6th

NEPAL PUBLIC HEALTH FOUNDATION LECTURE ON

"UNVEILING THE DEBATE ON EUTHANASIA"

BY DR. B D CHATAUT

NPHF

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Organized by

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FOREWORD

Even while mooting the idea of founding the Nepal Public Health Foundation during 2010, organizing lecture on public health issues annually by eminent professional was identified as a core activity. Subsequently, the first inaugural lecture was delivered by Mr. Kul Chandra Gautam, Advisor to NPHF and former Under Secretary General of the United Nations and Deputy Executive Director, UNICEF on the scope of modern public health under the title "10 + 2 Agenda for Public Health" with multi-dimensional approach. Since then, every year on 30 June, the lecture has been organized under various topics and this is the sixth lecture in series, which was delivered by Dr. B. D. Chataut, a former Director General of Health Services, acclaimed for his deep knowledge in public health and beyond. He chose to speak on Euthanasia, a highly sensitive issue under close scrutiny from medical, ethical, religious, cultural and socio-economic viewpoints.

The definition of Euthanasia is derived from the Greek words, meaning 'good death', 'easy death'. The practice is applied to end patient's life intentionally through the use of drugs and suspension of medical treatment to relieve the agony of unbearable pain and suffering from incurable disease. Dr. Chataut dealt this sensitive and controversial topic in great detail, providing global scenario with time-line events, case illustrations with arguments in favour of and against the practice of euthanasia. He also provided a list of diseases and health conditions in Nepal with possibility of opting for euthanasia. The presentation was followed by a lively discussion on right to life and dignity of death. It is obvious that the highly charged issue of euthanasia with ethical and moral implication deserves serious debate and cannot just be left under the carpet. I would like to express deep gratitude to Dr. Chataut for the brilliant exposure he gave on Euthanasia. The view expressed by him is personal and not the formal position of NPHF.

I would like to take the opportunity to thank all those involved in the organization of the event and publication of the monograph and in particular to Dr. Tirtha Rana for assistance in editing the text and to Ms. Chandana Rajopadhyaya for all necessary secretarial work.

Dr. Badri Raj Pande

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KEYNOTE ADDRESS

Defining euthanasia

The term euthanasia is originated from Greek word ‘esthetes’ which means "a good death"; some refer to the Greek word ‘euthanatos’ meaning "easy death”. It is the practice of ending a patient’s life intentionally by lethal drugs or suspension of medical treatment, to relieve suffering or pain, which he or she may have due to a painful and incurable disease or hopeless health condition. If, for example, a patient suffering from a terminal condition such as cancer is to be given an overdose of drugs to end his life or his life supports are to be withdrawn that would end the patient’s life , this would be considered as euthanasia.

In many cases, it is carried out at the persons' request but when they may be too ill and not able to request, the decision is made by relatives, medical attendants or, in some instances, the courts[1]. It is also called mercy killing very often. If euthanasia was only about killing someone it would mean the same thing as murder, so it involves more than just killing someone.

Euthanasia has been the subject of medical, ethical, political, cultural, religious, ideological and socio-economic discussion around the world for long time now.

Classification of euthanasia [2]

Euthanasia has been classified as:

- **Voluntary euthanasia** - when there is intentional killing of patients who freely made wish to die and gave their consent because of their pain and suffering.
- **Involuntary euthanasia** - when euthanasia is performed on persons who are able to provide informed consent, but do not, either because they do not choose to die, or because they were not asked. Many people think that it is murder.
- **Non - voluntary euthanasia-** when the explicit consent of the individuals concerned is unavailable as they are unable to say what they want to do, such as when the person is in a persistent vegetative state (it is a condition in which there is loss of ability to think and of awareness of surroundings, but non-cognitive function and normal sleep remain), or in the case of young children. In such cases, the decision can be made based on what the incapacitated individual would have wanted, or it could be made on substituted judgment of what the decision maker would want were he or she be in the incapacitated person's place. Or finally, the decision could be made by the doctors by their own decision.

This type of euthanasia is sometimes a choice for persons who are in coma or who are very young, as they cannot express what they want.

- **Physician Assisted Suicide (PAS)** - when a physician assists the patient in terminating his/her life at the patient's request. PAS involves a doctor knowingly and intentionally providing a person with the knowledge or means or both, required to commit suicide, including counselling about lethal doses of drugs, prescribing such lethal doses or supplying the drugs.

- **Assisted suicide -** it has several different interpretations. Perhaps the most widely and accepted is "the intentional hastening of death by a terminally ill patient with assistance from a doctor, relative or another person".

Active and passive euthanasia

Euthanasia can also be divided into active and passive category [2].

Active euthanasia

In active euthanasia active measures like giving lethal injection deliberately to cut short the life of a patient who is terminally illor suffering hopelessly is made on request of that patient. It also includes life-ending actions conducted by the patients or somebody else.

Active euthanasia is much more controversial than passive euthanasia. Individuals are torn by moral, ethical, religious, and compassionate arguments surrounding the issue.

In many jurisdictions active euthanasia can be considered as murder or manslaughter.

Passive euthanasia

In passive euthanasia, doctors refrain from using devices or drugs to keep a terminally ill patient alive by withholding or withdrawing life supporting drugs or mechanisms. It may also include not providing a patient with food or water and let him/her die.

Few Historical Timeline Events of Euthanasia & PAS and the Legal Dilemma [4]

During 5th century ancient Greek's and Roman's attitudes towards infanticide, active euthanasia, and suicide had tended to be tolerant when physicians, most likely performed frequent abortions and mercy killings.

During 12th to 15th century with the rise of Christianity human life was highly considered as a trust from God. The views of Hippocratic school (which forbid euthanasia) were reinforced.

During 17th to 18th century Common law tradition prohibited suicide and assisted suicide in the American colonies but was challenged, though there was not much widespread interest in the issue. In the 19th centu-

ry first US statute outlawing assisted suicide was enacted in the New York in 1828. Bills to legalize euthanasia was defeated in Ohio legislature in 1905. A similar initiative in 1906 that would legalize euthanasia not only for terminal adults but also for 'hideously deformed or idiotic children' was introduced and defeated as well.

In 1915 Harry J. Haiselden, chief of staff at Chicago's German-American Hospital, allowed a seven pound baby boy, born with severe birth defect to die rather than give him possibly lifesaving surgery, after conferring with boy's father. A public polls taken later in 1937, indicated that 45 percent of Americans believed that Dr. Haiselden's mercy killing was permissible.

In 1935 the Voluntary Euthanasia Legislation Society (VELS) was founded in England. In 1937, Voluntary Euthanasia Act was introduced in US Senate. With the World War II news of Nazi atrocities against mental patients and handicapped children broke out and the growing popularity of euthanasia was challenged again. In 1952 'The British and American Euthanasia Societies' submitted a petition to the United Nations Commission on Human Rights to amend the UN Declaration of Human Rights to include the right of incurable sufferers to euthanasia or merciful death'.

During 1970s, the idea of patient's right, especially the right to refuse medical care, even life-sustaining care gained acceptance which was aimed at removing physicians from decision making.

In April 1975 Karen Ann Quinlan, 21 , had fallen into coma after returning home from a party due to irreversible brain damage. She had drunk a few gin and tonics and consumed diazepam. She was hospitalized and eventually lapsed into a persistent vegetative state and was connected to a ventilator. Request by her parents to disconnect the ventilator was refused by doctors. Parents appealed to the New Jersey Supreme Court which granted their appeal and gave verdict to remove ventilator on March 31,1976 setting it as a legal landmark in the end-of-life issue.

By 1977, eight states -California, New Mexico, Arkansas, Nevada, Idaho, Oregon, North Carolina, and Texas - had signed right-to-die bills into law. In December 1984, American Medical Association published report detailing that with informed consent, a physician can withhold or withdraw treatment from a patient who is close to death, and may also discontinue life support of a patient in a permanent coma.

On June 4, 1990 Dr. Jack Kevorkian who was later known as 'Doctor Death', participated in his first assisted suicide. He was later in 1999 convicted of murder by a Michigan court sentencing him to 10-25 years in prison but on June 1, 2007, after serving a little more than eight years of his sentence, he was released from prison on good behavior.

In November 1994, "Oregon Death with Dignity Act" was passed becoming the first law in American history permitting physician-assisted suicide.

The Netherlands officially legalized euthanasia in 2001 after the issue having been discussed for 30 years.

On November 4, 2008 Washington became the second US state to legalize physician-assisted suicide. Similarly, in Dec 5, 2008 State of Montana legalized physician assisted suicide.

In March 2, 2014, Belgium legalized euthanasia for terminally and incurably ill children and became the world's first country to lift all age restrictions on euthanasia.

On February 6, 2015 Canada's Supreme Court struck down the country's law that bans doctor-assisted suicide.

Recently on April 30, 2015 South African court granted a terminally ill man, who was diagnosed with terminal prostate cancer in 2013, the right to have a doctor help him end his life.

This way up until now, issue of euthanasia and PAS has been increasingly gaining worldwide attention and momentum.

Some details of historical timeline of the events related to euthanasia and PAS is given in the Annex 1.

Euthanasia debate

The debate over a person's right to die usually in case of painful terminal illness is centuries-old and surrounded by religious, ethical, philosophical and practical issues. Many questions like: 'under what circumstances is euthanasia justifiable?', 'what is the moral difference between killing someone and letting them die?', 'should human being has the right to decide on the issue of life and death?', and many more are raised time and again. Different people and groups with different ideas respond in different ways to these questions. Some think that people should be allowed to die a painless and dignified death; some believe that God should only decide upon the issue of death, whereas some others believe that allowing voluntary euthanasia may be a start of "slippery slope" that will lead to involuntary euthanasia.

Arguments against euthanasia

Some people who argue against euthanasia believe that euthanasia is the rejection of the importance of human life [5]. In the name of personal autonomy euthanasia should not affect other people like friends, family, and relatives of the patient who are left behind. Some think that issues like life and death of people should not be left to human because life is given by God and thus god should decide upon it [1].

