of Death phase 1 participants, in collaboration with the World Health Organization. International guideline development for the determination of death. *Intensive Care Med.* 2014;40(6):788–97. doi: 10.1007/s00134-014-3242-7. Epub 2014 Mar 25.
39. Asian demography.The flight from marriage [cited 2015 November 7]. Available from: http://www.economist.com/node/21526329
40. Ageing.The kin and I [cited 2015 November 7]. Available from: http://www.economist.com/news/china/21662594-state-unprepared-rising-numbers-old-people-living-alone-kin-and-i
41. Gandhi A. Landscape of the Individual [cited 2015 November 7]. Available from: http://indianexpress.com/article/opinion/columns/landscape-of-the-individual/
42. Chopra J. India: not a Country to die in [cited 2015 December 16]. Available from: http://latikaroy.org/jo/2015/10/india-not-a-country-to-die-in/
43. The quality of death.Ranking end oflife care across the world. A report of Economic Intelligence Unit, Lein Foundation; 2010 [cited 2015 November 7]. Available from: http://www.virtualhospice.ca/Assets/Quality%20of%20Death%20Ranking%202010_20100915182153.pdf
44. The 2015 Quality of Death Index. Ranking palliative care across the world. A report of Economic Intelligence Unit, Lein Foundation; 2015 [cited 2015 November 10]. Available from: http://www.ara.cat/societat/EIU-Quality-Death-Index-FINAL_ARAFIL20151006_0002.pdf
45. Government of India, Law Commission of India, Passive Euthanasia – A Relook, Report No. 241, August 2012 [cited 2015 November 13]. Available from: http://lawcommissionofindia.nic.in/reports/report241.pdf
46. Beauchamp TL, Childress JF (eds). *Principles of Biomedical Ethics*, 7th ed. ISBN: 9780199924585.Oxford University Press; 2013.
47. Pope TM, West A. Legal briefing: voluntary stopping eating and drinking. *J Clin Ethics.* 2014 Spring;25(1):68–80.
48. Sanyas is civil death under Indian law: SC [cited 2015 December 20]. Available from: https://24x7news.wordpress.com/2009/06/10/sanyas-is-civil-death-under-indian-law-sc/
49. Euthanasia in the Netherlands.Euthanasia, assisted suicide and non-resuscitation on request [cited 2015 November 9]. Available from: https://www.government.nl/topics/euthanasia/contents/euthanasia-assisted-suicide-and-non-resuscitation-on-request
50. Organ sales 'thriving' in China [cited 2015 November 9]. Available from: http://news.bbc.co.uk/2/hi/asia-pacific/5386720.stm
51. Myatra SN, Salins N, Iyer S, Macaden SC, Divatia JV, Muckaden M, Kulkarni P, Simha S, Mani RK. End-of-life care policy: an integrated care plan for the dying: a Joint Position Statement of the Indian Society of Critical Care Medicine (ISCCM) and the Indian Association of Palliative Care (IAPC). *Indian J Crit Care Med.* 2014;18(9):615–35. doi: 10.4103/0972-5229.140155.
52. Gawande A. What doctors don't learn about death and dying [cited 2015 December 15]. http://ideas.ted.com/death-and-the-missing-piece-of-medical-school/
53. Mani RK, Amin P, Chawla R, Divatia JV, Kapadia F, Khilnani P, Myatra SN, Prayag S, Rajagopalan R, Todi SK, Uttam R. Guidelines for end-of-life and palliative care in Indian ICUs: ISCCM consensus ethical position statement. *Indian J Crit Care Med.* 2012;16(3):166–81. doi: 10.4103/0972-5229.102112.
54. Mani RK. Constitutional and legal protection for life support limitation in India. *Indian J Palliat Care.* 2015;21(3):258–61. doi: 10.4103/0973-1075.164903.

