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THE
SUPREME COURT CASES

(2018) 5 SCC

(2018) 5 Supreme Court Cases 1

(BEFORE DIPAK MISRA, C.J. AND DR A.K. SIKRI, A.M. KHANWILKAR, DR D.Y. CHANDRACHUD AND ASHOK BHUSHAN, JJ.)

COMMON CAUSE (A REGISTERED SOCIETY) .. Petitioner;

Versus

UNION OF INDIA AND ANOTHER .. Respondents.

Writ Petition (C) No. 215 of 2005†, decided on March 9, 2018

A. **Constitution of India — Art. 21 — Euthanasia — Passive euthanasia — Patients who are terminally ill or in permanent vegetative state or brain dead state without any hope for revival — Smoothening natural process of dying of such patients by withholding or withdrawing life prolonging medical support or treatment in accordance with express or implied will of such patients i.e. voluntary and non-voluntary passive euthanasia, held, permissible — Such patients, if adult and while in conscious mind, can also execute living will in form of "Advance Directive" directing not to prolong their life by medical treatment — Procedure for effectuating voluntary and non-voluntary passive euthanasia, when (a) there is an Advance Directive; and (b) when there is no Advance Directive — Detailed Safeguards and Guidelines laid down, to be in force till legislation is enacted to cover the field (*see* Shortnote *T*, from p. 37 below) — Their right to live with dignity till end of their natural span of life without intervention of medical life-sustaining measures is based on right to life, liberty, human dignity and privacy inherent under Art. 21 of the Constitution, as also Common Law right of autonomy and self-determination and right to refuse medical treatment — Judgments in *Gian Kaur*, (1996) 2 SCC 648 and *Aruna Ramachandra Shanbaug*, (2011) 4 SCC 454 analysed, explained and commented upon — Human and Civil Rights — Right to Die/ Euthanasia — Common Law**

† Under Article 32 of the Constitution of India

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In *P. Rathinam*, (1994) 3 SCC 394, the writ petitioners had assailed the constitutional validity of Section 309 of the Penal Code, 1860 (IPC) contending that the same is violative of Articles 14 and 21 of the Constitution. The Supreme Court declared Section 309 IPC ultra vires and held that it deserved to be effaced from the statute book to humanise our penal laws. In *Gian Kaur*, (1996) 2 SCC 648, the appellants' conviction under Section 306 IPC was assailed on the ground of it being unconstitutional by relying upon *P. Rathinam case*. The Constitution Bench in *Gian Kaur case* considered the correctness of *P. Rathinam decision* and opined 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 and held that Section 306 is constitutional. 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 Ramachandra Shanbaug*, (2011) 4 SCC 454. 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. But after perusing the reports, and addressing the legal issues, namely, active and passive euthanasia, the Court rejected the prayer of the writ petitioner.

The aforesaid matter was decided when the present writ petition was pending for consideration. 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.

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 Additional Solicitor General on behalf of the Union of India. Reliance was placed on the decision in *Aruna Shanbaug case*. The three-Judge Bench reproduced paras 24 and 25 from *Gian Kaur case* 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. The three-

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Judge Bench expressed the view that the opinion of the House of Lords in *Airedale N.H.S. Trust*, 1993 AC 789 has not been approved in *Gian Kaur case* and to that extent, the observation in *Aruna Shanbaug case* is incorrect. After so stating, the three-Judge Bench opined that *Aruna Shanbaug case* 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 case* 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 the Supreme 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 the present Bench.

This Constitution Bench of the Supreme Court unanimously held that passive euthanasia is permissible and "Advance Directive" can be executed by the patient.

B. **Constitution of India — Art. 21 — Euthanasia — Meaning — Intentional premature termination of life of another person at his/her request to cause "good death"**

— Euthanasia — Types — Active, passive, voluntary, non-voluntary and involuntary

— Active euthanasia — Causing death of a person with his/her consent by direct medical intervention — Some positive act on part of person causing death necessary

— Passive euthanasia — Withholding or withdrawing life prolonging medical treatment in accordance with express or implied will of terminally ill, permanent vegetative state (PVS)/brain dead patient resulting in his/her death

— Voluntary euthanasia — Terminating life at request of patient — Request may be made prior to development of illness or during course of illness

— Non-voluntary euthanasia — Terminating life without patient's consent — It may be for patient's good on proxy request when not in position to express own views; an alternative to non-treatment

— Involuntary euthanasia — Terminating life against patient's will — Human and Civil Rights — Right to Die/Euthanasia

C. **Constitution of India — Art. 21 — Passive euthanasia — Complex issue — Requires consideration of moral, ethical, religious, philosophical, social, economic, penal and constitutional aspects**

— Passive euthanasia — Withholding or withdrawal of life prolonging medical support in accordance with express or implied will of patient who is terminally ill, in PVS or brain dead state and consequent acceleration of

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natural process of dying which has already commenced — Held, permissible — Distinction between active and passive euthanasia and withholding and withdrawal of medical treatment, considered — Human and Civil Rights — Right to Die/Euthanasia

D. **Constitution of India — Arts. 32 and 136 — Function of Supreme Court — To ascertain and build law — Court should not act as moral or ethical arbiter — But it should consider interest of disadvantaged and vulnerable people**

Held :

Per Dipak Misra, C.J. and Khanwilkar, J.

Euthanasia — Concept

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). (Para 46)

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. 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. 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. 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. (Paras 202.5, 202.6 and 178)

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 legalised passive euthanasia either by way of legislations or through judicial interpretation but there remains uncertainty whether active euthanasia should be granted legal status. (Para 52)

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. (Para 176)

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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 recognised 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. (Para 177)

There are philosophers, thinkers and also scientists who feel that life is not confined to the physical frame and biological characteristics. 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. (Para 179)

Aruna Shanbaug case has discussed about these two categories of euthanasia —active and passive. The main idea behind the distinction between the two, 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. (Paras 46 and 47)

Aruna Ramachandra Shanbaug v. *Union of India*, (2011) 4 SCC 454 : (2011) 2 SCC (Civ) 280 : (2011) 2 SCC (Cri) 294, *affirmed on this point*

The Court in *Aruna Shanbaug case* had 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 had 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. The Court further categorised passive euthanasia into voluntary passive euthanasia and non-voluntary passive euthanasia. The voluntary passive euthanasia has been described 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. (Paras 46 and 48)

Aruna Ramachandra Shanbaug v. *Union of India*, (2011) 4 SCC 454 : (2011) 2 SCC (Civ) 280 : (2011) 2 SCC (Cri) 294, *affirmed on this point*

Airedale N.H.S. Trust v. *Bland*, 1993 AC 789 : (1993) 2 WLR 316 : (1993) 1 All ER 821 (CA & HL); *Vacco* v. *Quill*, 1997 SCC OnLine US SC 80 : 138 L Ed 2d 834 : 521 US 793 (1997); *Rodriguez* v. *Attorney General of Canada*, 1993 SCC OnLine Can SC 97 : (1993) 3 SCR 519 : 85 CCC 3d 15; *Conroy, In re*, 98 NJ 321 : 486 A 2d 1209 (NJ 1985), *considered*

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After the judgment of *Aruna Shanbaug case* was delivered, the Law Commission of India submitted its 241st Report which dealt with "Passive Euthanasia — A Relook". 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 right of self-determination on a higher pedestal. (Paras 127 and 131)

Airedale N.H.S. Trust v. *Bland*, 1993 AC 789 : (1993) 2 WLR 316 : (1993) 1 All ER 821 (CA & HL); *F. (Mental Patient: Sterilisation), In re*, (1990) 2 AC 1 : (1989) 2 WLR 1025 : (1989) 2 All ER 545 (HL); *R. (Pretty)* v. *Director of Public Prosecutions*, (2002) 1 AC 800 : (2001) 3 WLR 1598 : (2002) 1 All ER 1 : 2001 UKHL 61 (HL); *B. (Consent to Treatment: Capacity), In re*, (2002) 1 FLR 1090 sub nom *B. (Adult: Refusal of Medical Treatment), In re*, (2002) 2 All ER 449; *R. (Nicklinson)* v. *Ministry of Justice*, 2015 AC 657 : (2014) 3 WLR 200 : 2014 UKSC 38; *Cruzan* v. *Missouri Department of Health*, 1990 SCC OnLine US SC 123 : 111 L Ed 2d 224 : 110 S Ct 2841 : 497 US 261 (1990); *Vacco* v. *Quill*, 1997 SCC OnLine US SC 80 : 138 L Ed 2d 834 : 521 US 793 (1997); *Hunter and New England Area Health Service* v. *A.*, 2009 NSWSC 761; *Brightwater Care Group (Inc.)* v. *Rossiter*, 2009 WASC 229 : 40 WAR 84; *Australian Capital Territory* v. *JT*, 2009 ACTSC 105; *Vikas Yadav* v. *State of U.P.*, (2016) 9 SCC 541 : (2016) 3 SCC (Cri) 621, *considered*

Bolam v. *Friern Hospital Management Committee*, (1957) 1 WLR 582 : (1957) 2 All ER 118 (QB); *Quinlan, In re*, 355 A 2d 647 : 70 NJ 10 (NJ 1976); *Garger* v. *New Jersey*, 429 US 922 (1976); *Supt. of Belchertown State School* v. *Saikewicz*, 373 Mass 728 : 370 NE 2d 417 (1977); *B. (A Minor) (Wardship: Medical Treatment), In re*, (1981) 1 WLR 1421 : (1990) 3 All ER 927 (CA); *J. (A Minor) (Wardship: Medical Treatment), In re*, 1991 Fam 33 (CA) : (1991) 2 WLR 140 : (1990) 3 All ER 930; *Pretty* v. *United Kingdom*, (2002) 35 EHRR 1 : 2002 ECHR 423; *Haas* v. *Switzerland*, (2011) 53 EHRR 33 : 2011 ECHR 2422; *Quill* v. *Vacco*, 80 F 3d 716 (2d Cir 1996); *Auckland Area Health Board* v. *Attorney General*, (1993) 1 NZLR 235 (HC); *Messiha* v. *South East Health*, 2004 NSWSC 1061; *Brightwater Care Group (Inc.)* v. *Rossiter*, 2009 WASC 229 : 40 WAR 84; *Australian Capital Territory* v. *JT*, 2009 ACTSC 105, *cited*

In *Aruna Shanbaug case* at para 101 the two-Judge Bench noted that *Gian Kaur case* has approved the decision of the House of Lords in *Airedale case* and observed that euthanasia could be made lawful only by legislation. This perception is not correct. The Constitution Bench of the Supreme Court in *Gian Kaur case* has not 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. 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. 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. (Paras 45, 44.2, 44.3, 202.3 and 202.4)

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A careful and precise perusal of the judgment in *Gian Kaur 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. This is how the pronouncement in *Gian Kaur case* has to be understood. It is also not the ratio of the authority in *Gian Kaur case* that euthanasia has to be introduced only by a legislation. What has been stated in para 41 of *Gian Kaur case* is what has been understood to have been held in *Airedale case*. The Court has neither expressed any independent opinion nor has it approved the said part or the ratio as stated in *Airedale case*. There has been only a reference to *Airedale case* and the view expressed therein as regards legislation. Therefore, the perception in *Aruna Shanbaug case* that the Constitution Bench has approved the decision in *Airedale case* is not correct. It is also quite clear that *Gian Kaur case* 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 and it cannot thus be treated as a binding precedent for the purpose of laying down the principle that passive euthanasia can be made lawful "only by legislation". *Gian Kaur case* 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. However, the view of *Aruna Shanbaug case* that euthanasia could be made lawful only by legislation, which has not been accepted by the referral Bench, makes no difference to the present analysis. (Paras 44.4, 45, 202.1 and 202.2)

Gian Kaur v. *State of Punjab*, (1996) 2 SCC 648 : 1996 SCC (Cri) 374, *explained*

Aruna Ramachandra Shanbaug v. *Union of India*, (2011) 4 SCC 454 : (2011) 2 SCC (Civ) 280 : (2011) 2 SCC (Cri) 294, *overruled on this point*

Airedale N.H.S. Trust v. *Bland*, 1993 AC 789 : (1993) 2 WLR 316 : (1993) 1 All ER 821 (CA & HL), *referred to*

Compassion in Dying v. *Washington*, 49 F 3d 586 (9th Cir 1995); *Compassion in Dying* v. *Washington*, 850 F Supp 1454 (WD Wash 1994); *R.* v. *Cox*, 18-9-1992 (unreported); *Vikram Deo Singh Tomar* v. *State of Bihar*, 1988 Supp SCC 734 : 1989 SCC (Cri) 66; *J. (A Minor) (Wardship: Medical Treatment), In re*, 1991 Fam 33 (CA) : (1991) 2 WLR 140 : (1990) 3 All ER 930; *Washington* v. *Glucksberg*, 1997 SCC OnLine US SC 79 : 138 L Ed 2d 772 : 521 US 702 (1997); *Vacco* v. *Quill*, 1997 SCC OnLine US SC 80 : 138 L Ed 2d 834 : 521 US 793 (1997); *Charan Lal Sahu* v. *Union of India*, (1990) 1 SCC 613; *State of Kerala* v. *N.M. Thomas*, (1976) 2 SCC 310 : 1976 SCC (L&S) 227; *Common Cause* v. *Union of India*, (2014) 5 SCC 338 : (2014) 2 SCC (Cri) 557, *cited*

Per Sikri, J. (concurring)

The word euthanasia 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. 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*. 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

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brought to an end. In this thought process, the basic Greek ideology that it signifies "*an easy and gentle death*" still remains valid. (Paras 216 and 217)

Michael Manning: *Euthanasia and Physician-Assisted Suicide* (Paulist Press, 1998), *referred to*

In common parlance euthanasia can be of three types, namely, voluntary, non-voluntary and involuntary euthanasia. The terms can be described as under:

Voluntary euthanasia—People concerned to legalise 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. 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). (Para 218.1)

Non-voluntary euthanasia—Seen by some as subvariety 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 that his/her life be ended. This form of euthanasia is that which most intimately concerns the medical profession. Selective non-treatment of the newborn 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. (Para 218.2)

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 from 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 death. (Para 218.3)

"Euthanasia and Its Legality and Legitimacy from Indian and International Human Right Instruments Perspectives" in *Human Rights & Social Justice* by Muzafer Assadi, *referred to*

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 undertaken by the patient himself. Active euthanasia is not permissible in most countries. (Para 219)

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

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practitioner is not treated as the cause of death; instead, the patient is understood to have died because of his underlying condition. (Para 219)

In *Aruna Ramachandra Shanbaug case*, 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 case*. Therefore, without going into further debate on differential that is assigned to the term "euthanasia", ethically, philosophically, medically, etc., discussion should be confined 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. (Para 220)

Gian Kaur v. *State of Punjab*, (1996) 2 SCC 648 : 1996 SCC (Cri) 374, *relied on*

Aruna Ramachandra Shanbaug v. *Union of India*, (2011) 4 SCC 454 : (2011) 2 SCC (Civ) 280 : (2011) 2 SCC (Cri) 294, *affirmed on this point*

Per Chandrachud, J. (concurring)

Central to the debate are notions such as "involuntary", "non-voluntary" and "voluntary". Also "active" and "passive" are used, particularly in combination with "voluntary" euthanasia. In general, the following might be said:

(*i*) involuntary euthanasia refers to the termination of life against the will of the person killed;

(*ii*) non-voluntary euthanasia refers to the termination of life without the consent or opposition of the person killed;

(*iii*) voluntary euthanasia refers to the termination of life at the request of the person killed;

(*iv*) active euthanasia refers to a positive contribution to the acceleration of death;

(*v*) passive euthanasia refers to the omission of steps which might otherwise sustain life. (Para 384)

What is relatively straightforward is that involuntary euthanasia is illegal and amounts to murder. However, the boundaries between active and passive euthanasia are blurred since it is quite possible to argue that an omission amounts to a positive act. (Para 384)

Consent postulates that the individual is in a mental condition which enables her to choose and to decide on a course of action and convey this decision. Its voluntary nature is premised on its consensual character. Euthanasia becomes non-voluntary where the individual has lost those faculties of mind which enable her to freely decide on the course of action or lost the ability to communicate the chosen course of action. (Para 385)

Passive euthanasia—whether in the form of withholding or withdrawing treatment—has the effect of removing, or as the case may be, not providing supportive treatment. Its effect is to allow the individual to continue to exist until the end of the natural span of life. On the other hand, active euthanasia involves hastening of death: the lifespan of the individual is curtailed by a specific act

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designed to bring an end to life. Active euthanasia would on the state of the penal law as it stands constitute an offence. Hence, it is only Parliament which can in its legislative wisdom decide whether active euthanasia should be permitted. Passive euthanasia on the other hand would not implicate a criminal offence since the decision to withhold or withdraw artificial life support after taking into account the best interest of the patient would not constitute an illegal omission prohibited by law. (Para 450)

R. (Conway) v. *Secy. of State for Justice*, (2018) 2 WLR 322 : 2017 EWHC 2447 (Admin), *considered*

R. (Countryside Alliance) v. *Attorney General*, 2008 AC 719 : (2007) 3 WLR 922 (HL); *AXA General Insurance Ltd.* v. *HM Advocate*, (2012) 1 AC 868 : (2011) 3 WLR 871 (SC), *cited*

The distinctions between active and passive euthanasia are based on the manner in which death is brought about. They closely relate to the understanding and consequences of the legal concepts of act and omission. The expression "passive" has been used to denote the withdrawal or withholding of medical treatment. Implicit in this definition is the assumption that both the withdrawal of or withholding treatment stand on the same ethical or moral platform. There is a qualitative difference between a positive medical intervention (such as a lethal injection) which terminates life and a decision to not put a patient on artificial life support, which will not artificially prolong life. The former brings a premature extinction of life. The latter does not delay the end of life beyond its natural end point. Even though euthanasia is grounded in compassion and to relieve the patient of suffering, only certain types of deaths can be lawful. If active euthanasia amounts to "killing", the operation of criminal law can lead to medical practitioners being exposed to the indignity of criminal prosecutions and punishments. While passive euthanasia can appear to save the dignity of medical practitioners, it is perhaps at the expense of the patient's dignity. (Paras 385, 386, 388 and 390)

Hazel Biggs: "Euthanasia, Death with Dignity and the Law" (Hart Publishing, 2001), at pp. 12, 162; James Rachels: "Active and Passive Euthanasia", New England Journal of Medicine (9-1-1975), at pp. 78-80; James Rachels: *End of Life: Euthanasia and Morality* (Oxford University Press, 1986); Bruce R. Reichenbach: "Euthanasia and the Active-Passive Distinction", *Bioethics* (January 1987), Vol. 1, at pp. 51-73; James Rachels: *End of Life: Euthanasia and Morality* (Oxford University Press, 1986), at pp. 101-20; Len Doyal and Lesley Doyal: "Why Active Euthanasia and Physician-Assisted Suicide should be Legalised if Death is in a Patient's Best Interest Then Death Constitutes a Moral Good", British Medical Journal (2001), at pp. 1079-80; Rohini Shukla: "Passive Euthanasia in India: A Critique", Indian Journal of Medical Ethics (Jan-Mar 2016), pp. 35-38; Aparna Chandra and Mrinal Satish: "Misadventures of the Supreme Court in *Aruna Shanbaug* v. *Union of India*", *Law and Other Things* (13-3-2011) <http://lawandotherthings.com/2011/03/misadventures-of-supreme-court-in-aruna/>; Ratna Kapur: "The Spectre of Aruna Shanbaug", *The Wire* (18-5-2015) <https://thewire.in/2005/the-spectre-of-aruna-shanbaug/>, *referred to*

But, if the decision to proceed with euthanasia is the right one based on compassion and the humanitarian impulse to reduce pain and suffering, then the method used is not in itself important. Moreover, it is argued that passive euthanasia often involves more suffering since simply withholding treatment means that the patient may take longer to die and thus suffer more. Passive euthanasia may become questionable where the withholding or withdrawal of medical intervention may lead to a condition of pain and suffering, often a lingering and cruel death. The avoidance of suffering, which is the object and purpose of euthanasia, may hence

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not be the result of passive euthanasia and the converse may result. Besides raising troubling moral questions—especially where it is non-voluntary, it questions the efficacy of passive euthanasia. Moreover, it raises a troubling issue of the validity of the active-passive divide. (Paras 388 and 450)

Aruna Shanbaug judgment has been criticised in an article by Rohini Shukla in Indian Journal of Medical Ethics (2016) on the ground that it does not distinguish between the terms "withholding and withdrawing and uses them interchangeably". Throughout the above judgment, the words "withholding" and "withdrawing" are used interchangeably. However, the difference between the two is relevant to the distinction between what is "active" and "passive" as act and omission. Withholding life support implies that crucial medical intervention is restrained or is not provided—an act of omission on the part of the doctor. Withdrawing life support implies suspending medical intervention that was already in use to sustain the patient's life—an act of commission. If the basis of distinction between active and passive euthanasia is that in passive euthanasia the doctor only passively commits acts of omission, while in active euthanasia the doctor commits acts of commission then withdrawing medical treatment is an act of commission and therefore amounts to active euthanasia. In both these cases, the doctor is aware that his/her commissions or omissions will in all likelihood lead to the patient's death. However, in passive euthanasia death may not be the only consequence and the suffering that passive euthanasia often entails such as suffocation to death or starvation till death, raises the question of whether passive euthanasia, in such circumstances, militates against the idea of death with dignity—the very basis of legalising euthanasia. Shukla's criticism needs careful attention since it raises profound questions about the doctor-patient relationship and the efficacy of the distinction in the context of death with dignity. Where there is a duty to care, the distinction between an act and an omission may have questionable relevance. Acts and omissions are not disjunctive or isolated events. Treatment of the human body involves a continuous association between the caregiver and receiver. The expert caregiver is involved in a continuous process where medical knowledge and the condition of the patient as well as the circumstances require the doctor to evaluate choices—choices on the nature and extent of medical intervention, the wisdom about a course of action and about what should or should not be done. If the divide between active-passive is questioned, should both forms be disallowed or, in converse should both be allowed? More significantly, are both equally amenable to judicially manageable standards? (Paras 391 and 392)

Since the judgment legalised passive euthanasia, withdrawing medical support was the only option in *Aruna Shanbaug case* and if this had been done, she would have in all likelihood suffocated to death. Question is whether this could be the best possible death in consonance with the right to live with dignity (which extends to dignity when death approaches) and the extent to which it upholds the principle of prioritising the patient's autonomy and dignity over mere prolongation of life. Had the Court taken into account these consequences of passive euthanasia for the patient, it would be apparent that passive euthanasia is not a simple panacea for an individual faced with end of life suffering. (Para 394)

Aruna Ramachandra Shanbaug v. *Union of India*, (2011) 4 SCC 454 : (2011) 2 SCC (Civ) 280 : (2011) 2 SCC (Cri) 294, *disapproved on this point*

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The second and more critical flaw in *Aruna Shanbaug* judgment was the unjustified emphasis on doctor's agency in administering different types of euthanasia which led to ignoring the patient's autonomy and suffering. Respecting patient autonomy and reducing suffering are fundamental ethical values ascribed to euthanasia. It is also the foremost principle of bioethics. The effects of euthanasia on everyone (particularly her caregivers) were given greater importance than the patient's own wishes. (Para 395)

Aruna Ramachandra Shanbaug v. *Union of India*, (2011) 4 SCC 454 : (2011) 2 SCC (Civ) 280 : (2011) 2 SCC (Cri) 294, *disapproved on this point*

Roop Gurusahani and Raj Kumar Mani: "India: Not a Country to Die in", Indian Journal of Medical Ethics (Jan-Mar 2016), at pp. 30-35, *referred to*

Even while there are pertinent questions regarding the moral validity of the active-passive distinction, there appears to be a significant difference between active and passive euthanasia when viewed from the lens of the patient's consent. Consent gives an individual the ability to choose whether or not to accept the treatment that is offered. But consent does not confer on a patient the right to demand that a particular form of treatment be administered, even in the quest for death with dignity. Voluntary passive euthanasia, where death results from selective non-treatment because consent is withheld, is therefore legally permissible while voluntary active euthanasia is prohibited. Moreover, passive euthanasia is conceived with a purpose of not prolonging the life of the patient by artificial medical intervention. Both in the case of a withdrawal of artificial support as well as in non-intervention, passive euthanasia allows for life to ebb away and to end in the natural course. In contrast, active euthanasia results in the consequence of shortening life by a positive act of medical intervention. It is perhaps this distinction which necessitates legislative authorisation for active euthanasia, as differentiated from the passive. (Para 398)

The question of legality of these two forms of euthanasia has significant consequences. Death when it is according to the wishes and in the caregiver of the patient must be viewed as a moral good. The fact that active euthanasia is an illegal act (absent legislative authorisation) also prevents many professional and emotional carers from performing it even if they perceive it as a compassionate and otherwise appropriate response in line with the patient's wishes and caregiver, thereby prolonging the patient's suffering and indignity. These complex issues cannot be addressed when active euthanasia is not legalised and regulated. The meeting point between bioethics and law does not lie on a straight course. (Para 399)

The decision by a treating doctor to *withhold* or *withdraw* medical intervention in the case of a patient in the terminal stage of illness or in a persistently vegetative state or the like where artificial intervention will merely prolong the suffering and agony of the patient is protected by the law. Where the doctor has acted in such a case in the best interest of the patient and in bona fide discharge of the duty of care, the law will protect the reasonable exercise of a professional decision. (Para 521)

"The Dilemmas of Euthanasia", *Bio-Science* (August 1973), Vol. 23, No. 8, at p. 459; Margaret A. Somerville: "Legalising euthanasia: Why Now?", The Australian Quarterly (Spring 1996), Vol. 68, No. 3, at p. 1; Christopher N. Manning: "Live and Let Die: Physician-Assisted Suicide and the Right to Die", Harvard Journal of Law and Technology (1996), Vol. 9, No. 2, at p. 513; Alan Norrie: "Legal Form and Moral Judgement: Euthanasia and Assisted Suicide" in R.A. Duff, et al (ed), *The Structures of the Criminal Law* (Oxford

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University Press, 2011), at p. 134; Elizabeth Wicks: *The Right to Life and Conflicting Interests* (Oxford University Press, 2010), at p. 199; Elizabeth M. Andal Sorrentino: "The Right to Die?", Journal of Health and Human Resources Administration (Spring, 1986), Vol. 8, No. 4, p. 361; Atul Gawande: *Being Mortal: Medicine and What Matters in the End* (Hamish Hamilton, 2014), at p. 260; Henry Marsh: *Admissions: A Life in Brain Surgery*, (Weidenfeld & Nicolson, 2017), at pp. 265-66; Randy Pausch and Jeffrey Zaslow: *The Last Lecture*, (Hodder & Stoughton, 2008), at p. 17, *referred to*

The decision in *Aruna Shanbaug case* has proceeded on the hypothesis that the Constitution Bench in *Gian Kaur case* had "quoted with approval" the decision of the House of Lords in *Airedale case*. This hypothesis is incorrect. There was only a passing reference to the decision of the House of Lords. The decision in *Gian Kaur case* referred to the distinction made in *Airedale case* between cases in which a physician decides not to provide or to continue to provide treatment which would prolong life and cases in which a physician decides to actively bring an end to the life of the patient by administering a lethal drug. The Court in *Airedale case* observed that actively causing the death of the patient could be made lawful only by legislation. It was this aspect which was emphasised by the judgment in *Gian Kaur case*. Hence, the position adopted in *Aruna Shanbaug case*, that the Constitution Bench in *Gian Kaur case* quoted *Airedale case* with approval (as the basis of allowing passive euthanasia) is seriously problematic. (Para 376)

Ratna Kapur: "The Spectre of Aruna Shanbaug", *The Wire* (18-5-2015) <https://thewire.in/2005/the-spectre-of-aruna-shanbaug/>, *referred to*

Per Ashok Bhushan, J. (concurring)

Euthanasia is derived from the Greek word *euthanatos*; *eu* means well or good and *thanatos* means death. (Para 597)

In ancient Greek society, euthanasia as "good death" was associated with the drinking of "Hemlock". In last few centuries, euthanasia increasingly came to connote specific measures taken by physicians to hasten the death. The primary meaning, as has now been ascribed to the word is compassionate murder. In the last century, the thought has gained acceptance that euthanasia is to be distinguished from withdrawal of life saving treatments which may also result in death. Withdrawing medical treatment in a way hasten the death in case of terminal illness or persistent vegetative state (PVS) but is not to be treated as compassionate murder. Advancement in the medical science on account of which life can be prolonged by artificial devices are the developments of only last century. (Para 599)

Airedale N.H.S. Trust v. *Bland*, 1993 AC 789 : (1993) 2 WLR 316 : (1993) 1 All ER 821 (CA & HL), *relied on*

The withdrawal of medical treatment of terminally ill persons is a complex ethical, moral and social issue with which many countries have wrestled with their attempt to introduce a legal framework for end of life decision-making. In absence of a comprehensive legal framework on the subject the issue has to be dealt with great caution. (Para 557)

The act of withdrawal from live-saving devices is an independent right which can lawfully be exercised by informed decision. Withdrawal of medical assistance or withdrawal of medical devices which artificially prolong the life cannot be regarded as an act to achieve a good death. Artificial devices to prolong the life are implanted, when a person is likely to die due to different causes in his body.