Some people though morally consider euthanasia as right but fear with the possibility of increase in abuses and crimes afterwards. Others think that it gives doctors too much power-power to decide who dies and who lives [1].

Opponents of euthanasia argue on the following grounds [6] and these

also reflect the major consequences of euthanasia on the society.

Ethical argument:

- Euthanasia weakens society's respect for the importance of life and accepts that some lives are worthless than others.
- Accepting voluntary euthanasia will ultimately lead to involuntary euthanasia. It would not only be for people who are terminally ill.
- Euthanasia affects other people's right also, not just those of patients.
- Doctors have a moral responsibility to keep their patients alive as reflected by the Hippocratic Oath which in its ancient form stated " To please no one will I prescribe a deadly drug nor give advice which may cause his death."
- Legalizing euthanasia may unfairly target the poor and disabled people.
- It can become means of health care cost containment.

Religious argument:

- Several religions see euthanasia as a form of murder and morally unacceptable. At best, some see it as a form of suicide, which goes against the teaching of many religions.
- Euthanasia is against the will of God.

Practical arguments:

- There is a risk that patients may feel they are a burden on resources and are psychologically pressurized into consenting. They may feel the burden - emotionally, mentally, financially - on their family is overwhelming.
- It's not necessary to euthanize a patient if proper palliative care can be given.
- Good palliative care makes euthanasia unnecessary.
- Accepting euthanasia will lead to less good care of terminally ill patients.
- Vulnerable patients might be pressurized to end their lives.
- Motivation and commitment of doctors and nurses to save lives may be undermined.
- Euthanasia may be identified as a cost effective way to treat terminally ill and can become means of health care cost containment.
- It gives too much power of decision to doctors.
- Search for new cure and treatment for terminally ill may be discouraged.
- The patient might recover against all odds. The diagnosis might be wrong.

- Legalizing euthanasia will place society in a 'slippery slope' which will lead to unacceptable consequences.
- There is a risk things will start with those who are terminally ill and wish to die because of the intractable suffering, and eventually begin to include other patients. A ' slippery slope.'

"Slippery slope" argument:

Some people believe that even if allowing euthanasia is not a bad thing, it will lead bad things to happen. If euthanasia is allowed to get implemented for people asking to die, it may then be considered that it is also fine to allow euthanasia for people who are severely ill but alive. And if that was allowed then it may be allowed for people who do not want to die. This is cited as "slippery slope" or "precedent" argument. Those who believe in this argument point to times when this seems to have happened: in Germany, Adolf Hitler allowed disabled children to be killed. Some people today argue that if euthanasia was legalised it would lead to similar happenings again. Other people say that what Hitler did was not euthanasia and did not happen because they allowed euthanasia.

Arguments in favour of euthanasia

Majority of people who are in favour of euthanasia believe that, 'death is inevitable, everyone has to die but it does not mean that it be painful'. Proponents of physician-assisted suicide (PAS) feel that an individual's right to autonomy automatically entitles him to choose a painless death [7].

Arguments of the proponents of euthanasia [7]:

Right based argument

- People have an explicit right to self- determination, and thus should be allowed to choose their own fate.
- Death is a private matter and if there is no harm to others, no one (neither the state nor other people) has right to interfere.

Practical Argument

- Assisting a subject to die in a dignified, quick and compassionate manner reduces the risk of premature suicides. For the terminally ill patients who wish to end their sufferings euthanasia might be the better choice than requiring them continue to suffer.
- It reduces the risk of premature suicides as terminally ill patients who wish to end their sufferings, without incriminating loved ones, take their own lives in secret, sometimes violently.

- Euthanasia can be regulated and controlled by proper regulations though it's difficult. It is like a law that prohibits theft but does not stop bad people to stop stealing. There could be people who want to implement euthanasia for their selfish reasons and there are chances that vulnerable people will be pressurized to request euthanasia but these should be no reasons for prohibiting euthanasia.

- It is not necessary that permitting euthanasia will lead to undesirable consequences. Pro-euthanasia activists often cite the example of countries like the Netherlands, Belgium and US States like Oregon where euthanasia has been legalized but no problems have been created because of this.

- Scarce health resources can be stretched by allowing people to die if they want.

- It helps shorten the suffering and grief of patient's loved ones.

- It is possible that euthanasia happens anyway.

Futile care theory:

In today's setting of limited resources and unlimited health care demands, futile medical care, that is, a continued provision of medical care or treatment to the patient who do not meet certain criteria such as those in a coma or a persistent vegetative state, when there is no reasonable hope of a cure or benefit may need to be questioned. With the rising health care costs "Futile care theory" is fast becoming acceptable and it has been foreseen that euthanasia and assisted suicide will be foreseen acceptable to the healthcare economics [8].

Pro-euthanasia views of some renowned personalities:

B.P. Koirala - one of the most outstanding personality in the history of Nepal and also a cancer patient ,when being interviewed by Bhola Chatterjee on December 1981, was asked about his attitude towards suicide and euthanasia and he said:

"Man has a right to commit suicide, particularly when he is suffering from an incurable disease and he is a burden to his family and also to himself. I support suicide, but not when one commits it out of sheer frustration. **I am also an advocate of euthanasia.** When one is suffering from terminal cancer or from any ailment that has no cure, one has a right to euthanasia. As a matter of fact, I have told my people that if I get a paralytic stroke or if I am down with terminal cancer, I should be administered some injection to put me to eternal rest"[9].

The preeminent leader of Indian independence movement in British-ruled India, **Mahatma Gandhi** in spite of being a strong defender of non-violence, viewed that under certain conditions, killing a living being could even be an expression of non-violence. He argued that in few rare cases it may be better to kill people who are suffering unbearably at the end of life[10].

.....

World famous physicist, cosmologist and scientist, **Prof Stephen Hawking,** who was previously of view that 'while there's life, there's hope' has given his pro euthanasia views in early June 2015 as "To keep someone alive against their wishes is the ultimate indignity". He also said "I would consider assisted suicide only if I were in great pain or felt I had nothing more to contribute but was just a burden to those around me."[11].

Attitudes towards euthanasia:

Different literatures show that the attitude of people towards euthanasia is changing slowly in favour of it.

1) In **Britain** where euthanasia is illegal and anyone who practices killing another person deliberately even if the other person asks, could potentially face 14 years imprisonment. But according to the 2007 British Social Attitudes Survey[1], 80% of the public said they wanted the law changed to give terminally ill patients the right to die with a doctor's help.

2) Similarly, according to a study done in **Sweden[12]** among physicians working with adult dying patients about half of the physicians had discussed palliative care with all their dying patients, and more than half of the physicians had heard their patients expressing a wish to die. One-third had asked for active euthanasia whereas 10% had asked to assisted suicide.

3) A study in **USA [13]** on cancer patients, cancer specialists and the public suggest that about two-thirds of oncology patients and the public found euthanasia and PAS acceptable for patients with unremitting pain.

4) According to an article published in N Eng. J Med 2015 [19]; in **Belgium** where euthanasia for terminally ill people over aged 18 was legalized in 2002, after 11 years of experience, euthanasia is increasingly considered as the valid option at the end of life.

There was increased demand for euthanasia in Belgium between 2007 and 2013, as well as growing willingness among physicians to meet those requests, mostly after the involve-

ment of palliative care services. The rate of euthanasia increased significantly between 2007 and 2013, from 1.9 to 4.6% of deaths. The overall increase relates to increases in both the number of requests (from 3.5 to 6.0% of deaths) and the proportion of requests granted (from 56.3 to 76.8% of requests made).

5) **The Netherlands** where, euthanasia act came into effect in 2002, has the most liberal assisted suicide laws in the world. Under Dutch law, doctors can administer a lethal dose of muscle relaxants and sedatives to terminally ill patients at a patient's request.

Dutch doctors practice active euthanasia by lethal injections (96.6% of all deaths caused by physicians in 1990) and PAS is very infrequent (no more than 3.4% in 1990).

Findings from an article published in The Lancet in 2012 [20] revealed that, in 2010, of all deaths in the Netherlands, 2•8% were the result of euthanasia. Ending of life without an explicit patient request in 2010 occurred less often (0•2%) than in 2005, 2001, 1995, and 1990 i.e. 0•8%. Continuous deep sedation until death occurred, was administered more frequently in 2010 (12•3%) than in 2005 (8•2%).

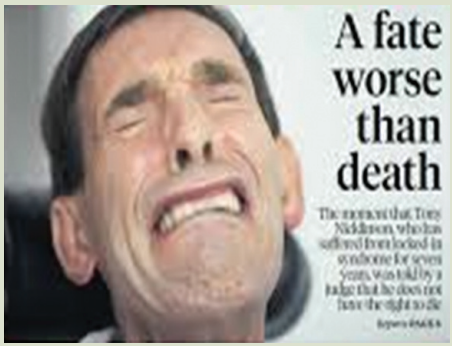
Of all deaths in 2010, 0•4% were the result of the patient's decision to stop eating and drinking to end life. In half of these cases the patients had made a euthanasia request that was not granted.

It reflects that regulated euthanasia and physician assisted suicide laws can lead to transparent practice and minimization of the abuses. Many recommend scope for other countries to inform the debate on legalization of assisted dying though translating those results is not that straightforward.

An example of sentiment of a terminally and hopelessly ill patient and his family:

Below is a story of Tony Nicklinson who suffered from locked-in syndrome. His case is one of the clear examples reflecting the sentiment caused by pain and suffering of terminally ill patient and his family members requesting for assisted dying:

Tony Nicklinson, a British former rugby player and a successful civil engineer suffered from 'locked-in syndrome,' - an incurable condition in which a patient loses all motor functions but remains awake and aware with cognitive abilities - following a stroke in 2005 at the age of 51. Because of the incurable condition he lost all his motor functions, paralyzed from the neck downwards, unable to speak or move any part of his body except head and eye. He could only communicate via letters on Perspex board and a computer system eyes that detected eye movements and turned them into words.



