

IN THE SUPREME COURT OF INDIA
CIVIL ORIGINAL JURISDICTION

WRIT PETITION (CIVIL) NO. 215 OF 2005

COMMON CAUSE (A REGD. SOCIETY)

.... PETITIONER

VERSUS

UNION OF INDIA & ANR

..... RESPONDENTS

J U D G M E N T

Dr D Y CHANDRACHUD, J

A Introduction: *On Death and Dying*

1 Life and death are inseparable. Every moment of our lives, our bodies are involved in a process of continuous change. Millions of our cells perish as nature regenerates new ones. Our minds are rarely, if ever, constant. Our thoughts are fleeting. In a physiological sense, our being is in a state of flux, change being the norm. Life is not disconnected from death. To be, is to die.

From a philosophical perspective, there is no antithesis between life and death. Both constitute essential elements in the inexorable cycle of existence.

2 Living in the present, we are conscious of our own mortality. Biblical teaching reminds us that:

“There is a time for everything, and a season for every activity under the heavens : a time to be born and a time to die, a time to plant, and a time to uproot, a time to kill and a time to heal, a time to wear down and a time to build, a time to weep and a time to laugh, a time to mourn and a time to dance.”
(Ecclesiastes 3)

3 The quest of each individual to find meaning in life reflects a human urge to find fulfilment in the pursuit of happiness. The pursuit of happiness is nurtured in creative pleasures and is grounded in things as fundamental as the freedom to think, express and believe, the right to self-determination, the liberty to follow a distinctive way of life, the ability to decide whether or not to conform and the expression of identity.

4 Human beings through the ages have been concerned with death as much as with dying. Death represents a culmination, the terminal point of life. Dying is part of a process: the process of living, which eventually leads to death. The fear of death is a universal feature of human existence. The fear is associated as much with the uncertainty of when death will occur as it is, with the suffering that may precede it. The fear lies in the uncertainty of when an

event which is certain will occur. Our fears are enhanced by the experience of dying that we share with those who were a part of our lives but have gone before us. As human beings, we are concerned with the dignity of our existence. The process through which we die bears upon that dignity. A dignified existence requires that the days of our lives which lead up to death must be lived in dignity; that the stages through which life leads to death should be free of suffering; and that the integrity of our minds and bodies should survive so long as life subsists. The fear of an uncertain future confronts these aspirations of a dignified life. The fear is compounded by the fact that as we age, we lose control over our faculties and over our ability to take decisions on the course of our future. Our autonomy as persons is founded on the ability to decide: on what to wear and how to dress, on what to eat and on the food that we share, on when to speak and what we speak, on the right to believe or not to believe, on whom to love and whom to partner, and to freely decide on innumerable matters of consequence and detail to our daily lives. Ageing leaves individuals with a dilution of the ability to decide. The fear of that loss is ultimately, a fear of the loss of freedom. Freedom and liberty are the core of a meaningful life. Ageing brings dependency and a loss of control over our ability to shape what we wish to happen to us.

5 The progression of life takes its toll on the human body and the mind. As we age, simple tasks become less simple and what seemed to be a matter of course may become less so. Human beings then turn ever more to the

substance that matters. As events, relationships, associations and even memories fall by the way, we are left with a lonesome remnant of the person, which defines the core of our existence. The quest of finding meaning in that core is often a matter of confronting our fears and tragedies.

6 The fear of pain and suffering is perhaps even greater than the apprehension of death. To be free of suffering is a liberation in itself. Hence the liberty to decide how one should be treated when the end of life is near is part of an essential attribute of personhood. Our expectations define how we should be treated in progressing towards the end, even when an individual is left with little or no comprehension near the end of life.

7 Dilemmas relating to the end of life have been on the frontline of debate across the world in recent decades. The debate has presented “a complex maze of dilemmas for all - the doctor, the lawyer, the patient and the patient’s relatives”¹ and straddles issues of religion, morality, bio-medical ethics and constitutional law. It has involved “issues ranging from the nature and meaning of human life itself, to the most fundamental principles on which our societies are and should be based”².

¹ “The Dilemmas of Euthanasia”, *Bio-Science* (August 1973), Vol. 23, No. 8, at page 459

² Margaret A. Somerville, “Legalising euthanasia: why now?”, *The Australian Quarterly* (Spring 1996), Vol. 68, No. 3, at page 1

8 There is an “ongoing struggle between technology and the law”; as “medical technology has become more advanced, it has achieved the capability both to prolong human life beyond its natural endpoint and to better define when that endpoint will occur”.³ Medical science has contributed in a significant way to enhancing the expectancy of life. Diseases once considered fatal have now become treatable. Medical research has redefined our knowledge of ailments – common and uncommon; of their links with bodily functions and the complex relationship between mental processes and physical well-being. Science which affects the length of life also has an impact on the quality of the years in our lives. Prolonging life should, but does not necessarily result in, a reduction of suffering. Suffering has a bearing on the quality of life. The quality of life depends upon the life in our years. Adding to the length of life must bear a functional nexus with the quality of life. Human suffering must have significance not only in terms of how long we live but also in terms of how well we live.

9 Modern medicine has advanced human knowledge about the body and the mind. Equipped with the tools of knowledge, science has shown the ability to reduce human suffering. Science has also shown an ability to prolong life. Yet in its ability to extend life, medical science has an impact on the quality of life, as on the nature and extent of human suffering. Medical interventions come with costs, both emotional and financial. The ability of science to

³ Christopher N. Manning, “Live And Let Die: Physician-Assisted Suicide And The Right To Die”, *Harvard Journal of Law and Technology* (1996), Vol. 9, No. 2, at page 513

prolong life must face an equally important concern over its ability to impact on the quality of life. While medical science has extended longevity, it has come with associated costs of medical care and the agony which accompanies an artificially sustained life. Medical ethics must grapple with the need to bring about a balance between the ability of science to extend life with the need for science to recognise that all knowledge must enhance a meaningful existence.

10 There is “no consensus as to the rights and wrongs of helping someone to die”⁴, as the legal status of euthanasia has been subjected to social, ethical and moral norms that have been handed down to us. Decisions regarding the end of life can be ethically more problematic when the individual is no longer mentally competent to make his or her own decisions.⁵ The existential and metaphysical issues involved in this debate, include the fear of the unknown, the uncertainty of when death will occur, the scarcity of health care, freedom or coercion in choosing to receive or not to receive medical treatment, the dignity and degradation of ageing and being able to care for oneself independently.⁶

11 Does the law have a role in these complex questions of life and death? If it does, what are the boundaries which judges – as interpreters of law –

⁴ Alan Norrie, “Legal Form and Moral Judgement: Euthanasia and Assisted Suicide” in R.A. Duff, et al (ed), *The Structures of the Criminal Law* (Oxford University Press, 2011), at page 134

⁵ Elizabeth Wicks, *The Right to Life and Conflicting Interests* (Oxford University Press, 2010), at page 199

⁶ Elizabeth M. Andal Sorrentino, “The Right To Die?”, *Journal of Health and Human Resources Administration* (Spring,1986), Vol. 8, No. 4, page 361

must observe while confronting these issues of living and dying? The law, particularly constitutional law, intervenes when matters governing freedom, liberty, dignity and individual autonomy are at stake. To deny a role for constitutional law would be to ignore our own jurisprudence and the primary role which it assigns to freedom and dignity. This case presents itself before the Court as a canvass bearing on the web of life: on the relationship between science, medicine and ethics and the constitutional values of individual dignity and autonomy. Among the issues which we confront are:

- (i) Does an individual have a constitutionally recognized right to refuse medical treatment or to reject a particular form of medical treatment;
- (ii) If an individual does possess such a right, does a right inhere in the individual to determine what course of action should be followed in the future if she or he were to lose control over the faculties which enable them to accept or refuse medical treatment;
- (iii) Does the existence of a right in the individual impose a corresponding duty on a medical professional who attends to the individual, to respect the right and what, if any, are the qualifications of that duty;
- (iv) Does the law permit a medical practitioner to withhold or refuse medical treatment towards the end of life to an individual who is no longer in control of his or her faculties in deference to a desire expressed while in a fit state of mind; and

- (v) Would a withholding or refusal of medical treatment be permissible so as to allow life to take its natural course, bereft of an artificial intervention, when there is no realistic hope of return to a normal life.

12 This Court has to consider euthanasia and its impact “not only at an individual level”, but also at the “institutional, governmental and societal levels”.⁷ The impact has to be analyzed not only in the context of the present era, but has to be contemplated for the future as well. The judge is not a soothsayer. Nor does the law have predictive tools at its command which can approximate those available to a scientist. Constitutional principle must have an abiding value. It can have that value if it is firmly grounded in the distilled experience of the past, is flexible to accommodate the concerns of the present and allows room for the unforeseeable future. The possibility of the abuse of euthanasia and the effect that legalising euthanasia would have on intangible societal fabrics and institutions is of utmost concern.

13 Contemporary writing on the subject reminds us about how serious these issues are and of how often they pose real dilemmas in medicine. They are poignantly brought out by Dr Atul Gawande in his acclaimed book, “**Being Mortal**”:

“If to be human is to be limited, then the role of caring professions and institutions - from surgeons to nursing homes - ought to be aiding people in their struggle with those limits. Sometimes we can offer a cure, sometimes only a salve,

⁷ Ibid

sometimes not even that. But whatever we can offer, our interventions, and the risks and sacrifices they entail, are justified only if they serve the large aims of a person's life. When we forget that, the suffering we inflict can be barbaric. When we remember it, the good we do can be breathtaking."⁸

He reminds us of how much people value living with dignity over merely living longer:

"A few conclusions become clear when we understand this: that our most cruel failure in how we treat the sick and the aged is the failure to recognize that they have priorities beyond merely being safe and living longer; that the chance to shape one's story is essential to sustaining meaning in life; that we have the opportunity to refashion our institutions, our culture, and our conversations in ways that transform the possibilities for the last chapters of everyone's lives."⁹

14 Dr Henry Marsh, a neurosurgeon in the UK has significantly titled his provocative memoir "Admissions" (2017). Speaking of euthanasia, he observes:

"We have to choose between probabilities, not certainties, and that is difficult. How *probable* is it that we will gain how many extra years of life, and what might the *quality* of those years be, if we submit ourselves to the pain and unpleasantness of treatment? And what is the probability that the treatment will cause severe side effects that outweigh any possible benefits? When we are young it is usually easy to decide – but when we are old, and reaching the end of our likely lifespan? We can choose, at least in theory, but our inbuilt optimism and love of life, our fear of death and the difficulty we have in looking at it steadily, make this very difficult. We inevitably hope that we will be one of the lucky ones, one of the long-term survivors, at the good and not the bad tail-end of the statisticians' normal distribution. And yet it has been estimated that in the developed world, 75 per cent of our lifetime medical costs are incurred in the last six

⁸ Atul Gawande, *Being Mortal: Medicine and What Matters in the End* (Hamish Hamilton, 2014), at page 260

⁹ *Ibid*, at page 243

months of our lives. This is the price of hope, hope which, by the laws of probability, is so often unrealistic. And thus we often end up inflicting both great suffering on ourselves and unsustainable expense on society.”¹⁰

These are but a few of the examples of emerging literature on the subject.

15 The central aspect of the case is the significance which the Constitution attaches to the ability of every individual in society to make personal choices on decisions which affect our lives. **Randy Pausch**, a Professor at Stanford had this to say in a book titled “**The Last Lecture**” (2008),¹¹ a discourse delivered by him in the shadow of a terminal illness.

“We cannot change the cards we are dealt, just how we play the hand”.

We may not be masters of our destiny. Nor can we control what life has in store. What we can determine is how we respond to our trials and tribulations.

B The reference

16 On 25 February 2014, three Judges of this Court opined that the issues raised in this case need to be considered by a Constitution Bench. The referring order notes that the case involves “social, legal, medical and constitutional” perspectives which should be considered by five judges. At the heart of the proceeding, is a declaration which Common Cause seeks that the right to die with dignity is a fundamental right which arises from the right to live

¹⁰ Henry Marsh, *Admissions: A Life in Brain Surgery*, (Weidenfeld & Nicolson, 2017), at page 265-266

¹¹ Randy Pausch and Jeffrey Zaslow, *The Last Lecture*, (Hodder & Stoughton, 2008), at page 17

with dignity. Article 21 of the Constitution is a guarantee against the deprivation of life or personal liberty except according to the procedure established by law. As our law has evolved, the right against the violation of life and personal liberty has acquired much more than a formal content. It can have true meaning, if only it includes the right to live with dignity. It is on this premise that the court is urged to hold that death with dignity is an essential part of a life of dignity. A direction is sought to the Union Government to adopt suitable procedures to ensure that persons with “deteriorated health” or those who are terminally ill should be able to execute a document in the form of “a living will and attorney authorization” which can be presented to a hospital for appropriate action if the person who has made it, is hospitalized with a serious illness which may cause the end of life. The petitioner also seeks, in the alternative, that this Court should issue guidelines and appoint an expert committee consisting of doctors, social scientists and lawyers who will govern the making of ‘living wills’.

17 Individuals who suffer from chronic disease or approach the end of the span of natural life often lapse into terminal illness or a permanent vegetative state. When a medical emergency leads to hospitalization, individuals in that condition are sometimes deprived of their right to refuse unwanted medical treatment such as feeding through hydration tubes or being kept on a ventilator and other life support equipment. Life is prolonged artificially resulting in human suffering. The petition is founded on the right of each

individual to make an informed choice. Documenting a wish in advance, not to be subjected to artificial means of prolonging life, should the individual not be in a position later to comprehend or decline treatment, is a manifestation of individual choice and autonomy. The process of ageing is marked by a sense of helplessness. Human faculties decline as we grow older. Social aspects of ageing, such as the loss of friendships and associations combine with the personal and intimate to enhance a sense of isolation. The boundaries and even the limits of constitutional law will be tested as the needs of the ageing and their concerns confront issues of ethics, morality and of dignity in death.

18 In support of its contention, the petitioner relies upon two decisions: a decision rendered in 1996 by a Constitution Bench in **Gian Kaur v State of Punjab**¹² (“**Gian Kaur**”) and a decision of 2011 rendered by two judges in **Aruna Ramachandra Shanbaug v Union of India**¹³ (“**Aruna Shanbaug**”). The decision in **Gian Kaur** arose from a conviction for the abetment of suicide. In an earlier decision rendered by two judges in 1994 - **P Rathinam v Union of India**¹⁴ (“**Rathinam**”), penalising an attempt to commit suicide was held to violate Article 21 on the foundation that the right to life includes the right to die. The decision in **Rathinam** was held not to have laid down the correct principle, in **Gian Kaur**. Hence the decision in **Aruna Shanbaug** noted that Article 21 does not protect the right to die and an attempt to commit suicide is a crime. However, in **Aruna Shanbaug**, the court held that since

¹²(1996) 2 SCC 648

¹³(2011) 15 SCC 480

¹⁴(1994) 3 SCC 394

Gian Kaur rules that the right to life includes living with human dignity, “in the case of a dying person who is terminally ill or in a permanent vegetative state, he may be permitted to terminate by a premature extinction of his life”, and this would not be a crime. The Bench which decided **Aruna Shanbaug** was of the view that **Gian Kaur** had “quoted with approval” the view of the House of Lords in the UK in **Airedale NHS Trust v Bland**¹⁵ (“**Airedale**”).

19 When these judgments were placed before a Bench of three judges in the present case, the court observed that there were “inherent inconsistencies” in the judgment in **Aruna Shanbaug**. The referring order accordingly opined that:

“Aruna Shanbaug (supra) aptly interpreted the decision of the Constitution Bench in Gian Kaur (supra) and came to the conclusion that euthanasia can be allowed in India only through a valid legislation. However, it is factually wrong to observe that in Gian Kaur (supra), the Constitution Bench approved the decision of the House of Lords in *Airedale v. Bland*: (1993) 2 W.L.R. 316 (H.L.). Para 40 of Gian Kaur (supra), clearly states that “even though it is not necessary to deal with physician assisted suicide or euthanasia cases, a brief reference to this decision cited at the Bar may be made...” Thus, it was a mere reference in the verdict and it cannot be construed to mean that the Constitution Bench in Gian Kaur (supra) approved the opinion of the House of Lords rendered in *Airedale* (supra). To this extent, the observation in Para 101 is incorrect.”

The referring order goes on to state that:

“In Paras 21 & 101, the Bench [in Aruna Shanbaug] was of the view that in Gian Kaur (supra), the Constitution Bench

¹⁵(1993) 2 WLR 316 (H.L)

held that euthanasia could be made lawful only by a legislation. Whereas in Para 104, the Bench contradicts its own interpretation of *Gian Kaur* (supra) in Para 101 and states that although this Court approved the view taken in *Airedale* (supra), it has not clarified who can decide whether life support should be discontinued in the case of an incompetent person e.g., a person in coma or PVS. When, at the outset, it is interpreted to hold that euthanasia could be made lawful only by legislation where is the question of deciding whether the life support should be discontinued in the case of an incompetent person e.g., a person in coma or PVS.”

The reason why the case merits evaluation by the Constitution Bench is elaborated in the Order dated 25 February 2014. Simply put, the basis of the reference to the Constitution Bench is that:

- (i) **Gian Kaur** affirms the principle that the right to live with dignity includes the right to die with dignity;
- (ii) **Gian Kaur** has not ruled on the validity of euthanasia, active or passive;
- (iii) **Aruna Shanbaug** proceeds on the erroneous premise that **Gian Kaur** approved of the decision of the House of Lords in **Airedale**;
- (iv) While **Aruna Shanbaug** accepts that euthanasia can be made lawful only through legislation, yet the court accepted the permissibility of passive euthanasia and set down the procedure which must be followed; and
- (v) **Aruna Shanbaug** is internally inconsistent and proceeds on a misconstruction of the decision in **Gian Kaur**.

20 This being the basis of the reference, it is necessary to consider the decisions in **Gian Kaur** and **Aruna Shanbaug**.

C Gian Kaur

21 Gian Kaur and Harbans Singh were spouses. They were convicted of abetting the suicide of Kulwant Kaur and were held guilty of an offence under Section 306 of the Penal Code. They were sentenced to six years' imprisonment. The conviction was upheld by the High Court. The conviction was assailed before this Court on the ground that Section 306 is unconstitutional. It was argued that the constitutionality of Section 306 rested on the two judge Bench decision in **Rathinam**, where Section 309 (penalising the attempt to commit suicide) was held to be unconstitutional. While **Rathinam** had rejected the challenge to the validity of Section 309 on the ground that it was arbitrary (and violated Article 14), the provision was held to be unconstitutional on the ground that it violated Article 21. The right to die was found to inhere in the right to life, as a result of which Section 309 was found to be invalid. The challenge in **Gian Kaur** was premised on the decision in **Rathinam**: abetment of suicide by another (it was urged) is merely assisting in the enforcement of the fundamental right under Article 21 and hence Section 306 (like Section 309) would violate Article 21.

22 The Constitution Bench in **Gian Kaur** disapproved of the foundation of **Rathinam**, holding that it was flawed. The Constitution Bench held thus:

“When a man commits suicide he has to undertake certain positive overt acts and the genesis of those acts cannot be traced to, or be included within the protection of the 'right to life' under Article 21. The significant aspect of 'sanctity of life'

is also not to be overlooked. Article 21 is a provision guaranteeing protection of life and personal liberty and by no stretch of imagination can 'extinction of life' be read to be included in 'protection of life'. Whatever may be the philosophy of permitting a person to extinguish his life by committing suicide, we find it difficult to construe Article 21 to include within it the 'right to die' as a part of the fundamental right guaranteed therein. 'Right to life' is a natural right embodied in Article 21 but suicide is an unnatural termination or extinction of life, and therefore, incompatible and inconsistent with the concept of 'right to life'. With respect and in all humility, we find no similarity in the nature of the other rights, such as the right to 'freedom of speech' etc. to provide a comparable basis to hold that the 'right to life' also includes the 'right to die'. With respect, the comparison is inapposite, for the reason indicated in the context of Article 21. The decisions relating to other fundamental rights wherein the absence of compulsion to exercise a right was held to be included within the exercise of that right, are not available to support the view taken in P. Rathinam qua Article 21."

The Court further held that:

"To give meaning and content to the word 'life' in Article 21, it has been construed as life with human dignity. Any aspect of life which makes it dignified may be read into it but not that which extinguishes it and is, therefore, inconsistent with the continued existence of life resulting in effacing the right itself. The 'right to die', if any, is inherently inconsistent with the 'right to life' as is 'death' with 'life'."

Gian Kaur holds that life within the meaning of Article 21 means a life of dignity. Extinguishment of life is (in that view) inconsistent with its continued existence. Hence, as a matter of textual construction, the right to life has been held not to include the right to die. In coming to that conclusion, it appears that **Gian Kaur** emphasises two strands (which the present judgment will revisit at a later stage). The first strand is the sanctity of life, which Article 21 recognises. Extinction of life, would in this view, in the manner which **Rathinam** allowed, violate the sanctity of life. The second strand that emerges

from **Gian Kaur** is that the right to life is a natural right. Suicide as an unnatural extinction of life is incompatible with it. The court distinguishes the right to life under Article 21 from other rights which are guaranteed by Article 19 such as the freedom of speech and expression. While free speech may involve the absence of a compulsion to exercise the right (the right not to speak) this could not be said about the right to life. The Constitution Bench noticed the debate on euthanasia in the context of individuals in a permanent vegetative state. A scholarly article on the decision notes that the Constitution Bench “seemed amenable to an exception being made for euthanasia in cases of patients in a condition of PVS¹⁶. This view of the decision in **Gian Kaur** does find support in the following observations of the Constitution Bench:

“Protagonism of euthanasia on the view that existence in persistent vegetative state (PVS) is not a benefit to the patient of a terminal illness being unrelated to the principle of ‘Sanctity of life’ or the ‘right to live with dignity’ is of no assistance to determine the scope of Article 21 for deciding whether the guarantee of ‘right to life’ therein includes the ‘right to die’. The ‘right to life’ including the right to live with human dignity would mean the existence of such a right up to the end of natural life. This also includes the right to a dignified life up to the point of death including a dignified procedure of death. In other words, this may include the right of a dying man to also die with dignity when his life is ebbing out. But the ‘right to die’ with dignity at the end of life is not to be confused or equated with the ‘right to die’ an unnatural death curtailing the natural span of life.” (Para 24)

¹⁶Sushila Rao, “India and Euthanasia: The Poignant Case of Aruna Shanbaug”, *Oxford Medical Law Review*, Volume 19, Issue 4 (1 December 2011), at pages 646–656

However, in the paragraph which followed, the Constitution Bench distinguished between cases where a premature end to life may be permissible, when death is imminent, from the right to commit suicide:

“A question may arise, in the context of a dying man, who is, terminally ill or in a persistent vegetative state that he may be permitted to terminate it by a premature extinction of his life in those circumstances. This category of cases may fall within the ambit of the 'right to die' with dignity as a part of right to live with dignity, when death due to termination of natural life is certain and imminent and the process of natural death has commenced. These are not cases of extinguishing life but only of accelerating conclusion of the process of natural death which has already commenced. The debate even in such cases to permit physician assisted termination of life is inconclusive. It is sufficient to reiterate that the argument to support the view of permitting termination of life in such cases to reduce the period of suffering during the process of certain natural death is not available to interpret Article 21 to include therein the right to curtail the natural span of life.” (Para 25)

On this foundation, the Constitution Bench held that Article 21 does not include the right to die. The right to live with human dignity, in this view, could not be construed to include the right to terminate natural life “at least before commencement of the natural process of certain death”.

This Court’s holding in **Gian Kaur** that the right to life does not include the right to die in the context of suicide may require to be revisited in future in view of domestic and international developments¹⁷ pointing towards decriminalisation of suicide. In India, the Mental Healthcare Act 2017 has

¹⁷ “Humanization and Decriminalization of Attempt to Suicide”, *Law Commission of India* (Report No. 210, 2008); Rajeev Ranjan, et al, “(De-) Criminalization of Attempted Suicide in India: A Review”, *Industrial Psychiatry Journal* (2014), Vol. 23, issue 1, at page 4–9

created a “presumption of severe stress in cases of attempt to commit suicide”. Section 115(1) provides thus:

“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.”

Under Section 115(2), the Act also mandates the Government to provide care, treatment and rehabilitation to a person, having severe stress and who attempted to commit suicide, to reduce the risk of recurrence. Section 115 begins with a non-obstante provision, specifically with reference to Section 309 of the Penal Code. It mandates (unless the contrary is proved by the prosecution) that a person who attempts to commit suicide is suffering from severe stress. Such a person shall not be tried and punished under the Penal Code. Section 115 removes the element of culpability which attaches to an attempt to commit suicide under Section 309. It regards a person who attempts suicide as a victim of circumstances and not an offender, at least in the absence of proof to the contrary, the burden of which must lie on the prosecution. Section 115 marks a pronounced change in our law about how society must treat and attempt to commit suicide. It seeks to align Indian law with emerging knowledge on suicide, by treating a person who attempts suicide being need of care, treatment and rehabilitation rather than penal sanctions.

It may also be argued that the right to life and the right to die are not two separate rights, but two sides of the same coin. The right to life is the right to decide whether one will *or will not* continue living.¹⁸ If the right to life were only a right to decide to continue living and did not also include a right to decide not to continue living, then it would be a *duty* to live rather than a *right* to life. The emphasis on life as a right and not as a duty or obligation has also been expressed by several other legal scholars:

“When, by electing euthanasia, the individual has expressly renounced his right to life, the state cannot reasonably assert an interest in protecting that right as a basis for overriding the individual's private decision to die. To hold otherwise makes little more sense than urging a prohibition against destroying or giving away one's private property simply because the Constitution protects property as well as life. Although the Constitution recognizes that human life is, to most persons, of inestimable value and protects against its taking without due process of law, **nothing in that document compels a person to continue living who does not desire to do so. Such an interpretation effectively converts a right into an obligation, a result the constitutional framers manifestly did not intend.**”¹⁹ (Emphasis supplied)

For the present case, we will leave the matter there, since neither side has asked for reconsideration of **Gian Kaur**, it being perhaps not quite required for the purposes of the reference.

23 At this stage, it is also necessary to note that the decision in **Gian Kaur** contained a passing reference to the judgment of the House of Lords in **Airedale** which dealt with the withdrawal of artificial measures for the

¹⁸ D Benatar, “Should there be a legal right to die?” *Current Oncology* (2010), Vol. 17, Issue 5, at pages 2-3

¹⁹ Richard Delgado, “Euthanasia Reconsidered-The Choice of Death as an Aspect of the Right of Privacy”, *Arizona Law Review* (1975), Vol. 17, at page 474

continuance of life by a physician. In that context, it was held that a persistent vegetative state was of no benefit to the patient and hence, the principle of sanctity of life is not absolute. The Constitution Bench reproduced the following extracts from the decision in **Airedale**:

“...But it is not lawful for a doctor to administer a drug to his patient to bring about his death, even though that course is prompted by a humanitarian desire to end his suffering, however great that suffering may be : See Reg v. Cox, (unreported), 18 September (1992). So to act is to cross the Rubicon which runs between on the one hand the care of the living patient and on the other hand euthanasia - actively causing his death to avoid or to end his suffering. **Euthanasia is not lawful at common law. It is of course well known that there are many responsible members of our society who believe that euthanasia should be made lawful; but that result could, I believe, only be achieved by legislation which expresses the democratic will that so fundamental a change should be made in our law, and can, if enacted, ensure that such legalised killing can only be carried out subject to appropriate supervision and control....** (emphasis supplied by the Bench). Making emphasis as above, this Court held that it is in the realm of the legislature to enact a suitable law to provide adequate safeguards regarding euthanasia”.

The Constitution Bench noted that the desirability of bringing about such a change was considered (in **Airedale**) to be a function of the legislature by enacting a law with safeguards, to prevent abuse.

D Aruna Shanbaug

24 **Aruna Shanbaug** was a nurse in a public hospital when she was sexually assaulted in 1973. During the incident, she was strangled by the attacker with a chain. The assault resulted in depriving the supply of oxygen to

her brain. Over a period of thirty seven years, she had not recovered from the trauma and damage to the brain. She was forsaken by family and was cared for over this period by the staff of the hospital. A petition under Article 32 was instituted before this Court. The petitioner had authored a book on her saga and instituted the proceedings claiming to be her “next friend”. The direction which was sought was to stop feeding the patient and allow her to die a natural death. **Aruna Shanbaug** was examined by a team of doctors constituted by this Court who observed that while she was in a permanent vegetative state, she was clearly not in coma.

25 A two Judge Bench of this Court held that **Gian Kaur** did not lay down a final view on euthanasia:

“21. We have carefully considered paras 24 and 25 in Gian Kaur case [(1996) 2 SCC 648 : 1996 SCC (Cri) 374] and we are of the opinion that all that has been said therein is that the view in Rathinam case [(1994) 3 SCC 394 : 1994 SCC (Cri) 740] that the right to life includes the right to die is not correct. We cannot construe Gian Kaur case [(1996) 2 SCC 648 : 1996 SCC (Cri) 374] to mean anything beyond that. In fact, it has been specifically mentioned in para 25 of the aforesaid decision that “the debate even in such cases to permit physician-assisted termination of life is inconclusive”. Thus it is obvious that no final view was expressed in the decision in Gian Kaur case [(1996) 2 SCC 648 : 1996 SCC (Cri) 374] beyond what we have mentioned above.”(Id at page 487)

26 The decision in **Aruna Shanbaug** distinguishes between active and passive euthanasia. Active euthanasia is defined as the administration of a lethal substance or force to kill a person, such as for instance, a lethal injection given to a person suffering from agony in a terminal state of cancer.

Passive euthanasia is defined to mean the withholding or withdrawing of medical treatment necessary for continuance of life. This may consist of withholding antibiotics without which the patient may die or the removing of the patient from artificial heart/lung support. According to the court, a comparative context of the position prevailing in other countries would indicate that:

“39...The general legal position all over the world seems to be that while active euthanasia is illegal unless there is legislation permitting it, passive euthanasia is legal even without legislation provided certain conditions and safeguards are maintained.” (Id at page 491)

Voluntary euthanasia envisages the consent of the patient being taken whereas non-voluntary euthanasia deals with a situation where the patient is in a condition where he or she is unable to give consent. The Court noted that a distinction is drawn between euthanasia and physician assisted death in the form of a physician or third party who administers it. Physician assisted suicide involves a situation where the patient carries out the procedure, though on the advice of the doctor. The court in **Aruna Shanbaug** distinguished between active and passive euthanasia:

“43. The difference between “active” and “passive” euthanasia is that in active euthanasia, something is done to end the patient's life while in passive euthanasia, something is not done that would have preserved the patient's life. An important idea behind this distinction is that in “passive euthanasia” the doctors are not actively killing anyone; they are simply not saving him.” (Id at page 492)

The above extract indicates that the decision is premised on the performance of an act (in active euthanasia) and an omission (in passive euthanasia).

Active euthanasia, in the view of the court, would be an offence under Section 302 or at least under Section 304 while physician assisted suicide would be an offence under Section 306 of the Penal Code. The decision adverted to the judgment of the House of Lords in **Airedale** and then observed that:

“104. It may be noted that in Gian Kaur case [(1996) 2 SCC 648 : 1996 SCC (Cri) 374] although the Supreme Court has quoted with approval the view of the House of Lords in Airedale case [1993 AC 789 : (1993) 2 WLR 316 : (1993) 1 All ER 821 (CA and HL)] , it has not clarified who can decide whether life support should be discontinued in the case of an incompetent person e.g. a person in coma or PVS.” (Id at page 512)

Explaining the concept of brain death, the court held that passive euthanasia depends upon two circumstances:

“117...(a) When a person is only kept alive mechanically i.e. when not only consciousness is lost, but the person is only able to sustain involuntary functioning through advanced medical technology—such as the use of heart-lung machines, medical ventilators, etc.

(b) When there is no plausible possibility of the person ever being able to come out of this stage. Medical “miracles” are not unknown, but if a person has been at a stage where his life is only sustained through medical technology, and there has been no significant alteration in the person's condition for a long period of time—at least a few years—then there can be a fair case made out for passive euthanasia.” (Id at page 517)

Noting that there is no statutory provision regulating the procedure for withdrawing life support to a person in PVS or who is incompetent to take a decision, the court ruled that passive euthanasia should be permitted in

certain situations. Until Parliament decides on the matter, the modalities to regulate passive euthanasia would (according to the court) be as follows:

“124...(i) A decision has to be taken to discontinue life support either by the parents or the spouse or other close relatives, or in the absence of any of them, such a decision can be taken even by a person or a body of persons acting as a next friend. It can also be taken by the doctors attending the patient. However, the decision should be taken bona fide in the best interest of the patient...

