CHAPTER 4
CONCEPT AND DEVELOPMENT OF EUTHANASIA

4.1 Introduction

All over the world, the debate on euthanasia and physician-assisted suicide is a continuing process. In India too, right to die has been a matter of debate for the past few decades. Every day, rational people all over the world plead to be allowed to die. Sometimes they plead for others to kill them. Some of them are dying already. Some of them want to die because they are unwilling to live in the only way left open to them.¹

Advances in medical science now allow both, living and dying, to be prolonged, a fact which has raised awareness of issues relating to death and dying in the community at large, popular fiction and the medical professions. The sentiments above reflect a commonly held belief that modern medicine can compel people to endure life beyond what they perceive to be dignified bounds. Statistical evidence also supports the popular perception that some doctors do sometimes engage in excessive treatment to prolong the lives of the terminally ill. As a result, recent years have seen repeated calls for legal reform to permit euthanasia and assisted death.²

Euthanasia is an emotional issue that strikes at the core of the belief systems of proponents and opponents alike, as acutely evidenced by landmark cases throughout the world.³ It raises complex issues ranging from the material to the spiritual, covering the entire gamut of legal, financial, emotional, psychological and religious aspects.⁴

The problem of euthanasia arises in extreme circumstances. In the first case, the life of a suffering person approaches a ruinous and horrific end. In the second, a collapsing health care system is unable to minister to the most grievously afflicted. It is a distress to ponder what it is like when such important matters go so dreadfully awry and to discern our responsibilities when they do. But such tragedies do befall us, challenging our capacities to craft decent and just social practices and to act rightly out of charity,

¹ R Dworkin, Life’s Dominion, 179 (1993).
³ For detailed discussion, see succeeding chapters.
compassion and respect. The choice has been condemned and defended for millennia. But never have the arguments been so passionate, so open, and so evenly divided. ‘To kill or not to kill’ becomes often the question to which doctors are in a dilemma to find a suitable answer. The problem is the same whether it concerns a mother’s life having to be saved by the termination of pregnancy, or of a patient suffering from an incurable disease, entailing unbearable suffering, who has to be relieved of his pain in the only way. In the past few years, the issue of euthanasia or mercy killing has captured all the importance but as it comes in contest with the ethical code of conduct of a doctor, so it has become one of the contemporary debatable issue which seems difficult to be resolved.

Health care professionals have an inherent ethical delegation to respect the sanctity of life and to provide relief from suffering. Beneficence, autonomy, and justice are accepted moral principles governing the behavior of health care professionals within society. Technological and medical advances have created a conflict between application of these moral principles and the use of certain types of medical treatment. Hippocratic Oath and the International Code of Medical Ethics pose ethical contradiction for doctors. According to the oath, the doctor is to protect and prolong patient’s life, whereas according to the medical ethics, the doctor is to relieve the pain of the patient. The latter is in favour of euthanasia and the former counters the doctrine of euthanasia. Thus in whatever form euthanasia is executed, it seems to be a paradoxical remedy. The paradox lies in the fact that while an attempt to prolong life violates the promise to relieve pain, relief of pain by killing violates the promise to prolong and protect life.

In the words of David Hume:

Wherever disputes arise, either in philosophy or common life concerning the bounds of duty, the question cannot, by

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6 Supra note 1 at 3.
7 M.A. Kamath, Medical Jurisprudence and Toxicology, 486 (1960).
8 Shree Ram, Insight Legal Essays, 199 (2010).
9 Lily Srivastava, Law and Medicine, 146 (2010).
10 Supra note 8 at 201.
any means, be decided with greater certainty, than by ascertaining on any side, the true interests of humanity. 11

Too great rigidity in a changing environment sooner or later leads to extinction or may be a source of weakness. 12 With mercy-killings on the increase and forming a new feature of modern life, each nation will have to make its own decision whether or not to legalize euthanasia. It is possible that the principle may claim some martyrs before it finally gains legal support throughout the world. 13

It is shown in succeeding chapter, that there is a widespread sentiment in the medical profession in England and America in favour of making euthanasia legal, and this general sentiment is growing. 14 The legalization of euthanasia would not tell us for certain that we should have a pleasant death, for this may overtake us unexpectedly, but it could assure us that we need not suffer, and would greatly diminish the sense of fear. 15

According to Daniel Callahan, the euthanasia debate is not just another moral debate. Rather it is “profoundly emblematic of three important turning points in Western thought”: the first is that of the legitimate conditions under which one person can kill another; the second involves the problem of determining the meaning and limits of self-determination; and the third, changing the essential nature of medicine and redirecting it “to the relief of that suffering which stems from life itself, not merely from a sick body.” 16 The idea that what is at issue here is not merely a normative issue but a meta-ethical one which involves the very way we conceive of the good life and understand ourselves. 17

The “right to die” is an issue that often ignites strong passions and perhaps produces extremists on both sides of the debate. While some are “pro-right” extremists, others prefer to take a more moderate approach, arguing that the focus should not be on the “right to die” but rather on such issues as the right of rational, mature individuals to choose the timing of their own death so as to avoid suffering and achieve what they may

12 S.J. Holmes, Life & Morals, 146 (1948).
13 Supra note 7 at 488.
14 Supra note 12 at 160.
17 Ibid.
deem a dignified death. However, it is clear that not even this moderate position is sufficient to calm the concerns of many who oppose recognition of a "right to die".  

4.2 Arguments Against Legalizing Euthanasia: A Conservative Point of View

4.2.1 Principle of Sanctity of Life

It is asserted that, while individuals clearly do have some rights regarding their medical treatment, these rights are not sufficient to override community interests in preserving life and our society's respect for life.  

According to Ronald Dworkin,

The instinct that deliberate death is a savage insult to the intrinsic value of life, even when it is in the patient’s interest, is the deepest, most important part of the conservative revulsion against euthanasia and that, for the conservative, choosing premature death is therefore the greatest possible insult to life’s sacred, fundamental and inherent value.  

Similarly, according to Peter Singer, “Euthanasia is an unequivocal evil.”  

4.2.2 Human Life is the Property of God

God has supreme dominion over His creatures. Sentient existence is almost always preferable to non-existence. Killing someone is destroying the creative design of the most exalted artist of all. Giving and taking of life are not meant to be in human control. God is sovereign of those moments. He has forbidden us to hasten others or ourselves into the next life. Our bodies are His private property and must be allowed to wear themselves out in the way decided by Him, however painful and horrible that may be.  

John Locke, a seventeenth century British philosopher, opposed suicide on the ground that a human life is the property not of the person living that life, who is just a tenant, but

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19 Id., at 63.
20 Supra note 16 at 495.
22 Supra note 16 at 494.
23 Supra note 1 at 76.
of God, so that suicide is a kind of theft or embezzlement. And euthanasia can therefore be seen as an insult to God’s gift of life. People today are fond of saying, It’s my body, and my life, and I can do what I want with it. But Scriptures say otherwise. For example, 1 Corinthians 6:19-20 states that, Do you not know that your body is a temple of the Holy Spirit, who is in you, whom you have received from God? You are not your own; you were bought at a price. Therefore, honor God with your body. Similarly, Ecclesiastes 8:8a states, No man has power over the wind to contain it; so no one has power over the day of his death.

4.2.3 Suffering comes from God

Suffering comes from God, for the good of our souls, so we must not interfere with God’s purpose. The Supreme Legislator of the World is infinitely just and wise in all his decisions respecting right and wrong, and is no way accountable to His creatures for the reasons of his conduct in the government of the World. So, it must be a degree of presumption highly criminal in any creature to refute assent to those decisions, only because he cannot comprehend the hidden principles of that impartial justice, which characterizes every decision of God.

Moreover, another argument is that being dead is not a state we experience, and so cannot be unpleasant. It was this that led Lucretius to think that the fear of death was confused. He reinforced this by a comparison with the time before birth: Look back at the eternity that passed before we were born, and mark how utterly it counts to us as nothing. This is a mirror that nature holds up to us, in which we may see the

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26 Supra note 1 at 195.
28 Ibid.
29 Supra note 15.
30 Supra note 24 at 53.
time that shall be after we are dead. Is there anything
terrifying in the sight – anything depressing?21

4.2.4 Responsibility of the State to protect its Citizens

The most basic responsibility of government is to protect the interests of everyone
in the community, particularly the interests of those who cannot protect themselves.22 We
do not allow people free choices on matters like, for instance, the taking of heroin. This is
a restriction of freedom, but, in the view of many, one that can be justified on
paternalistic grounds. If preventing people from becoming drug addict is justified
paternalism, why isn’t preventing people from having themselves killed? The question is
a reasonable one, because respect for individual freedom can be carried too far. The
precious words of Thomas Jefferson strike a chord:

The care of human life and happiness and not their
destruction is the first and only legitimate object of good
governance.33

However, John Stuart Mill thought that the state should never interfere with the
individual except to prevent harm to others. The individual’s own good, Mill thought, is
not a proper reason for the state intervention.34

4.2.5 Dignified Death may compromise with the Dignity of others

In the broader context of active voluntary euthanasia, death may be caused by drug
overdose, asphyxiation, or lethal injection. Such conduct promotes patient autonomy but
may not be inherently dignified because the dignity of others may be compromised.
Over-emphasising individual autonomy can cause other concepts of private and public
good, which might permit greater recognition of the potential effects on people other than
the patient, to be overlooked.35 In particular it is questionable whether the ability to
choose and practice euthanasia can actually promote dignity in dying while it remains

