CHAPTER – IV

LEGISLATIVE MARCH ON VOLUNTARY TERMINATION OF LIFE

4.1. INTERNATIONAL LAW - HUMAN RIGHTS - EUTHANASIA

4.1.1. PROVIDING COMPULSORY TREATMENT TO PATIENT - A HUMAN RIGHT

4.1.2. A RIGHT NOT TO BE SUBJECTED TO CRUEL INHUMAN OR DEGRADING TREATMENT

4.1.3. RIGHT TO LIFE OR DUTY TO LIVE?

4.2. EUROPEAN LIBERALISM

4.2.1. PIONEER THINKING OF NETHERLANDS

4.2.2. THE BELGIAN ACT ON EUTHANASIA

4.2.3. NEW HORIZONS IN LUXEMBOURG

4.3. MERCY KILLING IN GERMANY, SWITZERLAND AND FRANCE

4.3.1. GERMAN APPROACH

4.3.2. MERCY KILLING IN SWITZERLAND

4.3.3. FRENCH PASSIVE EUTHANASIA

4.4. UNEASY FORBEARANCE IN U.K.

4.4.1. DIANE PRETTY's case:

4.4.2. LATEST TRENDS IN REFORMING LAW ON EUTHANASIA

4.4.3. COUNCIL OF EUROPE

170
HUMAN RIGHTS PHILOSOPHY AND EUTHANASIA

Very often, intellectuals are inclined to vie the issue of euthanasia with Human Rights touch-stone. The base of human rights touch appears to have been equally fondling both the protagonists and antagonists of mercy killing. The Human Rights jurisprudence no doubt supports with all strength the proposition that the life of a person shall have to be preserved and protected by all means and even under difficult circumstances whatsoever and naturally opposes any proposal to terminate life even though the contrary medical opinion is known to be prophetically accurate. Equally powerful is the contra contention that 'the right to life does not impose a duty to live' and the endeavour to protect life, either by individual or by the State, should not command a mere living without dignity and with unbearable pain, and any attempt to save or perpetuate life by requiring the patient to continue to bear the unbearable pain based on religious and other moral dogmas, is nothing but a blatant violation of 'Right to Live with Dignity.' In fact, the Right-to-die debate was rekindled in Europe after the death of British motor neurone disease sufferer Diane Pretty who lost her battle in British and European Courts to end her life with her husband's help. Is the issue of euthanasia or assisted suicide is liable to be challenged under the Human Rights Act? And this question figured in the famous case.¹

¹ R. PRETTY Vs. DPP (2002) 1 AC 800.
There has been an interesting discussion on the Human Rights issues when Diana Pretty sought the assurance of the Director of Public Prosecutions not to prosecute her husband if she takes the assistance of her husband in her voluntary killing, and her husband should not face prosecution under Sec-2(1) of the Suicide Act 1961.

When the D.P.P. refused the confirmation sought by Mrs. Pretty, she challenged the decision of the D.P.P. and the matter reached the House of Lords and the European Court of Human Rights. Her main thrust of contention is that the provisions of the Suicide Act, 1961 infringed the rights granted under the European Convention on Human Rights, which was rejected by both the House of Lords and European Court. Of course, in the decision of the House of Lords, it was said that D.P.P. had no legal power to issue an immunity of prosecution. But on the human rights issues, the following were the conclusions basing on the European Convention:-

Art-2: - the Right to Life - On behalf of Mrs. Pretty it was argued that the right to life in Art-2 of the European Convention included 'a right to control the manner of one's death' and therefore a right to commit suicide. Both the House of Lords and the European Court held that Art-2 imposed a duty on the State to protect life which could not be taken to include a right to die. Mrs. Pretty's interpretation involves too great a stretch of the natural meaning of the words.
Art-3: the right not to suffer torture or inhuman and degrading treatment

Mrs. Pretty argued that by prohibiting her husband from killing her, the state was inflicting torture or inhuman or degrading treatment upon her. It was held by the European Court of Human Rights that even if Mrs. Pretty's medical condition could be said to amount to torture, inhuman or degrading treatment, it could not be said that this was inflicted by the State or was as a result of treatment by the State. The European Court also stated that the right under Art-3 had to read alongside the right to life in Art-2. It could not therefore be argued that a person had the right to be killed or helped to die under Art-3 as that would contravene the right to life under Art-2.

Art-8: The right to respect for private and family life

The argument was that the law on suicide interfered with Pretty's right to respect for private life. The House of Lords held that the right to private and family life did not bear on the right to choose to shorten life. The European Court of Human Rights disagreed and accepted the argument that the right to determine issues surrounding one's death was an aspect of private life. As was held in para-65, the court stated that –

"the very essence of the Convention is respect for human dignity and human freedom. Without in any way negating the principle of sanctity of life protected under the convention, the court considers that it is under Art-8 that notions of the quality of life take on significance. In an era of medical sophistication combined with longer life expectancies, many people are concerned that they should not be forced to linger on in old age or in states
of advanced physical or mental decrepitude which conflict with strongly held ideas of self and personal identity."

Nevertheless they took the view that even if the law on suicide did infringe Mrs. Pretty's rights under Art-8(1), the intervention could be justified to protect the interests of the State under Art-8(2). In particular, it enabled the law to ensure that vulnerable people were not taken advantage of by others and manipulated into committing suicide.

Art-9

It was argued that the law on assisted suicide infringed Pretty's right of freedom of thought, conscience and religion. She was being prevented from exercising her moral conviction that it would be best if her life was brought to an end. This argument was rejected on the basis that she was not being prevented from thinking or believing what she wished. It was permissible to prohibited actions motivated by person's beliefs, Art-9 only dealt with acts prohibiting the manifestations of a person's beliefs.

Art-14

It was argued that to allow people who were physically capable of committing suicide to do so, but to prohibit those physically incapable of committing suicide to arrange for another person to do so amounted to discrimination on the grounds of disability contrary to Art-14. The European Court accepted that Mrs. Pretty was discriminated against in this way but held that there were objective and reasonable justifications for the
discrimination, namely that any law that permitted assisted suicide could lead to vulnerable people being manipulated into killing themselves.

The Diane Pretty litigation indicates that the present law in the U.K. on suicide will not be open to challenge on the basis of European Convention. The decision is to be appreciated for the reason that –

Firstly, the decision was not saying that it was not contrary to the European convention for a State to prohibit assistance of suicide, nor saying that it would be contrary to the European Convention for a State to render it lawful. In other words, if the Government decided to change the law and legalise the assistance of suicide, this would probably be permitted under the Convention, provided there were adequate safeguards to ensure that vulnerable people’s rights to life would not be infringed.

Secondly, there is a high level judicial approval of the argument that if suicide is permitted, then logically, it should follow that those who, through their disability, are unable to commit suicide should be entitled to be killed by another.

Thirdly, there is recognition from the European Court of Human Rights that a competent person has a right to refuse life saving treatment and that this right is protected by the European Convention on Human Rights.

In deed, in R (Burke) vs. G.M.C. (2005) 3 FCR 169, the Court of Appeal stated that Art-3 gave a right to be protected from treatment or a lack...
of treatment which would result in dying in avoidably distressing circumstances.¹

4.1. PROVIDING COMPULSORY TREATMENT TO PATIENT - A HUMAN RIGHT

It may not look weird that a demand to provide or continue treatment to a supposedly terminally ill patient is in consonance with the human rights philosophy. Verily, the Human Rights Act has been invoked to require doctors to provide treatment for patients they might otherwise not treat. A recent decision R (BURKE) vs. G.M.C.² is an illustrating example. In this case, Leslie Burke suffered from cerebellar ataxia which may require artificial nutrition and hydration (ANH) in future. Burke intends to have his artificial feeding continued even when he becomes incompetent to survive. Hence, he sought a declaration from the court to clarify the circumstances in which it would be lawful for doctors to withdraw the feeding and hydration. He was concerned that the guidance issued by the G.M.C. on withdrawal of artificial feeding and hydration was inconsistent with the law. In this connection, he sought a number of declarations from the court, notably the following -

1. The withholding or withdrawal of artificial nutrition and hydration, leading to death by starvation or thirst would be a breach of Mr. Burke’s rights under Art-2, 3 and 8 and would be unlawful under domestic law.

² (2005) 3 FCR 169.
2. Where a competent patient requests or where an incompetent patient has, prior to becoming incompetent, made it clear that they would wish to receive artificial nutrition and hydration, the withholding or withdrawal of artificial nutrition and hydration, leading to death by starvation or thirst would be a breach of their rights under Art-2,3 or 8 and would be unlawful under domestic law.

3. The refusal of artificial nutrition and hydration to an incompetent patient would be a breach of Art-2 unless providing such artificial nutrition and hydration would amount to degrading treatment contrary to Art-3.

The Court of Appeal declined to give the declaration sought as he was not incompetent at that time of his request and the issue of his medical treatment in the future was a hypothetical question. The court emphatically stated that a patient did not have a right to demand whatever treatment he or she wanted, and approved the following propositions promoted by the G.M.C: -

(i) The doctor, exercising his professional clinical judgment, decides what treatment options are clinically indicated (i.e. will provide overall clinical benefit.) for her or his patient.

(ii) She or he then offers those treatment options to the patient in the course of which he explains to him or her the risks, benefits, side effects, etc. involved in each of the treatment options.
(iii) The patient then decides whether she or he wishes to accept any of those treatment options and, if so, which one. In the vast majority of cases, she or he will, of course, decide which treatment option she or he considers to be in her or his best interests and in doing so, she or he will or may take into account other, non-clinical factors. However, the patient may decide to accept or refuse the treatment option on the basis of the reasons which are irrational or for no reasons at all.

(iv) If she or he chooses one of the treatment options offered to him, the doctor will then proceed to provide it.

(v) If however, the patient refuses all of the treatment options offered, and instead informs the doctor that the patient wants a form of treatment which the doctor has not offered, the doctor will, no doubt, discuss that form of treatment with the patient (assuming that it is a form of treatment known to him or her) but if the doctor concludes that this treatment is not clinically indicated, the patient is not required (i.e. he is under no obligation) to provide it to the patient although the patient should offer to arrange a second opinion.

The court was adamant that a patient had no right to demand treatment on the basis of the right of autonomy and the court explained –

"Autonomy and the right of self-determination do not entitle the patient to insist on receiving a particular medical treatment regardless of the nature of
the treatment. Insofar as a doctor has a legal obligation to provide treatment this cannot be founded simply upon the fact that the patient demands it. The source of duty lies elsewhere.

This did not mean there was not a duty to provide ANH as the court explained:

"Once a patient is accepted into a hospital, the medical staff come under a positive duty at common law to care for the patient....... A fundamental aspect of this positive duty of care is a duty to take such steps as are reasonable to keep the patient alive. Where ANH is necessary to keep the patient alive, the duty of care will normally require the doctors to supply ANH.

The courts have accepted that where life involves an extreme degree of pain, discomfort or indignity to a patient, who is sentient but not competent and who has manifested no wish to be kept alive, the circumstances may absolve the doctors of the positive duty to keep the patient alive. Equally the courts have recognized that there may be no duty to keep alive a patient who is in a persistent vegetative state."¹

However, this did not apply where the patient was competent and wanting to receive ANH. Withdrawing ANH from a competent patient against his or her wishes would infringe her or his right to life under the ECHR, Art-2 and be guilty of murder except in the unlikely event that ANH would hasten

death. If there is doubt over the legality of withdrawing ANH, advice can be sought from the Court.¹

None of the International Human Rights Instruments addresses euthanasia directly. This however does not mean that euthanasia would be inconsistent with International Human Rights Law. The perspective that international law is entirely a decision making process and not just the reference to the trend of past decisions which are termed as ‘rules’, makes it possible to address relevant articles of the International Covenant on Civil and Political Rights and the European Convention for the protection of Human Rights and Fundamental Freedoms, which can provide a consensual basis for an open debate on euthanasia.

Proponents of euthanasia, often use the argument of the 'principle of human self-determination', which contend that human self-determination is not derived from the State and that the State in principle is not entitled to impose on its citizens ethical rules which interfere with their private lives.

For an encroachment upon individual rights strong arguments must be available, leading to the inevitable conclusion that, without such rules, essential values of the society would be endangered.

According to the opponents of euthanasia, the right of self-determination is a hybrid right. It is not mentioned in the European Council of Human Rights, but the International Covenant on Civil and Political Rights refers to it explicitly in Art-1, the general comment on which states that, “the right of self-determination is of particular importance because its realization is

an essential condition for the effective guarantee and observance of individual human rights and for the promotion and strengthening of human rights". This implies that an individual cannot bring a claim to protect his or her rights of self-determination but that a state should take individual self-determination into consideration while interpreting other rights in the Covenant.

It can be argued that these essential values of society will not be in danger when no alternatives exist. Denying the right to euthanasia in that case would force people to suffer against their will, which would be cruel and against their human dignity. On the other hand it can be questioned whether it is not so much the right to self-determination as the duty to prevent suffering which is crucial.

The Right to Life is the supreme right from which no derogation is permissible even in times of public emergency which threatens the life of the nation. However it is not an absolute right like the right not to be tortured. There are some limitations. According to the ICCPR, the interpretation of the right to life should be broad and should for instance include the duty of the State to reduce Infant mortality and to increase Life Expectancy. However, the traditional approach to the right to life is focused more on the limitations explicitly mentioned in Art-6 of the ICCPR and Art-2 of ECHR. The word 'arbitrary deprivation' in Art-6 can be considered as justifying the putting to end of some one's life. According to the General Comment on Art-6, the only explicitly mentioned justifiable limitation of the right to life is the death penalty. As far as other limitations are concerned, the General Comment
only states that “the deprivation of life by the authorities of the state is a matter of utmost gravity.” According to Ramcharan, contemporary issues such as abortion, euthanasia and the death penalty can affect the realization of the right to life.