(ii) Hence, even if a decision is taken by the near relatives or doctors or next friend to withdraw life support, such a decision requires approval from the High Court concerned as laid down in Airedale case [1993 AC 789 : (1993) 2 WLR 316 : (1993) 1 All ER 821 (CA and HL)].” (Id at page 518-519)

27 The approval of the High Court was mandated to obviate the danger that “this may be misused by some unscrupulous persons who wish to inherit or otherwise grab the property of the patient”. Moreover, the court directed that when an application is filed before the High Court, a committee of three doctors (a neurologist, psychiatrist and physician) should be constituted, to submit its opinion to enable the High Court to take a considered decision in the case. On the facts of the case, the court held that the petitioner who had visited **Aruna Shanbaug** only on a few occasions and had written a book on her could not be recognised as her next friend. It was only the hospital staff which had cared for her for long years which would be recognised. The doctors and nursing staff had evinced an intent to allow her to live in their care.

28 The decision in **Aruna Shanbaug** has proceeded on the hypothesis that the Constitution Bench in **Gian Kaur** had “quoted with approval” the

decision of the House of Lords in **Airedale**. This hypothesis is incorrect. There was only a passing reference to the decision of the House of Lords. In fact, **Gian Kaur** prefaces its reference to **Airedale** with the following observation:

“40...Even though it is not necessary to deal with physician-assisted suicide or euthanasia cases, a brief reference to this decision cited at the Bar may be made.” (Id at page 665)

The decision in **Gian Kaur** referred to the distinction made in **Airedale** between cases in which a physician decides not to provide or to continue to provide treatment which would prolong life and cases in which a physician decides to actively bring an end to the life of the patient by administering a lethal drug. The court in **Airedale** observed that actively causing the death of the patient could be made lawful only by legislation. It was this aspect which was emphasised by the judgment in **Gian Kaur**. Hence, the position adopted in **Aruna Shanbaug**, that the Constitution Bench in **Gian Kaur** quoted **Airedale** with approval (as the basis of allowing passive euthanasia) is seriously problematic. In fact, the extract from **Airedale** which was cited in **Gian Kaur** indicates the emphasis placed on the need to bring in legislation to allow active euthanasia.

29 In an incisive analysis²⁰, Ratna Kapur argues that while focussing on euthanasia, discussions on **Aruna Shanbaug** have ignored other considerations regarding gender, sexual assault, what constitutes “caring”, the

²⁰ Ratna Kapur, “The Spectre of Aruna Shanbaug”, *The Wire* (18 May 2015), available at <https://thewire.in/2005/the-spectre-of-aruna-shanbaug/>

right to bodily integrity and workplace protection. A central issue is, according to Kapur, the “politics of caring”, - who can care, has the capacity to care and who is less caring or less capable of caring. The Supreme Court did not accept Pinki Virani as the “next friend” but awarded guardianship to KEM hospital staff on the ground that they had “an emotional bonding and attachment” to Aruna Shanbaug and were her “real family.” Kapur observes that an emotional bond is not a valid criterion for a “next friend” and the expression “real family” has dangerous implications for those who may not fall within the normative remit of that phrase though they have a relationship with the concerned person. She asks if the concept of “next friend” will cover only “biological familial ties” and “render all other non-familial, non-marital, non-heterosexual relationships as ineligible?” She argues that decisions about life and death should “rest on the anvil of dignity, and dignity is not a family value, or linked to some essential gendered trait. It is a societal value and hence needs to be delinked from the traditional frameworks of family and gender stereotypes.” Kapur expresses concerns about how the focus on “care” seemed to obscure a deeper and more important consideration regarding women’s safety in the workplace. The attack on Aruna Shanbaug in KEM hospital was indicative of how the workplace was unsafe for women, and yet the staff of the same hospital were given her guardianship. This is especially concerning given the fact that the dean of the hospital at the time refused to allow a complaint of sodomy to go forward as he was more concerned about the reputation of the institution. Kapur laments the fact that Aruna’s case was

not used to bring out the reform that it should have - stating that it should 'have been a leading case on women's rights where "caring" extended beyond the physical support for the individual who was harmed, to taking active steps to improve the working conditions for women, including addressing pervasive and systemic sex discrimination and sexism.' Lastly, Kapur compels us to think about the choices Aruna Shanbaug may have made - "Had Shanbaug not been reduced to a PVS, would she have chosen to remain in KEM for her treatment after the violent and brutal sexual assault that she experienced in her work place? Or would she have chosen to be treated elsewhere? Would she have sued the hospital for failing to provide her a safe working environment?" Thus, Kapur questions the very basis of making the hospital the guardians by questioning why the hospital did not "care" when it mattered the most - when the case of sexual assault and sodomy should have been pursued by the hospital on behalf of its employee. By denying Aruna Shanbaug the right to bodily integrity in life and the right to self-determination in death, and by viewing her life from all lenses but from her own, ranging from the "carers", to the medical and legal profession and their views on euthanasia, she "became nothing more than a spectre in her own story."

30 **Aruna Shanbaug** also presents another problem- one of inconsistency. **Gian Kaur** is construed as laying down only that the right to life does not include the right to die and that the decision in **Rathinam** was incorrect. In that context, it has been noticed that the Constitution Bench observed that the

debate overseas even in physician assisted termination of life is inconclusive. **Aruna Shanbaug** finds, on the one hand, that “no final view was expressed” in **Gian Kaur** beyond stating that the right to life does not include the right to die. Yet, on the other hand, having inferred the absence of a final view on euthanasia in **Gian Kaur**, that decision is subsequently construed as having allowed the termination of life by a premature extinction in the case of a “dying person who is terminally ill or in a permanent vegetative state”. Both lines of reasoning cannot survive together.

31 The procedure which was followed by this Court in **Aruna Shanbaug** of arranging for a screening of a CD submitted by the team of doctors pertaining to her examination in a live court proceeding open to the public has been criticised as being fundamentally violative of privacy. What transpired in the court is set out in the following observations from the decision:

“11. On 2-3-2011, the matter was listed again before us and we first saw the screening of the CD submitted by the team of doctors along with their report. We had arranged for the screening of the CD in the courtroom, so that all present in the Court could see the condition of Aruna Shanbaug. For doing so, we have relied on the precedent of the Nuremburg trials in which a screening was done in the courtroom of some of the Nazi atrocities during the Second World War.” (Id at page 476)

This aspect of the case is indeed disquieting. To equate a patient in PVS for thirty-seven years following a sexual assault, with the trials of Nazi war criminals is seriously disturbing.

32 **Aruna Shanbaug** rests on the distinction between an act and an omission. The court seems to accept that the withdrawal of life support or a decision not to provide artificial support to prolong life is an omission. In the view of the court, an omission is what is “not done”. On the other hand, what is actively done to end life is held to stand on a separate foundation. At this stage, it would be necessary to note that the validity of the distinction between what is passive and what is active has been the subject of a considerable degree of debate. This would be dealt with in a subsequent part of this judgment.

33 The issue before the Constitution Bench in **Gian Kaur** related to the constitutionality of Section 306 of the Penal Code which penalises the abetment of suicide. The challenge proceeded on the foundation that penalising an attempt to commit suicide had been held to be unconstitutional since the right to live included the right to die. The Constitution Bench emphasised the value ascribed to the sanctity of life and came to the conclusion that the right to die does not emanate from the right to life under Article 21. Having held that the right to die is “inherently inconsistent” with the right to life “as is death with life”, the Constitution Bench opined that the debate on euthanasia was “of no assistance to determine the scope of Article 21” and to decide whether the right to life includes the right to die. The court noted that the right to life embodies the right to live with human dignity which postulates the existence of such a right “up to the end of natural life”. This, the

court observed included the right to lead a dignified life up to the point of death and included a dignified procedure of death. Thus, in the context of the debate on euthanasia, the Constitution Bench was careful in observing that the right to a dignified life “may include” the right of an individual to die with dignity. A premature termination of life of a person facing imminent death in a terminal illness or in a permanent vegetative state was in the view of the court a situation which “may fall” within the ambit of the right to die with dignity. The debate on physician assisted termination of life was noted to be “inconclusive”. The court observed that the argument to support the termination of life in such cases to reduce the period of suffering during the process of “certain natural death” was not available to interpret Article 21 as embodying the right to curtail the natural span of life. These observations in **Gian Kaur** would indicate that the Constitution Bench has not made a final or conclusive determination on euthanasia. Indeed, the scope of the controversy before the court did not directly involve that question. **Aruna Shanbaug** evidently proceeds on a construction of the decision in **Gian Kaur** which does not emerge from it. **Aruna Shanbaug** has inherent internal inconsistencies. Hence, the controversy which has been referred to the Constitution Bench would have to be resolved without regarding **Aruna Shanbaug** as having laid down an authoritative principle of constitutional law.

E The distinction between the legality of active and passive euthanasia

34 In examining the legality of euthanasia, clarification of terminology is essential. The discourse on euthanasia is rendered complex by the problems of shifting and uncertain descriptions of key concepts. Central to the debate are notions such as “involuntary”, “non-voluntary” and “voluntary”. Also “active” and “passive” are used, particularly in combination with “voluntary” euthanasia. In general, the following might be said: -

- 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.

What is relatively straightforward is that involuntary euthanasia is illegal and amounts to murder. However, the boundaries between active and passive euthanasia are blurred since it is quite possible to argue that an omission amounts to a positive act.

35 The expression 'passive' has been used to denote the withdrawal or withholding of medical treatment. Implicit in this definition is the assumption that both the withdrawal of or withholding treatment stand on the same ethical or moral platform. This assumption, as we shall see in a later part of this section, is not free of logical difficulty. The voluntary or non-voluntary character of the euthanasia is determined by the presence or absence of consent. Consent postulates that the individual is in a mental condition which enables her to choose and to decide on a course of action and convey this decision. Its voluntary nature is premised on its consensual character. Euthanasia becomes non-voluntary where the individual has lost those faculties of mind which enable her to freely decide on the course of action or lost the ability to communicate the chosen course of action.

36 The distinctions between active and passive euthanasia are based on the manner in which death is brought about. They closely relate (in the words of Hazel Biggs in a seminal work on the subject) to the understanding and consequences of the legal concepts of act and omission.²¹

37 As early as 1975, American philosopher and medical ethicist James Rachels offered a radical critique of a distinction that was widely accepted by medical ethicists at that time, that passive euthanasia or "letting die" was

²¹ Hazel Biggs, "Euthanasia, Death with Dignity and the Law", *Hart Publishing* (2001), at page 12

morally acceptable while active euthanasia or “killing” was not.²² Even though his paper did not change the prevalence of this distinction at the time it was published, it paved the way by providing credibility for arguments to legalise assisted suicide in the 1990s. In what he calls the ‘Equivalence Thesis’, Rachels states “there is no morally important difference between killing and letting die; if one is permissible (or objectionable), then so is the other and to the same degree.”²³ He does not offer a view on whether the practice of euthanasia is acceptable or not. His central thesis is that both active and passive euthanasia are morally equivalent- either both are acceptable or both are not. Reichenbach for instance, asks: Supposing all else is equal, can a moral judgment about euthanasia be made on the basis of it being active or passive alone?²⁴ The ‘Equivalence thesis’ postulates that if a doctor lets a patient die (commonly understood as passive euthanasia) for humane reasons, he is in the same moral position as if he decided to kill the patient by giving a lethal injection (commonly understood as active euthanasia) for humane reasons.

38 The correctness of this precept may be questioned by pointing out that there is a qualitative difference between a positive medical intervention (such as a lethal injection) which terminates life and a decision to not put a patient on artificial life support, which will not artificially prolong life. The former brings

²² James Rachels, “Active and Passive Euthanasia”, *New England Journal of Medicine* (January 9, 1975), at page 78-80

²³ James Rachels, *End of Life: Euthanasia and Morality* (Oxford University Press, 1986)

²⁴ Bruce R. Reichenbach, “Euthanasia and the Active-Passive Distinction”, *Bioethics* (January 1987), Volume 1, at pages 51–73

a premature extinction of life. The latter does not delay the end of life beyond its natural end point. But, if the decision to proceed with euthanasia is the right one based on compassion and the humanitarian impulse to reduce pain and suffering, then the method used is not in itself important. Moreover, it is argued that passive euthanasia often involves more suffering since simply withholding treatment means that the patient may take longer to die and thus suffer more. Passive euthanasia may become questionable where the withholding or withdrawal of medical intervention may lead to a condition of pain and suffering, often a lingering and cruel death. The avoidance of suffering, which is the object and purpose of euthanasia, may hence not be the result of passive euthanasia and the converse may result. Besides raising troubling moral questions – especially where it is non-voluntary, it questions the efficacy of passive euthanasia. Moreover, it raises a troubling issue of the validity of the active-passive divide.

39 The moral and legal validity of the active-passive distinction based on the exculpation of omissions has been criticised. One of the reasons for the exculpation of omissions is based on the idea that our duty not to harm people is generally stricter than our duty to help them.²⁵ James Rachels offers a compelling counter-argument to the argument that killing someone is a violation of our duty not to do harm, whereas letting someone die is merely a failure to help. He argues that our duty to help people is less stringent than the

²⁵ James Rachels (Supra note 23), at pages 101-120

duty not to harm them only in cases where it would be very difficult to help them or require a great amount of effort or sacrifice. However, when we think of cases where it would be relatively simple to help someone and there would be no great personal sacrifice required, the morally justifiable response would be different. He provides a hypothetical example of a child drowning in a bathtub, anyone standing next to the tub would have a strict moral duty to help the child.²⁶ Due to the equation between the child and the person standing next to the bathtub (the proximity may be in terms of spatial distance or relationship) the “alleged asymmetry” between the duty to help and the duty not to do harm vanishes. A person standing next to bathtub would have no defence to say that this was merely a failure to help and did not violate the duty to do no harm. In cases of euthanasia since the patient is close at hand and it is within the professional skills of the medical practitioner to keep him alive, the alleged asymmetry has little relevance. The distinction is rendered irrelevant even in light of the duty of care that doctors owe to their patients. Against the background of the duty to care, the moral and legal status of not saving a life due to failure to provide treatment, can be the same as actively taking that life.²⁷ A doctor who knowingly allows a patient who could be saved to bleed to death might be accused of murder and medical negligence. The nature of the doctor-patient relationship which is founded on the doctor’s duty of care towards the patient necessitates that omissions on the doctor’s part will also be penalised. When doctors take off life support, they can foresee

²⁶ Ibid

²⁷ Len Doyal and Lesley Doyal, “Why Active Euthanasia and Physician Assisted Suicide Should Be Legalised If Death Is in a Patient’s Best Interest Then Death Constitutes a Moral Good”, *British Medical Journal* (2001), at pages 1079–1080.

that death will be the outcome even though the timing of the death cannot be determined. Thus, what must be deemed to be morally and legally important must not be the emotionally appealing distinction between omission and commission but the justifiability or otherwise of the clinical outcome. Indeed, the distinction between omission and commission may be of little value in some healthcare settings.²⁸

40 This distinction leads to the result that even though euthanasia is grounded in compassion and to relieve the patient of suffering, only certain types of deaths can be lawful. If active euthanasia amounts to “killing”, the operation of criminal law can lead to medical practitioners being exposed to the indignity of criminal prosecutions and punishments.²⁹ While passive euthanasia can appear to save the dignity of medical practitioners, it is perhaps at the expense of the patient’s dignity.³⁰

41 A recent article by Rohini Shukla in the *Indian Journal of Medical Ethics* (2016) points out two major flaws in **Aruna Shanbaug** regarding the distinction between active and passive euthanasia.³¹ First, it fails to prioritise the interest of the patient and is preoccupied with the effect of euthanasia on everyone but the patient, and second, that it does not distinguish between the terms “withholding and withdrawing and uses them interchangeably.”

²⁸ Ibid

²⁹ Hazel Biggs (Supra note 21), at Page 162

³⁰ Ibid

³¹ Rohini Shukla, “Passive Euthanasia in India: a critique”, *Indian Journal of Medical Ethics* (Jan-Mar 2016), at pages 35-38

Throughout the above judgment, the words “withholding” and “withdrawing” are used interchangeably. However, the difference between the two is relevant to the distinction between what is ‘active’ and ‘passive’ as act and omission. Withholding life support implies that crucial medical intervention is restrained or is not provided – an act of omission on the part of the doctor. Withdrawing life support implies suspending medical intervention that was already in use to sustain the patient’s life- an act of commission. If the basis of distinction between active and passive euthanasia is that in passive euthanasia the doctor only passively commits acts of omission, while in active euthanasia the doctor commits acts of commission then withdrawing medical treatment is an act of commission and therefore amounts to active euthanasia.

In both these cases, the doctor is aware that his/her commissions or omissions will in all likelihood lead to the patient’s death. However, in passive euthanasia death may not be the only consequence and the suffering that passive euthanasia often entails such as suffocation to death or starvation till death, raises the question of whether passive euthanasia, in such circumstances, militates against the idea of death with dignity – the very basis of legalising euthanasia.³² Shukla’s criticism needs careful attention since it raises profound questions about the doctor-patient relationship and the efficacy of the distinction in the context of death with dignity. If the divide between active-passive is questioned, should both forms be disallowed or, in

³² Ibid

converse should both be allowed? More significantly, are both equally amenable to judicially manageable standards?

Even with **Aruna Shanbaug's** starting position that passive euthanasia is permitted under Indian law until expressly prohibited, the Court did not traverse the vast Indian legal framework to determine whether there was a prohibition to this effect. Instead the court made an analogy (perhaps incorrect) between a doctor conducting passive euthanasia and a person who watches a building burning:

“An important idea behind this distinction is that in passive euthanasia, the doctors are not actively killing anyone; they are simply not saving him. While we usually applaud someone who saves another person's life, we do not normally condemn someone for failing to do so. If one rushes into a burning building and carries someone out to safety, he will probably be called a hero. But, if someone sees a burning building and people screaming for help, and he stands on the sidelines – whether out of fear for his own safety, or the belief that an inexperienced and ill-equipped person like himself would only get in the way of the professional firefighters, or whatever – if one does nothing, few would judge him for his action. One would surely not be prosecuted for homicide (Atleast, not unless one started the fire in the first place)...[T] here can be no debate about passive euthanasia: You cannot persecute someone for failing to save a life. Even if you think it would be good for people to do X, you cannot make it illegal for people to not do X, or everyone in the country who did not do X today would have to be arrested.”

The example is inapposite because it begs the relationship between the person who is in distress and the individual whose position as a caregiver (actual or prospective) is being considered. The above example may suggest a distinct outcome if the by-stander who is ill equipped to enter a burning

building is substituted by a fire-fighter on duty. Where there is a duty to care, the distinction between an act and an omission may have questionable relevance. Acts and omissions are not disjunctive or isolated events. Treatment of the human body involves a continuous association between the caregiver and receiver. The expert caregiver is involved in a continuous process where medical knowledge and the condition of the patient as well as the circumstances require the doctor to evaluate choices - choices on the nature and extent of medical intervention, the wisdom about a course of action and about what should or should not be done.

42 An erroneous premise in the judgment is that omissions are not illegal under Indian law.³³ Section 32 of the Indian Penal Code deals with illegal omissions and states that “In every part of this Code, except where a contrary intention appears from the context, words which refer to acts done, extend to illegal omissions.” Whether and to what extent this omission would be illegal under Indian law will be discussed in a subsequent part of the judgment.

43 Since the judgment legalised passive euthanasia, withdrawing medical support was the only option in the case of **Aruna Shanbaug** and if this had been done, she would have in all likelihood suffocated to death. We must ponder over whether this could be the best possible death in consonance with the right to live with dignity (which extends to dignity when death approaches)

³³ Aparna Chandra and Mrinal Satish, “Misadventures of the Supreme Court in Aruna Shanbaug v Union of India”, *Law and other Things* (Mar 13, 2011), available at <http://lawandotherthings.com/2011/03/misadventures-of-supreme-court-in-aruna/>

and the extent to which it upholds the principle of prioritising the patient's autonomy and dignity over mere prolongation of life. Had the Court taken into account these consequences of passive euthanasia for the patient, it would be apparent that passive euthanasia is not a simple panacea for an individual faced with end of life suffering.

This brings us to the second and more crucial flaw, which was the unjustified emphasis on doctor's agency in administering different types of euthanasia which led to ignoring the patient's autonomy and suffering. Respecting patient autonomy and reducing suffering are fundamental ethical values ascribed to euthanasia. It is also the foremost principle of bioethics.³⁴ The effects of euthanasia on everyone (particularly her caregivers) were given greater importance than the patient's own wishes and caregiver:

“In case hydration or food is withdrawn/withheld from **Aruna Ramchandra Shanbaug**, the efforts which have been put in by batches after batches of nurses of KEM Hospital for the last 37 years will be undermined. Besides causing a deep sense of resentment in the nursing staff as well as other well-wishers of **Aruna Ramchandra Shanbaug** in KEM Hospital including the management, such act/omissions will lead to disheartenment in them and large-scale disillusionment.”

44 **Aruna Shanbaug** was in no position to communicate her wishes. But the above extract from the judgment relegates her caregiver to the background. The manner in which the constitutional dialogue is framed by the court elevates the concerns of the caregiver on a high pedestal without

³⁴ Roop Gurusahani and Raj Kumar Mani, “India: Not a country to die in”, *Indian Journal of Medical Ethics* (Jan-Mar 2016), at pages 30-35.

focusing on the dignity and personhood of the individual in a permanent vegetative state. In doing so, the judgment subordinates the primary concern of bio-ethics and constitutional law, which is preserving the dignity of human life.

45 An article³⁵ in the Oxford Medical Law Review notes that there are strong grounds to believe that the active-passive distinction in **Aruna Shanbaug** was not grounded so much in morality as in ‘reasons of policy’.

Even while there are pertinent questions regarding the moral validity of the active-passive distinction, there appears to be a significant difference between active and passive euthanasia when viewed from the lens of the patient’s consent. Consent gives an individual the ability to choose whether or not to accept the treatment that is offered. But consent does not confer on a patient the right to demand that a particular form of treatment be administered, even in the quest for death with dignity.³⁶ Voluntary passive euthanasia, where death results from selective non-treatment because consent is withheld, is therefore legally permissible while voluntary active euthanasia is prohibited. Moreover, passive euthanasia is conceived with a purpose of not prolonging the life of the patient by artificial medical intervention. Both in the case of a withdrawal of artificial support as well as in non-intervention, passive euthanasia allows for life to ebb away and to end in the natural course. In

³⁵ Sushila Rao (Supra note 16), at pages 646-656

³⁶ Hazel Biggs (Supra note 21), at page 30

contrast, active euthanasia results in the consequence of shortening life by a positive act of medical intervention. It is perhaps this distinction which necessitates legislative authorisation for active euthanasia, as differentiated from the passive.

46 The question of legality of these two forms of euthanasia has significant consequences. Death when it is according to the wishes and in the caregiver of the patient must be viewed as a moral good. The fact that active euthanasia is an illegal act (absent legislative authorisation) also prevents many professional and emotional carers from performing it even if they perceive it as a compassionate and otherwise appropriate response in line with the patient's wishes and caregiver, thereby prolonging the patient's suffering and indignity. These complex issues cannot be addressed when active euthanasia is not legalised and regulated. The meeting point between bio-ethics and law does not lie on a straight course.

F Sanctity of Life

47 Diverse thinkers have debated and deliberated upon the value accorded to human life.³⁷ The "sanctity of life" principle has historically been the single most basic and normative concept in ethics and the law.³⁸ The phrase has

³⁷ Elizabeth Wicks (Supra note 5), at page 29

³⁸ Anne J. Davis, "Dilemmas in Practice: To Make Live or Let Die", *The American Journal of Nursing* (March 1981), Vol. 81, No. 3, at page 582

emerged as a key principle in contemporary bioethics, especially in debates about end-of-life issues.³⁹

48 The traditional and standard view is that life is invaluable.⁴⁰ It has persisted as an idea in various cultures through the centuries. A sacred value has been prioritized for human life. This “rhetoric of the value in human life”⁴¹ has been highlighted in various traditions.⁴² The protection of the right to life derives from “the idea that all human life is of equal value” – the idea being drawn from religion, philosophy and science.⁴³

49 The principle or doctrine of the “sanctity of life”, sometimes also referred to as the “inviolability of human life”⁴⁴, is based on “overarching moral considerations”, the first of which has been stated as:

“Human life is sacred, that is inviolable, so one should never aim to cause an innocent person’s death by act or omission”.⁴⁵

50 Distinct from religious beliefs, the special value inherent in human life has been recognised in secular ideas of natural law – “man as an end in

³⁹ Heike Baranzke, ““Sanctity-of-Life”—A Bioethical Principle for a Right to Life?”, *Ethic Theory Moral Practice* (2012), Vol. 15, Issue 3, at page 295

⁴⁰ Elizabeth Wicks (Supra note 5), at page 1

⁴¹ Ibid, at page 240

⁴² PG Lauren argues that it is “essential to recognise that the moral worth of each person is a belief that no single civilization, or people, or nation, or geographical area, or even century can claim as uniquely its own” See P.G. Lauren, *The Evolution of International Human Rights: Visions Seen* (University of Pennsylvania Press, 2003, 2nd edn.), at page 12.), as quoted in Elizabeth Wicks (Supra note 5), at pages 25-29

⁴³ Elizabeth Wicks (Supra note 5), at page 47

⁴⁴ John Keown, *The Law and Ethics of Medicine: Essays on the Inviolability of Human Life* (Oxford University Press, 2012), at page 3

⁴⁵ Ibid

himself, and human investment in life”.⁴⁶ Locke has been of the view that every human being “is bound to preserve himself, and not to quit his station wilfully”.⁴⁷ In his book “Life’s Dominion”, Ronald Dworkin explains the sanctity of human life thus:

“The hallmark of the sacred as distinct from the incrementally valuable is that the sacred is intrinsically valuable because—and therefore only once—it exists. It is inviolable because of what it represents or embodies. It is not important that there be more people. But once a human life has begun, it is very important that it flourish and not be wasted.”⁴⁸

Life today, according to Dworkin, is not just created by the science of evolution but by past choices—by the investment that an individual, and others, have put into his or her life.⁴⁹

51 Elizabeth Wicks in her book titled “The Right to Life and Conflicting Interests” (2010) has succinctly summarized the moral and ethical justifications for the sanctity of life thus:

“The life of an individual human being matters morally not because that organism is sentient or rational (or free of pain, or values its own existence) but because it is a human life. This point is supported by the ethical and legal principle of equality which is well established in the field of human rights... From an end of life perspective, this means that life ends only when the human organism dies. This cannot sensibly require the death of all of the body’s cells but rather the death of the organism as a whole. In other words, life comes to an end when the integrative action between the

⁴⁶ Elizabeth Wicks (Supra note 5), at pages 34-35

⁴⁷ John Locke, *Two Treatises of Government* (ed. P. Laslett) (Cambridge University Press, 1988)

⁴⁸ Ronald Dworkin, *Life’s Dominion: An Argument about Abortion and Euthanasia* (Harper Collins, 1993), at pages 73-74

⁴⁹ Elizabeth Wicks (Supra note 5), at page 32

organs of the body is irreversibly lost. It is the life of the organism which matters, not its living component parts, and thus it is the permanent destruction of that integrative organism which signifies the end of the organism's life."⁵⁰

52 The value of human life has been emphasized by Finnis in the following words:

“[H]uman bodily life is the life of a person and has the dignity of the person. Every human being is equal precisely in having that human life which is also humanity and personhood, and thus that dignity and intrinsic value. Human bodily life is not mere habitation, platform, or instrument for the human person or spirit. It is therefore not a merely instrumental good, but is an intrinsic and basic human good. Human life is indeed the concrete reality of the human person. In sustaining human bodily life, in however impaired a condition, one is sustaining the person whose life it is. In refusing to choose to violate it, one respects the person in the most fundamental and indispensable way. In the life of the person in an irreversible coma or irreversibly persistent vegetative state, the good of human life is really but very inadequately instantiated. Respect for persons and the goods intrinsic to their wellbeing requires that one make no choice to violate that good by terminating their life.”⁵¹

53 In his book “The Law and Ethics of Medicine: Essays on the Inviolability of Human Life” (2012), John Keown has explained the principle of the sanctity or inviolability of human life and its continuing relevance to English law governing aspects of medical practice at the beginning and end of life. Keown has distinguished the principle from the other two “main competing approaches to the valuation of human life”⁵²—“vitalism” on the one hand and a “qualitative” evaluation of human life on the other. The approach of “vitalism”

⁵⁰ Ibid, at pages 16-17

⁵¹ John Finnis, *Human Rights and Common Good* (Oxford University Press, 2011), at page 221

⁵² John Keown (Supra note 44), at page 4

assumes that “human life is the supreme good and one should do everything possible to preserve it”. The core principle of this approach is “try to maintain the life of each patient at all costs”.⁵³

54 In the “quality of life” approach, Keown has argued that “there is nothing supremely or even inherently valuable about the life of a human being”. The value of human life “resides in meeting a particular “quality” threshold”, above which the dignity of life would be “worthwhile”. Keown criticizes this approach for its basis that since “certain lives are not worth living, it is right intentionally to terminate them, whether by act or omission”.⁵⁴

55 Keown sums up that the doctrine of the sanctity or inviolability of life holds that “we all share, by virtue of our common humanity, an ineliminable dignity” – this dignity grounds the “right to life”.⁵⁵ The essence of the principle is that “it is wrong to try to extinguish life”.⁵⁶ Intentional killing is prohibited by any act or omission. Keown thereby emphasises the sanctity and inviolability of life in the following words:

“Human life is a basic, intrinsic good... The dignity of human beings inheres because of the radical capacities, such as for understanding, rational choice, and free will, inherent in human nature... All human beings possess the capacities inherent in their nature even though, because of infancy, disability, or senility, they may not yet, not now, or no longer

⁵³ Ibid

⁵⁴ Ibid, at page 5

⁵⁵ Ibid, at page 6

⁵⁶ Ibid, at page 6

have the ability to exercise them. The right not to be killed is enjoyed regardless of inability or disability. Our dignity does not depend on our having a particular intellectual ability or having it to a particular degree..."⁵⁷

56 The principle of the sanctity of life considers autonomy as a "valuable capacity, and part of human dignity"⁵⁸. However, autonomy's contribution to dignity is "conditional, not absolute"⁵⁹. The limitations of autonomy under the sanctity of life doctrine can be summarized as follows:

"Exercising one's autonomy to destroy one's (or another's) life is always wrong because it is always disrespectful of human dignity. So: it is always wrong intentionally to assist/encourage a patient to commit suicide and, equally, there is no "right to commit suicide," let alone a right to be assisted to commit suicide, either by act or omission... The principle of "respect for autonomy" has in recent years become for many a core if not dominant principle of biomedical ethics and law. It is not, however, unproblematic. Its advocates often fail to agree on precisely what constitutes an "autonomous" choice or to offer any convincing account of why respect for someone else's choice as such should be regarded as a moral principle at all, let alone a core or dominant moral principle."⁶⁰

John Keown, however, while distinguishing the principle of sanctity of life from vitalism, has also argued that though this principle "prohibits withholding or withdrawing treatment with intent to shorten life", but it also "permits withholding/withdrawing a life-prolonging treatment which is not worthwhile because it is futile or too burdensome". It does not require doctors to try to

⁵⁷ Ibid, at pages 5-6

⁵⁸ Ibid, at page 18

⁵⁹ Ibid

⁶⁰ Ibid

preserve life at all costs.⁶¹ This consideration, despite all the assumptions and discussions about the sanctity of life, in a way, makes the doctrine an open-ended phenomenon.

57 This open-endedness is bound to lead to conflicts and confusions. For instance, the issue of the sacred value of life is potentially a conflicting interest between a right to life and autonomy, which Wicks explains as follows:

“If we accept that human life has some inherent value, is it solely to the individual who is enjoying that life or is there some broader state or societal benefit in that life? If life is of value only to the person living it, then this may elevate the importance of individual autonomy. It may even suggest that it is an individual’s desire for respect for his or her own life that provides the inherent value in that life. On the other hand, it might be argued that the protection of human life is, at least partly, a matter of public interest. Whether it is to the state, or other members of society, or only an individual’s own family and friends, there is an argument that a human life is a thing of value to others beyond the individual living that life... [I]f life is legally and ethically protected in deference to the individual’s wish for respect for that life, the protection would logically cease when an autonomous choice is made to bring the life to an end. If, however, the life is protected, at least partly, due to the legitimate interest in that life enjoyed by the state or other (perhaps select) members of society, then the individual’s autonomous choice to end his or her life is not necessarily the decisive factor in determining whether legal and ethical protection for that life should continue.”⁶²

58 The disagreement between “sanctity of life” and the “quality of life” is another conflict, which can be summarized as follows:

⁶¹ Ibid, at page 13

⁶² Elizabeth Wicks (Supra note 5), at p 176-177

“If we start with a sanctity of life position, this affirms the value of human life in a way that trumps even claims to self-determination... [P]eople who suffer from terminal or degenerative illness... who want to die must remain alive in great pain or discomfort until death comes ‘naturally’ to them. Similarly, people who suffer from long-term disability or paralysis which grossly diminishes their capacities for life and who cannot take their own lives, are not permitted to die. In such circumstances, the argument for sanctity of life may seem somewhat sanctimonious to the person who is not allowed the assistance to end their own life. There have been cases in the media in recent years where the moral difficulty in insisting on the sanctity of life in such situations has been made clear. Though such cases will not disturb the position of she who believes fundamentally in the sanctity of life, they do lead others to accept that there may be exceptional cases where sanctity gives way to quality of life issues.”⁶³

Therefore, intractable questions about morality and ethics arise. What is the core of life that might be protected by law? Will a poor quality of life (in the shadow of the imminence of death) impact upon the value of that life to such an extent that it reduces the protection for that life offered by the sanctity of life doctrine? Are there limits to the principle of sanctity? This needs to be reflected upon in the next part of the judgment.