32 Supra note 1 at 14.
33 Spiti Sarkar, “Right to Die: To be or not to be?”. Available at www.legalservicesindia.com/articles
/die.htm. (Accessed on 3.2.09).
34 Supra note 21 at 199-200
Health Care, 97 (1993).
unlawful and exposes practitioners to the prospect of criminal and professional sanction. For example, in R v. Cox\textsuperscript{36} where the doctor exercised absolute respect for his patient’s autonomy by responding to her appeals that he curtail her suffering by killing her, illustrates the dilemma. The patient allegedly achieved her dignified death but the doctor who assisted her was subjected to the indignity of a criminal trial. He was convicted of attempted murder and as a consequence faced a professional disciplinary hearing to assess his proficiency and moral integrity.\textsuperscript{37}

4.2.6 Slippery Slope Argument: Misuse of the Right to Die with Dignity

Some opponents of euthanasia worry that if euthanasia were legal, people would be killed who really wanted to stay alive. Of course, any remotely acceptable law permitting euthanasia for competent people would insist that they not be killed unless they have clearly asked to die. But someone who is terminally ill, and whose care is expensive or burdensome, or whose situation is agonizing for relatives and friends, may well feel guilty about the money and attention being devoted to him. Such a person is especially vulnerable to pressure, he might prefer that a doctor not even raise the question of whether he would like to consider dying with medical assistance; he might prefer that the question never arise, or that he not even have the right to request death.\textsuperscript{38} Although individual cases of euthanasia may win public sympathy and acquittal of those performing it, the practice obviously cannot be allowed to continue. It is open to considerable abuse and in any case a unqualified relative is neither the proper person to make so important a decision or to administer the euthanasia. If the relative happens to be a beneficiary under the Will of the sufferer, the practice of mercy killing becomes even more dubious.\textsuperscript{39} People would be put out of the way for the convenience and greed of others.\textsuperscript{40} Patients may make decisions under duress or undue pressure from family or other interested parties (perhaps the hospital).\textsuperscript{41} And even if there is no pressure or

\textsuperscript{36} R v. Cox (1992) 12 BMLR 38.
\textsuperscript{37} Supra note 2 at 31.
\textsuperscript{38} Supra note 1 at 190. For a detailed discussion, see J. David Velleman, "Against the Right to Die", in The Journal of Medicine and Philosophy, vol. 17, no. 6, 665-81 (1992).
\textsuperscript{39} Supra note 7 at 487.
\textsuperscript{40} Supra note 15 at 83.
\textsuperscript{41} Supra note 24 at 130.
falsification, can anyone who is ill, suffering pain, and very probably in a drugged and confused state of mind, make a rational decision about whether to live or die?\textsuperscript{42}

There is an American case of Harold Mohr who was convicted of manslaughter in April, 1950, because he killed his blind cancer-stricken brother at Allentown, Pennsylvania. The State Prosecutor in this case told the jury that an acquittal would encourage more mercy-kilings, and this argument probably weighed with the jurors.\textsuperscript{43}

We will start with euthanasia for the terminally ill, then slowly the service will expand until it is available to other groups.\textsuperscript{44} Opponents of euthanasia point to the abortion law. It was justified by the difficult cases (young teenage girls who are raped) and then in practice became abortion on demand. If you create a legal option, then do expect that those who take advantage of it will be greater than one anticipates. And the logic of the voluntary euthanasia position points to a wider circle of potential beneficiaries of the law. What is the ethical difference between a person who is terminally ill with cancer and wants to die and someone who is terminally ill with depression and wants to die? The anxiety here is less that everyone disabled will be marched into clinics and killed, but rather that the “definition” of terminal will become so elastic that in practice we will have to provide suicide service.\textsuperscript{45}

Dr. Martin Gumpret of New York says that in the state of the World today, many people lead hopeless and painful lives even without being incurably diseased, but nobody thinks of permitting their extinction. To legalise mercy-killing would put an intolerable strain on the doctors and the relatives of the patients concerned. There are also some psychological facts often ignored. One is that suffering is rarely continuous. An incurable patient can still get some joy out of life if he is not a neurotic. Secondly, suffering often seems more unbearable to the sensitive spectator than to the patient himself. A man may ask for release out of consideration more for his relatives than because he finds life impossible. He further point out that there is no place for intolerable pain in modern medicine and that if persons die in agony it is because qualified doctors are not available. Nobody can say at what moment an incurable disease may become curable. So long as

\textsuperscript{42} Supra note 21 at 196.
\textsuperscript{43} Supra note 7 at 488.
\textsuperscript{44} Supra note 24 at 131.
\textsuperscript{45} Id., at 132.
there is life, there is hope. So, from the social angle, it would be dangerous to concede further powers of life and death to official Committees. There is terrible example of Nazi Germany, where with the blessing of the Government, the official doctors murdered thousands of mental cases, defectives, epileptics, Jews and other racially unacceptable persons. In other words, no matter how humane the idea of mercy-killing may seem in theory, it would be unwise to license it in practice.46

J. Gay-Williams advances a complex argument that death is final and the chance of error too great to approve the practice of euthanasia; that its practice neither allows for the possibility of finding a new procedure that will pull the patient through nor for the occurrence of spontaneous remission; and finally that ‘knowing that we can take our life at any time (or ask another to take it) might well incline us to give up too easily’ and that ‘the very presence of the possibility of euthanasia may keep us from surviving when me might.’47

If euthanasia were permitted it would, in fact, lead to a general decline in respect for human life. In its most exaggerated form the claim is that permitting a single instance of euthanasia would very probably lead to a slide, to dangerous misuse. This objection is an application of what is variously called the slippery slope or ‘wedge’ argument.48

To this, liberals are inclined to say that, although these worries should not be lightly dismissed, there is little persuasive evidence that the ‘violation of the nature’ and ‘self-interest’ arguments are sound and that the extent, if any, to which these bad effects would in fact occur is only speculative. Dan Brock writes that, against these possible bad effects are the very real gains in self-determination and control over the process of dying that such an authorization of voluntary active euthanasia would yield.49 Thus, there is a logical slipperiness in that “the two principles (right of self-determination and mercy) commonly used to justify euthanasia and assisted suicide seem to admit of no logical limits and thus, in different contexts, could perfectly well be used to radically extend the practice”.50

46 Supra note 7 at 488-489.
47 Supra note 16 at 494.
48 Id., at 495.
49 Id., at 494.
50 Id., at 495.

Miss Voluntary Euthanasia is not likely to be going it alone for very long.\footnote{Ibid.}

He concluded that, on balance, the potential abuses of voluntary PAD combined with extensions to "far more objectionable practices," outweighed the utility of PAD in relieving the suffering of some patients who genuinely did want to die.\footnote{Ibid.}

4.2.7 The Dangers of a Cost-Benefit Analysis

Many who oppose the "right to die" movement believe that legalized euthanasia, even in its voluntary form, will begin to push both social institutions and individuals toward the adoption of a cost-benefit analysis that will result in the denial of medical care to those whom society deems too old, too ill, too needy or simply as not having a life worth preserving. Opponents of the "right to die" point to such "death-with-dignity" advocates as Daniel Callahan and Derek Humphry, who call for the legalization of euthanasia by touting its cost efficiency.\footnote{Sandra Meucci, “Death-Making in the Human Services.” Social Policy 18, no. 3 (1988): 17-20. Cited in supra note 18 at 60.} The appeal to a cost-benefit analysis might depersonalize death decisions and thus allow institutionally, rather than morally minded individuals to define and objectify those in need of medical care in such a way that human compassion and individual freedom will be replaced by a governmental equation that determines whether a person is entitled to live or die. In addition to expressed fears of a totalitarian state seeking to cut expenses, even at the cost of human life, opponents of the legalization of euthanasia can point to the apparent contradiction between the concept of voluntariness, which those who support legalization hold out as so important to their
argument, and the frequency of cost-benefit analysis in the literature supporting euthanasia.\textsuperscript{55}

It can be argued that as society begins to concentrate on the need to save money through the use of such principles as "utility" and cost-worthiness, it begins the process of institutionalizing the principle that not all lives are equally worth living. As a result, many individuals may be compelled to view death as the only socially responsible choice they have, or as the only choice that will save their families from the burden of growing medical costs. Under such conditions, the concept of a voluntary decision to die is, at best, little more than an illusion or, at worst, a convenient mechanism of relieving our guilt for allowing someone to die, who may have wished to live.\textsuperscript{56}

In the end, the ultimate fear is that euthanasia will not be viewed by society as a voluntary option to be taken only as a last resort, but will be viewed instead as a social duty. In support of exactly such a conclusion, opponents point to Charlotte Perkins Gilman, a supporter of euthanasia, who left a note at the scene of her self-euthanasia stating that,

> When all usefulness is over, and one is assured of an imminent and unavoidable death, it is the simplest of human rights to choose a quick and easy death.\textsuperscript{57}

It is ironic that despite that note's appeal to free choice, the title, "A Last Duty," clearly communicates Gilman's state of mind.\textsuperscript{58} Advocates have even gone so far as to suggest that individuals who are willing to contractually refuse expensive end-care might even be able to enjoy lower insurance premiums.\textsuperscript{59}

In response to these charges, supporters of the "right to die" point out that over the last two decades the many advances in medical technology have increased the expense of treatment tremendously, but when these technologies are applied to end-care patients they produce very few positive results, at a significant cost. In addition, for many these technologies are not only financially burdensome to themselves and their families but are

