# How not to Talk about Passive Euthanasia: A Lesson from India

Iain Brassington

CSEP/ Law,

University of Manchester

Oxford Road

Manchester

M13 9PL

UK

+44 (0)161 275 35 63

[iain.brassington@manchester.ac.uk](mailto:iain.brassington@manchester.ac.uk)

Competing interests

None

Funding received

None

Similar work

Section 2 gives a brief rehearsal of the definitions of passive euthanasia that is developed at more length in my “What Passive Euthanasia Is”, currently under review in another journal.

Abstract

The 2011 *Shanbaug* case has proved to be very important in shaping the debates about end of life care, and about assisted dying, in India. Ostensibly dealing with the question of whether it was permissible to withdraw treatment from a patient in PVS, it became a case about the legality of passive euthanasia; this is how it was treated by the Law Commission of India in 2012, and by the bench considering the *Common Cause* case in 2018. However, questions about the legality of passive euthanasia depend on having a coherent definition of “passive euthanasia”; in this paper, I argue that such a definition was absent from both the *Shanbaug* and the *Common Cause* rulings. As a result, they are highly unreliable.

# How not to Talk about Passive Euthanasia: A Lesson from India

## Introduction

Much ink has been spilled and many words uttered on the moral questions raised by end-of-life care. The debate has taken place in academic journals and seminar rooms, but also in legislatures and courtrooms around the world. Often, and particularly in respect of euthanasia, these contributions generate more heat than light – and sometimes precious little heat. Part of the reason for this is that there is a degree of unclarity in some of the terms used. My aim here is not to contribute to the normative debate about whether and in what circumstances euthanasia or assisted suicide should be permitted. Rather, it is to examine the way that the term “passive euthanasia” has been used – or, arguably, *mis*used – in the Indian legal system. I should say at the outset that I do not think that the problem I shall articulate is confined to the Indian legal system; but it is in India that we find a particularly good example – if “good” is the word – of it.

What I want to show is that a number of important statements about the legality of passive euthanasia in India are less clear, and therefore potentially less legally robust, than the people making them might have hoped, because they fall victim to the fallacy of equivocation: that is, of failing to recognise that a term “passive euthanasia” has two distinct meanings, and of sliding between them.

In the next section, I shall spend a little time considering the definition of “euthanasia”, and how we may categorise that into active and passive euthanasia; and I shall look also at a few examples of how the term “passive euthanasia” has been referred to in the ethical and medico-legal literature. The argument presented in those paragraphs is an abbreviated version an argument I make in greater depth elsewhere.[[1]](#footnote-1) Subsequently, I shall consider how the phrase has been handled in a couple of cases brought before the Supreme Court of India, and by the Law Commission of India, and why it matters.

## Defining Euthanasia(s)

Heather Draper’s definition of euthanasia has become something of a touchstone in the literature, and I shall take it as my jumping-off point here. For her, a death by euthanasia

must be defined as death that results from the intention of one person to kill another person, using the most gentle and easy means possible, that is solely motivated by the best interests of the person who dies.[[2]](#footnote-2)

This definition can probably be simplified a touch. That the death be brought about owing to a motivation to secure the best interests of the one who dies I take to be axiomatic and crucial to understanding euthanasia. (Even if one thinks that euthanasia represents a serious wrong, it seems reasonably straightforward to accept that it is markedly different from, say, killing by assassination, since the assassin does not have any concern for the best interests of his victim.) But since it would always be in the best interests of the one who dies for the most gentle and easy means possible to be used, we can add to this, and say that intentional killing that does not make use of the most easy means available is not euthanasia proper: it is, perhaps, attempted euthanasia at best. As such, for the sake of this paper, I shall understand euthanasia to be the intentional ending of one person’s life by another, motivated solely by the best interest of the one who dies. Call this “Definition 1”.

We may add to this a distinction between *active* and *passive* euthanasia, which terms refer respectively to instances of euthanasia in which a death is brought about that is not otherwise imminent, and those in which the barriers to an otherwise-imminent death are removed. Acccordingly, two more definitions might be offered:

**Definition 2:** Active euthanasia is the intentional ending of one person’s life by another, motivated solely by the best interest of the person who dies, through the deliberate administration of a life-ending substance or procedure;

and

**Definition 3:** Passive euthanasia is the intentional ending of one person’s life by another, motivated solely by the best interest of the person who dies, through the deliberate withholding of a life-preserving substance or procedure.

In a previous edition of this journal, Rohini Shukla has made the interesting suggestion that there might be an important moral distinction to be drawn between withholding and withdrawing treatment[[3]](#footnote-3); for the sake of this paper, I shall note that point, but put it to one side, and treat “withholding” to cover both situations in which a treatment regime is not begun, and situations in which a treatment regime once begun is removed. Accordingly, withdrawal of treatment should be thought of as withholding it *from this time forward*. The important point at the moment is that the difference between active and passive euthanasia is the difference between intentionally ending a life by adding something that otherwise wouldn’t be there, and intentionally ending a life by removing something that otherwise could be.