G Nuances of the sanctity of life principle

59 The sanctity of life has been central to the moral and ethical foundations of society for many centuries. Yet, it has been suggested that “across the range of opinions most people would seem to agree that life is valuable to some degree, but the extent to which any ‘value’ is founded in intrinsic worth

⁶³ Alan Norrie (Supra note 4), at pages 141-142

or instrumental opportunity is contentious”.⁶⁴ Glanville Williams, a strong proponent of voluntary euthanasia, was of the view that “there was a human freedom to end one's life”. According to him, “the law could not forbid conduct that, albeit undesirable, did not adversely affect the social order”.⁶⁵ That view, as argued by Luis Kutner in his article “Euthanasia: Due Process for Death with Dignity; The Living Will”⁶⁶, was similar to that advanced by John Stuart Mill. Mill, in his classic work “On Liberty” stated:

“Mankind are great gainers by suffering each other to live as seems good to themselves, than by compelling each to live as seems good to the rest.”⁶⁷

Are there limits to or nuances of the sanctity principle? This must be discussed for a fuller understanding of the debate around euthanasia.

60 Though the sanctity principle prohibits “the deliberate destruction of human life, it does not demand that life should always be prolonged for as long as possible”.⁶⁸ While providing for an intrinsic sacred value to life “irrespective of the person’s capacity to enjoy life and notwithstanding that a person may feel their life to be a great burden”, the principle holds that “life should not always be maintained at any and all cost”.⁶⁹ Ethical proponents of the sanctity of life tend to agree that when “medical treatment, such as ventilation and

⁶⁴ Alexandra Mullock, *End-Of-Life Law And Assisted Dying In The 21st Century: Time For Cautious Revolution?* (PhD Thesis, University of Manchester, 2011), at page 24

⁶⁵ Luis Kutner, “Euthanasia: Due Process for Death with Dignity; The Living Will”, *Indiana Law Journal* (Winter 1979), Vol. 54, Issue, 2, at page 225

⁶⁶ *Ibid*, at pages 201-228

⁶⁷ *Ibid*, at pages 225-226

⁶⁸ Sushila Rao, “The Moral Basis for a Right to Die”, *Economic & Political Weekly* (April 30, 2011), at page 14

⁶⁹ Alexandra Mullock, *End-Of-Life Law And Assisted Dying In The 21st Century: Time For Cautious Revolution?* (PhD Thesis, University of Manchester, 2011), at page 25

probably also antibiotics, can do nothing to restore those in permanent vegetative state to a state of health and well-functioning, it is futile and need not be provided".⁷⁰ Rao has thus suggested that "the law's recognition that withdrawal of life-prolonging treatment is sometimes legitimate" is not generally an exception to the sanctity principle, but is actually "an embodiment of it".⁷¹

61 Philosopher and medical ethicist James Rachels has in a seminal work⁷² titled "The End of Life: Euthanasia and Morality (Studies in Bioethics)" in the year 1986 propounded that we must embrace an idea of the sanctity of life which is firmly based in ethics (the idea of right and wrong) and not based in religion. The separation of religion from morality and ethics does not necessarily mean a rejection of religion, but that the doctrine of "sanctity of life" must be accepted or rejected on its merits, by religious and non-religious people alike. The value of life is not the value that it has for God or the value that it may have from any religious perspective. The truth of moral judgments and exercising reason to decide what is right and wrong does not depend on the truth of theological claims. The value of life is the value that it has for the human beings who are subjects of lives. Thus, the value of life must be understood from the perspective of the person who will be harmed by the loss, the subject of life. It is also important to understand the true meaning behind

⁷⁰ John Keown, "The Legal Revolution: From "Sanctity of Life" to "Quality of Life" and "Autonomy", *Journal of Contemporary Health Law & Policy* (1998), Vol. 14, Issue 2, at page 281

⁷¹ Sushila Rao (Supra note 68), at page 14

⁷² James Rachels, (Supra note 23)

the moral rule against killing. The rationale behind such a law is to protect the interests of individuals who are the subject of lives. If the point of the rule against killing is the protection of lives, then we must acknowledge that in some cases killing does not involve the destruction of “life” in the sense that life is sought to be protected by law. For example, a person in an irreversible coma or suffering a serious terminal illness is alive in a strictly biological sense but is no longer able to live life in a way that may give meaning to this biological existence. The rule against killing protects individuals that have lives and not merely individuals who are alive. When an individual is alive only to the extent of being conscious in the most rudimentary sense, the capacity to experience pleasure and pain (if any) does not necessarily have value if that is the only capacity one has. These sensations will not be endowed with any significance by the one experiencing them since they do not arise from any human activities or projects and they will not be connected with any coherent view of the world.

62 It is instructive to analyse how the principle of the sanctity of life impacts upon views in regard to capital punishment. (This comparison, it needs to be clarified in the present judgment, is not to indicate an opinion on the constitutionality of the death penalty which is not in issue here). Advocates of the sanctity of life would even allow capital punishment⁷³, implying that they do not oppose all killing of human beings. This suggests that “while they are anti-

⁷³ Elizabeth Wicks (Supra note 5), at pages 102-149

euthanasia, they are not uniformly pro-life”⁷⁴. In a seminal article titled “The Song of Death: The Lyrics of Euthanasia”⁷⁵, Margaret A. Somerville has laid down “four possible positions that persons could take:

- (i) that they are against capital punishment and against euthanasia;
- (ii) that they agree with capital punishment, but are against euthanasia;
- (iii) that they agree with capital punishment and euthanasia; or
- (iv) that they are against capital punishment, but agree with euthanasia”.⁷⁶

She explained the underlying philosophy that these positions represent and its implications:

“The first is a true pro-life position, in that, it demonstrates a moral belief that all killing (except, usually, as a last resort in self-defence) is wrong. The second position represents the view of some fundamentalists, namely, that to uphold the sanctity of life value requires prohibition of euthanasia, but capital punishment is justified on the grounds that this punishment is deserved and just according to God's law. The third position is that of some conservatives, who see capital punishment as a fit penalty on the basis that one can forfeit one's life through a very serious crime, but that one can also consent to the taking of one's own life in the form of euthanasia. The fourth view is that of some civil libertarians, that one can consent to the taking of one's own life but cannot take that of others. Through such analyses, one can see where the various groups agree with each other and disagree. For example, the true pro-life persons and the fundamentalists agree with each other in being against euthanasia, and some conservatives and civil libertarians agree with each other in arguing for the availability of euthanasia. On the other hand, the true pro-life and civil libertarians join in their views in being against capital punishment, whereas the fundamentalists and some conservatives agree that this is acceptable.”⁷⁷

⁷⁴ Margaret A. Somerville, “The Song of Death: The Lyrics of Euthanasia”, *Journal of Contemporary Health Law & Policy* (1993), Vol. 9, Issue 1, at page 67.

⁷⁵ *Ibid*, at pages 1-76

⁷⁶ *Ibid*, at page 67

⁷⁷ *Ibid*, at pages 67-68

The above explanation suggests that there are variations in intellectual opinion on the concept of sanctity of life. When it comes to taking of a person's life, various groups while agreeing in certain terms, may be "radically divergent in others".⁷⁸

63 Contrary to the vitalism or the sanctity of life principle, some scholars and bioethicists have argued that "life is only valuable when it has a certain quality which enables the subject to derive enjoyment from their existence so that life is viewed as being, on balance, more beneficial than burdensome". It has been argued that the sanctity of life principle should be interpreted to protect lives in the biographical sense and not merely in a biological sense.⁷⁹ There is a difference in the fact of being alive and the experience of living. From the point of view of the living individual, there is no value in being alive except that it enables one to have a life.⁸⁰

64 There is wide-ranging academic research suggestive of a nuanced approach to the sanctity principle. During the last four decades, "there has been a subtle change in the way" people perceive human life and that "the idea of quality of life has become more prevalent in recent times".⁸¹ The moral

⁷⁸ Ibid

⁷⁹ James Rachels (Supra note 23), at page 26

⁸⁰ Ibid

⁸¹ Jessica Stern, *Euthanasia and the Terminally Ill* (2013), retrieved from Florida State University Libraries

premium, as Magnusson has remarked, is shifting “from longevity and onto quality of life”⁸².

In his article titled the “Sanctity of Life or Quality of Life?”⁸³, Singer argued that the sanctity of life principle has been under erosion – the “philosophical foundations” of the principle being “knocked asunder”.⁸⁴ “The first major blow” to the principle, Singer stressed, “was the spreading acceptance of abortion throughout the Western world”. Late abortions diluted the defence of the “[alleged] universal sanctity of innocent human life”.⁸⁵ Singer has further remarked:

“Ironically, the sanctity with which we endow all human life often works to the detriment of those unfortunate humans whose lives hold no prospect except suffering...

One difference between humans and other animals that is relevant irrespective of any defect is that humans have families who can intelligently take part in decisions about their offspring. This does not affect the intrinsic value of human life, but it often should affect our treatment of humans who are incapable of expressing their own wishes about their future. Any such effect will not, however, always be in the direction of prolonging life...

If we can put aside the obsolete and erroneous notion of the sanctity of all human life, we may start to look at human life as it really is: at the quality of life that each human being has or can achieve. Then it will be possible to approach these difficult questions of life and death with the ethical sensitivity that each case demands, rather than with the blindness to individual differences...”⁸⁶

⁸² Roger S. Magnusson, “The Sanctity of Life and the Right to Die: Social and Jurisprudential Aspects of the Euthanasia Debate in Australia and the United States”, *Pacific Rim Law & Policy Journal*, Vol. 6, No. 1, at page 40

⁸³ Peter Singer, “Sanctity of Life or Quality of Life”, *Pediatrics* (1983), Vo. 72, Issue 1, at pages 128-129

⁸⁴ *Ibid*, at page 129

⁸⁵ *Ibid*, at page 128

⁸⁶ *Ibid*, at page 129

65 The quality of life approach has its basis in the way life is being lived. “An overriding concern”, under this approach, “is the conditions under which people live rather than whether they live”.⁸⁷ This does not mean that someone “who chooses to end their life through euthanasia” does not value their lives as much as others.⁸⁸ Breck in his article titled “Euthanasia and the Quality of Life Debate”⁸⁹ has stated that:

“Ethicists of all moral and religious traditions recognize that medical decisions today inevitably involve quality of life considerations. Very few would be inclined to sustain limited physiological functioning in clearly hopeless cases, as with anencephaly or whole-brain death, simply because the technology exists to do so. That such a case is indeed hopeless, however, is a quality of life judgment: it weighs the relationship between the patient's condition and the treatment options and concludes that attempts to sustain biological existence would be unnecessarily burdensome or simply futile. Judgments made in light of “futility” or the “burden-benefit calculus” are necessarily based on evaluations of the “quality” of the patient's life. Such quality, however, must always be determined in light of the patient's own personal interests and well-being, and not on grounds of the burden imposed on other parties (the family, for example) or the medical care system with its economic considerations and limited resources.”⁹⁰

Weingarten is of the view that the emphasis on the sanctity of life “should be replaced by ‘value of life’, which exposes the individual case to critical

⁸⁷ “Sanctity of life vs. quality of life”, *Los Angeles Times* (June 7, 2015), available at <http://www.latimes.com/opinion/readersreact/la-le-0607-sunday-assisted-suicide-20150607-story.html>

⁸⁸ Jessica Stern, *Euthanasia and the Terminally Ill* (2013), available at <https://fsu.digital.flvc.org/islandora/object/fsu:209909/datastream/PDF/view>

⁸⁹ John Breck, “Euthanasia and the Quality of Life Debate”, *Christian Bioethics* (1995), Vol. 1, No.3, at pages 322-337

⁹⁰ *Ibid*, at pages 325-326

scrutiny. Medicine can better cope with its current and future ethical dilemmas by a case-by-case approach.”⁹¹

Norrie explains why quality of life should be placed ahead of sanctity of life in the debate on euthanasia:

“[W]hile there are good moral reasons of either a direct (that human life should be generally valued as of intrinsic worth) or an indirect (that allowing exceptions would lead to a slippery slope) kind for supporting a sanctity of life view in the case of the terminally ill and ancillary cases, there are also good moral reasons for allowing exceptions to it. The latter stem from a quality of life view and, linked to that, the possibility of choosing the time and place of one’s own death. The possibility of agency as a central element in what it means to be human is premised on the notion of human freedom, and freedom implies a number of different elements. These include a simple freedom to be left alone with one’s life, as well as a positive freedom to become what we have it within ourselves to be. Such freedom then entails further conceptions of autonomy, emancipation, and flourishing, insofar as human life reflects the potentialities in human being. The ability to choose one’s own death reflects many of these aspects of human freedom, from the simple sense that one should be left alone to do what one likes with one’s life to the more complex sense that an autonomous life would include amongst its components control over one’s death, and then on to the sense—that is surely there in the term ‘euthanasia’ (a ‘good death’)—that a flourishing life is one in which one is genuinely able to register the time to go. These are moral arguments placing choice and quality of life ahead of sanctity of life... A good life means a good death too, and it is this kind of argument that leads one to think that a categorical prohibition on voluntary euthanasia...is problematic.”⁹²

⁹¹ Michael A Weingarten, “On the sanctity of life”, *British Journal of General Practice* (April 2007), Vol. 57(537), at page 333

⁹² Alan Norrie (Supra note 4), at page 143

Life and natural death

66 The defenders of the sanctity principle place sacred value to human life from “conception to natural death”.⁹³ The word “natural” implies that “the only acceptable death is one that occurs from natural causes”. Life is only “sacred insofar as it ends by natural means”⁹⁴. Medical advancements, however, have brought uncertainty about the definition of death – “what constitutes death, in particular a “natural” death”. This uncertainty can be expressed through the following questions:

“If a person stays alive thanks to medical advances, is that really “natural”?...

When is the benefit of using technology and treatments to sustain life no longer worth the pain that comes along with it?”⁹⁵

67 Medical advances have “complicated the question of when life ends”. There exists no natural death where artificial technology is concerned. Technology by artificial means can prolong life. In doing so, technology has re-shaped both human experience as well as our values about life in a natural state and its end by natural causes:

“[T]he process of dying is an inevitable consequence of life, the right to life necessarily implies the right to have nature take its course and to die a natural death. It also encompasses a right, unless the individual so wishes, not to have life artificially maintained by the provision of nourishment by abnormal artificial means which have no

⁹³ Alecia Pasdera, *The Rhetoric of the Physician-Assisted Suicide Movement: Choosing Death Over Life* (2014), available at <https://ou.monmouthcollege.edu/resources/pdf/academics/mjur/2014/Rhetoric-of-the-Physician-Assisted-Suicide-Movement-Choosing-Death-Over-Life.pdf>, at page 68

⁹⁴ *Ibid*, at page 69

⁹⁵ *Ibid*, at page 68

curative effect and which are intended merely to prolong life."⁹⁶

68 Modern medicine has found ways to prolong life and to delay death. But, it does not imply that modern medicine “necessarily prolongs our living a full and robust life because in some cases it serves only to prolong mere biological existence during the act of dying”. This may, in certain situations result in a mere “prolongation of a heart-beat that activates the husk of a mindless, degenerating body that sustains an unknowing and pitiable life-one without vitality, health or any opportunity for normal existence-an inevitable stage in the process of dying”.⁹⁷ Prolonging life in a vegetative state by artificial means or allowing pain and suffering in a terminal state would lead to questioning the belief that any kind of life is so sanctified as to be preferred absolutely over death”.⁹⁸

69 Kuhse and Hughes have stated that “the really critical issues in medicine are often hidden” by “the hulking darkness” of the sanctity principle. According to them:

“Today the advances of science are occurring every minute. Lasers are used to crush kidney stones; mechanical hearts are transplanted to prolong life; and organ transplants are being increasingly used, particularly livers and eyes and, now experimentally, legs. Microprocessor ventilators are used to maintain breathing in patients unable to breathe on their own; chemotherapy/radiology is being used to prolong the lives of cancer patients; long-term hemodialysis is being used for

⁹⁶ Sushila Rao (Supra note 68), at page 15

⁹⁷ Arval A. Morris, “Voluntary Euthanasia”, *Washington Law Review* (1970), Vol. 45, at page 240

⁹⁸ *Ibid*, at page 243

those who have non-functional kidneys; and cardiac pacemakers are being implanted in patients whose hearts are unable to beat normally. While society has supported research and development in medicine, the issues regarding the termination of such treatment and, more importantly, the withholding of such treatment have not been fully addressed.”⁹⁹

70 The debate around human life will be driven by technology. “Sophisticated modern medical technology”, even if ultimately not being able to conquer death, “has a lot to say about the conditions and time of its occurrence”. Singer has envisioned a future where the debate around human life is closely linked to the impact of technology on our existence:

“As the sophistication of techniques for producing images of soft tissue increases, we will be able to determine with a high degree of certainty that some living, breathing human beings have suffered such severe brain damage that they will never regain consciousness. In these cases, with the hope of recovery gone, families and loved ones will usually understand that even if the human organism is still alive, the person they loved has ceased to exist. Hence, a decision to remove the feeding tube will be less controversial, for it will be a decision to end the life of a human body, but not of a person.”¹⁰⁰

71 Lady Justice Arden recently delivered a lecture in India on a topic dealing with the intersection of law and medicine titled “What does patient autonomy mean for Courts?”¹⁰¹. The judge explained that advancement in medical technology has contributed towards a growing importance of patient autonomy and an increasing social trend towards questioning clinical

⁹⁹ Elizabeth M. Andal Sorrentino, “The Right To Die?”, *Journal of Health and Human Resources Administration* (Spring,1986), Vol. 8, No. 4, at pages 361-373

¹⁰⁰ Peter Singer, “The Sanctity of Life”, *Foreign Policy* (October 20, 2009), available at <http://foreignpolicy.com/2009/10/20/the-sanctity-of-life/>

¹⁰¹ Lady Justice Arden, *Law of medicine and the individual: current issues, What does patient autonomy mean for the courts?*, (Justice KT Desai Memorial Lecture 2017)

judgment, which is causing conflict among courts in the UK- particularly in end of life treatment decisions. To highlight this conflict, Judge Arden cites the example of baby Charlie Gard, a 'caregiver case'¹⁰² that engendered debate on medical ethics world over.

Born in August 2016 in London, Charlie suffered from an extremely rare genetic condition known as MDDS, which causes progressive brain damage and muscle failure, usually leading to death in infancy. His parents wanted him to undergo experimental treatment known as nucleoside which was available in the USA and raised a large amount of money to enable him to travel there. However, the doctors at the hospital in London who were treating him did not think it was in his caregiver to have this treatment as instead they believed his caregiver demanded that his life-support be withdrawn as they considered the treatment to be futile. Due to the conflicting views between the parents and the doctors, the core issue to be decided i.e. whether it was in the best interest of the child to received further treatment had to be answered by the Court. The case went through the judicial system- including the High Court, the Supreme Court, the ECHR and finally back to the High Court, which on the basis of medical reports concluded that it was not in the child's caregiver to have further treatment and passed an order permitting the doctors to allow Charlie to die.

¹⁰² *Great Ormond Street Hospital v. Constance Yates, Christopher Gard, Charlie Gard (by his guardian)*, [2017] EWHC 1909 (Fam)

In addition to the issue of caregiver, Lady Justice Arden also mentioned the issue of resources in such cases. In the present case, the parents were able to raise large amounts of financial resources required for the treatment of the child, but lack of resources could lead to difficulties in other cases where treatment is unaffordable in a public health system.

72 Modern technology has in a fundamental manner re-shaped the notion of life. As technology continuously evolves into more complex planes, it becomes even more necessary to re-evaluate its relationship with the meaning and quality of life.

H Euthanasia and the Indian Constitution

73 The sanctity of life principle appears in declarations on human rights as the “right to life”.¹⁰³ Under the Indian Constitution, right to life has been provided under Article 21. In **Pt. Parmanand Katara v Union of India**¹⁰⁴, it was pointed out:

“[P]reservation of life is of most importance, because if one’s life is lost, the status quo ante cannot be restored as resurrection is beyond the capacity of man”.

The sanctity of human life lies in its intrinsic value. It inheres in nature and is recognised by natural law. But human lives also have instrumental functions.

¹⁰³ John Keown (Supra note 44), at page 4

¹⁰⁴ AIR 1989 SC 2039

Our lives enable us to fulfil our needs and aspirations. The intrinsic worth of life is not conditional on what it seeks to or is capable to achieve. Life is valuable because it is. The Indian Constitution protects the right to life as the supreme right, which is inalienable and inviolable even in times of Emergency.¹⁰⁵ It clearly recognises that every human being has the inherent right to life, which is protected by law, and that “No person shall be deprived of his life... except according to procedure established by law”¹⁰⁶. It, thus, envisages only very limited circumstances where a person can be deprived of life.

According to Stephania Negri, the debate around euthanasia has “essentially developed within the framework of the universal rights to life and to human dignity”¹⁰⁷. This leads us to the relationship between end of life decisions and human dignity under the Indian Constitution.

Dignity

74 Human dignity has been “considered the unique universal value that inspires the major common bioethical principles, and it is therefore considered the *noyau dur* of both international bio law and international human rights

¹⁰⁵ Article 359

¹⁰⁶ Article 21

¹⁰⁷ Stefania Negri, “Universal Human Rights and End-of-Life Care” in S. Negri et al. (eds.), *Advance Care Decision Making in Germany and Italy: A Comparative, European and International Law Perspective*, Springer (2013), at page 18

law”¹⁰⁸. Ronald Dworkin observes that “the notion of a right to dignity has been used in many senses by moral and political philosophers”.¹⁰⁹

75 The first idea considers dignity as the foundation of human rights – “that dignity relates to the intrinsic value of persons (such that it is wrong to treat persons as mere things rather than as autonomous ends or agents)”¹¹⁰. According to this premise, every person, from conception to natural death, possesses inherent dignity:

“The sanctity of life view is often accompanied by a set of claims about human dignity, namely, that human beings possess essential, underived, or intrinsic dignity. That is, they possess dignity, or excellence, in virtue of the kind of being they are; and this essential dignity can be used summarily to express why it is impermissible, for example, intentionally to kill human beings: to do so is to act against their dignity.”¹¹¹

The other interpretation of dignity is by the supporters of euthanasia.¹¹² For them, right to lead a healthy life also includes leaving the world in a peaceful and dignified manner. Living with dignity, in this view, means the right to live a meaningful life having certain quality. This interpretation endorses the “quality of life” proposition.

¹⁰⁸ Ibid, at pages 21-22

¹⁰⁹ Ronald Dworkin, *Life's Dominion* (London: HarperCollins, 1993) as quoted in Deryck Beyleveld and Roger Brownsword, “Human Dignity, Human Rights, and Human Genetics”, *Modern Law Review* (1998), Vol. 61, at pages 665-666

¹¹⁰ Deryck Beyleveld and Roger Brownsword, “Human Dignity, Human Rights, and Human Genetics”, *Modern Law Review* (1998), Vol. 61, at page 666

¹¹¹ Christopher O. Tollefsen, “Capital Punishment, Sanctity of Life, and Human Dignity”, *Public Discourse* (September 16, 2011), available at <http://www.thepublicdiscourse.com/2011/09/3985/>

¹¹² Stefania Negri, “Ending Life and Death” in A. den Exter (eds.), *European Health Law*, MAKLU Press (2017), at page 241

Dignity has thus been invoked in support of contradictory claims and arguments. It could justify respect for life under the principle of the “sanctity of life”, as well as the right to die in the name of the principle of “quality of life”. In order to remove ambiguities in interpretation and application of the right to human dignity, Negri has suggested that dignity should be given a minimum core of interpretation:

“To be meaningful in the end-of-life discourse, and hence to avoid being invoked as mere rhetoric, dignity should be considered as a substantive legal concept, at whose basic minimum core is the legal guarantee assuring the protection of every human being against degradation and humiliation. Besides this, as international and national case law demonstrate, it can also play an important role as an interpretive principle, assisting judges in the interpretation and application of other human rights, such as the right to life and the right to respect for private life, both crucial in the end-of-life debate.”¹¹³
(Emphasis supplied)

Recognition of human dignity is an important reason underlying the preservation of life. It has important consequences. Is that dignity not compromised by pain and suffering and by the progressive loss of bodily and mental functions with the imminence of the end of life? Dignity has important consequences for life choices.

76 Morris, in his article, “Voluntary Euthanasia”, regards cruelty as a violation of human dignity:

¹¹³ Ibid

“All civilized men will agree that cruelty is an evil to be avoided. But few people acknowledge the cruelty of our present laws which require a man be kept alive against his will, while denying his pleas for merciful release after all the dignity, beauty, promise and meaning of life have vanished, and he can only linger for weeks or months in the last stages of agony, weakness and decay.” In addition, the fact that many people, as they die, are fully conscious of their tragic state of deterioration greatly magnifies the cruelty inherent in forcing them to endure this loss of dignity against their will.”¹¹⁴

He has further stated “it is exceedingly cruel to compel the spouse and children of a dying man to witness the ever-worsening stages of his disease, and to watch the slow, agonizing death of their loved one, degenerating before their eyes, being transformed from a vital and robust parent and spouse into a pathetic and humiliated creature, devoid of human dignity”.¹¹⁵

77 Liberty and autonomy promote the cause of human dignity. Arguments about autonomy are often linked to human dignity.¹¹⁶ Gostin evaluates the relationship between the dignity of dying with autonomy thus:

“The dying process, after all, is the most intimate, private and fundamental of all parts of life. It is the voice that we, as humans, assert in influencing this autonomous part of our life. At the moment of our death, this right of autonomy ought not to be taken from us simply because we are dying. An autonomous person should not be required to have a good reason for the decision that he or she will make; that is the nature of autonomy. We do not judge for other competent human beings what may be in their best interest, but instead allow them to determine that for themselves. As such, an autonomous person does not need to have a good understanding or even good reasons. All they need is an

¹¹⁴ Arval A. Morris (Supra note 97), at pages 251-252

¹¹⁵ Ibid

¹¹⁶ Sebastian Muders, *Autonomy and the Value of Life as Elements of Human Dignity* (Oxford University Press, 2017)

understanding of what they are confronting. There is no reason to believe that when a person faces imminent death that they have less human understanding, or less ability to fathom what they will face, than other people. Of course, death is a mystery. But death is what we will all confront sooner or later, and we all may wish to assert our interests in how we may die.”¹¹⁷

78 Sumner in his work titled “Dignity through Thick and Thin”¹¹⁸ discusses the dignity associated with patients:

“[P]atients associate dignity with concepts such as respect and esteem, presumably including self-respect and self-esteem, whereas they experience its opposite—indignity—as degrading, shameful, or embarrassing... Abstractly speaking, a person’s dignity seems to be a matter of assurance of her fully human status, both in her own eyes and in the eyes of others. Dignity is maintained when one can face others with pride and with confidence of being worthy of their respect; it is lost or impaired when being seen by others occasions feelings of shame, inferiority, or embarrassment. The element of degradation that is implicated in indignity seems a matter of feeling demoted or diminished from a higher standing to a lower, perhaps from the status of a fully functioning person to something lesser.”¹¹⁹

While stating that dignity and indignity are “basically subjective notions”¹²⁰ depending upon how individual patients experience them, he has further stated:

“One condition that patients report as degrading— as an indignity—is loss of control over the course of their own health care. Loss of autonomy matters in its own right, but it matters even more if it is the source for patients of shame and humiliation. This suggests that autonomy and well-being are themselves interconnected: Patients typically experience a

¹¹⁷ Lawrence O. Gostin, “The Constitutional Right to Die: Ethical Considerations”, *St John's Journal of Legal Commentary* (1997), Vol. 12, at pages 602-603

¹¹⁸ LW Sumner, “Dignity through Thick and Thin”, in Sebastian Muders, *Human Dignity and Assisted Death* (Oxford University Press, 2017)

¹¹⁹ *Ibid.*, at page 61

¹²⁰ *Ibid.*, at page 64

loss of the former as a decline in the latter, as something that makes their dying process go worse for them by causing them feelings of indignity. Appeals to dignity thus flesh out what is at stake for patients in terms of their autonomy and well-being, but they do not introduce any factors that fall outside the limits of these values.”¹²¹

79 An article titled “Euthanasia: A Social Science Perspective”¹²² in the *Economic & Political Weekly* has suggested that the discourses on death with dignity “need to be situated within processes of living with dignity in everyday contexts”.¹²³ The end of life must not be seen as “human disposal”, but, as “the enhancement of human dignity by permitting each man's last act to be an exercise of his free choice between a tortured, hideous death and a painless, dignified one.”¹²⁴

80 Under our Constitution, the inherent value which sanctifies life is the dignity of existence. Recognising human dignity is intrinsic to preserving the sanctity of life. Life is truly sanctified when it is lived with dignity. There exists a close relationship between dignity and the quality of life. For, it is only when life can be lived with a true sense of quality that the dignity of human existence is fully realized. Hence, there should be no antagonism between the sanctity of human life on the one hand and the dignity and quality of life on the other hand. Quality of life ensures dignity of living and dignity is but a process in realizing the sanctity of life.

¹²¹ Ibid, at page 68

¹²² Aneeta A Minocha, Arima Mishra and Vivek R Minocha, “Euthanasia: A Social Science Perspective”, *Economic & Political Weekly* (December 3, 2011), at pages 25-28

¹²³ Ibid, at page 27

¹²⁴ Arval A. Morris (Supra note 97), at page 247

81 Human dignity is an essential element of a meaningful existence. A life of dignity comprehends all stages of living including the final stage which leads to the end of life. Liberty and autonomy are essential attributes of a life of substance. It is liberty which enables an individual to decide upon those matters which are central to the pursuit of a meaningful existence. The expectation that the individual should not be deprived of his or her dignity in the final stage of life gives expression to the central expectation of a fading life: control over pain and suffering and the ability to determine the treatment which the individual should receive. When society assures to each individual a protection against being subjected to degrading treatment in the process of dying, it seeks to assure basic human dignity. Dignity ensures the sanctity of life. The recognition afforded to the autonomy of the individual in matters relating to end of life decisions is ultimately a step towards ensuring that life does not despair of dignity as it ebbs away.

82 From **Maneka Gandhi**¹²⁵ to **Puttaswamy**¹²⁶, dignity is the element which binds the constitutional quest for a meaningful existence. In **Francis Coralie Mullin v Administrator, Union Territory of Delhi**¹²⁷, this Court held that:

“The right to life enshrined in Article 21 cannot be restricted to mere animal existence. It means something much more than just physical survival...”

¹²⁵ Maneka Gandhi v Union of India, (1978) 1 SCC 248

¹²⁶ Justice KS Puttaswamy (Retd.) v Union of India, (2017) 10 SCC 1

¹²⁷ (1981) 1 SCC 608

We think that the right to life includes the right to live with human dignity.”

Explaining the ambit of dignity, this Court further held that:

“[A]ny form of torture or cruel, inhuman or degrading treatment would be offensive to human dignity and constitute an inroad into this right to live... [T]here is implicit in Article 21 the right to protection against torture or cruel, inhuman or degrading treatment which is enunciated in Article 5 of the Universal Declaration of Human Rights and guaranteed by Article 7 of the International Covenant on Civil and Political Rights.”

Dignity is the core value of life and personal liberty which infuses every stage of human existence. Dignity in the process of dying as well as dignity in death reflects a long yearning through the ages that the passage away from life should be bereft of suffering. These individual yearnings are enhanced by the experiences of sharing, observing and feeling with others: the loss of a parent, spouse, friend or an acquaintance to the cycle of life. Dignity in death has a sense of realism that permeates the right to life. It has a basic connect with the autonomy of the individual and the right to self-determination. Loss of control over the body and the mind are portents of the deprivation of liberty. As the end of life approaches, a loss of control over human faculties denudes life of its meaning. Terminal illness hastens the loss of faculties. Control over essential decisions about how an individual should be treated at the end of life is hence an essential attribute of the right to life. Corresponding to the right is a legitimate expectation that the state must protect it and provide a just legal order in which the right is not denied. In matters as fundamental as

death and the process of dying, each individual is entitled to a reasonable expectation of the protection of his or her autonomy by a legal order founded on the rule of law. A constitutional expectation of providing dignity in death is protected by Article 21 and is enforceable against the state.

