The Moral Basis for a Right to Die

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In *Aruna Ramchandra Shanbaug vs Union of India,* the Supreme Court permitted passive euthanasia for terminally ill patients in certain circumstances. Judicial reasoning tends to accord an inordinate degree of importance to an absolutist reading of the "sanctity of life" principle. But this tenet has already been compromised to such an extent as to render its continued influence tenuous at best. Moreover, the ethical and jurisprudential foundation for extending the right to die to encompass assisted suicide or active euthanasia in controlled circumstances already exists in the present framework. However, patients incapable of ending their lives are unjustly pre-empted from availing of the right to die in its plenary form.

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The debate surrounding the legalisation of euthanasia in India has proven both protracted and intractable. Opponents cry themselves hoarse about the "sanctity of life" (SOL) being violated by self-styled angels of death, and cite eclectic religious authorities to shore up their claim.[1] Proponents of a more liberal view, on the other hand, insist that a "right to life"[2] must include a concomitant right to choose when that life becomes unbearable or not worth living.[3]

Active and Passive Euthanasia

On 7 March 2011, the Supreme Court delivered a "path-breaking" judgment in the case of *Aruna Ramchandra Shanbaug vs Union of India*[4] (*Aruna*), permitting passive euthanasia for terminally ill patients in certain circumstances. Comparing itself to a "ship in an uncharted sea", the court borrowed heavily from the decision of the United Kingdom House of Lords (UKHL) in *Airedale NHS Trust vs Bland*[5] (*Bland*). The Court thus based the crux of its decision on the much-vaunted distinction between "active" and "passive" euthanasia. Active euthanasia generally refers to positive steps taken to deliberately induce death, whereas passive euthanasia infers withdrawing life support and treatment, and letting nature take its course (Wainey 1989: 651).

This active/passive distinction is couched in terms of a dichotomy between "killing" and "letting die", which stipulates that it is morally wrong to intentionally take a life, but permissible to allow the inevitable to happen by withdrawing or withholding treatment (Potts 1988: 504). Thus active euthanasia was deemed illegal and a crime in India by the Court, punishable as murder under Section 302 of the Indian Penal Code (IPC), 1860; or at the very least as culpable homicide not amounting to murder under Section 304 of the IPC.[6] On the other hand, passively permitting nature to take its course by withdrawing life support was an "omission",[7] and hence not a crime.

Now, in the context of a "right" or entitlement to die, it appears only logical that our musings should be focused on those situations when an individual could face legal or societal hindrances to choosing when and how she wishes to depart from this realm. Pondering an able-bodied individual's right to end her life is a rather unexciting endeavour, given that it will usually be extremely difficult to prevent or pre-empt. The rigour and fulsomeness of a right to die will be tested only by examining the distinctive ethical quandaries that arise when an individual seeks assistance from others in terminating her existence, and thus requires that the state countenance the "macabre" transaction.

The law as declared in *Aruna* presently concedes a right to die for terminally ill patients by refusing life-saving or life-preserving intervention by others. However, there is no right to be *assisted* to die, either by one's own hand or by another's intervention, variously referred to as "active euthanasia" or "assisted suicide".

Judicial reasoning, as well as public discourse, tends to accord an inordinate degree of importance to an absolutist reading of the SOL principle, which asserts

that life is regarded as sacred, regardless of whether that life contains any of the goods of human existence. Uncritical deference to this version of the SOL principle would indeed make the very idea of any form of assisted suicide unimaginable. Yet, on closer examination, it can be shown that the law does not in fact countenance an untrammelled notion of the SOL principle. This has important implications for our case, as also for the laborious, yet unsustainable, distinction drawn between passive and active euthanasia.

Thus, the basic purpose of this article is to demonstrate that the SOL principle has already been compromised to such an extent as to render its continued influence tenuous, at best. It also seeks to argue that the ethical and jurisprudential foundation for extending the right to die to encompass assisted suicide or active euthanasia in controlled circumstances already exists in the present framework. However, truly vulnerable persons at the "margins of existence" – those incapable of ending their lives because of mental incompetence or physical disability – are unjustly pre-empted from availing of the right to die in its plenary form.