\textsuperscript{55} \textit{Ibid.}
\textsuperscript{57} \textit{Ibid.}
\textsuperscript{59} Supra note 56.
also physically intrusive and unpleasant. Consequently, we all should have a choice whether such procedures should be performed on us. Such arguments are bolstered by research that suggests that the ease and profitability of caring for the elderly and debilitated within nursing homes provides a ready economic incentive for such institutions to prolong the lives of their clients as long as possible.\textsuperscript{60} In essence, proponents of euthanasia argue that the undesired and artificial prolonging of life is an evil just as dangerous as the involuntary removal of life. The key is to create a system that prevents both. Finally, in response to the charges of cold and unfeeling cost-benefit analysis, many supporters of the "right to die" are forced to point out that, while few individuals want to be responsible for deciding how and upon whom our national resources will be expended, current conditions leave us very little choice. In the ideal world the expense of medical treatment would not be an issue, but the world is far from ideal, and it is clear that such decisions must be made.\textsuperscript{61} In addition, it is foolish to assume that such issues are avoidable. It seems clear from the anecdotal evidence received from numerous physicians that such cost-benefit decisions are already being made and probably have been for some time.\textsuperscript{62} Indeed, even the "Declaration on Euthanasia" issued by the Vatican Congregation for the Doctrine of the Faith on 26 June, 1980, recognizes that as a long-standing principle the "cost" of a medical procedure is one of the acceptable standards upon which to base a decision to receive or refuse medical treatment.\textsuperscript{63}

4.2.8 Preservation of the Medical Profession

This argument against the "right-to-die" attempts to tie the integrity of the medical profession to the issue of killing. Opponents argue that the physician-patient relationship is one that necessitates a high degree of trust that would be impossible if our medical professionals were allowed to play any significant role in determining who will live and who will die.\textsuperscript{64} In addition, they argue that even if individuals are said to have a right to

\textsuperscript{60} Gunnar Almgren, "Bedside Decisions Pertaining to Artificial Nutrition and Hydration: Influences of Public Versus Nursing Home Industry Structure." Cited in supra note 58 at 25.


\textsuperscript{63} Vatican Congregation for the Doctrine of the Faith 1980, Sect. 4. Cited in Id., at 62.

\textsuperscript{64} J. J. Cole, "Moral Dilemma: To Kill or Allow to Die?" Death Studies 13, no. 4, 393-406 at 393 (1989).
end their own lives, nothing in this right could possibly be interpreted as to allow them to
demand that their physician participate in this act. Also, they argue that such an act is
inconsistent with the physician's oath "to do no harm" as well as the Principles of
Medical Ethics of the American Medical Association (AMA), which dedicate a doctor to
the "prolongation of life". Opponents warn that it is this very dedication to life that has
led the medical profession to discover new cures for diseases that were once considered
to be terminal and that if doctors are no longer dedicated to extending human life, the
impetus to discover new cures through the use of experimental drugs and procedures will
be seriously weakened.65

In response, advocates argue that the Hippocratic Oath was designed to prevent the
early practitioners of medicine from using their knowledge to enable others to engage in
murder or political assassination.66 In support of this position, they point to the growing
hospice movement, which was once itself thought to violate the Hippocratic Oath, but is
now gaining wide acceptance within the medical field.67 In addition, there is by no means
any clear consensus of opinion within the medical establishment itself. Medical journals
regularly carry articles debating the acceptance of and the ethical considerations
concerning euthanasia.68 As a result, advocates see any opposition based on the position
that euthanasia is inconsistent with medical practice as both fallacious and premature.69

In the words of Osier,

If a life is worth living at all, it is certainly worth living to
the very end, a position from which the conscientious
physician has no possible escape in the care of cases which
he is called upon to treat.70

65 Supra note 18 at 62.
67 Gentile, et. al., "Hospice Care for the 1990's: A Concept Coming of Age", in George E. Dickinson, et. al.,
68 Elizabeth Godley, "Patients' Right to Die Becoming Major Issue for MDs and MPs", Canadian Medical
69 Ibid.
70 Osier, "Our attitude toward incurable disease". Cited in John Keown, (ed.), Euthanasia Examined, 76
Even a doctor, who believes that a particular patient will not survive any longer, cannot say so confidently. And it is usually heard of a doctor saying (in India) that only God can save that patient. The words of the doctor themselves indicate that all the measures of treatment have not failed and one Eternal treatment “the treatment of God” is there. Moreover, medicine is at best an uncertain science, even a definite diagnosis does not ensure an accurate prognosis. In the field of science and medicine, there is always a chance of new medical development which can change a bleak picture and offer a hope of recovery and the patient may recover. In India, spate of examples can be cited where the doctors have declared the patient incurable and miraculously the patients found recovered. The doctors are supposed to give best medical care and, if slightest relief is provided to the patient, the object of medical science is fulfilled and this experiment may open new vistas of knowledge in the field of medical learning. So, to hasten death of a patient of incurable disease would not be an appropriate development.

The doctor’s legal and ethical duty is always to provide treatment in the patient’s “best interests”, but the patient’s understanding of “best interests” may be at odds with conventional medical wisdom and the law, especially if the patient, or her relatives, are convinced that only the immediate ending of suffering through death represents the best interests. A request for deliberate life shortening action or a refusal to consent to treatment are the probable consequences, and here clinicians may find themselves being pressed to take decisions that are contrary to their ethical or clinical judgements. Tensions are most likely to occur in clinical situations where the clinician believes it to be in the patient’s best interests to discontinue therapy but the patient or relatives disagree, or where the relatives or patient wish the treatment to be discontinued against the advice of the doctor. Hence when a caring physician is confronted by the disturbing realisation that conventional medicine is unable to assuage a patient’s distress and symptoms the pleas of patients and relatives for an end to suffering may be compelling. Whether the decision is to cease or continue medical treatment, doctors may need to be “tactfully resistant” in order to avoid sacrificing the interests of the patient “to the emotional distress of the

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73 Supra note 71 at 218.
The dilemma for the doctor lies in attempting to respect the wishes of patient and family while maintaining legal and ethical standards of care. If the exercise of patient’s rights compromises the professional integrity of those responsible for the provision of medical care the advancement of those rights becomes problematic. Despite this, patients, and their relatives, continue to seek clinically assisted death in order to curtail what they perceive as the futile suffering associated with protracted dying.

4.2.9 The Growing Science of Palliative Care

Palliative care is the science that treats the symptoms of a disease but not the disease itself. In other words, when it is clear that the illness is terminal and the patient is not going to be cured, palliative care is responsible for managing the pain during the last few weeks or months. Palliative care specialists estimate that in the vast majority of cases most of the pain of death can be alleviated. Naturally, there will still be the psychological pain of death, but the physical side can be managed very effectively.

At this point, advocates of voluntary euthanasia suspect that some doctors are managing pain so effectively that in effect lives are being shortened. Palliative care specialists disagree. Although it is a common practice at the final stages to increase the pain relief to levels that make death inevitable, there is no way anyone can know whether this hastens death or not. Pain, of course, can kill as well if the person did not have the appropriate levels of pain management, then that person might die sooner and in much greater pain.

Palliative care specialists are appealing to the “principle of double effect”, which actually goes back to Thomas Aquinas. When discussing self-defense, Aquinas distinguished between a directly intended primary end to an action and a merely foreseen consequence of an action. If a person attacks another and in the act of self-defense that other kills the former, then he can invoke the principle of double effect. The intention was not to kill, but to defend oneself, which had the foreseeable possible consequence of killing that person. So, in the same way, the goal of palliative care is the management of pain; sometimes the pain management needed will make death inevitable. But the

75 Supra note 2 at 37.
76 Supra note 24 at 130.
77 Ibid.
intention is not to kill; rather it is to ensure that the patient is comfortable in his final days and hours.\textsuperscript{78} The principle of double effect has been discussed in detail at the end of this chapter.

Thus, improved care for the terminally ill has eliminated pain and made voluntary euthanasia unnecessary. In almost all cases, it may even be possible to do it in a way that leaves patients in possession of their rational faculties and free from vomiting, nausea or other distressing side-effects. Elisabeth Kubler-Ross, whose \textit{On Death and Dying} is perhaps the best-known book on care for the dying, has claimed that none of her patients request euthanasia. Given personal attention and the right medication, she says, people come to accept their deaths and die peacefully without pain.\textsuperscript{79}

Passive euthanasia allows one to die by withdrawing or withholding life supporting means. Life supporting means may further be ordinary or extra-ordinary. Ordinary means such as nutrition and hydration, which are never to be withheld since they are one’s basic rights in order to survive. However, one may not be obliged to use extra-ordinary means to sustain life, such as discontinuance of medical treatment which is burdensome, dangerous, extraordinary to the expected outcome. To withdraw a life supportive treatment as condition worsens, is letting one die and not a direct killing. In this case, it is the disease that is killing and not the one who withdraws or consents to withdraw the treatment. The goal is to eliminate or relieve suffering by an evil means of death. The suffering of a patient may be lessened, but this act of killing can never be justified. These patients, whether having incurable disease, being elderly or suffering in the other ways, are crying out for help and love. Palliative care, not death is answer. Suffering and pain is manageable in advanced scientific age. Painkiller can be prescribed as long as there is no danger. Consciousness of patient is strongly encouraged, so that if dying, one may prepare to accept to meet the Almighty.\textsuperscript{80}

\subsection*{4.2.10 Mistaken Diagnosis may lead to Loss of Precious Life}

It is often said in debates about euthanasia that doctors be mistaken. In rare instances patients diagnosed by two competent doctors as suffering from an incurable condition have survived and enjoyed years of good health. Possibly the legalization of voluntary

\textsuperscript{78} Ibid.
\textsuperscript{79} Supra note 21 at 197-198.
\textsuperscript{80} S. Rajawat, “Euthanasia”, Cr LJ (Journal Section), 321-324 at 322 (2010).
euthanasia would, over the years, mean the deaths of a few people who would otherwise have recovered from their immediate illness and lived for some extra years.\textsuperscript{81}

