EUTHANASIA IN INDIA - DEBATING 'DEATH WITH DIGNITY'

Written by ***Anushka Merchant***

5th Year BLS LLB Student, Government Law College, Mumbai

ABSTRACT

Euthanasia is the act or practice of causing or hastening the death of a person who suffers from an incurable or terminal disease or condition, especially a painful one, for reasons of mercy. In India, it was argued that it was unlawful to cause or accelerate the death of a patient who was terminally ill or in a permanent vegetative state but it was lawful to withhold life-extending treatment where the prolongation of life was not in their best interest. It was observed that it was only in the former category of cases that the 'right to die with dignity' fell within the ambit of the fundamental freedom of the 'right to live with dignity' guaranteed under ***Article 21*** of the Constitution. In 2011, the Supreme Court in ***Aruna Ramachandra Shanbaug vs Union of India & Ors***., upheld the validity of passive euthanasia, even involuntary, in certain circumstances. However, it also held that euthanasia could be legalized *only* through legislation. A few years later, a larger bench of the Supreme Court in ***Common Cause (A Registered Society) vs Union of India & Anr.*** revisited the issues from social, legal, medical and constitutional perspectives and held that the principles laid down in 2011 were internally inconsistent and proceeded on a misconstruction of the previous case law.

This paper examines and analyzes the history and legal background of euthanasia, the different types of euthanasia, the relevant constitutional laws and the landmark decisions on the subject matter. It also discusses the concepts of 'living will' and 'advance medical directive' while focusing on the present day scenario.

INTRODUCTION

"I will prescribe regimens for the good of my patients according to my ability and my judgment and never do harm to anyone. I will not give a lethal drug to anyone if I am asked, nor will I advise such a plan…"[i]

This is an extract from the 'Hippocratic Oath', which finds its place in one of the most widely known Greek medical texts. It is an Oath historically taken by a new physician, swearing before a number of healing Gods, to uphold specific ethical standards.

Today, the moral and professional duties imposed on a medical practitioner by society, the judiciary and the legislature have been undergoing various changes. In the past decade, there has been a great shift especially in the case of physician-assisted suicide and euthanasia, concepts that have taken centuries to get acceptance and approval in countries all over the world. These are concepts that have faced great opposition on religious, legal and moralistic grounds.

Ever since the creation of the Constitution, the freedom guaranteed under ***Article 21***, which deals with the right to life and personal liberty has been subjected to various interpretations. These have had the effect of widening the scope of the Article, allowing for the incorporation and accommodation of the needs of the changing times. Recently, Justice J. Chelameswar of the Supreme Court in the right to privacy judgment, ***K.S. Puttaswamy and Another Vs. Union of India and Ors.***[ii], elaborated on the said concept and observed that *"An individual's right to refuse the life-prolonging medical treatment or terminate life is another freedom which falls within the zone of right of privacy."*

On 8th March 2018, the Supreme Court passed a landmark judgment in ***Common Cause (A Registered Society) v Union of India & Anr.***[iii] ("**Common Cause**"), where it extensively dealt with these issues. The judgment was delivered by a five-judge Constitutional Bench comprising of the then Chief Justice of India Dipak Misra, Justice A.K. Sikri, Justice A.M. Khanwilkar, Justice D.Y. Chandrachud and Justice Ashok Bhushan. The apex court was moved by way of a writ petition filed under ***Article 32*** of the Constitution, by a society known for espousing public causes. They prayed that the 'right to die with dignity' be declared to fall within the ambit of the 'right to live with dignity' under ***Article 21***, for terminally ill patients to be able to execute a 'living will & Attorney authorization' and for the issuance of guidelines thereof.

THE DECISION, DECONSTRUCTED

A. Article 21 and the 'Right to Die' Repository

Before passing its judgment the Bench thought it necessary to analyze and interpret previous decisions dealing with the same or similar subject matter.

i. ***Airedale N.H.S. Trust v. Bland***[iv] ("**Airedale**")**:** In 1993, the House of Lords held that it was not lawful to cause or accelerate death but it was lawful to withhold life-extending treatment where the prolonging of life would not be in the best interest of the patient. It held that it was solely in the realm of the legislature to legalize euthanasia and to provide the adequate safeguards.