Revisiting the 'SOL' Principle

The SOL principle is often mistakenly conflated with what John Keown (2006) has called "vitalism", which is the idea that human life should be preserved at all costs. What the SOL principle in fact proscribes is the deliberate destruction of human life; it does not demand that life should always be prolonged for as long as possible. It might therefore be argued, as Emily Jackson (2008: 126) cogently does, that the law's recognition that withdrawal of life-prolonging treatment is sometimes legitimate is not so much an exception to the SOL principle, as an *embodiment* of it.

In the most secular judicial interpretation of the SOL doctrine yet, Denman J of the UKHL explicated thus:

> In respecting a person's death, we are also respecting their life – giving it sanctity...A view that life must be preserved at all costs does not sanctify life...To care for the dying, to love and cherish them, and to free them from suffering rather than simply to postpone death is to have fundamental respect for the sanctity of life and its end.[8]

Hence, as the process of dying is an inevitable consequence of life, the right to life necessarily implies the right to have nature take its course and to die a natural death. It also encompasses a right, unless the individual so wishes, not to have life artificially maintained by the provision of nourishment by abnormal artificial means which have no curative effect and which are intended merely to prolong life.[9]

Furthermore, as was held by the UKHL in *Bland,* SOL is only one of a "cluster of ethical principles"[10] which we apply to decisions about how we should live. Another major determinant is respect for the individual, and for individual autonomy or the right of self-determination. "Erring on the side of life" as a default rule in this context often results in violating a person's body and human dignity in a way few would wish upon themselves (Annas 2005). Erring on the side of liberty – specifically, the patient's right to decide on treatment – is arguably more consistent with constitutional traditions in most democracies (ibid). The Massachusetts Supreme Judicial Court[11] has held that the right to privacy is a further personification of the

sacredness of individual free choice and self-determination as fundamental constituents of life. The Indian Supreme Court has also held that the right to privacy is embedded in the right to a dignified life, as per Article 21 of the Constitution.[12] The value of life as so perceived is lessened not by a decision to refuse treatment, but by the failure to allow a human being the right of choice.[13]

In fact, the strongest refutation of the alleged inviolability of the SOL principle lies in the fact that competent adults have the right to refuse any medical treatment, including life-sustaining treatment, as emphatically recognised by the Supreme Court in *Aruna*.[14] It is counter-intuitive to suggest that incompetent adults do not retain a similar interest in self-determination. Competent adults can even execute an advance directive stating their wishes and designating a person to act on their behalf,[15] and physicians can honour these wishes.

It goes without saying that the law must strenuously avoid any form of discrimination against incompetent patients. Insistence on laudable but therapeutically useless measures is no more justified for the incompetent patient than it is for the competent. As was cautioned in *Bland,* an individual's incapacity, together with the absence of an advance directive, should not serve as a basis for denying her the rights or freedoms which competent patients enjoy in the exercise of their right to privacy and self-determination. This would effectively render the incompetent patient a "second class citizen".[16]

Thus, in case the incompetent patient's desires cannot be ascertained, we can and should resort to the devices that the law has already evolved to ensure respect for the privacy, dignity and bodily integrity.[17] The approaches presently available to us include: (i) the "substituted judgment" test, whereby the decision-maker is required to act as a surrogate for the incompetent patient and to determine what decision the patient would have reached had she been able to do so; and (ii) the "best interests" test, whereby the decision-maker is required to follow whatever course is in the best interests of the incompetent patient. In other words, where it is not possible to know the patient's wishes, the decision-maker, rather than the patient, has to act reasonably to decide what is, in an objective sense, in the patient's best interests.[18] The latter approach has been explicitly approved by the Supreme Court in *Aruna*.[19]

A Moral Paradox

Several commentators have justified the active/passive distinction by averring that there is an important moral difference between killing a patient by administering, say, a lethal injection, and withdrawing treatment which is currently keeping her alive. Active euthanasia, runs the argument, interferes with nature's dominion, whereas withdrawal of treatment restores to nature her dominion.[20]

Here too, an absolutist version of the SOL principle rears its unseemly head. In a plethora of cases in the UK, a course of action which would lead to the patient's death was held to be compatible with the "best interests" test. Indeed, a majority in the House of Lords in *Bland* explicitly accepted that the doctors' *intention* in withdrawing artificial nutrition and hydration was, in Lord Browne-Wilkinson's words, to "bring about the death of Anthony Bland".[21] Lord Lowry said that "the intention to bring about the patient's death is there"[22] and Lord Mustill admitted that "the proposed conduct has the aim...of terminating the life of Anthony Bland".[23] In each case, however, life could be brought to an end only because the doctors had recourse to a course of action which could plausibly be described as a "failure to prolong life".