Not only this, legal sanctity to euthanasia by making enactment will help in shielding the negligent acts of the doctors on the one hand and persuade the greedy successors to do away with ailing ancestors with the connivance of the doctors on the other.\textsuperscript{82} Moreover, legalization of euthanasia will rather itself be an act of cruelty particularly in the Indian context of society where people do not leave hope till the last moment.\textsuperscript{83}

4.2.11 An Affirmative Act to take Human Life (i.e. Active Euthanasia) is equivalent to Murder

According to Justice Palok Basu, the affirmative act to take a human life is murder and if any person tries to defend himself on the ground that the act was a mercy killing, he has on the face of it chosen a wrong defence. There are four reasons to support this argument:

i. Such killings are done after a careful thought and it would mean that there is clear pre-meditation, which is an important element in the first degree murder.

ii. The criminal law unlike civil law does not accept the consent as valid defence in cases of homicide.

iii. The plea of the defendant will not be accepted that his motive was honest, because the common law system has given a special meaning to `malice aforethought’ in homicide law.

iv. The plea of relieving a person from painful life is of no merit in defeating the charge of murder. Courts have always held that any active shortening of life makes an act homicide, no matter for how much short time the victim would have lived.\textsuperscript{84}

According to G.E. Moore, killing (or murder) promotes a general feeling of insecurity which would take up time that could be spent to better purpose. But he did not leave it at that. It was only occasional murder that he thought he had shown to be wrong

\textsuperscript{81} Supra note 21 at 197.
\textsuperscript{83} Ibid.
\textsuperscript{84} Palok Basu, Law relating to Protection of Human Rights, 345 (2007).
at. For example, killing another in self defense or to relieve another from unbearable pain. But, a policy of universal murder is a different thing altogether.\textsuperscript{85}

According to Hobbes, murder is a species of injustice. Hobbes’s account of injustice is straightforwardly in terms of contract. It is unjust to break a contract. Each one of us has contracted not to kill, so killing is an infringement of contract and therefore unjust.\textsuperscript{86}

In Hart’s terminology, killing is contrary to natural law i.e. a minimum condition for the existence of a society is that there be some prohibition on killing. If people were never tempted to kill each other we should have no need of a concept of murder, but people are so tempted. If people were not so vulnerable there might be less need for restrictions on killing; but we are vulnerable. The minimum condition that must be met by people if they are to co-operate with each other is that they should not kill each other. To have a society is, amongst other things, to have a concept of murder and therefore to have general acceptance of an obligation not to kill or thus a prohibition on killing.\textsuperscript{87}

According to Peter Singer, there are four possible reasons against killing of self-conscious beings and those who do not choose to die:

i. The classical utilitarian claim that since self-conscious beings are capable of fearing their own death, killing them has worse effects on others.

ii. The preference utilitarian calculation that counts the thwarting of the victim’s desire to go on living as an important reason against killing.

iii. A theory of rights according to which to have a right one must have the ability to desire that to which one has a right, so that to have to life one must be able to desire one’s own continued existence.

iv. Respect for autonomous decisions of rational agents to continue to live till death comes in its natural course.\textsuperscript{88}

All the above objections are divided into two: ‘yellow-light objections (urging caution) and ‘red-light objections’ (admonishing one to stop). Euthanasia can be said pose a risk of adverse consequences or it can be said to be impermissible on its face.


\textsuperscript{86} Id., at 135.


\textsuperscript{88} Supra note 21 at 194.
There are many yellow-light objections like (a) slippery slope down which we can slide to holocaust, (b) compassionate homicide might erode the professional commitments of physicians as well as our trust in doctors, (c) patients could be depressed or pressurized at the time of decision, or misdiagnosed or haste in ending patient’s life could prevent possible recoveries, or relatives and health care providers might conspire to end the lives of the ill, or protective measures might be unequal to the task of preventing carelessness and misconduct. The definitive assessment of these objections requires that we examine the effectiveness of specific protections. Here the Oregon record (U.S.A), as it becomes available, and the experience of the Dutch, Belgians, and Swiss become useful. Many red-light objections emerge within particular religious traditions. The sectarian arguments often maintain that human life is sacred and not to be discarded lightly.99

4.3 Arguments for Legalising Euthanasia: A Liberal Point of View

4.3.1 Quality of Life is More Important than Sanctity of Life

Under the liberal or quality of life point of view, advocates of voluntary euthanasia have urged that morality and wisdom consist not in the pursuit of life but in the pursuit of quality of life and therefore, it may be desirable to end a life which is irreparably blasted by the most loathsome conditions or diseases. It is untrue that life is always a good and death is always an evil. So, voluntary euthanasia is sometimes excusable, permissible, virtuous or obligatory. Indeed, this group might be called Promethean, since they are hostile to the idea of just letting nature take its course; and they think that we should consciously and intelligently control our own destiny. This perspective is again grounded on ‘Moral Rules’ of autonomy, freedom or dignity – rules which typically prohibit the deprivation of freedom, thereby encouraging individual control of one’s life and death plans. But, of course, the liberals are against implementing the practice of euthanasia before appropriate safeguards can be provided. According to the advocates of this view, there is convincing evidence that what human beings generally regard as a life of minimal quality is bound up with an individual’s ability to satisfy certain kinds of reasonable desires or goals and that there is a difference - a vital logical, if not moral difference – between a life devoid of any quality, one almost devoid of quality and one that just lies on the negative side of the scale. In this context, the terms ‘meaningful life’ and

99 Supra note 5 at 341-342.
‘meaningless life’ often are used by individuals who wish to explain why cessation is the best possible solution to their problem. In its subjective sense, having a meaningful life signifies having a minimally adequate sense of purpose or worth, largely because an individual is attached to dominant goals and believes these goals are, or may be, attainable. Having a meaningless life in this subjective sense signifies the lack of both hope and a sense of worth, largely because the individual in question believes he does not have, or can no longer achieve, any important goal.90

In exigent and tragic circumstances, individuals do view their situation as being deeply problematic because it involves a threshold or judgment as to when, and under what conditions, death is better than living as well as the judgment that when it is, death is the best solution.91 Longer life is not such a supreme good that it outweighs all other considerations.92 The life of a permanent comatose, for example, is in no way preferable to death. Both are subjectively indistinguishable.93

Moreover, some pro-euthanasia people argue that the SOL principle is mistakenly conflated with what John Keown has called ‘vitalism’, which is the idea that human life should be preserved at all costs. What the SOL principle in fact proscribes is the deliberate destruction of human life; it does not demand that life should be prolonged for as long as possible. It might therefore be argued, as Emily Jackson cogently does, that the law’s recognition that withdrawal of life-prolonging treatment is sometimes legitimate is not so much an exception to the SOL principle, as an embodiment of it.94 Even the judicial reasoning, as well as public discourse, tends to accord an inordinate degree of importance to an absolutist reading of the SOL principle, which asserts that life is regarded as sacred, regardless of whether that life contains any of the goods of human existence. Uncritical deference to this version of the SOL principle would indeed make the very idea of any form of right to die unimaginable. Yet, on a closer examination, it

90 Supra note 16 at 492, 493.
91 Id.; at 494.
92 Supra note 1 at 197.
can be shown that the law does not in fact countenance an untrammeled notion of the SOL principle.\textsuperscript{95}

In the most secular judicial interpretation of the SOL principle yet, Denman J. in \textit{Osman v. United Kingdom}\textsuperscript{96}, explicated thus:

In respecting a person’s death, we are also respecting their life - giving it sanctity... A view that life must be preserved at all costs does not sanctify life...To care for the dying, to love and cherish them, and to free them from suffering rather than simply to postpone death is to have fundamental respect for the sanctity of life and its end.\textsuperscript{97}

Hence, as the process of dying is an inevitable consequence of life, the right to life necessarily implies the right to have nature take its course and to die a natural death. It also encompasses a right, unless the individual so wishes, not to have life artificially maintained by the provision of nourishment by abnormal artificial means which have no curative effect and which are intended merely to prolong life.\textsuperscript{98}

\textbf{4.3.2 Dignity is a Necessary condition of Good life}

This is the most striking feature of liberal approach. Liberals believe that the individuals are said to have a kind of dignity to the extent that they have reasonable power to control important aspects of their own lives. This is dignity as “self-possessed control”. It consists not in having unlimited power but in having a reasonable control over the significant aspects of one’s life, as well as in satisfying the necessary condition of not being treated indecently or disrespectfully.\textsuperscript{99} Justice Krishna Iyer has taken the view that the right to life is a fundamental right and embraces every dimension of life with dignity, accessibility to the highest material-spiritual ascent and ability to terminate life if it loses its basic value of pursuit of happiness.\textsuperscript{100} In the words of Leenen, “

\begin{itemize}
  \item \textsuperscript{95} Id. at 13,14.
  \item \textsuperscript{96} (1998) 29 EHRR 245.
  \item \textsuperscript{97} Supra note 94 at 14.
  \item \textsuperscript{98} In Re A Ward of Court. [1995] 2 ILRM 401. Cited in Ibid.
  \item \textsuperscript{99} Supra note 16 at 493.
  \item \textsuperscript{100} V.R. Krishna Iyer, \textit{Law and Life}, 148 (2008).
\end{itemize}
Not allowing euthanasia would come down to forcing people to suffer against their will, which would be cruel and a negation of their human rights and dignity.\textsuperscript{101}

4.3.3 Unbearable Pain and Agony

Probably the major argument in favour of euthanasia is that the person involved is in great or unbearable pain. Proponents of the right to die argue:

If I have been reduced to a corpse, suffering from an incurable, interminable disease, I don't deserve to live with so much pain. I fear death and the pain that will come with it, I want to have a sound sleep.\textsuperscript{102}

Similarly Mahatama Gandhi said,

Death is our friend, the truest of friends. He delivers us from agony. I do not want to die of a creeping paralysis of my faculties a defeated man.\textsuperscript{103}

Guaranteeing a person the right to die would dismiss the fear of death and mourning now prevalent in people. Pain is a subjective perception and is, at times, very difficult to assess objectively by any scale of measurement. The relationship between pain and desire for death is often described as a relatively straight-forward one; Intractable or severe pain is thought to lead to a desire for hastened death and I particular to thoughts of suicide.\textsuperscript{104}

Pain is not the only factor in suffering. One has to take into account mental distress caused by other manifestations of the disease, such as loss of control over bodily functions or loss of cognitive existence, causing a sense of loss of dignity of life.\textsuperscript{105} In the words of Khushwant Singh,

My explanation of suffering and pain in the last phases of one’s life is utterly mundane. As one gets older, nature deprives one of the means of enjoying life: one’s vision is


\textsuperscript{103}P. Rathinam \textit{v. Union of India} AIR 1994 SC 1844 at 1847.

