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A Study on the Acceptance of Passive Euthanasia in India

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Abstract: *Passive euthanasia is allowed in India as per Supreme Court guidelines in the case of Aruna Ranchandra Shanbhag v. UOI but there is no specific legislation regarding the application of passive euthanasia in India. Passive euthanasia has divided or mixed opinions. The aim of this paper is to analyse public awareness about passive euthanasia, their support towards it and the benefits and negatives of passive euthanasia. It also observes the maturity of Indians in accepting Passive Euthanasia and the relation between the gender of respondents and their support towards the practice of passive euthanasia. This study is based on both secondary and primary data. The primary data for the study is collected from 200 sample respondents by using a well structured questionnaire. The sampling method used in this study is convenient sampling. The independent variables are age, gender, educational qualification, employment status and marital status. The dependent variable is public maturity on accepting passive euthanasia in India. In the results of the study, it was found that majority are unaware of passive euthanasia but are still supportive of the practice. The major benefits and negatives of passive euthanasia were also identified as pain relief, control over final decisions, less caregiver guilt and issues with consent. It was also observed that the majority think that Indians do not have the maturity of accepting passive euthanasia. We should not oversee the choice of the patient for reasons of religious beliefs. Thus, Passive Euthanasia should be properly legalised with a legislation and strict guidelines in India.*

Keywords: Passive Euthanasia, Maturity, Awareness, Support, Legislation

I. INTRODUCTION

Passive euthanasia is also known as mercy killing and occurs when the patient dies because the medical professionals either don't do something necessary to keep the patient alive, or when they stop doing something that is keeping the patient alive. It Includes acts like switching off life-support machines, disconnecting feeding tube, etc. Before Hippocrates, physicians assumed that they had the authority to kill patients who had no hope of recovery even without the permission. Even in the ancient texts of bible, Quran and Rigveda have mentioned self-destruction or suicide. Many do not accept this practice as it causes the soul and body to be separated at an unnatural timing. This will affect the karma of the person and it is also against the teachings of ahimsa. In India there is no legislation for passive euthanasia but the Supreme Court in the case of Aruna Ranchandra Shanbhag v. UOI, allowed passive Euthanasia based on its guidelines and recommended that a separate law should be made regarding this and to decriminalise the attempt to suicide

The 241st report of law commission recommended a bill for passive euthanasia after the case of Aruna Ranchandra Shanbhag v. UOI. The government finalised the draft for “The management of patients with terminal illness-withdrawal of medical life support Bill" for persistent vegetative state (PVS) patients or irreversible medical conditions. The central objective of this was ‘Living Will’ and prevention of abuse and neglect of elderly. The Ministry of health and family welfare made an affidavit on January 2016 refusing to legalise active euthanasia.

The factors affecting the maturity of Indians in accepting Passive Euthanasia are

- Pain / Sufferings
- Attending Physicians

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- Consent
- Control over final life decisions
- Caregiver
- Organ transplantation
- Religious Beliefs

There are differing verdicts with regard to right to life and death. On 7 March 2011, involuntary passive euthanasia was allowed in the case of Aruna. In 2016, the Ministry of health and family welfare drafted a bill for passive euthanasia and left it for public comment to make an informed decision. Here the majority of the scientific community welcomed it whereas the majority of religious groups opposed it, in specific, Christians and Muslims opposed it whereas Hindus had mixed opinion regarding it. At present, the matter of passive euthanasia has mixed or divided opinions and once a legislation for passive euthanasia is made it would have an impact on cultural, political, public and medical spheres.

While comparing passive euthanasia in India and Netherlands. In India, passive euthanasia decision can be made by parents or spouse or close relatives on best interest of the person or can also be made by next friend on approval of High Court. It is also observed that there is no legislation in India legalising passive euthanasia. Whereas Netherlands is one of the first country to permit active euthanasia through the euthanasia act of 2002. It defines euthanasia as administration of drugs with death of patient as the ultimate result at explicit request of patient it also provides criterias for euthanasia and they are voluntary, unbearable suffering, no alternative, informed about situation, consultation of physician and in due care and attention.

OBJECTIVES

- To analyse public awareness of the concept of Passive Euthanasia
- To understand the benefits of Passive Euthanasia
- To understand the negatives of Passive Euthanasia
- To examine public support towards the practice of Passive Euthanasia
- To examine the maturity of Indians in accepting Passive Euthanasia

II. REVIEW OF LITERATURE

Amy and Eliza (2022) aimed to examine the attitude and factors affecting euthanasia through a cross-sectional study and it was found that the majority have a negative attitude towards euthanasia especially among Christians and catholics. ***Iga (2022)*** aimed to determine public views on euthanasia through a questionnaire among 9686 students in the age between 18 and 35 and it was found that religious affiliation is a major factor in deciding their views. ***Rami Saadeh (2021)*** aimed assess the attitude and factors affecting euthanasia through a self administered and it was found that gender and psychological status of a person plays a crucial role in his support towards euthanasia. ***Herath (2021)*** aimed to explore the acceptance of public on euthanasia through an online questionnaire among 425 respondents and it was found that majority support the creation of a legislation for euthanasia.

Chinmay Devidas Deshmukh and Satish Arun Polshettiwar (2021) aimed to analyse euthanasia and ethical dilemma through a survey and it was found that death is the ultimate option of the patient. ***Alejandro (2020)*** aimed to examine the approval rate of euthanasia through systematic review and it was found that European countries have the highest acceptance rate to euthanasia. ***Ashapurna Das (2019)*** aimed to analyse the status of euthanasia in different countries and it was found that the majority encourage euthanasia due to reasons of caregiver's burden, refusing care and encourages organ transplantation. ***Tamanna Tewari (2019)*** aimed to analyse how the concept of euthanasia and living wills are understood across different age groups through thematic analysis and it was found that younger people readily agreed to euthanasia whereas older people gave more importance to will power.

Alexander and John (2018) aimed to analyse the opinion of medical students regarding passive euthanasia through a three-part questionnaire among 1319 students and the results showed that religion and its importance in daily life was a major factor for negative opinion regarding passive euthanasia.***Gulden and Nesibe (2017)*** examine the perspectives and attitude towards euthanasia through descriptive study among thousand a 1170 students at kastamonre university and it

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was found that there is a difference in their attitude based on one's age, gender, income and space of living. ***Kalaivani (2014)*** aimed to analyse euthanasia through a doctrinal research and it was found that majority of the opinion that legalising passive euthanasia would be a slippery slope and that strict guidelines are required. ***Ardith (2011)*** aimed to assess the appropriateness of euthanasia through a survey among 230 nurses and it was found that it is important to provide social support, maintain privacy boundaries and to relieve psychological distress in euthanasia.

Caesar Roy (2011) aimed to analyse the position of euthanasia in India through an analytical study and it was found that there is a need to legalise euthanasia with adequate safeguards. **J. Pereira (2011)** aimed to analyse the laws and safeguards that are ignored in euthanasia through a doctrinal study it was found that almost 900 people annually are administered with lethal substances without explicit consent. ***Armaan (2009)*** aimed to analyse ethical tea or ethicality of euthanasia through questionnaires and with reference to literature works and it was found that euthanasia is a necessity and individual right. ***Judith (2009)*** and to analyse the frequency and characteristics of euthanasia through an empirical study it was found that medical end of life decision making is crucial and needs continuous attention and policies.

Alison Chapple (2007) aimed to explore the experiences of people with a ''terminal illness'', focusing on the patients'perspective of euthanasia and assisted suicide through a qualitative study using narrative interviews throughout the UK and it was found that UK law should be changed to allow assisted suicide or voluntary euthanasia was felt strongly by most people. ***Kusum Rajendra Gandhi (2007)*** aimed to understand the major issues in euthanasia through a doctrinal and it was found that there is a need to re-examine the issues at regular intervals and that it depends on the evolution of society and health care. ***Garrard and Stephen (2005)*** aimed to examine the permissibility and consequence of passive euthanasia and the results showed that although passive euthanasia creates tension, there is no reason to abandon passive euthanasia and it would be beneficial when correctly defined. ***Nuno (2005)*** aimed to compare the different national situations regarding euthanasia and it was found that there was no neutral position among the countries.

