SRI LAKSHMI NARAYANA INSTITUTE OF MEDICAL SCIENCES

Date: 06/02/2020

From
Dr. Aravind. C
Professor and Head,
Department of General Medicine
Sri Lakshmi Narayana Institute of Medical Sciences
Bharath Institute of Higher Education and Research
Chennai

To
The Dean,
Sri Lakshmi Narayana Institute of Medical Sciences
Bharath Institute of Higher Education and Research
Chennai

Sub: Permission to conduct value-added course: EUTHANASIA – An Indian Perspective

Respected Sir,

With reference to the subject mentioned above, the department proposes to conduct a value-added course titled: **EUTHANASIA – An Indian Perspective** on 26/03/2020. We solicit your kind permission for the same.

Kind Regards

Dr. Aravind. C

FOR THE USE OF DEAN'S OFFICE

Names of Committee members for evaluating the course:

The Dean: Dr. Balagurunathan

The HOD: Dr. Aravind. C

The Expert: Dr. Muthukumarasamy. B

The committee has discussed about the course and is approved.

Dean Subject Expert HOD

DEAN
Prof.K.BALAGURUNATHAN,M.S
(General surgeon)
SRI LAKSHMI NARAYANA
INSTITUTE OF MEDICAL SCIENCES
OSUDU PONDICHERRY

OFFICE OF THE DEAN

Sri Lakshmi Narayana Institute of Medical Sciences

OSUDU, AGARAM VILLAGE, VILLIANUR COMMUNE, KUDAPAKKAM POST,
PUDUCHERRY - 605 502.
[Recognised by Medical Council of India, Ministry of Health letter No. U/12012/249/2005-ME (P -II) dt. 11/07/2011]
[Affiliated to Bharath University, Chennai - TN]

Circular

10/02/2020

Sub: Organising Value-added Course: EUTHANASIA – An Indian Perspective reg

With reference to the above mentioned subject, it is to bring to your notice that Sri Lakshmi Narayana Institute of Medical Sciences, **Bharath Institute of Higher Education and Research**, is organising a Value added course, titled, "EUTHANASIA – An Indian Perspective reg" between March 2020 and May 2020. The course content is enclosed below.

The hard copy of the application should be sent to the institution by registered/ speed post only so as to reach on or before 21/03/2020. Applications received after the mentioned date shall not be entertained under any circumstances.

Dean

Encl: Copy of Course content and Registration form.

COURSE PROPOSAL

Course Title: **EUTHANASIA- An Indian Perspective**

Course Objective: To create an awareness among CRRIs about Physician Assisted Death / Euthanasia – its current standing in the Indian population

Course Outcome: Awareness was created among the interns who attended the course about Euthanasia – its moral and ethical implications and its standing in the Indian and global population

Course Audience: A batch of 25 CRRIs

Course Coordinator: Dr. C. Aravind

Course Faculties with Qualification and Designation:

1. Dr. Muthukumarasamy. B
   Professor
   Department of Medicine
2. Dr. Chellapandian
   Professor
   Department of Medicine

Course Curriculum/Topics with schedule

SlNo	Date	Topic	Time	Hours	Name of the faculty
1.	26/03/2020	What is euthanasia?	5 pm to 7 pm	2 hours	Dr. Muthukumarasamy. B
2.	30/03/2020	Physician assisted death	4: 30 pm to 6: 30 pm	2 hours	Dr. Muthukumarasamy. B
3.	02/04/2020	Arguments favouring Euthanasia/ PAS	5 pm to 7 pm	2 hours	Dr. Chellapandian
4.	03/04/2020	Arguments opposing Euthanasia/ PAS	5 pm to 7 pm	2 hours	Dr. Chellapandian

5.	06/04/2020	The global stand on PAS	5 pm to 7 pm	2 hours	Dr. Chellapandian
6.	08/04/2020	Legalization of Euthanasia/ PAS	4: 30 pm to 6: 30 pm	2 hours	Dr. Muthukumarasamy. B
7.	13/04/2020	Psychological implications on the patient and relatives	5 pm to 7 pm	2 hours	Dr. Chellapandian
8.	15/04/2020	Euthanasia/ PAS in clinical practice	5 pm to 7 pm	2 hours	Dr. Muthukumarasamy. B
9.	16/04/2020	Reasons for PAS/ Euthanasia	4 pm to 7 pm	3 hours	Dr. Chellapandian
10.	20/04/2020	Religious outlook on PAS/ Euthanasia	4 pm to 6 pm	2 hours	Dr. Chellapandian
11.	22/04/2020	Moral and ethical implications	4 pm to 7 pm	3 hours	Dr. Chellapandian
12.	27/04/2020	The physician's challenge	4 pm to 7 pm	3 hours	Dr. Muthukumarasamy. B
13.	08/05/2020	The Indian society and PAS/ Euthanasia	4 pm to 7 pm	3 hours	Dr. Chellapandian
			Total Hours	30	

REFERENCE BOOKS:

1. **HARRISON'S PRINCIPLES OF INTERNAL MEDICINE; 20th EDITION**
2. **Euthanasia: An Indian perspective; Vinod K. Sinha, S. Basu,1 and S. Sarkhel2; Indian J Psychiatry. 2012 Apr-Jun; 54(2): 177–183**

