

REPORTABLE

IN THE SUPREME COURT OF INDIA

CIVIL ORIGINAL JURISDICTION

WRIT PETITION (CIVIL) NO. 215 OF 2005

Common Cause (A Regd. Society)

...Petitioner(s)

Versus

Union of India and Another

...Respondent(s)

J U D G M E N T**Dipak Misra, CJI [for himself and A.M. Khanwilkar, J.]****I N D E X**

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A. Prologue:

Life and death as concepts have invited many a thinker, philosopher, writer and physician to define or describe them.

Sometimes attempts have been made or efforts have been undertaken to gloriously paint the pictures of both in many a colour and shade. Swami Vivekananda expects one to understand that life is the lamp that is constantly burning out and further suggests that if one wants to have life, one has to die every moment for it. John Dryden, an illustrious English author, considers life a cheat and says that men favour the deceit. No one considers that the goal of life is the grave. Léon Montenaeken would like to describe life as short, a little hoping, a little dreaming and then good night. The famous poet Dylan Thomas would state “do not go gentle into that good night.” One may like to compare life with constant restless moment spent in fear of extinction of a valued vapour; and another may sincerely believe that it is beyond any conceivable metaphor. A metaphysical poet like John Donne, in his inimitable manner, says:-

“One short sleep past, we wake eternally, And death
shall be no more; death, thou shalt die”.

Some would say with profound wisdom that life is to be lived only for pleasure and others with equal wise pragmatism

would proclaim that life is meant for the realization of divinity within one because that is where one feels the “self”, the individuality and one’s own real identity. Dharmaraj Yudhisthira may express that though man sees that death takes place every moment, yet he feels that the silence of death would not disturb him and nothing could be more surprising than the said thought. Yet others feel that one should never be concerned about the uncertain death and live life embracing hedonism till death comes. Charvaka, an ancient philosopher, frowns at the conception of re-birth and commends for living life to the fullest. Thus, death is complicated and life is a phenomenon which possibly intends to keep away from negatives that try to attack the virtue and vigour of life from any arena. In spite of all the statements, references and utterances, be it mystical, philosophical or psychological, the fact remains, at least on the basis of conceptual majority, that people love to live – whether at eighty or eighteen – and do not, in actuality, intend to treat life like an “autumn leaf”. As Alfred Tennyson says:-

“No life that breathes with human breath has ever truly longed for death.”

2. The perception is not always the same at every stage. There comes a phase in life when the spring of life is frozen, the rain of circulation becomes dry, the movement of body becomes motionless, the rainbow of life becomes colourless and the word ‘life’ which one calls a dance in space and time becomes still and blurred and the inevitable death comes near to hold it as an octopus gripping firmly with its tentacles so that the person “shall rise up never”. The ancient Greet philosopher, Epicurus, has said, although in a different context:-

“Why should I fear death?
If I am, then death is not.
If death is, then I am not.
Why should I fear that which
can only exist when I do not?”

But there is a fallacy in the said proposition. It is because mere existence does not amount to presence. And sometimes there is a feebleness of feeling of presence in semi-reality state when the idea of conceptual identity is lost, quality of life is

sunk and the sanctity of life is destroyed and such destruction is denial of real living. Ernest Hemingway, in his book 'The Old Man and the Sea', expounds the idea that man can be destroyed, but cannot be defeated. In a certain context, it can be said, life sans dignity is an unacceptable defeat and life that meets death with dignity is a value to be aspired for and a moment for celebration.

3. The question that emerges is whether a person should be allowed to remain in such a stage of incurable passivity suffering from pain and anguish in the name of Hippocratic oath or, for that matter, regarding the suffering as only a state of mind and a relative perception or treating the utterance of death as a "word infinitely terrible" to be a rhetoric without any meaning. In contradistinction to the same, the question that arises is should he not be allowed to cross the doors of life and enter, painlessly and with dignity, into the dark tunnel of death whereafter it is said that there is resplendence. In delineation of such an issue, there emerges the question in law – should he or she be given such treatment which has

come into existence with the passage of time and progress of medical technology so that he/she exists possibly not realizing what happens around him/her or should his/her individual dignity be sustained with concern by smoothening the process of dying.

4. The legal question does not singularly remain in the set framework of law or, for that matter, morality or dilemma of the doctors but also encapsulates social values and the family mindset to make a resolute decision which ultimately is a cause of concern for all. There is also another perspective to it. A family may not desire to go ahead with the process of treatment but is compelled to do so under social pressure especially in a different milieu, and in the case of an individual, there remains a fear of being branded that he/she, in spite of being able to provide the necessary treatment to the patient, has chosen not to do so. The social psyche constantly makes him/her feel guilty. The collective puts him at the crossroads between socially carved out 'meaningful guilt' and his constant sense of rationality and individual responsibility.

There has to be a legalistic approach which is essential to clear the maze and instill awareness that gradually melts the idea of “meaningful guilt” and ushers in an act of “affirmative human purpose” that puts humanness on a high pedestal.

5. There is yet another aspect. In an action of this nature, there can be abuse by the beneficiaries who desire that the patient’s heart should stop so that his property is inherited in promptitude and in such a situation, the treating physicians are also scared of collusion that may invite the wrath of criminal law as well as social stigma. The medical, social and ethical apprehensions further cloud their mind to take a decision. The apprehension, the cultural stigma, the social reprehension, the allegation of conspiracy, the ethical dilemma and eventually the shadow between the individual desire and the collective expression distances the reality and it is here that the law has to have an entry to alleviate the agony of the individual and dispel the collective attributes and perceptions so that the imbroglio is clear. Therefore, the heart of the matter is whether the law permits for accelerating the process

of dying sans suffering when life is on the path of inevitable decay and if so, at what stage and to what extent. The said issue warrants delineation from various perspectives.

B. Contentions in the Writ Petition:

6. The instant Writ Petition preferred under Article 32 of the Constitution of India by the petitioner, a registered society, seeks to 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; to issue directions to the respondents to adopt suitable procedure in consultation with the State Governments, where necessary; to ensure that persons of deteriorated health or terminally ill patients should be able to execute a document titled “My Living Will and Attorney Authorisation” which can be presented to the hospital for appropriate action in the event of the executant being admitted to the hospital with serious illness which may threaten termination of the life of the executant; to appoint a committee of experts including doctors, social scientists and lawyers to study into the aspect of issuing guidelines as to the

“Living Wills”; and to issue such further appropriate directions and guidelines as may be necessary.

7. It is asserted that every individual is entitled to take his/her decision about the continuance or discontinuance of life when the process of death has already commenced and he/she has reached an irreversible permanent progressive state where death is not far away. It is contended that each individual has an inherent right to die with dignity which is an inextricable facet of Article 21 of the Constitution. That apart, it is set forth that right to die sans pain and suffering is fundamental to one's bodily autonomy and such integrity does not remotely accept any effort that puts the individual on life support without any ray of hope and on the contrary, the whole regime of treatment continues in spite of all being aware that it is a Sisyphean endeavour, an effort to light a bulb without the filament or to expect a situation to be in an apple pie order when it is actually in a state of chaos.

8. It is put forth that the concept of sustenance of individual autonomy inheres in the right of privacy and also

comes within the fundamental conception of liberty. To sustain the stand of privacy, reliance has been placed on the decisions in ***Kharak Singh v. State of U.P. and others***¹, ***Gobind v. State of Madhya Pradesh and another***² and ***People's Union for Civil Liberties v. Union of India and another***³. Inspiration has also been drawn from the decision of the United States in ***Cruzan v. Director, Missouri Department of Health***⁴. It is averred that due to the advancement of modern medical technology pertaining to medical science and respiration, a situation has been created where the dying process of the patient is unnecessarily prolonged causing distress and agony to the patient as well as to the near and dear ones and, consequently, the patient is in a persistent vegetative state thereby allowing free intrusion. It is also contended that the petitioner-society is not claiming that the right to die is a part of the right to life but asserting the claim that the right to die with dignity is an inseparable

¹ (1964) 1 SCR 332 : AIR 1963 SC 1295

² (1975) 2 SCC 148

³ (1997) 1 SCC 301

⁴ 111 L Ed 2d 224 : 497 US 261 (1990) : 110 S.Ct. 2841 (1990)

and inextricable facet of the right to live with dignity. The execution of a living will or issuance of advance directive has become a necessity in today's time keeping in view the prolongation of treatment in spite of irreversible prognosis and owing to penal laws in the field that creates a dilemma in the minds of doctors to take aid of the modern techniques in a case or not. A comparison has been made between the fundamental rights of an individual and the State interest focusing on sanctity as well as quality of life. References have been made to the laws in various countries, namely, United Kingdom, United States of America, Australia, Denmark, Singapore, Canada, etc. The autonomy of the patient has been laid stress upon to highlight the right to die with dignity without pain and suffering which may otherwise be prolonged because of artificial continuance of life through methods that are really not of any assistance for cure or improvement of living conditions.

C. Stand in the counter affidavit and the applications for intervention:

9. A counter affidavit has been filed by the Union of India contending, *inter alia*, that serious thought has been given to regulate the provisions of euthanasia. A private member's Bill and the 241st report of the Law Commission of India have been referred to. It has been set forth that the Law Commission had submitted a report on The Medical Treatment of Terminally-ill Patients (Protection of Patients and Medical Practitioners) Bill, 2006 but the Ministry of Health and Family Welfare was not in favour of the enactment due to the following reasons:-

“a) Hippocratic oath is against intentional/voluntary killings of patient.

b) Progression of medical science to relieve pain, suffering, rehabilitation and treatment of so-called diseases will suffer a set back.

c) An individual may wish to die at certain point of time, his/her wish may not be persistent and only a fleeting desire out of transient depression.

d) Suffering is a state of mind and a perception, which varies from individual to individual and depends on various environmental and social factors.

e) Continuous advancement in medical science has made possible good pain management in patients of cancer and other terminal illness. Similarly,

rehabilitation helps many spinal injury patients in leading near normal life and euthanasia may not be required.

f) Wish of euthanasia by a mentally ill patient/in depression may be treatable by good psychiatric care.

g) It will be difficult to quantify suffering, which may always be subject to changing social pressures and norms.

h) Can doctors claim to have knowledge and experience to say that the disease is incurable and patient is permanently invalid?

i) Defining of bed-ridden and requiring regular assistance is again not always medically possible.

j) There might be psychological pressure and trauma to the medical officers who would be required to conduct euthanasia.”

10. The counter affidavit further states that after the judgment was delivered by this Court in ***Aruna Ramachandra Shanbaug v. Union of India and others***⁵, the Ministry of Law and Justice opined that the directions given by this Court have to be followed in such cases and the said directions should be treated as law. The Law Commission in its 241st Report titled “Passive Euthanasia – A Relook” again proposed for making a legislation on “Passive Euthanasia” and also prepared a draft Bill titled The Medical Treatment of

⁵ (2011) 4 SCC 454

Terminally Ill Patients (Protection of Patients and Medical Practitioners) Bill. The said Bill was referred to the technical wing of the Ministry of Health and Family Welfare (Directorate General of Health Services-Dte. GHS) for examination in June 2014. It is the case of the Union of India that two meetings were held under the chairmanship of Special Director General of Health Service which was attended by various experts. A further meeting was held under the chairmanship of Secretary, Ministry of Health and Family Welfare, on 22.05.2015 to examine the Bill. Thereafter, various meetings have been held by experts and the expert committee had proposed formulation of legislation on passive euthanasia.

11. Counter affidavits have been filed by various States. We need not refer to the same in detail. Suffice it to mention that in certain affidavits, emphasis has been laid on Articles 37, 39 and 47 which require the States to take appropriate steps as envisaged in the said Articles for apposite governance. That apart, it has been pronouncedly stated that the right to life does not include the right to die and, in any case, the right to

live with dignity guaranteed under Article 21 of the Constitution means availability of food, shelter and health and does not include the right to die with dignity. It is asseverated that saving the life is the primary duty of the State and, therefore, there is necessity for health care. It is also contended that the introduction of the right to die with dignity as a facet of the right under Article 21 will create a right that the said constitutional provision does not envisage and further it may have the potential effect to destroy the said basic right.

12. An application for intervention has been filed by the “Society for the Right to Die with Dignity” whose prayer for intervention has been allowed. The affidavit filed by the said society supports the concept of euthanasia because it is a relief from irrecoverable suffering of which pain is a factor. It has cited many an example from various texts to support passive euthanasia and suggested certain criteria to be followed. It has also supported the idea of introduction of living will and durable power of attorney documents and has filed a sample of living will or advance health directive or

advance declaration provided by Luis Kutner. Emphasis has been laid on peaceful exit from life and the freedom of choice not to live and particularly so under distressing conditions and ill-health which lead to an irrecoverable state. The management of terminally ill patients has been put at the centre stage. It has been highlighted that determination of the seemingly criteria will keep the element of misuse by the family members or the treating physician or, for that matter, any interested person at bay and also remove the confusion.

We have heard Mr. Prashant Bhushan, learned counsel for the petitioner. Mr. P.S. Narasimha, learned Additional Solicitor General for Union of India, Mr. Arvind P. Datar learned senior counsel and Mr. Devansh A. Mohta, learned counsel who have supported the cause put forth in the writ petition.

D. Background of the Writ Petition:

13. Before we engage ourselves with the right claimed, it is requisite to state that the present litigation has a history and while narrating the same, the assertions made in the Writ

Petition and the contentions which have been raised during the course of hearing, to which we shall refer in due course, are to be kept in mind.

D.1 P. Rathinam's case – The question of unconstitutionality of Section 309 of the Indian Penal Code:

14. Presently, it is necessary to travel backwards in time, though not very far. Two individuals, namely, P. Rathinam and Nagbhushan Patnaik, filed two Writ Petitions under Article 32 of the Constitution which were decided by a two-Judge Bench in ***P. Rathinam v. Union of India & another***⁶. The writ petitions assailed the constitutional validity of Section 309 of the Indian Penal Code (IPC) contending that the same is violative of Articles 14 and 21 of the Constitution. The Court posed 16 questions. The relevant ones read thus:-

“(1) Has Article 21 any positive content or is it merely negative in its reach?

(2) Has a person residing in India a right to die?

x x x x

(12) Is suicide against public policy?

⁶ (1994) 3 SCC 394

- (13) Does commission of suicide damage the monopolistic power of the State to take life?
- (14) Is apprehension of 'constitutional cannibalism' justified?
- (15) Recommendation of the Law Commission of India and follow-up steps taken, if any.
- (16) Global view. What is the legal position in other leading countries of the world regarding the matter at hand?"

15. Answering question No. (1), the Court, after referring to various authorities under Article 21, took note of the authority in ***State of Himachal Pradesh and another v. Umed Ram Sharma and others***⁷ wherein it has been observed that the right to life embraces not only physical existence but also the quality of life as understood in its richness and fullness within the ambit of the Constitution. In the said case, the Court had held that for residents of hilly areas, access to road was access to life itself and so, necessity of road communication in a reasonable condition was treated as a constitutional imperative. ***P. Rathinam*** perceived the elevated positive content in the said ruling. Answering question No. (2), the Court referred to the decision of the Bombay High Court in

⁷ (1986) 2 SCC 68 : AIR 1986 SC 847

Maruti Shripati Dubal v. State of Maharashtra⁸ that placed reliance on ***R.C. Cooper v. Union of India***⁹ wherein it had been held that what is true of one fundamental right is also true of another fundamental right and on the said premise, the Bombay High Court had opined that it cannot be seriously disputed that fundamental rights have their positive as well as negative aspects. Citing an example, it had stated that freedom of speech and expression includes freedom not to speak and similarly, the freedom of association and movement includes freedom not to join any association or move anywhere and, accordingly, it stated that logically it must follow that the right to live would include the right not to live, i.e., right to die or to terminate one's life.

16. After so stating, this Court approved the view taken by the Bombay High Court in ***Maruti Shripati Dubal*** and meeting the criticism of that judgment from certain quarters, the two-Judge Bench opined that the criticism was only partially correct because the negative aspect may not be

⁸ 1987 Cri LJ 473 : (1986) 88 Bom LR 589

⁹ (1970) 2 SCC 298 : AIR 1970 SC 1318

inferable on the analogy of the rights conferred by different clauses of Article 19 and one may refuse to live if his life, according to the person concerned, is not worth living. One may rightly think that having achieved all worldly pleasures or happiness, he has something to achieve beyond this life. This desire for communion with God may rightly lead even a healthy mind to think that he would forego his right to live and would rather choose not to live. In any case, a person cannot be forced to enjoy the right to life to his detriment, disadvantage or disliking. Eventually, it concluded that the right to live of which Article 21 speaks of can be said to bring in its trail the right not to live a forced life.

17. Answering all the questions, the Court declared Section 309 IPC *ultra vires* and held that it deserved to be effaced from the statute book to humanize our penal laws.

D.2 Gian Kaur's case – The question of unconstitutionality of Section 306 of the Indian Penal Code:

18. The dictum laid down by the two-Judge Bench in ***P. Rathinam*** did not remain a precedent for long. In ***Gian Kaur***

v. State of Punjab¹⁰, the Constitution Bench considered the correctness of the decision rendered in **P. Rathinam**. In the said case, the appellants were convicted by the trial Court under Section 306 IPC and the conviction was assailed on the ground that Section 306 IPC is unconstitutional and to sustain the said argument, reliance was placed on the authority in **P. Rathinam** wherein Section 309 IPC was held to be unconstitutional being violative of Article 21 of the Constitution. It was urged that once Section 309 IPC had been held to be 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 penalizing abetment of suicide is equally violative of Article 21. The two-Judge Bench before which these arguments were advanced in appeal referred the matter to a Constitution Bench for deciding the same. In the course of arguments, one of the amicus curiae, Mr. F.S. Nariman, learned senior counsel, had submitted that the debate on euthanasia is not relevant for deciding the question

¹⁰ (1996) 2 SCC 648

of constitutional validity of Section 309 and Article 21 cannot be construed to include within it the so-called “right to die” since Article 21 guarantees protection of life and liberty and not its extinction. The Constitution Bench, after noting the submissions, stated:-

“17. ... We, therefore, proceed now to consider the question of constitutional validity with reference to Articles 14 and 21 of the Constitution. 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.”

19. Thereafter, the Constitution Bench in **Gian Kaur** (supra) scrutinized the reasons given in **P. Rathinam** and opined that the Court in the said case took the view that if a person has a right to live, he also has a right not to live. The Court in **Gian Kaur** (supra) observed that the Court in **P. Rathinam** (supra), while taking such a view, relied on the decisions which relate to other fundamental rights dealing with different situations and those decisions merely hold that the right to do an act

also includes the right not to do an act in that manner. The larger Bench further observed that in all those decisions, it was the negative aspect of the right that was involved for which no positive or overt act was to be done. The Constitution Bench categorically stated that this difference has to be borne in mind while making the comparison for the application of this principle.

20. Delving into the facet of committing suicide, the larger Bench observed that 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. It also held that the significant aspect of 'sanctity of life' should not be overlooked. The Court further opined that by no stretch of imagination, extinction of life can be read to be included in protection of life because Article 21, in its ambit and sweep, cannot include within it the right to die as a part of fundamental right guaranteed therein. The Constitution Bench ruled:-

“‘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.”

21. Adverting to the concept of euthanasia, the Court observed that protagonism of euthanasia on the view that existence in persistent vegetative state (PVS) is not a benefit to the patient of 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. The Constitution Bench further explained that the said conception also includes the right to a dignified life up to the point of death including a dignified procedure of death or, in other words, it may include the right

of a dying man to also die with dignity when his life is ebbing out. It has been clarified that 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.

Thereafter, the Court proceeded to state:-

“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.”

[Emphasis supplied]

22. In view of the aforesaid analysis and taking into consideration various other aspects, the Constitution Bench declared Section 309 IPC as constitutional.

23. The Court held that the "right to live with human dignity" cannot be construed to include within its ambit the right to terminate natural life, at least before the commencement of the process of certain natural death. It then examined the question of validity of Section 306 IPC. It accepted the submission that Section 306 is constitutional. While adverting to the decision in ***Airedale N.H.S. Trust v. Bland***¹¹, the Court at the outset made it clear that it was not called upon to deal with the issue of physician-assisted suicide or euthanasia cases. The decision in ***Airedale***'s case (supra), was relating to the withdrawal of artificial measures for continuance of life by a physician. 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. To bring home the distinction between active and passive euthanasia, an illustration was noted in the context of administering lethal drug actively to bring the patient's life to an end. The significant dictum in that decision has been extracted in ***Gian Kaur*** (supra) wherein it is observed that it is not lawful for a doctor to administer a drug to his patient to bring about

¹¹ (1993) 2 WLR 316; (1993) 1 All ER 821, HL

his death even though that course is promoted by a humanitarian desire to end his suffering and however great that suffering may be. Further, to act so is to cross the rubicon which runs between the care of the living patient on one hand and euthanasia - actively causing his death to avoid or to end his suffering on the other hand. It has been noticed in **Airedale** that euthanasia is not lawful at common law. In the light of the demand of responsible members of the society who believe that euthanasia should be made lawful, it has been observed in that decision that the same can be achieved by legislation. The Constitution Bench has merely noted this aspect in paragraph 41 with reference to the dictum in **Airedale** case.

24. Proceeding to deal with physician assisted suicide, the Constitution Bench observed:-

“42. The decision of the United States Court of Appeals for the Ninth Circuit in *Compassion in Dying v. State of Washington*¹², which reversed the decision of United States District Court, W.D. Washington reported in 850 Federal Supplement 1454, has also relevance. The constitutional validity of the State statute that banned physician-assisted suicide by mentally competent, terminally ill adults was in question. The District Court held

¹² 49 F 3d 586

unconstitutional the provision punishing for promoting a suicide attempt. On appeal, that judgment was reversed and the constitutional validity of the provision was upheld.”

And again:-

“43. This caution even in cases of physician-assisted suicide is sufficient to indicate that assisted suicides outside that category have no rational basis to claim exclusion of the fundamental principles of sanctity of life. The reasons assigned for attacking a provision which penalises attempted suicide are not available to the abettor of suicide or attempted suicide. Abetment of suicide or attempted suicide is a distinct offence which is found enacted even in the law of the countries where attempted suicide is not made punishable. Section 306 IPC enacts a distinct offence which can survive independent of Section 309 in the IPC. The learned Attorney General as well as both the learned amicus curiae rightly supported the constitutional validity of Section 306 IPC.”

Eventually, the Court in **Gian Kaur** (supra), apart from overruling **P. Rathinam** (supra), upheld the constitutional validity of Section 306 IPC.

D.3 The approach in Aruna Shanbaug qua Passive Euthanasia vis-à-vis India:

25. Although the controversy relating to attempt to suicide or abetment of suicide was put to rest, yet the issue of

euthanasia remained alive. It arose for consideration almost after a span of eleven years in ***Aruna Shanbaug*** (supra). A writ petition was filed by the next friend of the petitioner pleading, *inter alia*, that the petitioner was suffering immensely because of an incident that took place thirty six years back on 27.11.1973 and was in a Persistent Vegetative State (PVS) and in no state of awareness and her brain was virtually dead. The prayer of the next friend was that the respondent be directed to stop feeding the petitioner and to allow her to die peacefully. The Court noticed that there was some variance in the allegation made in the writ petition and the counter affidavit filed by the Professor and Head of the hospital where the petitioner was availing treatment. The Court appointed a team of three very distinguished doctors to examine the petitioner thoroughly and to submit a report about her physical and mental condition. The team submitted a joint report. The Court asked the team of doctors to submit a supplementary report by which the meaning of the technical terms in the first report could be explained. Various other aspects were also made clear. It is also worth noting that the

KEM Hospital where the petitioner was admitted was appointed as the next friend by the Court because of its services rendered to the petitioner and the emotional bonding and attachment with the petitioner.

26. In ***Aruna Shanbaug*** (supra), after referring to the authority in ***Vikram Deo Singh Tomar v. State of Bihar***¹³, this Court reproduced paragraphs 24 and 25 from ***Gian Kaur***'s case and opined that the said paragraphs simply mean that the view taken in ***Rathinam's*** case to the effect that the 'right to life' includes the 'right to die' is not correct and para 25 specifically mentions that the debate even in such cases to permit physician-assisted termination of life is inconclusive. The Court further observed that it was held in ***Gian Kaur*** that there is no 'right to die' under Article 21 of the Constitution and the right to life includes the right to live with human dignity but in the case of a dying person who is terminally ill or in permanent vegetative state, he may be allowed a premature extinction of his life and it would not amount to a crime. Thereafter, the Court took note of the submissions of

¹³ 1988 Supp. SCC 734 : AIR 1988 SC 1782

the learned *amicus curiae* to the effect that the decision to withdraw life support is taken in the best interests of the patient by a body of medical persons. The Court observed that it is not the function of the Court to evaluate the situation and form an opinion on its own. The Court further noted that in England, the *parens patriae* jurisdiction over adult mentally incompetent persons was abolished by statute and the Court has no power now to give its consent and in such a situation, the Court only gives a declaration that the proposed omission by doctors is not unlawful.

27. After so stating, the Court addressed the legal issues, namely, active and passive euthanasia. It noted the legislations prevalent in Netherlands, Switzerland, Belgium, U.K., Spain, Austria, Italy, Germany, France and United States of America. It also noted that active euthanasia is illegal in all States in USA, but physician-assisted death is legal in the States of Oregon, Washington and Montana. The Court also referred to the legal position in Canada. Dealing with passive euthanasia, the two-Judge Bench opined that passive euthanasia is usually defined as withdrawing medical

treatment with a deliberate intention of causing the patient's death. An example was cited by stating that if a patient requires kidney dialysis to survive, not giving dialysis although the machine is available is passive euthanasia and similarly, withdrawing the machine where a patient is in coma or on heart-lung machine support will ordinarily result in passive euthanasia. The Court also put non-administration of life saving medicines like antibiotics in certain situations on the same platform of passive euthanasia. Denying food to a person in coma or PVS has also been treated to come within the ambit of passive euthanasia. The Court copiously referred to the decision in **Airedale**. In **Airedale** case, as has been noted in **Aruna Shanbaug**, Lord Goff observed that discontinuance of artificial feeding in such cases is not equivalent to cutting a mountaineer's rope or severing the air pipe of a deep sea diver. The real question has to be not whether the doctor should take a course in which he will actively kill his patient but whether he should continue to provide his patient with medical treatment or care which, if continued, will prolong his life.

28. Lord Browne-Wilkinson was of the view that removing the nasogastric tube in the case of Anthony Bland cannot be regarded as a positive act causing death. The tube by itself, without the food being supplied through it, does nothing. Its non-removal by itself does not cause death since by itself, it does not sustain life. The learned Judge observed that removal of the tube would not constitute the *actus reus* of murder since such an act by itself would not cause death.

29. Lord Mustill observed:-

“Threaded through the technical arguments addressed to the House were the strands of a much wider position, that it is in the best interests of the community at large that *Anthony Bland’s life should now end*. The doctors *have done all they can*. *Nothing will be gained by going on* and much will be lost. *The distress of the family will get steadily worse*. The strain on the *devotion of a medical staff charged with the care* of a patient whose condition will never improve, who may live for years and who does not even recognise that he is being cared for, will continue to mount. The large resources of skill, *labour and money now being devoted to Anthony Bland* might in the opinion of many be more fruitfully employed in improving the condition of other patients, who if treated may have useful, healthy and enjoyable lives for years to come.”

30. The two-Judge Bench further observed that the decision in ***Airedale*** by the House of Lords has been followed in a number of cases in U.K. and the law is now fairly well settled that in the case of incompetent patients, if the doctors act on the basis of notified medical opinion and withdraw the artificial life support system in the patient's best interest, the said act cannot be regarded as a crime. The learned Judges posed the question as to who is to decide what is that patient's best interest where he is in a PVS and, in that regard, opined that it is ultimately for the Court to decide, as *parens patriae*, as to what is in the best interest of the patient, though the wishes of close relatives and next friend and the opinion of medical practitioners should be given due weight in coming to its decision. For the said purpose, reference was made to the opinion of Balcombe J. in ***Re J (A Minor) (Wardship: Medical Treatment)***¹⁴ whereby it has been stated that the Court as representative of the Sovereign and as *parens patriae* will adopt the same standard which a reasonable and responsible parent would do.

¹⁴ [1991] 2 WLR 140; [1990] 3 All ER 930; [1991] Fam 33

31. The two-Judge Bench referred to the decisions of the Supreme Court of United States in ***Washington v. Glucksberg***¹⁵ and ***Vacco v. Quill***¹⁶ which addressed the issue whether there was a federal constitutional road to assisted suicide. Analysing the said decisions and others, the Court observed that the informed consent doctrine has become firmly entrenched in American Tort Law and, as a logical corollary, lays foundation for the doctrine that the patient who generally possesses the right to consent has the right to refuse treatment.

32. In the ultimate analysis, the Court opined that the ***Airedale*** case is more apposite to be followed. Thereafter, the Court adverted to the law in India and ruled that in ***Gian Kaur*** case, this Court had approved the decision of the House of Lords in ***Airedale*** and observed that euthanasia could be made lawful only by legislation. After so stating, the learned Judges opined:-

“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*

¹⁵ 138 L Ed 2d 772 : 521 US 702 (1997)

¹⁶ 138 L Ed 2d 834 : 521 US 793 (1997)

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.”

33. After so stating, the two-Judge Bench dwelled upon the concept of brain dead and various other aspects which included withdrawal of life support of a patient in PVS and, in that context, ruled thus:-

“125. In our opinion, if we leave it solely to the patient’s relatives or to the doctors or next friend to decide whether to withdraw the life support of an incompetent person there is always a risk in our country that this may be misused by some unscrupulous persons who wish to inherit or otherwise grab the property of the patient. Considering the low ethical levels prevailing in our society today and the rampant commercialisation and corruption, we cannot rule out the possibility that unscrupulous persons with the help of some unscrupulous doctors may fabricate material to

show that it is a terminal case with no chance of recovery. There are doctors and doctors. While many doctors are upright, there are others who can do anything for money (see George Bernard Shaw's play *The Doctor's Dilemma*). The commercialisation of our society has crossed all limits. Hence we have to guard against the potential of misuse (see Robin Cook's novel *Coma*). In our opinion, while giving great weight to the wishes of the parents, spouse, or other close relatives or next friend of the incompetent patient and also giving due weight to the opinion of the attending doctors, we cannot leave it entirely to their discretion whether to discontinue the life support or not. We agree with the decision of Lord Keith in *Airedale case*⁵ that the approval of the High Court should be taken in this connection. This is in the interest of the protection of the patient, protection of the doctors, relatives and next friend, and for reassurance of the patient's family as well as the public. This is also in consonance with the doctrine of *parens patriae* which is a well-known principle of law."

34. After so laying down, the Court referred to the authorities in ***Charan Lal Sahu v. Union of India***¹⁷ and ***State of Kerala and another v. N.M. Thomas and others***¹⁸ and further opined that the High Court can grant approval for withdrawing life support of an incompetent person under Article 226 of the Constitution because Article 226 gives abundant power to the High Court to pass suitable orders on

¹⁷ (1990) 1 SCC 613

¹⁸ (1976) 2 SCC 310

the application filed by the near relatives or next friend or the doctors/hospital staff praying for permission to withdraw the life support of an incompetent person. Dealing with the procedure to be adopted by the High Court when such application is filed, the Court ruled that when such an application is filed, the Chief Justice of the High Court should forthwith constitute a Bench of at least two Judges who should decide to grant approval or not and before doing so, the Bench should seek the opinion of a Committee of three reputed doctors to be nominated by the Bench after consulting such medical authorities/medical practitioners as it may deem fit. Amongst the three doctors, as directed, one should be a Neurologist, one should be a Psychiatrist and the third a Physician. The Court further directed:-

“134. ... The committee of three doctors nominated by the Bench should carefully examine the patient and also consult the record of the patient as well as take the views of the hospital staff and submit its report to the High Court Bench. Simultaneously with appointing the committee of doctors, the High Court Bench shall also issue notice to the State and close relatives e.g. parents, spouse, brothers/sisters, etc. of the patient, and in their absence his/her next friend, and supply a copy of the report

of the doctor's committee to them as soon as it is available. After hearing them, the High Court Bench should give its verdict.

135. The above procedure should be followed all over India until Parliament makes legislation on this subject.

136. The High Court should give its decision speedily at the earliest, since delay in the matter may result in causing great mental agony to the relatives and persons close to the patient. The High Court should give its decision assigning specific reasons in accordance with the principle of "best interest of the patient" laid down by the House of Lords in *Airedale case*. The views of the near relatives and committee of doctors should be given due weight by the High Court before pronouncing a final verdict which shall not be summary in nature."

35. We must note here that the two-Judge Bench declined to grant the permission after perusing the medical reports. For the sake of completeness, we think it apt to reproduce the reasoning:-

"122. From the above examination by the team of doctors, it cannot be said that Aruna Shanbaug is dead. Whatever the condition of her cortex, her brainstem is certainly alive. She does not need a heart-lung machine. She breathes on her own without the help of a respirator. She digests food, and her body performs other involuntary functions without any help. From the CD (which we had screened in the courtroom on 2-3-2011 in the presence of the counsel and others) it appears that

she can certainly not be called dead. She was making some sounds, blinking, eating food put in her mouth, and even licking with her tongue morsels on her mouth. However, there appears little possibility of her coming out of PVS in which she is in. In all probability, she will continue to be in the state in which she is in till her death.”

D.4 The Reference:

36. The aforesaid matter was decided when the present Writ Petition was pending for consideration. The present petition was, thereafter, listed before a three-Judge Bench which noted the submissions advanced on behalf of the petitioner and also that of the learned Additional Solicitor General on behalf of the Union of India. Reliance was placed on the decision in ***Aruna Shanbaug***. The three-Judge Bench reproduced paragraphs 24 and 25 from ***Gian Kaur*** and noted that the Constitution Bench did not express any binding view on the subject of euthanasia, rather it reiterated that the legislature would be the appropriate authority to bring the change.

37. After so holding, it referred to the understanding of ***Gian Kaur*** in ***Aruna Shanbaug*** by the two-Judge Bench and reproduced paragraphs 21 and 101 from the said judgment:-

“21. We have carefully considered paras 24 and 25 in *Gian Kaur* case and we are of the opinion that all that has been said therein is that the view in *Rathinam* case that the right to life includes the right to die is not correct. We cannot construe *Gian Kaur* case 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 beyond what we have mentioned above.

X X X X

“101. The Constitution Bench of the Supreme Court in *Gian 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 (vide SCC para 33). 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.”

(Emphasis supplied)

38. Commenting on the said analysis, the three-Judge Bench went on to say:-

“13. Insofar as the above paragraphs are concerned, *Aruna Shanbaug* aptly interpreted the decision of

the Constitution Bench in *Gian Kaur* 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*, the Constitution Bench approved the decision of the House of Lords in *Airedale N.H.S. Trust v. Bland*. Para 40 of *Gian Kaur*, clearly states that :

“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.”

(Emphasis supplied)

Thus, it was a mere reference in the verdict and it cannot be construed to mean that the Constitution Bench in *Gian Kaur* approved the opinion of the House of Lords rendered in *Airedale*. To this extent, the observation in para 101 of *Aruna Shanbaug* is incorrect.”

39. From the aforesaid, it is clear that the three-Judge Bench expressed the view that the opinion of the House of Lords in ***Airedale*** has not been approved in ***Gian Kaur*** (supra) and to that extent, the observation in ***Aruna Shanbaug*** (supra) is incorrect. After so stating, the three-Judge Bench opined that ***Aruna Shanbaug*** (supra) upholds the authority of passive euthanasia and lays down an elaborate procedure for executing the same on the wrong premise that the Constitution Bench in ***Gian Kaur*** (supra) had upheld the

same. Thereafter, considering the important question of law involved which needs to be reflected in the light of social, legal, medical and constitutional perspectives, in order to have a clear enunciation of law, it referred the matter for consideration by the Constitution Bench of this Court for the benefit of humanity as a whole. The three-Judge bench further observed that it was refraining from framing any specific questions for consideration by the Constitution Bench as it would like the Constitution Bench to go into all the aspects of the matter and lay down exhaustive guidelines. That is how the matter has been placed before us.

