

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was unable to communicate there would have been no scope for us to know what she went through had medical support been withdrawn.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 At first, she thought she would allow life to take its natural course by asking for medical support to be withdrawn, and instead of killing herself artificially by drinking the lethal drug, she preferred to just "slowly drift off" (5).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's medical condition, see: Virani Pinky. *Aruna's story: the true account of a rape and its aftermath*. Pune: Penguin Books; 1998. 18-84 pp.

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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

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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

in the USA are contemplating enactment of death with dignity legislation. Across the Atlantic, the European Court of Human Rights judgment on June 5, 2015, endorsing Vincent Lambert's right to end medical support, is a resounding affirmation of an individual's right to die with dignity. This article is an attempt to explore various dimensions of one's right to dignity in dying, in the global as well as the Indian context

Introduction

After being in a persistent vegetative state for nearly 42 years Aruna Shanbaug died of pneumonia, on May 18, 2015, in King Edward Memorial Hospital, Mumbai where she had worked as a nurse until 1973. Earlier, an attempt to terminate her life remained unsuccessful as the Supreme Court of India, on March 7, 2011, rejected the petition filed by Ms. Pinki Virani, a journalist claiming to be Shanbaug's next friend, praying for directions to stop feeding Shanbaug as it amounts to continuing "her existence in sub-human condition" which "violates her right under Article 21 of constitution of India to live with dignity" (1). The rejection notwithstanding, the Court's verdict was a landmark decision in the Indian context as the Court, for the first time accepted a person's right to assisted dying and recognised another person's authority to act as surrogate on behalf of an incapacitated individual. However, in practical terms, the decision did not offer much relief to many persons suffering from unbearable and irreversible agony due to terminal and incurable illness and waiting for assistance in dying. The Court, in effect, allowed only non-voluntary passive euthanasia ie withholding or withdrawal of life support in case of patients who are terminally ill and unable to consent due to loss of cognitive abilities, which too was made subject to mandatory approval by the High Court concerned. The consent of the individual and the medical opinion supporting the withholding or withdrawal of life support are not treated as final determinants.

Before Aruna Shanbaug, during the last four decades, four young women, Karen Ann Quinlan [1976] (2), Nancy Cruzan [(1990)] (3) Terri Schiavo [2005], (4) and Eluana Englaro [(2008)] (5) have been the subject of intense debate and long judicial campaigns concerning their right to end of life. In order to avoid lengthy and arduous judicial battle, on November 1, 2014, 29-year-old Brittany Maynard, suffering from glioblastoma moved from California to Oregon to take advantage of Oregon's Death with Dignity Law, (6) and ended her life saying that "death with dignity was the best option for me and my family." (7)

From Karen Quinlan [1976] (2) to Lee Carter [2015] (8) there have been numerous judicial pronouncements recognising one's right to assistance in dying by the Courts in the USA, UK, Canada, Australia, France, Italy, Germany, Switzerland and European Court of Human Rights and certain jurisdictions such as the Netherlands, Belgium and Luxembourg in Europe and the states of Oregon, Washington and Vermont in the USA have also enacted distinct legislations to regulate the process of assisted dying but the jurisprudence with regard

to end of life decisions continues to be hazy. This is partly because the operational spectrum of assisted dying includes several acts of omission and commission on the part of several players such as the individual, family members, physician, administrators and policymakers, each having his/her own imperatives, priorities and stakes. Furthermore, the values and moral perceptions differ according to cultural, religious, political and socio-economic milieu, making unanimous paradigms difficult.

In this article, I try to define death with dignity, discover its core values, explore the arguments for and against assisted dying, provide a glimpse of legislative strategies and judicial decisions across the world, go through the emerging voices and offer a brief account of the Indian scenario. I conclude that the right to end life is inherent in one's right to self-determination. In the practical context, end of life decision making is a multidimensional exercise involving a wide range of disciplines, including religious, cultural, economic, moral, ethical and legal perspectives. In such a pluralistic milieu, legislative wisdom provides better resolution than judicial deliberation. It is therefore imperative that comprehensive and fine-tuned legislative strategies are evolved in order to concretise a person's right to die with dignity.

