THE RIGHT TO DEATH WITH DIGNITY - A BASIC HUMAN RIGHT?

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What are we talking about?

"*In this world, nothing is certain except death and taxes*", said Benjamin Franklin. When he wrote that death was indeed a phenomenon that was ever present and potentially imminent – Franklin himself died some 5 months later at what was then an exceptional age of 84.[2] What may have turned out to be less certain in modern times has been the length and quality of life leading up to death. Medical advances have had the positive result of substantially increasing life expectancy. Less positively this has led to an increasing population suffering from

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[2] https://www.snopes.com/fact-check/death-and-taxes-quote/ from a letter written by Benjamin Franklin to jean-Baptiste Le Roy on 13 November 1789. The full quotation is: *"Our new Constitution is now established, everything seems to promise it will be durable; but, in this world, nothing is certain except death and taxes,"*

multiple co-morbidities dependent on a decreasing proportion of the economically active and healthy. In an increasingly secular world, the solace of an afterlife, coupled with a recognition of an absolute sanctity accorded to God-given life, offered in religion, is faced with a developing acceptance of the concepts of personal autonomy and choice with regard to the manner of living and, perhaps the means and timing of death.

There are few more sensitive subjects to confront a legal system than its treatment of the end of life. Most legal systems recognise the importance of human life and the need to protect and respect it. The roots of such recognition lie in the religious, cultural and instinctive respect for life as a supreme or superior value in itself. The extent to which what is often called the sanctity of life is accorded an absolute priority varies. Thus there remains acceptance in some countries, though perhaps a decreasing number, of a judicially imposed death penalty for serious crime. At the other end of the scale deliberate killing of another is universally outlawed unless this is for a legally recognised justification, such as lawful execution, or self-defence. While death remains an inevitability, its timing may be influenced. Medical science now offers the choice of an increasing range of treatments which are capable of prolonging life, either by curing or mitigating previously fatal disease, but also of reducing the pain and distress caused by illness. Sometimes interventions designed to reduce pain and suffering come at the cost of side effects which reduce life expectancy. Such options inevitably give rise to the contrary choices of not offering life prolonging treatments or of increasing the intensity of pain relief, which, whether or not intentionally, may result in an acceleration of death. These developments also offer choices with regard to the quality of life that may be available: these inevitably raise questions about what is and what is not intolerable suffering. In the background to a discussion of these issues lies the availability – throughout the history of man and womankind - of substances capable of bringing about an immediate end of life. Some of these can be self-administered, others cannot.

In discussing this ethically and morally challenging field it is helpful to divide legal consideration of measures that might be taken in association with a person's death into categories. One way of expressing such measures was provided by Dr DY Chandrachud J, as he then was, in *Common Cause v Union of India*:[3]

- *Involuntary euthanasia refers to the termination of life against the will of the person killed*
- *Non-voluntary euthanasia refers to the termination of life without the consent or opposition of the person killed.*
- *Voluntary euthanasia refers to the termination of life at the request of the person killed*
- *Active euthanasia refers to a positive contribution to the acceleration of death*
- *Passive euthanasia refers to the omission of steps which might otherwise sustain life.*

However, for the purpose of this paper four measures are identified which need to be distinguished in the context of the wish of many to have a dignified, peaceful and pain free death, and, for some, at a time of their choosing. While the public debate often confuses or merges these measures each brings different legal factors into play. They are:

- Suicide – death caused by an act of person intending to kill themselves
- Withholding or withdrawal of treatment resulting in death – withholding or ceasing treatment with the intention of allowing an underlying condition to cause death
- Assisted suicide – providing to a person to means for them to kill themselves

[3] 2018 SCC 1; [2018] AIR 1665, 1800 para 368. Dr Chandrachud is now Chief Justice of India

- Active euthanasia - a positive act by a third party intending to cause the death of a third person in order to bring their suffering to an end

These interventions will be examined principally from the perspective of the law - both judge-made and statutory - of England and Wales, but reference will also be made to the law and practice in some other jurisdictions. However a paper of this length cannot aspire to more than a cursory examination of examples of different approaches.

Suicide

At common law prior to the intervention of statute, the killing, whether of another or of oneself was recognised as a crime. The intellectual basis of this was based on religious concepts and the acceptance of an almost absolute priority to be given to the sanctity of human life.

> Suicide at common law
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> *the suicide is guilty of a double offence; one spiritual, in invading the prerogative of the Almighty, and rushing into his immediate presence uncalled for; the other temporal, against the king, who hath an interest in the preservation of all his subjects; the law has therefore ranked this among the highest, crimes, making it a peculiar species of felony, a felony committed on oneself.*
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> Blackstone Commentaries (1765-1770) Book 4 Chapter 14 page 189

Thus in discussing the justification for capital punishment and the need for caution in imposing it, Blackstone stated:[4]

To shed the blood of our fellow creature is a matter that requires the greatest deliberation, and the fullest conviction of our own authority : for life is the immediate gift of God to man; which neither he can resign, nor can resign, nor can it be taken from him, unless by the command or permission of him who gave it ; either expressly revealed, or collected from the laws of nature or society by clear and indisputable demonstration.

[4] Blackstone commentaries [1765-1770] Book 4 p 11
https://avalon.law.yale.edu/18th_century/blackstone_bk4ch1.asp

In discussing homicide Blackstone observed:[5]
Of crimes injurious to the persons of private subjects, the most principal and important is the offence of taking away that life, which is the immediate gift of the great creator; and which therefore no man can be entitled to deprive himself or another of, but in some manner either expressly commanded in, or evidently deducible from, those laws which the creator has given us; the divine laws, I mean, of either nature or revelation

So it followed that killing oneself was a serious crime:[6]
SELF-MURDER, … the law of England wifely and religiously confiders, that no man hath a power to destroy life, but by commission from God, the author of it: and, as the suicide is guilty of a double offence; one spiritual, in invading the prerogative of the Almighty, and rushing into his immediate presence uncalled for; the other temporal, against the king, who hath an interest in the preservation of all his subjects; the law has therefore ranked this among the highest, crimes, making it a peculiar species of felony, a felony committed on oneself. A felo de se *therefore is he that deliberately puts an end to his own existence, or commits any unlawful malicious act, the consequence of which is his own death… The party must be of years of discretion, and in his senses, else it is no crime. But this excuse ought not to be strained to that length, to which our coroners' juries are apt to carry it, viz. that the very act of suicide is an evidence of insanity; as if every man who acts contrary to reason, had no reason at all…*

Obviously punishment for this offence could not be inflicted directly on the offender, although Blackstone refers to the driving of a stake through their body, but their property could be forfeited and returned to the Crown. Thus the somewhat illogical position at unbridled common law is that a failed suicide gives rise to liability a punishment which a successful suicide cannot.

Suicide now widely legalized but not a right to die?

- UK: Suicide Act 1961 section 1
- Switzerland: *Haas v Switzerland* ECHR Application 31322/07 Jan 2021
- India – regulatory requirement for clause in life insurance contracts addressing entitlement to payout after suicide.
- First responders entitled to intervene to save life of potential suicide, particularly if ignorant of state of their mental health
- The right to respect for life [Article 2 ECHR] includes operational duty on the State to take reasonable steps to prevent a mentally ill patient in their care [even if "voluntary" patient] from committing suicide where a real and immediate danger of them doing so. *Rabone v Pennine Care NHS Trust* [2012] UKSC 2

[5] Ibid Book 4 ch 14 p177 https://avalon.law.yale.edu/18th_century/blackstone_bk4ch14.asp
[6] Ibid Book 4 ch 14 p189 https://avalon.law.yale.edu/18th_century/blackstone_bk4ch14.asp

In modern times suicide has been decriminalised by statute the UK,[7] and in many other jurisdictions.[8] For example, the European Court on Human Rights, in upholding the Swiss Federal Court in a decision accepting the legitimacy of rules restricting the prescription of lethal medication to an intending suicide, started from the premise that[9]

"an individual's right to decide by what means and at what point in his or her life will end, provided he or she is freely reaching a decision on this question is one of the aspects of private life within the meaning of Article 8 of the Convention."

The issue was whether assuming there was an obligation on the State to facilitate suicide with dignity, the legal restrictions were an interference with this right which was, as required by Article 8(2) proportionate and in accordance with law and took appropriate account of Article 2. The Court held that the Swiss restrictions were, having regard to the wide margin of appreciation appropriate in this field, of such a character.

Thus a person who is legally competent to take their own decisions and is not incapacitated by a suicidal mental illness can take their own life without assistance is free to do so. That is not to say that there are no consequences for the estate of a person who has killed themselves. Life insurance companies tend to impose conditions which restrict entitlement to the benefits available on death by suicide, particularly if no mental disorder is involved and if the death occurs soon after the commencement of the policy.[10]

The fact that an act has been decriminalised does not necessarily mean there is an absolute right to commit it. Thus first responders who attend an attempted suicide are likely to be justified in intervening to sustain life – at least to the point where the individual recovers sufficient capacity to consent to or refuse further treatment. In the case referred to in the previous paragraph the ECHR held that a right to choose when and how to commit suicide does not mean there is a "right to die",[11] a point considered further below. Indeed Article 2 of the ECHR imposes an operational duty on the state, when caring for a mentally ill patient who is at real and immediate danger of committing suicide, to take reasonable steps to prevent this, whether or not the patient has been formally detained in hospital under mental health legislation.[12]

Withholding or withdrawal of treatment resulting in death

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[7] Suicide Act 1961 section 1

[8] For what purports to be an extensive list of the legal position throughout the world [unverified by the writer] see https://en.wikipedia.org/wiki/Suicide_legislation

[9] *Haas v Switzerland* ECHR Application No 31322/07 paras 50-61 20 January 2011 https://hudoc.echr.coe.int/fre#%7B%22itemid%22:[%22001-102940%22]%7D

[10] In India there is a regulatory requirement for a clause In life insurance contracts addressing the issue https://life.futuregenerali.in/life-insurance-made-simple/life-insurance/does-life-insurance-policy-cover-suicidal-death/

[11] See *Haas* para 52

[12] *Savage v South Essex Partnership NHS Trust [2008] UKHL 74*; *Rabone v Pennine Care NHS Trust* [2012] UKSC 2. The author appeared as counsel for the deceased patient's parents in *Rabone* at first instance.

