

# Euthanasia: a review on worldwide legal status and public opinion

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## Abstract

The moral and ethical justifiability of euthanasia has been a highly contentious issue. It is a complex concept that has been highly discussed by scholars all around the world for decades. Debates concerning euthanasia have become more frequent during the past two decades. The fact that polls show strong public support has been used in legislative debates to justify that euthanasia should be legalised. However, critics have questioned the validity of these polls. Nonetheless, the general perceptions about life are shifting from a ‘quantity of life’ to a ‘quality of life approach’, and from a paternalist approach to that of the patient’s autonomy. A ‘good death’ is now being connected to choice and control over the time, manner and place of death. All these developments have shaped discussion regarding rights of the terminally ill to refuse or discontinue life-sustaining efforts or to even ask for actively ending their life.

**Key words:** *euthanasia, ethics, public opinion, law.*

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## 1. Background

The moral and ethical justifiability of euthanasia has been a highly contentious issue. It is a complex concept that has been highly discussed by scholars all around the world for decades. One of the earliest definitions of euthanasia, by Kohl and Kurtz, states it as “a mode or act of inducing or permitting death painlessly as a relief from suffering” (Beauchamp & Davidson, 1979: 295). The definition however fails to take into consideration the importance of ‘motive’ in euthanasia. For instance, as per this definition of euthanasia, it is immaterial as to whether the act has been committed with the motive of ending the life of the person so as to take away the property of the deceased or whether it has been carried out as a genuine effort to decrease the pain and suffering. Webster’s International dictionary defines euthanasia as “an act or practice of painlessly putting to death persons suffering from incurable conditions or diseases” (Beauchamp & Davidson, 1979: 295). This definition is an improvement on the previous one given that it takes into account the fact that the act of euthanasia can only be carried out when a person suffers from an incurable disease. Hailey in 1956 defined euthanasia as “administering an easy painless death to one who is suffering from an incurable and perhaps agonizing ailment” (Beauchamp & Davidson, 1979: 295). However, the above definitions also fail to account for the ‘motive’ factor in their description of euthanasia. The other drawback of these definitions is that they fail to differentiate between the various types of euthanasia – active

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and passive euthanasia. Reichel and Dyck take care of this issue by defining euthanasia as “an intentional and deliberate act to cause the immediate death of a person with incurable or painful disease”. The definition can however be critiqued to be too narrow given that it encompasses only active euthanasia within its ambit.

The confusion and inadequacy in the definitions saw a change in the terminology in the last two decades. The definition saw a real advance when Beauchamp and Davidson in 1979 came up with the most broad and inclusive definition that sought to include both active and passive euthanasia within its ambit.

*“A death of a person A is an instance of euthanasia if and only if it is intended by at least one other person B who is either the cause of death or a causally relevant feature of the event resulting in death; there is either sufficient evidence for B to believe that A is acutely suffering or irreversibly comatose, or there is sufficient evidence related to A's present condition such that one or more known causal laws supports B's belief; B's primary reason for intending A's death is cessation of A's suffering or irreversible comatoseness, where B does not intend A's death for a different primary reason, though there may be other relevant reasons and there is sufficient evidence for either A or B that causal means to A's death will not produce any more suffering than would be produced for A if B were not to intervene; the causal means to the event of A's death are chosen by A or B to be as painless as possible, unless either A or B has an overriding reason for a more painful causal means, where the reason for choosing the latter causal means does not conflict with the evidence; A is a nonfetal organism”* (Beauchamp & Davidson, 1979: 295).

The above definition tries to ensure that euthanasia envisage only those acts which are carried out with a motive of decreasing the person's suffering in case the condition is irreversible. It also makes sure that foeticide is not carried out in the garb of euthanasia. Similarly definitions came up such as Young's definition of euthanasia in 1996 as “bringing about the death of another person because she believes the latter's present existence is so bad that he would be better off dead, or believes that unless she intervenes and ends his life, his life will become so bad that he would be better off dead” (Beauchamp & Davidson, 1979: 295).