His desire to die that he expressed since 2007 was not heard because of fear of criminal prosecution under the British law. A trip to assisted- dying clinic in Switzerland, where assisted suicide is implemented in foreigners too, wasn't possible either because he would have been unable physically to perform the final act himself such as taking the lethal cocktail or administering the lethal injection himself because of his defunct motor system making him unable to use his hands.

Nicklinson, who described his life as "a living nightmare", with his family applied a request for assisted suicide to UK legislation. At the High Court in London, he described his existence as 'dull, miserable, demeaning, undignified and intolerable' and asked the court to declare that any doctor who killed him with his consent would not be charged with murder.

He had argued in court that he would be physically unable to administer a drug to himself, and that the only path to get rid him of "living nightmare" would be permission from the court to have somebody else, preferably a doctor, administer the required dose without fear of prosecution.

During the hearing Mr. Nicklinson could not be present at the court but

staying outside he said, 'I can't tell you how significant it would be in my life, or how much peace of mind I would have, just knowing that I can determine my own life instead of the state telling me what to do, staying alive regardless of my wishes or how much suffering I have to tolerate until I die of natural causes'.

He further added: 'It is misery created by accumulation of lot of things which in themselves, but taken together, ruin what's left of my life'.'I cannot scratch if I itch, I cannot pick my nose if it is blocked and I can only eat if I am fed like a baby- only. I won't grow out of it, unlike the baby. 'I am washed, dressed and put to bed by carers who are, after all, still strangers. You try defecating to order while suspended in a sling over a commode and see how you get on.'

Nicklinson's daughter told the court how her dad has 'absolutely no interest in his surroundings and very little interest in the people in his life ' following the stroke. She said her father's condition had 'ripped the very core and essence out of him': 'He is forced to live an existence, trapped in a broken body, following someone else's rules, rules that he cannot abide by." He is living a life he does not wish to live. This is pure torture for him".

However, his petition was rejected on the ground that to grant the request would mean a major change in the existing law. Although the judge acknowledged that his case was deeply moving, it was for parliament and not the courts to decide if the law should be changed. Earlier in the year 2012, an independent commission on assisted dying concluded for the first time that certain people should be helped to die. But this only applies to those who are terminally ill and are able to take the final action end their lives themselves-which excludes Mr. Nicklinson because he would not be able to take the lethal drugs, even if drugs were prepared by someone else. It would require someone else to kill him intentionally that would amount to a murder.

Not only Tony, but also his family was also equally in support of his request because they had seen him for long time suffering from the unbearable pain and suffering. As per one of his daughter's 'He is living a life he does not wish to live. This is pure torture for him.' She rejected the argument of pro-life campaigners, saying that her father had a life only in the biological sense of the word. And "Life should not be measured on the quantity; it should be the quality of life." I wouldn't like even for my worst enemy to stay alive in this condition for so many years". He refused food since that verdict on 17 Aug. 2012 and also contracted pneumonia. Six days after losing the court case he died. Ultimate result of the man who fought for the right to legally end his life was death but it was very slow and painful.

Below is a letter published in a renowned newspaper very recently which may reflect public opinion on euthanasia:

It is time to realize that euthanasia in such extreme cases of excruciating distress, is an act of compassion.

By letter

Published: June 13, 2015

KARACHI: Euthanasia is another word for mercy killing. It is the practice of intentionally ending a patient's life to relieve suffering and pain, which he or she may have due to a painful and incurable disease or condition. There have been about 2,700 mercy killings in the past year all over the world, and though it is frowned upon in most countries, euthanasia is legal in Switzerland, Luxembourg, Belgium, and the Netherlands. It has been said, "It is better to die in comfort than to live in perpetual pain." This statement has proven to be extremely accurate, despite the many disagreements it has faced.

Most people have a pessimistic view on euthanasia, but they don't understand the views of the patients themselves. People who go through insufferable pain everyday while alive would rather die in peace and comfort, despite the vehement refusal of their family and friends. In fact, it is cruel to force someone to live in so much discomfort and agony from day to day, moment to moment. Rather than helping them, we are just prolonging the inevitable, which just leads to more pain and suffering.

The patient's family usually spends millions on ineffective and fruitless medications and procedures, trying to extend their loved one's life. This is understandable, as they do this out of love, guilt, or any good intention that they may have. Unfortunately, it does more harm than good. They are doing it more for their own sake, because they are not ready to let go of their loved one. They need to know that, even if it is difficult, everything should be done solely to make the patient's last days comfortable and content.

Keeping patients on ventilators isn't real living. When they do not even know or feel what is happening around them, when they cannot see, hear, speak, feel, or even think properly, how can they ever be content or satisfied with their life? How can they be happy? How is it ok to make them suffer like this? Their pain doesn't disappear, it is just suppressed. Their death isn't evaded, it is delayed.

It is against nature to tamper with someone's life — or, in this case, their

death. Some people might disagree, protest, and argue that these patients are human beings, and that it is impossible for anyone to let their loved ones be taken away so easily. What needs to be understood is that it is the patient's needs that are the number one priority, no matter how it affects their families and friends in the long run. It is time to let go. It is time to realize that euthanasia, despite what people may think, in such extreme cases of excruciating distress, is an act of compassion.

Daniya Ghauri

Published in The Express Tribune, June 13th, 2015.

Current global scenario on euthanasia

As of June 2015, euthanasia had been legal only in the Netherlands, Belgium, Colombia and Luxembourg. Assisted suicide is legal in Switzerland, Germany, Japan, Albania and in the Washington, Oregon, Vermont, New Mexico and Montana states of USA[14].

In the Netherlands[20] euthanasia and PAS were formally legalized by the Parliament in 2001 after about 30 years of public debate and came into effect in 2002. Since the 1980s guidelines and procedures for performing and controlling euthanasia have been developed and adapted several times by the Royal Dutch Medical Association in collaboration with that country's judicial system [15].

In the Netherlands, the first country to the world to legalize euthanasia, the law requires following four major criteria for deciding on euthanasia:

- Patients must face a future of unbearable, interminable suffering.
- Request to die must be voluntary and well-considered.
- Doctor and patient must be convinced that there is no other solution.
- A second medical opinion must be obtained and life must be ended in a medically appropriate way.
- The patient facing incapacitation may leave a written agreement to their death.

Despite opposition, including that from the Belgian Medical Association, **Belgium** legalized euthanasia in 2002 after about 3 years of public discourse that included government commissions.

On 19 March 2009, the bill passed the second reading, making **Luxembourg** the third European Union country, after the Netherlands and Belgium, to decriminalize euthanasia [15]. Terminally ill patients will have the option of euthanasia after receiving the approval of two doctors and a panel of experts [19].

In the **USA,** active euthanasia is illegal throughout but assisted suicide is legal in five states: Oregon, Vermont, Washington, New Mexico, and Montana [14].

In **Mexico,** active euthanasia is illegal but since 2008 the law allows the terminally ill to refuse medication or further medical treatment to extend life[14].

In **Switzerland** [16] even though euthanasia is illegal, assisted suicide although not formally legalized is tolerated as a result of an ambiguity in a law dating back to the early 1900s that decriminalizes suicide. Switzerland allows non-physicians also to assist suicide but in other laws only physicians are allowed to assist suicide.

When talking about the **Asia and Pacific Region[17], Japan** has medical voluntary euthanasia approved by a high court in 1962 in the Yamagouchi case, but instances are extremely rare, seemingly because of complicated taboos on suicide, dying and death in that country.

In **Australia,** the Northern Territory of Australia had voluntary euthanasia and assisted suicide for nine months until the Federal Parliament repealed the law in 1997. Only four people were able to use it. Many attempts have been made by other states to change the law, so far unsuccessfully.

In **India,** the palliative care and quality of life issues in patients with terminal illnesses like advanced cancer and AIDS have become an important concern for clinicians. Parallel to this concern has arisen another controversial issue-euthanasia or "mercy–killing" of terminally ill patients. The legal status of PAS and euthanasia in India lies in the Indian Penal Code, which deals with the issues of euthanasia, both active and passive, and also PAS. According to Penal Code 1860, active euthanasia is an offence under Section 302 (punishment for murder) or at least under Section 304 (punishment for culpable homicide not amounting to murder). So, technically speaking, anybody willing to consider euthanasia or PAS needs to go through the courts of law in India and on no account have the courts considered a clear judgment on this issue allowing a PAS to go ahead [18].

Summary of global legal status on human euthanasia

The following table summarizes the global legal status on human euthanasia:

Country	Legal status	Voluntary euthanasia	Passive euthanasia	Remarks
Australia	Illegal	Once legal in Northern Territory in 1995 but revoked in 1997.		NGO wants government to bring back the euthanasia rights.
Albania			Assisted suicide is legal	
Belgium	Legalized in 2002	(1807 cases in 2013)		Being extended to terminally ill children.
Canada	Illegal			Feb 2015, Supreme court: Mentally competent but suffering have the right to a doctor's help in dying.
Columbia	Legal			1997, Court ruled: No person held criminal for taking life of "terminally ill".

Denmark	Illegal	Informally done		41% of deaths in 2003 under doctors taking "end-of-life" decisions to ease patients' suffering.
Finland	Illegal			Discreetly done. Doctors do not formally perform.
France	Illegal.		Informally done	President has strongly supported de-criminalization voluntary euthanasia. Opposed by religious and social conservatives
Germany				Assisted suicide is legal
India		Illegal		Withdrawal of life support allowed. 2011.
Ireland	Illegal for active euthanasia	Informally done ("right to die")	Removal of life support allowed if requested.	57% of adult in support of doctor assisted suicide (2010, Iris times poll)

Israel	Illegal for active euthanasia	Illegal	Hospital committee can de-criminalize passive eu-thanasia	
Japan	No official laws.Has a legal framework and could be legal	One case euthanatized by court decision in 1962	One euthanatized by court decision in 1995	Legal frame work to be complied.
Luxem-bourg	Legalized in 2008	Decriminal-ized in 2009	Legal	For terminally ill approval of two doctors and a experts panel required.
Mexico	Illegal	May be legalized soon	Law allows since 2008 in Mexico city and in a Western state since 2009.	Decrimi-nalization of active euthanasia has entered in the legisla-tive chamber (2007)
Nether-lands	Legal since 2002		Legal	Euthanasia for persons over the age of 70 who do not want to live being considered.