While there is no dispute that all passive euthanasia is letting die by withholding treatment, it does not follow that passive euthanasia and letting die by withholding treatment can be identified – that is, that all withholding is passive euthanasia. However, there is a significant number of commentators who do seem to be prepared to make that move, and to endorse the claim that any letting die by withholding treatment is passive euthanasia. For example, Jukka Varelius thinks of withholding treatment as passive euthanasia[[4]](#footnote-4); on an archived web-page, undated but copyrighted to 2014, the BBC states that

[p]assive euthanasia occurs when the patient dies because the medical professionals either don't do something necessary to keep the patient alive, or when they stop doing something that is keeping the patient alive.[[5]](#footnote-5)

In a sense, this is straightforward: this is what happens when someone commits passive euthanasia. However, the clear implication is that passive euthanasia occurs whenever someone withdraws or withholds life-sustaining treatment. That is less obvious. Nevertheless, it would appear that there are at least some sources in which the understanding of passive euthanasia can be understood as follows:

**Definition 3\*:** Passive euthanasia is the ending of one person’s life by another, motivated solely by the best interest of the person who dies, through the deliberate withholding of a life-preserving substance or life-preserving procedure.

The difference between Definition 3 and Definition 3\* lies in the necessity for there to be an intention to end life. Under Definition 3, such an intention is necessary; under Definition 3\*, it is not. Plainly, we cannot cleave to both: we have to jump one way or the other; and laws about passive euthanasia should do so also.

I have argued elsewhere that there are compelling moral reasons to prefer Definition 3 to Definition 3\*.[[6]](#footnote-6) However, my argument in this paper does not depend on choosing a definition. Rather, it rests on the contention that the law should choose one definition and stick to it. As such, it might be that within a given legal system, Definition 3\* of passive euthanasia is the one that holds. What matters for my current purposes is that it is important that it *does* hold, so that people who are governed by the law stand a chance of knowing what it is.

## Passive Euthanasia in Indian Law: The Shanbaug Case

The development of the law surrounding passive euthanasia in India provides an interesting example of how these definitions play out in the “real world”. The matter crystallised in 2011, in the *Shanbaug* case.[[7]](#footnote-7)

*Shanbaug* concerned a woman, Aruna Ramachandra Shanbaug, who, after a particularly brutal sexual assault, had been left in a persistent vegetative state for almost 40 years. The question before the Court concerned whether leave should be given to halt artificial nutrition. In many ways, the case reflected the English case of *Bland*, to which Katju J referred at length in his judgment, and which concerned the withdrawal of nutrition and hydration from a man who had been in a persistent vegetative state since being crushed in the Hillsborough disaster a shade under four years previously.[[8]](#footnote-8) (I shall return to the judgment from this case in a while, but note in the meantime that a significant difference between the two cases is that, in *Bland*, the medical staff were willing to remove treatment, and were seeking clarity about the legality of so doing; in *Shanbaug*, the petition was brought by a third party, the writer Pinki Virani.[[9]](#footnote-9)) What was not clear was whether this would be permissible under the terms of the Constitution’s Article 21 guarantee of a right to life.

Guarantees of a right to life might be understood in a number of ways, which we might place on a kind of mental spectrum. At one end of the spectrum is a “very hard” reading of the right, according to which individuals would be expected to preserve their own lives, as well as the lives of others. (Declaring someone a *felo de se* might be understood in this sense as reflecting the idea that he had violated a rule against self-preservation.) Moving along the spectrum from a very hard to a merely hard reading, it may mean that there is an overriding duty on all individuals to act to preserve the lives of all other individuals, such that to allow someone to die would be to violate their right to life. By contrast, a soft reading of the right to life may mean that there is a duty on individuals to act to preserve the lives of all other individuals up to a certain limit of reasonability. What is reasonable may change depending on who the protagonists are: maybe what is reasonable to expect from doctors in an emergency room is different from what is reasonable to expect from other people in other circumstances;[[10]](#footnote-10) but it may be reasonable even for doctors to give up the fight in some circumstances. And a still-softer reading may mean simply that each of us has a right bankable against others that they not take our life. Having settled on a reading – it does not matter at this point which we choose – we may then wonder whether the right is waivable. Katju J noted in his speech in *Shanbaug* that attempting suicide is a criminal offence in India under s. 309 of the Criminal Code;[[11]](#footnote-11) this would seem to suggest that the right to life is non-waivable.[[12]](#footnote-12) But to say that a right to life is non-waivable would appear to be to set about the task of transforming a right to life into an obligation to live – which is to say, not a right at all.[[13]](#footnote-13) And even if the right is waivable, it does not follow automatically that others may assist a person in ending their own life, or that they may end it at the request of the one who dies – although these would both be *compatible* with a waivable right to life, and the argumentative gaps could be filled in without too much difficulty.