\textsuperscript{104}Harvey Chochinov & William Breitbart, \textit{Handbook of Psychiatry In Palliative Medicine}, 57 (2000).

impaired, teeth gone, hearing defective, joys of eating and drinking reduced. Then come old-age ailments like arthritis, backaches, inability to walk, and so on. It is nature which compels one to come to the conclusion that one can’t bear pain and suffering any longer and you say to yourself: “I can’t take this any more; enough is enough. It is time for me to go.” That is why I believe a person has the right to end his or her life when fun has gone out of living.  

Dean Inge has remarked that it seems anomalous that a man may be punished for cruelty if he does not put a horse or a dog out of its mercy, but is liable to be hanged if he helps a cancer patient to an overdose of morphia.

4.3.4 Respect for Patient’s Autonomy and Self-determination

Many people regard euthanasia as the ultimate expression of individual autonomy and self-determination. Its proponents contend that a relaxation of the law to permit euthanasia, or clinically assisted dying in appropriate circumstances, would relieve suffering and enhance human dignity, by enabling people to maintain control of their lives until their final moments. There is no doubt that most people think the manner of their deaths as of special, symbolic importance: they want their deaths, if possible, to express and in that way vividly to confirm the values they believe most important to their lives. The idea of a good (or less bad) death includes timing as well.

4.3.4.1 Conscious and Competent Patients: Justifying Voluntary Euthanasia

Voluntary euthanasia and the value of voluntary autonomous choices, whether taken in advance or contemporaneously, provide the central focus, so that the debate revolves around the making of autonomous medical decisions in a changing medical environment. Those who are physically able, and hold no moral objections, might of course contemplate suicide. But suicide is rarely regarded as dignified and a more certain
Respect for individual autonomy is central to modern medical practice, dictating that all patients have the right to exercise self-determination in respect of their medical care. The law of consent gives legal expression to individual autonomy and permits a competent adult absolute sovereignty to give or withhold consent even if death will be the result. And regard for individual autonomy and autonomously made decisions can endure even after a patient loses the mental capacity to participate in medical decision-making. People who believe that competent patients should be permitted to arrange their own deaths, with the assistance of willing doctors if they wish, often appeal to the principle of autonomy. They say that it is crucial to people’s right to make central decisions for themselves that they should be allowed to end their lives when they wish, at least if their consent is an ‘informed consent’ and their decision is not plainly irrational.

The Concept of ‘Informed Consent’

The concept of ‘informed consent’ is developed by American Courts. There is a significant difference in the nature of express consent of the patient, known as ‘real consent’ in Britain and as ‘informed consent’ in America. In the English Law, the elements of consent are defined with reference to the patient. Consent is considered to be valid and real where (i) the patient gives consent voluntarily without any coercion, (ii) the patient has the capacity and competence to give consent (The C-Test), and (iii) the patient has minimum of adequate level of information about the nature of the procedure which he is consenting to. On the other hand, the concept of ‘informed consent’, while retaining the basic requirements of consent, shifts the emphasis to the doctor’s duty to disclose the

11 *Supra* note 2 at 36.
12 *Supra* note 1 at 190.
necessary information to the patient to secure his consent. Thus, an ‘informed decision’ is a decision taken by a competent patient, i.e. an adult who has capacity to take a decision as to his or her medical treatment after understanding the gravity or otherwise of his disease, the availability or otherwise of alternative medicine or technology to cure his disease, the consequences of those forms of treatment and the consequences of remaining untreated.\textsuperscript{13}

Guidelines have been laid down to judge competence. There is a presumption that a patient has the mental capacity to make decisions whether to consent to or refuse medical or surgical treatment offered to him/her. If mental capacity is not in issue and the patient, having been given the relevant information and offered the available options, chose to refuse the treatment, that decision has to be respected by the doctors. Considerations that the best interests of the patient would indicate that the decision should be to consent to treatment are irrelevant. If there is concern or doubt about the mental capacity of the patient, that doubt should be resolved as soon as possible, by doctors within the hospital or NHS Trust or by other normal medical procedures. In the meantime, while the question of capacity is being resolved, the patient must, of course, be cared for in accordance with the judgment of the doctors as to the patient’s best interests. If there are difficulties in deciding whether the patient has sufficient mental capacity, particularly if the refusal may have grave consequences for the patient, it is most important that those considering the issue should not confuse the question of mental capacity with the nature of the decision made by the patient, however grave the consequences. The view of the patient may reflect a difference in values rather than an absence of competence and the assessment of capacity should be approached with this firmly in mind. The doctors must not allow their emotional reaction to or strong disagreement with the decision of the patient to cloud their judgment in answering the primary question whether the patient has the mental capacity to make the decision. In the rare case where disagreement still exists about competence, it is of the utmost importance that the patient is fully informed of the steps being taken and made a part of the process. If the option of enlisting independent outside expertise is being considered, the doctor should discuss this with the patient so

\textsuperscript{13} Alka Bhatia, “The Role of Consent in Medical Treatment”, Nyayadeep, 58-71 at 63. Also see, Law Commission of India, 196th Report on Medical Treatment to Terminally Ill Patients (Protection of Patients and Medical Practitioners), 180 (2006).
that any referral to a doctor outside the hospital would be, if possible, on a joint basis with the aim of helping both sides to resolve the disagreement. It may be crucial to the prospects of a good outcome that the patient is involved before the referral is made and feels equally engaged in the process. If the hospital is faced with a dilemma which the doctors do not know how to resolve, it must be recognized and further steps taken as a matter of priority. Those in charge must not allow a situation of deadlock or drift to occur. If there is no disagreement about competence but the doctors are for any reason unable to carry out the wishes of the patient, their duty is to find other doctors who will do so. If all appropriate steps to seek independent assistance from medical experts outside the hospital have failed, the NHS Hospital Trust should not hesitate to make an application to the High Court or seek the advice of the Official Solicitor. The treating clinicians and the hospital should always have in mind that a seriously physically disabled patient who is mentally competent has the same right to personal autonomy and to make decisions as any other person with mental capacity.\(^{114}\)

John Lachs said, ‘that in the end, our lives belong to no one but ourselves’. Similarly, Dworkin, Nagel, Nozick, Rawls, Scanlon and Thomson suggest that each individual has a right to make the most intimate and personal choices to personal dignity and autonomy, a right that ‘encompasses the right to exercise control over the time and manner of one’s death. In other words, for the pro-euthanasia lobby, the patient should be in control and the doctor should be the servant of the patient. And the patient must be entitled at some stage to say ‘stop’, when he has had enough.\(^{115}\)

Giving invasive medical treatment contrary to patient’s will amounts to battery or in some cases, may amount to murder. Just as we count a desire to go on living is a reason against killing, so we must count a desire to die as a reason for killing. If one has a right to life, it does not mean that it would be wrong for one’s doctor to end one’s life, if he or she does so at one’s request. In making this request one waives one’s right to life.\(^{116}\) After


\(^{115}\) Supra note 16 at 493.

\(^{116}\) Supra note 1 at 195.
all, whether to die or not is ultimately a personal choice.\textsuperscript{117} And choice is a fundamental democratic principle and is the basis of the free enterprise system.\textsuperscript{118}

4.3.4.2 Unconscious or Incompetent Patients

(i) When the Patient had dictated his wish in the form of Living Will or Advance Directive.

It goes without saying that the law must strenuously avoid any form of discrimination against incompetent patients.\textsuperscript{119} So far as unconscious patient is concerned, we can respect his autonomy only by asking what he would have decided himself, under appropriate conditions, before he became incompetent. That may seem easy when the patient has signed a living will dictating what is to be done in such circumstances, or when he has made his last wishes known in a less formal but nevertheless emphatic way, for example, by repeatedly telling relatives.\textsuperscript{120} People are now realizing the importance of making decisions in advance about whether they want to be treated in a particular way. Every state in America, for example, now recognizes some form of advance directive, either ‘living wills’ or ‘health-care proxies’.\textsuperscript{121}

(a) Living Will

It is a document stipulating that specified medical procedures should not be used to keep the signer alive in certain specified circumstances.\textsuperscript{122}

(b) Health-care Proxy

It is a document appointing someone else to make life-and-death decisions for the signer when he no longer can.\textsuperscript{123}

Yet, even in such cases, there is no guarantee that he did not change his mind sometime after the last formal or informal declaration, or that he would not have changed his mind if he had thought about the matter again.\textsuperscript{124} Moreover, it also raises an important

\textsuperscript{117} Supra note 3 at 517.
\textsuperscript{118} Supra note 9 at 150.
\textsuperscript{119} Supra note 95 at 15.
\textsuperscript{120} Supra note 1 at 191.
\textsuperscript{121} Id., at 180.
\textsuperscript{122} Ibid.
\textsuperscript{123} Ibid.
\textsuperscript{124} Id., at 191.
question as to where is the line to be drawn between ‘being killed’ and ‘not being kept’ (or killing and letting die).  

