Dignity at Life's End: Prioritizing Palliative Care in Nepalese Healthcare

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Modern medicine has made remarkable progress in saving lives. Advanced medical technology can now keep a person's body functioning even when severe disease has taken away any real chance of recovery. In Nepal, intensive care units (ICUs) are expanding rapidly across major cities. Healthcare facilities now routinely use mechanical ventilators, dialysis services, ionotropes support, and total parenteral nutrition. While these tools save many lives during acute illnesses, however, they also blur the line between extending meaningful life and simply prolonging the process of dying.

This advancement in medical knowledge, skill and technology brings an ethical dilemma with it: when should medical care continue to fight death, and when should it shift to helping a patient die peacefully? This question is especially critical in Nepalese context. While ICU beds and high-tech life support are expanding, access to basic pain relief, palliative care, and planned end-of-life support remains deeply limited. Health care professionals often find themselves trapped between using every available machine and watching patients suffer unnecessarily. The core challenge is not just whether we can keep a heart beating, but whether doing so truly helps the patient, respects their dignity, and aligns with their values.

Understanding the Terminology: Euthanasia versus Stopping Futile Care

To make good clinical decisions, we must first clear up widespread confusion about medical terms. Active euthanasia means a doctor or third party intentionally giving a medication-such as a lethal injection-to directly end a patient's life at their request. Physician-assisted dying is slightly different: the clinician provides the prescription or means, but the patient takes the final action themselves. Both of these practices are fundamentally different from withholding or withdrawing life-sustaining treatment, issuing Do-Not-Resuscitate (DNR) orders, or giving proper doses of pain medicine and sedatives to keep a patient comfortable. International medical ethics guidelines make these distinctions clear.[1,2]

Stopping a mechanical ventilator, ending dialysis, or choosing not to perform chest compressions when recovery is impossible does not mean a doctor is performing euthanasia.[3] In these situations, the doctor's goal is not to kill the patient. Instead, the goal is to stop treatments that no longer provide any real medical benefit, allowing the underlying illness to take its natural path. Modern critical care ethics clearly establishes that stepping down burdensome, non-beneficial treatment while providing active symptom relief is a normal, moral, and essential part of good medicine.[3,4] Labelling treatment withdrawal as "killing" creates unnecessary fear and leads to situations where patients are kept on support machines far past the point of hope.

The Legal and Professional Context in Nepal

At present, Nepal has no legal framework that permits active euthanasia or physician-assisted dying.[5] Provisions in the National Penal Code of 2017 address criminal negligence, medical harm, and aiding suicide.[6] While the Penal Code does not explicitly define "euthanasia" as a separate crime, any deliberate act intended to cause a patient's death carries heavy legal risk for healthcare workers. Therefore, individual health care personels cannot legally or ethically create their own rules, even when facing heartbreaking clinical situations.

The professional stance of the Nepal Medical Council (NMC) is equally clear. The NMC Code of Ethics explicitly prohibits active euthanasia.[5] However, the NMC code also makes a crucial point that clinicians must understand: dying patients must receive care aimed at relieving pain and suffering.[5] Giving properly titrated opioids and sedatives to control severe pain is standard palliative care, not euthanasia, even if those medicines slightly speed up natural death as an unintended side effect.

If Nepalese society ever decides to discuss legalizing active euthanasia, it cannot be decided quickly in a hospital setting. It would require a broad nationwide discussion involving Parliament, the courts, bioethicists, medical experts, and community groups. Evidence from countries where assisted dying is legal shows that it introduces severe challenges regarding patient consent, psychological illness, abuse safeguards, and medical duties.[2,7] Nepal is not currently equipped to manage these complex safeguards.

Financial Burdens, Poverty, and the Limits of Autonomy

Ethical discussions around end-of-life care often center on four core principles: autonomy (respecting a patient's choice), beneficence (doing good), non-maleficence (doing no harm), and justice (fair care for all). In Nepal, however, these principles clash directly with hard socioeconomic realities. High-tech ICU care is expensive, and most families must pay medical bills directly out of their own pockets.

This reality creates a painful moral dilemma. When a patient or family asks doctors to stop ICU care, or asks for a life-ending intervention, it is rarely a simple expression of personal choice. Instead, families are often driven by economic devastation, overwhelming debt, unmanaged physical pain, or the feeling of being a heavy financial burden to their loved ones.

True autonomy cannot exist without real choices. If a patient asks to die simply because they cannot afford basic pain medicine, home care, or an ICU stay, that request is not free choice; it is coercion caused by poverty and system failure.[8] Studies show that emotional distress, family dynamics, and financial pressure heavily drive end-of-life requests.[2,7] Therefore, a request to stop care or end life should not automatically be viewed as a wish to die, but rather as a desperate cry for symptom relief, financial relief, and dignity.

Establishing Palliative Care as the Priority

Rather than debating whether Nepal should permit active euthanasia, our immediate ethical duty is to build robust palliative care services across the country. Palliative care in Nepal is still in its early stages and remains largely unavailable outside a few major cities.[9] A national study in Nepal revealed that nearly half of recommended palliative care medications were either unavailable in pharmacies or unaffordable for average families.[8] Furthermore, access to essential oral opioids remains limited by tight regulatory rules and a lack of clinical training.[10]

Nepal must urgently fix these structural gaps. Palliative care should never be viewed as "giving up" on a patient. Instead, it is an active, specialized branch of medicine focused on relieving pain, managing distressing symptoms, and helping patients live as comfortably and meaningfully as possible until natural death. To achieve this, Nepalese healthcare must focus on practical steps: expanding hospice facilities, integrating basic palliative training into medical and nursing schools, ensuring reliable supplies of pain medications, and encouraging early, open discussions between doctors, patients, and families about treatment goals. ICU care itself must shift its focus from asking what technology we can plug in, to asking what treatment actually helps the patient's overall well-being. When further aggressive treatment offers no benefit, transitioning smoothly to comfortable end-of-life care is the most compassionate service a clinical team can provide.

The debate on end-of-life care in Nepal should not be forced into a false choice between continuous, painful ICU intervention and legalizing active euthanasia. An ethically sound middle ground already exists: honest communication, advance care planning, withdrawal of futile life support, and compassionate palliative care. Medicine cannot always cure disease or prevent death. However, medicine can and must ensure that the journey toward the end of life is marked not by unnecessary suffering and financial ruin, but by dignity, comfort, and deep human respect.

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