ii. ***P. Rathinam v Union of India***[v] ("**P. Rathinam**")**:** In 1994, the Supreme Court of India penalized an attempt to commit suicide. The court arrived at this conclusion by asserting fundamental rights to have positive as well as negative aspects. Freedom of speech would include the freedom not to speak and freedom of association and movement would include the freedom not to associate or move. The logical corollary would thus be, that the right to live would include the right not to live, the right to die or the right to terminate one's life.

iii. ***Gian Kaur v State of Punjab***[vi] ("**Gian Kaur**")**:** The cases mentioned above were analyzed by the apex court in this case, in 1996. Here, the Court was concerned with the constitutional validity of ***Section 306*** and ***Section 309*** of the ***Indian Penal Code, 1860*** that provides for 'abetment to commit suicide' and 'attempt to commit suicide' respectively.

The Constitutional Bench distinguished between the case of a dying man who is terminally ill or in a permanent vegetative state ("**PVS**") on one hand and the termination or premature extinction of life on the other. It was observed that it is only in the former category of cases that the 'right to die with dignity' falls within the ambit of the 'right to live with dignity', as death in these cases is inevitable and imminent. It is merely an acceleration of the process of natural death that has already commenced in order to reduce suffering. The 'right to life' and the 'right to live with human dignity' include the right to a dignified life up to the point of death including a dignified procedure of death. Therefore, the 'right to die with dignity' at the end of life is not to be confused or equated with the 'right to die' an unnatural death, which amounts to the curtailment of the natural span of life. This is because the 'right to die', is as inconsistent with the 'right to life' as 'death' is with 'life'.

The Bench while disapproving the foundation of P. Rathinam, observed that in the case of suicide, the person has to undertake certain positive overt acts. The genesis of those acts,

the 'extinction of life' and the 'right to die' are incompatible and inconsistent with the concepts of 'right to life' and 'protection of life' dealt with under ***Article 21***. While contemplating the nature of the fundamental rights, it observed that the 'right to life' is a natural right and cannot cover cases of unnatural termination or extinction of life. It also found the comparison made by the court between the right to life under ***Article 21*** and the other rights guaranteed under ***Article 19*** such as the freedom of speech, association and movement, to be inapposite.

A reference was also made to Airedale and the view expressed therein as regards the role of the legislature. However, in making such a reference it neither gave any definite opinion with regard to euthanasia and physician-assisted suicide nor had it stated that the same could be made lawful *only* by way of legislation.

iv. ***Aruna Ramachandra Shanbaug v Union of India & Ors***.[vii] ("**Aruna Shanbaug**")**:** In 2011, the apex court noted that ***Article 21*** does not protect the 'right to die' and upheld the criminality of an attempt to commit suicide. However, the Bench proceeded on the wrong premise that Gian Kaur had "quoted with approval" the view of the House of Lords in Airedale. In arriving at this conclusion, the court accepted that euthanasia could be made lawful *only* through legislation. At the same time, it upheld the validity of passive euthanasia, even involuntary, in certain circumstances and laid down an elaborate procedure for executing the same.

After these judicial pronouncements, in 2012, the subject of passive euthanasia was extensively discussed in the 241st report of the Law Commission of India[viii]. However, no law was enacted thereafter.

In light of the decision in Aruna Shanbaug being internally inconsistent and it proceeding on a misconstruction of the decision in Gian Kaur, the same question of law was referred to the apex court, in the present case, Common Cause. The Court was required not to consider the Bench in Aruna Shanbaug as having laid down an authoritative principle of constitutional law. It was also required to revisit the issues independently in order to arrive at a fresh conclusion. In doing so, the Court approved the decision in Gian Kaur and concluded that the 'right to live with dignity' would include the 'right to die with dignity'. It also authorized the smoothening of the dying process in the case of a terminally ill patient or a person in a PVS who has no hope of recovery.

B. <u>Euthanasia</u>

In the 17th century, the City Magistrates of Athens allowed persons suffering from terminal illnesses to consume a poison called 'hemlock'. The word 'euthanasia' was coined for the purpose. It is derived from the Greek word '*euthanatos*', meaning 'good death' or 'easy death'. It is defined as "the act or practice of causing or hastening the death of a person who suffers from an incurable or terminal disease or condition, especially a painful one, for reasons of mercy"[ix]. Ever since, the concept has evolved into different types, and these have been the epicentre of debates, disagreements and disharmony all over the world. The types of euthanasia can be broadly categorized in two ways:

I. <u>Commission or Omission</u>

1. **Active** - involves a positive contribution to the acceleration of death; and
2. **Passive** - involves an omission of steps (withdrawal or withholding of medical treatment), which might otherwise sustain life.