III. RESEARCH METHODOLOGY

The aim of this paper is to analyse public awareness about passive euthanasia, their support towards it and the benefits and negatives of passive euthanasia. It also observes the maturity of Indians in accepting Passive Euthanasia and the relation between the gender of respondents and their support towards the practice of passive euthanasia. This study is based on both secondary and primary data. The primary data for the study is collected from 200 sample respondents by using a well structured questionnaire. The sampling method used in this study is convenient sampling. The independent variables are age, gender, educational qualification, employment status and marital status. The dependent variable is public maturity on accepting passive euthanasia in India. The tools of analysis used in the study are charts, graphs, percentages and chi square test for meaningful analysis.

RESEARCH HYPOTHESIS

Null Hypothesis (H0):

There is no significant relationship between the gender of the respondents and their support towards the practice of passive euthanasia.

Alternative Hypothesis (H1):

There is a significant relationship between the gender of the respondents and their support towards the practice of passive euthanasia.

Null Hypothesis (H0):

There is no significant relationship between the gender of the respondents and their agreeability on the statement that "Indians have the maturity of accepting Passive Euthanasia".

Alternative Hypothesis (H1):

There is a significant relationship between the gender of the respondents and their agreeability on the statement that "Indians have the maturity of accepting Passive Euthanasia".

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IV. ANALYSIS

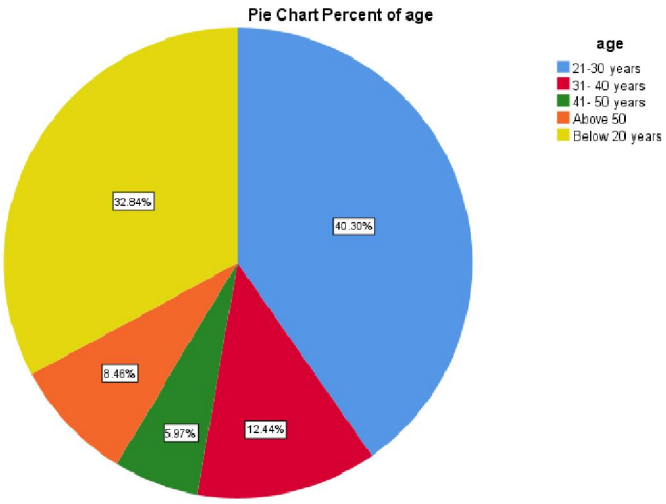

Fig 1 represents the distribution of sample respondents with respect to their age.

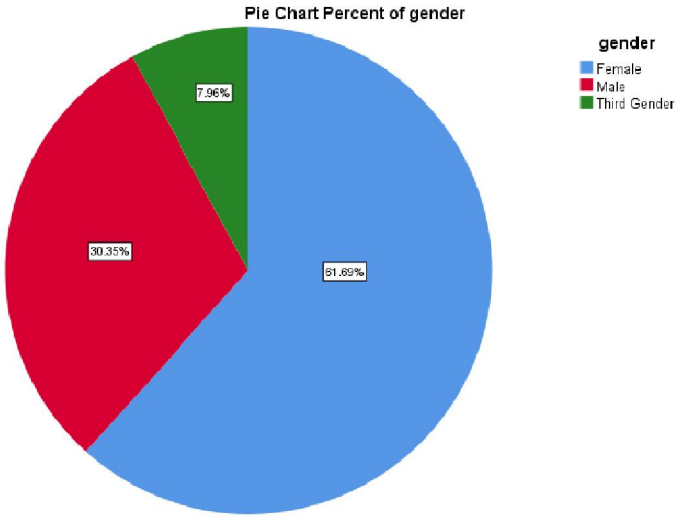

Fig 2 represents the distribution of sample respondents with respect to their gender.

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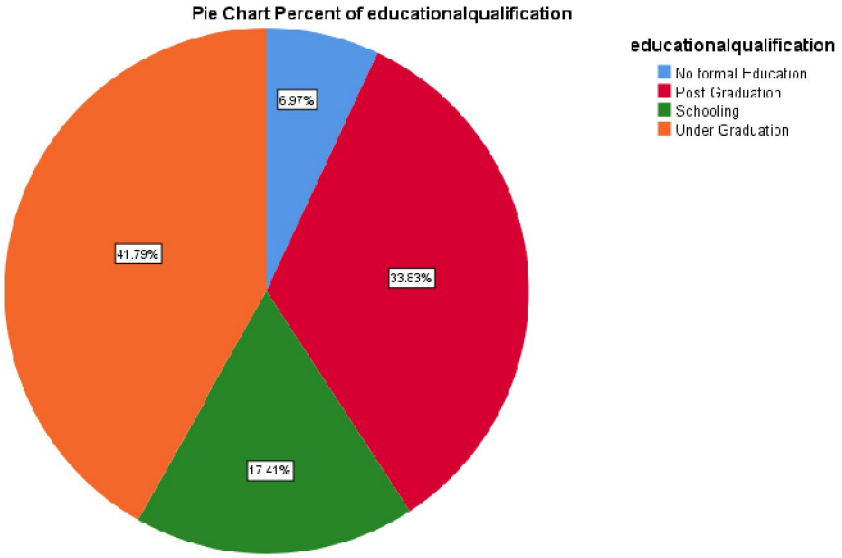

Fig 3 represents the distribution of sample respondents with respect to their educational qualification.

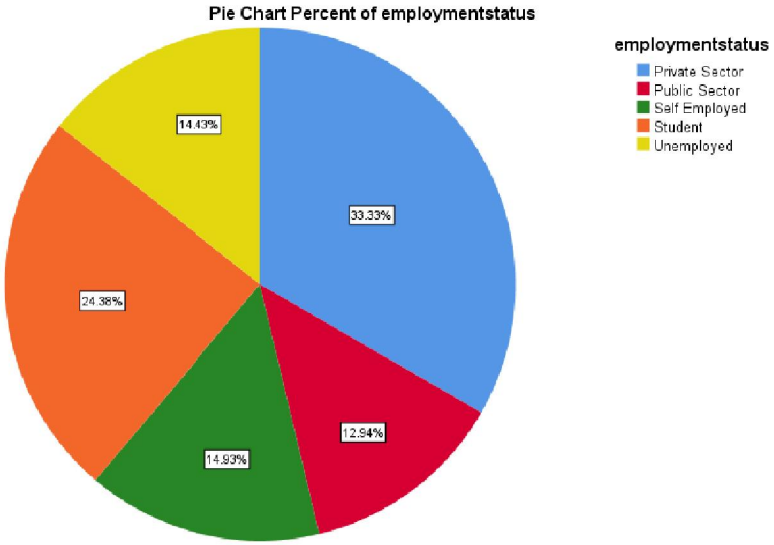

Fig 4 represents the distribution of sample respondents with respect to their employment status.

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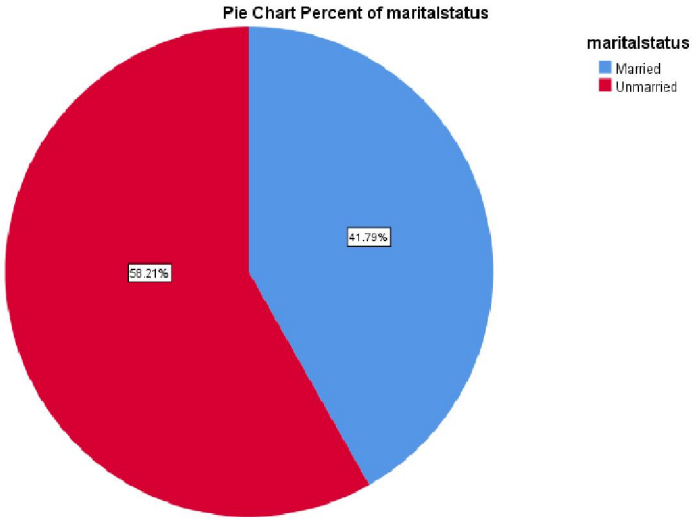

Fig 5 represents the distribution of sample respondents with respect to their marital status.

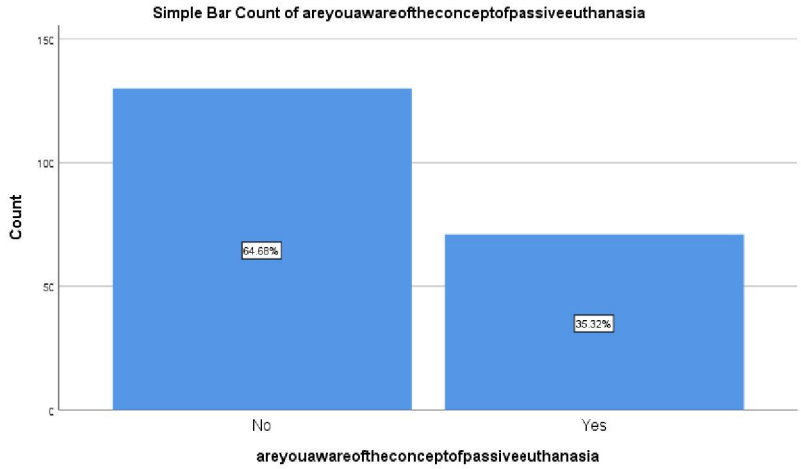

Fig 6 represents the distribution of sample respondents with respect to their awareness of the concept of passive euthanasia.

