DYING WITH DIGNITY: CASE FOR LEGALISING PHYSICIAN-ASSISTED SUICIDE

*Stanley Yeo**

IT IS important at the outset of this article to note its narrow confines which is to contend that a physician who assists with the suicide[1] of his or her patient (hereinafter described as "physician-assisted suicide"[2]), if done under certain strict conditions, should be decriminalized. For the purposes of the ensuing discussion, physician-assisted suicide constitutes a physician who has provided his or her patient with the necessary means or information to enable the patient suffering from a terminal disease to perform the life-ending act. Physicians alone are being considered here and no other professionals such as psychologists and social workers or family members and close associates of the patient. Furthermore, decriminalization is sought only in respect of cases where the patients of these physicians had freely chosen to terminate their own lives and had themselves done an act to facilitate it. This rules out voluntary active[3] euthanasia which constitutes the intentional putting to death of a terminally ill person who had requested it as an act of mercy. *A fortiori*, it is also not sought to decriminalize cases of involuntary active euthanasia, that is, where a person had put to death another who had not given his or her consent to dying.

The underlying premise for advocating the decriminalization of physician-assisted suicide is that it was the patient himself or herself, and

* Professor of Law, National University of Singapore.

1. The Indian Penal Code (IPC) uses the term "suicide" in various provisions but does not define it. It has been held that a finding of suicide must be based on evidence that the deceased intended to destroy his or her own life: see *Thomas Master CA* v. *Union of India* 2000 Cri LJ 3729 (Ker).

2. This decription is, strictly speaking, incorrect, since suicide is not a crime in India and remains so even if a physician had assisted the person to commit suicide. However, it has been used in this article so as to accord with the convention of the literature on the issue. The point to note is that the term is intended to refer to the act of the physician in assisting the suicide, rather than the suicide itself.

3. As distinct from "passive" euthanasia which is legal and involves withdrawal of treatment or the administering of high doses of pain-relieving drugs which has side-effects that hasten death. See, Law Commission of India, *156th Report on Medical Treatment of Terminally Ill Patients (Protection of Patients and Medical Practitioners)* (2006). *Available at* http://lawcommissionofindia.nic.in/reports/rep196.pdf (accessed on 1st Aug 2008).

not the physician, who had made the decision to terminate his or her own life, and who had himself or herself done the act which terminated it. This double act by the patient of requesting assistance to commit suicide and following up with committing suicide, sets it apart from voluntary active euthanasia where only the first act of the patient is present. In this regard, it is noteworthy that, in the Netherlands where physician-assisted suicide and voluntary active euthanasia by physicians have been legalized since 1984,[4] medical guidelines call for assisted suicide to be preferred over euthanasia because it "makes the patient's determination and willingness to take responsibility clearer".[5] For this reason, physician-assisted suicide is a limited activity which can be safely legalized and controlled without automatically leading to the legalization of voluntary active euthanasia.

As will be detailed in this article, the argument will be made for a defence provision to be added to the Indian Penal Code (IPC) which will acquit physicians, operating under certain strict conditions, of the offence of abetting suicide which appears as section 306 of the Code and reads:

> *Abetment of suicide* – If any person commits suicide, whoever abets the commission of such suicide, shall be punished with imprisonment of either description for a term which may extend to ten years, and shall also be liable to fine.

There could also be cases where a patient attempts to commit suicide with his or her physician's assistance but survives the act. Since the very same arguments for acquitting the physician of the section 306 offence applies to such cases, it will be suggested that the proposed defence be also made available to the physicians involved.

Part I of this article provides an overview of the current law in India pertaining to suicide, assisted suicide and voluntary active euthanasia, focusing in particular on the significance which the law attaches to the deceased's consent to dying or being killed. Part II then considers whether the criminalization of attempted suicide and abetting suicide violates certain fundamental rights enshrined in the Constitution. These preceding parts will set the stage for part III where the arguments are made to decriminalize physician-assisted suicide. Part IV presents the Oregon Death with Dignity Act[6] as a possible model on which to formulate a defence available to physicians assisting the suicide of their patients. The article concludes

4. Making the Netherlands the first country in the world to legalize both these practices. See generally, J. Griffiths, H. Weyers and M. Adams, I *Euthanasia and Law in Europe* (Portland: Hart Publishing, 2008).

5. Royal Dutch Medical Association (KNMG), *Position of the Federal Board of the KNMG Concerning Euthanasia* 9 (2003). *Availab*le at http://knmg.artsennet.nl/themes/24 (accessed on 1st August 2008).

6. Or Rev Stat § 127.800-127.897.

with the appeal that the time is ripe for such a change to the law in India and how this could be achieved.