The distinction between the active and passive types lies in the fundamental legal principles of *causation* and *intent*. If a patient ingests lethal medication prescribed by a physician, he is *killed* by that medication; but if life-sustaining medical treatment is withdrawn or withheld, he *dies* from an underlying fatal disease or pathology.

It is because of this distinction that the legal position world over is that active euthanasia is unlawful and could be made lawful *only* by way of legislation. On the other hand, passive euthanasia can be lawful even without legislation, provided there exist adequate guidelines and safeguards. This stems from the fact that active euthanasia involves an intention to cause death, a guilty mind or *mens rea*, which is absent in the case of passive euthanasia.

Another ground for debate are the boundaries between the active and passive types. They are quite obscure. It can be argued that an 'omission' could amount to a 'positive' act. Due to the lack of clarity, these debates follow: Should both forms be disallowed or, in converse should both be allowed? More significantly, are both equally amenable to judicially manageable standards?

II. <u>Consent</u>

1. **Voluntary** - termination of life at the request of the person killed;

2. **Non-voluntary** - termination of life without the consent or opposition of the person killed; and
3. **Involuntary** - termination of life against the will of the person killed. This is illegal as it amounts to murder.

The judgment has contemplated voluntary and non-voluntary euthanasia only. In order to examine these two types, it is necessary to analyze the following four cardinal principles of medical ethics:

i. **Necessity**: This allows a doctor, where it is in the best interests of the patient, to lawfully treat him if he cannot consent to the same. If however, the patient has made a valid advance medical directive against such treatment, which is free from reasonable doubt, it is to be given effect to. This principle applies in the case of non-voluntary euthanasia.
ii. **Beneficence**: This involves acting in the interest that is best for the patient. The best interest is determined after considering the medical, ethical, social, emotional and other welfare interests of the patient. In cases of an incompetent patient, the principle is to be applied and implemented after providing a cooling period to enable aggrieved persons to approach the court of law. While personal convictions and motives are not to influence such decisions, the wishes and opinions of the next friend, close relatives and medical practitioners are to be given due weight. Public interests and the interests of the State may also be considered. When a doctor, acting on the basis of an informed medical opinion and in a bona fide discharge of the duty of care, withdraws treatment in the patient’s best interest, the said act cannot be regarded as a crime and the law will protect such reasonable exercise of duty and care. This principle is applied in the case of voluntary and non-voluntary euthanasia.
iii. **Autonomy & Self-Determination**: All adults with the capacity to consent and to make decisions and choices are autonomous and have the right of self-determination. As per this principle, an informed patient is entitled to choose the manner of his treatment. He can also decline to consent to a specific treatment or all treatments, which might have the effect of prolonging life, even if such a decision entails a risk of death. In doing so, the patient protects the right of privacy from bodily interference and invasion and the doctor must in accordance with his duty comply with the patient's wishes. In the case of a patient who is incompetent to consent, the doctors are to respect the wishes as expressed in the

advance medical directive. This principle is concerned with cases of voluntary euthanasia.

iv. **Sanctity of Life**: Here, the termination of life by way of active measures is forbidden. This has always been the concern of the State. It is a principle that is philosophically, religiously and mythologically accepted by the majority but it is no longer an absolute one. This principle is applied in the case of voluntary and non-voluntary euthanasia.

Euthanasia, which until now been labelled as an 'unethical act'[x], has finally received due recognition in India. The present judgment clarifies that when passive euthanasia as a situational palliative measure becomes applicable, the best interest of the patient shall override the State's interest. The principle of sanctity of human life would have to yield to the principle of self-determination and the doctor's duty to act in the best interests of the patient would likewise be qualified by patient's wishes. Therefore, a medical practitioner is no longer compelled to treat a patient who has denied consent to the same or where it would merely prolong their suffering. The court drew sustenance from the constitutional values of liberty, dignity, autonomy and privacy. It also expressed its resentment as Aruna Shanbaug was not only wrongfully denied the right to bodily integrity in life but also the right to self-determination in death.