VALUE ADDED COURSE

1. Name of the programme and code

   Euthanasia – an Indian perspective; IM12

2. Duration & period

   30 hrs; March 2020 – May 2020

3. Information Brochure and course content of value-added courses

   Enclosed as Annexure – I

4. List of students enrolled

   Enclosed as Annexure – II

5. Assessment procedures:

   Short notes – Enclosed as Annexure – III

6. Certificate model

   Enclosed as Annexure – IV

7. No. of times offered during the same year

   1; March 2020- May 2020

8. Year of discontinuation

   2021

9. Summary report of each program year wise:

VALUE ADDED COURSE: January 2020 – April 2020					
Sl. No.	Course code	Course name	Resource persons	Target Students	Strength and year
1	IM12	Euthanasia – an Indian perspective	Dr. Muthukumarasamy. B Dr. Chellapandian	CRRI	25 (March 2020-May 2020)

10. Course feedback

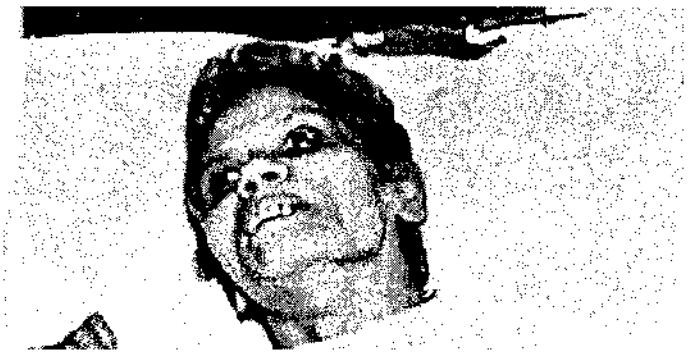
    Enclosed as Annexure - V

RESOURCE PERSON – Dr. Muthukumarasamy. B

COORDINATOR – Dr. C. Aravind

ANNEXURE – I

EUTHANASIA – An Indian Perspective



"Marte hain aarzoo mein marne ki
Maut aati hai par nahin aati"

- Mirza Ghalib

PARTICIPANT HAND BOOK

VALUE ADDED COURSE

COURSE DETAILS

PARTICULARS	DESCRIPTION
Course title	EUTHANASIA – AN INDIAN PERSPECTIVE
Course code	IM12
Objective	1. What is Euthanasia? 2. Physician assisted death 3. Arguments favouring Euthanasia/ PAS 4. Arguments opposing Euthanasia/ PAS 5. The global stand on PAS 6. Legalization of Euthanasia/ PAS 7. Psychological implications on the patient and relatives 8. Euthanasia/ PAS in clinical practice 9. Reasons for PAS/ Euthanasia 10. Religious outlook on PAS/ Euthanasia 11. Moral and ethical implications 12. Indian society PAS/ Euthanasia
Key competencies	On successful completion of the course, the students will have a better knowledge about PAS/ Euthanasia in the Indian health care setting
Target students	CRRIs
Duration	30 hours; between March 2020 and May 2020
Assessment procedure	SHORT NOTES

EUTHANASIA – AN INDIAN PERSPECTIVE

The phenomenal advances in medical science and technology have not been without a significant impact on society. They have brought into forefront issues that are altering the pattern of human living and societal values. *Pari passu* with these changes is the upsurge of affirmation of human rights, autonomy, and freedom of choice. These issues compel us to re-evaluate our concepts of societal and medical ethics and value systems.

Amongst these issues, the palliative care and quality of life issues in patients with terminal illnesses like advanced cancer and acquired immune deficiency syndrome (AIDS) have become an important area of clinical care and investigation. Significant progress has been made in extending a palliative care/quality of life research agenda to the clinical problems of patients with cancer, including efforts that focus on mental health related issues such as neuropsychiatric syndromes and psychological symptoms in patients with terminal medical illness. However, perhaps the most compelling and clinically relevant mental health issues in palliative care today concern the desire for death and physician-assisted suicide (PAS) and their relationship to depression.

Desire for death has been postulated as a construct that is central to a number of related issues or phenomena, including suicide and suicidal ideation, interest in PAS/euthanasia, and request for PAS/euthanasia. This construct, which was initially proposed by Brown and colleagues and further developed by Chochinov *et al*. focuses on the degree to which an individual wishes his or her life could end sooner. It ranges from suicidal intent (i.e., a desire to end one's life immediately) to a complete absence of any desire to die.

Advocates demanding autonomy for patients regarding how and when they die have been increasingly vocal during recent years, sparked by the highly publicized cases of Drs Jack Kevorkian, Timothy Quill, and Aruna Shanbaug. These cases have centered on the plight of dying patients with terminal illnesses.

What has often been overlooked, however, in the political and legal machinations, is the importance of medical, social, and psychological factors (e.g., depression) that may contribute to suicidal ideation, desire for hastened death, or requests for PAS by terminally ill patients.