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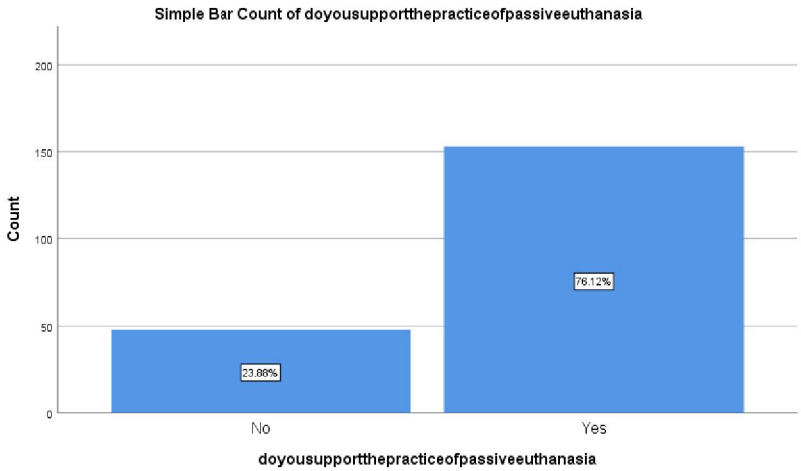

Fig 7 represents the distribution of sample respondents with respect to their support on the practice of passive euthanasia.

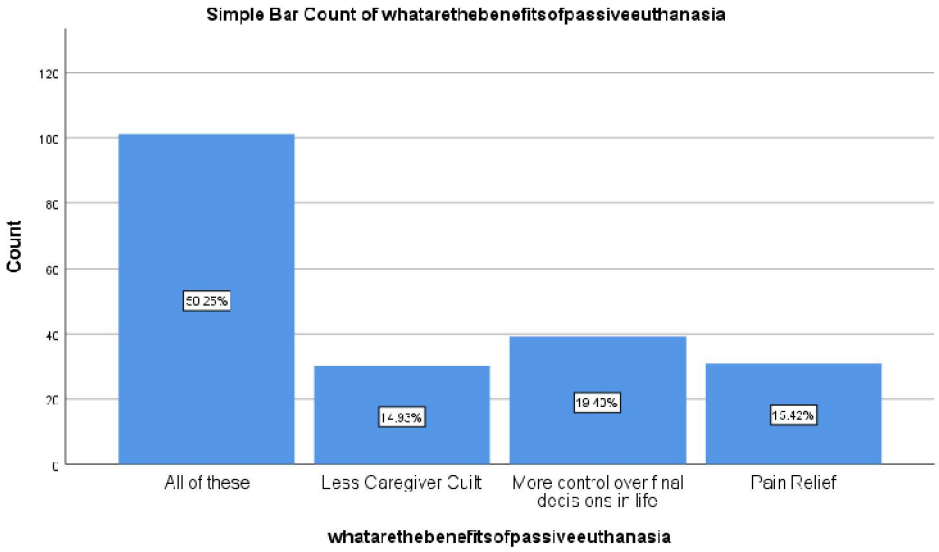

Fig 8 represents the distribution of sample respondents with respect to their opinion on the benefits of passive euthanasia.

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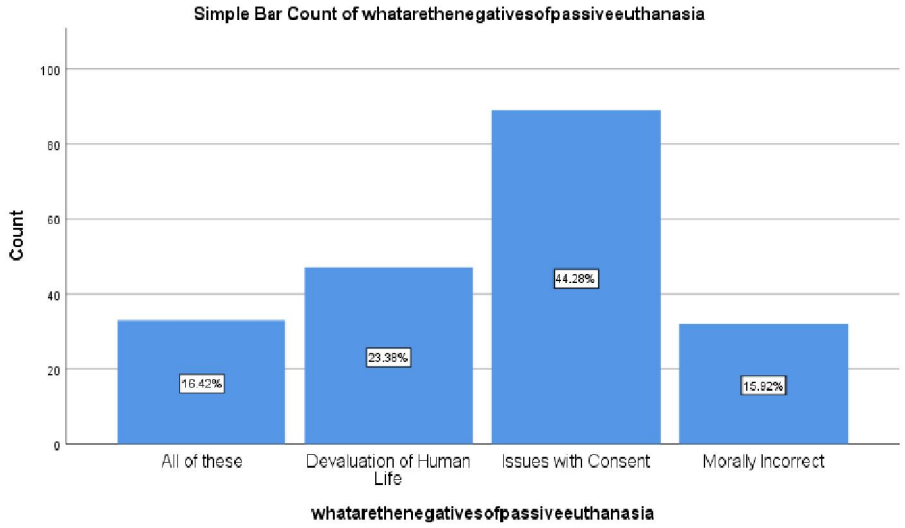

Fig 9 represents the distribution of sample respondents with respect to their opinion on the negatives of passive euthanasia.

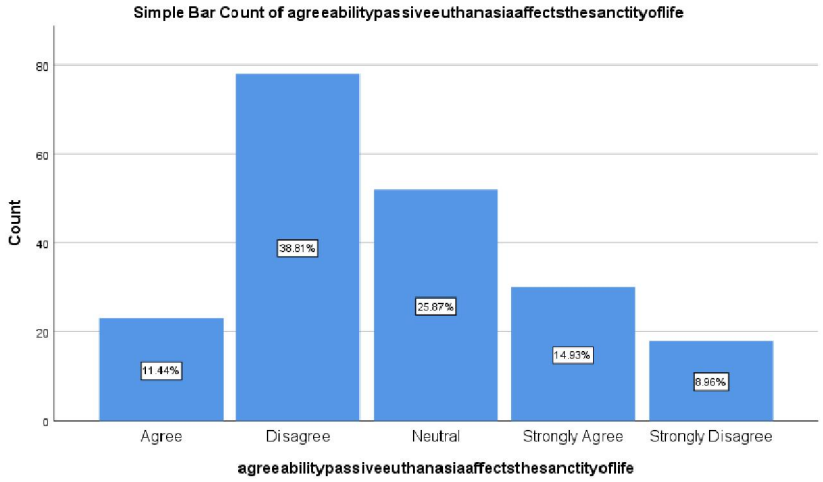

Fig 10 represents the distribution of sample respondents with respect to their agreeability on the statement that passive euthanasia affects the sanctity of life.

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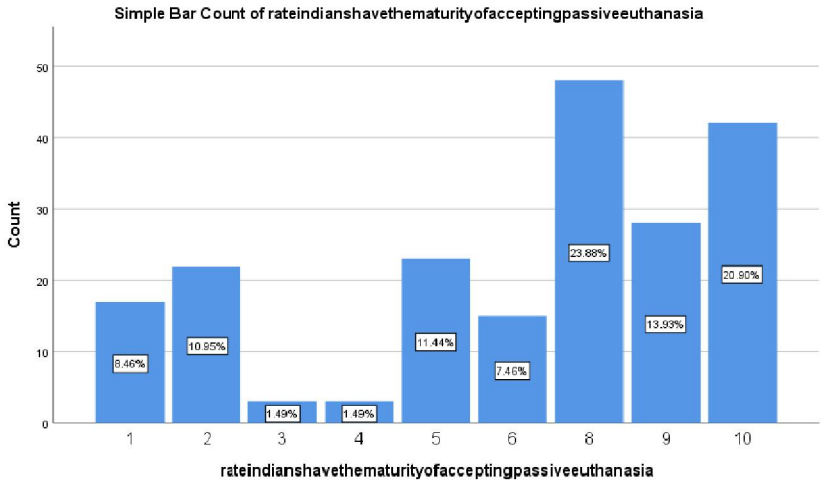

Fig 11 represents the distribution of sample respondents with respect to their agreeability on the statement that "Indians have the maturity of accepting passive euthanasia".