Privacy

83 The nine-judge Bench decision of this Court in **Justice K S Puttaswamy v Union of India**¹²⁸ held privacy to be the constitutional core of human dignity. The right to privacy was held to be an intrinsic part of the right to life and liberty under Article 21 and protected under Part III of the Constitution. Each of the six decisions has a vital bearing on the issues in the present case. Excerpts from the judgment are reproduced below:

Justice DY Chandrachud

“The right to privacy is an element of human dignity. The sanctity of privacy lies in its functional relationship with dignity. Privacy ensures that a human being can lead a life of dignity by securing the inner recesses of the human personality from unwanted intrusion. Privacy recognises the autonomy of the individual and the right of every person to make essential choices which affect the course of life. In doing so privacy recognises that living a life of dignity is essential for a human being to fulfil the liberties and freedoms which are the cornerstone of the Constitution.”

Justice Chelameswar

“Forced feeding of certain persons by the State raises concerns of privacy. An individual’s right to refuse life prolonging medical treatment or terminate his life is another freedom which falls within the zone of the right of privacy.”

¹²⁸ 2017 (10) SCC 1

Justice SA Bobde

“Privacy, with which we are here concerned, eminently qualifies as an inalienable natural right, intimately connected to two values whose protection is a matter of universal moral agreement: the innate dignity and autonomy of man... Both dignity and privacy are intimately intertwined and are natural conditions for the birth and death of individuals, and for many significant events in life between these events.”

Justice RF Nariman

“... a Constitution has to be read in such a way that words deliver up principles that are to be followed and if this is kept in mind, it is clear that the concept of privacy is contained not merely in personal liberty, but also in the dignity of the individual.”

Justice AM Sapre

“The incorporation of expression "Dignity of the individual" in the Preamble was aimed essentially to show explicit repudiation of what people of this Country had inherited from the past. Dignity of the individual was, therefore, always considered the prime constituent of the fraternity, which assures the dignity to every individual. Both expressions are interdependent and intertwined.”

Justice SK Kaul

“A person-hood would be a protection of one’s personality, individuality and dignity.”

“Privacy, for example is nothing but a form of dignity, which itself is a subset of liberty.”

84 The protective mantle of privacy covers certain decisions that fundamentally affect the human life cycle.¹²⁹ It protects the most personal and intimate decisions of individuals that affect their life and development.¹³⁰ Thus,

¹²⁹ Richard Delgado, “Euthanasia Reconsidered-The Choice of Death as an Aspect of the Right of Privacy”, *Arizona Law Review* (1975), Vol. 17, at page 474

¹³⁰ *Ibid*

choices and decisions on matters such as procreation, contraception and marriage have been held to be protected. While death is an inevitable end in the trajectory of the cycle of human life of individuals are often faced with choices and decisions relating to death. Decisions relating to death, like those relating to birth, sex, and marriage, are protected by the Constitution by virtue of the right of privacy. The right to privacy resides in the right to liberty and in the respect of autonomy.¹³¹ The right to privacy protects autonomy in making decisions related to the intimate domain of death as well as bodily integrity. Few moments could be of as much importance as the intimate and private decisions that we are faced regarding death.¹³² Continuing treatment against the wishes of a patient is not only a violation of the principle of informed consent, but also of bodily privacy and bodily integrity that have been recognised as a facet of privacy by this Court.

85 Just as people value having control over decisions during their lives such as where to live, which occupation to pursue, whom to marry, and whether to have children, so people value having control over whether to continue living when the quality of life deteriorates.¹³³

¹³¹ TL Beauchamp, "The Right to Privacy and the Right to Die", *Social Philosophy and Policy* (2000), Vol. 17, at page 276

¹³² *Ibid*

¹³³ D Benatar (Supra note 18)

86 In the case of **In re Quinlan** (1976),¹³⁴ the New Jersey Supreme Court dealt with a case of a patient, Karen Quinlan, who had suffered irreversible brain damage and was in a persistent vegetative state and had no prospect of recovery. The patient's father sought judicial authority to withdraw the life-sustaining mechanisms temporarily preserving his daughter's life, and his appointment as guardian of her person to that end. The father's lawyer contended that the patient was being forced to function against all natural impulses and that her right to make a private decision about her fate superseded the state's right to keep her alive. The New Jersey Supreme Court held that the patient had a right of privacy grounded in the US Constitution to terminate treatment and in a celebrated statement said that:

"the State's interest *contra* [the right to privacy] weakens and the individual's right to privacy grows as the degree of bodily invasion increases and the prognosis dims. Ultimately there comes a point at which the individual's rights overcome the State interest. It is for that reason that we believe [the patient's] choice, if she were competent to make it, would be vindicated by law."

Since Karen Quinlan was not competent to assert her right to privacy, the Court held that Karen's right of privacy may be asserted on her behalf by her guardian due to the reason that Karen Quinlan did not have the capacity to assert her right to privacy indicating that the right of privacy is so fundamental that others, who had been intimately involved with the patient, should be able to exercise it in circumstances when the patient is unable to do so. However,

¹³⁴ 70 N.J. 10; 355 A.2d 647 (1976)

subsequently scholars have argued that when euthanasia is founded in the right to privacy, only voluntary euthanasia can be permitted. The right to privacy can only be exerted by the patient and cannot be exercised vicariously.¹³⁵ The substituted judgment and caregiver criterion cannot be logically based on the right to privacy of the patient.¹³⁶

87 In the landmark case of **Pretty v United Kingdom**¹³⁷, the European Court of Human Rights analysed Article 8 of the European Convention on Human Rights (respect for private life). It held that the term “private life” is a broad term not susceptible to exhaustive definition and covers the physical and psychological integrity of a person. In relation to the withdrawing of treatment, it was held that the way in which an individual “chooses to pass the closing moments of her life is part of the act of living, and she has a right to ask that this too must be respected.” The right to privacy protects even those choices that may be considered harmful for the individual exercising the choice:

“The extent to which a State can use compulsory powers or the criminal law to protect people from the consequences of their chosen lifestyle has long been a topic of moral and jurisprudential discussion, the fact that the interference is often viewed as trespassing on the private and personal sphere adding to the vigour of the debate. However, even where the conduct poses a danger to health or, arguably, where it is of a life-threatening nature, the case-law of the Convention institutions has regarded the State's imposition of compulsory or criminal measures as impinging on the private life of the applicant within the meaning of Article 8 § 1... In the sphere of medical treatment, the refusal to accept a particular

¹³⁵Peter J. Riga, "Privacy and the Right to Die," *The Catholic Lawyer* (2017) Vol. 26: No. 2 , Article 2

¹³⁶ *Ibid*

¹³⁷ Application no. 2346/02

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.”

The Court further observed that:

“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.”

Thus, the Court concluded that the “choice to avoid what she considers will be an undignified and distressing end to her life” is guaranteed under the right to respect for private life under Article 8(1) of the Convention.

88 Subsequently in the case of **Haas v Switzerland**¹³⁸, the European Court of Human Rights has further held that the right to decide in which way and at which time an individual's life should end, provided that he or she was in a position freely to form her own will and to act accordingly, was one of the aspects of the right to respect for private life within the meaning of Article 8 of the Convention.

89 The right to privacy as held by this Court mandates that we safeguard the integrity of individual choice in the intimate sphere of decisions relating to

¹³⁸ Application no. 31322/07, para 51

death, subject to the restrictions to the right to privacy, as laid down by us. However, since privacy is not an absolute right and is subject to restrictions, the restrictions must fulfil the requirements as laid down by this Court in **Puttaswamy**.

90 The protection of these rights by the legal order is as much an emanation of the right to privacy which shares a functional relationship with the fundamental right to life and personal liberty guaranteed by the Constitution. Privacy recognises that the body and mind are inviolable. An essential attribute of this inviolability is the ability of the individual to refuse medical treatment.

Socio-Economic Concerns

91 One of the limitations of contemporary debates on euthanasia is that they do not take into consideration “certain socio-economic concerns that must necessarily be factored into any discourse”¹³⁹. This has been criticised as making the debate around ending life “incomplete” as well as “elitist”.

92 In an article titled “Euthanasia: cost factor is a worry”¹⁴⁰ Nagral (2011) seeks to construct a “critical linkage” between euthanasia and “the economic and social dimension” in the Indian context. Stating that many Indian doctors

¹³⁹ Sushila Rao (Supra note 16), at page 654

¹⁴⁰ S Nagral, “Euthanasia: Cost Factor is a Worry”, The Times of India (June 19, 2011), available at <http://www.timesofindia.com/home/sunday/Euthanasia-cost-factor-is-a-worry/articleshow/7690155.cms>

have been practising passive euthanasia silently and practically, Nagral contemplates the cost of treatment to be a critical factor in influencing the medical decision:

“[O]ne of the reasons for 'passive' euthanasia is that the patient or his family could be running out of money. In some cases, this overlaps with the incurability of the disease. In others, it may not. Costly medication and intervention is often withdrawn as the first step of this passive euthanasia process. Sometimes patients are 'transferred' to smaller (read cheaper) institutions or even their homes, with the tacit understanding that this will hasten the inevitable. If a third party is funding the patient's treatment, chances are that the intervention and support will continue. Shocking and arbitrary as this may sound, this is the reality that needs flagging because it is relevant to the proposed legitimization of passive euthanasia. In a system where out-of pocket payment is the norm and healthcare costs are booming, there has to be a way of differentiating a plea made on genuine medical grounds from one that might be an attempt to avoid financial ruin.”¹⁴¹

Rao (2011) has observed:

“In the absence of adequate medical insurance, specialised treatments like ventilator support, kidney dialysis, and expensive lifesaving drugs administered in private hospitals can turn middle-class families into virtual paupers. Poorly equipped government hospitals simply do not have enough life-support machines compared to the number of patients who need them.... This also leads to the inevitable possibility of a comatose patient's family and relatives potentially exploiting the euthanasia law to benefit from a premature death, by way of inheritance, etc.”¹⁴²

Norrie (2011) has placed the social and economic dimensions succinctly:

“This concerns the problem of the differential social impact that such a position would have on the poor and the well-to-

¹⁴¹ Ibid

¹⁴² Sushila Rao (Supra note 16), at page 654-655

do... Wealth, poverty, and class structure have a profound effect on the choices people make.”¹⁴³

The inadequacies of the range and reach of Indian healthcare may, it is observed, lead to a situation where euthanasia/active euthanasia may become “an instrument of cost containment”¹⁴⁴.

Restraints on Judicial Power

93 An earlier part of this judgment has dwelt on the criticism of the distinction between passive and active euthanasia, founded as it is on the act – omission divide. The criticism is that as a matter of substance, there is no valid distinguishing basis between active and passive euthanasia. The criticism takes one of two forms: either both should be recognised or neither should be allowed. The view that passive euthanasia involves an omission while active euthanasia involves a positive act is questioned on the ground that the withdrawal of artificial life support (as an incident of passive euthanasia) requires a positive act. While noticing this criticism, it is necessary to distinguish between active and passive euthanasia in terms of the underlying constitutional principles as well as in relation to the exercise of judicial power. Passive euthanasia – whether in the form of withholding or withdrawing treatment – has the effect of removing, or as the case may be, not providing supportive treatment. Its effect is to allow the individual to continue to exist until the end of

¹⁴³ Alan Norrie (Supra note 4), at page 144

¹⁴⁴ S Nagral, “Euthanasia: Cost Factor is a Worry”, The Times of India (June 19, 2011), available at <http://www.timesofindia.com/home/sunday/Euthanasia-cost-factor-is-a-worry/articleshow/7690155.cms>

the natural span of life. On the other hand, active euthanasia involves hastening of death: the life span of the individual is curtailed by a specific act designed to bring an end to life. Active euthanasia would on the state of the penal law as it stands constitute an offence. Hence, it is only Parliament which can in its legislative wisdom decide whether active euthanasia should be permitted. Passive euthanasia on the other hand would not implicate a criminal offence since the decision to withhold or withdraw artificial life support after taking into account the best interest of the patient would not constitute an illegal omission prohibited by law.

94 Moreover, it is necessary to make a distinction between active and passive euthanasia in terms of the incidents of judicial power. We may refer in this context to the felicitous words of Lord Justice Sales, speaking for the Queen's Bench Division in a recent decision delivered on 5 October 2017 in **Noel Douglas Conway v The Secretary of State for Justice**¹⁴⁵. Dealing with the plea that physician assisted suicide should be accepted as a principle by the court, the learned Judge observed thus:

“Parliament is the body composed of representatives of the community at large with what can be called a democratic mandate to make the relevant assessment in a case where there is an important element of social policy and moral value-judgment involved with much to be said on both sides of the debate (229) and (233). There is not a single, clear, uniquely rational solution which can be identified; the decision cannot fail to be influenced by the decision-makers' opinions about the moral case for assisted suicide, including in deciding what level of risk to others is acceptable and whether any safeguards are sufficiently robust; and it is not

¹⁴⁵ (2017) EWHC 2447 (Admin)

appropriate for professional judges to impose their personal opinions on matters of this kind (229)-(230) and (234). In *Nicklinson* in the Court of Appeal, Lord Judge CJ aptly referred to Parliament as representing “the conscience of the nation” for decisions which raise “profoundly sensitive questions about the nature of our society, and its values and standards, on which passionate but contradictory opinions are held” (Court of Appeal, (155). Parliament has made the relevant decision; opponents of section 2 have thus far failed to persuade Parliament to change the law despite active consideration given to the issue, in particular in relation to the *Falconer Bill* which contained essentially the same proposals as Mr Conway now puts before the court; and the democratic process would be liable to be subverted if, on a question of moral and political judgment, opponents of the legislation could achieve through the courts what they could not achieve in Parliament (231) per Lord Sumption, referring to *R (Countrywide Alliance) v Attorney General* (2008) AC 719, (45) per Lord Bingham and *AXA General Insurance Ltd v HM Advocate* (2012) 1 SC 868, (49) per Lord Hope”.

Emphasising the limitations on the exercise of the judicial power, Lord Justice

Sales observed:

“We also agree that his case on necessity becomes still stronger when the other legitimate aims are brought into account. As the conscience of the nation, Parliament was and is entitled to decide that the clarity of such a moral position could only be achieved by means of such a rule. Although views about this vary in society, we think that the legitimacy of Parliament deciding to maintain such a clear line that people should not seek to intervene to hasten the death of a human is not open to serious doubt. Parliament is entitled to make the assessment that it should protect moral standards in society by issuing clear and unambiguous laws which reflect and embody such standards”.

In taking the view which has been taken in the present judgment, the court has been conscious of the need to preserve to Parliament, the area which properly belongs to its legislative authority. Our view must hence be informed by the impact of existing legislation on the field of debate in the present case.

I Penal Provisions

95 The legality of and constitutional protection which is afforded to passive euthanasia cannot be read in isolation from the provisions of the Penal Code. Physicians are apprehensive about their civil or criminal liability when called upon to decide whether to limit life-supporting treatment.¹⁴⁶ A decision on the constitutional question cannot be rendered without analyzing the statutory context and the impact of penal provisions. The decision in **Aruna Shanbaug** did not dwell on the provisions of the Penal Code (apart from Sections 306 and 309) which have a vital bearing on the issue of euthanasia. Undoubtedly, constitutional positions are not controlled by statutory provisions, because the Constitution rises above and controls legislative mandates. But, in the present reference where no statutory provision is called into question, it is necessary for the court to analyse the relationship between what the statute penalizes and what the Constitution protects. The task of interpretation is to allow for their co-existence while interpreting the statute to give effect to constitutional principle. This is particularly so in an area such as the present where criminal law may bear a significant relationship to the fundamental constitutional principles of liberty, dignity and autonomy.

The first aspect which needs to be noticed is that our law of crimes deals with acts and omissions. Section 32 of the Penal Code places acts and omissions

¹⁴⁶ S Balakrishnan and RK Mani, "The constitutional and legal provisions in Indian law for limiting life support", *Indian Journal of Critical Care Medicine* (2005), Vol. 9, Issue 2, at page 108

on the same plane. An illegal omission (unless a contrary intent appears in the Code) is proscribed when the act is unlawful. Section 32 states:

“Words referring to acts include illegal omissions. — In every part of this Code, except where a contrary intention appears from the context, words which refer to acts done extend also to illegal omissions.”

The language of the statute which refers to acts applies, unless a contrary intent appears in the text, to omissions.

The next aspect is about when an act or omission is illegal. Section 43 explains the concept of illegality. It provides thus:

“Illegal”. “Legally bound to do”. — The word “illegal” is applicable to everything which is an offence or which is prohibited by law, or which furnishes ground for a civil action; and a person is said to be “legally bound to do” whatever it is illegal in him to omit.”

Here again, being legally bound to do something is the mirror image of what is illegal to omit doing.

Section 43 comprehends within the meaning of illegality, that (i) which is an offence; or (ii) which is prohibited by law; or (iii) which furnishes a ground for a civil action. Omissions and acts are mirror images. When it is unlawful to omit to do something, the individual is legally bound to do it.

This raises the question of whether an omission to provide life-sustaining treatment constitutes an illegal omission.

Section 81 protects acts which are done without a criminal intent to cause harm, in good faith, to prevent or avoid other harm to person or property. The law protects the action though it was done with the knowledge that it was likely to cause harm if a three-fold requirement is fulfilled. It comprehends an absence of criminal intent to cause harm, the presence of good faith and the purpose of preventing other harm. Section 81 provides thus:

“81. Act likely to cause harm, but done without criminal intent, and to prevent other harm.—Nothing is an offence merely by reason of its being done with the knowledge that it is likely to cause harm, if it be done without any criminal intention to cause harm, and in good faith for the purpose of preventing or avoiding other harm to person or property.

Explanation—It is question of fact in such a case whether the harm to be prevented or avoided was of such a nature and so imminent as to justify or excuse the risk of doing the act with the knowledge that it was likely to cause harm.”

Knowledge of the likelihood of harm is not culpable when a criminal intent to cause harm is absent and there exists an element of good faith to prevent or avoid other harm.

Section 92 of the IPC states:

“Act done in good faith for benefit of a person without consent.—Nothing is an offence by reason of any harm which it may cause to a person for whose benefit it is done in good faith, even without that person's consent, if the circumstances are such that it is impossible for that person to signify consent, or if that person is incapable of giving consent, and has no guardian or other person in lawful charge of him from whom it is possible to obtain consent in time for the thing to be done with benefit: Provided—
Provisos. First.—That this exception shall not extend to the intentional causing of death, or the attempting to cause death”

Section 92 protects an individual from a consequence which arises from the doing of an act for the benefit of another in good faith, though a harm is caused to the other. What was done is protected because it was done in good faith. Good faith is distinguished from an evil design. When a person does something to protect another from a harm or injury, the law protects what was done in good faith, treating the harm that may result as a consequence unintended by the doer of the act. This protection is afforded by the law even in the absence of consent when the circumstances are such that it is impossible for the person for whose benefit the act was done to consent to it. This may arise where the imminence of the apprehended danger makes it impossible to obtain consent. Another eventuality is where the individual is incapable of consenting (by being incapacitated in mind) and there is no person in the position of a guardian or person in lawful charge from whom consent can be obtained in time to perform the act for the benefit of that person. However, the first proviso to Section 92 makes it clear that the exception does not extend to the intentional causing of death or attempt to cause death to the individual, howsoever it may be for the benefit of the other. Absence of intent to cause death is the crucial element in the protection extended by Section 92.

Section 107 deals with abetment. It provides thus:

“Abetment of a thing.—A person abets the doing of a thing, who—
... (Thirdly) — Intentionally aids, by any act or illegal omission, the doing of that thing.”

Abetment embodies a three-fold requirement: first an intentional aiding, second the aiding of an act or illegal omission and third, that this must be toward the doing of that thing.

Explanation 2 of this Section states:

“Whoever, either prior to or at the time of the commission of an act, does anything in order to facilitate the commission of that act, and thereby facilitates the commission thereof, is said to aid the doing of that act.”

96 For abetting an offence, the person abetting must have intentionally aided the commission of the crime. Abetment requires an instigation to commit or intentionally aiding the commission of a crime. It presupposes a course of conduct or action which (in the context of the present discussion) facilitates another to end life. Hence abetment of suicide is an offence expressly punishable under Sections 305 and 306 of the IPC.

97 It is now necessary to dwell upon the provisions bearing upon culpable homicide and murder. Section 299 of the IPC states:

“**Culpable homicide.**—Whoever causes death by doing an act with the intention of causing death, or with the intention of causing such bodily injury as is likely to cause death, or with the knowledge that he is likely by such act to cause death, commits the offence of culpable homicide.”

Section 300 states:

“**Murder.**—Except in the cases hereinafter excepted, culpable homicide is murder, if the act by which the death is caused is done with the intention of causing death, or—

Secondly.—If it is done with the intention of causing such bodily injury as the offender knows to be likely to cause the death of the person to whom the harm is caused, or—
 Thirdly.—If it is done with the intention of causing bodily injury to any person and the bodily injury intended to be inflicted is sufficient in the ordinary course of nature to cause death, or—
 Fourthly.—If the person committing the act knows that it is so imminently dangerous that it must, in all probability, cause death, or such bodily injury as is likely to cause death, and commits such act without any excuse for incurring the risk of causing death or such injury as aforesaid.”

Active euthanasia involves an intention on the part of the doctor to cause the death of the patient. Such cases fall under the first clause of Section 300.

Exception 5 to Section 300 states:

“Culpable homicide is not murder when the person whose death is caused, being above the age of eighteen years, suffers death or takes the risk of death with his own consent.”

Section 304 provides:

“Whoever commits culpable homicide not amounting to murder, shall be punished with [imprisonment for life], or imprisonment of either description for a term which may extend to ten years, and shall also be liable to fine, if the act by which the death is caused is done with the intention of causing death, or of causing such bodily injury as is likely to cause death; or with imprisonment of either description for a term which may extend to ten years, or with fine, or with both, if the act is done with the knowledge that it is likely to cause death, but without any intention to cause death, or to cause such bodily injury as is likely to cause death.”

There also exists a distinction between active and passive euthanasia. This is brought out in the application of the doctrine of ‘double effect’. The Stanford Encyclopedia of Philosophy elucidates the position thus:

“The doctrine (or principle) of double effect is often invoked to explain the permissibility of an action that causes a serious harm, such as the death of a human being, as a side effect of promoting some good end. According to the principle of double effect, sometimes it is permissible to cause a harm as a side effect (or “double effect”) of bringing about a good result even though it would not be permissible to cause such a harm as a means to bringing about the same good end.”¹⁴⁷

It has been observed further:

“A doctor who intends to hasten the death of a terminally ill patient by injecting a large dose of morphine would act impermissibly because he intends to bring about the patient's death. However, a doctor who intended to relieve the patient's pain with that same dose and merely foresaw the hastening of the patient's death would act permissibly.”¹⁴⁸

98 A distinction arises between active and passive euthanasia from the provisions of the Penal Code. Active euthanasia involves an intention to cause the death of the patient. *Mens rea* requires a guilty mind; essentially an intent to cause harm or injury. Passive euthanasia does not embody an intent to cause death. A doctor may withhold life support to ensure that the life of a patient who is in the terminal stage of an incurable illness or in a permanent vegetative state, is not prolonged artificially. The decision to do so is not founded upon an intent to cause death but to allow the life of the patient to continue till and cease at the end of its natural term. Placing such a person on life support would have been an intervention in the natural process of death. A decision not to prolong life by artificial means does not carry an intention to cause death. The crucial element in Section 299 is provided by the expression

¹⁴⁷ “Doctrine of Double Effect”, *Stanford Encyclopedia of Philosophy* (July 28, 2004), available at <https://plato.stanford.edu/entries/double-effect/>

¹⁴⁸ *Ibid*

“**causes** death”. In a case involving passive euthanasia, the affliction of the patient is not brought about either by an act or omission of the doctor. There is neither an animus nor an intent to cause death. The creation of the condition of the patient is outside the volition of the doctor and has come about without a covert or overt act by the doctor. The decision to withhold medical intervention is not intended to cause death but to prevent pain, suffering and indignity to a human being who is in the end stage of a terminal illness or of a vegetative state with no reasonable prospect of cure. Placing a patient on artificial life support would, in such a situation, merely prolong the agony of the patient. Hence, a decision by the doctor based on what is in the best interest of the patient precludes an intent to cause death. Similarly, withdrawal of artificial life support is not motivated by an intent to cause death. What a withdrawal of life support does is not to artificially prolong life. The end of life is brought about by the inherent condition of the patient. Thus, both in a case of a withdrawal of life supporting intervention and withholding it, the law protects a bona fide assessment of a medical professional. There being no intent to cause death, the act does not constitute either culpable homicide or murder.

Moreover, the doctor does not inflict a bodily injury. The condition of a patient is on account of a factor independent of the doctor and is not an outcome of his or her actions. Death emanates from the pre-existing medical condition of the patient which enables life to chart a natural course to its inexorable end. The law protects a decision which has been made in good faith by a medical

professional not to prolong the indignity of a life placed on artificial support in a situation where medical knowledge indicates a point of no return. Neither the act nor the omission is done with the knowledge that it is likely to cause death. This is for the reason that the likelihood of death is not occasioned by the act or omission but by the medical condition of the patient. When a doctor takes a considered decision in the case of a patient in a terminal stage of illness or in a permanently vegetative state, not to provide artificial life support, the law does not attribute to the doctor the knowledge that it is likely to cause death.

99 Section 43 of the Penal Code defines the expression illegal to mean “...everything which is an offence or which is prohibited by law, or which furnishes ground in a civil action”. Withdrawing life support to a person in a permanently vegetative state or in a terminal stage of illness is not ‘prohibited by law’. Such an act would also not fall outside the purview of Section 92 for the reason that there is no intentional causing of death or attempt to cause death. Where a decision to withdraw artificial life support is made in the caregiver of the patient, it fulfils the duty of care required from a doctor towards the patient. Where a doctor has acted in fulfilment of a duty of care owed to the patient, the medical judgment underlying the decision protects it from a charge of illegality. Such a decision is not founded on an intention to cause death or on the knowledge that it is likely to cause death. An act done in pursuance of the duty of care owed by the doctor to a patient is not prohibited by law.

100 In a situation where passive euthanasia is non-voluntary, there is an additional protection which is also available in circumstances which give rise to the application of Section 92. Where an act is done for the benefit of another in good faith, the law protects the individual. It does so even in the absence of the consent of the other, if the other individual is in a situation where it is impossible to signify consent or is incapable of giving consent. Section 92 also recognises that there may be no guardian or other person in lawful charge from whom it is possible to obtain consent. However, the proviso to Section 92 stipulates that this exception shall not extend to intentionally causing death or attempting to cause death. The intent in passive euthanasia is not to cause death. A decision not to prolong life beyond its natural span by withholding or withdrawing artificial life support or medical intervention cannot be equated with an intent to cause death. The element of good faith, coupled with an objective assessment of the caregiver of the patient would protect the medical professional in a situation where a bona fide decision has been taken not to prolong the agony of a human being in a terminal or vegetative state by a futile medical intervention.

101 In 2006, the Law Commission of India submitted its 196th Report titled “Medical Treatment to Terminally Ill Patients (Protection of Patients and Medical Practitioners)”. The report by Justice M Jagannadha Rao as Chairperson contains a succinct elucidation of legal principles governing criminal law on the subject. Some of them are explained below:

- (i) An informed decision of a patient to refuse medical treatment is accepted at common law and is binding on a treating doctor. While a doctor has a duty of care, a doctor who obeys the instructions of a competent patient to withhold or withdraw medical treatment does not commit a breach of professional duty and the omission to treat will not be an offence;

- (ii) The decision of a patient to allow nature to take its course over the human body and, in consequence, not to be subjected to medical intervention, does not amount to a deliberate termination of physical existence. Allowing nature to take its course and a decision to not receive medical treatment does not constitute an attempt to commit suicide within the meaning of Section 309 of the Penal Code;

- (iii) Once a competent patient has decided not to accept medical intervention, and to allow nature to take its course, the action of the treating doctor in abiding by those wishes is not an offence, nor would it amount to an abetment under Section 306. Under Section 107, an omission has to be illegal to constitute an abetment. A doctor bound by the instructions of a patient to withhold or withdraw medical treatment is not guilty of an illegal act or an abetment. The doctor is bound by the decision of the patient to refuse medical intervention;

- (iv) A doctor who withholds or withdraws medical treatment in the best interest of a patient, such as when a patient is in a permanent vegetative state or in a terminal state of an incurable illness, is not guilty under Section 299 because there is no intention to cause death or bodily injury which is likely to cause death. The act of withholding or withdrawing a life support system in the case of a competent patient who has refused medical treatment and, in the case of an incompetent person where the action is in the best interest of the patient would be protected by good faith protections available under Sections 76, 79, 81 or, as the case may be, by Section 88, even if it is construed that the doctor had knowledge of the likelihood of death; and
- (v) The decision of the doctor, who is under a duty at common law to obey the refusal of a competent patient to take medical treatment, would not constitute a culpable act of negligence under Section 304A. When the doctor has taken such a decision to withhold or withdraw treatment in the best interest of the patient, the decision would not constitute an act of gross negligence punishable under Section 304A.

102 Introducing a structural safeguard, in the form of a Medical Board of experts can be contemplated to further such an objective. The Transplantation of Human Organs and Tissues Act 1994 provides for the constitution of Authorisation Committees under Section 9(4). Authorisation Committees are

contemplated at the state and district levels and a hospital board.¹⁴⁹ Once the process of decision making has been arrived at by fulfilling a mandated safeguard (the prior approval of a committee), the decision to withdraw life support should not constitute an illegal act or omission. The setting up of a broad-based board is precisely with a view to lend assurance that the duty of care owed by the doctor to the patient has been fulfilled. Once due safeguards have been fulfilled, the doctor is protected against the attribution of a culpable intent or knowledge. It will hence fall outside the definition of culpable homicide (Section 299), murder (Section 300) or causing death by a rash or negligent act (Section 304A). The composition of this broad-based committee has been dealt with in the last segment of this judgment.

J Advance Directives

103 A patient, in a sound state of mind, possesses the ability to make decisions and choices and can legitimately refuse medical intervention. Justice Cardozo had this to say in a seminal statement of principle in the 1914 decision in **Schloendorff v Society of NY Hospital**¹⁵⁰:

“Even human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient’s consent commits an assault.”

¹⁴⁹ Rule 6A, Transplantation of Human Organs and Tissues Act 1995

¹⁵⁰ 105 N.E. 92, 93 (N.Y. 1914)

Luis Kutner gave expression to the relationship of privacy with the inviolability of the person and the refusal of medical treatment:

“...The attitude of the law is to recognise the inviolability of the human body. The patient’s consent must be voluntary and informed. These notions are buttressed by the constitutionally recognized right to privacy. Clearly, then, a patient may refuse treatment which would extend his life. Such a decision must rest with the patient.”¹⁵¹

The difficulty, as Kutner notes, arises when a patient is unconscious or is not in a position to furnish his or her consent. The author notes that in such a case “the law assumes a constructive consent to such treatment as will save his life”. Kutner’s thesis contemplates what should happen, if the patient is incapable of giving consent:

“...The law, however, does recognize that a patient has a right to refuse to be treated, even when he is in extremis, provided he is in an adult and capable of giving consent. Compliance with the patient’s wishes in such circumstances is not the same as voluntary euthanasia. Where, however, the patient is incapable of giving consent, such as when he is in a coma, a constructive consent is presumed and the doctor is required to exercise reasonable care in applying ordinary means to preserve the patient’s life. However, he is not allowed to resort to extraordinary care especially where the patient is not expected to recover from the comatose state...”

104 Recognition of the right to accept or refuse medical treatment is founded upon autonomy. The **Stanford Encyclopaedia of Philosophy**¹⁵² postulates that there is “a rough consensus in medical ethics on the requirement of respect for patient autonomy”. However, a patient may not

¹⁵¹ Luis Kutner, “Due Process of Euthanasia: The Living Will, a proposal”, *Indiana Law Journal* (1969), Vol. 44, Issue 4, at page 539

¹⁵² “Advance Directives and Substitute Decision-Making”, *Stanford Encyclopaedia of Philosophy* (24 March 2009), available at <https://plato.stanford.edu/entries/advance-directives/>

always have the opportunity to grant or withhold consent to medical treatment. An unforeseen event may deprive the individual of the ability to indicate a desire to either receive or not to have medical treatment. An occasion necessitating treatment in sudden cases where a person suffers an accident, a stroke or coronary¹⁵³ episode may provide no time for reflection. In anticipation of such situations, “where an individual patient has no desire to be kept in a state of complete and indefinite vegetated animation with no possibility of recovering his mental and physical faculties, that individual, while still in control of all his/her faculties and his ability to express himself/herself”¹⁵⁴, could still retain the right to refuse medical treatment by way of “advance directives”.