Whichever way we cut the pie, though, the waivability or otherwise a right to life does not seem to be straightforwardly compatible with what the plaintiffs were asking in *Shanbaug*. After all, Ms Shanbaug had expressed no wish to die or to have treatment removed, and so could not be said to have waived her right to life anyway. And the fact that it was not the medical staff caring for Ms Shanbaug, but a third party, who had launched the case simply adds to the suspicions that one might plausibly have about how compatible withdrawing treatment would be with Ms Shanbaug’s constitutional rights. As such, an observer might plausibly expect that the case could have been dismissed reasonably quickly; and Katju J himself admitted that dismissal could have been warranted.[[14]](#footnote-14)

That the case was not dismissed can be attributed to the recognition that it raised important general points about end-of-life treatment, particularly concerning treatment of patients not expected to recover, that merited further consideration. Granted that Ms Shanbaug had a constitutional right to life, ought that to be taken to mean that others simply had a duty not to kill her (as would be implied by a soft reading of the right to life) or that others had a duty to take steps to preserve her life (as would be implied by a harder reading)? And, if the latter, what would it be reasonable to expect people to do in the discharge of that duty, granted that it may not be reasonable to expect medical staff to do everything conceivably possible? If there is no reasonable hope that a patient will recover, is there still a duty to treat? What if the patient’s general wellbeing is deteriorating? That is: how hard is the hard reading to be?

In trying to formulate its approach to these questions, the Bench spent a great deal of time considering euthanasia. This is no small matter. That such considerations were deemed relevant at all indicates that the Court was inclined to accept Definition 3\* – that is, that they treated the question of when it might be reasonable not to treat as being, more or less, the same as a question of when euthanasia might be permissible. After all, while it was proposed that Ms Shanbaug’s doctors should remove treatment, it does not follow from that that anyone intended her death: the petition did not mention taking other means to kill her in the event that she somehow survived the withholding of nutrition. There would be no reason to think about euthanasia at all were Definition 3 the moral and jurisprudential lodestone. And we do indeed find statements that cohere with Definition 3\*, and that lend weight to the supposition that the bench was inclined to accepting it, in Katju J’s speech. Thus:

Passive euthanasia entails withholding of medical treatment for continuance of life, e.g. withholding of antibiotics where without giving it a patient is likely to die, or removing the heart lung machine, from a patient in coma.[[15]](#footnote-15)

and

The difference between 'active' and 'passive' euthanasia is that in active euthanasia, something is done to end the patient's life while in passive euthanasia, something is not done that would have preserved the patient's life.

An important idea behind this distinction is that in 'passive euthanasia' the doctors are not actively killing anyone; they are simply not saving him.[[16]](#footnote-16)

While he admitted that not everyone is persuaded by the distinction, he said that he was.[[17]](#footnote-17) However, matters are complicated by statements Katju J made elsewhere in his speech. At paragraph 51, for example, he appeared to cleave to something much more like Definition 3, saying that “[p]assive euthanasia is usually defined as withdrawing medical treatment *with a deliberate intention of causing the patient's death*”[[18]](#footnote-18); and in the statement later in the same paragraph that “[d]enying food to a person in coma or PVS may also amount to passive euthanasia”, the word “may” is important: withholding life-sustaining interventions might, but need not, be seen as passive euthanasia. This “may” would be out of place if one were committed to Definition 3\*. Depending on which part of the speech one reads, then, Katju J’s understanding of the term “passive euthanasia” may appear to be different things – sometimes more like Definition 3, and sometimes more like Definition 3\*.

But, as I noted a moment ago, Definition 3 and Definition 3\* are mutually incompatible; and this means that we have to choose to accept one or the other. Correspondingly, moving between them without even acknowledging their incompatibility would seem to cast some doubt on the reliability of any reasoning concerning the nature of passive euthanasia. And, of course, since reasoning about the *lawfulness* of passive euthanasia depends on clarity concerning its nature, one might well expect there to be a knock-on effect there.