New Zealand	Illegal	Illegal	Illegal	Two decriminalization attempts failed in 1995 and 2003. Two "end of life choices" Bill also failed in 2012 & 2014
Norway	Illegal	Illegal	Illegal	Caregiver may receive reduced punishment
Philippines	Illegal	Illegal	Senate considered for passive euthanasia in 1997 without success.	Strong opposition of Catholic Church for legalization
Switzerland	Illegal	Assisted suicide is legal		Motive should not be selfish. Deadly drugs may be prescribed to a Swiss person or to a foreigner.
Sweden	Illegal for lethal substance	Legal since 2010		
Turkey	Illegal	Strictly illegal	Illegal	Life imprisonment to the implementer.

United Kingdom	Illegal	Four unsuccessful attempts made to pass the Bill		If the intention is solely to alleviate pain, that is not considered murder.
USA	Active is illegal	Assisted suicide is legal in Oregon, Washington, Vermont, New Mexico, Montana.	Patients retain the rights to refuse for medical treatment (passive)	The Supreme Court of the USA has not legally defined on euthanasia

Nepal's Health Achievement and the Context of Euthanasia

Though the history of health development in Nepal goes back only to about six decades, with the endeavors made as stated above, over the period of time, the achievements made at large are remarkable. Just to summarize some of them, communicable diseases like, diarrhea/ dysentery, acute respiratory infection, etc. have been controlled significantly to a considerable extent. Tuberculosis, malaria and HIVare on halt and in reversing trend. Nepal has achieved Polio Free Status, Measles Mortality Reduction Goal, Maternal and Neonatal Tetanus elimination status, and control of Japanese Encephalitis. Elimination of Leprosy at national level was achieved in 2010. Elimination level has been reached for kala-azar since 2013 .Trachoma is under control and targeted for elimination by 2020. Campaign for elimination of lymphatic filariasis is moving well with elimination target by 2017.Control of micronutrient deficiency has been achieved to a large extent.

A broad based service coverage network has been established extending up to village level, especially providing services into the area of essential health care package.

Private and NGO sector in health has grown very rapidly and aggressively and still is in a rising trend though it is mainly engaged in providing curative services. However the quality of care remains questionable and unmonitored.

National capacity to produce health human resources of almost all categories by government and private sector is broadly in place.

The process of producing specialty health services is also catching up in government and non-government sector in a visible manner. Facilities

are developing to deal with the problem of disease related to heart, lung, kidney, brain, liver etc. which are in rising trend. Children and women's health care facilities are being established throughout the country but without geographical equity.

Hospitals for providing specialty eye care services have been set up throughout the country mainly by NGO sector but provision of primary eye care services at the grass root level remains neglected and unaddressed.

The mechanism of **social mobilization** in delivering health services is well acknowledged and has been demonstrated in implementing the programs like campaigns of Vit. A supplementation, polio eradication, control of iodine deficiency disorders, leprosy elimination, visceral lesmeniasis (filariasis) elimination program, measles immunization, community drug program. The Female Community Health Volunteers program is an internationally recognized.

National policies, plans and strategies related to health are in place and that has helped to cater assistance of international development partners in health sector.

The **health indicators** have remarkably improved. For example:

Infant mortality rate reduced drastically from 255 per thousand live births in 2009 BS to 40.5 by 2068 BS. **Under five child mortality** which was 118 in 1996 dropped down to 54 in 2011. Nepal was provided with "Motivational Award" for reducing the child mortality rate - the fourth Millennium Development Goal (MDG).

Maternal mortality rate dropped down to 281 per 100 thousand live births in 2011 from 539 in 1996. Nepal was given the "MDG Achievement Award" for reducing the MMR - the fifth MDG.

The international conference on" Global Leaders Council for Reproductive Health" held in Geneva in June 2012 conferred the "Resolve Award" to Nepal for the progress made in the area of Reproductive Health by Nepal.

Life expectancy of Nepalese people raised from 27.8 years in 2009 BS to 68.8 years in 2068 BS.

Health conditions opting for euthanasia in Nepal

Against this back drop, where the patients suffering from terminally ill conditions like cancers, Alzheimer's disease, dementia, motor neuron disease, disability, HIV/AIDS and other critical ill health conditions leading to persistent vegetative state etc. are not getting the adequate health care and required end of life palliative care, there is a great possibility of opting for euthanasia and physician assisted suicide. It is high time that the health care planners and providers in Nepal need to be aware of this fact. Nepalese society should also be aware of this issue and should think about it.

There is lack of research and data published on the perception of Nep-

alese doctors, Nepalese people and critically ill people about euthanasia and PAS which needs to be explored. Further there is a real need to study the attitudes of Nepalese physicians especially psychiatrists, oncologists and palliative care physicians towards the concepts of euthanasia and PAS. We should also need to consider our multicultural and multi-religious society. It is essential to understand the effects of culture and religion in decision-making processes, especially in the area of euthanasia and PAS.

In 1990, a WHO expert committee [21] found that the greatest improvements in quality of life for cancer patients and their family would result from pain symptom management.

The committee recommended that the government devote specific attention to cancer pain relief and palliative care before considering laws allowing euthanasia.

Alternative to euthanasia and PAS and quality of health care and existence of palliative care in Nepal

Despite national health achievements it is a matter of serious concern and disappointment that the quality of health care provided in the country is not at acceptable level, both in public and private sector. It is also evidenced by the practice prevailing in the country that those who can financially afford and the high profile politicians frequently visit abroad for availing health care further showing their lack of faith in the quality of care in Nepal. To some extent good palliative care can deter the emerging thought of euthanasia but palliative care system in Nepal is almost non- existent. And the component for development of palliative care in national policy and program is lacking. As of 2003, even in America only thirty percent of hospitals had some palliative care program. [22].

Hospices are also seen as viable alternative to euthanasia to some extent. Those experienced in Hospice care say that the greatest fear of the dying is not physical pain, but the fear of being abandoned either by family, society or both. Unfortunately a culture of elderly people being abandoned, is a visibly rising trend in Nepal. And the availability of Hospices in Nepal is negligible.

What is Palliative care?

It is hard to live with a serious illness. The patient feels lonely, angry, scared, or sad. S/he may have pain or other disturbing symptoms. Palliative care can help the patient; and family and loved ones may be able to cope with.

Palliative care is a kind of care for people who have serious illness. It is different from the standard care to cure illness, called curative treatment. Palliative care focuses on improving the patient's quality of life- not just in body, but also in mind

and spirit. Sometimes palliative care is combined with curative treatment.

WHO defines Palliative care as an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychological and spiritual. Palliative care:

- provides relief from pain and other distressing symptoms;
- affirms life and regards dying as a normal process;
- intends neither to hasten or postpone death;
- integrates the psychological and spiritual aspects of patient care;
- offers a support system to help the patients live as actively as possible until death;
- offers a support system to help the family cope during the patients illness and in their own bereavement;
- uses a team approach to address the needs of patients and their families, including bereavement counseling, if indicated;
- will enhance quality of life, and may also positively influence the course of illness;
- is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications.

The main diseases and health conditions in Nepal that may opt for euthanasia:

Findings from a study in the Netherlands [3] showed that the reasons for proposing euthanasia by patient included the unbearable suffering that was often substantiated with physical symptoms (62%), function loss (33%), dependency (28%), or deterioration of health condition (15%). As many as 35% physicians reported that there had been alternatives to relieve patients' suffering which the majority refused.

In Nepal the following prevailing situation may opt for euthanasia:

Non-communicable Diseases (NCD): In Nepal, according to WHO Non Communicable Disease (NCD) country profile 2014, NCDs are estimated to account for 60% of all deaths out of which 22% death was attributed to Cardiovascular Diseases (CVD), 8% to cancer, 13% to chronic respiratory diseases, 3% to diabetes, 10% to injuries and 14% to other NCDs [23].

It is estimated that about 60% of patients diagnosed to have advanced incurable illnesses require specialist care which is not adequately available and the required palliative care is almost non- existent. in Nepal

Terminal cancer: Terminal illness constitutes an illness or disease from which the patient is not expected to recover. Terminal cancer means a patient with the disease is expected to pass away in a short period of time, usually one week to a few months. Some of the common symptoms of such patients are extreme distressing tiredness, debilitating pain, loss of appetite and weight, and problems with breathing.

Currently one of the most common causes of death is terminal cancer and is increasing globally.

Alzheimer's disease and Dementia: Alzheimer's is a type of dementia that causes problems with memory, thinking and behavior. Usually the symptoms develop slowly and get worse over time, becoming severe enough to interfere with daily tasks. The greatest risk factor is increasing age, and the majority of people with Alzheimer's are 65 and over.

Current Alzheimer's treatments cannot stop Alzheimer's from progressing but can temporarily slow the worsening of dementia symptoms. With the increasing number of elderly people and rising life expectancy in Nepal, the number of people suffering from Alzheimer's disease and dementia is also in rising trend. Though there has not been any survey about the people living with Alzheimer's disease and dementia in Nepal.

The World Alzheimer Report 2009, has estimated that 36 million people worldwide are living with dementia, with numbers doubling every 20 years to 66 million by 2030 and 115 million by 2050. Similarly, World Alzheimer Report 2011, showed that most people currently living with dementia have not received a formal diagnosis and thus do not have access to treatment, care and organized support . Nepal is not an exception, the case is similar here also [24].

Dementia describes a group of symptoms affecting memory, thinking and social abilities severely enough to interfere with the daily normal functioning as well as impaired judgment or language. Alzheimer's disease is the most common cause of dementia.