### ***Types of euthanasia***

Euthanasia can be classified in a number of ways. One way of classification can be by the manner in which the act of euthanasia is conducted – active and passive euthanasia. The other way of classification can be based on the nature of consent given by the person seeking euthanasia- voluntary, non-voluntary and involuntary. There is another terminology that is used in instances where a physician assists in the death of a patient. Jonsen defined physician assisted suicide (Jonsen, 1994-1995: 459) as “the situation where a doctor helps a patient to commit suicide by providing the patient with the means to end her life at the patient's autonomous request”. Euthanasia, whether active or passive, is therefore different from physician assisted suicide in the fact that in physician assisted suicide, the doctor prescribes medicines or drugs that would assist the patient in ending his life. He does not actively resort to the injection or intake of such drugs.

### ***Active Euthanasia***

That instance of euthanasia where a lethal substance or injection is administered to the patient so as to induce death is known as active euthanasia. Active Euthanasia has been under a lot of debate in the last few decades. People have generally opposed the idea of active euthanasia stating that the act violates the right to life of a patient. It also violates the doctor's Hippocratic Oath, since the oldest version of the oath does not talk about euthanasia as a duty that is bestowed upon the doctors. However, in contemporary times, active euthanasia has received support from more medical professionals and scholars. They have opined that the legalization of euthanasia is favorable for several reasons. Firstly, it allows terminally ill patients to end their suffering and extreme pain. They are not forced to endure their lives even against their will. Secondly, the concept of autonomy of life and the issue of right to die has crept into the arguments in favor of euthanasia. Proponents of euthanasia are of the opinion that every individual has a right to choose if he or she would like to end his life voluntarily and in what manner. It is essentially based on the concept of self-determination (Brock, 1992: 11). Philosophers, governments, medical professionals, scholars and social activists have time and again come up with various arguments but there has been no conclusion that has been reached in this aspect.

### ***Passive Euthanasia***

Passive euthanasia can be defined as those instances where necessary treatments such as antibiotics, drugs and other life support systems that are indispensable for the continuance of life are withheld. In case of passive euthanasia, no lethal drug is injected into the body of the patients so as to induce death. While most countries have spoken against the legalization of active euthanasia, some of them have gone ahead to legalize passive euthanasia. However, there are certain criticisms that cloud the domain of passive euthanasia as well. Passive euthanasia involves the withdrawal of life support systems that leads to the further worsening of the quality of life since it results in gradual death. In some situations there can be a possibility where the quality of life being lived is worse off than having no life at all. This could arise for a various reasons. The argument that comes up from pro- active euthanasia advocates is that living a life of extreme pain and suffering should have an automatic right of the patient to choose to make a decision regarding the inducement of his death.

## **2. Classification on the basis of nature of consent given by the patient**

Euthanasia can also be classified on the basis of the nature of consent that is obtained from the patient – voluntary, non-voluntary and involuntary.

### ***Voluntary Euthanasia***

Voluntary euthanasia refers to those instances of euthanasia in which a clearly competent person makes a voluntary and enduring request to be helped to die. Euthanasia can be said to be voluntary even in those instances where the person is no longer competent to give his consent but he had, in a previous situation, asserted his wish to die if such circumstances arose in future. If, while still competent, a person expresses his desire to die in particular situations of incurable diseases of extreme pain and suffering, the act of euthanasia in such circumstances results in the performance of voluntary euthanasia.

### ***Non-Voluntary Euthanasia***

Non-voluntary euthanasia refers to those instances of euthanasia where a person is either not competent, or unable at the time, to express a wish about euthanasia and has not

previously expressed a wish for it. The consent in such situations remains unexpressed due to a variety of reasons. For example, because a patient is seriously ill or handicapped, is a newborn infant, or because illness or “accident have rendered an initially competent person permanently incompetent, without that person having previously indicated as to whether she would or would not like euthanasia under certain circumstances” (Kuhse, 1992).

