Is active euthanasia the next step?

YES | Sushila Rao

The right declared in ‘Common Cause’ extends to active euthanasia in circumscribed circumstances

Yes, the operative term in the question being “is”, and not “should... be”. If passive euthanasia is a guaranteed fundamental right, a rigid “active” versus “passive” euthanasia distinction (APD) is analytically unsustainable. In *Common Cause v. Union of India*, the Supreme Court expounded the basis of its 2011 ruling in *Aruna Shanbaug v. Union of India*, which permitted “passive” euthanasia, including “involuntary” passive euthanasia for mentally incompetent patients, in certain terminal cases. Ruling that Article 21 of the Constitution guaranteed the “right to die with dignity”, the court also issued interim guidelines to enforce individuals’ living wills in case of future incompetence.

Active and passive

Aruna and *Common Cause* have incorporated the judicial APD evolved primarily by U.K. courts. In popular discourse, APD has become shorthand for an apparently axiomatic ethical and legal dichotomy between “killing” and “letting die”. But the ethical and jurisprudential underpinnings of the apex court’s rulings logically dictate that the right declared in *Common Cause* extends to “active” euthanasia in carefully circumscribed circumstances.

Overall, judges and commentators recognise that in the context of euthanasia, *ceteris paribus*, there is no legally intelligible difference between deliberately “doing” (active) and “not doing or stopping to do” (passive) something that leads to death. Nor is there any articulable reason why “withdrawal” (as opposed to “withholding”) of current treatment isn’t an illegal “active” decision that hastens death from the underlying cause, much like a lethal injection that also accelerates imminent death. To quote Lady Hale of the U.K. Supreme Court in *Nicklinson v. Ministry of Justice*, “Why does active assistance give rise to moral corruption on the part of the assister (or, for that matter, society as a whole), but passive assistance [does] not?”

As a result, APD is a morass of legal fictions about intentionality and the “ultimate” causation of death, which don’t withstand scrutiny. More importantly, it may unjustly deny a recognised fundamental right to those who need assistance to access it. A tragic U.K. case showcased the dangers of treating APD as an axiomatic rule that overrides legitimate requests to exercise the right. Diane Pretty, while mentally competent, was in the terminal stages of incurable motor neurone disease, which left her completely paralysed from the neck down. Faced with the prospect of progressive suffocation as her breathing and swallowing muscles failed, Pretty required assistance to effectuate a dignified and bearable death in a manner and time of her choosing.

To be clear, these inherent contradictions in APD are the inevitable outcome of fragmented rule-making by courts hamstrung by the lack of a comprehensive and coherent legislative and policy framework. APD is an elaborate and flawed judicial construct arguably necessitated by overarching policy concerns, namely, potential for abuse by unscrupulous individuals; the spectre of criminal prosecution of benign doctors and families; and the exercise of judicial restraint on a sensitive issue that warrants legislation embodying the democratic will.

These dilemmas fall within the realm of Parliament, which must act to resolve them. As Justice D.Y. Chandrachud notes, “the meeting point between bio-ethics and law does not lie on a straight

course," and these complex issues "*cannot* be addressed *without* the legalisation and regulation of active euthanasia" (emphasis added).

By emphatically erring on the side of self-determination and recognising passive euthanasia with certain safeguards as a fundamental right*, Common Cause* signals that APD's days are numbered. Whether couched as "dignified death" or "bodily autonomy", there is no reasonable basis for negating the right vis-à-vis a patient whose circumstances warrant assistance to exercise it.

The views expressed are personal

*Sushila Rao is a U.S.-based litigator***NO** | **Pinky Anand**

Another step in this direction could result in "killing" as opposed to "mercy killing"

Euthanasia has always been a tricky subject. While some deem it immoral and against the will of god, others see the act of ending the life of a person who is suffering indefinitely as a benevolent action, an almost charitable one.

A blurry line

Where do we draw the line between murder and an act of charity? Does the mental state of the person who is asking for death count? How do we account for depression, or losing the will to live, when there are treatments available by mental health specialists which can effectively turn a person's life around? Where does the concept of euthanasia stand in our law and how do we distinguish between a person who has lost the will to live and one who cannot live? What is "mercy killing" and how do we differentiate it from "killing"?

The Supreme Court, in *P. Rathinam v. Union of India* (1994), debated the constitutionality of the attempt to commit suicide under Section 309 of the Indian Penal Code and struck down the proviso. For the first time, the right to die was included within the right to live with dignity. The debate was raised again in *Gian Kaur v. State of Punjab* (1996), where the courts overruled the *P. Rathinam* judgment and held that the right to life did not include the right to die.