105 Broadly, there are two forms of advance directives:

- A **Living Will** which indicates a person’s views and wishes regarding medical treatment

- A **Durable Power of Attorney for Health Care** or Health care Proxy which authorises a surrogate decision maker to make medical care decisions for the patient in the event she or he is incapacitated

Although there can be an overlap between these two forms of advance directives, the focus of a durable power is on who makes the decision while

¹⁵³ Luis Kutner (Supra note 151), at page 551

¹⁵⁴ Luis Kutner (Supra note 65) at page 226

the focus of a living will is on what the decision should be. A “living will” has also been referred as “a declaration determining the termination of life,” “testament permitting death,” “declaration for bodily autonomy,” “declaration for ending treatment,” “body trust,” or other similar reference.¹⁵⁵ Living wills are not a new entity and were first suggested by US attorney, Luis Kutner, in late 1960s.¹⁵⁶

106 Advance directives have evolved conceptually to deal with cases where a patient who subsequently faces a loss of the mental faculty to decide has left instructions, when he or she was possessed of decision-making capacity, on how future medical decisions should be made. The **Stanford Encyclopaedia**¹⁵⁷ explains the concept thus:

“... For patients who lack the relevant decision-making capacity at the time the decision is to be made, a need arises for surrogate decision-making: someone else must be entrusted to decide on their behalf. Patients who formerly possessed the relevant decision-making capacity might have anticipated the loss of capacity and left instructions for how future medical decisions ought to be made. Such instructions are called an advance directive. One type of advance directive simply designates who the surrogate decision-maker should be. A more substantive advance directive, often called a living will, specifies particular principles or considerations meant to guide the surrogate’s decisions in various circumstances...”

Hazel Biggs¹⁵⁸ explains the meaning of “living wills” and advance directives:

“Usually a living will is thought of as a statement indicating a person’s preferred treatment options at the end of life, but the term “living will” is also “sometimes used for advance

¹⁵⁵ Luis Kutner (Supra note 151), at page 551

¹⁵⁶ Ibid

¹⁵⁷ “Advance Directives and Substitute Decision-Making”, *Stanford Encyclopaedia of Philosophy* (24 March 2009), available at <https://plato.stanford.edu/entries/advance-directives/>

¹⁵⁸ Hazel Biggs (Supra note 21), at page 115

directives which are concerned with other situations or which can be used to express a willingness to receive particular treatments". Some stipulate that specific treatments are acceptable while others are not, while others insist that all available appropriate medical resources should be utilised to maintain life. Living wills are not therefore exclusively associated with end-of-life decisions, although generally the purpose of a living will is to promote individual autonomy and choice for the patient; characteristics which have long been associated with euthanasia as a means of achieving death with dignity".

James C Turner¹⁵⁹ explains the concept of a living will thus:

"The living will is a document by which a competent adult signifies a desire that if there ever comes a time when there is no reasonable expectation of his recovery from physical or mental disability that he be allowed to die rather than be kept alive by artificial means or heroic measures. What the typical living will does, in effect, is to sanction passive euthanasia, or, as it has been called, antidysthanasia..

The living will is a document which directs one's physician to cease affirmative treatment under certain specified conditions. It can presumably apply to both the situation in which a person with a terminal disease lapses into the final stage of his illness and also the situation in which a victim of a serious accident deteriorates into a state of indefinite vegetated animation..."

107 The principles of patient autonomy and consent are the foundation of advance medical directives. A competent and consenting adult is entitled to refuse medical treatment. By the same postulate, a decision by a competent adult will be valid in respect of medical treatment in future. As Biggs states:

"...Founded upon respect for individual autonomy this is a right that operates through the law of consent to protect patients from unfettered medical paternalism. Common law holds that patients with the capacity to give consent are also competent to refuse or withhold consent, "even if a refusal may risk personal injury to health or even lead to premature death". Furthermore, a "refusal of treatment can take the form

¹⁵⁹ James C Turner, "Living Wills – Need for legal recognition", *West Virginia Law Review* (1976), Vo. 78, Issue 3, at page 370

of a declaration of intent never to consent to that treatment in the future, or never to consent in some future circumstances". Accordingly, any consent or refusal of consent made by a competent adult patient can also be valid in respect of the same treatment at any time in the future."

108 Advance directives are thus documents a person completes while still in possession of decisional capacity about how treatment decisions should be made in the event she or he loses decision making capacity in future. They cover three conditions: (i) a terminal condition; (ii) a persistently unconscious condition; and (iii) an end-stage condition.

109 A **terminal condition** is an incurable or irreversible condition which even with the administration of life-sustaining treatment will result in death in the foreseeable future. A **persistently unconscious** condition is an irreversible condition, in which thought and awareness of self and environment are absent. An **end-stage condition** is a condition caused by injury, disease or illness which results in severe and permanent deterioration indicated by incompetency and complete physical dependency for which treatment of the irreversible condition would be medically ineffective.

110 The reason for recognising an advance directive is based on individual autonomy. As an autonomous person, every individual has a constitutionally recognised right to refuse medical treatment. The right not to accept medical treatment is essential to liberty. Medical treatment cannot be thrust upon an

individual, however, it may have been conceived in the interest of the individual. The reasons which may lead a person in a sound state of mind to refuse medical treatment are inscrutable. Those decisions are not subject to scrutiny and have to be respected by the law as an essential attribute of the right of the individual to have control over the body. The state cannot compel an unwilling individual to receive medical treatment. While an individual cannot compel a medical professional to provide a particular treatment (this being in the realm of professional medical judgment), it is equally true that the individual cannot be compelled to undergo medical intervention. The principle of sanctity of life thus recognises the fundamental liberty of every person to control his or her body and as its incident, to decline medical treatment. The ability to take such a decision is an essential element of the privacy of the being. Privacy also ensures that a decision as personal as whether or not to accept medical treatment lies exclusively with the individual as an autonomous being. The reasons which impel an individual to do so are part of the privacy of the individual. The mental processes which lead to decision making are equally part of the constitutionally protected right to privacy.

111 Advance directives are founded on the principle that an individual whose state of mind is not clouded by an affliction which prevents him or her from taking decisions is entitled to decide whether to accept or not accept medical intervention. If a decision can be made for the present, when the individual is in a sound state of mind, such a person should be allowed to decide the course of

action which should be followed in the future if he or she were to be in a situation which affects the ability to take decisions. If a decision on whether or not to receive medical treatment is valid for the present such a decision must be equally valid when it is intended to operate in the future. Advance directives are, in other words, grounded in a recognition by the law of the importance of consent as an essential attribute of personal liberty. It is the consensual nature of the act underlying the advance directive which imparts sanctity to it in future in the same manner as a decision in the present on whether or not to accept medical treatment.

112 When a patient is brought for medical treatment in a state of mind in which he or she is deprived of the mental capacity to make informed choices, the medical professional needs to determine the line of treatment. One line of enquiry, which seeks to protect patient autonomy is how the individual would have made a decision if he or she had decision-making capacity. This is called the substituted judgment standard. An advance medical directive is construed as a facilitative mechanism in the application of the substituted judgment standard, if it provides to the physician a communication by the patient (when she or he was in a fit state of mind) of the desire for or restraint on being provided medical treatment in future.

113 Conceptually, there is a second standard, which is the caregiver standard. This is founded on the principle of beneficence. The second

standard seeks to apply an objective notion of a line of treatment which a reasonable individual would desire in the circumstances.

The **Stanford Encyclopaedia** contains an elucidation of these two standards:

“The Substituted Judgment standard:

The surrogate’s task is to reconstruct what the patient himself would have wanted, in the circumstances at hand, if the patient had decision-making capacity. Substantive advance directives are here thought of as a helpful mechanism for aiding the application of Substituted Judgment. The moral principle underlying this legal standard is the principle of respect for autonomy, supplemented by the idea that when a patient is not currently capable of making a decision for himself, we can nonetheless respect his autonomy by following or reconstructing, as best we can, the autonomous decision he would have made if he were able. In a subset of cases, a substituted judgment can implement an actual earlier decision of the patient, made in anticipation of the current circumstances; this is known as precedent autonomy.

The Caregiver standard:

The surrogate is to decide based on what, in general, would be good for the patient. The moral principle underlying this standard is the principle of beneficence. This legal standard has traditionally assumed a quite generic view of interests, asking what a “reasonable” person would want under the circumstances and focusing on general goods such as freedom from pain, comfort, restoration and/or development of the patient’s physical and mental capacities. This is because the Caregiver standard has mainly been employed when there is little or no information about the patient’s specific values and preferences. However, the concept of caregiver is simply the concept of what is best for the person. There is no reason why, in principle, the Caregiver judgment could not be as nuanced and individual as the best theory of well-being dictates.”

The difference between these two standards is that the first seeks to reconstruct the subjective point of view of the patient. The second allows for “a more generic view of interests”, without having to rely on the “idiosyncratic values and preference of the patient in question”.

114 The Encyclopaedia explains that the “orthodox view” contained the following ordering of priorities:

- “1. Honour a substantive advance directive, as an aid to Substituted Judgment, whenever such directive is available.
2. Absent an advance directive, apply the Substituted Judgment standard based on available information about the patient’s past decisions and values.
3. If you cannot apply the Substituted Judgment standard – either because the patient has never been competent or because information about the patient’s former wishes and values is unavailable – use the Caregiver standard.”

The above ordering of priorities in the orthodox view has been questioned. In prioritising advance directives and substituted judgments, the orthodox view “overlooks the possibility that the earlier competent self and the current incompetent self may have conflicting interests”. Advance directives and the substituted judgment standard were propounded to deal with afflictions such as a persistent vegetative state where the interests of the patient in such a state are not potentially different from what they used to be. The Stanford Encyclopaedia, however, notes that a loss of decision-making capacity may give rise to less drastic conditions in which the presently incompetent patient may have developed “powerful new interests” in a new phase of life. Patients facing Alzheimer’s or dementia face progressive mental deterioration. When such a patient was still in a competent state of mind, she may have regarded a state of dementia to be degrading. However, as the disease progresses, the interests of the patient change and her life may be enriched by the simple activities of life. The patient may cease to identify with his or her intellect and revisit an earlier desire not to prolong life. The Stanford Encyclopaedia states

that in such an eventuality, “the conflict is between the autonomy of the earlier self and the well-being of the current self”.

115 One way of seeking a philosophical resolution is to postulate that the former self and its interests will have priority, or a “special authority” over the current self. Such an approach prioritises autonomy over beneficence. This line of approach is, however, not free of difficulty. A patient may have lost the ability to take complex decisions. Yet the treating physician may not have “a license to discount the current well-being of the individual in favour of what mattered to him earlier”. This illustration emphasises the potential conflict between a pure application of the substituted judgment standard and the caregiver standard. The former seeks to preserve individual autonomy at all costs. The latter juxtaposes the role of the medical professional in determining what is in the best interest of the patient. The best interest standard is hence founded on the principle that a patient who has progressed from a competent mental state to an increasing lack of mental capacity faces a change of personal identity. An autonomous decision suited to an earlier identity may not always be a valid rationale for determining the course of action in respect of a new identity which a patient acquires in the course of illness:

“According to the threshold views, the earlier self has authority to determine the overall interests of the patient because the current self has lost crucial abilities that would allow it to ground these overall interests anew. This picture assumes that the earlier and current self are stages in the life of one entity, so that, despite the talk of local interests associated with each life-stage, there is an underlying continuity of interests between the two. But this is a very substantial assumption, and it has been contested by appeal

to an influential account of the metaphysics of personal identity over time, the psychological continuity account. Roughly, the idea is that, in the wake of a drastic transformation of one's psychology such as Alzheimer's disease, one does not survive as numerically the same individual, so whatever interests one's predecessor in one's body may have had are not a suitable basis for decisions on behalf of the new individual who has emerged after the transformation (Dresser 1986). The lack of identity between the earlier and current self undercuts the authority of the former over the latter."

116 In such a situation the doctor's duty to care assumes significance. The relationship between a doctor and her patient with an evolving mental condition needs a balance between the desires of the patient in a different mental state and the needs of the patient in the present condition. Neither can be ignored in preference to the other. The first recognises the patient as an autonomous individual whose desires and choices must be respected by law and medicine. The desire not to be subject to endless medical intervention, when one's condition of mind or body have reached an irreversible state is a profound reflection of the value to be left alone. Constitutional jurisprudence protects it as part of the right to privacy. On the other hand, the need to procure the dignity of the individual in a deteriorating and irreversible state of body or mind is as crucial to the value of existence. The doctor must respect the former while being committed as a professional to protect the latter.

117 Human experience suggests that there is a chasm of imponderables which divide the present from the future. Such a divide may have a bearing on whether and if so, the extent to which an advance directive should bind in the

future. As stated above, the sanctity of an advance directive is founded upon the expression of the will of an individual who is in a sound state of mind when the directive is executed. Underlying the consensual character of the declaration is the notion of the consent being informed. Undoubtedly, the reasons which have weighed with an individual in executing the advance directive cannot be scrutinized (in the absence of situations such as fraud or coercion which implicate the very basis of the consent). However, an individual who expresses the desire not to be subjected to a particular line of treatment in the future, should she or he be ailing in the future, does so on an assessment of treatment options available when the directive is executed. For instance, a decision not to accept chemotherapy in the event that the individual is detected with cancer in the future, is based on today's perception of the trauma that may be suffered by the patient through that treatment. Advances in medical knowledge between the date of the execution of the document and an uncertain future date when the individual may possibly confront treatment for the disease may have led to a re-evaluation by the person of the basis on which a desire was expressed several years earlier. Another fundamental issue is whether the individual can by means of an advance directive compel the withholding of basic care such as hydration and nourishment in the future. Protecting the individual from pain and suffering as well as the indignity of debility may similarly raise important issues. Advance directives may hence conceivably raise ethical issues of the extent to which the perception of the individual who executes it must prevail in priority to the best interest of the patient.

118 The substituted judgment standard basically seeks to determine what the individual would have decided. This gives primacy to the autonomy of the individual. On the other hand, as seen earlier, the best interest standard is based on the principle of beneficence. There is an evident tension between these two standards. What an individual would decide as an autonomous entity is a matter of subjective perception. What is in the best interest of the patient is an objective standard: objective, with the limitation that even experts differ. The importance of an advance directive lies in bringing to the fore the primacy of individual choice. Such a directive ensures that the individual retains control over the manner in which the body is treated. It allows the individual to decide not to accept artificial treatment which would prolong life in the terminal stage of an ailment or in a vegetative state. In doing so, recognition is granted to the effect of the advance directive upon the happening of a contingency in the future, just as the individual would in the present have a right to refuse medical treatment. The advance directive is an indicator to medical professionals of the underlying desire of the person executing it.

119 In a society such as ours where family ties have an important place in social existence, advance directives also provide a sense of solace to the family. Decisions such as whether to withhold or withdraw artificial life saving treatment are difficult for families to take. Advance directives provide moral authority for the family of the patient that the decision which has been taken to withdraw or withhold artificial life support is in accord with the stated desire of

the patient expressed earlier. But the ethical concerns which have been referred to earlier may warrant a nuanced application of the principle. The circumstances which have been adverted to earlier indicate that the decision on whether to withhold or withdraw medical treatment should be left to a competent body comprising of, but not restricted to medical professionals. Assigning a supervisory role to such a body is also necessary in order to protect against the possibility of abuse and the dangers surrounding the misuse of an advance directive. One cannot be unmindful of prevailing social reality in the country. Hence, it is necessary to ensure that an advance directive is not utilized as a subterfuge to fulfil unlawful or unethical purposes such as facilitating a succession to property.

120 The view which this judgment puts forth is that the recognition of advance directives as part of a regime of constitutional jurisprudence is an essential attribute of the right to life and personal liberty under Article 21. That right comprehends dignity as its essential foundation. Quality of life is integral to dignity. As an essential aspect of dignity and the preservation of autonomy of choice and decision-making, each individual must have the right on whether or not to accept medical intervention. Such a choice expressed at a point in time when the individual is in a sound and competent state of mind should have sanctity in the future if the individual were to cease to have the mental capability to take decisions and make choices. Yet, a balance between the application of the substituted judgment standard and the best interest standard is necessary

as a matter of public interest. This can be achieved by allowing a supervisory role to an expert body with whom shall rest oversight in regard to whether a patient in the terminal stage of an illness or in a permanent vegetative state should be withheld or withdrawn from artificial life support.

121 In 1995, the British Medical Association (BMA) published a report on advance statements about medical treatment with the intention to reflect “good clinical practice in encouraging dialogue about individuals’ wishes concerning their future treatment”.¹⁶⁰ The report theoretically discussed six different types of advance statements¹⁶¹:

- A requesting statement reflecting an individual's aspirations and preferences
- A statement of general beliefs and aspects of life that the individual values
- A statement naming a proxy
- A directive giving clear instructions refusing some or all treatment(s)
- A statement specifying a degree of irreversible deterioration after which no life-sustaining treatment should be given
- A combination of the above

122 A decade later, the Mental Capacity Act (MCA), 2005 was enacted, which came into force in October 2007. The statute “enabled individuals to write an advance directive or appoint a lasting power of attorney to make their

¹⁶⁰ A S Kessel and J Meran, “Advance directives in the UK: legal, ethical, and practical considerations for doctors”, *British Journal of General Practice* (1998), at page 1263

¹⁶¹ Ibid

views on health care known should they lose capacity”¹⁶². The Act enshrined in statute law the right of an adult with capacity to make an advance directive to refuse specific treatment at a point in the future when they lack capacity.

123 Before turning to MCA, it is of importance to state the position of the common law before the enactment of the legislation. English Law has recognised the entitlement of an individual possessed of the ability to take decisions to refuse medical treatment¹⁶³. The law has had to confront problems in applying this standard in difficult, practical situations. For instance, in a judgment in **Re B (Adult: Refusal of Medical Treatment)**¹⁶⁴, a patient who was suffering from tetraplegia declined to consent to artificial ventilation. Though the patient was found initially to suffer from depression and to lack decision making capacity, subsequent evaluation found that she was mentally competent. For a period of nine months, the hospital refused to respect the wishes of the patient not to place her on artificial ventilation, necessitating judicial intervention. When the case travelled to court, the President of the Family Division, Dame Butler-Sloss emphasised that “the right of the patient to demand cessation of treatment must prevail “over the natural desire of the medical and nursing professions to try to keep her alive”. The Judge recognised the serious danger of “a benevolent paternalism which

¹⁶² “Are advance directives legally binding or simply the starting point for discussion on patients’ best interests?”, *BMJ* (28 November 2009), Volume 339, page 1231

¹⁶³ *Re T (Adult: Refusal of Treatment)* [1942] 4 All ER 649; *Re C (Adult: Refusal of Medical Treatment)*[1994] 1 All ER 819; *St George’s Healthcare NHS Trust v S* [1998] 3 WLR 936

¹⁶⁴ [2002] 2 All ER 449

does not embrace recognition of the personal autonomy of the severely disabled patient”.

124 Commenting on the above decision, **Elizabeth Wicks** in her recently published book titled “**The State and The Body – Legal Regulation of Bodily Autonomy**”¹⁶⁵ observes that:

“... the desire to preserve life is strong and choices to end life, especially in circumstances where the life is not without an element of quality, are often seen as swimming against a strong tide of the value of life.”

125 In **Re AK (Adult Patient) (Medical Treatment: Consent)**¹⁶⁶, Justice Hughes (as he then was) in the High Court of Justice, reviewed the authorities, and summarised the common law position thus:

“Accordingly, the first principle of law which I am satisfied is completely clear, is that in the case of an adult patient of full capacity his refusal to consent to treatment or care must in law be observed. It is clear that in an emergency a doctor is entitled in law to treat by invasive means if necessary a patient who by reason of the emergency is unable to consent, on the grounds that the consent can in those circumstances be assumed. It is, however, also clearly the law that the doctors are not entitled so to act if it is known that the patient, provided he was of sound mind and full capacity, has let it be known that he does not consent and that such treatment is against his wishes. To this extent an advance indication of the wishes of a patient of full capacity and sound mind are effective. Care will of course have to be taken to ensure that such anticipatory declarations of wishes still represent the wishes of the patient. Care must be taken to investigate how long ago the expression of wishes was made. Care must be taken to investigate with what knowledge the expression of wishes was made. All the circumstances in which the expression of wishes was given will of course have to be investigated.”

¹⁶⁵ Elizabeth Wicks, *The State and the Body: Legal Regulation of Bodily Autonomy*, Hart Publishing (2016)

¹⁶⁶ [2001] 1 FLR 129

In **HE v A Hospital NHS Trust**¹⁶⁷, Justice Munby of the High Court of Justice (Family Division) considered an “Advance Medical Directive/Release” signed by a young woman, which sought to refuse the transfusion of blood or primary blood components in absolute and irrevocable terms. The Court had to decide whether the advance directive was valid and applicable. It was noted that:

“A competent adult patient has an absolute right to refuse consent to any medical treatment or invasive procedure, whether the reasons are rational, irrational, unknown or non-existent, and even if the result of refusal is the certainty of death... Consistently with this, a competent adult patient's anticipatory refusal of consent (a so-called ‘advance directive’ or ‘living will’) remains binding and effective notwithstanding that the patient has subsequently become and remains incompetent. An adult is presumed to have capacity, so the burden of proof is on those who seek to rebut the presumption and who assert a lack of capacity. It is therefore for those who assert that an adult was not competent at the time he made his advance directive to prove that fact.”

The Court then analyzed the specific aspects of the law governing advance directives:

“1. There are no formal requirements for a valid advance directive. An advance directive need not be either in or evidenced by writing. An advance directive may be oral or in writing.

2. There are no formal requirements for the revocation of an advance directive. An advance directive, whether oral or in writing, may be revoked either orally or in writing. A written advance directive or an advance directive executed under seal can be revoked orally.

3. An advance directive is inherently revocable. Any condition in an advance directive purporting to make it irrevocable, any even self-imposed fetter on a patient's ability to revoke an advance directive, and any provision in an advance directive purporting to impose formal or other conditions upon its revocation, is contrary to public policy and void. So, a

¹⁶⁷ [2003] 2 FLR 408

stipulation in an advance directive, even if in writing, that it shall be binding unless and until revoked in writing is void as being contrary to public policy.

4. The existence and continuing validity and applicability of an advance directive is a question of fact. Whether an advance directive has been revoked or has for some other reason ceased to be operative is a question of fact.

5. The burden of proof is on those who seek to establish the existence and continuing validity and applicability of an advance directive.

6. Where life is at stake the evidence must be scrutinised with especial care. Clear and convincing proof is required. The continuing validity and applicability of the advance directive must be clearly established by convincing and inherently reliable evidence.

7. If there is doubt that doubt falls to be resolved in favour of the preservation of life.”

126 The common law has been “refined” by passage of the MCA 2005, which makes statutory provision for advance decisions to refuse treatment.¹⁶⁸ The Mental Capacity Act has certain underlying principles¹⁶⁹, which can be stated as follows:

- A person must be assumed to have capacity unless it is established that she lacks capacity.
- A person is not to be treated as unable to make a decision unless all practicable steps to help her to do so have been taken without success.
- A person is not to be treated as unable to make a decision merely because she makes an unwise decision.

¹⁶⁸ Alexander Ruck Keene, “Advance Decisions: getting it right?”, available at http://www.39essex.com/docs/articles/advance_decisions_paper_ark_december_2012.pdf

¹⁶⁹ Section 1, Mental Capacity Act 2005

- An act done, or decision made, under the Act for or on behalf of a person who lacks capacity must be done, or made, in her caregiver.
- Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

127 Advance decisions are legally binding in England and Wales, as long as they meet certain requirements. Section 24 of the Act deals with the criteria for legally valid advance decisions to refuse treatment. Section 25 deals with the validity and applicability of advance decisions. The advance directive does not affect the liability which a person may incur for carrying out or continuing a treatment in relation to the person making the decision, unless the decision is at the material time— (a) valid, and (b) applicable to the treatment.

128 The law in UK empowers the Court of Protection to make a declaration as to whether an advance decision— (a) exists; (b) is valid; (c) is applicable to a treatment.¹⁷⁰ Moreover, a person will not incur any liability for the consequences of withholding or withdrawing a treatment from an individual, if she at the material time, reasonably believes that a valid advance decision applicable to the treatment, made by that individual, exists.¹⁷¹

¹⁷⁰ Section 26(4), Mental Capacity Act 2005

¹⁷¹ Section 26(3), Mental Capacity Act 2005

Until the implementation of the Mental Capacity Act 2005 in October 2007, nobody was able legally to make medical decisions on behalf of another adult in England and Wales. The Act imposes duties on the person who has to make a determination as to what is in an individual's caregiver. All the relevant circumstances must be taken into consideration, which are as follows¹⁷²:

- Considering whether it is likely that the person will at some time have capacity in relation to the matter in question, and if it appears likely that he or she will, when that is likely to be;
- Permitting and encouraging, so far as reasonably practicable, the person to participate, or to improve the ability to participate, as fully as possible in any act done for and any decision affecting the person;
- Where the determination relates to life-sustaining treatment he or she must not, in considering whether the treatment is in the caregiver of the person concerned, be motivated by a desire to bring about death;
- Considering so far as is reasonably ascertainable, the person's past and present wishes and feelings (and, in particular, any relevant written statement made when he or she had capacity); the beliefs and values that would be likely to influence the decision if the person had capacity; and the other factors that he or she would be likely to consider if able to do so; and

¹⁷² Section 4, Mental Capacity Act 2005

- Taking into consideration, if it is practicable and appropriate to consult them, the views of anyone named by the person as someone to be consulted on the matter in question or on matters of that kind; anyone engaged in caring for the person or interested in his or her welfare; any donee of a lasting power of attorney granted by the person; and any deputy appointed for the person by the court, as to what would be in the person's caregiver.

129 Even after the enforcement of the Mental Capacity Act 2005, there have been examples of life sustaining treatment being continued despite the desire of the patient to the contrary. In **W v M**¹⁷³, a patient who was in a minimally conscious state had previously expressed a desire against artificial intervention. An application was made to withdraw artificial nutrition and hydration. The application was refused by the judge on the basis that her life had some benefit, in spite of the wishes of the family and the previously expressed desire of the patient when she was competent that she would not like to continue living in such a condition. The judge took the view that the wishes of the patient were not binding and did not carry substantial weight, not being formally recorded so as to constitute an advance decision under the Mental Capacity Act, 2005. Adverting to this decision, Wicks notes that despite the emphasis in the Act of 2005, on the previously expressed desires

¹⁷³ [2011] EWHC 2443 (Fam)

of the patient, “these are just one relevant factor and may well not be regarded as the crucial one if they point towards death rather than continued life”¹⁷⁴.

Yet, a subsequent decision of the UK Supreme Court in **Aintree University Hospitals NHS Foundation Trust v James and Others**¹⁷⁵ “does signify greater acceptance of the centrality of the dying person’s choices”¹⁷⁶. But decided cases show the “medical evidence relating to the benefits of continued existence remains an influential consideration”¹⁷⁷. The result has been a greater emphasis in providing palliative care towards the end of life. The palliative care approach gives priority to providing dignity to a dying patient over an approach which only seeks to prolong life:

“A civilised society really ought to be able to respect the dignity and autonomy of the dying in a way that both gives value to their lives and dignity to their death. The withdrawal of medical treatment from a dying patient can, in some circumstances, be justified; the withdrawal of basic care and compassion cannot.”¹⁷⁸

130 The Mental Healthcare Act 2017, which was assented to by the President of India on 7 April 2017, enacts specific provisions for recognising and enforcing advance directives for persons with mental illness. The expression “mental illness” is defined by Section 2(s) thus:

“mental illness” means a substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgment, behaviour, capacity to recognise reality or ability to meet the ordinary demands of life, mental conditions

¹⁷⁴ Elizabeth Wicks (Supra note 165), at page 69

¹⁷⁵ [2013] UK SC 6

¹⁷⁶ Elizabeth Wicks (Supra note 165), at page 69

¹⁷⁷ Ibid

¹⁷⁸ Ibid, at page 71

associated with the abuse of alcohol and drugs, but does not include mental retardation which is a condition of arrested or incomplete development of mind of a person, specially characterised by subnormality of intelligence”.

The Act recognises an advance directive. An advance directive has to be in writing. The person subscribing to it must be a major. While making an advance directive, the maker indicates

- (i) The manner in which he or she wishes or does not wish to be cared for and treated for a mental illness; and
- (ii) The person he or she appoints as a nominated representative¹⁷⁹.

An advance directive is to be invoked only when the person who made it ceases to have the capacity to make mental healthcare treatment decisions. It remains effective until the maker regains the capacity to do so¹⁸⁰.

131 The Central Mental Health Authority constituted under the Act is empowered to make regulations governing the making of advance directives¹⁸¹.

132 The Mental Health Review Board constituted under the Act has to maintain an online register of all advance directives and to make them available to a mental health professional when required¹⁸².

¹⁷⁹ Section 5(1), Mental Healthcare Act, 2017 (India)

¹⁸⁰ Section 5(3), Mental Healthcare Act, 2017 (India)

¹⁸¹ Section 6, Mental Healthcare Act, 2017 (India)

133 Advance directives are capable of being revoked, amended or modified by the maker at any time¹⁸³. The Act specifies that an advance directive will not apply to emergency treatment¹⁸⁴ administered to the maker. Otherwise, a duty has been cast upon every medical officer in charge of a mental health establishment and a psychiatrist in charge of treatment to propose or give treatment to a person with a mental illness, in accordance with a valid advance directive, subject to Section 11¹⁸⁵. Section 11 elucidates a procedure which is to be followed where a mental health professional, relative or care-giver does not desire to follow the advance directive. In such a case, an application has to be made to the Board to review, alter, cancel or modify the advance directive. In deciding whether to allow such an application the Board must consider whether

- (i) The advance directive is truly voluntary and made without force, undue influence or coercion;
- (ii) The advance directive should apply in circumstances which are materially different;
- (iii) The maker had made a sufficiently well informed decision;
- (iv) The maker possessed the capacity to make decisions relating to mental health care or treatment at the time when it was made; and
- (v) The directive is contrary to law or to constitutional provisions¹⁸⁶.

¹⁸² Section 7, Mental Healthcare Act, 2017 (India)

¹⁸³ Section 8(1), Mental Healthcare Act, 2017 (India)

¹⁸⁴ Section 9, Mental Healthcare Act, 2017 (India)

¹⁸⁵ Section 10, Mental Healthcare Act, 2017 (India)

¹⁸⁶ Section 11(2), Mental Healthcare Act, 2017 (India)

A duty has been cast to provide access to the advance directive to a medical practitioner or mental health professional, as the case may be¹⁸⁷. In the case of a minor, an advance directive can be made by a legal guardian¹⁸⁸. The Act has specifically granted protection to medical practitioners and to mental health professionals against being held liable for unforeseen consequences upon following an advance directive¹⁸⁹.

134 Chapter IV of the Mental Healthcare Act 2017 contains detailed provisions for the appointment and revocation of nominated representatives. The provisions contained in Chapter IV stipulate qualifications for appointment of nominated representatives; an order of precedence in recognising a nominated representative when none has been appointed by the individual concerned; revocation of appointments and the duties of nominated representatives. Among those duties, a nominated representative is to consider the current and past wishes, the life history, values, culture, background and the caregiver of the person with a mental illness; give effective credence to the views of the person with mental illness to the extent of his or her understanding the nature of the decisions under consideration; to provide support in making treatment decisions; have the right to seek information on diagnosis and treatment, among other things.

¹⁸⁷ Section 11(3), Mental Healthcare Act, 2017 (India)

¹⁸⁸ Section 11(4), Mental Healthcare Act, 2017 (India)

¹⁸⁹ Section 13(1), Mental Healthcare Act, 2017 (India)

135 In the context of mental illness, Parliament has now expressly recognised the validity of advance directives and delineated the role of nominated representatives in being associated with healthcare and treatment decisions.

136 A comparative analysis of advance directives in various jurisdictions indicates some common components. They include the patient's views and wishes regarding: (i) Cardio-pulmonary Resuscitation (CPR) - treatment that attempts to start breathing and blood flow in people who have stopped breathing or whose heart has stopped beating; (ii) Breathing Tubes; (iii) Feeding/Hydration; (iv) Dialysis; (v) Pain Killers; (vi) Antibiotics; (vii) Directions for organ donation; and (viii) Appointment of Proxy/Health care agent/Surrogate, etc.

137 Legal recognition of advance directives is founded upon the belief that an individual's right to have a dignified life must be respected. In **Vishaka v State of Rajasthan**¹⁹⁰, the Court, in the absence of enacted law against sexual harassment at work places, had laid down the guidelines and norms for due observance at all work places or other institutions, until a legislation is enacted for the purpose. Certain precepts can be deduced from the existing global framework on advance directives. These include the following:

¹⁹⁰ (1997) 6 SCC 241

A) Advance directives reflect the right of an adult with capacity to make a decision to refuse specific treatment at a point in the future when they lack capacity. A person can be said to lack capacity when “in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain”¹⁹¹. He/she must be deemed to have capacity to make decisions regarding his treatment if such person has ability to— (a) understand the information that is relevant to take a decision on the treatment or admission or personal assistance; or (b) appreciate any reasonably foreseeable consequence of a decision or lack of decision on the treatment or admission or personal assistance; or (c) communicate such decision by means of speech, expression, gesture or any other means.¹⁹²

B) For a legally valid advance decision to refuse treatment, an advance directive must fulfil a basic criteria¹⁹³, which should include that- a directive must be made by a person after he has reached 18 years of age¹⁹⁴; the person must be mentally competent when the directive is made; the directive must specify – in medical or layman’s terms – the treatment refused; and, it can specify the circumstances in which the refusal is to apply.

