it becomes morally acceptable and justified. Euthanasia is more acceptable when there are no viable options for recovery and the dying patient chooses to end his own life. [9] Legalizing PAS is a logical progression of patient autonomy and the right to choose which therapies to accept or reject. The concept that requests for PAS are "rational" decisions given the circumstances of terminal illness, pain, greater handicap, and fears of becoming a burden to family and friends is often the foundation of arguments in support of legalizing PAS [2]. The option to accelerate one's death may seem reasonable given the prospect that these symptoms and circumstances may not be alleviated, even with aggressive palliative care and social supports. [10] Euthanasia proponents also object to the court's and religious organizations' "artificial and impractical" distinction between active and passive euthanasia. The traditional method of "passive" euthanasia, withdrawal of life support, actually entails taking a "active" step to speed up a terminally ill patient's death, and the act is legitimate because of the patient's permission. Legalization advocates also contend that the ability to choose how and when to pass away provides dying patients with a kind of "psychologic insurance." Put another way, some of the stress related to the dying process may be reduced by the knowledge that there is a way out of the agony of illness. Although there is little chance that many people with terminal illnesses will use this choice, it is feasible (as some PAS supporters contend) that many of them want the option to terminate their lives if specific circumstances occur. [9]

2. Arguments opposing legalization of PAS/euthanasia

Many distinct viewpoints have opposed the legalization of PAS and/or euthanasia. The desire to heal and prolong life is what drives the medical profession, as is often mentioned in the editorial pages of many medical magazines [3]. The Hippocratic Oath, which declares, "I will prescribe regimen for the good of my patients according to my ability and my judgment and never do harm to anyone," is the best example of this rule. I won't give advise that could kill him or administer a lethal medication to appease anyone. Therefore, it goes against the fundamental principle of the medical profession that a doctor might intentionally accelerate the death of a patient, whom the doctor has presumably been treating in an attempt to prolong and improve life. Professional psychiatric and psychological training supports the idea that suicide should be avoided at all costs from a mental health standpoint.

Suicidal thoughts in terminally sick patients may be an indication of an undetected, untreated mental disease, according to a number of studies that have confirmed the link between mental disorders (like as depression) and interest in PAS. [3, 4, 12] Therefore, the provision of adequate psychiatric therapy may be circumvented if a doctor complies with a suffering patient's expressed desire for PAS [4]. Similar claims have been made about physical symptoms and discomfort, implying that requests for PAS could be signs of subpar palliative care. [13] Even though a patient's desire for an early death may be the result of poorly managed physical and/or psychological symptoms, if PAS is legalized, doctors may unintentionally engage in PAS intended to relieve these symptoms, which may be better managed with better palliative care, rather than offering appropriate medical management.

Additionally, PAS opponents claim that people from lower socioeconomic classes or other marginalized groups will be "coerced," either directly or indirectly, into seeking PAS in order to overcome the challenges presented by their sickness. Because of the social and financial strain of caring for terminally ill family members, family members may gently imply that death would be better if it happened sooner rather than later. Because of their own unacknowledged emotions (countertransference), doctors may perceive PAS as the proper and ideal reaction to a fatal illness and the ensuing handicap. Because they believe that they would not want to live in a condition similar to that of their patients, doctors may be especially bad at identifying "irrational" requests for PAS. An even more terrifying prospect is that doctors or other healthcare professionals may suggest PAS as a solution because the alternative—providing appropriate palliative care—is too costly or challenging to obtain. Therefore, poorly managed or untreated physical and psychological illnesses may "coerce" patients with inadequate health insurance or limited financial resources to request PAS [5], believing that their only options are either death or more misery. Numerous studies have shown that psychological and physical symptoms are not adequately identified and treated [14], with many medically ill patients experiencing symptoms like anxiety and despair that go mostly unnoticed. [15] Only 5% of dying patients in Canada receive appropriate palliative care, according to a recent study of the country's palliative care system. [16]

In response to these worries, lawmakers drafting PAS standards have included a number of safeguards to reduce the possibility that PAS might be abused if it were legalized. These standards include: (1) a patient's voluntary request for assistance in dying; (2) proof of a terminal illness; and (3) the primary physician's documentation of the patient's care optimization efforts and the basis for the request [6]. However, detractors contend that these restrictions are more arbitrary than scientific and that the legal and medical communities will eventually find themselves on a "slippery slope" where euthanasia is eventually accepted as a practice for a larger patient population, including non-terminal, nonvoluntary patients. [17]