I Criminalising attempted suicide, assisting suicide and voluntary active euthanasia

As a starting point, suicide is not an offence in India, but attempted suicide is under section 309 of IPC.[7] The Indian Law Commission in its 42nd Report recommended the repeal of this offence on the ground that it was harsh and unjustifiable to punish a person who had already found life so unbearable. The recommendation was accepted by the government and a bill was passed by the *Rajya Sabha* in 1978 and was pending in the *Lok Sabha* when it was dissolved in 1979 as a result of which the bill lapsed.

It has already been noted that abetting (or assisting) suicide is an offence under section 306 of IPC. So too is abetting attempted suicide by virtue of section 309 read with 107[8] of IPC. In support of these offences, the Supreme Court of India has observed that:[9]

> [T]he arguments which are advanced to support the plea for not punishing a person who attempts to commit suicide do not avail for the benefit of another person assisting in the commission of suicide or in its attempt … The abettor is viewed differently, inasmuch as he abets the extinguishment of life of another person, and punishment of abetment is considered necessary to prevent abuse of the absence of such a penal provision.

Although voluntary active euthanasia is not the main concern of this article, it does share certain features with assisting suicide that render it useful to briefly consider it here. The difference between voluntary active euthanasia and assisting suicide is that the former, but not the latter, involves the accused performing an act, which directly causes the death of another. Apart from this, the similarities are that, for both activities, the accused intends for the other person to die knowing that he or she consents to being killed.

---

7. S. 309 reads: "Attempt to commit suicide – whoever attempts to commit suicide and does any act towards the commission of such offence, shall be punished with simple imprisonment for a term which may extend to one year or with fine, or with both."

8. S. 107 reads: "A person abets the doing of a thing who —

(a) instigates any person to do that thing;

(b) engages with one or more other person or persons in any conspiracy for the doing of that thing, if an act or illegal omission takes place in pursuance of that conspiracy, and in order to the doing of that thing; or

(c) intentionally aids, by any act or illegal omission, the doing of that thing."

9. *Gian Kaur* v. *State of Punjab*, AIR 1996 SC 1257 at para 37-38.

What role, if any, does the law give to the deceased's consent in such cases? There are several provisions in the IPC which attach significance to consent by a crime victim. If voluntary active euthanasia and assisting suicide are regarded as acts of mercy killing, reference may be made to section 88 of IPC which states in part that "nothing … is an offence by reason of any harm which it may cause, or be intended by the doer to cause … to any person for whose benefit it is done in good faith, and who has given consent … to suffer that harm …" However, this provision is unavailable to a person performing voluntary active euthanasia or assisting suicide because it expressly excludes cases where the accused "intended to cause death". In this regard, it is worthwhile noting that section 88 could be relied upon by a physician who engages in the accepted medical practice of withdrawing treatment from a terminally ill patient to hasten the process of dying from the disease.[10] The physician does not intend to cause his or her patient's death as such although he or she knows that the termination of treatment will cause the patient to die more quickly. The same may be said of a physician who administers strong doses of pain-relieving drugs to a patient knowing that a side-effect of these drugs is to hasten the patient's death. In both cases, the physician could invoke section 88 as he or she had withdrawn the treatment or administered the pain-relieving drugs in good faith for the benefit of the patient, as the patient (who had consented to the medical procedure) was relieved from prolonged suffering and severe pain.

Insofar as cases of voluntary active euthanasia are concerned, consent of the deceased is given some significance by rendering what would otherwise be the crime of murder to the lesser offence of culpable homicide not amounting to murder.[11] The relevant provision is exception 5 to section 300 of IPC which states that "[c]ulpable homicide is not murder when the person whose death is caused, being above the age of 18 years, suffers death or takes the risk of death with his own consent."[12]

In relation to assisting suicide, reference may be made to the more severe penalty imposed under section 305 compared to section 306,[13] where the deceased was under 18 years of age, insane, delirious, an idiot or intoxicated. The clear implication is that some recognition is afforded under section 306, by prescribing a lesser penalty compared to section 305, to the fact that the deceased in cases covered by section 306 could

10. Which is a form of passive euthanasia: see *supra* note 3. See *Airedale National Health Authority Trust* v. *Bland* [1993] AC 789 and referred to with approval by the Supreme Court of India in *Gian Kaur supra* note 9 at para 40.

11. Culpable homicide is defined in s. 299 and murder in s 300 of IPC.

12. See *In re: Kanaga Kosavan* (1931) 60 MLJ 616 and the cases cited therein for examples of the operation of this partial defence to murder.

have requested (and thereby given consent to) assistance in committing suicide.