E. Our analysis of Gian Kaur:

40. It is the first and foremost duty to understand what has been stated by the Constitution Bench in ***Gian Kaur***'s case. It has referred to the decision in ***Airedale*** (supra) that has been recapitulated in ***Aruna Shanbaug*** case which was a case relating to withdrawal of artificial measures of continuance of life by the physician. It is relevant to mention here that the Constitution Bench in ***Gian Kaur*** categorically noted that it was not necessary to deal with physician-assisted suicide or

euthanasia cases though a brief reference to the decisions cited by the Bar was required to be made. The Constitution Bench noted that **Airedale** held that 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 not an absolute one. The larger bench further noticed that in **Airedale**, it had been stated that 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. Thereafter, while again referring to **Airedale** case, the larger bench observed that it was a case relating to withdrawal of artificial measures for continuance of life by the physician. After so stating, the Court reproduced the following passage from the opinion of Lord Goff of Chieveley:-

“... 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 in *Gian Kaur*)

41. After reproducing the said passage, the Court opined thus:-

"41. The desirability of bringing about a change was considered to be the function of the legislature by enacting a suitable law providing therein adequate safeguards to prevent any possible abuse."

42. At this stage, it is necessary to clear the maze whether the Constitution Bench in ***Gian Kaur*** had accepted what has been held in ***Airedale***. On a careful and anxious reading of ***Gian Kaur***, it is noticeable that there has been narration, reference and notice of the view taken in ***Airedale*** case. It is

also worth noting that the Court was concerned with the constitutional validity of Section 309 IPC that deals with attempt to commit suicide and Section 306 IPC that provides for abetment to commit suicide. As noted earlier, the Constitution Bench, while distinguishing the case of a dying man who is terminally ill or in a persistent vegetative state and his termination or premature extinction of life, observed that the said category of cases may fall within the ambit of right to die with dignity as a part of right to life with dignity when death due to termination of natural life is inevitable and imminent and the process of natural death has commenced. The Constitution Bench further opined that the said cases do not amount to extinguishing the life but only amount to accelerating the process of natural death which has already commenced and, thereafter, the Constitution Bench stated that the debate with regard to physician assisted suicide remains inconclusive. The larger Bench has reiterated that the cases pertaining to premature extinction of life during the process of certain natural death of patients who are terminally ill or in persistent vegetative state were of assistance to

interpret Article 21 of the Constitution to include therein the right to curtail the natural span of life. On a seemingly understanding of the judgment in ***Gian Kaur***, we do not find that it has decried euthanasia as a concept. On the contrary, it gives an indication that in such situations, it is the acceleration of the process of dying which may constitute a part of right to life with dignity so that the period of suffering is reduced. We are absolutely conscious that a judgment is not to be construed as a statute but our effort is to understand what has been really expressed in ***Gian Kaur***. Be it clarified, it is understood and appreciated that there is a distinction between a positive or overt act to put an end to life by the person living his life and termination of life so that an individual does not remain in a vegetative state or, for that matter, when the death is certain because of terminal illness and he remains alive with the artificially assisted medical system. In ***Gian Kaur***, while dealing with the attempt to commit suicide, the Court clearly held that when a man commits suicide, he has to undertake certain positive overt acts and the genesis of those acts cannot be tested to or be

included within the protection of the expression “right to life” under Article 21 of the Constitution. It was also observed that a dignified procedure of death may include the right of a dying man to also die with dignity when the life is ebbing out. This is how the pronouncement in **Gian Kaur** has to be understood. It is also not the ratio of the authority in **Gian Kaur** that euthanasia has to be introduced only by a legislation. What has been stated in paragraph 41 of **Gian Kaur** is what has been understood to have been held in **Airedale’s** case. The Court has neither expressed any independent opinion nor has it approved the said part or the ratio as stated in **Airedale**. There has been only a reference to **Airedale’s** case and the view expressed therein as regards legislation. Therefore, the perception in **Aruna Shanbaug** that the Constitution Bench has approved the decision in **Airedale** is not correct. It is also quite clear that **Gian Kaur** does not lay down that passive euthanasia can only be thought of or given effect to by legislation. Appositely understood, it opens an expansive sphere of Article 21 of the Constitution. Therefore, it can be held without any hesitation

that ***Gian Kaur*** has neither given any definite opinion with regard to euthanasia nor has it stated that the same can be conceived of only by a legislation.

F. Our analysis of Aruna Shanbaug qua legislation:

43. Having said this, we shall focus in detail what has been stated in ***Aruna Shanbaug***. In paragraph 101 which has been reproduced hereinbefore, the two-Judge Bench noted that ***Gian Kaur*** has approved the decision of the House of Lords in ***Airedale*** and observed that euthanasia could be made lawful only by legislation. This perception, according to us, is not correct. As already stated, ***Gian Kaur*** does not lay down that passive euthanasia could be made lawful only by legislation. In paragraph 41 of the said judgment, the Constitution Bench was only adverting to what has been stated by Lord Goff of Chieveley in ***Airedale***'s case. However, this expression of view of ***Aruna Shanbaug*** which has not been accepted by the referral Bench makes no difference to our present analysis. We unequivocally express the opinion that ***Gian Kaur*** is not a binding precedent for the purpose of

laying down the principle that passive euthanasia can be made lawful “only by legislation.”

G. The Distinction between Active and Passive Euthanasia:

44. As a first step, it is imperative to understand the concept of euthanasia before we enter into the arena of analysis of the expanded right of Article 21 in ***Gian Kaur*** and the understanding of the same. Euthanasia is basically an intentional premature termination of another person’s life either by direct intervention (active euthanasia) or by withholding life-prolonging measures and resources (passive euthanasia) either at the express or implied request of that person (voluntary euthanasia) or in the absence of such approval/consent (non-voluntary euthanasia). ***Aruna Shanbaug*** has discussed about two categories of euthanasia - active and passive. While dealing with active euthanasia, also known as “positive euthanasia” or “aggressive euthanasia”, it has been stated that the said type of euthanasia entails a positive act or affirmative action or act of commission entailing the use of lethal substances or forces to cause the intentional

death of a person by direct intervention, e.g., a lethal injection given to a person with terminal cancer who is in terrible agony. Passive euthanasia, on the other hand, also called “negative euthanasia” or “non-aggressive euthanasia”, entails withdrawing of life support measures or withholding of medical treatment for continuance of life, e.g., withholding of antibiotics in case of a patient where death is likely to occur as a result of not giving the said antibiotics or removal of the heart lung machine from a patient in coma. The two-Judge Bench has also observed that the legal position across the world seems to be that while active euthanasia is illegal unless there is a legislation permitting it, passive euthanasia is legal even without legislation, provided certain conditions and safeguards are maintained. The Court has drawn further distinction between voluntary euthanasia and non-voluntary euthanasia in the sense that voluntary euthanasia is where the consent is taken from the patient and non-voluntary euthanasia is where the consent is unavailable, for instances when the patient is in coma or is otherwise unable to give consent. Describing further about active euthanasia, the

Division Bench has observed that the said type of euthanasia involves taking specific steps to cause the patient's death such as injecting the patient with some lethal substance, i.e., sodium pentothal which causes, in a person, a state of deep sleep in a few seconds and the person instantly dies in that state. That apart, the Court has drawn a distinction between euthanasia and physician assisted dying and noted that the difference lies in the fact as to who administers the lethal medication. It has been observed that in euthanasia, a physician or third party administers it while in physician assisted suicide, it is the patient who does it though on the advice of the doctor. Elaborating further, the two-Judge Bench has opined that the predominant difference between "active" and "passive" euthanasia is that in the former, a specific act is done to end the patient's life while the latter covers a situation where something is not done which is necessary in preserving the patient's life. The main idea behind the distinction, as observed by the Bench, is that in passive euthanasia, the doctors are not actively killing the patient, they are merely not saving him and only accelerating

the conclusion of the process of natural death which has already commenced.

45. The two-Judge Bench, thereafter, elaborated on passive euthanasia and gave more examples of cases within the ambit of passive euthanasia. The learned Judges further categorized passive euthanasia into voluntary passive euthanasia and non-voluntary passive euthanasia. The learned Judges described voluntary passive euthanasia as a situation where a person who is capable of deciding for himself decides that he would prefer to die because of various reasons whereas non-voluntary passive euthanasia has been described to mean that a person is not in a position to decide for himself, e.g., if he is in coma or PVS.

46. While scrutinizing the distinction between active and passive euthanasia, the paramount aspect is “foreseeing the hastening of death”. The said view has been propagated in several decisions all over the world. The Supreme Court of Canada, in the case of **Rodriguez v. British Columbia**

(Attorney General)¹⁹, drew the distinction between these two forms of euthanasia on the basis of intention. Echoing a similar view, the Supreme Court of the United States affirmed the said distinction on the basis of “intention” in the case of **Vacco** (supra) wherein Chief Justice Rehnquist observed that the said distinction coheres with the fundamental legal principles of causation and intention. In case when the death of a patient occurs due to removal of life-supporting measures, the patient dies due to an underlying fatal disease without any intervening act on the part of the doctor or medical practitioner, whereas in the cases coming within the purview of active euthanasia, for example, when the patient ingests lethal medication, he is killed by that medication.

47. This distinction on the basis of “intention” further finds support in the explanation provided in the case ***In the matter of Claire C. Conroy***²⁰ wherein the Court made an observation that people who refuse life-sustaining medical treatment may not harbour a specific intent to die, rather they may fervently

¹⁹ 85 C.C.C. (3d) 15 : (1993) 3 S.C.R. 519

²⁰ 98 N.J. 321 (1985) : (1985) 486 A.2d 1209 (N.J.)

wish to live but do so free of unwanted medical technology, surgery or drugs and without protracted suffering.

48. Another distinction on the basis of “action and non-action” was advanced in the **Airedale** case. Drawing a crucial distinction between the two forms of euthanasia, Lord Goff observed that passive euthanasia includes cases in which a doctor decides not to provide, or to continue to provide, for his patient, treatment or care which could prolong his life and active euthanasia involves actively ending a patient’s life, for example, by administering a lethal drug. As per the observations made by Lord Goff, the former can be considered lawful either because the doctor intends to give effect to his patient’s wishes by withholding the treatment or care, or even in certain circumstances in which the patient is incapacitated from giving his consent. However, active euthanasia, even voluntary, is impermissible despite being prompted by the humanitarian desire to end the suffering of the patient.

49. It is perhaps due to the distinction evolved between these two forms of euthanasia, which has gained moral and legal

sanctity all over, that most of the countries today have legalized passive euthanasia either by way of legislations or through judicial interpretation but there remains uncertainty whether active euthanasia should be granted legal status.

H. Euthanasia : International Position:

H.1 U.K. Decisions:

H.1.1 Airedale Case:

50. In the obtaining situation, we shall now advert to the opinions stated in ***Airedale*** case. In the said case, one Anthony Bland, a supporter of Liverpool Football Club, who had gone to Hillsborough Ground, suffered severe injuries as a result of which supply to his brain was interrupted. Eventually, he suffered an irreversible damage to the brain as a consequence of which he got into a condition of persistent vegetative state (PVS). He became incapable of voluntary movement and could feel no pain. He was not in a position to feel or communicate. To keep him alive, artificial means were taken recourse to. In such a state of affairs, the treating doctors and the parents of Bland felt that no fruitful purpose would be served by continuing the medical aid. As there were

doubts with regard to stoppage of medical care which may incur a criminal liability, a declaration from the British High Court was sought to resolve the doubts. The Family Division of the High Court granted the declaration which was affirmed by the Court of Appeal. The matter travelled to the House of Lords.

51. Lord Keith of Kinkel opined that regard should be had to the whole artificial regime which kept Anthony Bland alive and it was incorrect to direct attention exclusively to the fact that nourishment was being provided. In his view, the administration of nourishment by the means adopted involved the application of a medical technique.

52. Lord Keith observed that in general, it would not be lawful for a medical practitioner who assumed responsibility for the care of an unconscious patient simply to give up treatment in circumstances where continuance of it would confer some benefit on the patient. On the other hand, a medical practitioner is under no duty to continue to treat such a patient where a large body of informed and responsible

medical opinion is to the effect that no benefit at all would be conferred by continuance of treatment. Existence in a vegetative state with no prospect of recovery is, by that opinion, regarded as not being a benefit, and that, if not unarguably correct, at least forms a proper basis for the decision to discontinue treatment and care. He was of the further opinion that since existence in PVS is not a benefit to the patient, the principle of sanctity of life is no longer an absolute one. It does not compel a medical practitioner to treat a patient, who will die if not treated, contrary to the express wishes of the patient. It does not compel the temporary keeping alive of patients who are terminally ill where to do so would merely prolong their suffering. On the other hand, it forbids the taking of active measures to cut short the life of a terminally ill patient.

53. Lord Keith further stated that it does no violence to the principle of sanctity of life to hold that it is lawful to cease to give medical treatment and care to a PVS patient who has been in that state for over three years considering that to do so involves invasive manipulation of the patient's body to which

he has not consented and which confers no benefit upon him. He also observed that the decision whether or not the continued treatment and care of a PVS patient confers any benefit on him is essentially one for the practitioners in charge.

54. Lord Goff of Chieveley also held that the principle of sanctity of life is not an absolute one and there is no absolute rule that the patient's life must be prolonged by such treatment or care, if available, regardless of the circumstances.

55. Lord Goff observed that though he agreed that the doctor's conduct in discontinuing life support can properly be categorised as an omission, yet discontinuation of life support is, for the present purposes, no different from not initiating life support in the first place as in such a case, the doctor is simply allowing his patient to die in the sense that he is desisting from taking a step which might, in certain circumstances, prevent his patient from dying as a result of his pre-existing condition; and as a matter of general

principle, an omission such as this will not be unlawful unless it constitutes a breach of duty to the patient.

56. The learned Law Lord further observed that the doctor's conduct is to be differentiated from that of, for example, an interloper who maliciously switches off a life support machine in the sense that although the interloper performs the same act as the doctor who discontinues life support, yet the doctor, in discontinuing life support, is simply allowing his patient to die of his pre-existing condition, whereas the interloper is actively intervening to stop the doctor from prolonging the patient's life, and such conduct cannot possibly be categorised as an omission. This distinction as per Lord Goff appears to be useful in the context as it can be invoked to explain how discontinuance of life support can be differentiated from ending a patient's life by a lethal injection. Lord Goff stated that the reason for this difference is that the law considers discontinuance of life support to be consistent with the doctor's duty to care for his patient, but it does not, for reasons of policy, consider that it forms any part of his duty to

give his patient a lethal injection to put the patient out of his agony.

57. Emphasising on the patient's best interest principle, Lord Goff referred to ***F v. West Berkshire Health Authority***²¹ wherein the House of Lords stated the legal principles governing the treatment of a patient who, for the reason that he was of unsound mind or that he had been rendered unconscious by accident or by illness, was incapable of stating whether or not he consented to the treatment or care. In such circumstances, a doctor may lawfully treat such a patient if he acts in his best interests, and indeed, if the patient is already in his care, he is under a duty so to treat him.

58. Drawing an analogy, Lord Goff opined that a decision by a doctor whether or not to initiate or to continue to provide treatment or care which could or might have the effect of prolonging such a patient's life should also be governed by the same fundamental principle of the patient's best interest. The learned Law Lord further stated that the doctor who is caring for such a patient cannot be put under an absolute obligation

²¹ [1989] 2 All ER 545 : [1990] 2 AC 1

to prolong his life by any means available to the doctor, regardless of the quality of the patient's life. Common humanity requires otherwise as do medical ethics and good medical practice accepted in the United Kingdom and overseas. Lord Goff said that the doctor's decision to take or not to take any step must be made in the best interests of the patient (subject to his patient's ability to give or withhold his consent).

59. Lord Goff further stated that in such cases, the question is not whether it is in the best interests of the patient that he should die, rather the correct question for consideration is whether it is in the best interests of the patient that his life should be prolonged by the continuance of such form of medical treatment or care. In Lord Goff's view, the correct formulation of the question is of particular importance in such cases as the patient is totally unconscious and there is no hope whatsoever of any amelioration of his condition. Lord Goff opined that if the question is asked whether it is in the best interests of the patient to continue the treatment which has the effect of artificially prolonging his life, that question

can sensibly be answered to the effect that the patient's best interests no longer require such a treatment to be continued.

60. Lord Goff opined that medical treatment is neither appropriate nor requisite simply to prolong a patient's life when such treatment has no therapeutic purpose of any kind and such treatment is futile because the patient is unconscious and there is no prospect of any improvement in his condition. Thereafter, the learned Law Lord observed that regard should also be had to the invasive character of the treatment and to the indignity to which a patient is subjected by prolonging his life by artificial means which, in turn, causes considerable distress to his family. In such cases, Lord Goff said that it is the futility of the treatment which justifies its termination and in such circumstances, a doctor is not required to initiate or to continue life- prolonging treatment or care keeping in mind the best interests of the patient.

61. Lord Goff, referring to ***West Berkshire Health Authority*** (supra), said that it was stated therein that where a doctor provides treatment to a person who is incapacitated

from saying whether or not he consents to it, the doctor must, when deciding on the form of treatment, act in accordance with a responsible and competent body of relevant professional opinion on the principles set down in ***Bolam v. Friern Hospital Management Committee***²². Lord Goff opined that this principle must equally be applicable to decisions to initiate or to discontinue life support as it is to other forms of treatment. He also referred to a Discussion Paper on Treatment of Patients in Persistent Vegetative State issued in September, 1992 by the Medical Ethics Committee of the British Medical Association pertaining to four safeguards in particular which, in the Committee's opinion, should be observed before discontinuing life support for such patients, which were: (1) every effort should be made at rehabilitation for at least six months after the injury; (2) the diagnosis of irreversible PVS should not be considered confirmed until at least 12 months after the injury with the effect that any decision to withhold life-prolonging treatment will be delayed for that period; (3) the diagnosis should be agreed by two other

²² [1957] 1 W.L.R. 582 : [1957] 2 All ER 118

independent doctors; and (4) generally, the wishes of the patient's immediate family will be given great weight.

62. According to him, the views expressed by the Committee on the subject of consultation with the relatives of PVS patients are consistent with the opinion expressed by the House of Lords in ***West Berkshire Health Authority*** (supra) that it is good practice for the doctor to consult relatives. Lord Goff observed that the Committee was firmly of the opinion that the relatives' views would not be determinative of the treatment inasmuch as if that would have been the case, the relatives would be able to dictate to the doctors what is in the best interests of the patient which cannot be right. Even so, a decision to withhold life-prolonging treatment such as artificial feeding must require close cooperation with those close to the patient and it is recognised that, in practice, their views and the opinions of doctors will coincide in many cases.

63. Thereafter, Lord Goff referred to American cases, namely, ***Re Quinlan***²³ and ***Superintendent of Belchertown State***

²³ 355 A. 2d 647 : (1976) 70 NJ 10

School v. Saikewicz²⁴ wherein the American Courts adopted what is called the substituted judgment test which involves a detailed inquiry into the patient's views and preferences. As per the substituted judgment test, when the patient is incapacitated from expressing any view on the question whether life-prolonging treatment should be withheld, an attempt is made to determine what decision the patient himself would have made had he been able to do so. In later American cases concerning PVS patients, it has been held that in the absence of clear and convincing evidence of the patient's wishes, the surrogate decision-maker has to implement as far as possible the decision which the incompetent patient would have made if he was competent.

64. However, Lord Goff acknowledged that any such test (substituted judgment test) does not form part of English law in relation to incompetent adults on whose behalf nobody has power to give consent to medical treatment. In contrast, England followed a straightforward test based on the best interests of the patient coined by the House of Lords in ***West***

²⁴ (1977) 373 Mass 728 : 370 N.E. 2d 417 (1977)

Berkshire Health Authority (supra). He opined that the same test (patient's best interest) should be applied in the case of PVS patients where the question is whether life-prolonging treatment should be withheld. The learned Law Lord further observed that consistent with the best interests test, anything relevant to the application of the test may also be taken into account and if the personality of the patient is relevant to the application of the test (as it may be in cases where the various relevant factors have to be weighed), it may be taken into account as was done in ***Re J. (A Minor) (Wardship: Medical Treatment)*** (supra). But where the question is whether life support should be withheld from a PVS patient, it is difficult to see how the personality of the patient can be relevant, though it may be of comfort to his relatives if they believe, as in the present case, and indeed may well be so in many other cases, that the patient would not have wished his life to be artificially prolonged if he was totally unconscious and there was no hope of improvement in his condition.

65. As regards the extent to which doctors should, as a matter of practice, seek the guidance of the court by way of an application for declaratory relief before withholding life-prolonging treatment from a PVS patient, Lord Goff took note of the judgment of Sir Stephen Brown P, the President of the Family Division, wherein he held that the opinion of the court should be sought in all cases of similar nature. Lord Goff also noted that Sir Thomas Bingham M.R. in the Court of Appeal expressed his agreement with Sir Stephen Brown P. in the following words:-

"This was in my respectful view a wise ruling, directed to the protection of patients, the protection of doctors, the reassurance of patients' families and the reassurance of the public. The practice proposed seems to me desirable. It may very well be that with the passage of time a body of experience and practice will build up which will obviate the need for application in every case, but for the time being I am satisfied that the practice which the President described should be followed."

66. It is worthy to mention that Lord Goff was of the view that there was a considerable cost involved in obtaining guidance from the court in cases of such nature. He took note of the suggestions forwarded by Mr. Francis, the counsel for

the respondents, to the effect that reference to the court was required in certain specific cases, i.e., (1) where there was known to be a medical disagreement as to the diagnosis or prognosis, and (2) problems had arisen with the patient's relatives-disagreement by the next of kin with the medical recommendation; actual or apparent conflict of interest between the next of kin and the patient; dispute between members of the patient's family; or absence of any next of kin to give consent. Lord Goff said that the President of the Family Division should be able to relax the present requirement so as to limit applications for declarations only to those cases in which there is a special need for the procedure to be invoked.

67. Lord Mustill observed that an argument had been advanced that it was in the best interest of the community at large that Anthony Bland's life should end. The doctors had done all they could have done. It was a lose-lose situation as nothing would be gained by continuing Bland's treatment and much would be lost. The distress of Bland's family members would steadily get worse and so would be the strain of the medical staff charged with the care of Bland despite the fact

that Bland's condition would never improve and he would never recognize that he was being cared for. Further, the learned Law Lord observed that large resources in terms of skill, labour and money had been applied for maintaining Bland in his present condition which, in the opinion of many, could be fruitfully employed in improving the conditions of other patients who, if treated, may have useful, healthy and enjoyable lives for years to come.

68. Lord Lowry, agreeing with the reasoning of Lord Goff of Chieveley with whom the other learned Law Lords were also in general agreement, dismissed the appeal. In coming to this conclusion, Lord Lowry opined that the court, in reaching a decision according to law, ought to give weight to informed medical opinion both on the point whether to continue the artificial feeding regime of a patient in PVS and also on the question of what is in the best interests of a patient. Lord Lowry rejected the idea that informed medical opinion in these respects was merely a disguise which, if accepted, would legalise euthanasia. Lord Lowry also rejected the Official Solicitor's argument that the doctors were under a "duty to

feed" their patients in PVS as in the instant case, the doctors overwhelmingly held the opposite view which had been upheld by the courts below. The doctors considered that it was in the patient's best interests that they should stop feeding him. Lord Lowry observed that the learned Law Lords had gone further by saying that the doctors are not entitled to feed a patient in PVS without his consent which cannot be obtained.

69. Lord Lowry further opined that there is no proposed guilty act in stopping the artificial feeding regime inasmuch as if it is not in the interests of an insentient patient to continue the life- supporting care and treatment, the doctor would be acting unlawfully if he continued the care and treatment and would perform no guilty act by discontinuing it. There is a gap between the old law on the one hand and new medicine and new ethics on the other. It is important, particularly in the area of criminal law which governs conduct, that the society's notions of what the law is and what is right should coincide. One role of the legislator, as per Lord Lowry, is to detect any disparity between these notions and to take appropriate action to close the gap.

70. Lord Browne-Wilkinson observed that the ability to sustain life artificially is a relatively recent phenomenon. Existing law may not provide an acceptable answer to the new legal questions which it raises.

71. In the opinion of the learned Law Lord, there exists no doubt that it is for the Parliament and not the courts to decide the broader issues raised by cases of such nature. He observed that recent developments in medical science have fundamentally changed the meaning of death. In medicine, the cessation of breathing or of heartbeat is no longer death because by the use of a ventilator, lungs which in the unaided course of nature stop breathing can be made to breathe artificially thereby sustaining the heartbeat. Thus, people like Anthony Bland, who would have previously died through inability to swallow food, can be kept alive by artificial feeding. This has led the medical profession, in Lord Browne-Wilkinson's view, 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. He further said that if the judges seek to develop new law to regulate the

new circumstances, the law so laid down will reflect the judges' views on the underlying ethical questions, questions on which there is a legitimate division of opinion. He proceeded to state that where a case raises wholly new moral and social issues, it is neither for the judges to develop new principles of law nor would it be legitimate for the Judges to arrive at a conclusion as to what is for the benefit of one individual whose life is in issue.

72. For the said reasons, the learned Law Lord observed that it is imperative that the moral, social and legal issues raised by the case at hand should be considered by the Parliament and only if the Parliament fails to act, the judge-made law will, by necessity, provide a legal answer to each new question as and when it arises.

73. The function of the court, in Lord Browne-Wilkinson's view, in such circumstances is to determine a particular case in accordance with the existing law and not to develop new law laying down a new regimen. He held that it is for the Parliament to address the wider problems which such a case raises and lay down principles of law generally applicable to

the withdrawal of life support systems. He explained why the removal of the nasogastric tube in the present case could not be regarded as a positive act causing death since the tube itself, without the food being supplied through it, does nothing. The removal of the tube by itself does not cause death since it does not sustain life by itself. Therefore, the removal of the tube would not constitute the *actus reus* of murder since such positive act would not be the cause of death.

74. Thus, Lord Browne-Wilkinson observed that in case of an adult who is mentally competent, the artificial feeding regime would be unlawful unless the patient consented to it as a mentally competent patient can, at any time, put an end to life support systems by refusing his consent to their continuation. He also observed that the House of Lords in ***West Berkshire Health Authority*** (supra) developed the principle based on the concept of necessity under which a doctor can lawfully treat a patient who cannot consent to such treatment if it is in the best interests of the patient to receive such treatment. The learned Law Lord opined that the correct answer to the case at

hand depends on the extent of the right to lawfully continue to invade the bodily integrity of Anthony Bland without his consent. To determine the extent of the said right, Lord Browne-Wilkinson observed that it can be deduced from ***West Berkshire Health Authority*** (supra) wherein both Lord Brandon of Oakbrook and Lord Goff made it clear that the right to administer invasive medical care is wholly dependent upon such care being in the best interests of the patient and moreover, a doctor's decision whether to continue invasive care is in the best interests of the patient has to be assessed with reference to the test laid down in ***Bolam*** (supra).

75. Lord Browne-Wilkinson held that if there comes a stage where a responsible doctor comes to the reasonable conclusion (which accords with the views of a responsible body of medical opinion) that further continuance of an intrusive life support system is not in the best interests of the patient, the doctor can no longer lawfully continue that life support system as to do so would constitute the crime of battery and the tort of trespass.

76. In Lord Browne-Wilkinson's view, the correct legal question in such cases is not whether the court thinks it is in the best interests of the patient in PVS to continue to receive intrusive medical care but whether the doctor responsible has arrived at a reasonable and bona fide belief that it is not in the best interests of the patient to continue to receive artificial medical regime.

77. Accordingly, Lord Browne-Wilkinson observed that on an application to the court for a declaration that the discontinuance of medical care will be lawful, the sole concern of the courts is to be satisfied that the doctor's decision to discontinue is in accordance with a respectable body of medical opinion and that it is reasonable. Adverting to various passages, Lord Browne-Wilkinson dismissed the appeal.

78. It is pertinent to mention here that in adopting the "best interests" principle in **Airedale**, the House of Lords followed its earlier decision in **In re F (Mental Patient : Sterilisation)**²⁵ and in adopting the omission/commission distinction, it followed the approach of the Court of Appeal in

²⁵ [1990] 2 AC 1 : [1989] 2 WLR 1025 : [1989] 2 All ER 545

*In re B (A Minor) (Wardship : Medical Treatment)*²⁶ and *In re J (A Minor) (Wardship : Medical Treatment)*²⁷ which raised the question of medical treatment for severely disabled children. In the context of cases where the patients are unable to communicate their wishes, it is pertinent to mention the observations made by Lord Goff in the **Airedale** case. As observed by Lord Goff, the correct question in cases of this kind would be “whether it is in his best interests that treatment which has the effect of artificially prolonging his life should be continued”. Thus, it was settled in the case of **Airedale** that it was lawful for the doctors to discontinue treatment if the patient refuses such treatment. And in case the patient is not in a situation permitting him to communicate his wishes, then it becomes the responsibility of the doctor to act in the “best interest” of the patient.

H.1.2 Later cases:

79. With reference to the ongoing debate pertaining to assisted dying, Lord Steyn in the case of **R (on the**

²⁶ [1981] 1 WLR 1424 : [1990] 3 All ER 927

²⁷ [1991] Fam 33 : [1990] 3 All ER 930 : [1991] 2 WLR 140

application of Pretty) v. Director of Public Prosecutions²⁸

explained that on one hand is the view which finds support in the Roman Catholic Church, Islam and other religions that human life is sacred and the corollary is that euthanasia and assisted suicide are always wrong, while on the other hand, as observed by Lord Steyn, is the belief defended by millions that the personal autonomy of individuals is predominant and it is the moral right of individuals to have a say over the time and manner of their death. Taking note of the imminent risk in legalizing assisted dying, Lord Steyn took note of the utilitarian argument that the terminally ill patients and those suffering great pain from incurable illnesses are often vulnerable and not all families, whose interests are at stake, are wholly unselfish and loving and there exists the probability of abuse in the sense that such people may be persuaded that they want to die or that they ought to want to die. Further, Lord Steyn observed that there is also the view that if the genuine wish of a terminally ill patient to die is expressed by the patient, then they should not be forced against their will to

²⁸ [2002] 1 All ER 1 : [2001] UKHL 61

endure a life that they no longer wish to endure. Without expressing any view on the unending arguments on either side, Lord Steyn noted that these wide-ranging arguments are ancient questions on which millions have taken diametrically opposite views and still continue to do. In the case of ***In re B (Consent to Treatment – Capacity)***²⁹, the primacy of patient autonomy, that is, the competent patient's right to decide for herself whether to submit to medical treatment over other imperatives, such as her best interests objectively considered, was recognized thereby confirming the right of the competent patient to refuse medical treatment even if the result is death and thus, a competent, ventilator-dependent patient sought and won the right to have her ventilator turned off.

80. Taking a slightly divergent view from ***Airedale***, Lord Neuberger in ***R (on the application of Nicklinson and another) v. Ministry of Justice***³⁰ observed that the difference between administering fatal drug to a person and setting up a machine so that the person can administer the drug to himself is not merely a legal distinction but also a moral one and,

²⁹ [2002] 1 FLR 1090 : [2002] 2 All ER 449

³⁰ [2014] UKSC 38

indeed, authorizing a third party to switch off a person's life support machine, as in ***Airedale***, is a more drastic interference and a more extreme moral step than authorizing a third party to set up a lethal drug delivery system to enable a person, only if he wishes, to activate the system to administer a lethal drug. Elaborating further on this theory, the Law Lord explained that in those cases which are classified as "omission", for instance, switching off a life support machine as in ***Airedale*** and ***Re B (Treatment)***, the act which immediately causes death is that of a third party which may be wrong whereas if the final act is that of a person who himself carries it out pursuant to a voluntary, clear, settled and informed decision, that may be the permissible side of the line as in the latter case, the person concerned had not been "killed" by anyone but had autonomously exercised his right to end his life. The Law Lord, however, immediately clarified that it is not intended to cast any doubt on the correctness of the decisions in ***Airedale*** and ***Re B (Treatment)***.

81. Suffice it to say, he concurred with the view in ***Airedale*** case which he referred to as ***Bland*** case. Lord Mance agreed

with Lord Neuberger and Lord Sumption. In his opinion, he referred to **Airedale** case and thereafter pointed out that a blanket prohibition was unnecessary and stated in his observations that persons in tragic position represent a distinct and relatively small group, and that by devising a mechanism enabling careful prior review (possibly involving the Court as well as medical opinion), the vulnerable can be distinguished from those capable of forming a free and informed decision to commit suicide. Lord Mance acknowledged that the law and courts are deeply engaged in the issues of life and death and made a reference to the observations of Lord Neuberger.

82. We may note with profit that the prayer of Mr. Nicklinson and Mr. Lamb were rejected by the Court of Appeal.

83. Lord Mance referred to the expression by Rehnquist CJ in **Washington** (supra) in a slightly different context that there is “an earnest and profound debate about the morality, legality, and practicality of assisted suicide” and “our holding permits this debate to continue as it should in a democratic society”.

84. Lord Wilson concurred with the judgment rendered by Lord Neuberger, referred to **Airedale** case and said:-

“As Hoffmann LJ suggested in his classic judgment in the Court of Appeal in *Airedale NHS Trust v Bland* [1993] AC 789 at 826, a law will forfeit necessary support if it pays no attention to the ethical dimension of its decisions. In para 209 below Lord Sumption quotes Hoffmann LJ’s articulation of that principle but it is worth remembering that Hoffmann LJ then proceeded to identify two other ethical principles, namely those of individual autonomy and of respect for human dignity, which can run the other way.”

And further:-

“In the *Pretty* case, at para 65, the ECHR was later to describe those principles as of the very essence of the ECHR. It was in the light (among other things) of the force of those two principles that in the *Bland* case the House of Lords ruled that it was lawful in certain circumstances for a doctor not to continue to provide life-sustaining treatment to a person in a persistent vegetative state...”

200. I agree with the observation of Lord Neuberger at para 94 that, in sanctioning a course leading to the death of a person about which he was unable to have a voice, the decision in the *Bland* case was arguably more extreme than any step which might be taken towards enabling a person of full capacity to exercise what must, at any rate now, in the light of the effect given to article 8 of the ECHR in the *Haas* case at para 51, cited at para 29 above, be regarded as a positive legal right to commit suicide. Lord Sumption suggests in para 212-213 below that

it remains morally wrong and contrary to public policy for a person to commit suicide. Blackstone, in his Commentaries on the Laws of England, Book 4, Chapter 14, wrote that suicide was also a spiritual offence “in evading the prerogative of the Almighty, and rushing into his immediate presence uncalled for”. If expressed in modern religious terms, that view would still command substantial support and a moral argument against committing suicide could convincingly be cast in entirely non-religious terms. Whether, however, it can be elevated into an overall conclusion about moral wrong and public policy is much more difficult.”