¹⁹¹ Section 2, Mental Capacity Act 2005 (UK)

¹⁹² Section 4, Mental Healthcare Act, 2017 (India)

¹⁹³ Section 24, Mental Capacity Act, 2005 (UK)

¹⁹⁴ A parent acting on behalf of his child cannot make such a declaration.

- C) At any time before reaching the comatose state, an individual can revoke the directive. In other words, an individual may withdraw or alter an advance decision at any time when he/she has capacity to do so. Such withdrawal (including a partial withdrawal) need not be in writing. A directive must be revoked if the statements or actions subsequent to the written document indicate contrary consent.¹⁹⁵
- D) An advance decision will not be applicable to the treatment in question if – (a) at the material time, the person, who made it, did not have the capacity to give or refuse consent to it¹⁹⁶; (b) the treatment is not the treatment specified in the advance decision¹⁹⁷; (c) any circumstances specified in the advance decision are absent¹⁹⁸; or (d) there are reasonable grounds for believing that circumstances exist which the person making the directive did not anticipate at the time of the advance decision and which would have affected his decision had he anticipated them.¹⁹⁹
- E) If a person intends specifically to refuse life-sustaining procedures²⁰⁰, he/she must – clearly indicate that it is to apply even if life is at risk and death will predictably result; put the decision in writing; and, ensure it is signed and witnessed.

¹⁹⁵ Luis Kutner (Supra note 65), at page 228

¹⁹⁶ Section 25(3), Mental Capacity Act 2005 (UK)

¹⁹⁷ Section 25(4) (a), Mental Capacity Act 2005 (UK)

¹⁹⁸ Section 25(4) (b), Mental Capacity Act 2005 (UK)

¹⁹⁹ Section 25(4) (c), Mental Capacity Act 2005 (UK)

²⁰⁰ Section 25 (5) and (6), Mental Capacity Act 2005 (UK)

- F) In the event that there is more than one valid Advance Directive, none of which have been revoked, the most recently signed Advance Directive will be considered as the last expression of the patient's wishes and will be given effect.
- G) A person will not incur any liability for the consequences of withholding or withdrawing a treatment from an individual, if he, at the material time, reasonably believes that a valid advance decision applicable to the treatment, made by that individual, exists.²⁰¹
- H) An advance directive must clearly contain the following: (a) full details of its maker, including date of birth, home address and any distinguishing features; (b) the name and address of a general practitioner and whether they have a copy; (c) a statement that the document should be used if the maker lacks capacity to make treatment decisions; (d) a clear statement of the decision, the treatment to be refused and the circumstances in which the decision will apply; (d) the date the document was written (or reviewed); and, (e) the person's signature and the signature of a witness.²⁰²

²⁰¹ Section 26(3), Mental Capacity Act 2005 (UK)

²⁰² Alexander Ruck Keene, "Advance Decisions: getting it right?", available at http://www.39essex.com/docs/articles/advance_decisions_paper_ark_december_2012.pdf

138 Advance directives also have limitations. Individuals may not fully understand treatment options or recognize the consequences of certain choices in the future. Sometimes, people change their minds after expressing advance directives and forget to inform others. Another issue with advance directives is that vague statements can make it difficult to understand the course of action when a situation arises. For example, general statements rejecting "heroic treatments" are vague and do not indicate whether you want a particular treatment for a specific situation (such as antibiotics for pneumonia after a severe stroke). On the other hand, very specific directives for future care may not be useful when situations change in unexpected ways. New medical therapies may also have become available since an advance directive was given. Thus, advance directives should be reviewed and revised regularly if feelings about certain issues change, so that current wishes and decisions are always legally documented.

139 An important facet which a regime of advanced care directives must factor in, is the existence of variables which affect the process. These include, in our society, institutional aspects such as the paucity of access to publicly funded Medicare, declining standards of professional ethics and the

inadequacy of institutional responses to the lack of professional accountability in the medical profession.

140 A report submitted in October 2017 by the American Bar Association's Commission on Law and Ageing to the US Department of Health Services, dwelt on several variables which bear upon advance directives. The following observations provide an insight:

"A good starting point in understanding this landscape is a realization that law and regulation are but one slice of the universe of variables that profoundly affect the experience of dying...

...other key variables include institutional innovation, the role of financing systems, professional and public education and professional standards and guidelines. All these operate in a larger framework that is defined by family, workplace, community life and spirituality. Thus, the isolation of law and regulation as a strategy for behaviour change requires a sense of humility in establishing expectations, lest we overstate the influence of law in the human experience of dying..."²⁰³

141 There are variables which "profoundly affect the experience of dying" even in a developed society. They provide a sobering reflection of the gulf which separates the needs of patients and the availability of services to the poor, in a society like ours with large impoverished strata. Patient autonomy may mean little to the impoverished citizen. For marginalised groups in urban and rural India, even basic medical care is a distant reality. Advance directives postulate the availability of medical care. For, it is on the hypothesis of such

²⁰³ "Advance Directives And Advance Care Planning: Legal And Policy Issues", *U.S. Department of Health and Human Services* (October 2007), available at <https://aspe.hhs.gov/system/files/pdf/75366/adacplpi.pdf>, at page 1

care being available that the right to choose or refuse treatment is based. The stark reality in our society is that medical facilities are woefully inadequate. Primary medical care is a luxury in many places. Public hospitals are overwhelmed by the gap between the demand for medical care and its supply. Advance directives may have little significance to large segments of Indian society which are denied access to basic care. Advance directives also require an awareness of rights. The stark reality is that the average Indian is deprived of even basic medical facilities in an environment where absence of rudimentary care is the norm. Moreover, absolute notions of patient autonomy need to be evaluated in the context of the Indian social structure where bonds of family, religion and caste predominate. The immediate family and in many situations, the larger unit of the extended family are caregivers. In the absence of a social security net, universal medical coverage and compulsory insurance, it is the family to which a patient turns to in distress. Families become the caregivers, willingly or as a result of social conditioning, especially in the absence of resources and alternative institutional facilities. The views of the family which are drawn by close bonds of kinship have to be factored into the process. At the other end of the spectrum, rising costs of medical care in the urban areas threaten to ruin the finances of a family when a member is struck by a serious illness. To them, advance directives may provide a measure of assurance when a crucial decision as to whether to prolong artificial support in an irreversible medical situation is to be taken. The fact that the patient had expressed a desire in the form of an advance directive

obviates a sense of moral guilt on the part of the caregivers, when the family accepts the doctors' wisdom to withdraw or withhold artificial support. Another important variable which a regime of advance directives must bear in mind is the danger of misuse. The regime of advance directives which is intended to secure patient autonomy must contain safeguards against the greed of avaricious relatives colluding with willing medical professionals. The safeguards must be robust to obviate the dangers. The complexities of culture and of the social strata adverted to above only emphasise the wide diversity that prevails within the country. Our solution must take into account the diversity across the country. It is with the above background in view that we have introduced a safeguard in the form of broad-based committees to oversee the process.

142 In order to ensure clarity in the course of action to be followed I agree with the guidelines contained in the judgment of the learned Chief Justice in regard to Advance Directives as well as in regard to the procedural mechanisms set up in the judgment.

K Conclusion

143 The court is above all, engaged in the task of expounding the Constitution. In doing so, we have been confronted with the enormous task of finding substance and balance in the relationship between life, morality and the experience of dying. The reason which has impelled the court to recognise

passive euthanasia and advance directives is that both bear a close association to the human urge to live with dignity. Age brings isolation. Physical and mental debility bring a loss of self worth. Pain and suffering are accompanied by a sense of being helpless. The loss of control is compounded when medical intervention takes over life. Human values are then lost to technology. More significant than the affliction of ageing and disease is the fear of our human persona being lost in the anonymity of an intensive care ward. It is hence necessary for this court to recognise that our dignity as citizens continues to be safeguarded by the Constitution even when life is seemingly lost and questions about our own mortality confront us in the twilight of existence.

- (i) The sanctity of human life is the arterial vein which animates the values, spirit and cellular structure of the Constitution. The Constitution recognises the value of life as its indestructible component. The survival of the sanctity principle is founded upon the guarantees of dignity, autonomy and liberty;
- (ii) The right to a dignified existence, the liberty to make decisions and choices and the autonomy of the individual are central to the quest to live a meaningful life. Liberty, dignity and autonomy are essential to the pursuit of happiness and to find meaning in human existence;

- (iii) The entitlement of each individual to a dignified existence necessitates constitutional recognition of the principle that an individual possessed of a free and competent mental state is entitled to decide whether or not to accept medical treatment. The right of such an individual to refuse medical treatment is unconditional. Neither the law nor the Constitution compel an individual who is competent and able to take decisions, to disclose the reasons for refusing medical treatment nor is such a refusal subject to the supervisory control of an outside entity;
- (iv) Constitutional recognition of the dignity of existence as an inseparable element of the right to life necessarily means that dignity attaches throughout the life of the individual. Every individual has a constitutionally protected expectation that the dignity which attaches to life must subsist even in the culminating phase of human existence. Dignity of life must encompass dignity in the stages of living which lead up to the end of life. Dignity in the process of dying is as much a part of the right to life under Article 21. To deprive an individual of dignity towards the end of life is to deprive the individual of a meaningful existence. Hence, the Constitution protects the legitimate expectation of every person to lead a life of dignity until death occurs;
- (v) The constitutionally recognised right to life is subject to the procedure established by law. The procedure for regulation or deprivation must, it is

well-settled, be fair, just and reasonable. Criminal law imposes restraints and penal exactions which regulate the deprivation of life, or as the case may be, personal liberty. The intentional taking away of the life of another is made culpable by the Penal Code. Active euthanasia falls within the express prohibitions of the law and is unlawful;

(vi) An individual who is in a sound and competent state of mind is entitled by means of an advance directive in writing, to specify the nature of medical intervention which may not be adopted in future, should he or she cease to possess the mental ability to decide. Such an advance directive is entitled to deference by the treating doctor. The treating doctor who, in a good faith exercise of professional medical judgment abides by an advance directive is protected against the burden of criminal liability;

(vii) The decision by a treating doctor to withhold or withdraw medical intervention in the case of a patient in the terminal stage of illness or in a persistently vegetative state or the like where artificial intervention will merely prolong the suffering and agony of the patient is protected by the law. Where the doctor has acted in such a case in the best interest of the patient and in *bona fide* discharge of the duty of care, the law will protect the reasonable exercise of a professional decision;

(viii) In **Gian Kaur**, the Constitution Bench held, while affirming the constitutional validity of Section 306 of the Penal Code (abetment of suicide), that the right to life does not include the right to die. **Gian Kaur** does not conclusively rule on the validity of passive euthanasia. The two Judge Bench decision in **Aruna Shanbaug** proceeds on an incorrect perception of **Gian Kaur**. Moreover, **Aruna Shanbaug** has proceeded on the basis of the act – omission distinction which suffers from incongruities of a jurisprudential nature. **Aruna Shanbaug** has also not dwelt on the intersection between criminal law and passive euthanasia, beyond advertent to Sections 306 and 309 of the Penal Code. **Aruna Shanbaug** has subordinated the interest of the patient to the interest of others including the treating doctors and supporting caregivers. The underlying basis of the decision in **Aruna Shanbaug** is flawed. Hence, it has become necessary for this Court in the present reference to revisit the issues raised and to independently arrive at a conclusion based on the constitutional position;

(ix) While upholding the legality of passive euthanasia (voluntary and non-voluntary) and in recognising the importance of advance directives, the present judgment draws sustenance from the constitutional values of liberty, dignity, autonomy and privacy. In order to lend assurance to a decision taken by the treating doctor in good faith, this judgment has mandated the setting up of committees to exercise a supervisory role and

function. Besides lending assurance to the decision of the treating doctors, the setting up of such committees and the processing of a proposed decision through the committee will protect the ultimate decision that is taken from an imputation of a lack of *bona fides*; and

- (x) The directions in regard to the regime of advance directives have been issued in exercise of the power conferred by Article 142 of the Constitution and shall continue to hold the field until a suitable legislation is enacted by Parliament to govern the area.

144 I agree with the directions proposed in the judgment of the learned Chief Justice.

145 The reference shall stand disposed of in the above terms.

.....J
[Dr D Y CHANDRACHUD]

**New Delhi;
March 9, 2018.**

REPORTABLE

IN THE SUPREME COURT OF INDIA

CIVIL ORIGINAL JURISDICTION

WRIT PETITION (CIVIL) NO. 215 OF 2005

COMMON CAUSE (A REGISTERED SOCIETY) ... PETITIONER

VERSUS

UNION OF INDIA AND ANR. ... RESPONDENTS

J U D G M E N T

ASHOK BHUSHAN, J.

I had advantage of going through the draft judgment of Hon'ble the Chief Justice. Though, broadly I subscribe to the views expressed by Hon'ble the Chief Justice on various principles and facets as expressed in the judgment, but looking to the great importance of issues involved, I have penned my reasons for my views expressed. However, I am in full agreement with the directions and safeguards as enumerated by Hon'ble the Chief Justice in Paras 191 to 194 of the Judgment with regard to advance medical directives.

I also had the benefit of going through the erudite opinion of Dr. Justice D.Y. Chandrachud, which expresses almost the same views which are reflected in my judgment.

This Constitution Bench has been constituted on a reference made by a three-Judge Bench vide its order dated 25th February, 2014. The writ petition filed in public interest prayed for essentially following two reliefs:

(a) declare 'right to die with dignity' as a fundamental right within the fold of Right to Live with dignity guaranteed under Article 21 of the Constitution of India;

(b) issue direction to the Respondent, to adopt suitable procedures, in consultation with State Governments where necessary, to ensure that persons of deteriorated health or terminally ill should be able to execute a document titled "MY LIVING WILL & ATTORNEY AUTHORISATION" which can be presented to hospital for appropriate action in event of the executant being admitted to the hospital with serious illness which may threaten termination of life of the executant or in the alternative, issue appropriate guidelines to this effect;"

2. Petitioner in support of writ petition has placed reliance on Constitution Bench judgment in ***Gian Kaur Vs. State of Punjab, (1996) 2 SCC 648*** as well as two-Judge Bench judgment in ***Aruna Ramachandra Shanbaug Vs. Union of India & Ors., (2011) 4 SCC 454***. Petitioner's case is that this Court in the above two judgments has although disapproved active euthanasia but has granted its approval to passive euthanasia. The three-Judge Bench after referring to paragraphs 24 and 25 of Constitution Bench judgment observed that Constitution Bench did not express any binding view on the subject of euthanasia rather reiterated that legislature would be the appropriate authority to bring the change. Three-Judge Bench further observed that view of two Judge Bench in ***Aruna Ramachandra Shanbaug*** that the Constitution Bench in ***Gian Kaur*** has approved the judgment of House of Lords in ***Airedale NHS Trust Vs. Bland, (1993) 1 All ER 821***, is not correct and further opinion expressed by two-Judge Bench judgment in paragraphs 101 and 104 is inconsistent. In the above view of the matter the three-Judge Bench made the reference to the Constitution

Bench. It is useful to extract paragraphs 17, 18 and 19 of the referring order which is to the following effect:

*"17) In view of the inconsistent opinions rendered in **Aruna Shanbaug (supra)** and also considering the important question of law involved which needs to be reflected in the light of social, legal, medical and constitutional perspective, it becomes extremely important to have a clear enunciation of law. Thus, in our cogent opinion, the question of law 12 Page 13 involved requires careful consideration by a Constitution Bench of this Court for the benefit of humanity as a whole.*

18) We refrain from framing any specific questions for consideration by the Constitution Bench as we invite the Constitution Bench to go into all the aspects of the matter and lay down exhaustive guidelines in this regard.

19) Accordingly, we refer this matter to a Constitution Bench of this Court for an authoritative opinion."

3. We have heard Shri Prashant Bhushan, learned counsel appearing for the petitioner. Shri P.S. Narasimha, learned Additional Solicitor General appearing for the Union of India. Shri Arvind Datar, learned senior counsel for Vidhi Centre for Legal Policy, Shri Sanjay R. Hegde, learned senior counsel for Indian Society of

Critical Care Medicine, Mr. Devansh A. Mohta, learned counsel for Society for Right to Die with Dignity and Mr. Praveen Khattar, learned counsel for Delhi Medical Council. We have also been assisted by Dr. R.R. Kishore Member of the Bar who has joined the Bar after carrying on the profession of doctor for more than 40 years.

A. PETITIONER'S CASE

4. The petitioner is a registered society which is engaged in taking of the common problems of the people. The petitioner vide this public interest litigation brings to the notice of this Court the serious problem of violation of fundamental right to life, liberty, privacy and the right to die with dignity of the people of this country, guaranteed to them under Article 21 of the Constitution of India. It is submitted that the citizens who are suffering from chronic diseases and/or are at the end of their natural life span and are likely to go into a state of terminal illness or permanent vegetative state are deprived of their rights to refuse cruel and unwanted medical treatment, like feeding

through hydration tubes, being kept on ventilator and other life supporting machines in order to artificially prolong their natural life span. This sometimes leads to extension of pain and agony both physical and mental which they desperately seek to end by making an informed choice and clearly expressing their wishes in advance, (called a living will) in the event of they going into a state when it will not be possible for them to express their wishes.

5. The petitioner further pleads that it is a common law right of the people, of any civilised country, to refuse unwanted medical treatment and no person can force him/her to take any medical treatment which the person does not desire to continue with. It is submitted that to initiate a medical treatment to a person who has reached at an end of his life and the process of his/her death has already commenced against the wishes of that person will be violative of his/her right to liberty. The right to be free from unwanted life-sustaining medical treatment is a right protected by Article 21. Even the right to privacy which has also been held to be

a part of right to life is being violated as the people are not being given any right to make an informed choice and a personal decision about withholding or withdrawing life sustaining medical treatment.

B. MAN & MEDICINE

6. Human being a mortal, death is an accepted phenomenon. Anyone born on the earth is sure to die. Human body is prone to disease and decay. Human being after getting knowledge of various science and art always fought with failure and shortcomings of human body. Various ways and means of healing its body were found and invented by mankind. The branch of medicine is practiced from ancient time both in India and other parts of the World. In our country "Charak Samhita" is a treatise of medicine which dates back 1000 BC.

7. In Western World "Hippocrates" is regarded as "father of western medicine". Hippocratic period dates from 460 BC. "Corpus Hippocraticum" comprises of not only general medical prescription, description of diseases, diagnosis, dietary recommendations but also

opinion of professional ethics of a physician. Thus, those who practiced medicine from ancient time were ordained to follow some ethical principles. For those who follow medical profession 'Hippocratic Oath' was always treated to be Oath to which every medical professional was held to be bound. It is useful to refer to original Hippocratic Oath, (as translated into English):

"I swear by Apollo, the healer, Asclepius, Hygieia, and Panacea, and I take to witness all the gods, all the goddesses, to keep according to my ability and my judgment, the following Oath and agreement:

To consider dear to me, as my parents, him who taught me this art; to live in common with him and, if necessary, to share my goods with him; To look upon his children as my own brothers, to teach them this art.

I will prescribe regimens for the good of my patients according to my ability and my judgment and never do harm to anyone.

I will not give a lethal drug to anyone if I am asked, nor will I advise such a plan; and similarly I will not give a woman a pessary to cause an abortion.

But I will preserve the purity of my life and my arts.

I will not cut for stone, even for patients in whom the disease is manifest; I will

leave this operation to be performed by practitioners, specialists in this art.

In every house where I come I will enter only for the good of my patients, keeping myself far from all intentional ill-doing and all seduction and especially from the pleasures of love with women or with men, be they free or slaves.

All that may come to my knowledge in the exercise of my profession or in daily commerce with men, which ought not to be spread abroad, I will keep secret and will never reveal.

If I keep this oath faithfully, may I enjoy my life and practice my art, respected by all men and in all times; but if I swerve from it or violate it, may the reverse be my lot."

8. The noticeable portion of the Hippocratic Oath is that medical practitioner swears that he will not give a lethal drug to anyone nor he will advise such a plan.

9. At this juncture, it shall be useful to refer to thoughts of Plato, a celebrated Greek Philosopher, on "physician" and treatment which he expressed in his treatise 'Republic'. Plato in "The Republic of Plato", (translated by Francis Macdonald Cornford) while discussing "physician", in Chapter IX states:

"Shall we say, then, that Asclepius recognized this and revealed the art of medicine for the benefit of people of sound constitution who normally led a healthy life, but had contracted some definite ailment? He would rid them of their disorders by means of drugs or the knife and tell them to go on living as usual, so as not to impair their usefulness as citizens. But where the body was diseased through and through, he would not try, by nicely calculated evacuations and doses, to prolong a miserable existence and let his patient beget children who were likely to be as sickly as himself. Treatment, he thought, would be wasted on a man who could not live in his ordinary round of duties and was consequently useless to himself and to society."

10. Plato in the same Chapter in little harsher words further states:

"But if a man had a sickly constitution and intemperate habits, his life was worth nothing to himself or to anyone else; medicine was not meant for such people and they should not be treated, though they might be richer than Midas."

11. From what has been noted above, it is apparent that although on one hand medical professional has to take Hippocratic Oath that he shall treat his patient according to his ability and judgment and never do harm to anyone. Further, he will not give any lethal drug to

anyone even he is asked for, on the other hand Plato held that those who has sickly constitution and intemperate habits should not be helped by medicine. Thus, the cleavage in views regarding ethics of a medical professional as well as not supporting medical treatment for those who are thoroughly diseased is found from ancient time in Greek thoughts itself.

12. The dilemma of medical professional still continues to this day and medical professionals are hesitant in adopting a course which may not support the life of a patient or lead to patient's death. Numerous cases raising conflicting views were brought before the Courts in the different parts of the World, some of which we shall refer hereinafter.

13. There has been considerable development in medical science from ancient time to this day. There has been substantial acceptance of natural and human rights of the human beings which found expression in "United Nations Human Rights Declaration, 1948" and subsequent declarations. The right of self-determination of an

individual has been recognised throughout the World.

C. CONCEPT OF LIFE & DEATH

14. In the ancient India, on 'life' and 'death' there is considerable literature. According to Hinduism, life never comes to an end. The soul never die although body may decay. The soul is continuous and perpetual which is not merely a biological identity, death is not the end of life but only a transformation of a body. In "Bhagavad-gita" Chapter II Verse 22 (as translated in English), it is stated by Lord Krishna:

"22.As a man shedding worn-out garments, takes other new ones, likewise the embodied soul, casting off worn-out bodies, enters into others that are new."

15. The death was never feared in ancient Indian culture and mythology. Death was treated sometimes a means to obtain liberation that is 'moksha'. Every life is a gift of God and sacred and it has to be protected at all cost. No person is bestowed with the right to end his or her life. However, an individual's act of discarding mortal body may be permissible under certain

circumstances. In ancient Indian religion, sanctity was attached to a Yogi (a person who has mastered the art of regulating his involuntary physical and mental functions, at will) can discard his/her mortal coil(body) through the process of higher spiritual practices called yoga. Such state was known as 'Samadhi'. But there was no concept in ancient India/mythology of putting an end to life of another human being which was always regarded as crime and against 'dharma'.

16. The Vedic Rules also forbid suicide whereas according to ancient hindu culture, a man in his fourth stage, i.e., Vanaprastha could go into the forest sustaining only on water and air, end his body. A Brahmin also could have got rid of his body by drowning oneself in a river, precipitating oneself from a mount, burning oneself or starving oneself to death; or by one of those modes of practising austerities, mentioned above. The Laws of Manu as contained in **Sacred Books of the East**, Edited by Max Muller, Volume 25 Chapter VI verses 31 and 32 refers to above. The Book also refers

to views of various commentators on verses 31 and 32. It is useful to extract verses 31 and 32 and Note of the author on aforesaid verses containing the views of different commentators which are to the following effect:

"31. Or let him walk, fully determined and going straight on, in a north-easterly direction, subsisting on water and air, until his body sinks to rest.

32. A Brahmana, having got rid of his body by one of those modes practised by the great sages, is exalted in the world of Brahman, free from sorrow and fear.

 31. Gov. and Kull. take yukta, firmly resolved' (Nar., Ragh.), in the sense of 'intent on the practice of Yoga.' Gov. and Kull. (see also Medh. on the next verse) say that a man may undertake the Mahaprasthanā, or 'Great Departure,' on a journey which ends in death, when he is incurably diseased or meets with a great misfortune, and that, because it is taught in the Sastras, it is not opposed to the Vedic rules which forbid suicide. From the parallel passage of Ap. II, 23, 2, it is, however, evident that a voluntary death by starvation was considered the befitting conclusion of a hermit's life. The antiquity and general prevalence of the practice may be inferred from the fact that the Gaina ascetics, too, consider it particularly meritorious.

32. *By one of those modes,' i.e. drowning oneself in a river, precipitating oneself from a mount, burning oneself or starving oneself to death' (Medh.); or 'by one of those modes of practising austerities, mentioned above, verse 23' (Gov., Kull., Nar., Nand.). Medh. adds a long discussion, trying to prove that the world of Brahman,' which the ascetic thus gains, is not the real complete liberation."*

17. The Hindu Sculpture also says that life and death is the gift of God and no human being has right to take away the said gift. The suicide is disapproved in Hindu way of life and it is believed that those who commit suicide did not attain Moksha or Salvation from the cycle of life and death.

18. The Muslims also strongly condemn suicide as they believe that life and death of a person depends on Allah's will and human beings are prohibited in going against HIS will.

19. Christianity also disapprove taking of one's life. Bible says that human being is a temple of God and the spirit of God dwelleth in the body and no man can defile the temple. Reference is made to Chapter 3 verses 16

and 17 of I CORINTHIANS , which is as below:-

"16. Know Ye not that ye are the temple of God, and that the Spirit of God dwelleth in you?"

17. If any man defile the temple of God, him shall God destroy; for the temple of God is holy, which temple ye are."

20. **Pope John Paul II** in, "The Gospel of Life",

denouncing euthanasia writes:

"Laws which authorise and promote euthanasia are therefore radically opposed not only to the good of the individual but also to the common good; as such they are completely lacking in authentic juridical validity. Disregarded for the right to life, precisely because it leads to the killing of the person whom society exists to serve, is what most directly conflicts with the possibility of achieving the common good. Consequently, a civil law authorising euthanasia ceases by that very fact to be a true, morally binding civil law."

21. The tenets of Jainism also talks about the practice of religiously nominated self-build death called "Sallkhana", meaning 'fast upto death'.

22. The Buddhist sculpture states that Lord Buddha had also allowed self-build death for the extremely ill person as an act of compassion.

23. In different religions and cultures, there are clear injunctions against taking life of oneself.

24. The petitioner in the Writ Petition has categorically clarified that petitioner is neither challenging the provisions of I.P.C. by which "attempt to suicide" is made a penal offence nor praying right to die be declared as fundamental right under Article 21. It is useful to refer to Para 7 of the Writ Petition, in which petitioner pleads following:-

*"It is submitted at the outset that the petitioner in the instant petition is neither challenging the Section 309 of Indian Penal Code, vide which Attempt to Suicide is a penal offence nor is asking right to die per se as a fundamental right under Article 21 (as the issue is squarely covered by the Constitution Bench judgment of this Hon'ble Court in the case of **Gian Kaur vs. State of Punjab and in other connected matters, (1996) 2 SCC 648.** The endeavour of the Petitioner in the instant petition is to seek guidelines from this Hon'ble Court whereby the people who are diagnosed of suffering from terminal*

diseases or ailments can execute Living Will or give directives in advance or otherwise to his/her attorney/executor to act in a specific manner in the event he/she goes into persistent vegetative state or coma owing to that illness or due to some other reason."

D. THE RELEVANT PROVISIONS OF IPC

25. The Indian Penal Code, 1860, is a general penal code defining various acts which are offence and providing for punishment thereof. Chapter XVI deals with "offences affecting the human body". The provisions of Indian Penal Code which are relevant in the present context are Section 306 and Section 309. Section 306 relates to abetment of suicide. It provides "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". Another provision which is relevant is Section 309 i.e. attempt to commit suicide. The provision states, 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 (or with fine, or with both). The issues which have come up for consideration in the present case have to be dealt with keeping in view the above provisions of Indian Penal Code which declares certain acts to be offence.

E. LEGISLATION IN REFERENCE TO EUTHANASIA

26. The only statutory provision in our country which refers to euthanasia is statutory regulations framed under Indian Medical Council Act, 1956, namely The Indian Medical Council (Professional Conduct, Etiquette & Ethics) Regulations, 2002. Chapter VI of the Regulations deals with "Unethical Acts". Regulation 6 is to the following effect:

"6. UNETHICAL ACTS

A physician shall not aid or abet or commit any of the following acts which shall be construed as unethical-

.....

6.7 Euthanasia- *Practising euthanasia shall constitute unethical conduct. However, on specific occasion, the question of withdrawing supporting devices to sustain cardiopulmonary 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. 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."

27. The Law Commission of India had stated and submitted a detailed report on the subject in 196th report on "Medical Treatment to Terminally Ill Patients (Protection of Patients and Medical Practitioners)". Law Commission examined various provisions of Indian Penal Code and other statutory provisions, judgments of this court and different courts of other countries and had made certain recommendations. A draft bill was also made part of the recommendation. Draft bill namely Medical Treatment to Terminally Ill Patients (Protection of Patients and Medical Practitioners) Bill, 2006, was made part of the report as an Annexure.

28. Chapter 8 of the report contains summary of recommendations. It is not necessary to reproduce all the recommendations. It is sufficient to refer to para 1

and 2 of the recommendations:

"...In the previous chapters, we have considered various important issues on the subject of withholding or withdrawing medical treatment (including artificial nutrition and hydration) from terminally ill-patients. In Chapter VII, we have considered what is suitable for our country. Various aspects arise for consideration, namely, as to who are competent and incompetent patients, as to what is meant by 'informed decision', what is meant by 'best interests' of a patient, whether patients, their relations or doctors or hospitals can move a Court of law seeking a declaration that an act or omission or a proposed act or omission of a doctor is lawful, if so, whether such decisions will be binding on the parties and doctors, in future civil and criminal proceedings etc. Questions have arisen whether a patient who refuses treatment is guilty of attempt to commit suicide or whether the doctors are guilty of abetment of suicide or culpable homicide not amounting to murder etc. On these issues, we have given our views in Chapter VII on a consideration of law and vast comparative literature.

In this chapter, we propose to give a summary of our recommendations and the corresponding sections of the proposed Bill which deal with each of the recommendations. (The draft of the Bill is annexed to this Report). We shall now refer to our recommendations.

1) There is need to have a law to protect patients who are terminally ill, when they

take decisions to refuse medical treatment, including artificial nutrition and hydration, so that they may not be considered guilty of the offence of 'attempt to commit suicide' under sec.309 of the Indian Penal Code, 1860.

It is also necessary to protect doctors (and those who act under their directions) who obey the competent patient's informed decision or who, in the case of (i) incompetent patients or (ii) competent patients whose decisions are not informed decisions, and decide that in the best interests of such patients, the medical treatment needs to be withheld or withdrawn as it is not likely to serve any purpose. Such actions of doctors must be declared by statute to be 'lawful' in order to protect doctors and those who act under their directions if they are hauled up for the offence of 'abetment of suicide' under sections 305, 306 of the Indian Penal Code, 1860, or for the offence of culpable homicide not amounting to murder under section 299 read with section 304 of the Penal Code, 1860 or in actions under civil law.

2)Parliament is competent to make such a law under Entry 26 of List III of the Seventh Schedule of the Constitution of India in regard to patients and medical practitioners. The proposed law, in our view, should be called 'The Medical Treatment of Terminally Ill Patients (Protection of Patients, Medical Practitioners) Act."

29. The 196th Report was again revised by the Law

Commission of India in 241st Report dated August, 2012. The 2006 draft bill was redrafted by Law Commission which was Annexure 1 to the report. The above bill however could not fructify in a law. The Ministry of health and family welfare had published another draft bill namely The Medical Treatment of Terminally Ill Patients (Protection of Patients & Medical Practitioners) Bill, 2016, as a private member bill which was introduced in Rajya Sabha on 5th August 2016, which is still pending.

30. From the above, it is clear that only statutory provision on euthanasia is regulation 6.7 of the 2002 Regulations as referred above. The regulations prohibit practicing euthanasia and declare that practicing euthanasia constitute unethical conduct on behalf of the medical practitioner. The regulation however carves an exception that 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. The regulation further

provides that team of doctors shall declare withdrawal of support system.

31. The withdrawal of medical treatment of terminally ill Persons is complex ethical, moral and social issue with which many countries have wrestled with their attempt to introduce a legal framework for end of life decision making. In absence of a comprehensive legal framework on the subject the issue has to be dealt with great caution.