A final provision worth noting is the defence of necessity afforded by section 81 of IPC. It reads: "Nothing is an offence merely by reason of its being done with the knowledge that it is likely to cause harm, if it be done without any criminal intention to cause harm, and in good faith for the purpose of preventing or avoiding other harm to person or property." On its face, the provision is wide enough to cover acts of voluntary active euthanasia or assisting suicide where the accused was motivated by the desire to relieve the deceased of severe pain due to a terminal disease. This is further buttressed by the fact that section 81 is available as a defence to murder which would be the usual offence committed by a person performing euthanasia.[14] However, it is highly unlikely that the courts will extend the scope of section 81 to such cases given the existence of specific provisions in the code like sections 88, 306 and exception 5 to section 300 which have the effect of rendering the accused criminally liable for his or her act of voluntary active euthanasia or assisting suicide.

In sum, this brief survey of the law as it stands holds criminally responsible people who assist another to commit or attempt to commit suicide, or who perform acts of voluntary active euthanasia. The consent of the deceased to be killed, even if informed and freely given, is of no avail and, at most, serves to reduce the charge or the punishment but does not exculpate the accused altogether.

II The constitutional validity of criminalizing physician-assisted suicide

An interesting development in this area of law has been several challenges made before the Supreme Court of India to the constitutional validity of the offence of abetting suicide under section 306 of the IPC.

The leading decision is *Gian Kaur* v. *State of Punjab*[15] which involved an appeal by the appellants against their convictions for abetting the commission of suicide by one Kulwant Kaur on the basis that the offence under section 306 was unconstitutional. A bench of five judges of the Supreme Court approached the appeals by inquiring first whether the closely related offence under section 309 of attempted suicide was in violation of the Constitution, the premise being that if it was not, section 306 will likewise not be.

13. S. 305 provides for the death penalty or imprisonment for life, compared with 10 years' imprisonment under s. 306.

14. Unless exception 5 to s 300 of IPC applies, in which case, the offence is culpable homicide not amounting to murder.

15. *Supra* note 9.

The court held unanimously that section 309 and, consequently, section 306, did not violate articles 14 and 21 of the Constitution of India. In relation to article 14 which affords equality before the law,[16] the appellants had contended firstly that section 309 offence violated it because the absence of a plausible definition of an attempted suicide made that offence arbitrary since it was not known which attempts were serious and which were not. Secondly, section 309 treated all attempts to commit suicide by the same measure without referring to the circumstances in which the attempt was made. The court rejected the first contention on the ground that the definition of suicide was capable of being broadly defined and whether or not the circumstances of a given case involved an attempted suicide could be left to a court to decide.[17] The court then proceeded to reject the appellants' second contention by noting that section 309 permits a sentencing judge to tailor the penalty appropriately taking into account the nature, gravity and extent of the attempted suicide.[18]

As for article 21 of the Constitution which embodies the fundamental right to "protection of life",[19] the appellants argued that this right included both the positive and negative aspects so that the right to live includes the right not to live, that is, the right to die or to end one's life.[20] Accordingly, section 309 violated article 21 by criminalizing attempted suicide. The court rejected this argument by noting that "by no stretch of imagination can 'extinction of life' be read to be included in 'protection of life.'"[21] In the course of its deliberations, the court opined that the right afforded by article 21 includes "the right to live with human dignity … right up to the end of natural life … [including] a dignified procedure of death."[22] However, such a right to die with dignity was "not to be confused or equated with the 'right to die' an unnatural death curtailing the natural span of life."[23] This distinction drawn by the court between the right to die a natural death with

16. The Article reads: "*Equality before the law*: The State shall not deny to any person equality before the law or the equal protection of the law within the territory of India."

17. *Supra* note 9 at para 30, citing a passage from the Supreme Court of India decision of *Rathinam* v. *Union of India* AIR 1994 SC 1844.

18. *Ibid*.

19. The Article reads: "*Protection of life and personal liberty*: No person shall be deprived of his life or personal liberty except according to procedure established by law."

20. Relying on the judgment of the Supreme Court of India in *Rathinam*, *supra* note 17 which had held on this basis that s. 309 violated Art. 21 of the Constitution.

21. *Supra* note 9 at and thereby overruling *Rathinam* on this issue. See also *State of Maharashtra* v. *Maruti Shripati Dubal*, AIR 1997 SC 411.

22. *Id*., para 24.

23. *Ibid*.

dignity and that of dying an unnatural death will be considered further below. Having held that article 21 does not include the right to die an unnatural death, the court concluded that the challenge to the constitutional validity of section 306 also failed.