Passive euthanasia in India: a critique

ROHINI SHUKLA

Abstract

Given its preoccupation with the doctor's agency in administering euthanasia, the legal discourse on euthanasia in India has neglected the moral relevance of the patient's suffering in determining the legitimate types of euthanasia. In this paper, I begin by explicating the condition for the possibility of euthanasia in terms of the following moral principle: the doctor ought to give priority to the patient's suffering over the patient's life. I argue that the form of passive euthanasia legally permissible in India is inconsistent with this moral principle, owing to the consequences it entails for the patient.

Inevitably, it is acts of commission on the part of the doctor that can provide the best possible death, which is the moral objective of euthanasia. To meet this objective, doctors must be seen as agents who possess the moral integrity and technical expertise to judge when and how the patient's life ought to be terminated, depending on the patient's medical condition. They are not bound to save lives and provide care unconditionally.

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Introduction

For over 40 years – precisely 41 years and 173 days, for not a moment of suffering ought to be discounted, Aruna Shanbaug remained locked up in ward number 4 of KEM hospital, Parel, Mumbai. Her struggle to die ended on May 18, 2015. The absence of bed sores on Aruna's dying body was celebrated and the nurses' tremendous "attachment" to her was much exalted. All this, despite the bitter fact that Aruna lived a life, to use Peter Singer's words, "so miserable as not to be worth living" (1).

In March 2011, owing to Pinky Virani's indefatigable efforts, the Supreme Court of India deemed passive euthanasia legal. A detailed discussion of the different ways of implementing passive euthanasia is due, given the equivocality of the term in the legal document. I hope to throw some light on several inconsistencies in the verdict's arguments in favour of passive euthanasia (and against active euthanasia). Beyond the legal debates that ensued, euthanasia needs serious moral reflection in India.

We seem to intuitively understand that the pain of aching knees is qualitatively different from the pain of chronic cancer,

paralysis or coma. Perhaps it is impossible to analyse and define what this difference really is, both in medical and moral terms. Despite this ambiguity, the medical fraternity must deal intimately with pain – by studying its causes as well as the preventive, curative and healing measures, by treating it and by simply witnessing it. By virtue of their profession, are doctors morally obliged to "care" for patients, "heal" their pain and thereby, sustain their lives "unconditionally"? It is important to note at the outset that the discourse on euthanasia begins by answering this question in the negative; thence follows another, more perplexing question. What are the morally permissible methods of implementing euthanasia, given that the patient is certain to die a slow and painful death because of her/his irreversible medical condition (like that of Aruna)?

In this paper, I begin by explicating the condition for the possibility of euthanasia in terms of the following moral principle: the doctor ought to give priority to the patient's suffering over the patient's life. I argue that the form of passive euthanasia that has been legally permissible in India since 2011 is inconsistent with this moral principle, owing to the consequences it entails for the patient. Inevitably, it is acts of commission on the part of the doctor that can provide the best possible death, which is the moral objective of euthanasia. In order to meet this objective, doctors must be seen as agents who possess the moral integrity and technical expertise to judge when and how the patient's life ought to be terminated, depending on the patient's medical condition.

Moral integrity and euthanasia

Imagine a reckless doctor, who does not care whether her/his patients die or continue to live in pain. S/he will neither take responsibility for the consequences of her/his actions, nor will s/he feel morally implicated if the patient expresses her/his wish to die. Regardless of whether doctors perceive their decisions as morally fraught however, they remain moral agents because their actions (commissions and omissions alike) affect the patient's condition in some way or the other. Taking as a given the essential moral agency of the doctor, whether reckless or otherwise, we must begin by inquiring into what makes euthanasia an ethical dilemma in the first place.

Euthanasia presupposes what Dhanvanti Nayak and Sundar Sarukkai call "integrity"(2) in medical practice and discourse. A person with moral integrity, unlike our imagined reckless doctor is "one who sticks to her/his principles despite other pressures and temptations" (2).The important question then is: what are the moral principles implicit in euthanasia that guide the actions of doctors with integrity? The etymology of euthanasia does not make any such principle explicit, for it leaves unanswered the practical question of how an easy and painless death is to be delivered.