85. Lord Sumption commenced the judgment stating that English judges tend to avoid addressing the moral foundations of law. It is not their function to lay down principles of morality and the attempt leads to large generalisations which are commonly thought to be unhelpful. He further observed that in some cases, however, it is unavoidable and this is one of them. He referred to the opinion of Hoffmann LJ in **Airedale** case and the concept of sanctity of life and, eventually, reproduced a passage from Hoffmann LJ and opined:-

“215. Why should this be so? There are at least three reasons why the moral position of the suicide (whom I will call “the patient” from this point on, although the term may not always be apt) is different from that of a third party who helps him to

kill himself. In the first place, the moral quality of their decisions is different. A desire to die can only result from an overpowering negative impulse arising from perceived incapacity, failure or pain. This is an extreme state which is unlikely to be shared by the third party who assists. Even if the assister is moved by pure compassion, he inevitably has a greater degree of detachment. This must in particular be true of professionals such as doctors, from whom a high degree of professional objectivity is expected, even in situations of great emotional difficulty. Secondly, whatever right a person may have to put an end to his own life depends on the principle of autonomy, which leaves the disposal of his life to him. The right of a third party to assist cannot depend on that principle. It is essentially based on the mitigating effect of his compassionate motive. Yet not everyone seeking to end his life is equally deserving of compassion. The choice made by a person to kill himself is morally the same whether he does it because he is old or terminally ill, or because he is young and healthy but fed up with life. In both cases his desire to commit suicide may be equally justified by his autonomy. But the choice made by a third party who intervenes to help him is very different. The element of compassion is much stronger in the former category than in the latter. Third, the involvement of a third party raises the problem of the effect on other vulnerable people, which the unaided suicide does not. If it is lawful for a third party to encourage or assist the suicide of a person who has chosen death with a clear head, free of external pressures, the potential arises for him to encourage or assist others who are in a less good position to decide. Again, this is a more significant factor in the case of professionals, such as doctors or carers, who encounter these dilemmas regularly, than it is in the case of, say, family

members confronting them for what will probably be the only time in their lives.”

86. Dealing with the appeal by Nicklinson, Lord Sumption referred to the view of the Canadian Supreme Court in **Rodriguez** (supra) and opined:-

“....the issue is an inherently legislative issue for Parliament, as the representative body in our constitution, to decide. The question what procedures might be available for mitigating the indirect consequences of legalising assisted suicide, what risks such procedures would entail, and whether those risks are acceptable, are not matters which under our constitution a court should decide.”

87. Dealing with Martin’s appeal, Lord Sumption dismissed the same. While doing so, he said:-

“256. This state of English law and criminal practice does not of course resolve all of the problems arising from the pain and indignity of the death which was endured by Tony Nicklinson and is now faced by Mr Lamb and Martin. But it is worth reiterating these well-established propositions, because it is clear that many medical professionals are frightened by the law and take an unduly narrow view of what can lawfully be done to relieve the suffering of the terminally ill under the law as it presently stands. Much needless suffering may be occurring as a result. It is right to add that there is a tendency for those who would like to see the existing law changed, to overstate its difficulties. This was particularly evident in the submissions

of Dignity and Choice in Dying. It would be unfortunate if this were to narrow yet further the options open to those approaching death, by leading them to believe that the current law and practice is less humane and flexible than it really is.”

88. Lord Hughes agreed with the reasoning of Lord Sumption and dismissed the private appeals and allowed the Appeals preferred by the Director of Public Prosecutions. Lord Clarke concurred with the reasoning given by Lord Sumption, Lord Reed and Lord Hughes. Lord Reed agreed with the view with regard to the dismissal of the appeals but observed some aspects with regard to the issue of compatibility.

89. Lord Lady Hale entirely agreed with the judgment of Lord Neuberger. Lord Kerr in his opinion stated:-

“358. I agree with Lord Neuberger that if the store put on the sanctity of life cannot justify a ban on suicide by the able-bodied, it is difficult to see how it can justify prohibiting a physically incapable person from seeking assistance to bring about the end of their life. As one of the witnesses for one of the interveners, the British Humanist Association, Professor Blackburn, said, there is ‘no defensible moral principle’ in denying the appellants the means of achieving what, under article 8 and by all the requirements of compassion and humanity, they should be entitled to do. To insist that these unfortunate individuals should continue to endure the misery that is their lot is not to champion the

sanctity of life; it is to coerce them to endure unspeakable suffering.”

And again:-

“360. If one may describe the actual administration of the fatal dose as active assistance and the setting up of a system which can be activated by the assisted person as passive assistance, what is the moral objection to a person actively assisting someone’s death, if passive assistance is acceptable? Why should active assistance give rise to moral corruption on the part of the assister (or, for that matter, society as a whole), but passive assistance not? In both cases the assister’s aid to the person who wishes to die is based on the same conscientious and moral foundation. That it is that they are doing what the person they assist cannot do; providing them with the means to bring about their wished-for death. I cannot detect the moral distinction between the individual who brings a fatal dose to their beloved’s lips from the person who sets up a system that allows their beloved to activate the release of the fatal dose by the blink of an eye.”

Eventually, Lady Hale dismissed the appeal and allowed the appeals of the Director of Public Prosecutions.

H.2 The legal position in the United States:

90. In the United States of America, active euthanasia is illegal but physician-assisted death is legal in the States of Oregon, Washington and Montana. A distinction has been drawn between euthanasia and physician-assisted suicide. In

both Oregon and Washington, only self-assisted dying is permitted. Doctor-administered assisted dying and any form of assistance to help a person commit suicide outside the provisions of the legislation remains a criminal offence.

91. As far as the United States of America is concerned, we think it appropriate to refer to ***Cruzan*** (supra). The said case involved a 30 year old Missouri woman who was lingering in a permanent vegetative state as a result of a car accident. Missouri requires 'clear and convincing evidence' of patients' preferences and the Missouri Supreme Court, reversing the decision of the state trial court, rejected the parents' request to impose a duty on their daughter's physician to end life-support. The United States Supreme Court upheld that States can require 'clear and convincing evidence' of a patient's desire in order to oblige physicians to respect this desire. Since Nancy Cruzan had not clearly expressed her desire to terminate life support in such a situation, physicians were not obliged to follow the parents' request.

92. Chief Justice Rehnquist, in his opinion, stated:-

“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.”

He further proceeded to state:-

“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. Until about 15 years ago and the seminal decision in *In re Quinlan*, 70 N.J. 10, 355 A.2d 647, *cert. denied sub nom. Garger v. New Jersey*, 429 U.S. 922 (1976), the number of right-to-refuse-treatment decisions were relatively few. Most of the earlier cases involved patients who refused medical treatment forbidden by their religious beliefs, thus implicating First Amendment rights as well as common law rights of self-determination. More recently, however, with the advance of medical technology capable of sustaining life well past the point where natural forces would have brought certain death in earlier times, cases involving the right to refuse life-sustaining treatment have burgeoned.”

93. Meeting the submissions on behalf of the petitioner, the learned Chief Justice opined:-

“The difficulty with petitioners' claim is that, in a sense, it begs the question: an incompetent person is not able to make an informed and voluntary choice to exercise a hypothetical right to refuse treatment or any other right. Such a "right" must be exercised for her, if at all, by some sort of surrogate. Here, Missouri has in effect recognized that, under

certain circumstances, a surrogate may act for the patient in electing to have hydration and nutrition withdrawn in such a way as to cause death, but it has established a procedural safeguard to assure that the action of the surrogate conforms as best it may to the wishes expressed by the patient while competent. Missouri requires that evidence of the incompetent's wishes as to the withdrawal of treatment be proved by clear and convincing evidence. The question, then, is whether the United States Constitution forbids the establishment of this procedural requirement by the State. We hold that it does not."

94. The learned Chief Justice came to hold that there was no clear and convincing evidence to prove that the patient's desire was not to have hydration and nutrition. In the ultimate analysis, it was stated:-

"No doubt is engendered by anything in this record but that Nancy Cruzan's mother and father are loving and caring parents. If the State were required by the United States Constitution to repose a right of "substituted judgment" with anyone, the Cruzans would surely qualify. But we do not think the Due Process Clause requires the State to repose judgment on these matters with anyone but the patient herself. Close family members may have a strong feeling -- a feeling not at all ignoble or unworthy, but not entirely disinterested, either -- that they do not wish to witness the continuation of the life of a loved one which they regard as hopeless, meaningless, and even degrading. But there is no automatic assurance that the view of close family members will necessarily be the same

as the patient's would have been had she been confronted with the prospect of her situation while competent. All of the reasons previously discussed for allowing Missouri to require clear and convincing evidence of the patient's wishes lead us to conclude that the State may choose to defer only to those wishes, rather than confide the decision to close family members."

The aforesaid decision has emphasized on "bodily integrity" and "informed consent".

95. The question that was presented before the Court was whether New York's prohibition on assisted suicide violates the Equal Protection Clause of the Fourteenth Amendment. The Court held that it did not and in the course of the discussion, Chief Justice Rehnquist held:-

"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 recognized and endorsed in the medical profession 6 and in our legal traditions, is both important and logical; it is certainly rational."

Dealing with the conclusion in ***Cruzan*** (supra), it was

held:-

“This Court has also recognized, at least implicitly, the distinction between letting a patient die and making that patient die. In *Cruzan v. Director, Mo. Dept. of Health*, 497 U. S. 261, 278 (1990), we concluded that “[t]he principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions,” and we assumed the existence of such a right for purposes of that case, *id.*, at 279. But our assumption of a right to refuse treatment was grounded not, as the Court of Appeals supposed, on the proposition that patients have a general and abstract “right to hasten death,” 80 F. 3d, at 727–728, but on well-established, traditional rights to bodily integrity and freedom from unwanted touching, *Cruzan*, 497 U. S., at 278–279; *id.*, at 287– 288 (O’Connor, J., concurring). In fact, we observed that “the majority of States in this country have laws imposing criminal penalties on one who assists another to commit suicide.” *Id.*, at 280. *Cruzan* therefore provides no support for the notion that refusing life-sustaining medical treatment is “nothing more nor less than suicide.”

From the aforesaid passages, it is crystal clear that the U.S. Supreme Court has recognized that there is a distinction, in the context of the prevalent law, between letting a patient die and making that patient die. Right to refuse treatment is not grounded on the proposition that the patients have general

and abstract right to hasten death. The learned Chief Justice has also endorsed the view of the American Medical Association emphasizing the fundamental difference between refusing life-sustaining treatment and demanding a life-ending treatment.

96. In **Vacco** (supra), while ruling that a New York ban on physician assisted suicide was constitutional, the Supreme Court of the United States applied the standard of intent to the matter finding that a doctor who withdraws life support at the request of his patient intends only to respect his patient's wishes. This, the Court said, is in sharp contrast to a doctor who honours a patient's request to end life which necessarily requires more than an intent to respect the patient's wishes, i.e., it requires the intent to kill the patient. A major difference, the Court determined, in the two scenarios is that the former may cause the patient to die from underlying causes while the latter will cause the patient to die. The Court noted that the law plainly recognized the difference between "killing" and "letting die". It also recognised that the State of New York had, as a matter of policy, a compelling interest in forbidding

assisted suicide, while allowing a patient to refuse life support was simply an act of protecting a common law right which was the right to retain bodily integrity and preserve individual autonomy since the prevention of “unwanted touching” was, in the opinion of the Court, a very legitimate right to protect.

H.3 Australian Jurisdiction:

97. Moving to Australian jurisdiction, in ***Hunter and New England Area Health Service v. A***³¹, the Supreme Court of New South Wales considered the validity of a common law advance directive (there being no legislative provisions for such directives in NSW) given by Mr. A refusing kidney dialysis. One year after making the directive, Mr. A was admitted to a hospital emergency department in a critical state with decreased level of consciousness. His condition deteriorated to the point that he was being kept alive by mechanical ventilation and kidney dialysis. The hospital sought a judicial declaration to determine the validity of his advance directive. The Court, speaking through McDougall J., confirmed the directive and held that the hospital must respect the advance

³¹ [2009] NSWSC 761

directive. Applying the common law principle, the Court observed:-

“A person may make an 'advance care directive': a statement that the person does not wish to receive medical treatment, or medical treatment of specified kinds. If an advance care directive is made by a capable adult, and it is clear and unambiguous, and extends to the situation at hand, it must be respected. It would be a battery to administer medical treatment to the person of a kind prohibited by the advance care directive.”

98. In ***Brightwater Care Group (Inc.) v. Rossiter***³², the Court was concerned with an anticipatory refusal of treatment by Mr. Rossiter, a man with quadriplegia who was unable to undertake any basic human function including taking nutrition or hydration orally. Mr. Rossiter was not terminally ill, dying or in a vegetative state and had full mental capacity. He had ‘clearly and unequivocally’ indicated that he did not wish to continue to receive medical treatment which, if discontinued, would inevitably lead to his death. Martin, CJ, considering the facts and the common law principle, held :-

“At common law, the answers to the questions posed by this case are clear and straightforward.

³² [2009] WASC 229 : 40 WAR 84

They are to the effect that Mr Rossiter has the right to determine whether or not he will continue to receive the services and treatment provided by Brightwater and, at common law, Brightwater would be acting unlawfully by continuing to provide treatment [namely the administration of nutrition and hydration via a tube inserted into his stomach] contrary to Mr Rossiter's wishes.”

99. In ***Australian Capital Territory v. JT***³³, an application to stop medical treatment, other than palliative care, was rejected. The man receiving treatment suffered from paranoid schizophrenia and was, therefore, held not mentally capable of making a decision regarding his treatment. Chief Justice Higgins found that it would be unlawful for the service providers to stop providing treatment. The Chief Justice distinguished this situation from Rossiter as the patient lacked ‘both understanding of the proposed conduct and the capacity to give informed consent to it’. It is clear that mental capacity is the determining factor in cases relating to self-determination. Since the right of self-determination requires the ability to make an informed choice about the future, the requirement of mental capacity would be an obvious prerequisite. Chief Justice Higgins undertook a detailed

³³ [2009] ACTSC 105

analysis and rightly distinguished ***Auckland Area Health Board v. Attorney-General***³⁴ in which a court similarly bound to apply the human right to life and the prohibition on cruel and degrading treatment found that futile treatment could be withdrawn from a patient in a persistent vegetative state. He agreed with Howie J. in ***Messiha v. South East Health***³⁵ that futility of treatment could only be determined by consideration of the best interests of the patient and not by reference to the convenience of medical cares or their institutions.

100. The above decision basically considered the circumstances in which technically futile treatment may be withdrawn from patients at their direct or indirect request or in their best interests.

H.4 Legal Position in Canada:

101. In Canada, physician-assisted suicide is illegal as per Section 241(b) of the Criminal Code of Canada. The Supreme Court of Canada in ***Rodriguez*** (supra) has drawn a distinction between “intentional actor” and “merely foreseeing”. Delivering the judgment on behalf of the majority, Justice

³⁴ [1993] NZLR 235

³⁵ [2004] NSWSC 1061

Sopinka rejected the argument that assisted suicide was similar to the withdrawal of life-preserving treatment at the patient's request. He also rejected the argument that the distinction between assisted suicide and accepted medical treatment was even more attenuated in the case of palliative treatment which was known to hasten death. He observed:-

“The distinction drawn here is one based upon intention - in the case of palliative care the intention is to ease pain, which has the effect of hastening death, while in the case of assisted suicide, the intention is undeniably to cause death.”

He added:-

“In my view, distinctions based on intent are important, and in fact form the basis of our criminal law. While factually the distinction may, at times, be difficult to draw, legally it is clear.”

102. The Supreme Court of Canada in ***Carter v. Canada (Attorney General)***³⁶ held that the prohibition on physician-assisted death in Canada (in Sections 14 and 241(b) of the Canadian Criminal Code) unjustifiably infringed the right to life, liberty and security of the person in Article 7 of the Charter of Rights and Freedoms in the Canadian Constitution.

³⁶ 2015 SCC 5

103. The Supreme Court declared the infringing provisions of the Criminal Code void insofar as they prohibit physician-assisted death for a competent adult person who (1) clearly consents to the termination of life; and (2) has a grievous and irremediable medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition. 'Irremediable', it should be added, does not require the patient to undertake treatments that are not acceptable to the individual.

104. After the Supreme Court's decision, the Canadian Government appointed a Special Joint Committee on Physician-Assisted Dying to 'make recommendations on the framework of a federal response on physician assisted dying in consonance with the Constitution, the Charter of Rights and Freedoms, and the priorities of Canadians'. The Special Joint Committee released its report in February 2016 recommending a legislative framework which would regulate 'medical assistance in dying' by imposing both substantive and procedural safeguards, namely:-

Substantive Safeguards:

- A grievous and irremediable medical condition (including an illness, disease or disability) is required;
- Enduring suffering that is intolerable to the individual in the circumstances of his or her condition is required;
- Informed consent is required;
- Capacity to make the decision is required at the time of either the advance or contemporaneous request; and
- Eligible individuals must be insured persons eligible for publicly funded health care services in Canada.

Procedural Safeguards:

- Two independent doctors must conclude that a person is eligible;
 - A request must be in writing and witnessed by two independent witnesses;
 - A waiting period is required based, in part, on the rapidity of progression and nature of the patient's medical condition as determined by the patient's attending physician;
 - Annual report analyzing medical assistance in dying cases are to be tabled in Parliament;
- and
- Support and services, including culturally and spiritually appropriate end-of-life care services for indigenous patients, should be improved to ensure that requests are based on free choice, particularly for vulnerable people.

105. It should be noted that physician assisted dying has already been legalized in the province of Quebec. Quebec passed an Act respecting end-of-life care (the Quebec Act) in June 2014 with most of the Act coming into force on 10 December, 2015. The Quebec Act provides a ‘framework for end-of-life care’ which includes ‘continuous palliative sedation’ and ‘medical aid in dying’ defined as ‘administration by a physician of medications or substances to an end-of-life patient, at the patient’s request, in order to relieve their suffering by hastening death. In order to be able to access medical aid in dying under the Quebec Act, a patient must:-

- (1) be an insured person within the meaning of the Health Insurance Act (Chapter A-29);
- (2) be of full age and capable of giving consent to care;
- (3) be at the end of life;
- (4) suffer from a serious and incurable illness;
- (5) be in an advanced state of irreversible decline in capability; and
- (6) experience constant and unbearable physical or psychological suffering

(7) which cannot be relieved in a manner the patient deems tolerable.

106. The request for medical aid in dying must be signed by two physicians. The Quebec Act also established a Commission on end-of-life care to provide oversight and advice to the Minister of Health and Social Services on the implementation of the legislation regarding end-of-life care.

H.5 Other Jurisdictions:

107. Presently, we think it appropriate to deal with certain legislations in other countries and the decisions in other jurisdictions. In ***Aruna Shanbaug***, the Court has in detail referred to the legislations in Netherlands, i.e., the Termination of Life on Request and Assisted Suicide (Review Procedures) Act, 2002 that regulates euthanasia. The provisions of the said Act lay down that euthanasia and physician-assisted suicide are not punishable if the attending physician acts in accordance with the criteria of due care. As the two-Judge Bench has summarized, this criteria concern the patient's request, the patient's suffering (unbearable and

hopeless), the information provided to the patient, the presence of reasonable alternatives, consultation of another physician and the applied method of ending life. To demonstrate their compliance, the Act requires physicians to report euthanasia to a Review Committee. It has been observed that the said Act legalizes euthanasia and physician-assisted suicide in very specific cases under three specific conditions and euthanasia remains a criminal offence in cases not meeting the laid down specific conditions with the exception of several situations that are not subject to restrictions of law at all because they are considered normal medical practice. The three conditions are : stopping or not starting a medically useless (futile) treatment, stopping or not starting a treatment at the patient's request and speeding up death as a side effect of treatment necessary for alleviating serious suffering.

108. Reference has been made to the Swiss Criminal Code where active euthanasia has been regarded as illegal. Belgium has legalized the practice of euthanasia with the enactment of the Belgium Act on Euthanasia of May 28th, 2002 and the

patients can wish to end their life if they are under constant and unbearable physical or psychological pain resulting from an accident or an incurable illness. The Act allows adults who are in a 'futile medical condition of constant and unbearable physical or mental suffering that cannot be alleviated' to request voluntary euthanasia. Doctors who practise euthanasia commit no offence if the prescribed conditions and procedure is followed and the patient has the legal capacity and the request is made voluntarily and repeatedly with no external pressure.

109. Luxembourg too has legalized euthanasia with the passing of the Law of 16th March, 2009 on Euthanasia and Assisted Suicide (Lux.). The law permits euthanasia and assisted suicide in relation to those with incurable conditions with the requirements including repeated requests and the consent of two doctors and an expert panel.

110. The position in Germany is that active assisted suicide is illegal. However, this is not the case for passive assisted suicide. Thus, in Germany, if doctors stop life-prolonging measures, for instance, on the written wishes of a patient, it is

not considered as a criminal offence. That apart, it is legal for doctors in Germany to administer painkillers to a dying patient to ease pain. The said painkillers, in turn, cause low breathing that may lead to respiratory arrest and, ultimately, death.

H.6 International considerations and decisions of the European Court of Human Rights (ECHR):

111. Certain relevant obligations when discussing voluntary euthanasia are contained in the **International Covenant on Civil and Political Rights (ICCPR)**. The following rights in the ICCPR have been considered by the practice of voluntary euthanasia:

- right to life (Article 6)
- freedom from cruel, inhuman or degrading treatment (Article 7)
- right to respect for private life (Article 17)
- freedom of thought, conscience and religion (Article 18).

112. Right to life under Article 6(1) of the ICCPR provides: Every human being has the inherent right to life. This right shall be protected by law. No one shall be arbitrarily deprived of his life. The second sentence of Article 6(1) imposes a positive obligation on the States to provide legal protection of

the right to life. However, the subsequent reference to life not being ‘arbitrarily deprived’ operates to limit the scope of the right (and therefore the States’ duty to ensure the right). Comments from the UN Human Rights Committee suggest that laws allowing for voluntary euthanasia are not necessarily incompatible with the States’ obligation to protect the right to life.

113. The UN Human Rights Committee has emphasised that laws allowing for euthanasia must provide effective procedural safeguards against abuse if they are to be compatible with the State’s obligation to protect the right to life. In 2002, the UN Committee considered the euthanasia law introduced in the Netherlands. The Committee stated that:-

“where a State party seeks to relax legal protection with respect to an act deliberately intended to put an end to human life, the Committee believes that the Covenant obliges it to apply the most rigorous scrutiny to determine whether the State party’s obligations to ensure the right to life are being complied with (articles 2 and 6 of the Covenant).”

114. The European Court of Human Rights (ECHR) has adopted a similar position to the UN Human Rights Committee when considering euthanasia laws and the right to life in

Article 2 of the European Convention for the Protection of Human Rights and Fundamental Freedoms (European Convention). According to the ECHR, the right to life in Article 2 cannot be interpreted as conferring a right to die or a right to self determination in terms of choosing death rather than life. However, the ECHR has held that a State's obligation to protect life under that Article does not preclude it from legalising voluntary euthanasia, provided adequate safeguards are put in place and adhered to. In ***Pretty v. United Kingdom (application no. 2346/02)***³⁷, the ECHR ruled that the decision of the applicant to avoid what she considered would be an undignified and distressing end to her life was part of the private sphere covered by the scope of Article 8 of the Convention. The Court affirmed that the right of an individual to decide how and when to end her life, provided that the said individual was in a position to make up her own mind in that respect and to take the appropriate action, was one aspect of the right to respect for private life under Article 8 of the Convention. The Court, thus, recognised, with conditions, a

³⁷ [2002] ECHR 423 (29 April, 2002)

sort of right to self-determination as to one's own death, but the existence of this right is subject to two conditions, one linked to the free will of the person concerned and the other relating to the capacity to take appropriate action. However, respect for the right to life compels the national authorities to prevent a person from putting an end to life if such a decision is not taken freely and with full knowledge.

115. In ***Hass v. Switzerland (application no. 31322/07)***³⁸, the ECHR explained that:-

“creates for the authorities a duty to protect vulnerable persons, even against actions by which they endanger their own lives... this latter Article obliges the national authorities to prevent an individual from taking his or her own life if the decision has not been taken freely and with full understanding of what is involved”.

Accordingly, the ECHR concluded that:-

“the right to life guaranteed by Article 2 of the Convention obliges States to establish a procedure capable of ensuring that a decision to end one's life does indeed correspond to the free will of the individual concerned.”

³⁸ [2011] ECHR 2422: (2011) 53 EHRR 33

116. In a recent decision regarding end of life issues, ***Lambert and others v. France (application no. 46043/14)***³⁹, the ECHR considered whether the decision to withdraw artificial nutrition and hydration of Vincent Lambert violated the right to life in Article 2. Vincent Lambert was involved in a serious road accident which left him tetraplegic and with permanent brain damage. He was assessed in expert medical reports as being in a chronic vegetative state that required artificial nutrition and hydration to be administered via a gastric tube.

117. Mr. Lambert's parents applied to the ECHR alleging that the decision to withdraw his artificial nutrition and hydration breached, inter alia, the State's obligations under Article 2 of the European Convention. The ECHR highlighted that Article 2 imposes on the States both a negative obligation (to refrain from the 'intentional' taking of life) and a positive obligation (to 'take appropriate steps to safeguard the lives of those within its jurisdiction'). The Court held that the decision of a doctor to discontinue life-sustaining treatment (or 'therapeutic abstention') did not involve the State's negative obligation

³⁹ [2015] ECHR 185

under Article 2 and, therefore, the only question for the Court under Article 2 was whether it was consistent with the State's positive obligation.

118. The ECHR emphasized that 'the Convention has to be read as a whole', and, therefore:-

“in a case such as the present one reference should be made, in examining a possible violation of Article 2, to Article 8 of the Convention and to the right to respect for private life and the notion of personal autonomy which it encompasses.”

119. The Court noted that there was a consensus among European member States 'as to the paramount importance of the patient's wishes in the decision-making process, however those wishes are expressed'. It identified that in dealing with end of life situations, States have some discretion in terms of striking a balance between the protection of the patients' right to life and the protection of the right to respect their private life and their personal autonomy. The Court considered that the provisions of the Law of 22 April 2005 'on patients' rights and the end of life' promulgated in France making changes in the French Code of Public Health, as interpreted by the

Conseil d'Etat, constituted a legal framework which was sufficiently clear to regulate with precision the decisions taken by doctors in situations such as in Mr. Lambert's case. The Court found the legislative framework laid down by domestic law, as interpreted by the *Conseil d'État*, and the decision-making process which had been conducted in meticulous fashion, to be compatible with the requirements of the State's positive obligation under Article 2. With respect to negative obligations, the ECHR observed that the "therapeutic abstention" (that is, withdrawal and withholding of medical treatment) lacks the intention to end the patient's life and rather, a doctor discontinuing medical treatment from his or her patient merely intends to "allow death to resume its natural course and to relieve suffering". Therefore, as long as therapeutic abstention as authorised by the French Public Health Code is not about taking life intentionally, the ECHR opined that France had not violated its negative obligation to "refrain from the intentional taking of life".

120. When considering the State's positive obligations to protect human life, the ECHR noted that the regulatory

framework developed in the Public Health Code and the decision of the *Conseil d'Etat* established several “important safeguards” with respect to therapeutic abstention and the regulation is, therefore, “apt to ensure the protection of patients’ lives.”

121. All this compelled the ECHR to conclude that there was no violation of the State’s positive obligation to protect human life which, together with the absence of violation of negative obligations, resulted in the conclusion that “there would be no violation of Article 2 of the Convention in the event of implementation of the *Conseil d'Etat* judgment.” Thus, the ECHR in the ***Lambert*** (supra) case struck the balance between the sanctity of life on the one hand and the notions of quality of life and individual autonomy on the other.

I. The 241st Report of The Law Commission of India on Passive Euthanasia:

122. After the judgment of ***Aruna Shanbaug*** was delivered, the Law Commission of India submitted its 241st report which dealt with ‘Passive Euthanasia – A Relook’. The report in its introduction has dealt with the origin of the concept of

euthanasia. It states that the word “Euthanasia” is derived from the Greek words “eu” and “thanotos” which literally mean “good death” and is otherwise described as “mercy killing”. The word euthanasia, as pointed out in the Report, was used by Francis Bacon in the 17th Century to refer to an easy, painless and happy death as it is the duty and responsibility of the physician to alleviate the physical suffering of the body of the patient. A reference has also been made in the Report to the meaning given to the term by the House of Lords. The Select Committee on “Medical Ethics” in England defined Euthanasia as “a deliberate intervention undertaken with the express intention of ending a life to relieve intractable suffering”. Impressing upon the voluntary nature of euthanasia, the report has rightly highlighted the clarification as provided by the European Association of Palliative Care (EAPC) Ethics Task Force in a discussion on Euthanasia in 2003 to the effect that “medicalised killing of a person without the person’s consent, whether non-voluntary (where the person is unable to consent) or involuntary (against the person’s will) is not euthanasia: it is a murder.”

123. The Commission in its report referred to the observations made by the then Chairman of the Law Commission in his letter dated 28th August, 2006 addressed to the Hon'ble Minister which was extracted. It is pertinent to reproduce the same:-

“A hundred years ago, when medicine and medical technology had not invented the artificial methods of keeping a terminally ill patient alive by medical treatment, including by means of ventilators and artificial feeding, such patients were meeting their death on account of natural causes. Today, it is accepted, a terminally ill person has a common law right to refuse modern medical procedures and allow nature to take its own course, as was done in good old times. It is well-settled law in all countries that a terminally ill patient who is conscious and is competent, can take an ‘informed decision’ to die a natural death and direct that he or she be not given medical treatment which may merely prolong life. There are currently a large number of such patients who have reached a stage in their illness when according to well-informed body of medical opinion, there are no chances of recovery. But modern medicine and technology may yet enable such patients to prolong life to no purpose and during such prolongation, patients could go through extreme pain and suffering. Several such patients prefer palliative care for reducing pain and suffering and do not want medical treatment which will merely prolong life or postpone death.”

124. The report rightly points out that a rational and humanitarian outlook should have primacy in such a complex matter. Recognizing that passive euthanasia, both in the case of competent and incompetent patients, is being allowed in most of the countries subject to the doctor acting in the best interests of the patient, the report summarized the broad principles of medical ethics which shall be observed by the doctor in taking the decision. The said principles as obtained in the report are the patient's autonomy (or the right to self-determination) and beneficence which means following a course of action that is best for the patient uninfluenced by personal convictions, motives or other considerations. The Report also refers to the observations made by Lord Keith in **Airedale** case providing for a course to safeguard the patient's best interest. As per the said course, which has also been approved by this Court, the hospital/medical practitioner should apply to the Family Division of the High Court for endorsing or reversing the decision taken by the medical practitioners in charge to discontinue the treatment of a PVS patient. With respect to the ongoing debates on "legalizing

euthanasia”, the Report reiterates the observations made in **Airedale** that euthanasia (other than passive euthanasia) can be legalized by means of legislation only.

125. The Report, in upholding the principle of the patient’s autonomy, went on to state:-

“...the patient (competent) has a right to refuse medical treatment resulting in temporary prolongation of life. The patient’s life is at the brink of extinction. There is no slightest hope of recovery. The patient undergoing terrible suffering and worst mental agony does not want his life to be prolonged by artificial means. She/he would not like to spend for his treatment which is practically worthless. She/he cares for his bodily integrity rather than bodily suffering. She/he would not like to live 28 like a ‘cabbage’ in an intensive care unit for some days or months till the inevitable death occurs. He would like to have the right of privacy protected which implies protection from interference and bodily invasion. As observed in Gian Kaur’s case, the natural process of his death has already commenced and he would like to die with peace and dignity. No law can inhibit him from opting such course. This is not a situation comparable to suicide, keeping aside the view point in favour of decriminalizing the attempt to suicide. The doctor or relatives cannot compel him to have invasive medical treatment by artificial means or treatment.”

126. The Report supports the view of several authorities especially Lord Browne-Wilkinson (in **Airedale** case) and

Justice Cardozo that in case of any forced medical intervention on the body of a patient, the surgeon/doctor is guilty of 'assault' or 'battery'. The Report also laid emphasis on the opinion of Lord Goff placing the right of self-determination on a high pedestal. The said relevant observations of Lord Goff, as also cited in the Report, are as follows:-

“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.”

127. We have referred to the report of the Law Commission post ***Aruna Shanbaug*** only to highlight that there has been affirmative thought in this regard. We have also been apprised by Mr. Narasimha, learned Additional Solicitor General appearing for the Union of India, that there is going to be a law with regard to passive euthanasia.

J. Right to refuse treatment:

128. Deliberating on the issue of right to refuse treatment, Justice Cardozo in ***Schloendorff v. Society of New York Hospital***⁴⁰ observed:-

“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 the operation without his patient’s consent commits an assault for which he is liable in damages.”

129. In a somewhat different context, King C.J. in ***F v. R***⁴¹ identified “the paramount consideration that a person is entitled to make his own decisions about his life”. The said statement was cited with approval by Mason CJ, Brennan, Dawson, Toohey and McHugh, JJ. in ***Rogers v. Whitaker***⁴². Cardozo’s statement has been cited and applied in many cases. Thus, in ***Malette v. Shulman***⁴³, Robins J.A., speaking with the concurrence of Catzman and Canthy JJA, said:-

“A competent adult is generally entitled to reject a specific treatment or all treatment, or to select an alternative form of treatment even if the decision may entail risks as serious as death and may

⁴⁰ (1914) 105 NE 92 : (1914) 211 NY 125

⁴¹ (1983) 33 SASR 189 at 193

⁴² [1992] HCA 58 : (1992) 175 CLR 479 at 487

⁴³ 67 DLR (4th) 321 (1990) : 72 OR (2d) 417

appear mistaken in the eyes of the medical profession or of the community it is the patient who has the final say on whether to undergo the treatment.”

130. The recognition of the freedom of competent adults to make choices about their medical care necessarily encompasses recognition of the right to make choices since individual free choice and self-determination are themselves fundamental constituents of life. Robins J.A. further clarified in ***Malette*** at page 334:-

“To deny individuals freedom of choice with respect to their health care can only lessen and not enhance the value of life.”

131. In the 21st century, with the advancement of technology in medical care, it has become possible, with the help of support machines, to prolong the death of patients for months and even years in some cases. At this juncture, the right to refuse medical treatment comes into the picture. A patient (terminally ill or in a persistent vegetative state) exercising the right to refuse treatment may ardently wish to live but, at the same time, he may wish to be free from any medical surgery, drugs or treatment of any kind so as to avoid protracted

physical suffering. Any such person who has come of age and is of sound mind has a right to refuse medical treatment. This right stands on a different pedestal as compared to suicide, physician assisted suicide or even euthanasia. When a terminally ill patient refuses to take medical treatment, it can neither be termed as euthanasia nor as suicide. Albeit, both suicide and refusal to take treatment in case of terminal ailment shall result in the same consequences, that is, death, yet refusal to take treatment by itself cannot amount to suicide. In case of suicide, there has to be a self initiated positive action with a specific intention to cause one's own death. On the other hand, a patient's right to refuse treatment lacks his specific intention to die, rather it protects the patient from unwanted medical treatment. A patient refusing medical treatment merely allows the disease to take its natural course and if, in this process, death occurs, the cause for it would primarily be the underlying disease and not any self initiated act.

132. In **Rodriguez** (supra), Justice Sopinka, speaking for the Supreme Court of Canada, held:-

“Canadian Court has recognized a common law right of patients to refuse to consent to medical treatment or to demand that the treatment, once commenced, be withdrawn or discontinued. This right has been specially recognized to exist even if the withdrawal from or refusal of treatment may result in death.”

133. In ***Secretary, Department of Health and Community Services (NT) v. JWB and SMB***⁴⁴, the High Court of Australia acknowledged the fundamental right of personal inviolability. Justice McHugh observed that the voluntary decision of an adult person of sound mind as to what should be done to his or her body must be respected. It was further observed that under the doctrine of trespass, the common law respects and protects the autonomy of adult persons and also accepts the right to self-determination in respect of his or her body which can be altered only with the consent of the person concerned.