(ii) Where the Patient had not indicated his wish

An individual’s incapacity together with absence of advance directive, should not serve as basis for denying him the rights of freedoms which competent patients enjoy in the exercise of their right to privacy and self-determination. This would effectively render the incompetent patient a ‘second class citizen’.

(a) Medical Power of Attorney: The Principle of ‘Substituted Judgment’ or ‘Judgment of a Surrogate’

If someone had not indicated his wishes, formally or informally, then of course it is possible that he never considered the matter at all, and had no view either way. In such a case, relatives might ask whether he would have wanted to be allowed to die or to be killed if he had thought about it. That is a very tricky judgment; everything depends upon the setting one imagines. Some people do think they can sensibly judge what some friend or relative would have wanted. Their opinion is usually based on their sense of what would be most consistent with the patient’s values and personality as a whole.

It involves a detailed inquiry into patient’s views and preferences. The surrogate decision maker has to gather from material facts as far as possible the decision which the incompetent patient would have made if he was competent. In Re Conroy it was held that this right can be exercised by a surrogate decision maker when there was clear evidence that the incompetent person would have exercised it. Where such evidence was lacking the Court held that an individual’s right could still be invoked in certain circumstances.

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125 Id., at 181
126 Supra note 95 at 15.
127 Supra note 1 at 191. Also see, Law Commission of India, 196th Report on Medical Treatment to Terminally Ill Patients (Protection of Patients and Medical Practitioners), 169-170 (2006).
128 98 NJ 321, 486 A.2d 1209 (1985). Cited in Alan Stoudemire, Barry S. Fogel(Ed.), Medical-Psychiatric Practice, 543 (1993). In re Quinlan 70 N.J.10, 355 A. 2d 647, Karen Quinlan suffered severe brain damage as a result of anoxia, and entered into PVS. Her father sought judicial approval to disconnect her respirator. The New Jersey Supreme Court granted the prayer, holding that Karen had a right of privacy grounded in the U.S. Constitution to terminate treatment. The Court concluded that the way Karen’s right to privacy could be exercised would be to allow her guardian and family to decide whether she would exercise it in the circumstances. However, in Cruzan v. Director, Missouri Department of Health, 497 U.S. 261(1990), the US Supreme Court rejected the petition for withdrawal of life support of Nancy Cruzan, who lay in PVS in a Missouri State hospital, on the ground that there was no clear and convincing evidence that while the patient was competent she had desired that if she became incompetent and in a PVS, her life support should be withdrawn.
circumstances under objective ‘best interest’ standards (discussed below). If none of these conditions obtained, it was best to err in favour of preserving life.

(b) The ‘Principle of Best Interest of the Patient’

There is another way to find a solution in such cases i.e. the ‘principle of best interest’ of the patient which is being followed by English Courts. For example, in *Airedale NHS Trust v. Bland* it was held that if 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 for medical men to apply such treatment as in their informed medical opinion is in the “best interests of the unconscious patient, and the said act cannot be regarded as a crime. Existence in a vegetative state with no prospect of recovery is by that opinion regarded as not being of benefit to the patient. And keeping him alive artificially would be most startling, and could lead to the most adverse and cruel effects upon the patient. It is ultimately for the Court to decide, as *parens patriae*, as to what is in the best interest of the patient, though the wishes of close relatives and next friend, and opinion of medical practitioners should be given due weight in coming to its decision. This is in the interest of the protection of the patient, protection of the doctors, and for the reassurance of the patient’s family and the public.

From the above case law, it is clear that where a competent patient who is adequately informed, refuses treatment, the doctors are bound by his refusal. But in cases of minors, incompetent persons and PVS patients, the doctor must consider whether giving or continuing or withdrawing treatment is in the best interests of the patient. A balance sheet of advantages and disadvantages has to be drawn up. The best interests are not confined to medical interests but encompass ethical, social, emotional and welfare considerations. There cannot be any single test of what is in the best interests of an incompetent patient but it must depend upon a variety of considerations depending upon the facts of the case. Where a patient is not competent, it is lawful for doctors to take a decision to give, withhold or withdraw medical treatment if they consider that to be the appropriate action to be taken in the best interests of the patient.

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130 For details, see Re A, 2000(1) FLR 549. Cited in Id., at 185.
4.3.5 Euthanasia does not Frustrate Nature

Prolonging the life of a patient who is riddled with disease or no longer conscious does nothing to help realize the natural wonder of a human life, that nature’s purposes are not served when plastic, suction, and chemistry keep a heart beating in a lifeless, mindless body, a heart that nature, on its own, would have stilled.\textsuperscript{131}

4.3.6 Euthanasia represents a Humanitarian and Compassionate Measure

We put animals out of their misery, then why can’t we do it for our fellowmen? There are many cases of hopelessly diseased people who realize that they are intolerable burdens to their families and there is no point in prolonging a painful existence which is beyond recovery. It is inhuman, cruel and uncompassionate to unnecessarily prolong the life of the incurably ill. So, euthanasia represents a humanitarian measure based on unselfish motive of relieving pain. There is scarcely any movement one could name that is more unequivocally based on motives of pure philanthropy.\textsuperscript{132}

The crucifixion of the flesh is nowhere more cruel or senseless than in the prolongation of life under hopeless conditions of torment. We are still bound up in the meshes of superstitions which usurp the name of religion; for the Churches tell us that in no case may we take it upon ourselves to send an immortal soul to its account with God, not even our own, for that is exclusively the province of the Creator himself. Yet, we recognize the necessity of doing so in the case of death sentence and war. Why, then, can we not recognize it in the case of those who beg and pray for release from disease?\textsuperscript{133}

Some believe that euthanasia is in reality one of the crying needs of humanity, not only because so many people suffer months of torment before their final exit or release, but also because nearly everybody fears death. And this fear of death could be completely done away with by having ‘Euthanasia Gardens’ in every civilized land, thereby making our Earth a happier abode for all.\textsuperscript{134} All natural processes should be pleasant, and death is no exception to it. Therefore, making euthanasia a crime would, indeed, be a veritable

\textsuperscript{131}\textit{Supra} note 1 at 215.

\textsuperscript{132}\textit{Supra} note 12 at 160.

\textsuperscript{133}\textit{Supra} note 15 at 81.

\textsuperscript{134}\textit{Id.} at 80-82.
crime perpetrated by the law itself, and a mockery of justice, while pretending to punish wrongdoing.135

The great trinity of Altruism—“Benevolence, Beneficence and caring love”—permits and sometimes requires the taking of an innocent life when reliable evidence indicates that, for the recipient, it is the best of all beneficent alternatives and when the resulting death is a greater good or lesser evil than the failure to intervene. An altruistic theory does not preclude liberal values. However, it does insist that loving-kindness precedes autonomy in two ways. Although both loving-kindness and autonomy are necessary, the former is more fundamental since it will generally lead intelligent people to protect the autonomy of other persons, but not vice versa. Moreover, when the only (or best) way to protect important goods or prevent serious harm is by rendering aid, then acts of loving-kindness overrule considerations of autonomy. The intuition, albeit not a simple one, is that in certain circumstances it is kind and morally preferable to end a life and that in these circumstances ‘beneficent euthanasia’ is morally permissible. One should neither overlook the merits of the individual case nor choose to err on the side of possible harm when there is known and clear evidence of benefit to the individual. In other words, when there is a choice between known preferable beneficence for an individual and possible social harm, then if we are to err, it should on the side of beneficence. For goodness does not derive from fear or flawed abstract moral principles but, rather, from the capacity to feel love and to practice it by acting beneficently. We have the duty to relieve the fortuitous distress of others when we can do so without great inconvenience to ourselves. Moreover, the argument against unnecessary cruelty and humiliation is perhaps more convincing. To require that human beings be kept alive against their will, denying their pleas for merciful release after dignity, beauty, promise and meaningful life have vanished and they can only linger in agony, weakness, or decay, is cruel and humiliating treatment. And it seems especially inhumane not to put an end to irremediable suffering when a competent person requests it and will die anyway.136

135 Id., at 83-84.
136 Supra note 16 at 496-497.
4.3.7 Legalizing Euthanasia will prevent the Back Street Suicides, Mercy-killing and Death-tourism

Legalizing euthanasia will prevent the current duplicitous and unregulated practice of the medical profession and the secretive suicide, attempted suicide and assisted suicide cases, thereby introducing transparency in the system.\(^{137}\)

4.3.8 We should Save Scarce Medical Resources

We live in a world where medical demands are potentially unlimited. The death of those who want to die would save scarce medical resources. It seems very odd to insist that those who are terminally ill and want to die must continue to occupy a bed and use expensive drugs, when down the corridor in the same hospital might be a young child who needs the doctor’s time and access to the same drugs.\(^{138}\)

4.3.9 The Slippery-slope argument is unconvincing

Advocates of euthanasia see no reason why a carefully written law cannot confine the euthanasia option to certain limited groups. Helga Kuhse writes:

In its logical version, the ‘slippery slope’ argument is unconvincing. There are no logical grounds why the reasons that justify euthanasia - mercy and respect for autonomy – should logically also justify killings that are neither merciful nor show respect for autonomy. In its empirical version, the slippery slope argument asserts that justified killings will, as a matter of fact, lead to unjustified killings. There is little empirical evidence to back up this claim. Whilst the Nazi ‘euthanasia’ program is often cited as an example of what can happen when a society acknowledges that some lives are not worthy to be lived, the motivation behind these killings was neither mercy nor respect for autonomy; it was rather, racial prejudice and the belief that the racial purity of the *Volk* required the elimination of certain individuals and groups. In the

\(^{137}\) *Supra* note 24 at 128-129.