Withholding of withdrawal of life sustaining treatment before 1989

- *Children*
  - Consent to give treatment: by *Gillick* competent children, parents, persons with parental responsibility, wardship, court's inherent jurisdiction
  - Refusal to have treatment: refusal by *Gillick* competent children, parents, persons with parental responsibility could be overridden by court in inherent jurisdiction, e.g. children of Jehovah's Witnesses
- *Competent adults*
  - Consent by adult patient, if mentally competent required for treatment: treatment = assault if no consent *Ms B v An NHS Hospital Trust* [2002] EWHC 429 (Fam)
  - Refusal of competent adult final whether rational or not *Bland* per Lord Goff
- *Mentally incompetent patients*
  - Doctor accepted as knowing best, acting in accordance with responsible medical practice (*Bolam* test?). No exercise of inherent jurisdiction
  - Allowing nature to take its course: *R v Arthur* (1981)

In the law of England and Wales withholding or withdrawing life sustaining treatment is not necessarily unlawful and essentially depends on, firstly, whether this requires an act or an omission to terminate treatment, and secondly whether it would be unlawful to provide or continue treatment. The authority to give or stop treatment at all depends on the existence of either the decision of a mentally competent patient, or, in the case of the mentally incompetent, on the decision of a duly authorised third party or court. Essentially it is lawful to withhold or discontinue treatment either where this is "futile" or where the mentally competent patient withholds or withdraws consent, even if the result is likely to be the death of the patient.

An act or an omission?

In the case of medical treatment a distinction must be drawn between what the law regards as a positive act causing death on the one hand, and an omission to act, followed by death from an underlying cause, on the other. For example the administration by a doctor of a lethal injection with the intention of causing death is unlawful homicide, whereas an omission to continue treatment which has no prospect of producing a recovery in a PVS patient, such as stopping the supply of nutrition via a naso-gastric tube may be lawful. Thus in *Airedale NHS Trust v Bland* Lord Goff of Chievely put it this way:[13]

I agree that the doctor's conduct in discontinuing life support can properly be categorised 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 simply 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; and 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.

[13] [1993] AC 789, 866

Lord Goff distinguished the withdrawal of, say artificial ventilation by a doctor, from the switching off of the machine by an "interloper" because the latter was an active intervention in the doctor's intended prolongation of life:[14]

Although the interloper may perform exactly the same act as the doctor who discontinues life support, his doing so constitutes interference with the life-prolonging treatment then being administered by the doctor. 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.

In the end for Lord Goff the distinction was founded in a proper understanding of the doctor's duty of care to their patient. They may be under a duty to offer effective treatment, where it is available, but there is no duty to continue treatment beyond what was clinically effective. This has to be distinguished from the deliberate administration of a lethal injection designed to end life:[15]

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 any part of his duty to give his patient a lethal injection to put him out of his agony.

It can be argued that this distinction between acts and omissions is artificial,[16] and that the better distinction is between care for the patient, the principal intention of which is the benign one of the alleviation of pain, or the cessation of treatment which is reasonably considered to be futile, and an act or omission the principal intention of which is to bring the patient's life to an end. Such an approach would apply what is known as the doctrine of double effect to both acts and omissions. Where the intention behind the act or omission is the alleviation of suffering, that would be regarded as a lawful act, even if the doctor is aware that the likely result will be the shortening of life, but that it would be unlawful to bring a life to an end, whether by an act or omission, as the only [or even best] means of alleviating suffering. In simpler terms this could be described as the difference between trying to alleviate suffering and trying to end the life of the patient. An even better approach which avoids concern as to whether there has been an act or omission at all is that advocated by Lady Hale in *Aintree University Hospitals NHS Foundation Trust v James*,[17] considering why the provisions of the 2005 Act refer to "acts" not "omission":

"*The reason for this, in my view, is that the fundamental question is whether it is lawful to give the treatment, not whether it is lawful to withhold it.*"

The adult patient with mental decision-making capacity

The common law is clear that an adult with the capacity to make a decision about medical treatment is entitled to refuse medical treatment even if the treatment is capable of being

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[14] ibid

[15] ibid

[1616] Indeed Lord Lowry in the same case voiced his disagreement with the approach of Lord Goff and the rest of the majority on this point [ibid page 875]. For other speeches agreeing with the Goff approach see Lord Keith of Kinkel [ibid] page 859], Lord Browne-Wilkinson [ibid page 881-882], Lord Mustill [ibid page 893, 898]

[17] [2013] UKSC 67; [2014] AC 591 para 20

effective, and even if the result is likely or even certain to be death. As Lord Goff said in *Bland*:[18]

… it is established that the principle of self-determination requires that respect must be given to the wishes of the patient, so that if an adult patient of sound mind refuses, however unreasonably, to consent to treatment or care by which his life would or might be prolonged, the doctors responsible for his care must give effect to his wishes, even though they do not consider it to be in his best interests to do so

Therefore it is unlawful for treatment to be imposed on a competent patient who refuses such treatment and in many cases such an intrusion on their autonomy will be an assault and a breach of their human rights – in the case of the ECHR, Article 8. Thus where a young patient in her 20s with full capacity who was completely paralysed and dependent on artificial ventilation for life following a serious spinal malformation, the hospital whose staff had refused to remove the ventilation was held vicariously liable to her for an assault and breach of her rights and damages were awarded. This was so even though the treating clinical staff believed that the patient would be able to enjoy a reasonable quality of life at home with portable ventilation equipment and nursing care and that she could not appreciate the benefits of such interventions unless she had tried them. The patient profoundly disagreed with this assessment and asserted her right to judge such matters for herself. The court had no hesitation in upholding her right to refuse and ruled that the hospital's duty in these circumstances was to transfer her to the care of clinical staff who were willing to respect the patient's autonomy. Damages were awarded for the assault and breach of Article 8.[19]

Some ethicists, while conceding the clarity of the law, question whether it is right always to give primacy to the principle of autonomy over that of beneficence.[20] However the law is clear as can be seen from the authorities cited by the judge: the choice of the competent takes priority over other considerations, whether given at the time treatment is offered or being provided or in advance. See for example:

> Lord Reid in *S v McC; W v W*:[21]
> *"… English law goes to great lengths to protect a person of full age and capacity from interference with his personal liberty. We have too often seen freedom disappear in other countries not only by coups d'état but by gradual erosion: and often it is the first step that counts. So it would be unwise to make even minor concessions."*
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> Lord Goff of Chievely in *In re F (Mental Patient: sterilisation)*:[22]
> *"I start with the fundamental principle, now long established, that every person's body is inviolate."*
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> Lord Donaldson of Lymington in *re T (Adult: refusal of medical treatment)*:[23]

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[18] [1993] AC 789, 864

[M.] *Ms B v An NHS Hospital Trust* [2002] EWHC 429 (Fam) [2002] 1 FLR 1090, [2002] Lloyds Rep Med 265. Butler-Sloss P. The author appeared as counsel for the hospital trust

[20] See for example Huxtable, *Re B (Consent to Treatment: Capacity) A right to die or is it right to die?* Heinonline https://heinonline.org/HOL/LandingPage?handle=hein.journals/chilflq14&div=32&id=&page=

[21] [1972] AC 25, 42

[22] [1990] 2 AC 1, 72

[23] [1993] Fam 95, 113

"…. . the patient's right of choice exists whether the reasons for making that choice are rational, irrational, unknown or even non-existent."

Butler-Sloss P in the same case, citing a Canadian case:[24]
"The right to determine what shall be done with one's own body is a fundamental right in our society. The concepts inherent in this right are the bedrock upon which the principles of self-determination and individual autonomy are based. Free individual choice in matters affecting this right should, in my opinion, be accorded very high priority."

In *re MB (Medical Treatment)* she said:[25]
"*A mentally competent patient has an absolute right to refuse to consent to medical treatment for any reason, rational or irrational, or for no reason at all, even where that decision may lead to his or her own death*"

Lord Keith of Kinkel in *Airedale NHS Trust v Bland*:[26]

".. the principle of the sanctity of life, which it is the concern of the state, and the judiciary as one of the arms of the state, … is not an absolute one. It does not compel a medical practitioner on pain of criminal sanctions to treat a patient, who will die if he does not, contrary to the express wishes of the patient."

Lady Black in *An NHS Trust v Y*:[27]

"… it is unlawful to administer medical treatment to an adult who is conscious and of sound mind, without his consent; to do so is both a tort and the crime of battery. Such an adult is at liberty to decline treatment even if that will result in his death, and the same applies where a person, in anticipation of entering into a condition such as PVS, has given clear instructions that in such an event he is not to be given medical care, including artificial feeding, designed to keep him alive.