Attitudes Toward Hastened Death and Pas: Importance of Psychiatric Issues

Media coverage of Drs. Kevorkian, Quill, Aruna Shanbaug, and others, as well as court rulings, state referendums, and the increasing accessibility of life-extending medical procedures, have all sparked public interest. As a result,

ethical concerns over end-of-life alternatives have been freely discussed by the general public and the medical profession. The US Supreme Court's ruling allowed experts to "experiment" with legalizing PAS, [7] as has recently happened in the state of Oregon, while also upholding individual states' rights to forbid it [9,10]. [18] Due in part to this increased focus, some academics have polled the general public, medical professionals, and medically ill patients about sentiments toward PAS and euthanasia. [19–31] High levels of public support for PAS legalization have been shown by these surveys, along with comparatively high rates of medical professionals endorsing and even using PAS. All of the guidelines that have been put forth thus far have recommended that psychiatric examination be a crucial part of any evaluation of a patient's request for PAS. [32–34] It is obvious that if PAS is made legal, mental health practitioners will need to be heavily involved in the assessment of individuals who are nearing the end of their lives and desire PAS. [16, 35–38] Few studies have examined the reasons behind patients' desire for accelerated death, despite the apparent significance of a mental health professional's assessment in evaluating requests for PAS.

Few studies have examined the reasons behind patients' desire for accelerated death, despite the apparent significance of a mental health professional's assessment in evaluating requests for PAS. Meier *et al*. [28] reported that just 2% of doctors sought mental health advice for patients who requested PAS or euthanasia. Furthermore, despite the overwhelming support from psychiatrists for legalization, a study by Ganzini *et al*. [25] found that just 6% of Oregon psychiatrists felt “confident” in their competence to determine if a psychiatric illness was compromising the judgment of a patient requesting PAS.

Euthanasia and Pas in Clinical Practice

Numerous surveys detailing the use of PAS and euthanasia by medical personnel have been published. For instance, a 1995 anonymous poll of doctors in Washington revealed that 26% of respondents had at least one PAS request, and two-thirds of those doctors had accepted it. [20] Despite the unlawful status, these numbers indicate that PAS is not an uncommon occurrence (it is also likely that some physicians who had really carried out these orders were afraid to report their conduct for fear of penalties, even if the survey was anonymous). A survey of doctors treating AIDS patients in the San Francisco area revealed even more startling findings. [8]

According to Slome *et al*. [39], 98% of respondents had received requests for PAS, and over half of all responding physicians said they had approved requests, with some doctors satisfying dozens of such requests.

Furthermore, almost half of the sample (48%) said they would probably approve a hypothetical patient's initial request for PAS in response to a hypothetical vignette. Asch's study on critical care nurses is arguably the most stunning research on the use of PAS and euthanasia to date. [19] Based on data from an anonymous survey, this study discovered that 17% of participants had at least one PAS request, and 11% had approved one [9].

About 5% of nurses who responded admitted to hastening a patient's death at the doctor's request but without the patient's or family's consent (referred to by some authors as "nonvoluntary euthanasia"). Furthermore, 4.7% of the sample reported having accelerated a patient's demise without the doctor's knowledge or consent. In order to speed up dying, respondents reported stopping oxygen therapy or increasing pain medication. [19] According to responder nurses' reports, Asch proposed that these procedures were taken to lessen the patients' pain. It should be mentioned that Asch's contentious study received a lot of feedback, including numerous recommendations that methodological flaws such ambiguous question phrasing could render the results untrustworthy. [40] Even while these statistics might not fully reflect the actual prevalence of PAS or euthanasia, requests for help in dying are obviously not uncommon occurrences, and doctors occasionally provide them in defiance of legal prohibitions. Furthermore, the appropriateness of patient requests and physician responses is unknown due to regulatory restrictions that restrict doctors' capacity to confer with colleagues about how to respond to a request for PAS.

However, data on the frequency of requests for assistance in dying and the percentage of terminally ill patients whose lives end in this way are available in the Netherlands, where PAS and euthanasia have been routinely performed for more than 20 years. In 1984, the Dutch Supreme Court ruled that euthanasia was legal as long as certain requirements were fulfilled. Both the patient and the doctor must concur that the patient's suffering is unbearable and that all other options for relief have been tried [10]. The decision to help end the patient's life must be approved by a second doctor who must be consulted. Lastly, each of these circumstances needs to be properly recorded and submitted to the government agency in charge of overseeing euthanasia. Due to the availability of these records, a number of studies have documented the percentage of deaths in the Netherlands where PAS and euthanasia are involved (these estimates were adjusted to account for underreporting of euthanasia admitted by many Dutch physicians). Van der Maas *et al*.'s paper [41] on euthanasia and PAS practices in the Netherlands between 1990 and 1995 included both official euthanasia reports and anonymous survey responses to estimate euthanasia and PAS rates. They came to the conclusion that approximately 4.7% of all deaths in the Netherlands in 1995 involved euthanasia and PAS, a significant rise over the 2.7% of deaths involving medical aid recorded in a 1991 research. [11, 31]

Data from the Netherlands is used by proponents of PAS as proof that legalization has not resulted in widespread misuse or overuse of PAS or euthanasia.