The fundamental moral principle – fundamental in the sense that it is the very condition for the possibility of euthanasia as a medical practice – is that the patient's suffering ought to be prioritised over the patient's life. In this sense, the concept of euthanasia stands as an exception in medical discourse; the patient's aliveness is presupposed by the effectivity of medical treatment, but with respect to euthanasia, there is an intended reversal. Euthanasia considers the act of ending life to be the treatment, for it alone leads to the end of suffering desired by the patient. Life is not presupposed but surrendered, to make the treatment possible. It is important to note that the irreversibility of the patient's condition is central to this reversal. As we will see, this moral principle of prioritising the patient's suffering over the patient's life, given the irreversibility of her/his medical condition, provides effective guidelines for deeming only certain ways of implementing euthanasia morally legitimate.

Let us begin by revisiting some of the arguments made in the 2011 verdict that legalised passive euthanasia in India.

Revisiting the 2011 verdict

In 2011, the verdict of the Supreme Court bench comprising Justices Markandey Katju and Gyan Sudha Misra distinguished between active and passive euthanasia in the following manner.

Active euthanasia entails the use of lethal substances or forces to kill a person, eg a lethal injection given to a person with terminal cancer who is in terrible agony. Passive euthanasia entails withholding of medical treatment for continuance of life, eg withholding of antibiotics where without giving it a patient is likely to die, or removing the heart lung machine, from a patient in coma (3).

Besides making a deliberate attempt to debase active euthanasia by using words such as "force" and "kill", the verdict is flawed on two serious counts regarding the distinction it makes between active and passive euthanasia. First, no distinction is made between the different types of passive euthanasia. Throughout the document, the words "withholding" and "withdrawing" are used interchangeably. There is, however, a subtle difference between the two, which is relevant to the larger distinction between active and passive euthanasia. Withholding life support implies that crucial medical intervention is restrained, for example, not performing a kidney transplant when it is necessary for the patient's survival. This would involve acts of omission on the part of the doctor. Withdrawing life support, on the other hand, implies suspending the medical intervention that is already operative to sustain the patient's life. This would involve acts of commission; in Aruna's case, the legal document acknowledges that withdrawing medical intervention would include stopping food supply. We must note that the doctor is fully aware of the fact that death is a highly likely consequence of withholding or withdrawing medical support.

Now, if the criterion for distinguishing passive from active euthanasia is the doctor's agency, that is, if in passive euthanasia the doctor only passively commits acts of omission, while in active euthanasia the doctor actively commits acts of commission, then withdrawing medical treatment would be a

form of active and not passive euthanasia. In the section titled "Legal Issues: Active and Passive Euthanasia", the verdict focuses on the question of the doctor's agency in distinguishing between active and passive euthanasia. This is evident in the crude analogy drawn between a doctor conducting passive euthanasia and a person who is (merely) witnessing a building burn. Passive euthanasia as per the verdict is equivalent to "simply not saving" (3) the patient, which is presumably morally unproblematic because failing to save is "normally" (3) not condemned, whereas killing is. By implication, just as a person who is watching a building burn, and is not actively saving trapped people cannot be prosecuted "for failing to save a life", (3) a doctor cannot be prosecuted for failing to save the patient after medical support has been withdrawn or withheld.

The point is if the doctor's being an active agent in performing euthanasia is the reason for condemning active euthanasia, then the same reasoning deems passive euthanasia as defined in the verdict condemnable. How then does the verdict claim that passive euthanasia is morally justifiable, while active euthanasia is not?