The Right to Life can be used as an argument in favour as well as against euthanasia. Those opposed to euthanasia argue that “the right to die” would be in contradiction to right to life. According to them, the right to life is a supreme life in which human dignity and self determination (and also other rights) are grounded. They stress that International Law has not discussed this issue and that Art-6 and 2 do not provide any possibilities to make euthanasia justifiable. Arguments in favour of euthanasia are that – a right to life is a right to life worth-living. This is a more subjective interpretation and presents a more liberal approach to self determination and human dignity. In this sense, the request of the patient is of decisive importance. The right to life is a liberty right, and also a positive right, as it provides patients with the opportunity to refrain from it. According to Nowak, “the state’s duty to ensure does not go so far as to require that life and health be protected against the express wish of those affected. An obligation to sanction suicide with criminal law, can not be derived from Art-6. As a result of the accessory character, the conclusion is also applicable to the offence of ‘aiding a suicide’.
4.1.2. A right not to be subjected to cruel, inhuman or degrading treatment

The aim of Art-7 of ICCPR, according to General Comment is “to protect both the dignity and the physical and mental integrity of the individual. It is the duty of the state party to afford every one protection through legislative and other measures as may be necessary against the acts prohibited by Art-7”. Since most of the cases, concerning Art-7 of ICCPR and 3 of ECHR deal with the treatment of persons in detention, so their application in this context could be questioned. However, the fact that neither Article contains any definition of the concepts which it covers or acts that are prohibited, does not allow limitations which may suggest that cruel, inhuman or degrading treatment is allowed in any case. This supposes that Art-7 can be interpreted broadly that failing to provide, or inadequately providing, palliative care to a person who suffers unbearably constitutes lack of proper medical care.

The practice of euthanasia has arisen against a background of developing medical technologies. Arguably, medicine itself shares responsibility for legalized Dutch euthanasia practice. Hitech medicine can disproportionately provide cruel, inhuman or degrading treatment and disproportionately lengthen a patient's suffering. Invasive medical treatment and its side effects may well lead a patient to request euthanasia. As to the duty of states, Art-7 and 3 imply that states have much responsibility to
protect persons against cruel, inhuman and degrading treatment. This would plead for a further development of palliative care.¹

The Belgian Law on Euthanasia -2002 represents a very important step towards the right to choose. It must be seen in the wider context of the efforts by right-to-die organizations at the European level. On 25th. September, 1999, in the absence of a substantial number of its members, the Parliamentary Assembly of the European Council adopted Recommendation No. 1418 entitled "PROTECTION OF THE HUMAN RIGHTS AND DIGNITY OF THE TERMINALLY ILL AND THE DYING." To a number of honorable proposals about living wills and the recognition of the right to refuse treatment, was added an explicit condemnation of euthanasia which upheld the absolute prohibition of intentionally putting an end to the life of incurable or dying patients, referring to Art-2 of the European Convention of Human Rights (which states that "no one shall be deprived of his life intentionally");

"recognizing that a terminally ill or dying person’s wish to die never constitutes any legal claim to die at the hand of another person"; and "recognizing that a terminally ill or dying person’s wish to die can not of itself constitute a legal justification to carry out actions intended to bring about death."²

While one need not give this recommendation more importance than it deserved (since it had no constraining power), nevertheless opponents to the

¹ Dr. B.R. Sharma, Reader, Dept. of Forensic Medicine & Toxicology, Govt. Medical College & Hospital, Chandigarh.
² Jacqueline Herremans: She is Centre d’Action Laique’s Representative to the IHEU General Assembly and President of the Belgian Right to Die Society (ADMD): Belgium’s legalization of Euthanasia -1-2-2003- www.iheu.org/node/1110.
decriminalization of euthanasia repeatedly referred to it, embellished as it was by the aura of reference to the European Convention on Human Rights. Furthermore the European Court of Human Rights alluded to it in the recent case of Diane Pretty, whose request to die with dignity was rejected.

Has recommendation 1418 been superseded? It would certainly be premature to bury it. Nevertheless, it has been subjected to serious criticism and will in all likelihood turn out to be but a temporary stage, indeed a mistake, in the European Council’s debate around end-of-life questions.

Euthanasia, and in particular the new Dutch and Belgian legislation on the issue, was on the agenda of a hearing held in Paris in October, 2002 by the Committee on Social Questions, Health and Family.

Mrs. Gatterer, of the Australian Parliament, whose report had initiated Recommendation 1418, presided. But the tone of the debate had changed since 1999. In contrast to the discussions that led to Recommendation 1418, the voices of those defending the right to die were heard. J. Herremans and Dr. Michael Irwin, President of the World Federation of Right to die societies. Traditional voices, too were heard. An observer representing the Holy See asserted that there was but one single morality – that derived from the Decalogue – and indulged in the shortcut between euthanasia and Nazism.

Dick Marty, a member of the Swiss Parliament entrusted with preparing the report, concluded the session by stating that –

"the Belgian and Dutch legislators in no way stand accused. Whatever our judgment on their position, we should respect it – these are countries with a
great humanist tradition, where life is clearly valued very highly.... The 1999 decision of the Council of Europe against euthanasia does not stop there. The debate goes on.”

4.1.3. RIGHT TO LIFE OR DUTY TO LIVE?

Every one in this planet admits that Right to life is a natural, fundamental and inalienable right, claimed by the individual, guaranteed and protected by the State and endured by the society. Many antagonists of euthanasia, more specifically, religiously obsessed ‘purists’ vociferously claim that the ‘Right to life’ is to be glossed through the religious facsimile that no one, except nature representing Divinity, shall lay his hand on the ‘life’ and simply saying, the God-given life shall be taken only by God or His Authority i.e. Nature. Any maneuver or manipulation, be it technological or medical, either to truncate or terminate the life is construed to be defilement or desecration of the sanctum sanctorum of God. Such is the antagonism towards euthanasia.

Dr. Henry R. Glick in his book ‘The Right to Die : Policy Innovation and its Consequences(1992 Columbia University Press) intends to show how legal wrangling over treatment-withdrawal, euthanasia and physician assisted suicide has crested at State and National levels. Many states have right to die laws but they vary from State to State. Few are considered ‘comprehensive’ meaning that they create loopholes or that they ignore whole areas tied to the issue. Compounding the situation is widespread ignorance- surprisingly even among doctors, nurses and other health-care professionals – about these laws and what they mean. Criticism of right-to-
die legislation typically springs from ethical considerations that has the core of the issue bound by a familiar moral dilemma: Can 'life' effectively end even though there is still a pulse? If so, when should whatever remains be terminated? Glick says that the lack of comprehensive right-to-die laws may be the result of a public paradox. Despite opinion polls shown in the vast majority of Americans favouring such laws, when given legal options for directing how their deaths may be arranged according to their wishes—such as through Living Wills—most people choose to do nothing. He further says that it is clear that the majority of people want to be able to avoid being kept alive by heroic measures. Almost, no one wants a technologically prolonged death. But most people do not translate their ideas into actions. They just hold opinions.

It may be still harder and difficult to shape a popular opinion on the basis of the availability of sophisticated life-sustaining medical technology and high tech medicine now abundantly available than ever before. The political, social and economic realities continue to muddy the issue and the legislation on right-to-die may have ramifications on these fronts. Any measure affecting the way older, terminally ill or hopelessly comatose patients are treated could have enormous economic consequences for a national health system that of late has been drawn increasing criticism for being fiscally—if not ethically—out of whack. In a time when fewer than 30% of Americans can afford comprehensive health insurance, life support is often outrageously expensive, clocking in at upwards of $10,000 a day in some cases. On the eve of the unveiling of the Clinton administration's proposals
for health-care reform, there is talk in Washington for living wills, for example, to be used to limit medical coverage.

Right-to-Die policies touch so many sensitive nerves that they pose a political quandary of potentially epic proportions. Glicks likens the situation – characterized by growing national uneasiness amid a din of ethical, legal and social debate – to the ferment over abortion that led to Roe vs. Wade (1973). He says that 'Right to Die advocates see most of these proposals, whether they are withdrawing treatment, euthanasia or physician assisted suicide, as essentially murder. The anti-abortion people have taken up the right to die as a parallel issue. These proposals, in their view, are a way of hastening death.

The Glick’s observations are mostly based on developments in Florida, California and Massachusetts etc. He depicts Florida, with its high elderly population, as a bellwether state in bringing the issue to the fore in national politics. An interesting case of Estelle Browning of Florida who had taken care of her last wishes rather well, is worth reckoning.

In 1985, the 85 year old Dunedin, Florida woman had written a living will stipulating that, should she become ill and unable to make medical decisions for herself, she did not want to be kept alive by machines or fed artificially. An year later, Browning suffered a massive stroke and landed in exactly that predicament. As she lay in pain in her hospital bed, lapsing in and out of consciousness and being fed through a tube, her legal guardian, hospital staff, lawyers and the courts hashed out whether or not to obey her wishes and disconnect her support.
Browning's case had slipped through a loophole in Florida's law that allowed for only terminally ill patients to refuse life-sustaining treatment, living will or no. Browning wasn't "terminal", but her condition promised little hope for recovery. She spent three years in a semi-vegetative state, suffering from bleeding, vomiting, bedsores and other chronic problems. Finally in 1990, in GUARDIANSHIP OF BROWNING vs. STATE OF FLORIDA, the Florida supreme court extended the living-will option to patients who weren't terminally ill. But the ruling didn't come soon enough for Estelle Browning. She had died in 1989, after three years under anguished circumstances she had carefully planned to avoid. Though it was clearly a watershed decision on the right-to-die issue in Florida, the ruling failed to tie up all of the state's loose ends on the subject. The case touched off a melee of Florida lawmakers, lobbyists, and special interest groups, a fight that continues today with no popular – or legal – consensus in sight.¹

Public awareness about the right to die in Florida reached a high point in 1967, when Walter Sackett, a retired Miami doctor, made the issue his personal crusade after winning a seat in the Florida House of Representatives. In his profile of Sackett's work in the Right to Die, Glick credits this novice legislator with being the first to put the topic on a legislative agenda anywhere in the U.S. Sackett put forth the state's first living will legislation, arguing that terminally ill patients and their families should be spared unwanted and futile medical treatment. Not content with

¹http://mailer.fsu.edu/~research/RinR/Final.html.
that, Sackett went a step further and advocated euthanasia for indigent retarded patients who were wards of the State.

The main argument of the opponents of euthanasia emphasizes that such legal accord may fall into the wrong hands as Michigan's Dr. Jack Kevorkian, the inventor of the "Mercitron" carbon monoxide suicide machine. Kevorkian has made a reputation for helping a number of chronically ill patients kill themselves, a practice that has earned him suspension of his state medical license and prompted the Michigan legislature to enact a law specifically designed to stop him. "Dr. Death" — one of his monikers in the popular press — spent the first part of 1993 helping patients commit suicide while racking against time to beat the new state law.

The bizarre legal leapfrog — which brought advocates to a froth on both sides of the debate — nevertheless produced the first federal ruling on the right to withdraw treatment. Cruzan, a 30 year old Missouri woman in an irreversible vegetative state since a 1983 car accident, hadn't executed a living will but had told friends and family that she would not have wanted to be kept alive in such a condition.

When the Missouri state supreme court refused to allow Nancy's feedings to be discontinued, the Cruzans appealed to the U.S.Supreme Court and lost. Later, the State reversed itself and in 1990, Nancy's feeding tubes were disconnected and she died.
4.2. EUROPEAN LIBERALISM

History of Euthanasia:

For over 700 years, the Anglo-American common law tradition has punished or otherwise disapproved of both suicide and assisting suicide. In the 13th century, Henry de Bracton, one of first legal treatise writers, observed that "just as a person may commit felony by slaying another so may he do so by slaying himself." For the most part, the early American colonies adopted the common law approach. For example, the legislators of the Providence Plantations, which would later become Rhode Island, declared in 1647, that "self murder is by all agreed to be the most unnatural, and it is by this present Assembly declared, to be that, wherein he that doth it, kills himself out of a premeditated hatred against his own life or other humor ....... his goods and chattels are the king's custom, but not his debts nor lands; but in case he be an infant, a lunatic mad or distracted man, he forfeits nothing." Virginia also required ignominious burial for suicides, and their estates were forfeited to the crown.

William Penn abandoned the criminal forfeiture sanction in Pennsylvania in 1701, and the other colonies (and later, the other States) eventually followed this example.

But the Statement of Zephania Swift, who went on to become Chief Justice of Connecticut that — "there can be no act more contemptible, than to

(www.euthanasia.com/history.html
attempt to punish an offender for a crime, by exercising a mean act of revenge upon lifeless clay, that is insensible of the punishment.

There can be no greater cruelty, than the inflicting of a punishment, as the forfeiture of goods, which must fall solely on the innocent offspring of the offender. .... Suicide is so abhorrent to the feelings of mankind, and that strong love of life, which is implanted in the human heart, that it cannot be so frequently committed, as to become dangerous to society.