134. There is a presumption of capacity whereby an adult is presumed to have the capacity to consent to or to refuse medical treatment unless and until that presumption is rebutted. Butler-Sloss LJ, in ***Re MB (Medical Treatment)***⁴⁵, stated that in deciding whether a person has the capacity to

⁴⁴ (1992) 66 AJLR 300 : (1992) 175 CLR 218

⁴⁵ [1997] EWCA Civ 3093 : [1997] 2 FLR 426

make a particular decision, the ultimate question is whether that person suffers from some impairment or disturbance of mental functioning so as to render him or her incapable of making the decision. The consent may be vitiated if the individual concerned may not have been competent in law to give or refuse that consent; or even if the individual was competent in law, the decision has been obtained by undue influence or some other vitiating means; or the apparent consent or refusal does not extend to the particular situation; or the terms of the consent or refusal are ambiguous or uncertain; or if the consent or refusal is based on incorrect information or incorrect assumption. In circumstances where it is practicable for a medical practitioner to obtain consent to treatment, then, for the consent to be valid, it must be based on full information, including as to its risks and benefits.

135. Where it is not practicable for a medical practitioner to obtain consent for treatment and where the patient's life is in danger if appropriate treatment is not given, then the treatment may be administered without consent. This is justified by what is sometimes called the "emergency principle"

or “principle of necessity”. Usually, the medical practitioner treats the patient in accordance with his clinical judgment of what is in the patient’s best interests. Lord Goff of Chieveley has rightly pointed out in ***F v. West Berkshire Health Authority*** (supra) that for the principle of necessity to apply, two conditions must be met:-

- (a) There must be “a necessity to act when it is not practicable to communicate with the assisted person”; and
- (b) “the action taken must be such as a reasonable person would in all the circumstances take, acting in the best interests of the assisted person.”

136. However, Lord Goff pointed out that the principle of necessity does not apply where the proposed action is contrary to the known wishes of the assisted person to the extent that he/she is capable of rationally forming such a wish. It follows that the principle of necessity cannot be relied upon to justify a particular form of medical treatment where the patient has given an advance care directive specifying that he/she does not wish to be so treated and where there is no reasonable

basis for doubting the validity and applicability of that directive.

K. Passive Euthanasia in the context of Article 21 of the Constitution:

137. We have to restrict our deliberation to the issue whether euthanasia can come within the ambit and sweep of Article 21.

Article 21 reads as follows:-

“21. Protection of life and personal liberty.—No person shall be deprived of his life or personal liberty except according to procedure established by law.”

138. The word ‘liberty’ is the sense and realization of choice of the attributes associated with the said choice; and the term ‘life’ is the aspiration to possess the same in a dignified manner. The two are intrinsically interlinked. Liberty impels an individual to change and life welcomes the change and the movement. Life does not intend to live sans liberty as it would be, in all possibility, a meaningless survival. There is no doubt that no fundamental right is absolute, but any restraint imposed on liberty has to be reasonable. Individual liberty aids in developing one’s growth of mind and assert individuality. She/he may not be in a position to rule others but

individually, she/he has the authority over the body and mind. The liberty of personal sovereignty over body and mind strengthens the faculties in a person. It helps in their cultivation. Roscoe Pound, in one of his lectures, has aptly said:-

“... although we think socially, we must still think of individual interests, and of that greatest of all claims which a human being may make, the claim to assert his individuality, to exercise freely the will and the reason which God has given him. We must emphasize the social interest in the moral and social life of the individual, but we must remember that it is the life of a free-willing being.”

139. Liberty allows freedom of speech, association and dissemination without which the society may face hurdles in attaining the requisite maturity. History is replete with narratives how the thoughts of individuals, though not accepted by the contemporaneous society, later on gained not only acceptance but also respect. One may not agree with Kantian rigorism, but one must appreciate that without the said doctrine, there could not have been dissemination of further humanistic principles. There is a danger in discouraging free thinking and curtailing the power of

imagination. Holmes in ***Adkins v. Children's Hospital***⁴⁶ has observed:-

“It is merely an example of doing what you want to do, embodied in the word “liberty”.”

140. The concept of liberty perceives a hazard when it feels it is likely to become hollow. This necessarily means that there would be liberty available to individuals subject to permissible legal restraint and it should be made clear that in that restraint, free ideas cannot be imprisoned by some kind of unknown terror. Liberty cannot be a slave because it constitutes the essential marrow of life and that is how we intend to understand the conception of liberty when we read it in association with the term ‘life’ as used in Article 21 of the Constitution. The great American playwright Tennessee Williams has said:-

“To be free is to have achieved your life.”

141. Life as envisaged under Article 21 has been very broadly understood by this Court. In ***Board of Trustees of the Port of Bombay v. Dilipkumar Raghavendranath Nadkarni and***

⁴⁶ 261 US 525, 568(1923)

others⁴⁷, the Court has held that the expression “life” does not merely connote animal existence or a continued drudgery through life. The expression ‘life’ has a much wider meaning and, therefore, where the outcome of a departmental enquiry is likely to adversely affect the reputation or livelihood of a person, some of the finer graces of human civilization which make life worth living would be jeopardized and the same can be put in jeopardy only by law which inheres fair procedures.

142. In ***Maneka Gandhi v. Union of India and another***⁴⁸, Krishna Iyer J., in his own inimitable style, states that among the great guaranteed rights, life and liberty are the first among equals carrying a universal connotation cardinal to a decent human order and protected by constitutional armour. Once liberty under Article 21 is viewed in a truncated manner, several other freedoms fade out automatically. To sum up, personal liberty makes for the worth of the human person. Travel makes liberty worthwhile. ‘Life’ is a terrestrial opportunity for unfolding personality, rising to higher status, moving to fresh woods and reaching out to reality which

⁴⁷ (1983) 1 SCC 124

⁴⁸ (1978) 1 SCC 248

makes our earthly journey a true fulfilment – not a tale told by an idiot full of sound and fury signifying nothing, but a fine frenzy rolling between heaven and earth. The spirit of man is at the root of Article 21. In the absence of liberty, other freedoms are frozen.

143. In ***State of Andhra Pradesh v. Challa Ramkrishna Reddy and others***⁴⁹, this Court held that right to life is one of the basic human rights and it is guaranteed to every person by Article 21 of the Constitution and not even the State has the authority to violate that right. A prisoner, whether a convict or under-trial or a detenu, does not cease to be a human being. Even when lodged in jail, he continues to enjoy all his fundamental rights including the right to life guaranteed to him under the Constitution. The Court further ruled that on being convicted of crime and deprived of their liberty in accordance with the procedure established by law, prisoners still retain the residue of constitutional rights.

144. Having said so, we are required to advert to the issue whether passive euthanasia can only be conceived of through

⁴⁹ AIR 2000 SC 2083 : (2000) 5 SCC 712

legislation or this Court can, for the present, provide for the same. We have already explained that the ratio laid down in ***Gian Kaur*** does not convey that the introduction of passive euthanasia can only be by legislation. In ***Aruna Shanbaug***, the two-Judge Bench has placed reliance on the Constitution Bench judgment in ***Gian Kaur*** to lay down the guidelines. If, eventually, we arrive at the conclusion that passive euthanasia comes within the sweep of Article 21 of the Constitution, we have no iota of doubt that this Court can lay down the guidelines.

145. We may clearly state here that the interpretation of the Constitution, especially fundamental rights, has to be dynamic and it is only such interpretative dynamism that breathes life into the written words. As far as Article 21 is concerned, it is imperative to mention that dynamism can, of course, infuse life into life and liberty as used in the said Article.

146. In this regard, we may reproduce a couple of paragraphs from ***Central Inland Water Transport***

Corporation Limited and another v. Brojo Nath Ganguly

and another⁵⁰. They read as under:-

“25. The story of mankind is punctuated by progress and retrogression. Empires have risen and crashed into the dust of history. Civilizations have nourished, reached their peak and passed away. In the year 1625, Carew, C.J., while delivering the opinion of the House of Lords in *Re the Earldom of Oxford* in a dispute relating to the descent of that Earldom, said:

“... and yet time hath his revolution, there must be a period and an end of all temporal things, *finis rerum*, an end of names and dignities, and whatsoever is terrene....”

The cycle of change and experiment, rise and fall, growth and decay, and of progress and retrogression recurs endlessly in the history of man and the history of civilization. T.S. Eliot in the First Chorus from “*The Rock*” said:

“O perpetual revolution of configured stars,
O perpetual recurrence of determined seasons,
O world of spring and autumn, birth and dying;
The endless cycle of idea and action,
Endless invention, endless experiment.”

26. The law exists to serve the needs of the society which is governed by it. If the law is to play its allotted role of serving the needs of the society, it must reflect the ideas and ideologies of that society. It must keep time with the heartbeats of the society and with the needs and aspirations of the people. As

⁵⁰ (1986) 3 SCC 156

the society changes, the law cannot remain immutable. The early nineteenth century essayist and wit, Sydney Smith, said: “When I hear any man talk of an unalterable law, I am convinced that he is an unalterable fool.” The law must, therefore, in a changing society march in tune with the changed ideas and ideologies”

[Emphasis added]

147. We approve the view in the aforesaid passages. Having approved the aforesaid principle, we are obliged to state that the fundamental rights in their connotative expanse are bound to engulf certain rights which really flow from the same. In ***M. Nagaraj and others v. Union of India and others***⁵¹, the Constitution Bench has ruled:-

“19. The Constitution is not an ephemeral legal document embodying a set of legal rules for the passing hour. It sets out principles for an expanding future and is intended to endure for ages to come and consequently to be adapted to the various crises of human affairs. Therefore, a purposive rather than a strict literal approach to the interpretation should be adopted. A constitutional provision must be construed not in a narrow and constricted sense but in a wide and liberal manner so as to anticipate and take account of changing conditions and purposes so that a constitutional provision does not get fossilised but remains flexible enough to meet the newly emerging problems and challenges.”

⁵¹ (2006) 8 SCC 212

And again:-

“29. ... constitutionalism is about limits and aspirations. According to Justice Brennan, interpretation of the Constitution as a written text is concerned with aspirations and fundamental principles. In his article titled “Challenge to the Living Constitution” by Herman Belz, the author says that the Constitution embodies aspiration to social justice, brotherhood and human dignity. It is a text which contains fundamental principles. ...”

148. In this context, we may make a reference to a three-Judge Bench decision in **V.C. Rangadurai v. D. Gopalan and others**⁵² wherein the majority, while dealing with Section 35(3) of the Advocates Act, 1961, stated:-

“8. ... we may note that words grow in content with time and circumstance, that phrases are flexible in semantics, that the printed text is a set of vessels into which the court may pour appropriate judicial meaning. That statute is sick which is allergic to change in sense which the times demand and the text does not countermand. That court is superficial which stops with the cognitive and declines the creative function of construction. So, we take the view that 'quarrying' more meaning is permissible out of Section 35(3) and the appeal provisions, in the brooding background of social justice, sanctified by Article 38, and of free legal aid enshrined by Article 39A of the Constitution.”

⁵² (1979) 1 SCC 308

The learned Judges went on to say:-

“11. ... Judicial 'Legisputation' to borrow a telling phrase of J. Cohen, is not legislation but application of a given legislation to new or unforeseen needs and situations broadly falling within the statutory provision. In that sense, 'interpretation is inescapably a kind of legislation' (The Interpretation and Application of Statutes, Read Dickerson, p. 238). Ibid. p. 238. This is not legislation *stricto sensu* but application, and is within the court's province.”

149. The aforesaid authorities clearly show the power that falls within the province of the Court. The language employed in the constitutional provision should be liberally construed, for such provision can never remain static. It is because stasticity would mar the core which is not the intent.

K.1 Individual Dignity as a facet of Article 21:

150. Dignity of an individual has been internationally recognized as an important facet of human rights in the year 1948 itself with the enactment of the Universal Declaration of Human Rights. Human dignity not only finds place in the Preamble of this important document but also in Article 1 of the same. It is well known that the principles set out in UDHR are of paramount importance and are given utmost weightage

while interpreting human rights all over the world. The first and foremost responsibility fixed upon the State is the protection of human dignity without which any other right would fall apart. Justice Brennan in his book *The Constitution of the United States: Contemporary Ratification* has referred to the Constitution as "a sparkling vision of the supremacy of the human dignity of every individual."

151. In fact, in the case of ***Christine Goodwin v. the United Kingdom***⁵³ the European Court of Human Rights, speaking in the context of the Convention for the Protection of Human Rights and Fundamental Freedoms, has gone to the extent of stating that "the very essence of the Convention is respect for human dignity and human freedom". In the South African case of ***S v. Makwanyane***⁵⁴ O' Regan J. stated in the Constitutional Court that "without dignity, human life is substantially diminished."

152. Having noted the aforesaid, it is worthy to note that our Court has expanded the spectrum of Article 21. In the latest

⁵³ [2002] ECHR 588

⁵⁴ 1995 (3) SA 391

nine-Judge Bench decision in ***K.S. Puttaswamy and another v. Union of India and others***⁵⁵, dignity has been reaffirmed to be a component under the said fundamental right. Human dignity is beyond definition. It may at times defy description. To some, it may seem to be in the world of abstraction and some may even perversely treat it as an attribute of egotism or accentuated eccentricity. This feeling may come from the roots of absolute cynicism. But what really matters is that life without dignity is like a sound that is not heard. Dignity speaks, it has its sound, it is natural and human. It is a combination of thought and feeling, and, as stated earlier, it deserves respect even when the person is dead and described as a 'body'. That is why, the Constitution Bench in ***M. Nagaraj*** (supra) lays down:-

“....It is the duty of the State not only to protect the human dignity but to facilitate it by taking positive steps in that direction. No exact definition of human dignity exists. It refers to the intrinsic value of every human being, which is to be respected. It cannot be taken away. It cannot give (sic be given). It simply is. Every human being has dignity by virtue of his existence. ...”

⁵⁵ (2017) 10 SCC 1

153. The concept and value of dignity requires further elaboration since we are treating it as an inextricable facet of right to life that respects all human rights that a person enjoys. Life is basically self-assertion. In the life of a person, conflict and dilemma are expected to be normal phenomena. Oliver Wendell Holmes, in one of his addresses, quoted a line from a Latin poet who had uttered the message, "Death plucks my ear and says, Live- I am coming". That is the significance of living. But when a patient really does not know if he/she is living till death visits him/her and there is constant suffering without any hope of living, should one be allowed to wait? Should she/he be cursed to die as life gradually ebbs out from her/his being? Should she/he live because of innovative medical technology or, for that matter, should he/she continue to live with the support system as people around him/her think that science in its progressive invention may bring about an innovative method of cure? To put it differently, should he/she be "guinea pig" for some kind of experiment? The answer has to be an emphatic "No" because such futile waiting mars the pristine concept of life, corrodes

the essence of dignity and erodes the fact of eventual choice which is pivotal to privacy. Recently, in ***K.S. Puttaswamy*** (supra), one of us (Dr. Chandrachud J.), while speaking about life and dignity, has observed:-

“118. Life is precious in itself. But life is worth living because of the freedoms which enable each individual to live life as it should be lived. The best decisions on how life should be lived are entrusted to the individual. They are continuously shaped by the social milieu in which individuals exist. The duty of the State is to safeguard the ability to take decisions — the autonomy of the individual — and not to dictate those decisions. “Life” within the meaning of Article 21 is not confined to the integrity of the physical body. The right comprehends one’s being in its fullest sense. That which facilitates the fulfilment of life is as much within the protection of the guarantee of life.

119. To live is to live with dignity. The draftsmen of the Constitution defined their vision of the society in which constitutional values would be attained by emphasising, among other freedoms, liberty and dignity. So fundamental is dignity that it permeates the core of the rights guaranteed to the individual by Part III. Dignity is the core which unites the fundamental rights because the fundamental rights seek to achieve for each individual the dignity of existence. Privacy with its attendant values assures dignity to the individual and it is only when life can be enjoyed with dignity can liberty be of true substance. Privacy ensures the fulfilment of dignity and is a core value which the protection of life and liberty is intended to achieve.”

154. In ***Mehmood Nayyar Azam v. State of Chhattisgarh and others***⁵⁶, a two-Judge Bench held thus:-

“Albert Schweitzer, highlighting on Glory of Life, pronounced with conviction and humility, "the reverence of life offers me my fundamental principle on morality". The aforesaid expression may appear to be an individualistic expression of a great personality, but, when it is understood in the complete sense, it really denotes, in its conceptual essentiality, and connotes, in its macrocosm, the fundamental perception of a thinker about the respect that life commands. The reverence of life is inseparably associated with the dignity of a human being who is basically divine, not servile. A human personality is endowed with potential infinity and it blossoms when dignity is sustained. The sustenance of such dignity has to be the superlative concern of every sensitive soul. The essence of dignity can never be treated as a momentary spark of light or, for that matter, 'a brief candle', or 'a hollow bubble'. The spark of life gets more resplendent when man is treated with dignity sans humiliation, for every man is expected to lead an honourable life which is a splendid gift of "creative intelligence"”

155. The aforesaid authority emphasizes the seminal value of life that is inherent in the concept of life. Dignity does not recognize or accept any nexus with the status or station in life. The singular principle that it pleasantly gets beholden to is the integral human right of a person. Law gladly takes cognizance

⁵⁶ (2012) 8 SCC 1

of the fact that dignity is the most sacred possession of a man. And the said possession neither loses its sanctity in the process of dying nor evaporates when death occurs. In this context, reference to a passage from ***Vikas Yadav v. State of Uttar Pradesh and others***⁵⁷ is note worthy. The two Judge Bench of this Court, while dealing with the imposition of a fixed term sentence under Section 302 IPC, took note of the fact that the High Court had observed the magnitude of vengeance of the accused and the extent to which they had gone to destroy the body of the deceased. Keeping in view the findings of the High Court, this Court stated:-

“From the evidence brought on record as well as the analysis made by the High Court, it is demonstrable about the criminal proclivity of the accused persons, for they have neither the respect for human life nor did they have any concern for the dignity of a dead person. They had deliberately comatosed the feeling that even in death a person has dignity and when one is dead deserves to be treated with dignity. That is the basic human right. The brutality that has been displayed by the accused persons clearly exposes the depraved state of mind.”

⁵⁷ (2016) 9 SCC 541

The aforesaid passage shows the pedestal on which the Court has placed the dignity of an individual.

156. Reiterating that dignity is the most fundamental aspect of right to life, it has been held in the celebrated case of ***Francis Coralie Mullin v. The Administrator, Union Territory of Delhi***⁵⁸:-

"We think that the right to life includes the right to live with human dignity and all that goes along with it, namely, the bare necessities of life such as adequate nutrition, clothing and shelter and facilities for reading, writing and expressing one-self in diverse forms, freely moving about and mixing and commingling with fellow human beings. Of course, the magnitude and content of the components of this right would depend upon the extent of the economic development of the country, but it must, in any view of the matter, include the right to the basic necessities of life and also the right to carry on such functions and activities as constitute the bare minimum expression of the human-self. Every act which offends against or impairs human dignity would constitute deprivation protanto of this right to live and it would have to be in accordance with reasonable, fair and just procedure established by law which stands the test of other fundamental rights. Now obviously, any form of torture or cruel, inhuman or degrading treatment would be offensive to human dignity and constitute an inroad into this right to live and it would, on this view, be prohibited by Article 21 unless it is in accordance with procedure prescribed

⁵⁸ (1981) 1 SCC 608

by law, but no law which authorises and no procedure which leads to such torture or cruel, inhuman or degrading treatment can ever stand the test of reasonableness and non-arbitrariness: it would plainly be unconstitutional and void as being violative of Articles 14 and 21. It would thus be seen that there 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."

157. In ***National Legal Services Authority v. Union of India and others***⁵⁹, the Apex Court has held that there is a growing recognition that the true measure of development of a nation is not economic growth; it is human dignity.

158. In ***Shabnam v. Union of India and another***⁶⁰, it has been further held that:-

"This right to human dignity has many elements. First and foremost, human dignity is the dignity of each human being 'as a human being'. Another element, which needs to be highlighted, in the context of the present case, is that human dignity is infringed if a person's life, physical or mental welfare is harmed. It is in this sense torture, humiliation, forced labour, etc. all infringe on human dignity."

⁵⁹ (2014) 5 SCC 438

⁶⁰ (2015) 6 SCC 702

159. In ***Gian Kaur*** (supra), the Constitution Bench indicates acceleration of the conclusion of the process of death which has commenced and this indication, as observed by us, allows room for expansion. In the said case, the Court was primarily concerned with the question of constitutional validity of Sections 306 and 309 of IPC. The Court was conscious of the fact that the debate on euthanasia was not relevant for deciding the question under consideration. The Court, however, in no uncertain terms expounded that the word "life" in Article 21 has been construed as life with human dignity and it takes within its ambit the "right to die with dignity" being part of the "right to live with dignity". Further, the "right to live with human dignity" would mean existence of such a right upto the end of natural life which would include the right to live a dignified life upto the point of death including the dignified procedure of death. While adverting to the situation of a dying man who is terminally ill or in a persistent vegetative state where he may be permitted to terminate it by a premature extinction of his life, the Court observed that the said category of cases may fall within the ambit of "right to die with dignity" as part of the right to live with dignity when death due to

the termination of natural life is certain and imminent and the process of natural death has commenced, for these are not cases of extinguishing life but only of accelerating the conclusion of the process of natural death which has already commenced. The sequitur of this exposition is that there is little doubt that a dying man who is terminally ill or in a persistent vegetative state can make a choice of premature extinction of his life as being a facet of Article 21 of the Constitution. If that choice is guaranteed being part of Article 21, there is no necessity of any legislation for effectuating that fundamental right and more so his natural human right. Indeed, that right cannot be an absolute right but subject to regulatory measures to be prescribed by a suitable legislation which, however, must be reasonable restrictions and in the interests of the general public. In the context of the issue under consideration, we must make it clear that as part of the right to die with dignity in case of a dying man who is terminally ill or in a persistent vegetative state, only passive euthanasia would come within the ambit of Article 21 and not the one which would fall within the description of active euthanasia in which positive steps are taken either by the

treating physician or some other person. That is because the right to die with dignity is an intrinsic facet of Article 21. The concept that has been touched deserves to be concretised, the thought has to be realized. It has to be viewed from various angles, namely, legal permissibility, social and ethical ethos and medical values.

160. The purpose of saying so is only to highlight that the law must take cognizance of the changing society and march in consonance with the developing concepts. The need of the present has to be served with the interpretative process of law. However, it is to be seen how much strength and sanction can be drawn from the Constitution to consummate the changing ideology and convert it into a reality. The immediate needs are required to be addressed through the process of interpretation by the Court unless the same totally falls outside the constitutional framework or the constitutional interpretation fails to recognize such dynamism. The Constitution Bench in ***Gian Kaur***, as stated earlier, distinguishes attempt to suicide and abetment of suicide from acceleration of the process of natural death which has commenced. The authorities, we

have noted from other jurisdictions, have observed the distinctions between the administration of lethal injection or certain medicines to cause painless death and non-administration of certain treatment which can prolong the life in cases where the process of dying that has commenced is not reversible or withdrawal of the treatment that has been given to the patient because of the absolute absence of possibility of saving the life. To explicate, the first part relates to an overt act whereas the second one would come within the sphere of informed consent and authorized omission. The omission of such a nature will not invite any criminal liability if such action is guided by certain safeguards. The concept is based on non-prolongation of life where there is no cure for the state the patient is in and he, under no circumstances, would have liked to have such a degrading state. The words “no cure” have to be understood to convey that the patient remains in the same state of pain and suffering or the dying process is delayed by means of taking recourse to modern medical technology. It is a state where the treating physicians and the family members know fully well that the treatment is

administered only to procrastinate the continuum of breath of the individual and the patient is not even aware that he is breathing. Life is measured by artificial heartbeats and the patient has to go through this undignified state which is imposed on him. The dignity of life is denied to him as there is no other choice but to suffer an avoidable protracted treatment thereby thus indubitably casting a cloud and creating a dent in his right to live with dignity and face death with dignity, which is a preserved concept of bodily autonomy and right to privacy. In such a stage, he has no old memories or any future hopes but he is in a state of misery which nobody ever desires to have. Some may also silently think that death, the inevitable factum of life, cannot be invited. To meet such situations, the Court has a duty to interpret Article 21 in a further dynamic manner and it has to be stated without any trace of doubt that the right to life with dignity has to include the smoothening of the process of dying when the person is in a vegetative state or is living exclusively by the administration of artificial aid that prolongs the life by arresting the dignified and inevitable process of dying. Here, the issue of choice also

comes in. Thus analysed, we are disposed to think that such a right would come within the ambit of Article 21 of the Constitution.

L. Right of self-determination and individual autonomy:

161. Having dealt with the right to acceleration of the process of dying a natural death which is arrested with the aid of modern innovative technology as a part of Article 21 of the Constitution, it is necessary to address the issues of right of self-determination and individual autonomy.

162. John Rawls says that the liberal concept of autonomy focuses on choice and likewise, self-determination is understood as exercised through the process of choosing⁶¹. The respect for an individual human being and in particular for his right to choose how he should live his own life is individual autonomy or the right of self-determination. It is the right against non-interference by others, which gives a competent person who has come of age the right to make decisions concerning his or her own life and body without any

⁶¹ Rawls, John, *Political Liberalism* 32, 33, New York: Columbia University Press, 1993.

control or interference of others. Lord Hoffman, in ***Reeves v.***

Commissioner of Police of the Metropolis⁶² has stated:-

"Autonomy means that every individual is sovereign over himself and cannot be denied the right to certain kinds of behaviour, even if intended to cause his own death."

163. In the context of health and medical care decisions, a person's exercise of self-determination and autonomy involves the exercise of his right to decide whether and to what extent he/she is willing to submit himself/herself to medical procedures and treatments, choosing amongst the available alternative treatments or, for that matter, opting for no treatment at all which, as per his or her own understanding, is in consonance with his or her own individual aspirations and values.

164. In ***Airedale*** (supra), Lord Goff has expressed that 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

⁶²[2000] 1 AC 360, 379

his/her life would or might be prolonged, the doctors responsible for his/her care must give effect to his/her wishes, even though they do not consider it to be in his/her best interests to do so and to this extent, the principle of sanctity of human life must yield to the principle of self-determination. Lord Goff further says that the doctor's duty to act in the best interests of his patient must likewise be qualified with the patient's right of self determination. Therefore, as far as the United Kingdom is concerned, it is generally clear that whenever there is a conflict between a capable adult's exercise of the right of self-determination and the State's interest in preserving human life by treating it as sanctimonious, the right of the individual must prevail.

165. In the United States, the aspect of self-determination and individual autonomy is concretised in law as all fifty States along with the District of Columbia, the capital, which is commonly referred as Washington D.C., have passed legislations upholding different forms of Advance Directives. In the United States, even before the enactment of the said laws,

a terminally ill person was free to assert the right to die as an ancillary right to the constitutionally protected right to privacy. In ***In Re Quinlan*** (supra), where a 21 year old girl in chronic PVS was on ventilator support, the Court, while weighing Quinlan's right to privacy qua the State's interest in preserving human life, found that as the degree of bodily invasion increases and the prognosis for the patient's recovery dims, the patient's right to privacy increases and the State's interest weakens. The Supreme Court of New Jersey finally ruled that the unwritten constitutional right of privacy was broad enough to encompass a patient's decision to decline medical treatment in certain circumstances. Again, in ***Re Jobes***⁶³, which was also a case concerned with a PVS patient, the Court, following the decision in ***In Re Quinlan***, upheld the principle of self determination and autonomy of an incompetent person.

166. The Canadian Criminal Code asserts and protects the sanctity of life in a number of ways which directly confront the autonomy of the terminally ill in their medical decision

⁶³ (1987) 108 N.J. 394

making. However, the Supreme Court of Canada in ***Reibl v. Hughes***⁶⁴ approved an oft-quoted statement of Cardozo J. in ***Scholoendorf*** (supra) that "every human being of adult years and sound mind has a right to determine what shall be done with his own body" and Chief Justice Laskin in ***Reibl*** (supra) has further added that battery would lie where surgery or treatment was performed without consent or where apart from emergency situations, surgery or medical treatment was given beyond that to which there was consent. Thus, the Supreme Court of Canada suggested that competent adults have the right to make their own medical decisions even if such decisions are unwise.

167. In ***Aruna Shanbaug*** (supra), this Court has observed that autonomy means the right to self-determination where the informed patient has a right to choose the manner of his treatment. To be autonomous the patient should be competent to make decisions and choices. In the event that he is incompetent to make choices, his wishes expressed in advance in the form of a Living Will, or the wishes of surrogates acting on his behalf

⁶⁴ [1980 2 SCR 880 at 890-891]

('substituted judgment') are to be respected. The surrogate is expected to represent what the patient may have decided had he/she been competent or to act in the patient's best interest. It is expected that a surrogate acting in the patient's best interest follows a course of action because it is best for the patient, and is not influenced by personal convictions, motives or other considerations.

168. Thus, enquiring into common law and statutory rights of terminally ill persons in other jurisdictions would indicate that all adults with the capacity to consent have the common law right to refuse medical treatment and the right of self determination.

169. We may, however, add a word of caution that doctors would be bound by the choice of self-determination made by the patient who is terminally ill and undergoing a prolonged medical treatment or is surviving on life support, subject to being satisfied that the illness of the patient is incurable and there is no hope of his being cured. Any other consideration cannot pass off as being in the best interests of the patient.

M. Social morality, medical ethicality and State interest:

170. Having dwelt upon the issue of self-determination, we may presently delve into three aspects, namely, social morality, medical ethicality and the State interest. The aforesaid concepts have to be addressed in the constitutional backdrop. We may clearly note that the society at large may feel that a patient should be treated till he breathes his last breath and the treating physicians may feel that they are bound by their Hippocratic oath which requires them to provide treatment and save life and not to put an end to life by not treating the patient. The members of the family may remain in a constant state of hesitation being apprehensive of many a social factor which include immediate claim of inheritance, social stigma and, sometimes, the individual guilt. The Hippocratic oath taken by a doctor may make him feel that there has been a failure on his part and sometimes also make him feel scared of various laws. There can be allegations against him for negligence or criminal culpability.

171. In this regard, two aspects are to be borne in mind. First, withdrawal of treatment in an irreversible situation is

different from not treating or attending to a patient and second, once passive euthanasia is recognized in law regard being had to the right to die with dignity when life is ebbing out and when the prolongation is done sans purpose, neither the social morality nor the doctors' dilemma or fear will have any place. It is because the sustenance of dignity and self-respect of an individual is inhered in the right of an individual pertaining to life and liberty and there is necessity for this protection. And once the said right comes within the shelter of Article 21 of the Constitution, the social perception and the apprehension of the physician or treating doctor regarding facing litigation should be treated as secondary because the primacy of the right of an individual in this regard has to be kept on a high pedestal.

172. It is to be borne in mind that passive euthanasia fundamentally connotes absence of any overt act either by the patient or by the doctors. It also does not involve any kind of overt act on the part of the family members. It is avoidance of unnecessary intrusion in the physical frame of a person, for the inaction is meant for smooth exit from life. It is paramount

for an individual to protect his dignity as an inseparable part of the right to life which engulfs the dignified process of dying sans pain, sans suffering and, most importantly, sans indignity.

173. There are philosophers, thinkers and also scientists who feel that life is not confined to the physical frame and biological characteristics. But there is no denial of the fact that life in its connotative expanse intends to search for its meaning and find the solution of the riddle of existence for which some lean on atheism and some vouchsafe for faith and yet some stand by the ideas of an agnostic. However, the legal fulcrum has to be how Article 21 of the Constitution is understood. If a man is allowed to or, for that matter, forced to undergo pain, suffering and state of indignity because of unwarranted medical support, the meaning of dignity is lost and the search for meaning of life is in vain.

N. Submissions of the States

174. In this context, we may reflect on the submissions advanced on behalf of certain States. As stated earlier, there

is a categorical assertion that protection of human life is paramount and it is obligatory on behalf of the States to provide treatment and to see that no one dies because of lack of treatment and to realise the principles enshrined in Chapter IV of the Constitution. Emphasis has been laid on the State interest and the process of abuse that can take place in treating passive euthanasia as permissible in law. To eliminate the possibility of abuse, safeguards can be taken and guidelines can be framed. But on the plea of possibility of abuse, the dignity in the process of dying being a facet of Article 21 should not be curbed.

Mr. Datar, learned senior counsel in the course of arguments, has advanced submissions in support of passive euthanasia and also given suggestions spelling out the guidelines for advance directive and also implementation of the same when the patient is hospitalized. The said aspect shall be taken into consideration while giving effect to the advance directive and also taking steps for withdrawal of medical support.

O. Submissions of Intervenor (Society for the Right to Die with Dignity):

175. Mr. Mohta, learned counsel appearing for the intervenor, that is, Society for the Right to Die with Dignity, has drawn our attention to certain articles and submitted that from the days of Plato to the time of Sir Thomas More and other thinkers, painless and peaceful death has been advocated. He would also submit that ancient wisdom of India taught people not to fear death but to aspire for deathlessness and conceive it as “Mahaprasthanasana”. It is his submission that in the modern State, the State interest should not over-weigh the individual interest in the sphere of a desire to die a peaceful death which basically conveys refusal of treatment when the condition of the individual suffering from a disease is irreversible. The freedom of choice in this sphere, as Mr. Mohta would put it, serves the cause of humanitarian approach which is not the process to put an end to life by taking a positive action but to allow a dying patient to die peaceably instead of prolonging the process of dying without purpose that creates a dent in his dignity.

176. The aforesaid argument, we have no hesitation to say, has force. It is so because it is in accord with the constitutional precept and fosters the cherished value of dignity of an individual. It saves a helpless person from uncalled for and unnecessary treatment when he is considered as merely a creature whose breath is felt or measured because of advanced medical technology. His “being” exclusively rests on the mercy of the technology which can prolong the condition for some period. The said prolongation is definitely not in his interest. On the contrary, it tantamounts to destruction of his dignity which is the core value of life. In our considered opinion, in such a situation, an individual interest has to be given priority over the State interest.

P. Advance Directive/Advance Care Directive/Advance Medical Directive:

177. In order to overcome the difficulty faced in case of patients who are unable to express their wishes at the time of taking the decision, the concept of Advance Medical Directives emerged in various countries. The proponents of Advance Medical Directives contend that the concept of patient

autonomy for incompetent patients can be given effect to, by giving room to new methods by which incompetent patients can beforehand communicate their choices which are made while they are competent. Further, it may be argued that failure to recognize Advance Medical Directives would amount to non-facilitation of the right to have a smoothened dying process. That apart, it accepts the position that a competent person can express her/his choice to refuse treatment at the time when the decision is required to be made.

178. Advance Directives for health care go by various names in different countries though the objective by and large is the same, that is, to specify an individual's health care decisions and to identify persons who will take those decisions for the said individual in the event he is unable to communicate his wishes to the doctor.

179. The Black's Law Dictionary defines an advance medical directive as, "a legal document explaining one's wishes about medical treatment if one becomes incompetent or unable to communicate". A living will, on the other hand, is a document prescribing a person's wishes regarding the medical treatment

the person would want if he was unable to share his wishes with the health care provider.

180. Another type of advance medical directive is medical power of attorney. It is a document which allows an individual (principal) to appoint a trusted person (agent) to take health care decisions when the principal is not able to take such decisions. The agent appointed to deal with such issues can interpret the principal's decisions based on their mutual knowledge and understanding.

181. Advance Directives have gained lawful recognition in several jurisdictions by way of legislation and in certain countries through judicial pronouncements. In vast majority of the States in USA, it is mandatory for the doctors to give effect to the wishes of the patients as declared by them in their advance directives. California was the first State to legally sanction living will. The United States Congress in 1990, with the objective of protecting the fundamental principles of self-autonomy and self-determination, enacted the Patient Self-Determination Act (PSDA) which acknowledged the rights of the patient to either refuse or accept treatment. Following this,

all 50 States enacted legislations adopting advance directives. Apart from this, several States of USA also permit the patients to appoint a health care proxy which becomes effective only when the patient is unable to make decisions.