In both cases, the doctor is aware that her/his omissions or commissions will in all likelihood lead to the patient's death. One can never predict with indubitable certainty that death will be the only consequence in passive euthanasia, and as we will see, this uncertainty makes defending passive euthanasia all the more problematic; nevertheless, the likelihood is crucial. The verdict, rather conveniently, sidesteps discussing the moral relevance of the difference between active and passive euthanasia in terms of the doctor's agency (which is highlighted elsewhere in the verdict through the analogy mentioned above). Instead, the verdict holds that only the latter is morally justifiable based on a dubious deontological claim that in passive euthanasia the doctor's intention is to continue the patient's life, rather than to end it intentionally. Now, if the intention of the doctor is to continue the patient's life, then why should s/he withhold or withdraw medical treatment as a kind of euthanasia?[1] Besides if the moral justifiability of passive euthanasia is based on the doctor's wishing to continue the patient's life, then it is not a form of euthanasia at all. Since euthanasia implies that the doctor intends to deliver the best possible death for the sake of releasing the patient from suffering, then by virtue of the doctor's intention to continue the patient's life, that particular treatment ceases to be euthanasia.

Interestingly, the verdict discusses physician-assisted suicide or "physician-assisted killing" (3) very briefly, without attempting a moral evaluation. The laws allowing physician-assisted suicide operative in the Netherlands, Switzerland, Belgium and the American states of Washington, Oregon and Montana are reviewed in the verdict, but only in a sketchy manner. The verdict dismisses physician-assisted suicide as irrelevant to the discussion of euthanasia in India because Section 309 of the Indian Penal Code considered any form of suicide a criminal offence in 2011.[2]

The second, and to my mind, the most crucial flaw in the legal discussion about the types of euthanasia is reflected through what is considered the most persuasive argument against passive euthanasia. The patient slips far into the background, and it is as if the effects of euthanasia on everyone but the patient are important.

In case hydration or food is withdrawn/withheld from Aruna Ramchandra Shanbaug, the efforts which have been put in by batches after batches of nurses of KEM Hospital for the last 37 years will be undermined. Besides causing a deep sense of resentment in the nursing staff as well as other well wishers of Aruna Ramchandra Shanbaug in KEM Hospital including the management, such acts/omissions will lead to disheartenment in them and large scale disillusionment (3).

This reasoning is followed by absurd claims and sweeping generalisations, such as "Indian society is emotional and care-oriented"(3) and the "unfortunate low level of ethical standards to which our society has descended, its raw and widespread commercialisation, and the rampant corruption" (3) is lamented.

Owing to an undeserved preoccupation with the doctor's agency in administering different types of euthanasia, the verdict ignores the two most fundamental ethical concerns of euthanasia, the patient's suffering, and the moral principle that guides the doctors' integrity in treating such suffering. If the doctor is to maintain her/his integrity, the patient's suffering must be accorded priority over the patient's life, which in turn, needs to be given priority over the doctor's agency. Only then can the different types of euthanasia be evaluated in terms of which method is best suited for a particular patient's medical condition. For instance, a patient who has cancer of the digestive tract cannot swallow the lethal drink, so the lethal injection would perhaps be the best way of carrying out euthanasia. If, on the other hand, a patient is paralysed, or is unable to inject her/himself for other reasons, then the lethal drink might be better suited.

Passive euthanasia: is it really euthanasia?

Going back to the question of passive euthanasia, one may ask, what happens to a patient when medical support is withheld or withdrawn? This remains an important question because, despite the inconsistencies in the arguments put forward by the verdict, passive euthanasia is the only way to legally administer euthanasia in India. The 2011 verdict considered Aruna's case as the model case to evaluate the morality of euthanasia. She was partially brain dead and in all significant aspects, could be said to have been in coma (6).[3] Withholding life support was not possible in her case, because KEM hospital had been providing her medical support for about 42 years. Withdrawing medical support was the only option, and if it had been done, Aruna would have, in all likelihood, suffocated to death, or died after suffering in other excruciating ways. Thus, passive euthanasia would have lead to an unnecessary amplification of her pain for an indeterminate period of time. In what way could this

be the best possible death? And how would it uphold the moral principle of prioritising the patient's suffering over her life? Had the Supreme Court taken into account these consequences of passive euthanasia for the patient, perhaps active euthanasia and physician-assisted suicide might have seemed worthy of more than a quick dismissal.