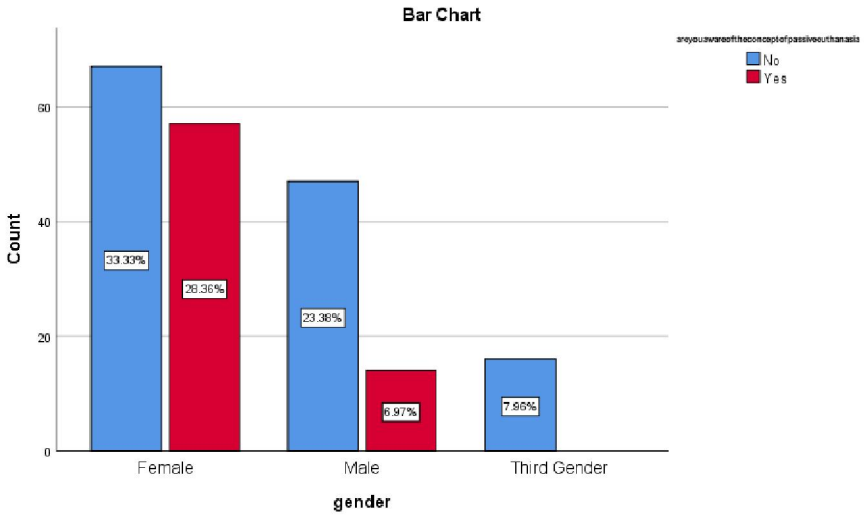

Fig 12 represents the gender distribution of sample respondents with respect to their awareness of the concept of passive euthanasia.

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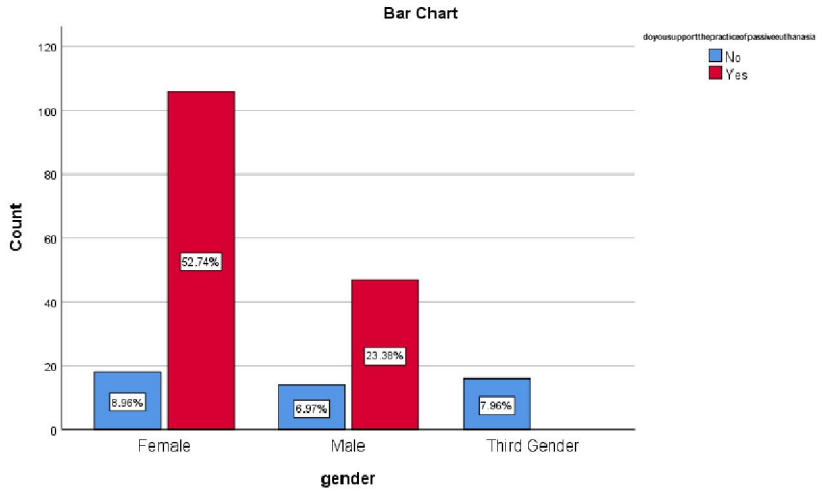

Fig 13 represents the gender distribution of sample respondents with respect to their support on the practice of passive euthanasia.

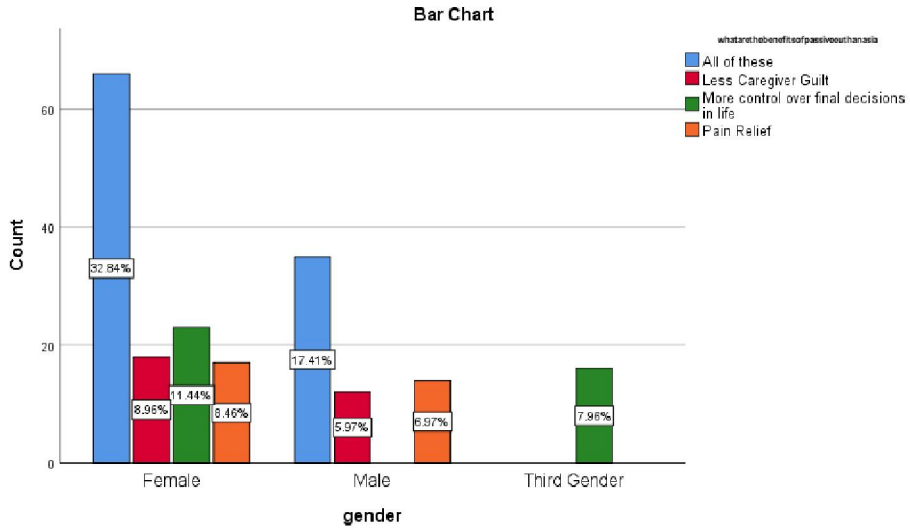

Fig 14 represents the gender distribution of sample respondents with respect to their opinion on the benefits of passive euthanasia.

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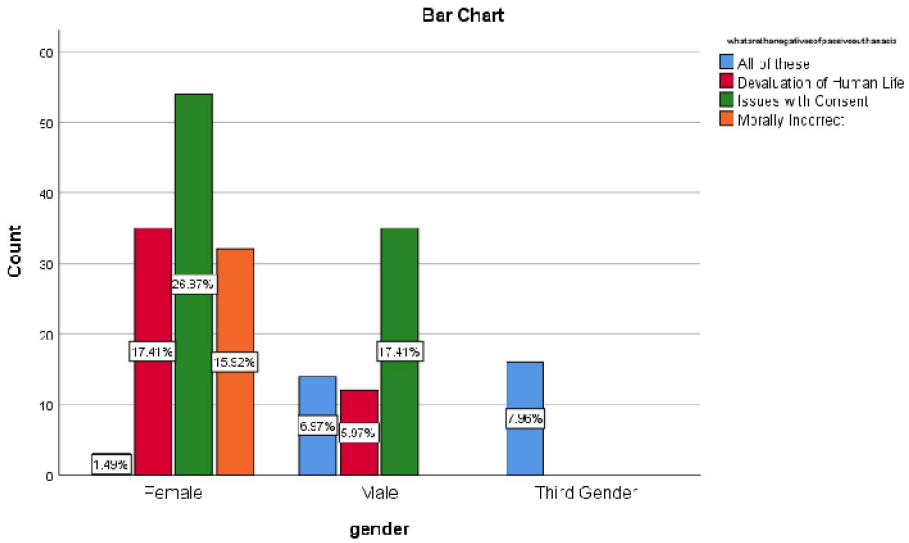

Fig 15 represents the gender distribution of sample respondents with respect to their opinion on the negatives of passive euthanasia.

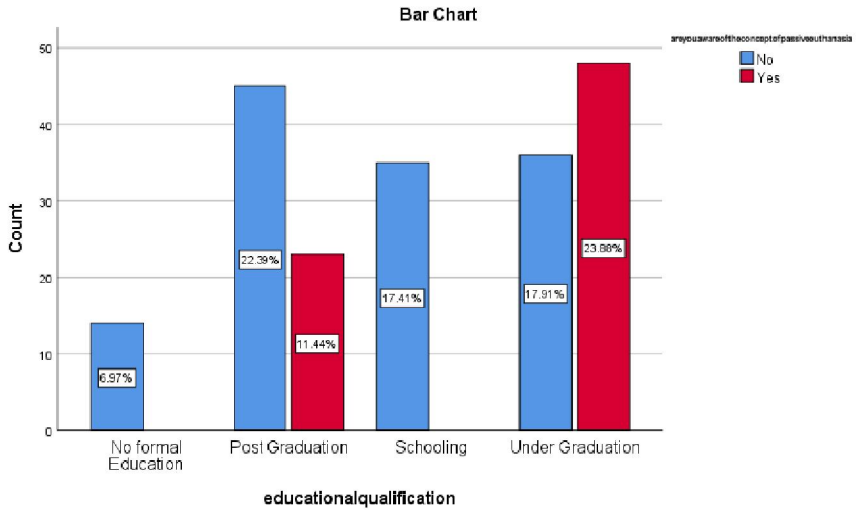

Fig 16 represents the educational qualification distribution of sample respondents with respect to their awareness of the concept of passive euthanasia.