Core values and conflicting arguments

Controversy about a person's right to end his life is not new. The debate has been "ranging from Plato and Aristotle in ancient Greece to Augustine and Thomas Aquinas in the Middle Ages, and Hume and Kant in the more modern times" (9). Plato found suicide disgraceful but he made several exceptions including the self-killing "compelled by extreme and unavoidable personal misfortune" (10) Aristotle concludes that self-killing does not treat oneself unjustly so long as it is done voluntarily because the harm done to oneself is consensual (11). The Roman Stoic, Seneca, claimed that since "mere living is not a good, but living well", a wise person "lives as long as he ought, not as long as he can." (12) Thomas Aquinas disapproved self-killing "because it injures other people and the community of which the individual is a part; and because it violates God's authority over life, which is God's gift." (13, 14, 15)

In the modern context, the act of assistance in dying may manifest itself in various forms such as killing by physicians by administering deadly drugs, withdrawal of nutrition and/or life sustaining medical treatment, withholding of nutrition and/or life sustaining medical treatment and non-persuasion to take nutrition and/or life sustaining medical treatment. The moral and legal discussion concerning assisted dying, therefore, revolves around the core values such as love, trust, compassion, autonomy, sanctity of life, human dignity, rationality and equity. At the core of the argument supporting assisted suicide are the twin goals of maximising individual autonomy and minimising human suffering. Autonomy is a long cherished concept found in moral, political and bioethical philosophy. It is the capacity of a rational human being to exercise his/her self-determination,

free from external authority and influences. At times, self-governance may appear to be tainted with subjectivity and the acts of a self-directing individual may be disagreeable to others. But, we ought to realise that others cannot impose their norms, standards and choices to define and regulate the sufferings of an individual. Concepts of dignity vary from person to person. What may be dignified to one may appear to be false or hypocritical to others. To many, the British Supreme Court's decision to withhold life sustaining treatment from "a gravely ill man" (16) as being in his best interest, may appear to be an expression of excessive judicial paternalism. To others, it may appear a pragmatic judicial approach founded in the imperatives of individual and societal good.

For the proponents, the most compelling reason for providing assistance in dying is love and compassion. It is for this reason that the request for assistance in dying has come in the case of several incapacitated individuals from the closest family member, namely parents or spouse, not from any distant relative or some other person acting as guardian. In the UK, in Anthony Bland's case (1993), the parents requested withdrawal of life support from their son who was in a persistent vegetative state (PVS) (17). In Robert Wendland's case, his wife Rose sought intervention to get his feeding tube removed (18). In the case of Eluana Englaro, an Italian woman, who entered into a persistent vegetative state following a car accident, her father requested that her feeding tube be removed and she be allowed to die "naturally" (19). In the case of Terri Schiavo, a resident of Florida, in PVS following respiratory and cardiac arrest, her husband Michael filed a petition to remove her feeding tube (4). In France, in the case of Vincent Humbert, a mute and blind quadriplegic, his mother Marie Humbert campaigned for her crippled son's right to die and having failed in her efforts, she attempted to kill her son with an injection of barbiturates, which sent him into a coma which was followed by switching off his life support by Dr Frederic Chaussoy leading to his death (20). Such compassion is a response to the intensity of suffering of a loved one and it overtakes the desire to keep the loved one alive. There are occasions when assistance in dying is the most humane act that can be performed by those who are responsible for care of their loved ones. However, some continue to argue that assistance in dying "denies the inherent value of humanity and of human life by trading life for comfort." (21).

Undoubtedly, the State possesses an essential interest in the preservation of life of its citizens. Based on this interest attempted suicide or assistance in suicide is an offence in many jurisdictions. However, the State's interest needs to be balanced against a person's right to refuse medical treatment or to have treatment withdrawn. As early as 1905, the US Supreme Court had balanced an individual's liberty interest in declining an unwanted smallpox vaccination against the State's interest in preventing disease. (22) This has been followed by several other decisions. As such, a person's right not to be subjected to medical intervention outweighs the State's interest in the preservation of life. While the State's interest lies in the preservation of life of its citizens, the individual interest