182. In order to deal with the technicalities and intricacies associated with an instrument as complex as an Advance Directive, several derivatives/versions have evolved over time. The National Right to Life Committee (NRLC) in the United States came up with a version of a living will which was called 'Will to Live' which is a safeguard of the lives of patients who wish to continue treatment and not refuse life-sustaining treatment. This form of active declaration gains importance in cases where the will of the patient cannot be deciphered with certainty and the Courts order withdrawal of life supporting treatment where they deem the life of the patient as not worthwhile.

183. Yet another measure for finding and accessing the patient's advance directive was the setting up of the U.S. Living Will Registry. As per this model, it was obligatory on the part of the hospital administration to ask a patient, who would

be admitted, if he/she had an advance directive and store the same on their medical file. A special power to the Advance Directives introduced by Virginia was the "Ulysses Clause" which accords protection in situations when the patient goes into relapse in his/her condition, that is, schizophrenia and refuses treatment which they would not refuse if not for the said relapse.

184. A new type of advance directive is the "Do Not Resuscitate Order" (DNRO) in Florida which is a form of patient identification device developed by the Department of Health to identify people who do not wish to be resuscitated in the event of respiratory or cardiac arrest. In Florida State of United States, where an unconscious patient with the phrase "Do Not Resuscitate" tattooed on his chest was brought in paramedics, the doctors were left in a conundrum whether the message was not to provide any medical treatment to the patient and ultimately, the doctors opted not to perform any medical procedure and the patient, thereafter, died. This case highlights the dynamics involved in the concept of advanced directives due to the intricacies surrounding the concept.

185. The Mental Capacity Act governs the law relating to advance directives in the UK. Specific guidelines as to the manner in which the advance directive should be drafted and the necessary conditions that need to be fulfilled in order to give effect to the directives have been categorically laid out in the said piece of legislation. A few specific requirements in case of refusal of life sustaining treatment is the verification of the decision-maker that the refusal operates even if life is at risk and that the directive should be in the written form and signed and witnessed. However, an advance directive refusing food and water has not been recognized under this statute. Further, the Act recognizes the rights of the patient to appoint a health care proxy who is referred to as "lasting power of attorney". In order for the proxy decision-maker so appointed to be competent to consent or refuse life-sustaining treatment of the decision-maker, an express provision delegating the said authority should be a part of the advance directive. In general, as per the settled law vide the decision in **Airedale**, life sustaining treatment including artificial nutrition and hydration can be withdrawn if the patient consents to it and in

case of incompetent patients, if it is in their best interest to do so.

186. Australia too, by way of legislation, has well established principles governing Advance Health Directives. Except Tasmania, all states have a provision for Advance Directives. The Advance Directives as postulated by the different legislations in each State in Australia differ in nature and their binding effect but the objective of every type remains the same, that is, preservation of the patient's autonomy. There are several circumstances when the advance health care directives or certain provisions contained therein become inoperative.

187. In Queensland, the directive becomes inoperative if the medical health practitioner is of the opinion that giving effect to the directive is inconsistent with good medical practice or in case of a change in circumstances, including new advances in medicine, medical practice and technology, to the extent that giving effect to the directive is inappropriate.

188. In the State of Victoria, an advance directive ceases to apply due to a change in the condition of the patient to the extent that the condition in relation to which the advance

directive was given no longer exists. Further, South Australia permits a medical practitioner to refuse to comply with a certain provision in an advance directive in case he/she has enough reason to believe that the patient did not intend the provision to apply in certain conditions or the provision would not reflect the present wishes of the patient. In Western Australia, the occurrence of a change in circumstances which either the decision maker could have never anticipated at the time of making the directive or which could have the effect on a reasonable person in the position of the decision maker to change his/her mind regarding the treatment decision would invalidate the said treatment decision in the directive. In Northern Territory, an advance consent direction is disregarded in case giving effect to it would result in such unacceptable pain and suffering to the patient or would be so unjustifiable and rather it is more reasonable to override the wishes of the patient. Furthermore, if the medical practitioner is of the opinion that the patient would have never intended the advance consent direction to apply in the circumstances, then the advance consent direction need not be complied with.

189. Canada does not have a federal legislation exclusively to regulate advance directives. Rather, there are eleven different provincial approaches governing the law on passive euthanasia and advance directives in Canada. The provinces of Alberta, Saskatchewan, Manitoba, Prince Edward Island, Newfoundland and Labrador and Northwest Territories have a provision for both proxy and instructional directives, whereas, the States of British Columbia, Ontario, Quebec and Yukon provide only for appointment of a proxy while simultaneously recognizing the binding nature of previously given instructions. The respective legislations of the provinces/territories differ from one another on several criteria, for instance, minimum age requirement and other formalities to be complied with, such as written nature of the advance directive, etc. Furthermore, some of the provinces mandate a prior consultation with a lawyer. Wishes orally expressed have also been recognized by some provinces.

190. Having dealt with the principles in vogue across the globe, we may presently proceed to deal with the issue of advance medical directive which should be ideal in our

country. Be it noted, though the learned counsel for the petitioner has used the words “living will”, yet we do not intend to use the said terminology. We have already stated that safeguards and guidelines are required to be provided. First, we shall analyse the issue of legal permissibility of the advance medical directive. In other jurisdictions, the concepts of “living will” and involvement of Attorney are stipulated. There is no legal framework in our country as regards the Advance Medical Directive but we are obliged to protect the right of the citizens as enshrined under Article 21 of the Constitution. It is our constitutional obligation. As noticed earlier, the two-Judge Bench in ***Aruna Shanbaug*** (supra) has provided for approaching the High Court under Article 226 of the Constitution. The directions and guidelines to be given in this judgment would be comprehensive and would also cover the situation dealt with ***Aruna Shanbaug*** case.

191. In our considered opinion, Advance Medical Directive would serve as a fruitful means to facilitate the fructification of the sacrosanct right to life with dignity. The said directive, we think, will dispel many a doubt at the relevant time of need

during the course of treatment of the patient. That apart, it will strengthen the mind of the treating doctors as they will be in a position to ensure, after being satisfied, that they are acting in a lawful manner. We may hasten to add that Advance Medical Directive cannot operate in abstraction. There has to be safeguards. They need to be spelt out. We enumerate them as follows:-

(a) Who can execute the Advance Directive and how?

- (i) The Advance Directive can be executed only by an adult who is of a sound and healthy state of mind and in a position to communicate, relate and comprehend the purpose and consequences of executing the document.
- (ii) It must be voluntarily executed and without any coercion or inducement or compulsion and after having full knowledge or information.
- (iii) It should have characteristics of an informed consent given without any undue influence or constraint.

- (iv) It shall be in writing clearly stating as to when medical treatment may be withdrawn or no specific medical treatment shall be given which will only have the effect of delaying the process of death that may otherwise cause him/her pain, anguish and suffering and further put him/her in a state of indignity.

(b) What should it contain?

- (i) It should clearly indicate the decision relating to the circumstances in which withholding or withdrawal of medical treatment can be resorted to.
- (ii) It should be in specific terms and the instructions must be absolutely clear and unambiguous.
- (iii) It should mention that the executor may revoke the instructions/authority at any time.

- (iv) It should disclose that the executor has understood the consequences of executing such a document.
- (v) It should specify the name of a guardian or close relative who, in the event of the executor becoming incapable of taking decision at the relevant time, will be authorized to give consent to refuse or withdraw medical treatment in a manner consistent with the Advance Directive.
- (vi) 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 to.

(c) How should it be recorded and preserved?

- (i) The document should be signed by the executor in the presence of two attesting witnesses, preferably independent, and countersigned by

the jurisdictional Judicial Magistrate of First Class (JMFC) so designated by the concerned District Judge.

- (ii) The witnesses and the jurisdictional JMFC shall record their satisfaction that the document has been executed voluntarily and without any coercion or inducement or compulsion and with full understanding of all the relevant information and consequences.
- (iii) The JMFC shall preserve one copy of the document in his office, in addition to keeping it in digital format.
- (iv) The JMFC shall forward one copy of the document to the Registry of the jurisdictional District Court for being preserved. Additionally, the Registry of the District Judge shall retain the document in digital format.
- (v) The JMFC shall cause to inform the immediate family members of the executor, if not present at

the time of execution, and make them aware about the execution of the document.

- (vi) A copy shall be handed over to the competent officer of the local Government or the Municipal Corporation or Municipality or Panchayat, as the case may be. The aforesaid authorities shall nominate a competent official in that regard who shall be the custodian of the said document.
- (vii) The JMFC shall cause to handover copy of the Advance Directive to the family physician, if any.

(d) When and by whom can it be given effect to?

- (i) In the event the executor becomes terminally ill and is undergoing prolonged medical treatment with no hope of recovery and cure of the ailment, the treating physician, when made aware about the Advance Directive, shall ascertain the genuineness and authenticity thereof from the jurisdictional JMFC before acting upon the same.

- (ii) The instructions in the document must be given due weight by the doctors. However, it should be given effect to only after being fully satisfied that the executor is terminally ill and is undergoing prolonged treatment or is surviving on life support and that the illness of the executor is incurable or there is no hope of him/her being cured.
- (iii) If the physician treating the patient (executor of the document) is satisfied that the instructions given in the document need to be acted upon, he shall inform the executor or his guardian / close relative, as the case may be, about the nature of illness, the availability of medical care and consequences of alternative forms of treatment and the consequences of remaining untreated. He must also ensure that he believes on reasonable grounds that the person in question understands the information provided, has

cogitated over the options and has come to a firm view that the option of withdrawal or refusal of medical treatment is the best choice.

- (iv) The physician/hospital where the executor has been admitted for medical treatment shall then constitute a Medical Board consisting of the Head of the treating Department and at least three experts from the fields of general medicine, cardiology, neurology, nephrology, psychiatry or oncology with experience in critical care and with overall standing in the medical profession of at least twenty years who, in turn, shall visit the patient in the presence of his guardian/close relative and form an opinion whether to certify or not to certify carrying out the instructions of withdrawal or refusal of further medical treatment. This decision shall be regarded as a preliminary opinion.

- (v) In the event the Hospital Medical Board certifies that the instructions contained in the Advance Directive ought to be carried out, the physician/hospital shall forthwith inform the jurisdictional Collector about the proposal. The jurisdictional Collector shall then immediately constitute a Medical Board comprising the Chief District Medical Officer of the concerned district as the Chairman and three expert doctors from the fields of general medicine, cardiology, neurology, nephrology, psychiatry or oncology with experience in critical care and with overall standing in the medical profession of at least twenty years (who were not members of the previous Medical Board of the hospital). They shall jointly visit the hospital where the patient is admitted and if they concur with the initial decision of the Medical Board of the hospital,

they may endorse the certificate to carry out the instructions given in the Advance Directive.

(vi) The Board constituted by the Collector must beforehand ascertain the wishes of the executor if he is in a position to communicate and is capable of understanding the consequences of withdrawal of medical treatment. In the event the executor is incapable of taking decision or develops impaired decision making capacity, then the consent of the guardian nominated by the executor in the Advance Directive should be obtained regarding refusal or withdrawal of medical treatment to the executor to the extent of and consistent with the clear instructions given in the Advance Directive.

(vii) The Chairman of the Medical Board nominated by the Collector, that is, the Chief District Medical Officer, shall convey the decision of the Board to the jurisdictional JMFC before giving

effect to the decision to withdraw the medical treatment administered to the executor. The JMFC shall visit the patient at the earliest and, after examining all aspects, authorise the implementation of the decision of the Board.

- (viii) It will be open to the executor to revoke the document at any stage before it is acted upon and implemented.

(e) What if permission is refused by the Medical Board?

- (i) If permission to withdraw medical treatment is refused by the Medical Board, it would be open to the executor of the Advance Directive or his family members or even the treating doctor or the hospital staff to approach the High Court by way of writ petition under Article 226 of the Constitution. If such application is filed before the High Court, the Chief Justice of the said High Court shall constitute a Division Bench to decide upon grant of approval or to refuse the

same. The High Court will be free to constitute an independent Committee consisting of three doctors from the fields of general medicine, cardiology, neurology, nephrology, psychiatry or oncology with experience in critical care and with overall standing in the medical profession of at least twenty years.

- (ii) The High Court shall hear the application expeditiously after affording opportunity to the State counsel. It would be open to the High Court to constitute Medical Board in terms of its order to examine the patient and submit report about the feasibility of acting upon the instructions contained in the Advance Directive.
- (iii) Needless to say that the High Court shall render its decision at the earliest as such matters cannot brook any delay and it shall ascribe reasons specifically keeping in mind the principles of "best interests of the patient".

(f) Revocation or inapplicability of Advance Directive

(i) An individual may withdraw or alter the Advance Directive at any time when he/she has the capacity to do so and by following the same procedure as provided for recording of Advance Directive. Withdrawal or revocation of an Advance Directive must be in writing.

(ii) An Advance Directive shall not be applicable to the treatment in question if there are reasonable grounds for believing that circumstances exist which the person making the directive did not anticipate at the time of the Advance Directive and which would have affected his decision had he anticipated them.

(iii) If the Advance Directive is not clear and ambiguous, the concerned Medical Boards shall not give effect to the same and, in that event, the

guidelines meant for patients without Advance Directive shall be made applicable.

(iv) Where the Hospital Medical Board takes a decision not to follow an Advance Directive while treating a person, then it shall make an application to the Medical Board constituted by the Collector for consideration and appropriate direction on the Advance Directive.

192. It is necessary to make it clear that there will be cases where there is no Advance Directive. The said class of persons cannot be alienated. In cases where there is no Advance Directive, the procedure and safeguards are to be same as applied to cases where Advance Directives are in existence and in addition there to, the following procedure shall be followed:-

(i) In cases where the patient is terminally ill and undergoing prolonged treatment in respect of ailment which is incurable or where there is no hope of being cured, the physician may inform the hospital which, in turn, shall constitute a Hospital Medical Board in

the manner indicated earlier. The Hospital Medical Board shall discuss with the family physician and the family members and record the minutes of the discussion in writing. During the discussion, the family members shall be apprised of the pros and cons of withdrawal or refusal of further medical treatment to the patient and if they give consent in writing, then the Hospital Medical Board may certify the course of action to be taken. Their decision will be regarded as a preliminary opinion.

- (ii) In the event the Hospital Medical Board certifies the option of withdrawal or refusal of further medical treatment, the hospital shall immediately inform the jurisdictional Collector. The jurisdictional Collector shall then constitute a Medical Board comprising the Chief District Medical Officer as the Chairman and three experts from the fields of general medicine, cardiology, neurology, nephrology, psychiatry or oncology with experience in critical care and with

overall standing in the medical profession of at least twenty years. The Medical Board constituted by the Collector shall visit the hospital for physical examination of the patient and, after studying the medical papers, may concur with the opinion of the Hospital Medical Board. In that event, intimation shall be given by the Chairman of the Collector nominated Medical Board to the JMFC and the family members of the patient.

- (iii) The JMFC shall visit the patient at the earliest and verify the medical reports, examine the condition of the patient, discuss with the family members of the patient and, if satisfied in all respects, may endorse the decision of the Collector nominated Medical Board to withdraw or refuse further medical treatment to the terminally ill patient.
- (iv) There may be cases where the Board may not take a decision to the effect of withdrawing medical treatment of the patient on the Collector nominated Medical Board may

not concur with the opinion of the hospital Medical Board. In such a situation, the nominee of the patient or the family member or the treating doctor or the hospital staff can seek permission from the High Court to withdraw life support by way of writ petition under Article 226 of the Constitution in which case the Chief Justice of the said High Court shall constitute a Division Bench which shall decide to grant approval or not. The High Court may constitute an independent Committee to depute three doctors from the fields of general medicine, cardiology, neurology, nephrology, psychiatry or oncology with experience in critical care and with overall standing in the medical profession of at least twenty years after consulting the competent medical practitioners. It shall also afford an opportunity to the State counsel. The High Court in such cases shall render its decision at the earliest since such matters cannot brook any delay. Needless to say, the High Court shall ascribe reasons specifically keeping in mind the principle of "best interests of the patient"..

193. Having said this, we think it appropriate to cover a vital aspect to the effect the life support is withdrawn, the same shall also be intimated by the Magistrate to the High Court. It shall be kept in a digital format by the Registry of the High Court apart from keeping the hard copy which shall be destroyed after the expiry of three years from the death of the patient.

194. Our directions with regard to the Advance Directives and the safeguards as mentioned hereinabove shall remain in force till the Parliament makes legislation on this subject.

Q. Conclusions in seriatim:

195. In view of the aforesaid analysis, we record our conclusions in seriatim:-

- (i) A careful and precise perusal of the judgment in ***Gian Kaur*** (supra) case reflects the right of a dying man to die with dignity when life is ebbing out, and in the case of a terminally ill patient or a person in PVS, where there is no hope of recovery, accelerating the process of death for reducing the

period of suffering constitutes a right to live with dignity.

(ii) The Constitution Bench in ***Gian Kaur*** (supra) has not approved the decision in ***Airedale*** (supra) inasmuch as the Court has only made a brief reference to the ***Airedale*** case.

(iii) It is not the ratio of ***Gian Kaur*** (supra) that passive euthanasia can be introduced only by legislation.

(iv) The two-Judge bench in ***Aruna Shanbaug*** (supra) has erred in holding that this Court in ***Gian Kaur*** (supra) has approved the decision in ***Airedale*** case and that euthanasia could be made lawful only by legislation.

(v) There is an inherent difference between active euthanasia and passive euthanasia as the former entails a positive affirmative act, while the latter relates to withdrawal of life support measures or

withholding of medical treatment meant for artificially prolonging life.

(vi) In active euthanasia, a specific overt act is done to end the patient's life whereas in passive euthanasia, something is not done which is necessary for preserving a patient's life. It is due to this difference that most of the countries across the world have legalised passive euthanasia either by legislation or by judicial interpretation with certain conditions and safeguards.

(vii) Post ***Aruna Shanbaug*** (supra), the 241st report of the Law Commission of India on Passive Euthanasia has also recognized passive euthanasia, but no law has been enacted.

(viii) An inquiry into common law jurisdictions reveals that all adults with capacity to consent have the right of self-determination and autonomy. The said rights pave the way for the right to refuse

medical treatment which has acclaimed universal recognition. A competent person who has come of age has the right to refuse specific treatment or all treatment or opt for an alternative treatment, even if such decision entails a risk of death. The 'Emergency Principle' or the 'Principle of Necessity' has to be given effect to only when it is not practicable to obtain the patient's consent for treatment and his/her life is in danger. But where a patient has already made a valid Advance Directive which is free from reasonable doubt and specifying that he/she does not wish to be treated, then such directive has to be given effect to.

(ix) Right to life and liberty as envisaged under Article 21 of the Constitution is meaningless unless it encompasses within its sphere individual dignity. With the passage of time, this Court has expanded the spectrum of Article 21 to include within it the

right to live with dignity as component of right to life and liberty.

(x) It has to be stated without any trace of doubt that the right to live with dignity also includes the smoothening of the process of dying in case of a terminally ill patient or a person in PVS with no hope of recovery.

(xi) A failure to legally recognize advance medical directives may amount to non-facilitation of the right to smoothen the dying process and the right to live with dignity. Further, a study of the position in other jurisdictions shows that Advance Directives have gained lawful recognition in several jurisdictions by way of legislation and in certain countries through judicial pronouncements.

(xii) Though the sanctity of life has to be kept on the high pedestal yet in cases of terminally ill persons or PVS patients where there is no hope for

revival, priority shall be given to the Advance Directive and the right of self-determination.

(xiii) In the absence of Advance Directive, the procedure provided for the said category hereinbefore shall be applicable.

(xiv) When passive euthanasia as a situational palliative measure becomes applicable, the best interest of the patient shall override the State interest.

196. We have laid down the principles relating to the procedure for execution of Advance Directive and provided the guidelines to give effect to passive euthanasia in both circumstances, namely, where there are advance directives and where there are none, in exercise of the power under Article 142 of the Constitution and the law stated in ***Vishaka and Others v. State of Rajasthan and Others***⁶⁵. The directive and guidelines shall remain in force till the Parliament brings a legislation in the field.

⁶⁵ (1997) 6 SCC 241

197. The Writ Petition is, accordingly, disposed of. There shall be no order as to costs.

.....CJI
(Dipak Misra)

.....J.
(A.M. Khanwilkar)

New Delhi;
March 09, 2018

IN THE SUPREME COURT OF INDIA

CIVIL ORIGINAL JURISDICTION

WRIT PETITION (CIVIL) NO. 215 OF 2005

COMMON CAUSE (A REGD. SOCIETY)

.....PETITIONER(S)

VERSUS

UNION OF INDIA AND ANOTHER

.....RESPONDENT(S)

J U D G M E N T

A.K. SIKRI, J.

Michael Kirby, a former Judge of the Australian High Court, while discussing about the role of judiciary in the context of HIV law¹, talks about the consciousness with which the judiciary is supposed to perform its role. In this hue, while discussing about the responsibility of leadership which the society imposes upon Judges, he remarks: “Nowhere more is that responsibility tested than when a completely new and unexpected problem presents itself to society. All the judges’ instincts for legality, fairness and reasonableness must then be summoned up, to help lead society towards an informed, intelligent and just solution to the problem.”

¹ ‘The Role of Judiciary and HIV Law’ – *Michael Kirby*, published in the book titled ‘HIV Law, Ethics and Human Rights’, edited by *D.C. Jayasuriya*.

The problem at hand, just solution whereof is imminently needed, is that of *Euthanasia*. This Court is required to summon up instincts for legality, fairness and reasonableness in order to find just solution to the problem. In this process, the Court is duty bound to look into the relevant provisions of the Constitution of India, particularly those pertaining to the fundamental rights, and to discharge the task of expounding those basic human rights enshrined in the Chapter relating to Fundamental Rights. The issue of euthanasia, with the seminal importance that is attached to it, has thrown the challenge of exposition, development and obligation of the constitutional morality and exhorts the Court to play its creative role so that a balanced approach to an otherwise thorny and highly debatable subject matter is found.

- 2) The Courts, in dispensation of their judicial duties of deciding cases, come across all types of problems which are brought before them. These cases may be broadly classified into three categories: (i) the easy cases, (ii) the intermediate cases, and (iii) the hard cases. Professor *Ronald Dworkin*² has argued that each legal problem has one lawful solution and even in the hard cases, the Judge is never free to choose among alternatives that are all inside the bounds of law. This may not be entirely correct

² Dworkin, "Judicial Discretion," 6 J. of Phil. 624 (1963)

inasmuch as judicial discretion does exist. This is true, at least, in solving '*hard cases*'³. It is found that meaning of certain legal norms, when applied with respect to a given system of facts, is so simple and clear that their application involves no judicial discretion. These are termed as the '*easy cases*'. This may even apply to '*intermediate cases*'. These would be those cases where both sides appear to have a legitimate legal argument supporting their position and a conscious act of interpretation is noted, before a Judge can conclude which side is right in law and there is only one lawful situation. However, when it comes to the hard cases, the Court is faced with number of possibilities, all of which appear to be lawful within the context of the system. In these cases, judicial discretion exists as the choice is not between lawful and unlawful, but between lawful and lawful. A number of lawful solutions exist. In this scenario, the Court is supposed to ultimately choose that solution which is in larger public interest. In other words, there are limitations that find the Court with respect to the manner in which it chooses among possibilities (procedural limitations) and with respect to the considerations it takes into account in the choice (substantive limitations). Thus, discretion when applied to a court of justice means sound

3 See Aharon Barak: Judicial Discretion, Yale University Press.

discretion guided by law. It must be governed by legal rules. To quote Justice *Cardozo*:

“Given freedom of choice, how shall the choice be guided? Complete freedom – unfettered and undirected – there never is. A thousand limitations – the product some of statute, some of precedent, some of vague tradition or of an immemorial technique – encompass and hedge us even when we think of ourselves as ranging freely and at large. The inscrutable force of professional opinion presses upon us like the atmosphere, though we are heedless of its weight. Narrow at best is any freedom that is allotted to us⁴

3) Thus, though the judicial discretion is with the Court, the same is limited and not absolute. The Court is not entitled to weigh any factor as it likes. It has to act within the framework of the limitations, and after they have been exhausted, there is a freedom of choice which can also be described as ‘*sovereign prerogative of choice*’⁵. Instant case falls in the category of ‘*hard cases*’ and the Court has endeavoured to make a choice, after evaluating all the pros and cons, which in its wisdom is the “*just result*” of the contentious issue.

4) Adverting to the Indian precedents in the first instance, we have before us two direct judgments of this Court which may throw some light on the subject and demonstrate as to how this topic has been dealt with so far. The first judgment is that of a

⁴ B. Cardozo: *The Growth of the Law* 144 (1924), at 60-61

⁵ Justice O. Holmes opined this expression in ‘*Collected Legal Papers*’ 239 (1921)

Constitution Bench in the case titled ***Gian Kaur v. State of Punjab***⁶. Second case is known as ***Aruna Ramachandra Shanbaug v. Union of India and Others***⁷, which is a Division Bench judgment that takes note of ***Gian Kaur*** and premised thereupon goes much farther in accepting passive euthanasia as a facet of Article 21 of the Constitution.

- 5) In the instant case, while making reference to the Constitution Bench vide its order dated February 25, 2014⁸, the three Judge Bench has expressed its reservation in the manner the ratio of the Constitution Bench in ***Gian Kaur*** is applied by the Division Bench in ***Aruna Ramachandra Shanbaug***. This reference order accepts that ***Aruna Ramachandra Shanbaug*** rightly interpreted the decision in ***Gian Kaur*** insofar as it held that euthanasia can be allowed in India only through a valid legislation. However, the reference order declares that ***Aruna Ramachandra Shanbaug*** has committed a factual error in observing that in ***Gian Kaur*** the Constitution Bench approved the decision of the House of Lords in ***Airedale N.H.S. Trust v. Bland***⁹. As per the reference order, ***Gian Kaur*** merely referred to the said judgment which cannot be construed to mean that the Constitution Bench in ***Gian Kaur***

6 (1996) 2 SCC 648

7 (2011) 4 SCC 454

8 Reported as (2014) 5 SCC 338

9 (1993) 2 WLR 316 (HL)

approved the opinion of the House of Lords rendered in ***Bland***. The reference order also accepts the position that in ***Gian Kaur*** the Constitution Bench approved that '*right to live with dignity*' under Article 21 of the Constitution will be inclusive of '*right to die with dignity*'. However, it further notes that the decision does not arrive at a conclusion for validity of euthanasia, be it active or passive. Therefore, the only judgment that holds the field in India is ***Aruna Ramachandra Shanbaug***, which upholds the validity of passive euthanasia and lays down an elaborate procedure for executing the same on '*the wrong premise that the Constitution Bench in ***Gian Kaur*** had upheld the same*'.

- 6) The aforesaid discussion contained in the reference order prompted the reference court to refer the matter to the Constitution Bench. No specific questions were framed for consideration by the Constitution Bench. However, importance of the issue has been highlighted in the reference order in the following manner:

"17. In view of the inconsistent opinions rendered in *Aruna Shanbaug* and also considering the important question of law involved which needs to be reflected in the light of social, legal, medical and constitutional perspectives, it becomes extremely important to have a clear enunciation of law. Thus, in our cogent opinion, the question of law 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. Accordingly, we refer this matter to a Constitution Bench of this Court for an authoritative opinion.”

- 7) I have given a glimpse of the narratives for the simple reason that the Hon’ble the Chief Justice, in his elaborate opinion, has already discussed this aspect in detail. Likewise, it can be found in the separate judgments authored by my esteemed brethren – Chandrachud, J. and Bhushan, J. Those judgments discuss in detail the law laid down in ***Gian Kaur*** as well as ***Aruna Ramachandra Shanbaug***, including critique thereof. To avoid repetition, I have eschewed that part of discussion. For the same reason, I have also not ventured to discuss the law in some other countries and historic judgments rendered by the courts of foreign jurisdiction, as this aspect is also taken care of by them. However, my analysis of the above two judgments is limited to the extent it is necessitated for maintaining continuum and clarity of thought.
- 8) At the outset, I say that I am in complete agreement with the conclusion and also the directions given therein in the judgment of the Hon’ble the Chief Justice and also with the opinions and

reasoning of my other two learned brothers. My purpose is not to add my ink to the erudite opinion expressed in otherwise eloquent opinions penned by my learned brothers. At the same time, having regard to the importance of the issue involved, I am provoked to express my own few thoughts, in my own way, which I express hereinafter.

- 9) In the writ petition filed by the petitioner – Common Cause, it has made the following prayers:

“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 executants or in the alternative, issue appropriate guidelines to this effect;

c) appoint an expert committee of experts including doctors, social scientists and lawyers to study into the aspect of issuing guidelines as to the Living Wills;

d) pass such other and further order/s as this Hon’ble Court may deem fit and proper on the facts and in the circumstances of the case.”

- 10) Having regard to the aforesaid prayers, the reference order and the arguments which were addressed by Mr. Prashant Bhushan,

learned counsel who appeared for the petitioner, and Mr. Arvind Datar, learned senior counsel who made elaborate submissions on behalf of the interveners – Vidhi Centre for Legal Policy, and Mr. R.R. Kishore, Advocate, who gave an altogether new dimension to the seminal issue, I find that following issues/questions of law of relevance need to be discussed:

- (i) Whether the Right to Live under Article 21 of the Constitution includes the Right to Die? {Now that attempt to commit suicide is not a punishable offence under Section 309 of the Indian Penal Code, 1860 (for short, 'IPC') vide Section 115 of the Mental Healthcare Act, 2017 (Act No. 10 of 2017)}
- (ii) Whether the '*right to die with dignity*' as a fundamental right falls within the folds of the '*right to live with dignity*' under Article 21 of the Constitution?
- (iii) Whether the observations in ***Aruna Ramachandra Shanbaug*** that the Constitution Bench in ***Gian Kaur*** permitted passive euthanasia stand correct?
- (iv) Whether there exists inconsistency in the observations in ***Aruna Ramachandra Shanbaug*** with regard to what has been held in ***Gian Kaur***?
- (v) Whether mere reference to verdict in a judgment can be

construed to mean that the verdict is approved? {with respect to Article 141 – What is binding?; whether the Constitution Bench in ***Gian Kaur*** approved the decision of the House of Lords in ***Bland***?}

- (vi) Whether the law on passive euthanasia, as held valid in ***Aruna Ramachandra Shanbaug***, holds true in the present times as well? {The Treatment of Terminally-ill Patients Bill, 2016 is based on the aforementioned judgment}
- (vii) Whether active euthanasia is legal in India?
- (viii) Whether assisted suicide/physician administered suicide is legal in India? {The 2016 bill in the current form, under Clause 5(3) permits for physician assisted suicide}
- (ix) Whether there exists a right to a *Living Will/Advance Directives*? Whether there exists the fundamental right to choose one's own medical treatment? {With Right to Privacy now a fundamental right under Article 21, the principle of self-determination in India stands on a higher footing than before}
- (x) Definition of '*Terminal Illness*'.

11) It is not necessary for me to answer all the aforesaid questions. I say so for the reason that all these aspects are dealt with by the

Hon'ble the Chief Justice in his opinion. Therefore, in this 'addendum', I would be focusing myself to the core issues.

EUTHANASIA DEFINED

12) The Oxford English Dictionary defines 'euthanasia' as '*the painless killing of a patient suffering from an incurable and painful disease or in an irreversible coma*'. The word appears to have come into usage in the early 17th century and was used in the sense of 'easy death'. The term is derived from the Greek 'euthanatos', with 'eu' meaning well, and 'thanatos' meaning death. In ancient Greece and Rome, citizens were entitled to a good death to end the suffering of a terminal illness. To that end, the City Magistrates of Athens kept a supply of poison to help the dying '*drink the hemlock*'¹⁰.

13) The above Greek definition of euthanasia apart, it is a loaded term. People have been grappling with it for ages. Devised for service in a rhetoric of persuasion, the term 'euthanasia' has no generally accepted and philosophically warranted core meaning. It is also defined as: *killing at the request of the person killed*. That is how the Dutch medical personnel and civil authorities define euthanasia. In Nazi discourse, euthanasia was any killing carried out by medical means or medically qualified personnel,

10 Michael Manning, Euthanasia and Physician-Assisted Suicide (Paulist Press, 1998).

whether intended for the termination of suffering and/or of the burden or indignity of a life not worth living (*Lebensunwertes Leben*), or for some more evidently public benefit such as eugenics (racial purity and hygiene), *Lebensraum* (living space for Germans), and/or minimizing the waste of resources on 'useless mouths'. Understandably, in today's modern democracies these Nazi ideas and practices cannot be countenanced. Racist eugenics are condemned, though one comes across discreet allusions to the burden and futility of sustaining the severely mentally handicapped. The popular conception which is widely accepted is that some sorts of life are not worth living; life in such a state demeans the patient's dignity, and maintaining it (otherwise than at the patient's express request) insults that dignity; proper respect for the patient and the patient's best interests requires that that life be brought to an end. In this thought process, the basic Greek ideology that it signifies 'an easy and gentle death' still remains valid. Recognition is to the Human Rights principle that 'right to life' encompasses 'right to die with dignity'.

- 14) In common parlance, euthanasia can be of three types, namely, 'voluntary euthanasia' which means killing at the request of a

person killed which is to be distinguished from '*non-voluntary euthanasia*', where the person killed is not capable of either making or refusing to make such a request. Second type of euthanasia would be involuntary euthanasia where the person killed is capable of making such a request but has not done so¹¹.

These terms can be described as under:

(i) *Voluntary Euthanasia*: People concerned to legalize the termination of life on medical grounds have always concentrated on Voluntary Euthanasia (this implies that the patient specifically requests that his life be ended.) It is generally agreed that the request must come from someone who is either; (a) in intolerable pain or (b) who is suffering from an illness which is agreed as being terminal. It may be prior to the development of the illness in question or during its course. In either case it must not result from any pressure from relatives or those who have the patients in their care. Both active and passive euthanasia can be termed as forms of voluntary euthanasia.

(ii) *Non-Voluntary Euthanasia*: Seen by some as sub-variety of voluntary euthanasia. This involves the death, ostensibly for his own good, of someone who cannot express any views on the matter and who must, therefore, use some sort of proxy request

11 These definitions of voluntary, non-voluntary and involuntary euthanasia correspond to those employed by the House of Lords Select Committee on Medical Ethics (Walton Committee)

that his/her life be ended. This form of Euthanasia is that which most intimately concerns the medical profession. Selective non-treatment of the new-born or the doctor may be presented with demented and otherwise senilely incompetent patients. In practice, non-voluntary euthanasia presents only as an arguable alternative to non treatment.

(iii) Involuntary Euthanasia: It involves ending the patient's life in the absence of either a personal or proxy invitation to do so. The motive 'The relief of suffering' may be the same as voluntary euthanasia-but its only justification - "a paternalistic decision as to what is best for the victim of the disease." In extreme cases it could be against the patient's wishes or could be just for social convenience. It is examples of the latter which serve as warnings as to those who would invest the medical professional with more or unfettered powers over life and death¹².