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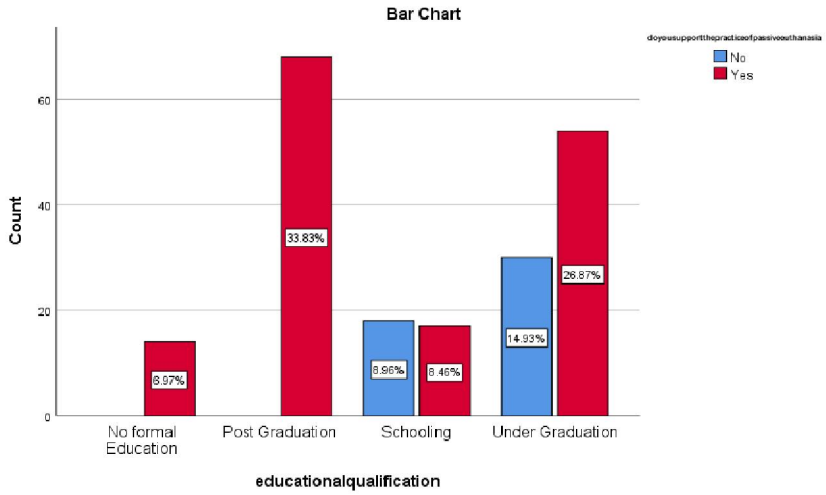

Fig 17 represents the educational qualification distribution of sample respondents with respect to their support on the practice of passive euthanasia.

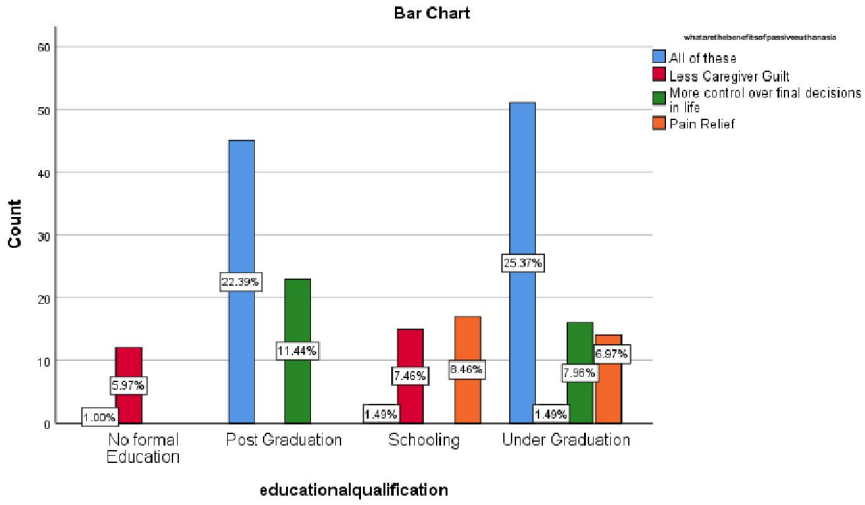

Fig 18 represents the educational qualification distribution of sample respondents with respect to their opinion on the benefits of passive euthanasia.

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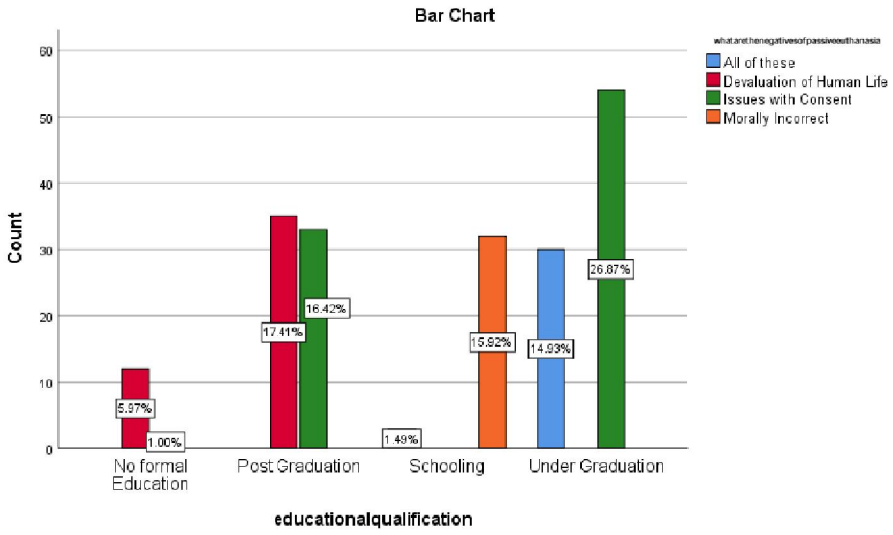

Fig 19 represents the educational qualification distribution of sample respondents with respect to their opinion on the negatives of passive euthanasia.

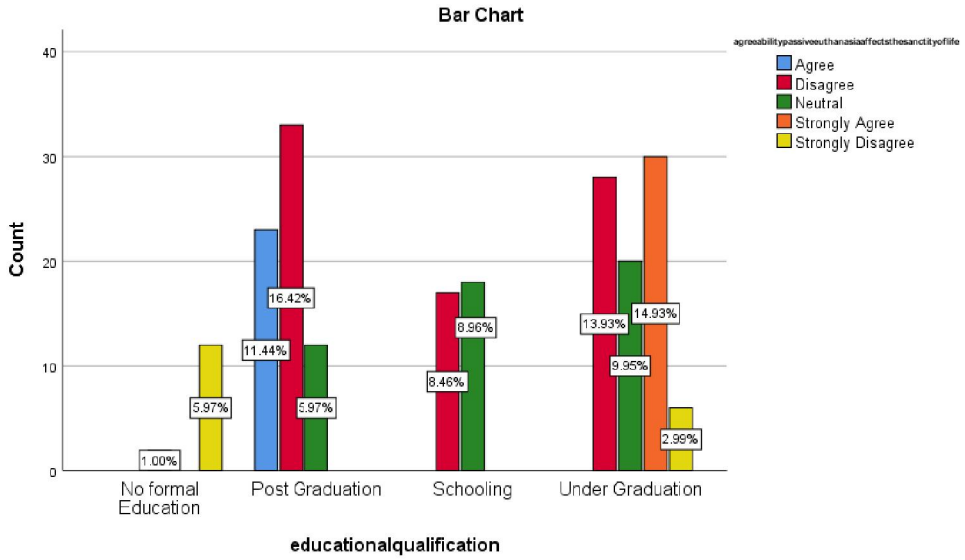

Fig 20 represents the educational qualification distribution of sample respondents with respect to their agreeability on the statement that passive euthanasia affects the sanctity of life.

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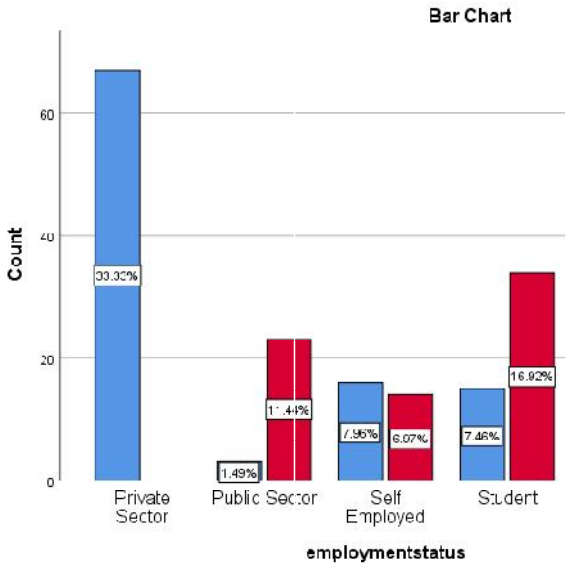

Fig 21 represents the employment status distribution of sample respondents with respect to their awareness of the concept of passive euthanasia.

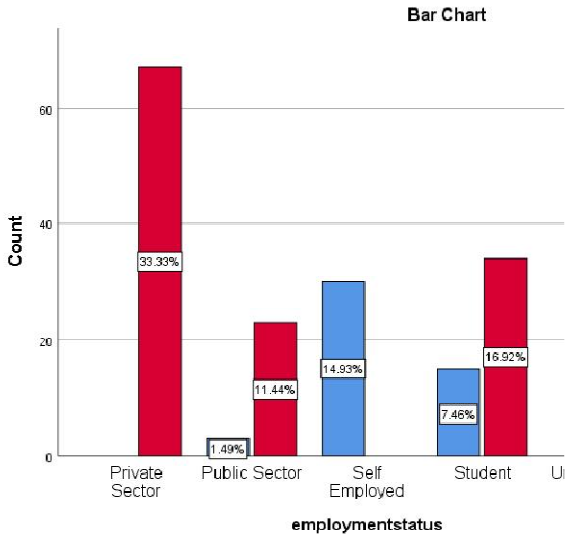

Fig 22 represents the employment status distribution of sample respondents with respect to their support on the practice of passive euthanasia.