Paralysis: Paralysis is a symptomatic condition in which there is loss of ability to move one or more muscles caused by problems with the nerves or spinal cord the brain uses to control muscles. It can be localized or generalized. The most common causes of paralysis are: stroke, head injury, spinal cord injury and multiple sclerosis. Paralysis can also cause a number of secondary conditions, such as urinary incontinence, and bowel incontinence. There is currently no cure for paralysis, except in certain conditions. In Nepal along with the incidences of strokes and cases of head and spinal injuries caused by very common road traffic accidents and falls leading to paralysis the number of paralytic patients is in rising trend.

Vegetative State (VS): VS is an entity in which there is loss of ability to think and awareness of surroundings. The patients lose their higher brain functions. Generally their breathing and circulation remain

relatively intact but are hopelessly dependent. They may occasionally grimace, cry or laugh. They are unable to respond to command and do not speak. They have no control over the bladder or bowels. They need to be fed. When cared for, they can continue in this vegetative state for years. In Nepal to come across the patients in vegetative state has become quite common these days.

Renal failure: About 20-30 percent people with diabetes develop kidney disease known as diabetic nephropathy though not all of these will develop kidney failure. There is no cure of nephropathy and treatment options include medications, dialysis, and kidney transplant.

It is estimated, that in developing countries the number of new cases of end-stage renal failure (those, whose kidney is fully damaged and without dialysis or transplantation, cannot survive) is about 100-150 per million population per year. Calculating with the population of Nepal of 28 million, there would be around 2800-4200 new patients per year needing dialysis or transplantation in Nepal[25].In Nepal inadequate required service availability and patients affordability may lead to think of suicide or euthanasia.

HIV/AIDS: HIV stands for Human Immunodeficiency Virus .The infection if untreated , it leads to the disease termed as Acquire Immunodeficiency Syndrome (AIDS)..

HIV attacks the body's immune system which fights off infections. When the body can't fight the infection and disease the person with HIV infection becomes vulnerable to opportunistic infections and progresses to AIDS - a very debilitating lethal disease and the last stage of HIV infection.

As of 2012 data, 48700 people in Nepal were living with HIV/AIDS.

According to study done among HIV positive and drug using participants published in 2009 in Journal of International AIDS society, study participants perceived that health providers seemed to believe that health care was not appropriate for people with HIV because they were going to die. In such cases, the participants felt that health providers were reluctant to pursue expensive treatment to people with HIV as it is seen as an unnecessary investment. In some districts and VDCs (e.g Doti), there are that celebrate the death of HIV-affected person believing that they would not contract HIV/AIDS if they celebrate the death of family members who die of this disease.

This reflects that there is lack of sensitive counseling and the palliative care which are essentially needed to HIV/AIDS patients in Nepal [26].

Different policies and strategies on HIV/AIDS have been formulated in Nepal. However, their implementation, monitoring and evaluation is still weak.

In such a situation that prevails with a severe lack of treatment facility accessible to the patients the circumstances provoke for suicide or euthanasia.

Some others reasons for seeking euthanasia:

Though many think that euthanasia is requested because of unbearable pain, studies show that it may not only be the reason for seeking euthanasia. Quality of life of terminally ill people can be severely damaged by physical conditions such as incontinence, nausea, vomiting, breathlessness, paralysis, disability and difficulty in swallowing resulting them to think about euthanasia. Similarly, psychological distress, particularly depression, is a major factor for suicide and for request to hasten death. Other factors like fearing loss of control or dignity, feeling a burden, or dislike of being dependent may also result them to think about euthanasia.

Conclusion

Ongoing debate on euthanasia globally is born out of the ethical, psychological, medical and legal issues. The major challenge is in the protection of the principle of valuing human life while achieving an individual's autonomy and relieving him/her from unbearable sufferings. This complex and challenging issue requires multi-sectoral attention primarily from physicians, lawyers, psychologists, public health experts and policy makers.

At times when large sections of medical professionals are not comfortable with euthanasia, increasing requests from the sufferers time and again requires this issue to be given more thought and effort in consideration of maintaining human dignity and respectful passage to death on request can be given to patients suffering from irreversible terminally ill and hopeless health conditions. Similarly, in the health care market where there are limited resources, continued provision of medical care or treatment to a patient when there is no reasonable hope of a cure or benefit, instead there is only pain and suffering; euthanasia and PAS can be given a second thought.

However, it is very important to be very careful not to make euthanasia a way to: giving improper palliative care, pressurizing vulnerable patients to end their lives and involuntary euthanasia. Countries that have successfully regulated euthanasia and PAS laws can be taken as the model from where it can be learnt how these laws can lead to transparent practice and minimization of the abuses.

Annex I:

Historical timeline of some major events of euthanasia movement

The following table summarizes some of the landmark events of the euthanasia movement [4]:

Time		Event
500 BC to 16th Century AD	5th Century B.C.-1st Century B.C.	**Ancient Greeks and Romans Tended to Support Euthanasia:** "In ancient Greece and Rome, before the coming of Christianity, attitudes toward infanticide, active euthanasia, and suicide had tended to be tolerant. Pagan physicians likely performed frequent abortions as well as both voluntary and involuntary mercy killings although Hippocratic oath prohibited such acts.
	12th Century-15th Century	With the rise of Christianity, human life was highly considered as a trust from God. Hippocratic school of thought that forbade euthanasia was reinforced.
17th Century to 19th Century	17th Century	Common law tradition prohibited suicide and assisted suicide in the American colonies
	17th -18th Century	**Renaissance and Reformation Writers Challenged Church Opposition to Euthanasia:** although there was no real widespread interest in the issues of euthanasia or physician-assisted suicide during that time, writers challenged the authority of the church with regard to its authoritative teaching on all matters including ethical matters, euthanasia and suicide
	Late 18th Century	**American Evangelical Christians rejected suicide and euthanasia**
	1828	**First US Statute outlawing assisted suicide was enacted in New York**
	1870 s	Samuel Williams, a non-physician, advocated the use of Morphine drugs not only to alleviate terminal pain, but to intentionally end a patient's life.
	1885	The Journal of the American Medical Association (JAMA) attacked Samuel Williams' euthanasia proposal.

1900-1949	1905-1906	**Bills to Legalize Euthanasia was defeated in Ohio** legislature by a vote of 79 to 23. In 1906, a similar initiative that would legalize euthanasia not only for terminal adults, but also for 'hideously deformed or idiotic children' was introduced and defeated as well.
	1915	Harry J. Haiselden, forty-five-year-old chief of staff at Chicago's German-American Hospital allowed a seven pound deformed baby boy to die rather than give him possibly lifesaving surgery after conferring with boy's father
	1930 s	With the Great Depression and more troubled economic times, public support for euthanasia increased. Public opinion polls indicated in 1937 that fully 45 percent of Americans believed that Dr. Haiselden's mercy killing was permissible.
	1935	The Voluntary Euthanasia Legislation Society (VELS) was founded in England by a public health physician
	1936	**Bill to legalize euthanasia was defeated in British House of Lords**
	1937	Voluntary Euthanasia Act was introduced in US Senate
	1938	National Society for the Legalization of Euthanasia was founded which was later renamed as **Euthanasia Society of America (ESA) by the** notable men who believed so strongly in the right of an incurably diseased individual to have his life terminated.
	1940s	With the WWII, news of Nazi atrocities against mental patients and handicapped children (involuntary euthanasia) broke out and the growing popularity of euthanasia was challenged again.
	1946	The Committee of 1776 Physicians for Legalizing Voluntary Euthanasia in New York State came into existence

1950-1979	1950	Poll showed declining support for PAS: When an opinion poll in 1950 asked Americans whether they approved of allowing physicians by law to end incurably ill patients' lives by painless means if they and their families requested it, only 36 percent answered 'yes,' approximately 10 percent less than in the late 1930 s."
	1952	The British and American Euthanasia Societies submitted a petition to the United Nations Commission on Human Rights to amend the UN Declaration of Human Rights to include '..the right of incurable sufferers to euthanasia or merciful death'
	1962	Pauline Taylor became president of ESA who believed that it was the right time to begin convincing the public that letting someone die, instead of resorting to extreme measures, was both humane and ethically permissible.
	1965	Donald McKinney became president of the ESA who viewed that there was a fundamental distinction between passive and active euthanasia
	1968	Harvard Medical School Committee defined "irreversible coma" as a new criterion for death. Need of new definition was because of the great burden that trying to revive irreversibly comatose patients puts on the patients themselves, their families, hospitals and the community
	1969	Hastings Center was founded to study ethical problems in medicine and biology and was important in the development of bioethics as a discipline.
	1970s	With the goal to remove physicians from decision making and to let individual patients weigh the benefits and burdens of continued life, idea of patient's right especially the right to refuse medical care, even life-sustaining care gained acceptance
	1972	The US Senate Special Commission on Aging holds the first national hearings on death with dignity entitled "Death with Dignity: An Inquiry into Related Public Issues." The hearings showed that Americans were becoming increasingly unhappy about 'the brutal irony of medical miracles,' which extended the dying process only to diminish patient dignity and quality of life.

1974	Society for the Right to Die was founded that was dedicated to pursue the legalization of active euthanasia, a reenergized campaign to seek euthanasia laws through the political process.
March 31, 1976	In April 1975 Karen Ann Quinlan, 21 year old, had fallen into coma after returning home from a party due to irreversible brain damage. She had drunk a few gin and tonic and diazepam. She was hospitalized and eventually lapsed into a persistent vegetative state and was connected to a ventilator. New Jersey Supreme Court gave the verdict to remove ventilator on March 31, 1976 setting it as a legal landmark in the end-of-life issue.
Oct 1, 1976	California became the first state in the nation to grant terminally ill persons the right to authorize withdrawal of life-sustaining medical treatment when death is believed to be imminent
1977	By 1977, eight states -- California, New Mexico, Arkansas, Nevada, Idaho, Oregon, North Carolina, and Texas -- had signed right-to-die bills into law.
1980	The World Federation of Right to Die Societies was founded that included the membership of many organizations from countries around the world.
May 5, 1980	Pope John Paul II issued the Declaration on Euthanasia, opposing mercy killing but permitting increased use of painkillers and a patient's refusal of extraordinary means for sustaining life.
Dec 1984	American Medical Association published report detailing its formal position that with informed consent, a physician can withhold or withdraw treatment from a patient who is close to death, and may also discontinue life support of a patient in a permanent coma.
1987	The California State Bar became the first major public body to approve of physician aid in dying.
1988	Unitarian Universalist Association of Congregations passed resolution in support of aid in dying and became the first religious body to affirm a right to die.
Jan. 8, 1988	JAMA published an anonymous article that described how a a health worker (gynecology resident in a hospital) euthanized (injecting with overdose of morphine) a patient suffering from painful ovarian cancer.

