Euthanasia and the Right to Die

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On March 7th, 2011, the Law Commission of India, Ministry of Law and Justice in a landmark judgment recommended to the Government of India that terminally ill patients should be allowed to end their lives. By passing this judgment, India joins a small select group of nations that allow euthanasia in some form or other. This judgment has led to a vigorous debate in the media about euthanasia. Just what is euthanasia and what is the difference between active and passive forms of euthanasia? The word euthanasia is derived from Greek: eu ‘well’ + thanatos ‘death’. The Oxford dictionary defines euthanasia as the practice of killing without pain a person who is suffering from a disease that cannot be cured¹. The Stedman's medical dictionary gives a more comprehensive definition and defines it as the act or practice of ending the life of an individual suffering from a terminal illness or an incurable condition, as by lethal injection or the suspension of extraordinary medical treatment.²

Before we dwell deeper into the subject it is important to understand a few medical terms namely the difference between brain dead (BD) and persistent vegetative state (PVS). By all accounts Aruna Shanbaug has been in a PVS for the past thirty odd years. When she was strangled her brain was deprived of precious oxygen and blood leading to anoxic encephalopathy. Anoxic encephalopathy may also occur following other causes of cardiac and respiratory arrest. Most patients do not survive the initial anoxic insult to the brain, either their heart naturally stops after sometime (cardiac death ensures) or their brain dies (brain death ensures). We shall come to brain death later. Some patients though do survive thanks in no small part to sophisticated life sustaining measures such as ventilators and advances in critical care medicine. If these patients are followed the outcomes are varied. Some may “wake up” and start interacting with the environment (talking, responding appropriately to pain and so forth). Some who are in minimally conscious state (MCS) are able to demonstrate cognitively mediated behaviors but only inconsistently. A few may “wake up”, open their eyes and even yawn but when closely assessed have no meaningful interaction with their environment. It is these patients who after a period of observation are determined to be in a PVS. A person who is in a PVS shall never talk, walk or interact with his loved ones in a meaningful manner. In a way he is a vegetable. PVS is very different from BD. In BD there is irreversible damage either to the whole brain or the brain stem. For a person to be brain dead certain strictly defined criteria need to be met. These criteria with minor variations such as length of observation, interval between repeat testing, number of physicians needed to certify BD are essentially similar across the world and include absence of all brainstem function (brainstem reflexes) on clinical testing, no response to pain and no spontaneous respirations. The diagnosis of brain death is primarily clinical meaning that it is made after a thorough neurological examination conducted by a trained physician preferably one skilled in neurosciences (neurologist or neurosurgeon). In cases where for some reason the clinical examination is incomplete or in doubt as in barbiturate overdose, confirmatory tests such as an electroencephalogram (EEG), conventional angiography, transcranial doppler ultrasound, somatosensory evoked potentials and technetium-99m hexamethylpropyleneamineoxime are available to confirm BD.

The question of passive euthanasia may arise in patients who are in PVS. It may be requested by one of the family member to “end the patient’s suffering”. Active euthanasia on the other hand is usually requested by a patient who is terminally ill and in pain such as those with advanced cancer or those suffering from progressive neurodegenerative conditions such as amyotrophic lateral sclerosis (ALS) which in its final stages leads to difficulty in breathing. Terminal patients with ALS are further unable to clear their own secretions and are unable to swallow or cough. These patients may request their doctor for a mercy killing, ‘Please kill me and end my suffering and pain’. A point to clarify here is that the question of euthanasia whether active or passive does not even arise in a patient who is BD. Brain death is now around the world medically and legally synonymous with cardiorespiratory death. Once a patient is declared brain dead, he is dead. You do not have to wait for the heart to stop before you can say the patient is dead. As someone said rightly “you cannot die twice-once when the brain stops and once when the heart stops”. Hence in a BD patient, the law allows the physician to stop the ventilator and discontinue all other critical care support. Remember the patient is already dead so there is no need for the ventilator to keep running. This of course should be done with sensitivity and respect for the family. So the question of euthanasia whether active or passive is mute in a BD patient. Usually after a patient is declared BD the family is approached to consider organ donation. If the family decides to donate organs, the “dead patient” is kept on the ventilator till the organs can be harvested. If the family decides against organ donation, the ventilator is stopped and the body handed over to the next of kin.