There can of course be no necessity of any punishment” is indicative of the fact that the sanction was taken off out of consideration for the family of the person who committed suicide, and not acceptance of suicide. The condemnation extended to any person who aided or abetted such suicide in any way, even if their advice or counsel led to the act.¹

In 1920, the book 'Permitting the Destruction of Life not Worthy of Life' was published in which authors Alfred Hoche, M.D., a Professor of Psychiatry at the University of Freiburg, and Karl Binding, a Professor of law from the University of Leipzig, argued that patients who ask for 'death assistance' should, under very carefully controlled conditions, be able to obtain it from a physician.²

The decriminalization of euthanasia in Netherlands, followed by Belgium, has generated a stormy discussion throughout the globe, particularly in Western world. It becomes pertinent to refer to Recommendation 1418 of the Parliamentary Assembly of the Council of

¹ www.euthanasia.com/history.html.
Europe, which urged the member States “to respect and protect the dignity of terminally ill or dying persons in all respects”. In this connection, it recommended three measures i.e. –

1. Recognising and protecting a terminally ill or dying person’s right to comprehensive palliative care;
2. Protecting the terminally ill or dying person’s right to self-determination;
3. Upholding the prohibition against intentionally taking the life of terminally ill or dying persons.

But these recommendations are strictly subjected to Art-2 of the European Convention on Human Rights which states that "NO ONE SHALL BE DEPRIVED OF HIS LIFE INTENTIONALLY."

In September 2003, the Social, Health and Family Affairs Committee of the Council, submitted a report on euthanasia, written by the Committee’s rapporteur Mr. Dick Marty, which favoured legalization of euthanasia. The report stated that some doctors practiced active, voluntary euthanasia or assisted in suicide, on terminally ill patients who experienced 'constant, unbearable pain and suffering without hope of any improvement, and the practice being confined to the shadows of discretion or secrecy, the probability of decisions taken in an arbitrary manner either by the physicians or even family members where it would be more pernicious if carried out beyond any procedure or control, and such exercise carries the greatest risk of abuse, and as the penal and professional sanctions were very rare, there was a striking divergence between the law and practice, and finally this gap is to be reconciled to maintain rule of law.
The report mentioned that the legislations of Netherlands and Belgium on euthanasia aimed at bridging the gap between the law and practice, and 'to bring such practices out of the grey area of uncertainty and potential abuse by establishing strict and transparent procedures, mechanisms and criteria which doctors and nursing staff have to observe in their decision making' and further stated that 'No body has the right to impose on the terminally-ill and the dying the obligation to live out their life in unbearable suffering and anguish where they themselves have persistently expressed the wish to end it' and further pointed out that 'palliative care could not take away unbearable pain and suffering in all cases and in any event, the issue went beyond the alleviation of pain – and “the degree of patients' own suffering, including mental anguish and loss of dignity that they feel, is something that only then can assess, individuals suffering in the same situation may take different end-of-life decisions, but each human being's choice is deserving of respect.”

Such was the force of argument in favour of euthanasia.

This report, of course turned down by the Council of Europe – which is larger than European Union, was flawed by J.Keown /Rose F Kennedy, Professor of Christian Ethics, of Georgetown University, in their article “Mr.Marty's Muddle : a superficial and selective case for euthanasia in Europe” for overstating the arguments for legalization and downplaying or
ignoring arguments against it. It was held that the supposed gap between law in theory and in practice is only notional, but not real, and any statistical data purported to have been favoring legalization is not reliable, more over such legalization would further worsen the medical and public integrity in values, and one can not consider Dr. Kevorkian as a model of good medical practice, for of the 69 people he assisted in suicide only a quarter were terminally ill. The slippery slope will be very steep. Of course, those opposed to euthanasia do not believe that life should be preserved at all costs – that is a cheap caricature. The Marty Report is held to be an exercise in failed cosmetic surgery.

4.2.1. PIONEER THINKING OF NETHERLANDS

Euthanasia has been legalized in 2001 in Netherlands and Belgium in 2002. Both the Netherlands and Belgium have legalized euthanasia as well as assisted suicide. If a third party performs the last act that intentionally causes a patient’s death, euthanasia has occurred, and if the patient performs the act causing the death, himself or herself, then it becomes an act of assisted suicide. It is felt that Dutch discussion leading up to passage of the euthanasia law was carried forward not from the perspective of the patient but from the perspective of the doctor. Government - conducted research indicated that 60% of doctors did not report euthanasia cases to the municipal pathologist out of fear of being prosecuted for violating the Dutch Criminal Code. Art-293 of that Code makes clear that to kill some one is a crime, and if some one kills another person at his request, the punishment can be as much as twelve years in prison. Parliament then decided to
amend Art-293 of the Criminal Code to exclude doctors from imprisonment if they kill their patients in accord with Sec-2 of the "Termination of Life on Request and Assisted Suicide Act." The text of "Die Care Criteria" of the euthanasia Act, Chapter-II, Section-2 states that the attending physician must:

a) be convinced that the patient has made a voluntary an carefully considered request (to be killed);

b) be convinced that the patient's suffering is unbearable and that there are no prospects of improvement;

c) have informed the patient about his or her situation and prospects'

d) have come to the conclusion, together with the patient, that there is no reasonable alternative in the light of the patient's situation;

e) have consented with at least one other, independent physician, who must have seen the patient and have given a written opinion on the due care criteria; and

f) have terminated the patient's life or provided assistance with suicide with due medical care and attention.

By excluding doctors from the frame of liability, the Criminal Code has become subjective. The assumption behind the law is that doctors can be trusted not to misuse their skills to kill and this sort of trust can never be the foundation of law. The change in Dutch Criminal Code makes it possible for
the doctor to misuse his practice, and in trying to protect the doctor, the rights of the patient have been ignored.

Both Euthanasia and assisted suicide have been widely practiced in the Netherlands since 1973 although they were against the law until 2002. The Dutch situation between 1973 and 2002 was an outgrowth of a series of court decisions and medical association guidelines, beginning with a 1973 District Court case in which Geertruida Postma, a Dutch Physician, was convicted of the crime of euthanasia after she ended the life of her seriously ill mother. In fact, the practices of euthanasia and physician assisted suicide have been going on under an umbrella of official tolerance for decades, and practiced under an agreement worked out between the government and the medical association, but it has not been officially legal. Even in this legally murky environment, euthanasia has been practiced freely although the exact number of cases is not known because of underreporting. Dutch Physician Dr. Richard Fenigsen has written that Dutch general practitioners are estimated to perform from 5000 to 20,000 cases per year, which he notes that in American terms would be from 80,000 to 300,000.

On April 10, 2001, the Dutch Parliament approved the Termination of Life on Request and Assisted Suicide(Review Procedures) Act,2001. This Act impacted some provisions of the country's criminal code specifically stating that the offences of euthanasia and assisted suicide are not punishable if they have been 'committed by a physician who has met the requirements of due care' that are described in the Act and if they informed

\[\text{Dr. Fenigsen, 'A case against Dutch Euthanasia' Hastings Centre Report special supp. Jan/Feb, 1989.}\]

197
the municipal 'autopsist' in accordance with the Burial and Cremation Act. In addition, the law recognizes the right of a physician to carry out euthanasia based on a written advance request for death of a currently incapacitated patient who is 16 years old or older.

Taking into consideration of the ethical aspects involved in euthanasia, it is important to realize that the content of legislation legalizing euthanasia is seldom dictated by the positions one takes on particular moral issues. For example, the view that voluntary euthanasia is morally permissible in certain circumstances does not by itself settle the question of whether euthanasia should be legalized. The possibility of legalization of euthanasia may also carry with it other aspects like abortion, value of human life etc. For Ex. The practice of non-voluntary euthanasia i.e. in the case of severely disabled new born infants. Voluntary euthanasia, on the other hand, could be defended on the distinct ground that the State should not interfere with the free, informed choices of its citizens in matters that do not cause harm to others.

It is observed that the legal definitions of homicide in the west changed somewhat as a result of new attitudes towards the elderly and the terminally ill. Traditionally, European codes acquitted a person for a "mercy killing", whereas Anglo-American codes did not do so. But in the 1990s, a widespread "Right to Die" movement in North America and Europe sought the legalization of certain forms of euthanasia. As per the Britannica Book of the year 2007, the procedures for the assessment of the decision process leading to physician-assisted suicide and voluntary euthanasia – which were
tolerated in the Netherlands under well-defined restraints – was altered in an effort to increase openness and faith in the system.

Euthanasia and Assisted suicide have been widely practiced in the Netherlands for a number of years. Unlike their professional counterparts in other nations, Dutch physicians have led the way in permitting the practices – practices that illustrate how physician-advocacy of induced death can expand and be used to justify virtually unlimited euthanasia and assisted suicide.

Dr. Geertruida Postma, a Dutch physician created a historic event in the annals of Dutch euthanasia when she was convicted of a crime of euthanasia in 1973 after she ended the life of her seriously ill mother by administering a lethal injection. The conditions under which the elderly woman died might have never come to the attention of authorities had it not been for Dr. Postma's insistence that her actions be made public. Her admission that she had given her mother a lethal injection seemed calculated to force public and legal reconsideration of the laws against assisted suicide and euthanasia.

This highly visible case became a rallying point for those seeking to change the law. Doctors in the province signed an open letter to the Netherlands Minister of Justice stating that euthanasia was commonly practiced. While finding Dr. Postma guilty of the crime of mercy killing that was punishable by imprisonment for a maximum of 12 years, the court imposed a one-week suspended sentence and week's probation.

2 Sections – 293 and 294 of Penal Code of Netherlands.
The Dutch Court relied heavily on expert testimony by the District's Medical Inspector who set forth certain conditions under which the average physician thought euthanasia should be considered acceptable.¹

On the initiative of physicians and with the support of the Dutch Medical Association, and cases like Alkamaar, Amelo and Assen etc. that followed, each widening the boundaries and further liberalizing the conditions under which euthanasia and assisted suicide, although remaining illegal, would not be punished.

In Alkmaar case² a woman was led to 'psychological suffering' because of her advancing age and physical condition making her dependent upon others, requested for death successfully. This case gave rise to the 1986 decision by the Hague Court of Apeals recognizing "PSYCHIC SUFFERING" and "POTENTIAL DISFIGUREMENT OF PERSONALITY" as grounds for induced death. The Courts have also exonerated physicians who assisted in the suicides of a young woman with 'anorexia nervosa (Amelo), Tijdschrift voor Gezondheidsrecht 1992, No.19, and a woman who was depressed over the death of her two children and the failure of her marriage (Assen) Nederlandse Jurisprudentie 1994, no. 656.

Under the guidelines in effect for ending a life on request, euthanasia and assisted suicide continued to be punishable but were not prosecuted if the guidelines were followed. The burden of proof was on the physician who

¹ According to Carlos Gomez, Regulating Death (1991) P.30, the guidelines required that the patient must be considered incurable and experiencing subjectively unbearable suffering; the request for termination of life should be in writing and there should be adequate consultation with other physicians before death could be induced.

was required to justify the death to an "Evaluation Commission" that could, if it deemed fit, bring the case to the public prosecutor.

In an effort to determine the frequency of assisted suicide and euthanasia, two national studies were undertaken. To obtain the most complete and accurate information, physicians were granted both immunity and anonymity related to their responses. The first study released by the Dutch government on September 10, 1991, found that physician-induced deaths accounted for more than 9.1 percent of annual deaths. Of those death, 2300 were from requested euthanasia; 400 were assisted suicide and 1,040 (an average of approximately 3 per day) died from euthanasia which was administered without the patients' knowledge or consent.¹

Similar results were found in a follow up study five years later. (Paul J. van der Maas, et al, "Euthanasia, physician-assisted suicide, and other medical practices involving the end of life in the Netherlands, 1990-1995."²

In addition, the 1990 study also determined that 50% of Dutch Physicians suggested euthanasia to patients. Both the 1990 and 1995 studies found that although reporting of physician-assisted suicide deaths was required by law, the majority of such deaths went unreported.

Generally, Dutch physicians seem certain that there is no need for any real oversight of their activities.

At a 1990 Right to Die conference held in Netherlands, Dr. H.S. Cohen, a Dutch general practitioner who has often carried out euthanasia, was asked if there was ever any abuse related to the practice of euthanasia. Cohen dismissed the possibility, saying that the Dutch medical establishment is of such high integrity that it is "not corruptible."

LEGALIZING OF EUTHANASIA AND ASSISTED SUICIDE

As aforesaid, euthanasia and PAS have been in actual practice for more than two decades and which practices have been finally codified into law in 2001. The law is found to be very liberal as it is not limited to adults, nor an applicant should be "terminally ill". The justifiable ground is 'hopeless and unbearable suffering, regardless of life expectancy'. Measures ensuring proper use of the law are found in provisions which enable review of the cases by medical committees; instances of suspected wrongdoing being referred to judicial investigators etc. It is learnt that the Dutch Government is reviewing a protocol to allow euthanasia, with parent consent, for infants born with terminal and painful illness.

The Dutch Parliament carved a niche on April 10, 2001 when it approved the legislation legalizing euthanasia and assisted suicide under the title "TERMINATION OF LIFE ON REQUEST AND ASSISTED SUICIDE (Review Procedure) ACT-2001". The Act amended sections of the criminal code, specifically stating that the offenses of euthanasia and assisted suicide are not punishable if they have been "committed by a physician who has met the requirements of due care" that are described in the Act and if they have

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1 Rita Marker, Deadly Compassion (1993) pp. 142-143.
informed the municipal “AUTOPSIST” in accordance with the Burial and Cremation Act.