An additional ground relied on by the Supreme Court in *Gian Kaur* to support the validity of section 306 was that the provision enacts a distinct offence the existence of which was independent of section 309. The arguments in favour of decriminalizing section 309 are inapplicable to section 306 since the latter offence is not concerned with the criminal responsibility of the suicidal person as such, but with an abettor who assists the termination of life of another person.[24]

A brief reference may be made to the Supreme Court of Canada case of *Rodriguez* v. *British Columbia (Attorney-General)*[25] because it accords broadly with the observations of the Supreme Court of India in *Gian Kaur* concerning the constitutional validity of the offence of abetting suicide. The facts were that the appellant was dying from a progressive and incurable disease of motor neurons and had sought a declaration that she be entitled to assistance in committing suicide when her condition became unbearable. The declaration was necessary because the Canadian Criminal Code makes it an offence to assist suicide.[26] The appellant contended that this offence limited her "right to life" under section 7[27] of the Canadian Charter of Rights and Freedoms (which enshrines constitutional rights) by depriving her of the ability to end her life when she was no longer able to do so without assistance. The Supreme Court held that, even though the criminal code's prohibition infringed the interests sought to be protected by section 7 of the charter, the prohibition fulfilled the state's objectives of preserving life and protecting the vulnerable and reflected the state's policy that human life should not be depreciated by permitting life to be taken.

The appellant in *Rodriguez* also invoked the equality clause under section 15[28] of the charter contending that, due to her physical disability, she was deprived of a benefit or subjected to a burden. The court rejected this contention on the ground that, even if there was some violation of the

24. *Supra* note 9 at paras 37-38.

25. (1993) 107 DLR 4th 342. See further M. Dunsmuir and M. Tiedemann, "Euthanasia and Assisted Suicide in Canada" *available at* http://www.parl.gc.ca/information/library/prbpubs/919-e.htm#2thecriminal (accessed on 1st Aug 2008).

26. S. 241.

27. The section reads: "Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice."

28. The section reads: "Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability."

equality clause, the infringement was permissible to protect human life which included prohibiting assisting suicide.

Based on this brief examination of *Gian Kaur* whose stance was closely similar to *Rodriguez*, questions concerning the constitutional validity of the offence of abetting suicide under section 306 can be safely put to rest. However, it is important to note that this does not in any way prevent the legislature from abolishing or qualifying that offence. While the constitutional basis for the offence may be sound, it is the prerogative of Parliament to decide whether the offence should remain or be qualified in some way. The Supreme Court of India in *Gian Kaur* said as much when it noted that "[t]he desirability of bringing about a change [is] the function of the legislature."[29] Indeed, the court provided a window for such legislative revision by saying: [30]

> A question may arise, in the context of a dying man, who is terminally ill … that he may be permitted to terminate it by a premature extinction of his life in those circumstances. This category of cases may fall within the ambit of the 'right to die' with dignity as part of [the] right to live with dignity, when death due to termination of natural life is certain and imminent and the process of natural death has commenced. These are not cases of extinguishing life but only of accelerating conclusion of the process of natural death which has already commenced.

The court was thereby opining that it may be permissible for a terminally ill patient whose natural life was certain to end soon on account of his or her disease, to request for his life to be extinguished sooner. Such a request would not constitute "the 'right to die' an unnatural death curtailing the natural span of life" which 'right' the court had earlier rejected.[31] However, the court was tentative in its opinion, concluding its discussion by stating that the "debate even in such cases to permit physician-assisted termination of life is inconclusive."[32] The concluding part of this article contends that there are sound reasons for coming down in favour of lifting the current prohibition of physician -assisted suicide.

III The case for decriminalizing physician-assisted suicide

There are essentially two main reasons which, when combined together, present a strong case for permitting physicians to assist in the suicide of

29. *Supra* note 9 at para 41.
30. *Id.* at para 25.
31. See the main text accompanying *supra* note 23.
32. *Supra* note 9 at para 25.

their patients under certain strict conditions. The first reason revisits the issue of the right to live and to die with dignity that was discussed in the preceding part. What is claimed is not a constitutional right but an appeal on humanitarian grounds that a patient whose death from a terminal disease is imminent and certain, should be able to request for assistance from his or her physician to extinguish his or her natural life prematurely in order to be spared of an ignominiously slow and painful death. All too often, references to "life" in the context of physician-assisted suicide is restricted in its meaning to the physical aspects of life. This is most evident when one speaks of keeping a person alive or assisting him or her to die. Significant advances in medical science have done much to prolong the physical lives of patients, even those suffering from terminal diseases. However, "life" comprises not just its physical aspects but the intellectual, emotional, psychological and spiritual make-up of a person. The following comment by two Indian medical experts is apposite: [33]

> Life is not mere living but living in health. Health is not the absence of illness but a glowing vitality – the feeling of wholeness with a capacity for continuous intellectual and spiritual growth. Physical, social, spiritual and psychological well being are intrinsically interwoven into the fabric of life.

