



Right to Die with Dignity: Euthanasia Debate in Neuroscience

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Abstract

Technology's role in clinical neurology has grown exponentially during the past two decades. Physicians have forgotten that it is their responsibility to help their patients die in peace and comfort, as this is now a legally protected fundamental inherent right according to the Common Cause decision. There is a chance that India's strong religious beliefs opposing abortion and euthanasia would ultimately trump the recently legitimized right to die with dignity by the country's highest court. People in India with terminal diseases have flooded government offices and the courts with requests for palliative care regulations. This is largely a legal and ethical discussion, but it has also touched on issues of human rights, health, religion, economics, spirituality, and culture. According to professionals in the field of public health, it is crucial to determine the mental health of the person requesting euthanasia. Feelings of hopelessness, sadness, and unhappiness are typically at the forefront of people's minds when they decide to terminate their lives through euthanasia. The study seeks to trace the debate of death with dignity and neuroscience in terms of passive euthanasia in the form of withdrawal of life support system.

10816

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Introduction

In clinical neurosciences, there has been an extraordinary use of technology during the past two decades. Younger doctors are incredibly effective at what they have been taught to do, but have lost sight as this is inevitable and part of their duty to ensure that people have a pleasant death, a death with dignity as well which is now an intrinsic fundamental right through the Common Cause² judgement. Textbooks, journals, clinical gatherings, and group discussions can provide with guidelines and statistical data on various outcomes for various management strategies regarding death and death with dignity in regard to the patient's particular request as medical directives, counselling sessions, state's health care budget into curing as opposed to caring and when does a terminally sick person have enough, who makes the decisions and should judgments always be supported by the best available law, science and technology?

Many a times physicians at a public hospital in the late 1970s urged the family of a terminally ill moribund patient to shift the elderly person home so that the person might die in peace. Factors that had a role were the price and challenges of transferring a body. Does the patient and family's input get sufficient consideration in treatment plans, checklists, and decision? In most cases, neurosurgeons and neurologists are not the best people to provide palliative care. End-of-life management scenario discussions typically need to begin during the first few days, if not hours, of hospitalization. Complicating matters is the likelihood that the patients who are now dead were otherwise healthy before the sudden disaster. It is not in bad taste or ghastly to bring up the subject of death where one who puts their confidence in a physician as a physician deserves the chance to bring in a happy death or death with dignity.³The right

to die with dignity just legitimized by India's Supreme court may ultimately be overridden by the country's strong religious views opposing abortion and euthanasia. The government and the courts in India have professed for palliative care laws in response to requests from people with grave medical conditions across the country. While this is a legal and ethical argument, it has also touched on human rights, health, religion, economics, spirituality, society, and culture.

Euthanasia & Neuroscience: The Debate

Some physicians believe passive euthanasia is already standard practice in the majority of hospitals across the country, since many low-income terminally ill patients or their families opt out of life-prolonging care due to the high costs associated with it. Yet for the fortunate few who can afford it, keeping alive with cutting-edge medical technologies and palliative care is becoming the norm.

According to Suresh Bada Math, Department of Psychiatry, National Institute of Mental Health & Neuro Sciences, earlier diseases outcome was discussed in terms of cure but in the contemporary world of diseases such as cancer, AIDS, diabetes, hypertension, and mental illness, debates are framed in terms of care, since cure is distant. Elderly, low-income, and terminally ill individuals are more likely to choose euthanasia than other demographics, hence the government has been pushing palliative care measures for them. For the care and well-being of those in need, including the elderly, those with terminal illnesses like AIDS, cancer, or renal failure, and those with neurological problems, there are a number of programs available. The newest version of our National Health Protection Scheme provides a response to the problem of inadequate treatment for terminal illnesses. An anonymous senior health ministry official remarked, "Patients desire decent care, and if we offer it for them, why would they opt for euthanasia?" According to professionals in the field of public health, determining the mental health of the person

²Common Cause (A Regd. Society) v. Union of India, (2018) 5 SCC 1.

³Ganapathy K., *Good Death in Neurological Practice*, Neurol India 2021, 2022 Oct 2; 69:792-6. DOI: 10.4103/0028-3886.325314, (Sep. 20, 2022, 07:50 PM),



requesting euthanasia is crucial. Depression, hopelessness, agony, and a lack of care are the primary reasons people choose euthanasia. If patients are given the best care possible, they are able to reverse their decision to end their lives via euthanasia or accept a natural death. When patients receive high-quality palliative care, fewer ask for euthanasia, according to a recent study. Many patients lack exposure to contemporary methods of pain management.⁴