The inclusion of ‘Due Care’ requirements transformed the crimes into medical treatments as physicians had advocated. Under the new law, minors between 16 yrs. And 18 yrs. may request that their lives be terminated and, although parents or guardians must be consulted, they have no authority to prevent the requested death. Children between the ages of 12 yrs. and 16 yrs. may request euthanasia or assisted suicide but a parent or guardian must agree with the decision.¹

In addition, the law recognizes the right of a physician to carry out euthanasia based on a written advance request for death of a currently incapacitated patient who is 16 yrs old or older. (Although the person must be at least 16 years old to be euthanized, there is no requirement that one be at least 16 when the request is put in writing.)

Under the previous system, doctors had been reluctant to report their death-inducing activities. According to the Dutch Government, the primary reason for changing the law was “to bring matters into the open, to apply uniform criteria in assessing every case in which a doctor terminates life, and hence to ensure that maximum care is exercised in such cases.” This assumed that legalization would make doctors more forthcoming, more accurate and more careful. But that did not happen.

In fact, Dutch doctors felt that the formalities contained in the new law were “too much fuss” and, consequently, fewer, not more, cases of

¹ Chapter-II. Due Care Criteria-Sec2(2 to 4).
physician-induced death were reported leading to consideration of possible 
penalties for non-reporting. Nonetheless, Dutch physicians and medical 
professionals continued to expand the boundaries of acceptable euthanasia.

Within few days of the passage of the said legislation, Dutch Health 
Minister Els Borst, who had guided the bill through Parliament said the 
government should consider introducing a suicide pill for patients who are 
healthy but are ready to die. Borst said this would be carefully regulated. On 
December 16, 2004, a report commissioned by the Royal Dutch Medical 
Association (KNMG) argued that the criteria in place for euthanasia were 
unhelpful in defining the limits of medical practice. Stating that the 
guidelines were ‘an illusion’, it concluded that euthanasia should be allowed 
for virtually any one who did not want to live.

According to Dr. Rob Jonquiere of the Dutch Voluntary Euthanasia 
Society, the proposal addresses and ‘an existential problem’ outside of the 
medical domain but should, nevertheless, be adopted since it is within the 
context of ending unbearable suffering. The KNMG said it would ‘take the 
lead’ in discussing how the issue confronts doctors in practice.

Three months later, the University Medical Centre Groningen, 
acknowledged that it had been euthanizing infants, not only in the case of 
terminally ill newborns but also in cases of children who had ‘spina bifida’ 
and other disabilities. In publishing its procedures for pediatric euthanasia, 
the medical centre explained that the ‘approach suits our legal and social 
culture,’ although it acknowledged that it was “unclear to what extent it would 
be transferable to other countries.”
According to the Remmelink Report provided by the Dutch Government, 400 patients were given the means to kill themselves; 2300 patients asked their doctors to kill them, 1,040 doctors actively killed their patients without the patient's knowledge or consent, and 4,941 doctors administered lethal morphine injections without their patient's explicit consent. That is 8,681 euthanized patients, 69% of which were put to death solely at the physician's discretion.¹

Dr. Fenigsen agrees with these optimists that the Dutch are not on a slippery slope, but for a different reason. "Dutch doctors who practice euthanasia are not on a slope. From the very beginning, they have been at the bottom. This is because in his research he has found 'involuntary euthanasia..... is rampant. He found that a staggering 62% of all newborns and infants' deaths resulted from medical decisions, and that in 1995 alone there were 900 lethal injections given to patients who had not requested euthanasia."²

Since the landmark law in Netherlands was passed, other countries including France and Britain have also considered legalizing euthanasia. However, mercy killings have also drawn stark parallels with Nazi Germany.

4.2.2. THE BELGIAN ACT ON EUTHANASIA

The 21st Century reflected some strange reformist attitudes in some parts of western culture. Gay marriage became legal; same-sex couples

¹ www.euthanasia.com/hollchart.html.
² www.wheaton.edu/CACE/resources/onlinearticles/euthanasia/html.
were permitted to adopt children; the private use of cannabis was decriminalized; and euthanasia was legalized.

The Belgian Act legalizing euthanasia was passed on May 28, 2002 and went into effect on September 23, 2002. Belgium has become the second country after the Netherlands to decriminalize euthanasia.

When the bill was voted 86-51 in favour (with 10 abstentions), Annie Mie Descheemaeker of the Flemish Green Party said, "Every one has the right to die in dignity. People are not afraid of being dead but they fear the process of dying. I am sure that having the option of euthanasia actually gives people the courage to go on day after day."  

The Belgian law sets out strict conditions governing assisted suicide, but it does not give doctors a license to kill. Patients wishing to end their own lives must be conscious when the demand is made and repeat their request for euthanasia. Minors can not seek assistance to die.

It limits euthanasia to competent adults and emancipated minors. Further, in case of persons who are not in the terminal stages of illness, a third medical opinion must be sought. Every mercy killing case would have to be filed before a Special Commission to decide if the doctors in charge obeyed regulations.

However, only two years later, lawmakers introduced a proposal to extend euthanasia to children and individuals suffering from dementia. According to ruling Flemish Liberal party Senators Jeannine Leduc and Paul

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1 [www.tvnz.co.nz/view/page/425822/101532](http://www.tvnz.co.nz/view/page/425822/101532)
Wille who introduced the bill, terminally ill children and teenagers have as much right to choose when they want to die as any one else. The bill did not pass. However, a later report indicated that physicians in Belgium are, nonetheless, administering lethal drugs to newborns and older infants. This has led to new calls to expand the scope of euthanasia in Belgium.

The Belgian Act on Euthanasia defines Euthanasia as "INTENTIONALLY TERMINATING LIFE BY SOME ONE OTHER THAN THE PERSON CONCERNED AT THE LATTER'S REQUEST." But Assisted Suicide remains illegal. As per the law, to seek the benefit of the legislation, the patient should have attained the age of majority and the request should be 'voluntary, well-considered and repeated' and the patient should be "in a futile medical condition of constant and unbearable physical or mental suffering that can not be alleviated." The law mandates that all acts of euthanasia shall be reported to the State authorities.

Embrace of euthanasia by medical professionals has led to the formulation of more convenient ways to end patients' live. In early 2005, a pharmaceutical company announced that home "euthanasia kits" would be available soon in more than two hundred Belgian pharmacies so that doctors could carry out in-home deaths with greater ease. Reports indicated that the kits will contain barbiturate, a paralyzing agent, an anesthetic, and instructions for use, and will cost approximately 45 Euros.

As in Netherlands, the practices of euthanasia and assisted suicide in Belgium illustrate how rapidly induced death, first accepted for difficult cases,
expands to death-on-demand and how that actual demand need not be made by the victim.

The Belgian Act on euthanasia is also subjected to criticism that it does not provide enough safeguards against abuse. According to Filip Dewinter, leader of the far-right Vlaams Blok, the law makes it easy for people who are not terminally ill to commit euthanasia. Some have expressed concern that the law applies equally to patients who are in the final stages of a terminal illness and those who may have incurable diseases but years yet to live, and also to incurable psychological illness.

Mario Verstraete decided to die in beauty on 30th. September of 2003. Mario, a member of the board of the Dutch speaking Association for the Right to Die in Dignity, was the only patient who was heard first-hand in the Senate hearing. He was suffering from multiple sclerosis. In full serenity, he spoke of his life and of his wish that his request to die in dignity be respected when he so decides, and he made his decision after the vote but had to wait until the law was enforced.¹

Belgium euthanasia cases double since legalization (9-2-2006)

Statistics published show that almost 400 euthanasia cases were reported in Belgium in 2005, almost double the level when the Belgian Parliament adopted controversial legislation. In the early 21st century further reflected reformist attitudes. Gay marriage became legal; same-sex couples were permitted to adopt children; the private use of cannabis was

decriminalized; and euthanasia was legalized. Between September-2002 when euthanasia was decriminalized, and the end of 2003, 259 cases of mercy killing were officially recorded. During that period, the number of cases rose from 8 to 21 per month.¹

4.2.3. NEW HORIZONS IN LUXEMBOURG

Luxembourg lashes at criminal euthanasia. Luxembourg simply followed the track of Holland and Belgium. The silent revolution to decriminalize euthanasia received a hilarious high voltage of enthusiasm when the Parliament of Grand Duchy of Luxembourg has approved the bill Err/Huss on de-criminalization of euthanasia. Thus in the countries of Benelux (the Netherlands, Belgium and Luxembourg), now exists a right for patients to receive the medical assistance to make of the ultimate moment of their life an act of freedom. The untiring warriors Jean Huss and Lydie Err who have been fighting with all their heart, commitment notwithstanding virulent attacks of opponents, finally succeeded to provide Physician Assisted Suicide to the needy in their country and the bill finally got approved on 19th February, 2008 by vote of 30 to 26. Of course, the law will not go into effect until completion of the legislative process, expected toward the summer.² A historical moment for the supporters of Right to Die Movement.

² www.internationaltaskforce.org.
The Bill, which still has to be approved in a second reading to take effect, fuelled passionate debates in Luxembourg, where Catholic values remain firmly entrenched. The medical community was mostly against it.

"This Bill is not a permit to kill. It's not a law for the parents or the doctors but for the patient and the patient alone to decide if he wants to put an end to his suffering." said Socialist lawmaker Ms. Lydie Err who helped draft it. According to the Bill, euthanasia will be strictly regulated and can be mentioned in a "living will." Doctors will have to consult with a colleague to confirm that the person is suffering from a "grave and incurable condition." Further, a national commission made up mainly of doctors and officials would also be created to check on a case-by-case basis that all legal conditions and procedures are respected.

France's National Assembly overwhelmingly endorsed legislation legalizing passive euthanasia. With 548 votes out of 551 in favour of the bill, support crossed party lines for a broader patients' rights bill, which includes the passive euthanasia clause. Passive euthanasia allows medical personnel only narrow options like withdrawing life sustaining medication. This legislation falls far short of laws in Netherland and Belgium that allow active euthanasia under strict circumstances, and Switzerland which allows certain forms of patient suicide. Legalising euthanasia took on new urgency after a disabled French man Vincent Humbert, took his life with mother's help. Like elsewhere in the world, hundreds of doctors in France are believed to have quietly practiced euthanasia at some point in their careers.
4.3. MERCY KILLING IN GERMANY, SWITZERLAND AND FRANCE

4.3.1. GERMANY:

A wide spread 'mercy killing' program of the sick and disabled was in place in the Nazi Regime Code named "Aktion T 4", the Nazi euthanasia program to eliminate 'life unworthy of life' at first focused on newborns and very young children. Midwives and doctors were required to register children up to age three who showed symptoms of mental retardation, physical deformity, or other symptoms included on a questionnaire from the Reich Health Ministry. The Nazi euthanasia program quickly expanded to include older disabled children and adults. Hitler's decree of October, 1939, typed on his personal stationery and back dated to Sept.1, enlarged the authority of certain physicians to be designated by name in such manner that persons who, according to human judgment, are incurable can, upon a most careful diagnosis of their condition of sickness, be accorded a mercy death.¹

Binding and Hoche turned out to be the prophets of direct medicalized killing. Prior to the Nazis' assumption of power, such thinking was not a majority view in German psychiatry and medicine. But under the Nazis, there was increasing discussion in medical and political circles of the legitimacy of mercy killing, of Hoche's concept of the mentally dead, and of the enormous economic drain on German Society caused by the large number of impaired Germans.

The Killing of Children — indeed the entire Nazi "euthanasia" program — began simply with a petition to allow the "mercy killing" (GNADENTOD,

literally 'mercy death') of Baby Knauer, an infant, who was born blind, with one leg and part of one arm missing, and apparently an idiot. In late 1938 or early 1939, Hitler ordered Karl Brandt, his personal physician and close confidant, to go to the clinic at the University of Leipzig where the child was hospitalized, to consult with the physicians there and determine whether the information submitted about the child was accurate. If the information was correct, Brandt was authorized to inform the physicians to carry out euthanasia and any legal proceedings against the physicians would be quashed by order of the Hitler.

As per the deposition of Brandt at the Nuremberg Medical Trial in 1947, the request of the father of the baby for euthanasia was granted and executed.

As per the Nuremberg trial testimony, the child-killing program began with new borns, then proceeded to children up to the ages of 3 and 4 and soon to older ones. The authorization for the killing project was, at first, oral, secret and 'kept in a very narrow scope, covering only the most serious cases. It later became loose, extensive and known among a wider and wider circle of physicians and officials. Subsequently, a project to implement 'medical killing of children' was said to have been formulated and the impression of medical propriety was maintained in a confidential directive sent on Aug. 18, 1939, which ordered 'the earliest possible registration' of all children under 3 years of age in whom 'serious hereditary diseases' were suspected; and included on the list of diseases were idiocy and mongolism (especially when associated with blindness and deafness), microcephaly,
hydrocephaly; paralysis, and spastic conditions and malformations of all kinds, but especially of the limbs, head and spinal column. The registration was necessary “for the clarification of scientific questions in the field of congenital malformation and mental retardations.”

4.3.2. MERCY KILLING IN SWITZERLAND

An interesting situation exists in Switzerland. According to Swiss Penal Code Art-115, suicide is not a crime and assisting suicide is a crime if and only if the motive is selfish. It condones assisting suicide for altruistic reasons. It does not require the involvement of a physician no that the patient be terminally ill. It only requires that the motive be unselfish. Switzerland also allows voluntary organizations to help people, including foreigners, end their lives. Where lethal medication is required, a doctor’s prescription is obtained. All acts of assisted suicide are reported to the police and investigated. Murder upon request by the victim (euthanasia) is considered less severely than murder without the victim’s request (homicide) but it remains illegal. Decriminalizing euthanasia was tried in 1997 but it was recommended to remain illegal because it would have created dangerous legal circumstances where a non-physician helper would have to be prosecuted whereas the physician would not.