Unfortunately, medical science has not been able to achieve the same kind of progress, as it has had for the physical aspects of life, in relation to these other vital aspects of human life. While not wishing at all to demean the good work of medical scientists, what such work has done is to create, in some cases of terminally ill patients suffering severe pain, the inhumane and degrading situation of prolonging their lives under conditions which are hugely detrimental to their intellectual, emotional, psychological and spiritual well being.[34]

It is precisely on account of these very difficult circumstances experienced by terminally ill patients that the medical profession has devised practices of not prolonging the life of such patients any more than they need to by withdrawing treatment or by administering very high doses of pain-killing drugs. However, the critical question remains of whether these practices fall short of meeting the need of the patient to have his or her intellectual, emotional, psychological and spiritual health adequately attended to. The answer must be "No" insofar as medical science has only

33. M. Indira and A. Dhal, "Meaning of life, suffering and death", paper presented at the International Conference on "Health Policy, Ethics and Human Value" held in New Delhi in 1986 and cited by the Supreme Court of India in *Rathinam*, *supra* note 17 at 29.

34. For a similar view, see Ratanlal and Dhirajal, *Law of Crimes* 1827 (New Delhi: Bharat, Law House, 2007).

been able to mask the physical pain by drugs, without doing much more. For such patients then, the process of dying remains particularly distressing. Clearly, what is preventing physicians from going further to actively terminate the lives of these patients is the criminal prohibition against voluntary active euthanasia and assisted suicide. But the medical profession is helpless to do anything about this (other than perhaps clandestinely practising euthanasia or assisting suicide). As the Supreme Court in *Gian Kaur* correctly observed, the power and responsibility lies with the legislature to revise the criminal law so as to permit physicians to legitimately do more to alleviate the suffering of their patients than they are presently permitted to do.[35]

Under the current state of affairs, it is probably too much of a leap to ask the legislature to legitimize voluntary active euthanasia. It is understandable for sizable sections of the community (and the medical profession for that matter) to resist supporting this step because it empowers physicians to actively extinguish the life of their patients. However, the concern is much less were a physician to be only empowered to assist his or her patient to commit suicide since the act of extinguishing life is performed by the patient himself or herself and not by the physician. Measures which enhance the role of the patient and diminish that of the physician could be implemented, such as prohibiting physicians to suggest suicide to their patients. This and other measures will be considered in the latter part of this paper.

The second reason offered in support of decriminalizing physician-assisted suicide is that such cases should be dictated primarily by the patient's choice to terminate his or her own life, and not by the role of the physician or the interest of the state in the matter. To elaborate, the present prohibition of physician-assisted suicide under section 306 is premised on the concern that physicians may abuse their position if their assistance of suicide were legalised,[36] and also because the state has an interest in promoting the objective of protecting or preserving life which decriminalizing of physician-assisted suicide will degrade. In respect of physicians, there is no denying that the possible abuse of their roles is a serious problem which needs to be addressed. (This concern will be addressed in part IV). For now, it may be observed that this concentration on the role of physicians is at the expense of overlooking the decision of the patient to commit suicide. The same criticism may be made of viewing section 306 as being concerned to promote the interest of the state to protect or preserve life. Here again, by concentrating on the state's interest,

35. See the main text accompanying *supra* note 29.

36. As commented on by the Supreme Court in *Gian Kaur*, see the main text accompanying *supra* note 9.

that of the patient as an individual in deciding whether to commit suicide is ignored. This is of particular concern when the concept of "life" conventionally adopted by the state is largely restricted to the physical aspects of life whereas, for the individual, it goes beyond that to cover the intellectual, emotional, psychological and spiritual aspects of his or her personality. Furthermore, even accepting the state's interest of protecting or preserving the physical life of a person, no social purpose is served when the subjects in question are terminally ill patients suffering severely painful diseases which cause their lives to cease being useful to themselves and to others.[37] The following general proposition by John Stuart Mill in his famous tract *On Liberty* is pertinent as to how the criminal law should treat such patients who decide to take their own lives: [38]

> [T]he sole end for which mankind are warranted individually or collectively in interfering with the liberty of action of any of their number, is self-protection. That the only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant. … The only part of the conduct of any one, for which he is amenable to society, is that which concerns others. In the part which merely concerns himself, his independence is, of right, absolute. Over himself, over his own body and mind, the individual is sovereign.

These two main reasons comprising the right of terminally ill patients to die with dignity and their right to choose to commit suicide, combine to make a very strong case for decriminalizing physician-assisted suicide. Given the very unhappy and painful circumstances which rob these patients of their ability to die with dignity, the law should honour their individual autonomy to decide to commit suicide. As a logical and humane corollary of this recognition, the law should permit physicians to assist their patients to die in the least painful way by using the best information and drugs that medical science has to offer.