is best served by freedom of choice and non-violation of privacy. Viewed in the context of equity too, one may not find it wise to continue the life sustaining treatment of a person, endlessly. In a world where even primary health care is not available to millions of people, and even safe drinking water is a luxury in certain parts, how far is it equitable to spend resources on prolonging the life of a person in an irreversible vegetative state? According to some estimates, "Expenditure at the end of life seems disproportionately large" (23). "Out of every four Medicare dollars – over \$ 125 billion – is spent on care near the end of life, and the financial burden on families can be staggering" (24). "About 25 per cent of all health-care costs are devoted to the caring of patients in the last year of life" (25) and "the high cost of dying" is emerging as an area of concern for healthcare policy makers (26). We ought, however, to appreciate that fast advancing biotechnology, growing institutionalisation of healthcare and increasing material value of the human body has imparted new dimensions to end of life issues, contemplating a delicate balancing of individual and societal perspectives. Decisions regarding prolongation and termination of life are now linked to the imperatives of necessity. At times, the dictates of utility may reduce continuance to futility. Such an apprehension is not unfounded when we see the recent debate about the healthcare reform legislation in the United States, initiated by President Barak Obama, wherein the old, infirm and chronically ill are being targeted as the main consumers of healthcare budgets. There are scholars who feel that the "potential for costs to spiral out of control is particularly acute with regard to life-extending interventions for the elderly." (27). Viewed in a wider context, "only a state or society or community in which all necessary medical attention was absolutely guaranteed to all—and in which, therefore, anyone ever seeking to extend his or her life to the last instant of bare existence would be both entitled and able to do so—could be said to bring a practical rationality to the ethical principle of "always to care." (28).

The debate notwithstanding, there may be times in one's life when the decision to die may provide the greatest relief and it may be the most dignified act of her/his life. There are occasions when dying provides an acceptable resolution to unending suffering. The German philosopher Friedrich Nietzsche was perhaps closest to the reality when he wrote, "There is a certain right by which we may deprive a man of life, but none by which we may deprive him of death" (29).

Legislative strategies

The issue of assistance in dying is inherently complex and formulation of legislative strategies is a challenging task. Several vital questions need to be addressed such as:

1. When is a person dead?
2. If a brain-dead person is treated as dead, at what point of time can the life support system be withdrawn?
3. Does a person have a right to choose the time and manner of his death?.
4. How can one ensure that the desire to die is truly informed and free from extraneous considerations?

5. Who is competent to take a decision on behalf of a brain-dead individual?
6. How can one determine the best interests of an incapacitated individual?
7. How can it be ensured that the process of assisted dying is not abused?
8. Who will take a decision on behalf of an unborn child of a pregnant woman in PVS?
9. In the event of conflicting maternal-fetal interests, whose interest should prevail?

The intricacies notwithstanding, the compelling nature of the issue of dying with dignity has prompted certain jurisdictions to evolve suitable legislative strategies. The legislations are based on the common law doctrines, national constitutions, judicial pronouncements and international covenants such as the Universal Declaration of Human Rights, the European Convention on Human Rights, the International Covenant on Civil and Political Rights and the International Covenant on Economic, Social and Cultural Rights. The legal foundations of one's entitlement to assisted dying can be traced to the right to autonomy which includes informed consent, privacy, right to refuse medical intervention, right to religious freedom and right to dignified death; and all these perspectives are reflected in the legislative enactments. The Netherlands, (30) Belgium (31) and Luxembourg (32) in Europe; and the states of Oregon (6) Washington (33) and Vermont (34) in the USA, have enacted legislations to regulate the process of assisted dying. In two US states, namely Montana (35) and New Mexico (36) the process has been legitimised by judicial mandate. In Switzerland, although there is no separate law on euthanasia, article 115 of the Swiss Criminal Code, 1942, provides that: "Any person who for selfish motives incites or assists another to commit or attempt to commit suicide shall, if that other person thereafter commits or attempts to commit suicide, be liable to a custodial sentence not exceeding five years or to a monetary penalty." Consequently, assisting suicide is a crime only if the motive for doing so is selfish such as personal gain, and this protects those providing assistance to any person in the act of dying. Swiss law only allows for providing the means to commit suicide, and the reasons for doing so must be altruistic.

In France, the Patients' Rights and End-of-Life Act (number 2005-370)¹⁵ was passed into law by a unanimous vote on April 22, 2005. "The law's major provision concerns conditions that define and authorise passive euthanasia practices. Withholding and withdrawing of "all treatment" (including artificial hydration and nutrition) is not only legal and morally unproblematic but even obligatory when treatment amounts to "unreasonable obstinacy," that is, when "treatment appears as useless, disproportionate, or having the sole effect of artificially sustaining life" (Article L 1110-5 du CSP al. 2)." (37).

The major perspectives reflected in the legislations are presence of terminal and/or incurable illness, a bonafide patient-physician relationship, the patient's best interest, the patient's unimpaired judgment and valid consent, a legitimate surrogate decision maker in case of incapacitated individual, freedom from undue influence and absence of abuse.