\(^{138}\) *Id.*, at 129.
Netherlands, a ‘social experiment’ with active euthanasia is currently in progress. As yet there is no evidence that this has sent Dutch society down a slippery slope.\textsuperscript{139}

Thus, supporters of euthanasia substantiate their view by giving various examples. They say, for example, if we crush an insect and believe this to be a permissible act, we do not conclude that it is permissible to kill all living things. We conclude only that it is permissible to kill that kind of insect, or at most, all kinds of insects. Similarly, if we are taught to kill Nazis and the criteria for a Nazi and the circumstances of permissible killing are clearly spelled out, we do not kill all German nationals. We do not mistakenly generalize even further and kill all Europeans. Nor do we proceed either in fact or in mind to kill all human beings. Again, there is convincing evidence that the killing of human beings in “X” situations does not necessarily lead to the killing of human being in non-“X” situations. Or, to be more concrete, the merciful killing of patients who want to die does not necessarily lead to the killing of the unwanted or the extermination of the human species.\textsuperscript{140}

4.3.10 Doctor has a no Legal or Ethical Duty to prolong the life of a Dying Patient.

The fact that ‘Doctor’ is the ‘savior of life’, cannot be seen in isolation because he has the responsibility of acting in the betterment of humanity over all. Keeping in view the availability of limited medical resources, he might not be able to save and serve every single human life.\textsuperscript{141}

Therefore, we must distinguish between ‘acute illness’ and ‘terminal illness’. Both are distinct biological entities and what is appropriate for one may be inappropriate for the other. For example, intravenous infusions, antibiotics, respirators and cardiac resuscitation are all supportive measures for use in acute or recurrent illnesses to assist a patient through a critical period towards recovery. Generally, to use such measures in the terminally ill, with no prospect or expectation of a return to health, is inappropriate and, therefore, bad medicine. A doctor clearly has a duty to sustain life where life is sustainable; he has no duty, legal or ethical, to prolong the distress of a dying patient.\textsuperscript{142}

\textsuperscript{139} Supra note 24 at 131-132.
\textsuperscript{140} Supra note 16 at 495.
\textsuperscript{141} Supra note 8 at 202.
4.3.11 Organ Use, Organ Transplant and Medical Research, Education and Training

Beyond the post-mortem, other than organ transplant, there has been a longer range use of human bodies – the exploitation of cadavers as teaching material in medical schools. This is a long step removed from the rationale of the transplant – a dramatic gift of life from the dying to the near-dead; while it is true that medical education will inevitably save lives, the clear and immediate purpose of the donation is to facilitate training.143

However, it should be noted that in India, commercialization of organs has been a blot on the ethical foundation of the medical profession. In recent years we have seen an organized network involving hospitals, doctors, touts, and agents doing unethical trading in human organs through the ‘organ racket’ despite the fact that we have a law on this subject.144

4.3.12 Relieving Pain is not equivalent to Murder

If correctly used, pain relieving drugs are safer than commonly supposed. There is circumstantial evidence that those whose pain is relieved may outlive those whose nutrition and rest continue to be disturbed by persistent pain.145

The Principle of Double Effect

The principle of double effect refers to the fact that some conduct has simultaneous intentional and unintentional consequences. In general terms, double effect suggests that while it is wrong to perform a bad act for the sake of the good consequences that may follow, it may be permissible to perform a good act even if some bad consequences can be anticipated. A graphic illustration of the ambiguities involved in the application of double effect is offered by Hart’s example concerning the case of a man trapped inside a burning vehicle who implores a passerby to shoot him dead and relieve him of further pain and suffering.146 Clearly the bystander can foresee that if he does nothing the trapped man will burn to death in agony. Yet if he acts as requested and shoots the man dead he will be criminally liable for causing the man’s death. Death is inevitable; the only

144 Lily Srivastava, Law and Medicine, 105 (2010).
145 Supra note 142.
choice is how it occurs. Which would be the good act, shooting the man or allowing him to die in the fire? The criminal law dictates that deliberately hastening the death of another is conduct that attracts criminal liability, regardless of the circumstances. An alternative for the passer-by might be to simply knock out the trapped man, thereby sparing him from further conscious appreciation of his agony while allowing the fire to inevitably kill him. This can be seen as analogous to the situation where a doctor uses strong pain-killing medication to relieve the pain that is frequently symptomatic of terminal disease knowing that the patient will inevitably die of the disease. Terminal pain can usually be controlled by the administration of narcotic drugs, but the effectiveness of the drugs gradually decreases as the body becomes accustomed to them. Simultaneously, the disease process tends to lead to even more severe symptoms, requiring that the dosage is incrementally increased to ensure adequate pain relief throughout a prolonged period of terminal care. Alongside their beneficial, palliative effects, these drugs can produce harmful side-effects which, in high doses can dull the responses, cause drowsiness, and suppress appetite and respiration, ultimately causing death. Controlling pain in terminal care thereby presents a clinical setting where double effect may readily occur. Narcotics may be used both to relieve symptoms and avoid further suffering but might also hasten death, raising complex legal and ethical issues. Medicine takes as its central aims the preservation of life and the relief of suffering. In the context of double effect these objectives are apparently contradictory since the relief of suffering may bring life to an end.147

The tension between these principles, and the legitimacy of double effect, were central to the notorious case of Dr Bodkin Adams.148 Dr Adams was tried for murder following the death of an eighty-four year old patient in his care. The patient had named him as a beneficiary in her will and there was evidence that large doses of heroine and morphine had been instrumental in her death. The drugs were prescribed and administered by Dr Adams who claimed that they were required for symptomatic relief. At issue was the right of the doctor to give such medication in circumstances where it might have a detrimental effect on the patient’s longevity. Confronting the situation the

147 Supra note 2 at 55.
judgement stated that a doctor “is entitled to do all that is proper and necessary to relieve
pain and suffering, even if the measures he takes may incidentally shorten human life”.149
Hence, it does appear to be legally permissible for a doctor to use whatever measures she
deems appropriate to keep the patient comfortable and pain free, even if death may be
hastened as an indirect or even inevitable consequence. More contemporary cases
indicate that the courts, and public opinion, are prepared to allow doctors to exercise their
considerable discretion in this area, though this approach may be at odds with criminal
law dicta. The tension is revealed in the trial of Dr Cox, where Ognall J stated that:

If a doctor genuinely believes that a certain course is
beneficial to his patient, either therapeutically or
analgesically, then even though he recognises that that
course carries with it a risk to life, he is fully entitled
nonetheless to pursue it.150

By implication, while it would be bad to give a lethal dose of medication with the
intention of killing, it is permissible to perform the good act of administering high doses
of analgesia to relieve suffering, even if the patient dies as a result. From the perspective
of the criminal law the crucial factor is the intention of the actor, so that:

If the acts done are intended to kill and do, in fact, kill, it
does not matter if a life is cut short by weeks or months, it
is just as much murder as if it were cut short by years.151

Accordingly, the intention, or mens rea, of the practitioner of double effect must be
clearly identified before legal responsibility can be established. For murder the mens rea
is the intention unlawfully to kill or do serious bodily harm to another person. Giving
pain relieving medication with the sole intention of alleviating symptoms is beyond
reproach. However, the medication may also have unintentional but foreseen
consequences, that are problematic for criminal law because the law of homicide extends
the concept of intention to include foresight of the consequences of one’s actions.152 If it
is possible to extrapolate that the drug was given because of its side effects as well as for

151 Ibid.
its therapeutic value, the subjective intention of the clinician is ambiguous and the action may be unlawful. Where the use of double effect in terminal care is concerned, the recognition, or foresight, that one consequence of administering high doses of analgesics is death must surely always be there. Fried has analysed the relevance of foresight in this context, and suggested that it can be permissible to follow a course of action which will foreseeably lead to a person’s death, so long as death is not the intended result.\textsuperscript{153} Criminal law would certainly find this an acceptable argument since proof of intention is an essential requirement in the successful prosecution of any homicide case. Where death has occurred but was not the intended consequence, the position regarding \textit{mens rea} was clarified in \textit{Nedrick’s} case, in which it was held that:

When determining whether the defendant had the necessary intent, it may be helpful for a jury to ask themselves two questions. (1) How probable was the consequence which resulted from the defendant’s voluntary act? (2) Did he foresee that consequence? If he did not appreciate that death or serious harm was likely to result from his act, he cannot have intended to bring it about. If he did, but thought that the risk to which he was exposing the person killed was only slight, then it may be easy for the jury to conclude that he did not intend to bring about that result. On the other hand, if the jury are satisfied that at the material time the defendant recognised that death or serious harm would be virtually certain . . . to result from his voluntary act, then that is a fact from which they may find it easy to infer that he intended to kill or do serious harm, even though he may not have had any desire to achieve that result.\textsuperscript{154}

Norman echoes this opinion when he argues that if analgesics are administered specifically to relieve pain, and simultaneously to hasten death, life has indeed been

\textsuperscript{153} C. Fried, \textit{Right and Wrong} (1978). Cited in \textit{Ibid.}
\textsuperscript{154} \textit{Id.}, at 57.
intentionally terminated and that, if the doctor “says that she is not intentionally ending the patient’s life, she is deceiving either herself or others”. This may well be true but to endorse that sentiment in the arena of terminal care leaves doctors vulnerable to the rigours of the criminal law. Yet if the control of symptomatic pain is the only available treatment, it is essential that it be provided without reservation, even though death is a recognised side effect. Failure to do so would be more harmful and therefore unethical. Ordinarily, the assessment of whether a specific treatment will be beneficial to a patient incorporates a judgement that it would be in the patient’s “best interests”. For the terminal or incurable patient determining whether a course of treatment is in the best interests of a particular patient can be problematic. The patient may consider that her best interests lie in alleviating pain and suffering by ending her life, while her professional and emotional carers favour symptomatic relief. In this context “best interests” has been described as a “pious fiction” which disguises the fact that the patient’s interests cannot be easily divorced from those of the carers, calling into question the intentions of the clinician and raising doubts about the efficacy of a particular treatment. Should those doubts include concerns about the cause of a patient’s death and lead to criminal proceedings a genuinely held belief that the actions taken were in the patient’s best interests will not alone absolve the clinician from responsibility. The distinction between subjective intention and acting in the patients best interests is, in many respects, analogous to that between intention and motive in criminal law.