It is important to emphasise that in such a case the death of a patient with decision making capacity following a refusal of life sustaining treatment is not suicide:[28]

"… in cases of this kind, there is no question of the patient having committed suicide, nor therefore of the doctor having aided or abetted him in doing so. It is simply that the patient has, as he is entitled to do, declined to consent to treatment which might or would have the effect of prolonging his life, and the doctor has, in accordance with his duty, complied with his patient's wishes."

Children and adults without decision-making capacity

Where the patient is a child or an adult lacking the relevant mental decision-making capacity, withholding or withdrawal of treatment is lawful if this is in accordance with responsible medical practice and is in the best interests of the patient. Where the patient lacks the capacity to consent to treatment and the treatment to be withdrawn consists of artificial

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[24] Ibid 116; the Canadian case was *Malette v Schulman* 67 DLR (4th) 321, 336:
[25] [1997] 2 FLR 426; for a Canadian case similar to MB's *see Nancy B v Hôtel-Dieu de Québec et al*. (1992) 86 DLR (4th) 385,. The author appeared in *MB* as counsel for the patient.
[26] [1993] AC 789, 839; see also Lord Goff of Chievely at 864, Lord Mustill at 891, 1062
[27] [2018] UKSC 46 July 2018 para 21i
[28] Ibid 864, per Lord Goff of Chievely

nutrition or hydration or where there is a dispute about the patient's best interests, the issue of whether continued treatment is in the patient's best interests can be determined by the court. In *Bland* the House of Lords gave guidance that generally proposals to withdraw artificial nutrition and hydration should be referred to the court, but more recently that guidance has been rescinded by the Supreme Court, so long as the provisions of the Mental Capacity Act 2005 [which of course had not been in place at the time of the *Bland* case] and good medical practice had been followed and there was no dispute with the patient's family or other interested persons, or other cause for doubt.[29]

In England and Wales the Mental Capacity Act 2005 follows the common law in defining capacity: a person lacks the mental capacity to make decisions of any kind, including those concerning medical treatment if they are unable by reason of an impairment or disturbance of the mind or brain: [30]

(a) to understand the information relevant to the decision,

(b) to retain that information,

(c) to use or weigh that information as part of the process of making the decision, or

(d) to communicate his decision (whether by talking, using sign language or any other means).

Every adult and every child of appropriate maturity is presumed to have the relevant capacity which the abilities of which must be tested against the actual decision to be made rather than as a matter of generality. Where capacity to make the relevant decision is lacking profound moral, legal and ethical issues arise when decisions have to be made about life sustaining treatment. The legal answer in England and Wales is that where a patient lacks capacity treatment may *only* be provided where it is in the best interests of the patient to receive it.[31] Thus where life sustaining treatment ceases to be in the patient's best interests it should be withheld or withdrawn as the case may be. Treatment will not be in the patient's best interests where it is futile and where no recovery will occur.

Proposals to withdraw artificial nutrition and hydration from patients suffering from a permanent vegetative state have been regarded as particularly sensitive, if not controversial, and until recently good practice in England and Wales have required judicial approval of them. Since *Bland* which introduced the practice the cases in which the court has been prepared to authorise such withdrawal have expanded from strict diagnosis of a permanent vegetative state to patients in a minimally conscious state, collectively known as "prolonged

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[29] *An NHS Trust v Y* [2018] UKSC 46, July 2018

[30] *Mental Capacity Act 2005* sections 2, 3(1); for the common law see *re C {Adult)(Refusal of Treatment)* [1994] 1 WLR 290, 295; *re MB (Medical treatment)* [supra]; *Cruzan v Director, Missouri Department of Health* [1990] 110 S Ct 2841, US Supreme Court

[31] The factors that can and cannot be taken into account are defined in the Mental Capacity Act 2005 section 4. In brief summary age, appearance and anything leading to "unjustified assumptions" should be disregarded. Relevant factors include, the permanence or otherwise of the incapacity, the present and past wishes expressed by the patient, their beliefs and values and other factors the patient would be likely to consider if able to do so, the views of those close to the patient as to what the patient's wishes might have been if able to express them. A decision to withdraw life sustaining treatment must not be motivated by a desire to bring about the patient's death.

disorder of consciousness". The Supreme Court has decided that, since the passing of the Mental Capacity Act 2005, the associated code of practice and other guidance provided a sufficient protective framework in law and practice, it was no longer justifiable to require the court's permission to be obtained for withdrawal, although the court was available in cases of uncertainty or dispute.[32] It should be noted that in the Court's opinion in these cases[33]

the fundamental question facing a doctor, or a court, considering treatment of a patient who is not able to make his or her own decision is not whether it is lawful to withdraw or withhold treatment, but whether it is lawful to give it. It is lawful to give treatment only if it is in the patient's best interests. Accordingly, if the treatment would not be in the patient's best interests, then it would be unlawful to give it, and therefore lawful, and not a breach of any duty to the patient, to withhold or withdraw it.

It is clear from the judgment of the court that they saw no distinction to be drawn in this regard between withdrawal of treatment from cases of PDOC or others with a degenerative neurological condition or other critical illness.[34] There has been some criticism of this decision on the ground that it heralds a return to "medical paternalism" when in other areas, such as that of informed consent, or the standard of care, the direction of travel had been away from leaving decisions in the hands of the medical profession without the external judicial scrutiny of what is reasonable or responsible.[35]

The other major procedural development since *Bland* has been the expansion of the role of the Court of Protection by the Mental Capacity Act 2005 to give it jurisdiction over the health and welfare of persons lacking capacity, thus replacing the inherent parens patriae jurisdiction. The Court is expressly empowered[36] to make decisions on behalf of an incapacitated person, thus, in many cases avoiding the need to make declarations as opposed to directly deciding on a patient's behalf whether or not to authorise treatment. The Act also provides a regime for the making and registration of lasting powers of attorney under which a person of sound mind may a appoint an attorney to make treatment and other decisions if the donor is incapacitated from doing so.

The position of parents

Unfortunately the cases which have most troubled to courts in recent times have been those concerning proposals to withdraw treatment from children. While the test to be applied is superficially simple, namely what is in the best interests of the child, profound challenges can arise where a proposal to stop life sustaining treatment of a small seriously ill child is opposed by their parents. Two cases in particular have been played out in the media over lengthy periods of time, those concerning Charlie Gard and Archie Evans. Space does not

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[32] *An NHS Trust v Y* [2018] UKSC 46, distinguishing *In re F (Mental Patient: Sterilisation*) and *Airedale NHS Trust v Bland* (above), not approving *In re M (Adult Patient) (Minimally Conscious State: Withdrawal of Treatment)* [2011] EWHC 2443 (Fam), [2012] 1 WLR 1653*;* approving *R v (Burke v General Medical Council* [2006] QB 273, *In re Briggs (Incapacitated Person)* [2018] Fam 62, *In re M (Incapacitated Person: Withdrawal of Treatment)* [2017] EWCOP 18, [2018] 1 WLR 465 and following the European Court of Human Rights in *Burke v UK* (Application No 19807/0) 11 July 2006, *Lambert v France* (2016) 62 EHRR 2

[33] *An NHS Trust v Y* at para 92

[34] Ibid para 119

[35] Foster, *The rebirth of medical paternalism: AN NHS Trust v Y* (2018) 45 JME issue 1 page 3 https://jme.bmj.com/content/45/1/3

[36] Mental Capacity Act 2005 section 16

allow for a full analysis of the legal processes but a brief description demonstrates the challenge.

The case of Charlie Gard[37] raised these issues in stark form. Charlie suffered from an extremely rare and incurable mitochondrial DNA depletion syndrome which had led to paralysis and an inability to breathe without artificial ventilation. The treating doctors, supported by the hospital's ethics committee, considered that his quality of life was and would remain so poor that he should not be subjected to long term ventilation, which would have required a tracheostomy. Charlie's parents disagreed, believing that a treatment offered in the USA might assist him. The attending medical team considered this treatment would be futile. An application was made to the Family Court where Francis J [no relation] ruled that it would be in Charlie's best interests for treatment to be discontinued in spite of the parent's wishes. The parents' appeal to the Court of Appeal was dismissed and the Supreme Court refused permission to appeal to it. The parents then approached the ECHR which also dismissed their appeal. The legal process did not quieten the public furore that had now developed. Support was voiced by Pope Francis and President Trump. Further medical experts came forward to support the treatment offered in the USA. As a result, the hospital returned to Francis J to allow him to consider this new evidence. At a 4 day hearing at which the parents were legally represented on a pro bono bias, the judge was not persuaded to change his order. Further examinations and tests were ordered. Following a multi-disciplinary meeting involving this wider group of experts the parents withdrew their appeal having accepted that further treatment would not assist Charlie. The case had involved multiple legal hearings, conducted in the full glare of the media and considerable pressure on the legal system, not to mention the demands on the resources of the hospital and the stress and distress of the parents.[38]

Archie Evans developed a neurogenerative brain disorder of unknown cause which led quickly to the total disintegration of the substance of his brain. He lost the capacity for sight, hearing, taste, sense of touch and thought. The unanimous medical opinion was that the

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[37] Without purporting to be a full list of hearings and judgments in the case the following may be noted:

