

## Debating Euthanasia in India: A Review of the Proceedings at the UNSECO Bioethics Forum, Manipal

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### Abstract

This review is about the discussion that followed my presentation at the UNESCO Bioethics Forum, Manipal. To contextualise, I begin with a brief account of the legal status of euthanasia in India, and then summarize the main argument of my presentation - if the moral objective of euthanasia is to end a patient's suffering by ending his or her life in the best possible way, then the form of euthanasia legal in India is inconsistent with this moral objective owing to the consequences it entails for the patient. Given this background, I elaborate on two issues that came up in the discussion - the missing framework of patients' rights, and the medical fraternity's reluctance to espouse multidisciplinary approaches in understanding the morality and legality of euthanasia. Contrary to popular belief as voiced at this forum, developing the framework of patients' rights, and simultaneously espousing multidisciplinary approaches, as I hope to show, would take the discussions of euthanasia in better informed directions.

**Keywords:** Euthanasia; Passive euthanasia by omission; India, Aruna shanbaug; Patients' rights; Multidisciplinarity

### Introduction

On the 26th of March, 2015, I presented a paper titled 'Passive Euthanasia in India: a Critique' [1] at the UNESCO Bioethics Forum (BEF), Manipal Unit of Chair in Bioethics (Haifa). The presentation was conducted at one of India's top medical training institutes - Kasturba Medical College, Manipal. I had the opportunity to address and converse with a range of professionals from the medical fraternity and otherwise - undergraduate and graduate students, medical and humanities professors, practicing doctors, nurses, care providers, and psychiatrists.

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### The Legal Status of Euthanasia in India

In March 2011, passive euthanasia by omission (here onwards referred to as PEO) was legalized in India. Physicians were given the right to withdraw or withhold life support, in order to end the lives of

patients suffering from irreversible and chronic medical conditions [2]. Active euthanasia, as well as passive euthanasia by commission (also referred to as physician assisted suicide) remain illegal.

The tragic case of Aruna Shanbaug, a nurse at the King Edward Memorial Hospital, Mumbai, was the single most influential case in legalizing PEO in India [3]. In 1973, Aruna was raped in the premises of the KEM hospital; the rape was followed by an attempt to murder, which rendered severe brain injuries among others, as a result of which she slipped into a comatose state. She died in 2015, after 40 years of coma. Pinky Virani, a journalist and women's rights activist issued a plea to euthanize Aruna in 2010, thereby initiating the legal discourse that eventually legalized PEO. At that time, the KEM hospital was strictly opposed to Pinky Virani's plea, for they considered it their collective responsibility to care for, and nurture Aruna, till her life (or perhaps, death?) took its natural course [2]. Importantly however, while in coma, Aruna's family abandoned her, giving the KEM hospital staff an unusual legal status - they were Aruna's ex-employers, caretakers and doctors, as well as her 'next friend' [3]. Being 'next friend' gave them the right to decide whether Aruna should or should not opt for PEO, on her behalf. Pinky Virani had no say in this matter. The Supreme Court ultimately refused to grant Pinky Virani's plea, ruling in favour of the KEM hospital [2].

Aruna's suffering continued, despite the Supreme Court's decision to legalize PEO.

### The Morality of PEO

My presentation critically analysed the moral legitimacy of PEO as a method of implementing euthanasia. The main argument was as follows: if the moral objective of euthanasia is to end a patient's suffering by ending his or her life in the best possible way, then PEO is inconsistent with this moral objective owing to the consequences it entails for the patient. Administering PEO would most likely lead to "an unnecessary amplification of pain" [1] for "an indeterminate

period of time” [1], as was clearly demonstrated by how Aruna’s life eventually ended. PEO thus does not end a patient’s suffering in the best possible way.

This inconsistency is telling. Withdrawing or withholding medical support as a method of implementing euthanasia is explicitly concerned with the doctor’s preference to perform acts of omission, and not acts of commission [1,2]. To take an example that came up in the discussion, doctors’ prefer withholding oxygen supply, as opposed to prescribing a lethal injection/pill, despite knowing that the ultimate consequence of both these acts is the patient’s death. This preference leads to important questions, some of which were asked during the discussion: Since euthanasia is, in principle, a practice that seeks to end the patients’ suffering, is it moral to employ methodologies that disregard precisely the patients’ suffering? Majority of the participants answered in the affirmative. Another question that naturally followed was: What justifies the suffering caused by a doctor’s act of omission? It was in the popular answer to this question that I saw the most glaring logical fallacy, *petitio principii* or what is commonly called begging the question. To crudely paraphrase – the suffering caused by a doctor’s act of omission is considered justified, because the doctor prefers acts of omission (as opposed to acts of commission).

