

Concept of Death and Euthanasia: Do Sociocultural, Psychological and Religious Orientation Matter Besides Medico-Legal Decision?

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Abstract

Euthanasia, which earlier referred to 'Good Dying' evolved to connote 'Assisted dying'. This has medical, legal and psychosocial implications. Netherlands is the country which legalised the process followed by few other countries. Cross-cultural acceptance and implementation of euthanasia is something that looks extremely difficult because it involves a number of cultural factors. It is closely associated with the connotation each culture gives to the concept of 'death'. There are psychological, social, religious, political, medical and legal aspects associated with euthanasia or assisted death. The sociocultural variations across three continents, viz, Asia, Europe and Africa are projected. The ancient Indian concept of euthanasia and the contemporary social and legal reactions to euthanasia are discussed in this article.

Keywords: euthanasia, assisted death

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Euthanasia is an issue that relates to multiple fields such as medicine, ethics, philosophy, religion, culture, psychology, economy, and law. Hence it is one of the topics that spikes a debate with the trigger of one incident in a country and more often than not gets depleted after the individual in question dies. For a nation to bring a policy accepting euthanasia as a legal option exercised by the citizens, there needs to be a convergence among the various disciplines mentioned above. This explains the reason why it is not legalised in many countries. The nations that legalised euthanasia are Netherlands, Belgium, Luxembourg, Canada, Columbia and Australia. Netherlands was the first country that legalised it in the year 2002. The process of legalising is expected to precede animated debate. Yet, the sensitivity of the issue always leaves a sense of ambivalence while adopting it.

The term 'euthanasia' literally means 'good dying' (*Eu Thanatos*) with no reference to the 'assisted suicide', the connotation it has in the contemporary times. The term used to connote a good death without any prolonged suffering. Brinbacher (2015) discussed five different meanings of Euthanasia each referring to different method.

1. Providing medical psychological and spiritual assistance in relieving pain and suffering to the dying person
2. Allowing the suffering patient to die by not prolonging life artificially
3. Actively speeding up the death to shorten suffering either by voluntary or non-voluntary euthanasia
4. Not continuing life-sustaining treatment for a patient in persistent unconscious condition and
5. Ending the life of those considered a burden to society and family

In modern times the meaning of euthanasia gradually changed from the process of dying without suffering to that of assistance by a physician in dying painlessly

What is so different in euthanasia from other medical decisions?

The arguments in favour of euthanasia have the merit of logical correctness. Births and deaths are certainties. It is important to realize death as certainty and accept its process as an inevitable event in an individual's life. Once it is accepted, it is important to prepare the conscious and awaken the subconscious to the inevitable fact of life called the death.

Generalising it to an illness and treatment process, rationally, the patient's or family's participation is considered an accepted norm in a number of medical decisions such as, whether to go for surgery or not, whether to resuscitate or not, whether or not to provide assisted breathing, whether to admit in intensive care unit, or whether to dialyse or not. Viewed from this perspective, fulfilling one's own wish to be assisted in dying painlessly stands the logic of continuity of decision making.

There have been several changes in medical practices since the time of Hippocrates till date. Those under Hippocratic oath 'give no deadly medicine to anyone if asked, nor suggest any such counsel.' However, with the wide acceptance and practice of evidence-based approach in protecting lives, the "process" of ending one's life also gained attention. The argument is while the process of birth is not under the control of the unborn, the process of death which is under the control can be considered the basic right of the individual with his ability of reasoning. In countries that adopted euthanasia, from legal perspective, the desire to die or not to die in a particular pattern can be declared in the will of an individual that is binding on the family members.

It was Bacon (1623) who identified two types of euthanasia. He called the spiritual and psychological preparation of the soul to die as 'Euthanasia Interior'. According to him

this was not adequate. The individual should be helped in dying quietly and easily. This assistance in termination of life physically was called 'Euthanasia Exterior'. Andreas, Prousalis and Kulkarni (2018) discussed three types of euthanasia. According to them, a physician or a third person ending the life of a person intentionally on the competent request of the person concerned by administering drugs is called *Voluntary Active Euthanasia*. Aiding in a person's death without the informed consent because the condition of the patient does not provide a scope either because of being in a vegetative state or being a young child is *non-voluntary euthanasia*. Terminating the life of a patient against his/her will is *involuntary euthanasia*. Voluntary Active Euthanasia can be administered in two ways. In the first case the physician assists the patient in dying on the person's competent request by providing drugs which is taken by the patient (Harris, Richard and Khanna, 2006). In second type, the physician administers the drugs to end the life of the patient on the expression of the person's competent request.

The cases cited below from the pan continental experience of the first author across Asia, Africa and Europe may help in understanding the types of euthanasia and the associated sociocultural reactions to it.