11 April 2017	*Great Ormond Street Hospital for Children NHS Foundation Trust v Yates* [2017] EWHC 972 (Fam) Francis J (granting application for withdrawal of treatment
23 May 2017	*Great Ormond Street Hospital for Children NHS Foundation Trust v Yates* Court of Appeal [2017] EWCA Civ 410; 2017] MedLR 417
8 June 2018	Supreme Court refuses permission: not arguable that UK courts lacked jurisdiction to make order or that it should not be made by reference to best interests. https://www.supremecourt.uk/news/permission-to-appeal-hearing-in-the-matter-of-charlie-gard.html
13 June 2017	*Gard and others v UK App* Application 39793/17 [2017] ECHR 559 (interim measures granted pending decision)
19 June 2017	Supreme Court "with considerable hesitation" direct further stay pending ECHR proceedings https://www.supremecourt.uk/cases/docs/charlie-gard-190617.pdf
27 June 2017	*Gard v UK (Admissibility)* (2017) 65 EHRR SE9; [2017] 2 FLR 773 (ruled that complaint manifestly ill-founded
10 July 2017	*Re Gard* [2017] 7 WLUK 179 (application for judge to recuse himself on ground of bias refused
24 July 2017	*Great Ormond Street Hospital for Children NHS Foundation Trust v Yates (no 2)* [2017] EWHC 1909 (Fam) [2017] 4 WLR 131 Francis J (application to affirm order of 11 April 2017 granted after 4 day hearing of application)

[38] For a very detailed ethical critique of this case see: Wilkinson, Savulascu *Ethics, conflict and medical treatment for children: from disagreement to dissensus* (2018) Elsevier, London https://www.ncbi.nlm.nih.gov/books/NBK537987/

condition was irreversible. The treating doctors view was that it was in Archie's best interests to withdraw artificial ventilation, hydration and fluid on which his continued life depended. Although his parents vehemently opposed this proposal, the court approved withdrawal as being in his best interests, and, after multiple proceedings in domestic and European courts[39] that decision was upheld. The alternative offers of treatment offered in the Vatican and in Germany did not hold out any prospect of reversing the condition or do more than offering some chance of extending a vegetative or semi-vegetative condition, even if it was arguably unlikely that such care would actually cause any harm – apart from the infliction of futile treatment itself. Throughout proceedings the courts were clear what while the parents' opposition had to be taken into account and respected in the end it was the assessment of best interests that prevailed. This was succinctly summed up by the Supreme Court in refusing permission to appeal:[40]

16. …*Doctors need to know what the law requires of them. The founding rule is that it is not lawful for them (or any other medical team) to give treatment to Alfie which is not in his interests. A decision that, although not in his best interests, Alfie's continued ventilation can lawfully continue because (perhaps) it is not causing him significant harm would be inconsistent with the founding rule*

17. *We are satisfied that the current law of England and Wales is that decisions about the medical treatment of children, like those about the medical treatment of adults, are governed by what is in their best interests. We are also satisfied that this does not discriminate against the parents of children such as Alfie in the enjoyment of their right to respect for their family life because their situation is not comparable with that of the parents of children who are taken away from them by the state to be brought up elsewhere*

This raises the question whether it is indeed right for the parents' bona fide and understandable views as to their child's best interests should be capable of being overridden in this way, particularly if little or no harm in terms of suffering was likely to result from following them. The opposite view might be that even without inflicting pain to impose futile treatment would in itself be an interference with the patient's dignity. Ethicists have pointed to the dangers in describing treatment as "futile" as what this means may depend on the beholders ethical standpoint and values.

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[39] The hearings and judgments in the public domain were:

20 Feb 2018	2018 EWHC 308 (Fam) Hayden J
6 Mar 2018	2018 EWCA Civ 550 King, McFarlane, McCombe LJJ
20 Mar 2018	Supreme Court (refusal of permission) https://www.supremecourt.uk/cases/docs/alfie-evans-order-200318.pdf Lady Hale, Lord Kerr, Lord Wilson
28 Mar 2018	2018 ECHR 297 (14238/18)
11 Apr 2018	2018 EWHC 818 (Fam) Hayden J
16 Apr 2018	2018 EWCA Civ 805 Davis, King, Moylan LJJ
20 Apr 2018	Supreme Court: In the matter of Alfie Evans No 2 https://www.supremecourt.uk/docs/in-the-matter-of-alfie-evans-court-order.pdf Lady Hale, Lord Kerr, Lord Wilson
23 Apr 2018	2018 ECHR 357 (188770/18)
24 Apr 2018	2018 EWHC 953 (Fam) Hayden J
25 Apr 2018	2018 EWCA Civ 984 McFarlane, King, Coulson LJJ

[40] https://www.supremecourt.uk/cases/docs/alfie-evans-order-200318.pdf]:

Medically assisted suicide

Medically assisted suicide can be described as the provision to a patient of the means to end their own life. In an attempt to clarify the terminology in what is often a heated debate, the British Medical Association has proposed two definitions to cover different types of assistance:[41]

- Assisted dying: *prescribing life ending drugs for terminally ill, mentally competent adults to administer themselves after meeting legal safeguards*

- Assisted suicide: *giving assistance to die to people with long term progressive conditions and other people who are not dying, in addition to patients with a terminal illness*

Without legislation the common law would regard either of these as assisting suicide. In England and Wales this is unlawful by virtue of statute and in punishable by up to 14 years imprisonment.[42] Prosecutions can only be brought with the consent of the Director of Public Prosecutions, which while emphasising that assisting suicide is not decriminalised – that is a matter for Parliament - a discretion not to prosecute may be exercised where the public interest factors against a prosecution outweigh those in favour of it. The factors which will make a prosecution less likely are:

- *the victim had reached a voluntary, clear, settled and informed decision to commit suicide;*
- *the suspect was wholly motivated by compassion;*
- *the actions of the suspect, although sufficient to come within the definition of the offence, were of only minor encouragement or assistance;*
- *the suspect had sought to dissuade the victim from taking the course of action which resulted in his or her suicide;*
- *the actions of the suspect may be characterised as reluctant encouragement or assistance in the face of a determined wish on the part of the victim to commit suicide;*
- *the suspect reported the victim's suicide to the police and fully assisted them in their enquiries into the circumstances of the suicide or the attempt and his or her part in providing encouragement or assistance*.[43]

Since that policy came into force the number of cases forwarded for prosecution has been relatively small. Between April 2009 and March 2022 174 cases of alleged assisted suicide were referred to the CPS by the police. Of these 148 were not proceeded with by the CPS or withdrawn by the police. The report does not describe what happened in the balance of cases but the CPS report of April 2022 stated that four cases had been "successfully" prosecuted,

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[41] *Assisted dying*: British Medical Journal https://www.bmj.com/assisted-dying . They offer a third definition: voluntary euthanasia: *a doctor directly administering life ending drugs to a patient who has given consent*. In law this is homicide and is addressed above

[42] Suicide Act 1961 section 2

[43] *Suicide: Policy for Prosecutors in Respect of Cases of Encouraging or Assisting Suicide* Crown Prosecution Service February 2010, updated October 2014 https://www.cps.gov.uk/legal-guidance/suicide-policy-prosecutors-respect-cases-encouraging-or-assisting-suicide

one case ended with an acquittal in March 2015, and eight were referred for prosecution for homicide or other serious crime.[44]

This position has been heavily criticised because of the uncertainty and distress this causes well intentioned family members who wish to support their gravely ill loved ones in the wish to end their suffering.[45] This has not infrequently come to the fore as an issue for relatives who have assisted, or have wished to assist relatives to travel to Switzerland to take advantage of the services of Dignitas.[46] Those services, if provided in England and Wales, would be unlikely to attract a favourable exercise of the prosecutor's discretion for those involved in assessing the applicant, and providing the relevant prescription. Those in favour of legalising assisted suicide point to the illogicality of "forcing those who wish to obtain such assistance to go tote expense, and stress or travelling to Switzerland. The Swiss Criminal code only criminalises assistance of suicide where the assistance is provided for "selfish motives".[47] However that does not extend to a right to assistance with suicide from either the State or an individual.

Assisted dying [as defined by the BMJ, see above] is also legal in certain states of the USA: California, Colorado, Hawaii, Montana, Oregon, Vermont, Washington, and in Washington, DC, and also the state of Victoria, Australia. Assisted suicide is legal in Switzerland.

As an example, Oregon's Death with Dignity Act [48] came into effect in 1997 after considerable public and legal debate. It applies only to adults who have been diagnosed as terminally ill to whom it makes assisted suicide available. There is no requirement of unbearable suffering. What it permits is the issue of a prescription of life terminating drugs which the patient takes for themselves.