The practice of assisted suicide in Switzerland has led many people to believe that the practice has been legalized in that country. In fact, it is not the case. There is an important distinction between the Swiss situation and that of Oregon, the Netherlands and Belgium where the law considers euthanasia and/or assisted suicide to be ‘medical treatment.’
According to Swiss law, “whoever, from selfish motives, induces another to commit suicide or assists him therein shall be punished, if the suicide was successful or attempted, by confinement in a penitentiary for not more than five years or by imprisonment.”

The key words are “from selfish motives.” Thus, in Switzerland, there is no prosecution if the person assisting a suicide successfully claims that he is acting unselfishly. While this results in de facto legalization, assisted suicide is not legal, only unpunishable, unless a selfish motive is proven. It should also be noted that there is no illusion that assisted suicide is a medical practice. The person assisting a suicide need not be a medical professional to escape prosecution.

All the three Right-to-Die organizations in Switzerland help terminally ill people to die by providing counseling and lethal drugs. Police are always informed. As already mentioned, only one group DIGNITAS in Zurich, will accept foreigners who must be either terminal, or severely mentally ill, or clinically depressed beyond treatment. It must be noted that Dutch euthanasia law has caveats permitting assisted suicide for the mentally ill in rare and incurable cases, provided the person is competent.

4.3.3. FRENCH PASSIVE EUTHANASIA

France does not have a specific law banning assisted suicide, but such a case could be prosecuted under S-223-6 of the Penal Code for failure to assist a person in danger. Convictions are rare and punishments minor. France bans all publications that advise on suicide. Derek Humphry’s famous book on euthanasia “The Final Exist” was also banned in 1991. But there
has been a fierce debate on euthanasia since 1995 and the movement growing strong. There is a change in French law in 2003 that a law now permits terminally ill patients to refuse treatment, but short of legalizing euthanasia.

A French court convicted a doctor for the poisoning death of a terminally ill cancer patient Thursday. Dr. Laurence Tramois, 35 yrs. old doctor and nurse Chantal Chanel, 40 yrs. were accused of poisoning and sentenced to a one-year suspended prison sentence for prescribing a fatal dose of potassium chloride that resulted in the death of Paulette Drualis in August 23, 2003 when she was suffering from terminal pancreatic cancer.¹

A year and two months after a celebrated case of euthanasia incited a parliamentary commission on the subject, France has passed a law allowing terminally ill or gravely injured patients the right to die. The law which was passed by the National Assembly on 30th. November but has to be ratified by the Senate, stops short of legalizing active euthanasia, and according to this law, terminally ill patients in France will be given the right to demand an end to treatment, including artificial feeding. This Bill drawn up after eight months of consultations by 31 MPs, treads a fine line between active euthanasia, which remains illegal, and passive euthanasia, which will be authorized. Under the said law, doctors will be able to switch off life-support machines at patient's request “if these extend life artificially.” But it

nevertheless clarifies a common, yet illegal, situation, according to health minister Phillippe Douste-Blazy, who called it 'a third way, a French way."

The compromise follows the widely reported case of active euthanasia in which Vincent Humbert, aged 22, was seriously injured in a road accident and helped to death by his mother and a doctor on 26th September 2003 (BMJ 2003;327:1068)

Dr. Douste-Blazy said that 100 000 patients a year in France have their life support machines turned off, although the law previously had no system for dealing with it.

Under the new law, terminally ill but conscious patients may refuse treatment to prolong their lives. Seriously disabled patients who are not terminally ill may also request an end to treatment.

Palliative treatment must continue, however, and the doctor may give increasingly strong doses of painkillers, even if it risks shortening the patient's life. If the patient is unconscious, the doctor must consult with other doctors and the patient's family or the person closest to them. People may also stipulate in writing in advance how to be treated in such circumstances. Patients who are conscious but in a vegetative state may also have their life support stopped. If they have an infection or a life threatening complication, they will not be treated as it will be considered 'out of proportion' to the benefit, according to the law. Under no circumstances may doctors cease treatment on their own initiative, nor, once a decision has

1 France passes 'right to die' law Paris Brad Spurgeon—www.bmj.com/cgi/content/full/329/7478/1307.
been made to end treatment, may they inject patients with drugs to kill them quickly.

The law reinforces palliative care, however, for which Dr. Douste–Blazy announced 1990 more beds in the next two years. 35 mobile units in 2005 and the training of personnel.

The law has been criticized by pro-euthanasia associations and Marie Humbert, the mother of Vincent, who has been charged, along with Dr. Froric Chaussoy, for premeditated poisoning and giving a toxic substance. She allegedly gave her son a deadly dose of a sedative, and Dr. Chaussoy turned off his life support. Ms. Humbert told French television that the new law would not have prevented her son from suffering.

Another mother, Micho de Somer, wrote to President Jacques Chirac in October asking that her son be allowed to die humanely. Eddy de Somer, aged 26, had head and brain stem injuries in a motor scooter accident on 21st August 2001 that left his quadriplegic, blind in one eye, and incapable of speech. The new law allows his treatment to be stopped by, for example, removal of his intravenous feeding, which would kill him through starvation.

"This new law maintains the current hypocrisy and does not respect the right of people suffering from an incurable and grave handicap to autonomy and liberty," Dr. Jean Cohen, president of the Association for the Right to Die in Dignity, told newspaper Le Figaro.

In SPAIN, Immaculada Echevarria, a Spanish woman who had suffered muscular dystrophy for 40 years, was allowed to have doctors
disconnect her breathing machine in a case that highlighted the issue of euthanasia in Spain, where the practice also remains illegal. The Government authorities allowed the procedure because Echevarria's case technically involved a refusal of medical treatment.¹

DENMARK has no specific law banning assisted suicide.

4.4. UNEASY FORBEARANCE IN U.K.

UNITED KINGDOM AND EUTHANASIA

English common law is a conservative tradition. Judges are loathe to play the role of legislators and parliament is hesitant to enact legislation on controversial social issues.

We may observe that Common Law traditions, originally, considered suicide as a form of felony. But subsequently, there has been a marked shift from this position in the Suicide Act enacted in 1961. This Act made 'complicity in suicide' a crime, while abrogating suicide from the status of a crime. (Sec-2).

Here is an important case AIRDLE N.H.S. TREUST vs. BLAND² where the ethics of the medical profession came under discussion. Mr. Anthony Bland met with an accident and for three years, he was in a condition known as 'persistent vegetative state' (PVS). The said condition was the result of destruction of the cerebral cortex on account of prolonged deprivation of oxygen and the cortex had resolved into a watery mass. The

¹ www.iurist.law.pitt.edu/paperchase/2007/03/french-court-convicts-doctor-
² (1993) 2 WLR 316.
cortex is that part of the brain which is the seat of cognitive function and sensory capacity. The patient cannot see, hear or feel anything. He cannot communicate in any way. Consciousness has departed for ever. But the brain-stem, which controls the reflective functions of the body, in particular the heart beat, breathing and digestion, continues to operate. In the eyes of the medical world and of the law, a person is not clinically dead so long as the brain-stem retains its function.

In order to maintain Mr. Bland in his present condition, feeding and hydration are achieved by artificial means of a nasogastric tube while the excretory functions are regulated by a catheter and other artificial means. The Catheter is used from time to time to give rise to infusions which have to be dealt with by appropriate medical treatment. As for Bland, according to eminent medical opinion, there was no prospect whatsoever that he would ever make a recovery from his present condition but there was every likelihood that he would maintain the present state of existence for many years to come provided the artificial means of medical care is continued.

The doctors and the parents of Bland felt, after three years, that no useful purpose would be served by continuing the artificial medical care and that it would be appropriate to stop these measures aimed at prolonging his existence.

Since there were doubts whether withdrawal of life support measures could amount to a criminal offence, the Hospital Authority (the appellant) moved the High Court for a declaration designed to resolve these doubts.
The Family Division of the High Court granted the declarations sought for on 19.11.92. That judgment was affirmed by the Court of Appeal (Sir Thomas Bingham M.R., Butler-Sloss and Hoffman L.JJ) on 9.12.1992. The declarations granted by the Court were as follows:

"that despite the inability of the defendant to consent thereto, the plaintiff and the responsible attending physicians:

(1) may lawfully discontinue all life-sustaining treatment and medical supportive measures designed to keep the defendant alive in his existing persistent vegetative state including the termination of ventilation, nutrition and hydration by artificial means; and

(2) may lawfully discontinue and thereafter need not furnish medical treatment to the defendant except for the sole purpose of enabling him to end his life and die peacefully with the greatest dignity and the least of pain suffering and distress."

On further appeal to the House of Lords, Lord Keith of Kinkel observed that the object of medical treatment and care is, after all, to benefit the patient. But it is unlawful, both under the law of torts and criminal law of battery, to administer medical treatment to an adult, who is conscious and of sound mind, without his consent.¹

Such a person is completely at liberty to decline to undergo treatment, even if the result of his doing will be that he will die.

¹ In re F. Mental Patient: Sterilisation, 1990 (2) AC 1.
This extends to the situation where the person, in anticipation of his death through one cause or another and entering into a condition such as P.V.S., gives clear instructions that in such event, he is not to be given medical care, including artificial feeding, designed to keep him alive. The second point is that it very commonly occurs that a person due to accident or some other cause, becomes unconscious and is thus not able to give or withhold consent to medical treatment. In that situation, it is lawful, under the principle of necessity, for medical men to apply such treatment as in their informed opinion is in the "best interests" of the unconscious patient. In In re J (A Minor) (Wardship: Medical Treatment)¹ the Court of Appeal held it to be lawful to withhold life saving treatment from a very young child in circumstances where the child's life, if saved, would be one irredeemably racked by pain and agony. In the case of a permanently insensate being, who if continuing to live would never experience the slightest actual discomfort, it is difficult, if not possible, to make any relevant comparison between continued existence and the absence of it. It is, however, perhaps permissible to say that to an individual with no cognitive capacity whatever, and no prospect of ever recovering any such capacity in this world, it would be a matter of complete indifference whether he lives or not. Lord Keith observed:

"a medical practitioner is under no duty to continue to treat such a patient where a large body of informed and responsible medical opinion is to the effect that no benefit at all would be conferred by continuance. Existence in a vegetative state with no prospect of recovery is by that opinion regarded

¹ (1991) Fam. 33.
as not being a benefit, and that, if not unarguably correct, at least forms a proper basis for the decision to discontinue treatment and care.¹ After stating that the principle of sanctity of life is important for the State, Lord Keith said it was not absolute. He said:

"It (the principle of sanctity of life) does not compel a medical practitioner on pain of terminal sanction to treat a patient, who will die, if he does not, contrary to the express wishes of the patient. It does not authorize forcible feeding of prisoners on hunger strike. It does not compel the temporary keeping alive of patients who are terminally ill where to do so would merely prolong their suffering. On the other hand, it forbids the taking of active measures to cut short the life of a terminally-ill patient. In my opinion, it does no violence to the principle to hold that it is lawful to cease to give medical treatment and care to a P.V.S. patient who has been in that state for over three years, considering that to do so involves invasive manipulations of the patient's body to which he has not consented and which confers no benefit upon him."

Lord Keith observed that the law in other countries and in particular in USA was the same that such withdrawal is not treated as a criminal offence. He said:

"it is of some comfort to observe that in other common-law jurisdictions, particularly in the United States where there are many cases on the subject, the Courts have, with near unanimity, concluded that it is not

¹ Bolam vs. Freim Hospital Management Committee 1957(1) WLR 582.
unlawful to discontinue medical treatment and care, including artificial feeding of P.V.S. patients and others in similar conditions". 

He also pointed out that, in order to protect the interests of patients, doctors and patients families and reassurance to the public, it is permissible to seek a declaration from the Family Division and the Court of Appeal for permission for withdrawal of life support. This is necessary till a body of experience and practice is built up.

Lord Goff of Chievely quoted from Lord Bingham's judgment in the Court of Appeal and the following part of that extract from Lord Bingham's Judgment is important:

"...in law, Anthony is still alive. It is true that his condition is such that it can be described as a living death; but he is nevertheless still alive. This is because, as a result of development in modern medicine and technology, doctors no longer associate death exclusively with breathing and heart beat, and it has come to be accepted that death occurs when the brain, and in particular the brain stem has been destroyed.\(^1\) ..... he is still alive...as a matter of law. ..... We are concerned with circumstances in which it may be lawful to withdraw from a patient medical treatment or care by means of which his life must be prolonged by such treatment or care, if available, regardless of the circumstances. First, it is established that the principle of self determination requires that respect must be given to the wishes of the patient, so that if an adult patient of sound mind refuses, however


223
unreasonably, to consent to treatment or care by which his life would or might be prolonged, the doctors responsible for his care must give effect to his wishes, even though they do not consider it to be in his best interests of the patient to do so.¹

To this extent, the principle of sanctity of human life must yield to the principle of self-determination² and, for present purposes perhaps more important, the doctor's duty to act in the best interests of his patient must likewise be qualified. On this basis, it has been held that a patient of sound mind may, if properly informed, require that life support should be discontinued.³

Moreover, the same principle applies where the patient's refusal to give consent has been expressed at an earlier date, before he becomes unconscious or otherwise incapable of communicating it; though in such circumstances, especial care may be necessary to ensure that the prior refusal of consent is still properly to be referred as applicable in the circumstances which have subsequently occurred: See, e.g. In re T (Adult: Refusal of Treatment)⁴. I wish to add that, in cases of this kind, there is no question of the patient having committed suicide, nor therefore of the doctor having aided or abetted him in doing so. It is simply that the patient has, as he is entitled to do, decline to consent to treatment which might or would have the effect of prolonging his life, and the doctor has, in accordance with

¹ See Schloendorff vs. Society of New York Hospital (1914) 211 NY 125 per Cardozo J; S vs. McC (Orse S.) and M (D.S. Intervener); W vs. W (1972) AC24(43) per Lord Reid; and Sidaway vs. Board of Governors of the Bethlem Royal Hospital and Maudsley Hospital (1985) A.C 871(882) per Lord Scarman.
² See ante, pp 351 H-352A, per Hoffman L.J.
⁴ 1992(3) W.L.R. 782.
his duty, complied with his duty, complied with his patient's wishes. Lord Goff went on to further quote the following words of Lord Bingham on informed consent:

"But, in many cases, not only may the patient be in no condition to be able to say whether or not he consents to the relevant treatment or care, but also he may have given no prior indication of his wishes with regard to it. In the case of a child, who is a ward of Court, the Court itself will decide whether medical treatment should be provided in the child's best interests, taking into account medical opinion.