F. TWO IMPORTANT JUDGMENTS OF THIS COURT ON THE SUBJECT:-

32. The first important judgment delivered by the Constitution Bench of this court touching the subject is the judgment of Constitution Bench in ***Gian Kaur Vs. State of Punjab, (1996) 2 SCC 648***. In the above case, the appellants were convicted under Section 306 and awarded sentence for abetment of commission of suicide by one Kulwant Kaur. The conviction was maintained by the High Court against which the appeal was filed as special leave in this Court. One of the grounds for

assailing the conviction before this Court was that Section 306 IPC is unconstitutional. The reliance was placed on two-Judge Bench decision of this court in ***P.Rathinam Vs. Union of India & Anr., (1994) 3 SCC 394,*** wherein Section 309 IPC was held to be unconstitutional as violative of Article 21 of the Constitution.

33. Section 306 was sought to be declared as unconstitutional being violative of Article 21 of the Constitution. The Law Commission by its 22nd report had recommended for deletion of Section 309 and a Bill was introduced in 1972 to amend the Indian Penal Code by deleting Section 309. The Constitution Bench dwelt the question as to whether 'right to die' is included in Article 21. The Constitution Bench concluded that 'right to die' "cannot be included as part of fundamental rights guaranteed under Article 21".

34. The challenge to section 309 on the basis of Articles 14 and 21 was repelled. This court further held that Section 306 of Indian Penal Code does not violate Article 21 and Article 14 of the Constitution of India.

35. The second judgment which needs to be noted in detail is two-Judge Bench judgment of this court in ***Aruna Ramachandra Shanbaug Vs. Union of India & Ors., (2011) 4 SCC 454.*** Writ Petition under Article 32 on behalf of Aruna Ramachandra Shanbaug was filed by one M/s. Pinky Virani claiming to be best friend. Aruna Ramachandra Shanbaug was staff nurse working in King Edward Memorial (*KEM*) Hospital, Parel, Mumbai. On 27.11.1973, she was attacked by a sweeper of the hospital who wrapped a dog chain around her neck and yanked her back with it. While sodomising her, he twisted the chain around her neck, as a result supply of oxygen to the brain stopped and the brain got damaged. On the next day she was found in unconscious condition. From the date of above incident she continued to be in persistent vegetative state(PVS) having no state of awareness, she was bed-ridden, unable to express herself, unable to think, hear and see anything or communicate in any manner. In writ petition under Article 32 it was prayed that the hospital where she is laying for last 36 years be directed to stop feeding and

let her die peacefully. In the above case, Two-Judge Bench considered all aspects of euthanasia, the court examined both active and passive euthanasia. Dealing with active and passive euthanasia and further voluntary and involuntarily euthanasia, following was laid down in para 39 and 40:

"39. Coming now to the legal issues in this case, it may be noted that euthanasia is of two types: active and passive. Active euthanasia entails the use of lethal substances or forces to kill a person e.g. a lethal injection given to a person with terminal cancer who is in terrible agony. Passive euthanasia entails withholding of medical treatment for continuance of life e.g. withholding of antibiotics where without giving it a patient is likely to die, or removing the heart-lung machine, from a patient in coma. The general legal position all over the world seems to be that while active euthanasia is legal even without legislation provided certain conditions and safeguards are maintained."

40. A further categorisation of euthanasia is between voluntary euthanasia and non-voluntary euthanasia. Voluntary euthanasia is where the consent is taken from the patient, whereas non-voluntary euthanasia is where the consent is unavailable e.g. when the patient is in coma, or is otherwise unable to give consent. While there is no legal difficulty in the case of the former, the latter poses several problems, which we shall address."

36. The court held that in India, active euthanasia is illegal and crime. In paragraph 41, following was held:

"41. As already stated above active euthanasia is a crime all over the world except where permitted by legislation. In India active euthanasia is illegal and a crime under Section 302 or at least under Section 304 of the Penal Code, 1860. Physician-assisted suicide is a crime under Section 306 IPC (abetment to suicide). Active euthanasia is taking specific steps to cause the patient's death, such as injecting the patient with some lethal substance e.g. sodium pentothal which causes a person deep sleep in a few seconds, and the person instantaneously and painlessly dies in this deep sleep."

37. The court noticed various judgments of different countries in the above context. Two-Judge Bench also referred to Constitution Bench judgment in **Gian Kaur Vs. State of Punjab**. In Para 101 and 104, following has been laid down:

*"101. The Constitution Bench of the Supreme Court in **Gina Kaur V. State of Punjab** held that both euthanasia and assisted suicide are not lawful in India. That decision overruled the earlier two-Judge Bench decision of the Supreme Court in **P.Rathinam V. Union of India**. The Court held that the right to life under Article 21 of the Constitution does not include the right to die. In **Gian Kaur case** the Supreme Court*

approved of the decision of the House of Lords in **Airedale case** and observed that euthanasia could be made lawful only by legislation.

104. It may be noted that in **Gian Kaur Case** although the Supreme Court has quoted with approval the view of the House of Lords in **Airedale case**, it has not clarified who can decide whether life support should be discontinued in the case of an incompetent person e.g. a person in coma or PVS. This vexed question has been arising often in India because there are a large number of cases where persons go into coma (due to an accident or some other reason) or for some other reason are unable to give consent, and then the question arises as to who should give consent for withdrawal of life support. This is an extremely important question in India because of the unfortunate low level of ethical standards to which our society has descended, its raw and widespread commercialisation, and the rampant corruption, and hence, the Court has to be very cautious that unscrupulous persons who wish to inherit the property of someone may not get him eliminated by some crooked method."

38. Two-Judge Bench noticed that there is no statutory provision in this country as to the legal procedure to withdraw life support to a person in Persistent Vegetative State (PVS) or who is otherwise incompetent to take the decision in this connection. The court, however, issued certain directions which were to

continue to be the law until Parliament makes a law on this subject. In paragraph 124, following has been laid down: -

*"124. There is no statutory provision in our country as to the legal procedure for withdrawing life support to a person in PVS or who is otherwise incompetent to take a decision in this connection. We agree with Mr. Andhyarujina that passive euthanasia should be permitted in our country in certain situations, and we disagree with the learned Attorney General that it should never be permitted. Hence, following the technique used in **Vishaka case**, we are laying down the law in this connection which will continue to be the law until Parliament makes a law on the subject:*

- (i) A decision has to be taken to discontinue life support either by the parents or the spouse or other close relatives, or in the absence of any of them, such a decision can be taken even by a person or a body of persons acting as a next friend. It can also be taken by the doctors attending the patient. However, the decision should be taken bona fide in the best interest of the patient.

In the present case, we have already noted that Aruna Shanbaug's parents are dead and other close relatives are not interested in her ever since she had the unfortunate assault on her. As already noted above, it is the KEM hospital staff, who have been amazingly caring for her day and night for so many long years, who

really are her next friends, and not Ms. Pinki Virani who has only visited her on few occasions and written a book on her. Hence it is for the KEM Hospital staff to take that decision. KEM Hospital staff have clearly expressed their wish that Aruna Shanbaug should be allowed to live.

Mr. Pallav Shishodia, learned Senior Counsel, appearing for the Dean, KEM Hospital, Mumbai, submitted that Ms. Pinki Virani has no locus standi in this case. In our opinion it is not necessary for us to go into this question since we are of the opinion that it is the KEM Hospital staff who is really the next friend of Aruna Shanbaug.

We do not mean to decry or disparage what Ms. Pinki Virani has done. Rather, we wish to express our appreciation of the splendid social spirit she has shown. We have seen on the internet that she has been espousing many social causes, and we hold her in high esteem. All that we wish to say is that however much her interest in Aruna Shanbaug may be it cannot match the involvement of the KEM Hospital staff who have been taking care of Aruna day and night for 38 years.

However, assuming that the KEM Hospital staff at some future time changes its mind, in our opinion in such a situation KEM Hospital would have to apply to the Bombay High Court for approval of the decision to withdraw life support.

- (ii) *Hence, even if a decision is taken by the near relatives or doctors or next friend to withdraw life support, such a decision requires approval from the High Court concerned as laid down in **Airedale case.***

In our opinion, this is even more necessary in our country as we cannot rule out the possibility of mischief being done by relatives or others for inheriting the property of the patient."

G. LAW ON SUBJECT IN OTHER COUNTRIES

39. The debate on Euthanasia had gathered momentum in last 100 years. The laws of different countries expresses thoughts of people based on different culture, philosophy and social conditions. Assisted suicide was always treated as an offence in most of the countries. Physician assisted suicide is also not accepted in most of the countries except in few where it gain ground in last century. In several countries including different States of U.S.A., European Countries and United Kingdom, various legislations have come into existence codifying different provisions pertaining to physician assisted suicide. The right to not commence or withdraw medical

treatment in case of terminally ill or PSV patients, advance medical directives have also been made part of different legislations in different countries.

40. Physician assisted suicide has not been accepted by many countries. However, few have accepted it and made necessary legislation to regulate it. Switzerland, Netherlands, Belgium, Luxembourg, and American States of Oregon, Washington, Montana and Columbia has permitted physician assisted suicide with statutory regulations. Courts in different parts of the world have dealt with the subject in issue in detail. It is not necessary to refer to different legislation of different countries and the case law on subject of different countries. For the purposes of this case, it shall be sufficient to notice few leading cases of United Kingdom, United States Supreme Court and few others countries.

United Kingdom

41. Euthanasia is criminal offence in the United Kingdom. According to Section 2(1) of the Suicide Act, 1961, a person assisting an individual, who wish to die

commits an offence. The provision states that it is an offence to aid, abet, counsel or procure the suicide of another or an attempt by another to commit suicide, however, it is not a crime if it is by their own hands. There has been large parliamentary opposition to the current United Kingdom Law concerning assisted suicide but there has been no fundamental change in the law so far. In 1997, the Doctor Assisted Dying Bill as well as in 2000, the Medical Treatment (Prevention of Euthanasia) Bill were not approved. The most celebrated judgment of the House of Lords is ***Airedale N.H.S. Trust Vs. Bland, (1993) A.C. 789.***

42. Anthony David Bland was injured on 15th April, 1989 at the Hillsborough football ground in which his lungs were crushed and punctured, the supply of oxygen to the brain was interrupted. As a result, he sustained catastrophic and irreversible damage to the higher centres of the brain, which had left him in a condition known as a persistent vegetative state(P.V.S.). Medical opinion was unanimous that there was no hope of improvement in his condition or recovery. At no time

before the disaster had the patient indicated his wishes if he should find himself in such a condition. Bland's father sought declarations that Hospital authorities may discontinue all his life-sustaining treatment and medical support measures and further lawfully discontinue and thereafter need not furnish medical treatment to the patient except for the sole purpose of enabling the patient to end his life and die peacefully with the greatest dignity and the least of pain, suffering and distress.

43. The lower court granted the declarations sought for. The court of appeal upheld the order. Official Solicitor filed an appeal before the House of Lords. **Lord Goff** held that it is not lawful for a doctor to administer a drug to his patient to bring about his death, even though that course is prompted by a humanitarian desire to end his suffering. Such act is actively causing death i.e. euthanasia which is not lawful. It was further held that a case in which doctor decides not to provide or continue to provide treatment or care, it may be lawful. Following was stated by Lord Goff:

"First, it is established that the principle of self-determination requires that respect must be given to the wishes of the patient, so that if an adult patient of sound mind refuses, however 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.....

To this extent, the principle of the sanctity of human life must yield to the principle of self-determination(see ante, pp.826H-827A, per Hoffmann L.J.), and, for present purposes perhaps more important, the doctor's duty to act in the best interests of his patient must likewise be qualified. On this basis, it has been held that a patient of sound mind may, if properly informed, require that life support should be discontinued: see *Nancy B. v. H"tel-Dieu de Quebec* (1992) 86 D.L.R. (4th) 385. Moreover the same principle applies where the patient's refusal to give his consent has been expressed at an earlier date, before he became unconscious or otherwise incapable of communicating it; though in such circumstances especial care may be necessary to ensure that the prior refusal of consent is still properly to be regarded as applicable in the circumstances which have subsequently occurred: see, e.g., *In re T.(Adult: Refusal of Treatment)* (1993) Fam.95. I wish to add that, in cases of this kind, there is no question of the patient having committed suicide, nor therefore of the doctor having aided or abetted him in doing so. It is simply that the patient has, as he is entitled to do,

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.....

I must however stress, at this point, that the law draws a crucial distinction between cases in which a doctor decides not to provide, or to continue to provide, for his patient treatment or care which could or might prolong his life, and those in which he decides, for example by administering a lethal drug, actively to bring his patient's life to an end. As I have already indicated, the former may be lawful, either because the doctor is giving effect to his patient's wishes by withholding the treatment or care, or even in certain circumstances in which (on principles which I shall describe) the patient is incapacitated from stating whether or not he gives his consent. But it is not lawful for a doctor to administer a drug to his patient to bring about his death, even though that course is prompted by a humanitarian desire to end his suffering, however great that suffering may be: see *Reg. v. Cox* (unreported), 18 September, 1992. So to act is to cross the Rubicon which runs between on the one hand the care of the living patient and on the other hand euthanasia-actively causing his death to avoid or to end his suffering. Euthanasia is not lawful at common law. It is of course well known that there are many responsible members of our society who believe that euthanasia should be made lawful; but that result could, I believe, only be achieved by legislation which expresses the democratic will that so fundamental a change should be made in our

law, and can, if enacted, ensure that such legalised killing can only be carried out subject to appropriate supervision and control.....

At the heart of this distinction lies a theoretical question. Why is it that the doctor who gives his patient a lethal injection which kills him commits an unlawful act and indeed is guilty of murder, whereas a doctor who, by discontinuing life support, allows his patient to die, may not act unlawfully – and will not do so, if he commits no breach of duty to his patient ?”

44. **Lord Browne-Wilkinson** in his judgment noticed the following questions raised in the matter:

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

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

Answering the questions following was held:

"Anthony Bland has been irreversibly brain damaged; the most distinguished medical

opinion is unanimous that there is no prospect at all that the condition will change for the better. He is not aware of anything. If artificial feeding is discontinued and he dies, he will feel nothing. Whether he lives or dies he will feel no pain or distress. All the purely physical considerations indicate that it is pointless to continue life support. Only if the doctors responsible for his care held the view that, though he is aware of nothing, there is some benefit to him in staying alive, would there be anything to indicate that it is for his benefit to continue the.....

In these circumstances, it is perfectly reasonable for the responsible doctors to conclude that there is no affirmative benefit to Anthony Bland in continuing the invasive medical procedures necessary to sustain his life. Having so concluded, they are neither entitled nor under a duty to continue such medical care. Therefore they will not be guilty of murder if they discontinue such care."

45. Another judgment which needs to be noticed is **Ms. B Vs. An NHS Hospital Trust, 2002 EWHC 429**. The claimant, Ms. B has sought declaration from the High Court that the invasive treatment which is currently being given by the respondent by way of artificial ventilation is an unlawful trespass. The main issue raised in the case is as to whether Ms. B has the capacity to make her own

decision about her treatment in hospital. Ms. B, aged 43 years, had suffered a devastating illness which has caused her to become tetraplegic and whose expressed wish is not to be kept artificially alive by the use of a ventilator. The High Court in the above context examined several earlier cases on the principle of autonomy. Paragraphs 16 to 22 are to the following effect:

"16. In 1972 Lord Reid in S v McC: W v W [1972] AC 25 said, at page 43:

"...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."

17. In re F (Mental Patient: Sterilisation) [1990] 2 AC 1, Lord Goff of Chieveley said at page 72:

"I start with the fundamental principle, now long established, that every person's body is inviolate."

18. Lord Donaldson of Lynton, MR said in re T (Adult: Refusal of Treatment) [1993] Fam 95, at page 113:

"... . the patient's right of choice exists

whether the reasons for making that choice are rational, irrational, unknown or even non-existent."

19. In re T (Adult: Refusal of Treatment), I cited Robins JA in *Malette v Shulman* 67 DLR (4th) 321 at 336, and said at page 116-117:

"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."

20. In re MB (Medical Treatment) [1997] 2 FLR 426, I said at 432:

"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", (referring to *Sidaway v Board of Governors of the Bethlehem Royal Hospital and the Maudsley Hospital* [1985] AC 871, per Lord Templeman at 904-905; and to Lord Donaldson M.R. in re T (Adult: Refusal of Treatment) (see above)).

21. This approach is identical with the jurisprudence in other parts of the world. In *Cruzan v Director, Missouri Department of Health* (1990) 110 S. Ct 2841, the United States Supreme Court stated that:

"No right is held more sacred, or is more carefully guarded... than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law."

b. The sanctity of life

22. Society and the medical profession in particular are concerned with the equally fundamental principle of the sanctity of life. The interface between the two principles of autonomy and sanctity of life is of great concern to the treating clinicians in the present case. Lord Keith of Kinkel in *Airedale NHS Trust v Bland* [1993] AC 789, said at page 859:

".. 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.""

46. The judgment of House of Lords in **Regina (Pretty) Vs. Director of Public Prosecutions (Secretary of State**

for the Home Department intervening), (2002) 1 AC 800, also needs to be referred to. The claimant, who suffered from a progressive and degenerative terminal illness, faced the imminent prospect of a distressing and humiliating death. She was mentally alert and wished to control the time and manner of her dying but her physical disabilities prevented her from taking her life unaided. She wished her husband to help her and he was willing to do so provided that in the event of his giving such assistance he would not be prosecuted under Section 2(1) of the Suicide Act, 1961. The claimant accordingly requested the Director of Public Prosecutions to undertake that he would not consent to such a prosecution under Section 2(4). On his refusal to give that undertaking the claimant, in reliance on rights guaranteed by the European Convention for the Protection of Human Rights and Fundamental Freedoms as Schedule to the Human Rights Act, 1998, sought relief by way of judicial review.

47. The Divisional Court of the Queen's Bench Division concluded that the Director has no power to give an

undertaking and dismissed the claim. The House of Lords again reiterated the distinction between the cessation of life-saving or life-prolonging treatment on the one hand and the taking of action intended solely to terminate life on the other. In paragraph 9 of the judgment following was held:

"9. In the Convention field the authority of domestic decisions is necessarily limited and, as already noted, Mrs Pretty bases her case on the Convention. But it is worthy of note that her argument is inconsistent with E two principles deeply embedded in English law. The first is a distinction between the taking of one's own life by one's own act and the taking of life through the intervention or with the help of a third party. The former has been permissible since suicide ceased to be a crime in 1961. The latter has continued to be proscribed. The distinction was very clearly expressed by Hoffmann LJ in Airedale NHS Trust v Bland [1993] AC 789, 831:F

"No one in this case is suggesting that Anthony Bland should be given a lethal injection. But there is concern about ceasing to supply food as against, for example, ceasing to treat an infection with antibiotics. Is there any real distinction? In order to come to terms with our intuitive feelings about whether there is a distinction, I must start by considering why most of us would

be appalled if he was given a lethal injection. It is, I think, connected with our view that the sanctity of life entails its inviolability by an outsider. Subject to exceptions like self-defence, human life is inviolate even if the person in question has consented to its violation. That is why although suicide is not a crime, assisting someone to commit suicide is. It follows that, even if we think Anthony Bland would have consented, we would not be entitled to end his life by a lethal injection."

The second distinction is between the cessation of life-saving or life-prolonging treatment on the one hand and the taking of action lacking medical, therapeutic or palliative justification but intended solely to terminate life on the other. This distinction provided the rationale of the decisions in Bland. It was very succinctly expressed in the Court of Appeal *In re J (A Minor) (Wardship: Medical Treatment)* [1991] Fam 33, in which Lord Donaldson of Lynton MR said, at p 46:

"What doctors and the court have to decide is whether, in the best interests of the child patient, a particular decision as to medical treatment should be taken which as a side effect will render death more or less likely. This is not a matter of semantics. It is fundamental. At the other end of the age spectrum, the use of drugs to reduce pain will often be fully justified, notwithstanding that

this will hasten the moment of death. What can never be justified is the use of drugs or surgical procedures with the primary purpose of doing so."

United States of America

48. The State of New York in 1828 enacted a statute declaring assisted suicide as a crime. New York example was followed by different other States.

49. **Cardozo, J.**, about a century ago in ***Schloendorff Vs. Society of New York Hospital***, 211 N.Y. 125, while in Court of Appeal had recognised the right of self-determination by every adult human being. Following was held:

"Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages. Pratt v. Davis, 224 Ill., 300, 79 N.E. 562, 7 L.R.A. (N.S.) 609, 8 Ann. Cas, 197; Mohr v. Williams, 95 Minn. 261, 104 N.W. 12.1 L.R. A.(N.S.), 111 Am. St. Rep. 462, 5 Ann. Cas, 303. This is true, except in cases of emergency where the patient is unconscious, and where it is necessary to operate before consent can be obtained."

50. Supreme Court of United States of America in **Nancy Beth Cruzan Vs. Director, Missouri Department of Health, 497 U.W. 261**, had occasion to consider a case of patient who was in persistent vegetative state, her guardian brought a declaratory judgment seeking judicial sanction to terminate artificial hydration and nutrition of patient. The Supreme Court recognised right possessed by every individual to have control over own person. Following was held by **Rehnquist, CJ**:

"At common law, even the touching of one person by another without consent and without legal justification was a battery. See **W. Keeton, D.Dobbs, R. Keeton, & D. Owen, Prosser and Keeton on Law of Torts, 9, pp.39-42 (5th ed. 1984)**. Before the turn of the century, this Court observed that "no right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law." **Union Pacific R. Co. v. Botsford, 141 U.S. 250, 251, 11 S.Ct. 1000, 1001, 35 L.Ed. 734 (1891)**. This notion of bodily integrity has been embodied in the requirement that informed consent is generally required for medical treatment. Justice Cardozo, while on the Court of Appeals of New York, aptly described this doctrine: "Every human being of adult years and sound mind has a right to determine

what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages," **Schloendorff v. Society of New York Hospital**, 211 N.Y. 125, 129-130, 105 N.E. 92, 93 (1914). The informed consent doctrine has become firmly entrenched in American tort law. See **Keeton, Dobbs, Keeton, & Owen, supra**, 32, pp.189-192; **F. Rozovsky, Consent to Treatment**, A Practical Guide 1-98 (2d ed. 1990).

The logical corollary of the doctrine of informed consent is that the patient generally possesses the right, not to consent, that is, to refuse treatment."

51. Referring to certain earlier cases following was held:

"Reasoning that the right of self-determination should not be lost merely because an individual is unable to sense a violation of it, the court held that incompetent individuals retain a right to refuse treatment. It also held that such a right could be exercised by a surrogate decision maker using a "subjective" standard when there was clear evidence that the incompetent person would have exercised it. Where such evidence was lacking, the court held that an individual's right could still be invoked in certain circumstances under objective "best interest" standards. *Id.*, at 361-368, 486 A.2d, at 1229-1233. Thus, if some trustworthy evidence existed that the individual would have wanted to terminate treatment, but not enough to

clearly establish a person's wishes for purposes of the subjective standard, and the burden of a prolonged life from the experience of pain and suffering markedly outweighed its satisfactions, treatment could be terminated under a "limited-objective" standard. Where no trustworthy evidence existed, and a person's suffering would make the administration of life-sustaining treatment inhumane, a "pure-objective" standard could be used to terminate treatment. If none of these conditions obtained, the court held it was best to err in favour of preserving life. *Id.*, at 364-368, 486 A.2d, at 1231-1233."

In the facts of the above case, the claim of parents of Cruzan was refused since guardian could not satisfactorily prove that Cruzan had expressed her wish not to continue her life under circumstances in which she drifted.

52. All different aspects of euthanasia were again considered by the United States Supreme Court in *Washington, Et Al,, Vs. Harold Glucksberg Et Al, 521 US 702 equivalent to 138 L.Ed 2d 772*. A Washington State statute enacted in 1975 provided that a person was guilty of the felony of promoting a suicide attempt when the person knowingly caused or aided another person to

attempt suicide. An action was brought in the United States District Court for the Western District of Washington by several plaintiffs, among whom were (1) physicians who occasionally treated terminally ill, suffering patients, and (2) individuals who were then in the terminal phases of serious and painful illness. The plaintiffs, asserting the existence of a liberty interest protected by the Federal Constitution's Fourteenth Amendment which extended to a personal choice by a mentally competent, terminally ill adult to commit physician-assisted suicide, sought a declaratory judgment that the Washington Statute was unconstitutional on its face. The District Court, granting motions for summary judgment by the physicians and the individuals, ruled that the statute was unconstitutional because it placed an undue burden on the exercise of the asserted liberty interest (850 F Supp 1454, 1994 US Dist LEXIS 5831). On appeal, the United States Court of Appeals for the Ninth Circuit, expressed the view that (1) the Constitution encompassed a due process liberty interest in controlling the time

and manner of one's death; and (2) the Washington Statute was unconstitutional as applied to terminally ill, competent adults who wished to hasten their deaths with medication prescribed by their physicians (79 F3d 790, 1996 US App LEXIS 3944).

53. On certiorari, the United States Supreme Court reversed. In an opinion by **Rehnquist, C.J.**, joined by O'Connor, Scalia, Kennedy, and Thomas, JJ., it was held that the Washington Statute did not violate the due process clause- either on the Statute's face or as the Statute was applied to competent, terminally ill adults who wished to hasten their deaths by obtaining medication prescribed by their physicians - because (1) pursuant to careful formulation of the interest at stake, the question was whether the liberty specially protected by the due process clause included a right to commit suicide which itself included a right to assistance in doing so; (2) an examination of the nation's history, legal traditions, and practices revealed that the asserted right to assistance in committing suicide was not a fundamental liberty

interest protected by the due process clause; (3) the asserted right to assistance in committing suicide was not consistent with the Supreme Court's substantive due process line of cases; and (4) the State's assisted suicide ban was at least reasonably related to the promotion and protection of a number of Washington's important and legitimate interests.

54. The US Supreme Court held that Washington statute did not violate the due process clause. **CJ, Rehnquist** while delivering the opinion of the Court upheld the State's ban on assisted suicide to the following effect:

*"...In almost every State-indeed, in almost every western democracy-it is a crime to assist a suicide. The States' assisted-suicide bans are longstanding expressions of the States' commitment to the protection and preservation of all human life. **Cruzan, supra, at 280, 111 L.Ed 2d 224, 110 S Ct 2841** ("The States-indeed, all civilized nations-demonstrate their commitment to life by treating homicide as a serious crime. Moreover, the majority of States in this country have laws imposing criminal penalties on one who assists another to commit suicide"); see *Stanford v. Kentucky*, 492 US 3561, 373, 106 L ED 2d 306, 109 S Ct 2969 (1989) ("The primary and most reliable indication of a national consensus is ... the pattern of enacted laws"). Indeed, opposition to and condemnation of suicide-*

and, therefore, of assisting suicide—are consistent and enduring themes of our philosophical, legal, and cultural heritages.”

55. Another judgment of US Supreme Court which needs to be noted is ***Dennis C. Vacco, Attorney General of New York, Et Al. Vs. Timothy E. Quill Et Al, 521 US 793***. New York state law as in effect in 1994 provided that a person who intentionally caused or aided another person to attempt or commit suicide was guilty of felony; but under other statutes, a competent person could refuse even life-saving medical treatment. Plaintiff sought declaratory relief and injunctive against the enforcement of criminal law asserting that such law is violative of statutes of the Federal Constitution Fourteenth Amendment.

56. **Rehnquist, CJ.** in his opinion again upheld distinction between assisted suicide and withdrawing of life sustaining treatment. Following was laid down:

"[1d] The Court of Appeals, however, concluded that some terminally ill people—those who are on life support systems—are treated differently from those who are not, in that the former may “hasten death” by

ending treatment, but the latter may not "hasten death" through physician-assisted suicide. 80 F.3d, at 729. This conclusion depends on the submission that ending or refusing lifesaving medical treatment "is nothing more nor less than assisted suicide." Ibid. Unlike the Court of Appeals, we think the distinction between assisting suicide and withdrawing life-sustaining treatment, a distinction widely recognised and endorsed in the medical profession and in our legal traditions, is both important and logical; it is certainly rational...

The distinction comports with fundamental legal principles of causation and intent. First, when a patient refuses life-sustaining medical treatment, he dies from an underlying fatal disease or pathology; but if a patient ingests lethal medication prescribed by a physician, he is killed by that medication....

Furthermore, a physician who withdraws, or honors a patient's refusal to begin, life-sustaining medical treatment purposefully intends, or may so intend, only to respect his patient's wishes and "to cease doing useless and futile or degrading things to the patient when the patient no longer stands to benefit from them."

57. However, there are four States which have passed legislation permitting euthanasia. These States include **Oregon, Washington, Missouri and Texas.**

Canada

58. Section 241(b) of the Criminal Code provides that everyone who aids or abets a person in committing suicide commits an indictable offence. In ***Rodriguez Vs. British Columbia (Attorney General), 1993 (3) SCR 519***, the Supreme Court of Canada has considered the issue of assisted suicide. A 42 year old lady who was suffering from an incurable illness applied before the Supreme Court of British Columbia for an order that Section 241(b) which prohibits giving assistance to commit suicide, be declared invalid. The application was dismissed and the matter was taken to the Supreme Court of Canada which held that prohibition of Section 241(b) which fulfils the government's objective of protecting the vulnerable, is grounded in the State interest in protecting life and reflects the policy of the State that human life should not be depreciated by allowing life to be taken.

Switzerland

59. In Switzerland the assisted suicide is allowed only

for altruistic reasons. A person is guilty and deserved to be sentenced for imprisonment on assisted suicide when he incites someone to commit suicide for selfish reasons.

Netherlands

60. The Netherlands has the most experience with physician-hastened death. Both euthanasia and assisted suicide remain crimes there but doctors who end their patients' lives will not be prosecuted if legal guidelines are followed. Among the guidelines are:

31. The request must be made entirely of the patient's own free will.
32. The patient must have a long-lasting desire for death.
33. The patient must be experiencing unbearable suffering.
34. There must be no reasonable alternatives to relative suffering other than euthanasia.
35. The euthanasia or assisted suicide must be reported to the coroner.

61. The above discussion clearly indicates that pre-dominant thought as on date prevailing in other part of

the World is that assisted suicide is a crime. No one is permitted to assist another person to commit suicide by injecting a lethal drug or by other means. In India, Section 306 of the Indian Penal Code specifically makes it an offence. The Constitution Bench of this Court in **Gian Kaur (supra)** has already upheld the constitutional validity of Section 306, thus, the law of the land as existing today is that no one is permitted to cause death of another person including a physician by administering any lethal drug even if the objective is to relieve the patient from pain and suffering.

H. RATIO OF GIAN KAUR VS. STATE OF PUNJAB

62. In **Gian Kaur's case (supra)**, the constitutional validity of Section 306 of Indian Penal Code, 1860 was challenged. The appellant had placed reliance on Two Judge Bench Judgment of this Court in **P. Rathinam Vs. Union of India (supra)**, where this Court declared Section 309 IPC to be unconstitutional as violative of Article 21 of the Constitution. It was contended that Section 309 having already been declared as

unconstitutional, any person abetting the commission of suicide by another is merely assisting in the enforcement of the fundamental right under Article 21 and, therefore, Section 306 IPC penalising assisted suicide is equally violative of Article 21. The Court proceeded to consider the constitutional validity of Section 306 on the above submission. In Para 17 of the judgment, this Court had made observation that reference to euthanasia cases tends to befog the real issue. Following are the relevant observations made in Para 17:-

"....Any further reference to the global debate on the desirability of retaining a penal provision to punish attempted suicide is unnecessary for the purpose of this decision. Undue emphasis on that aspect and particularly the reference to euthanasia cases tends to befog the real issue of the constitutionality of the provision and the crux of the matter which is determinative of the issue."

The Constitution Bench held that Article 21 does not include right to die. Paragraph 22 of the judgment contains the ratio in following words:-

"....Whatever may be the philosophy of

permitting a person to extinguish his life by committing suicide, we find it difficult to construe Article 21 to include within it the "right to die" as a part of the fundamental right guaranteed therein. "Right to life" is a natural right embodied in Article 21 but suicide is an unnatural termination or extinction of life and, therefore, incompatible and inconsistent with the concept of "right to life"....."

Although, right to die was held not to be a fundamental right enshrined under Article 21 but it was laid down that the right to life includes right to live with human dignity, i.e., right of a dying man to also die with dignity when his life is ebbing out. Following pertinent observations have been made in Para 24:-

"....The "right to life" including the right to live with human dignity would mean the existence of such a right up to the end of natural life. This also includes the right to a dignified life up to the point of death including a dignified procedure of death. In other words, this may include the right of a dying man to also die with dignity when his life is ebbing out. But the "right to die" with dignity at the end of life is not to be confused or equated with the "right to die" an unnatural death curtailing the natural span of life."