That said, when considering the lawfulness of passive euthanasia, Katju J noted that

while we can debate whether active euthanasia should be legal, there can be no debate about passive euthanasia: You cannot prosecute someone for failing to save a life. Even if you think it would be good for people to do X, you cannot make it illegal for people to not do X, or everyone in the country who did not do X today would have to be arrested.[[19]](#footnote-19)

A simple – perhaps simplistic – reading of this would take it at face value, and treat it as a claim that, since there are many instances in which it would be absurd to prosecute someone for not saving a life, and since passive euthanasia is not saving a life, it would be absurd to prosecute someone for passive euthanasia. But such a reading would be fallacious. After all, even if some instances of not saving a life ought not to be prosecuted, it doesn’t follow that no instance should. The fact that there are some – perhaps many – instances in which Aisha is not and ought not to be prosecuted for not saving Arjun’s life will not tell us about every possible Aisha and every possible Arjun. A lot depends on the context in which we find them, Aisha’s capabilities, and so on. More importantly, a lot seems to ride on whether we think that Aisha has an all-things-considered duty at least to try to save Arjun’s life. Indeed, though it is not made explicit, the message a little later is fairly clear:

In fact we have many laws that penalize people for what they did not do. A person cannot simply decide not to pay his income taxes, or to bother to send his/ her children to school (where the law requires sending them), or not to obey a policeman’s order to put down one’s [*sic*] gun.[[20]](#footnote-20)

The subtext here is that it may be proper to prosecute someone for not having done something, provided that it is the sort of thing that one would be expected to have a duty to do in the normal run of things. And so the question would still be one of whether the medical staff looking after a given patient had a duty to preserve that patient’s life, given that not everybody does, given what is medically possible, and so on. However, if it is decided that it would be lawful for medical staff not to administer life-saving treatment to at least some of their patients, and if not saving that life is passive euthanasia, it would follow that passive euthanasia would be (or, at least, could be) lawful in India. It is worth repeating that much here depends on accepting Definition 3\*; if one thinks that there is a class of withholding treatment that is not passive euthanasia, then the lawfulness of passive euthanasia cannot be deduced from the lawfulness of a given instance of withholding treatment without further specifying that this is the kind of withholding that is properly classed as passive euthanasia.

But having satisfied itself that a medic who does not treat in order to preserve life *is* engaged in providing passive euthanasia, the Court decided that passive euthanasia, *qua* withdrawing life-sustaining treatment from Ms Shanbaug, was potentially lawful, provided the medical staff caring for her sought and obtained the permission of the Bombay High Court.[[21]](#footnote-21)

In articulating the Court’s decision, Katju J opined that this was entirely in line with the legal position in other countries:

The general legal position all over the world seems to be that while active euthanasia is illegal unless there is legislation permitting it, passive euthanasia is legal even without legislation provided certain conditions and safeguards are maintained.[[22]](#footnote-22)

Given that relatively few states permit the intentional ending of patients’ lives, this could only be true granted Definition 3\*. And there is a reasonable number of people who would go along with the supposition that it is not uncommon to find regimes in which passive euthanasia, so long as it is understood in accordance with Definition 3\*, is legal. For example, in his hugely influential *The Value of Life*, John Harris writes that “The law […] forbids active euthanasia, but passive euthanasia is outlawed only where there is a positive duty to save life”[[23]](#footnote-23) – which implies that passive euthanasia is legal except where it is expressly forbidden. Leanne Bell writes in her 2012 textbook *Medical Law and Ethics* that “passive euthanasia involves the withholding or withdrawing of treatment from the patient, i.e. an omission rather than an act, and, in certain circumstances, *can be legal*”[[24]](#footnote-24). Similarly, Banović *et al* assert confidently that “active direct euthanasia is a forbidden way of the deprivation of the patients’ life, while its passive form is commonly accepted”[[25]](#footnote-25). Likewise, with an emphasis on Germany, Trappe asserts that

[p]assive euthanasia is the omission or reduction of possibly life-prolonging treatment measures. Passive euthanasia requires the patient’s consent and is legally and ethically permissible.[[26]](#footnote-26)

For their part, Khader and Mrayyan argue for the legal permissibility of passive euthanasia in Jordan, based on their understanding of the term to cover “allowing a patient to die by withholding treatment”[[27]](#footnote-27) – that is, based on having accepted a version of Definition 3\*.

Nevertheless, the problem should be clear. As we have seen, Katju J’s speech appears sometimes to cohere with Definition 3, and sometimes with Definition 3\*. Since the two are incompatible – intention to end life either is or isn’t part of the concept of passive euthanasia, and can’t be both – this must be seen as a potential weakness in the ruling.

## Passive Euthanasia after Shanbaug

In 2012, in the light of *Shanbaug*, the Law Commission of India published a review of the law on passive euthanasia, which proceeded on the understanding that passive euthanasia

involves withholding of medical treatment or withholding life-support system[s] for continuance of life […]. The core point of distinction between active and passive euthanasia as noted by [the] Supreme Court is that in active euthanasia, something is done to end the patient’s life while in passive euthanasia something is not done that would have preserved the patient’s life.[[28]](#footnote-28)

This is clearly reflective of Definition 3\*. And even if there had been weaknesses in the *Shanbaug* decision, statements like this would stand a decent chance of mitigating them: stipulating that, henceforward, a particular phrase or concept is to be interpreted thus and so is a perfectly workaday piece of positive lawmaking. The Commission asserted further that “[t]he Supreme Court [made] it clear that passive euthanasia is permissible in our country as in other countries”[[29]](#footnote-29). Again, even if one does not agree with those who think that passive euthanasia really is as obviously permissible in other countries as it is made out to be here, that does not really matter. After all, sovereign legislatures are free to define terms as they see fit.