DEFINITION OF EUTHANASIA AND PAS

The English philosopher Sir Francis Bacon coined the phrase "euthanasia" early in the 17th century. Euthanasia is derived from the Greek word eu, meaning "good" and thanatos meaning "death," and early on signified a "good" or "easy" death. Euthanasia is defined as the administration of a lethal agent by another person to a patient for the purpose of relieving the patient's intolerable and incurable suffering. Typically, the physician's motive is merciful and intended to end suffering. Euthanasia is performed by physicians and has been further defined as "active" or "passive." Active euthanasia refers to a physician deliberately acting in a way to end a patient's life. Passive euthanasia pertains to withholding or withdrawing treatment necessary to maintain life. There are three types of active euthanasia. Voluntary euthanasia is one form of active euthanasia which is performed at the request of the patient. Involuntary euthanasia, also known as "mercy killing," involves taking the life of a patient who has not requested for it, with the intent of relieving his pain and suffering. In nonvoluntary euthanasia, the process is carried out even though the patient is not in a position to give consent.

PAS, on the other hand, involves a physician providing medications or advice to enable the patient to end his or her own life. While theoretical and/or ethical distinctions between euthanasia and PAS may be subtle to some, the practical distinctions may be significant. Many terminally ill patients have access to potentially lethal medications, at times even upon request from their physicians, yet do not use these medications to end their own lives.

Both euthanasia and PAS have been distinguished, legally and ethically, from the administration of high-dose pain medication meant to relieve a patient's pain that may hasten death (often referred to as the rule of double effect) or even the withdrawal of life support. The distinction between euthanasia/PAS and the administration of high-dose pain medications that may hasten death is premised on the intent behind the act. In

euthanasia/PAS, the intent is to end the patient's life, while in the administration of pain medications that may also hasten death; the intent is to relieve suffering.

Distinctions between withdrawal of life support and euthanasia/PAS are, in many ways, considerably clearer. Long-standing civil case law has supported the rights of patients to refuse any unwanted treatment, even though such treatment refusals may cause death. On the other hand, patients have not had the converse right to demand treatments or interventions that they desire. This distinction has had the effect of allowing a patient on life support the ability to end his or her life on request, yet a patient who is not dependent on life support does not have such a right.

LEGALIZATION OF PAS AND EUTHANASIA

Arguments supporting legalization of PAS/euthanasia

The arguments supporting legalization of euthanasia/PAS are substantial. Proponents perceive PAS as an act of humanity toward the terminally ill patient. They believe the patient and family should not be forced to suffer through a long and painful death, even if the only way to alleviate the suffering is through suicide. According to the proponents of PAS, it becomes ethical and justified when the quality of life of the terminally ill patient becomes so low that death remains the only justifiable means to relieve suffering. Lack of any justifiable means of recovery and the dying patient himself making the choice to end his life are conditions which make euthanasia more justifiable. To the advocate for PAS, legalization of PAS is a natural extension of patient's autonomy and the right to determine what treatments are accepted or refused. Arguments in favor of legalization of PAS are typically premised on the assumption that requests for PAS are "rational" decision, given the circumstances of terminal illness, pain, increased disability, and fears of becoming (or continuing to be) a burden to family and friends. Given the possibility that these symptoms and circumstances may not be relieved, even with aggressive palliative care and social services, the decision to hasten one's death may seem rational. Proponents of euthanasia also criticize the "artificial and impractical" demarcation drawn by the court and the religious organizations between active and passive euthanasia. Withdrawal of life support, the classical form of "passive" euthanasia, actually involves taking an "active" step to hasten the death of a terminally ill patient and it is the patient's consent which lends legitimacy to the act. If, following consent

of a similar nature, a physician administers a lethal dose of injection, there is no reason why this act should be considered as illegal or immoral. Moreover, the desire to include one's physician in carrying out a decision to end one's life can be viewed as an extension of the natural reliance of terminally ill patients on their physicians for help with most aspects of their illness, as well as reasonable mechanism to ensure that they do not become more disabled and burdensome to their family or friends by attempting suicide unsuccessfully (causing a persistent vegetative state or increased disability).

Another argument raised by proponents of legalization is that merely knowing that one can control the timing and manner of death serves as a form of "psychologic insurance" for dying patients. In other words, knowing there can be an escape from the suffering of illness may alleviate some of the stress associated with the dying processes. It may be (as argued by some proponents of PAS) that many individuals with a terminal illness desire the option to end their lives if certain possible conditions arise, even though the likelihood that they will utilize this option is small.

Arguments opposing legalization of PAS/euthanasia

Opposition to legalization of PAS and/or euthanasia has come from numerous different perspectives. As frequently noted in the editorial pages of various medical journals, the medical profession is guided by a desire to heal and extend life. This guideline is best exemplified in the Hippocratic Oath which states, "I will prescribe regimen for the good of my patients according to my ability and my judgment and never do harm to anyone. To please no one will I prescribe a deadly drug, nor give advice that may cause his death." Thus, the possibility that a physician may directly hasten the death of a patient – one whom the physician has been presumably treating in an effort to extend and improve life – contradicts the central tenet of the medical profession.