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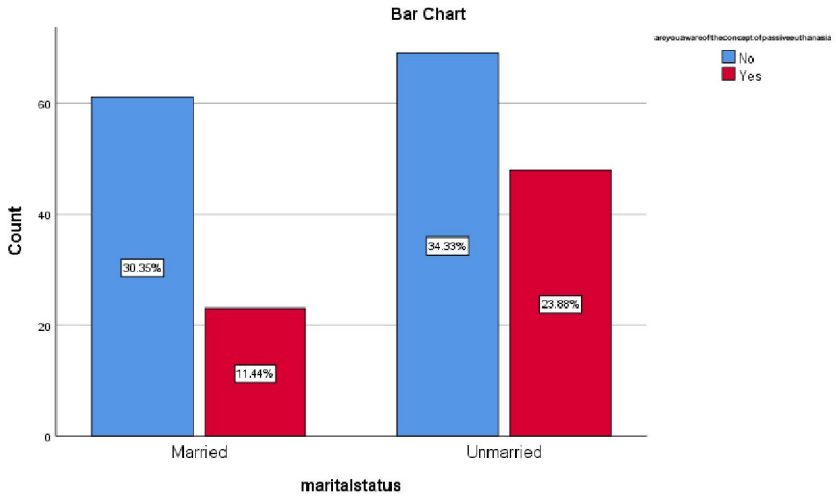

Fig 23 represents the marital status distribution of sample respondents with respect to their awareness of the concept of passive euthanasia.

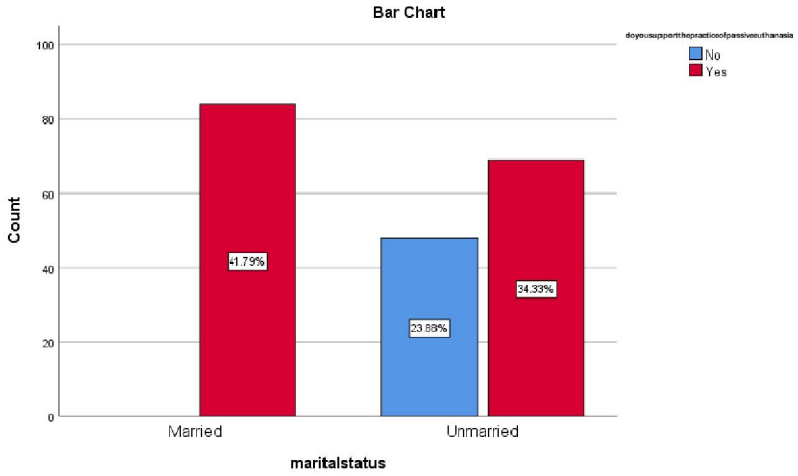

Fig 24 represents the marital status distribution of sample respondents with respect to their support on the practice of passive euthanasia.

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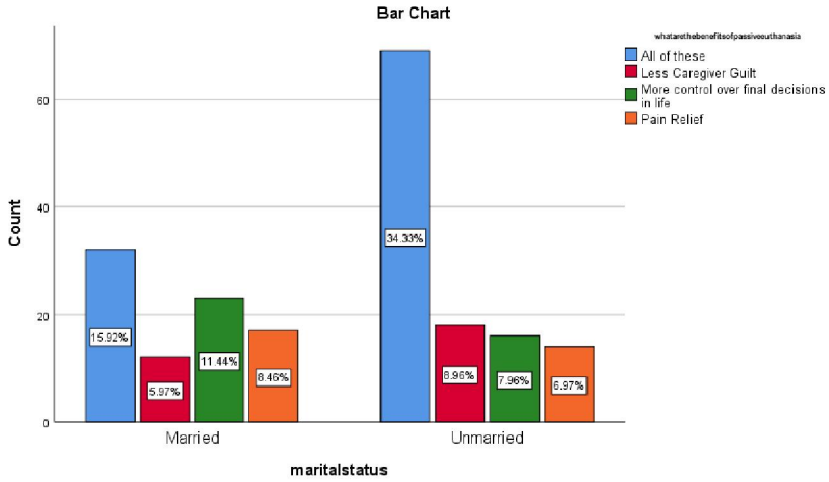

Fig 25 represents the marital status distribution of sample respondents with respect to their opinion on the benefits of passive euthanasia.

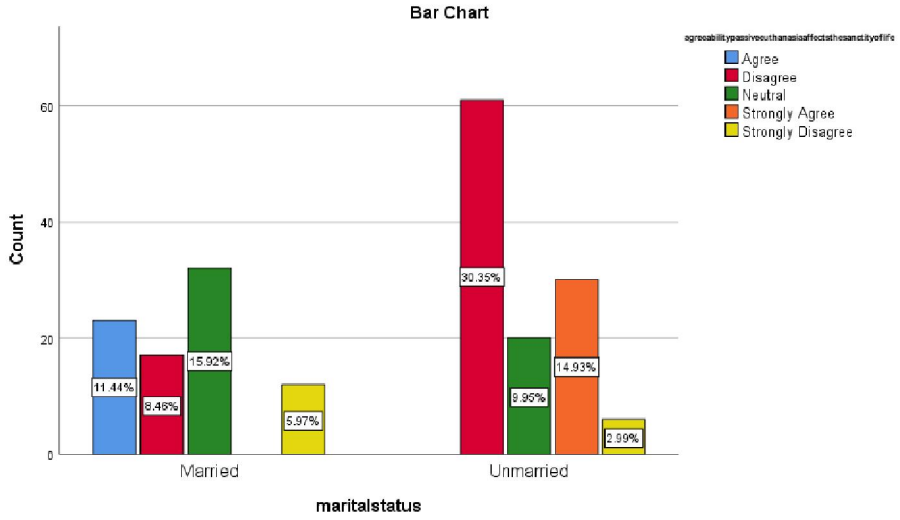

Fig 26 represents the marital status distribution of sample respondents with respect to their agreeability on the statement that passive euthanasia affects the sanctity of life.

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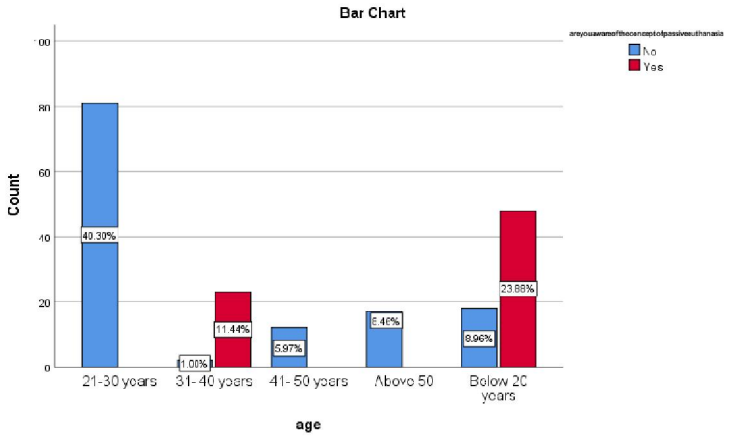

Fig 27 represents the age distribution of sample respondents with respect to their awareness of the concept of passive euthanasia.

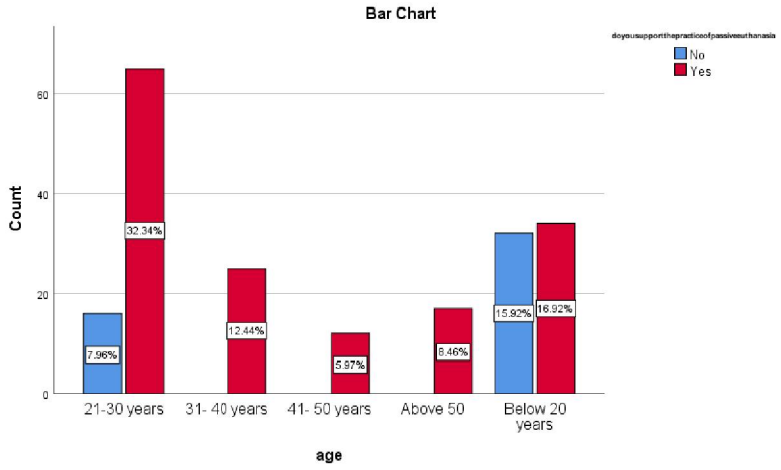

Fig 28 represents the age distribution of sample respondents with respect to their support on the practice of passive euthanasia.