In the UK, the Commission on Assisted Dying under the Chairmanship of Lord Charles Falconer published a Briefing Paper, in January 2012, entitled "The effectiveness of legal safeguards in jurisdictions that allow assisted dying," by Penney Lewis and Isra Black. The briefing paper identifies "eight categories of safeguard that are used in jurisdictions that permit assisted dying and specifies how each of these safeguards is applied in the Netherlands, Belgium, Oregon and Switzerland. These categories are: the type of assistance; the person's condition and/or experience of suffering; making the request for assistance; the age of the person requesting assistance; consultation and referral requirements; the identity of the assistor; due medical care; and the reporting and scrutiny of cases." (38).

Different jurisdictions have adopted different methodologies to achieve the above objectives. The biggest challenge arises while determining the best interest of an incapacitated patient. One may feel that a person suffering from terminal and incurable illness, with loss of cognitive abilities, may be best served by withdrawing life sustaining treatment. This will give him freedom from misery, distress and indignity. But, this is just one view. There can be another view, namely, that shortening life is no solution. The effort should be to ameliorate a patient's suffering by providing the best possible medical care, not by withdrawing life support because elimination of pain, not the person, is the goal. As such, best interest may be interpreted either way. It is a matter of individual choice. In this context, it may be enlightening to note what the Supreme Court of New Jersey said in Karen Ann Quinlan's case (2).

"We have no doubt ... that if Karen were herself miraculously lucid for an interval (not altering the existing prognosis of the condition to which she would soon return) and perceptive of her irreversible condition, she could effectively decide upon discontinuance of the life-support apparatus, even if it meant the prospect of natural death."

Since it is not practicable to give a detailed account of all the legislations in this article, some reflections may suffice. The Oregon Death with Dignity Act 1997, the first legislation in the world to permit terminally ill patients to determine the time of their death, permits a capable adult Oregon resident to request his or her physician to write a prescription of a lethal dose of medication for the purpose of ending his/her life, subject to the following conditions:

- The person has been diagnosed, by a physician, with a terminal illness that will kill the patient within six months
- The request is confirmed by two witnesses, at least one of whom is not related to the patient, is not entitled to any portion of the patient's estate, is not the patient's physician, and is not employed by a health care facility caring for the patient.
- After the request is made, another physician must examine the patient's medical records and confirm the diagnosis.
- The patient must be determined to be free of a mental condition impairing judgment.

- If the request is authorised, the patient must wait at least fifteen days and make a second oral request before the prescription may be written.
- The patient has a right to rescind the request at any time.
- Should either physician have concerns about the patient's ability to make an informed decision, or feel the patient's request may be motivated by depression or coercion, the patient must be referred for a psychological evaluation.

Similarly, in the Netherlands, the Termination of Life on Request and Assisted Suicide (Review Procedures) Act which took effect on April 1, 2002, legalises euthanasia and physician-assisted suicide in very specific cases, under very specific circumstances. The law allows a medical review board to suspend prosecution of doctors who performed euthanasia when each of the following conditions is fulfilled:

- the patient's suffering is unbearable, with no prospect of improvement
- the patient's request for euthanasia is voluntary and persists over time (the request cannot be granted when under the influence of others, psychological illness or drugs)
- the patient must be fully aware of his/her condition, prospects and options
- there must be consultation with at least one other independent doctor who needs to confirm the conditions mentioned above
- the death must be carried out in a medically appropriate fashion by the doctor or by the patient, in which case the doctor must be present
- the patient must be at least 12 years old (patients between 12 and 16 years of age require the consent of their parents)

A regional review committee assesses whether a case of termination of life on request or assisted suicide complies with the due care criteria. Depending on its findings, the case will either be closed or, if the conditions are not met, brought to the attention of the Public Prosecutor.

Judicial decisions across the world

From Karen Quinlan [1976] (2) to Lee Carter [(2015) (9)] there have been several judicial pronouncements by the apex Courts across the world on one's right to end his/her life. However, despite in-depth judicial deliberations during the last four decades, the issue continues to reflect heterogeneous approaches. It may be worthwhile to quote some of the decisions of the courts in the USA, Canada, the UK, Ireland, Switzerland, France, Germany, Italy, the European Court of Human Rights, and Australia.