### ***Involuntary Euthanasia***

Involuntary euthanasia refers to those instances where a competent person's life is brought to an end despite an explicit expression of opposition to euthanasia. Such a situation of involuntary euthanasia can arise when a person is either not asked to give or withhold his consent to the inducement of his death or refuses to consent to the act. Involuntary euthanasia is considered to be akin to murder since the death is caused against the will of the patient. Medical practitioners usually do not carry out involuntary euthanasia in an explicit manner. It has however mostly been argued that some “widely-accepted medical practices, such as the administration of increasingly large doses of pain killing drugs that will eventually cause the patient's death, or the unconsented-to withholding of life-sustaining treatment amount to involuntary euthanasia” (Kuhse, 1992).

### **3. Legal status and public opinion of Euthanasia: worldwide perspectives**

Debates concerning euthanasia have become more frequent during the past two decades. The fact that polls show strong public support has been used in legislative debates to justify that euthanasia should be legalised.<sup>1</sup> However, critics have questioned the validity of these polls. Although the word “euthanasia” is derived from the ancient Greek eu (good) and thanatos (death), there is a general consensus in research, legislation and in the medical field to adopt a definition similar to the one used in the Netherlands: “Euthanasia is defined as the administration of drugs with the explicit intention of ending the patient’s life at his/her explicit request.” However, some authors suggested avoiding the use of the term “euthanasia” because of possible ambiguity and since this term can be emotionally charged. In addition, answers given to questions on euthanasia may be influenced by the wording of the question. A large scale Norwegian study in 2016, found moderate to large question wording and question order effects in an attitudes towards dying survey experiment (Magelssen, Supphellen, Nortvedt & Materstvedt, 2016). Another concern is the fact that people may not be well informed about end-of life practices. Within the context of a public information day, Gallagher found that almost half of people thought that treatment withdrawal was euthanasia and an Oregon study revealed much confusion in patients about their end-of-life options. For some, such confusion may be understandable because they believe that there is no moral distinction between acts or omissions that result in death. They contend that “passive” and “active” euthanasia are morally equivalent. However, legislation as well as medical practice invariably distinguish between these practices. Therefore, the results of these public surveys must be looked at with caution. Nonetheless, the general perceptions about life are shifting from a ‘quantity of life’ to a ‘quality of life approach’, and from a paternalist approach to that of the patient’s autonomy. A ‘good death’ is now being connected to choice and control over the time, manner and place of death. All these developments have shaped discussion regarding rights of the terminally ill to refuse or discontinue life-sustaining efforts or to even ask for actively ending their life.

### ***Europe***

In various European countries, the question whether the possibility of terminating the life of suffering and terminally ill patients in medical practice should be legalised, has been publicly debated. In 2002, both the Netherlands and Belgium legalised (active voluntary) euthanasia (Deliens & van der Wal, 2003: 1240). In Switzerland, (physician) assisted suicide (PAS) is not prosecuted when it is done without ‘self-interest’ (Bosshard, Fischer & Bar, 2002: 527). Although in most countries euthanasia remains illegal, sanctions are also often being downgraded and applied infrequently. Sometimes amendments in the law distinguish a medical decision that ends the life of a patient with unbearable pain at the request of the patient from murder (Bamgbose, 2004: 290). In most European countries, public debates on these issues are being held. Two elements have been particularly important in this change, in the social and political debate and in the procedural rule-making. First, the evidence that euthanasia occurs in many European countries (as well as outside Europe) has increased concern about the necessity to better understand how euthanasia is performed and how to ensure safe practice (Deliens & van der Wal, 2003: 1240). The growing support of the general public for a ‘right to die’ legislation has been an important influence for the euthanasia debate (Benson, 1999: 2658). European studies of public attitudes towards euthanasia show that a majority of citizens think that euthanasia and/or PAS is acceptable or should be legalised: 80–93% in Germany (Helou, Wende, Hecke, Rohrmann, Buser & Dierks, 2000: 308) ; 84% in Great Britain (O’Neill, Feenan, Hughes & McAlister, 2003: 721); 82% in Switzerland (Hurst & Mauron, 2003: 271); 61% in France (Teisseyre, Mullet & Sorum, 2005: 357); 50% in Finland (Ryynanen, Myllykangas, Viren, & Heino, 2002: 322); 24–65% in Poland (Domino, 2002: 105). However, far from all European countries were studied (in particular, the Eastern European countries were missed out), and the use of different instruments or questions limits comparability between countries. Many previous studies were also limited to health professionals’ attitudes towards euthanasia (legislation), which is important because medical professionals will be the primary actors (Ben Diane, Peretti-Watel, Lapiana, Favre, Galinier, Pegliasco, et al., 2003, 154). Awareness of public opinion is, however, also important since individuals and families would be initiators of the requests for euthanasia and subjects of the decision-making process (Genuis, S. J., Genuis, S. K., & Chang, 1994: 701).