1980-1999	1990 s	Growing interest in the right-to-die movement became apparent through a survey that showed more than half of Americans supported Physician-assisted death.
	June 4, 1990	Dr. Jack Kevorkian participated in his first assisted suicide. He was pictured as 'Doctor death' on the May 31, 1993 cover of Time magazine.
	June 25, 1990	Supreme court ruled in Nancy Cruzan (permanently unconscious) case that a person has the right to refuse lifesaving medical service.
	Nov 5, 1990	US Congress passes the Patient Self-Determination Act, requiring hospitals that receive federal funds to tell patients that they have a right to demand or refuse treatment. It would take effect the next year.
	1991	Two organizations, Concern for Dying and Society for the Right to Die merged to form 'Choice in Dying' that became known for defending patients' rights and promoting living wills
	Nov 1991	Washington State introduced ballot Initiative 119 to legalize "physician-aid-in-dying" but it was defeated.
	Nov 1992	California voters defeated the 'California Death with Dignity Act.'
	Apr 1993	Compassion in Dying was founded in Washington state to counsel the terminally ill and provide information about how to die without suffering and 'with personal assistance, if necessary, to intentionally hasten death.'
	May 1994	The New York State Task Force on Life and the Law published report against PAS arguing against its legalization.
	Nov 1994	The Oregon Death With Dignity Act is passed, becoming the first law in American history permitting physician-assisted suicide.
	Apr 30, 1997	President Clinton signed the 'Assisted Suicide Funding Restriction Act of 1997' prohibiting the use of federal funds to cause a patient's death.
	June 26, 1997	US Supreme court ruled that there no constitutional right to die.
	Nov 1997	Oregonians vote 60 to 40 percent in favor of keeping the Death with Dignity Act.

	Nov 1998	Jack Kevorkian on national television showed a videotape of him administering lethal injection to a man suffering from a progressive neurodegenerative disease. Michigan was defeated for its PAS proposal by a vote of 29% to 71%
	1999	Jack Kevorkian was convicted of murder by a Michigan court sentencing him to 10-25 years in prison.
2000-Present	2000	Maine Death with Dignity Act that reads "Should a terminally ill adult, who is of sound mind, be allowed to ask for and receive a doctor's help to die?" was defeated.
	2001	The Netherlands officially legalized euthanasia.
	2003	US Attorney-General Ashcroft challenged the Oregon Death with Dignity Act to reverse the finding of a lower court judge.
	2005	Terri Schiavo who had damaged brain since 1990 had her feeding tube removed after long court battle .
	Jan. 17, 2006	US Supreme Court upheld Oregon's Death with Dignity Act in *Gonzales v. Oregon* .
	June 1, 2007	Jack Kevorkian sentenced on Apr. 13, 1999 to 10-25 years in prison for his role in the euthanasia was paroled after serving 8 years. Tony Nicklinson, a locked-in syndrome sufferer since 2005 expressed his desire to die .
	Feb. 19, 2008	The Luxembourg parliament adopted a law legalizing physician-assisted suicide and euthanasia.
	Nov. 4, 2008	Washington Death with Dignity Act was passed making Washington the second US state to legalize physician-assisted suicide.
	Dec. 5, 2008	State of Montana legalized physician assisted suicide making it the third US state to legalize physician aid in dying.
	Dec. 31, 2009	The Montana Supreme Court affirmed that physician-assisted suicide is not "against public policy"
	Nov. 6, 2012	Massachusetts Death with Dignity ballot measure was defeated.

May 20, 2013	Like the laws in Oregon and Washington, Vermont's law implemented safeguards to govern physicians who are now allowed to prescribe death-inducing medication to terminally ill residents of the state, making it the fourth state to allow PAS.
Jan. 13, 2014	PAS was ruled legal by New Mexico judge stating that, "This court cannot envision a right more fundamental, more private or more integral to the liberty, safety and happiness of a New Mexican than the right of a competent, terminally ill patient to choose aid in dying."
Mar. 2, 2014	Belgium legalized euthanasia for terminally and incurably ill children and became the world's first country to lift all age restrictions on euthanasia. According to the law, the child must be "near death, in 'constant and unbearable physical' pain with no available treatment." The child must also have "capacity of discernment and be conscious at the moment of the request."
Feb. 6, 2015	Canada's Supreme Court struck down the country's law that bans doctor-assisted suicide saying that the law denies people the right 'to make decisions concerning their bodily integrity and medical care' and leaves them 'to endure intolerable suffering.
Apr. 30, 2015	South African court granted a terminally ill man Robin Stransham-Ford, 65 who was diagnosed with terminal prostate cancer in 2013, the right to have a doctor help him end his life.

Annex II:

Health in Nepal and the context of euthanasia

Brief overview of the Health Development in Nepal

The history of traditional health care and medicine in Nepal may be considered to be long enough being practiced by certain categories of spiritual and faith healers like 'Dhami', 'Jhankri', 'Jharphuke', 'Lama', 'Gubhaju'and traditional practitioners such as 'Amchi' (practicing Tibetan medicine) 'Sudeni' etc. Existence of many such spiritual and faith healers and practice of seeking services from them is still prevalent in many communities of Nepal. There were some others who used dietary and herbal remedies and still continue to practice the herb based medical system called Gurau. Historically there has also been a category of 'Kabiraja' who practiced under Ayurvedic system of medicine. It has been in the forefront of health care and has been inherent to Nepal since the early periods of the country's history. Just a few of those who practiced Homeopathic and Unani system of medicine still continue to practice. Health care was also dominated by religious and magical beliefs in ancient times.

While the number of traditional and spiritual as well as faith healers is gradually faltering, they still remain as the first contact point of consultation whenever available, in case of illnesses in many instances. It is so, especially in rural set up and underdeveloped communities. Though the Government of Nepal has adopted the policy of also developing the Ayurvedic system in the country as one of the priorities, there is no substantial progress made as of now.

Prior to the end of Rana regime in 1951, there are records available showing that some of the rulers availed services of expatriate practioners of allopathic or modern system of medicine for themselves and their family members during their reign. Following that, perhaps, there had been realization for a need to develop health sector of Nepal with the introduction of system of modern medicine. Establishment of Bir Hospital in Kathmandu in 1890 AD and setting up of Department of Health Services (DHS) in 1933 AD could be taken as milestone examples taken in this direction. In the subsequent 18 years of establishment of DHS till 1951, government established 33 hospitals and several Ayurvedic dispensaries were set up scattered all over the country. In 1951 a plan was chalked out for establishing a number of health facilities in different parts of the country with the status given as health posts, health centers and hospitals at the district, zonal and central level.

These health facilities were staffed with poorly trained lower level of health workers as trained health manpower was not available in the country at that time. To address this situation of crunch of availability of health manpower, in 1934 AD an Ayurveda Vidyalaya (School

of Ayurveda) and a Civil Medical School were established for developing middle level health manpower. A nursing school was established at Bir Hospital very much later in 1950s with technical support of WHO etc.

Systemic planning and programming of health development as a part of overall National Development in Nepal with a rational scientific approach to disease started only after the advent of democracy in Nepal in 1951 AD.

Since early part of 1950s the government started sending more Nepalese nationals abroad to be trained as doctors mainly in the neighboring countries. Some were sent under the scholarship availed by the friendly countries ad some under Colombo Plan. Later on British Council helped for facilitating specialized training to Nepalese doctors under the Colombo Plan. This is how a pool of health manpower was created to manage the newly established health facilities of the country in the beginning.

A process of having National Development Periodic Plans, usually for the period of five years in Nepal started since 1956. As of now nine Five Year Plans and three Three Year Plans (period reduced due to political transitional situations) have been implemented and thirteenth plan of three years period started from mid - July 2013 is under implementation.

During the **First Five Years Plan (1956-61),** the Ministry of Health was established in 1956 to gear up the health development in Nepal. In this plan stress was given on curative aspect of health. An Auxiliary Nurses Training Center was established in Hetauda in 1958 which was later moved to Bharatpur. Initiation of the malaria control activities in 1958 indicated that the government's attention attracted towards preventive medicine too.

During the **Second Plan Period(1962-1965),** which was initiated after a gap of one year, the stress on curative aspect continued, preventive aspects of health was also given additional emphasis . The starting of smallpox survey (in 1962) as well as start of pilot projects for control of leprosy (in 1963)) can be taken as indication of government's further recognition and importance given to preventive medicine in the country.

During the **Third Periodic Plan of (1965-70**) five years, while efforts to promote and improve the curative aspect of health care were still on, the emphasis on disease prevention led to the establishment of vertical projects such as: Leprosy Eradication Project (in 1965),control of tuberculosis (in 1965 and) Smallpox Eradication Project (in 1967). Family Planning and Maternal and Child Health Project was begun in 1968.

During Fourth Periodic Plan (1970-75) policy of integrating the vertical projects with the purpose of reducing duplication and encouraging cost effectiveness was adopted. And an Integrated Health Service Project was initiated on pilot basis in 1971.

In 1972 Institute of Medicine, now the premier medical institution of Nepal, was established under Tribhuvan University with the mandate of training health care workers at all levels to cater the health care needs of Nepal.

To enhance production of various grades of middle and basic level health workers required mainly for preventive activities training institutions producing such categories of health workers were shifted from Ministry of Health.

Fifth Plan Period (1975-80) : Nepal as a signatory of Health for All strategic document at the International

Health Conference at Alma Ata in 1978, adopted and implemented primary health care as an effective method to provide basic health care services to the majority of the people.