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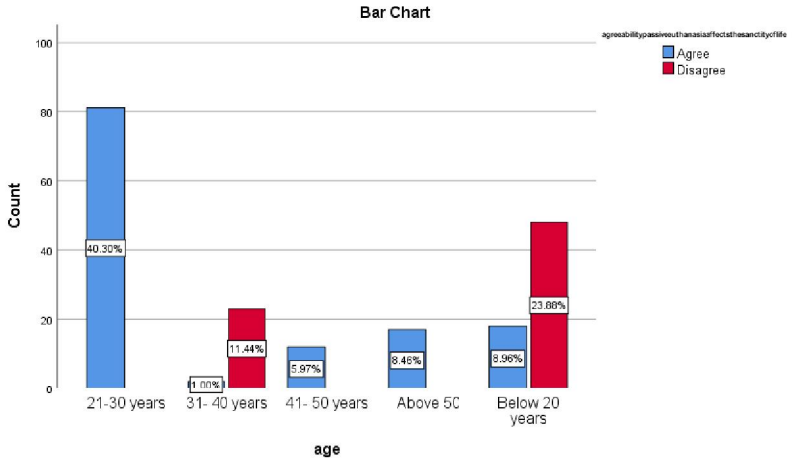

Fig 29 represents the age distribution of sample respondents with respect to their agreeability on the statement that passive euthanasia affects the sanctity of life.

gender * doyousupportthepracticeofpassiveeuthanasia Crosstabulation

Count

		doyousupportthepracticeofpassiveeuthanasia		
		No	Yes	Total
gender	Female	18	106	124
	Male	14	47	61
	Third Gender	16	0	16
Total		48	153	201

Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	57.011[a]	2	.000
Likelihood Ratio	52.533	2	.000
N of Valid Cases	201		

a. 1 cells (16.7%) have expected count less than 5. The minimum expected count is 3.82.

Fig 30 represents the chi-square test between the gender distribution of sample respondents and their support towards the practice of passive euthanasia.

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gender * rateindianshavethematurityofacceptingpassiveeuthanasia Crosstabulation

Count

		rateindianshavethematurityofacceptingpassiveeuthanasia									
		1	10	2	3	4	5	6	8	9	Total
gender	Female	17	12	20	3	3	23	15	3	28	124
	Male	0	14	2	0	0	0	0	45	0	61
	Third Gender	0	16	0	0	0	0	0	0	0	16
Total		17	42	22	3	3	23	15	48	28	201

Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	210.159[a]	16	.000
Likelihood Ratio	218.691	16	.000
N of Valid Cases	201		

a. 14 cells (51.9%) have expected count less than 5. The minimum expected count is .24.

Fig 31 represents the chi-square test between the gender distribution of sample respondents and their agreeability on the statement that "Indians have the maturity of accepting passive euthanasia".

V. RESULTS

In the distribution of sample respondents with respect to their age (**figure 1**), it is depicted that 40.30%, 12.44%, 5.97%, 8.46% and 32.84% are in the age between 21 to 30, 31 to 40, 41 to 50, about 50 and below 20 years respectively.

In the distribution of sample respondents with respect to their gender (**figure 2**), it is depicted that 61.69%, 30.35% and 7.96% were female, male and third gender respectively.

In the distribution of sample respondents with respect to the educational qualification (**figure 3**), it is depicted that 6.97%, 3.83%, 17.41% and 41.79% with no formal education, post graduation, schooling and under graduation respectively.

In the distribution of sample respondents with respect to their employment status (**figure 4**), it is depicted that 33.33%, 12.94%, 14.93%, 24.38% and 14.43% have responded as private sector, public sector, self-employed, student and unemployed respectively.

In the distribution of sample respondents with respect and status (**figure 5**), it is depicted that 41.79% are married and 58.21% are unmarried.

In the distribution of sample respondents with respect to their awareness of the concept of passive euthanasia (**figure 6**), it is depicted that 64.68% and 35.32% have responded in negative and in positive respectively.

In the distribution of sample respondents with respect to their support on the practice of passive euthanasia (**figure 7**), it is depicted that 23.88% and 76.12% have responded in negative and in positive respectively.

In the distribution of sample respondents with respect to their opinion on the benefits of passive euthanasia (**figure 8**), it is depicted that 50.25%, 14.93%, 19.40% and 15.42% have responded as all of this, less caregiver guilt, more control over final decisions in life and pain relief respectively.

In the distribution of sample respondents with respect to their opinion on the negatives of passive euthanasia (**figure 9**), it is depicted that 16.42%, 23.38%, 44.28% and 15.92% have responded as all of these, devaluation of human life, issues with consent and morally incorrect respectively.

In the distribution of sample respondents with respect to their agree ability on the statement that affects the sanctity of life (**figure 10**), it is depicted that 11.44%, 38.81%, 25.87%, 14.93% and 8.96% have responded as agree, disagree, neutral, strongly agree and strongly disagree respectively

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In the distribution of sample respondents with respect to the statement that "Indians have the maturity of accepting passive euthanasia" (**figure 11**), 8.46%, 10.95%, 1.49%, 1.49%, 11.44%, 7.46%, 23.88%, 13.93% and 20.90% have rated from 1- 10 respectively.

In the gender distribution of sample respondents with respect to their awareness of the concept of passive euthanasia (**figure 12**), in female, 33.33% and 28.36% , in male , 23.38%, 6.97% and in third gender, 7.96% and 0% have responded in negative and in positive respectively.

In the gender distribution of sample respondents with respect to their support on the practice of (**figure 13**), it is depicted that in female, 8.96% and 52.74%, in male , 6.97% and 23.38% and in third gender, 7.96% and 0% have responded in negative and in positive respectively.

In the gender distribution of sample respondents with respect to their opinion on the benefits of passage euthanasia (**figure 14**), it is depicted that in female, 32.84%, 8.96%, 11.44% and 8.46%, in male, 17.41%, 5.97%, 0% and 6.97% and in third gender, 0%, 0%, 7.96% and 0% have responded as all of these, less caregiver guilt, more control over final decisions in life and pain relief respectively,

In the gender distribution of sample respondents with respect to their opinion on the negatives of (**figure 15**), it is depicted that in females, 1.49%, 17.41%, 26.87% and 15.92%, in male, 6.97%, 5.97%, 17.41% and 0% and in third gender, 7.96%, 0%, 0% and 0% have responded as all of these, devaluation of human life, issues with consent and morally incorrect respectively.

In the educational qualification distribution of sample respondents with respect to their awareness of the concept of (**figure 16)**, it is depicted that in no formal education, 6.97%, 0%, in post-graduation, 22.39%, 11.44%, in schooling , 17.41%, 0% and in under graduation, 17.91% and 23.88% have responded in negative and in positive respectively.

In the educational qualification distribution of sample respondents with respect to their support on the practice of passive euthanasia (**figure 17**), it is depicted that in no formal education, 0%, 6.97%, in post graduation, 0%, 33.83%, in schooling, 8.96%, 8.46% and in under graduation, 14.93% and 26.87% have responded in negative and in positive respectively.

In the educational qualification distribution of sample respondents with respect to their opinion on the benefits of (**figure 18**), it is depicted that in no formal education, 1%, 5.97%, 0%, 0%, in post graduation, 22.39%, 0%, 11.44%, 0%, schooling, 1.49%, 7.46%, 0%, 8.46% and in under graduation, 25.37%, 1.49%, 7.96% and 6.97% have responded as all of these, less caregiver guilt, more control over final decisions in life and pain relief respectively.

In the qualification distribution of sample respondents with respect to their opinion on the negative aspects of (**figure 19**), it is depicted that in no formal education, 0%, 5.97%, 1%, 0%, in post graduation, 0%, 17.41%, 16.42, 0%, in schooling, 1.49%, 0% 0%, 15.92% and in under graduation, 14.93%, 0%, 26.87% and 0% have responded as all of these, devaluation of human life, issues with consent and morally incorrect respectively.

In the educational qualification distribution of sample respondents with respect to agree ability on the statement that Passive Euthanasia affects the sanctity of life (**figure 20**), it is depicted that in no formal education, 0%, 0%, 1%, 0%, 5.97%, in post graduation, 11.44%, 16.42%, 5.97%, 0%, in schooling, 0%, 8.46%, 8.96%, 0%, 0% and in under graduation, 13.93%, 9.95%, 14.90% and 2.99% have responded as agree, disagree, neutral, strongly agree and strongly disagree respectively.