*Shanbaug*’s influence was felt again in 2018, when the Indian Supreme Court ruled in the case of *Common Cause*[[30]](#footnote-30), which considered whether there was a Constitutionally-guaranteed right to die with dignity, and in which the Bench spent a great deal of time considering the jurisprudence of passive euthanasia and end-of-life treatment both in India and around the world. Whatever progress had been made by the Law Commission in shoring up a clear definition of “passive euthanasia”, however, seems not to have been quite enough: when the judgment was handed down in early 2019, there was, once again, inconsistency concerning the definition of terms – if anything, more flagrant than there had been in *Shanbaug*. Misra CJI, referring to *Shanbaug*, repeated the claim that “passive euthanasia is usually defined as withdrawing medical treatment *with a deliberate intention of causing the patient’s death*”[[31]](#footnote-31) – which reflects Definition 3. This understanding is apparently confirmed at the beginning of paragraph 44:

Euthanasia is basically an *intentional* premature termination of another person’s life either by direct intervention (active euthanasia) or by withholding life-prolonging measures and resources (passive euthanasia) either at the express or implied request of that person (voluntary euthanasia) or in the absence of such approval/consent (non-voluntary euthanasia).[[32]](#footnote-32)

However, at the end of that same paragraph, he stated that

[t]he main idea behind the distinction [between active and passive euthanasia], as observed by the Bench [in *Shanbaug*], is that in passive euthanasia, the doctors are not actively killing the patient, they are merely not saving him and only accelerating the conclusion of the process of natural death which has already commenced.[[33]](#footnote-33)

This represents a slide to Definition 3\*: an intent to end life is no longer apparently important. This is a slide that Misra CJI appears not to have noticed or tried to halt, but confirmed at paragraph 196(vi):

In active euthanasia, a specific overt act is done to end the patient‘s life whereas in passive euthanasia, something is not done which is necessary for preserving a patient's life.[[34]](#footnote-34)

Neither was it a slide resisted by the other judges hearing the case. Indeed, at paragraph 98 of his opinion, Chandrachud J said explicitly that “[i]n a case involving passive euthanasia, [t]here is neither an animus nor an intent to cause death.”[[35]](#footnote-35)

However, the slide from Definition 3 to Definition 3\* was important, since it informed the Bench’s pronouncements about the legality of passive euthanasia, which largely echoed those made in *Shanbaug*. Misra CJI asserted repeatedly that passive euthanasia is legal in several countries – for example, he said that

[i]t is perhaps due to the distinction evolved between [active and passive] euthanasia, which has gained moral and legal sanctity all over, that most of the countries today have legalized passive euthanasia either by way of legislations or through judicial interpretation but there remains uncertainty whether active euthanasia should be granted legal status.[[36]](#footnote-36)

Versions of this statement can be found throughout the opinion – and, again, attracted no demurral from other judges.[[37]](#footnote-37) Once again, the statement can only be true if we accept Definition 3\*. But it is worth noting that, in making this statement, Misra CJI – like Katju J in *Shanbaug* – drew significant support for this claim from Lord Goff’s speech in the English *Bland* case. He advanced the claim that

Lord Goff observed that passive euthanasia includes cases in which a doctor decides not to provide, or to continue to provide, for his patient, treatment or care which could prolong his life and active euthanasia involves actively ending a patient’s life, for example, by administering a lethal drug.[[38]](#footnote-38)

The problem with this is that Misra CJI is flat-out wrong.

In *Bland*, Lord Goff did point out that

the law draws a crucial distinction between cases in which a doctor decides not to provide, or to continue to provide for his patient treatment or care which could or might prolong his life and those in which he decides, for example by administering a lethal drug, actively to bring his patient's life to an end.[[39]](#footnote-39)

The latter is clearly illegal; the former may be legal. In fairness to Misra CJI, if we adhere to Definition 3\*, then this would allow us to deduce that passive euthanasia would be legal, in line with its being nothing but the non-provision of life-sustaining treatment. However, there is no reason to suppose that Lord Goff had anything like Definition 3\* in mind. Contrary to Misra CJI’s assertion, Lord Goff made no direct reference to passive euthanasia at all. What he did suggest was that

it is not lawful for a doctor to administer a drug to his patient to bring about his death, even though that course is prompted by a humanitarian desire to end his suffering, however great that suffering may be[…]. So to act is to cross the Rubicon which runs between on the one hand the care of the living patient and on the other hand euthanasia – actively causing his death to avoid or to end his suffering. Euthanasia is not lawful at common law.[[40]](#footnote-40)