But the Court cannot give its consent on behalf of an adult patient who is incapable of himself deciding whether or not to consent to treatment. I am of the opinion that there is nevertheless no absolute obligation upon the doctor who has the patient in his care to prolong his life, regardless of circumstances. Indeed, it would be most startling, and could lead to the most adverse and cruel effects upon a patient, if any such absolute rule were held to exist. It is scarcely consistent with primacy given to the principle of self-determination in those cases in which the patient of sound mind has declined to give his consent, that the law should provide no means of enabling treatment to be withheld in appropriate circumstances where the patient is in no condition to indicate, if that was his wish, that he did not consent to it. The point was put forcibly in the judgment of the Supreme Court of Massachusetts in Superintendent of Belchertown State School vs Saikewicz\(^1\) as follows:

\(^1\) (1977) 370 N.E. 2d 417 (428).
"To presume that the incompetent person must always be subjected to what may rational and intelligent persons may achieve is to downgrade the status of the incompetent person by placing a lesser value on his intrinsic human worth and vitality." Lord Goff continued:

"I must, however, stress, at this point, that the law draws a 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 the patient's life to an end. As I have already indicated, the former may be lawful, either because the doctor is giving effect to his patient's wishes by withholding the treatment or care, or even in circumstances in which (on principles which I shall describe), the patient is incapacitated from stating whether or not he gives his consent. But 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. See Reg vs. Cox. Euthanasia is not lawful at common law; but that result could, I believe, only be achieved by legislation...."

Lord Goff then quotes the crucial reasoning of Lord Bingham as to why stoppage of life support is not an offence. Bingham M. R. stated:

"Why is it that a doctor who gives his patient a lethal injection which kills him commits an unlawful act and indeed is guilty of murder, whereas a doctor who, by discontinuing life-support, allows his patient to die, may not act

1 (unreported) (18th Sept. 1992)....
unlawfully – and will not do so, if he commits no breach of duty to his patient? Prof. Glanville Williams has suggested\(^1\) that the reason is that what the doctor does when he switches off a life support machine, "is in substance not an act but an omission to struggle", and that "the omission is not a breach of duty by the doctor, because he is not obliged to continue in a hopeless case."

Significantly, Lord Goff further explains what happens in a withdrawal of life support. He says:

"I agree that the doctor's conduct in discontinuing life support can properly be categorized as an omission. It is true that it may be difficult to describe what the doctor actually does as an omission, for example, where he takes some positive step to bring the life support to an end. But discontinuation of life support is, for present purposes, no different from not initiating life support, in the first place. In each case, the doctor is allowing his patient to die in the sense that he is desisting from taking a step which might, in certain circumstances, prevent his patient from dying as a result of his pre-existing condition; but as a matter of general principle, an omission such as this will not be unlawful unless it constitutes a breach of duty to the patient. I also agree that the doctor's conduct is to be differentiated from that of, for example, an interloper who maliciously switches off a life support machine...

Accordingly, whereas the doctor in discontinuing life support, is simply allowing his patient to die of his pre-existing condition, the interloper is actively intervening to stop the doctor from prolonging the patient's life, and such conduct cannot possibly be categorised as an omission.

.....discontinuance of life support can be differentiated from ending a patient's life by a lethal injection. ..... the reason for that difference is that, whereas the law considers that discontinuance of life-support may be consistent with the doctor's duty to care for his patient, it does not, for reasons of policy, consider that it forms part of his duty to give his patient a lethal injection to put him out of his agony."

After referring to In re F (Mental Patient: Sterilisation)\(^1\), in which it was held that a doctor may, when treating an unconscious patient, treat such a patient if he acts in his "best interests" – Lord Goff said, the same principle applies when a doctor decides whether or not to stop the life support in the best interests of the patient. A doctor, for example, is not, as held by Thomas J in Auckland Area Health Authority vs. AG\(^2\) bound to perform a surgery on a cancer patient if it is likely to result in shortening the patient's life further. He may then lawfully administer palliatives to reduce the pain and suffering. He said that, therefore, "when the doctor's treatment of his patient is lawful, the patient's death will be regarded in law as exclusively caused by the injury or disease to which his condition is attributed."

Life support systems are new innovations in Medical technology. Life support methods can be initially adopted, "But if he neither recovers sufficiently to be taken off it nor dies, the question will ultimately arise whether he should be kept on it indefinitely." After quoting Prof. Ian Kennedy and from Thomas J of New Zealand, Lord Goff said that the question is not whether the doctor should take a course which will kill the patient, the

\(^1\) 1990(2) AC 1.
\(^2\) 1993(1) NZLR 235.
question is "whether in the best interests of the patient that his life should be prolonged by the continuance of this form of medical treatment or care. In the present case the continuance is, according to doctor, of no utility at all as it has no therapeutic purpose of any kind".

Rejecting the American Court's view that a surrogate or substitute could be allowed to take a decision on behalf of an incompetent patient, Lord Goff said:

".... I do not consider that any such test forms part of English law in relation to incompetent adults, on whose behalf nobody has power to give consent to medical treatment. Certainly, in In re F², your Lordship's House adopted a straightforward test based on the best interests of the patient;...."

Lord Goff finally approved Lord Bingham MR's view that Courts could grant declarations for stoppage of life support, in the interests of patients, doctors and patients' families and in the context of re-assurance to the public.

Lord Lowry agreed with Lord Goff.

Lord Browne-Wilkinson's opinion is equally important. We shall only refer to certain important aspects. Lord Browne-Wilkinson stated that till recently, death was beyond human control but recent developments in medical science have fundamentally affected those previous uncertainties.

² 1990(2) AC 1.
"In medicine, the cessation of breathing of heartbeat is no longer death. By the use of a ventilator, lungs which in the unaided course of nature would have stopped breathing, can be made to breathe, thereby sustaining heartbeat. This has led medical profession to redefine death in terms of brain-stem death."

In medical terms, an unconscious patient kept alive by use of a ventilator is called 'a ventilated corpse'. He also poses the question, arising out of modern technology:

"Given that there are limited resources available for medical care, is it right to devote money to sustaining the lives of those who are, and always will be, unaware of their own existence rather than to treating those who, in a real sense, can be benefited e.g. those deprived of dialysis for want of resources."

New problems have also arisen in computing damages in accident cases on the basis whether the person is alive or dead. Question of succession depends upon the timing of death. Omission to do certain thing may constitute offence "where the accused was under a duty to the deceased to do the act which he omitted to do".

Counsel Mr. Munby contended that 'removal of the nasogastric tube necessary to provide artificial feeding and the discontinuance of the existing regime of artificial feeding', constitute 'positive acts of commission'. Lord Browne Wilkinson said: (p 881)
"I do not accept this. Apart from the act of removing the nasogastric tube, the mere failure to continue to do what you have previously done, is not, in any ordinary sense, to do anything positive; on the contrary, it is by definition an omission to do what you have previously done.

The positive act of removing the nasogastric tube presents more difficulty. It is undoubtedly a positive act, similar to switching off a ventilator in the case of a patient whose life is being sustained by artificial ventilation. But, in my judgment, in neither case should the act be classified as positive, since to do so would be to introduce intolerably fine distinctions. If, instead of removing the nasogastric tube, it was left in place but no further nutrients were provided for the tube to convey to the patient's stomach, that would not be an act of commission. Again, as has been pointed out\(^1\), if the switching off a ventilator were to be classified as a positive act, exactly the same result can be achieved by installing a time-clock which requires to be re-set every 12 hours; the failure to reset the machine could not be classified as a positive act."

His lordship concluded:

"In my judgment, essentially what is being done is to omit to feed or to ventilate; the removal of the nasogastric tube or the switching off of a ventilator are merely incidents of that omission.\(^2\)

Any treatment given by a doctor to a patient which is invasive (i.e. involves any interference with the physical integrity of the patient) is unlawful unless

\(^2\) See Glanville Williams, Textbook of Criminal Law, p. 282; Skegg, p.169 et seq"
done with the consent of the patient; it constitutes the crime of battery and the tort of trespass to the person. In the case of a charge of murder by omission to do an act and the act of omission could only be done with the consent of patient, refusal by the patient, will be a valid defence for a doctor.

"The doctor cannot owe to the patient any duty to maintain his life where that life can only be sustained by intrusive medical care to which the patient will not consent."

The court held that in a situation where a person is barely alive, and could be put to a more humane death, by administering a lethal drug. The court observed that –

"... As I see it, the doctor's decision whether or not to take any such step must (subject to his patient's ability to give or withhold his consent) be made in the best interests of the patient. It is this principle too which, in my opinion, underlies the established rule that a doctor may, when caring for a patient who is, for example, dying of cancer, lawfully administer painkilling drugs despite the fact that he knows that an incidental effect of that application will be to abbreviate the patient's life. Such a decision may properly be made as part of the care of the living patient, in his best interests; and on this basis, the treatment will be lawful. Moreover, where the doctor's treatment of his patient is lawful, the patient's death will be regarded in law as exclusively caused by the injury or disease to which his condition is attributable......"

In judging his best interests, the Court was of the opinion, that the doctor should consider the option of hastening his death, as it may be the
best thing for him, in that situation. The Court, convinced that in an extreme situation like this, it was justified to bring about the death of the patient, in his ‘best interests’, and debated whether ethics would dictate that death be brought about quickly (by administering a lethal drug), rather than a prolonged torture of stopping artificial feeding and other treatment. However, in the existing regime of criminal law at the time, the Court concluded that stopping ‘invasive treatment’ would not constitute breach in criminal law, even though a clear act of commission causing death would probably have.

Though a consolidated and uniform trend on this issue has not yet emerged, there are sporadic judgments in the recent past recognizing the justification for ‘Physician Assisted Suicide’.

In the case of minors, the Court, exercising the Crown’s right as parens patriae under the wardship jurisdiction, can consent on the child’s behalf. Until 1960 (in UK), the Court had the same parens patriae jurisdiction over adults who were mentally incompetent. But by the joint effect of the Mental Health Act, 1959 and the revocation of the warrant under the Sign Manual under which the jurisdiction of the Crown as parens patriae over those of unsound mind was conferred on the Courts, the Courts ceased to have any parens patriae jurisdiction over the person of a mentally incompetent adult, being left only with the statutory jurisdiction over his property (as opposed to his person) conferred by the Act of 1954. Lord Browne Wilkinson observed:
"Faced with this problem, the House of Lords in In re F.\(^1\) developed and laid down a principle, based on concepts of necessity, under which a doctor can lawfully treat a patient who cannot consent to such treatment if it is in the interests of the patient to receive such treatment. In my view, the correct answer to the present case depends on the extent of the right to continue lawfully to invade the bodily integrity of Anthony Bland without his consent. If, in the circumstances, they have no right to continue artificial feeding, they cannot be in breach of any duty, by ceasing to provide such feeding."

While accepting the procedure of obtaining a declaration from Court, he says:

"(In re F), both Lord Brandon of Oakbrook\(^2\) and Lord Goff\(^3\) make it clear that the right to administer invasive medical care is wholly dependent upon such care being in the best interests of the patient wholly dependent upon such care being in the best interests of the patient. Moreover, a doctor's decision whether invasive care is in the best interests of the patient falls to the assessed by reference to the test laid down in Bolam v. Frienn Hospital Management Committee\(^2\) viz., is the decision in accordance with a practice accepted at the time by a responsible body of medical opinion."

On the basis of that test, Lord Browne-Wilkinson concludes that “if there comes a stage where the responsible doctor comes to the reasonable conclusion (which accords with the views of a responsible body of medical opinion), that further continuance of an intrusive life support system is not in the “best interests” of the patient, he can no longer lawfully continue that life

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\(^1\) (1990) (2) A.C. page 1; (2)(at p.64); (3) (at p.75, 77).

\(^2\) 1957 (1) WLR 582.
support system; to do so would constitute the crime of battery and the tort of trespass to the person. Therefore, he cannot be in breach of any duty to maintain the patient's life. Therefore, he is not guilty of murder by omission."

The above judgment of the House of Lords in Airedale lays down a crucial principle of law when it says that withholding or withdrawal of life support to a dying patient merely amounts to allowing the patient to die a natural death and that where death in the normal course is certain, withholding or withdrawal of life support is not an offence. If a patient capable of giving informed consent refuses to give consent or has, in advance, refused such consent, the doctor cannot administer life support systems to continue his life even if the doctor thinks that it is in the patient's interest to administer such system. The patient's right of self-determination is absolute. But the duty of a doctor to save life of a patient is not absolute.