Critics contend that the 75% rise in PAS [12] or euthanasia-related deaths (from 2.7 to 4.7%) indicates a growing trend toward their more frequent usage and, consequently, a higher number of potentially inappropriate euthanasia instances. A 1994 Dutch Supreme Court ruling that extended the right to euthanasia/PAS to patients with chronic illnesses that are not terminal, including mental disorders like depression, provided the illness is refractory to treatment and causes intolerable suffering, amply illustrates these concerns.

There have been a few instances where mentally ill Dutch adults have been granted PAS or euthanasia as a result of this court decision, despite the fact that the great majority of requests for PAS from mentally ill people have been turned down. This experience has been found to support the "slippery slope" theory [17], which holds that legalizing PAS will eventually increase the number of patients who are eligible for this "intervention," many of whom may not be suitable candidates (e.g., physically healthy but clinically depressed individuals).

Reasons for Seeking Hastened Death/Pas

There is an increasing amount of literature outlining the kinds of psychological and physical issues that might lead to

calls for PAS and a wish for an early death. Many of the presumptions made by the early proponents and opponents of legalization have been reinforced by a rising consensus, notwithstanding the inconsistent nature of this material. In particular, pain, sadness, social support, and cognitive impairment are the problems with the most widespread empirical backing.

Suicide Among the Medically Ill

Not every patient who wants to die quickly asks their doctors for help. Prior to the PAS discussion, rates of suicide among medically ill groups had long been the subject of empirical research and therapeutic concern. According to the majority of this research, persons with medical conditions are more likely than physically healthy populations to experience sadness and suicidal thoughts. [12, 42, 43] Poor prognosis and advanced disease, sadness, hopelessness, loss of control, helplessness, delirium, weariness and exhaustion of resources, pre-existing psychopathology, and prior suicide attempts are among these suicide vulnerability factors in cancer and AIDS patients [13].

Hinduism – Suicide, Euthanasia, and Pas

It has been noted that the Hindu term for suicide, Atma Gatha, also includes intentionality. [44] In Hinduism, it was forbidden to intentionally murder oneself for selfish reasons. [45] Subjectively, evil sprang from ignorance and passion; objectively, evil included the karmic repercussions that hindered the advancement of emancipation. The Dharma sutras strongly forbade suicide in this scenario. [45]

Hinduism, however, honoured enlightened individuals who freely choose how to pass away. As a result, the Pandavas praised "Mahaparasthana," or the great journey, during their trek through the Himalayas, where they thrived on water and air until they died one by one. [44] Other instances of such venerated deaths include fasting, self-immolation, and drowning at sacred sites, according to Crawford [14, 45].

In Indian tradition, such deaths by enlightened individuals have never been associated with the common idea of suicide. Suicide has long been seen to make succeeding lives more difficult.

Can the above-mentioned Hindu position be applied to the euthanasia debate? Particular attention should be paid to the Indian perspective on life and death.

According to Hinduism, death serves as a prefiguration and model for the ultimate ideals of immortality and freedom, as well as a means of totally severing the bonds that bind man's ego or soul to cosmic impermanence. [44] According to Crawford [45], "spiritual death" in the Indian context is equivalent to a "good death," meaning that the person must be in a condition of equilibrium and serenity. According to Crawford [45], the idea of active euthanasia would not be unpalatable to the Indian psyche in order to guarantee such a noble death. However, this perspective has been challenged by writers [46] who assert that "spiritual death" or "iccha mrtu" can only occur when an advanced soul voluntarily decides to leave the body. It is also asserted that since the evolving soul is at a higher level of consciousness, it cannot be compared to mental peace. Therefore, Hindus would typically maintain their skepticism toward euthanasia, although being less rigid than other religions. It has been suggested that the Indian notion of Ahimsa may give birth to a strong opposition to euthanasia. However, violence that is unavoidable is not regarded as sin even under the Gandhian paradigm of Ahimsa. [46]

Attitudes of Psychiatrists Toward Voluntary Euthanasia in India

One of the main concerns raised is that the terminally ill patient's request for PAS could be influenced by depression. Therefore, the role of the psychiatrist becomes crucial in determining if these patients are depressed [15]. In certain jurisdictions, it is actually required by law for a psychiatric evaluation to be completed before a patient is allowed to undergo PAS. [26] It is said that the psychiatrists will serve as gatekeepers in this very contentious matter after being given this important position. It has also been suggested that psychiatrists' attitudes may influence their assessment because very few of them would feel comfortable identifying depression in terminally sick patients. [25]