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Lifesaving treatment and devices are put by physicians to prolong the life of a person. (Paras 609 and 603)

Withdrawal of life-saving devices, leads to natural death which is arrested for the time being due to above device and the act of withdrawal put the life on the natural track. Decision to withdraw life-saving devices is not an act to cause good death of the person rather, decision to withdraw or not to initiate life-supporting measures is a decision when treatment becomes futile and unnecessary. Practice of euthanasia in this country is prohibited and for medical practitioners it is already ordained to be unethical conduct. (Para 606)

K.S. Puttaswamy v. *Union of India*, (2017) 10 SCC 1, *relied on*

A critically ill patient who is mentally competent to take a decision, decides not to take support of life prolonging measures, and respecting his wisdom if he is not put on such devices like ventilator, etc. it is not at all euthanasia. Large number of persons in advance age of life decide not to take medical treatment and embrace death in its natural way; their death cannot be termed as euthanasia. The decision not to take lifesaving medical treatment by a patient, who is competent to express his opinion cannot be termed as euthanasia, but a decision to withdraw lifesaving treatment by a patient who is competent to take decision as well as with regard to a patient who is not competent to take decision can be termed as passive euthanasia. On the strength of the precedents in this country and weight of precedents of other countries, such action of withdrawing lifesaving device is legal. Thus, such acts, which are commonly expressed as passive euthanasia is lawful and legally permissible in this country. (Para 607)

Court is not a legislative body nor is entitled or competent to act as a moral or ethical arbiter. The task of the Supreme Court is not to weigh or evaluate or reflect different beliefs and views or give effect to its own but to ascertain and build the law of land as it is now understood by all. Message which need to be sent to vulnerable and disadvantaged people should not, however, obliviously to encourage them to seek death but should assure them of care and support in life. (Para 608)

Nancy B. v. *Hotel Dieu de Quebec*, (1992) 86 DLR (4th) 385 (Que SC); *T. (Adult: Refusal of Treatment), In re*, 1993 Fam 95 : (1992) 3 WLR 782 : (1992) 4 All ER 649 (CA); *B. (Adult: Refusal of Medical Treatment), In re*, (2002) 2 All ER 449; *S.* v. *McC. (Orse. S.) and M. (D.S. Intervener)*, 1972 AC 24 : (1970) 3 WLR 366 (HL); *R. (Pretty)* v. *Director of Public Prosecutions*, (2002) 1 AC 800 : (2001) 3 WLR 1598 : (2002) 1 All ER 1 : 2001 UKHL 61 (HL); *Schloendorff* v. *Society of New York Hospital*, 105 NE 92 : 211 NY 125 (1914); *Cruzan* v. *Missouri Department of Health*, 1990 SCC OnLine US SC 123 : 111 L Ed 2d 224 : 110 S Ct 2841 : 497 US 261 (1990); *Compassion in Dying* v. *Washington*, 79 F 3d 790 (1996); *Vacco* v. *Quill*, 1997 SCC OnLine US SC 80 : 138 L Ed 2d 834 : 521 US 793 (1997); *Washington* v. *Glucksberg*, 1997 SCC OnLine US SC 79 : 138 L Ed 2d 772 : 521 US 702 (1997); *Rodriguez* v. *Attorney General of Canada*, 1993 SCC OnLine Can SC 97 : (1993) 3 SCR 519 : 85 CCC 3d 15; *Gian Kaur* v. *State of Punjab*, (1996) 2 SCC 648 : 1996 SCC (Cri) 374, *referred to*

Pratt v. *Davis*, 224 Ill 300 : 79 NE 562 (1906); *Mohr* v. *Williams*, 95 Minn 261 : 104 NW 12 (1905); *Union Pacific Rly. Co.* v. *Botsford*, 1891 SCC OnLine US SC 217 : 35 L Ed 734 : 11 S Ct 1000 : 141 US 250 (1891); *Conroy, In re*, 98 NJ 321 : 486 A 2d 1209 (NJ 1985); *Quill* v. *Vacco*, 80 F 3d 716 (2d Cir 1996); *Stanford* v. *Kentucky*, 1989 SCC OnLine US SC 151 : 106 L Ed 2d 306 : 109 S Ct 2969 : 492 US 361 (1989), *cited*

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E. **Constitution of India — Art. 21 — Constitutional value of euthanasia — Considered having regard to theological, philosophical and constitutional models**

— Life, liberty and dignity — Human dignity in euthanasia — Though right to life does not include right to die (*Gian Kaur case*), but right to live with dignity protected under Art. 21 includes right to live with dignity up to end of natural life by smoothening process of dying — Dignity in death has a sense of realism that permeates right to life — Right to dignity is neither lost in process of dying nor when death occurs — Individual cannot be deprived of his/her dignity till end of his/her life — Right to die with dignity being legal, neither morality, not doctor's dilemma, nor patient's fear will have any place — There is constitutional expectation of providing dignity in death which is protected under Art. 21 and is enforceable against the State

— Life, liberty and dignity — Human dignity is an inextricable facet of right to life — It is intrinsic in preserving sanctity and quality of life — Liberty, autonomy and self-determination are its essential attributes

— Life and liberty — Connotation and amplitude — Both are interlinked concepts — Together they constitute right of core significance

— Liberty — Of personal sovereignty over body and mind falls under Art. 21

— Life and natural death — Life is not mere biological existence — It relates to quality of life — Prolongation of life by means of modern medical technology of a patient who is terminally ill, in PVS or brain dead state — In certain circumstances it renders life to mere biological existence — Thus notion of life is reshaped

— Right to privacy — It is constitutional core of dignity — Comprehends right to take decisions relating to own bodily integrity and death by refusing medical treatment — Every person has a right to make essential choices which affect course of life — Patient's right to refuse life prolonging medical treatment or terminate his/her life, is a freedom which falls within ambit of privacy — Continuing treatment against wishes of patient violative of his/her bodily privacy — Patient must have freedom to decide whether to continue living when quality of life deteriorates

— Right to health — A facet of Art. 21

— Sanctity of life — Meaning and limits — Concepts of sacred value and inviolability of human life considered in context of religion, morality and ethics, as also right to life, autonomy and quality of life — Quality of life needs to be protected — When a person is only alive in most rudimentary sense without having any capacity to experience pleasure or pain, life loses its value — Rule against killing applies where person has life in qualitative sense not where person living merely in vegetative sense — Human and Civil Rights — Right to Die/Euthanasia

F. **Constitution of India — Pt. III — Fundamental Rights — Liberal, dynamic and expansive interpretation needed**

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G. **Jurisprudence — Law and morality — Normally moral basis of law is not required to be examined by court in its interpretative process — But moral aspect gains significance when some legal norms are jurisprudentially expounded by courts or developed as common law principles — Common Law**

Held :

Per Dipak Misra, C.J. and Khanwilkar, J.

Life and liberty

Under Article 21 of the Constitution word "liberty" is the sense and realisation 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. (Para 142)

The language employed in the constitutional provision should be liberally construed, for such provision can never remain static. It is because staticity would mar the core which is not the intent. 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. The word "liberty" is the sense and realisation 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. (Paras 153, 149 and 142)

There is no doubt that no fundamental right is absolute, but any restraint imposed on liberty has to be reasonable. 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 the conception of liberty is intended to be understood when it is read in association with the term "life" as used in Article 21 of the Constitution. Life as envisaged under Article 21 has been very broadly understood by the Supreme Court. (Paras 142, 144 and 145)

The fundamental rights in their connotative expanse are bound to engulf certain rights which really flow from the same. 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. There is a danger in discouraging free thinking and curtailing the power of imagination. (Paras 151 and 143)

Adkins v. *Children's Hospital of the District of Columbia*, 1923 SCC OnLine US SC 105 : 67 L Ed 785 : 261 US 525 (1923); *Maneka Gandhi* v. *Union of India*, (1978) 1 SCC 248; *M. Nagaraj* v. *Union of India*, (2006) 8 SCC 212 : (2007) 1 SCC (L&S) 1013, *relied on*

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Port of Bombay v. *Dilipkumar Raghavendranath Nadkarni*, (1983) 1 SCC 124 : 1983 SCC (L&S) 61; *State of A.P.* v. *Challa Ramkrishna Reddy*, (2000) 5 SCC 712; *Central Inland Water Transport Corpn. Ltd.* v. *Brojo Nath Ganguly*, (1986) 3 SCC 156 : 1986 SCC (L&S) 429; *V.C. Rangadurai* v. *D. Gopalan*, (1979) 1 SCC 308, *affirmed on this point*

P. Rathinam v. *Union of India*, (1994) 3 SCC 394 : 1994 SCC (Cri) 740; *State of H.P.* v. *Umed Ram Sharma*, (1986) 2 SCC 68; *Maruti Shripati Dubal* v. *State of Maharashtra*, 1986 SCC OnLine Bom 278 : 1987 Cri LJ 743 : (1986) 88 Bom LR 589; *Rustom Cowasjee Cooper* v. *Union of India*, (1970) 2 SCC 298; *Carter* v. *Attorney General of Canada*, 2015 SCC OnLine Can SC 1 : 2015 SCC 5, *referred to*

Earl of Oxford, In re, 1625 Jones, W. 97 : (1626) 82 ER 51 (HL), *cited*

Dignity

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, the Supreme 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. (Para 202.9)

The nine-Judge Bench of the Supreme Court in *Puttaswamy case* has reaffirmed that human dignity is a component of Article 21. 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 it deserves respect even when the person is dead and described as a "body". Dignity does not recognise 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 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. 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 needs consideration. 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, such a right would come within the ambit of Article 21 of the Constitution. (Paras 156, 160 and 166)

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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. (Para 202.10)

K.S. Puttaswamy v. *Union of India*, (2017) 10 SCC 1; *Christine Goodwin* v. *United Kingdom*, 2002 ECHR 588; *S.* v. *Makwanyane*, 1995 SCC OnLine ZACC 2 : (1995) 3 SA 391, *relied on*

Kharak Singh v. *State of U.P.*, (1964) 1 SCR 332 : AIR 1963 SC 1295 : (1963) 2 Cri LJ 329; *Gobind* v. *State of M.P.*, (1975) 2 SCC 148 : 1975 SCC (Cri) 468; *PUCL* v. *Union of India*, (1997) 1 SCC 301; *Cruzan* v. *Missouri Department of Health*, 1990 SCC OnLine US SC 123 : 111 L Ed 2d 224 : 110 S Ct 2841 : 497 US 261 (1990), *referred to*

In *Gian Kaur case* the Court 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 up to the end of natural life which would include the right to live a dignified life up to the point of death including the dignified procedure of death. 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. 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. (Paras 164 and 165)

Gian Kaur v. *State of Punjab*, (1996) 2 SCC 648 : 1996 SCC (Cri) 374, *relied on*

Mehmood Nayyar Azam v. *State of Chhattisgarh*, (2012) 8 SCC 1 : (2012) 4 SCC (Civ) 34 : (2012) 3 SCC (Cri) 733 : (2012) 2 SCC (L&S) 449; *Vikas Yadav* v. *State of U.P.*, (2016) 9 SCC 541 : (2016) 3 SCC (Cri) 621; *Francis Coralie Mullin* v. *State (UT of Delhi)*, (1981) 1 SCC 608 : 1981 SCC (Cri) 212; *National Legal Services Authority* v. *Union of India*, (2014) 5 SCC 438; *Shabnam* v. *Union of India*, (2015) 6 SCC 702 : (2015) 3 SCC (Cri) 355, *affirmed*

Vikas Yadav v. *State of U.P.*, 2015 SCC OnLine Del 7129, *held, affirmed on this point*

Sushila Rao: "India and Euthanasia: The Poignant Case of Aruna Shanbaug", Oxford Medical Law Review, Vol. 19, Issue 4 (1-12-2011), at pp. 646-656; "Humanization and Decriminalization of Attempt to Suicide", Law Commission of India (Report No. 210, 2008); Rajeev Ranjan, et al, "(De-) Criminalization of Attempted Suicide in India: A Review", Industrial Psychiatry Journal (2014), Vol. 23, Issue 1, at pp. 4-9; D. Benatar, "Should There be a Legal Right to Die?" *Current Oncology* (2010), Vol. 17, Issue 5, at pp. 2-3; Richard Delgado: "Euthanasia Reconsidered—The Choice of Death as an Aspect of the Right of Privacy", Arizona Law Review (1975), Vol. 17, at p. 474., *referred to*

Per Sikri, J. (concurring)

Life, liberty, dignity, privacy

Euthanasia is a complexed and complicated issue. Article 21 of the Constitution has been interpreted by the Court in most expansive terms, particularly when it comes to the meaning that is assigned to "right to life". Right to life has

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been treated as more than "mere animal existence". Article 21 recognises right to live with human dignity. The legal position which stands as of today is that right to life does not include right to die. 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*". (Paras 236, 238, 241 and 330)

Kharak Singh v. *State of U.P.*, (1964) 1 SCR 332 : AIR 1963 SC 1295 : (1963) 2 Cri LJ 329; *K.S. Puttaswamy* v. *Union of India*, (2017) 10 SCC 1; *Rustom Cavasjee Cooper* v. *Union of India*, (1970) 1 SCC 248; *Gian Kaur* v. *State of Punjab*, (1996) 2 SCC 648 : 1996 SCC (Cri) 374; *State* v. *Sanjay Kumar Bhatia*, 1985 SCC OnLine Del 134 : 1985 Cri LJ 931; *Maruti Shripati Dubal* v. *State of Maharashtra*, 1986 SCC OnLine Bom 278 : 1987 Cri LJ 743; *Chenna Jagadeeswar* v. *State of A.P.*, 1987 SCC OnLine AP 263 : 1988 Cri LJ 549; *P. Rathinam* v. *Union of India*, (1994) 3 SCC 394 : 1994 SCC (Cri) 740; *CESC Ltd.* v. *Subhash Chandra Bose*, (1992) 1 SCC 441 : 1992 SCC (L&S) 313; *Prem Shankar Shukla* v. *State (UT of Delhi)*, (1980) 3 SCC 526 : 1980 SCC (Cri) 815; *Francis Coralie Mullin* v. *State (UT of Delhi)*, (1981) 1 SCC 608 : 1981 SCC (Cri) 212; *Bandhua Mukti Morcha* v. *Union of India*, (1984) 3 SCC 161 : 1984 SCC (L&S) 389; *Khedat Mazdoor Chetna Sangath* v. *State of M.P.*, (1994) 6 SCC 260 : 1994 SCC (Cri) 1643; *M. Nagaraj* v. *Union of India*, (2006) 8 SCC 212 : (2007) 1 SCC (L&S) 1013; *Maharashtra University of Health Sciences* v. *Satchikitsa Prasarak Mandal*, (2010) 3 SCC 786 : (2010) 1 SCC (L&S) 894; *Selvi* v. *State of Karnataka*, (2010) 7 SCC 263 : (2010) 3 SCC (Cri) 1; *Mehmood Nayyar Azam* v. *State of Chhattisgarh*, (2012) 8 SCC 1 : (2012) 4 SCC (Civ) 34 : (2012) 3 SCC (Cri) 733 : (2012) 2 SCC (L&S) 449; *Shabnam* v. *Union of India*, (2015) 6 SCC 702 : (2015) 3 SCC (Cri) 355; *Jeeja Ghosh* v. *Union of India*, (2016) 7 SCC 761 : (2016) 3 SCC (Civ) 551, *referred to*

Ronald Dworkin: *Taking Rights Seriously* (A&C Black, 2013) 239; Ronald Dworkin: *Is Democracy Possible Here? Principles for a New Political Debate* (Princeton University Press, 2006); Harvard University Press, 2011; Kenneth W. Simons: "Dworkin's Two Principle of Dignity: An Unsatisfactory Non-consequentialist Account of Interpersonal Moral Duties", 90 Boston Law Rev. 715 (2010); Aharon Barak: *Human Dignity: The Constitutional Value and the Constitutional Right*, *referred to*

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. 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. (Para 269)

Sushila Rao: *Economic and Political Weekly*, Vol. 46, No. 18 (30-4-2011-6-5-2011), pp. 13-16; John Finnis: *Human Rights and Common Good: Collected Essays*, Vol. III; S.D. Sharma: *Administration of Justice in Ancient Bharat*, (1988); Toman E. Hill: "Humanity as an End in itself" (1980) 91 Ethics 84; Jeremy Waldron: "How Law Protects Dignity", *referred to*

In *K.S. Puttaswamy*, (2017) 10 SCC 1, 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.

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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. Chelameswar, J. in *K.S. Puttaswamy case*, observed: "Forced feeding of certain persons by the State raises concerns of privacy. An individual's right to refuse life prolonging medical treatment or terminate his life is another freedom which falls within the zone of privacy." Liberty by itself, which is a facet of Article 21 of the Constitution, duly recognised in *K.S. Puttaswamy case*, 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. (Paras 300 and 301)

K.S. Puttaswamy v. *Union of India*, (2017) 10 SCC 1, *relied on*

David Feldman: *Civil Liberties & Human Rights in England & Wales*; Arval A. Morris: "Voluntary Euthanasia", Washington Law Review (1970), Vol. 45, at p. 240, *referred to*

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? (Para 304)

National Legal Services Authority v. *Union of India*, (2014) 5 SCC 438, *affirmed*

Anuj Garg v. *Hotel Assn. of India*, (2008) 3 SCC 1, *cited*

Dignity is, thus, the core value of life and dying in dignity stands recognised in *Gian Kaur case*. It becomes a part of right of self-determination. Passive euthanasia and death with dignity are inextricably linked, which can be summed up with the following pointers: (Paras 308 and 311)

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; Today many patients insist on more than just a right to healthcare 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; A dreadful, painful death on a rational but incapacitated terminally-ill patient are an affront to human dignity. (Paras 311.1 to 311.3)

Gian Kaur v. *State of Punjab*, (1996) 2 SCC 648 : 1996 SCC (Cri) 374, *relied on*

A. Kolnai: "Dignity", in R.S. Dillon (Ed.) *Dignity, Character, and Self-Respect* (London, Routledge, 1995) 53-75, at pp. 55, 56; R.S. Downie: K.S. Calman, *Healthy Respect: Ethics in Health Care* (Oxford, Oxford University Press, 1994) at 51-53, *referred to*

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

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and dignity of hastening the process of death or the situation may be reversible, though chances thereof are far remote. (Para 312)

Dr R.R. Kishore: "End of Life Issues and the Moral Certainty : A Discovery through Hinduism" Eubios Journal of Asian and International Bioethics, Vol. 13(6), Nov. 2003 at pp. 210-13, *referred to*

While discussing a 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. Though western thinking is that the concept of human dignity has 2500 years' history, in many eastern civilisations including India human dignity as core human value was recognised thousands of years ago. (Para 260)

S.D. Sharma: *Administration of Justice in Ancient Bharat*, (1988); Thomas Aquinas (1225-1274): *Summa Theologia*, *referred to*

The issue is not purely a legal one. It has moral and philosophical overtones. It has even religious overtones. 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 contemplations. 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 views, though these two are not identical. (Paras 245 and 277)

Lochner v. *New York*, 1905 SCC OnLine US SC 100 : 49 L Ed 937 : 198 US 45 (1905), *referred to*

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. 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. 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. (Paras 256 and 259)

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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; John Keown: *Euthanasia, Ethics and Public Policy* (Cambridge: Cambridge University Press, 2002) p. 37; T.N. Madan: "Dying with Dignity" (1992) 35(4) *Social Science and Medicine* 425-32; T.N. Madan: "Living and Dying" in *Non-Renunciation: Themes and Interpretations of the Hindu Culture* (New Delhi, Oxford University Press, 1987); J. Parry: *Death and the Regeneration of Life* (Cambridge, Cambridge University Press, 1982); Justice Holmes: "The Path of the Law", 10 Harvard Law Review 457-78, at p. 459 (1897); Lon L. Fuller: "The Morality of Law" (Revised Edn.), Yale University Press, *referred to*

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 person concerned has a right to take his own life, which is God's creation, nor anybody else has this right. However, 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. (Para 274)

Per Chandrachud, J. (concurring)

Dignity

Under our Constitution, the inherent value which sanctifies life is the dignity of existence. Recognising human dignity is intrinsic to preserving the sanctity of life. Life is truly sanctified when it is lived with dignity. There exists a close relationship between dignity and the quality of life. For, it is only when life can be lived with a true sense of quality that the dignity of human existence is fully realised. Hence, there should be no antagonism between the sanctity of human life on the one hand and the dignity and quality of life on the other hand. Quality of life ensures dignity of living and dignity is but a process in realising the sanctity of life. (Para 437)

The right to a dignified existence, the liberty to make decisions and choices and the autonomy of the individual are central to the quest to live a meaningful life. Liberty, dignity and autonomy are essential to the pursuit of happiness and to find meaning in human existence. Human dignity is an essential element of a meaningful existence. A life of dignity comprehends all stages of living including the final stage which leads to the end of life. Liberty and autonomy are essential attributes of a life of substance. It is liberty which enables an individual to decide upon those matters which are central to the pursuit of a meaningful existence. The expectation that the individual should not be deprived of his or her dignity in the final stage of life gives expression to the central expectation of a fading life: control over pain and suffering and the ability to determine the treatment which the individual should receive. When society assures to each individual a protection against being subjected to degrading treatment in the process of dying, it seeks to assure basic human dignity. Dignity ensures the sanctity of life. The recognition afforded to the autonomy of the individual in matters relating to end-of-life decisions is ultimately a step towards ensuring that life does not despair of dignity as it ebbs away. (Paras 516 and 438)

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The entitlement of each individual to a dignified existence necessitates constitutional recognition of the principle that an individual possessed of a free and competent mental state is entitled to decide whether or not to accept medical treatment. The right of such an individual to refuse medical treatment is unconditional. Neither the law nor the Constitution compel an individual who is competent and able to take decisions, to disclose the reasons for refusing medical treatment nor is such a refusal subject to the supervisory control of an outside entity. (Para 517)

Dignity is the core value of life and personal liberty which infuses every stage of human existence. Dignity in the process of dying as well as dignity in death reflects a long yearning through the ages that the passage away from life should be bereft of suffering. These individual yearnings are enhanced by the experiences of sharing, observing and feeling with others: the loss of a parent, spouse, friend or an acquaintance to the cycle of life. Dignity in death has a sense of realism that permeates the right to life. It has a basic connect with the autonomy of the individual and the right to self-determination. Loss of control over the body and the mind are portents of the deprivation of liberty. As the end of life approaches, a loss of control over human faculties denudes life of its meaning. Terminal illness hastens the loss of faculties. Control over essential decisions about how an individual should be treated at the end of life is hence an essential attribute of the right to life. Corresponding to the right is a legitimate expectation that the State must protect it and provide a just legal order in which the right is not denied. In matters as fundamental as death and the process of dying, each individual is entitled to a reasonable expectation of the protection of his or her autonomy by a legal order founded on the rule of law. A constitutional expectation of providing dignity in death is protected by Article 21 and is enforceable against the State. (Para 439)

Constitutional recognition of the dignity of existence as an inseparable element of the right to life necessarily means that dignity attaches throughout the life of the individual. Every individual has a constitutionally protected expectation that the dignity which attaches to life must subsist even in the culminating phase of human existence. Dignity of life must encompass dignity in the stages of living which lead up to the end of life. Dignity in the process of dying is as much a part of the right to life under Article 21. To deprive an individual of dignity towards the end of life is to deprive the individual of a meaningful existence. Hence, the Constitution protects the legitimate expectation of every person to lead a life of dignity until death occurs. (Para 518)

K.S. Puttaswamy v. *Union of India*, (2017) 10 SCC 1; *Maneka Gandhi* v. *Union of India*, (1978) 1 SCC 248, *relied on*

Ronald Dworkin: *Life's Dominion* (London: HarperCollins, 1993); Deryck Beyleveld and Roger Brownsword: "Human Dignity, Human Rights, and Human Genetics", Modern Law Review (1998), Vol. 61, at pp. 665-66; Christopher O. Tollefsen: "Capital Punishment, Sanctity of Life, and Human Dignity", *Public Discourse* (16-9-2011), <http://www.thepublic discourse.com/2011/09/3985/>; Stefania Negri: "Ending Life and Death" in A. den Exter (eds.), European Health Law, MAKLU Press (2017), at p. 241; Arval A. Morris: "Voluntary Euthanasia", Washington Law Review (1970), Vol. 45, at p. 240, 247, 251-252; Sebastian Muders: *Autonomy and the Value of Life as Elements of Human Dignity* (Oxford University Press, 2017); Lawrence O. Gostin: "The Constitutional Right to Die: Ethical Considerations", St John's Journal of Legal Commentary (1997), Vol. 12, at pp. 602-603; L.W. Sumner: "Dignity through Thick and Thin", in Sebastian Muders, *Human Dignity*

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and Assisted Death (Oxford University Press, 2017); Aneeta A. Minocha, Arima Mishra and Vivek R. Minocha: "Euthanasia: A Social Science Perspective", Economic & Political Weekly (3-12-2011), at pp. 25-28, *referred to*

Privacy

The right to privacy was held to be an intrinsic part of the right to life and liberty under Article 21 and protected under Part III of the Constitution. The protective mantle of privacy covers certain decisions that fundamentally affect the human life cycle. It protects the most personal and intimate decisions of individuals that affect their life and development. Thus, choices and decisions on matters such as procreation, contraception and marriage have been held to be protected. While death is an inevitable end in the trajectory of the cycle of human life of individuals are often faced with choices and decisions relating to death. Decisions relating to death, like those relating to birth, sex, and marriage, are protected by the Constitution by virtue of the right of privacy. The right to privacy resides in the right to liberty and in the respect of autonomy. The right to privacy protects autonomy in making decisions related to the intimate domain of death as well as bodily integrity. Few moments could be of as much importance as the intimate and private decisions that we are faced regarding death. Continuing treatment against the wishes of a patient is not only a violation of the principle of informed consent, but also of bodily privacy and bodily integrity that have been recognised as a facet of privacy by the Supreme Court. (Paras 440 and 441)

K.S. Puttaswamy v. *Union of India*, (2017) 10 SCC 1, *relied on*

Just as people value having control over decisions during their lives such as where to live, which occupation to pursue, whom to marry, and whether to have children, so people value having control over whether to continue living when the quality of life deteriorates. The protection of these rights by the legal order is as much an emanation of the right to privacy which shares a functional relationship with the fundamental right to life and personal liberty guaranteed by the Constitution. Privacy recognises that the body and mind are inviolable. An essential attribute of this inviolability is the ability of the individual to refuse medical treatment. The right to privacy envisages safeguarding the integrity of individual choice in the intimate sphere of decisions relating to death. However, since privacy is not an absolute right and is subject to restrictions, the restrictions must fulfil the requirements as laid down by this Court in *Puttaswamy case*. (Paras 442, 446 and 447)

Haas v. *Switzerland*, (2011) 53 EHRR 33, *referred to*

Richard Delgado: "Euthanasia Reconsidered—The Choice of Death as an Aspect of the Right of Privacy", Arizona Law Review (1975), Vol. 17, at p. 474; T.L. Beauchamp: "The Right to Privacy and the Right to Die", *Social Philosophy and Policy* (2000), Vol. 17, at p. 276; D. Benatar: "Should There be a Legal Right to Die?" *Current Oncology* (2010), Vol. 17, Issue 5, at pp. 2-3; Peter J. Riga: "Privacy and the Right to Die", *The Catholic Lawyer* (2017) Vol. 26: No. 2, Article 2, *referred to*

Sanctity of life

The "sanctity of life" principle has historically been the single most basic and normative concept in ethics and the law. The phrase has emerged as a key principle in contemporary bioethics, especially in debates about end-of-life issues. The traditional and standard view is that life is invaluable. It has persisted as an

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idea in various cultures through the centuries. A sacred value has been prioritised for human life. This "rhetoric of the value in human life" has been highlighted in various traditions. The protection of the right to life derives from "the idea that all human life is of equal value"—the idea being drawn from religion, philosophy and science. The principle or doctrine of the "sanctity of life", sometimes also referred to as the "inviolability of human life", is based on "overarching moral considerations", the first of which has been stated as: "Human life is sacred, that is inviolable, so one should never aim to cause an innocent person's death by act or omission." (Paras 400 to 402)

Elizabeth Wicks: The Right to Life and Conflicting Interests (Oxford University Press, 2010); Anne J. Davis: "Dilemmas in Practice: To Make Live or Let Die", The American Journal of Nursing (March 1981), Vol. 81, No. 3, at p. 582; Heike Baranzke: ""Sanctity-of-Life"—A Bioethical Principle for a Right to Life?", *Ethic Theory Moral Practice* (2012), Vol. 15, Issue 3, at p. 295; P.G. Lauren: *The Evolution of International Human Rights: Visions Seen* (University of Pennsylvania Press, 2003, 2nd Edn.), at p. 12; John Keown: *The Law and Ethics of Medicine: Essays on the Inviolability of Human Life* (Oxford University Press, 2012), at p. 3; John Locke: *Two Treatises of Government* (ed. P. Laslett) (Cambridge University Press, 1988); Ronald Dworkin, *Life's Dominion: An Argument about Abortion and Euthanasia* (HarperCollins, 1993), at pp. 73-74; John Finnis: *Human Rights and Common Good* (Oxford University Press, 2011), at p. 221, *referred to*