Case1: This experience relates to Indian set up way back in early 1980s. It was a crowded emergency department in a Primary Health Centre (PHC) managed by a single doctor, who could hardly find time for his lunch. A patient accompanied by about twenty people from a village was brought in a condition requiring immediate resuscitation. The doctor had to suspend his lunch midway and attend to the emergency. He started cardiac massage which was the right thing to do. The method of cardiac massage involves repeated pressing of the chest involving a minimum of 5 centimetre's compression. This was done in the full vicinity of the crowd of twenty who accompanied the patient. Despite the best efforts the doctor could not save the patient. However, the act of cardiac massage was beyond the comprehension of

the villagers who misconstrued it as the cruelty of the doctor. The message that ‘the doctor killed the patient’ spread in the village. This raised the fury of the village resulting in manhandling the doctor.

One can interpret this as the public misperception of ‘Non-voluntary euthanasia’ and the sociocultural reaction to the same. Indian psyche does not accept active euthanasia. In the much-debated case of Aruna Shanbaug, who was in a vegetative state for 42 years, from 1973 till 2015, the apex court of India rejected the plea to discontinue her life support based on the dissent of the treating hospital staff to euthanise her. Finally, Ms. Shanbaug died of pneumonia in 2015. It is only in the year 2018 that passive euthanasia for terminally ill or patients in vegetative state is allowed by the Supreme court under stringent guidelines. The sociocultural set up in India where the institution of family has close bonding and sentiments and affiliation need is very strong, active euthanasia is a difficult thing to be accepted. Further, the Indian culture, where medical profession is held in high esteem and the doctor is perceived as a ‘life-saver’, the very concept of ‘physician assisted death’ creates severe cognitive dissonance.

Case2. This was in early 90s in Botswana, Africa. The doctor was in emergency Department. A man of about 60 years age wheeled in a trolley his obese wife weighing around 100 Kilo grams. According to his report, the wife drank too much alcohol and did not obey him and stop drinking. He took a cane and beat her up. After sometime she became silent and still. The doctor found her ‘brought dead’ and the post mortem report revealed the cause of death as acute shock.

The alcoholic woman who perhaps was a burden to herself and the family. But her life was ended by her husband against her will. Thus, this can be an example of involuntary euthanasia. In African Ntomba culture, which perceives the energy of the community Chief as that of the tribe, killing the Chief who is found to be losing the energy is an accepted norm

to protect the vitality of the tribe (Bikopo and Van Bogaert, 2010). Thus, ending the life for the general good of the family, community or tribe may not be perceived as an unpardonable crime in African culture.

Case3: This was in Netherlands in early 2000s. The scenario relates to an old age nursing home.

The concerned patient was 75 years old. He had given a declaration that he would like to take farewell from his life the moment he gets next COPD exacerbation and this was the moment of farewell from his near and dear and life as well. He was beginning to get dyspnoea due to his illness. The room where he was admitted was buzzing with family members visiting him during his supper time. Some of them having supper with him, children and grandchildren cuddling and kissing him farewell. All looked happy bidding him farewell. Around 9 pm in the evening, the process of euthanasia started. In the morning the author heard that “everything went on smoothly” and the end was peaceful to the satisfaction of all! This is a case of ‘Voluntary Euthanasia’ that has legal sanction in the country.

Netherlands’ constitutional provision allows the doctor to assist the consented patients to death. The law, religion (or atheism), and the society by and large accepted euthanasia as a norm rather than a stigma. Hence the process of will, execution and participation became a natural part of the culture. It may be pertinent to mention here that the acceptance of the law in Netherlands did not come very easily, and the nation had to go through a process of opposition, debate, struggle, studies involving medical bodies, law professionals and policy makers. The landmark decision was given by Supreme Court in the year 1984, called Alkmaar case where a 95-year-old woman was assisted to death by the physician. The physician took the decision when the woman could not eat or drink anymore and appealed to the doctor to stop this agony and end her life. The physician was sure that there was no scope for any improvement in the condition and assisted her to death. A case was filed against the

doctor and finally he was acquitted by the Court of the Hague. Following this, the Royal Dutch Medical Association issued guidelines for administering euthanasia. Three salient aspects of the guidelines are discussed by Borst-Eilers (1992)

1. The request for euthanasia should come voluntarily from the patient and be persistent
2. The suffering of the patient should be intolerable with no hope of solution, alleviation or improvement in the condition
3. The physician can take the call on euthanasia only after an independent consultation with an experienced colleague

Even after going through the whole process of formulating, reviewing and revising the law, there is no universal acceptance of euthanasia in Netherlands. However, there was a perceivable increase in cases of euthanasia, that raised from 424 in 1990 to 1424 in 1994 (Van der Wai, 1992). There were many checks and bounds to ensure compliance with the guidelines. Yet, there may be instances indicating slight deviations from the stringent guidelines.