From a mental health perspective, professional psychiatric and psychological training reinforces the view that suicide should be prevented at all costs. Several studies have supported this connection between mental disorder (e.g., depression) and interest in PAS, suggesting that suicidal ideation in terminally ill patients is a manifestation of undiagnosed, untreated mental illness. Consequently, physician compliance with a suffering patient's stated wish for PAS may circumvent the provision of appropriate psychiatric care. Similar arguments have been made regarding pain and physical symptoms, suggesting that requests for PAS may be evidence of inadequate palliative care. In spite of the fact that improperly

managed physical and/or psychiatric symptoms may underlie a patient's wish for hastened death, physicians may unknowingly participate in PAS designed to alleviate precisely these symptoms that possibly could be managed with better palliative care, as opposed to providing proper medical management, if PAS is legalized.

Opponents of PAS additionally posit that individuals of lower socioeconomic classes or other disenfranchised groups will be "coerced," either directly or indirectly, into requesting PAS as a means of resolving the difficulties posed by their illness. Family members may subtly suggest that death, since inevitable, would be preferable if it occurred sooner rather than later because of the social and financial burdens involved in caring for terminally ill family members. Physicians may view PAS, perhaps because of their own unrecognized feelings (countertransference), as the appropriate and preferable response to a terminal illness and resulting disability. Thus, physicians may be particularly poor at recognizing "irrational" requests for PAS because of their belief that they would not want to live in a condition similar to that of their patients. An even more frightening possibility is that physicians or other health care providers might recommend PAS as an option because the alternative – providing adequate palliative care – is too expensive or difficult to obtain. Thus, patients with poor health insurance or limited financial resources may be "coerced" into requesting PAS by poorly managed or untreated physical and psychological symptoms, perceiving their only options to be either continued suffering or death. Several studies have demonstrated inadequate recognition and treatment of both psychological and physical symptoms, with symptoms such as depression and anxiety going largely unrecognized in many medically ill patients. According to a recent review of palliative care in Canada, only 5% of dying patients in Canada receive adequate palliative care. These and related studies are often cited by opponents of legalization for PAS/euthanasia as evidence that legalization is premature until all dying patients and their families have access to skilled and effective palliative care service.

In response to these concerns, legislators proposing guidelines for PAS have incorporated several mechanisms to minimize the risk that PAS, if legalized, will be misused. These guidelines include (1) a voluntarily request for assistance in dying on the part of the patient, (2) evidence of a terminal illness, and (3) documentation by the primary physician of the reason for the request and efforts made to optimize the patient's care. Opponents, however, suggest that these limitations are more arbitrary than scientific, and they argue that the legal and medical communities will eventually end up on a "slippery slope," where euthanasia is

ultimately legalized as an acceptable practice for a wider patient population, including non-terminal, nonvoluntary patients. Opponents point to a similar evolution of euthanasia use in The Netherlands where regulations regarding PAS have gradually weakened over the 13 years since this practice was decriminalized. For example, in 1994, the Dutch Supreme Court accepted the argument that a chronic disease is an acceptable basis for euthanasia, even if not terminal, and more recent cases have extended this "right" even to patients without a physical illness.

ATTITUDES TOWARD EUTHANASIA AND PAS: IMPORTANCE OF PSYCHIATRIC ISSUES

Public interest has been spurred by media attention devoted to Drs. Kevorkian, Quill, Aruna Shanbaug, and others, as well as legal decision, state referenda, and the growing availability of life-extending medical treatments. As a result, both the public and the medical community have openly debated ethical issues relating to end-of-life options. While the US Supreme Court upheld the rights of individual states to prohibit PAS, its decision simultaneously opened the door for professionals to "experiment" with legalization of PAS, as has recently occurred in the state of Oregon. In part spurred by this increased attention, a number of researchers have surveyed attitudes toward euthanasia and PAS among the lay public, medical professionals, and medically ill patients. These surveys have demonstrated high rates of public support for legalization of PAS, as well as relatively significant rates of endorsement and even performance of PAS among medical professionals. The proposed guidelines offered to date have all suggested that psychiatric evaluation must comprise critical components of any assessment of a patient's request for PAS. Clearly, if PAS is legalized, mental health professionals must play an important role in the evaluation of patients at the end of life who request PAS. Despite the apparent importance of a mental professional's evaluation in assessing requests for PAS, little research has been conducted that has focused on the basis for patients' interest in hastened death. In their study of physician response to request for PAS/euthanasia, Meier *et al.* found that physicians sought mental health consultation for only 2% of their patients who requested PAS or euthanasia. Furthermore, a study by Ganzini *et al.* indicated that only 6% of Oregon psychiatrists felt "confident" in their ability to assess whether a psychiatric disorder was impairing the

judgment of a patient requesting PAS, despite overwhelming support from psychiatrists for legalization.

EUTHANASIA AND PAS IN CLINICAL PRACTICE

A number of surveys have been published documenting the practice of euthanasia and PAS among health care professionals. For example, an anonymous survey of Washington physicians conducted in 1995 found that 26% of responding physicians had received at least one request for PAS and two-thirds of those physicians had granted such requests. These statistics suggest that PAS is not a rare event, despite the illegal status (it is also possible that despite the anonymous nature of the survey, some physicians who had in fact carried out these requests were unwilling to acknowledge their actions for fear of repercussions). Even more striking results were reported in a survey of San Francisco area physicians looking after AIDS patients. Slome *et al.* found that 98% of respondents had received requests for PAS and that more than half of all responding physicians reported having granted requests for PAS, with some physicians fulfilling dozens of such requests. Moreover, in response to a hypothetical vignette, nearly half of the sample (48%) indicated that they would be likely to grant a hypothetical patient's initial request for PAS.