There is another reason, based on legal reasoning, for decriminalizing physician-assisted suicide. Presently, as part of palliative care afforded to terminally ill patients, physicians administer high doses of pain-relieving drugs such as opiates knowing that a side-effect is to shorten the patient's life. On one view, this permissible practice is not readily distinguishable

37. *Cf.* Ratanlal and Dhirajlal, *supra* note 34 at 1825 who view the state's objective of preserving life in the following terms: "[A] man is a social animal. As a member of society, he has duties towards society, community, neighbours, family and friends. His life is useful not only to himself but to others. This, others have also claim over the life of an individual."

38. 11 (Chicago: The Great Books Foundation, 1955).

from physician-assisted suicide since, in both cases, the patient's natural span of life has been shortened by the intervention of the physician. Certainly, in cases of assisted suicide the extinguishing of life is much quicker, but the point remains that the patient in both cases did not die naturally from his or her disease alone. The distinguishing feature is said to lie in the different mental states of the physician. The physician who administers pain-relieving drugs knows that they are likely to cause death, while the one assisting suicide intends to cause death. As noted previously,[39] the former physician could invoke the defence of consent under section 88 but that defence would be unavailable to the latter physician because of his or her intention. Yet, it need not always be that a physician who assists suicide invariably intends to cause the patient's death; he or she may only know that the patient is likely to use such assistance to commit suicide. This is borne out by the fact that in cases of physician-assisted suicide, the ultimate act of causing death is performed by the patient, not the physician. Hence, it is entirely feasible for the physician to genuinely contend that, in providing the information or fatal medication, he or she had not thereby intended the patient's death, leaving that outcome to be determined by the patient alone.[40] Furthermore, the observation may be made that the physician administering high doses of opiates to the patient has a much greater causal connection with the patient's death compared to the one who only supplied the information or drug which the patient used to cause his or her own death. In sum, it is not so obvious that a physician administering high doses of pain-relieving drugs should be legally permitted to do so, but not a physician supplying a fatal drug to a patient to administer himself or herself.

One must also address concerns which are sometimes used to justify prohibiting physician-assisted suicide. One is that such assistance runs counter to the training and ethics of physicians which is to preserve life, not to extinguish it. There is no denying that this is so if the concept of "life" is limited to its physical aspects alone. But, as we have seen, "life" is much more encompassing and covers the intellectual, emotional, psychological and spiritual aspects of the human personality as well. Once physicians acknowledge this, the weight they attach to preserving a patient's physical life should be greatly diminished. This is because prolonging the life of a terminally ill patient suffering unbearable mental, emotional and spiritual anguish is not something that a physician would wish for or has been trained to promote. That said, it is acknowledged that assisting a

39. See the main text accompanying *supra* note 10 and attendant discussion.

40. As a result of which the physician may likewise successfully invoke the s. 88 defence. This argument has yet to be tested in the courts.

41. K.R. Stevens, "Emotional and Psychological Effects of Physician-assisted Suicide and Euthanasia on Participating Physicians" 21 *Issues L & Med* 187 (2006).

patient to commit suicide can be emotionally and psychologically distressing for the physician involved.[41] However, the solution is not to prohibit physician-assisted suicide but to provide education, counseling and other means of support to physicians.

Another concern is the danger that some physicians will abuse their position should assisting their patients to suicide be decriminalized.[42] A physician could apply undue influence on a vulnerable patient to commit suicide after conducting a cost-benefit analysis of the situation. For instance, the physician may have concluded that suicide serves the best interests of the community because the patient's condition cannot be improved despite being afforded all that medical science can provide, the distress of the patient and his or her family will grow, and the medical resources can be more fruitfully employed for the benefit of other patients. A physician exerting pressure on a patient to commit suicide would deny the patient's right to freely decide whether or not to do so. However, it is submitted that the solution lies not in issuing a blanket prohibition against physician-assisted suicide but in enacting stringent and effective safeguards against such undue influence by physicians.

A further concern, and closely related to the one concerning physician abuse, is the danger that the decision of some patients to commit suicide may not have been entirely voluntary. Besides the patient's physician, undue influence on the patient to request for assistance to commit suicide could come from family members, friends and others whose views the patient respects. But, as with the preceding concerns, the proper remedy is not to prohibit physician-assisted suicide but in implementing safeguards to ensure that the patient's decision to commit suicide was entirely free and voluntary.

IV A possible model: Oregon Death with Dignity Act

If physician-assisted suicide is to be decriminalized, how should this be done? In particular, what are the requirements which must be satisfied before such assistance can be rendered and what are the safeguards needed to combat physician abuse and to ensure that the patient's decision to suicide was entirely voluntary?