It was estimated in 2014 that around 30 million people in India suffered from serious neurological illnesses.⁵ This number did not include those suffering from neurotrauma or neurological infections. Several thousand people suffer neurological fatalities every day due to things like acute serious head traumas, neurovascular illnesses, malignant brain tumours, degenerative disorders, and infections of the nervous system. Between 1989 and 2010, fatalities from neurological causes among those aged 75 and up increased. No other illnesses showed such a sharp increase.⁶ Between 2001 and 2014, mortality in England attributable to neurological diseases increased by 39 percent, according to research. About 49% of hospital fatalities and 26% of nursing home deaths were attributed to neurological disorders; 18% of neurological deaths happened at home, 5% in a hospice, and 2% elsewhere. Alzheimer's disease, Parkinson's disease, stroke, and epilepsy are only few of the neurological illnesses whose prevalence has grown dramatically over the past quarter-century, as revealed by the Global Burden of

Disease study. 16 percent of all fatalities are caused by neurological diseases. Increases in the prevalence of dementia and other degenerative disorders have been linked to the general trend toward longer life expectancy.⁷

As living conditions and medical treatment improve, more people are living longer, but many of them are also suffering more. Therefore, neurology is a field that calls for more than simply technical mastery of cutting-edge equipment, but also judgment, knowledge, and compassion. The therapeutic dilemma is also a dilemma of options. All of the ethical, social, economic, and humane factors, as well as the wishes of the patient, should be taken into account. How much authority does the subject matter expert have when it comes to the care of the terminally sick, especially during the acute or hyperacute phases of their illness? Is terminal care reserved only for those with terminal neurological disorders? Even normal young people suffer from neurosurgical problems such head trauma, hypertensive brain haemorrhage, and aneurysmal subarachnoid haemorrhage. If the patient has a malignant brain tumour, several secondary tumours, or another ailment with a high risk of death, neither the doctor nor the patient's family will bring up end-of-life care until it is too late. However, vigorous treatment at the end of life is common for cancer patients who pass away in a hospital (36%) or intensive care unit (ICU), which may lower the chances of a peaceful passing.⁸ Caregivers who have suffered a loss are more likely to experience psychological distress in the future. If the patient's vital signs on the monitor, such as heart rate and blood pressure, look normal, it might be difficult to explain to family members that the patient has died from brain stem compression. In India, the medicolegal complications of providing "grief therapy" are

10818

⁴How will India accept Passive Euthanasia? Mint, 12 March, 2018, (Sep. 20, 2022, 08:15 PM), <https://www.livemint.com/Science/Whfhf9I34eZ8iAXWaHVqK/How-will-India-accept-passive-euthanasia.html>.

⁵Gourie-Devi, *Epidemiology of neurological disorders in India: Review of background, prevalence and incidence of epilepsy, stroke, Parkinson's disease and tremors*, *Neurol India* 2014;62:588-98, (Sep. 21, 2022, 09:23 PM), <https://pubmed.ncbi.nlm.nih.gov/25591669/>.

⁶Dr. Russell Blaylock, *Neurodegenerative Disease A Pandemic*, (Sep. 21, 2022, 10:50 PM), <https://alzheimerdisease.tv/neurological-disease-deaths-rising-sharply/>.

⁷Jacqui Thornton, *Data show big rise in deaths of people with neurological disorders*, *BMJ* 2018;360. <https://doi.org/10.1136/bmj.k1278>, (Sep. 21, 2022, 11:05 PM),

<https://www.bmj.com/content/360/bmj.k1278>.

⁸Ibid.



largely overlooked. Until brain death is confirmed, the patient cannot have artificial life support turned off. At the present time, a pronouncement of brain death may only be made if the patient's family has given their approval for organ donation. It is possible that better end-of-life care may be provided if neurosurgeons and neurologists were exposed to the fundamentals of palliative care. As is the cultivation of grief counselling abilities, which necessitates an appreciation for the emotional, social, and spiritual requirements of this period.

In the 1960s, the concept of a "happy death" emerged. A good death means that the patient's wishes for care, quality of life, and respect for their own dignity have been honoured. In this case, the patient, their loved ones, and the medical staff have had minimal to no physical discomfort. The death is in line with acceptable medical, societal, and moral norms. Death maintains thanksgiving, the conviction that life is still worth living, and a modicum of hope. There is no practice of using excessive or pointless medical interventions to extend life expectancy. The doctor and nurse are people you can put your whole faith in, rely on, and feel safe talking to about everything from your most held convictions to your deepest held worries. Possibility to bid farewell to loved ones.⁹