Netherlands has a long history of debates and discussions on euthanasia. One of the earliest cases on euthanasia that came up in Netherlands was the Postma Case (Gevers, 1996: 326) in 1973. In that case, a physician was convicted for having facilitated the death of her mother who had consistently requested him for euthanasia. The Alkmaar Case (Gevers, 1996: 326) followed the Postma Case in 1984 where a 73 year old, chronically ill woman in the advanced stages of multiple sclerosis, was euthanized by the doctor after several requests. This was the first case where the Supreme Court of Netherlands recognized the doctrine of necessity and allowed euthanasia to be carried out in specific circumstances. The court went on to formulate guidelines that were to be followed by the doctors and the patient while carrying out euthanasia. The guidelines state that the request for euthanasia was to be made by the patient and it should be “entirely free and voluntary, well considered and persistent”. Euthanasia could be allowed in only those circumstances where the patient was experiencing intolerable suffering and pain, with no hope of improvement and with no available means to alleviate the patient’s suffering. It was also

mandated that a doctor should perform euthanasia only after he had consulted an impartial colleague who has experience in the field.

The various euthanasia requests that came up before the court led the Netherlands Parliament to legalise active euthanasia in 2002 through the enactment of the Termination of Life on Request and Assisted Suicide (Review Procedures) Act, 2002. The act defines euthanasia as the “deliberate termination of the life of a person on his request by another person” (Gevers, 1996: 326). The Act envisages the creation of a medical review board that has the power to suspend prosecution of doctors who have performed euthanasia when each of the following conditions is fulfilled - the patient's suffering is unbearable with no prospect of improvement or alternative remedies, the patient's request for euthanasia must be voluntary and must be shown to be persistent over time, the patient cannot make the request under the influence of others, psychological illness or drugs, the patient must be fully aware of his condition, diagnoses and options, the doctor, before carrying out euthanasia must consult with at least one other independent doctor who needs to confirm the conditions mentioned above, the death must be carried out in a medically appropriate manner by the doctor or patient, and the doctor must be present and the patient should be at least 12 years old (patients between 12 and 16 years of age require the consent of their parents).

The Groningen Protocol was developed in 2004, which allowed euthanasia of children below the age of 12 only if the requirements of the protocol were followed – the child should be suffering from hopeless and unbearable pain, the consent of the parents to termination of life is a necessity, the doctor must consult an impartial colleague and there should be careful execution of termination of life.

Widespread prevalence of permissive attitudes towards euthanasia in Netherlands has been well documented in research (Cohen, Marcoux, Bilsen, Deboosere, van der Wal, Deliens, 2006: 743). Relatively more permissive attitudes have been found among the general public in comparison to practitioners, however, overall research suggests that there is an unambiguous support for euthanasia and the legal act in Netherlands (Rietjens, van der Heide, Onwuteaka Phillipson, van der Maas, van der Wal, 2005: 1723). Despite the international criticism and slippery slope argument the public opinion has remained largely unaltered (Holsteyn & Trappenburg, 2001). Several reasons have been posited to explain this pattern of support such as the role of the Dutch healthcare system, general openness of the society towards contemporary ideas (Rietjens, van der Maas, Onwuteaka Phillipsen, van Delden, van der Heide, 2009: 271) and less religiosity (Verbakel & Jaspers, 2010: 121). However, this tolerant public opinion does not imply ‘absolute’ support for euthanasia and physician assisted suicide. Initial surveys conducted among the general population in Netherlands focused on euthanasia in general and contained questions such as “What should a doctor do when a patient asks him to put an end to his suffering by administering a lethal injection?” (Rietjens, van der Heide, Onwuteaka Phillipson, van der Maas, van der Wal, 2005: 1723) and “Please tell me whether you think euthanasia (terminating the life of the incurably sick) can always be justified, never be justified, or something in between” (Cohen, Marcoux, Bilsen, Deboosere, van der Wal, Deliens, 2006: 743). Although the results of such surveys mirrored the openness of the Dutch majority towards euthanasia, but, they were unable to capture the complexity of their opinions. A mixed method study by Kouwenhoven et al. (2012), conducted after almost 8 years of the euthanasia legislation in Netherlands, presented some important findings in this regard.