Since Aruna was unable to communicate there would have been no scope for us to know what she went through had medical support been withdrawn. The case of Cody Curtis (4) will help us understand better. Cody was diagnosed with liver cancer. Despite multiple operations and regular medications, she suffered a relapse and at the age of 52, she expressed the wish to discontinue living. At first, she thought she would allow life to take its natural course by asking for medical support to be withdrawn, and instead of killing herself artificially by drinking the lethal drug, she preferred to just "slowly drift off" (5). But she realised eventually that drifting off by allowing nature to take its course was too unbearable to live through. Her body was dependent on an equivalent of 10 mg of intravenous morphine per hour, for three weeks, and yet she was unable to bear the pain. She revised her decision and opted for physician-assisted suicide, using Oregon's Death with Dignity Act.

One's decision to opt for euthanasia is not solely based on the present experience of pain; it is made in anticipation of a miserable death. The verdict does not acknowledge the value of legalising euthanasia to give patients who are chronically ill (like Cody Curtis) and older patients, who fear slipping into a state in which they would be unable to communicate the kind of death they desire, the security of dying with dignity. Euthanasia allows patients to gain control over the way death occurs when medical conditions pose a real threat to their future well-being. Passive euthanasia, however, owing to its consequences for the patient, fails to confer such control.

Concluding remarks

Notwithstanding the verdict's arguments in favour of passive euthanasia, acts of commission on the part of doctors are inevitable, if the best possible death is to be provided. Only if the patient's suffering is prioritised over the patient's life, would it become clear that passive euthanasia defeats the very purpose of euthanasia by unnecessarily prolonging a miserable life till death finally takes over. We need to abandon the overwhelming preoccupation with the doctor's agency in administering euthanasia, to ensure that euthanasia is not reduced to another way of dying in misery.

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Notes

1 The verdict is not consistent regarding what the doctor's intention is in performing passive euthanasia. To begin with it says the intention is "continuance of life" (3) and later it says, "Passive euthanasia is usually defined as withdrawing medical treatment with a deliberate intention of causing the patient's death" (3).

2 Suicide was decriminalised in 2014.

3 For a detailed description of Aruna'smedical condition, see: Virani Pinky. Aruna's story: the true account of a rape and its aftermath. Pune: Penguin Books; 1998. 18-84 pp.

References

1. Singer P. *Practical ethics*. 2nd ed. Melbourne: Cambridge University Press; 1993.
2. Nayak D, Sarukkai S. Integrity in medical practice. *Indian J Med Ethics.* 2014 Oct–Dec;11(4):203–5
3. Aruna Ramchandra Shanbaug vs Union of India & Or on 7 March, 2011. Writ Petition (Criminal) No, 115 of 2009 [cited 2015 Jun 12]. Available from: http://indiankanoon.org/doc/235821/
4. Richardson, P. How to die in Oregon [documentary]. Clearcut Productions. English. 2011.
5. Dixon N. On the difference between physician-assisted suicide and active euthanasia. *Hastings Cent Rept.* 1998 Sep-Oct;28(5):25–9.
6. Virani P. *Aruna's story: the true account of a rape and its aftermath*. Pune: Penguin Books; 1998. 18-84 pp.

Aruna Shanbaug and the right to die with dignity: the battle continues

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Abstract

Aruna Shanbaug's protracted continuance in a persistent vegetative state (PVS) for nearly 42 years needs to be viewed seriously by all those who believe in a person's inalienable right to dignity in dying. A terminally ill and/or incapacitated individual is a helpless person confronted with perpetual risk of intrusion in to his autonomy by the moral paternalists, owing to false notion of human virtues. Legislative inadequacy coupled with judicial heterogeneity has exposed the decision making process to unwarranted ambiguity. Misapplication of moral and juristic principles is a global challenge. 29-year-old Brittany Maynard's recent act of ending her life by migrating from California to Oregon has ignited a fierce debate and nearly half of the states

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