Case 4: In the early 2000s a couple in the 80s of age got admitted in an old age nursing home, shared a double bed room to spend the last part of their lives together. Both were terminally ill. The man had expressed his conscious desire not to undergo any further investigations, hospitalisation, ICU admission or resuscitation. However, when his conditions started worsening, when the doctor and other health care professionals visited and interviewed him, he showed some wavering about further investigation. This prevented them from acting as per his earlier voluntary request. After months when he slipped into lower level of consciousness, the first family contact was consulted and the decision for continuous sedation was taken to end his life.

The conflicting stand of the patient's wish with full cognition and consciousness and the hesitation expressed when the condition is critical places the physician in a fix. The

decision- making process of the doctor becomes very difficult. As long as the doctor complies with guidelines the probability of legal action is low.

Execution of euthanasia is not just a matter related to medical and legal fields, satisfying which the nation can implement the act. It has deep cultural and religious influences. A number of studies have been carried out ever since euthanasia was accepted legally in some countries. According to Isgandarova (2015) Islam as a religion does not approve suicide even for reasons of alleviating pain and suffering, as the victim has no scope for suffering or repentance for taking life, which even a murderer has. Hence, voluntary euthanasia where the patient is assisted to death is a difficult thing to accept. There are other religions that have strong reservations on euthanasia. Inthorn, Schick Tanz, Rimon-Zarfaty, Raz (2015) found that lay people in Israel were opposed to withdrawal or withholding of euthanasia.

Other factors that influence attitude towards euthanasia are trust, Konke (2014) studied the relationship between attitude towards euthanasia and people's trust in each other, the nation, the health care and the press. It was found that positive attitudes towards euthanasia was positively related to the trust in nation in general, health care system and peoples' mutual trust at individual level.

The entire process includes physical, psychological, spiritual and social aspects of the client, health workers and families concerned. The outcome depends on the synchrony with the cultural and national norms and personal beliefs and attitudes, and sentiments associated with the ultimate factor of human life called death, which triggers different emotions in different cultures.

The Honourable Supreme Court of India has passed a historic law permitting passive euthanasia in the year 2018 under two conditions-

1. In case of the brain- dead patients, the ventilators can be switched off and

2. In case of patients in persistent vegetative state, the feeding can be tapered off and pain-relieving medicines introduced

The proponents may argue that whether active or passive euthanasia, the patient depends on the physician's involvement in assessment of the condition and initiation of withdrawal or withholding. Hence, in practice it may not really make a difference whether the physician is actively administering a lethal agent to ease the death or withdrawing the life support to prolong the vegetative state. Hence there cannot be a discretion in branding one as legal and the other as illegal. The proponents further state that the availability of an option for ending the suffering may relieve the patient from the stress. The arguments of the proponents are one of protecting the individual's autonomy and dignity in life and death.

On the other hand, the opponents have their logic. In Indian condition where there is a sharp divide between the rich and the poor, the feeling of 'being a burden on the family' is determined by the affordability of treatment. Further, the patient may have depression as a comorbid condition and may opt for ending one's life more due to the mental state than due to pain. In fact, it was found in a study by Hariharan et al (2014) that in the urban set up of Hyderabad, 133 out of 1000 cardiac patients were found to suffer from severe depression and 321 out of 1000 were found to have severe anxiety. Neither the patients nor the treating doctors were aware of such comorbid condition. Thus, in a health care system where the approach is not holistic and the mental health state assessment is not mandatory, allowing active euthanasia based on the voluntary expression of the patient's wish may not stand the medical or legal scrutiny. Yet another argument of those who oppose active euthanasia is that in case of illness like cancer, the innovations are very fast and the treatment approach and the prognosis has been undergoing drastic changes at a very fast pace. Given such circumstances, can one really certify a condition as 'no chance of improvement'? More than anything, the ancient *Ayurveda*, the ancient Indian Medical System differs from the western model in one

of the basic ethics. While the Western model strongly advocates total transparency and informed consent from the patient by revealing all truth about the disease, *Charaka* advocates that speaking the truth about the disease to the patient is not absolute. The fundamental ethical expression is left to the discretion of the *Vaidya*, who decides based on the assessment of the impact of revelation on the patient and the family. Indian health care system still holds this 'ethic of trust' while the Western system is dominated by the 'ethic of right'. Guided by this principle, legalising active euthanasia appears a difficult situation to digest.

Nevertheless, the Indian culture could accept the Supreme Court's pronouncement on passive euthanasia because of its traditional practices. *Prayopavesa/Samadhi Marana/Sanyasa Marana* refer to a traditional practice in Hinduism where an individual after fulfilling all worldly responsibilities has no ambition or desire to live fasts unto death. This is also allowed in case of terminal illness. A similar practice in Jainism is called *Santhara*. These traditions are very similar to passive euthanasia, which is ingrained into the religion and culture but practiced judiciously and not many cases of misuse or controversies have come to light. Thus, it is a matter of trust than a legal right. The public perception of weak rule of law in the country is one of the causes of scepticism not only among the medical professionals but also others.

Thus, the acceptance of euthanasia as a constitutional provision is a factor that has social, psychological, spiritual, philosophical considerations apart from the medical discretion.

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