The principle of the sanctity of life considers autonomy as a "valuable capacity, and part of human dignity". However, autonomy's contribution to dignity is "conditional, not absolute". The issue of the sacred value of life is potentially a conflicting interest between a right to life and autonomy. The disagreement between "sanctity of life" and the "quality of life" is another conflict. Therefore, intractable questions about morality and ethics arise. What is the core of life that might be protected by law? Will a poor quality of life (in the shadow of the imminence of death) impact upon the value of that life to such an extent that it reduces the protection for that life offered by the sanctity of life doctrine? Are there limits to the principle of sanctity? (Paras 409 to 411)

Elizabeth Wicks: The Right to Life and Conflicting Interests (Oxford University Press, 2010), at pp. 176-77; Alan Norrie: "Legal Form and Moral Judgement: Euthanasia and Assisted Suicide" in R.A. Duff, et al (ed), *The Structures of the Criminal Law* (Oxford University Press, 2011), at pp. 141-142, *referred to*

The doctrine of "sanctity of life" must be accepted or rejected on its merits, by religious and non-religious people alike. The value of life is not the value that it has for God or the value that it may have from any religious perspective. The truth of moral judgments and exercising reason to decide what is right and wrong does not depend on the truth of theological claims. The value of life is the value that it has for the human beings who are subjects of lives. Thus, the value of life must be understood from the perspective of the person who will be harmed by the loss, the subject of life. The rule against killing protects individuals that have lives and not merely individuals who are alive. When an individual is alive only to the extent of being conscious in the most rudimentary sense, the capacity to experience pleasure and pain (if any) does not necessarily have value if that is the only capacity one has. These sensations will not be endowed with any significance by the one experiencing them since they do not arise from any human activities or projects and they will not be connected with any coherent view of the world. The quality of life approach has its basis in the way life is being lived. "An overriding concern",

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"is the conditions under which people live rather than whether they live". This does not mean that someone "who chooses to end their life through euthanasia" does not value their lives as much as others. (Paras 414 and 419)

The sanctity of life principle appears in declarations on human rights as the "right to life". Under the Indian Constitution, right to life has been provided under Article 21. The sanctity of human life is the arterial vein which animates the values, spirit and cellular structure of the Constitution. The Constitution recognises the value of life as its indestructible component. The survival of the sanctity principle is founded upon the guarantees of dignity, autonomy and liberty. The sanctity of human life lies in its intrinsic value. It inheres in nature and is recognised by natural law. But human lives also have instrumental functions. Our lives enable us to fulfil our needs and aspirations. The intrinsic worth of life is not conditional on what it seeks to or is capable to achieve. Life is valuable because it *is*. The Indian Constitution protects the right to life as the supreme right, which is inalienable and inviolable even in times of Emergency. It clearly recognises that every human being has the inherent right to life, which is protected by law, and that "No person shall be deprived of his life … except according to procedure established by law". It, thus, envisages only very limited circumstances where a person can be deprived of life. (Paras 428 and 515)

Parmanand Katara v. *Union of India*, (1989) 4 SCC 286 : 1989 SCC (Cri) 721, *affirmed*

Alexandra Mullock: *End-of-Life Law and Assisted Dying in the 21st Century: Time for Cautious Revolution?* (PhD Thesis, University of Manchester, 2011), at pp. 24-25; Luis Kutner: "Euthanasia: Due Process for Death with Dignity; The Living Will", Indiana Law Journal (Winter 1979), Vol. 54, Issue, 2, at p. 225; Sushila Rao: "The Moral Basis for a Right to Die", *Economic & Political Weekly* (30-4-2011), at p. 14; John Keown: "The Legal Revolution: From "Sanctity of Life" to "Quality of Life" and "Autonomy", Journal of Contemporary Health Law & Policy (1998), Vol. 14, Issue 2, at p. 281; Sushila Rao: "The Moral Basis for a Right to Die", Economic & Political Weekly (30-4-2011), at p. 14; Elizabeth Wicks: The Right to Life and Conflicting Interests (Oxford University Press, 2010), at pp. 102-149; Margaret A. Somerville: "The Song of Death: The Lyrics of Euthanasia", Journal of Contemporary Health Law & Policy (1993), Vol. 9, Issue 1, at p. 67; James Rachels: *End of Life: Euthanasia and Morality* (Oxford University Press, 1986), at p. 26; Roger S. Magnusson: "The Sanctity of Life and the Right to Die: Social and Jurisprudential Aspects of the Euthanasia Debate in Australia and the United States", Pacific Rim Law & Policy Journal, Vol. 6, No. I, at p. 40; Peter Singer: "Sanctity of Life or Quality of Life", *Pediatrics* (1983), Vol. 72, Issue 1, at pp. 128-129; Sanctity of Life Versus Quality of Life", *Los Angeles Times* (7-6-2015), <http://www.latimes.com/opinion/readersreact/la-le-0607-sunday-assisted-suicide-20150607- story.html>; Jessica Stern: Euthanasia and the Terminally Ill (2013) <https://fsu.digital.flvc.org/islandora/object/fsu: 209909/datastream/PDF/view>; John Breck: "Euthanasia and the Quality of Life Debate", *Christian Bioethics* (1995), Vol. 1, No. 3, at pp. 322-337; Michael A. Weingarten: "On the Sanctity of Life", British Journal of General Practice (April 2007), Vol. 57(537), at p. 333; Alan Norrie: "Legal Form and Moral Judgement: Euthanasia and Assisted Suicide" in R.A. Duff, et al (ed), *The Structures of the Criminal Law* (Oxford University Press, 2011), at p. 143; Stefania Negri: "Universal Human Rights and End-of-Life Care" in S. Negri et al. (Eds.), Advance Care Decision Making in Germany and Italy: A Comparative, European and International Law Perspective, Springer (2013), at p. 18, *referred to*

Life and natural death

The word "natural" implies that "the only acceptable death is one that occurs from natural causes". Life is only "sacred insofar as it ends by natural means".

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Medical advancements, however, have brought uncertainty about the definition of death — "what constitutes death, in particular a "natural" death". Medical advances have "complicated the question of when life ends". There exists no natural death where artificial technology is concerned. (Paras 421 and 422)

Modern medicine has found ways to prolong life and to delay death. But, it does not imply that modern medicine "necessarily prolongs our living a full and robust life because in some cases it serves only to prolong mere biological existence during the act of dying". This may, in certain situations result in a mere "prolongation of a heartbeat that activates the husk of a mindless, degenerating body that sustains an unknowing and pitiable life—one without vitality, health or any opportunity for normal existence—an inevitable stage in the process of dying". Prolonging life in a vegetative state by artificial means or allowing pain and suffering in a terminal state would lead to questioning the belief that any kind of life is so sanctified as to be preferred absolutely over death. (Para 423)

Modern technology has in a fundamental manner reshaped the notion of life. As technology continuously evolves into more complex planes, it becomes even more necessary to re-evaluate its relationship with the meaning and quality of life. (Para 427)

Great Ormond Street Hospital v. *Yates*, 2017 EWHC 1909 : (2017) 4 WLR 131 (Fam), *referred to*

Alecia Pasdera: The Rhetoric of the Physician-Assisted Suicide Movement: Choosing Death Over Life (2014), available at *https:// ou.monmouthcollege.edu/_resources/pdf/academics/mjur/2014/Rhetoric-of-the-Physician- Assisted-Suicide-Movement-Choosing-Death-Over-Life.pdf*, at p. 68; Sushila Rao: "The Moral Basis for a Right to Die", Economic & Political Weekly (30-4-2011), at p. 15; Arval A. Morris: "Voluntary Euthanasia", Washington Law Review (1970), Vol. 45, at p. 240; Elizabeth M. Andal Sorrentino: "The Right to Die?", Journal of Health and Human Resources Administration (Spring, 1986), Vol. 8, No. 4, at pp. 361-373; Peter Singer: "The Sanctity of Life", *Foreign Policy* (20-10-2009) <http://foreignpolicy.com/2009/10/20/the-sanctity-of-life/>; Lady Justice Arden, Law of Medicine and the Individual: Current Issues, What does Patient Autonomy Mean for the Courts?, (Justice K.T. Desai Memorial Lecture 2017), *referred to*

Per Ashok Bhushan, J. (concurring)

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

(*1*) Sanctity of life,

(*2*) Right of self-determination,

(*3*) Dignity of the individual human being. (Para 600)

The sanctity of life is one thought which is philosophically, religiously and mythologically accepted by the large number of population of the world practising different faiths and religions. Sanctity of life entails its inviolability by an outsider. Sanctity of life is the concern of State. (Para 601)

Right of self-determination also encompasses in it bodily integrity. Without consent of an adult person, who is in fit state of mind, even a surgeon is not authorised to violate the body. Sanctity of the human life is the most fundamental of the human social values. The acceptance of human rights and development of its meaning in recent times has fully recognised the dignity of the individual human being. All the above three principles enable an adult human being of conscious

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mind to take decision regarding extent and manner of taking medical treatment. An adult human being of conscious mind is fully entitled to refuse medical treatment or to decide not to take medical treatment and may decide to embrace the death in natural way. Euthanasia as the meaning of the word suggest is an act which leads to a good death. Some positive act is necessary to characterise the action as euthanasia. Euthanasia is also commonly called "assisted suicide" due to the above reasons. (Para 602)

H. **Common Law — Right of self-determination and individual autonomy — Right to choose how one should live his/her own life — Right to self-determination encompasses in it bodily integrity — Every adult person having capacity to decide has right to choose his/her own way of life which includes right to decide whether to have medical treatment or to refuse the same — Wishes of patient should be given effect to even if considered to be against his/her best interest — Principle of sanctity of life should yield to that of self-determination — Constitution of India, Art. 21**

I. **Medical Jurisprudence — Euthanasia — Right to refuse medical treatment — Refusal by terminally ill or PVS patient to take medical treatment neither amounts to euthanasia nor suicide — By refusal patient allows disease to take its natural course — Constitution of India — Art. 21 — Human and Civil Rights — Right to Die/Euthanasia — Common Law — Penal Code, 1860, S. 309**

J. **Medical Jurisprudence — Euthanasia — Right to refuse medical treatment — Based on right to self-determination and autonomy — Competence to accept or refuse treatment — There is presumption of capacity to consent to or refuse medical treatment unless same is rebutted — Patient from whom consent is obtained by medical practitioner should have full information including risk and benefits involved in giving consent — Situation in which medical treatment can be given without consent — "Emergency principle" and "principle of necessity" — Applicability — Constitution of India — Art. 21 — Human and Civil Rights — Right to Die/Euthanasia — Common Law**

Held :

Per Dipak Misra, C.J. and Khanwilkar, J.

The liberal concept of autonomy focuses on choice and likewise, self-determination is understood as exercised through the process of choosing. 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 control or interference of others. (Para 168)

Lambert v. *France*, 2015 ECHR 185, *considered*

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

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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. Thus all adults with the capacity to consent have the Common Law right to refuse medical treatment and the right of self-determination. 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. (Paras 169, 174 and 175)

Reeves v. *Commr. of Police of the Metropolis*, (2000) 1 AC 360 : (1993) 3 WLR 363 (HL); *Jobes, In re*, 108 NJ 394 (1987); *Reibl* v. *Hughes*, 1980 SCC OnLine Can SC 88 : (1980) 2 SCR 880; *Airedale N.H.S. Trust* v. *Bland*, 1993 AC 789 : (1993) 2 WLR 316 : (1993) 1 All ER 821 (CA & HL), *relied on*

Aruna Ramachandra Shanbaug v. *Union of India*, (2011) 4 SCC 454 : (2011) 2 SCC (Civ) 280 : (2011) 2 SCC (Cri) 294, *affirmed on this point*

Rawls, John, *Political Liberalism*, 32, 33 (New York: Columbia University Press, 1993), *relied on*

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. 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. (Paras 135 and 136)

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 in deciding whether a person has the capacity to 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

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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. (Para 139)

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. 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".

However, 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. (Para 140)

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. (Para 202.8)

F. v. *R.*, (1983) 33 SASR 189; *Rogers* v. *Whitaker*, 1992 HCA 58 : (1992) 175 CLR 479; *Department of Health and Community Services* v. *JWB and SMB*, (1992) 66 AJLR 300 : (1992) 175 CLR 218; *Rodriguez* v. *Attorney General of Canada*, 1993 SCC OnLine Can SC 97 : (1993) 3 SCR 519 : 85 CCC 3d 15; *F. (Mental Patient: Sterilisation), In re*, (1990) 2 AC 1 : (1989) 2 WLR 1025 : (1989) 2 All ER 545 (HL), *relied on*

Schloendorff v. *Society of New York Hospital*, 105 NE 92 : 211 NY 125 (1914); *Malette* v. *Shulman*, (1990) 67 DLR (4th) 321 : 72 OR (2d) 417 (CA); *MB (Medical Treatment), In re*, 1997 EWCA Civ 3093 : (1997) 2 FLR 426, *approved*

Per Sikri, J. (concurring)

In the context of euthanasia, "personal autonomy" of an individual, as a part of human dignity, can be pressed into service. In addition to personal autonomy, other facets of human dignity, namely, "self-expression" and "right to determine"

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also support the argument that it is the choice of the patient to receive or not to receive treatment. (Paras 305 and 306)

Ronald Dworkin, *Life's Dominion* (2nd Edn., Vintage Books, New York 1944) 239; Ronald Dworkin, *Life's Dominion* (London, Harper-Collins, 1993) at p. 166, *referred to*

It is a common law right of people, of any civilised country, to refuse unwanted medical treatment and no person can force him/her to take any medical treatment which the person does not desire to continue with. (Para 329)

Aruna Ramachandra Shanbaug v. *Union of India*, (2011) 4 SCC 454 : (2011) 2 SCC (Civ) 280 : (2011) 2 SCC (Cri) 294, *affirmed on this point*

Schloendorff v. *Society of New York Hospital*, 105 NE 92 : 211 NY 125 (1914); *Sidaway* v. *Board of Governors of the Bethlem Royal Hospital*, 1985 AC 871 : (1985) 2 WLR 480 : (1985) 1 All ER 643 (HL); *Nancy B.* v. *Hotel Dieu de Quebec*, (1992) 86 DLR (4th) 385 (Que SC); *T. (Adult: Refusal of Treatment), In re*, 1993 Fam 95 : (1992) 3 WLR 782 : (1992) 4 All ER 649 (CA); *Airedale N.H.S. Trust* v. *Bland*, 1993 AC 789 : (1993) 2 WLR 316 : (1993) 1 All ER 821 (CA & HL), *cited*

Per Chandrachud, J. (concurring)

Respecting patient autonomy and reducing suffering are fundamental ethical values ascribed to euthanasia. Dignity has basic connect with autonomy of the individual and right to self-determination. In matters as fundamental as death and the process of dying, each individual is entitled to a reasonable expectation of protection of his or her autonomy by a legal order founded on rule of law. (Paras 53 and 97)

Recognition of the right to accept or refuse medical treatment is founded upon autonomy. The *Stanford Encyclopaedia of Philosophy* postulates that there is "a rough consensus in medical ethics on the requirement of respect for patient autonomy". However, a patient may not always have the opportunity to grant or withhold consent to medical treatment. An unforeseen event may deprive the individual of the ability to indicate a desire to either receive or not to have medical treatment. (Para 470)

Luis Kutner: "Due Process of Euthanasia: The Living Will, A Proposal", Indiana Law Journal (1969), Vol. 44, Issue 4, at pp. 539, 551; "Advance Directives and Substitute Decision-Making", *Stanford Encyclopaedia of Philosophy* (24-3-2009) <https://plato.standford.edu/entries/advance-directives/>; Luis Kutner: "Euthanasia: Due Process for Death with Dignity; The Living Will", Indiana Law Journal (Winter 1979), Vol. 54, Issue, 2, at p. 226, *referred to*

Per Ashok Bhushan, J. (concurring)

Right of self-determination encompasses in it bodily integrity. The rights of bodily integrity and self-determination are the rights which belong to every human being. When an adult person having mental capacity to take a decision can exercise his right not to take treatment or withdraw from treatment, the above right cannot be negated for a person who is not able to take an informed decision due to terminal illness or being in a persistent vegetative state (PVS). Without consent of an adult person, who is in a fit state of mind, even a surgeon is not authorised to violate the body. (Paras 611 and 602)

K. **Constitution of India — Art. 21 — Passive euthanasia — Economic considerations may be an instrument of cost curtailment in view of high cost factor involved in modern medical treatment, lack of capacity to afford health**

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services and limited availability of medical facilities — In such circumstances, economic considerations would support passive euthanasia — Utilitarian principle of evaluating policies in virtue of their effect on individual welfare or utility considered — Human and Civil Rights — Right to Die/Euthanasia — Economic Theory, Law and Economics — Economic analysis of law — When warranted

Held :

Per Sikri, J.

The matter of euthanasia can be considered in the context of economic principles also. This aspect can be dealt with in two ways: 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? (Paras 321 to 321.2)

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. Under certain circumstances i.e. when the patient is in PVS or brain dead/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 conclusion in favour of passive euthanasia. (Paras 323 and 324)

Shivashakti Sugars Ltd. v. *Shree Renuka Sugar Ltd.*, (2017) 7 SCC 729 : (2017) 4 SCC (Civ) 234, *explained*

"Health Care Rationing: Can We Afford to Ignore Euthanasia?", Health Services Management Research 1997; 10; 32-41; Mooney G.: *The Valuation of Human Life*, London: Macmillan Press, 1977; *Economics and Euthanasia* by Stephen Heasell, Department of Economics and Politics, Nottingham Trent University, and David Paton, Nottingham University Business School, *referred to*

At times, for deciding legal issues, economic analysis of law assumes importance. 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 optimality—was originally introduced to help solve a serious objection to widely held moral theory, utilitarianism. 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. This economic principle has been applied in a limited sense only as a supporting consideration with the aim to promote efficiency. (Para 325)

Jeffrie G. Murphy & Jules L. Coleman: *Philosophy of Law (An Introduction to Jurisprudence)*, *referred to*

Per Chandrachud, J. (concurring)

One of the limitations of contemporary debates on euthanasia is that they do not take into consideration "certain socio-economic concerns that must necessarily be factored into any discourse". Cost of treatment is a critical factor in influencing the medical decision. "Sometimes patients are 'transferred' to smaller (read

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cheaper) institutions or even their homes, with the tacit understanding that this will hasten the inevitable." "In the absence of adequate medical insurance, specialised treatments like ventilator support, kidney dialysis, and expensive life-saving drugs administered in private hospitals can turn middle-class families into virtual paupers. Poorly equipped government hospitals simply do not have enough life-support machines compared to the number of patients who need them." The inadequacies of the range and reach of Indian Health Care may lead to a situation where euthanasia/active euthanasia may become "an instrument of cost containment". Wealth, poverty, and class structure have a profound effect on the choices people make. (Paras 448 and 449)

S. Nagral: "Euthanasia: Cost Factor is a Worry", *The Times of India* (19-6-2011) <http://www.timesofindia.com/home/sunday/Euthanasia-cost-factor-is-a-worry/articleshow/7690155.cms>; Sushila Rao: "India and Euthanasia: The Poignant Case of Aruna Shanbaug", Oxford Medical Law Review, Vol. 19, Issue 4 (1-12-2011), at pp. 654-655; Alan Norrie: "Legal Form and Moral Judgement: Euthanasia and Assisted Suicide" in R.A. Duff, et al (ed), *The Structures of the Criminal Law* (Oxford University Press, 2011), at p. 144, *referred to*

L. **Constitution of India — Art. 21 — Passive euthanasia — Withholding or withdrawing life prolonging treatment of patient — By allowing the same to a person who is terminally ill, in PVS or brain dead state and thereby hastening process of natural death with dignity in compliance with wishes of the patient, medical practitioner would not be guilty of any penal provision under Penal Code — Contrasted with position obtaining in respect of active euthanasia under prevailing law — Penal Code, 1860 — Ss. 43, 76, 79, 81, 88, 92, 107, 300, 306 and 399 — Human and Civil Rights — Right to Die/ Euthanasia**

M. **Penal Code, 1860 — Ss. 299 and 300 — "Cause death" — Decision not to prolong life of a terminally ill/permanent vegetative state patient by medical treatment does not involve intention to cause death**

N. **Penal Code, 1860 — Ss. 43 and 32 — Illegality — Act or Omission which is prohibited by law — When omission to do something is unlawful, individual is legally bound to do it**

O. **Penal Code, 1860 — S. 81 — Protection to act done with knowledge that it is likely to cause harm — Available when act done without criminal intent to cause harm, in good faith and for preventing other harm**

P. **Penal Code, 1860 — S. 92 — Act done in good faith for benefit of another person, even if causes unintended harm to that person protected under S. 92 — Such act would be protected even if it was not possible to obtain consent of that person**

Q. **Penal Code, 1860 — Ss. 107, 305, 306 — To constitute abetment, there must be course of conduct or action of intentionally aiding or facilitating another person to end life**

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R. **Interpretation of Statutes — Particular Statutes or Provisions — Penal statutes or provisions — Interpretation in background of constitutional principles — Where penal statute bears significant relationship to fundamental constitutional principles of liberty, dignity and autonomy on which question in issue is based, Court, while analysing penal provisions, should give effect to constitutional principles**

Held :

Per Chandrachud, J.

The constitutionally recognised right to life is subject to the procedure established by law. The procedure for regulation or deprivation must, it is well-settled, be fair, just and reasonable. Criminal law imposes restraints and penal exactions which regulate the deprivation of life, or as the case may be, personal liberty. The intentional taking away of the life of another is made culpable by the Penal Code. Active euthanasia falls within the express prohibitions of the law and is unlawful. (Para 519)

The legality of and constitutional protection which is afforded to passive euthanasia cannot be read in isolation from the provisions of the Penal Code. Physicians are apprehensive about their civil or criminal liability when called upon to decide whether to limit life-supporting treatment. Undoubtedly, constitutional positions are not controlled by statutory provisions, because the Constitution rises above and controls legislative mandates. But, in the present reference where no statutory provision is called into question, it is necessary for the Court to analyse the relationship between what the statute penalises and what the Constitution protects. The task of interpretation is to allow for their co-existence while interpreting the statute to give effect to constitutional principle. This is particularly so in an area such as the present where criminal law may bear a significant relationship to the fundamental constitutional principles of liberty, dignity and autonomy. (Para 452)

S. Balakrishnan and R.K. Mani, "The Constitutional and Legal Provisions in Indian Law for Limiting Life Support", Indian Journal of Critical Care Medicine (2005), Vol. 9, Issue 2, at p. 108, *referred to*

A distinction arises between active and passive euthanasia from the provisions of the Penal Code. Active euthanasia involves an intention to cause the death of the patient. Mens rea requires a guilty mind; essentially an intent to cause harm or injury. Passive euthanasia does not embody an intent to cause death. A doctor may withhold life support to ensure that the life of a patient who is in the terminal stage of an incurable illness or in a permanent vegetative state, is not prolonged artificially. The decision to do so is not founded upon an intent to cause death but to allow the life of the patient to continue till and cease at the end of its natural term. Placing such a person on life support would have been an intervention in the natural process of death. A decision not to prolong life by artificial means does not carry an intention to cause death. The crucial element in Section 299 is provided by the expression "causes death". In a case involving passive euthanasia, the affliction of the patient is not brought about either by an act or omission of the doctor. There is neither an animus nor an intent to cause death. The creation of the condition of the patient is outside the volition of the doctor and has come about without a

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covert or overt act by the doctor. The decision to withhold medical intervention is not intended to cause death but to prevent pain, suffering and indignity to a human being who is in the end stage of a terminal illness or of a vegetative state with no reasonable prospect of cure. Placing a patient on artificial life support would, in such a situation, merely prolong the agony of the patient. Hence, a decision by the doctor based on what is in the best interest of the patient precludes an intent to cause death. Similarly, withdrawal of artificial life support is not motivated by an intent to cause death. What a withdrawal of life support does is not to artificially prolong life. The end of life is brought about by the inherent condition of the patient. Thus, both in a case of a withdrawal of life supporting intervention and withholding it, the law protects a bona fide assessment of a medical professional. There being no intent to cause death, the act does not constitute either culpable homicide or murder. (Para 462)

Section 32 of the Penal Code places acts and omissions on the same plane. An *illegal* omission (unless a contrary intent appears in the Code) is proscribed when the act is unlawful. Further, Section 43 comprehends within the meaning of illegality, that (*i*) which is an offence; or (*ii*) which is prohibited by law; or (*iii*) which furnishes a ground for a civil action. Omissions and acts are mirror images. When it is unlawful to *omit* to do something, the individual is legally *bound* to do it. This raises the question of whether an omission to provide life-sustaining treatment constitutes an illegal omission. (Paras 453 and 454)

"Doctrine of Double Effect", *Stanford Encyclopedia of Philosophy* (28-7-2004) <https://plato.stanford.edu/entries/double-effect/>, *referred to*

Section 81 protects acts which are done without a criminal intent to cause harm, in good faith, to prevent or avoid other harm to person or property. The law protects the action though it was done with the knowledge that it was likely to cause harm if a threefold requirement is fulfilled. It comprehends an absence of criminal intent to cause harm, the presence of good faith and the purpose of preventing other harm. Knowledge of the likelihood of harm is not culpable when a criminal intent to cause harm is absent and there exists an element of good faith to prevent or avoid other harm. (Para 455)

The doctor does not inflict a bodily injury. The condition of a patient is on account of a factor independent of the doctor and is not an outcome of his or her actions. Death emanates from the pre-existing medical condition of the patient which enables life to chart a natural course to its inexorable end. The law protects a decision which has been made in good faith by a medical professional not to prolong the indignity of a life placed on artificial support in a situation where medical knowledge indicates a point of no return. Neither the act nor the omission is done with the knowledge that it is likely to cause death. This is for the reason that the likelihood of death is not occasioned by the act or omission but by the medical condition of the patient. When a doctor takes a considered decision in the case of a patient in a terminal stage of illness or in a permanently vegetative state, not to provide artificial life support, the law does not attribute to the doctor the knowledge that it is likely to cause death. (Para 463)

Withdrawing life support to a person in a permanently vegetative state or in a terminal stage of illness is not "prohibited by law" within the meaning of Section 43

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IPC Such an act would also not fall outside the purview of Section 92 for the reason that there is no intentional causing of death or attempt to cause death. Where a decision to withdraw artificial life support is made in the caregiver of the patient, it fulfils the duty of care required from a doctor towards the patient. Where a doctor has acted in fulfilment of a duty of care owed to the patient, the medical judgment underlying the decision protects it from a charge of illegality. Such a decision is not founded on an intention to cause death or on the knowledge that it is likely to cause death. An act done in pursuance of the duty of care owed by the doctor to a patient is not prohibited by law. (Para 464)

Section 92 protects an individual from a consequence which arises from the doing of an act for the benefit of another in good faith, though a harm is caused to the other. What was done is protected because it was done in good faith. Good faith is distinguished from an evil design. When a person does something to protect another from a harm or injury, the law protects what was done in good faith, treating the harm that may result as a consequence unintended by the doer of the act. This protection is afforded by the law even in the absence of consent when the circumstances are such that it is impossible for the person for whose benefit the act was done to consent to it. This may arise where the imminence of the apprehended danger makes it impossible to obtain consent. Another eventuality is where the individual is incapable of consenting (by being incapacitated in mind) and there is no person in the position of a guardian or person in lawful charge from whom consent can be obtained in time to perform the act for the benefit of that person. However, the first proviso to Section 92 makes it clear that the exception does not extend to the *intentional* causing of death or attempt to cause death to the individual, howsoever it may be for the benefit of the other. Absence of intent to cause death is the crucial element in the protection extended by Section 92. (Para 456)

For abetting an offence, the person abetting must have intentionally aided the commission of the crime. Abetment requires an instigation to commit or intentionally aiding the commission of a crime. It presupposes a course of conduct or action which (in the context of the present discussion) facilitates another to end life. Hence abetment of suicide is an offence expressly punishable under Sections 305 and 306 IPC. (Para 458)

In 2006, the Law Commission of India submitted its 196th Report titled "Medical Treatment to Terminally-Ill Patients (Protection of Patients and Medical Practitioners)". The Report by Justice M. Jagannadha Rao as Chairperson contains a succinct elucidation of legal principles governing criminal law on the subject. Some of them are explained below: (Para 466)

While a doctor has a duty of care, a doctor who obeys the instructions of a competent patient to withhold or withdraw medical treatment does not commit a breach of professional duty and the omission to treat will not be an offence; (Para 466.1)

And a decision to not receive medical treatment does not constitute an attempt to commit suicide within the meaning of Section 309 of the Penal Code; (Para 466.2)

Once a competent patient has decided not to accept medical intervention, and to allow nature to take its course, the action of the treating doctor in abiding by those

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wishes is not an offence, nor would it amount to an abetment under Section 306. Under Section 107, an omission has to be illegal to constitute an abetment. A doctor bound by the instructions of a patient to withhold or withdraw medical treatment is not guilty of an illegal act or an abetment. The doctor is bound by the decision of the patient to refuse medical intervention; (Para 466.3)

The act of withholding or withdrawing a life support system in the case of a competent patient who has refused medical treatment and, in the case of an incompetent person where the action is in the best interest of the patient would be protected by good faith protections available under Sections 76, 79, 81 or, as the case may be, by Section 88, even if it is construed that the doctor had knowledge of the likelihood of death. (Para 466.4)

Introducing a structural safeguard, in the form of a Medical Board of experts can be contemplated to further such an objective. The Transplantation of Human Organs and Tissues Act, 1994 provides for the constitution of Authorisation Committees under Section 9(4). The Authorisation Committees are contemplated at the State and district levels and a hospital board. Once the process of decision-making has been arrived at by fulfilling a mandated safeguard (the prior approval of a committee), the decision to withdraw life support should not constitute an illegal act or omission. The setting up of a broad-based board is precisely with a view to lend assurance that the duty of care owed by the doctor to the patient has been fulfilled. Once due safeguards have been fulfilled, the doctor is protected against the attribution of a culpable intent or knowledge. It will hence fall outside the definition of culpable homicide (Section 299), murder (Section 300) or causing death by a rash or negligent act (Section 304-A). (Para 467)

Schloendorff v. *Society of New York Hospital*, 105 NE 92 : 211 NY 125 (1914), *referred to*

S. **Constitution of India — Art. 21 — Euthanasia — Passive Euthanasia (Voluntary and Non-Voluntary) — Procedure for effectuating when (a) there is an Advance Directive; and (b) when there is no Advance Directive — Detailed Safeguards and Guidelines laid down, to be in force till legislation is enacted to cover the field — Living will — Advance Directive — Adult terminally ill patient, while possessed of mental capacity to take informed decision relating to own healthcare and treatment, has right to execute Advance Directive document expressing his/her will of not to be treated with life prolonging medical supportive measures till end of his/her natural life in case of his/her future mental impairment, PVS or brain dead/clinically dead state — Object and reason for recognising Advance Directive, stated — Meaning of terminal condition, persistently unconscious condition and end-stage condition, explained — Concept of Advance Directive based on fundamental right to liberty to live with dignity till end of natural life, right to privacy and common law rights of individual autonomy, self-determination and concept of sanctity of life**

Held :

Per Dipak Misra, C.J. and Khanwilkar, J.