The SOL principle thus works insidiously to ensure that only certain types of death – namely, those achieved by suffocation, dehydration, starvation and infection, through the withdrawal or withholding of, respectively, ventilation, artificial nutrition and hydration, and antibiotics – can lawfully be brought about. More crucially, the SOL principle prohibits doctors from acting to achieve that end quickly, and more humanely, by the administration of a single lethal injection.[24]

Lord Browne-Wilkinson lamented this paradox in *Bland* in the following words:

> How can it be lawful to allow a patient to die slowly, though painlessly, over a period of weeks from lack of food but unlawful to produce his immediate death by a lethal injection, thereby saving his family from yet another ordeal to add to the tragedy that has already struck them? I find it difficult to find a moral answer to that question.[25]

As Simon Blackburn (2001) puts it, differentiating between withdrawal of treatment and killing may salve some consciences, but it is very doubtful whether it ought to. It often condemns the subject to a painful, lingering death, fighting for breath or dying of thirst, while those who could do something stand aside, withholding a merciful death.

Conclusions

In *Aruna*, the Supreme Court made precious little attempt to engage with the fallacious moral contours of the active-passive distinction. There are thus strong grounds to believe that the active-passive distinction is not grounded so much in morality or ethics as in "reasons of policy", to quote Lord Goff of Chievely in *Bland*.[26] In *Aruna*, concern for the actor's culpability under the IPC as the cause of death appears to be the animating force for adopting the active-passive distinction. A supplementary factor may be the Court's desire to avoid accusations of overstepping its boundaries, and relegating a volatile matter entailing a positive act designed to kill, to the popularly elected legislature's domain.

It is important to emphasise that I am not asserting that it is practically possible or desirable to legalise active euthanasia in India, as yet. Such a step would entail a complex policy debate regarding the availability of palliative and hospice care for terminally ill patients,[27] and necessitate stringent safeguards to protect vulnerable patients from unscrupulous relatives or doctors. The significance of what has been argued above is simply to highlight the fallacy inherent in drawing an ethical distinction between passive and active euthanasia.

NOTES

1 See, for example, Vincent (2011).
2 Article 21 of the Constitution (1950) guarantees that no person shall be deprived of his life or personal liberty, except according to procedure established by law.
3 See the arguments of the Petitioner in *C A Thomas Master vs Union of India*, 2000 Cri LJ 3729 (Ker).
4 MANU/SC/0176/2011.
5 [1993] AC 789.
6 Supra 1 at [41].
7 Ibid at [28].

8 Denman, J in *Osman vs United Kingdom*, (1998) 29 EHRR 245.
9 *In Re A Ward of Court*, [1995] 2 ILRM 401.
10 Supra 2 at 826.
11 *Superintendent of Belchertown State School vs Saikewicz*, 373 Mass 728, 742, 370 NE 2d 417 (Massachusetts 1977).
12 See *R Rajagopal vs State of Tamil Nadu*, (1975) 2 SCC 148.
13 Supra 17.
14 Supra 1 at [53].
15 An advance directive is a document in which the individual specifies what action should be taken in the event of her incapacity. See further, Dressing (2003).
16 Supra 2.
17 It is a civil wrong, and may be a crime, to impose medical treatment on a conscious adult of sound mind without his or her consent. See *In Re F (Mental Patient: Sterilisation),* [1990] 2 AC 1.
18 Supra 2 at 851.
19 Supra 1 at [96].
20 See, for example, McGee (2005).
21 Supra 17 at 881.
22 Ibid at 876.
23 Ibid at 887.
24 Supra 8.
25 Supra 2 at 885.
26 Supra 2 at 866.
27 See Prakash (2011) in *The Hindu.*

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