In 1975, **First Long Term Health Plan (FLTHP) (1975-1995)** was produced and implementation initiated.

In 1976, Integrated Community Health Services Development Project was established with the objective of carrying forward the integration process as per the recommendation of FLTHP.

In 1979 having achieved the smallpox eradication in Nepal, Small Pox Eradication Project was converted into Expanded Program on Immunization (EPI).

During the **Sixth Periodic Plan** (1980 - 1985) discussions were initiated for attracting private investors in the development of rural and urban heath services but it could not actually materialize. The process of integrating vertical projects continued to be considered seriously.

In 1982, **six antigens** were introduced throughout the country by EPI and program for goiter and cretinism control was also established.

Towards the end of sixth plan, late King Birendra in 1985 enunciated a strategy of fulfilling **Basic Minimum Needs** (BMN) goal for the Nepalese people. Health too was one of the components of BMN and it worked as a boost in health development in Nepal.

With the cropping up of vertical projects and their ongoing expansion resulting into higher and higher resource needs steps for the integration of vertical projects were taken in line with the recommendation of FLTHP.

Seventh Plan Period (1985-90): In 1986 Department of Health Services, having had a life span of 53 years was dissolved and divisions of department of health were kept directly under Ministry of Health , ten in number.

In 1988 the **National Female Community Health Volunteers (FCHV)** Program was established to enhance primary health care network through community participation and to expand outreach services by local women working voluntarily.

This program has proved very effective with international recognition. Across the 75 districts of the country there are now more than 50 thousand FCHVs assisting with PHC activities and acting as a bridge between government health services and the community and serve as front line health service delivery persons.

The process of integration got completed more or less at the peripheral level by 1987 and at the central level by 1990.

In 1990 Malaria Eradication Project, Family Planning/Maternal and Child Health Project and Expanded Programme on Immunization were amalgamated into one of the division at the Ministry of Health. Two departments - Department of Ayurveda and Department of Drug Administration - existed under the Ministry of Health. Side by side one Regional Directorate of Health Services was set up each infive Development Regions of the country.

A **National Health Policy 1991** was introduced in 1991 by the Ministry of Health of the new democratic government. The new health policy meant, *inter alia,* to give priority to preventive and promotive health services and expand health service coverage up to grass root level by establishing at least one Primary Health in each of 105 electoral constituency and one health service facility in all Village Development Committees. This resulted into establishment of broad based service coverage network in the country within five years as planned. To mobilize NGO and private sector with community participation to provide health services was also one of the significant component of this policy. This policy of inclusion of NGO and private sector in health gave a big boost to establish nursing homes, hospitals and even medical colleges in the country by private sector which is in ever increasing trend.

The **Eighth Periodic Plan(1992-1997**) of five years which was due to start in 1990 was postponed because of the transitional situation created by major political change at that time from Panchayat polity to reintroduction of parliamentary political system and the plan kicked off only from mid July 1992. The bridging period of two years from 1990 to 1992 was termed as " Plan Holiday".

During this plan period the process of consolidation of integration was continued and emphasis was given in implementing the newly introduced national health policy vigorously. Health system was restructured and a new organogram came into effect from mid-July 1993 (1st Shrawan, 2050 BS). The Department of Health Service (DHS) was re-established in 1993 as per the new organogram. The new hierarchical organizational structure of the MoH had three departments i.e. DHS, Department of Ayurveda and Department of Drug Administration and five Regional Health Directorates above the district level and district hospitals, district public health offices, primary health centers, health posts and sub- health posts at and below the district level. A mechanism for having outreach services

at the grass root level in a regular basis was also enunciated.

In 1992, the processfor establishment of **BP Koirala Institute of Health Science**, Dharan and **BP Koirala Memorial Cancer Hospital, Bharatpur** was initiated.

In 1992 training of a new cadre of health workers named as **Maternal and Child Health Workers** (WCHW) was begun.

Second Long Term Health Plan (SLTHP) (1997-2017): A long term perspective SLTHP was developed with the "vision of an integrated health system including public, NGO and private sectors envisaging equitable access to health care, self-reliance, full-community participation, decentralization, gender sensitivity and efficient management, resulting in improved health status of the population".

The SLTHP was prepared through a wide participatory approach following a rigorous exercise of information collection, discussion, analysis, dissemination of findings and conclusions in different occasion and setting over the period of two years. It involved many national and international experts at various stages of its development.

The SLTHP under the package of "Essential Health Care Services" identified twenty interventions for implementation to address principal health problems of Nepal, took note of various commitments made by Nepal to fulfill in regard to health promotion including the global ones, cost effectiveness and gender sensitivity etc.

Ninth Periodic Plan (1997-2002): In this plan period health sector agenda focused on poverty alleviation and health sector was expected to play an important role in line with implementation of SLTHP.

Tenth Periodic Plan (2002-2007): Health sector was mandated in continuing the activities of ninth plan period. An agenda of health sector reform was added up but ended with poor achievement.

In 2002National Academy of Health Science, Bir Hospital, Kathmandu was established.

In 2004 training of MCHWs to upgrade them as ANMs was initiated.

Sector Wide Approach (SWAP) which came into effect in **2004** for establishing good partnership with development partners in health sector has continues to hold. As well in **2004 Health Sector Strategy : An Agenda for Reform** as endorsed by Council of Ministers was brought into effect within the context of health planning process based on Sector Wide Approach. This strategy formulation was designed against the backdrop of Nepal's commitments on delivering the poverty reduction strategy and the Millennium Development Goals and guided by National Health Policy, 1991 and Second Long Term Health Plan. First Nepal Health Sector Program (NHSP-I) was developed to implement the strategy for the 2004-2009. It attempted to put

"clear systems in place to ensure that the poor and vulnerable communities have priority for access".

After the abolition of monarchy in **2006** the **Interim Constitution of Nepal, 2063 BS** promulgated in January 2007 established people's **health as fundamental right** of the people.

In 2005, Government introduced Maternity Incentive Scheme to encourage delivery at health institution. Subsequently it evolved into Ama Program in 2009.

The Eleventh Periodic Plan (2007-2010) :Because of the prevailing political environment of instability, fluidity and uncertainty about the time and type of formal and stable government to come into power, the existing government decided to formulate a plan for three years only instead of five. In this plan attention was paid towards addressing the increasing health problems due to non communicable diseases and their rising trend.

It was in **2008** that government introduced **free health care program** to mitigate economic barriers in accessing health care services.

In the **Twelfth PeriodicPlan (2010-2013)** which was also of three years span the main objective of health sector was set to improve the health status of the people by ensuring increased access and utilization to quality health services to citizens of all geographical areas and all sector of the community on the equity basis and help the government's long term vision of poverty alleviation.

The **Thirteenth Periodic Plan (2013-2016):** Due to the protracted political transition it was the third interim plan of three years span in sequential order which is under implementation currently . The main objective of health sector is this plan remains increasing the equity based access and utilization of quality health services to the people of all sectors, regions and community through appropriate strategies.

National Health Policy, 2014 AD: The National Health Policy, 1991 was revisited after more than two decades and a new version came into effect in 2014 AD. In this policy, *inter alia*, it has been emphasized to ensure provision of universal health coverage; give more leverage to addressing non-communicable diseases which are in rising trend and establishment of specialty and tertiary health care facilities in the country with due consideration of maintaining geographical balance.

Nepal Health Sector Strategy , 2015-2020 has been issued and stands on four strategic principles : 1. equitable access to health services 2. Quality health services 3.Health systems reform and 4. Multi- sector approach. Equitable service utilization, strengthening service delivery and demand generation to underserved populations, including the urban poor is envisioned to take place under these strategic principles.

References

1. BBC, Ethics guide-Euthanasia and physician assisted suicide. 2014.
2. Wikipedia. Euthanasia. 2015; Available from: http://en.wikipedia org/wiki/Euthanasia.
3. Buiting, H., et al.,Reporting of euthanasia and physician-assisted suicide in the Netherlands: descriptive study. BMC medical ethics, 2009.**10**(1): p. 18.
4. ProCon.org. Historical Timeline-History of Euthanasia and Physician-Assisted Suicide. 2015; Available from: http://euthanasia.procon.org/view.timeline.php?timelineID=000022.
5. Euthanasia.com. Euthanasia facts. Available from: http://www.euthanasia.com/page4.html.
6. BBC. Anti-euthanasia arguments. 2014; Available from: http://www.bbc.co.uk/ethics/euthanasia/against/against_1.shtml#h4.
7. Sinha, V.K., S. Basu, and S. Sarkhel, Euthanasia: An Indian perspective. Indian journal of psychiatry, 2012.**54**(2): p. 177.
8. The Life Resources Charitable Trust. Futile-Care Theory and Healthcare Rationing. 2011; Available from: http://www.life.org.nz/euthanasia/euthanasiaethicalkeyissues/futile-care/.
9. Chatterjee, B., The portrait of a revolutionary, BP Koirala 1982: Ankur Publishing House.
10. Geielen J, Mahatma Gandhi's view on euthanasia and assisted suicide. Med Ethics, 2012.**38**(7).
11. Gurdian, T. Stephen Hawking: 'I would consider assisted suicide'. 2015; Available from: http://www.theguardian.com/science/2015/jun/03/stephen-hawking-i-would-consider-assisted-suicide?
12. Valverius, E., T. Nilstun, and B. Nilsson, Palliative care, assisted suicide and euthanasia: nationwide questionnaire to Swedish physicians.Palliative medicine, 2000.**14**(2): p. 141-148.
13. Emanuel, E.J., et al.,Euthanasia and physician-assisted suicide: attitudes and experiences of oncology patients, oncologists, and the public.The Lancet, 1996.**347**(9018): p. 1805-1810.
14. Wikipedia. 2015. Legality of euthanasia; Available from: http://en.wikipedia.org/wiki/Legality_of_euthanasia.

15. Pereira, J., Legalizing euthanasia or assisted suicide: the illusion of safeguards and controls.Current Oncology, 2011.**18**(2): p. e38.