Perhaps the most striking research to date regarding the use of PAS and euthanasia was a study of critical care nurses conducted by Asch. This study, based on the results of an anonymous survey, found that 17% of respondents reported having received at least one request for PAS and 11% had granted such a request. Approximately 5% responding nurses acknowledged having hastened a patient's death at the request of the physician, but without the request of the patient or the family (termed "nonvoluntary euthanasia" by some writers). Moreover, 4.7% of the sample indicated that they had hastened a patient's death without the knowledge of or request by the physician. Respondents described having stopped oxygen therapy or increased pain medication in order to hasten death. Asch suggested that based on the reports of respondent nurses, these actions were done in order to ease the suffering of the patients. The traditional role of nursing in palliative care was cited as the basis for these results. It should also be noted that Asch's controversial study generated considerable response, including many suggestions that methodological issues such as vague wording of questions may make these data unreliable. Nevertheless, while these data may not accurately indicate the true prevalence of PAS or euthanasia, requests for assistance in dying are clearly

not rare events and physicians occasionally grant such requests despite legal prohibitions. Furthermore, because legal restrictions limit the ability of physicians to consult with colleagues regarding how to react to a request for PAS, the appropriateness of patient requests and physician responses is unknown.

In The Netherlands, however, where PAS and euthanasia have been practiced regularly for more than 20 years, data are available regarding the frequency of requests for assistance in dying and the proportion of terminally ill patients whose lives end in this manner. Euthanasia was granted its current status in 1984 after a Dutch Supreme Court decision authorized this practice, provided a number of conditions were met. Specifically, the patient's request for PAS must be considered free, conscious, explicit, and persistent. Both the physician and patient must agree that the patient's suffering is intolerable, and other measures for relief must have been exhausted. A second physician must be consulted and must concur with the decision to assist in ending the patient's life. Finally, all of these conditions must be adequately documented and reported to the governmental body supervising the practice of euthanasia. Because of the availability of such records, several studies have documented the proportion of deaths in The Netherlands in which euthanasia and PAS are implicated (these estimates were adjusted to account for underreporting of euthanasia acknowledged by many Dutch physicians). While reporting on euthanasia and PAS practices in The Netherlands from 1990 to 1995, van der Maas *et al.* incorporated both official reports of euthanasia as well as responses to anonymous surveys to estimate the rates of euthanasia and PAS. They concluded that euthanasia and PAS were involved in roughly 4.7% of all deaths in The Netherlands during 1995, a substantial increase over the 2.7% of deaths involving medical assistance reported in a 1991 study.

Supporters of PAS point to data from The Netherlands as evidence that legalization has not led to widespread abuse or overuse of euthanasia or PAS. However, critics suggest that the 75% increase in deaths involving euthanasia or PAS (from 2.7 to 4.7%) demonstrates a growing tendency toward their more frequent use and thus a greater number of potentially inappropriate cases of euthanasia. Such concerns are clearly reflected in a 1994 Dutch Supreme Court decision in which the right to euthanasia/PAS was extended to include patients' suffering from chronic illnesses that are not terminal, including mental disorders such as depression, provided the illness is refractory to treatment and causes intolerable suffering. Although the vast majority of requests for PAS from mentally ill individuals have been denied, isolated cases have occurred in which mentally ill Dutch adults have been

allowed to receive PAS or euthanasia as a result of this court ruling. This experience has been identified as evidence of the "slippery slope" argument, in which legalization of PAS is presumed to lead to a gradual widening of the group of patients eligible for this "intervention," many of whom may not be appropriate candidates (e.g., physically healthy but clinically depressed individuals).

REASONS FOR SEEKING HASTENED DEATH/PAS

A growing body of literature has emerged indicating the types of physical and psychological concerns that may give rise to a desire for hastened death and requests for PAS. Although this literature has not always been consistent, a growing consensus has supported many of the assumptions put forth by the initial advocates and opponents of legalization. Specifically, the issues that have received the broadest empirical support are pain, depression, social support, and cognitive dysfunction.

SUICIDE AMONG THE MEDICALLY ILL

Not all patients who seek a hastened death request assistance from their physicians. Rates of suicide among medically ill populations have been a topic of clinical concern and empirical research for many years prior to the emergence of the PAS debate. This research has generally concluded that depression and suicide among patients with medical illnesses are not particularly common but rather occur more often than in physically healthy populations. These suicide vulnerability factors in cancer and AIDS patients include poor prognosis and advanced disease, depression, hopelessness, loss of control, a sense of helplessness, delirium, fatigue and exhaustion of resources, pre-existing psychopathology, and previous suicide attempts. The role of psychiatric and psychosocial assessment and intervention has been well accepted as a critically important aspect of the care of patients with advanced cancer or AIDS.

CONDUCTING SUICIDE, EUTHANASIA, AND PAS

It has been pointed out that in Hinduism, the word for suicide, atma-gatha, has also the elements of intentionality.

The intention to voluntarily kill oneself for selfish motives was condemned in Hinduism. Subjectively, the evil sprang from a product of ignorance and passion; objectively, the evil encompassed the karmic consequences which impeded the progress of liberation. It was in this context that the Dharmasutras vehemently prohibited suicide.