We planned a study at the Central Institute of Psychiatry, Ranchi, to find out how Indian psychiatrists feel about euthanasia because they may have to serve as gatekeepers in PAS matters in the future, even if legalizing PAS is still not a very crucial prerogative for the Indian legislative [16]. This investigation produced some intriguing results. Ninety-nine of the 165 psychiatrists who took part in the study finished the questionnaire. Just 28% of the participants were against legalizing PAS, compared to over 55% who supported it. Deeply held moral principles, such as the idea that a doctor's job is to save life, religious convictions, pressure from PAS to enhance palliative care, and resource diversion from palliative care, were important determinants of the attitude. In the event of terminal illness, 60% of respondents said they would take PAS into consideration. Pain in 70% of cases, no chance of recovery in 50% of cases, loss of mental faculties in 49% of cases, incapacity to care for oneself, and poor quality of life in 35% of cases each would be the factors influencing their decision to consider PAS. If asked to provide an expert opinion, 60% of respondents said they would not be confidence in their ability to diagnose depression in terminally ill patients during a single interview. This discovery is unexpected because it suggests that judgments of psychiatrists who serve as gatekeepers in the future may be influenced by factors other than specialist knowledge, such as moral standards and prior attitudes regarding PAS.

An additional sample survey of 200 physicians conducted by the Society for the Right to Die with Dignity in Bombay [17, 47] provided insight into the opinions of medical professionals in our nation on PAS and euthanasia: Ninety percent said they were thinking about the topic and were worried about it; 78% said that patients should have the freedom to make their own decisions in the event of a terminal illness; 74% said that artificial life support should not be continued when death is imminent, but only 65% said they would remove life support; 41% said that Living Will should be respected; and 31% expressed doubts.

The Indian Reality

One could argue that issues pertaining to euthanasia and PAS [18] are unimportant in a nation where people's basic human rights are frequently ignored, illiteracy is widespread, over half of the population lacks access to drinkable water, infections claim lives every day, and there is little access to medical care. Nonetheless, India is a diverse nation in terms of cultures, educational attainment, and religious affiliations. Given this context, the Indian euthanasia topic is more complicated because the country has a legislation that penalizes anyone who even attempts suicide.

In a February 2008 meeting of its ethics committee, the Medical Council of India expressed the following opinions

regarding euthanasia: Euthanasia will be considered unethical behavior.

On certain occasions, however, a team of physicians—rather than just the treating physician—must decide whether to remove supportive devices to maintain cardio-pulmonary function even after brain death.

The termination of the support system will be announced by a group of physicians. The doctor in charge of the patient, the Chief Medical Officer or Medical Officer in charge of the hospital, and a physician chosen by the hospital's supervisor from the hospital staff or in compliance with the Transplantation of Human Organ Act, 1994, will make up this team. [48]

Euthanasia is illegal in India. Attempts to commit suicide are criminal under Section 309 of the Indian Penal Code (IPC), whereas aiding and abetting suicide is included under Section 306. With the assistance of family members, only those who are brain dead can be removed from life support. Similarly, the Honourable Supreme Court believes that the right to die is not included in the right to life protected by Article 21 of the Constitution. According to the court, elimination of life cannot be incorporated into Article 21, which guarantees the preservation of life and personal liberty.

On March 7, 2011, a significant advancement occurred in this field. In a historic ruling, the Supreme Court permitted passive euthanasia. [19] After a two-judge panel rejected the mercy killing of Aruna Shaunbag, who had been in a vegetative condition in a Mumbai hospital for 37 years, they established strict parameters that allow for the legalization of passive euthanasia through a high-court-monitored process. The court added that the patient's spouse, parents, or other close family members may file such a plea with the high court. After receiving such a plea, the top justices of the high courts would form a bench to make a decision. A committee made up of at least three well-known physicians would then be appointed by the bench to provide them with advice. [49]

Conclusion

Like the rest of the globe, medical knowledge is advancing in India, and as a result, we now have devices that can artificially extend life. In addition to being extremely expensive for the subject's family, this could unintentionally prolong dying pain. As a result, end-of-life concerns are emerging as significant ethical dilemmas in contemporary Indian medicine. Both proponents and opponents of PAS and euthanasia are as active in India as they are worldwide. Nevertheless, it appears that the Indian legislature is indifferent to these. Pro-euthanasia advocates have benefited greatly from the historic Supreme Court ruling, but there is still a long way to go until the legislation is passed by the legislature.

Furthermore, worries about its abuse continue to be a significant problem that should be resolved before it is enacted into legislation in our nation.

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