He can desist from prolonging life by artificial means if it is in the best interests of the patient. Such an omission is not an offence. The doctor or the hospital may seek a declaration from the Court that such withholding, which is proposed, will be lawful.

4.4.1. DIANE PRETTY's case:

The famous case of Diane Pretty had the opportunity to scan and scrutinize the provisions of Sec-2 of the Suicide Act, 1961.

Sec-2. Criminal Liability for complicity in another's suicide:-

235
(1) A person who aids, abets, counsels or procures the suicide of another, or an attempt by another commit suicide, shall be liable on conviction on indictment to imprisonment for a term not exceeding fourteen years.

(2) If on the trial of an indictment for murder or manslaughter it is proved that the accused aided, abetted, counseled or procured the suicide of the person in question, the jury may find him guilty of that offence.

(3) ..........(provision giving effect to Schedule-1)

(4) ........ No proceedings shall be instituted for an offence under this section except by or with the consent of the Director of Public Prosecutions.

In this case, one Mrs. Diana Pretty, a British Citizen was suffering from 'Motor Neurone Disease' and she intended to take the assistance of her husband to commit suicide. Since the proposed act of assistance of the husband to assist Pretty to commit suicide falls within the sphere of Sec-2 of the Suicide Act of 1961, she was inclined to seek immunity for her husband from the State, and her claim was denied by the House of Commons.

In R (Pretty) vs. D.P.P\(^1\) the Court held that there is no incompatibility between Sec-2(1) of the Act of 1961 and the European Convention on Human Rights.

It could not be interpreted as conferring a right to die or to enlist the aid of another in bringing about one's own death. (Art-2 – dealing with Right to Life). As to Art-3 (prohibition of inhuman or degrading treatment), the Director of Public Prosecutions had refused to give an advance undertaking

\(^1\) (2002) 1 A.C. 800.
that he would not give his consent under Sec-2(4) of the Suicide Act, 1961, to the prosecution of the husband of the applicant for an offence. It cannot plausibly be argued this act, assisting his terminally ill wife to commit suicide she being unable to do so unaided, was inflicting the proscribed treatment on the applicant and would be contrary to Sec-2(1) of the Suicide Act, 1961.

The appellant approached the European Court of Human Rights in PRETTY vs. U.K.\(^1\) where the ECHR held that the appellant being physically incapable of taking her own life, the interference conformed to the requirements of Art-8(2). States were entitled to regulate through the operation of the general criminal law activities detrimental to the life and safety of other individuals, and the more serious the harm involved, the more heavily would weigh considerations of public health and safety against the countervailing principle of person autonomy. Sec-2 was designed to safeguard life by protecting the weak and the vulnerable and especially those not in a condition to take informed decisions against acts intended to end life or to assist in ending life.

The right not to be treated extraordinarily, like the constitutional right to treatment, has also been the subject of lengthy discussion in recent euthanasia literature and some Court cases that have been decided in Western countries. Some scholars have recently been arguing that the State has no right to force a person to live in a state of unbearable pain and bear the expense of unproductive medical treatment. Every person must have a right to choose the way of life and the State cannot force a person to

die in a particular manner. The desire for control over how we die should be left with us and this desire certainly means a sharp turning away from the sanctity of life ethic. In England, there is the famous case of Dr. Nigel Cox¹ who was tried for attempted murder. In August 1991, Lilian Boyes was dying in the Royal Hampshire Country Hospital in Winchester. For twenty years she had suffered from an extremely painful form of rheumatoid arthritis. Now at seventy, she had developed ulcers and abscesses on her arms and legs, fractured vertebrae, internal bleeding, deformed hands and feet, swollen joints and gangrene from steroid treatments. Simply to be touched caused her great pain. She reached the point at which she wanted to be helped to die. Dr. Cox initially refused but later agreed and injected two ampoules of potassium chloride—a double dose of a lethal drug that has no curative or pain killing properties. Dr. Cox entered in the medical notes the details of the injection he gave. No one raised any complaint at the time, but some days later a Roman Catholic nurse who did not usually work on that ward read the notes and reported it to the management who called the police. Dr. Cox was therefore charged with attempted murder. He was found guilty. The judge told him that he had 'betrayed his unequivocal duty as a physician', and gave a twenty-month suspended prison sentence. As regards his medical profession, the general medical council reviewed his case and said that while a doctor could ease pain and suffering, it is 'wholly outside that duty to shorten life in order to relieve suffering'. Nevertheless, the

¹ Rex vs. Cox, unpublished, 18 September 1992, cited in Peter Singer, Rethinking Life and Death, supra note 5, at 139-40.
Council added, it had decided 'to temper justice with mercy' and impose no penalty.¹

4.4.2. LATEST TRENDS IN REFORMING LAW ON EUTHANASIA.

Doctors in the United Kingdom can accompany their patients every step of the way, up until the last. The law stops them helping their patients take the final step, even if that is patient's fervent wish. The chameleon of euthanasia continues to change, and the current shade is Physician Assisted Suicide. The politically correct position for clinicians is 'studied neutrality' since doctors will not really be involved in assisted suicide. Thus the issue has slipped past the British Medical Association and the recent House of Lords' report on assisted dying suggests that euthanasia and assisted suicide are different. R.J.D. George, I.G. Finlay and David Jeffrey in their article "Taking the final step: changing the law on euthanasia and physician assisted suicide"² argued that if physician assisted suicide is legalized, doctors would have the new duty of therapeutic killing, even if they planned only to prescribe lethal medication, and euthanasia and P.A.S. are one and the same, and legalizing physician assisted suicide will have a profound and ubiquitous effect on clinical codes, duties, and practices.

THE ASSISTED DYING FOR THE TERMINALLY ILL BILL 2004

A Bill was introduced in October 2005 in the House of Lords that would allow a competent and terminally ill person who has attained the age of majority and suffering unbearably to request either assisted suicide or

² www.bmj.com/cgi/content/full/331/7518/684?maxtoshow.
voluntary euthanasia. The Assisted Dying for the Terminally Ill Bill 2004 requires that an assessment of the patient is to be made by attending physician that the patient is likely to die of natural causes within a few months, and that the patient is competent to make the request and that he or she is suffering unbearably, the patient must sign a written declaration of intent. If this has not been revoked within 14 days of the date on which the request was first made, the patients can receive the means to take his or her own life or, if the patient is physically unable to do that, have his or her life ended through voluntary euthanasia. All the cases of euthanasia would be reviewed by a medical committee.

The Assisted Dying for the Termination Ill Bill 2004 contains a number of important safeguards, including that the patient is suffering a terminal illness, is in unbearable pain and has consulted a specialist in palliative medicine. By contrast, the Medical Treatment (Prevention of Euthanasia) Bill proposed in 1999 states in clause 1:

"It shall be unlawful for any person responsible for the care of a patient to withdraw or withhold from the patient medical treatment or sustenance if his purpose or one of his purposes in doing so is to hasten or otherwise cause the death of the patient."

The Bill attempted to tighten the law in that it prevents a doctor withholding treatment from a patient if the purpose is to hasten death. This might outlaw the present treatment of patients suffering from PVS, unless doctors could claim that the treatment is withheld not to produce death, 'but because the treatment is not producing any benefit to the patient. The use
of the word 'purpose' rather than 'intend' was designed to make it clear that a
doctor who foresaw death being the result of her or his treatment or non-
treatment would not be breaking the law if death was not her or his purpose. Morris (2000), a commentator felt the Bill (if enacted) would have placed doctors in a difficult position.

Of course a strong case can be made for leaving the law as it is. Mc.Call Smith accepts the present law as a satisfactory, if a little untidy, compromise between the different arguments. He even finds the uncertainty. Another commentator Briggs (2001:5) finding the uncertainty and complexity of the law problematic observed that

"Sophistry and creative legalism may be effective in the court room, but medical practice can not always be tailored to take advantage of them."

She is particularly critical of the failure of the law to provide clear guidance to those working day-to-day in the area.¹

MARVELLOUS MENTAL CAPACITY ACT?

A confusion now surrounds the Hippocratic Oath, more particularly with the passage of the Labour's Mental Capacity Act and the determination of the Government to enforce 'living wills' whereby the medical professionals could face prison for denying right to die. The doctors and nurses may be required by the new law to end lives rather than save them. The Lord Chancellor has warned doctors that they risk going on trial for assault if they

refused to allow patients who made 'living wills' to die. This new law gives full legal force to living wills, or advance decisions, in which patients say, sometimes years in advance, how they wish to be treated if they become incapacitated and lose the ability to speak for themselves. In fact, the new law amounts to the introduction of euthanasia through the back door.

In a 'living will' a patient can demand that life-preserving treatment be withdrawn if they become too ill to communicate or feed themselves. The guidelines issued by Lord Falconer – with the backing of Health Secretary – say that doctors may declare themselves conscientious objectors if they have religious or moral objections to carrying out the instructions of a living will. But in that case a doctor must pass his or her patient over to another doctor who will follow the instructions to allow the patient to die. 1

The Guidelines issued by Lord Falconer tell the medical workers:

"You will not incur liability for providing treatment in a patient's best interests unless you are satisfied that a valid and applicable advance decision exists. If you are satisfied that an advance decision exists which is valid and applicable, then not to abide by it could lead to a legal claim for damages or a criminal prosecution for assault."

The warning over damages claims raises the prospect that family or friends of a patient who have a financial interest in their death could sue a doctor who fails to kill them. It also opens the bizarre possibility that a patient who recovers could sue a doctor for not letting them die. This ministerial guidance on the Mental Capacity Act came in a week when the influential

1 www.thisislondon.co.uk (visited on 7-5-07.)
Nuffield Council on Bioethics recommended that premature babies born at 22 weeks or earlier should not be resuscitated, a suggestion that led to fears that the life-saving efforts of doctors will be bound by inflexible rules.

Dr. Peter Saunders, Surgeon and head of the Christian Medical Fellowship said "Clinical circumstances exist where it is entirely appropriate to withhold food and fluids: for example in a dying patient when their delivery proves both burdensome and ineffective for the patient. But we are concerned that patients will make unwise and hasty advance refusals of food and fluids without being properly informed about the diagnosis.

It is too easy for patients to be driven by fears of meddlesome treatment and 'being kept alive', into making advance refusals that later might be used against them. Commonly patients change their minds about what care they would like as their condition changes.

This law does not allow real conscientious objection. A doctor who believes it would be clinically wrong to withdraw food and fluids must pass their patient over to another doctor who will do so. That makes them complicit in the death."

Philosophy Professor David Conway of the Civitas think tank said: "This is opening a terrible can of worms and it threatens to cause havoc."

The guidelines from ministers come amid deepening concern over the implications of the Mental Capacity Act. The Act gives statutory force to the legal precedent set by the courts which say that it can be in the best interests of an incapacitated patient to be allowed to die through withdrawal
of food and fluids. But there has been alarm at the ease at which a patient can give instructions that they should die.

Under the law, a living will that entails death needs to be in writing or included in medical note, but will still be valid if a patient is too ill to sign their name to it.

The law also allows people to nominate a friend or relative with the power to order the withdrawal of life-preserving treatment if they become incapacitate – and to do so just by ticking a box on a form. At one hospital trust in West London, doctors have already been provided with space in patients' notes to record requests that they be allowed to die if they become critically ill.

The Health Department also made clear in a court case in 2006 that decisions on whether to provide a patient with life-saving treatment – such as provision of artificial nutrition and hydration – can be influenced by the cost of providing treatment. The new guidelines thus make clear that doctors who obey living wills and allow their patient to die will not be faced with prosecution even if it turns out that the living will was not valid or did not exist.

Dr. Jacqueline Laing, an academic lawyer of London Metropolitan University said:

"Many people will have filled in advance forms in ignorance of their lethal implications and of alternative courses of action. The Act inverts good medical practice by criminalizing medical staff who intervene to save the lives..."
of their patients with simple cures and in certain cases, even food and fluids. Any conscientious opt-out is nullified by the threat of prosecution.” She further added that ‘the lethal direction of the Act and the cost-saving implications for the N.H.S. should be obvious.”

‘The Assisted Dying for the terminally ill’ bill of Lord Joffe which seeks to make it legal for doctors to prescribe drugs that a terminally ill person could take to end his or her own life’ is stoutly opposed by 73% of the Royal College of Physicians. Palliative care is suggested to be a better substitute to prevent the prevalence of assisted dying.

**IMPLICATIONS OF THE M.C.A.2005:**

The Mental Capacity Act 2005 provides a statutory framework to empower and protect vulnerable people who are not able to take their own decisions. It makes it clear who can take decisions and in which situations, and how they should go about this issue. This Act provides a comprehensive framework for decision making on behalf of adults aged 16 and over who lack capacity to make decisions on their own behalf. The Act applies to England Wales. Scotland has its own legislation – The Adults with incapacity (Scotland) Act, 2000.. Northern Ireland is currently governed by common law. This Act came into force from April 2007.

The Act applies to all decisions taken on behalf of people who permanently or temporarily lack capacity, including decisions relating to

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1 [www.news.bbc.co.uk](http://www.news.bbc.co.uk).
2 [www.thisislondon.co.uk/news/article](http://www.thisislondon.co.uk/news/article).
medical treatment. All doctors working with adults who lack, or who may lack, capacity will need to be familiar with both its underlying principles and its basic provisions. In general, the Act confirms and reinforces best practice, placing the pre-existing common law provisions on a statutory footing, and much of it may therefore be familiar to those with experience of working with adults lacking decision-making capacity. There are however, a number of new features, including the ability to nominate substitute decision-makers under a Lasting Power of Attorney (LPA), the development of a new Court of Protection with extended powers, and specific provisions for enrolling incapacitated adults in certain forms of research.