Motive can be described as the reason why a person commits an act which is intellectually distinct from whether the consequences of the act were intended or foreseen. The attitude of the law as to this distinction was succinctly enunciated by Farquharson J in R v. Arthur when he advised the jury that,

However noble his (the doctor’s) motives were . . . is irrelevant to the question of your deciding what his intent was.

156 M Brazier, Medicine, Patients and the Law, 109 (1992). Cited in Ibid.
157 Ibid., at 58.
158 (1981) 12 BMLR 1. Ibid.
A rather different emphasis is offered by the case of *R v. Steane* however. During the second World War, Steane was alleged to have assisted the Germans by making radio broadcasts. He argued in his defence that his intention in so doing had been to protect his family from the threat of harm, rather than to assist the enemy. Steane was convicted at first instance but appealed, and on appeal it was noted that:

> While, no doubt, the motive of a man’s act and his intention in doing the act are in law different things, it is none the less true that in many offences a specific intention is a necessary ingredient and the jury have to be satisfied that a particular act was done with that specific intent, although the natural consequences might, if nothing else was proved, be said to show the intent for which it was done.\(^{160}\)

The judgement recognised that some actions may be “equally consistent with an innocent intent as with a criminal intent” and accordingly it was held that Steane did not possess the specific intention to assist the enemy as was required for the offence with which he was charged.\(^{161}\)

Thus, it is revealed that in criminal law “the concept of ‘intention’ has a chameleon-like character and changes its meaning according to its context”.\(^{162}\) Following the dicta in *Nedrick*, doctors who use double effect and are “virtually certain” that death will result have the *mens rea* of murder. Adopting the reasoning employed in *Steane* would provide an acquittal due to the lack of “specific” intent and *Mohan*\(^{163}\) suggests that juries should regard criminal intention within the common-sense and ordinary meaning of the word, as, “a decision to bring about a certain consequence”. Price argues that, because of the inconsistency it promotes in the law, the doctrine of double effect is “the prime catalyst for jurisprudential distortion”\(^{164}\) in the context of medical decisions at the end of life. He

\(^{159}\) [1947] 1 All ER 813.

\(^{160}\) *Id.*, at 820.

\(^{161}\) Today it is widely believed that Steane is been better categorised as a case of duress of circumstance, see C. Clarkson and H. Keating, Criminal Law: Text and Materials, 147 (1998). Cited in *supra* note 2 at 58.


asserts that life-shortening pain relieving measures are justified and suggests that a new
defence justifying killing in these circumstances would be a more appropriate way for the
law to legitimate the proper use of these techniques.\textsuperscript{165} In accord with Price’s argument,
John Harris offers an ethical perspective whereby he contends that the actual intention to
produce a consequence is of lesser significance than being responsible for causing that
consequence.

If you know that as a result of what you deliberately choose
to do, the patient will die, then that death is your
responsibility. The question you must address is: ought this
patient to die in these circumstances? If they should, then it
doesn’t matter whether you intend it or not, if they
shouldn’t you should neither intend it nor allow it to
happen as a second effect.\textsuperscript{166}

Under Harris’s interpretation, the moral intent of the actor is as significant as the
consequences of the action and the circumstances within which the act is carried out. It is
then not just consequential harm that denotes criminal intent but also the fact that the
harm caused resulted from an evil intent.\textsuperscript{167} The differences between these legal and
ethical responses to the use of double effect may explain the tension in the relationship
between those who wish doctors to use it to end a life of suffering (patients and relatives),
and those who must perform it (doctors). Medication may be justifiably administered,
even if it has the side effect of causing death, so long as the intention of the doctor
prescribing and giving the drug is therapeutic and beneficial, but morally the practice is
less easily justified. Distinctions must surely also be drawn between the unintentional use
of double effect which results in death, and its deliberate application, which is a
manipulation of its current legal status. Where a patient specifically asks the doctor to
prescribe drugs for the express purpose of causing death and promoting dignity, the

\textsuperscript{165} Ibid.
\textsuperscript{166} Professor John Harris speaking during Hypotheticals: Kill or Cure? broadcast on BBC 2 tele-
practice cannot be easily legitimated and may be better defined as assisted suicide or even active euthanasia. 168

"Out of sight, out of mind" seems to be the operative phrase among those who oppose euthanasia and assisted suicide. "If at first you don’t succeed, try, try again" depicts the response of proponents. Those who seek to legalize euthanasia and assisted suicide pursue their agenda with great dedication and zeal, coupled with savvy public relations instincts and a strategy that launches multi-directional attacks on state laws banning both practices. Proponents and critics of the ‘right to die’ thus offer various reasons for and against legalizing voluntary euthanasia and assisted suicide. 169

4.4 Killing vs. Letting Die

The prevailing legal framework in many countries differentiates sharply between physician conduct withdrawing Life Saving Medical Treatment (LSMT), thereby prompting death and conduct providing or administering a lethal substance. The patient's voluntary rejection of treatment in the former makes the physician's conduct legal, while the voluntary request to hasten death in the latter fails to legalize the physician's conduct. Various judicial pronouncements around the world insisted that doctors implementing a patient's rejection of LSMT were not assisting suicide or performing euthanasia. Rather, they were respecting the patient's self-determination and bodily integrity. Accordingly, withdrawal of LSMT merely allowed a natural dying process to occur while administration of a lethal substance precipitated death by unnatural means and constituted unlawful killing. Does the dichotomy hold up? Are there good reasons to honor a stricken patient's request to remove life support but not to receive a lethal substance? 170

Those who oppose and favour the distinction offer different reasons and justifications to do so. For example, state of mind of the physician or letting nature take its course or hazards of abuse. 171 "Withdrawal of life support systems' is different from 'Euthanasia' or 'Assisted Suicide'. With advances in science and technology, it is possible to prolong life by use of ventilator and artificial nutrition. In the case of patients

168 Ibid.
171 Id., at 1799-1816.
with serious diseases or in last stages of a disease, where a body of medical experts is of opinion that the prolongation of life serves no purpose and there are no chances of recovery, the doctors have no duty in law to merely prolong life. This principle is now accepted in all countries as part of the common law. If, in such cases, the treatment is withheld or withdrawn, and the patient is left to nature or the body is left to nature, there is no criminal or civil liability in as much as there is no ‘duty’ in common law, to keep a person alive if informed medical opinion is that there are absolutely no chances of survival. Withholding or withdrawing life support is today permitted in most countries, in certain circumstances, on the ground that it is lawful for the doctors or hospitals to do so. Courts in several countries grant declarations in individual cases that such withholding or withdrawal is lawful.\footnote{172 Law Commission of India, \textit{196th Report on Medical Treatment to Terminally Ill Patients (Protection of Patients and Medical Practitioners)}, 159 (2006).}

Our Supreme Court in \textit{Gian Kaur v. State of Punjab}\footnote{173 1996 (2) SCC 648.} clearly held that euthanasia and assisted suicide are not lawful in our country. The court, however, referred to the principles laid down by the House of Lords in \textit{Airedale NHS Trust v. Bland}\footnote{174 1993(1) All ER 821 (HL).} where the House of Lords accepted that withdrawal of life supporting systems on the basis of informed medical opinion, would be lawful because such withdrawal would only allow the patient who is beyond recovery to die a normal death, where there is no longer any duty to prolong life. Thus, it is accepted that this is different from euthanasia and assisted suicide. However, it is worth to note the following observations of Lord Goff in \textit{Airedale’s} case. Lord Goff observed:

\begin{quote}
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
\end{quote}
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 (unreported) (18th Sept. 1992). Euthanasia is not lawful at common law; but that result could, I believe, only be achieved by legislation.\footnote{Supra note 172 at 24.}

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 unlawfully – and will not do so, if he commits no breach of duty to his patient? Prof. Glanville Williams has suggested (See his Textbook of Criminal Law, 2nd Ed (1983) p 282) 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.”\footnote{Ibid.}

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. 177

It was further observed that,

[D]iscontinuance 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. 178

Thus, researcher concludes that the debate over euthanasia rests on arguments in favour of and against right to die which are based on various justifications. Law must take into consideration these fears and justifications before legalizing right to die in any form.

177 ibid
178 Id., at 25.