- 15) Contrary to the above, in legal parlance, euthanasia has since come to be recognised as of two distinct types: the first is active euthanasia, where death is caused by the administration of a lethal injection or drugs. Active euthanasia also includes physician-assisted suicide, where the injection or drugs are supplied by the physician, but the act of administration is

12 See Euthanasia and Its Legality and Legitimacy from Indian and International Human Right Instruments Perspectives published in Human Rights & Social Justice by Muzafer Assadi

undertaken by the patient himself. Active euthanasia is not permissible in most countries. The jurisdictions in which it is permissible are Canada, the Netherlands, Switzerland and the States of Colorado, Vermont, Montana, California, Oregon and Washington DC in the United States of America. Passive euthanasia occurs when medical practitioners do not provide life-sustaining treatment (i.e. treatment necessary to keep a patient alive) or remove patients from life sustaining treatment. This could include disconnecting life support machines or feeding tubes or not carrying out life saving operations or providing life extending drugs. In such cases, the omission by the medical practitioner is not treated as the cause of death; instead, the patient is understood to have died because of his underlying condition.

- 16) In ***Aruna Ramachandra Shanbaug***, the Court recognised these two types of euthanasia i.e. active and passive. It also noted that active euthanasia is impermissible, which was so held by the Constitution Bench in ***Gian Kaur***. Therefore, without going into further debate on differential that is assigned to the term euthanasia, ethically, philosophically, medically etc., we would be confining ourselves to the aforesaid legal meaning assigned to

active and passive euthanasia. Thus, insofar as active euthanasia is concerned, this has to be treated as legally impermissible, at least for the time being. It is more so, as there is absence of any statutory law permitting active euthanasia. If at all, legal provisions in the form of Sections 306 and 307 IPC etc. point towards its criminality. The discussion henceforth, therefore, would confine to passive euthanasia.

PASSIVE EUTHANASIA AND ARUNA RAMACHANDRA SHANBAUG

- 17) In ***Aruna Ramachandra Shanbaug***, a two Judges' Bench of this Court discussed in much greater detail various nuances of euthanasia by referring to active and passive euthanasia as well as voluntary and involuntary euthanasia; legality and permissibility thereof; relationship of euthanasia vis-a-vis offences concerned under the IPC and doctor assisted death; etc.
- 18) The Court also took note of legislations in some countries relating to euthanasia or physician assisted death. Thereafter, it discussed in detail the judgment in ***Bland*** wherein the House of Lords had permitted the patient to die. Ratio of ***Bland*** was culled out in the following manner:

“*Airedale* (1993) decided by the House of Lords has been followed in a number of cases in UK, and the law is now fairly well settled that in the case of incompetent patients, if the doctors act on the basis of

informed medical opinion, and withdraw the artificial life support system if it is in the patient's best interest, the said act cannot be regarded as a crime."

- 19) The Court was of the opinion that this should be permitted when the patient is in a Persistent Vegetative State (PVS) and held that it is ultimately for the Court to decide, as *parens patriae*, as to what is in the best interest of the patient. The wishes of the close relatives and next friends and opinion of the medical practitioners should be given due weight by the Court in coming to its decision. The Court then noted the position of euthanasia with reference to Section 306 (abetment of suicide) and Section 309 (attempt to commit suicide) of the IPC, inasmuch as, even allowing passive euthanasia may come in conflict with the aforesaid provisions which make such an act a crime. While making a passing observation that Section 309 should be deleted by the Parliament as it has become anachronistic, the Court went into the vexed question as to who can decide whether life support should be discontinued in the case of an incompetent person, e.g. a person in coma or PVS. The Court pointed out that it was a vexed question, both because of its likely misuse and also because of advancement in medical science. It noted:

"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.

105. Also, since medical science is advancing fast, doctors must not declare a patient to be a hopeless case unless there appears to be no reasonable possibility of any improvement by some newly discovered medical method in the near future. In this connection we may refer to a recent news item which we have come across on the internet of an Arkansas man Terry Wallis, who was 19 years of age and newly married with a baby daughter when in 1984 his truck plunged through a guard rail, falling 25 feet. He went into coma in the crash in 1984, but after 24 years he has regained consciousness. This was perhaps because his brain spontaneously rewired itself by growing tiny new nerve connections to replace the ones sheared apart in the car crash. Probably the nerve fibres from Terry Wallis' cells were severed but the cells themselves remained intact, unlike Terri Schiavo, whose brain cells had died (see *Terri Schiavo* case on Google). However, we make it clear that it is experts like medical practitioners who can decide whether there is any reasonable possibility of a new medical discovery which could enable such a patient to revive in the near future."

- 20) It held that passive euthanasia would be permissible when a person is 'dead' in clinical sense. It chose to adopt the standard

of *'brain death'*, i.e. when there is an *'irreversible cessation of all functions of the entire brain, including the brain stem'*. The Court took note of President's Committee on Bioethics in the United States of America which had come up with a new definition of *'brain death'* in the year 2008, according to which a person was considered to be braindead when he could no longer perform the fundamental human work of an organism. Three such situations contemplated in that definition are the following:

- “(1) openness to the world, that is receptivity to stimuli and signals from the surrounding environment,
- (2) the ability to act upon the world to obtain selectively what it needs, and
- (3) the basic felt need that drives the organism to act ... to obtain what it needs.”

21) The Court held that when the aforesaid situation is reached, a person can be presumed to be dead. In paragraph 115 of the judgment, the position is summed up as under:

“When this situation is reached, it is possible to assume that the person is dead, even though he or she, through mechanical stimulation, may be able to breathe, his or her heart might be able to beat, and he or she may be able to take some form of nourishment. It is important, thus, that it be medically proved that a situation where any human functioning would be impossible should have been reached for there to be a declaration of brain death—situations where a person is in a persistent vegetative state but can support breathing, cardiac functions, and digestion *without* any mechanical aid are necessarily those that will not come within the ambit of brain death.”

22) The Court clarified that brain death was not the same as PVS inasmuch as in PVS the brain stem continues to work and so some degree of reactions may occur, though the possibility of regaining consciousness is relatively remote.

23) The Court further opined that position in the case of euthanasia would be slightly different and pointed out that the two circumstances in which it would be fair to disallow resuscitation of a person who is incapable of expressing his or her consent to the termination of his or her life. These are:

“(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.”

24) Taking a clue from the judgment in ***Vishaka and Others v. State of Rajasthan and Others***¹³, the Court laid down the law, while allowing passive euthanasia, i.e. the circumstances when there

¹³ (1997) 6 SCC 241

could be withdrawal of life support of a patient in PVS. This is stated in paragraph 124 of the judgment, which we reproduce below:

“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* [*Vishaka v. State of Rajasthan*], 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.”

- 25) It can be discerned from the reading of the said judgment that court was concerned with the question as to whether one can seek right to die? This question has been dealt with in the context of Article 21 of the Constitution, namely, whether this provision gives any such right. As is well-known, Article 21 gives ‘right to life’ and it is guaranteed to all the citizens of India. The question was as to whether ‘right to die’ is also an integral part of ‘right to

life'. In ***Gian Kaur*** this 'right to die' had not been accepted as an integral part of 'right to life'. The Court in ***Aruna Ramachandra Shanbaug*** maintained this position insofar as an active euthanasia is concerned. However, passive euthanasia, under certain circumstances, has been accepted.

- 26) It may be pertinent to mention that the petitioner (Aruna) in the said case was working as a nurse in the King Edward Memorial Hospital (KEM), Parel, Mumbai. The tragic incident happened on the evening of 27th November, 1973. Aruna was attacked by a sweeper in the hospital who wrapped a dog chain around her neck and yanked her back with it. He tried to rape her but on finding that she was menstruating, he sodomized her. To immobilize her during this act, he twisted the chain around her neck. She was found unconscious by one cleaner on the next day. Her body was on the floor and blood was all over the floor. The incident did not allow oxygen to reach her brain as a result of which her brain got damaged.
- 27) The petition was filed by Ms. Pinki Virani as next friend of Aruna Shanbaug. According to facts of the case, Aruna has been surviving on mashed food as she was not able to chew or taste any food and she could not move her hands or legs. It is alleged

that there is not the slightest possibility of any improvement in her condition and her body lies on the bed in the KEM Hospital like a dead animal, and this has been the position for the last 36 years. The prayer of the petitioner was that the respondents be directed to stop feeding Aruna, and let her die peacefully.

28) The court appointed a team of three eminent and qualified doctors to investigate and report on the medical condition of Aruna. The team included, Dr. J.V. Divatia¹⁴, Dr. Roop Gursahani¹⁵ and Dr. Nilesh Shah¹⁶. The team of doctors studied her medical history and observed that Aruna would get uncomfortable if the room in which she was located was over crowded, she was calm when fewer people were around her. In fact, the hospital staff had taken care and was willing to continue to do so. Moreover, Aruna's body language did not suggest that she wants to die. Therefore, the doctors opined that there is no need for euthanasia in the instant case.

29) Reliance was placed on the landmark judgment of the House of Lords in ***Bland***, where for the first time in the English history, the right to die was allowed through the withdrawal of life support

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15 Consultant Neurologist at P.D. Hinduja, Mumbai.

16 Professor and Head, Department of Psychiatry at Lokmanya Tilak Municipal Corporation Medical College and General Hospital.

systems including food and water. This case placed the authority to decide whether a case is fit or not for euthanasia in the hands of the court. In this case, Aruna did not have the capacity to consent for the proposed medical process. Therefore, the next big question that was to be answered was who should decide on her behalf.

- 30) Since, there was no relative traced directly, nor did she have any frequent visitor who could relate to her, it was extremely crucial for the court to declare who should decide on her behalf. As there was lack of acquaintance, it was decided by beneficence. Beneficence is acting in the interest that is best for the patient, and is not influenced by personal convictions, motives or other considerations. Public interest and the interests of the state were also considered in the said matter.
- 31) On the aforesaid principle of beneficence and studying the position in some other countries, the court in its judgment said, the right to take decision on behalf of Aruna was vested with the hospital and its management and not Ms. Pinki. The court also said that allowing euthanasia would mean reversing the efforts of the hospital and its staff. In order to ensure that there is no misuse of this technique, the Supreme Court has vested the

power with the High Court to decide if life is to be terminated or not.

- 32) Thus, the Supreme Court allowed passive euthanasia in certain conditions, subject to the approval by the High Court following the due procedure. It held that when an application for passive euthanasia is filed the Chief Justice of the High Court should forthwith constitute a Bench of at least two Judges who should decide to grant approval or not. Before doing so, the Bench should seek the opinion of a committee of three reputed doctors to be nominated by the Bench after consulting such medical authorities/medical practitioners as it may deem fit. Simultaneously with appointing the committee of doctors, the High Court Bench shall also issue notice to the State and close relatives e.g. parents, spouse, brothers/sisters etc. of the committee to them as soon as it is available. After hearing them, the High Court Bench should give its verdict. The above procedure should be followed all over India until Parliament makes legislation on this subject. I am not carrying out the critique of this judgment at this stage and the manner in which it has been analysed by those who are the proponents of passive euthanasia and those who are against it. It is, more so, when my

Brother, Chandrachud, J., has dealt with this aspect in detail in his discourse. In any case, as noted above, in view of the reference order dated February 25, 2014, the validity of this aspect has to be examined, which exercise is undertaken by me at an appropriate stage.

EUTHANASIA: A COMPLEX CONCEPT

- 33) As discussed hereinafter, issue of euthanasia is a complexed and complicated issue over which there have been heated debates, not only within the confines of courts, but also among elites, intelligentsia and academicians alike. Some of these complexities may be captured at this stage itself.
- 34) The legal regime webbed by various judgments rendered by this Court would reflect that the Indian position on the subject is somewhat complex and even complicated to certain extent. First, let us touch the topic from the constitutional angle.
- 35) Article 21 of the Constitution mandates that no person shall be deprived of his life or personal liberty, except according to the procedure established by law. This Article has been interpreted by the Court in most expansive terms, particularly when it comes to the meaning that is assigned to 'right to life'. It is not necessary to take stock of various faces of right to life defined by

this Court. What is important for our purpose is to point out that right to life has been treated as more than 'mere animal existence'. In ***Kharak Singh v. State of U.P. & Ors.***¹⁷ it was held that the word 'life' in Article 21 means right to live with human dignity and it does not merely connote continued drudgery. It takes within its fold "some of the finer graces of human civilisation, which makes life worth living" and that the expanded concept of life would mean the "tradition, culture and heritage" of the concerned person. This concept has been reiterated and reinforced, time and again, in a series of judgments. It may not be necessary to refer to those judgments. Suffice is to mention that a nine Judge Constitution Bench of this Court in ***K.S. Puttaswamy and Another v. Union of India and Others***¹⁸ has taken stock of all important judgments which have echoed the message enshrined in ***Kharak Singh's*** case. We may, however, point out that in the case of ***C.E.S.E. Limited and Others v. Subhash Chandra Bose and Others***¹⁹, Justice K. Ramaswamy observed that physical and mental health have to be treated as integral part of right to life, because without good health the civil and political rights assured by our Constitution cannot be

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(1964) 1 SCR 332

18 (2017) 10 SCC 1

19 (1992) 1 SCC 441

enjoyed. Though Justice Ramaswamy rendered minority opinion in that case, on the aforesaid aspect, majority opinion was not contrary to the views expressed by Justice Ramaswamy. Thus, Article 21 recognizes right to live with human dignity²⁰.

36) The question that arises at this juncture is as to whether right to life enshrined in Article 21 of the Constitution includes right to die. If such a right is recognised, that would provide immediate answer to the issue involved, which is pertaining to voluntary or passive euthanasia. However, the judgments of this Court, as discussed hereinafter, would demonstrate that no straightforward answer is discernible and, as observed above, the position regarding euthanasia is somewhat complex in the process.

37) It would be interesting to point out that in ***Rustom Cavasjee Cooper v. Union of India***²¹ the Court held that what is true of one fundamental right is also true of another fundamental right. This Court also made a specific observation that there cannot be serious dispute about the proposition that fundamental rights have their positive as well as negative aspect. For example, freedom of speech and expression includes freedom not to speak. Likewise, freedom of association and movement includes

²⁰ Aspects of human dignity as right to life in the context of euthanasia shall be discussed in greater detail at the relevant stage.

²¹ (1970) 1 SCC 248

freedom not to join any association or move anywhere. Freedom of business includes freedom not to do any business. In this context, can it be said that right to life includes right to die or right to terminate ones own life? The Constitution Bench in **Gian Kaur**, however, has taken a view that right to live will not include right not to live.

- 38) We have already pointed out that Section 306 of the IPC makes abetment to suicide as a punishable offence. Likewise, Section 309 IPC makes attempt to commit suicide as a punishable offence. Intention to commit suicide is an essential ingredient in order to constitute an offence under this provision. Thus, this provision specifically prohibits a person from terminating his life and negates right to die. Constitutional validity of this provision, on the touchstone of Article 21, was the subject matter of **Gian Kaur's** case²². The Court held Sections 306 and 309 IPC to be constitutionally valid. While so holding, the Court observed that when a man commits suicide, he has to undertake certain

²² It may be noted that the Delhi High Court in *State v. Sanjay Kumar*, (1985) CrL.J. 931, and the Bombay High Court in *Maruti Sharipati Dubai v. State of Maharashtra*, (1987) CrL.J. 743, had taken the view that Section 309 of IPC was unconstitutional, being violative of Articles 14 and 21 of the Constitution. On the other hand, the Andhra Pradesh High Court in *C. Jagadeeswar v. State of Andhra Pradesh*, (1983) CrL.J. 549, had upheld the validity of Section 309 holding that it did not offend either Article 14 or Article 21 of the Constitution. A Division Bench of this Court in *R. Rathinam v. Union of India and Another*, (1994) 3 SCC 394, had held that Section 309 IPC deserves to be effaced from the statute book to humanise our penal laws, terming this provision as cruel and irrational, which results in punishing a person again who had already suffered agony and would be undergoing ignominy because of his failure to commit suicide. It is in this backdrop **Gian Kaur's** case was referred to and decided by the Constitution Bench.

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, the Court found 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'.

Thus, the legal position which stands as of today is that right to life does not include right to die. It is in this background we have to determine the legality of passive euthanasia.

- 39) Matter gets further complicated when it is examined in the context of morality of medical science (Hippocratic Oath). Every doctor is supposed to take specific oath that he will make every attempt to save the life of the patient whom he/she is treating and who is under his/her treatment. The Hippocratic Oath goes on to say:

"I swear by Apollo the Healer, by Asclepius, by

Hygieia, by Panacea, and by all the gods and goddesses, making them my witnesses, that I will carry out, according to my ability and judgment, this oath and this indenture.

To hold my teacher in this art equal to my own parents; to make him partner in my livelihood; when he is in need of money to share mine with him; to consider his family as my own brothers, and to teach them this art, if they want to learn it, without fee or indenture; to impart precept, oral instruction, and all other instruction to my own sons, the sons of my teacher, and to indentured pupils who have taken the physician's oath, but to nobody else.

I will use treatment to help the sick according to my ability and judgment, but never with a view to injury and wrong-doing. Neither will I administer a poison to anybody when asked to do so, nor will I suggest such a course. Similarly I will not give to a woman a pessary to cause abortion. But I will keep pure and holy both my life and my art. I will not use the knife, not even, verily, on sufferers from stone, but I will give place to such as are craftsmen therein.

Into whatsoever houses I enter, I will enter to help the sick, and I will abstain from all intentional wrong-doing and harm, especially from abusing the bodies of man or woman, bond or free. And whatsoever I shall see or hear in the course of my profession, as well as outside my profession in my intercourse with men, if it be what should not be published abroad, I will never divulge, holding such things to be holy secrets.

Now if I carry out this oath, and break it not, may I gain for ever reputation among all men for my life and for my art; but if I break it and forswear myself, may the opposite befall me."

- 40) This oath, thus, puts a moral and professional duty upon a doctor to do everything possible, till the last attempt, to save the life of a patient. If that is so, would it not be against medical ethics to let a person die by withdrawing medical aid or, even for that matter, life

supporting instruments. Paradoxically, advancement in medical science has compounded the issue further. There has been a significant advancement in medical science. Medical scientists have been, relentlessly and continuously, experimenting and researching to find out better tools for not only curing the disease with which human beings suffer from time to time, noble attempt is to ensure that human life is prolonged and in the process of enhancing the expectancy of life, ailments and sufferings therefrom are reduced to the minimal. There is, thus, a fervent attempt to improve the quality of life. It is this very advancement in the medical science which creates dilemma at that juncture when, in common perception, life of a person has virtually become unlivable but the medical doctors, bound by their Hippocratic Oath, want to still spare efforts in the hope that there may still be a chance, even if it is very remote, to bring even such a person back to life. The issue, therefore, gets compounded having counter forces of medical science, morality and ethical values, the very concept of life from philosophical angle. In this entire process, as indicated in the beginning and demonstrated in detail at the appropriate stage, the vexed question is to be ultimately decided taking into consideration the normative law, and in particular, the constitutional values.

- 41) Then, there is also a possibility of misuse and it becomes a challenging task to ensure that passive euthanasia does not become a tool of corruption and a convenient mode to ease out the life of a person who is considered inconvenient. This aspect would be touched upon at some length at the appropriate stage. This point is highlighted at this juncture just to demonstrate the complexity of the issue.
- 42) I may add that the issue is not purely a legal one. It has moral and philosophical overtones. It has even religious overtones. As Professor *Upendra Baxi* rightly remarks that judges are, in fact, not jurisprudes. At the same time, it is increasingly becoming important that some jurisprudential discussion ensues while deciding those cases which have such more and philosophical overtones as well. Such an analyses provides not only legal basis for the conclusions arrived at but it also provides logical commonsense justification as well. Obviously, whenever the court is entering into a new territory and is developing a new legal norm, discussion on normative jurisprudence assumes greater significance as the court is called upon to decide what the legal norm should be. At the same time, this normative jurisprudence discourse has to be preceded by analytical jurisprudence, which

is necessary for the court to underline existing nature of law. That would facilitate knowing legal framework of what is the current scenario and, in turn, help in finding the correct answers. When we discuss about the philosophical aspects of the subject matter, it is the 'value of life' which becomes the foremost focus of discussion. The discussion which follows hereinafter keeps in mind these parameters.

THE TWO ISSUES

43) As already stated above, as of now insofar 'active euthanasia' is concerned, it is legally impermissible. Our discussion centres around 'passive euthanasia'. Another aspect which needs to be mentioned at this stage is that in the present petition filed by the petitioner, the petitioner wants that 'advance directive' or 'living will' should be legally recognised. In this backdrop, two important questions arise for considerations, viz.,

- (I) whether passive euthanasia, voluntary or even, in certain circumstances, involuntary, is legally permissible? If so under what circumstances (this question squarely calls for answer having regards to the reference order made in the instant petition)? and
- (II) whether a 'living will' or 'advance directive' should be legally

recognised and can be enforced? If so, under what circumstances and what precautions are required while permitting it?

44) Answers to these questions have been provided in the judgment of Hon'ble The Chief Justice, with excellent discourse on all relevant aspects in an inimitable and poetic style. I entirely agree with the reasoning and outcome. In fact, with the same fervour and conclusion, separate judgments are written by my brothers, Dhananjay Chandrachud and Ashok Bhushan, JJ. exhibiting expected eloquence and erudition. I have gone through those opinions and am in complete agreement thereby. In this scenario, in my own way, I intend to deal with the aforesaid questions on the following hypothesis:

(i) Issue of passive euthanasia is highly debatable, controversial and complex (already indicated above).

(ii) It is an issue which cannot be put strictly within the legal confines, but has social, philosophical, moral and even religious overtones.

(iii) When the issue of passive euthanasia is considered on the aforesaid parameters, one would find equally strong views on both sides. That is the reason which makes it a thorny and

complex issue and brings within the category of 'hard cases'.

(iv) In this entire scenario when the issue is considered in the context of dignity of the person involved, one may tend to tilt in favour of permitting passive euthanasia.

(v) At the same time, in order to achieve a balance, keeping in view the competing and conflicting interests, care can be taken to confine permissibility of passive euthanasia only in rare cases, particularly, when the patient is declared 'brain dead' or 'clinically dead' with virtually no chances of revival.

(vi) In this process, as far as 'living will' or 'advance directive' is concerned, that needs to be permitted, along with certain safeguards. It would not only facilitate prevention of any misuse but take care of many apprehensions expressed about euthanasia.

With the outlining of the structured process as aforesaid, I proceed to discuss these aspects in detail hereinafter.

45) As pointed out above, **Aruna Ramachandra Shanbaug** decides that passive euthanasia, even involuntary, in certain circumstances would be justified. The reference order in the instant case, however, mentions that for coming to this conclusion, the Bench relied upon **Gian Kaur**, but that case does

not provide any such mandate. In this backdrop, we take up the first question about the legality of passive euthanasia.

FIRST ISSUE

Whether passive euthanasia, voluntary or even, in certain circumstances, involuntary, is legally permissible? If so under what circumstances (this question squarely calls for answer having regards to the reference order made in the instant petition)?

46) I intend to approach this question by discussing the following facets thereof:

- (a) Philosophy of euthanasia
- (b) Morality of euthanasia
- (c) Dignity in euthanasia
- (d) Economics of euthanasia

(A) Philosophy of Euthanasia

"I am the master of my fate; I am the captain of my soul"
- William Ernest Henley²³

"Death is our friend ... he delivers us from agony. I do not want to die of a creeping paralysis of my faculties – a defeated man."
- Mahatma Gandhi²⁴

"When a man's circumstances contain a preponderance of things in accordance with nature, it is appropriate for him to remain alive; when possess or sees in prospect a majority of contrary, it is appropriate for him to depart from life."
- Marcus Tullius Cicero

²³ As quoted in *P. Rathinam v. Union of India & Anr.*, (1994) 3 SCC 394

²⁴ Same as in 14 above.

“Euthanasia, and especially physician-assisted suicide, appears as the ultimate post-modern demand for dignity in an era of technologically-mediated death.”

- Dr. Jonathan Moreno

- 47) The afore-quoted sayings of some great persons bring out a fundamental truth with universal applicability. Every person wants to lead life with good health and all kinds of happiness. At the same time, nobody wants any pain, agony or sufferings when his or her life span comes to an end and that person has to meet death. The following opening stanza from a song in a film captures this message beautifully:

रोते हुए आते हैं सब, हंसता हुआ जो जाएगा
वो मुकद्दर का सिकन्दर जानेमन कहलाएगा

“Every person in this world comes crying. However, that person who leaves the world laughing/smiling will be the luckiest of all”
(Hindi Film – Muqaddar Ka Sikandar)

- 48) It became unbearable for young prince Siddharth when he, for the first time, saw an old crippled man in agony and a dead body being taken away. He did not want to encounter such a situation in his old life and desired to attain *Nirvana* which prompted him to renounce the world so that he could find the real purpose of life; could lead a life which is worth living; and depart this world peacefully. He successfully achieved this purpose of life and became *Gautam Buddha*. There are many such similar

examples.

Life is mortal. It is transitory. It is as fragile as any other object. It is a harsh reality that no human being, or for that matter, no living being, can live forever. Every creature who takes birth on this planet earth has to die one day. Life has a limited shelf age. In fact, unlike the objects and articles which are produced by human beings and may carry almost same life span, insofar as humans themselves are concerned, span of life is also uncertain. Nobody knows how long he/she will be able to live. The gospel truth is that everybody has to die one day, notwithstanding the pious wish of a man to live forever²⁵. As *Woody Allen* said once: '*I do not want to achieve immortality through my work. I want to achieve it through not dying*'. At the same time, nobody wants to have a tragic end to life. We all want to leave the world in a peaceful manner. In this sense, the term 'euthanasia' which has its origin in Greek language signifies 'an easy and gentle death'.

- 49) According to *Charles I. Lugosi*, the sanctity of life ethic no longer dominates American medical philosophy. Instead, quality of life has become the modern approach to manage human life that is

²⁵ It is well known that medical scientists are intensely busy in finding the ways to become ageless and immortal, but till date have remained unsuccessful in achieving this dream.

at the margin of utility²⁶. It is interesting to note that the issue of euthanasia was debated in India in 1928. Probably this was the first public debate on euthanasia to be reported. A Calf in Gandhi's ashram was ailing under great pain. In spite of every possible treatment and nursing...the condition of the calf was so bad that it could not even change its side or even it could not be lifted about in order to prevent pressure ulcers/sores. It could not even take nourishment and was tormented by flies. The surgeon whose advice was sought in this matter declared the case to be past help and past hope. After painful days of hesitation and discussions with the managing committee of Goseva Sangh and the inmates of the ashram, Gandhi made up his mind to end the life of the calf in a painless way as possible. There was a commotion in orthodox circles and Gandhi critically examined the question through his article which appeared in Navajivan (dated 30-9-1928) and Young India (4-10-1928). Probably this was the first public debate on euthanasia and animal/veterinary euthanasia and the debate also covered the issue of human euthanasia. It is equally interesting to note that Gandhi and his critics discussed the issue of '*painlessly ending the life to end suffering*' without using the term '*euthanasia*'. But, he meant the

26 Charles I. Lugosi, 'Natural Disaster, Unnatural Deaths: The Killings on the Life Care Floors at Tenet's Memorial Centre after Hurricane Katrina', Issues in Law and Medicine, Vol. 23, Summer, 2007.

same. Further it is more interesting to learn that at various instances Gandhiji had touched upon the issues of the present day debates on Voluntary euthanasia, Non-voluntary euthanasia, Involuntary euthanasia, as well as passive euthanasia, active euthanasia, physician-assisted euthanasia and the rejection or 'termination of treatment'. Gandhi advocated the development of positive outlook towards life and strived for the humane nursing and medical care even when cure was impossible. It was the way he analysed Karma and submitted to the will of the God.

50) Mahatma Gandhi said:

"In these circumstances I felt that humanity demanded that the agony should be ended by ending life itself. The matter was placed before the whole ashram. At the discussion a worthy neighbour vehemently opposed the idea of killing even to end pain. *The ground of his opposition was that one has no right to take away life which one cannot create. His argument seemed to me to be pointless here. It would have point if the taking of life was actuated by self-interest.* Finally, in all humility but with the clearest of convictions, I got in my presence a doctor kindly to administer the calf a quietus by means of a position injection. The whole thing was over in less than two minutes.

But the question may very legitimately be put to me: would I

apply the same principle to human beings? Would I like it to be applied in my own case? My reply is 'yes'; the same law holds good in both the cases. The law, 'as with one so with all', admits of no exceptions, or the killing of the calf was wrong and violent. In practice, however, we do not cut short the sufferings of our ailing dear ones by death because, as a rule, we have always means at our disposal to help them and they have the capacity to think and decide for themselves. But supposing that in the case of an ailing friend, I am unable to render any aid whatever and recovery is out of question and the patient is lying in an unconscious state in the throes of agony, then I would not see any *himsa* in putting an end to his suffering by death.

Just as a surgeon does not commit *himsa* but practices the purest *ahimsa* when he wields his knife, one may find it necessary, under certain imperative circumstances, to go a step further and sever life from the body in the interest of the sufferer. It may be objected that whereas the surgeon performs his operation to save the life of the patient, in the other case we do just the reverse. But on a deeper analysis it will be found that the ultimate object sought to be served in both the cases is the same, namely, to relieve the suffering soul within from pain. In the one case you do it by severing the diseased portion from the

body, in the other you do it by severing from the soul the body that has become an instrument of torture to it. In either case it is the relief of the soul within from pain that is aimed at, the body without the life within being incapable of feeling either pleasure or pain.

To conclude then, to cause pain or wish ill to or to take the life of any living being out of anger or a selfish intent, is *himsa*. On the other hand, after a calm and clear judgment to kill or cause pain to a living being from a pure selfless intent may be the purest form of ahimsa. Each such case must be judged individually and on its own merits. The final test as to its violence or non-violence is after all the intent underlying the act.”

- 51) **Ethical Egoism** propounded in modern times by **Thomas Hobbes** in “Leviathan” also operates from the general rule that if any action increases my own good, then it is right. Ethical egoism in the context of euthanasia would mean that if a person wants or does not want to end his/her life using euthanasia, this desire is presumed to be motivated by a need for self benefit, and is therefore an ethical action²⁷. The perspective of the world community is gradually shifting from sanctity of life to quality of

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John Keown, *Euthanasia, Ethics and Public Policy*, (Cambridge: Cambridge University Press, (2002) p. 37

life sustained and preserved.

52) Philosophers believe that we have to control switch that can end it all, on request. In medical/legal parlance, it is called euthanasia: *'an easy and gentle death'*. Philosophically, this debate is about our right, when terminally ill, to choose how to die. It is about the right to control how much we have to suffer and when and how we die. It is about having some control over our dying process in a system that can aggressively prolong life with invasive technology. Luckily, we also have the technology that allows us to experience a *gentle death* on our own terms, rather than by medically set terms. In his famous essay on *Liberty*, John Stuart Mill argues strongly for our right to self-determination. He writes: *"over himself, over his own body and mind, the individual is sovereign...he is the person most interested in his own well being."* These words were written over a century ago.

53) Philosophically, therefore, one may argue that if a person who is undergoing miserable and untold sufferings and does not want to continue dreadful agony and is terminally ill, he should be free to make his choice to terminate his life and to put an end to his life so that he dies peacefully.

54) At the same time, Buddhism, Jainism and Hinduism are against euthanasia. However, their concept of '*good death*' is extremely interesting – specially principles of Buddhism as they are echoed in the present day understanding of euthanasia. Without elaborating and to put it in nutshell:

- Buddhism, Jainism, and Hinduism, in particular, embrace the concept of the *good death* as a means of achieving dignity and spiritual fulfilment at the end of life without resorting to artificially shortening its span.
- Buddhists believe that human existence is rare and rebirth as a human is rarer still. Consequently it is best approached cautiously without attempting to exert control over the dying process. At the point of dying, a Buddhist should ideally be conscious, rational and alert.
- Traditional Hindu religious culture also emphasizes the *good death* as a reflection of the quality of life that preceded it. If a good, dignified death is attained, it is perceived as evidence of having lived a worthy life because “the manner of one’s passing out-weighs all previous claims and intimations of one’s moral worth”²⁸.

- “a good death certifies a good life”²⁹.
- The *good death* is achieved when death occurs in full consciousness, in a chosen place and at a chosen time; and
- As with Buddhism great significance is attached to the element of choice and the maintenance of control,³⁰ so if at all possible, “one must be in command and should not be overtaken by death. To be so overtaken is the loss of dignity”.³¹ Thus the final moments of life should be calm, easy and peaceful if dignity is to be preserved.

Many of the insights of these traditional religions are echoed in the modern Western understanding of euthanasia, as a means of achieving death with dignity, which focuses on avoiding dependence and loss of control. Choosing to deliberately end one’s life allows control over the time, place and method of one’s dying and explains why euthanasia appears to offer death with dignity. Rather than active euthanasia these ancient religions advocate calm, control and compassion as a means of achieving dignity.

(B) Morality of Euthanasia

55) At the outset, I would like to clarify that while discussing a

²⁹ T N Madan, “Living and Dying” in *Non-Renunciation: Themes and Interpretations of the Hindu Culture* (New Delhi, Oxford University Press, 1987).

³⁰ J Parry, *Death and the Regeneration of Life* (Cambridge, Cambridge University Press, 1982)

³¹ T N Madan, “Dying with Dignity” (1992) 35 (4) *Social Science and Medicine* 425–32.

particular norm of law, the law *per se* is to be applied and, generally speaking, it is not the function of the Courts to look into the moral basis of law. At the same time, some legal norms, particularly those which are jurisprudentially expounded by the Courts or developed as common law principles, would have moral backing behind them. In that sense moral aspects of an issue may assume relevance. This relevancy and rationale is quite evident in the discussion about euthanasia. In fact, the very concept of dignity of life is substantially backed by moral overtones. We may remind ourselves with the following classical words uttered by *Immanuel Kant*:

“We must not expect a good constitution because those who make it are moral men. Rather it is because of a good constitution that we may expect a society composed of moral men.”

- 56) It is well known that Justice Holmes’ legal philosophy revolved around its central theme that law and morals are to be kept apart, maintaining a sharp distinction between them. Notwithstanding, even he accepted that under certain circumstances distinction between law and morals loses much of its importance. To quote:

“I do not say that there is not a wider point of view from which the distinction between law and morals becomes of secondary importance, as all mathematical distinctions vanish in the presence of the infinite”.³²

32 Justice Holmes: *The Path of the Law*, 10 Harvard Law review 457-78, at p. 459 (1897)

- 57) Euthanasia is one such critical issue where the law relating to it cannot be divorced from morality. *Lon L. Fuller*³³ has argued with great emphasis that it is the morality that makes the law possible. He also points towards morality as the substantive aims of law. In fact, as would be noticed later, the conceptualisation of doctrine of dignity by *Ronald Dworkin* is supported with moral ethos. With the aid of dignity principle, he has argued in favour of euthanasia. Likewise, and ironically, *John Finnis*, Professor of Law and Legal Philosophy Emeritus in the University of Oxford, while opposing euthanasia, also falls back on the morality conception thereof. It is this peculiar feature which drives us to discuss the issue of euthanasia from the stand point of morality.
- 58) Influenced primarily by the aforesaid considerations, I deem it relevant to indulge into discussion on morality.
- 59) When we come to the moral aspects of 'end of life' issues, we face the situation of dilemma. On the one hand, it is an accepted belief that every human being wants to die peacefully. Nobody wants to undergo any kind of suffering in his last days. So much so a person who meets his destiny by sudden death or easy death is often considered as a person who would have lived his life by practicing moral and ethical values. Rightly or wrongly, it is

³³ Lon L. Fuller: *The Morality of Law* (Revised Edition), Yale University Press

perceived that such a person who exhibited graceful behaviour while living his life is bestowed grace by the death when time to depart came. However, it does not happen to most of the people. Ageing is a natural phenomena. No doubt, as the person advances in age, he becomes mature in his wisdom. However, old age brings, along with it, various ailments and diseases as well. Physical health and physical functioning declines over the life course, particularly, in later life. A rise in chronic disease and other conditions such as arthritis, high blood pressure and obesity can cause loss in function and lead to generally decreasing trajectory for health over the lifespan. Thus, ageing has both positive and negative aspects. This ageing leads to extinction of human life which may generally be preceded by grave sickness and disease.