The final clause of the penultimate sentence here is, I think, important: Lord Goff understands euthanasia to be nothing but actively causing death with a motivation to end suffering. He does not make any statement about the legality of passive euthanasia because, simply put, it never appears to occur to him that there might be something to say. (This understanding was repeated 2017 by Sir Ernest Ryder in his speech in *Conway*.[[41]](#footnote-41)) He does talk a little later about a doctor who “is simply allowing his patient to die of his pre-existing condition”, but he does not refer to that as killing – and therefore not as euthanasia. This doctor is, in fact, contrasted to an interloper who switches off a life-support machine and who does, nefariously in this case, intend the patient’s death.[[42]](#footnote-42) In other words, though Lord Goff gave himself the opportunity to say that withdrawing treatment would be passive euthanasia, he did not actually say it. On this basis, we may infer that he did not understand all withdrawal or withholding to be such. In other words, the Bench in *Common Cause* appears to have been inaccurate in its use of the precedent from *Bland*. Indeed, the term “passive euthanasia” is used only once in the entire *Bland* judgement, and by Lord Mustill, not Lord Goff; in this context, the term is once again understood according to Definition 3, and – though this part of the speech is a little unclear – there is no clear claim made that it would be lawful either way.[[43]](#footnote-43) In other words, in looking for an authority to back up their decisions, it would seem that the Indian judges had seriously misunderstood a case that was central to their own reasoning, and upon which they relied heavily. This ought to trouble us, because it suggests that there may be cracks in the legal edifice.

## Why this Matters

To recap: *Shanbaug* concerned the withdrawal of life-sustaining treatment; in the course of deciding that it would be permissible in principle to withdraw life-sustaining treatment in this case, Katju J saw fit to declare that, therefore, passive euthanasia was lawful in India. Yet this declaration rests on two incompatible definitions of passive euthanasia, and so it is not clear how his words should be interpreted. His opinion was incorporated into the review of the law published in 2012 by the Law Commission of India, and restated in 2018 in the *Common Cause* ruling, which – again – obscured the question of whether passive euthanasia required the intent to end life. I have suggested that a large part of this chain of legal reasoning can be attributed to a misunderstanding of elements of the English *Bland* case; and that, even putting that aside, there is a potential difficulty in working out what the findings are supposed to mean, given that they allowed for ambiguity in respect of whether the intention to end the life of the patient was a necessary part of an action’s counting as passive euthanasia.

There is a number of reasons why this might be a concern.

In the first place, there is a general point to be made that any set of laws in which the definition of a central term is unclear is likely to be vulnerable to all manner of objection as a matter of principle. In addition, though, there are reasons why we may be concerned in practice.

Had the decision in *Shanbaug* been that it was unlawful to withhold treatment because withholding treatment is euthanasia and euthanasia is illegal, a possible consequence would have been to require that people – even those capable of making decisions for themselves – be given treatment against their will; distinguishing between actions in which death is intended by medical staff and in which it is merely foreseen would have avoided that.[[44]](#footnote-44) As things stand, the Indian law escapes this particular oddity. However, the possibility that, in avoiding this particular bear-trap, Indian judges have taken a step that is very much bigger than they thought they were taking cannot be discounted.

Neither *Shanbaug* nor *Common Cause* was a case that sought to establish that medical staff may set out to end life. Neither did the Bill proposed at the end of the report of the Law Commission deal with that possibility: it was concerned with a patient’s right to refuse treatment.[[45]](#footnote-45) We may assume, then, that the judges who ruled in the cases, and the Commissioners, intended their comments and proposals to refer solely to those patients from whom it was proposed to withhold life-sustaining treatment. And yet by defining this as “passive euthanasia”, and by failing to differentiate between the intentional and merely foreseen ending of a life, the door was, apparently unwittingly, left open to their recommendations being taken as giving the green light to at least some instances of one person’s deliberately ending another’s life, potentially without the knowledge or consent of the person whose life is to be ended. A more precise definition of “passive euthanasia” that cleaved closely to Definition 3 would have helped avoid this.