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. Advance Directives for

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healthcare go by various names in different countries though the objective by and large is the same, that is, to specify an individual's healthcare 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. (Paras 184 and 185)

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 healthcare provider. (Para 186)

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 healthcare 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. (Para 187)

A failure to legally recognise 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. 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. (Paras 202.11 and 202.12)

Advance Medical Directive would serve as a fruitful means to facilitate the fructification of the sacrosanct right to life with dignity. The said directive 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. However, Advance Medical Directive cannot operate in abstraction. There has to be safeguards. They need to be spelt out. They are enumerated as follows: (Para 198)

Who can execute the Advance Directive and how?

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. It must be voluntarily executed and without any coercion or inducement or compulsion and after having full knowledge or information. It should have characteristics of an informed consent given without any undue influence or constraint. 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. (Paras 198.1, 198.1.1, 198.1.2, 198.3 and 198.1.4)

What should it contain?

It should clearly indicate the decision relating to the circumstances in which withholding or withdrawal of medical treatment can be resorted to. It should be in

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specific terms and the instructions must be absolutely clear and unambiguous. It should mention that the executor may revoke the instructions/authority at any time. It should disclose that the executor has understood the consequences of executing such a document. 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 authorised to give consent to refuse or withdraw medical treatment in a manner consistent with the Advance Directive. 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. (Para 198.2)

How should it be recorded and preserved?

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 District Judge concerned. 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. The JMFC shall preserve one copy of the document in his office, in addition to keeping it in digital format. 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. 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. 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. The JMFC shall cause to hand over copy of the Advance Directive to the family physician, if any. (Para 198.3)

When and by whom can it be given effect to?

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. (Para 198.4.1)

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. (Para 198.4.2)

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 beliefs on reasonable grounds that the person in question understands the information provided, has cogitated over the options and has come to a firm

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view that the option of withdrawal or refusal of medical treatment is the best choice. (Para 198.4.3)

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. (Para 198.4.4)

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 district concerned 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. (Para 198.4.5)

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. (Para 198.4.6)

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. (Para 198.4.7)

It will be open to the executor to revoke the document at any stage before it is acted upon and implemented. (Para 198.4.8)

What if permission is refused by Medical Board?

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

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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. (Para 198.5.1)

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. (Para 198.5.2)

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". (Para 198.5.3)

Revocation or inapplicability of Advance Directives.

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. (Para 198.6.1)

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. (Para 198.6.2)

If the Advance Directive is not clear and ambiguous, the Medical Boards concerned shall not give effect to the same and, in that event, the guidelines meant for patients without Advance Directive shall be made applicable. (Para 198.6.3)

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. (Para 198.6.4)

Cases where there is no Advance Directive

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: (Para 199)

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. (Para 199.1)

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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. (Para 199.2)

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. (Para 199.3)

There may be cases where the Board may not take a decision to the effect of withdrawing medical treatment of the patient or 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". (Para 199.4)

It is 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. (Para 200)

When passive euthanasia as a situational palliative measure becomes applicable, the best interest of the patient shall override the State interest. (Para 202.14)

The principles relating to the procedure for execution of Advance Directive and the guidelines to give effect to passive euthanasia in both circumstances, namely, where there are Advance Directives and where there are none, have been laid down in exercise of the power under Article 142 of the Constitution and the law stated in

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Vishaka, (1997) 6 SCC 241. The directive and guidelines shall remain in force till Parliament brings a legislation in the field. (Para 203)

Vishaka v. *State of Rajasthan*, (1997) 6 SCC 241 : 1997 SCC (Cri) 932, *referred to*

Per Sikri, J. (concurring)

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 is brain dead/clinically dead. Such an advance authority is akin to well-recognised common law right to refuse medical treatment. (Paras 328 and 333)

Gian Kaur v. *State of Punjab*, (1996) 2 SCC 648 : 1996 SCC (Cri) 374; *Cruzan* v. *Missouri Department of Health*, 1990 SCC OnLine US SC 123 : 111 L Ed 2d 224 : 110 S Ct 2841 : 497 US 261 (1990); *K.S. Puttaswamy* v. *Union of India*, (2017) 10 SCC 1, *relied on*

Aruna Ramachandra Shanbaug v. *Union of India*, (2011) 4 SCC 454 : (2011) 2 SCC (Civ) 280 : (2011) 2 SCC (Cri) 294, *affirmed on this point*

T. (Adult: Refusal of Treatment), In re, 1993 Fam 95 : (1992) 3 WLR 782 : (1992) 4 All ER 649 (CA); *B. (Adult: Refusal of Medical Treatment), In re*, (2002) 2 All ER 449; *Malette* v. *Shulman*, (1990) 67 DLR (4th) 321 : 72 OR (2d) 417 (CA), *approved*

Schloendorff v. *Society of New York Hospital*, 105 NE 92 : 211 NY 125 (1914); *Sidaway* v. *Board of Governors of the Bethlem Royal Hospital*, 1985 AC 871 : (1985) 2 WLR 480 : (1985) 1 All ER 643 (HL); *Nancy B.* v. *Hotel Dieu de Quebec*, (1992) 86 DLR (4th) 385 (Que SC); *T. (Adult: Refusal of Treatment), In re*, 1993 Fam 95 : (1992) 3 WLR 782 : (1992) 4 All ER 649 (CA); *Skinner* v. *Oklahoma*, 1942 SCC OnLine US SC 125 : 86 L Ed 1655 : 316 US 535 (1942); *Williams* v. *Fears*, 1900 SCC OnLine US SC 211 : 45 L Ed 186 : 179 US 270 (1900), *cited*

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. (Para 335)

On the one hand autonomy of an individual gives him right to choose his destiny and, therefore, he may decide beforehand, 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. But 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

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241st Reports. Instead, attempt can be made to provide safeguards for exercise of such Advance Directive. Section 5 of the Mental Health Ccare Act, 2017 and Section 3 of the Transplantation of Human Organs and Tissues Act, 1994 provide such safeguards. (Paras 336 and 337)

All the suggestions of the counsel 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. (Para 341)

Per Chandrachud, J. (concurring)

A patient, in a sound state of mind, possesses the ability to make decisions and choices and can legitimately refuse medical intervention. Advance Directives have evolved conceptually to deal with cases where a patient who subsequently faces a loss of the mental faculty to decide has left instructions, when he or she was possessed of decision-making capacity, on how future medical decisions should be made. Advance Directives are thus documents a person completes while still in possession of decisional capacity about how treatment decisions should be made in the event she or he loses decision-making capacity in future. They cover three conditions: (*i*) a terminal condition; (*ii*) a persistently unconscious condition; and (*iii*) an end-stage condition. The Advance Directive is an indicator to medical professionals of the underlying desire of the person executing it. (Paras 468, 472, 474 and 486)

"Advance Directives and Substitute Decision-Making", *Stanford Encyclopaedia of Philosophy* (24-3-2009) <https://plato.standford.edu/entries/advance-directives/>; Hazel Biggs: "Euthanasia, Death with Dignity and the Law" (Hart Publishing, 2001), at p. 115; James C. Turner: "Living Wills — Need for Legal Recognition", West Virginia Law Review (1976), Vol. 78, Issue 3, at p. 370, *referred to*

An individual who is in a sound and competent state of mind is entitled by means of an Advance Directive in writing, to specify the nature of medical intervention which may not be adopted in future, should he or she cease to possess the mental ability to decide. Such an Advance Directive is entitled to deference by the treating doctor. The treating doctor who, in a good faith exercise of professional medical judgment abides by an Advance Directive is protected against the burden of criminal liability. (Para 520)

A *terminal condition* is an incurable or irreversible condition which even with the administration of life-sustaining treatment will result in death in the foreseeable future. A *persistently unconscious* condition is an irreversible condition, in which thought and awareness of self and environment are absent. An *end-stage condition* is a condition caused by injury, disease or illness which results in severe and permanent deterioration indicated by incompetency and complete physical dependency for which treatment of the irreversible condition would be medically ineffective. (Para 475)

The reason for recognising an Advance Directive is based on individual autonomy. As an autonomous person, every individual has a constitutionally recognised right to refuse medical treatment. The right not to accept medical treatment is essential to liberty. Medical treatment cannot be thrust upon an individual, however, it may have been conceived in the interest of the individual. The reasons which may lead a person in a sound state of mind to refuse

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medical treatment are inscrutable. Those decisions are not subject to scrutiny and have to be respected by the law as an essential attribute of the right of the individual to have control over the body. The State cannot compel an unwilling individual to receive medical treatment. While an individual cannot compel a medical professional to provide a *particular* treatment (this being in the realm of professional medical judgment), it is equally true that the individual cannot be compelled to undergo medical intervention. The principle of sanctity of life thus recognises the fundamental liberty of every person to control his or her body and as its incident, to decline medical treatment. The ability to take such a decision is an essential element of the privacy of the being. Privacy also ensures that a decision as personal as whether or not to accept medical treatment lies exclusively with the individual as an autonomous being. The reasons which impel an individual to do so are part of the privacy of the individual. The mental processes which lead to decision-making are equally part of the constitutionally protected right to privacy. (Para 476)

Advance Directives are founded on the principle that an individual whose state of mind is not clouded by an affliction which prevents him or her from taking decisions is entitled to decide whether to accept or not accept medical intervention. If a decision can be made for the present, when the individual is in a sound state of mind, such a person should be allowed to decide the course of action which should be followed in the future if he or she were to be in a situation which affects the ability to take decisions. If a decision on whether or not to receive medical treatment is valid for the present such a decision must be equally valid when it is intended to operate in the future. Advance Directives are, in other words, grounded in a recognition by the law of the importance of consent as an essential attribute of personal liberty. It is the consensual nature of the act underlying the Advance Directive which imparts sanctity to it in future in the same manner as a decision in the present on whether or not to accept medical treatment. (Para 477)

When a patient is brought for medical treatment in a state of mind in which he or she is deprived of the mental capacity to make informed choices, the medical professional needs to determine the line of treatment. One line of enquiry, which seeks to protect patient autonomy is how the individual would have made a decision if he or she had decision-making capacity. This is called the substituted judgment standard. An Advance Medical Directive is construed as a facilitative mechanism in the application of the substituted judgment standard, if it provides to the physician a communication by the patient (when she or he was in a fit state of mind) of the desire for or restraint on being provided medical treatment in future. (Para 478)

Conceptually, there is a second standard, which is the caregiver standard. This is founded on the principle of beneficence. The second standard seeks to apply an objective notion of a line of treatment which a reasonable individual would desire in the circumstances. The difference between these two standards is that the first seeks to reconstruct the subjective point of view of the patient. The second allows for "a more generic view of interests", without having to rely on the "idiosyncratic values and preference of the patient in question". An autonomous decision suited to an earlier identity may not always be a valid rationale for determining the course of action in respect of a new identity which a patient acquires in the course of illness. (Paras 479, 480 and 483)

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The relationship between a doctor and her patient with an evolving mental condition needs a balance between the *desires* of the patient in a different mental state and the *needs* of the patient in the present condition. Neither can be ignored in preference to the other. The first recognises the patient as an autonomous individual whose desires and choices must be respected by law and medicine. The desire not to be subject to endless medical intervention, when one's condition of mind or body have reached an irreversible state is a profound reflection of the value to be left alone. Constitutional jurisprudence protects it as part of the right to privacy. On the other hand, the need to procure the dignity of the individual in a deteriorating and irreversible state of body or mind is as crucial to the value of existence. The doctor must respect the former while being committed as a professional to protect the latter. (Para 484)

Human experience suggests that there is a chasm of imponderables which divide the present from the future. Such a divide may have a bearing on whether and if so, the extent to which an Advance Directive should bind in the future. The sanctity of an Advance Directive is founded upon the expression of the will of an individual who is in a sound state of mind when the directive is executed. Underlying the consensual character of the declaration is the notion of the consent being informed. Undoubtedly, the reasons which have weighed with an individual in executing the Advance Directive cannot be scrutinised (in the absence of situations such as fraud or coercion which implicate the very basis of the consent). However, an individual who expresses the desire not to be subjected to a particular line of treatment in the future, should she or he be ailing in the future, does so on an assessment of treatment options available when the directive is executed. Advances in medical knowledge between the date of the execution of the document and an uncertain future date when the individual may possibly confront treatment for the disease may have led to a re-evaluation by the person of the basis on which a desire was expressed several years earlier. Another fundamental issue is whether the individual can by means of an Advance Directive compel the withholding of basic care such as hydration and nourishment in the future. Protecting the individual from pain and suffering as well as the indignity of debility may similarly raise important issues. Advance Directives may hence conceivably raise ethical issues of the extent to which the perception of the individual who executes it must prevail in priority to the best interest of the patient. The Advance Directive is an indicator to medical professionals of the underlying desire of the person executing it. (Paras 485 and 486)

In a society such as ours where family ties have an important place in social existence, Advance Directives also provide a sense of solace to the family. Decisions such as whether to withhold or withdraw artificial life saving treatment are difficult for families to take. Advance Directives provide moral authority for the family of the patient that the decision which has been taken to withdraw or withhold artificial life support is in accord with the stated desire of the patient expressed earlier. The Court is above all, engaged in the task of expounding the Constitution. In doing so, the Court have been confronted with the enormous task of finding substance and balance in the relationship between life, morality and the experience of dying. The reason which has impelled the Court to recognise passive euthanasia and Advance Directives is that both bear a close association to the human urge to live with dignity. Age brings isolation. Physical and mental debility bring a loss of self-worth. Pain and suffering are accompanied by a sense of being helpless. The loss of control is compounded when medical intervention takes over

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life. Human values are then lost to technology. More significant than the affliction of ageing and disease is the fear of our human persona being lost in the anonymity of an intensive care ward. It is hence necessary for this Court to recognise that our dignity as citizens continues to be safeguarded by the Constitution even when life is seemingly lost and questions about our own mortality confront us in the twilight of existence. (Paras 487 and 514)

The recognition of Advance Directives as part of a regime of constitutional jurisprudence is an essential attribute of the right to life and personal liberty under Article 21. That right comprehends dignity as its essential foundation. Quality of life is integral to dignity. As an essential aspect of dignity and the preservation of autonomy of choice and decision-making, each individual must have the right on whether or not to accept medical intervention. Such a choice expressed at a point in time when the individual is in a sound and competent state of mind should have sanctity in the future if the individual were to cease to have the mental capability to take decisions and make choices. Yet, a balance between the application of the substituted judgment standard and the best interest standard is necessary as a matter of public interest. This can be achieved by allowing a supervisory role to an expert body with whom shall rest oversight in regard to whether a patient in the terminal stage of an illness or in a permanent vegetative state should be withheld or withdrawn from artificial life support. (Para 488)

In the context of mental illness, Parliament has now expressly recognised the validity of Advance Directives and delineated the role of nominated representatives in being associated with healthcare and treatment decisions. (Para 506)

A comparative analysis of Advance Directives in various jurisdictions indicates some common components. They include the patient's views and wishes regarding: (*i*) Cardio-pulmonary resuscitation (CPR) — treatment that attempts to start breathing and blood flow in people who have stopped breathing or whose heart has stopped beating; (*ii*) Breathing tubes; (*iii*) Feeding/hydration; (*iv*) Dialysis; (*v*) Pain killers; (*vi*) Antibiotics; (*vii*) Directions for organ donation; and (*viii*) Appointment of proxy/healthcare agent/surrogate, etc. (Para 507)

Certain precepts can be deduced from the existing global framework on Advance Directives. These include the following: (Para 508)

Advance Directives reflect the right of an adult with capacity to make a decision to refuse specific treatment at a point in the future when they lack capacity. A person can be said to lack capacity when "in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain". He/she must be deemed to have capacity to make decisions regarding his treatment if such person has ability to— (*a*) understand the information that is relevant to take a decision on the treatment or admission or personal assistance; or (*b*) appreciate any reasonably foreseeable consequence of a decision or lack of decision on the treatment or admission or personal assistance; or (*c*) communicate such decision by means of speech, expression, gesture or any other means. (Para 508.1)

For a legally valid advance decision to refuse treatment, an Advance Directive must fulfil a basic criteria, which should include that—a directive must be made by a person after he has reached 18 years of age; the person must be mentally competent when the directive is made; the directive must specify—in medical or

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layman's terms—the treatment refused; and, it can specify the circumstances in which the refusal is to apply. (Para 508.2)

At any time before reaching the comatose state, an individual can revoke the directive. In other words, an individual may withdraw or alter an advance decision at any time when he/she has capacity to do so. Such withdrawal (including a partial withdrawal) need not be in writing. A directive must be revoked if the statements or actions subsequent to the written document indicate contrary consent. (Para 508.3)

An advance decision will not be applicable to the treatment in question if — (*a*) at the material time, the person, who made it, did not have the capacity to give or refuse consent to it; (*b*) the treatment is not the treatment specified in the advance decision; (*c*) any circumstances specified in the advance decision are absent; or (*d*) there are reasonable grounds for believing that circumstances exist which the person making the directive did not anticipate at the time of the advance decision and which would have affected his decision had he anticipated them. (Para 508.4)

If a person intends specifically to refuse life-sustaining procedures, he/she must — clearly indicate that it is to apply even if life is at risk and death will predictably result; put the decision in writing; and, ensure it is signed and witnessed. (Para 508.5)

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. (Para 508.6)

A person will not incur any liability for the consequences of withholding or withdrawing a treatment from an individual, if he, at the material time, reasonably beliefs that a valid advance decision applicable to the treatment, made by that individual, exists. (Para 508.7)

An Advance Directive must clearly contain the following:

(*a*) full details of its maker, including date of birth, home address and any distinguishing features;

(*b*) the name and address of a general practitioner and whether they have a copy;

(*c*) a statement that the document should be used if the maker lacks capacity to make treatment decisions;

(*d*) a clear statement of the decision, the treatment to be refused and the circumstances in which the decision will apply;

(*e*) the date the document was written (or reviewed); and,

(*f*) the person's signature and the signature of a witness. (Para 508.8)

Advance Directives also have limitations. Individuals may not fully understand treatment options or recognise the consequences of certain choices in the future. Sometimes, people change their minds after expressing Advance Directives and forget to inform others. Another issue with Advance Directives is that vague statements can make it difficult to understand the course of action when a situation arises. For example, general statements rejecting "heroic treatments" are vague and do not indicate whether you want a particular treatment for a specific situation

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(such as antibiotics for pneumonia after a severe stroke). On the other hand, very specific directives for future care may not be useful when situations change in unexpected ways. New medical therapies may also have become available since an Advance Directive was given. Thus, Advance Directives should be reviewed and revised regularly if feelings about certain issues change, so that current wishes and decisions are always legally documented. (Para 509)

An important facet which a regime of advanced care directives must factor in, is the existence of variables which affect the process. These include, in our society, institutional aspects such as the paucity of access to publicly funded medicare, declining standards of professional ethics and the inadequacy of institutional responses to the lack of professional accountability in the medical profession. (Para 510)

A report submitted in October 2017 by the American Bar Association's Commission on Law and Ageing to the US Department of Health Services, dwelt on several variables which bear upon Advance Directives. (Para 511)

There are variables which "profoundly affect the experience of dying" even in a developed society. They provide a sobering reflection of the gulf which separates the needs of patients and the availability of services to the poor, in a society like ours with large impoverished strata. Patient autonomy may mean little to the impoverished citizen. For marginalised groups in urban and rural India, even basic medical care is a distant reality. Advance Directives postulate the availability of medical care. For, it is on the hypothesis of such care being available that the right to choose or refuse treatment is based. The stark reality in our society is that medical facilities are woefully inadequate. Primary medical care is a luxury in many places. Public hospitals are overwhelmed by the gap between the demand for medical care and its supply. Advance Directives may have little significance to large segments of Indian society which are denied access to basic care. Advance Directives also require an awareness of rights. The stark reality is that the average Indian is deprived of even basic medical facilities in an environment where absence of rudimentary care is the norm. Moreover, absolute notions of patient autonomy need to be evaluated in the context of the Indian social structure where bonds of family, religion and caste predominate. The immediate family and in many situations, the larger unit of the extended family are caregivers. In the absence of a social security net, universal medical coverage and compulsory insurance, it is the family to which a patient turns to in distress. Families become the caregivers, willingly or as a result of social conditioning, especially in the absence of resources and alternative institutional facilities. The views of the family which are drawn by close bonds of kinship have to be factored into the process. At the other end of the spectrum, rising costs of medical care in the urban areas threaten to ruin the finances of a family when a member is struck by a serious illness. To them, Advance Directives may provide a measure of assurance when a crucial decision as to whether to prolong artificial support in an irreversible medical situation is to be taken. The fact that the patient had expressed a desire in the form of an Advance Directive obviates a sense of moral guilt on the part of the caregivers, when the family accepts the doctors' wisdom to withdraw or withhold artificial support. Another important variable which a regime of Advance Directives must

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bear in mind is the danger of misuse. The regime of Advance Directives which is intended to secure patient autonomy must contain safeguards against the greed of avaricious relatives colluding with willing medical professionals. The safeguards must be robust to obviate the dangers. The complexities of culture and of the social strata adverted to above only emphasise the wide diversity that prevails within the country. Our solution must take into account the diversity across the country. It is with the above background in view that a safeguard in the form of broad-based committees to oversee the process have been introduced. (Para 512)

The directions in regard to the regime of Advance Directives have been issued in exercise of the power conferred by Article 142 of the Constitution and shall continue to hold the field until a suitable legislation is enacted by Parliament to govern the area. (Para 524)

I agree with the directions proposed in the judgment of the learned Chief Justice. The reference shall stand disposed of in the above terms. (Para 525)

T. (Adult: Refusal of Treatment), In re, (1942) 4 All ER 649; *C. (Adult: Refusal of Treatment), In re*, (1994) 1 WLR 290 : (1994) 1 All ER 819; *St. George's Health Care N.H.S. Trust* v. *S.*, 1999 Fam 26 : (1998) 3 WLR 936 (CA); *B. (Adult: Refusal of Medical Treatment), In re*, (2002) 2 All ER 449; *M. (Adult Patient), In re*, (2012) 1 WLR 1653 : 2011 EWHC 2443 (Fam); *Aintree University Hospitals NHS Foundation Trust* v. *James*, 2013 UK SC 67; *AK (Adult Patient) (Medical Treatment: Consent), In re*, (2001) 1 FLR 129; *HE* v. *A Hospital N.H.S. Trust*, (2003) 2 FLR 408, *referred to*

A.S. Kessel and J. Meran: "Advance Directives in the UK: Legal, Ethical, and Practical Considerations for Doctors", British Journal of General Practice (1998), at p. 1263; "Are Advance Directives Legally Binding or Simply the Starting Point for Discussion on patients' Best Interests?", BMJ (28-11-2009), Vol. 339, p. 1231; Elizabeth Wicks, *The State and the Body: Legal Regulation of Bodily Autonomy*, (Hart Publishing, 2016), at p. 69; Alexander Ruck Keene, "Advance Decisions: Getting it Right?" <http://www.39essex.com/docs/articles/advance_decisions_paper_ark_december_2012.pdf>; Luis Kutner, "Euthanasia: Due Process for Death with Dignity; The Living Will", Indiana Law Journal (Winter 1979), Vol. 54, Issue, 2, at p. 228; "Advance Directives and Advance Care Planning: Legal and Policy Issues", US Department of Health and Human Services (October 2007) <https://aspe.hhs.gov/system/files/pdf/75366/adacplpi.pdf> at p. 1, *referred to*

Per Ashok Bhushan, J. (concurring)

The question is who is competent to take decision in case of terminally ill or PVS patient, who is not able to take decision. In case of a person who is suffering from a disease and is taking medical treatment, there are three stakeholders; the person himself, his family members and doctor treating the patient. In cases of incompetent patients who are unable to take an informed decision, it is in the best interests of the patient that the decision be taken by the competent medical experts and that such decision be implemented after providing a cooling period at least of one month to enable aggrieved person to approach the court of law. The best interest of the patient as determined by medical experts shall meet the ends of justice. The medical team by taking decision shall also take into consideration the opinion of the blood relations of the patient and other relevant facts and circumstances. (Paras 611 and 612)

The concept of Advance Medical Directive is also called living will is of recent origin, which gained recognition in latter part of the 20th century. Advance Medical Directives are not exclusively associated with end-of-life decisions. However, it

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is vital to ensure that form of an Advance Medical Directive reflects the needs of its author and is sufficiently authoritative and practical to enable its provisions to be upheld. In most of the western countries Advance Medical Directives have taken a legalistic form incorporating a formal declaration to be signed by competent witnesses. The laws also make provisions for updating confirmation of its applicability and revocation. Protecting the individual autonomy is obviously the primary purpose of an Advance Medical Directive. The right to decide one's own fate presupposes a capacity to do so. The answer as to when a particular Advance Medical Directive becomes operative usually depends upon an assent of when its author is no longer competent to participate in medical decision-making. (Paras 614 and 615)

An Advance Medical Directive is an individual's advance exercise of his autonomy on the subject of extent of medical intervention that he wishes to allow upon his own body at a future date, when he may not be in a position to specify his wishes. The purpose and object of Advance Medical Directive is to express the choice of a person regarding medical treatment in an event when he loses capacity to take a decision. Use and operation of Advance Medical Directive is to confine only to a case when person becomes incapacitated to take an informed decision regarding his medical treatment. So long as an individual can take an informed decision regarding his medical treatment, there is no occasion to look into Advance Medical Directives. A person has unfettered right to change or cancel his Advance Medical Directives looking to the need of time and advancement in medical science. Hence, a person cannot be tied up or bound by his instructions given at an earlier point of time. (Para 616)

The concept of Advance Medical Directive originated largely as a response to development in medicines. Many people living depending on machines cause great financial distress to the family with the cost of long-term medical treatment. Advance Medical Directive was developed as a means to restrict the kinds of medical intervention in event when one becomes incapacitated. The foundation for seeking direction regarding Advance Medical Directive is extension of the right to refuse medical treatment and the right to die with dignity. When a competent patient has right to take a decision regarding medical treatment, with regard to medical procedure entailing right to die with dignity, the said right cannot be denied to those patients, who have become incompetent to take an informed decision at the relevant time. The concept of Advance Medical Directive has gained ground to give effect to the rights of those patients, who at a particular time are not able to take an informed decision. (Para 617)

Another concept which has been accepted in several countries is recognition of instrument through which a person nominates a representative to make decision regarding their medical treatment at a point of time when the person executing the instrument is unable to make an informed decision. This is called attorney authorisation leading to medical treatment. (Para 618)

The right to execute an Advance Medical Directive is nothing but a step towards protection of the aforesaid right by an individual, in event he becomes incompetent to take an informed decision, in particular stage of life. It has to be recognised by all including the States that a person has right to execute an

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Advance Medical Directive to be utilised to know his decision regarding manner and extent of medical treatment given to his body, in case he is incapacitated to take an informed decision. Such right by an individual does not depend on any recognition or legislation by a State and such rights can be exercised by an individual in recognition and in affirmation of his right of bodily integrity and self-determination which are duly protected under Article 21 of the Constitution. The procedure and manner of such expression of such right is a question which needs to be addressed to protect the vulnerable, infirm and old from any misuse. It is the duty of the State to protect its subjects specially those who are infirm, old and need medical care. The duty of doctor to extend medical care to the patients, who comes to them in no manner diminishes in any manner by recognition of concept that an individual is entitled to execute an Advance Medical Directive. The physicians and medical practitioners treating a person, who is incompetent to express an informed decision have to act in a manner so as to give effect to the express wishes of an individual. (Para 624)

The directions and safeguards which have been enumerated by the Hon'ble Chief Justice in his judgment shall be sufficient to safeguard the interests of the patients, doctors and society till the appropriate legislation is framed and enforced. (Para 627)

The conclusion is that a person with competent medical facility is entitled to execute an Advance Medical Directive subject to various safeguards as noted above. (Para 628)

T. **Jurisprudence — Decision-making process of court — Kinds of cases which come up before Supreme Court for adjudication viz. easy cases, intermediate cases and hard cases — In hard cases there are multiple lawful situations in which Court is required to exercise discretion in larger public interest — This has to be done within framework of limitations, procedural as well as substantive — After considering all alternatives, Court has freedom of "sovereign prerogative choice"**

Held :

Per Sikri, J.