Nevertheless, Hinduism venerated enlightened people who voluntarily decided their mode of death. Thus, the Pandavas eulogized "Mahaparasthana" or the great journey through their Himalayan sojourn when they walked in pilgrimage, thriving on air and water till they left their bodies one after another. Crawford lists fasting, self-immolation, and drowning at holy places as other examples of such venerated deaths. Such deaths by enlightened persons have never been equated with the popular notion of suicide in the Indian tradition. It has been always considered that suicide increases the difficulties in subsequent lives.

Can the Hindu stance as mentioned above be extended to the question of euthanasia? Here, the Indian attitude toward life and death needs special mention.

In the Hindu tradition, death acts as a prefiguration and model, through which the ties that bind man's self or soul to cosmic impermanence can be completely broken and through which ultimate goals of immortality and freedom can be finally and definitely attained. Crawford considers "spiritual death" in the Indian context to be synonymous with a "good death," i.e., the individual must be in a state of calm and equipoise. Crawford surmises that to ensure such a noble death, the concept of active euthanasia would not be unacceptable to the Indian psyche. However, this view has been criticized by authors who claim that "spiritual death" or "iccha mrtu" can only be possible when the evolved soul chooses to abandon the body at will. It is also claimed that the evolving soul cannot be equated with mental tranquility as it is at a higher level of consciousness. Thus, though less dogmatic than other religions, Hindus would traditionally remain skeptic in their view about euthanasia. It has been proposed that a strong objection to euthanasia might arise from the Indian concept of Ahimsa. However, even in the Gandhian framework of Ahimsa, violence that is inevitable is not considered as sin. This emphasizes flexibility of the Indian mind. Hence, though a little skeptic, the Indian mind would not consider the thought of euthanasia and PAS as a sacrilege.

A major concern that has been expressed is that the wish of the terminally ill patient requesting PAS may be colored by depression. Hence, psychiatrist's role becomes important for assessing depression in these patients. It is in fact a legal requirement in some places that psychiatric assessment should be mandatory before a patient is granted the permission to undergo PAS. It is claimed that after being allotted this crucial role, the psychiatrists would act as a gatekeeper in this highly controversial issue. It has also been proposed that since very few psychiatrists would feel confident in detecting depression in the terminally ill, their attitude might color their judgment.

Though legalization of PAS is still not a very important prerogative for the Indian legislature, we designed a study at the Central Institute of Psychiatry, Ranchi, to see the attitude of Indian psychiatrists about euthanasia, as they might have to act as gatekeepers in PAS issues in the future. Certain interesting findings emerged in this study. Out of the 165 psychiatrists who participated in the study, 99 completed the questionnaire. More than 55% of the subjects favored PAS and believed that it should be legalized, whereas only 28% opposed the idea. The major factors that determined the attitude included deeply held moral values like role of physician is to preserve life, PAS would pressurize for improved palliative care, religious beliefs, and diversion of resources from palliative care. 60% believed that they would consider PAS on themselves in case of terminal suffering. The factors determining their decision to consider PAS would be pain in 70% cases, no hope of recovery in 50% cases, loss of mental faculties in 49% cases, inability to take care of self and poor quality of life in 35% cases each. 60% of the respondents believed that they would not be confident in diagnosing depression in the terminally ill patients during a single interview with the patients if they were called for giving an expert opinion. This is a surprising finding as it implies that more than expert knowledge, the moral principles and previous attitude regarding PAS may influence the judgments of the psychiatrists if they were act as a gatekeeper in the future.

Another sample survey of 200 doctors carried out by the Society for the Right to Die with Dignity in Bombay also gave a glimpse of what views health professionals in our country held regarding euthanasia and PAS: Ninety percent stated they had the topic in mind and were concerned, while 78% argued that patients should have the right to choose in case of terminal illness; 74% believed that artificial life supports should not be extended when death

is imminent, but only 65% stated that they would withdraw life supports; 41% argued that Living Will should be respected, and 31% had reservations about the issue.

THE INDIAN REALITY

It can be argued that in a country where the basic human rights of individuals are often left unaddressed, illiteracy is rampant, more than half the population is not having access to potable water, people die every day due to infections, and where medical assistance and care is less, for the few people, issues related to euthanasia and PAS are irrelevant. However, India is a country of diversities across religious groups, educational status, and cultures. In this background, the debate on euthanasia in India is more confusing as there is also a law in this land that punishes individuals who even try to commit suicide.

The Medical Council of India, in a meeting of its ethics committee in February 2008 in relation to euthanasia opined: Practicing euthanasia shall constitute unethical conduct. However, on specific occasions, the question of withdrawing supporting devices to sustain cardio-pulmonary function even after brain death shall be decided only by a team of doctors and not merely by the treating physician alone. A team of doctors shall declare withdrawal of support system. Such team shall consist of the doctor in-charge of the patient, Chief Medical Officer / Medical Officer in-charge of the hospital, and a doctor nominated by the in-charge of the hospital from the hospital staff or in accordance with the provisions of the Transplantation of Human Organ Act, 1994.