In England and Wales various attempts have been made in Parliament to introduce legislation to legalise assisted suicide: the Assisted Dying Bill[49] a private members Bill was before

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[44] *Assisted Suicide* April 2022, Director of Public Prosecutions https://www.cps.gov.uk/publication/assisted-suicide

[45] See for example https://www.theguardian.com/uk-news/2013/aug/18/two-arrested-assisted-suicide-dignitas Observer 18 August 2013

[46] For a description of the way Dignitas operates see its on line brochure at http://www.dignitas.ch/images/stories/pdf/so-funktioniert-dignitas-e.pdf

[47] Article 115 of the Swiss Criminal Code. It is also notable that the Code provides for a relatively low penalty in the case of a mercy killing: Article 114 provides *"Any person who for commendable motives, and in particular out of compassion, causes the death of a person at that person's own genuine and insistent request shall be liable to a custodial sentence not exceeding three years or to a monetary penalty."*

[48] This description is gratefully taken from the House of Lords report on the Assisted Dying for the Terminally Ill Bill [see eblow]

[49] Introduced by Baroness Meacher in the House of Lords 8 October 2021: see https://lordslibrary.parliament.uk/assisted-dying-bill-hl/ ; 2nd reading debate 22 October 2021 at which the Bill was committed to a committee of the whole House, but the Bill fell on the end of the parliamentary session. A similar fate earlier befell the Assisted Dying for the Terminally Ill Bill 2004- 2005. This was proposed by Lord Joffe, https://publications.parliament.uk/pa/ld/ldasdy.htm but not before a House of Lords Select Committee had published a very thorough report on the legal and ethical issues. The Bill would have legalised both assisted suicide and voluntary euthanasia. The Committee's report on the Bill https://publications.parliament.uk/pa/ld200405/ldselect/ldasdy/86/8602.htm included an observation that remains constantly relevant: *While opinion has often been divided within our Committee on both the principles underlying the ADTI Bill and on its practical effects, there has been unanimity on one point at least—that, while the most careful account must be taken of expert evidence, at the end of the day the acceptability of assisted*

Parliament in 2021. Such Bills have each been met with detailed and impressive debate about the ethics and practicalities of the measures proposed but in each case the Bill has failed to complete a passage through Parliament.[50]

Euthanasia or mercy killing

Euthanasia in this sense is causing the death of another with the intention of relieving their [at least implicitly, intolerable] suffering. In Belgium statute defines euthanasia as an act carried out by a third party which intentionally ends the life of the an individual at their request.[51] Without legislation in the common law world, the benign motive is no defence – taking of the life of another with the intention of doing so or of causing serious harm is unlawful homicide and almost invariably murder as euthanasia involves a deliberate act performed with the intention of ending life. Euthanasia is now permitted under various conditions by statute in the Netherlands, Belgium, Luxembourg and Canada, in the latter case for patients whose death is "reasonably foreseeable".

In the United Kingdom the common law remains in force. Repeated attempts by parliamentarians to legislate in favour of assisted suicide have failed, but all such Bills, including the recent Assisted Dying Bill[52] would have retained the prohibition on a health professional administering medicine with the intention of causing the patient's death.[53] Nonetheless the DPP is conducting a public consultation in relation to the guidance given to prosecutors in this type of case.[54] The DPP has defined "mercy killing" for this purpose as "*any killing in which the suspect believes they are acting wholly out of compassion for the deceased*". It includes cases where the "victim" is seriously physically unwell and unable to undertake thee act to cause death themselves and may have asked the suspect to do it. The DPP's overarching test for deciding whether to prosecute is a two stage one: firstly to decide whether there is sufficient evidence to provide a realistic prospect of a conviction; secondly whether it is in the public interest to prosecute. The proposed new guidance[55] sets out non exhaustive lists of public interest factors in favour tending in favour and against prosecution.

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suicide or voluntary euthanasia is an issue for society to decide through its legislators in Parliament. Report § 11

[50] For the very helpful briefings published by the UK Parliamentary authorities see Lipscombe et al *The Law on assisted suicide* House of Commons Library 1 July 2022 https://researchbriefings.files.parliament.uk/documents/SN04857/SN04857.pdf ; Gajjar & Hobbs *Assisted dying* UK Parliament POSTbrief 26 September 2022 https://researchbriefings.files.parliament.uk/documents/POST-PB-0047/POST-PB-0047.pdf

[51] Section 2 of the Law of 28 May 2002: the requirements are that a person (a) "does an act capable of encouraging or assisting the suicide or attempted suicide of another person, and (b) [the] act was intended to encourage or assist suicide or an attempt at suicide"

[52] See above clause 4(5)

[53] The Assisted Dying Bill 2014 introduced in the House of Lords by Lord Falconer (lapsed) The Assisted Dying (no 2) Bill 2015 https://publications.parliament.uk/pa/bills/cbill/2015-2016/0007/16007.pdf (rejected on a vote in the House of Commons) https://www.theguardian.com/society/2015/sep/11/mps-begin-debate-assisted-dying-bill

[54] *Consultation on public interest guidance for suicide pact and 'mercy killing' type cases*, 14 January 2022 https://www.cps.gov.uk/consultation/consultation-public-interest-guidance-suicide-pact-and-mercy-killing-type-cases /. The consultation is closed but no further guidance has as yet been issued.

[55] *Proposed changes to 'Homicide: Murder and Manslaughter Guidance'* CPS https://www.cps.gov.uk/proposed-changes-homicide-murder-and-manslaughter-guidance

Those in favour of prosecution include mattes such as the victim's youth, absence of capacity or a settled and informed decision to end their life, pressure, absence of close relationship, use of excessive force. The final such factor is that:

the suspect was acting in his or her capacity as a medical doctor, nurse, other healthcare professional, a professional carer [whether for payment or not], or as a person in authority, such as a prison officer, and the victim was in his or her care. [This factor does not apply merely because someone was acting in a capacity described within it: it applies only where there was, in addition, a relationship of care between the suspect and the victims such that it will be necessary to consider whether the suspect may have exerted some influence on the victim.]

Suggested factors tending against prosecution include:

- *the victim had reached a voluntary, clear, settled and informed decision to end their life;*
- *the suspect was wholly motivated by compassion;*
- *the victim was seriously physically unwell and unable to undertake the act;*
- *the actions of the suspect may be characterised as reluctant, in the face of a determined wish on the part of the victim to end their life;*
- *the suspect attempted to take their own life at the same time, in pursuance of a suicide pact;*
- *the suspect reported the death to the police and fully assisted them in their enquiries into the circumstances and their part in it.*

In the meantime prosecutions for so-called mercy killings continue. For example Graham Mansfield was charged with murder convicted of the manslaughter of his wife before attempting to kill himself, presumably on the basis that this was a suicide pact[56]. He was sentenced to two years imprisonment suspected for two years in what the judge called "an unusual case" in which he was satisfied the defendant had "acted out of love" for his wife.[57] She was suffering from stage 4 lung cancer but a nurse or paramedic thought she had not reached the 'point of her last days'. The husband claimed his wife had reached to point where she was so ill, she had told him she just wanted to die. He killed her by cutting her throat. These facts, taken mainly from the CPS own press release about the case[58] raise a number of issues. In particular, the case illustrates the reason why a more structured and transparent approach to prosecution decisions is to be welcomed. It must be a moot point whether it is appropriate to prosecute a person in these circumstances at all, if the result is likely to be a non-custodial sentence. The whole process indicates an ambivalent view towards the intrinsic value of human life, which does little to serve the public interest in protecting it or in supporting autonomy and freedom from interference in private choices. In considering the public interest it is appropriate to have regard not only to the proportionality of the process but also the impact on the defendant, their family, and others who are under pressure to relieve loved ones from suffering by helping them to die. On the other hand there is a clear need to protect the vulnerable from oppression, abuse and unwarranted invasion of their autonomy or best interests.

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[56] Under the Homicide Act 19757 section 4 a killing in pursuance of a suicide pact is manslaughter not murder

[57] https://www.bbc.co.uk/news/uk-england-manchester-62250733 21 July 2022

[58] https://www.cps.gov.uk/north-west/news/greater-manchester-man-found-guilty-killing-his-terminally-ill-wife 21 July 2022

Developments in India

India

- Constitution [Art 21]; prohibits taking of life otherwise than in accordance with law
- Penal Code [306/309]: outlaws abetting suicide, attempted suicide
- Mental Health Act 2017 section 115(1) no offence if committed under "severe stress" which shall be presumed unless proved otherwise
- Indian Medical council Regs 2002 chapter 6 reg 6.7: euthanasia unethical but not withdrawal of treatment
- Indian Law Commission 2006 recommended legitimizing passive euthanasia and withdrawal of treatment, following *Bland*.
- *Ramachandran Shanbaug* [Supreme Court] [2011]: withdrawal of treatment from PVS patient could be lawful with approval of High Court as parens patriae
- *Common Cause v union of India* [Supreme Court] [2018]
  - Art 21 = right to life with human dignity
  - When terminally ill there is right to die with dignity, i.e. a right to be free from unwanted interference
  - Those lacking capacity should not be deprived of these rights and decisions should be taken in their best interest [following *Bland*; disapproving of reasons in *Shanbaugh*]
  - Procedure for advance directives prescribed

As in many countries India's Constitution places great importance on the right to life:[59] *Protection of life and personal liberty.—No person shall be deprived of his life or personal liberty except according to procedure established by law*.