Interestingly, the results indicated that majority of the physicians and general population considered physical symptoms as a prerequisite to unbearable suffering. Only a minority of physicians and general public agreed with performing euthanasia in cases of chronic depression (physicians 35% public 28%), early dementia (physicians 28%, public 24%) or being tired of living (physicians 36%, public 26%) even though the law permits euthanasia or PAS for mental suffering (Kouwenhoven et al., 2012). This suggests that although there is broad support for euthanasia and PAS, the opinion of professionals and the general public in Netherlands is contingent on various factors.

After the Netherlands legalised euthanasia in 2002 (Weber, 2001: 372) by providing an exemption for doctors, Belgium followed suit. The Belgium Act of Euthanasia of May 28, 2002 defines euthanasia as “intentionally terminating life by someone other than the person concerned, at the latter’s request”. The Act legalized active euthanasia (The Belgian Act of Euthanasia of May 28th, 2002) for competent adults and emancipated minors upon their request. The provision however necessitates the fulfilment of certain conditions. The request should be voluntary and the patient requesting euthanasia must be in a “medically futile condition of constant and unbearable physical or mental suffering that cannot be alleviated”. The Belgian Parliament went one step ahead of the 2002 act when it legalized euthanasia for terminally ill children on February 13, 2014 (European Institute of Bioethics). Certain safeguards were however placed to ensure that children are not exploited by means of the provisions of this act. The act requires the patient to be conscious of their decision and they are required to give a free informed consent only after they are made aware of the meaning of euthanasia. The request for euthanasia should be voluntary and must have been approved by the child's parents and medical team. The child’s illness needs to be terminal, he must be in extreme pain and suffering with no available treatment to alleviate his distress. The law also makes provision for a psychologist to determine the patient's maturity to make the decision.

It is interesting to note that post the enactment of the law in Belgium, the number of mercy killings has remained constant (Cohen, 2009: 438). This means the only difference now is that doctors do not have to carry out the procedure illegally. In general, the permissiveness towards euthanasia in Belgium is quite high, close to that in Netherlands, despite being a population majorly consisting of a Catholic majority. This may be due to the low level of religiosity in Belgium (Verbakel & Jaspers, 2010: 121). In a large-scale study conducted to understand the public opinion on Euthanasia in Belgium, interviews were conducted with leading scholars and practitioners in February 2003 and February 2005 (Cohen, 2009: 436). In Belgium, three-quarters of the society were found to be in favour of legalising euthanasia (Cohen, 2009: 436), as they recognize the importance of the quality of life (Cohen, 2009: 436). It was observed in the study that focus in the North (largely Dutch speaking), where people are more open about euthanasia, is on the patient’s autonomy. However, in the South (French speaking), the people tend to rely on physicians; this also explains why the number of reported cases is higher in the North (Cohen, 2009: 436).

The law in Switzerland allows the prescription of deadly drugs to a Swiss person or to a foreigner, where the patient takes an active role in the administering the drug to himself. Article 115 of the Swiss Penal Code, which came into effect in 1942, considers assisting suicide a crime if and only if the motive is selfish. In Switzerland, active assisted

suicide, a doctor prescribing and handing over a lethal drug, is illegal (*BBC News*, 25 June 2010).