Unites States of America

The Supreme Court of New Jersey, in Karen Ann Quinlan's case in 1976, was the first to hold that the right to privacy includes a patient's right to refuse medical treatment in some situations. The New Jersey Supreme Court ruled that "Karen's

right of privacy may be asserted on her behalf by her guardian under the peculiar circumstances here present." (2) In 1977, the Supreme Court of Massachusetts in *Superintendent of Belchertown State School v. Saikewicz* upheld a person's right to refuse medical treatment under the common law right to informed consent, as well as on the basis of a constitutional right to privacy (39). In 1980, the Supreme Court of Florida in *Satz v. Perlmutter* ruled that a competent adult patient, with no minor dependents, suffering from a terminal illness has the constitutional right to refuse or discontinue extraordinary medical treatment where all affected family members consent (40). In 1981, in *re Storar*, the court in New York upheld a person's right to refuse medical treatment under the common law right to informed consent (41). In 1986, in *Brophy v. New England Sinai Hospital*, the Supreme Judicial Court of Massachusetts held that the "State's interest in the preservation of life does not overcome [the patient's] right to discontinue treatment," and that such a position is not contrary to the "State's interest in the prevention of suicide." (42).

The US Supreme Court, in 1990, in *Cruzan v. Director MDH*, while interpreting the Due Process Clause, held that "a competent person has a constitutionally protected right to refuse lifesaving hydration and nutrition" (3). The Supreme Court of Massachusetts, in a case of a competent adult who was a Jehovah's Witness and a mother of a minor child, ruled that the patient had the right to refuse to consent to the blood transfusion even though such refusal would, in all probability, lead to her death due to haemorrhage (43).

In a momentous pronouncement the Supreme Court of the United States, on June 26 1997, in *Vacco v. Quill*, issued a unanimous (9-0) decision holding that a New York ban on physician-assisted suicide was constitutional, and preventing doctors from assisting their patients even those terminally ill and/or in great pain, was a legitimate state interest that was well within the authority of the state to regulate (44).

In 2001, in *Wendland v. Wendland*, the California Supreme Court ruled that the wife of a physically and mentally disabled person lacked the legal authority to refuse tube feedings on her husband's behalf, in the absence of durable power of attorney for health care, because the constitutional right to life and right to privacy required that the incompetent person receive special protection. (18)

In the case of Florida resident Terri Schiavo, who was in a PVS, the Supreme Court of Florida, on a petition filed by her husband Michael Schiavo, struck down the Florida legislation and ruled to disconnect Terri Schiavo from life support, despite opposition from Terri's parents. After a prolonged legal battle, lasting seven years, Terri Schiavo's feeding tube was removed on March 18, 2005, and she died on March 31, aged 41 years (45).

In 2006, the United States Supreme Court, in *Gonzales v. Oregon*, ruled, by a 6-3 decision, that the United States Attorney General could not enforce the federal Controlled Substances Act against physicians who prescribed drugs, in

compliance with the state law namely, the Oregon Death with Dignity Act for the assisted suicide of the terminally ill (46).

The Supreme Court of Montana, on December 31, 2009 upheld the Helena District Judge Dorothy McCarter's decision of December 5, 2008 in favour of Robert Baxter, holding that assisted suicide is an acceptable defense to any homicide charges against the doctor. Justice William Leaphart writing for the Court, stated, "In physician aid in dying, the patient, not the physician, commits the final death-causing act by self-administering a lethal dose of medicine." Robert Baxter, who was diagnosed with leukemia 12 years ago, died of lymphoma on December 5, 2008 — the day McCarter issued her ruling (34).

On January 13, 2014, Ms Nan G Nash, judge of the 2nd District Court in Albuquerque, New Mexico, ruled that terminally ill residents have a constitutional right to obtain "aid in dying." The judge said, "This court cannot envision a right more fundamental, more private or more integral to the liberty, safety and happiness of a New Mexican than the right of a competent, terminally ill patient to choose aid in dying." With this pronouncement, New Mexico becomes the fifth state in the USA to allow doctors to prescribe fatal drugs to terminally ill patients in order to end their lives. (47).

On January 24, 2014, a judge in Texas, directed a hospital not to keep Ms Muñoz, a brain-dead pregnant woman, on life support against her family's wishes. Ms Muñoz, 33, was 22 weeks pregnant and had been on life support since November, 2013. The Texas law bans abortion after 20 weeks of pregnancy. However, the judge ignored the state's compelling interest in protecting the unborn children, as reflected in the Texas legislation which treats an unborn child as alive "at every stage of gestation, from fertilization until birth." The judge said the law did not apply to Ms Muñoz because she was dead (48).