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. The 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

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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 discretion guided by law. 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*". (Paras 206 and 207)

"The Role of Judiciary and HIV Law"—Michael Kirby, in D.C. Jayasuriya (Ed.), *HIV Law, Ethics and Human Rights*; Dworkin, "Judicial Discretion", 6 J of Phil 624 (1963); *Aharon Barak: Judicial Discretion*, Yale University Press; B. Cardozo: *The Growth of the Law* 144 (1924), at 60-61; Justice O. Holmes: *Collected Legal Papers*, 239 (1921), *referred to*

U. **Human and Civil Rights — Universal Declaration of Human Rights, 1948 — Interpretation — Must keep pace with changing society — Needs of present have to be addressed through interpretative process accordingly unless same falls outside framework of the Constitution**

V. **Jurisprudence — Normative and analytical jurisprudence — When Court dealing with new concept and developing new legal norm, analytical and normative jurisprudence have significance**

Held :

Per Sikri, J.

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. (Para 245)

W. **Jurisprudence — Law and social dynamism — Law must take cognizance of changing social ideology and developments and see how much strength and sanction can be drawn from the Constitution to convert the same into reality — Present immediate needs required to be addressed by Court through interpretative process**

Held :

Per Dipak Misra, C.J. and Khanwilkar, J.

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 fall outside the constitutional framework or the constitutional interpretation fails to recognise such dynamism. (Para 166)

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89. 355 A 2d 647 : 70 NJ 10 (NJ 1976), *Quinlan, In re* cert. denied sub nom *Garger* v. *New Jersey*, 429 US 922 (1976) 86*f*, 96*f-g*, 123*b*, 123*c-d*, 237*b*
90. (1975) 2 SCC 148 : 1975 SCC (Cri) 468, *Gobind* v. *State of M.P.* 63*a*
91. 1972 AC 24 : (1970) 3 WLR 366 (HL), *S.* v. *McC. (Orse. S.) and M. (D.S. Intervener)* 181*c-d*, 286*d-e*
92. (1970) 2 SCC 298, *Rustom Cowasjee Cooper* v. *Union of India* 66*c-d*
93. (1970) 1 SCC 248, *Rustom Cavasjee Cooper* v. *Union of India* 150*b-c*
94. (1964) 1 SCR 332 : AIR 1963 SC 1295 : (1963) 2 Cri LJ 329, *Kharak Singh* v. *State of U.P.* 63*a*, 149*e*, 149*f-g*
95. (1957) 1 WLR 582 : (1957) 2 All ER 118 (QB), *Bolam* v. *Friern Hospital Management Committee* 86*a-b*, 90*b*
96. 1942 SCC OnLine US SC 125 : 86 L Ed 1655 : 316 US 535 (1942), *Skinner* v. *Oklahoma* 187*c-d*
97. (1942) 4 All ER 649, *T. (Adult: Refusal of Treatment), In re* 257*f*
98. 1923 SCC OnLine US SC 105 : 67 L Ed 785 : 261 US 525 (1923), *Adkins* v. *Children's Hospital of the District of Columbia* 112*f*
99. 105 NE 92 : 211 NY 125 (1914), *Schloendorff* v. *Society of New York Hospital* 109*d*, 123*d-e*, 181*c*, 185*c-d*, 248*f-g*, 289*d*, 290*c-d*
100. 224 Ill 300 : 79 NE 562 (1906), *Pratt* v. *Davis* 289*e*
101. 1905 SCC OnLine US SC 100 : 49 L Ed 937 : 198 US 45 (1905), *Lochner* v. *New York* 164*a*
102. 95 Minn 261 : 104 NW 12 (1905), *Mohr* v. *Williams* 289*e*
103. 1900 SCC OnLine US SC 211 : 45 L Ed 186 : 179 US 270 (1900), *Williams* v. *Fears* 188*a*
104. 1891 SCC OnLine US SC 217 : 35 L Ed 734 : 11 S Ct 1000 : 141 US 250 (1891), *Union Pacific Rly. Co.* v. *Botsford* 290*a-b*
105. 1625 Jones, W. 97 : (1626) 82 ER 51 (HL), *Earl of Oxford, In re* 114*c-d*

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The Judgments* of the Court were delivered by

DIPAK MISRA, C.J. (*for himself and Khanwilkar, J.; Sikri, J., Chandrachud, J. and Ashok Bhushan, J., concurring*)—

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* **Ed.**: Dipak Misra, C.J. delivered the judgment of the Court for himself and Khanwilkar, J. Sikri, J., Chandrachud, J. and Ashok Bhushan, J. rendered separated concurring judgments.

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A. *Prologue*

1. 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."

2. 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 realisation 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."

3. 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

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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 Greek 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.

4. 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 realising what happens around him/her or should his/her individual dignity be sustained with concern by smoothening the process of dying.

5. 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 instil

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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.

6. 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***

7. 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.

8. 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.

9. It is put forth that the concept of sustenance of individual autonomy inheres in the right of privacy and also comes within the fundamental

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conception of liberty. To sustain the stand of privacy, reliance has been placed on the decisions in *Kharak Singh* v. *State of U.P.*[1], *Gobind* v. *State of M.P.*[2] and *PUCL* v. *Union of India*[3]. Inspiration has also been drawn from the decision of the United States in *Cruzan* v. *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 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, the United Kingdom, the 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*

10. 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 setback.
>
> (*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.

1 (1964) 1 SCR 332 : AIR 1963 SC 1295 : (1963) 2 Cri LJ 329
2 (1975) 2 SCC 148 : 1975 SCC (Cri) 468
3 (1997) 1 SCC 301
4 1990 SCC OnLine US SC 123 : 111 L Ed 2d 224 : 110 S Ct 2841 : 497 US 261 (1990)

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(*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."

11. The counter-affidavit further states that after the judgment was delivered by this Court in *Aruna Ramachandra Shanbaug* v. *Union of India*[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 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 22-5-2015 to examine the Bill. Thereafter, various meetings have been held by experts and the expert committee had proposed formulation of legislation on passive euthanasia.

12. 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 healthcare. It is also contended that the introduction of the right to die with dignity as a facet of

5 (2011) 4 SCC 454 : (2011) 2 SCC (Civ) 280 : (2011) 2 SCC (Cri) 294

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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.

13. 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 seemly 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.

14. We have heard Mr Prashant Bhushan, learned counsel for the petitioner. Mr P.S. Narasimha, learned Additional Solicitor General for the 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*

15. 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 case*[6] *— The question of unconstitutionality of Section 309 of the Penal Code*

16. 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*[6]. The writ petitions assailed the constitutional validity of Section 309 of the Penal Code, 1860 (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: (SCC p. 407, para 24)

> "(*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?
>
> * * *
>
> (*12*) Is suicide against public policy?

6 *P. Rathinam* v. *Union of India*, (1994) 3 SCC 394 : 1994 SCC (Cri) 740

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(*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?"

17. Answering Question (1), the Court, after referring to various authorities under Article 21, took note of the authority in *State of H.P.* v. *Umed Ram Sharma*[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*[6] perceived the elevated positive content in the said ruling. Answering Question (2), the Court referred to the decision of the Bombay High Court in *Maruti Shripati Dubal* v. *State of Maharashtra*[8] that placed reliance on *Rustom Cowasjee 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.

18. After so stating, this Court in *P. Rathinam case*[6] approved the view taken by the Bombay High Court in *Maruti Shripati Dubal*[8] 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 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

7 (1986) 2 SCC 68 : AIR 1986 SC 847
6 *P. Rathinam* v. *Union of India*, (1994) 3 SCC 394 : 1994 SCC (Cri) 740
8 1986 SCC OnLine Bom 278 : 1987 Cri LJ 743 : (1986) 88 Bom LR 589
9 (1970) 2 SCC 298 : AIR 1970 SC 1318

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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.

19. Answering all the questions, the Court in *P. Rathinam case*[6] declared Section 309 IPC ultra vires and held that it deserved to be effaced from the statute book to humanise our penal laws.

D.2 *Gian Kaur case*[10] — *The question of unconstitutionality of Section 306 of the Penal Code*

20. The dictum laid down by the two-Judge Bench in *P. Rathinam*[6] did not remain a precedent for long. In *Gian Kaur* v. *State of Punjab*[10], the Constitution Bench considered the correctness of the decision rendered in *P. Rathinam*[6]. 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*[6] 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 penalising 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 Amici Curiae, Mr F.S. Nariman, learned Senior Counsel, had submitted that the debate on euthanasia is not relevant for deciding the question 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: (*Gian Kaur case*[10], SCC p. 658, para 17)

> "*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."

21. Thereafter, the Constitution Bench in *Gian Kaur*[10] scrutinised the reasons given in *P. Rathinam*[6] 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

6 *P. Rathinam* v. *Union of India*, (1994) 3 SCC 394 : 1994 SCC (Cri) 740
10 *Gian Kaur* v. *State of Punjab*, (1996) 2 SCC 648 : 1996 SCC (Cri) 374

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Court in *Gian Kaur*[10] observed that the Court in *P. Rathinam*[6], 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.

22. Delving into the facet of committing suicide, the larger Bench in *Gian Kaur*[10] 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:

> "22. … "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*[6] qua Article 21."

23. Adverting to the concept of euthanasia, the Court in *Gian Kaur*[10] 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

10 *Gian Kaur* v. *State of Punjab*, (1996) 2 SCC 648 : 1996 SCC (Cri) 374
6 *P. Rathinam* v. *Union of India*, (1994) 3 SCC 394 : 1994 SCC (Cri) 740

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death curtailing the natural span of life. Thereafter, the Court proceeded to state: (SCC pp. 660-61, para 25)

> "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)

24. In view of the aforesaid analysis and taking into consideration various other aspects, the Constitution Bench in *Gian Kaur*[10] declared Section 309 IPC as constitutional.

25. The Court in *Gian Kaur*[10] 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 case*[11], 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*[10] wherein it is observed that it is not lawful for a doctor to administer a drug to his patient to bring about his death even though that course is 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

10 *Gian Kaur* v. *State of Punjab*, (1996) 2 SCC 648 : 1996 SCC (Cri) 374
11 1993 AC 789 : (1993) 2 WLR 316 : (1993) 1 All ER 821 (CA & HL)

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other hand. It has been noticed in *Airedale*[11] 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 para 41 with reference to the dictum in *Airedale case*[11].

26. Proceeding to deal with physician-assisted suicide, the Constitution Bench observed: (*Gian Kaur case*[10], SCC p. 666, para 42)

> "*42.* The decision of the United States Court of Appeals for the Ninth Circuit in *Compassion in Dying* v. *Washington*[12], which reversed the decision of United States District Court, W.D. Washington reported in *Compassion in Dying* v. *Washington*[13], 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 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: (SCC p. 666, para 43)

> "*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 Amici Curiae rightly supported the constitutional validity of Section 306 IPC."

Eventually, the Court in *Gian Kaur*[10], apart from overruling *P. Rathinam*[6], upheld the constitutional validity of Section 309 IPC.

D.3 *The approach in Aruna Shanbaug*[5] *qua passive euthanasia vis-à-vis India*

27. 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*[5]. A writ petition was filed by the next friend of the petitioner pleading, inter alia,

11 *Airedale N.H.S. Trust* v. *Bland*, 1993 AC 789 : (1993) 2 WLR 316 : (1993) 1 All ER 821 (CA & HL)
10 *Gian Kaur* v. *State of Punjab*, (1996) 2 SCC 648 : 1996 SCC (Cri) 374
12 49 F 3d 586 (9th Cir 1995)
13 850 F Supp 1454 (WD Wash 1994)
6 *P. Rathinam* v. *Union of India*, (1994) 3 SCC 394 : 1994 SCC (Cri) 740
5 *Aruna Ramachandra Shanbaug* v. *Union of India*, (2011) 4 SCC 454 : (2011) 2 SCC (Civ) 280 : (2011) 2 SCC (Cri) 294

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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.

28. In *Aruna Shanbaug*[5], after referring to the authority in *Vikram Deo Singh Tomar* v. *State of Bihar*[14], this Court reproduced paras 24 and 25 from *Gian Kaur case*[10] and opined that the said paragraphs simply mean that the view taken in *Rathinam case*[6] 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*[10] 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 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.

29. After so stating, the Court in *Aruna Shanbaug*[5] addressed the legal issues, namely, active and passive euthanasia. It noted the legislations prevalent in Netherlands, Switzerland, Belgium, UK, Spain, Austria, Italy, Germany, France and the 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

5 *Aruna Ramachandra Shanbaug* v. *Union of India*, (2011) 4 SCC 454 : (2011) 2 SCC (Civ) 280 : (2011) 2 SCC (Cri) 294
14 1988 Supp SCC 734 : 1989 SCC (Cri) 66 : AIR 1988 SC 1782
10 *Gian Kaur* v. *State of Punjab*, (1996) 2 SCC 648 : 1996 SCC (Cri) 374
6 *P. Rathinam* v. *Union of India*, (1994) 3 SCC 394 : 1994 SCC (Cri) 740

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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*[11].

30. In *Airedale case*[11], as has been noted in *Aruna Shanbaug*[5], Lord Goff observed that discontinuance of artificial feeding in such cases is not equivalent to cutting a mountaineer's rope or severing the airpipe 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. 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.

31. Lord Mustill observed: (*Airedale case*[11], AC p. 896 C-E)

> "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." (*Aruna Shanbaug case*[5], SCC p. 507, para 82) (emphasis supplied in *Aruna Shanbaug*[5])

11 *Airedale N.H.S. Trust* v. *Bland*, 1993 AC 789 : (1993) 2 WLR 316 : (1993) 1 All ER 821 (CA & HL)

5 *Aruna Ramachandra Shanbaug* v. *Union of India*, (2011) 4 SCC 454 : (2011) 2 SCC (Civ) 280 : (2011) 2 SCC (Cri) 294

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32. The two-Judge Bench in *Aruna Shanbaug*[5] further observed that the decision in *Airedale*[11] 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 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 *J. (A Minor) (Wardship: Medical Treatment), In re*[15] 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.

33. The two-Judge Bench in *Aruna Shanbaug*[5] referred to the decisions of the Supreme Court of United States in *Washington* v. *Glucksberg*[16] and *Vacco* v. *Quill*[17] 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.

34. In the ultimate analysis, the Court in *Aruna Shanbaug*[5] opined that the *Airedale case*[11] is more apposite to be followed. Thereafter, the Court adverted to the law in India and ruled that in *Gian Kaur case*[10], this Court had approved the decision of the House of Lords in *Airedale*[11] and observed that euthanasia could be made lawful only by legislation. After so stating, the learned Judges opined: (*Aruna Shanbaug case*[5], SCC pp. 512-13, para 104)

> "*104.* It may be noted that in *Gian Kaur case*[10] although the Supreme Court has quoted with approval the view of the House of Lords in *Airedale case*[11], 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

5 *Aruna Ramachandra Shanbaug* v. *Union of India*, (2011) 4 SCC 454 : (2011) 2 SCC (Civ) 280 : (2011) 2 SCC (Cri) 294
11 *Airedale N.H.S. Trust* v. *Bland*, 1993 AC 789 : (1993) 2 WLR 316 : (1993) 1 All ER 821 (CA & HL)
15 1991 Fam 33 (CA) : (1991) 2 WLR 140 : (1990) 3 All ER 930
16 1997 SCC OnLine US SC 79 : 138 L Ed 2d 772 : 521 US 702 (1997)
17 1997 SCC OnLine US SC 80 : 138 L Ed 2d 834 : 521 US 793 (1997)
10 *Gian Kaur* v. *State of Punjab*, (1996) 2 SCC 648 : 1996 SCC (Cri) 374

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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."

35. 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: (*Aruna Shanbaug case*[5], SCC pp. 519-20, para 125)

"*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*[11] 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."

5 *Aruna Ramachandra Shanbaug* v. *Union of India*, (2011) 4 SCC 454 : (2011) 2 SCC (Civ) 280 : (2011) 2 SCC (Cri) 294

11 *Airedale N.H.S. Trust* v. *Bland*, 1993 AC 789 : (1993) 2 WLR 316 : (1993) 1 All ER 821 (CA & HL)

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36. After so laying down, the Court in *Aruna Shanbaug*[5] referred to the authorities in *Charan Lal Sahu* v. *Union of India*[18] and *State of Kerala* v. *N.M. Thomas*[19] 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 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: (*Aruna Shanbaug case*[5], SCC pp. 522-23, paras 134-136)

> "*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*[11]. 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."

5 *Aruna Ramachandra Shanbaug* v. *Union of India*, (2011) 4 SCC 454 : (2011) 2 SCC (Civ) 280 : (2011) 2 SCC (Cri) 294
18 (1990) 1 SCC 613
19 (1976) 2 SCC 310 : 1976 SCC (L&S) 227
11 *Airedale N.H.S. Trust* v. *Bland*, 1993 AC 789 : (1993) 2 WLR 316 : (1993) 1 All ER 821 (CA & HL)

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37. We must note here that the two-Judge Bench in *Aruna Shanbaug*[5] declined to grant the permission after perusing the medical reports. For the sake of completeness, we think it apt to reproduce the reasoning: (SCC p. 518, para 122)

> "*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***

38. 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[20] 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*[5]. The three-Judge Bench reproduced paras 24 and 25 from *Gian Kaur*[10] 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.

39. After so holding, it referred to the understanding of *Gian Kaur*[10] in *Aruna Shanbaug*[5] by the two-Judge Bench and reproduced paras 21 and 101 from the said judgment: (*Common Cause case*[20], SCC p. 343, para 12)

> "*12. … '21.* We have carefully considered paras 24 and 25 in *Gian Kaur case*[10] and we are of the opinion that all that has been said therein is that the view in *Rathinam case*[6] that the right to life includes the right to die is not correct. We cannot construe *Gian Kaur case*[10] 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*

5 *Aruna Ramachandra Shanbaug* v. *Union of India*, (2011) 4 SCC 454 : (2011) 2 SCC (Civ) 280 : (2011) 2 SCC (Cri) 294
20 *Common Cause* v. *Union of India*, (2014) 5 SCC 338 : (2014) 2 SCC (Cri) 557
10 *Gian Kaur* v. *State of Punjab*, (1996) 2 SCC 648 : 1996 SCC (Cri) 374
6 *P. Rathinam* v. *Union of India*, (1994) 3 SCC 394 : 1994 SCC (Cri) 740

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was expressed in the decision in Gian Kaur case[10] *beyond what we have mentioned above*.' (*Aruna Shanbaug case*[5], SCC p. 487)

* * *

'*101.* The Constitution Bench of the Supreme Court in *Gian Kaur* v. *State of Punjab*[10] 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*[6]. 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*[10] *the Supreme Court approved of the decision of the House of Lords in Airedale case*[11] *and observed that euthanasia could be made lawful only by legislation*.' (*Aruna Shanbaug case*[5], SCC p. 512)" (emphasis in original)

40. Commenting on the said analysis, the three-Judge Bench went on to say: (*Common Cause case*[20], SCC pp. 343-44, para 13)

"*13.* Insofar as the above paragraphs are concerned, *Aruna Shanbaug*[5] aptly interpreted the decision of the Constitution Bench in *Gian Kaur*[10] 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*[10], the Constitution Bench approved the decision of the House of Lords in *Airedale N.H.S. Trust* v. *Bland*[11]. Para 40 of *Gian Kaur*[10], clearly states that: (SCC p. 665)

> '*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*.'

Thus, it was a mere reference in the verdict and it cannot be construed to mean that the Constitution Bench in *Gian Kaur*[10] approved the opinion of the House of Lords rendered in *Airedale*[11]. To this extent, the observation in para 101 of *Aruna Shanbaug*[5] is incorrect." (emphasis in original)

41. From the aforesaid, it is clear that the three-Judge Bench expressed the view that the opinion of the House of Lords in *Airedale*[11] has not been approved in *Gian Kaur*[10] and to that extent, the observation in *Aruna Shanbaug*[5] is incorrect. After so stating, the three-Judge Bench opined that *Aruna Shanbaug*[5] 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*[10] 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

10 *Gian Kaur* v. *State of Punjab*, (1996) 2 SCC 648 : 1996 SCC (Cri) 374
5 *Aruna Ramachandra Shanbaug* v. *Union of India*, (2011) 4 SCC 454 : (2011) 2 SCC (Civ) 280 : (2011) 2 SCC (Cri) 294
6 (1994) 3 SCC 394 : 1994 SCC (Cri) 740
11 *Airedale N.H.S. Trust* v. *Bland*, 1993 AC 789 : (1993) 2 WLR 316 : (1993) 1 All ER 821 (CA & HL)
20 *Common Cause* v. *Union of India*, (2014) 5 SCC 338 : (2014) 2 SCC (Cri) 557

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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***[10]

42. It is the first and foremost duty to understand what has been stated by the Constitution Bench in *Gian Kaur case*[10]. It has referred to the decision in *Airedale*[11] that has been recapitulated in *Aruna Shanbaug case*[5] 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*[10] categorically noted that it was not necessary to deal with physician-assisted suicide or euthanasia cases though a brief reference to the decisions cited at the Bar was required to be made. The Constitution Bench noted that *Airedale*[11] 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*[11], 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*[11], the larger Bench observed that it was a case relating to withdrawal of artificial measures for continuance of life by the physician.

43. After so stating, the Court in *Gian Kaur*[10] reproduced the following passage from the opinion of Lord Goff of Chieveley: (SCC p. 665, para 40)

> "*40.* … '… But it is not lawful for a doctor to administer a drug to his patient to bring about his death, even though that course is prompted by a humanitarian desire to end his suffering, however great that suffering may be (see *R.* v. *Cox*[21]). 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.*' (*Airedale case*[11], AC p. 865 E-G)" (*emphasis supplied in Gian Kaur*[10])

10 *Gian Kaur* v. *State of Punjab*, (1996) 2 SCC 648 : 1996 SCC (Cri) 374

11 *Airedale N.H.S. Trust* v. *Bland*, 1993 AC 789 : (1993) 2 WLR 316 : (1993) 1 All ER 821 (CA & HL)

5 *Aruna Ramachandra Shanbaug* v. *Union of India*, (2011) 4 SCC 454 : (2011) 2 SCC (Civ) 280 : (2011) 2 SCC (Cri) 294

21 18-9-1992, Ognall, J. (unreported).

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After reproducing the said passage, the Court opined thus: (*Gian Kaur*[10], SCC p. 665, para 41)

> "*41.* The desirability of bringing about such 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."

44. At this stage, it is necessary to clear the maze whether the Constitution Bench in *Gian Kaur*[10] had accepted what has been held in *Airedale*[11].

44.1. On a careful and anxious reading of *Gian Kaur*[10], it is noticeable that there has been narration, reference and notice of the view taken in *Airedale case*[11]. 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.

44.2. On a seemly understanding of the judgment in *Gian Kaur*[10], 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*[10]. 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.

10 *Gian Kaur* v. *State of Punjab*, (1996) 2 SCC 648 : 1996 SCC (Cri) 374
11 *Airedale N.H.S. Trust* v. *Bland*, 1993 AC 789 : (1993) 2 WLR 316 : (1993) 1 All ER 821 (CA & HL)

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44.3. In *Gian Kaur*[10], 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.

44.4. This is how the pronouncement in *Gian Kaur*[10] has to be understood. It is also not the ratio of the authority in *Gian Kaur*[10] that euthanasia has to be introduced only by a legislation. What has been stated in para 41 of *Gian Kaur*[10] is what has been understood to have been held in *Airedale case*[11]. The Court has neither expressed any independent opinion nor has it approved the said part or the ratio as stated in *Airedale*[11]. There has been only a reference to *Airedale case*[11] and the view expressed therein as regards legislation. Therefore, the perception in *Aruna Shanbaug*[5] that the Constitution Bench has approved the decision in *Airedale*[11] is not correct. It is also quite clear that *Gian Kaur*[10] 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*[10] 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*[5] *qua legislation*

45. Having said this, we shall focus in detail what has been stated in *Aruna Shanbaug*[5]. In para 101 which has been reproduced hereinbefore, the two-Judge Bench noted that *Gian Kaur*[10] has approved the decision of the House of Lords in *Airedale*[11] and observed that euthanasia could be made lawful only by legislation. This perception, according to us, is not correct. As already stated, *Gian Kaur*[10] does not lay down that passive euthanasia could be made lawful only by legislation. In para 41 of the said judgment, the Constitution Bench was only adverting to what has been stated by Lord Goff of Chieveley in *Airedale case*[11]. However, this expression of view of *Aruna Shanbaug*[5] which has not been accepted by the referral Bench makes no difference to our present analysis. We unequivocally express the opinion that *Gian Kaur*[10] is not a binding precedent for the purpose of laying down the principle that passive euthanasia can be made lawful "only by legislation".

10 *Gian Kaur* v. *State of Punjab*, (1996) 2 SCC 648 : 1996 SCC (Cri) 374
11 *Airedale N.H.S. Trust* v. *Bland*, 1993 AC 789 : (1993) 2 WLR 316 : (1993) 1 All ER 821 (CA & HL)
5 *Aruna Ramachandra Shanbaug* v. *Union of India*, (2011) 4 SCC 454 : (2011) 2 SCC (Civ) 280 : (2011) 2 SCC (Cri) 294

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G. *The distinction between active and passive euthanasia*

46. 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*[10] 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*[5] 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.

47. That apart, the Court in *Aruna Shanbaug*[5] 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

10 *Gian Kaur* v. *State of Punjab*, (1996) 2 SCC 648 : 1996 SCC (Cri) 374
5 *Aruna Ramachandra Shanbaug* v. *Union of India*, (2011) 4 SCC 454 : (2011) 2 SCC (Civ) 280 : (2011) 2 SCC (Cri) 294

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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.

48. The two-Judge Bench in *Aruna Shanbaug*[5], thereafter, elaborated on passive euthanasia and gave more examples of cases within the ambit of passive euthanasia. The learned Judges further categorised 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.

49. While scrutinising 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 *Rodriguez* v. *Attorney General of Canada*[22], 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 *Vacco*[17] wherein Rehnquist, C.J. 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.

50. This distinction on the basis of "intention" further finds support in the explanation provided in *Conroy, In re*[23] 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 wish to live but do so free of unwanted medical technology, surgery or drugs and without protracted suffering.

51. Another distinction on the basis of "action and non-action" was advanced in the *Airedale case*[11]. 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

5 *Aruna Ramachandra Shanbaug* v. *Union of India*, (2011) 4 SCC 454 : (2011) 2 SCC (Civ) 280 : (2011) 2 SCC (Cri) 294

22 1993 SCC OnLine Can SC 97 : (1993) 3 SCR 519 : 85 CCC 3d 15

17 *Vacco* v. *Quill*, 1997 SCC OnLine US SC 80 : 138 L Ed 2d 834 : 521 US 793 (1997)

23 98 NJ 321 : 486 A 2d 1209 (NJ 1985)

11 *Airedale N.H.S. Trust* v. *Bland*, 1993 AC 789 : (1993) 2 WLR 316 : (1993) 1 All ER 821 (CA & HL)

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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.

52. 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 legalised 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 *UK decisions*

H.1.1 *Airedale case*[11]

53. In the obtaining situation, we shall now advert to the opinions stated in *Airedale case*[11]. 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.

54. 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.

55. 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

11 *Airedale N.H.S. Trust* v. *Bland*, 1993 AC 789 : (1993) 2 WLR 316 : (1993) 1 All ER 821 (CA & HL)

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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.

56. 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.

57. 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.

58. 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.

59. 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.

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60. Emphasising on the patient's best interest principle, Lord Goff referred to *F. (Mental Patient: Sterilisation), In re*[24] 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.

61. 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 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).

62. 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.

63. 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.

24 (1990) 2 AC 1 : (1989) 2 WLR 1025 : (1989) 2 All ER 545 (HL)

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64. Lord Goff, referring to *F. (Mental Patient: Sterilisation), In re*[24], 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*[25]. 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 independent doctors; and (*4*) generally, the wishes of the patient's immediate family will be given great weight.

65. 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 *F. (Mental Patient: Sterilisation), In re*[24] 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.

66. Thereafter, Lord Goff referred to American cases, namely, *Quinlan, In re*[26] and *Supt. of Belchertown State School* v. *Saikewicz*[27] 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.