German law also states that active assisted suicide, the act where a doctor prescribes and hands over a lethal drug, is illegal. German law however allows assisted suicide if the lethal drug is taken without any help, such as someone guiding or supporting the patient's hand. The law also clearly forbids actively assisted euthanasia as per Paragraph 216 of the Criminal Code. By contrast, it is not illegal to purchase lethal medications for someone who wants to die. Germany allows passive assisted suicide. Doctors are allowed to “switch off assisted breathing and feeding systems for a terminally ill patient, if this is the expressed will of the patient”. This is regulated by the advanced decision by the patient. Indirect assisted suicide is also permitted by means of administering strong painkillers, which can have the effect on weakened organs of cutting short life, such as giving morphine to cancer patients during their final stages. The German laws have been backed by the decision of the German Federal Court of Justice which ruled that the cutting of life support for consenting, terminally-ill patients is not a crime (Schadenberg, 2014). It is interesting to note that in Germany, the term ‘euthanasia’ is avoided, as it relates to the policies of the Nazi era. The memory of Nazi history has been posited as a probable reason for their reservations against the practice of euthanasia (Cohen, Marcoux, Bilsen, Deboosere, van der Wal, Deliëns, 2006: 743). In a study that involved 12 European countries from 1981-1999, found that despite the increase in permissiveness and decrease in religious beliefs, there was no significant increase in euthanasia acceptance among adult citizens in Germany (18-year-old or above) (Cohen, Marcoux, Bilsen, Deboosere, van der Wal, Deliëns, 2006: 743).

The French parliament has voted unambiguously in favour of a law allowing terminally ill patients to cease treatment and enter a “deep and continuous sedation” until they die. Patients are also allowed to make living wills, stating that they do not want to be kept alive artificially if they are too ill to decide. Passive Euthanasia was legalized in France way back in 2005. The confusion remains as to whether active euthanasia has been legalized in France due to this law (Chazan, 2015). Public opinion on the other hand, has seemed to have shifted towards an acceptance oriented attitude regarding euthanasia. Data from 1981, 1990, 1999-2000 and 2008 wave of the European Values Survey (EVS) showed that France along with Netherlands, Belgium, Denmark and Sweden ) (Cohen, Marcoux, Bilsen, Deboosere, van der Wal, Deliëns, 2006: 743).

### ***Asia***

In the case of India, even though the exact statistics on the number of euthanasia requests is not readily available, there have been numerous instances that have come up in news reports where people have demanded euthanasia (Satija, 2015). In India, the debate surrounding euthanasia has mainly focused on the various judicial decisions that have tried to analyse as to whether right to life under Article 21 of the constitution encompasses within its ambit the right to die. In the case of *R Rathinam v. Union of India* (1994 (3) SCC 394), the court held that Section 309 of I.P.C., which deals with attempt to commit suicide, violates Article 21, and is hence void. In *Gian Kaur v. State of Punjab* (1996 (2) SCC 648), a constitutional bench held that the “*right to life*” does not include within its ambit the “*right to die*”. Public consciousness about euthanasia reached the pinnacle with the Aruna Shanbaug incident in 1973. Shanbaug, a nurse at KEM Hospital, Mumbai went into a persistent vegetative state when a sweeper sexually assaulted her. The hospital staff took



care of her for 37 years after which an activist journalist, Pinki Virani filed a writ petition (*Aruna Shanbaug v Union of India* 2011 (4) SCC 454) at the Supreme Court in 2009 requesting the court to grant euthanasia for Shanbaug. The court in a landmark decision in 2011 went on to legalize passive euthanasia in certain instances. The Supreme Court specified two irreversible conditions to permit Passive Euthanasia – 1) the brain-dead for whom the ventilator can be switched off 2) those in a “Permanent Vegetative State for whom the feed can be tapered out and pain-managing palliatives be added, according to laid-down international specifications”. The court further laid down the following guidelines:

- The decision to discontinue life support is to be taken either by the parents or the spouse or other close relatives, or in their absence, a next friend. The doctors attending the patient can also take it.
- The decision should be taken in a bona fide manner in the best interests of the patient.
- The decision requires approval from the High Court concerned.
- When such an application is filed, the Chief Justice of the High Court should constitute a Bench of at least two Judges who should decide as to whether to grant approval or not. A committee of three reputed doctors is to be nominated by the Bench, who is to give report regarding the condition of the patient.