Or maybe the door was not *un*wittingly left open. It is possible that the judges and the Commissioners intended their judgments and proposals to be radical – more radical than the laws in other nations from which they went through the motions of taking their lead – and that they were strategic in leaving the definition of “passive euthanasia” unclear, in order to leave the door to at least some deliberate killing open. But in that case, the difficulty would seem to be one of reconciling their positions with the Constitution. Recall that a right to life might mean – on a hard reading – that agents have a positive duty to preserve life at all costs; or it may mean – on a much softer reading – simply that there is a duty not to kill. This duty not to kill would be compatible with deciding that life-sustaining treatment is not, or is no longer, worthwhile, or with accepting a patient’s refusal. I take it that harder readings are much less plausible than softer ones. But it is possible that there was a real unclarity in the Constitution that the Bench sought to clarify. Either way, though, declaring passive euthanasia to be lawful without ruling out intentionally ending someone’s life goes way beyond what would be permitted even under the softer reading, and so – plausibly – way beyond what the Constitution allows, or what its drafters envisaged.

Naturally, national constitutions can and do change, and sometimes they should. Maybe India should change its Constitution in this respect; maybe not. I am not trying to enter into that particular battle here. But suppose that there is a case to be made for changing the Constitution to make explicit provision for ending someone’s life: in that case, there are procedures set out under Part XX by which this may be done. One of the difficulties with the *Shanbaug* case and the subsequent jurisprudence is that they risk undermining the Constitution, or the right to life enshrined therein, and quite possibly doing so inadvertently, owing to a lack of care in defining “passive euthanasia”.[[46]](#footnote-46)