24 (1990) 2 AC 1 : (1989) 2 WLR 1025 : (1989) 2 All ER 545 (HL)
25 (1957) 1 WLR 582 : (1957) 2 All ER 118 (QB)
26 355 A 2d 647 : 70 NJ 10 (NJ 1976), cert. denied sub nom *Garger* v. *New Jersey*, 429 US 922 (1976)
27 373 Mass 728 : 370 NE 2d 417 (1977)

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67. 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 *F. (Mental Patient: Sterilisation), In re*[24]. 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 *J. (A Minor) (Wardship: Medical Treatment), In re*[15]. 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.

68. 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: (*Airedale case*[11], AC pp. 815 H-816 A)

> "... 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."

69. 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

24 (1990) 2 AC 1 : (1989) 2 WLR 1025 : (1989) 2 All ER 545 (HL)
15 1991 Fam 33 (CA) : (1991) 2 WLR 140 : (1990) 3 All ER 930
11 *Airedale N.H.S. Trust* v. *Bland*, 1993 AC 789 : (1993) 2 WLR 316 : (1993) 1 All ER 821 (CA & HL)

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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.

70. 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 recognise 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.

71. 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.

72. 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.

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73. 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.

74. In the opinion of the learned Law Lord, there exists no doubt that it is for 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.

75. 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 Parliament and only if Parliament fails to act, the Judge-made law will, by necessity, provide a legal answer to each new question as and when it arises.

76. 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 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.

77. 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 *F. (Mental Patient: Sterilisation), In re*[24] 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

24 (1990) 2 AC 1 : (1989) 2 WLR 1025 : (1989) 2 All ER 545 (HL)

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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 *F. (Mental Patient: Sterilisation), In re*[24] 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*[25].

78. 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.

79. 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.

80. 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.

81. It is pertinent to mention here that in adopting the "best interests" principle in *Airedale*[11], the House of Lords followed its earlier decision in *F. (Mental Patient: Sterilisation), In re*[24] and in adopting the omission/commission distinction, it followed the approach of the Court of Appeal in *B. (A Minor) (Wardship: Medical Treatment), In re*[28] and *J. (A Minor) (Wardship: Medical Treatment), In re*[15] 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*[11]. 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 *Airedale*[11] that it was lawful for the doctors

24 (1990) 2 AC 1 : (1989) 2 WLR 1025 : (1989) 2 All ER 545 (HL)
25 *Bolam* v. *Friern Hospital Management Committee*, (1957) 1 WLR 582 : (1957) 2 All ER 118 (QB)
11 *Airedale N.H.S. Trust* v. *Bland*, 1993 AC 789 : (1993) 2 WLR 316 : (1993) 1 All ER 821 (CA & HL)
28 (1981) 1 WLR 1421 : (1990) 3 All ER 927 (CA)
15 1991 Fam 33 (CA) : (1991) 2 WLR 140 : (1990) 3 All ER 930

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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***

82. With reference to the ongoing debate pertaining to assisted dying, Lord Steyn in *R. (Pretty)* v. *Director of Public Prosecutions*[29] 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 legalising 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 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.

83. In *B. (Consent to Treatment: Capacity), In re*[30], 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 recognised 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.

84. Taking a slightly divergent view from *Airedale*[11], Lord Neuberger in *R. (Nicklinson)* v. *Ministry of Justice*[31] 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, indeed, authorising a third party to switch off a person's life support machine, as in *Airedale*[11], is a more drastic interference and a more extreme moral step than authorising 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

29 (2002) 1 AC 800 : (2001) 3 WLR 1598 : (2002) 1 All ER 1 : 2001 UKHL 61 (HL)
30 (2002) 1 FLR 1090 sub nom *B. (Adult: Refusal of Medical Treatment), In re*, (2002) 2 All ER 449
11 *Airedale N.H.S. Trust* v. *Bland*, 1993 AC 789 : (1993) 2 WLR 316 : (1993) 1 All ER 821 (CA & HL)
31 2015 AC 657 : (2014) 3 WLR 200 : 2014 UKSC 38

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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*[11] and *B. (Consent to Treatment: Capacity), In re*[30], 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*[11] and *B. (Consent to Treatment: Capacity), In re*[30].

85. Suffice it to say, he concurred with the view in *Airedale case*[11] which he referred to as *Bland case*[11]. Lord Mance agreed with Lord Neuberger and Lord Sumption. In his opinion, he referred to *Airedale case*[11] 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.

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

87. Lord Mance referred to the expression by Rehnquist, C.J. in *Washington*[16] 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".

88. Lord Wilson concurred with the judgment rendered by Lord Neuberger, referred to *Airedale case*[11] and said: [*R. (Nicklinson) case*[31], AC p. 820, para 199]

> "*199.* … As Hoffmann, L.J. suggested in his classic judgment in the Court of Appeal in *Airedale N.H.S. Trust* v. *Bland*[11], AC at p. 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, JSC quotes Hoffmann, L.J.'s articulation of that principle but it is worth remembering that Hoffmann, L.J. 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."

11 *Airedale N.H.S. Trust* v. *Bland*, 1993 AC 789 : (1993) 2 WLR 316 : (1993) 1 All ER 821 (CA & HL)
30 (2002) 1 FLR 1090 sub nom *B. (Adult: Refusal of Medical Treatment), In re*, (2002) 2 All ER 449
16 *Washington* v. *Glucksberg*, 1997 SCC OnLine US SC 79 : 138 L Ed 2d 772 : 521 US 702 (1997)
31 *R. (Nicklinson)* v. *Ministry of Justice*, 2015 AC 657 : (2014) 3 WLR 200 : 2014 UKSC 38

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And further: (AC pp. 820-21, paras 199 & 200)

> "*199*. … In *Pretty case*[32], 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 *Bland case*[11] 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, PSC 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 *Bland case*[11] 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 *Haas case*[33] at para 51, cited at para 29 above, be regarded as a positive legal *right* to commit suicide. Lord Sumption, JSC suggests in paras 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." (emphasis in original)

89. 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, L.J. in *Airedale case*[11] and the concept of sanctity of life and, eventually, reproduced a passage from Hoffmann, L.J. and opined: [*R. (Nicklinson) case*[31], AC pp. 826-27, para 215]

> "*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

32 *Pretty* v. *United Kingdom*, (2002) 35 EHRR 1 : 2002 ECHR 423
11 *Airedale N.H.S. Trust* v. *Bland*, 1993 AC 789 : (1993) 2 WLR 316 : (1993) 1 All ER 821 (CA & HL)
33 *Haas* v. *Switzerland*, (2011) 53 EHRR 33 : 2011 ECHR 2422
31 *R. (Nicklinson)* v. *Ministry of Justice*, 2015 AC 657 : (2014) 3 WLR 200 : 2014 UKSC 38

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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."

90. Dealing with the appeal by Nicklinson, Lord Sumption referred to the view of the Canadian Supreme Court in *Rodriguez*[22] and opined: [*R. (Nicklinson) case*[31], AC pp. 835-36, para 234]

"*234*. … 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."

91. Dealing with Martin's appeal, Lord Sumption dismissed the same. While doing so, he said: [*R. (Nicklinson) case*[31], AC p. 846, para 256]

"*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

22 *Rodriguez* v. *Attorney General of Canada*, 1993 SCC OnLine Can SC 97 : (1993) 3 SCR 519 : 85 CCC 3d 15

31 *R. (Nicklinson)* v. *Ministry of Justice*, 2015 AC 657 : (2014) 3 WLR 200 : 2014 UKSC 38

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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."

92. 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.

93. Lady Hale entirely agreed with the judgment of Lord Neuberger. Lord Kerr in his opinion stated: [*R. (Nicklinson) case*[31], AC p. 873, para 358]

"*358*. I agree with Lord Neuberger, PSC 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: (AC p. 873, para 360)

"*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."

31 *R. (Nicklinson)* v. *Ministry of Justice*, 2015 AC 657 : (2014) 3 WLR 200 : 2014 UKSC 38

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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*

94. 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.

95. As far as the United States of America is concerned, we think it appropriate to refer to *Cruzan*[4]. 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.

96. Rehnquist, C.J. in his opinion, stated: (*Cruzan case*[4], SCC OnLine US SC para 6)

> "*6.* … '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: (SCC OnLine US SC para 7)

> "*7.* 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 *Quinlan, In re*[26] 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."

4 *Cruzan* v. *Missouri Department of Health*, 1990 SCC OnLine US SC 123 : 111 L Ed 2d 224 : 110 S Ct 2841 : 497 US 261 (1990)

26 355 A 2d 647 : 70 NJ 10 (NJ 1976), cert. denied sub nom *Garger* v. *New Jersey*, 429 US 922 (1976)

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97. Meeting the submissions on behalf of the petitioner, the learned Chief Justice opined: (*Cruzan case*[4], SCC OnLine US SC para 23)

> "*23*. 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."

98. 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: (*Cruzan case*[4], SCC OnLine US SC para 32)

> "*32*. 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 emphasised on "bodily integrity" and "informed consent".

4 *Cruzan* v. *Missouri Department of Health*, 1990 SCC OnLine US SC 123 : 111 L Ed 2d 224 : 110 S Ct 2841 : 497 US 261 (1990)

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99. 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, Rehnquist, C.J. held: (*Vacco case*[17], SCC OnLine US SC)

> "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. (*Quill* v. *Vacco*[34], F 3d at p. 729.) This conclusion depends on the submission that ending or refusing life saving 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 and in our legal traditions, is both important and logical; it is certainly rational."

Dealing with the conclusion in *Cruzan*[4], it was held: (*Vacco case*[17], SCC OnLine US SC)

> "This Court has also recognized, at least implicitly, the distinction between letting a patient die and making that patient die. In *Cruzan* v. *Missouri Department of Health*[4], SCC OnLine US SC para 18 : US p. 278, 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 p. 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", *Quill* v. *Vacco*[34], F 3d at pp. 727-28, but on well-established, traditional rights to bodily integrity and freedom from unwanted touching, *Cruzan*[4], US at pp. 278-79; *id.*, at pp. 287-88 (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.*, SCC OnLine US SC para 24 : US at p. 280. *Cruzan*[4] therefore provides no support for the notion that refusing life-sustaining medical treatment is "nothing more nor less than suicide."

100. From the aforesaid passages, it is crystal clear that the US Supreme Court has recognised 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 emphasising the fundamental

17 *Vacco* v. *Quill*, 1997 SCC OnLine US SC 80 : 138 L Ed 2d 834 : 521 US 793 (1997)
34 80 F 3d 716 (2d Cir 1996)
4 *Cruzan* v. *Missouri Department of Health*, 1990 SCC OnLine US SC 123 : 111 L Ed 2d 224 : 110 S Ct 2841 : 497 US 261 (1990)

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difference between refusing life-sustaining treatment and demanding a life-ending treatment.

101. In *Vacco*[34], 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 recognised 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***

102. Moving to Australian jurisdiction, in *Hunter and New England Area Health Service* v. *A.*[35], 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 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."

103. In *Brightwater Care Group (Inc.)* v. *Rossiter*[36], 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

34 *Quill* v. *Vacco*, 80 F 3d 716 (2d Cir 1996)
35 2009 NSWSC 761
36 2009 WASC 229 : 40 WAR 84

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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, C.J., 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. 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."

104. In *Australian Capital Territory* v. *JT*[37], 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. Higgins, C.J. found that it would be unlawful for the service providers to stop providing treatment. The Chief Justice distinguished this situation from *Rossiter*[36] 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. Higgins, C.J. undertook a detailed analysis and rightly distinguished *Auckland Area Health Board* v. *Attorney General*[38] 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*[39] 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.

105. 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*

106. 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*[22] has drawn a distinction between "intentional actor" and "merely foreseeing". Delivering the judgment on behalf of the majority, Sopinka, J. 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

37 2009 ACTSC 105
36 *Brightwater Care Group (Inc.)* v. *Rossiter*, 2009 WASC 229 : 40 WAR 84
38 (1993) 1 NZLR 235 (HC)
39 2004 NSWSC 1061
22 *Rodriguez* v. *Attorney General of Canada*, 1993 SCC OnLine Can SC 97 : (1993) 3 SCR 519 : 85 CCC 3d 15

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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: (SCC OnLine Can SC)

> "... 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: (SCC OnLine Can SC)

> "... In my view, distinctions based upon 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."

107. The Supreme Court of Canada in *Carter* v. *Attorney General of Canada*[40] 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.

108. 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.

109. 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*:
>
> (*i*) A grievous and irremediable medical condition (including an illness, disease or disability) is required;
>
> (*ii*) Enduring suffering that is intolerable to the individual in the circumstances of his or her condition is required;
>
> (*iii*) Informed consent is required;
>
> (*iv*) Capacity to make the decision is required at the time of either the advance or contemporaneous request; and

40 2015 SCC OnLine Can SC 1 : 2015 SCC 5

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(*v*) Eligible individuals must be insured persons eligible for publicly funded healthcare services in Canada.

Procedural safeguards:

(*i*) Two independent doctors must conclude that a person is eligible;

(*ii*) A request must be in writing and witnessed by two independent witnesses;

(*iii*) 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;

(*iv*) Annual report analysing medical assistance in dying cases are to be tabled in Parliament;

and

(*v*) 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.

110. It should be noted that physician-assisted dying has already been legalised 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 10-12-2015. 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.

111. 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.

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H.5 ***Other jurisdictions***

112. Presently, we think it appropriate to deal with certain legislations in other countries and the decisions in other jurisdictions. In *Aruna Shanbaug*[5], 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 summarised, 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 legalises 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.

113. Reference has been made to the Swiss Criminal Code where active euthanasia has been regarded as illegal. Belgium has legalised the practice of euthanasia with the enactment of the Belgium Act on Euthanasia of 28-5-2002 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.

114. Luxembourg too has legalised euthanasia with the passing of the Law of 16-3-2009 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.

115. 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.

5 *Aruna Ramachandra Shanbaug* v. *Union of India*, (2011) 4 SCC 454 : (2011) 2 SCC (Civ) 280 : (2011) 2 SCC (Cri) 294

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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)***

116. 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:

(*i*) Right to life (Article 6)

(*ii*) Freedom from cruel, inhuman or degrading treatment (Article 7)

(*iii*) Right to respect for private life (Article 17)

(*iv*) Freedom of thought, conscience and religion (Article 18).

117. Right to life under Article 6(1) of the ICCPR provides that 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.

118. 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 beliefs 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)."

119. 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*[32], the ECHR ruled that the decision

32 (2002) 35 EHRR 1 : 2002 ECHR 423

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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 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.

120. In *Haas* v. *Switzerland*[33], the ECHR explained that Article 2:

> "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".

121. In a recent decision regarding end of life issues, *Lambert* v. *France*[41], 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.

122. 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 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.

33 (2011) 53 EHRR 33 : 2011 ECHR 2422
41 2015 ECHR 185

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123. The ECHR emphasised 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".

124. 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 22-4-2005 "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'État*, 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".

125. 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'État* established several "important safeguards" with respect to therapeutic abstention and the regulation is, therefore, "apt to ensure the protection of patients' lives".

126. 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'État judgment". Thus, the ECHR in the *Lambert*[41] 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.

41 *Lambert* v. *France*, 2015 ECHR 185

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I. ***The 241st Report of the Law Commission of India on passive euthanasia***

127. After the judgment of *Aruna Shanbaug*[5] 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 "thanatos" 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".

128. The Commission in its Report referred to the observations made by the then Chairman of the Law Commission in his letter dated 28-8-2006 addressed to the Hon'ble Minister which was extracted. It is pertinent to reproduce the same:

> "2.4. … '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.' "

5 *Aruna Ramachandra Shanbaug* v. *Union of India*, (2011) 4 SCC 454 : (2011) 2 SCC (Civ) 280 : (2011) 2 SCC (Cri) 294

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129. The Report rightly points out that a rational and humanitarian outlook should have primacy in such a complex matter. Recognising 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 summarised 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*[11] 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 "legalising euthanasia", the Report reiterates the observations made in *Airedale*[11] that euthanasia (other than passive euthanasia) can be legalised by means of legislation only.

130. The Report, in upholding the principle of the patient's autonomy, went on to state:

> "11.2. … 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 case*[10], 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 viewpoint in favour of decriminalising the attempt to suicide. The doctor or relatives cannot compel him to have invasive medical treatment by artificial means or treatment."

11 *Airedale N.H.S. Trust* v. *Bland*, 1993 AC 789 : (1993) 2 WLR 316 : (1993) 1 All ER 821 (CA & HL)

10 *Gian Kaur* v. *State of Punjab*, (1996) 2 SCC 648 : 1996 SCC (Cri) 374

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131. The Report supports the view of several authorities especially Lord Browne-Wilkinson (in *Airedale case*[11]) 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:

> "11.2. … '… 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.' (*Airedale case*[11], AC p. 864 G)"

132. We have referred to the Report of the Law Commission post *Aruna Shanbaug*[5] 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*

133. Deliberating on the issue of right to refuse treatment, Cardozo, J. in *Schloendorff* v. *Society of New York Hospital*[42] 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."

134. In a somewhat different context, King, C.J. in *F.* v. *R.*[43] 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, C.J., Brennan, Dawson, Toohey and McHugh, JJ. in *Rogers* v. *Whitaker*[44]. Justice Cardozo's statement has been cited and applied in many cases. Thus, in *Malette* v. *Shulman*[45], Robins, J.A., speaking with the concurrence of Catzman and Canthy, JJ.A., 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 appear mistaken in

11 *Airedale N.H.S. Trust* v. *Bland*, 1993 AC 789 : (1993) 2 WLR 316 : (1993) 1 All ER 821 (CA & HL)
5 *Aruna Ramachandra Shanbaug* v. *Union of India*, (2011) 4 SCC 454 : (2011) 2 SCC (Civ) 280 : (2011) 2 SCC (Cri) 294
42 105 NE 92 : 211 NY 125 (1914)
43 (1983) 33 SASR 189 at p. 193
44 1992 HCA 58 : (1992) 175 CLR 479 at p. 487
45 (1990) 67 DLR (4th) 321 : 72 OR (2d) 417 (CA)

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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."

135. 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*[45] at p. 334:

> "To deny individuals freedom of choice with respect to their healthcare can only lessen and not enhance the value of life."

136. 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.

137. In *Rodriguez*[22], Sopinka, J. speaking for the Supreme Court of Canada, held: (SCC OnLine Can SC)

> "Canadian Courts have recognized a common law right of patients to refuse 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...."

138. In *Department of Health and Community Services* v. *JWB and SMB*[46], the High Court of Australia acknowledged the fundamental right of personal inviolability. McHugh, J. observed that the voluntary decision of an adult person of sound mind as to what should be done to his or her body must

45 *Malette* v. *Shulman*, (1990) 67 DLR (4th) 321 : 72 OR (2d) 417 (CA)

22 *Rodriguez* v. *Attorney General of Canada*, 1993 SCC OnLine Can SC 97 : (1993) 3 SCR 519 : 85 CCC 3d 15

46 (1992) 66 AJLR 300 : (1992) 175 CLR 218

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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.

139. 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, L.J. in *MB (Medical Treatment), In re*[47], stated that in deciding whether a person has the capacity to 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.

140. 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. (Mental Patient: Sterilisation), In re*[24] 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". (AC p. 75 H)

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.

47 1997 EWCA Civ 3093 : (1997) 2 FLR 426
24 (1990) 2 AC 1 : (1989) 2 WLR 1025 : (1989) 2 All ER 545 (HL)

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K. ***Passive euthanasia in the context of Article 21 of the Constitution***

141. 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."

142. The word "liberty" is the sense and realisation 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."

143. 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 of the District of Columbia*[48] has observed: (SCC OnLine US SC para 66)

> "*66*. … It is merely an example of doing what you want to do, embodied in the word "liberty"."

144. 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

48 1923 SCC OnLine US SC 105 : 67 L Ed 785 : 261 US 525 at p. 568 (1923)

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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."

145. Life as envisaged under Article 21 has been very broadly understood by this Court. In *Port of Bombay* v. *Dilipkumar Raghavendranath Nadkarni*[49], 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 civilisation which make life worth living would be jeopardised and the same can be put in jeopardy only by law which inheres fair procedures.

146. In *Maneka Gandhi* v. *Union of India*[50], 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 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.

147. In *State of A.P.* v. *Challa Ramkrishna Reddy*[51], 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 undertrial 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.

148. Having said so, we are required to advert to the issue whether passive euthanasia can only be conceived of through legislation or this Court can, for the present, provide for the same. We have already explained that the ratio laid down in *Gian Kaur*[10] does not convey that the introduction of passive euthanasia can only be by legislation. In *Aruna Shanbaug*[5], the two-Judge

49 (1983) 1 SCC 124 : 1983 SCC (L&S) 61
50 (1978) 1 SCC 248
51 (2000) 5 SCC 712 : AIR 2000 SC 2083
10 *Gian Kaur* v. *State of Punjab*, (1996) 2 SCC 648 : 1996 SCC (Cri) 374
5 *Aruna Ramachandra Shanbaug* v. *Union of India*, (2011) 4 SCC 454 : (2011) 2 SCC (Civ) 280 : (2011) 2 SCC (Cri) 294

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Bench has placed reliance on the Constitution Bench judgment in *Gian Kaur*[10] 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.

149. 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.

150. In this regard, we may reproduce a couple of paragraphs from *Central Inland Water Transport Corpn. Ltd.* v. *Brojo Nath Ganguly*[52]. They read as under: (SCC p. 178, paras 25 & 26)

> "*25*. The story of mankind is punctuated by progress and retrogression. Empires have risen and crashed into the dust of history. Civilisations 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 *Earl of Oxford, In re*[53] in a dispute relating to the descent of that Earldom, said: (ER p. 53)
>
> > '… 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 civilisation. 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 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 supplied)

10 *Gian Kaur* v. *State of Punjab*, (1996) 2 SCC 648 : 1996 SCC (Cri) 374
52 (1986) 3 SCC 156 : 1986 SCC (L&S) 429
53 1625 Jones, W. 97 : (1626) 82 ER 51 (HL)

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151. 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* v. *Union of India*[54], the Constitution Bench has ruled: (SCC pp. 240-41, para 19)

> "*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."

And again: (SCC p. 244, para 29)

> "*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. …"

152. In this context, we may make a reference to a three-Judge Bench decision in *V.C. Rangadurai* v. *D. Gopalan*[55] wherein the majority, while dealing with Section 35(3) of the Advocates Act, 1961, stated: (SCC p. 312, para 8)

> "*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 39-A of the Constitution."

The learned Judges went on to say: (SCC p. 313, para 11)

> "*11*. … Judicial "Legisputation" to borrow a telling phrase of J. Cohen [*The Interpretation and Application of Statutes*, Read Dickerson, p. 238], is not legislation but application of a given legislation to new or unforeseen

54 (2006) 8 SCC 212 : (2007) 1 SCC (L&S) 1013
55 (1979) 1 SCC 308

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needs and situations broadly falling within the statutory provision. In that sense, "interpretation is inescapably a kind of legislation" *Ibid.*, p. 238. This is not legislation stricto sensu but application, and is within the court's province."

153. 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 staticity would mar the core which is not the intent.

K.1 ***Individual dignity as a facet of Article 21***

154. Dignity of an individual has been internationally recognised 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".

155. In fact, in *Christine Goodwin* v. *United Kingdom*[56] 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*[57] O'Regan, J. stated in the Constitutional Court that "without dignity, human life is substantially diminished".

156. Having noted the aforesaid, it is worthy to note that our Court has expanded the spectrum of Article 21. In the latest nine-Judge Bench decision in *K.S. Puttaswamy* v. *Union of India*[58], 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,

56 2002 ECHR 588
57 1995 SCC OnLine ZACC 2 : (1995) 3 SA 391
58 (2017) 10 SCC 1

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the Constitution Bench in *M. Nagaraj*[54] lays down: (*M. Nagaraj case*[54], SCC p. 244, para 26)

> "*26. … 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. …* (*K.S. Puttaswamy case*[58], SCC p. 405, para 113)" (emphasis supplied in *K.S. Puttaswamy*[58])

157. 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.

158. Recently, in *K.S. Puttaswamy*[58], one of us (Dr Chandrachud, J.), while speaking about life and dignity, has observed: (SCC pp. 406-407, paras 118 & 119)

> "*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

54 *M. Nagaraj* v. *Union of India*, (2006) 8 SCC 212 : (2007) 1 SCC (L&S) 1013
58 *K.S. Puttaswamy* v. *Union of India*, (2017) 10 SCC 1

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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."

159. In *Mehmood Nayyar Azam* v. *State of Chhattisgarh*[59], a two-Judge Bench held thus: (SCC p. 6, para 1)

"*1.* … 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 insegregably 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"."

160. The aforesaid authority emphasises the seminal value of life that is inherent in the concept of life. Dignity does not recognise 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 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 U.P.*[60] is noteworthy. 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[61] 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: (*Vikas Yadav case*[60], SCC p. 593, para 77)

59 (2012) 8 SCC 1 : (2012) 4 SCC (Civ) 34 : (2012) 3 SCC (Cri) 733 : (2012) 2 SCC (L&S) 449
* **Ed.**: Albert Schweitzer was awarded the Noble Prize for Peace in 1952.
60 (2016) 9 SCC 541 : (2016) 3 SCC (Cri) 621
61 *Vikas Yadav* v. *State of U.P.*, 2015 SCC OnLine Del 7129

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"*77.* … 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."

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

161. 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. *State (UT of Delhi)*[62]: (SCC pp. 618-19, para 8)

"*8.* … 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 necessaries 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 pro tanto 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 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."

162. In *National Legal Services Authority* v. *Union of India*[63], 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.

62 (1981) 1 SCC 608 : 1981 SCC (Cri) 212
63 (2014) 5 SCC 438

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163. In *Shabnam* v. *Union of India*[64], it has been further held that: (SCC p. 713, para 14)

> "*14*. 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 armed. It is in this sense torture, humiliation, forced labour, etc. all infringe on human dignity." (emphasis in original)

164. In *Gian Kaur*[10], 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 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 up to the end of natural life which would include the right to live a dignified life up to 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.

165. 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

64 (2015) 6 SCC 702 : (2015) 3 SCC (Cri) 355
10 *Gian Kaur* v. *State of Punjab*, (1996) 2 SCC 648 : 1996 SCC (Cri) 374

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deserves to be concretised, the thought has to be realised. It has to be viewed from various angles, namely, legal permissibility, social and ethical ethos and medical values.

166. 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 recognise such dynamism. The Constitution Bench in *Gian Kaur*[10], 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 authorised 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

10 *Gian Kaur* v. *State of Punjab*, (1996) 2 SCC 648 : 1996 SCC (Cri) 374

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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***

167. 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.

168. John Rawls says that the liberal concept of autonomy focuses on choice and likewise, self-determination is understood as exercised through the process of choosing[65]. 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 control or interference of others. Lord Hoffman, in *Reeves* v. *Commr. of Police of the Metropolis*[66] has stated: (AC p. 369 B)

> "... 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."

169. 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.

170. In *Airedale*[11], 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 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

65 Rawls, John, *Political Liberalism*, 32, 33 (New York: Columbia University Press, 1993).
66 (2000) 1 AC 360 : (1993) 3 WLR 363 (HL)
11 *Airedale N.H.S. Trust* v. *Bland*, 1993 AC 789 : (1993) 2 WLR 316 : (1993) 1 All ER 821 (CA & HL)

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interest in preserving human life by treating it as sanctimonious, the right of the individual must prevail.

171. 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 *Quinlan, In re*[26], 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 *Jobes, In re*[67], which was also a case concerned with a PVS patient, the Court, following the decision in *Quinlan, In re*[26], upheld the principle of self-determination and autonomy of an incompetent person.

172. 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 making. However, the Supreme Court of Canada in *Reibl* v. *Hughes*[68] approved an oft-quoted statement of Cardozo, J. in *Schloendorff*[42] that "every human being of adult years and sound mind has a right to determine what shall be done with his own body" and Laskin, C.J. in *Reibl*[68] 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.

173. In *Aruna Shanbaug*[5], 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 ("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

26 355 A 2d 647 : 70 NJ 10 (NJ 1976), cert. denied sub nom *Garger* v. *New Jersey*, 429 US 922 (1976)
67 108 NJ 394 (1987)
68 1980 SCC OnLine Can SC 88 : (1980) 2 SCR 880 at pp. 890-91
42 *Schloendorff* v. *Society of New York Hospital*, 105 NE 92 : 211 NY 125 (1914)
5 *Aruna Ramachandra Shanbaug* v. *Union of India*, (2011) 4 SCC 454 : (2011) 2 SCC (Civ) 280 : (2011) 2 SCC (Cri) 294

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of action because it is best for the patient, and is not influenced by personal convictions, motives or other considerations.

174. 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.

175. 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***

176. 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.

177. 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 recognised 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.

178. 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

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the dignified process of dying sans pain, sans suffering and, most importantly, sans indignity.

179. 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*

180. 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 Part 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.

181. 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 hospitalised. 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)*

182. 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 "Mahaprasthana". It is his submission that in the modern State, the State interest should not overweigh 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.

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183. 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***

184. 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 recognise 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.

185. Advance Directives for healthcare go by various names in different countries though the objective by and large is the same, that is, to specify an individual's healthcare 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.