In India, euthanasia is a crime. Section 309 of the Indian Penal Code (IPC) deals with the attempt to commit suicide and Section 306 of the IPC deals with abetment of suicide – both actions are punishable. Only those who are brain dead can be taken off life support with the help of family members. Likewise, the Honorable Supreme Court is also of the view that that the right to life guaranteed by Article 21 of the constitution does not include the right to die. The court held that Article 21 is a provision guaranteeing protection of life and personal liberty and by no stretch of imagination can extinction of life be read into it. However, various pro-euthanasia organizations, the most prominent among them being the Death with Dignity Foundation, keep on fighting for legalization of an individual's right to choose his own death.

A major development took place in this field on 7 March 2011. The Supreme Court, in a landmark judgment, allowed passive euthanasia. Refusing mercy killing of Aruna Shaunbag, lying in a vegetative state in a Mumbai Hospital for 37 years, a two-judge bench laid down a set of tough guidelines under which passive euthanasia can be legalized through a high-court monitored mechanism. The court further stated that parents, spouses, or close relatives of the patient can make such a plea to the high court. The chief justices of the high courts, on receipt of such a plea, would constitute a bench to decide it. The bench in turn would appoint a committee of at least three renowned doctors to advise them on the matter.

ANNEXURE – II

Bharath Institute of Higher Education and Research

Sri Lakshmi Narayana Institute of Medical Sciences

Participant list with signatures

Value-added course: **EUTHANASIA – An Indian Perspective (dated 26/03/2020)**

Sl.No	Reg.No	Name of the candidate	Signature
1.	U15MB250	AARTHI .H	
2.	U15MB251	ABARNA. M	
3.	U15MB252	ABINAYA.J	
4.	U15MB274	DEEPIKA PRIYADHARSHINI. B	
5.	U15MB275	DEVANAND .M	
6.	U15MB276	DEVANATHAN. R	
7.	U15MB277	DHANA PRIYA.P	
8.	U15MB278	DHANALAKSHMI. M	
9.	U15MB279	DHANUSH .R	
10.	U15MB285	EZHILARASI. R	
11.	U15MB286	FATHIMA BANU. A	
12.	U15MB287	GAYATHRI .M	
13.	U15MB288	GOGUL SUGAN. K	
14.	U15MB289	GOKULA KRISHNAN. E	
15.	U15MB268	ASWIN. B	
16.	U15MB262	ARUL NIVETHINI V.A	
17.	U15MB265	ARUN PRASAD. K	
18.	U15MB311	KISHORE. K	
19.	U15MB333	NIVETHITHA. A. N	
20.	U15MB335	NIVETHITHA. R. N	

21.	U15MB337	PIRAI NILA. M	
22.	U15MB336	PADMA SUNDARI	
23.	U15MB342	PREETHIKA. R	
24.	U15MB320	MALAISENAN. E	
25.	U15MB294	HARINI. L	

SRI LAKSHMI NARAYANA INSTITUTE OF MEDICAL SCIENCES

Annexure - IM

EUTHANASIA – An Indian Perspective

SHORT NOTES

Student Name:

AMUL SUBHASH

Course Code: IM12

WRITE SHORT NOTES ON THE FOLLOWING:

1. What is Physician Assisted Death?
2. What are the psychological implications of Euthanasia?
3. Suggest arguments in favour of PAS
4. What are the moral and ethical issues against PAS?
5. Euthanasia in the Indian setting

10

10

Dr. MVS

1) A deliberate intervention undertaken with the express intention of ending a life, to relieve intractable suffering.

2

2) psychological implications of euthanasia → patient's drive for assisted suicide, having a sense of powerlessness, and feeling isolated.

2

3) Some of the most compelling arguments made in favor of PAS come from patients such as Maynard, who suffer from life-threatening illnesses.

2

4) A physician facilitates a patient's death by providing the necessary means and/or information to enable the patient to perform the life-ending act.

2

those who favor PAS view the process as a peaceful and painless death, those who oppose it believe that the consequence of any form of suicide is illegal and ethical ramifications.

5) Euthanasia is legal in India under strict guidelines patients must consent through a living will, and must be either terminally ill or on a vegetative state

2

SRI LAKSHMI NARAYANA INSTITUTE OF MEDICAL SCIENCES

Annexure - III

EUTHANASIA – An Indian Perspective

SHORT NOTES

Student Name:
ASHISH RANJAN

Course Code: IM12

WRITE SHORT NOTES ON THE FOLLOWING:

1. What is Physician Assisted Death?
2. What are the psychological implications of Euthanasia?
3. Suggest arguments in favour of PAS
4. What are the moral and ethical issues against PAS?
5. Euthanasia in the Indian setting

(Dr. L. Aravind)

1) A deliberate intervention undertaken with the intention of ending a life, to relieve intractable suffering

2) psychological implications of euthanasia - patient is offered assisted suicide, having a sense of powerlessness and feeling isolated

2

3) Some of the most compelling arguments, made in favor of PAS come from patients such as hayanal, who suffer from life-threatening illness

2

4) patient death by providing a necessary means & information to enable the patient to perform the life ending act

2

5) Is legal in India under strict guidelines, patient must consent through a living will, and must be either terminal by ill or in a vegetative State

2

ANNEXURE IV

Sri Lakshmi Narayana Institute of Medical Sciences

CERTIFICATE OF MERIT

This is to certify that AKSSHAYA .M.R has actively participated in the Value Added Course on "Euthanasia an Indian Perspective" between March 2020 - May 2020 Organized by Sri Lakshmi Narayana Institute of Medical Sciences, Pondicherry- 605 502, India.