So now let us move on to the topic of euthanasia. Active euthanasia (as for example mercy killing via a lethal injection or by giving an overdose of pain killers and sleeping pills) is currently illegal in almost all countries of the world. In most countries a physician who assists in active euthanasia can be prosecuted, lose his license to practice medicine and can even be jailed. Put in another way the law as it stands now condemns a physician for actively killing someone (even though the patient requests it) but does not condemn a physician for failing to save a terminally ill patient’s life (aka active euthanasia is illegal but not passive euthanasia). Netherlands and Switzerland are two countries where active euthanasia is practiced openly though the medical, legal and social implications remain active topics for both professional and public debate. The courts in these two countries have allowed physicians to practice active euthanasia under certain strict conditions. In these countries too it is usually physician assisted euthanasia (the physician prescribes the lethal medication but it the patient who self administers the lethal medication) is more widely accepted (both by the public at large as well as ethically and morally by the physician

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community) than active euthanasia (physician administers the lethal injection himself). In Netherlands the following guidelines if followed strictly have traditionally protected physicians from prosecution: the patient’s wish to die must be expressed clearly and repeatedly, the patient’s decision must be well informed and voluntary, the patient must be suffering intolerably with no hope for relief however the patient does NOT have to be terminally ill (mental suffering is acceptable as a reason for performing assisted suicide and euthanasia in a patient who may be physically healthy), the physician must consult with at least one other physician, the physician must notify the local coroner that death resulting from unnatural causes has occurred.

There is an ever increasing demand for the “right to die with dignity”. In an essay in the International Herald Tribune the right to die was defined as follows: “every person shall have the right to die with dignity; this right shall include the right to choose the time of one’s death and to receive medical and pharmaceutical assistance to die painlessly. No physician, nurse or pharmacist shall be held criminally or civilly liable for assisting a person in the free exercise of this right.” A fundamental thought underlying the right to die is the belief that one’s body and one’s life are one’s own, to dispose of as one sees fit. So theoretically if one wants to commit suicide one should have the freedom/ right to do so. Opponents of the right to die point out that legalizing suicide one should have the freedom/ right to do so. Different religions have different thoughts of view when it comes to the right to die. Hinduism in fact accepts the right to die for those suffering from terminal illnesses allowing death through the non-violent practices of fasting to death (Prayopavesa). Some Jains practice Santhara by which they seek voluntary death through fasting. Since the decision to practice Santhara is taken while one possesses a sound mind and is aware of the intent it cannot be equated to suicide which is usually carried out in haste when a person is in the midst of depression they point out.

So euthanasia remains a very complex topic with medical, legal and social implications. A concept which is virtually non-existent in India but quite common in the United States is the concept of a living will. A living will is an advance directive and a legal document in which a person makes known his or her wishes regarding life prolonging medical treatments. In a living will a person indicates beforehand which treatments he would or would not want to receive in the event he suffers a terminal illness or is in a PVS and is unable to speak and make decisions for himself. So it reasons that the living will does not become effective till the patient is incapacitated. As long as the patient can make decisions with a sound mind he can decide what treatments he wants or does not want. However after he becomes incapacitated or enters a PVS the living will comes into play. If in the living will he has documented that in the event of suffering a cardiac arrest in the background of a terminal illness he would not want to be resuscitated and put on a ventilator, his wishes shall be respected by his treating physicians. A comprehensive living will can give a patient substantial autonomy over what happens to their body at the final hour of their terminal illness.

We wish to highlight here that passive euthanasia in the form of withholding extraordinary life supporting measures (such as the decision to intubate and mechanically ventilate a terminally ill patient) is already routinely practiced in critical care units across India on a daily basis. In our experience once the hopelessness of the medical situation and the gravity of the illness is explained to the relatives, they usually comprehend and request discharge from the unit so that the patient can take his last breath at home surrounded by family and friends. It is only when disagreement about termination of care arises among family members or when a conflict of interest is perceived by the family members with respect to the treating physicians that these cases reach the attention of the media and the public at large such as in the case of Aruna Shanbaug. We hope that these misconceptions about passive euthanasia shall abate with better public education. The judgment on March 7th is indeed a landmark one and its implications on the Indian health system in the coming years shall be profound and keenly watched by all.

References
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2. Stedman’s Online Medical Dictionary at http://www.stedmans.com