Fallacious reasoning such as this is deceptive, in so far as the proponents fail to understand exactly which inferential leap begs the question it purportedly answers. The important question sidestepped here is – why do doctors prefer acts of omission in the first place, and is such a preference morally tenable given the consequences it entails for the already suffering patient? The following two points that came up in the discussion, help clear the grounds to expose the fallacious reasoning mentioned above.

### The Missing Framework of Patients’ Rights

The nature of events that caused the legalisation of PEO, as we saw, inevitably place the debate within the larger framework of women’s rights and safety [4]. Since the 2011 verdict, the moral and legal dilemmas surrounding euthanasia are almost always discussed with reference to Aruna’s case. As a prototypical case however, Aruna’s is a complicated one, not only because of what caused her medical condition. The crucial complication is that the decision making party was entirely comprised of medical professionals. It is therefore not surprising that there is an undue weightage given to the duties, responsibilities, and preferences of physicians – it is as if, by virtue of being a patient, the doctors’ preference for acts of omission assume legal and moral priority. But does requesting euthanasia (either directly or through a ‘next friend’) imply an unqualified surrender of the patient’s agency? What RB Ghooi and SR Deshpande [5,6] observe about the status of patients’ rights in India brings us to the crux of the problem that leads to these questions. While it was only in 2002, that the Medical Council of India formulated the Code of Ethics Regulations (COER), where we see the concept of patient’s rights articulated, “this code does not represent patients’ rights; those mentioned are incidental to the duties and responsibilities of physicians” [7].

Naturally, if patients’ rights are considered incidental to the duties and responsibilities of physicians, privileging the physicians’ preferences in implementing their ‘duties’ would seem unproblematic. To conceptualise patients’ rights that are meant to benefit patients, a distinction must be made between “a duty-centric approach as represented by the COER” [7] and “the rights-centric approach of the

AAPS (Association of American Physicians and Surgeons)” [7]. To begin with, espousing the latter in the context of euthanasia would require studying several cases in tandem with Aruna’s – especially those in which the decision making party is not fully comprised of members from the medical fraternity itself. If one abandons the notion of merely incidental patients’ rights, the privilege given to the physicians’ preference will seem unwarranted, and the popular argument mentioned earlier will seem obviously mistaken. It will be within the ambit of the constitution to address questions essential to legalizing any form of euthanasia: Do patients have the right to die a painless death? And if they do, how could such a death be administered painlessly? It is implicit in these questions that PEO is not a legitimate form of euthanasia, for it does not administer death painlessly. The 2011 verdict however skirts these questions (one might wonder if this is even possible while discussing euthanasia), by making euthanasia seem like a matter solely concerning physicians [1].

### Espousing a Multidisciplinary Approach

Besides studying cases in which the decision making parties are more representative of the euthanasia situation, the struggles of other countries to legalise euthanasia prompt one to include, and draw from discourses other than medicine to understand the moral and legal debates regarding euthanasia holistically. Narratives of patients with chronic disorders composed by their respective caretakers/family members [8,9], and the global academic disciplines of applied and practical ethics [10,11], moral and legal philosophy [12,13], and other allied discourses that fall under the blanket term of ‘humanities’, ‘arts’ or ‘soft sciences’ in India, often address questions of life and death in various different contexts. It would be rather fatuous to dismiss these perspectives because they lack the practical knowhow that training and work experience in medicine provide. During the discussion, I realised that my training in philosophy and interdisciplinary humanities worked against me – the idea that physicians must not be the only ones deciding how euthanasia can be implemented came across as ‘overly empathetic’ and ‘impractical.’

It is worth reiterating the obvious - euthanasia is a multi-faceted issue, of which practical execution by physicians is one aspect. The overwhelming preoccupation with one perspective (the physician’s) can be counterbalanced by opening up the discourse to other disciplines – by first understanding what the subjects of medicine (and not it’s deliverers), as well as theorists from outside medical disciplines have to say. At the least, doing so would make apparent the fact that a euthanasia situation is morally vexed for all parties that comprise it. For there seems to be no sound argument that would justify dismissing any discipline that addresses, in different ways, the dilemmas involved.

### Concluding Remarks

The 2011 verdict was a legal milestone, which earned the issue of euthanasia considerable public debate and discussion in India. I have reviewed one such discussion that was hosted by the UNESCO Bioethics Forum, Manipal. Drawing from the discussion that followed my presentation, we have two ways that would further our understanding of the legal and moral issues regarding euthanasia in India, given especially the overwhelming preoccupation with the physicians’ side of the story - developing the framework of patient’s rights, and simultaneously espousing multidisciplinary approaches.

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