The Supreme Court, in *Aruna Shanbaug v. Union of India* (2011), laid down guidelines for passive euthanasia and held it to be the withdrawal of life-sustaining treatment from patients who are not in a position to make an informed decision. The debate has now been furthered with the recent ruling, where the Supreme Court has held the right to die with dignity as an inextricable part of the right to life. The judgment has created safeguards to protect a person who is in a vulnerable state, and has included the creation of living wills as an acceptable mode by which the right to euthanasia may be exercised. The creation of a living will allows a person to express her desire to turn off life support if she is ever in a condition where she becomes eligible for passive euthanasia. The judgment is laudable since it frees those close to the patient from the guilt of taking away life-sustaining support. It allows a person to die with dignity and respect. It has come as a part of the series of judgments that the courts have given, expanding the definition of right to life to encompass the right to privacy and dignity.

Psychological issue

Euthanasia is an extremely contentious issue because it is a decision fraught with emotion. It is unnatural for a person to seek death. Passive withdrawal is the maximum that we may tread on this contentious path. The will to die is often a psychological issue. Life has many twists and turns, and many of us often face loss and depression which temporarily rob us of our strength to fight. If

any further step is taken, it will make people suffering from mental illness vulnerable to their own minds as well as unscrupulous elements.

As of today, courts have handed us the right to choose our death in dignity, but the line has to be trodden carefully. Another step in this direction could result in “killing” as opposed to “mercy killing”.

*Pinky Anand is Additional Solicitor General of India***IT'S COMPLICATED | Dhvani Mehta**

Parliament should frame legislation to replace the court’s guidelines that govern passive euthanasia

The Supreme Court in *Common Cause v. Union of India* categorically refused to confer a right to “active” euthanasia. The administration of a lethal drug by a physician, as well as by a patient (when supplied the drug by a physician), falls within the meaning of active euthanasia. The administration of a lethal drug by a physician even with the consent of a patient constitutes culpable homicide punishable under the Indian Penal Code. When the drug is being administered by the patient herself, it is suicide under Section 309 of the IPC, which punishes an attempt to commit suicide.

Use of terms

The court does, however, permit physicians to withhold or withdraw life-sustaining treatment, both from patients who have consented to this and from those who are incompetent to do so. This is what the court calls “passive euthanasia”. The use of the terms “active” and “passive” has been criticised by the Indian Council of Medical Research in a publication released this month defining terms used in end-of-life care. Using passive euthanasia to describe the withholding or withdrawal of treatment wrongly suggests that there is something unnatural about the process. Instead, such withholding or withdrawal ought to be seen as allowing death to take its natural course. The court also sees it this way, despite its use of the term “passive euthanasia”.

In fact, this is why the court permits “passive euthanasia”, while not extending the same recognition to “active euthanasia”. In the eyes of the law, the distinction between committing a positive act (administering a drug) versus withdrawing treatment (taking a patient off the ventilator) is one that has significance. As Justice Chandrachud says, in active euthanasia, the act of the doctor “causes” death. In passive euthanasia, “death emanates from the pre-existing medical condition of the patient which enables life to chart a natural course to its inexorable end”. Although his opinion recognises that the moral, ethical and philosophical debate on this issue has criticised the act/omission distinction, he concludes that judicial restraint demands that only Parliament and not the courts take a final call on legalising active euthanasia.

Section 115 of the Mental Healthcare Act creates a presumption that any person attempting to commit suicide is under severe stress and is not to be tried or punished. This is a positive step towards decriminalising suicide, which is a precondition to permitting active euthanasia. The court has expounded on the rights to autonomy, dignity, liberty and privacy while recognising the right to a dignified death. If these rights are to be given their full effect, it would be hard to justify why “passive euthanasia” is permitted, while “active euthanasia” is not.

Framing legislation

However, this is not necessarily where Parliament should be focusing its legislative energy next. While other countries have sophisticated regimes on assisted dying, India has only just recognised a constitutional right to refuse medical treatment. The guidelines laid down by the court to govern

“passive euthanasia” and advance directives until Parliament enacts legislation are unworkable in their complexity. Parliament should frame legislation to replace these guidelines after allowing doctors and patients time to have conversations about end of life decision-making and to evolve a procedure that is practicable and fair, and which takes into account the peculiarities of Indian society. Active euthanasia should follow only after learning from this experience.

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The India-Japan economic relationship remains underwhelming in relation to strategic ties

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