16. Hurst, S.A. and A. Mauron, Assisted suicide and euthanasia in Switzerland: allowing a role for non-physicians. BMJ: British Medical Journal, 2003. **326**(7383): p. 271.

17. ERGO. Euthanasia Progress In The 20th and 21st Century 2010; Available from: http://www.finalexit.org/assisted_suicide_world_laws_page2.html.

18. Khan, F. and G. Tadros, Physician-assisted suicide and euthanasia in Indian context: Sooner or later the need to ponder!Indian journal of psychological medicine, 2013.**35**(1): p. 101.

19. Chambaere, K., et al.,Recent Trends in Euthanasia and Other End-of-Life Practices in Belgium.New England Journal of Medicine, 2015.**372**(12): p. 1179-1181.

20. Onwuteaka-Philipsen, B.D., et al.,Trends in end-of-life practices before and after the enactment of the euthanasia law in the Netherlands from 1990 to 2010: a repeated cross-sectional survey.The lancet, 2012.**380**(9845): p. 908-915.

21. World Health Organization. (1990). Cancer pain relief and palliative care: Report of a WHO Expert Committee[Technical Report Series 8 04]. Geneva, Switzerland.

22. Center to Advance Palliative Care(CAPC) ," Making the case for Hospital-Based Palliative Care" http:// .cape. org/building - a- hospital-based- palliative- care- program / (http//www.merrian-webbler.com/dictionary/palliative)(2008)

23. WHO. World Health Organization - Noncommunicable Diseases (NCD) Country Profiles , 2014. 2014; Available from: http://www.who.int/nmh/countries/npl_en.pdf.

24. Gautam, M. World alzheimer's day: Alzheimer's disease remains neglected in the country. 2011; Available from: http://www.ekantipur.com/the-kathmandu-post/2011/09/21/nation/world-alzheimers-day-alzheimers-disease-remains--neglected-in-the-country/226562.html.

25. Paudel B. World Kidney Day and Kidney Diseases in Nepal. 2012; Available from: http://www.badripaudel.com/badri/patient-info/kidney-disease/world-kidney-day-and-nepal.html.

26. Jha, C.K. and J. Madison, Disparity in health care: HIV, stigma, and marginalization in Nepal.Journal of the International AIDS Society, 2009.**12**(1): p. 16.

Addendum

There was a lively discussion on the issue of Euthanasia during the sixth lecture series. The issues raised were:

- Euthanasia needs to be dealt through spiritual perspective mainly in the context of Nepal.
- It is very important to be very empathetic while talking about euthanasia rather than be detected by medical professionals, spiritual gurus or any scholars. One has right to live then one should have right to die.
- Such debate can be initiated but will take long time to be concluded however, it can be initiated through awareness and recognizing it in political system.
- The challenging aspect of Euthanasia was also pointed which includes tradition and cultural belief of our country where our Aatma is regarded as God and killing it is against our culture. In this concern, it is very challenging to accept euthanasia in our society and make people believe on it. The suicidal cases should not be increased while focusing on euthanasia as it can be debatable topic too.
- The current issue regarding art of dying was also raised. In this concern, it was agreed that if we learn about art of living then we should learn about art of dying too. Therefore in this context, everyone should be prepared for the death.
- It was emphasized that survival and death should not be guided by values of doctor but should be based on spirit of one who really wants to live or die.

Nepal Public Health Foundation

Concept

Nepal confronts with triple burden of diseases, malnutrition, and a weak health system as the major threat to nation's health as well as a formidable barrier to meeting Millennium Development Goal. While communicable diseases are still an important cause of preventable deaths, the chronic non-communicable diseases have emerged as major killers. Injuries and disasters, along with emerging and reemerging diseases associated with the change in environment, constitute the third category in the burden of diseases.

In spite of economic backwardness, difficult terrain and decade of violent conflict, there has been remarkable improvement in health indicators such as Infant Mortality Rate, Maternal Mortality Ratio and Total Fertility Rate. The right of Nepali people for basic health care is enshrined in the interim constitution of 2007. However, the nutritional status has not changed much, and there is much to be desired for achieving health for all, calling for a need to integrating health action with equitable and sustainable development efforts, strengthen health system through revitalization of Primary Health Care and ensure good nutritional status through multi-sectoral collaboration.

To meet such challenge, a concerted public health response is needed which gives as much emphasis on multi-sectoral cost effective intervention for health promotion and disease prevention as to affordable diagnostic and therapeutic health care. It requires both capacity for "research for health", healthy public policy development and analysis, pilot interventions and evaluation, in developing models of prevention and control strategies, health care management, health care financing and health system organizations. It highlights the role of systematic review and system thinking as important tool to strengthen health systems. Such response demand effective and efficient networking with public health professionals and institutions both within the nation and on regional and global level, so as to ensure policy and interventions that are evidence based, context specific and result oriented.

To launch such response a critical mass of public health experts and activists have to come together in an apex body that has full autonomy exercised by its governing board and general body. Such an organization should be able to work together with government and non-government organizations, private sector and community based organizations, health sciences and research institutions, and most importantly, people's health movements. It would be the principle vehicle of civil society to ensure public health advocacy and community based action that would empower the people at community level and above.

Nepal Public Health Foundation is conceived to become such organization.

Vision Ensuring health as the right and responsibility of the Nepali people

Mission Concerted public health action, research and policy dialogue for health development, particularly of the socio-economically marginalized population.

Goal Ensure Civil Society's pro-active intervention in public health

Objectives The Objectives of Nepal Public Health Foundation are to:

Engage public health stakeholders for systematic review and analysis of existing and emerging health scenario to generate policy recommendations for public health action; especially in the context of the changing physical and social environment, the increasing health gap between the rich and the poor, and the impact of other sectors on health.

Prioritize public health action and research areas, facilitate pilot interventions in collaboration with national and international partnerships with special emphasis to building communities capacity for health care.

Strengthen health system through systems thinking for effectively responding to the problems of public health.

Support/establish existing or new community based public health training institutions.

Ensure continued public health education (CPHE) by disseminating latest advancements in public health knowledge and research. Publish books, monographs, educational materials and self-learning manuals.

Provide research fund for deserving researchers and public health institutions, with priority given to community-based institutions.

Focus area of NPHF

- Health policy and Systems Research
- Human Resource Development
- Communicable disease control
- Non- communicable disease control
- Nutritional Research
- Maternal and Child Health
- Disaster Prevention and Management
- Co-ordination, Advocacy and communication
- Social Determinants for Health
- Health Economics
- Health Technology Research
- Epidemiology, Biostatistics and Demography

Glimpse of Sixth Lecture Series

From Left; Dr. Sharad Raj Onta, General Secretary;
Dr. Tirtha Rana, Treasurer, NPHF; Dr. BD Chataut, Key Note Speaker;
Dr. Badri Raj Pande, Acting Executive Chair, NPHF

Biographical Sketch of Dr. B.D. Chataut,
MBBS(Luck), MSc CHDC(Lon), DPH (London), Dceh (London)

Dr. B.D. Chataut, MBBS(Luck), MSc CHDC(Lon), DPH (London), Dceh (London)

Dr. Bhuwaneshwaree Datt (B.D.) Chataut was born in Dadeldhura, Far-western Region of Nepal. He earned MBBS degree from King George's Medical College, Lucknow, under Colombo Plan. He did his MSc. in Community Health from London School of Hygiene and Tropical Medicine, London. He also underwent additional specialized trainings at International Centre for Eye Health London; John Hopkins University, School of Hygiene and Public Health, Baltimore, USA ; Management Health Sciences, Boston, USA; International Health Programs, Consortium for Public Health, California, USA - all under WHO Fellowship.nDr. Chataut worked for the Ministry of Health (MoH) for 34 years. His services covered many tiers of the public sector health facilities, ranging from Primary Health Center to Central Hospital and Regional Directorate, Department and Ministry of Health. At the MoH headquarters in Kathmandu, he worked in various capacities including Chief Specialist; Chief of Planning Division; Chief of Curative and Nursing Division simultaneously. He was also spokes person of MoH for about five years.

At the Department of Health he worked as Director of Planning Division and Director of Child Health Division simultaneously, and ultimately as Director General (DG). In the history of MoH in Nepal, Dr Chataut was the first DG with a status of Level 12 of Health Service Act, which equates to secretary of Government of Nepal and only the DG to remain on chair until compulsory age retirement. He also served as Chairman of the Board of Patan Hospital and Maternity Hospital, Kathmandu. Among his milestone achievements include the development of Second Long Term Health Plan (1997-2017), for which he played a key leadership role; development and implementation of Health Management Information System for Nepal. He also played a catalytic role in rolling out the Vitamin A supplementation program. He also worked in capacity of National Consultant to develop the National Health Policy, 2014. He represented the Ministry of Health in various international forums, including the World Health Assembly (six times).

Dr. Chataut has worked as WHO consultant for two years in Bangladesh and one year in Myanmar and for the shorter time in WHO South East Regional Office, New Delhi; Indonesia; Maldives; Sri Lanka and Thailand. He has also served in various regional policy and technical advisory committees groups of WHO South East Asia Region from time to time. He has been attached to several NGOs. A life member of Nepal Medical Association he held several positions and was Senior Vice President in 1991 after which, he says, he rather left playing active role, as the association inclined to run based on political ideology. He was also the first Nepalese to get elected as the President of the Foreign Students Association, Lucknow, while studying in Lucknow. Dr. Chataut has been awarded Coronation, Gorkha Dakshin Bahu, DirghSewaPadak, and Prabal Gorakha Dakshin Bahu medals. After his retirement from the Government service in 2005 , he has been also nominated Member of High Level Advisory Committees of Ministry of Health and Population, Nepal time and again. At present, Dr. Chataut is Managing Director of Central Institute of Science and Technology and Founder Principal of CiST College, Kathmandu, established in 2009.

Dr. Chataut is also the founding member of NPHF. He has travelled to approximately 50 countries around the world.