



Position Statement on Euthanasia

The Indian Association of Palliative Care opposes euthanasia in all its forms. Good symptom control through palliative care can pre-empt the request for euthanasia. Withholding or withdrawing treatment that is medically futile does not amount to euthanasia.

The Indian Association of Palliative Care (IAPC) is an association of professionals devoted to the teaching, promotion and delivery of palliative care in the country. Palliative care includes support during therapy, end-of-life care and bereavement support to families. Specialists in the field of palliative care work closely with terminally-ill and dying patients, and are deeply concerned about euthanasia.

The debate on euthanasia or mercy killing has been raging for some time in the country. The case of Aruna Shanbaug, who has been lying in a vegetative state in a hospital following a brutal assault more than 4 decades ago, has highlighted the need for a consensus on the issue. Euthanasia has been discussed at legislative levels and rules are being drafted for the approval of the Parliament. The Supreme Court has called for opinions of individuals and organizations working in this area. Members of the IAPC feel it is important to respond to the court.

Palliative care specialists the world over are united in their understanding of what euthanasia is, and what it is not. Euthanasia can never be passive, and the very terminology “passive euthanasia” is tragic and scientifically unsound.ⁱ Withholding or withdrawing futile treatments or measures that merely prolong life, is medically and ethically right, and is not “euthanasia”.

Freedom from pain is a fundamental human rightⁱⁱ and the physician is bound to use drugs or procedures to alleviate pain and suffering. For the last 25 years, sedation is being used to reduce the distress of a terminally-ill patient in most parts of the worldⁱⁱⁱ and this cannot be equated to euthanasia.^{iv}

IAPC reaffirms that the role of palliative care is to reduce suffering of patients, and not to hasten or delay death.

PURPOSE

There is a significant conflict between healthcare professionals and others on how they understand end-of-life care and euthanasia.^v The purpose of this statement is to remove any ambiguity and to clarify the principles to which IAPC adheres.

Euthanasia is the act of intentionally, knowingly and directly causing the death of a patient.^{vi}

Assisted suicide is the act of intentionally, knowingly and directly providing the means of death, so that a person can use those to commit suicide.^{vi}

Palliative care is an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.^{vii}

It should be appreciated that the scope of palliative care extends from diagnosis^{viii} to bereavement, and addresses the various dimensions of suffering.^{ix}

It is clear that there is a world of difference between euthanasia or assisted suicide and palliative care.

IAPC opposes euthanasia in all its forms.

IAPC recognizes and acknowledges that:

1. Palliative support right from the diagnosis helps to maintain quality of life and to reduce the suffering caused by the illness and its treatment.
2. A team approach for addressing needs of the patients, care givers and the family can have a positive influence on the impact of the illness.
3. Quality of life can be maintained with good symptom control, and physical, psychosocial, and spiritual support.
4. Death is inevitable and should neither be hastened nor postponed.

POSITION STATEMENT OF IAPC

Practice of medicine is guided by the principles of autonomy, beneficence and justice.^x

Autonomy grants the patient the right to accept or reject treatment, including life-sustaining measures. Physicians may withhold or withdraw life-sustaining measures in line with patient's wishes, and this is not euthanasia.^{xi}

The principle of beneficence dictates that all measures taken should increase the benefit to and reduce the suffering of the patient. It is acknowledged that though such

efforts, including palliative sedation, may lead to unintended death of the patient, this is not euthanasia.^{xii}

Justice requires that all patients are treated equally irrespective of differences in their physical, psychological or spiritual needs. Advance care planning will ensure a uniform and comprehensive approach towards patients whose needs are different.

Palliative care is interdisciplinary and multidimensional but not location-specific. It can be provided at home or in hospitals, nursing homes, palliative care centres or hospices.^{xiii}

Access to palliative care is still limited in India, as a result of which the suffering of most people is not addressed. The demand for euthanasia is a result of inadequate palliative care, and provision of comprehensive palliative care will significantly reduce the demand. Any request for euthanasia should be referred to palliative care experts for management.^{xiv}

IAPC would like recommend to the government to:

1. Formulate a National Policy for Palliative Care as palliative care is an integral part of healthcare.
2. Educate people to record their end-of-life preferences that must be binding, within the ambit of the law and do not involve euthanasia.
3. Set up palliative care facilities in public and private health care establishments to maximize the reach of care even to people in remote areas.
4. Include palliative care in undergraduate and postgraduate studies, so that every medical graduate is capable of assessing the needs of patients and offering palliative care.
5. Make measures for control of pain and symptoms widely available at affordable prices.

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Appendix: Terminology

In common parlance, euthanasia and mercy killing are interchangeably used. The modern meaning of euthanasia may differ from country to country, but when the term was introduced in English language by Sir Francis Bacon in 17th Century it meant *“an easy, painless, happy death, during which it was the physician's responsibility to alleviate the physical sufferings of the body.”*

Here are some common terms explained in lay parlance.

Active euthanasia: When a doctor or healthcare provider actively ends another person's life by injecting a drug or poisonous substance, with the intent to end life.

Passive euthanasia: When a doctor helps in ending the life of a patient by withdrawing the life support system, with the intent to end life.

Voluntary euthanasia: When a patient consents to euthanasia, and may actually ask for it.

Involuntary euthanasia: When a patient who had refused euthanasia when it was offered is subjected to active euthanasia. (When the person has refused, is the concept of euthanasia still valid? Isn't this plain and simple murder? Therefore I have rephrased this.)

Non-Voluntary euthanasia: When the patient has neither asked for nor refused the option of euthanasia.

Assisted suicide: Suicide is the act of ending one's own life. In assisted suicide, the means (a medication or a weapon) to end life is provided to the person with the knowledge of the patient's intention to use it to end life.

Aid in dying: Aid in dying is an end-of-life care option in which a mentally competent, terminally-ill adult requests the physician to provide a prescription for a medication that the patient can self-administer to bring about a peaceful death.