Dr. Muthukumarasamy. B
RESOURCE PERSON

Dr. C. Aravind
COORDINATOR

ANNEXURE - IX

Sri Lakshmi Narayana Institute of Medical Sciences

Affiliated to Bharath Institute of Higher Education & Research
Deemed to be University under section 3 of the UGC Act, 1956

CERTIFICATE OF MERIT

This is to certify that AARTHI .H has actively participated in the Value Added Course on Euthanasia – An Indian Perspective between March 2020 - May 2020 Organized by Sri Lakshmi Narayana Institute of Medical Sciences, Pondicherry- 605 502, India.

Dr. Muthukumarasamy. B
RESOURCE PERSON

Dr. C. Aravind
COORDINATOR

ANNEXURE - V

Student Feedback Form

Course Name: LEADERSHIP : AN INDIAN PERSPECTIVE

Subject Code: IM12

Name of Student: Anusuya. N Roll No.: 017-MB-272

We are constantly looking to improve our classes and deliver the best training to you. Your evaluations, comments and suggestions will help us to improve our performance

Sl. NO	Particulars	1	2	3	4	5
1	Objective of the course is clear				✓	
2	Course contents met with your expectations				✓	
3	Lecturer sequence was well planned				✓	
4	Lectures were clear and easy to understand					✓
5	Teaching aids were effective					✓
6	Instructors encourage interaction and were helpful					✓
7	The level of the course				✓	
8	Overall rating of the course	1	2	3	4	5

** Rating: 5 – Outstanding; 4 - Excellent; 3 – Good; 2– Satisfactory; 1 - Not-Satisfactory*

Suggestions if any:

—

Signature

Date: 01/05/2020

ANNEXURE - V

Student Feedback Form

Course Name: HUMAN RIGHTS - AN INDIAN PERSPECTIVE

Subject Code: **IM12**

Name of Student: Anil Sinha Roll No.: 017MB267

We are constantly looking to improve our classes and deliver the best training to you. Your evaluations, comments and suggestions will help us to improve our performance

Sl. NO	Particulars	1	2	3	4	5
1	Objective of the course is clear				✓	
2	Course contents met with your expectations				✓	
3	Lecturer sequence was well planned				✓	
4	Lectures were clear and easy to understand				✓	
5	Teaching aids were effective				✓	
6	Instructors encourage interaction and were helpful				✓	
7	The level of the course				✓	
8	Overall rating of the course	1	2	3	4	5

** Rating: 5 – Outstanding; 4 - Excellent; 3 – Good; 2– Satisfactory; 1 - Not-Satisfactory*

Suggestions if any:

Signature

Date: 03/05/2020

COURSE COMPLETION LETTER

From,

Dr. C. Aravind

Department of Internal Medicine

Sri Lakshmi Narayana Institute of Medical Sciences

Bharath Institute of Higher Education and Research,

Chennai.

To,

The Dean,

Sri Lakshmi Narayana Institute of Medical Sciences

Bharath Institute of Higher Education and Research,

Chennai.

Sub: Completion of value-added course: EUTHANASIA – An Indian Perspective

Respected Sir,

With reference to the subject mentioned above, the department has conducted the value-added course titled: **"EUTHANASIA – An Indian Perspective"**. We solicit your kind action to send certificates for the participants. Also, I am attaching the photographs captured during the conduct of the course.

Kind Regards

Dr. C. Aravind

Encl: Photographs

ANNEXURE - III

SRI LAKSHMI NARAYANA INSTITUTE OF MEDICAL SCIENCES

EXPLAINING PROGNOSIS FOR A PATIENT WITH TERMINAL ILLNESS

SHORT NOTES

Course Code: IM10

WRITE SHORT NOTES ON THE FOLLOWING:

1. How to prepare oneself before breaking the news to the patient and family?
2. How to help the family take in the news
3. Pain relief in terminal illness
4. Providing options to the patient and family

OFFICE OF THE DEAN

Sri Lakshmi Narayana Institute of Medical Sciences

OSUDU, AGARAM VILLAGE, VILLIANUR COMMUNE, KUDAPAKKAM POST,
PUDUCHERRY - 605 502.
[Recognised by Medical Council of India, Ministry of Health letter No. U/12012/249/2005-ME (P -II) dt. 11/07/2011]
[Affiliated to Bharath University, Chennai - TN]

Circular

15/12/2015

Sub: Organising Value-added Course: Stress management among medical students reg

With reference to the above- mentioned subject, it is to bring to your notice that Sri Lakshmi Narayana Institute of Medical Sciences, **Bharath Institute of Higher Education and Research**, is organisinga Value added course, titled, "**Stress management among medical students**" between January 2016 and April 2016. The course content is enclosed below.

The hard copy of the application should be sent to the institution by registered/ speed post only so as to reach on or before 31/12/2015. Applications received after the mentioned date shall not be entertained under any circumstances.

Encl: Copy of Course content

COURSE PROPOSAL

Course Title: Stress management among medical students