Aggressive therapy, drugs, and interventions are ceased when end of life is inevitable with patient or family permission. Death and the act of dying are fundamental to the functioning of all cultures. Specific, individual, and diverse conceptions of a good death exist. Ideas change with time, both individually and collectively, and even after they pass from this world. Because to medical and technological developments, people are living longer in their later years, which might stretch out the dying process. The most crucial element of a decent death, according to Japanese seniors, is "trusting my physician." Maintaining

positive ties with one's family was viewed as crucial in Chinese culture. Planning for one's financial security after death is a serious matter in India. Death with dignity is not a one moment, but rather a sequence of gatherings with loved ones. Support and care provided towards the end of life should be adaptable and responsive to the needs of the dying individual. The process of dying must be viewed as one that may be manipulated. Despite death's inherent link to living things, people are often uncomfortable broaching the subject. Sustaining inner tranquillity is a prerequisite for practicing the art of dying properly. Having someone there for you as you pass away is crucial. An integral part of a death with dignity is dying at one's own house.¹⁰ Expenses must be taken into account as well. For dying patients and their loved ones, interventions that enhance end-of-life care have far-reaching consequences. Sudden circumstances prevent family members from having the necessary conversations about death and dying. Terminal diseases provide an opportunity to address and complete unfinished emotional and material matters. Not being a burden on loved ones, settling one's affairs, and passing on feeling one's life was meaningful are all essential components of a good death.

10819

Regulations and the lack of clear, explicit, unambiguous legislation may stand in the way of a good death, even if the family and the accompanying professionals understand and wholeheartedly urge it to happen. One such ambiguous area is the decision to turn off artificial life support. In the United States, a person who is considered brain dead might be considered alive in India. With the exception of the state of Kerala, in India, organ transplant permission is required before any procedure, even those used to determine whether or not a person has died from their brain stem. A lack of legislation has put doctors in a difficult position when deciding whether or not to keep patients on life support. Removing this assistance can be

⁹What Is a Good Death? How to die well, Psychology Today. (Sep. 22, 2022, 11:25 PM), <https://www.psychologytoday.com/us/blog/understanding-grief/202003/what-is-good-death>.

¹⁰What Is a Good Death? WebMD, (Sep. 21, 2022, 11:49 PM), <https://www.webmd.com/healthy-aging/news/20180619/what-is-a-good-death>.



questioned. Using scarce life-saving resources on those who are hopelessly beyond help and already dead presents a moral conundrum. A set of guidelines and processes for living wills have been suggested. We still haven't seen any genuine enforcement or implementation of them, unfortunately. It will take time for the government to create new guidelines. In the 2011 case of Aruna Shanbaug,¹¹ the highest court had previously approved passive euthanasia, allowing the removal of life-sustaining care from patients unable to make an educated decision with the goal to accelerate the death of a terminally ill patient. The verdict was the result of a petition brought before the court by the non-profit group "Common Cause," which asked the court to adopt the "living will" format used in most other nations where living will as advanced medical directives was recognised and right to die with dignity got the status of fundamental right.¹² A living will is a document that allows a person to state their healthcare preferences in advance, in the event that they become terminally ill and are unable to do so themselves. When a person is declared brain dead in the United Kingdom, the state takes ownership of the corpse and makes the decision of whether or not to keep them on life support.¹³

Way Forward

There is a current absence of clarity in India regarding mental health or neurological diseases to be invoked under terminal illness like the other developing nations who have matured themselves with euthanasia laws and perspectives. Doctors should keep in mind that even the best of intentions might very seldom get them involved in meritless medicolegal actions. It is believed that "*res ipsa loquitur*" applies in all cases, and that if ever a Good Samaritan's actions were challenged, the courts would look at the

circumstances surrounding the incident and determine that no malicious intent was there. As long as the primary motivation was to facilitate a death with dignity in accordance with the wishes of the family, any procedural slip-ups would be overlooked. Ideally, the numerous ambiguities will be soon be made abundantly obvious, either through a test case or by proper legislation. According to statements issued by the Kerala & Gujarat Government in 2022, brain stem death is now considered sufficient for official certification of death under the state's Registration of Births and Deaths. The gap between medical research and the law persists, however, because governments are responsible for deciding whether or not to recognize brain stem death as comparable to death. The Supreme Court of India has outlined procedures to follow in the absence of a valid Advance Directive for Healthcare. The decision to remove life support must be made by the patient's parents, spouse, or other close relatives; in their absence, the choice can be made by a next friend or group of friends. Physicians treating the patient can also benefit from its use. Besides the approval of a hospital-established medical board, such a judgment also needs the presence of two witnesses and the countersignature of a first-class court magistrate of that region. Knowledge of both medical practice and medical law should inform the decision to do what is best for the patient.

10820

¹¹Aruna Ramachandra Shanbaug v. Union of India and Ors. (2011) 4 SCC 454.

¹²Common Cause (A Regd. Society) v. Union of India, (2018) 5 SCC 1.

¹³*Passive Euthanasia Now a Legal Reality in India*, The Wire, (Sep. 25, 2022, 08:48 PM), <https://thewire.in/health/passive-euthanasia-now-a-legal-reality-in-india>.