DECISION MAKING CAPACITY:

In legal context, Decision Making Capacity refers a person's ability to do something, including making a decision, which may have legal consequences for the person themselves or for other people. Although the concept of capacity is inevitably complex, as per Sec-2(1) of the M.C.Act of 2005, a person lacks capacity if, at the time the decision needs to be made, he or she is unable to make or communicate the decision because of an 'impairment of, or a disturbance in the functioning of, the mind or brain. The Act contains a two-stage test of capacity:

- Is there an impairment of or disturbance in the functioning of, the person’s mind or brain? If so,

- Is the impairment or disturbance sufficient that the person lacks the capacity to make that particular decision?
The assessment of capacity is also 'task-specific', i.e. it focuses on the specific decision that needs to be made at the specific time the decision is required. It does not matter therefore if the incapacity is temporary, or the person retains the capacity to make other decisions, or if the person's capacity fluctuates. The inability to make a decision must be a result of the impairment or disturbance already mentioned. This could be the result of a variety of factors, including mental illness, learning disability, dementia, brain damage, or intoxication. The important point is that the impairment or disturbance renders the individual unable to make the decision in question. If the impairment is temporary and the decision can be put off until such a time as he or she is likely to regain capacity, then it should be deferred. While it is clear that an unconscious patient will lack capacity, most other categories of patient will retain some decision-making capacity, however slight it may be.

It may be observed that the basic principles governing all decisions and actions under this Act are rooted in the best practice and the common law and appear to be fully compliant with the relevant provisions of Human Rights Act.

1. The English law that every adult has a right to make decisions unless it is proven otherwise echoes one of the main principles of medical practice i.e. the respect for autonomy.

2. Every thing practically must be done to support individuals to make their own decisions, before it is decided that they lack capacity.
3. The fact that an individual makes a rash, unwise or irrational decision, or begins to act out of character, is not itself proof of incapacity i.e. otherwise known as the freedom to make unwise decisions.

4. Where it is determined that an individual lacks capacity, any decision or action taken on his or her behalf must be in his or her best interests.

5. Whenever a person is making a decision on behalf of an adult who lacks capacity, he or she must ensure that the decision is the least restrictive of that individual's fundamental rights or freedoms.

WHO SHOULD ASSESS CAPACITY?

The person who wishes to make a decision on behalf of an incapacitated person is responsible for assessing his or her capacity. Where consent to medical treatment is required, the health professional proposing the treatment needs to decide whether the patient has the capacity to consent. The reasons why capacity are in doubt should be recorded in the medical record, as should details of the assessment process and its findings. The more serious the decision, the more formal the assessment of capacity is likely to be, and where appropriate, it might be advisable to refer to a psychiatrist or psychologist for a second opinion.

Under this Act, a person is regarded as being unable to make a decision if, at the time the decision needs to be made, he or she fails:

- to understand the information relevant to the decision
- to retain the information relevant to the decision
- to use or weigh the information, or
- to communicate the decision (by any means).

Further, this Act requires that any decision that a person lacks capacity must be based on a ‘reasonable belief’ backed by objective reasons. If the individual flatly refuses, no one can be required to undergo an assessment. That apart, the fundamental tenet that all decisions taken on behalf of someone who lacks capacity must be taken in his or her best interests, which is a common law principle is codified in this Statute and this gives its moral compass. The ‘best interest judgment’ should not be a ‘substituted judgment’ but an objective one. This Act prescribes that an individual must be permitted, as far as possible, in the decision making process and the decision maker must also take into account the likelihood that the person will regain capacity. The decision must also consider the person's past and present wishes and feelings, including any relevant written statement made when she or he had capacity which may include general statements of wishes or 'Living Wills'.

HEALTH INTERVENTIONS – CARE AND TREATMENT:

Under common law, where an adult lacks capacity to make decisions on his or her own behalf, health interventions will be lawful where there is both a necessity to act, and any action is in the best interests of the
incapacitated adult.¹ This aspect of giving legal protection to decision makers in such circumstances is well entrenched in the Mental Capacity Act, 2005.

The Act clarifies that an action or intervention will be lawful i.e. health professionals will enjoy protection from liability – where the decision maker has a reasonable belief both that the individual lacks capacity, and the action or decision is in his or her best interests. It applies to any one making a decision on behalf of another, irrespective whether they have a professional relationship with the incapacitated individual. In medical treatment, it is applicable not only to an episode of treatment itself, but also to those necessary ancillary procedures such as conveying a person to a hospital.

There are limits to these powers. A valid advance decision, and a valid decision by an attorney or a court appointed deputy would take precedence. The Act also sets limits to the extent to which the freedom of movement of an incapacitated person can be restricted. An incapacitated person can only be restrained where there is a reasonable belief that it is necessary to prevent harm to the incapacitated person. Any restraint must also be in accordance with the underlying principles mentioned earlier – it must be proportionate to the risk, and of the minimum level necessary to protect the incapacitated person.

Although reasonable use of restraint may be lawful, the Act makes it clear that it will never be lawful under the Act to deprive a person of his or her liberty within the meaning of Article-5(1)of the European Convention on

¹ Refer to F vs. West Berkshire Health Authority [1989] 2 All ER 545.
Human Rights. The onus is on the person wishing to act to objectively justify his or her belief that the person being cared for is likely to be harmed unless some sort of physical intervention or other restraining action is taken. The significance of this point was established by the European Court of Human Rights judgment in the "Bournewood" case which held that a patient who was compliant but unable to consent to detention had been unlawfully detained after having been admitted into hospital under the common law doctrine of necessity.

The "Bournewood" case\(^1\) concerned an autistic man with severe learning disabilities who was informally admitted to Bournewood Hospital under common law. The European Court of Human Rights found that he had been deprived of his liberty unlawfully without a legal procedure with safeguards and rapid access to a court of appeal. The Court made it clear that the question of whether someone has in fact been deprived of liberty depends on the particular circumstances of the case.

The Bournewood case raised a question – should the statutory framework cover all those who lack capacity whether expressing objection or not? According to the Bournewood decision, the common law principle of necessity provides authority to treat, and possibly to detain, those who do not have the capacity to consent to such treatment and who are not resisting. It is not necessary to invoke the powers of the Mental Health Act. To a large extent this decision reflects a broad consensus that it would be inappropriate to subject all non-resisting incapable patients to the full formality of the

\(^1\) H.L. vs. United Kingdom [2004] ECHR.
Mental Health Act. On the other hand, it illustrates most starkly the absence of safeguards provided for this group of highly vulnerable people. The common law provides authority to treat, thus protecting the case staff, but it provides none of the safeguards for the vulnerable individual which would flow from the use of the Mental Health Act, an omission which has become known as the Bourne wood gap.

This Act advises that the following cases should continue to go before the court: -Proposals to withdraw or withhold artificial nutrition and hydration from patients in a persistent vegetative state.

Cases involving organ or bone marrow donation by a person lacking the capacity to consent.

Proposals for non-therapeutic sterilization.

Some termination of pregnancy cases.

Cases where there is a doubt or dispute about whether a particular treatment will be in a person's best interests.

Cases involving ethical dilemmas in untested areas.

The Mental Capacity Act contains special safeguards in relation to the withdrawing and withholding of life sustaining treatment in relation to an adult who lacks capacity.

ADVANCE DECISIONS REFUSING TREATMENT

Although the legality of valid and applicable advance refusals of treatment has been established at common law, the Act provides welcome
statutory clarification. The Act’s powers are restricted explicitly to advance
decisions to refuse treatment. Although broader general advance statements
or ‘living wills’ which indicate treatment preferences may well be relevant to a
broader ‘best interests’ assessment, they are not legally binding. An
advance refusal of treatment is binding if –

the person making the directive was 18 or older when it was made, and
had the necessary mental capacity.

It specifies in lay terms if necessary, the specific treatment to be refused
and the particular circumstances in which the refusal is to apply

The person making the directive has not withdrawn the decision at a time
when he or she had the capacity to do so.

The person making the directive has not appointed, after the directive
was made, an attorney to make the specified decision.

The person making the directive has not done any thing clearly
inconsistent with the directive remaining a fixed decision.

Although advance decisions can be oral or in writing, an advance refusal will
only apply to life-sustaining treatment where it is in writing, is signed and
witnessed, and contains a statement that it is to apply even where life is at
risk. Advance decisions can not be used to refuse basic care, which includes
warmth, shelter and hygiene measures to maintain body cleanliness. This
also includes the offer of oral food and water, but not artificial nutrition and
hydration. Further, it is said that in order to ensure that an existing Living
Will is binding under the Mental Capacity Act, it must be written "The decisions set out in my living will apply, even if my life is at risk as a result" referring to the refusal of life-supporting treatment.

INDEPENDENT MENTAL CAPACITY ADVOCATES:

Another novel feature of this Act is the development of an independent advocacy scheme to support particularly vulnerable incapacitated adults – most often those who lack any other forms of external support – in making certain decisions. Where it is clear that a decision needs to be made on behalf of an incapacitated adult in relation to either serious medical treatment or place of residence and there is no one close to the adult to provide advice or guidance, including an attorney of deputy, then the services of an independent advocate will be engaged. Serious medical treatment is defined as treatment which involves providing, withdrawing or withholding treatment in circumstances where:

➢ in the case of a single treatment being proposed, there is a fine balance between its benefits to the patient and the burdens and risks it is likely to entail for him or her in a case where there is a choice of treatments, a decision as to which one to use is finely balanced, or

➢ what is proposed would be likely to involve serious consequences for the patient.¹ Dr. Jacqueline Laing, of the Human Rights and Social Justice Research Institute at London Metropolitan University, said of the Mental Capacity Act, says that "There are sound reasons to believe that the Mental Capacity Act, by endangering those who cannot speak for themselves, is

¹ www.bma.org.uk.
incompatible with the European Convention of Human Rights and other international instruments. By requiring doctors, on pain of an assault charge, to dehydrate non-dying patients to death and even perform non-therapeutic research and tissue removal at the behest of unaccountable third parties, this Act allows the basest of motives to override the rights and safety of the most vulnerable.¹

DEVELOPMENTS IN INTERNATIONAL ARENA:

The issue of euthanasia, more particularly active voluntary euthanasia, had received only little attention at the international level. But there are certain significant developments recently and there has been preliminary consideration of the issue of active voluntary euthanasia by a committee of the Council of Europe, and attempts to introduce legislation in support of active voluntary euthanasia in European Parliament.

4.4.3. COUNCIL OF EUROPE:

In 1987, the issue of voluntary euthanasia was raised before the Council of Europe by the Netherlands government. The Netherlands government was at the time considering the introduction of legislation dealing with the active voluntary euthanasia and had sought advice on the subject from the Council of Europe. The matter was referred to a working party of the ad-hoc committee of experts on progress in Bio-Medical Science of the Council of Europe. (CAHBI).

Questionnaires on euthanasia, prepared by the Secretariate in collaboration with experts from the Netherlands, were sent to all member

States as well as those non-member States that have observer status with the CAHBI.

Under its terms of reference, the working party was instructed to examine the replies received to this questionnaire and to prepare a draft opinion on euthanasia. In particular, the working party was requested to give an opinion on the feasibility and the desirability of the undertaking a study of the legal, human rights, ethical and medical problems relating to euthanasia.

On the basis of the opinion provided by the working party, the CAHBI reached the conclusion that whilst it would be possible to undertake a study on problems relating to active euthanasia (which it defined as 'a deliberate act to end the life of a severely suffering patient at his or her request), such a study was not appropriate or timely. A report was subsequently submitted by the Secretary General of the Council of Europe to the 16th Conference of European Ministers of Justice in respect of the work of the CAHBI. With regard to active voluntary euthanasia, it was reported that in December 1987, the CAHBI adopted an opinion for the committee of Ministers on the feasibility and the desirability of undertaking a study on the legal, human rights, ethical and medical problems relating to euthanasia and that in this very detailed opinion, the conclusion was reached that such a study, even if it is feasible, is not desirable.

EUROPEAN PARLIAMENT:

In 1989, a Dutch member of the European Parliament Mrs. Van Hemeldonck, proposed a resolution on the care of terminally ill. The matter
was referred to committee and a report ensued dealing with the treatment of the terminally ill parties. The report authored by Leon Schwartzenberg, Professor of Medicine and world renowned cancer specialist, contained a clause supporting active voluntary euthanasia. That clause provided:

"In the absence of any curative treatment, and the following the failure of Palliative Care correctly provided at both a psychological and medical level, each time a fully conscious patient insistently and repeatedly requests an end to an existence which has for him been robbed of all dignity and each time a team of doctors created for that purpose establishes the impossibility of providing further specific care, the request should be satisfied without thereby involving any respect for human life."

The Schwartzenberg report was narrowly adopted by the European Parliament’s Environment, Public Health and Consumer’s Committee in June 1991. Debate on the report in the plenary sitting of the European Parliament was originally scheduled to take place later in 1991 but was postponed on a number of occasions and thus unlikely to be reactivated in the foreseeable future. Even if the European Parliament were to adopt the resolution, it would have no legal effect unless members of the European Parliament can persuade the European Commission to draft legislation which, if approved by the Council of Ministers, would be binding on member states1.

1 Margaret Otlowski, Voluntary Euthanasia and the Common Law, Oxford University Press, 2000- Page.388-89.