The Shanbaug decision was followed by a PIL (*Common Cause v Union of India* (2014) 5 SCC 338) that was filed by NGO Common Cause to declare the right to die within Article 21. A three-judge bench observed that the judgment in *Aruna Shanbaug v. State of Punjab*. Therefore, the court referred the issue to a constitution bench, which shall be heard by strength of at least five judges. The Shanbaug decision remains the legal status of euthanasia in India.

Regarding the opinion of the general public on Euthanasia, there is a lack of national level data. Studies majorly review the legal developments and arguments for and against the legalization of euthanasia. Furthermore, the few opinion surveys that have been conducted, have majorly focused on the population of professionals such as doctors, lawyers and judges rather than the public in general. One such study conducted on 200 doctors across 28 hospitals in Delhi reported that, majority of the doctors did not support active euthanasia, but, there was a strong support for voluntary passive euthanasia among psychiatrists and intensivists (as opposed to oncologists and hematologists) (Singh, Sharma, Aggarwal, Gandhi, Rajpurohit, 2015: 49).

In China, euthanasia has not been legalised. The proposed legislation to legalize euthanasia in the National People’s Congress in 1995 was not passed (Scherer & Simon, 1999). The first survey in China regarding the public opinion on euthanasia dates to 1985 (Pang, 2003). Since then there have been several public opinion surveys in the 1990’s as well which have shown the support of public, especially the younger respondents with higher education, towards voluntary active euthanasia (Pang, 2003). China however, is also majorly influenced by Confucianism which morally sanctions euthanasia in very limited circumstances. In addition to this, due to China’s strained healthcare system it is advocated that reforms should focus on reforming the healthcare system rather than legalization of euthanasia (Chai, 2015).

The Japanese Government has no official laws on the status of euthanasia and the Supreme Court of Japan has never ruled in this matter. However, there have been two local court cases that have decided the nation's policy towards euthanasia (Hongo, 2014). While the Kawasaki Kyodo Hospital Case created guidelines on Decision Making Process of Terminal Care, the Court gave certain conditions that are necessary to carry out active and passive euthanasia in the Tokai University Hospital Euthanasia Case (Katsunori, 2012).

For passive euthanasia, the following three conditions must be met:

- The Patient must be suffering from an incurable disease, and must be in the final stages of the disease.
- The patient must give express consent to stopping treatment. If the patient is not able to give clear consent, their consent may be determined from a pre-written document.
- The patient may be passively euthanized by stopping medical treatment, chemotherapy, dialysis, artificial respiration, blood transfusion, etc.

For active euthanasia, the following four conditions must be met:

- The patient must be suffering from unbearable physical pain.
- Death must be inevitable and drawing near.
- The patient must give consent.
- The physician must have exhausted all other measures of pain relief.

Both euthanasia and assisted suicide are illegal in Singapore as per S.17 of the Advanced Medical Directive Act 1997. The Act has express provisions stating that -

*“nothing in the Act shall authorise an act that causes or accelerates death as distinct from an act that permits the dying process to take its natural course”.*

*“nothing in this Act shall condone, authorise or approve abetment of suicide, mercy killing or euthanasia”.*

Active Euthanasia in Thailand qualifies as murder under S. 288 of the Criminal Code. Physician-Assisted Suicide qualifies as assistance of suicide under S. 307 of the Criminal Code. Under S. 12 of the National Health Act of Thailand, a person is given the right to make a living will to refuse the public health service that is provided to lengthen his terminal stage of life or to refuse the services to lessen his sufferings from the illness (Aisha, 2011).

### **USA**

While some states in the US have legalised euthanasia or physician assisted suicide, others have still not gone ahead with the decriminalisation of euthanasia. Results of the World Values Survey 1981, 1990 and 2000 point towards an increased acceptance of euthanasia among Americans. The General Social Survey (1977-2002) showed that the acceptance of euthanasia among general public increased from 1978 and peaked in 1990-1991 and then slightly decreased from 1994-2002. Another systematic review of 39 studies (1991-2000) concerning the attitude of physicians regarding physician assisted death and euthanasia revealed that physicians held more favourable attitudes towards physician assisted death. The acceptance rate of physician assisted death ranged from 14 to 66 percent, whereas for active voluntary euthanasia it ranged from 23 to 63 percent. Around one third of the physicians would agree to participate in physician assisted death, if it were made legal.