- 60) Horace, Roman poet in his poem on the 'Ages of Man' wrote quite scathingly of the attributes of old age:

"Many ills encompass an old man, whether because he seeks, gain, and then miserably holds aloof from His store and fears to use it, because, in all that he does, he lacks fire and courage, is dilatory and slow to form hopes, is sluggish and greedy of a longer life, peevish, surly, given to praising the days he spent as a boy, and to reproving and condemning the young.

(Ars Poetica, pp.169-74)

We find a more contemporary echo of this in William Shakespeare's (1564-1616) famous verse 'All the

World's a Stage':

all the word's stage, and all the men and women merely
players;

they have their exits and their entrances,
and one man in his time plays many parts,
his acts being seven ages....Last scene of all,
that ends this strange eventful history,
is second childishness and mere oblivion,
sans teeth, sans eyes, sans taste, sans everything.
(As You Like It, Act II, scene VII)"

It may, however, be added (for the sake of clarification) that
advent of disease is not the confines of old age only. One may
become terminally ill at any age. Such a disease may be
acquired even at birth.

- 61) The moral dilemma is that it projects both the sides--protracted as well as intractable. On the one hand, it is argued by those who are the proponents of a liberal view that a right to life must include a concomitant right to choose when the life becomes unbearable and not so worth living, when such a stage comes and the sufferer feels that that the life has become useless, he should have right to die. Opponents, on the other hand, project '**Sanctity of Life' (SOL)** as the most important factor and argue that this 'SOL' principle is violated by self-styled angles of death. Protagonists on 'SOL' principle believe that life should be preserved at all costs and the least which is expected is that

there should not be a deliberate destruction of human life, though it does not demand that life should always be prolonged as long as possible.

62) It might therefore be argued, as Emily Jackson (2008) cogently does, that the law's recognition that withdrawal of life-prolonging treatment is sometimes legitimate is not so much an exception to the SOL principle, as an embodiment of it.

63) In the most secular judicial interpretation of the SOL doctrine yet, Denman J of the UKHL explicated thus:

“in respect a person's death, we are also respecting their life – giving it sanctity...A view that life must be preserved at all costs does not sanctify life...to care for the dying, to love and cherish them, and to free them from suffering rather than simply to postpone death is to have fundamental respect for the sanctity of life and its end.”

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

65) A moral paradox which emerges is beautifully described by

Sushila Rao³⁴, in the following words:

“Several commentators have justified the active/passive distinction by averring that there is an important moral difference between killing a patient by administering, say, a lethal injection, and withdrawing treatment which is currently keeping her alive. Active euthanasia, runs the argument, interferes with nature’s dominion, whereas withdrawal of treatment restores to nature her dominion.

Here too, an absolutist version of the SOL principle rears its unseemly head. In a plethora of cases in the UK, a course of action which would lead to the patient’s death was held to be compatible with the “best interests” test. Indeed, a majority in the House of Lords in *Bland* explicitly accepted that the doctor’s intention in withdrawing artificial nutrition and hydration was, in Lord Browne-Wilkinson’s words, to “bring about the death of Anthony Bland”. Lord Lowry said that “the intention to bring about the patient’s death is there” and Lord Mustill admitted that “the proposed conduct has the aim.. of terminating the life of Anthony Bland”. In each case, however, life could be brought to an end only because the doctors had recourse to a course of action which could plausibly be described as a “failure to prolong life”.

The SOL principle thus works insidiously to ensure that only certain types of death—namely, those achieved by suffocation, dehydration, starvation and infection, through the withdrawal or withholding of, respectively, ventilation, ratification nutrition and hydration, and antibiotics-can lawfully be brought about. More crucially, the SOL principle prohibits doctors from acting to achieve that end quickly, and more humanly, by the administration of a single lethal injection.

Lord Browne-Wilkinson lamented this paradox in *Bland* in the following words:

“How can it be lawful to allow a patient to die slowly, though painlessly, over a period of weeks from lack of food but unlawful to produce his immediate death by a lethal injection, thereby saving his family from yet

34

Sushila Rao : Economic and Political Weekly, Vol. 46, No. 18 (April 30-May 6, 2011), pp. 13-16

another ordeal to add to the tragedy that has already struck them? I find it difficult to find a moral answer to that question.

As Simon Blackburn (2001) puts it, differentiating between withdrawal of treatment and killing may salve some consciences, but it is very doubtful whether it ought to. It often condemns the subject to a painful, lingering death, fighting for breath or dying of thirst, while those who could do something stand aside, withholding a merciful death.”

- 66) Interestingly, Sushila Rao concludes that even the active-passive distinction is not grounded much in morality and ethics as in ‘reasons of policy’.
- 67) *John Finnis* strongly believes that moral norms rule out the central case of euthanasia and discards the theory of terminating people’s life on the ground that doing so would be beneficial by alleviating human suffering or burdens. He also does not agree that euthanasia would benefit ‘*other people*’ at least by alleviating their proportionately greater burdens³⁵.
- 68) Moral discourse of *John Finnis* proceeds on the ‘intention of the person who is facing such a situation’. He draws distinction between what one intends (and does) and what one accepts as

35 According to John Finnis, there is no real and morally relevant distinction between active euthanasia and passive euthanasia inasmuch as one employs the method of deliberate omissions (or forbearances or abstentions) in order to terminate life (passive euthanasia) and other employs ‘a deliberate intervention’ for the same purpose (active euthanasia). In this sense, in both the cases, it is an intentional act whether by omission or by intervention, to put an end to somebody’s life and, therefore, morally wrong.

foreseen side effects is significant by giving importance to free choice. There would be free choice, he argues, only when one is rationally motivated towards incompatible alternative possible purposes. Therefore, there may be a possibility that a person may choose euthanasia but not as a free choice and it would be morally wrong. In a situation where that person is not in a position to make a choice (for e.g. when he is in comma) this choice shall be exercised by others which, according to him, violates the autonomy of the person involved. It is significant to mention that Finnis accepts that autonomy of the patient or prospective patient counts. It reads:

“Is this to say that the autonomy of the patient or prospective patient counts for nothing? By no means. Where one does not know that the requests are suicidal in intent, one can rightly, as a healthcare professional or as someone responsible for the care of people, give full effect to requests to withhold specified treatments or indeed any and all treatments, even when one considers the requests misguided and regrettable. For one is entitled and indeed ought to honour these people's autonomy, and can reasonably accept their death as a side effect of doing so.”³⁶

- 69) He, however, explains thereafter that even if such a decision is taken, said person would be proceeding on one or both of two philosophically and morally erroneous judgments: (i) that human life in certain conditions or circumstances retains no intrinsic

36 John Finnis: “Human Rights and Common Good: Collected Essays”, Volume III

value and dignity; and/or (ii) that the world would be a better place if one's life were intentionally terminated. And each of these erroneous judgments has very grave implications for people who are in poor shape and/or whose existence creates serious burdens for others.

It is, thus, clear that taking shelter of same morality principles, jurists have reached opposing conclusions. Whereas euthanasia is morally impermissible in the estimation of some, others treat it as perfectly justified. As would be noted later, riding on these very moral principles, *Dworkin* developed the dignity of life argument and justified euthanasia.

The aforesaid discussion on the philosophy of euthanasia, coupled with its morality aspect, brings out the conflicting views. Though philosophical as well as religious overtones may indicate that a person does not have right to take his life, it is still recognised that a human being is justified in his expectation to have a peaceful and dignified death. Opposition to euthanasia, on moral grounds, proceeds primarily on the basis that neither the concerned person has a right to take his own life, which is God's creation, nor anybody else has this right. However, one startling feature which is to be noted in this opposition is that while opposing euthanasia, no segregated discussion on active and

passive euthanasia is made. It also does not take into consideration permissibility of passive euthanasia under certain specific circumstances. Clarity on this aspect is achieved when we discuss the issue of euthanasia in the context of dignity.

(C) Dignity in Euthanasia

70) This Court acknowledges its awareness of the sensitive and emotional nature of euthanasia controversy, and the vigours of opposing views, even within the medical fraternity, and seemingly absolute convictions that the subject inspires. This is so demonstrated above while discussing philosophical, moral, ethical and religious overtones of the subject involved. These valid aspects, coupled with one's attitude towards life and family and their values, are likely to influence and to colour one's thinking and conclusions about euthanasia. Notwithstanding the same, these aspects make the case as '*hard case*'. However, at the end of the day, the Court is to resolve the issue by constitutional measurements, free of emotion and of predilection. One has to bear in mind what Justice *Oliver Wendell Holmes Jr.* said in his dissenting judgment in ***Lochner* v. *New York***³⁷, which is reproduced below:

“[The Constitution] is made for people of fundamentally differing views, and the accident of our finding certain

37 198 US 45, 76 (1905)

opinions natural and familiar or novel and even shocking ought not to conclude our judgment upon the question whether statutes embodying them conflict with the Constitution of the United States.”

71) With these preliminary remarks we return to the doctrine of dignity as an aspect of Article 21 of the Constitution, a brief reference to which has already been made above.

72) Let me first discuss certain aspects of human dignity in general. Insofar as concept of human dignity is concerned, it dates back to thousands of years. Historically, human dignity, as a concept, found its origin in different religions which is held to be an important component of their theological approach. Later, it was also influenced by the views of philosophers who developed human dignity in their contemplations³⁸. Jurisprudentially, three types of models for determining the content of the constitutional value of human dignity are recognised. These are: (i) Theological Model, (ii) Philosophical Model, and (iii) Constitutional Model. Legal scholars were called upon to determine the theological basis of human dignity as a constitutional value and as a constitutional right. Philosophers also came out with their views justifying human dignity as core human value. Legal understanding is influenced by theological and philosophical

38 Though western thinking is that the concept of human dignity has 2500 years' history, in many eastern civilizations including India human dignity as core human value was recognised thousands of years ago

views, though these two are not identical. Aquinas, Kant as well as *Dworkin* discussed the jurisprudential aspects of human dignity. Over a period of time, human dignity has found its way through constitutionalism, whether written or unwritten.

Theological Model of Dignity

'Amritasya Putrah Vayam'

[We are all begotten of the immortal.] This is how Hinduism introduces human beings.

'Every individual soul is potentially divine'

– proclaimed Swami Vivekananda

73) Hinduism doesn't recognize human beings as mere material beings. Its understanding of human identity is more ethical-spiritual than material. That is why a sense of immortality and divinity is attributed to all human beings in Hindu classical literature.

74) Professor S.D. Sharma, sums up the position with following analysis³⁹:

“Consistent with the depth of Indian metaphysics, the human personality was given a metaphysical interpretation. This is not unknown to the modern occidental philosophy. The concept of human personality in Kant's philosophy of law is metaphysical entity but Kant was not able to reach the subtler unobserved element of personality, which was the basic theme of the concept of personality in Indian legal philosophy”

39 Prof. S.D. Sharma : “Administration of Justice in Ancient Bharat”, (1988).

75) It is on the principle that the soul that makes the body of all living organisms its abode is in fact an integral part of the Divine Whole

– Paramaatman – that the Vedas declare unequivocally:

*Ajyesthaaso Akanisthaasa Yete; Sam Bhraataro Vaavrudhuh
Soubhagaya*

[No one is superior or inferior; all are brothers; all should strive for the interest of all and progress collectively]

– *RigVeda, Mandala-5, Sukta-60, Mantra-5*

76) Even in Islam, tradition of human rights became evident in the medieval ages. Being inspired by the tenets of the Holy Koran, it preaches the universal brotherhood, equality, justice and compassion. Islam believes that man has special status before God. Because man is a creation of God, he should not be harmed. Harm to a human being is harm to a God. God, as an act of love, created man and he wishes to grant him recognition, dignity and authority. Thus, in Islam, human dignity stems from the belief that man is a creation of God – the creation that God loves more than any other.

77) The Bhakti and Sufi traditions too in their own unique ways popularized the idea of universal brotherhood. It revived and regenerated the cherished Indian values of truth, righteousness, justice and morality.

78) Christianity believes that the image of God is revealed in Jesus and through him to human kind. God is rational and determines his goals for himself. Man was created in the image of God, and he too is rational and determines his own goals, subject to the God as a rational creation. Man has freedom of will. This is his dignity. He is free to choose his goals, and he himself is a goal. His supreme goal is to know God. Thus he is set apart from a slave and from all the creations under him. When a man sins, he loses his human dignity. He becomes an object⁴⁰.

Philosophical Model of Dignity

79) The modern conception of human dignity was affected by the philosophy of Kant⁴¹. Kant's moral theory is divided into two parts: ethics and right (jurisprudence). The discussion of human dignity took place within his doctrine of ethics and does not appear in his jurisprudence⁴². Kant's jurisprudence features the concept of a person's right to freedom as a human being.

80) According to Kant, a person acts ethically when he acts by force of a duty that a rational agent self-legislates onto his own will. This self-legislated duty is not accompanied by any right or coercion, and is not correlative to the rights of others. For Kant,

40 Based on the approach of Thomas Aquinas (1225-1274) in his work Summa Theologia

41 See Toman E. Hill, 'Humanity as an End in itself' (1980) 91 Ethics 84

42 See Pfordten, 'On the Dignity of Man in Kant'

ethics includes duties to oneself (e.g. to develop one's talents) and to others (e.g. to contribute to their happiness). This ability is the human dignity of man. This is what makes a person different than an object. This ability makes a person into an end, and prevents her from being a mere means in the hands of another.

81) Professor Upendra Baxi in his First Justice H.R. Khanna Memorial Lecture⁴³, on the topic *Protection of Dignity of Individual under the Constitution of India* has very aptly remarked that dignity notions, like the idea of human rights, are supposed to be the gifts of the West to the Rest, though, this view is based on the prescribed ignorance of the rich traditions of non-European countries. He, then, explains Eurocentric view of human dignity by pointing out that it views dignity in terms of personhood (moral agency) and autonomy (freedom of choice). Dignity here is to be treated as '*empowerment*' which makes a triple demand in the name of respect for human dignity, namely:

1. Respect for one's capacity as an agent to make one's own free choices.
2. Respect for the choices so made.
3. Respect for one's need to have a context and conditions in which one can operate as a source of free and informed

⁴³ Delivered on 25th February, 2010 at Indian Institute of Public Administration, New Delhi.

choice.

82) To the aforesaid, Professor Baxi adds:

“I still need to say that the idea of dignity is a metaethical one, that is it marks and maps a difficult terrain of what it may mean to say being 'human' and remaining 'human', or put another way the relationship between 'self', 'others', and 'society'. In this formulation the word 'respect' is the keyword: dignity is respect for an individual person based on the principle of freedom and capacity to make choices and a good or just social order is one which respects dignity via assuring 'contexts' and 'conditions' as the 'source of free and informed choice'. Respect for dignity thus conceived is empowering overall and not just because it, even if importantly, sets constraints state, law, and regulations.”

83) *Jeremy Waldron*⁴⁴ opines that dignity is a sort of status-concept: it has to do with the standing (perhaps the formal legal standing or perhaps, more informally, the moral presence) that a person has in a society and in her dealings with others. He has ventured even to define this term “dignity” in the following manner:

“Dignity is the status of a person predicated on the fact that she is recognized as having the ability to control and regulate her actions in accordance with her own apprehension of norms and reasons that apply to her; it assumes she is capable of giving and entitled to give an account of herself (and of the way in which she is regulating her actions and organizing her life), an account that others are to pay attention to; and it means finally that she has the wherewithal to demand that her agency and her presence among us as human being be taken seriously and accommodated in the lives of others, in others' attitudes and actions towards her, and in social life generally”.

44 See Article of Jeremy Waldron : “How Law Protects Dignity”

- 84) Kant, on the other hand, has initially used dignity as a '*value idea*', though in his later work he also talks of 'respect' which a person needs to accord to other person, thereby speaking of it more as a matter of status.

Constitutional Perspective of Dignity

- 85) The most important lesson which was learnt as a result of Second World War was the realization by the Governments of various countries about the human dignity which needed to be cherished and protected. It is for this reason that in the U.N. Charter, 1945, adopted immediately after the Second World War, dignity of the individuals was mentioned as of core value. The almost contemporaneous Universal Declaration of Human Rights (1948) echoed same sentiments.
- 86) Article 3 of the Geneva Conventions explicitly prohibits “outrages upon personal dignity”. There are provisions to this effect in International Covenant on Civil and Political Rights (Article 7) and the European Convention of Human Rights (Article 3) though implicit. However, one can easily infer the said implicit message in these documents about human dignity. The ICCPR begins its preamble with the acknowledgment that the rights contained in the covenant “derive from the inherent dignity of the human

person”. And some philosophers say the same thing. Even if this is not a connection between dignity and law as such, it certainly purports to identify a wholesale connection between dignity and the branch of law devoted to human rights. One of the key facets of twenty-first century democracies is the primary importance they give to the protection of human rights. From this perspective, dignity is the expression of a basic value accepted in a broad sense by all people, and thus constitutes the first cornerstone in the edifice of human rights. Therefore, there is a certain fundamental value to the notion of human dignity, which some would consider a pivotal right deeply rooted in any notion of justice, fairness, and a society based on basic rights.

87) *Aharon Barak*, former Chief Justice of the Supreme Court of Israel, attributes two roles to the concept of human dignity as a constitutional value, which are:

1. Human dignity lays a foundation for all the human rights as it is the central argument for the existence of human rights.
2. Human dignity as a constitutional value provides meaning to the norms of the legal system. In the process, one can discern that the principle of purposive interpretation exhorts us to interpret all the rights given by the Constitution, in the light of the human dignity. In this sense, human dignity influences the

purposive interpretation of the Constitution. Not only this, it also influences the interpretation of every sub-constitutional norm in the legal system. Moreover, human dignity as a constitutional value also influences the development of the common law.

88) Within two years of the adoption of the aforesaid Universal Declaration of Human Rights that all human beings are born free and equal in dignity and rights, India attained independence and immediately thereafter Members of the Constituent Assembly took up the task of framing the Constitution of this Country. It was but natural to include a Bill of Rights in the Indian Constitution and the Constitution Makers did so by incorporating a Chapter on Fundamental Rights in Part III of the Constitution. However, it would be significant to point out that there is no mention of “dignity” specifically in this Chapter on Fundamental Rights. So was the position in the American Constitution. In America, human dignity as a part of human rights was brought in as a Judge-made doctrine. Same course of action followed as the Indian Supreme Court read human dignity into Articles 14 and 21 of the Constitution.

89) Before coming to the interpretative process that has been developed by this Court in evolving the aura of human dignity

predicated on Articles 14 and 21 of the Constitution, I am provoked to discuss as to how *Dworkin* perceives interpretative process adopted by a Judge.

- 90) *Dworkin*, being a philosopher – jurist, was aware of the idea of a Constitution and of a constitutional right to human dignity. In his book, *Taking Rights Seriously*, he noted that everyone who takes rights seriously must give an answer to the question why human rights vis-a-vis the State exist. According to him, in order to give such an answer one must accept, as a minimum, the idea of human dignity. As he writes:

“Human dignity....associated with Kant, but defended by philosophers of different schools, supposes that there are ways of treating a man that are inconsistent with recognizing him as a full member of the human community, and holds that such treatment is profoundly unjust.”⁴⁵

- 91) In his Book, “*Is Democracy Possible Here?*”⁴⁶ *Dworkin* develops two principles about the concept of human dignity. First principle regards the intrinsic value of every person, viz., every person has a special objective value which value is not only important to that person alone but success or failure of the lives of every person is important to all of us. The second principle, according to *Dworkin*, is that of personal responsibility. According to this

⁴⁵ *Ibid.*, 1

⁴⁶ Ronald Dworkin, *Is Democracy Possible Here? Principles for a New Political Debate* (Princeton University Press, 2006).

principle, every person has the responsibility for success in his own life and, therefore, he must use his discretion regarding the way of life that will be successful from his point of view. Thus, *Dworkin's* jurisprudence of human dignity is founded on the aforesaid two principles which, together, not only define the basis but the conditions for human dignity. *Dworkin* went on to develop and expand these principles in his book, *Justice for Hedgehogs* (2011)⁴⁷.

- 92) When speaking of rights, it is impossible to envisage it without dignity. In his pioneering and all inclusive “Justice for Hedgehogs”, he proffered an approach where respect for human dignity, entails two requirements; first, self-respect, i.e., taking the objective importance of one’s own life seriously; this represents the free will of the person, his capacity to think for himself and to control his own life and second, authenticity, i.e., accepting a “special, personal responsibility for identifying what counts as success” in one’s own life and for creating that life “through a coherent narrative” that one has chosen.⁴⁸ According to *Dworkin*, these principles form the fundamental criteria supervising what we should do in order to live well.⁴⁹ They further explicate the

47 *Ibid* 13

48 Kenneth W. Simons, *Dworkin's Two Principle of Dignity: An unsatisfactory Nonconsequentialist Account of Interpersonal Moral Duties*, 90 Boston law Rev. 715 (2010)

49 *Ibid*

rights that individuals have against their political community,⁵⁰ and they provide a rationale for the moral duties we owe to others. This notion of dignity, which *Dworkin* gives utmost importance to, is indispensable to any civilised society. It is what is constitutionally recognised in our country and for good reason. Living well is a moral responsibility of individuals; it is a continuing process that is not a static condition of character but a mode that an individual constantly endeavours to imbibe. A life lived without dignity, is not a life lived at all for living well implies a conception of human dignity which *Dworkin* interprets includes ideals of self-respect and authenticity.

- 93) This constitutional value of human dignity, has been beautifully illustrated by *Aharon Barak*, as under:

“Human dignity as a constitutional value is the factor that unites the human rights into one whole. It ensures the normative unity of human rights. This normative unity is expressed in the three ways: first, the value of human dignity serves as a normative basis for constitutional rights set out in the constitution; second, it serves as an interpretative principle for determining the scope of constitutional rights, including the right to human dignity; third, the value of human dignity has an important role in determining the proportionality of a statute limiting a constitutional right.”⁵¹

- 94) We have to keep in mind that while expounding the aforesaid notion of dignity, *Dworkin* was not interpreting any Constitution.

50 Supra 15

51 Aharon Barak, Human Dignity : The Constitutional Value and the Constitutional Right

This notion of dignity, as conceptualised by *Dworkin*, fits like a glove in our constitutional scheme. In a series of judgments, dignity, as an aspect of Article 21, stands firmly recognised. Most of the important judgments have been taken note of and discussed in ***K.S. Puttaswamy***⁵².

- 95) In ***K.S. Puttaswamy***, the Constitution Bench has recognised the dignity of existence. Liberty and autonomy are regarded as the essential attributes of a life with dignity. In this manner, sanctity of life also stands acknowledged, as part of Article 21 of the Constitution. That apart, while holding the right of privacy as an intrinsic part of right to life and liberty in Article 21, various facets thereof are discussed by the learned Judges in their separate opinions. A common theme which flows in all these opinions is that that privacy recognises the autonomy of the individual; every person has right to make essential choices which affect the course of life; he has to be given full liberty and freedom in order to achieve his desired goals of life; and the concept of privacy is contained not merely in personal liberty, but also in the dignity of the individual. Justice Chelameshwar, in ***K.S. Puttaswamy***,

⁵² *Prem Shankar Shukla v. UT of Delhi*, (1980) 3 SCC 526; *Francis Coralie Mullin v. UT of Delhi*, (1981) 1 SCC 608; *Bandhua Mukti Morcha v. Union of India*, (1984) 3 SCC 161; *Kheda Mazdoor Chetna Sangath v. State of Madhya Pradesh*, (1994) 6 SCC 260; *M. Nagaraj v. Union of India*, (2006) 8 SCC 212; *Maharashtra University of Health Sciences v. Satchikitsa Prasarak Mandal*, (2010) 3 SCC 786; *Selvi v. State of Karnataka*, (2010) 7 SCC 263; *Mehmood Nayyar Azam v. State of Chhattisgarh*, (2012) 8 SCC 1; *Shabnam v. Union of India*, (2015) 6 SCC 702; *Jeeja Ghosh v. Union of India*, (2016) 7 SCC 761.

made certain specific comments which are reflective of euthanasia, though this term is not specifically used. He observed: *“forced feeding of certain persons by the State raises concerns of privacy and individual’s right to refuse life prolonging medical treatment or terminate his life is another freedom which falls within the zone of privacy.”*

- 96) Liberty by itself, which is a facet of Article 21 of the Constitution, duly recognised in ***K.S. Puttaswamy***, ensures and guarantees such a choice to the individual. In fact, the entire structure of civil liberties presupposes that freedom is worth fostering. The very notion of liberty is considered as good for the society. It is also recognised that there are some rights, encompassing liberty, which are needed in order to protect freedom. *David Feldman*⁵³ beautifully describes as to why freedom (or liberty) is given:

“The guiding principle for many liberal rights theorists may be seen as respect for individuals’ own aspirations, as a means of giving the fullest expression to each individual’s moral autonomy. A fundamental principle entailed by respect for moral autonomy is that individuals should *prima facie* be free to select their own ideas of the Good, and develop a plan for life, or day-to-day strategy, accordingly. Their choice of goods should be constrained only to the extent necessary to protect society and the similar liberties of other people. The law should protect at least the basic liberties, that is, those necessary to the pursuit of any socially acceptable conception of the good life. This is the approach which John Rawls adopts in *A Theory of Justice*. It requires that basic liberties be given considerable respect, and

⁵³ David Feldman: *Civil Liberties & Human Rights in England & Wales*

that they should have priority over the pursuit of social goods (such as economic development) perhaps even to the extent of giving them the status of entrenched, constitutional rights, in order to shield them from challenge in the day-to-day rough and tumble of political contention. This gives liberty a priority over other values, which, whether viewed as a description of liberal society or as a prescription for its improvement, is very controversial. Philosophers have doubted whether there are adequate grounds for the priority of liberty. Professor H.L.A. Hart has argued that (at least in a society where there is limited abundance of wealth and resources) it is rational to prefer basic freedoms to an improvement in material conditions only if one harbours the ideal of 'a public-spirited citizen who prizes political activity and service to others as among the chief goods of life and could not contemplate as tolerable an exchange of the opportunities of such activity for mere material goods or contentment'.

A rather different thesis runs through Professor Joseph Raz's book, *The Morality of Freedom*: people are autonomous moral actors, and autonomy is given expression primarily through making one's own decisions, but such freedom is valuable partly because it advances social ends. Raz points out that the identification of basic liberties therefore depends, in part at least, on governmental notions of the public good. In respect of rights to freedom of expression, privacy, freedom of religion, and freedom from discrimination, for example, 'one reason for affording special protection to individual interests is that thereby one also protects a collective good, an aspect of a public culture'. At the same time, certain social goods are needed if freedom is to have value. Freedom is useful only if the social and economic structure of society provides a sufficient range of choices to allow people's capacity for choice to be exercised. Accordingly, freedom is seen as a collective rather than an individual good. This may constrain the range of freedoms and the purposes to which they may morally be put: a decision to make a freedom into a constitutional right is an expression of the collective political culture of a community. This thesis does not make the morality of freedom depend on people striving for perfection: individuals may not always, or ever, think about the moral consequences of their decisions, or may consciously make decisions which do not make for self-

improvement. Instead, it looks only for a social commitment to the idea of the moral significance of individual choice. Raz marries the idea of the individual to that of society by recognizing that individual freedom of choice is contingent on social arrangements.”

- 97) In his Article, Life's Dominion, *Ronald Dworkin*, while building the hypothesis on dignity concept, exhorts that people must decide about their own death, or someone else's in three main kind of situations, namely, (i) *conscious and competent*: it is a situation where a person is suffering from some serious illness because of which he is incapacitated but he is still conscious and also competent to decide about his fate, he should be given a choice to decide as to whether he wants to continue to get the treatment; (ii) *unconscious*: where the patient is unconscious and dying, doctors are often forced to decide whether to continue life support for him or not under certain circumstances relatives have to take a decision. However, at times, unconscious patients are not about to die. At the same time, they are either in coma or in PVS. In either case, they are conscious. In such a situation, where recovery is impossible, it should be left to the relatives to decide as to whether they want the patient to remain on life support (ventilator, etc.); and (iii) *conscious but incompetent*. These factors may support, what is known as '*living will*' or '*advance directive*', which aspect is dealt with specifically while answering

the second issue.

- 98) When a person is undergoing untold suffering and misery because of the disease with which he is suffering and at times even unable to bear the same, continuing to put him on artificial machines to prolong his vegetable life would amount to violating his dignity. These are the arguments which are raised by some jurists and sociologists⁵⁴.
- 99) There is a related, but interesting, aspect of this dignity which needs to be emphasised. Right to health is a part of Article 21 of the Constitution. At the same time, it is also a harsh reality that everybody is not able to enjoy that right because of poverty etc. The State is not in a position to translate into reality this right to health for all citizens. Thus, when citizens are not guaranteed the right to health, can they be denied right to die in dignity?
- 100) In the context of euthanasia, 'personal autonomy' of an individual, as a part of human dignity, can be pressed into service. In ***National Legal Services Authority v. Union of India and Others***⁵⁵, this Court observed:

“Article 21, as already indicated, guarantees the protection of “personal autonomy” of an individual. In

54 (i) *Morris: Voluntary Euthanasia*

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

55 (2014) 5 SCC 438

Anuj Garg v. Hotel Assn. of India [(2008) 3 SCC 1] (SCC p. 15, paras 34-35), this Court held that personal autonomy includes both the negative right of not to be subject to interference by others and the positive right of individuals to make decisions about their life, to express themselves and to choose which activities to take part in. Self-determination of gender is an integral part of personal autonomy and self-expression and falls within the realm of personal liberty guaranteed under Article 21 of the Constitution of India.”

101) In addition to personal autonomy, other facets of human dignity, namely, ‘self expression’ and ‘right to determine’ also support the argument that it is the choice of the patient to receive or not to receive treatment.

102) We may again mention that talking particularly about certain hard cases involving moral overtones, *Dworkin* specifically discussed the issues pertaining to abortion and euthanasia with emphasis that both supporters and critics accept the idea of sanctity of life. Decisions regarding death – whether by abortion or by euthanasia – affect our human dignity. In *Dworkin's* opinion, proper recognition of human dignity leads to the recognition of the freedom of the individual. Freedom is a necessary condition for self worth. *Dworkin* adds: “*Because we cherish dignity, we insist on freedom Because we honour dignity, we demand democracy.*”⁵⁶

⁵⁶ *Ibid.*, at 239

103) Dignity is, thus, the core value of life and dying in dignity stands recognised in ***Gian Kaur***. It becomes a part of right of self determination.

104) The important message behind *Dworkin's* concept of human dignity can be summarised in the following manner:

(1) He describes belief in individual human dignity as the most important feature of Western political culture giving people the moral right “to confront the most fundamental questions about the meaning and value of their own lives”⁵⁷.

(2) In an age when people value their independence and strive to live independent and fulfilled lives it is important “that life ends *appropriately*, that death keeps faith with the way we want to have lived”⁵⁸.

(3) Death is “not only the start of nothing but the end of everything”⁵⁹ and, therefore, it should be accomplished in a manner compatible with the ideals sought during life.

105) Taking into consideration the conceptual aspects of dignity and the manner in which it has been judicially adopted by various judgments, following elements of dignity can be highlighted (in

⁵⁷ R Dworkin, *Life's Dominion* (London, Harper-Collins, 1993) at 166.

⁵⁸ R Dworkin, *Life's Dominion* (London, HarperCollins, 1993) at 179.

⁵⁹ *Ibid*.

the context of death with dignity):

- (I) Encompasses **self-determination**; implies a quality of life consistent with the ability to exercise self-determined choices;
- (ii) Maintains/ability to make **autonomous choices**; high regard for individual autonomy that is pivotal to the perceived quality of a person's life;
- (iii) **Self-control** (retain a similar kind of control over dying as one has exercised during life – a way of achieving death with dignity);
- (iv) Law of **consent**: The ability to choose - orchestrate the timing of their own death;
- (v) Dignity may be compromised if the dying process is prolonged and involves becoming incapacitated and dependent;
- (vi) Respect for human dignity means respecting the **intrinsic value of human life**;
- (vii) Avoidance of dependency;
- (viii) Indefinite continuation of futile physical life is regarded as undignified;
- (ix) Dignity commands emphatic respect⁶⁰;

- Reason and emotion are both significant in treatment decisions, especially at the end of life where compassion

⁶⁰ A Kolnai, "Dignity", in R S Dillon (ed.) *Dignity, Character, and Self-Respect* (London, Routledge, 1995) 53–75, at 55.

is a natural response to appeals made on the basis of stifled self-determination;

- Compassion represents a collision of “imaginative insight” and empathy; and
- Compassion is here distinguished from pity, which is regarded as “inappropriate to the dignity of the autonomous person, especially its overtones of paternalism”,⁶¹ because compassion is believed to provoke an active, and by implication positive, response.⁶²

(x) Dignity **engenders a sense of serenity and powerfulness**, fortified by “qualities of composure, calmness, restraint, reserve, and emotions or passions subdued and securely controlled without being negated or dissolved”⁶³; and

(x) **Observer’s Dignity aspect:**

- a person possessed of dignity at the end of life, might induce in an observer a sense of tranquility and admiration which inspires images of power and self-assertion through restraint and poised composure; and
- dignity clearly does play a valuable role in contextualizing

⁶¹ R S Downie, K S Calman, *Healthy Respect: Ethics in Health Care* (Oxford, Oxford University Press, 1994) at 51–53.

⁶² *Ibid.*

⁶³ A Kolnai, “Dignity”, in R S Dillon (ed.) *Dignity, Character, and Self-Respect* (London, Routledge, 1995) 53–75, at 56.

people's perceptions of death and dying, especially as it appears to embody a spirit of self-determination that advocates of voluntary euthanasia crave.

106) Once we examine the matter in the aforesaid perspective, the inevitable conclusion would be that passive euthanasia and death with dignity are inextricably linked, which can be summed up with the following pointers:

(i) The opportunity to die unencumbered by the intrusion of medical technology and before experiencing loss of independence and control, appears to many to extend the promise of a dignified death. When medical technology intervenes to prolong dying like this it does not do so unobtrusively;

(ii) Today many patients insist on more than just a right to health care in general. They seek a right to choose specific types of treatment, able to retain control throughout the entire span of their lives and to exercise autonomy in all medical decisions concerning their welfare and treatment;

(iii) A dreadful, painful death on a rational but incapacitated terminally ill patient are an affront to human dignity.

107) The aforesaid discussion takes care of those who oppose

euthanasia on moral and ethical principles. We feel that at least the case for passive euthanasia is made out. Certain moral dilemma as to what is the exact stage when such a decision to withdraw medical support, would still remain. At times, a physician would be filled with profound ethical uncertainties when a person is suffering unbearable pain and agony, the question would be as to whether such suffering has reached the stage where it is incurable and, therefore, decision should be taken to allow such person to pass away in peace and dignity of hastening the process of death or the situation may be reversible, though chances thereof are far remote. Dr. R.R. Kishore, who possesses medical as well as law degree at the same time, lists the following questions which a physician will have to answer while taking such a decision:

- (i) Is it professionally permissible to kill or to help in dying a terminally ill and incurable patient?
- (ii) How does such a decision affect the person concerned and the society in general?
- (iii) What are the values that are attracted in such situations?
- (iv) How to assess that the individual's urge to die is based on cool and candid considerations and is not an impulsive act reflecting resources constraints, inadequate care or

discrimination?

(v) What are the practical risks involved in case a decision is taken to terminate the life of the patient?

(vi) Where should the physician look for guidance in situations of such moral dilemma?