United Kingdom

The House of Lords, in 1992, in *Re T*, held that "if a patient, while competent and properly informed about the consequences of refusing or agreeing to treatment (in the circumstances of his or her present condition) had given a clear direction, then that direction is binding (49). In 1993, in the case of Anthony Bland who was in a persistent vegetative state, the House of Lords held that in making the decision whether or not to provide medical treatment, the question to be asked is whether it is in the best interests of the patient that his life should be prolonged. The previously expressed wishes of the patient should be taken into account in the assessment of best interest. The court ruled that it was in the patient's best interests for treatment to be withheld and that its discontinuance was in accordance with good medical practice. As a result, he became the first patient in English legal history to be allowed to die by the courts through the withdrawal of life-prolonging treatment (17).

In 2002, in *Re B* the House of Lords while deciding the fate of a 43-year-old woman who had become tetraplegic, and who no

longer wished to be kept alive by means of artificial ventilation, held that a competent patient has the right to refuse treatment and their refusal must be respected, even if it results in their death (50).

The British Supreme Court, on October 30, 2013, in *Aintree University Hospitals NHS Foundation Trust v. James*, allowed the withholding of life-sustaining treatment from "a gravely ill man". The Court's affirmation of a terminally ill person's right to end his life is clearly manifest in the judgment. In para 357, the Court, inter-alia, asks the question: "More importantly, is the sanctity of life protected or enhanced by insisting that those who freely wish to but are physically incapable of bringing their lives to an end, should be required to endure untold misery until a so-called natural death overtakes them?" (51). However, the same Court, on June 25, 2014, in a divergent pronouncement, dismissed Nicklinson's and Lamb's appeal holding that "no assistance could be given to a person who wishes to die unless and until a Judge of the High Court has been satisfied that his wish to do so was voluntary, clear, settled and informed" (52). This decision disappointed many who were expecting a rather affirmative decision from the UK Supreme Court in view of their earlier pronouncements.

Ireland

A 59-year-old woman, suffering from multiple sclerosis since 1989, who was immobile, in great pain and distress, and wanted assistance in dying, approached the High Court of Ireland with the prayer to declare section 2, subsection (2) of the Criminal Law (Suicide) Act 1993 as contrary to the Constitution of Ireland and violative of her rights as enshrined in the European Convention on Human Rights and Fundamental Freedoms. After thorough deliberation, in a detailed judgment on January 10, 2013, the Irish High Court rejected her prayer (53).

The European Court of Human Rights

In 2002, Mrs Diane Pretty, who was paralysed and suffering from a degenerative and incurable illness of the nervous system, called motor neuron disease, challenged the decision of the House of Lords in the European Court of Human Rights at Strasbourg, France, alleging that the refusal of the Director of Public Prosecutions to grant her husband immunity from prosecution if he assisted her in committing suicide, and the prohibition in domestic law on assisting suicide infringed her rights under Articles 2, 3, 8, 9 and 14 of the European Convention on Human Rights. The European Court, on April 29, 2002, dismissed her application holding that there has been no violation of the Convention (54).

However, following Diane Pretty's case, the European Court of Human Rights adopted a more liberal approach in three successive decisions between 2011 and 2013 holding that article 8.1 of the European Convention on Human Rights encompasses the right to decide how and when to die, and in particular the right to avoid a distressing and undignified end to life, provided that the decision is made freely. In Haas

v Switzerland the Court ruled, "In the light of this case-law, the Court considers that an individual's right to decide by what means and at what point his or her life will end, provided he or she is capable of freely reaching a decision on this question and acting in consequence, is one of the aspects of the right to respect for private life within the meaning of Article 8 of the Convention" (55). In *Koch v Germany*, the Court held, "Having regard to the above considerations, in particular to the exceptionally close relationship between the applicant and his late wife and his immediate involvement in the realisation of her wish to end her life, the Court considers that the applicant can claim to have been directly affected by the Federal Institute's refusal to grant authorisation to acquire a lethal dose of pentobarbital of sodium (56). In *Gross v Switzerland*, the Court held, "Having regard to the above, the Court considers that the applicant's wish to be provided with a dose of sodium pentobarbital allowing her to end her life falls within the scope of her right to respect for her private life under Article 8 of the Convention." (57).