C. Advance Medical Directives

The Petitioners originally prayed that a patient who is terminally ill or in a PVS be allowed to execute a 'living will', a document prescribing the medical treatment the patient would want in case he becomes incompetent or unable to communicate the same. What was in return approved by the Court, was the execution of an 'advance medical directive', a document whereby a patient may refuse to consent to medical treatment, or medical treatment of specified kinds, in case he becomes incompetent or unable to communicate the same. Advance medical directives gained recognition in the latter half of the 20th century and were first recognized by statute in the United States of America in 1976.

Dead Donor's Authorization: Patients in India are allowed to authorize the removal of organs and tissues from their body before death. Such authorization is to be given in writing, in the presence of two witnesses, in the form prescribed by the accompanying Rules and is to be retained at the institution where it is made. It is open to the donor to revoke his pledge at any

time. The organs may then be donated if no contraindications are identified[xi]. This kind of authorization is thus a clear indication of an age-old statutory recognition of the concept of an advance medical directive in the country.

The Bench in Common Cause held that *"an advance medical directive would serve as a fruitful means to facilitate the fructification of the sacrosanct right to life with dignity"*[xii] *and "a failure to recognize it would amount to non-facilitation of the right to have a smoothened dying process."*[xiii] This is, therefore, a way forward from the draft Bill on terminally ill patients of 2016[xiv], which had declared advance medical directives to be void and of no effect.

After due consideration of the various legislations in different countries, the apex court laid down safeguards for the operation of advance medical directives. These are quasi-legislative in nature and have been issued in exercise of the power conferred by ***Article 142*** of the Constitution. These safeguards are to remain in force until the Parliament legislates on the same.

Due Execution: The directive must be voluntarily executed by an adult of sound mind and disposition, who is fully informed and who is capable of communicating and understanding the purpose and consequences of the same. There must be an absence of coercion, undue influence and constraint. The date of execution or revision must be indicated. The directive must be in writing and must be signed by the executor in the presence of two attesting witnesses and countersigned by the jurisdictional Judicial Magistrate of First Class ("**JMFC**").

Contents: The directive must clearly indicate the decision, the treatment to be withheld or withdrawn and the circumstances in which the decision is to apply. It must contain relevant information about the executor and the general practitioner. A guardian or close relative must also be appointed, who is to authorize or give consent on behalf of the executor, in case of incapacity. The following are common components of a directive: (i) Cardio-pulmonary Resuscitation; (ii) breathing tubes; (iii) feeding/hydration; (iv) dialysis; (v) painkillers; (vi) antibiotics; and (vii) organ donation.

Keeping Record: The JMFC will preserve the directive and forward a copy to the Registry of the District Court. A copy will also be forwarded to a competent officer of the local Government, who will appoint a custodian of the document. Another copy will be forwarded to the family members and the family physician if any.

Hospital Medical Board: The physician/hospital shall constitute a Medical Board consisting of the Head of the treating Department and at least three experts from the fields of general medicine, cardiology, neurology, nephrology, psychiatry or oncology with experience of at least twenty years. After visiting the patient it will certify the course of action to be taken. This decision shall be regarded as a preliminary opinion.

The judgment also provides a procedure when there is no advance directive. In such a case, the hospital shall constitute a Medical Board in the manner indicated above. A discussion as regards the pros and cons of withdrawing or withholding treatment is to be conducted between the Board, family physician and family members. The consenting family members are to give their consent in writing. The Board will then certify the course of action to be taken. This decision will be regarded as a preliminary opinion.

Collector's Medical Board: After the Hospital Medical Board has made its decision; the Collector is to constitute a Medical Board comprising of the Chief District Medical Officer as the Chairman and three medical experts. This Board shall visit and physically examine the patient, study the medical papers and will then certify the course of action to be taken. However, in cases where the Hospital Medical Board takes a decision to not enforce an advance directive, the reasons are to be duly considered by the Collector's Medical Board whilst making its own decision.

Enforcement by JMFC: If the decisions of the Hospital Medical Board and the Collector's Medical Board concur, the JMFC shall visit the patient and family members at the earliest, physically examine the patient, verify the medical reports and once satisfied in all respects, it may endorse the decision of withdrawing or withholding further medical treatment. The Magistrate will intimate its order to the High Court. Copies of the same shall be retained by the Registry of the High Court and will be destroyed after the expiry of three years from the death of the patient.