In the employment status distribution of sample respondents with respect to their awareness of the concept of passive euthanasia (**figure 21**), it is depicted that in private sector, 33.33%, 0%, in public sector, 1.49%, 11.44%, self employed, 7.96%, 6.97%, in student, 7.46%, 16.92% and in unemployed, 14.43% and 0% have responded in negative and in positive respectively

In the employment status distribution of sample respondents with respect to their support on the practice of (**figure 22**), it is depicted that in private sector, 0%, 33.33%, in public sector, 1.49%, 11.44%, and self-employed, 14.93% percent, in student, 7.46%, 16.92% and in unemployed, 0% and 14.43% have responded in negative and in positive respectively.

In the marital status distribution of sample respondents with respect to their awareness of the concept of passive euthanasia (**figure 23**), it is depicted that married, 30.35%, 11.44%, in unmarried, 34.33% and 23.88% have responded in negative and in positive respectively.

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In status distribution of sample respondents with respect to their support on the practice of passive euthanasia (**figure 24**), It is depicted that in married, 0%, 41.79% and in unmarried, 23.88% and 34.33% have responded in negative and in positive respectively

In the marital status distribution of sample respondents with respect to their opinion on the benefits of passive euthanasia (**figure 25**), it is depicted that in married, 15.92%, 5.97% and 11.44%, 8.46% and in unmarried, 34.33%, 8.96%, 7.96% and 6.97% have responded as all of these, less caregiver guilt, more control over final decisions in life and and pain relief respectively.

In the distribution of sample respondents with respect to their statement that passive euthanasia affects the sanctity of life (**figure 26**), it is depicted that in married, 11.44%, 8.46%, 15.92%, 0% and 5.97% and in unmarried, 0%, 30.35%, 9.95%, 14.93% and 2.99% have responded as agree, disagree, neutral, strongly agree and strongly disagree respectively.

The age distribution of sample respondents with respect to their awareness of the concept of passive euthanasia (**figure 27**), it is depicted that in age 21 to 30, 40.30%, 0%, in age 31 to 40, 1%, 11.44%, in age 41 to 50, 5.97%, 0%, in age above 50, 8.46%, 0% and in age below 20, 8.96% and 23.88% have responded in negative and in positive respectively.

In the age distribution of sample respondents with respect to their support on the practice of passive euthanasia (**figure 28**), it is depicted that in age 21 to 30, 7.96%, 32.34%, age 31 to 40, 0%, 12.44%, in age 41 to 50, 0%, 5.97%, in age above 50, 0%, 8.46%, in age below 20, 15.92% and 16.92% have responded in negative and in positive respectively.

In the age distribution of sample respondents with respect to statement that passive euthanasia affects the sanctity of life (**figure 29**), it is depicted that in age 21 to 30, 40.30%, 0%, in age 31 to 40, 1%, 11.44%, in age 41 to 50, 5.97%, 0%, in age above 50, 8.46%, 0% and in age below 20, 8.96% and 23.88% have responded in positive and a negative respectively

In the chi-square test between the gender distribution of sample respondents and their support towards the practice of passive euthanasia (**figure 30**), it is depicted that the minimum expected count is 3.82

In the chi-square test between the gender distribution of sample respondents and their agreeability on the statement that "Indians have the maturity of accepting passive euthanasia" (**figure 31**), it is depicted that the minimum expected count is 0.24

VI. DISCUSSION

In the distribution of sample respondents with respect to their awareness of the concept of passive euthanasia (figure 6) with respect to gender (figure 12), educational qualification (figure 16), employment Status (figure 21), marital status (figure 23) and age (figure 27), The overall majority have responded in negative that they are unaware of passive euthanasia. This could be because there is no official legislation or initiatives taken by the government in regard to passive euthanasia.

In the distribution of sample respondents with respect to their support on the practice of passive euthanasia (figure 7), with respect to gender (figure 13), educational qualification (figure 17), employment status (figure 22), marital status (figure 23), and age (figure 28), The overall majority have responded in positive that they do support the practice of passive euthanasia.this could be because through the development of society, there is an increase in the acceptance of passive euthanasia understanding that it is the ultimate choice of the patient and preference is given to patients wish over others. It could also be because it gives an opportunity for organ transplantation.

In the distribution of sample respondents with respect to their opinion on the benefits of passive euthanasia (figure 8) with respect to gender figure 14, educational qualification (figure 18) and marital status (figure 25), the overall majority have responded as all of these including less caregiver guilt, more control over life decisions in life and pain relief. This could be because passive euthanasia does relieve the person from pain and puts his wish over others.

In the distribution of sample respondents with respect to their opinion on the negatives of passive euthanasia (figure 9), with respect to gender (figure 15) and educational qualification (figure 19), the overall majority have responded as issues with consent. This could be because when passive euthanasia is exercised there might come problems as to whether the consent of the person was obtained and also arises a confusion as to who can decide on the life of the person.

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In the distribution of sample respondents with respect to their agreeability on the statement that passive euthanasia affects the sanctity of life (figure 10) with respect to educational qualification (figure 20), marital status (figure 26) and age (figure 29), the overall majority have responded as disagree that passive euthanasia doesn't affect the sanctity of life. This could be because the religious beliefs of disruption of peace due to unnatural time of death and karma following it are now less prevalent and there is a growing support and understanding of public on passive euthanasia.

In the distribution of sample respondents with respect to their agreeability on the statement that "Indians have the maturity of accepting passive euthanasia" (figure 11). The majority have rated as 8 with 1 being strongly agree and 10 being strongly disagree. This could be India being a cultural and religious country, the religious beliefs might affect their support towards passive euthanasia.

In the chi-square test between the gender distribution of sample respondents and their support towards the practice of passive euthanasia (figure 30), it is depicted that the minimum expected count is 3.82 which is greater than 0.5 which makes that null hypothesis is true in the present case. The results reveal that there is no significant relationship between the gender distribution of sample respondents and their support towards the practice of passive euthanasia.

In the chi-square test between the gender distribution of sample respondents and their agreeability on the statement that "Indians have the maturity of accepting passive euthanasia" (figure 31), it is depicted that the minimum expected count is 0.24 which is greater than 0.5 which makes that null hypothesis is true in the present case. The results reveal that there is no significant relationship between the gender distribution of sample respondents and their agreeability on the statement that "Indians have the maturity of accepting passive euthanasia".

Passive euthanasia is a disputed topic and is divided by the choice of the person and religious beliefs. The reason for this is that India being a country rich in different cultural and religious practices these beliefs tend to be factors for opposing Passive Euthanasia. Earlier in India, the topic was dominated with religious beliefs but recently there has been An increasing rate of acceptance towards passage euthanasia. In India there is no legislation but there are guidelines laid down in the case of Aruna Ramchandra v. union of India in this case a petition was filed for permission for euthanasia where the person had no state of awareness and was on persistent vegetative state here the court appointed a medical examination committee and permitted passive euthanasia .The important points in the guidelines made by the Supreme Court in this case or that the decisions of passive euthanasia can be made by the parents or Spouse or close relatives on the best interest of the patient. In case the decision is taken by doctors or next friend then it requires the approval of the High Court to prevent the misuse of this practice. There have been occasions when the thought of making a law for passing euthanasia arose but it was usually not welcomed by the religious groups. In my opinion passive euthanasia should be legalised, we should not oversee the wish or choice of the patient for reasons of religious believes of another or for others opinion. But it is also observed that there might arise few problems where the person dying might not have consciousness and this may cause miss use of this practice. In order to protect the patient and remove this issue, an assessment should be made by medical professionals appointed for this concern.

VII. SUGGESTIONS

Passive Euthanasia should be properly legalised in India, we cannot oversee the wish or choice of patient for reason of religious beliefs of another or their opinion

An issue that might arise is the person dying might not have consciousness and there can be misuse of this. To remove this, there should be medical professionals appointed to assess the state of the person dying.

VIII. CONCLUSION

Passive euthanasia is a divided issue and previous research works indicate that the major issue or factors affecting support of passive euthanasia is this religion. The objective of this study is to analyse public awareness and support on passive euthanasia. To analyse its benefit and negative and to examine the maturity of Indians in accepting passive euthanasia. Even though the majority are unaware of passive euthanasia, they support it. There is an increasing rate of acceptance towards euthanasia in india with the evolving society. The findings show that the major benefits of passive euthanasia are pain relief, less caregiver guilt, more control or final decisions in life . It is thus suggested that Passive Euthanasia should be allowed in India with strict provisions that can ensure better implementation of the law for the

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benefit the society. Future studies can be conducted on active euthanasia and perceptions of the public regarding it. It is thus concluded that there is a need for legislation to prevent the abuse or misuse and to give the ultimate option to the person and his wishes.

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