A model that Indian legislators could seriously consider adopting is to be found in the State of Oregon on the west coast of the United States of America. Oregon became the first jurisdiction in that country to enact a

42. This was noted by the Supreme Court of India in *Gian Kaur*, *supra* note 9 at para 38.

law authorizing physician-assisted suicide by enacting the Oregon Death with Dignity Act[43] in 1994.[44] The opening provision spells out the essential details: [45]

> An adult who is capable, is a resident of Oregon, and has been determined by the attending physician and consulting physician to be suffering from a terminal disease, and who has voluntarily expressed his or her wish to die, may make a written request for medication for the purpose of ending his or her life in a humane and dignified manner.

To elaborate, for a person to be eligible to receive prescription drugs for use in physician-assisted suicide, he or she must be a resident of Oregon, be 18 years of age or more and have been diagnosed by his or her attending physician as suffering from an incurable and irreversible disease which, within reasonable medical judgment, will cause death within six months. The patient must have made both an oral and a written request, and have repeated the oral request to the attending physician no less than 15 days after making the first oral request.[46] The Act requires the request for medication to be in a prescribed form, signed and dated by the patient and witnessed by at least two people who attest, in the patient's presence that, to the best of their knowledge and belief, the patient is capable, acting voluntarily and is not being coerced to sign the request. Additionally, at least one of the witnesses must not be related to the patient or entitled to a benefit from the patient's estate, or be an owner, operator or employee of a healthcare facility where the patient is receiving treatment or is a resident.

---

43. The Act adopted the model advocated by Dr Timothy Quill in his article "Death and Dignity: A Case of Individualised Decision" 324 *N Engl J Med* 691 (1991). For more details of the history, content and critique of the legislation, see R. Cohen-Almagor and M.G. Hartman, "The Oregon Death with Dignity Act: Review and Proposals for Improvement" 27 *J LEGIS* 269 (2001); J. Keown, *Euthanasia, Ethics and Public Policy*, Ch. 15 (Cambridge: Cambridge University Press, 2002); K.L. Tucker, "Federalism in the context of assisted dying: Time for the laboratory to extend beyond Oregon to the Neighbouring State of California" 41 *Willamette L Rev* 863 (2005); J. Reiver and D. Wilmington, "The modern art of dying: history of euthanasia in the United States" 27 *J Legal Med* 109 (2006).

44. However, its implementation was delayed until 1997 as a result of a court injunction.

45. 127.805 s. 2.01.

46. Obviously, such requests cannot be made by patients whose illness denies them the capacity to decide or to communicate their wish to commit suicide. Neither will legalizing physician-assisted suicide assist a patient whose illness renders them physically incapable of committing suicide. In the Netherlands, there have been cases where patients with early dementia were able to communicate their wish to commit suicide and to carry out the life-terminating act: see Griffiths, Weyers and Adams, *supra* note 4 at 45.

The attending physician must determine whether the patient's request was voluntary and informed, and must refer the patient for counseling if he or she might be experiencing depression or a psychological disorder affecting judgment on this matter. The physician must also inform the patient of alternatives such as pain management and palliative care. A second consulting physician must examine the patient and the medical record and confirm the conclusions of the attending physician. The physicians involved must keep detailed medical records of the process leading to the prescription, and these records are to be reviewed by Oregon's Department of Human Services. Physicians are permitted by the Act to dispense a prescription for the requested drug, but not to administer it. Physicians dispensing the drug must be registered under both the State's Board of Medical Examiners and the Federal Drug Enforcement Administration.

The Act makes it a serious offence for a physician who, without the patient's authorization, willfully alters or forges a request for a prescription or conceals or destroys a rescission of that request with intent or effect of causing the patient's death. It is also a serious offence for a physician to coerce or exert undue influence on a patient to request a prescription for the purpose of ending the patient's life, or to destroy a rescission of such a request.

These are stringent controls which appear to be working reasonably well in practice.[47] In particular, they have prevented a stampede of requests, feared by some critics of the Act, from eventuating. However, the legislation does have some weaknesses. One is that it does not require the patient to have experienced any suffering whatsoever, requiring only that the patient have a terminal illness which will produce death within six months. Arguably, physician-assisted suicide should be restricted to cases where the quality of a patient's life is adversely affected by severe pain (which may or may not be physical).[48] The experiencing of such pain is necessary to support the patient's claim that he or she is not being allowed to die with dignity. Another weakness of the legislation is that the physicians involved are only required to have acted *bona fide* (i.e. "in good faith") which is a much lower standard than the "reasonable standard of care" which is required of physicians engaging in other forms of medical treatment. Consequently, a physician who was negligent in the process of assisted suicide will not be held accountable so long as he or she had acted in good faith.[49] The Oregon

47. G. Tulloch, *Euthanasia – Choice and Death* 66 (Edinburgh: Edinburgh University Press, 2005).

48. This is a requirement of the scheme in the Netherlands: see Griffiths, Weyers and Adams, *supra* note 4 at 89-93. Under that scheme, pain and suffering can consist of the fear of further deterioration and the risk of not being able to die with dignity.