186. *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 healthcare provider.

187. 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 healthcare 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.

188. 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

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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 healthcare proxy which becomes effective only when the patient is unable to make decisions.

189. 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.

190. Yet another measure for finding and accessing the patient's Advance Directive was the setting up of the US 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.

191. 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 Advance Directives due to the intricacies surrounding the concept.

192. The Mental Capacity Act governs the law relating to Advance Directives in 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 recognised under this statute. Further, the Act recognises the rights of the patient to appoint a healthcare proxy who is referred to as "lasting power of attorney". In order for the proxy decision-maker so appointed

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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*[11], 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.

193. 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 healthcare directives or certain provisions contained therein become inoperative.

194. 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.

195. 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.

196. 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

11 *Airedale N.H.S. Trust* v. *Bland*, 1993 AC 789 : (1993) 2 WLR 316 : (1993) 1 All ER 821 (CA & HL)

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Columbia, Ontario, Quebec and Yukon provide only for appointment of a proxy while simultaneously recognising 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 recognised by some provinces.

197. 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*[5] 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*[5].

198. 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:

198.1. ***Who can execute the Advance Directive and how***?

198.1.1. 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.

198.1.2. It must be voluntarily executed and without any coercion or inducement or compulsion and after having full knowledge or information.

198.1.3. It should have characteristics of an informed consent given without any undue influence or constraint.

198.1.4. 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

5 *Aruna Ramachandra Shanbaug* v. *Union of India*, (2011) 4 SCC 454 : (2011) 2 SCC (Civ) 280 : (2011) 2 SCC (Cri) 294

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cause him/her pain, anguish and suffering and further put him/her in a state of indignity.

198.2. ***What should it contain?***

198.2.1. It should clearly indicate the decision relating to the circumstances in which withholding or withdrawal of medical treatment can be resorted to.

198.2.2. It should be in specific terms and the instructions must be absolutely clear and unambiguous.

198.2.3. It should mention that the executor may revoke the instructions/ authority at any time.

198.2.4. It should disclose that the executor has understood the consequences of executing such a document.

198.2.5. 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 authorised to give consent to refuse or withdraw medical treatment in a manner consistent with the Advance Directive.

198.2.6. 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.

198.3. ***How should it be recorded and preserved?***

198.3.1. 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 District Judge concerned.

198.3.2. 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.

198.3.3. The JMFC shall preserve one copy of the document in his office, in addition to keeping it in digital format.

198.3.4. 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.

198.3.5. 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.

198.3.6. 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.

198.3.7. The JMFC shall cause to hand over copy of the Advance Directive to the family physician, if any.

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198.4. ***When and by whom can it be given effect to?***

198.4.1. 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.

198.4.2. 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.

198.4.3. 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 beliefs 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.

198.4.4. 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.

198.4.5. 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 district concerned 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.

198.4.6. 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

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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.

198.4.7. 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.

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

198.5. ***What if permission is refused by the Medical Board?***

198.5.1. 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.

198.5.2. 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.

198.5.3. 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".

198.6. ***Revocation or inapplicability of Advance Directive***

198.6.1. 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.

198.6.2. 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.

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198.6.3. If the Advance Directive is not clear and ambiguous, the Medical Boards concerned shall not give effect to the same and, in that event, the guidelines meant for patients without Advance Directive shall be made applicable.

198.6.4. 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.

199. 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:

199.1. 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.

199.2. 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.

199.3. 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.

199.4. There may be cases where the Board may not take a decision to the effect of withdrawing medical treatment of the patient or 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

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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".

200. 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.

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

Q. *Conclusions in seriatim*

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

202.1. A careful and precise perusal of the judgment in *Gian Kaur case*[10] 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.

202.2. The Constitution Bench in *Gian Kaur*[10] has not approved the decision in *Airedale*[11] inasmuch as the Court has only made a brief reference to the *Airedale case*[11].

202.3. It is not the ratio of *Gian Kaur*[10] that passive euthanasia can be introduced only by legislation.

202.4. The two-Judge Bench in *Aruna Shanbaug*[5] has erred in holding that this Court in *Gian Kaur*[10] has approved the decision in *Airedale case*[11] and that euthanasia could be made lawful only by legislation.

10 *Gian Kaur* v. *State of Punjab*, (1996) 2 SCC 648 : 1996 SCC (Cri) 374
11 *Airedale N.H.S. Trust* v. *Bland*, 1993 AC 789 : (1993) 2 WLR 316 : (1993) 1 All ER 821 (CA & HL)
5 *Aruna Ramachandra Shanbaug* v. *Union of India*, (2011) 4 SCC 454 : (2011) 2 SCC (Civ) 280 : (2011) 2 SCC (Cri) 294

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202.5. 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.

202.6. 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.

202.7. Post *Aruna Shanbaug*[5], the 241st Report of the Law Commission of India on Passive Euthanasia has also recognised passive euthanasia, but no law has been enacted.

202.8. 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.

202.9. 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.

202.10. 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.

202.11. A failure to legally recognise 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.

202.12. 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.

5 *Aruna Ramachandra Shanbaug* v. *Union of India*, (2011) 4 SCC 454 : (2011) 2 SCC (Civ) 280 : (2011) 2 SCC (Cri) 294

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

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

203. 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* v. *State of Rajasthan*[69]. The directive and guidelines shall remain in force till Parliament brings a legislation in the field.

204. The writ petition is, accordingly, disposed of. There shall be no order as to costs.

Dr A.K. Sikri, J. (*concurring*)— Michael Kirby, a former Judge of the Australian High Court, while discussing about the role of judiciary in the context of HIV law[70], 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.*"

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.

206. 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

69 (1997) 6 SCC 241 : 1997 SCC (Cri) 932

70 "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.

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intermediate cases, and (*iii*) the hard cases. Professor Ronald Dworkin[71] 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 inasmuch as judicial discretion does exist. This is true, at least, in solving "*hard cases*"[72]. 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 choses 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 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 us."[72a]

207. 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*"[73]. 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.

208. 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

71 Dworkin, "Judicial Discretion", 6 J of Phil 624 (1963).
72 See *Aharon Barak: Judicial Discretion*, Yale University Press.
72a B. Cardozo: *The Growth of the Law* 144 (1924), at 60-61.
73 Justice O. Holmes opined this expression in *Collected Legal Papers*, 239 (1921).

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the subject and demonstrate as to how this topic has been dealt with so far. The first judgment is that of a Constitution Bench in *Gian Kaur* v. *State of Punjab*[10]. Second case is known as *Aruna Ramachandra Shanbaug* v. *Union of India*[5], which is a Division Bench judgment that takes note of *Gian Kaur*[10] and premised thereupon goes much farther in accepting passive euthanasia as a facet of Article 21 of the Constitution.

209. In the instant case, while making reference to the Constitution Bench vide its order dated 25-2-2014[20], the three-Judge Bench has expressed its reservation in the manner the ratio of the Constitution Bench in *Gian Kaur*[10] is applied by the Division Bench in *Aruna Ramachandra Shanbaug*[5]. This reference order accepts that *Aruna Ramachandra Shanbaug*[5] rightly interpreted the decision in *Gian Kaur*[10] 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*[5] has committed a factual error in observing that in *Gian Kaur*[10] the Constitution Bench approved the decision of the House of Lords in *Airedale N.H.S. Trust* v. *Bland*[11]. As per the reference order, *Gian Kaur*[10] merely referred to the said judgment which cannot be construed to mean that the Constitution Bench in *Gian Kaur*[10] approved the opinion of the House of Lords rendered in *Bland*[11]. The reference order also accepts the position that in *Gian Kaur*[10] 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*[5], 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*[10] *had upheld the same*".

210. 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: (*Common Cause case*[20], SCC p. 345, paras 17 & 18)

> "*17.* In view of the inconsistent opinions rendered in *Aruna Shanbaug*[5] 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.

10 (1996) 2 SCC 648 : 1996 SCC (Cri) 374
5 (2011) 4 SCC 454 : (2011) 2 SCC (Civ) 280 : (2011) 2 SCC (Cri) 294
20 *Common Cause* v. *Union of India*, (2014) 5 SCC 338 : (2014) 2 SCC (Cri) 557
11 1993 AC 789 : (1993) 2 WLR 316 : (1993) 1 All ER 821 (CA & HL)

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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."

211. 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*[10] as well as *Aruna Ramachandra Shanbaug*[5], 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.

212. 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.

213. 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 *Gian Kaur* v. *State of Punjab*, (1996) 2 SCC 648 : 1996 SCC (Cri) 374

5 *Aruna Ramachandra Shanbaug* v. *Union of India*, (2011) 4 SCC 454 : (2011) 2 SCC (Civ) 280 : (2011) 2 SCC (Cri) 294

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214. 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 the following issues/questions of law of relevance need to be discussed:

214.1. (*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 Penal Code, 1860 (for short "IPC") vide Section 115 of the Mental Health Care Act, 2017 (10 of 2017).]

214.2. (*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?

214.3. (*iii*) Whether the observations in *Aruna Ramachandra Shanbaug*[5] that the Constitution Bench in *Gian Kaur*[10] permitted passive euthanasia stand correct?

214.4. (*iv*) Whether there exists inconsistency in the observations in *Aruna Ramachandra Shanbaug*[5] with regard to what has been held in *Gian Kaur*[10]?

214.5. (*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*[10] approved the decision of the House of Lords in *Bland*[11]?)

214.6. (*vi*) Whether the law on passive euthanasia, as held valid in *Aruna Ramachandra Shanbaug*[5], holds true in the present times as well? (The Treatment of Terminally-Ill Patients Bill, 2016 is based on the aforementioned judgment.)

214.7. (*vii*) Whether active euthanasia is legal in India?

214.8. (*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.]

214.9. (*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.)

214.10. (*x*) Definition of "*terminal illness*".

215. 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

5 *Aruna Ramachandra Shanbaug* v. *Union of India*, (2011) 4 SCC 454 : (2011) 2 SCC (Civ) 280 : (2011) 2 SCC (Cri) 294

10 *Gian Kaur* v. *State of Punjab*, (1996) 2 SCC 648 : 1996 SCC (Cri) 374

11 *Airedale N.H.S. Trust* v. *Bland*, 1993 AC 789 : (1993) 2 WLR 316 : (1993) 1 All ER 821 (CA & HL)

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Justice in his opinion. Therefore, in this "*addendum*", I would be focusing myself to the core issues.

Euthanasia defined

216. *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*"[74].

217. 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, 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 minimising 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*".

218. 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 so[75]. These terms can be described as under:

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

75 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).

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218.1. *Voluntary euthanasia*—People concerned to legalise 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.

218.2. *Non-voluntary euthanasia*—Seen by some as subvariety 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 that his/her life be ended. This form of euthanasia is that which most intimately concerns the medical profession. Selective non-treatment of the newborn 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.

218.3. *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 from 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 death[76].

219. 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 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 D.C. 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.

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

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220. In *Aruna Ramachandra Shanbaug*[5], 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*[10]. 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*[5]**

221. In *Aruna Ramachandra Shanbaug*[5], a two-Judge 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-à-vis offences concerned under the IPC and doctor assisted death, etc.

222. 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*[11] wherein the House of Lords had permitted the patient to die. Ratio of *Bland*[11] was culled out in the following manner: (*Aruna Shanbaug case*[5], SCC p. 507, para 84)

> "*84. Airedale*[11] (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."

223. The Court in *Aruna Shanbaug case*[5] 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) 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 Parliament as it has become anachronistic, the Court went into the vexed question as to

5 *Aruna Ramachandra Shanbaug* v. *Union of India*, (2011) 4 SCC 454 : (2011) 2 SCC (Civ) 280 : (2011) 2 SCC (Cri) 294

10 *Gian Kaur* v. *State of Punjab*, (1996) 2 SCC 648 : 1996 SCC (Cri) 374

11 *Airedale N.H.S. Trust* v. *Bland*, 1993 AC 789 : (1993) 2 WLR 316 : (1993) 1 All ER 821 (CA & HL)

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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: (SCC pp. 513-14, paras 104 & 105)

> "*104*. It may be noted that in *Gian Kaur case*[10] although the Supreme Court has quoted with approval the view of the House of Lords in *Airedale case*[11], 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 ft. 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."

224. The Court in *Bland*[11] 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 brain dead when he could no longer perform the fundamental human work of an organism. Three such situations

10 *Gian Kaur* v. *State of Punjab*, (1996) 2 SCC 648 : 1996 SCC (Cri) 374

11 *Airedale N.H.S. Trust* v. *Bland*, 1993 AC 789 : (1993) 2 WLR 316 : (1993) 1 All ER 821 (CA & HL)

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contemplated in that definition are the following: (*Aruna Shanbaug case*[5], SCC p. 516, para 114)

> "(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."

225. The Court held that when the aforesaid situation is reached, a person can be presumed to be dead. In para 115 of the judgment, the position is summed up as under: (*Aruna Shanbaug case*[5], SCC p. 516)

> "*115*. 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." (emphasis in original)

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.

226. 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: (*Aruna Shanbaug case*[5], SCC p. 517, para 117)

> "(*a*) When a person is only kept alive mechanically i.e. when not only consciousness is lost, but the person is only able to sustain involuntary functioning through advanced medical technology—such as the use of heart-lung machines, medical ventilators, etc.
>
> (*b*) When there is no plausible possibility of the person ever being able to come out of this stage. Medical "miracles" are not unknown, but if a person has been at a stage where his life is only sustained through medical technology, and there has been no significant alteration in the person's condition for a long period of time—at least a few years—then there can be a fair case made out for passive euthanasia."

5 *Aruna Ramachandra Shanbaug* v. *Union of India*, (2011) 4 SCC 454 : (2011) 2 SCC (Civ) 280 : (2011) 2 SCC (Cri) 294

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227. Taking a clue from the judgment in *Vishaka* v. *State of Rajasthan*[69], the Court laid down the law, while allowing passive euthanasia i.e. the circumstances when there could be withdrawal of life support of a patient in PVS. This is stated in para 124 of the judgment, which we reproduce below: (*Aruna Shanbaug case*[5], SCC pp. 518-19)

> "*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*[69] 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.

69 (1997) 6 SCC 241 : 1997 SCC (Cri) 932

5 *Aruna Ramachandra Shanbaug* v. *Union of India*, (2011) 4 SCC 454 : (2011) 2 SCC (Civ) 280 : (2011) 2 SCC (Cri) 294

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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*[11].

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."

228. It can be discerned from the reading of the said judgment that the 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*[10] this "right to die" had not been accepted as an integral part of "right to life". The Court in *Aruna Shanbaug*[5] maintained this position insofar as an active euthanasia is concerned. However, passive euthanasia, under certain circumstances, has been accepted.

229. It may be pertinent to mention that the petitioner (Aruna) in *Aruna Shanbaug case*[5] was working as a nurse in King Edward Memorial Hospital (KEM), Parel, Mumbai. The tragic incident happened on the evening of 27-11-1973. 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 sodomised her. To immobilise 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.

230. The petition was filed by Ms Pinki Virani as next friend of Aruna Shanbaug. According to the 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 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.

11 *Airedale N.H.S. Trust* v. *Bland*, 1993 AC 789 : (1993) 2 WLR 316 : (1993) 1 All ER 821 (CA & HL)

10 *Gian Kaur* v. *State of Punjab*, (1996) 2 SCC 648 : 1996 SCC (Cri) 374

5 *Aruna Ramachandra Shanbaug* v. *Union of India*, (2011) 4 SCC 454 : (2011) 2 SCC (Civ) 280 : (2011) 2 SCC (Cri) 294

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231. The Court in *Aruna Shanbaug case*[5] 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. Divatia[77], Dr Roop Gursahani[78] and Dr Nilesh Shah[79]. The team of doctors studied her medical history and observed that Aruna would get uncomfortable if the room in which she was located was overcrowded, 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.

232. Reliance was placed on the landmark judgment of the House of Lords in *Bland*[11], where for the first time in the English history, the right to die was allowed through the withdrawal of life support 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.

233. 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 in *Aruna Shanbaug*[5] 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.

234. On the aforesaid principle of beneficence and studying the position in some other countries, the Court in its judgment in *Aruna Shanbaug*[5] 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.

235. 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

5 *Aruna Ramachandra Shanbaug* v. *Union of India*, (2011) 4 SCC 454 : (2011) 2 SCC (Civ) 280 : (2011) 2 SCC (Cri) 294

77 Professor and Head, Department of Anaesthesia, Critical Care and Pain at Tata Memorial Hospital, Mumbai.

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

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

11 *Airedale N.H.S. Trust* v. *Bland*, 1993 AC 789 : (1993) 2 WLR 316 : (1993) 1 All ER 821 (CA & HL)

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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 25-2-2014[20], the validity of this aspect has to be examined, which exercise is undertaken by me at an appropriate stage.

Euthanasia: A complex concept

236. 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.

237. 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 a certain extent. First, let us touch the topic from the constitutional angle.

238. 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.*[1] 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 person concerned. 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* v. *Union of India*[58] has taken stock of all important judgments which have echoed the message enshrined in *Kharak Singh case*[1]. We may, however, point out that in *CESC Ltd.* v. *Subhash Chandra Bose*[80], K. Ramaswamy, J. 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 enjoyed. Though Ramaswamy, J. rendered minority opinion in that case, on the

20 *Common Cause* v. *Union of India*, (2014) 5 SCC 338 : (2014) 2 SCC (Cri) 557
1 (1964) 1 SCR 332 : AIR 1963 SC 1295 : (1963) 2 Cri LJ 329
58 (2017) 10 SCC 1
80 (1992) 1 SCC 441 : 1992 SCC (L&S) 313

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aforesaid aspect, majority opinion was not contrary to the views expressed by Ramaswamy, J. Thus, Article 21 recognises right to live with human dignity[81].

239. 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.

240. It would be interesting to point out that in *Rustom Cavasjee Cooper* v. *Union of India*[82] 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 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*[10], however, has taken a view that right to live will not include right not to live.

241. We have already pointed out that Section 306 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 case*[10, 83]. The Court held Sections 306 and 309 IPC to be constitutionally valid. While so holding, the

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

82 (1970) 1 SCC 248

10 *Gian Kaur* v. *State of Punjab*, (1996) 2 SCC 648 : 1996 SCC (Cri) 374

83 It may be noted that the Delhi High Court in *State* v. *Sanjay Kumar Bhatia*, 1985 SCC OnLine Del 134 : 1985 Cri LJ 931 and the Bombay High Court in *Maruti Shripati Dubal* v. *State of Maharashtra*, 1986 SCC OnLine Bom 278 : 1987 Cri LJ 743 had taken the view that Section 309 IPC was unconstitutional, being violative of Articles 14 and 21 of the Constitution. On the other hand, the Andhra Pradesh High Court in *Chenna Jagadeeswar* v. *State of A.P.*, 1987 SCC OnLine AP 263 : 1988 Cri LJ 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 *P. Rathinam* v. *Union of India*, (1994) 3 SCC 394 : 1994 SCC (Cri) 740 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 case*, (1996) 2 SCC 648 : 1996 SCC (Cri) 374 was referred to and decided by the Constitution Bench.

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Court 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. 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.

242. 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 wrongdoing. 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 wrongdoing 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.

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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."

243. 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 impress 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 unliveable 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 counterforces 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.

244. 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.

245. 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

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"value of life" which becomes the foremost focus of discussion. The discussion which follows hereinafter keeps in mind these parameters.

The two issues

246. As already stated above, as of now insofar as "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 consideration 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 regard to the reference order made in the instant petition.)

(*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?

247. Answers to these questions have been provided in the judgment of the 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

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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.

248. As pointed out above, *Aruna Shanbaug*[5] 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*[10], 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 regard to the reference order made in the instant petition.)

249. 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 Henley*[84]

"*Death is our friend … he delivers us from agony. I do not want to die of a creeping paralysis of my faculties — a defeated man.*"

— *Mahatma Gandhi*[85]

"*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*

"*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*

5 *Aruna Ramachandra Shanbaug* v. *Union of India*, (2011) 4 SCC 454 : (2011) 2 SCC (Civ) 280 : (2011) 2 SCC (Cri) 294
10 *Gian Kaur* v. *State of Punjab*, (1996) 2 SCC 648 : 1996 SCC (Cri) 374
84 As quoted in *P. Rathinam* v. *Union of India*, (1994) 3 SCC 394
85 <http://www.mkgandhi.org/articles/last_words.htm> last accessed 16-3-2018.

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250. The aforequoted 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 lifespan 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 मुक़द्दर 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*)

251. 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.

252. 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 lifespan, 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 forever.[86] 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".

253. 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 at the margin of utility.[87] 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

86 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.

87 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.

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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 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.

254. 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 poison 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.

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Just as a surgeon does not commit himsa but practises 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."

255. *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 action.[88] The perspective of the world community is gradually shifting from sanctity of life to quality of life sustained and preserved.

256. 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.

257. 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.

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

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258. 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 a nutshell:

258.1. 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.

258.2. 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.

258.3. Traditional Hindu religious culture also emphasises 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 outweighs all previous claims and intimations of one's moral worth"[89].

258.4. "A good death certifies a good life"[90].

258.5. The *good death* is achieved when death occurs in full consciousness, in a chosen place and at a chosen time; and

258.6. As with Buddhism great significance is attached to the element of choice and the maintenance of control[91], 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".[92] Thus, the final moments of life should be calm, easy and peaceful if dignity is to be preserved.

259. 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***

260. At the outset, I would like to clarify that while discussing a 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

89 T.N. Madan, "Dying with Dignity" (1992) 35(4) *Social Science and Medicine* 425-32.
90 T.N. Madan, "Living and Dying" in *Non-Renunciation: Themes and Interpretations of the Hindu Culture* (New Delhi, Oxford University Press, 1987).
91 J. Parry, *Death and the Regeneration of Life* (Cambridge, Cambridge University Press, 1982).
92 T.N. Madan, "Dying with Dignity" (1992) 35 (4) *Social Science and Medicine* 425-32.

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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."

261. 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 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."[93]

262. Euthanasia is one such critical issue where the law relating to it cannot be divorced from morality. *Lon L. Fuller*[94] 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 standpoint of morality.

263. Influenced primarily by the aforesaid considerations, I deem it relevant to indulge into discussion on morality.

264. 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 practising moral and ethical values. Rightly or wrongly, it is 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 phenomenon. No doubt, as the person advances in age, he becomes mature in his wisdom. However,

93 Justice Holmes, "The Path of the Law", 10 Harvard Law Review 457-78, at p. 459 (1897).
94 Lon L. Fuller, "The Morality of Law" (Revised Edn.), Yale University Press

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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.

265. 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 world's a 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.

266. 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.

267. 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.

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268. In the most secular judicial interpretation of the SOL doctrine yet, Denman, J. of 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."

269. 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.

270. A moral paradox which emerges is beautifully described by *Sushila Rao*[95], 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 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*[11] 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". I 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.

95 Sushila Rao: *Economic and Political Weekly*, Vol. 46, No. 18 (30-4-2011-6-5-2011), pp. 13-16.

11 *Airedale N.H.S. Trust* v. *Bland*, 1993 AC 789 : (1993) 2 WLR 316 : (1993) 1 All ER 821 (CA & HL)

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Lord Browne-Wilkinson lamented this paradox in *Bland*[11] in the following words: (AC p. 885 G)

> '... 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 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."

Interestingly, Sushila Rao concludes that even the active-passive distinction is not grounded much in morality and ethics as in "reasons of policy".

271. John Finnis strongly beliefs 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 burdens.[96]

272. 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 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 coma) 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

11 *Airedale N.H.S. Trust* v. *Bland*, 1993 AC 789 : (1993) 2 WLR 316 : (1993) 1 All ER 821 (CA & HL)

96 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.

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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."[97]

273. John Finnis, 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 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.

274. 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 person concerned 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*

275. 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

97 John Finnis: *Human Rights and Common Good: Collected Essays*, Vol. III.

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judgment in *Lochner* v. *New York*[98], which is reproduced below: (SCC OnLine US SC para 48)

> "*48.* … [The Constitution] is made for people of fundamentally differing views, and the accident of our finding certain 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."

276. 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.

277. 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 contemplations.[99] 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 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*

278. Hinduism does not recognise 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.

98 1905 SCC OnLine US SC 100 : 49 L Ed 937 : 198 US 45 at p. 76 (1905)

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

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279. Professor S.D. Sharma, sums up the position with the following analysis[100]:

> "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."

280. 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*

281. 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 beliefs 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.

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

283. Christianity beliefs 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 object.[101]

Philosophical Model of Dignity

284. The modern conception of human dignity was affected by the philosophy of Kant.[102] Kant's moral theory is divided into two parts: ethics and right (jurisprudence). The discussion of human dignity took place within

100 Prof. S.D. Sharma : *Administration of Justice in Ancient Bharat*, (1988).
101 Based on the approach of Thomas Aquinas (1225-1274) in his work *Summa Theologia.*
102 *See* Toman E. Hill, "Humanity as an End in Itself" (1980) 91 Ethics 84.

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his doctrine of ethics and does not appear in his jurisprudence.[103] Kant's jurisprudence features the concept of a person's right to freedom as a human being.

285. 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, 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.

286. Professor Upendra Baxi in his First Justice H.R. Khanna Memorial Lecture[104], 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:

286.1. Respect for one's capacity as an agent to make one's own free choices.

286.2. Respect for the choices so made.

286.3. Respect for one's need to have a context and conditions in which one can operate as a source of free and informed choice.

287. 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."

288. *Jeremy Waldron*[105] 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:

103 See Pfordten, *On the Dignity of Man in Kant*.
104 Delivered on 25-2-2010 at Indian Institute of Public Administration, New Delhi.
105 See Article of Jeremy Waldron : "How Law Protects Dignity".

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"Dignity is the status of a person predicated on the fact that she is recognised 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."

289. 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

290. The most important lesson which was learnt as a result of the Second World War was the realisation 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 UN 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.

291. Article 3 of the Geneva Convention explicitly prohibits "outrages upon personal dignity". There are provisions to this effect in the 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. 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.

292. 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:

292.1. Human dignity lays a foundation for all the human rights as it is the central argument for the existence of human rights.

292.2. Human dignity as a constitutional value provides meaning to the norms of the legal system. In the process, one can discern that the principle

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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.

293. 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.

294. 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.

295. 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-à-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 recognising him as a full member of the human community, and holds that such treatment is profoundly unjust."[106]

296. In his Book, *Is Democracy Possible Here?*[107] 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 principle, every person has the responsibility for success in his own

106 Ronald Dworkin, *Taking Rights Seriously* (A&C Black, 2013) 239.
107 Ronald Dworkin, *Is Democracy Possible Here? Principles for a New Political Debate* (Princeton University Press, 2006).

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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)[108].

297. 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.[109] According to Dworkin, these principles form the fundamental criteria supervising what we should do in order to live well.[109] They further explicate the rights that individuals have against their political community,[108] 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.

298. 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."[110]

108 Harvard University Press, 2011.

109 Kenneth W. Simons, "Dworkin's Two Principle of Dignity: An Unsatisfactory Non-Consequentialist Account of Interpersonal Moral Duties", 90 Boston Law Rev. 715 (2010)

110 Aharon Barak, *Human Dignity: The Constitutional Value and the Constitutional Right*.

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299. We have to keep in mind that while expounding the aforesaid notion of dignity, Dworkin was not interpreting any Constitution. 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[111] have been taken note of and discussed in *K.S. Puttaswamy*[58].

300. In *K.S. Puttaswamy*[58], 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. Chelameswar, J. in *K.S. Puttaswamy*[58], made certain specific comments which are reflective of euthanasia, though this term is not specifically used. He observed: (SCC p. 530, para 373)

> "*373.* … Forced feeding of certain persons by the State raises concerns of privacy. An individual's right to refuse life prolonging medical treatment or terminate his life is another freedom which falls within the zone of privacy."

301. Liberty by itself, which is a facet of Article 21 of the Constitution, duly recognised in *K.S. Puttaswamy*[58], 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[112] beautifully describes as to why freedom (or liberty) is given:

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111 *Prem Shankar Shukla* v. *State (UT of Delhi)*, (1980) 3 SCC 526 : 1980 SCC (Cri) 815; *Francis Coralie Mullin* v. *State (UT of Delhi)*, (1981) 1 SCC 608 : 1981 SCC (Cri) 212; *Bandhua Mukti Morcha* v. *Union of India*, (1984) 3 SCC 161 : 1984 SCC (L&S) 389; *Khedat Mazdoor Chetna Sangath* v. *State of M.P.*, (1994) 6 SCC 260 : 1994 SCC (Cri) 1643; *M. Nagaraj* v. *Union of India*, (2006) 8 SCC 212 : (2007) 1 SCC (L&S) 1013; *Maharashtra University of Health Sciences* v. *Satchikitsa Prasarak Mandal*, (2010) 3 SCC 786 : (2010) 1 SCC (L&S) 894; *Selvi* v. *State of Karnataka*, (2010) 7 SCC 263 : (2010) 3 SCC (Cri) 1; *Mehmood Nayyar Azam* v. *State of Chhattisgarh*, (2012) 8 SCC 1 : (2012) 4 SCC (Civ) 34 : (2012) 3 SCC (Cri) 733 : (2012) 2 SCC (L&S) 449; *Shabnam* v. *Union of India*, (2015) 6 SCC 702 : (2015) 3 SCC (Cri) 355; *Jeeja Ghosh* v. *Union of India*, (2016) 7 SCC 761 : (2016) 3 SCC (Civ) 551.