This is reinforced by the Indian Penal Code which makes attempted suicide an offence and the abetment of suicide offences punishable by imprisonment and a fine.[60] The apparent starkness of these provisions is, however, modified by the Mental Health Act 2017 which prohibits trial and punishment for the offence of a person who has "*severe stress*", which they will be presumed to have unless proved otherwise.[61]

The Indian Medical Council Regulations proscribe euthanasia as unethical, but permit the withdrawal of *supporting devices to sustain cardio-pulmonary function even after brain death* only by a team of doctors.[62] The phrasing suggests that "euthanasia" is here intended to

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[59] Constitution of India Article 21 https://legislative.gov.in/sites/default/files/COI_English.pdf

[60] Indian Penal Code:
306. Abetment of suicide.—If any person commits suicide, whoever abets the commission of such suicide, shall be punished with imprisonment of either description for a term which may extend to ten years, and shall also be liable to fine."
309. Attempt to commit suicide.—Whoever attempts to commit suicide and does any act towards the commission of such offence, shall be punished with simple imprisonment for a term which may extend to one year 3 [or with fine, or with both. https://legislative.gov.in/sites/default/files/A1860-45.pdf

[61] Mental Health Act 2017 section 115(1): *Notwithstanding anything contained in section 309 of the Indian Penal Code any person who attempts to commit suicide shall be presumed, unless proved otherwise, to have severe stress and shall not be tried and punished under the said code.*

[62] The Indian Medical Council Regulations 2002 (11 March 2002 Chapter 6 regulation 6.7: *Practicing euthanasia shall constitute unethical conduct. However on specific occasion, the question of withdrawing supporting devices to sustain cardio-pulmonary function even after brain death, shall be decided only by a team of doctors and not merely by the treating physician alone. A team of doctors shall declare withdrawal of support system.*

cover withdrawal of life sustaining treatment and, if so, does not allow for the withdrawal of artificial nutrition or hydration.

Various initiatives proposing statutory reform of the law have been made:

- In 1971 the Law Commission of India recommended the repeal of section 309 of the Penal Code.[63]
- In 1994 *Rathinam v Union of India* [64] a two judge bench of the Supreme Court ruled that Section 309 of the Penal Code was ultra vires the Constitution
- In 1996 the Supreme Court of India in *Gian Kaur v State of Punjab*[65] recognised (without deciding) that withdrawal of life support or premature extinction of life might be allowed in the case of a dying person in spite of the Penal Code provisions mentioned above, which were confirmed to be constitutional, overruling *Rathinam*.[66] The Court said that a right to a dignified life up to the point of death might include the right to die with dignity, but this was not to be confused with "*a right to die an unnatural death curtailing the natural span of life".*
- In 2006 the Law Commission of India accepted that [active] euthanasia and assisted suicide should continue to be offences, but proposed a Bill legitimising passive euthanasia, and the right of competent patients, and in the case of the incompetent patient, doctors, to decide that treatment should be withdrawn, relying on the English case of *Airedale NHS Trust v Bland*.[67] The Commission. The issue of active euthanasia was a matter for legislation. The government opposed the Bill on a number of grounds,
    - The Hippocratic oath was against intentional killing of patients
    - Medical progress in pain relief, which is advancing constantly, would be set back
    - A wish to die might not be permanent and caused by a transient depression
    - Suffering is a perception which varies between individuals
    - A wish to die or be killed by a mentally ill person may be treatable
    - Suffering cannot be quantified
    - There is a difficulty in identifying appropriate definitions
    - There is a risk of pressure being applied to doctors[68]
- In 2008 the Commission again recommended repeal of section 309 of the Penal Code.[69]

Such team shall consist of the doctor in charge of the patient, Chief Medical Officer / Medical Officer in charge of the hospital and a doctor nominated by the in-charge of the hospital from the hospital staff or in accordance with the provisions of the Transplantation of Human Organ Act, 1994.
https://www.cgmedicalcouncil.org/act_imc_reg5.html

[63] *Indian Penal Code* Report No 42 Law Commission of India June 1971
https://cdnbbsr.s3waas.gov.in/s3ca0daec69b5adc880fb464895726dbdf/uploads/2022/08/2022081095.pdf

[64] (1994) 3 SCC 394

[65] As explained in the *Common Cause* case para 21, 23

[66] *Gian Kaur v State of Punjab* (1996) 2 SCC 648

[67] Report No 196; The Medical Treatment of Terminally Ill Patients (Protection of Patients and Medical Practitioners) Bill 2006

[68] A summary of the points recorded in the *Common Cause* case [para 9]

[69] *Humanization and Decriminalization of Attempt to Suicide*: Report No 210 Law Commission of India October 2008
https://cdnbbsr.s3waas.gov.in/s3ca0daec69b5adc880fb464895726dbdf/uploads/2022/08/2022081095.pdf

- In 2011 the Supreme Court of India in *Aruna Ramachandran Shanbaug v Union of India*,[70] also following *Bland*, considered the issue of passive euthanasia/withdrawal of treatment in the case of an incompetent patient in a persistent vegetative state. It held that while this could be lawful, permission was required from the High Court, under its parens patriae jurisdiction, supported by evidence from a medical panel.[71] Doctors could not be accused on an offence where he was under a common law duty to obey a refusal of a competent patient or to act in the best interests of an incompetent patient. The court observed that section 309 ought to be repealed as it was "*anachronistic*". However in the later *Common Cause* case the Supreme Court ruled that the court here had proceeded on an erroneous understanding of *Gian Kaur*.[72]
- In 2012 the Law Commission of India again reported on the topic, repeating the previous recommendation, but altering the required procedure to align with the *Shanbaug* decision of the Supreme Court of India in recommending that the courts should be empowered to permit withholding of life support from patients in irreversible coma or persistent vegetative state. It endorsed the recommendation for the repeal of section 309. [73]. With regard to the incompetent patient[74]
  It would be unjust and inhumane to thrust on him the invasive treatment of infructuous nature knowing fully well that the end is near and certain. He shall not be placed on a worse footing than a patient who can exercise his volition and express his wish to die peacefully and with dignity. Had he been alive, what he would have in all probability decided as a rational human being? Would it be in his best interests that he should be allowed to die in natural course? These decisions have to be taken by the High Court as parens patriae and this will be a statutory safeguard against arbitrary or uninformed decisions.

  The report included a proposed Bill including its recommendations. Again this was considered by the Government which sought expert advice but apparently no conclusion had been reached before the *Common Cause* case.[75]
- A Bill was introduced in the Lok Sabha in 2016 for the protection of patients and doctors assisting a suicide or withholding/withdrawing medical treatment including life support of terminally ill patients.[76] The Bill sought to recognise and enforce a patient's right to decide and express a desire to an attending doctor to withhold medical treatment or to intentionally assist him to commit suicide, subject to certain

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[70] (2011) 4 SCC 454

[71] Ibid para 125: The Court considered court approval was required because "*there is always a risk in our country that this may be misused by some unscrupulous persons who wish to inherit or otherwise grab the property of the patient. Considering the low ethical levels prevailing in our society today and the rampant commercialisation and corruption, we cannot rule out the possibility that unscrupulous persons with the help of some unscrupulous doctors may fabricate material to show that it is a terminal case with no chance of recovery. There are doctors and doctors. While many doctors are upright, there are others who can do anything for money*?
In *Bland* it was determined that the parens patriae jurisdiction had been abrogated, but in this case the court's power was found to be located in Article 226 of the Constitution .

[72] *Common Cause case* para 42

[73] *Passive Euthanasia – A Relook*, August 2012 report No 241 Law Commission of India
https://cdnbbsr.s3waas.gov.in/s3ca0daec69b5adc880fb464895726dbdf/uploads/2022/08/2022081061-1.pdf

[74] Report no 241 para 11.9

[75] See *Common Cause* para 10

[76] Bill no 2016 of 2016: The Treatment of Terminally Ill Patients 2016
http://164.100.47.4/billstexts/lsbilltexts/asintroduced/2656.pdf

precautionary conditions. In the case of a mentally incompetent patient or one who has not taken an informed decision it was proposed that the doctor cold take the relevant decision if they consider that the treatment should be withheld, or they suggests suicide with a humane and dignified death, the decision is supported by a panel of three independent doctors, and the High Court has given permission.

- In 2018 a five judge bench of the Supreme Court in *Common Cause v Union of India*[77] ruled in a monumental judgment that the right to life in Article 21 of the Indian constitution had to be construed as a right to "life with human dignity". That must include a right to dignity up to the end of natural life and the point of death. In the case of a terminally ill person or one in a persistent vegetative state, when death due to termination of natural life is certain, that right included a right to die with dignity. It was ruled that a terminally ill, dying person could make a choice of "premature extinction of life" as a facet of Article 21, subject to regulatory safeguards. Such a choice was limited to passive euthanasia, as in the withdrawal of treatment, and did not extend to the active termination of life through "positive steps". Dignity implied a right to be free of unwanted physical interference, including medical treatment. Where a terminally ill person is incapable of making treatment decisions, they should not be deprived of their Article 21 rights as described, but those rights can be respected by decisions being taken by others on the basis of the patient's best interests. The court ruled that such decisions should be made by the medical experts having regard to the views of close family and all relevant circumstances.

  To enhance the rights of those who have become incompetent to make treatment decisions the Court approved the mechanism of advance directives, made by the patient while competent as a means of exercising their choice. The Court laid down extremely detailed safeguards under which an advanced directive could be valid. In addition to various procedural requirements these included[78]

  - The patient has to be of sound mind and able to communicate, relate and comprehend the purposes of the document
  - It must be voluntarily executed and free from coercion
  - It should be in writing clearly stating that treatment may be withdrawn or specifying that no treatment should be given which only delays the process or death which might otherwise cause pain, anguish, or suffering and further put them in a state of indignity.