Refusal of Permission by the Medical Board: If permission is refused, it would be open to the executor, his family members or even the treating physician/hospital to approach the High Court by way of a writ petition under ***Article 226*** of the Constitution. The High Court will be free to constitute an independent Committee consisting of three medical experts. The Committee after examining the patient would submit a feasibility report. Based on this and the

principle of beneficence, the High Court shall render its decision at the earliest and shall ascribe reasons for the same.

Revocation: An individual may withdraw or alter the directive at any time when he/she has the capacity to do so and by following the same procedure as provided for the recording of it. In the event of there being more than one valid directive, none of which have been revoked, the most recently signed directive will be considered.

Unenforceable Directive: If an advance directive is unclear or ambiguous or if it is inapplicable to the treatment in question or if there are reasonable grounds for believing that the circumstances that exist are ones which the person making the directive did not anticipate at the time and which would have affected his decision had he anticipated them, then the directive cannot be enforced.

In the present case, the Bench held that the right of executing an advance medical directive by a competent patient does not depend on any legislation by the State. Such an individual has the right to refuse medical treatment including withdrawal from life-saving devices, in recognition and affirmation of his right to bodily integrity and self-determination and in accordance with safeguards as referred to above.

CONCLUSION

The judgment, in this case, has cleared all ambiguities that were created by previous judicial pronouncements. It discussed at length various concepts and principles. In doing so, it has broadened horizons in the medico-legal field. It also has brought about a lot of clarity in two respects. Firstly, with regard to the manner in which future cases of passive euthanasia, voluntary and non-voluntary are to be dealt with and; secondly, as regards the extent, scope and protection of an individuals rights, as guaranteed under ***Article 21***.

In acknowledging the levels of depredation prevailing in the country and in discharging its duty to prevent abuse of the process of law, the Bench thought it necessary to sacrifice individual freedom to some extent. It therefore, did not deem it fit to legalize active euthanasia and has subjected the enforcement of passive euthanasia and the execution of advance medical directives to rigorous regulatory mechanisms. This was done to rule out the possibility of foul play on the part of relatives and others for the purpose of insurance, inheritance or the like.

This will ensure that the ultimate decision of the patient or treating doctor will always be protected.

Additionally, the stance taken by the court will help relieve the patient and family members from having to bear an unnecessary emotional and financial burden in a situation where merely on account of the advancement of modern medical technology, the dying process of the patient is unnecessarily prolonged even though there is no real chance of survival.

Although we have come a long way from what was practised seventeen centuries ago by way of the Hippocratic Oath, the apex court has taken a step in the right direction by embracing the changing nature of human rights. It has empowered the citizen, both in life and death. In India, euthanasia can now finally achieve what it was set out to achieve, a 'good death'; giving the patient dignity in death at a time when one's life is completely devoid of it.

REFERENCES

[i] Michael North, *The Hippocratic Oath* – Greek Medicine from Gods to Galen, The National Library of Medicine, Greece (Oct. 17, 2009, 08:02 PM), https://www.nlm.nih.gov/hmd/greek/greek_oath.html

[ii] AIR 2017 SC 4161

[iii] AIR 2018 SC 1665

[iv] (1993) 2 WLR 316

[v] (1994) 3 SCC 394

[vi] (1996) 2 SCC 648

[vii] (2011) 4 SCC 454

[viii] Law Commission of India, *Passive Euthanasia – A Relook*, (Oct. 18, 2018, 10:09 AM), http://lawcommissionofindia.nic.in/reports/report241.pdf

[ix] Black's Law Dictionary (10th ed. 2014) at 672.

[x] Indian Medical Council (Professional Conduct, Etiquette & Ethics) Regulations, 2002, Regulation 6, (India)

[xi] Transplantation of Human Organs and Tissues Act, 1994, §. 3, Act No. 42 of 1994 (India)

[xii] Common Cause, *supra* note 3, at 170.

[xiii] Common Cause, *supra* note 3, at 161.

[xiv] Shri Baijayant Panda, M.P., *Bill No. 293 of 2016 - Terminally-Ill Patients (Protection of Patients and Medical Practitioners) Bill, 2016*, (Oct. 18, 2018, 12:23 PM),

http://164.100.24.219/BillsTexts/LSBillTexts/AsIntroduced/2656.pdf