1. See my “What Passive Euthanasia Is”, forthcoming [↑](#footnote-ref-1)
2. Draper, H, “Euthanasia”, in R Chadwick (ed.), *Encyclopaedia of Applied Ethics Vol. 2*, (San Diego: Academic Press, 1998), p 176 [↑](#footnote-ref-2)
3. Shukla, R, “Passive Euthanasia in India: A Critique”, *Indian Journal of Medical Ethics* 13[1](2016:*passim* [↑](#footnote-ref-3)
4. Varelius, J, “Mental Illness, Natural Death, and Non-Voluntary Passive Euthanasia”, *Ethical Theory and Moral Practice* 19[3] (2016): *passim* [↑](#footnote-ref-4)
5. <http://www.bbc.co.uk/ethics/euthanasia/overview/activepassive_1.shtml>; accessed 13.vi.19 [↑](#footnote-ref-5)
6. “What Passive Euthanasia Is”, forthcoming [↑](#footnote-ref-6)
7. *Aruna Ramchandra Shanbaug v. Union of India and Others* (2011) 4 SCC 454 [↑](#footnote-ref-7)
8. *Airedale NHS Trust v Bland*, [1993] 1 All ER 821 [↑](#footnote-ref-8)
9. *Aruna Ramchandra Shanbaug v. Union of India and Others* (2011) 4 SCC 454, at 3. Virani’s claim to be Aruna Shanbaug’s next friend was treated with some scepticism by the Bench.) [↑](#footnote-ref-9)
10. The classic example here would be that of a mountaineer whose own survival depends on abandoning his fellow mountaineer to his fate: see, for example, Simpson, J, *Touching the Void* (London: Vintage, 1997): *passim* [↑](#footnote-ref-10)
11. *Aruna Ramchandra Shanbaug v. Union of India and Others* (2011) 4 SCC 454, at 97 [↑](#footnote-ref-11)
12. The Mental Healthcare Act 2017 stipulates at s. 115(1) that “any person who attempts to commit suicide shall be presumed, unless proved otherwise, to have severe stress and shall not be tried and punished under the said Code”; but an agreement that a person should not be prosecuted under a law is not quite the same as a repeal of that law. [↑](#footnote-ref-12)
13. One may wonder, then, whether the law on suicide is entirely within the spirit of the Constitution – though I shall leave that question hanging here. [↑](#footnote-ref-13)
14. *Aruna Ramchandra Shanbaug v. Union of India and Others* (2011) 4 SCC 454, at 4 [↑](#footnote-ref-14)
15. *Aruna Ramchandra Shanbaug v. Union of India and Others* (2011) 4 SCC 454, at 38 [↑](#footnote-ref-15)
16. *Aruna Ramchandra Shanbaug v. Union of India and Others* (2011) 4 SCC 454, at 44-45 [↑](#footnote-ref-16)
17. *Aruna Ramchandra Shanbaug v. Union of India and Others* (2011) 4 SCC 454, at 49 [↑](#footnote-ref-17)
18. *Aruna Ramchandra Shanbaug v. Union of India and Others* (2011) 4 SCC 454 at 51; emphasis mine [↑](#footnote-ref-18)
19. *Aruna Ramchandra Shanbaug v. Union of India and Others* (2011) 4 SCC 454, at 46 [↑](#footnote-ref-19)
20. *Aruna Ramchandra Shanbaug v. Union of India and Others* (2011) 4 SCC 454, at 48 [↑](#footnote-ref-20)
21. *Aruna Ramchandra Shanbaug v. Union of India and Others* (2011) 4 SCC 454, at 126 [↑](#footnote-ref-21)
22. *Aruna Ramchandra Shanbaug v. Union of India and Others* (2011) 4 SCC 454, at 39 [↑](#footnote-ref-22)
23. Harris, J, *The Value of Life* (London: Routledge, 1985), p 39 [↑](#footnote-ref-23)
24. Bell, L, *Medical Law and Ethics* (?: Pearson, 2012), p 204 [↑](#footnote-ref-24)
25. Banović, B *et al*, “An Ethical Review of Euthanasia and Physician-assisted Suicide”, *Iranian Journal of Public Health* 46[2] (2017): 173 [↑](#footnote-ref-25)
26. Trappe, H-J, “Ethik in Intensivmedizin und Sterbehilfe”, *Medizinische Klinik - Intensivmedizin und Notfallmedizin* 112[3] (2017): 216 [↑](#footnote-ref-26)
27. Khader, A & Mrayyan, M, “Euthanasia for Children with Cancer: A Policy Brief”, *IOSR Journal of Nursing and Health Science* 6[1] (2017): 111-112 [↑](#footnote-ref-27)
28. Law Commission of India, *Passive Euthanasia – A Relook (Report No. 241)*, August 2012, at 1.2 [↑](#footnote-ref-28)
29. Law Commission of India, *Passive Euthanasia – A Relook (Report No. 241)*, August 2012, at 6.1 [↑](#footnote-ref-29)
30. *Common Cause (A Regd. Society) v Union of India* [2018] INSC 204, at 6 [↑](#footnote-ref-30)
31. *Common Cause (A Regd. Society) v Union of India* [2018] INSC 204, at 27; emphasis mine [↑](#footnote-ref-31)
32. *Common Cause (A Regd. Society) v Union of India* [2018] INSC 204, at 44; emphasis mine [↑](#footnote-ref-32)
33. *Common Cause (A Regd. Society) v Union of India* [2018] INSC 204, at 44 [↑](#footnote-ref-33)
34. *Common Cause (A Regd. Society) v Union of India* [2018] INSC 204, at 196 [↑](#footnote-ref-34)
35. *Common Cause (A Regd. Society) v Union of India* [2018] INSC 204, at 98 [↑](#footnote-ref-35)
36. *Common Cause (A Regd. Society) v Union of India* [2018] INSC 204, at 49 [↑](#footnote-ref-36)
37. *Common Cause (A Regd. Society) v Union of India* [2018] INSC 204, *per* Bhushan J at 80 [↑](#footnote-ref-37)
38. *Common Cause (A Regd. Society) v Union of India* [2018] INSC 204, at 48 [↑](#footnote-ref-38)
39. *Airedale NHS Trust v Bland*, [1993] 1 All ER 821, at 867 [↑](#footnote-ref-39)
40. *Airedale NHS Trust v Bland*, [1993] 1 All ER 821, at 867 [↑](#footnote-ref-40)
41. *Conway v Secretary of State for Justice* [2017] EWCA Civ 16, at 8 [↑](#footnote-ref-41)
42. *Airedale NHS Trust v Bland*, [1993] 1 All ER 821, at 868 [↑](#footnote-ref-42)
43. *Airedale NHS Trust v Bland*, [1993] 1 All ER 821, at 891 [↑](#footnote-ref-43)
44. In the English case of *R v Woollin* ([1998] 4 All ER 103) Lord Steyn held that a jury may be directed to find a defendant guilty of murder under English law if his action was such as to make death a virtual certainty, irrespective of his desire or wish. Might this mean that English law could view any withholding of life-sustaining treatment as tantamount to intentionally ending a life if death is virtually certain?  I do not think so. Not the least of the reasons here is that a competent patient’s right to refuse treatment is absolute; and the Mental Capacity Act (2005) formalises the right of competent individuals to formulate advance instructions refusing treatment in the event that they become non-competent. As such, withholding of life-sustaining treatment is permissible when that treatment is refused. On top of that, in respect of non-competent patients who have not given instructions about their treatment, the justification for treatment in English law evaporates if it does not serve the patient’s best interests.  By contrast, all the cases considered by Lord Steyn in *Woollin* concerned actions that were clearly intended to be contrary to someone's interest. [↑](#footnote-ref-44)
45. This outline Bill also – perhaps inadvertently – proposed that patients should have the right to request treatment, and that this should be seen as binding, irrespective of whether it is warranted (see §§ 3(1)(ii) and 3(2). This provision alone probably warrants another paper! [↑](#footnote-ref-45)
46. I am very grateful to Margot Brazier, Swati Gola, Søren Holm, and Alex Mullock for their comments on an earlier draft of this paper. Any improvements arising from their comments are due to them; any lapses are due to me. [↑](#footnote-ref-46)