Canada

In Canada, the Ontario Court of Appeal in *Malette v. Shulman* (1990) held, "The doctrine [of informed consent] presupposes the patient's capacity to make a subjective treatment decision based on her understanding of the necessary medical facts provided by the doctor and on her assessment of her own personal circumstances" and "a doctor is not free to disregard a patient's advance instructions any more than he would be free to disregard instructions given at the time of the emergency." (58). In 1992, the Quebec Superior Court, while deciding the case of Nancy B, a competent woman with an incurable neurological disorder praying for withdrawal of artificial ventilation, without which she was incapable of breathing independently, held that she was entitled to the relief sought, and ordered that the treating doctor be permitted to stop ventilation if and when the woman so instructed. The Court found that the woman's right to refuse treatment was almost absolute, subject only to the corresponding right of others not to have their own health threatened (59).

However, in 1993, in *Rodriguez v. British Columbia*, the Canadian Supreme Court, by majority, upheld the blanket prohibition on assisted suicide (60). However, 22 years later, on February 6, 2015, the Canadian Supreme Court through a landmark decision in *Carter v. Canada*, reversed their earlier stand and recognised an individual's right to end his/her life (8). The judgment is unique as the Court has not only recognised an individual's right to end his/her life at will; but has also relaxed the existing parameters like 'terminal illness that will kill the patient within six months' (6) to "grievous and irremediable medical condition causing enduring suffering"; offering a much wider latitude in the decision-making process.

Australia

In 2003, the Supreme Court of Victoria, Australia held that the Public Advocate (who had been appointed guardian) had the

power to refuse further nutrition and hydration administered via percutaneous endoscopic gastrostomy (PEG) to a 69-year-old woman in the advanced stages of dementia (61).

On August 14, 2009, the Supreme Court of West Australia ruled that a nursing home in Perth must respect the wish of 49-year-old Mr. Christian Rossiter, suffering from quadriplegia and he may be starved to death. Chief Justice Wayne Martin in his order said, "Mr. Rossiter is not a child, nor is he terminally ill, nor dying. He is not in a vegetative state, nor does he lack the capacity to communicate his wishes. There is therefore no question of other persons making decisions on his behalf. "Rather, this is a case in which a person with full mental capacity and the ability to communicate his wishes has indicated that he wishes to direct those who have assumed responsibility for his care to discontinue the provision of treatment which maintains his existence." (62).

On June 17, 2010, Supreme Court of South Australia granted to a South Australian woman confined to a wheelchair, the right to die by refusing to take food and medication. South Australian Supreme Court Justice Chris Kourakis in his judgment said a competent adult was not under a duty to take life-sustaining medication and a refusal to do so was therefore not suicide. The judge held that "Once that proposition is accepted it is difficult to maintain the proposition that self starvation is suicide as a matter of logic or by reference to consistent ethical principles," (63)

Switzerland

On November 3, 2006, the Swiss Federal Supreme Court opened a new chapter in the debate over assisted suicide and euthanasia. While recognising the right to self-determination of a 53-year-old manic depressive under Article 8 of the European Convention on Human Rights, the Swiss court responded with a sweeping opinion upholding the right of those suffering from "incurable, permanent, severe psychological disorders" to terminate their own lives. The Court held that the right to decide on the method and date of one's own death is a part of the Right of Self-Determination, guaranteed by article 8 of the European Convention on Human Rights (64).

Germany

In June 2010, the Federal Court of Justice, the highest court in Germany, ruled that "it was not a criminal offense to cut off life-sustaining treatment for a patient." "The court overturned the conviction of a lawyer who "was found guilty of attempted manslaughter for advising a client to sever the intravenous feeding tube that was keeping her mother alive, although in a persistent vegetative state. The mother had told her daughter that she did not wish to be kept alive artificially." (65).

Italy

On November 13, 2008, in the case of Eluana Englaro, a woman who entered a persistent vegetative state on January 18, 1992, following a car accident, the Italian Constitutional Court

awarded Eluana's father the right to stop his daughter from being fed (19).

France

On June 24, 2014, The Council of State, France's top administrative court, ruled that doctors had the right to end the medical support that has kept Vincent Lambert, 38, brain-damaged and quadriplegic, alive since 2008 following a road accident. Vincent's deeply religious Catholic parents challenged the Council's judgment in the European Court of Human Rights at Strasbourg. (66) However, the European court in its judgment delivered on June 5, 2015, upheld the ruling of the French court (67).