(vii) Does the physician's or the patient's religion play any role in decision making process?

108) What are the parameters to be kept in mind and the dangers which may be encountered while taking decision on the aforesaid questions, is beautifully explained by **Dr. R.R. Kishore**⁶⁴ in the following words:

“Contemporary world order is founded on reason, equity and dignity. Reason envisages definition and distinctness. What is the distinction between ‘killing’ and ‘letting die’? or, in other words, what is the difference between ‘causing death’ and ‘denial to prevent death’? Also, can the prolongation of life be ever ‘unnecessary’? And, if yes, what are the criteria to determine the life's worth? Equity mandates equality of opportunity, balancing of interests and optimization of resources. This means addressing questions such as; for how long one should live? Who should die first? What should be the ideal method of terminating one's life? Dignity imposes obligation to preserve life at all costs and in the event of an individual's conscious expression to end his life, contemplates a valid purpose and truly informed consent. Deontologically, in the context of sanctity of life, there is not much of conflict between secular and religious concepts as both consider life as sacred and worthy of protection. But, the differences appear in the face of application of advanced technology which has the

64 Dr.R.R. Kishore,MD, LLB – End of Life Issues and the Moral Certainty: A Discovery through Hinduism

potential of keeping alive the terminally ill and incurable persons who would have otherwise died. Since the technological resources are not unlimited prioritization becomes a functional imperative, bringing in the concepts of worth and utility. In other words, the questions like whose life is more precious and worthy of protection have to be answered. This is a formidable task, attracting multiple and diverse perspectives, moral as well as strategic, leading to heterogeneous approaches and despite agreement on fundamental issue of value of life the decisions may seem to be at variance. A fair and objective decision in such circumstances may be a difficult exercise and any liberalization is fraught with following apprehensions:

- Danger of abuse
- Enhanced vulnerability to the poor
- Slippery slope outcome
- Weakening of protection of life notions

Any ethical model governing end of life decisions should therefore be impervious to all extraneous forces such as, the utilitarian bias, poverty, and subjectivity i.e., inadequate appreciation of socio-economic, family, cultural and religious perspectives of the individual. The poor and resourceless are likely to face deeper and more severe pain and agony before dying and as such may request their physicians to terminate their lives much earlier than those who have better access to resource. This poverty-death nexus makes an objective decision difficult, constituting a formidable challenge to committed physicians and others involved with the end of life issues. Taking a decision on case to case basis, depending on individual's material constraints and inadequacies, enhances the problem rather than solving it, as it reduces the life from an eternal bliss to a worldly award, subjecting its preservation to socio-economic exigencies. For these reasons many feel that the safer and more respectable course to improve death is to provide good palliative care and emotional support rather than assisting the end of life. The moral ambiguities notwithstanding, decision to assist or not to assist the act of dying by correctly interpreting the patient's wish and the accompanying circumstances, including the moral dictates, constitutes a practical problem. Let us see how Hinduism addresses these issues."

109) In the article, ***End of Life Issues and the Moral Certainty***⁶⁵, the author after posing the moral dilemma, noted above, discusses the approach to find the solutions.

110) I had indicated at the earlier stage that Hippocratic Oath, coupled with ethical norms of medical profession, stand in the way of euthanasia. It brings about a situation of dilemma insofar as medical practitioner is concerned. On the one hand his duty is to save the life of a person till he is alive, even when the patient is terminally ill and there are no chances of revival. On the other hand, the concept of dignity and right to bodily integrity, which recognises legal right of autonomy and choice to the patient (or even to his relations in certain circumstances, particularly when the patient is unconscious or incapacitated to take a decision) may lead to exercising his right of euthanasia.

111) Dignity implies, apart from a right to life enjoyment of right to be free of physical interference. At common law, any physical interference with a person is, *prima facie*, tortious. If it interferes with freedom of movement, it may constitute a false imprisonment. If it involves physical touching, it may constitute a battery. If it puts a person in fear of violence, it may amount to an

⁶⁵ See Footnote 63.

assault. For any of these wrongs, the victim may be able to obtain damages.

112) When it comes to medical treatment, even there the general common law principle is that any medical treatment constitutes a trespass to the person which must be justified, by reference either to the patient's consent or to the necessity of saving life in circumstances where the patient is unable to decide whether or not to consent.

113) Rights with regard to medical treatment fall essentially into two categories: first, rights to receive or be free of treatment as needed or desired, and not to be subjected involuntarily to experimentation which, irrespective of any benefit which the subjects may derive, are intended to advance scientific knowledge and benefit people other than the subject in the long term; secondly, rights connected incidentally with the provision of medical services, such as rights to be told the truth by one's doctor.

114) Having regard to the aforesaid right of the patients in common law, coupled with the dignity and privacy rights, it can be said that passive euthanasia, under those circumstances where patient is in PVS and he is terminally ill, where the condition is irreversible

or where he is braindead, can be permitted. On the aforesaid reasoning, I am in agreement with the opinion of the other members of this Bench in approving the judgment in ***Aruna Ramachandra Shanbaug***.

(D) Economics of Euthanasia

115) This is yet another reason for arriving at the same conclusion.

116) When we consider the matter of euthanasia in the context of economic principles, it becomes another reason to support the aforesaid conclusion. This aspect can be dealt with in two ways.

117) First, because of rampant poverty where majority of the persons are not able to afford health services, should they be forced to spend on medical treatment beyond their means and in the process compelling them to sell their house property, household things and other assets which may be means of livelihood Secondly, when there are limited medical facilities available, should a major part thereof be consumed on those patients who have no chances of recovery? In Economic & Political Weekly dated February 10, 2018, it is reported:

“India is one of the worst India is one of the worst countries to die in, especially for those suffering from terminal illnesses. In 2015, the Economist Intelligence Unit brought out a Quality of Death Index, which ranked India 67th out of the 80 countries it had

surveyed. In December 2017, a joint report published by the World Health Organization and the World Bank revealed that 49 million Indians are pushed into poverty every year due to out-of-pocket expenditure on healthcare, accounting for half of the 100 million who meet such a fate worldwide. India's Central Bureau of Health Intelligence data puts the figure even higher. This unconscionable situation is the direct outcome of the sorry state of our public health system. India's spending on health is among the lowest in the world. The *Economic Survey 2017–18* shows that the government spends only 1.4% of its gross domestic product (GDP) on health. The 2017 National Health Policy, which otherwise exudes piety in its abstractions, aims to increase government expenditure to 2.5% of GDP by 2025. By all accounts, this is too little too late.

The situation improves only marginally for the better-off sections. With over 90% of intensive care units in the private healthcare sector, it is largely this section that can access expensive treatments. But this does not improve end-of-life situations for them. Awareness and training in palliative care remain grossly inadequate. For those making profit in the private healthcare sector, there is no incentive to provide such treatment. Instead, treatment for the terminally ill continues to involve prolonging life with expensive, invasive, and painful treatment with very little concern for the patients themselves or their families.”

118) Some of the apprehensions expressed in ethical debates about euthanasia can be answered when the ethical debate about euthanasia is not divorced from an economic consideration of cost and benefits of euthanasia to society. *P.R. Ward*⁶⁶ argues that ethics is concerned with individuals and, therefore, does not take into account the societal perspective. On the other hand, economics is sought to be concerned with relative costs and

66 Healthcare rationing: can we afford to ignore euthanasia? *Health Services Management Research* 1997; 10; 32-41

benefits to society and can help to determine if euthanasia is of benefit to the majority in society. According to him, the net benefit to the individual (from ethical considerations) can be compared with the net benefit to society (from economics), and that both can be included in an overall decision rule for whether or not to legalise euthanasia. *Ward* draws on the health economics literature (for example, *Mooney*⁶⁷) to suggest that a positive answer to this question is implicit in many health-rationing decisions and is applicable to the euthanasia decision. He also asserts that *'introducing an economic perspective is not incompatible with ethical issues'*.

119) No doubt, protagonists of ethical aspects of euthanasia oppose the aforesaid view. According to them, euthanasia also involves the specific act of a medical professional killing a patient and the ethical status of this act has implications both for individuals and for society. Their counter argument, therefore, is that to be able to make an economic assessment of euthanasia, we would have to be able to evaluate the cost and benefits of this act of killing. However, even they accept that if the act of killing by euthanasia is ethically acceptable in some circumstances, it would be appropriate to consider the net benefits of the act to the individual

67 Mooney, G. *The Valuation of Human Life*. London: Macmillan Press, 1977

patient along with the wider economic considerations⁶⁸. In the instant case, we have come to the conclusion that under certain circumstances, i.e. when the patient is in PVS or braindead/clinically dead, at least passive euthanasia would even be ethically acceptable, on the application of doctrine of dignity. In such a situation, the economic considerations would strengthen the aforesaid conclusion.

120) At times, for deciding legal issues, economic analysis of law assumes importance⁶⁹. It is advocated that one of the main reasons which should prompt philosophers of law to undertake economic analysis seriously is that the most basic notion in the analysis – efficiency or Pareto optimality⁷⁰ - was originally introduced to help solve a serious objection to widely held moral theory, utilitarian. Utilitarians hold that the principle of utility is the criterion of the right conduct. If one has to evaluate policies in virtue of their effect on individual welfare or utility, one norm of utility has to be compared with that of another. We may clarify that this economic principle has been applied in a limited sense only as a supporting consideration with the aim to promote

68 See – *Economics and Euthanasia* by **Stephen Heasell**, Department of Economics and Politics, Nottingham Trent University, and **David Paton**, Nottingham University Business School.

69 This aspect is discussed in some detail by this Court in *Shivashakti Sugars Ltd. v. Shree Renuka Sugar Limited and Other*, (2017) 7 SCC 729

70 Jeffrie G. Murphy & Jules L. Coleman: *Philosophy of Law (An introduction to Jurisprudence)*

efficiency.

121) If we understand correctly the logic behind opposition to euthanasia, particularly, passive euthanasia, it proceeds on the basis that third person should not have right to take a decision about one's life and, more importantly, it is difficult to ascertain, at a particular stage, as to whether time has come to take such a decision, namely, withdraw the medical support. Insofar as latter aspect is concerned, we feel that in ***Aruna Ramachandra Shanbaug***, this Court has taken due care in prescribing the circumstances, namely, when the person is in a Permanent Vegetative State (PVS) with no reversible chance or when he is 'brain dead' or 'clinically dead'. Insofar as first aspect is concerned, the subject matter of the present writ petition takes care of that.

THE SECOND ISSUE

122) With this, we advert to the second question formulated above, which is as under:

Whether a 'living will' or 'advance directive' should be legally recognised and can be enforced? If so, under what circumstances and what precautions are required while permitting it?

123) In this writ petition, the petitioner has sought a direction to the

respondents to adopt suitable procedures to ensure that persons of deteriorated health or terminally ill should be able to execute a document titled 'living will and/or advance authorisation' which can be presented to the hospital for appropriate action in the event of the executant being admitted to the hospital with serious illness which may threaten termination of life of the executant. In nutshell, the petitioner wants that citizens should have right to decide in advance not to accept any kind of treatment at a stage when they are terminally ill. Expressing this in advance in a document is known as 'living will' or 'advance directive', whereby the aforesaid self-determination of the person is to be acted upon when he reaches PVS or his brain dead/clinically dead.

- 124) It is an undisputed that Doctors' primary duty is to provide treatment and save life but not in the case when a person has already expressed his desire of not being subjected to any kind of treatment. It is a common law right of people, of any civilized 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. The foundation of the aforesaid right has already been laid down by this Court in ***Aruna Ramachandra Shanbaug*** while dealing with the issue of

‘involuntary passive euthanasia’. To quote:

“66. Passive euthanasia is usually defined as withdrawing medical treatment with a deliberate intention of causing the patient's death. For example, if a patient requires kidney dialysis to survive, not giving dialysis although the machine is available, is passive euthanasia. Similarly, if a patient is in coma or on a heart-lung machine, withdrawing of the machine will ordinarily result in passive euthanasia. Similarly not giving life-saving medicines like antibiotics in certain situations may result in passive euthanasia. Denying food to a person in coma or PVS may also amount to passive euthanasia.

67. As already stated above, euthanasia can be both voluntary or non-voluntary. In voluntary passive euthanasia a person who is capable of deciding for himself decides that he would prefer to die (which may be for various reasons e.g. that he is in great pain or that the money being spent on his treatment should instead be given to his family who are in greater need, etc.), and for this purpose he consciously and of his own free will refuses to take life-saving medicines. In India, if a person consciously and voluntarily refuses to take life-saving medical treatment it is not a crime...

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78. ... 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 [see *Schloendorff v. Society of New York Hospital* [211 NY 125 : 105 NE 92 (1914)] , NE at p. 93, per Cardozo, J.; *S. v. McC. (Orse S.) and M (D.S. Intervener)* [1972 AC 24 (HL)], *W v. W*; AC at p. 43, per Lord Reid; and *Sidaway v. Board of Governors of the Bethlem Royal Hospital* [1985 AC 871 : (1985) 2 WLR 480 : (1985) 1 All ER 643 (HL)] AC at p. 882, per Lord Scarman]. To this extent, the principle of the sanctity of human life must yield to the principle of self-determination [see (Court of Appeal transcript in

the present case, at p. 38 F 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. Hotel Dieu de Quebec* [(1992) 86 DLR (4th) 385 (Que SC)] . 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. *T. (Adult: Refusal of Treatment)*, *In re* [1993 Fam 95 : (1992) 3 WLR 782 : (1992) 4 All ER 649 (CA)]]. 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..."

125) The aforesaid principle has also been recognised by this Court in its Constitution Bench judgment passed in ***Gian Kaur*** wherein it was held that although '*Right to Life*' under Article 21 does not include '*Right to Die*', but '*Right to live with dignity*' includes '*Right to die with dignity*'. To quote:

"24. 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.

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.”

126) In fact, the Law Commission of India was asked to consider on the feasibility of making legislation on euthanasia, taking into account the earlier 196th Report of the Law Commission as well as the judgment of this Court in ***Aruna Ramachandra Shanbaug***. In August, 2012, Law Commission came out with a detailed 241st Report on the issue of passive euthanasia, wherein it approved the concept of Right to Self Determination also. The Law Commission made some important observations in its report

such as:

“2.4 The following pertinent observations made by the then Chairman of the Law Commission in the forwarding letter dated 28 August 2006 addressed to the Hon’ble Minister are extracted below:

“A hundred years ago, when medicine and medical technology had not invented the artificial methods of keeping a terminally ill patient alive by medical treatment, including by means of ventilators and artificial feeding, such patients were meeting their death on account of natural causes. Today, it is accepted, a terminally ill person has a common law right to refuse modern medical procedures and allow nature to take its own course, as was done in good old times. It is well-settled law in all countries that a terminally ill patient who is conscious and is competent, can take an ‘informed decision’ to die a natural death and direct that he or she be not given medical treatment which may merely prolong life. There are currently a large number of such patients who have reached a stage in their illness when according to well-informed body of medical opinion, there are no chances of recovery. But modern medicine and technology may yet enable such patients to prolong life to no purpose and during such prolongation, patients could go through extreme pain and suffering. Several such patients prefer palliative care for reducing pain and suffering and do not want medical treatment which will merely prolong life or postpone death.”

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5.2 The 196th Report of the Law Commission stated the fundamental principle that a terminally ill but competent patient has a right to refuse treatment including discontinuance of life sustaining measures and the same is binding on the doctor, “provided that the decision of the patient is an ‘informed decision’ ”. ‘Patient’ has been defined as a person suffering from terminal illness. “Terminal illness” has also been defined under Section 2 (m). The definition of a ‘competent patient’ has to be understood by the definition of ‘incompetent patient’. ‘Incompetent

patient' means a patient who is a minor or a person of unsound mind or a patient who is unable to weigh, understand or retain the relevant information about his or her medical treatment or unable to make an 'informed decision' because of impairment of or a disturbance in the functioning of the mind or brain or a person who is unable to communicate the informed decision regarding medical treatment through speech, sign or language or any other mode (vide Section 2(d) of the Bill, 2006). "Medical Treatment" has been defined in Section 2(i) as treatment intended to sustain, restore or replace vital functions which, when applied to a patient suffering from terminal illness, would serve only to prolong the process of dying and includes life sustaining treatment by way of surgical operation or the administration of medicine etc. and use of mechanical or artificial means such as ventilation, artificial nutrition and cardio resuscitation. The expressions "best interests" and "informed decision" have also been defined in the proposed Bill. "Best Interests", according to Section 2(b), includes the best interests of both on incompetent patient and competent patient who has not taken an informed decision and it ought not to be limited to medical interests of the patient but includes ethical, social, emotional and other welfare considerations. The term 'informed decision' means, as per Section 2 (e) "the decision as to continuance or withholding or withdrawing medical treatment taken by a patient who is competent and who is, or has been informed about – (i) the nature of his or her illness, (ii) any alternative form of treatment that may be available, (iii) the consequences of those forms of treatment, and (iv) the consequences of remaining untreated.

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5.8 The Law Commission of India clarified that where a competent patient takes an 'informed decision' to allow nature to have its course, the patient is, under common law, not guilty of attempt to commit suicide (u/s 309 IPC) nor is the doctor who omits to give treatment, guilty of abetting suicide (u/s 306 IPC) or of culpable homicide (u/s 299 read with Section 304 of IPC).

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7.2 In this context, two cardinal principles of medical ethics are stated to be patient autonomy and beneficence (vide P. 482 of SCC in Aruna's case):

1. "Autonomy means the right to self-determination, where the informed patient has a right to choose the manner of his treatment. To be autonomous, the patient should be competent to make decision and choices. In the event that he is incompetent to make choices, his wishes expressed in advance in the form of a living will, OR the wishes of surrogates acting on his behalf (substituted judgment) are to be respected. The surrogate is expected to represent what the patient may have decided had she/she been competent, or to act in the patient's best interest.

2. Beneficence is acting in what (or judged to be) in the patient's best interest. Acting in the patient's best interest means following a course of action that is best for the patient, and is not influenced by personal convictions, motives or other considerations.....

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11.2 The discussion in the foregoing paras and the weighty opinions of the Judges of highest courts as well as the considered views of Law Commission (in 196th report) would furnish an answer to the above question in clearest terms to the effect that legally and constitutionally, the patient (competent) has a right to refuse medical treatment resulting in temporary prolongation of life. The patient's life is at the brink of extinction. There is no slightest hope of recovery. The patient undergoing terrible suffering and worst mental agony does not want his life to be prolonged by artificial means. She/he would not like to spend for his treatment which is practically worthless. She/he cares for his bodily integrity rather than bodily suffering. She/he would not like to live like a 'cabbage' in an intensive care unit for some days or months till the inevitable death occurs. He would like to have the right of privacy protected which implies protection from interference and bodily invasion. As observed in Gian Kaur's case, the natural process of his death has already commenced and he would like to die with peace and dignity. No law can inhibit him from opting

such course. This is not a situation comparable to suicide, keeping aside the view point in favour of decriminalizing the attempt to suicide. The doctor or relatives cannot compel him to have invasive medical treatment by artificial means or treatment. If there is forced medical intervention on his body, according to the decisions cited supra (especially the remarks of Lord Brown Wilkinson in Airedale's case), the doctor / surgeon is guilty of 'assault' or 'battery'. In the words of Justice Cardozo, "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." Lord Goff in Airedale's case places the right to self determination on a high pedestal. He observed that "in the circumstances such as this, the principle of sanctity of human life must yield to the principle of self determination and the doctor's duty to act in the best interests of the patient must likewise be qualified by the wish of the patient." The following observations of Lord Goff deserve particular notice:

"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."

127) And finally, the Law Commission in its 241st Report gave

Summary of Recommendations as under:

"14. Summary of Recommendations

14.1 Passive euthanasia, which is allowed in many countries, shall have legal recognition in our country too subject to certain safeguards, as suggested by the 17th Law Commission of India and as held by the Supreme Court in Aruna Ramachandra's case [(2011) 4 SCC 454]. It is not objectionable from legal and constitutional point of

view.

14.2 A competent adult patient has the right to insist that there should be no invasive medical treatment by way of artificial life sustaining measures / treatment and such decision is binding on the doctors / hospital attending on such patient provided that the doctor is satisfied that the patient has taken an 'informed decision' based on free exercise of his or her will. The same rule will apply to a minor above 16 years of age who has expressed his or her wish not to have such treatment provided the consent has been given by the major spouse and one of the parents of such minor patient.

14.3 As regards an incompetent patient such as a person in irreversible coma or in Persistent Vegetative State and a competent patient who has not taken an 'informed decision', the doctor's or relatives' decision to withhold or withdraw the medical treatment is not final. The relatives, next friend, or the doctors concerned / hospital management shall get the clearance from the High Court for withdrawing or withholding the life sustaining treatment. In this respect, the recommendations of Law Commission in 196th report is somewhat different. The Law Commission proposed an enabling provision to move the High Court.

14.4 The High Court shall take a decision after obtaining the opinion of a panel of three medical experts and after ascertaining the wishes of the relatives of the patient. The High Court, as parens patriae will take an appropriate decision having regard to the best interests of the patient.

14.5 Provisions are introduced for protection of medical practitioners and others who act according to the wishes of the competent patient or the order of the High Court from criminal or civil action. Further, a competent patient (who is terminally ill) refusing medical treatment shall not be deemed to be guilty of any offence under any law.

14.6 The procedure for preparation of panels has been set out broadly in conformity with the recommendations of 17th Law Commission. Advance medical directive given by the patient

before his illness is not valid.

14.7 Notwithstanding that medical treatment has been withheld or withdrawn in accordance with the provisions referred to above, palliative care can be extended to the competent and incompetent patients. The Governments have to devise schemes for palliative care at affordable cost to terminally ill patients undergoing intractable suffering.

14.8 The Medical Council of India is required issue guidelines in the matter of withholding or withdrawing of medical treatment to competent or incompetent patients suffering from terminal illness.

14.9 Accordingly, the Medical Treatment of Terminally Ill Patients (Protection of Patients and Medical Practitioners) Bill, 2006, drafted by the 17th Law Commission in the 196th Report has been modified and the revised Bill is practically an amalgam of the earlier recommendations of the Law Commission and the views / directions of the Supreme Court in Aruna Ramachandra case. The revised Bill is at Annexure I.”

128) I am also of the view that such an advance authority is akin to well recognised common law right to refuse medical treatment (See: Re T (Adult: ***Refusal of Medical Treatment***⁷¹), Re B (Adult: ***Refusal of Medical Treatment***⁷²), ***Crahan v. Director, Missouri Department of Health***⁷³, ***Malette v. Shulam***⁷⁴.

129) In a recent landmark judgment of the nine Judge Constitution Bench in the case of ***K.S. Puttaswamy*** authoritatively held that right to life enshrined in Article 21 includes right to privacy. One

71 (1992) 4 All ER 649

72 (2002) 2 All ER 449

73 497 U.S. 261 (1990)

74 67 DLR (4th) 321

of the facet of this right acknowledged is an individual's decision to refuse life prolonging medical treatment or terminate his life. Justice Chelameswar in his separate opinion has described the same in the following manner:

“373. Concerns of privacy arise when the State seeks to intrude into the body of subjects. [*Skinner v. Oklahoma*, 1942 SCC OnLine US SC 125 : 86 L Ed 1655 : 316 US 535 (1942)]“20. There are limits to the extent to which a legislatively represented majority may conduct biological experiments at the expense of the dignity and personality and natural powers of a minority—even those who have been guilty of what the majority defines as crimes.” (SCC OnLine US SC para 20)—Jackson, J.] Corporeal punishments were not unknown to India, their abolition is of a recent vintage. Forced feeding of certain persons by the State raises concerns of privacy. An individual's rights to refuse life prolonging medical treatment or terminate his life is another freedom which falls within the zone of the right to privacy. I am conscious of the fact that the issue is pending before this Court. But in various other jurisdictions, there is a huge debate on those issues though it is still a grey area. [For the legal debate in this area in US, See Chapter 15.11 of *American Constitutional Law* by Laurence H. Tribe, 2nd Edn.] A woman's freedom of choice whether to bear a child or abort her pregnancy are areas which fall in the realm of privacy. Similarly, the freedom to choose either to work or not and the freedom to choose the nature of the work are areas of private decision-making process. The right to travel freely within the country or go abroad is an area falling within the right to privacy. The text of our Constitution recognised the freedom to travel throughout the country under Article 19(1)(d). This Court has already recognised that such a right takes within its sweep the right to travel abroad. [*Maneka Gandhi v. Union of India*, (1978) 1 SCC 248] A person's freedom to choose the place of his residence once again is a part of his right to privacy [*Williams v. Fears*, 1900 SCC OnLine US SC 211 : 45 L Ed 186 : 179 US 270 (1900)] —“8. Undoubtedly the right of locomotion, the right to

remove from one place to another according to inclination, is an attribute of personal liberty....” (SCC OnLine US SC para 8)] recognised by the Constitution of India under Article 19(1)(e) though the predominant purpose of enumerating the above-mentioned two freedoms in Article 19(1) is to disable both the federal and State Governments from creating barriers which are incompatible with the federal nature of our country and its Constitution. The choice of appearance and apparel are also aspects of the right to privacy. The freedom of certain groups of subjects to determine their appearance and apparel (such as keeping long hair and wearing a turban) are protected not as a part of the right to privacy but as a part of their religious belief. Such a freedom need not necessarily be based on religious beliefs falling under Article 25. Informational traces are also an area which is the subject-matter of huge debate in various jurisdictions falling within the realm of the right to privacy, such data is as personal as that of the choice of appearance and apparel. Telephone tapings and internet hacking by State, of personal data is another area which falls within the realm of privacy. The instant reference arises out of such an attempt by the Union of India to collect biometric data regarding all the residents of this country. The above-mentioned are some of the areas where some interest of privacy exists. The examples given above indicate to some extent the nature and scope of the right to privacy.”

NATURE OF LIVING WILL OR ADVANCE DIRECTIVE

130) Advance directives are instruments through which persons express their wishes at a prior point in time, when they are capable of making an informed decision, regarding their medical treatment in the future, when they are not in a position to make an informed decision, by reason of being unconscious or in a PVS or in a coma. A medical power of attorney is an instrument through which persons nominate representatives to make decisions

regarding their medical treatment at a point in time when the persons executing the instrument are unable to make informed decisions themselves. Clause 11 of the draft Treatment of Terminally-Ill Patients (Protection of Patients and Medical Practitioners) Bill, 2016 states that advance directives or medical power of attorney shall be void and of no effect and shall not be binding on any medical practitioner. This blanket ban, including the failure even to give some weight to advance directives while making a decision about the withholding or withdrawal of life-sustaining treatment is disproportionate. It does not constitute a fair, just or reasonable procedure, which is a requirement for the imposition of a restriction on the right to life (in this case, expressed as the right to die with dignity) under Article 21.

131) At this juncture, we may again reiterate that on the one hand autonomy of an individual gives him right to choose his destiny and, therefore, he may decide before hand, in the form of advance directive, at what stage of his physical condition he would not like to have medical treatment, and on the other hand, there are dangers of misuse thereof as well. *David Feldman* explained the same in the following manner:

“...However, while it is undoubtedly a criminal act to do anything intending to hasten another person's death, there is no absolute duty on a doctor to try to save the life

of a patient, for two reasons.

The first is that any treatment is *prima facie* a trespass to the person, and if the patient is adult and competent to consent it will be unlawful without that consent. A doctor therefore acts lawfully – indeed, could not lawfully act otherwise – when he withholds treatment at the request of a terminally ill patient. This has been called passive, as distinct from active, euthanasia. To ensure that medical staff know of their wishes, some people have executed what are sometimes called ‘living wills’, giving directions to medical staff to withhold treatment in specified circumstances, and making their wishes known to anyone who might be appointed as their representative in the event that they become incapable for any reason. The efficacy of such prior indications was accepted, *obiter*, by Lord Goff in *Airedale NHS Trust v. Bland*, above. In such circumstances, the patient voluntarily accepts non-treatment while in a state to do so rationally. However, where there is the slightest doubt about the wishes of a patient, that patient should be treated, because the paternalism which decides for someone else when it is best to die is effectively denying them the opportunity to make the most of their lives as autonomous individuals. Furthermore, it would seem to be wrong in principle to put pressure to bear on a patient to elect to die. In those states of the USA where voluntary euthanasia is lawful, the ethical problems for patients, doctors, next of kin, and nursing staff are immense. Where the patient is not mentally competent to confirm the choice to die at the time when the choice is about to be given effect, it will also be impossible to know whether the choice expressed earlier was truly voluntary, whether the consent was informed, and whether or not the patients would want to reconsider were he able to do so. In the Netherlands, where it is lawful to practice voluntary euthanasia, it seems that the procedural safeguards designed to protect people against involuntary euthanasia are very hard to enforce and are regularly flouted.

Secondly, the doctrine of double effect allows the doctor to take steps which carry a substantial risk to life in order to treat, in good faith and with the patient's consent, some disease or symptom. This is essential, because virtually any treatment carries some risk to the patient. It is particularly relevant to the euthanasia issue in cases

where the primary object (e.g. pain control in terminal cancer treatment) can only be achieved by administering drugs at a level which is likely to shorten life, but enhances the quality of life while it lasts. A trade-off between length of life and quality of life is permissible.”

132) At the same time, possibility of misuse cannot be held to be a valid ground for rejecting advance directive, as opined by the Law Commission of India as well in its 196th and 241st Report. Instead, attempt can be made to provide safeguards for exercise of such advance directive. For example, Section 5 of the Mental Healthcare Act, 2017 recognises the validity of advance directives for the treatment of mental illness under the Mental Healthcare Act, 2017. The draft Mental Healthcare Regulations have recently been made available for public comment by the Ministry of Health and Family Welfare. These prescribe the form in which advance directives may be made. Part II, Chapter 1 of the Regulations allow a Nominated Representative to be named in the Advance Directive. An advance directive is to be in writing and signed by two witnesses attesting to the fact that the Directive was executed in their presence. A Directive to be registered with the Mental Health Review Board. It may be changed as many times as desired by the person executing it and the treating mental health professional must be informed of such change. Similarly, Section 3 of the Transplantation of Human

Organs and Tissues Act, 1994 allows persons to authorise the removal of human organs and tissues from their body before death. The form in which this authorisation is to be made is prescribed in Form 7 of the Transplantation of Human Organs and Tissues Rules, 2014. This is also to be in writing and in the presence of two witnesses. A copy of the pledge is to be retained at the institution where the pledge is made and the person making the pledge has the option to withdraw the pledge at any time. Where such authorisation had been made, the person lawfully in charge of the donor's body after his death is required to grant the concerned medical practitioner all reasonable facilities for the removal of human organs or tissues, unless such person has reason to believe that the donor had substantially revoked his authority.

- 133) Mr. Datar, learned counsel appearing for the intervenor, has also brought to our notice various safeguards for advance directive provided in other jurisdiction in many ways i.e. by prescribing the form that the directive must take, by specifying who may act as witnesses, by allowing the possibility of amendment and by allowing the validity of the directive to be challenged. Some of these examples are as follows:

(a) In U.K., under Section 24 of the Mental Capacity Act, 2005, a person above the age of 18 years who has capacity may execute an advance directive. A person is said to lack capacity if in relation to a matter at the material time, he is unable to make a decision for himself because of an impairment of or disturbance in the functioning of the mind or brain. In Netherlands, under Article 2 of the Termination of Life on Request and Assisted Suicide (Review Procedures) Act, patients aged 16 or above may make advance directives. In Germany, the authorisation of the court is required for the termination of treatment in the case of minors. In Switzerland, persons with mental illnesses are considered exceptions and cannot discontinue medical treatment if it is an expression or symptom of their mental illness. In Hungary, pregnant women may not refuse treatment if it is seen that they are able to carry the pregnancy.

(b) Section 25 of the Mental Capacity Act, an advance decision to refuse life-sustaining treatment must be in writing. It must be signed by the patient or someone on his behalf and signed by a witness. It must also include a written statement by the patient that the decision will apply to the specific treatment even if the patient's life is at risk. Under Article 7: 450 of the Dutch Civil Code, an advance directive should be in written form, dated and

signed to be valid. Section 110Q of the Western Australia Guardianship and Administration Act, 1990 requires advance directives to be signed in the presence of two witnesses, who must both be at least 18 years of age and one of whom must be a person authorised to witness legal documents under the relevant law. Section 15 of the South Australia Advance Directives Act, 2013 sets out requirements for 'suitable' witnesses under the Act. A person may not be a witness if she is appointed as a substitute decision-maker under the advance directive, has a direct or indirect interest in the estate of the person executing the advance directive or is a health practitioner responsible for the health care of the person executing the advance directive. Similar disqualifications for witnesses are prescribed in the Oregon Death with Dignity Act, 2002 when a person makes a written request for medication for the purpose of ending her life in a humane and dignified manner.

(c) Under Section 24(3) of the UK Mental Capacity Act, 2005, a person may alter or withdraw an advance decision at any time he has the capacity to do so. Under Section 25(2)(c), an advance decision will not be applicable if a person has done anything else clearly inconsistent with the advance decision. Under Section 3.06 of the Oregon Death with Dignity Act, 2005, a person may

rescind her written request for medicating at any time regardless of her mental state. To allow for a change of mind, Section 3.08 also requires at least 15 days to lapse between the patient's initial oral request and the writing of a prescription, while a minimum of 48 hours must elapse between the patient's written request and the writing of a prescription. Under Section 110S of the Western Australia Guardianship and Administration Act, 1990, a treatment decision in an advance directive does not operate if circumstances exist or have arisen that the maker of that directive could not reasonably have anticipated at the time of making the directive and that would have caused a reasonable person in the maker's position to have changed her mind about the directive. While determining whether such circumstances have arisen, the age of the maker and the period that has elapsed between the time at which the directive was made and the circumstances that have arisen are factors that must be taken into account while determining the validity of the directive.

(d) Section 26(4) of the UK Mental Capacity Act permits courts to make a declaration as to whether the advance decision exists, is valid, and applicable to a treatment. Under Article 373 of the Swiss Civil Code, 'any person closely related to the patient can contact the adult protection authority in writing and claim that...

the patient decree is not based on the patient's free will.' Under Section 110V, 110W, 110X, 110Y and 110Z of the Western Australia Guardianship and Administration Act, 1990, any person who has a 'proper interest' in the matter, in the view of the State Administrative Tribunal, may apply to it for a declaration with respect to the validity of an advance directive. It can also interpret the terms of the directive, give directions to give effect to it or revoke a treatment decision in the directive.

134) Mr. Datar has suggested that this Court should frame the guidelines to cover the following aspects:

- (a) Who will be competent to execute an advance directive?
- (b) In what form will an advance directive have to be issued in order to be valid?
- (c) Who is to ensure that an advance directive is properly obeyed?
- (d) What legal consequences follow from the non-obedience to an advance directive?
- (e) In what circumstances can a doctor refuse to enforce an advance directive?

135) He has given the following suggestions on the aforesaid aspects:

- (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 directives 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 or 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 (i.e. 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.

136) All these suggestions and various aspects of advance directives have been elaborately considered and detailed directions are given by the Hon'ble the Chief Justice in his judgment, with which

I duly concur. In summation, I say that this Court has, with utmost sincerity, summoned all its instincts for legality, fairness and reasonableness in giving a suitable answer to the vexed issue that confronts the people on daily basis, keeping in mind the competing interests and balancing those interests. It will help lead society towards an informed, intelligent and just solution to the problem.

137) My last remarks are a pious hope that the Legislature would step in at the earliest and enact a comprehensive law on 'living will/advance directive' so that there is a proper statutory regime to govern various aspects and nuances thereof which also take care of the apprehensions that are expressed against euthanasia.

.....J.
(A.K. SIKRI)

**NEW DELHI;
MARCH 09, 2018.**