The case was considered further this year by the Court and the guidelines in the original decision have been modified in the face of reported practical difficulties.[79]

It is of interest that after painstaking consideration and the application of very sophisticated jurisprudence and taking account of the multiple social and religious contexts of India that the Supreme Court has adopted a relatively similar approach to that adopted in the UK by its highest court before the arrival of legislation, in both countries the courts have been, possibly reluctantly, compelled to develop the law through common law techniques, while clearly

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[77] (2018) 5 SCC 1 https://main.sci.gov.in/supremecourt/2005/9123/9123_2005_Judgement_09-Mar-2018.pdf ; [2018] AIR 1565. The summary of this decision is largely derived from the helpful headnote in the All India Reports. The judgments extend to 534 pages and will repay detailed reading, but a detailed analysis of each judgment is beyond the scope of this paper.

[78] Ibid judgment of Dipak Misra CJI and AM Khanwilkar J, para 189

[79] *Common Cause v Union of India* Order 24 January 2023 https://main.sci.gov.in/supremecourt/2019/25360/25360_2019_3_504_41295_Judgement_24-Jan-2023.pdf

considering that the complex social and cultural issues involved require parliamentary intervention.

Human rights law

European Convention on Human Rights

- Article 2: *Everyone's right to life shall be protected by law*
- Article 8: *Everyone has the right to respect for his private and family life*
- Regulation of access to lethal drugs for suicide not breach of Article 2: *Haas v Switzerland* Application no 31322/07 ECHR First Section 20 January 2011 para 54
- There is no "right to die" but margin of appreciation allows state to permit or prohibit suicide – *Pretty v UK* Application no 2346/02 4th Section 29 July 2002
- BUT, while not "right to die" Article 8 included a right to choose the moment and manner of death, provided the decision is free and informed. Therefore prevention/regulation of assisted suicide is an interference with Art 8 but this may be justified if in accordance with law and proportionate in a democratic society – *Mortier v Belgium* ECHR Third Section Application78017/17 4 October 2022 [judgment only available in French..]
- Decriminalisation of euthanasia under conditions not necessarily a breach of Article 2 - *Mortier*

There is a spectrum of law and practice in this field among countries which endorse the recognised principles of human rights, ranging from outright prohibition through to cautious recognition of choice and autonomy. While there are many potentially relevant international instruments, an examination of European human rights law suggests that in the absence of an international consensus as to the right approach in this area a wide margin of appreciation is accorded to member states

As already seen there is no international consistency in the law governing this area either in the common law world or elsewhere. While all jurisdictions outlaw intentional or, in various ways, involuntary homicide in general, various approaches are taken to either causing or assisting in the death of a person for the purpose of alleviating suffering. Thus in the Netherlands, [and the state of Oregon] active termination of life is permitted under certain strict conditions. Switzerland permits assisting a person to commit suicide, again under specified conditions.

The starting point in the ECHR, analogous to the position in India, is the imposition on states of an obligation to respect and protect the right to life. The principle of the sanctity of life is recognised in many human rights conventions. Article 2 of the European Convention on Human Rights requires states to protect everyone's right to life and not to deprive anyone of their life intentionally except in very limited circumstances:

1. *Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law.*

Further exceptions or defences are provided for self-defence and lawful arrest:

2. Deprivation of life shall not be regarded as inflicted in contravention of this article when it results from the use of force which is no more than absolutely necessary:
(a) in defence of any person from unlawful violence;
(b) in order to effect a lawful arrest or to prevent the escape of a person lawfully detained; (c) in action lawfully taken for the purpose of quelling a riot or insurrection."

There is no consensus between the parties to the ECHR in relation to the legality of ceasing treatment artificially sustaining life, although the majority of states do permit this. However there was nonetheless a consensus as to the *"role primordial de la volonte du patient dans la prise de decision"*[80]

This consideration involves Article 8:

(1) *Everyone has the right to respect for his private and family life…*
(2) *There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic wellbeing of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others*

Article 2 does not explicitly refer to euthanasia, assisted suicide or withholding/withdrawal of treatment, but the European Court of Human Rights has had occasion to examine each of these issues. A common thread through the judgments is that in considering the application of Article 2 account must be taken of the rights to privacy and autonomy under Article 8 and vice versa, and, that, in the absence of a consensus between signatory states, a wide margin of appreciation can be recognised.[81]

[80] *Mortier v Belgium* – see below
[81] *Haas v Switzerland* [below] para 54, 148; *Lambert v France* [above] para 142

"... In the sphere of medical treatment, the refusal to accept a particular treatment might, inevitably, lead to a fatal outcome, yet the imposition of medical treatment, without the consent of a mentally competent adult patient, would interfere with a person's physical integrity in a manner capable of engaging the rights protected under Article 8 § 1 of the Convention. As recognised in domestic case-law, a person may claim to exercise a choice to die by declining to consent to treatment which might have the effect of prolonging his life ...

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

Pretty v UK paras 63, 65

Balance of Article to and 8 rights required

There is no "right to die".[82] A complaint that the Director of Public Prosecution's refusal to undertake not to prosecute the complainant's husband if he were to assist her to end her life was held to be a breach of her Article 2 and 8 rights. The Court in *Pretty v UK* noted that Article 2 covered not only intentional killing but also situations where the lawful application of force left to an unintended outcome of death. The state's obligations extended beyond refraining from intentional and unlawful killing to a requirement to take appropriate steps to safeguard the lives of those within its jurisdiction.[83] The Court held that:[84]

> *39. .....Article 2 cannot, without a distortion of language, be interpreted as conferring the diametrically opposite right, namely a right to die; nor can it create a right to self-determination in the sense of conferring on an individual the entitlement to choose death rather than life.*
>
> *40. The Court accordingly finds that no right to die, whether at the hands of a third person or with the assistance of a public authority, can be derived from Article 2 of the Convention.*

It went on the state that even if, which they were not deciding, it was possible for a state to permit assisted suicide without infringing article 2, that did not mean it was an infringement for another state not do so.[85] The Court in *Pretty* rejected the complainant's argument that a blanket ban on assisted suicide was a breach of her Article 8 [right to a private life] rights. They accepted that her Article 8 rights had been interfered with because:[86]

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[82] *Pretty v United Kingdom* Application no 2346/02 4th Section 29 July 2002

[83] Ibid §38; *Osman v United Kingdom* 28 October 1998, Reports 1998-VIII 3159 §115; *Keenan v United Kingdom* Application 2722/95 ECHR 2001-III [protection of prisoner from suicide

[84] *Pretty* Ibid §39-40

[85] Ibid §41

[86] *Pretty* §65; see also *Rodriguez v Attorney-General of* Canada [1994] 2 Can LR 136 Supreme Court of Canada

> *In an era of growing medical sophistication combined with longer life expectancies, many people are concerned that they should not be forced to linger on in old age or in states of advanced physical or mental decrepitude which conflict with strongly held ideas of self and personal identity was engaged.*

And referring to an analogous Canadian case,

> *The prohibition on the appellant in that case receiving assistance in suicide contributed to her distress and prevented her from managing her death. This deprived her of autonomy and required justification under principles of fundamental justice*

However the interference could be justified under Article 2 because states are entitled to regulate through the criminal law activities which are detrimental to the life and safety of other individuals

- The more serious the harm involved the most heavily will public health and safety considerations weigh in the balance against the principle of personal autonomy.
- The law against assisting suicide was designed to protect the weak and vulnerable and in particular those not able to make informed decisions against acts intended to end or assisting in ending life. Such a ban was not disproportionate There had to be a margin of appreciation:[87]
  Doubtless the condition of terminally ill individuals will vary. But many will be vulnerable and it is the vulnerability of the class which provides the rationale for the law in question. It is primarily for States to assess the risk and the likely incidence of abuse if the general prohibition on assisted suicides were relaxed or if exceptions were to be created. Clear risks of abuse do exist, notwithstanding arguments as to the possibility of safeguards and protective procedures.

By way of comment the Court in *Pretty* did not in fact treat the English law, when taken with the procedure adopted by the DPP, as being a blanket ban in any event. They recognised and implicitly approved of [88]

a system of enforcement and adjudication which allows due regard to be given in each particular case to the public interest in bringing a prosecution, as well as to the fair and proper requirements of retribution and deterrence.

No right to die

That there is no right to die was confirmed recently in *Mortier v Belgium* the first case in which the ECHR has been asked to consider the conformity of a domestic law authorising euthanasia with the Convention:[89]

En particulier, la Cour a estimé qu'il n'est pas possible de déduire de l'article 2 un droit de mourir, que ce soit de la main d'un tiers ou avec l'assistance d'une autorité publique

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[87] Ibid § 74, 76

[88] Ibid §76-78

[89] *Mortier v Belgium* ECHR Third Section Application 78017/17 4 October 2022 § 119. The judgment has only been published in French

On the other hand the right to autonomy and respect for private life includes the right to choose the manner and moment of one's death if the choice is free[90]
Le droit pour une personne de choisir la manière et le moment de la fin de sa vie, pourvu qu'elle soit en mesure de former librement sa volonté à ce propos et d'agir en conséquence, est l'un des aspects du droit au respect de sa vie privée au sens de l'article 8 de la Convention

Active euthanasia not incompatible with the Convention

Most recently the Court has accepted that active euthanasia is potentially compatible with the Convention. Many would consider that euthanasia, the intentional causing of the death of a person by a third party to alleviate suffering, as the most extreme of the three measures we are considering. The Court accepted that it had to determine whether an act authorised by the Belgian law could occur in conformity with the Convention; it was not asked to decide whether there was a right to euthanasia.[91] It held that the right to life under Article 2 was not necessarily incompatible with a conditional decriminalisation of euthanasia. The Belgian law was a recognition of the individual\s right under Article 8 to choose how to avoid what to them was unbearable suffering, and an undignified and distressing end of their life. However to be compatible with Article 2 the law had to provide adequate protection against abuse and thus to ensure respect for life.[92] The Court noted that the United Nations Rights of Man indicated that euthanasia did not constitute a breach of the right to life if it was surrounded by