49. International Task Force on Euthanasia and Assisted Suicide, "Seven Years of Assisted Suicide in Oregon*" available at* http://www.internationaltaskforce.org/orrpt7.htm (accessed 1st Aug 2008).

model would be the better for requiring a physician to meet the reasonable standard of care demanded under the tort of negligence when discharging the duties imposed on him or her by the Act.

Additional requirements have been suggested by two American researchers which, if implemented, would improve considerably the proper use of the Oregon legislation.[50] One is for the physician to be prohibited from suggesting assisted suicide to the patient. Another is that patients could have decided to commit suicide due to severe pain; to avoid this, palliative care should be provided to patients before receiving their requests for assisted suicide. The researchers also recommended that, to avoid any collusion between the attending and consulting physicians, a small committee of medical specialists should review the requests for physician-assisted suicide and appoint the consulting physician. Another recommendation was for pharmacists to be required to report all prescriptions for lethal medication thereby providing a further check on the physicians' reporting.

V The way forward

The beginning of the 21st century has witnessed India's economy growing as never before, making an increasingly sizable portion of the society able to both afford and to demand medical treatment and services which will prolong life. It will be a matter of time before this social phenomenon spawns the debate concerning the prohibition of assisted suicide and voluntary active euthanasia conducted by physicians. This article seeks to promote the debate by contending that India is ready to take the step of decriminalizing physician-assisted suicide performed under strict conditions. Indeed, as has been noted previously, the seed for the debate was sown by none other than the Supreme Court in *Gian Kaur*.[51] That seed may have prompted the editors of *Ratanlal and Dhirajlal's Law of Crimes*, a leading and influential criminal law commentary, to assert the following:[52]

> As a normal rule, every human being has to live and continue to enjoy the fruits of life till nature intervenes to end it. Death is certain. It is a fact of life. Suicide is not a feature of normal life. It is an abnormal situation.… But if a person … is seriously sick or having [a] incurable disease, it is improper as well as immoral to ask him to live a painful life and suffer agony. It is an insult to humanity. Right to life means right to live peacefully as [an] ordinary

50. Cohen-Almagor and Hartman, *supra* note 43 at 293-298.
51. See the quote in the main text accompanying *supra* note 30.
52. *Supra* note 34 at 1825.

> human being. One can appreciate the theory that an individual may not be permitted to die with a view to avoiding his social obligations. He should perform all duties towards fellow citizens. At the same time, however, if he is suffering from unbearable physical ailments or mental imbalances, if he is unable to take normal care of his body or has lost all senses and if his real desire is to quit the world, he cannot be compelled to continue with torture and painful life. In such cases, it will indeed be cruel not to permit him to die.

The proposal to decriminalize physician-assisted suicide should be considered in isolation from the question of whether or not voluntary active euthanasia should also be legalized. While that may be the next step after physician-assisted suicide has been legalised, it does not at all follow that this must be taken.[53] The patient's terminating of his or her own life distinguishes it sufficiently from voluntary active euthanasia where it is the physician who terminates the patient's life. This distinction is important because the patient's decision to die at a time, place and method of his or her own choosing is manifested in not only his or her request for assistance in committing suicide but also in his or her act of suicide. By contrast, for voluntary active euthanasia, only the former manifestation is present which, some may argue, leaves the patient's choice to die less certain and is also open to greater abuse given that the physician is the one administering the fatal medication. Accordingly, lumping voluntary active euthanasia with physician-assisted suicide is apt to muddy the case for legalizing physician-assisted suicide and should be strenuously avoided. The Oregon experience, where only physician-assisted suicide has been legalized, is a prime example of a jurisdiction which has successfully achieved this.

Legislatively speaking, the simplest way of implementing this proposal is to introduce a new provision in the IPC which recognises a defence closely following the model contained in the Oregon Death with Dignity Act. The defence provision should also incorporate the improvements to the Act mentioned in part IV of this article, such as the need for the patient to be suffering, as well as the additional safeguards recommended by two American researchers. The defence will be applicable to the offences of abetting suicide and of abetting attempted suicide. Hence, these offences will continue to operate against persons assisting suicide who are not physicians. Physicians found abusing their power to assist the suicide of their patients could also be convicted of these offences since they would have failed to meet one or more of the stringent conditions of the defence. In addition, a new offence against errant physicians could be introduced such as the one contained in the Oregon Death with Dignity Act. Finally, in

53. In this connection, one should be wary of the "slippery slope" argument.

acknowledgement of the difficult role which physicians are asked to perform, a regime of education, counseling and support should be afforded to those of them who may be adversely affected by their experience of assisting their patients to commit suicide.