Indian scenario

There is no legislative enactment in India concerning one's right to end life. However, in a positive development, Section 309 of the Indian Penal Code which criminalised attempt to commit suicide is expected to be repealed. However, section 306 of the Indian Penal Code which says "If any person commits suicide, whoever abets the commission of such suicide, shall be punished with imprisonment of either description for a term which may extend to ten years, and shall also be liable to fine" will remain intact. Hence, any act of providing assistance in dying will continue to be a criminal offence. This is almost similar to the British law where suicide was decriminalised by the Suicide Act, 1961; but under Section 2(1) "A person who aids, abets, counsels or procures the suicide of another, or attempt by another to commit suicide shall be liable on conviction on indictment to imprisonment for a term not exceeding fourteen years."

It is noteworthy that after the repeal of Section 309 of the Indian Penal Code, a patient's right to refuse medical treatment, which is a universally accepted right of an individual emerging out of the right to self determination, shall stand vindicated in India too. Thus, a patient's refusal to take medical treatment will not constitute an offence.

Before the case of Aruna Shanbaug, the issue had been deliberated by the Supreme Court in 1996, rejecting a person's right to end his/her life (68). Another case filed in 2005 is pending before a constitution bench of the Court (69). In view of the large proportion of vulnerable population in India, one of the biggest objections against assisted dying is founded in concern against its misuse by the family members, near relatives, surrogates and unscrupulous physicians. This is what the Hon'ble Supreme Court of India has also said in their aforesaid judgment in Aruna Shanbaug's case. In fact, this is one of the main reasons why the apex Court has subjected the right to passive euthanasia to mandatory approval of the High Court. The possibility of misuse is undoubtedly a valid concern but it needs to be understood in a more practical context. If a family member or close relative looking after the patient wants to kill him for greed or some other unlawful motive he can easily do it by not providing the medical care which is due, or by diluting such care, which does not constitute any

offence, rather than colluding with the physician and resorting to euthanasia. Why will a family member or a surrogate seek judicial intervention by the High Court, when an easier option is available to him?

Conclusion

The protracted continuance of Aruna Shanbaug in PVS is not a solitary instance. Many individuals across the world have suffered --- and are still suffering -- such colossal indignity during the last days of their life, owing to undue extension of the dying process, in utter violation of their autonomy and the right of self-determination and callous disregard for their pain and agony. Legislative inadequacy coupled with judicial heterogeneity has exposed the decision making process to unwarranted ambiguity. A pious and humane act of providing assistance in dying to a terminally and incurably ill person is treated as an offence owing to antiquated and proscriptive laws rooted in religious misinterpretation, a false notion of virtue and undue moral paternalism. Many lives are forced to linger aimlessly prolonging the suffering of the individual, and heavily burdening the already stressed families. The Canadian Supreme Court's pronouncement, on February 6, 2015, in *Carter v. Canada* (8) affirming a person's right to die with dignity, reversing the law in vogue for almost a quarter of a century, has come as an oasis in the sultry desert of denial and negativity. It is equally heartening to know that, following Brittany Maynard's death, in the USA, "More than a dozen states, plus the District of Columbia, are considering controversial medically assisted death legislation this year" (70).

No doubt, end of life decision making is an intricate exercise involving careful assessment of the veracity of the individual's consent, scientific evaluation of the severity and course of his/her illness, exclusion of extraneous forces, knowledge of evolving utilitarian notions, risks involved in the event of a potentially wrong decision and the possibilities of other options. One of the biggest challenges continues to be the determination of consent which contemplates a valid purpose and truly informed consent in the case of conscious individuals and the assessment of best interest in the case of those who are incapacitated. In view of the profound and irreversible stakes involved, the matter calls for thorough and deep deliberation. At the core of the argument supporting assisted suicide are the twin goals of maximising individual autonomy and minimising human suffering. An incapacitated individual is a helpless person confronted with the perpetual risk of intrusion into his autonomy by the social paternalists. Incessant infliction of pain and agony on a person is not consistent with human dignity, which is an essential element of sanctity of life. An act violating the dignity of life is, therefore, contrary to the sanctity of life. The possibility of abuse of vulnerable persons is a valid concern; but it can always be curbed by appropriate legislative and regulatory mechanisms. This is clear from the fact that in jurisdictions where assisted dying has been practised for decades, not a single case of abuse has been reported so far. Judicial decisions may fill the vacuum for some time; but they cannot be a substitute for

legislative enactments. The situation calls for the enactment of comprehensive and fine-tuned legislative strategies in order to relieve the suffering of many awaiting a dignified exit from the unbearable agony of living with death.

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