"solides garanties legales et institutionelles permettant de verifier que les professionels de la medicine appliquent une decision explicite, non ambigue, libre et eclairee de leur patient"

so that all patients were protected against pressure and abuse. There was a margin of appreciation accorded to states although this was not without limit..[93] On the Court's analysis of the protections required by the Belgian law to be applied in advance of the act of euthanasia it ruled that in principle it assured the protection of the right to life of patients required by Article 2.[94] The ingredients of the law which allowed the Court to come to this conclusion were that

- a doctor is not permitted to proceed to euthanasia if the patient, being an adult or a competent child is aware of the request;
- the request is voluntary, considered, and repeated and not the result of external pressure;
- the patient must also be in a medical condition without cure, and which causes physical or mental suffering which is constant, intolerable and cannot be ameliorated.[95]

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[90] *Mortier §124*; see also *Pretty §67*
[91] *Mortier §§ 125-127*
[92] *Mortier §139*
[93] Mortier §143
[94] Mortier §155
[95] §150 in French reads: *l'article 3 de la loi relative à l'euthanasie ne permet à un médecin de procéder à l'euthanasie que si le patient majeur ou mineur émancipé est conscient au moment de sa demande, que sa demande est formulée de manière volontaire, réfléchie et répétée, et qu'elle ne résulte pas d'une pression extérieure. De plus, l'euthanasie n'est autorisée que si le patient se trouve dans une situation médicale sans issue et qu'il fait état d'une souffrance physique ou psychique constante et insupportable qui ne peut être apaisée et qui résulte d'une affection accidentelle ou pathologique grave et incurable*

It was not a breach of a near relative's Article 8 rights not to have been consulted before the euthanasia where not have done so would have been contrary to the patient's wishes.

However the Court found that a system of review after the death that permitted the doctor who had led the decision-making process and administered the lethal injection to be a member of the review panel was an inadequate safeguard for the purpose of Article 2.

Article 8 engaged by prevention of assisted suicide but not necessarily unlawful

Prevention by law of an exercise of choice to seek her husband's assistance to commit suicide to avoid an undignified and distressing end to life has been held to be a possible interference with the right to respect for her private life under Article 8.[96] A law restricting access to lethal drugs for the purpose of committing suicide was not necessarily a breach of Article 8, but an individual's right to decide the manner and timing of their end of life was an aspect of their private life.[97] It was the ECHR's opinion that the regulations in place requiring a prescription before provision of a lethal drug pursue the legitimate aim of *"protecting everybody from hasty decisions and preventing abuse, and, in particular, ensuring that a patient lacking discernment does not obtain a lethal dose of sodium pentobarbital…*" Such regulations were all the more necessary in respect of a country such as Switzerland, where the legislation and practice allow for relatively easy access to assisted suicide.

The facts in the case cited demonstrate graphically why safeguards are required. A person suffering from a serious bipolar affective disorder had approached Dignitas for assistance in ending his life but several psychiatrists to whom he was ferred to obtain the necessary lethal substance refused. He approached several official bodies seeking permission to obtain the substance without a prescription but was refused. A subsequent letter to 170 psychiatrists also failed to identify anyone prepared to prescribe the drug.

Withdrawal of artificial nutrition and hydration may be compatible with Convention

The Article 2 and 8 rights of a patient suffering degenerative brain disease were not infringed by official guidance or legislation permitting in certain circumstances the withdrawal of artificial nutrition and hydration;[98] On the other hand, the administration of potentially lethal dose diamorphine to a sick child without the parents' consent and the making of a "do not resuscitate" order was not a breach of Article 2, given the absence of an intention to kill the child or to hasten death.[99]

Is the law capable of resolving the ethical issues involvcd?

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[96] *Pretty v UK* Application no. 2346/02 4th Section 29 July 2002

[97] *Haas v Switzerland* Application no 31322/07 ECHR First Section 20 January 2011 para 51

[98] *Burke v UK* Application no. 19807/06 July 2006;. *Lambert v France*

[99] *Glass v UK* Application no. 61827/00 March 2003

Conflicting ethical values to be balanced?

- Sanctity of life v autonomy – which prevails?
- Acts v omissions – a real distinction?
- Patient's right to choose v protection of vulnerable – are they compatible?
- Personal benefit v society's interest – does society have right to interfere?
- Personal suffering v social benefits – effect on advances of palliative and curative care?
- Who decides – patient, relatives, guardian's doctors, court?
- Patient's choice of outcome or doctor's right to refuse?
- Necessity v benefit – from whose point of view?
- Personal solution v slippery slope?

A short list of issues which inevitably arise in the debate about life shortening measures is offered above. When courts and legislators are asked to rule on euthanasia and related matters it is inevitable that they have regard to prevailing ethics.

A useful analysis of such issues was offered by the House of Lords committee which considered Lord Joffe's 2005 Assisted dying for the Terminally Ill Bill. They observed that those supporting the Bill started from the ethical principle of autonomy and freedom of choice whereas those opposing it laid overarching emphasis on the sanctity of life. It was pointed out that while the principle of sanctity of life was commonly advocated on the basis of religious principles, religious beliefs was not a necessary foundation for it. It was quite possible to identify a secular basis for the importance of life and its protection. Both sides accepted that each principle was valid and important, but differed on which principle should prevail over the other in the circumstances of suffering at the end of life. The committee addressed the suggested inconsistency between applying the sanctity of life principle to prevent the actions of euthanasia or assisted suicide to alleviate suffering and allowing the omission to keep a patient alive in withholding/withdrawal of life sustaining treatment. While they accepted that the result of both an act to cause death and an omission to keep alive were very similar from the patient's point of view, there was a significant difference from the doctor's: most people did not consider that withholding futile treatment actually caused the death of the patient, whereas the action of providing or administering the means of death does.

With regard to autonomy those supporting the Bill argued that autonomy embraced a right to choose the manner and means of their death and that the Bill contained sufficient provisions to protect the vulnerable and mentally incapacitated. Others took the view that respect for autonomy could not extend to requiring a third party to assist or provide the means of causing death and also raised fears about the limited proposals in the Bill being a "slippery slope" to a wider and even more controversial circumstances such as where individuals felt, rightly or wrong pressurised to end their lives to ease the burden they represented to others.

It is clear from these and similar debates that the common law is unlikely to find answers to these fraught issues without legislative intervention. Lawyers and judges can only look for legal answers within the framework of law in which they work. Different societies, with their various social cultural religious and historical contexts are likely to land on different solutions, and as contexts change, so may their answers.

It is notable that judges have on occasion referred to literary and philosophical sources for guidance in this challenging area, perhaps none more so than the justices of the Supreme Court of India in the *Common Cause* case.

For example the judgment of AK Sikri J included the following quotations:[100]
"I am the master of my fate; I am the captain of my soul" - William Ernest Henley
"Death is our friend … he delivers us from agony. I do not want to die of a creeping paralysis of my faculties – a defeated man."- Mahatma Gandhi
"When a man's circumstances contain a preponderance of things in accordance with nature, it is appropriate for him to remain alive; when possess or sees in prospect a majority of contrary, it is appropriate for him to depart from life." - Marcus Tullius Cicero
"Every person in this world comes crying. However, that person who leaves the world laughing/smiling will be the luckiest of all" (Hindi Film – Muqaddar Ka Sikandar)
'I do not want to achieve immortality through my work. I want to achieve it through not dying' – Woody Allen

Further examples from the lead judgment are given in the box below.

Reflections on life and death by the Supreme Court of India

Common Cause v Union of India [2018] SCC 1

- *The lamp is constantly burning out, and that is its life. If you want to have life, you have to die every moment for it. Life and death are only different expressions of the same thing looked at from different standpoints* Swami Vivekananda *Karma Yoga – the Ideal of Karma Yoga*
- *When I consider life, 'tis all a cheat; yet fooled with hope, men favour the deceit.* John Dryden *Life a Cheat*
- *La vie est breve, Un peu d'espoir, Un peu de reve, Et puis - bonsoir!* Leon Montenaeken, *Peu de Chose*
- *Do not go gentle into that good night, Old age should burn and rave at close of day; Rage, rage against the dying of the light.* Dylan Thomas, *Under Milk Wood*
- *One short sleep past, we wake eternally, And death shall be no more; death, thou shalt die.* John Donne *Holy Sonnets: Death, be not proud*
- *While life is yours, live joyously.* Charvaka
- *No life that breathes with human breath has ever truly longed for death.* Tennyson, *The Two Voices*
- *Why should I fear death? If I am, then death is not? If death is, then I am not.* Epicurus, *Letter to Menoeceus*

It is suggested that neither the lawyer nor the judge is qualified to decide on the balance to be drawn between these and other ethical factors in this area, certainly not without the assistance of the parliamentary guardians of the public interest. The court setting is not the arena in which the merits of the ethical case for or against any particular measure can be determined,

[100] See paras 46 – 50 judgment of AK Sikri J pages 38 of 112 et seq

if, indeed they are capable of final determination at all. It is only because of the absence of legislation and notable reluctance of politicians to grapple with these issues that the common law is required to intervene to provide solutions in everyday life – and death.