63. The Constitution Bench, however, noticed the

distinction between a dying man, who is terminally ill or in a persistent vegetative state, when process of natural death has commenced, from one where life is extinguished. The Court, however, held that permitting termination of life to such cases to reduce the period of suffering during the process of certain natural death is not available to interpret Article 21 to include therein the right to curtail the natural span of life. Paragraph 25 of the judgment is to the following effect:-

"25. A question may arise, in the context of a dying man who is terminally ill or in a persistent vegetative state that he may be permitted to terminate it by a premature extinction of his life in those circumstances. This category of cases may fall within the ambit of the "right to die" with dignity as a part of right to live with dignity, when death due to termination of natural life is certain and imminent and the process of natural death has commenced. These are not cases of extinguishing life but only of accelerating conclusion of the process of natural death which has already commenced. The debate even in such cases to permit physician-assisted termination of life is inconclusive. It is sufficient to reiterate that the argument to support the view of permitting termination of life in such cases to reduce the period of

suffering during the process of certain natural death is not available to interpret Article 21 to include therein the right to curtail the natural span of life."

64. The Constitution Bench in above paragraphs has observed that termination of life in case of those who are terminally ill or in a persistent vegetative state, may fall within the ambit of "right to die" with dignity as a part of right to live with dignity when death due to termination of natural life is certain and imminent and process of natural death has commenced. But even in those cases, physician assisted termination of life can not be included in right guaranteed under Article 21. One more pertinent observation can be noticed from Para 33, where this Court held that:

"33.We have earlier held that "right to die" is not included in the "right to life" under Article 21. For the same reason, "right to live with human dignity" cannot be construed to include within its ambit the right to terminate natural life, at least before commencement of the natural process of certain death...."

(emphasis by us)

65. The distinction between cases where physician decides not to provide or to discontinue to provide for treatment or care, which could or might prolong his life and those in which he decides to administer a lethal drug, was noticed while referring to the judgment of the House of Lords's case in ***Airedale's case (supra)***. In ***Airedale's case (supra)***, it was held that it is not lawful for a doctor to administer a drug to his patient to bring about his death. Euthanasia is not lawful at common law and euthanasia can be made lawful only by legislation. It is further relevant to notice that in Para 40, this Court had observed that it is not necessary to deal with physician assisted suicide or euthanasia cases. Paragraph 40, is as follows:-

"40. Airedale N.H.S. Trust v. Bland was a case relating to withdrawal of artificial measures for continuance of life by a physician. Even though it is not necessary to deal with physician-assisted suicide or euthanasia cases, a brief reference to this decision cited at the Bar may be made. In the context of existence in the persistent vegetative state of no benefit to the patient, the principle of sanctity of life, which is the concern of the State, was stated to be not an absolute one. In such

cases also, the existing crucial distinction between cases in which a physician decides not to provide, or to continue to provide, for his patient, treatment or care which could or might prolong his life, and those in which he decides, for example, by administering a lethal drug, actively to bring his patient's life to an end, was indicated and it was then stated as under: (All ER p. 867 : WLR p. 368)

"... But it is not lawful for a doctor to administer a drug to his patient to bring about his death, even though that course is prompted by a humanitarian desire to end his suffering, however great that suffering may be [see R. v. Cox, (18-9-1992, unreported)] per Ognall, J. in the Crown Court at Winchester. So to act is to cross the Rubicon which runs between on the one hand the care of the living patient and on the other hand euthanasia - actively causing his death to avoid or to end his suffering. Euthanasia is not lawful at common law. It is of course well known that there are many responsible members of our society who believe that euthanasia should be made lawful; but that result could, I believe, only be achieved by legislation which expresses the democratic will that so fundamental a change should be made in our law, and can, if enacted, ensure that such legalised killing can only be

carried out subject to appropriate supervision and control. ..."

66. A conjoint reading of observations in Paras 25, 33 and 40 indicates that although for a person terminally ill or in PSV state, whose process of natural death has commenced, termination of life may fall in the ambit of right to die with dignity but in those cases also there is no right of actively terminating life by a physician. The clear opinion has thus been expressed that euthanasia is not lawful. But at the same time, the Constitution Bench has noticed the distinction between the cases in which a physician decides not to provide or to continue to provide for his patient's treatment or care which could or might prolong his life and those in which physician decides actively to bring life to an end. The **ratio** of the judgment is contained in Paragraph 22 and 24, which is to the following effect:-

(i)“....Whatever may be the philosophy of permitting a person to extinguish his life by committing suicide, we find it difficult to construe Article 21 to include within it the “right to die” as a part of the fundamental right guaranteed therein.

"Right to life" is a natural right embodied in Article 21 but suicide is an unnatural termination or extinction of life and, therefore, incompatible and inconsistent with the concept of "right to life"....."

(ii)"....The "right to life" including the right to live with human dignity would mean the existence of such a right up to the end of natural life. This also includes the right to a dignified life up to the point of death including a dignified procedure of death. In other words, this may include the right of a dying man to also die with dignity when his life is ebbing out. But the "right to die" with dignity at the end of life is not to be confused or equated with the "right to die" an unnatural death curtailing the natural span of life."

67. We have noticed above that in Para 17, this Court had observed that reference to euthanasia cases tends to befog the real issue and further in Para 40, it was observed that "even though it is not necessary to deal with physician assisted suicide or euthanasia cases"; the Constitution Bench has neither considered the concept of euthanasia nor has laid down any ratio approving euthanasia.

68. At best, the Constitution Bench noted a difference between cases in which physician decides not to provide

or to continue to provide for medical treatment or care and those cases where he decides to administer a lethal drug activity to bring his patient's life to an end. The judgment of House of Lords in **Airedale's case (supra)** was referred to and noted in the above context. The **Airedale's case (supra)** was cited on behalf of the appellant in support of the contention that in said case the withdrawal of life saving treatment was held not to be unlawful.

69. We agree with the observation made in the reference order of the three-Judge Bench to the effect that the Constitution Bench did not express any binding view on the subject of euthanasia. We hold that no binding view was expressed by the Constitution Bench on the subject of Euthanasia.

I. CONCEPT OF EUTHANASIA

70. Euthanasia is derived from the Greek words **euthanatos**; *eu* means well or good and **thanatos** means death. **New Webster's Dictionary (Deluxe Encyclopedic Edition)** defines Euthanasia as following:

"A painless putting to death of persons having an incurable disease; an easy death. Also mercy killing."

71. The Oxford English Dictionary defines 'euthanasia':
"The painless killing of a patient suffering from an incurable and painful disease or in an irreversible coma". The definition of the word 'euthanasia' as given by the World Health Organisation may be noticed which defines it as: "A deliberate act undertaken by one person with the intention of either painlessly putting to death or failing to prevent death from natural causes in cases of terminal illness or irreversible coma of another person".

72. In ancient Greek Society, Euthanasia as 'good death' was associated with the drinking of 'Hemlock'. Drinking of Hemlock had become common not only in cases of incurable diseases but also by those individuals who faced other difficult problems or old age. In ancient times, in Greece freedom to live was recognised principle, which permitted the sick and desperates to terminate their lives by themselves or by taking outside

help. In last few centuries, Euthanasia increasingly came to connote specific measures taken by physicians to hasten the death. The primary meaning, as has now been ascribed to the word is compassionate murder. In the last century, the thought has gained acceptance that Euthanasia is to be distinguished from withdrawal of life saving treatments which may also result in death. Withdrawing medical treatment in a way hasten the death in case of terminal illness or Persistent Vegetative State (PVS) but is not to be treated as compassionate murder. Advancement in the medical science on account of which life can be prolonged by artificial devices are the developments of only last century. **Lord Browne Wilkinson, J., in Airedale N.H.A. Trust v. Bland, 1993 (2) W.L.R. 316 (H.L.)**, at page 389 observed:

".....Death in the traditional sense was beyond human control. Apart from cases of unlawful homicide, death occurred automatically in the course of nature when the natural functions of the body failed to sustain the lungs and the heart. Recent developments in medical science have fundamentally affected these previous certainties. In medicine, the cessation of breathing or of heartbeat is no longer

death. By the use of a ventilator, lungs which in the unaided course of nature would have stopped breathing can be made to breathe, thereby sustaining the heartbeat. Those, like Anthony Bland, who would previously have died through inability to swallow food can be kept alive by artificial feeding. This has led the medical profession to redefine death in terms of brain stem death, i.e., the death of that part of the brain without which the body cannot function at all without assistance. In some cases it is now apparently possible, with the use of the ventilator, to sustain a beating heart even though the brain stem, and therefore in medical terms the patient, is dead; "the ventilated corpse."

73. In recent times, three principles had gained acceptance throughout the world they are:

1. Sanctity of life
2. Right of self-determination
3. Dignity of the individual human being

74. The sanctity of life is one thought which is philosophically, religiously and mythologically accepted by the large number of population of the world practicing different faiths and religions. Sanctity of life entails it's inviolability by an outsider. Sanctity of life is the concern of State.

75. Right of self-determination also encompasses in it bodily integrity. Without consent of an adult person, who is in fit state of mind, even a surgeon is not authorised to violate the body. Sanctity of the human life is the most fundamental of the human social values. The acceptance of human rights and development of its meaning in recent times has fully recognised the dignity of the individual human being. All the above three principles enable an adult human being of conscious mind to take decision regarding extent and manner of taking medical treatment. An adult human being of conscious mind is fully entitled to refuse medical treatment or to decide not to take medical treatment and may decide to embrace the death in natural way. Euthanasia, as noted above, as the meaning of the word suggest is an act which leads to a good death. Some positive act is necessary to characterise the action as Euthanasia. Euthanasia is also commonly called "assisted suicide" due to the above reasons.

J. WITHDRAWAL OF LIFE SAVING DEVICES

76. Withdrawal of medical assistance or withdrawal of

medical devices which artificially prolong the life cannot be regarded as an act to achieve a good death. Artificial devices to prolong the life are implanted, when a person is likely to die due to different causes in his body. Life saving treatment and devices are put by physicians to prolong the life of a person. The Law Commission of India in its 196th Report on "Medical Treatment to Terminally Ill Patients (Protection of Patients and Medical Practitioners)" on the subject had put introductory note to the following effect:

"The title to this Report immediately suggests to one that we are dealing with 'Euthanasia' or 'Assisted Suicide'. But we make it clear at the outset that Euthanasia and Assisted Suicide continue to be unlawful and we are dealing with a different matter 'Withholding Life-support Measures' to patients terminally ill and, universally, in all countries, such withdrawal is treated as 'lawful'."

77. The Law Commission of India was of the opinion that withdrawing life supporting measures of patient terminally ill is a concept, different from Euthanasia. The opinion of **Cardozo, J.**, rendered more than hundred years ago that every human being of adult years and

sound mind has a right to determine what shall be done with his own body, is now universally accepted principle. The judgment of the U.S. Supreme Court and House of Lords, as noticed above, also reiterate the above principle.

78. Recently, in a nine-Judges judgment in ***K.S. Puttaswamy and Another Vs. Union of India and Others, (2017) 10 SCC 1, Justice J. Chelameswar*** elaborating the concept of right to life as enshrined in Article 21 under the Constitution of India has observed:

"An individual's right to refuse the life-prolonging medical treatment or terminate life is another freedom which falls within the zone of right of privacy."

79. Withdrawal of life-saving devices, leads to natural death which is arrested for the time being due to above device and the act of withdrawal put the life on the natural track. Decision to withdraw life-saving devices is not an act to cause good death of the person rather, decision to withdraw or not to initiate life-supporting measures is a decision when treatment becomes futile and unnecessary. Practice of Euthanasia in this country is

prohibited and for medical practitioners it is already ordained to be unethical conduct. The question as to what should be the measures to be taken while taking a decision to withdraw life-saving measures or life-saving devices is another question which we shall consider a little later.

80. Two-Judge Bench in ***Aruna Ramachandra Shanbaug Vs. Union of India and Ors., (2011) 4 SCC 454*** has held that withdrawal of life-saving measures is a passive Euthanasia which is permissible in India. A critically ill patient who is mentally competent to take a decision, decides not to take support of life prolonging measures, and respecting his wisdom if he is not put on such devices like ventilator etc., it is not at all Euthanasia. Large number of persons in advance age of life decide not to take medical treatment and embrace death in its natural way, can their death be termed as Euthanasia. Answer is, obviously 'No'. The decision not to take life saving medical treatment by a patient, who is competent to express his opinion cannot be termed as euthanasia, but a decision to withdraw life saving

treatment by a patient who is competent to take decision as well as with regard to a patient who is not competent to take decision can be termed as passive euthanasia. On the strength of the precedents in this country and weight of precedents of other countries as noted above, such action of withdrawing life saving device is legal. Thus, such acts, which are commonly expressed as passive euthanasia is lawful and legally permissible in this country.

81. We remind ourselves that this Court is not a legislative body nor is entitled or competent to act as a moral or ethical arbiter. The task of this Court is not to weigh or evaluate or reflect different believes and views or give effect to its own but to ascertain and build the law of land as it is now understood by all. Message which need to be sent to vulnerable and disadvantaged people should not, however, obliviously to encourage them to seek death but should assure them of care and support in life.

82. We thus are of the considered opinion that the act

of withdrawal from life-saving devices is an independent right which can lawfully be exercised by informed decision.

K. DECISION FOR WITHDRAWAL OF LIFE-SAVING TREATMENT IN CASE OF A PERSON WHO IS INCOMPETENT TO TAKE AN INFORMED DECISION.

83. One related aspect which needs to be considered is that is case of those patients who are incompetent to decide due to their mental state or due to the fact that they are in permanent persistent vegetative state or due to some other reasons unable to communicate their desire. When the right of an adult person who expresses his view regarding medical treatment can be regarded as right flowing from Article 21 of the Constitution of India, the right of patient who is incompetent to express his view cannot be outside the fold of Article 21 of the Constitution of India. It is another issue, as to how, the decision in cases of mentally incompetent patients regarding withdrawal of life-saving measures, is to be taken.

84. The rights of bodily integrity and self-determination are the rights which belong to every human being. When an adult person having mental capacity to take a decision can exercise his right not to take treatment or withdraw from treatment, the above right cannot be negated for a person who is not able to take an informed decision due to terminal illness or being a Persistent Vegetative State (PVS). The question is who is competent to take decision in case of terminally-ill or PVS patient, who is not able to take decision. In case of a person who is suffering from a disease and is taking medical treatment, there are three stake holders; the person himself, his family members and doctor treating the patient. The American Courts give recognition to opinion of "surrogate" where person is incompetent to take a decision. No person can take decision regarding life of another unless he is entitled to take such decision authorised under any law. The English Courts have applied the "best interests" test in case of a incompetent person. The best interests of the patient have to be found out not by doctor treating the

patient alone but a team of doctors specifically nominated by the State Authority. In **Aruna Shanbaug** (*supra*), two-Judge Bench of this Court has opined that in such cases relying on doctrine of 'parens patriae (father of the country)', it is the Court alone which is entitled to take a decision whether to withdraw treatment for incompetent terminally-ill or PVS patient. In paragraphs 130 and 131 following has been held:

"130. In our opinion, in the case of an incompetent person who is unable to take a decision whether to withdraw life support or not, it is the Court alone, as parens patriae, which ultimately must take this decision, though, no doubt, the views of the near relatives, next friend and doctors must be given due weight.

Under which provision of law can the Court grant approval for withdrawing life support to an incompetent person

131. In our opinion, it is the High Court under [Article 226](#) of the Constitution which can grant approval for withdrawal of life support to such an incompetent person. [Article 226\(1\)](#) of the Constitution states :

"226. Power of High Courts to issue certain writs.-
(1)Notwithstanding anything

in [article 32](#), every High Court shall have power, throughout the territories in relation to which it exercises jurisdiction, to issue to any person or authority, including in appropriate cases, any Government, within those territories directions, orders or writs, including writs in the nature of habeas corpus, mandamus, prohibition, quo warranto and certiorari, or any of them, for the enforcement of any of the rights conferred by Part III and for any other purpose".

(emphasis supplied)

A bare perusal of the above provisions shows that the High Court under [Article 226](#) of the Constitution is not only entitled to issue writs, but is also entitled to issue directions or orders."

85. Various learned counsel appearing before us have submitted that seeking declaration from the High Court in cases where medical treatment is needed to be withdrawn is time taking and does not advance the object nor is in the interest of terminally-ill patient. It is submitted that to keep check on such decisions, the State should constitute competent authorities consisting of pre-dominantly experienced medical practitioners

whose decision may be followed by all concerned with a rider that after taking of decision by competent body a cooling period should be provided to enable anyone aggrieved from the decision to approach a Court of Law. We also are of the opinion that in cases of incompetent patients who are unable to take an informed decision, it is in the best interests of the patient that the decision be taken by competent medical experts and that such decision be implemented after providing a cooling period at least of one month to enable aggrieved person to approach the Court of Law. The best interest of the patient as determined by medical experts shall meet the ends of justice. The medical team by taking decision shall also take into consideration the opinion of the blood relations of the patient and other relevant facts and circumstances.

L. ADVANCE MEDICAL DIRECTIVE

86. The petitioner by the Writ Petition has also sought a direction to the respondent to adopt suitable procedures to ensure that persons of deteriorated health

or terminally ill should be able to execute a document titled "MY LIVING WILL & ATTORNEY AUTHORISATION". The petitioner submits that it is an important personal decision of the patient to use or not to use the life sustaining treatment in case of terminal illness and stage of persistent vegetative state. The petitioner pleads that the petitioner's endeavour is only to seek a 'choice' for the people which is not available at present and they are left to the mercy of doctors who to save themselves from any penal consequences half heartedly, despite knowing that the death is inevitable continue administering the treatment which the person might not have wanted to continue with. A person will be free to issue advance directives both in a positive and negative manner, meaning thereby that a person is not necessarily required to issue directive that the life sustaining treatment should not be given to him in the event of he or she going into persistent vegetative state or in an irreversible state. The person can also issue directives as to all the possible treatment which should be given to him when he is not able to express

his/her wishes on medical treatment. The petitioner also refers to and rely on various legislations in different countries, which recognises the concept of advance medical directive. Petitioner pleads that in India also law in the nature "Patient Autonomy & Self-determination Act" should be enacted. Petitioner has also alongwith his Writ Petition has annexed a draft titling it "Patient's Self-determination Act".

87. The concept of advance medical directive is also called living will is of recent origin, which gained recognition in latter part of 20th century. The advance medical directive has been recognised first by Statute in United States of America when in the year 1976, State of California passed "Natural Death Act". It is claimed that 48 states out of 50 in the United States of America have enacted their own laws regarding Patient's Rights and advance medical directives. Advance medical directive is a mechanism through which individual autonomy can be safeguarded in order to provide dignity in dying. As noted above, the Constitution Bench of this Court in the case of **Gian Kaur (supra)** has laid

down that right to die with dignity is enshrined in Article 21 of the Constitution. It is to be noticed that advance medical directives are not exclusively associated with end of life decisions. However, it is vital to ensure that form of an advance medical directive reflects the needs of its author and is sufficiently authoritative and practical to enable its provisions to be upheld. In most of the western countries advance medical directives have taken a legalistic form incorporating a formal declaration to be signed by competent witnesses. The laws also make provisions for updating confirmation of its applicability and revocation. Protecting the individual autonomy is obviously the primary purpose of an advance medical directive. The right to decide one's own fate pre-supposes a capacity to do so. The answer as to when a particular advance medical directive becomes operative usually depends upon an assent of when its author is no longer competent to participate in medical decision making. The Black's Law Dictionary defines the Advance Medical Directive as "a legal document explaining one's

wishes about medical treatment if one becomes incompetent or unable to communicate". An advance medical directive is an individual's advance exercise of his autonomy on the subject of extent of medical intervention that he wishes to allow upon his own body at a future date, when he may not be in a position to specify his wishes. The purpose and object of advance medical directive is to express the choice of a person regarding medical treatment in an event when he loses capacity to take a decision. Use and operation of advance medical directive is to confine only to a case when person becomes incapacitated to take an informed decision regarding his medical treatment. So long as an individual can take an informed decision regarding his medical treatment, there is no occasion to look into advance medical directives. A person has unfettered right to change or cancel his advance medical directives looking to the need of time and advancement in medical science. Hence, a person cannot be tied up or bound by his instructions given at an earlier point of time.

88. The concept of advance medical directive originated

largely as a response to development in medicines. Many people living depending on machines cause great financial distress to the family with the cost of long term medical treatment. Advance medical directive was developed as a means to restrict the kinds of medical intervention in event when one become incapacitated. The foundation for seeking direction regarding advance medical directive is extension of the right to refuse medical treatment and the right to die with dignity. When a competent patient has right to take a decision regarding medical treatment, with regard to medical procedure entailing right to die with dignity, the said right cannot be denied to those patients, who have become incompetent to take an informed decision at the relevant time. The concept of advance medical directive has gained ground to give effect to the rights of those patients, who at a particular time are not able to take an informed decision. Another concept which has been accepted in several countries is recognition of instrument through which a person nominates a representative to make decision regarding their medical

treatment at a point of time when the person executing the instrument is unable to make an informed decision. This is called attorney authorisation leading to medical treatment. In this country, there is no legislation governing such advance medical directives. It is, however, relevant to note a recent legislation passed by the Parliament namely "The Mental Healthcare Act, 2017", where as per Section 5 every person, who is not a minor has a right to make an advance directive in writing regarding treatment to his mental illness in the way a person wishes to be treated or mental illness. The person wishes not to be treated for mental illness and nomination of individual and individual's as his/her representative. Section 5 is to the following effect:-

"5. (1) Every person, who is not a minor, shall have a right to make an advance directive in writing, specifying any or all of the following, namely:—

(a) the way the person wishes to be cared for and treated for a mental illness;

(b) the way the person wishes not to be cared for and treated for a mental illness;

(c) the individual or individuals, in order of precedence, he wants to appoint as his nominated representative as provided under section 14.

(2) An advance directive under sub-section (1) may be made by a person irrespective of his past mental illness or treatment for the same.

(3) An advance directive made under sub-section (1), shall be invoked only when such person ceases to have capacity to make mental healthcare or treatment decisions and shall remain effective until such person regains capacity to make mental healthcare or treatment decisions.

(4) Any decision made by a person while he has the capacity to make mental healthcare and treatment decisions shall over-ride any previously written advance directive by such person.

(5) Any advance directive made contrary to any law for the time being in force shall be ab initio void."

89. Section 6 of the Act provides that an advance directive shall be made in the manner as has been prescribed by the regulations made by the Central Authority. In the draft Medical Healthcare Regulation published by Ministry of Health and Family Welfare, a form is prescribed in which advance directive may be

made. Other aspects of medical directive have also been dealt with by draft regulation. Thus, in our country, recognition of advance directives regarding medical treatment has started to be recognised and are in place relating to specified field and purpose. Another legislation which also recognise some kind of advance directive relating to a person's body is Section 3 of the Transplantation of Human Organs and Tissues Act, 1994. Section 3 sub-sections (1) and (2) which are relevant for the present purpose is as follows:-

"3. Authority for removal of [human organs or tissues or both].-(1) Any donor may, in such manner and subject to such conditions as may be prescribed, authorise the removal, before his death, of any [human organ or tissue or both] of his body for therapeutic purposes.

(2) If any donor had, in writing and in the presence of two or more witnesses (at least one of whom is a near relative of such person), unequivocally authorised at any time before his death, the removal of any [human organ or tissue or both] of his body, after his death, for therapeutic purposes, the person lawfully in possession of the dead body of the donor shall, unless he has any reason to believe that the donor had subsequently revoked the authority aforesaid, grant to a registered medical practitioner all reasonable facilities for the removal, for therapeutic purposes, of

that [human organ or tissue or both] from the dead body of the donor."

90. The rules have been framed under Section 24 of the Transplantation of Human Organs and Tissues Act, 1994 namely Transplantation of Human Organs and Tissues Rules, 2014 where form of authorisation for organ or tissue pledging is Form 7, which provides that an authorisation by donor in presence of two witnesses which is also required to be registered by Organ Donor Registry.

91. The statutory recognition of the above mentioned authorisation in two statutes is clear indication of acceptance of the concept of advance medical directive in this country.

92. Learned counsel for the petitioner as well as for the interveners and the Additional Solicitor General of India has expressed concern regarding manner and procedure of execution of advance medical directive. It is submitted that unless proper safeguards are not laid down, those who are vulnerable, infirm and aged may be

adversely affected and efforts by those related to a person to expedite death of a person for gaining different benefits, cannot be ruled out. We have been referred to various legislations in different countries, which provides a detailed procedure of execution of advance medical directive, competence of witnesses, mode and manner of execution, authority to register and keep such advance medical directive.

93. Shri Arvind Datar, learned senior counsel has in its written submissions referred to certain aspects, which may be kept in mind while formulating guidelines for advance medical directive, which are as follows:

a) Only adult persons, above the age of eighteen years and of sound mind at the time at which the advance directive is executed should be deemed to be competent. This should include persons suffering from mental disabilities provided they are of sound mind at the time of executing an advance directive.

b) Only written advance directives that have been executed properly with the notarised signature of the person executing the advance directive, in the presence of two adult witnesses shall be valid and enforceable in the eyes of the law. The form should require a reaffirmation that

the person executing such directive has made an informed decision. Only those advance directives relating to the withdrawal or withholding of life-sustaining treatment should be granted legal validity. The determination that the executor of the advance directive is no longer capable of making the decision should be made in accordance with relevant medical professional regulations or standard treatment guidelines, as also the determination that the executor's life would terminate in the absence of life-sustaining treatment. The constitution of a panel of experts may also be considered to make this determination. The use of expert committees or ethics committees in other jurisdictions is discussed at Para 28 of these written submissions.

c) Primary responsibility for ensuring compliance with the advance directive should be on the medical institution where the person is receiving such treatment.

d) If a hospital refuses to recognise the validity of an advance directive, the relatives or next friend may approach the jurisdictional High Court seeking a writ of mandamus against the concerned hospital to execute the directive. The High Court may examine whether the directive has been properly executed, whether it is still valid (Le, whether or not circumstances have fundamentally changed since its execution, making it invalid) and/or applicable to the particular circumstances or treatment.

e) No hospital or doctor should be made liable in civil or criminal proceedings for

having obeyed a validly executed advance directive.

f) Doctors citing conscientious objection to the enforcement of advance directives on the grounds of religion should be permitted not to enforce it, taking into account their fundamental right under Article 25 of the Constitution. However, the hospital will still remain under this obligation.

94. The right to self-determination and bodily integrity has been recognised by this Court as noted above. The right to execute an advance medical directive is nothing but a step towards protection of aforesaid right by an individual, in event he becomes incompetent to take an informed decision, in particular stage of life. It has to be recognised by all including the States that a person has right to execute an advance medical directive to be utilised to know his decision regarding manner and extent of medical treatment given to his body, in case he is incapacitated to take an informed decision. Such right by an individual does not depend on any recognition or legislation by a State and we are of the considered opinion that such rights can be exercised by an individual in recognition and in affirmation of his

right of bodily integrity and self-determination which are duly protected under Article 21 of the Constitution. The procedure and manner of such expression of such right is a question which needs to be addressed to protect the vulnerable, infirm and old from any misuse. It is the duty of the State to protect its subjects specially those who are infirm, old and needs medical care. The duty of doctor to extend medical care to the patients, who comes to them in no manner diminishes in any manner by recognition of concept that an individual is entitled to execute an advance medical directive. The physicians and medical practitioners treating a person, who is incompetent to express an informed decision has to act in a manner so as to give effect to the express wishes of an individual.

95. The concept of advance medical directive has gained ground throughout the world. Different countries have framed necessary legislation in this regard. Reference of few of such legislations shall give idea of such statutory scheme formulated by different countries to achieve the object. The Republic of Singapore has passed

an enactment namely ADVANCE MEDICAL DIRECTIVE ACT (Act 16 of 1996). Section 3 of the Act, sub-section (1) empowers a person who is not mentally disordered and attained the age of 21 years to make an advance directive in the prescribed form.

Other provisions of Statute deals with duty of witness, registration of directives, objections, revocation of directive, panel of specialists, certification of terminal illness, duty of medical practitioner and other related provisions. The Belgian Act on Euthanasia, 2002 also contains provisions regarding advance directive in Section 4. Swiss Civil Code 1907 in Articles 362 and 365 provides for advance care directive, its execution and termination. Mental Capacity Act, 2005 (England) also contemplates for an advance directive. The Statute further provides that an advance directive is applicable in life sustaining treatment only. When the decision taken in writing, signed by the patient or by another person in patient's presence on his direction. Pennsylvania Act 169 of 2006 also contains provisions with regard to execution of

advance medical directive and other related provisions, its revocation etc.

In our country, there is yet no legislation pertaining to advance medical directive. It is, however, relevant to note that Ministry of Health and Family Welfare vide its order dated 06.05.2016 uploaded the Law Commission's 241st report and solicited opinions, comments on the same. An explanatory note has also been uploaded by the Ministry of Health and Family Welfare where in paragraph 6 following was stated:

“ Living Will has been defined as “A document in which person states his/her desire to have or not to have extraordinary life prolonging measures used when recovery is not possible from his/her terminal condition”.

However, as per para 11 of the said Bill the advance medical directive (living will) or medical power of attorney executed by the person shall be void and of no effect and shall not be binding on any medical practitioner.”

Although in Clause 11 of the draft bill, it was contemplated that advance medical directives are not binding on medical practitioner but the process of

legislation had not reached at any final stage. The directions and safeguards which have been enumerated by Hon'ble Chief Justice in his judgment shall be sufficient to safeguard the interests of patients, doctors and society till the appropriate legislation is framed and enforced.

We thus conclude that a person with competent medical facility is entitled to execute an advance medical directive subject to various safeguards as noted above.

M. CONCLUSIONS:

From the above discussions, we arrive on following conclusions:-

(i) The Constitution Bench in ***Gian Kaur's case*** held that the "right to life: including right to live with human dignity" would mean the existence of such right up to the end of natural life, which also includes the right to a dignified life upto the point of death including a dignified procedure of death. The above

right was held to be part of fundamental right enshrined under Article 21 of the Constitution which we also reiterate.

(ii) We agree with the observation made in the reference order of the three-Judge Bench to the effect that the Constitution Bench in *Gian Kaur's case* did not express any binding view on the subject of euthanasia. We hold that no binding view was expressed by the Constitution Bench on the subject of Euthanasia.

(iii) The Constitution Bench, however, noted a distinction between cases in which physician decides not to provide or continue to provide for treatment and care, which could or might prolong his life and those in which he decides to administer a lethal drug even though with object of relieving the patient from pain and suffering. The later was held not to be covered under any right flowing from Article 21.

(iv) Thus, the law of the land as existing today is that no one is permitted to cause death of another person including a physician by administering any lethal

drug even if the objective is to relieve the patient from pain and suffering.

(v) An adult human being of conscious mind is fully entitled to refuse medical treatment or to decide not to take medical treatment and may decide to embrace the death in natural way.

(vi) Euthanasia as the meaning of words suggest is an act which leads to a good death. Some positive act is necessary to characterise the action as Euthanasia. Euthanasia is also commonly called "assisted suicide" due to the above reasons.

(vii) We are thus of the opinion that the right not to take a life saving treatment by a person, who is competent to take an informed decision is not covered by the concept of euthanasia as it is commonly understood but a decision to withdraw life saving treatment by a patient who is competent to take decision as well as with regard to a patient who is not competent to take decision can be termed as passive euthanasia, which is lawful and legally permissible in this country.

(viii) The right of patient who is incompetent to express his view cannot be outside of fold of Article 21 of the Constitution of India.

(ix) We also are of the opinion that in cases of incompetent patients who are unable to take an informed decision, "the best interests principle" be applied and such decision be taken by specified competent medical experts and be implemented after providing a cooling period to enable aggrieved person to approach the court of law.

(x) An advance medical directive is an individual's advance exercise of his autonomy on the subject of extent of medical intervention that he wishes to allow upon his own body at a future date, when he may not be in a position to specify his wishes. The purpose and object of advance medical directive is to express the choice of a person regarding medical treatment in an event when he loses capacity to take a decision. The right to execute an advance medical directive is nothing

but a step towards protection of aforesaid right by an individual.

(xi) Right of execution of an advance medical directive by an individual does not depend on any recognition or legislation by a State and we are of the considered opinion that such rights can be exercised by an individual in recognition and in affirmation of his right of bodily integrity and self-determination.

In view of our conclusions as noted above the writ petition is **allowed** in the following manner:

(a) The right to die with dignity as fundamental right has already been declared by the Constitution Bench judgment of this Court in ***Gian Kaur case (supra)*** which we reiterate.

(b) We declare that an adult human being having mental capacity to take an informed decision has right to refuse medical treatment including withdrawal from life saving devices.

(c) A person of competent mental faculty is entitled to execute an advance medical directive in accordance with safeguards as referred to above.

96. Before we conclude, we acknowledge our indebtedness to all the learned Advocates who have rendered valuable assistance with great industry and ability which made it possible for us to resolve issues of seminal public importance. We record our fullest appreciation for the assistance rendered by each and every counsel in this case.

.....J.
(ASHOK BHUSHAN)

NEW DELHI,
MARCH 09, 2018.