Regarding the legal status of euthanasia in USA, the state of Oregon legalized euthanasia through the Death with Dignity Act of 1997. The provisions of the act allow patients who are terminally ill or hopelessly ill to request for lethal medication. The patient

is required to make two verbal requests and another in writing with a witness, for the doctors to end his life. There should at least be two doctors and they should “agree on the diagnosis, the prognosis of the disease and the capability of the patient”. Since the state has legalized physician assisted suicide, he is required to personally administer the medication.

Washington became the second state in the US to legalize euthanasia in 2008 through the Washington Death with Dignity Act. The patient is again required to make two verbal requests and another one in writing. The requests need to be 15 days apart and the patient must be suffering from a terminally ill condition with a life expectancy of six months or less.

Montana, in December 2009 legalized euthanasia through *Baxter v. Montana* (*Baxter v Montana* 354 Mont. 234). Competent patient had the right to die with dignity. Physician can assist the patient by providing prescription lethal medication that the patients are required to take on their own.

Vermont legalized euthanasia in May 2013. Euthanasia was granted a legal status by enactment of Act 39 of the End of Life Choices. The law also requires that the patient provide two oral and one written request. The most important requirement of the Vermont state law is that the patient needs to be a resident of the state so as to participate in euthanasia.

California has most recently legalized euthanasia. The topic was brought to the forefront in California by the case of Brittany Maynard, a 29-year-old with a brain tumor who moved from San Francisco to Oregon and took her own life. In the case of *Barber v. Superior Court*, two physicians had honored a family's request to withdraw both respirator and intravenous feeding and hydration tubes from a comatose patient. The physicians were charged with murder, despite the fact that they were doing what the family wanted. The court held that all charges should be dropped because the treatments had all been ineffective and burdensome. The court went on to say that the withdrawal of treatment, even if life ending, was morally and legally permitted. Competent patients had the right to decide to withdraw treatments, usually after the treatments were found to be ineffective, painful, or burdensome (Procon.org, 21 February 2017). The Californian Parliament finally passed a bill legalizing physician assisted suicide in September 2015 (the bill became effective from January 1, 2016).

### ***Australia***

The debate about euthanasia started in Australia with the enactment of the Rights of the Terminally ill Act (ROTA), 1995. A watershed moment in the history of euthanasia, this act legalized voluntary euthanasia and physician assisted suicide in the Northern Territory of Australia. This jurisdiction was the first in the world to legalize euthanasia and the first to repeal it. This act permitted a physician to respond to the request of a terminally ill adult patient (18 years and above) experiencing severe suffering. Within nine months of the enactment of this act, there were seven requests for euthanasia out of which four patients were legally granted permission. During this time, the act met with strong opposition especially from religious leaders. In 1997, by a margin of four votes the act was repealed and the Euthanasia Laws Act, 1997 was integrated into the Northern Territory (Self Government) Act (Plattner, 1997: 645).

Thereafter, there have been several futile attempts to pass laws supporting euthanasia despite the overarching support of the public demonstrated through various opinion polls since 1987 (Tran, 2015). Plattner (1997) termed the repeal of ROTA as mere

“symbolic formality”. Even through the 1990s, surveys showed the stable support of the public, with variations depending on circumstances (Sikora, 2009: 31). Voluntary and non-voluntary euthanasia was more likely to be supported by Australians when death was impending (Sikora & Lewins, 2007: 68).

#### **4. Conclusion**

Euthanasia is a highly sensitive issue. The issue of support or rejection of euthanasia far being black or white is contingent upon several factors such as the type of illness, degree of suffering, religious affiliation, country’s health care system and socioeconomic status of patients. For countries that have legalized euthanasia, counterarguments such as religious reasons, slippery slope arguments, lack of an efficient health care system and compromising ethics have been posed. Formulation of guidelines and their strict implementation in this case becomes important. However, in addition to the laws, medical professionals also need to be equipped with the knowledge and expertise to make such challenging decisions. Therefore, opinion of the public and medical professionals is of limited importance unless the legal and health machineries are ready to handle euthanasia requests.

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