58 *K.S. Puttaswamy* v. *Union of India*, (2017) 10 SCC 1

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

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"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 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 I 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."

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302. 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 kinds 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.

303. 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 sociologists.[113]

304. 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?

305. 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*[63], this Court observed: (SCC p. 491, para 75)

"*75.* Article 21, as already indicated, guarantees the protection of "personal autonomy" of an individual. In *Anuj Garg* v. *Hotel Assn. of India*[114] (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-

113 (*i*) Morris: Voluntary Euthanasia

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

63 (2014) 5 SCC 438

114 (2008) 3 SCC 1

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expression and falls within the realm of personal liberty guaranteed under Article 21 of the Constitution of India."

306. 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.

307. 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*."[115]

308. Dignity is, thus, the core value of life and dying in dignity stands recognised in *Gian Kaur*[10]. It becomes a part of right of self-determination.

309. The important message behind Dworkin's concept of human dignity can be summarised in the following manner:

309.1. 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"[116].

309.2. 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"[117].

309.3. Death is "not only the start of nothing but the end of everything"[118] and, therefore, it should be accomplished in a manner compatible with the ideals sought during life.

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

310.1. Encompasses *self-determination*; implies a quality of life consistent with the ability to exercise self-determined choices;

310.2. Maintains/ability to make *autonomous choices*; high regard for individual autonomy that is pivotal to the perceived quality of a person's life;

310.3. *Self-control* (retain a similar kind of control over dying as one has exercised during life—a way of achieving death with dignity);

115 Ronald Dworkin, *Life's Dominion* (2nd Edn., Vintage Books, New York 1944) 239.
10 *Gian Kaur* v. *State of Punjab*, (1996) 2 SCC 648 : 1996 SCC (Cri) 374
116 R. Dworkin, *Life's Dominion* (London, Harper-Collins, 1993) at p. 166.
117 *Id* at p. 179.
118 *Ibid*.

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310.4. Law of *consent*: The ability to choose—orchestrate the timing of their own death;

310.5. Dignity may be compromised if the dying process is prolonged and involves becoming incapacitated and dependent;

310.6. Respect for human dignity means respecting the *intrinsic value of human life*;

310.7. Avoidance of dependency;

310.8. Indefinite continuation of futile physical life is regarded as undignified;

310.9. Dignity commands emphatic respect[119]:

310.9.1. Reason and emotion are both significant in treatment decisions, especially at the end of life where compassion is a natural response to appeals made on the basis of stifled self-determination;

310.9.2. Compassion represents a collision of "imaginative insight" and empathy; and

310.9.3. Compassion is here distinguished from pity, which is regarded as "inappropriate to the dignity of the autonomous person, especially its overtones of paternalism",[120] because compassion is believed to provoke an active, and by implication positive, response.[121]

310.10. 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"[122]; and

310.11. *Observer's dignity aspect*:

310.11.1. 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

310.11.2. Dignity clearly does play a valuable role in contextualising people's perceptions of death and dying, especially as it appears to embody a spirit of self-determination that advocates of voluntary euthanasia crave.

311. 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:

311.1. The opportunity to die unencumbered by the intrusion of medical technology and before experiencing loss of independence and control, appears

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

120 R.S. Downie, K.S. Calman, *Healthy Respect: Ethics in Healthcare* (Oxford, Oxford University Press, 1994) at 51-53.

121 *Ibid*.

122 A. Kolnai, "Dignity", in R.S. Dillon (Ed.) *Dignity, Character, and Self-Respect* (London, Routledge, 1995) 53-75, at 56.

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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;

311.2. Today many patients insist on more than just a right to healthcare 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;

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

312. 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?

313. 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[123] 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,

123 Dr R.R. Kishore, MD, LLB — *End of Life Issues and the Moral Certainty: A Discovery Through Hinduism.*

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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 optimisation 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 potential of keeping alive the terminally ill and incurable persons who would have otherwise died. Since the technological resources are not unlimited prioritisation 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 liberalisation is fraught with following apprehensions:

(*i*) Danger of abuse;

(*ii*) Enhanced vulnerability to the poor;

(*iii*) Slippery slope outcome;

(*iv*) 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 resources. 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."

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314. In the article, "End of Life Issues and the Moral Certainty"[124], the author after posing the moral dilemma, noted above, discusses the approach to find the solutions.

315. 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.

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

317. 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.

318. 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.

319. 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 brain dead, 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*[5].

124 Dr R.R. Kishore, "End of Life Issues and the Moral Certainty: A Discovery Through Hinduism" Eubios Journal of Asian and International Bioethics, Vol. 13(6), Nov. 2003 at pp. 210-13.

5 *Aruna Ramachandra Shanbaug* v. *Union of India*, (2011) 4 SCC 454 : (2011) 2 SCC (Civ) 280 : (2011) 2 SCC (Cri) 294

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(D) ***Economics of euthanasia***

320. This is yet another reason for arriving at the same conclusion.

321. 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:

321.1. 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.

321.2. Secondly, when there are limited medical facilities available, should a major part thereof be consumed on those patients who have no chances of recovery?

322. In *Economic & Political Weekly* dated 10-2-2018, it is reported:

> "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."

323. 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[125] 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 benefits to society

125 "Healthcare Rationing: Can We Afford to Ignore Euthanasia?", Health Services Management Research 1997; 10; 32-41.

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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[126]) 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*".

324. 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 patient along with the wider economic considerations[127]. In the instant case, we have come to the conclusion that under certain circumstances i.e. when the patient is in PVS or brain dead/ 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.

325. At times, for deciding legal issues, economic analysis of law assumes importance[128]. 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 optimality[129]—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 efficiency.

326. 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

126 Mooney G., *The Valuation of Human Life*, London: Macmillan Press, 1977.

127 See *Economics and Euthanasia* by Stephen Heasell, Department of Economics and Politics, Nottingham Trent University, and David Paton, Nottingham University Business School.

128 This aspect is discussed in some detail by this Court in *Shivashakti Sugars Ltd.* v. *Shree Renuka Sugar Ltd.*, (2017) 7 SCC 729 : (2017) 4 SCC (Civ) 234.

129 Jeffrie G. Murphy & Jules L. Coleman: *Philosophy of Law (An Introduction to Jurisprudence).*

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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*[5], 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

327. 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?***

328. 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 a 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 is brain dead/clinically dead.

329. It is an undisputed fact 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*[5] while dealing with the issue of "involuntary passive euthanasia". To quote: (SCC pp. 497-98, 501 & 502, paras 66, 67 & 78)

> "*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.

5 *Aruna Ramachandra Shanbaug* v. *Union of India*, (2011) 4 SCC 454 : (2011) 2 SCC (Civ) 280 : (2011) 2 SCC (Cri) 294

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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…

* * *

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*[42], NE at p. 93, per Cardozo, J.; *S.* v. *McC. (Orse. S.) and M. (D.S. Intervener)*[130], AC at p. 43, per Lord Reid; and *Sidaway* v. *Board of Governors of the Bethlem Royal Hospital*[131], 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*[132]). 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*[133]]. 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.' (*Airedale case*[11], AC p. 864 C-G) (emphasis in original)

42 105 NE 92 : 211 NY 125 (1914)
130 1972 AC 24 : (1970) 3 WLR 366 (HL)
131 1985 AC 871 : (1985) 2 WLR 480 : (1985) 1 All ER 643 (HL)
132 (1992) 86 DLR (4th) 385 (Que SC)
133 1993 Fam 95 : (1992) 3 WLR 782 : (1992) 4 All ER 649 (CA)
11 *Airedale N.H.S. Trust* v. *Bland*, 1993 AC 789 : (1993) 2 WLR 316 : (1993) 1 All ER 821 (CA & HL)

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330. The aforesaid principle has also been recognised by this Court in its Constitution Bench judgment passed in *Gian Kaur*[10] 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: (SCC pp. 660-61, paras 24 & 25)

> "*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."

331. 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*[5]. In August 2012, the 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 28-8-2006 addressed to the Hon'ble Minister are extracted below:

10 *Gian Kaur* v. *State of Punjab*, (1996) 2 SCC 648 : 1996 SCC (Cri) 374

5 *Aruna Ramachandra Shanbaug* v. *Union of India*, (2011) 4 SCC 454 : (2011) 2 SCC (Civ) 280 : (2011) 2 SCC (Cri) 294

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'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.'

* * *

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 2006 Bill]. "*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

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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'.

* * *

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 (under Section 309 IPC) nor is the doctor who omits to give treatment, guilty of abetting suicide (under Section 306 IPC) or of culpable homicide (under Section 299 read with Section 304 IPC).

* * *

7.2. In this context, two cardinal principles of medical ethics are stated to be patient autonomy and beneficence (vide p. 482, para 12 of SCC in *Aruna case*[5]):

'*12*. … '*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 he/she been competent, or to act in the patient's best interest. …

2. Beneficence is acting in what is (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. …'

* * *

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

5 *Aruna Ramachandra Shanbaug* v. *Union of India*, (2011) 4 SCC 454 : (2011) 2 SCC (Civ) 280 : (2011) 2 SCC (Cri) 294

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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 case*[10], 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 decriminalising 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 Browne-Wilkinson in *Airedale case*[11]), the doctor/surgeon is guilty of "assault" or "battery". In the words of Justice Cardozo[42], '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 case*[11] 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: (AC p. 864G)

> '... 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.' " (emphasis in original)

332. 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

10 *Gian Kaur* v. *State of Punjab*, (1996) 2 SCC 648 : 1996 SCC (Cri) 374
11 *Airedale N.H.S. Trust* v. *Bland*, 1993 AC 789 : (1993) 2 WLR 316 : (1993) 1 All ER 821 (CA & HL)
42 *Schloendorff* v. *Society of New York Hospital*, 105 NE 92 : 211 NY 125 (1914)

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Supreme Court in *Aruna Ramachandra case*[5]. 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 the Law Commission in 196th report are 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 the 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 to issue guidelines in the matter of withholding or withdrawing of medical treatment to competent or incompetent patients suffering from terminal illness.

5 *Aruna Ramachandra Shanbaug* v. *Union of India*, (2011) 4 SCC 454 : (2011) 2 SCC (Civ) 280 : (2011) 2 SCC (Cri) 294

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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*[5]. The revised Bill is at Annexure I."

333. I am also of the view that such an advance authority is akin to well-recognised common law right to refuse medical treatment [see: *T. (Adult: Refusal of Treatment), In re*[133], *B. (Adult: Refusal of Medical Treatment), In re*[134], *Cruzan* v. *Missouri Deptt. of Health*[4], *Malette* v. *Shulman*[45]].

334. In a recent landmark judgment of the nine-Judge Constitution Bench in *K.S. Puttaswamy*[58] authoritatively held that right to life enshrined in Article 21 includes right to privacy. One of the facet of this right acknowledged is an individual's decision to refuse life prolonging medical treatment or terminate his life. Chelameswar, J. in his separate opinion has described the same in the following manner: (SCC pp. 530-31, para 373)

"*373*. Concerns of privacy arise when the State seeks to intrude into the body of subjects. [*Skinner* v. *Oklahoma*[135]: '*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)

5 *Aruna Ramachandra Shanbaug* v. *Union of India*, (2011) 4 SCC 454 : (2011) 2 SCC (Civ) 280 : (2011) 2 SCC (Cri) 294
133 1993 Fam 95 : (1992) 3 WLR 782 : (1992) 4 All ER 649 (CA)
134 (2002) 2 All ER 449
4 1990 SCC OnLine US SC 123 : 111 L Ed 2d 224 : 110 S Ct 2841 : 497 US 261 (1990)
45 (1990) 67 DLR (4th) 321 : 72 OR (2d) 417 (CA)
58 *K.S. Puttaswamy* v. *Union of India*, (2017) 10 SCC 1
135 1942 SCC OnLine US SC 125 : 86 L Ed 1655 : 316 US 535 (1942)

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(*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*[50]] A person's freedom to choose the place of his residence once again is a part of his right to privacy [*Williams* v. *Fears*[136]: '*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 abovementioned 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 tappings 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 abovementioned 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

335. 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.

50 (1978) 1 SCC 248
136 1900 SCC OnLine US SC 211 : 45 L Ed 186 : 179 US 270 (1900)

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336. 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 N.H.S. Trust* v. *Bland*[11], 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 practise 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

11 1993 AC 789 : (1993) 2 WLR 316 : (1993) 1 All ER 821 (CA & HL)

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life while it lasts. A trade-off between length of life and quality of life is permissible."

337. 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 Reports. Instead, attempt can be made to provide safeguards for exercise of such Advance Directive. For example, Section 5 of the Mental Health Care Act, 2017 recognises the validity of Advance Directives for the treatment of mental illness under the Mental Health Care Act, 2017. The draft Mental Health Care 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 is 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 medical practitioner concerned 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.

338. 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:

338.1. In UK, 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

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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.

338.2. 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 110-Q 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 healthcare 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.

338.3. 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 110-S 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.

338.4. 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 Sections 110-V, 110-W, 110-X, 110-Y and 110-Z of the Western Australia

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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.

339. Mr Datar has suggested that this Court should frame the guidelines to cover the following aspects:

339.1. Who will be competent to execute an Advance Directive?

339.2. In what form will an Advance Directive have to be issued in order to be valid?

339.3. Who is to ensure that an Advance Directive is properly obeyed?

339.4. What legal consequences follow from the non-obedience to an Advance Directive?

339.5. In what circumstances can a doctor refuse to enforce an Advance Directive?

340. Mr Datar has given the following suggestions on the aforesaid aspects:

340.1. 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.

340.2. 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 eye 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.

340.3. Primary responsibility for ensuring compliance with the Advance Directive should be on the medical institution where the person is receiving such treatment.

340.4. If a hospital refuses to recognise the validity of an Advance Directive, the relatives or next friend may approach the jurisdictional High Court seeking a writ of mandamus against the hospital concerned 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.

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340.5. No hospital or doctor should be made liable in civil or criminal proceedings for having obeyed a validly executed Advance Directive.

340.6. 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.

341. 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.

342. 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.

DR D.Y. CHANDRACHUD, J. (*concurring*)—

A. *Introduction: On Death and Dying*

343. Life and death are inseparable. Every moment of our lives, our bodies are involved in a process of continuous change. Millions of our cells perish as nature regenerates new ones. Our minds are rarely, if ever, constant. Our thoughts are fleeting. In a physiological sense, our being is in a state of flux, change being the norm. Life is not disconnected from death. To be, is to die. From a philosophical perspective, there is no antithesis between life and death. Both constitute essential elements in the inexorable cycle of existence.

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

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

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

346. Human beings through the ages have been concerned with death as much as with dying. Death represents a culmination, the terminal point of life.

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

347. The progression of life takes its toll on the human body and the mind. As we age, simple tasks become less simple and what seemed to be a matter of course may become less so. Human beings then turn ever more to the substance that matters. As events, relationships, associations and even memories fall by the way, we are left with a lonesome remnant of the person, which defines the core of our existence. The quest of finding meaning in that core is often a matter of confronting our fears and tragedies.

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

349. Dilemmas relating to the end of life have been on the frontline of debate across the world in recent decades. The debate has presented "a complex maze of dilemmas for all — the doctor, the lawyer, the patient and the patient's relatives"[137] and straddles issues of religion, morality, biomedical ethics and constitutional law. It has involved "issues ranging from the nature and meaning

137 "The Dilemmas of Euthanasia", *Bio-Science* (August 1973), Vol. 23, No. 8, at p. 459.

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of human life itself, to the most fundamental principles on which our societies are and should be based"[138].

350. There is an "ongoing struggle between technology and the law"; as "medical technology has become more advanced, it has achieved the capability both to prolong human life beyond its natural endpoint and to better define when that endpoint will occur".[139] Medical science has contributed in a significant way to enhancing the expectancy of life. Diseases once considered fatal have now become treatable. Medical research has redefined our knowledge of ailments — common and uncommon; of their links with bodily functions and the complex relationship between mental processes and physical well-being. Science which affects the length of life also has an impact on the quality of the years in our lives. Prolonging life should, but does not necessarily result in, a reduction of suffering. Suffering has a bearing on the quality of life. The quality of life depends upon the life in our years. Adding to the length of life must bear a functional nexus with the quality of life. Human suffering must have significance not only in terms of how long we live but also in terms of how well we live.

351. Modern medicine has advanced human knowledge about the body and the mind. Equipped with the tools of knowledge, science has shown the ability to reduce human suffering. Science has also shown an ability to prolong life. Yet in its ability to extend life, medical science has an impact on the quality of life, as on the nature and extent of human suffering. Medical interventions come with costs, both emotional and financial. The ability of science to prolong life must face an equally important concern over its ability to impact on the quality of life. While medical science has extended longevity, it has come with associated costs of medical care and the agony which accompanies an artificially sustained life. Medical ethics must grapple with the need to bring about a balance between the *ability* of science to extend life with the *need* for science to recognise that all knowledge must enhance a meaningful existence.

352. There is "no consensus as to the rights and wrongs of helping someone to die"[140], as the legal status of euthanasia has been subjected to social, ethical and moral norms that have been handed down to us. Decisions regarding the end of life can be ethically more problematic when the individual is no longer mentally competent to make his or her own decisions.[141] The existential and metaphysical issues involved in this debate, include the fear of the unknown,

138 Margaret A. Somerville, "Legalising Euthanasia: Why Now?", The Australian Quarterly (Spring 1996), Vol. 68, No. 3, at p. 1.

139 Christopher N. Manning, "Live and Let Die: Physician-Assisted Suicide and the Right to Die", Harvard Journal of Law and Technology (1996), Vol. 9, No. 2, at p. 513.

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

141 Elizabeth Wicks, *The Right to Life and Conflicting Interests* (Oxford University Press, 2010), at p. 199.

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the uncertainty of when death will occur, the scarcity of healthcare, freedom or coercion in choosing to receive or not to receive medical treatment, the dignity and degradation of ageing and being able to care for oneself independently.[142]

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

353.1. (*i*) Does an individual have a constitutionally recognised right to refuse medical treatment or to reject a particular form of medical treatment?

353.2. (*ii*) If an individual does possess such a right, does a right inhere in the individual to determine what course of action should be followed in the future if she or he were to lose control over the faculties which enable them to accept or refuse medical treatment?

353.3. (*iii*) Does the existence of a right in the individual impose a corresponding duty on a medical professional who attends to the individual, to respect the right and what, if any, are the qualifications of that duty?

353.4. (*iv*) Does the law permit a medical practitioner to withhold or refuse medical treatment towards the end of life to an individual who is no longer in control of his or her faculties in deference to a desire expressed while in a fit state of mind? and

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

354. This Court has to consider euthanasia and its impact "not only at an individual level", but also at the "institutional, governmental and societal levels".[143] The impact has to be analysed not only in the context of the present era, but has to be contemplated for the future as well. The Judge is not a soothsayer. Nor does the law have predictive tools at its command which can approximate those available to a scientist. Constitutional principle must have an abiding value. It can have that value if it is firmly grounded in the distilled experience of the past, is flexible to accommodate the concerns of the present and allows room for the unforeseeable future. The possibility of the abuse of euthanasia and the effect that legalising euthanasia would have on intangible societal fabrics and institutions is of utmost concern.

142 Elizabeth M. Andal Sorrentino, "The Right To Die?", Journal of Health and Human Resources Administration (Spring, 1986), Vol. 8, No. 4, p. 361.
143 *Ibid.*

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

> "If to be human is to be limited, then the role of caring professions and institutions—from surgeons to nursing homes—ought to be aiding people in their struggle with those limits. Sometimes we can offer a cure, sometimes only a salve, sometimes not even that. But whatever we can offer, our interventions, and the risks and sacrifices they entail, are justified only if they serve the large aims of a person's life. When we forget that, the suffering we inflict can be barbaric. When we remember it, the good we do can be breathtaking."[144]

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

> "A few conclusions become clear when we understand this: that our most cruel failure in how we treat the sick and the aged is the failure to recognise that they have priorities beyond merely being safe and living longer; that the chance to shape one's story is essential to sustaining meaning in life; that we have the opportunity to refashion our institutions, our culture, and our conversations in ways that transform the possibilities for the last chapters of everyone's lives."[145]

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

> "We have to choose between probabilities, not certainties, and that is difficult. How *probable* is it that we will gain how many extra years of life, and what might the *quality* of those years be, if we submit ourselves to the pain and unpleasantness of treatment? And what is the probability that the treatment will cause severe side-effects that outweigh any possible benefits? When we are young it is usually easy to decide—but when we are old, and reaching the end of our likely lifespan? We can choose, at least in theory, but our inbuilt optimism and love of life, our fear of death and the difficulty we have in looking at it steadily, make this very difficult. We inevitably hope that we will be one of the lucky ones, one of the long-term survivors, at the good and not the bad tail-end of the statisticians' normal distribution. And yet it has been estimated that in the developed world, 75 per cent of our lifetime medical costs are incurred in the last six months of our lives. This is the price of hope, hope which, by the laws of probability, is so often unrealistic. And thus we often end up inflicting both great suffering on ourselves and unsustainable expense on society."[146] (emphasis in original)

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

144 Atul Gawande, *Being Mortal: Medicine and What Matters in the End* (Hamish Hamilton, 2014), at p. 260.
145 Ibid., at p. 243.
146 Henry Marsh, *Admissions: A Life in Brain Surgery*, (Weidenfeld & Nicolson, 2017), at pp. 265-66.

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357. The central aspect of the case is the significance which the Constitution attaches to the ability of every individual in society to make personal choices on decisions which affect our lives. Randy Pausch, a Professor at Stanford had this to say in a book titled *The Last Lecture* (2008),[147] a discourse delivered by him in the shadow of a terminal illness:

> "We cannot change the cards we are dealt, just how we play the hand."

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

B. ***The reference***

358. On 25-2-2014[20], three Judges of this Court opined that the issues raised in this case need to be considered by a Constitution Bench. The referring order notes that the case involves "social, legal, medical and constitutional" perspectives which should be considered by five Judges. At the heart of the proceeding, is a declaration which Common Cause seeks that the right to die with dignity is a fundamental right which arises from the right to live with dignity. Article 21 of the Constitution is a guarantee against the deprivation of life or personal liberty except according to the procedure established by law. As our law has evolved, the right against the violation of life and personal liberty has acquired much more than a formal content. It can have true meaning, if only it includes the right to live with dignity. It is on this premise that the Court is urged to hold that death with dignity is an essential part of a life of dignity. A direction is sought to the Union Government to adopt suitable procedures to ensure that persons with "deteriorated health" or those who are terminally ill should be able to execute a document in the form of "a living will and attorney authorisation" which can be presented to a hospital for appropriate action if the person who has made it, is hospitalised with a serious illness which may cause the end of life. The petitioner also seeks, in the alternative, that this Court should issue guidelines and appoint an expert committee consisting of doctors, social scientists and lawyers who will govern the making of "living wills".

359. Individuals who suffer from chronic disease or approach the end of the span of natural life often lapse into terminal illness or a permanent vegetative state. When a medical emergency leads to hospitalisation, individuals in that condition are sometimes deprived of their right to refuse unwanted medical treatment such as feeding through hydration tubes or being kept on a ventilator and other life support equipment. Life is prolonged artificially resulting in human suffering. The petition is founded on the right of each individual to make an informed choice. Documenting a wish in advance, not to be subjected to artificial means of prolonging life, should the individual not be in a position later to comprehend or decline treatment, is a manifestation of individual choice and autonomy. The process of ageing is marked by a sense of helplessness.

147 Randy Pausch and Jeffrey Zaslow, *The Last Lecture*, (Hodder & Stoughton, 2008), at p. 17.
20 *Common Cause* v. *Union of India*, (2014) 5 SCC 338 : (2014) 2 SCC (Cri) 557

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Human faculties decline as we grow older. Social aspects of ageing, such as the loss of friendships and associations combine with the personal and intimate to enhance a sense of isolation. The boundaries and even the limits of constitutional law will be tested as the needs of the ageing and their concerns confront issues of ethics, morality and of dignity in death.

360. In support of its contention, the petitioner relies upon two decisions: a decision rendered in 1996 by a Constitution Bench in *Gian Kaur* v. *State of Punjab*[10] ("*Gian Kaur*") and a decision of 2011 rendered by two Judges in *Aruna Ramachandra Shanbaug* v. *Union of India*[5] ("*Aruna Shanbaug*"). The decision in *Gian Kaur*[10] arose from a conviction for the abetment of suicide. In an earlier decision rendered by two Judges in 1994 — *P. Rathinam* v. *Union of India*[6] ("*Rathinam*"), penalising an attempt to commit suicide was held to violate Article 21 on the foundation that the right to life includes the right to die. The decision in *Rathinam*[6] was held not to have laid down the correct principle, in *Gian Kaur*[10]. Hence the decision in *Aruna Shanbaug*[5] noted that Article 21 does not protect the right to die and an attempt to commit suicide is a crime. However, in *Aruna Shanbaug*[5], the Court held that since *Gian Kaur*[10] rules that the right to life includes living with human dignity, "in the case of a dying person who is terminally ill or in a permanent vegetative state, he may be permitted to terminate by a premature extinction of his life", and this would not be a crime. The Bench which decided *Aruna Shanbaug*[5] was of the view that *Gian Kaur*[10] had "quoted with approval" the view of the House of Lords in the UK in *Airedale N.H.S. Trust* v. *Bland*[11] ("*Airedale*").

361. When these judgments were placed before a Bench of three Judges in the present case, the Court observed that there were "inherent inconsistencies" in the judgment in *Aruna Shanbaug*[5]. The referring order accordingly opined that: (*Common Cause case*[20], SCC pp. 343-44, para 13)

> "*13. … Aruna Shanbaug*[5] aptly interpreted the decision of the Constitution Bench in *Gian Kaur*[10] 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*[10], the Constitution Bench approved the decision of the House of Lords in *Airedale* v. *Bland*[11]. Para 40 of *Gian Kaur*, clearly states that: (SCC p. 65)
>
> > '*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.*'
>
> Thus, it was a mere reference in the verdict and it cannot be construed to mean that the Constitution Bench in *Gian Kaur*[10] approved the opinion of

10 (1996) 2 SCC 648 : 1996 SCC (Cri) 374
5 (2011) 4 SCC 454 : (2011) 2 SCC (Civ) 280 : (2011) 2 SCC (Cri) 294
6 (1994) 3 SCC 394 : 1994 SCC (Cri) 740
11 1993 AC 789 : (1993) 2 WLR 316 : (1993) 1 All ER 821 (CA & HL)
20 *Common Cause* v. *Union of India*, (2014) 5 SCC 338 : (2014) 2 SCC (Cri) 557

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the House of Lords rendered in *Airedale*[11]. To this extent, the observation in para 101 of *Aruna Shanbaug*[5] is incorrect." (emphasis in original)

The referring order goes on to state that: (SCC p. 344, para 15)

"*15*. In paras 21 and 101, the Bench [in *Aruna Shanbaug*[5]] was of the view that in *Gian Kaur*[10], the Constitution Bench held that euthanasia could be made lawful only by a legislation. Whereas in para 104, the Bench contradicts its own interpretation of *Gian Kaur*[10] in para 101 and states that although this Court approved the view taken in *Airedale*[11], it has not clarified who can decide whether life support should be discontinued in the case of an incompetent person e.g. a person in coma or PVS. When, at the outset, it is interpreted to hold that euthanasia could be made lawful only by legislation where is the question of deciding whether the life support should be discontinued in the case of an incompetent person e.g. a person in coma or PVS."

The reason why the case merits evaluation by the Constitution Bench is elaborated in the order dated 25-2-2014[20]. Simply put, the basis of the reference to the Constitution Bench is that:

361.1. *Gian Kaur*[10] affirms the principle that the right to live with dignity includes the right to die with dignity;

361.2. *Gian Kaur*[10] has not ruled on the validity of euthanasia, active or passive;

361.3. *Aruna Shanbaug*[5] proceeds on the erroneous premise that *Gian Kaur*[10] approved of the decision of the House of Lords in *Airedale*[11];

361.4. While *Aruna Shanbaug*[5] accepts that euthanasia can be made lawful only through legislation, yet the Court accepted the permissibility of passive euthanasia and set down the procedure which must be followed; and

361.5. *Aruna Shanbaug*[5] is internally inconsistent and proceeds on a misconstruction of the decision in *Gian Kaur*[10].

362. This being the basis of the reference, it is necessary to consider the decisions in *Gian Kaur*[10] and *Aruna Shanbaug*[5].

C. *Gian Kaur*[10]

363. Gian Kaur and Harbans Singh were spouses. They were convicted of abetting the suicide of Kulwant Kaur and were held guilty of an offence under Section 306 of the Penal Code. They were sentenced to six years' imprisonment. The conviction was upheld by the High Court. The conviction was assailed before this Court on the ground that Section 306

11 *Airedale N.H.S. Trust* v. *Bland*, 1993 AC 789 : (1993) 2 WLR 316 : (1993) 1 All ER 821 (CA & HL)
5 *Aruna Ramachandra Shanbaug* v. *Union of India*, (2011) 4 SCC 454 : (2011) 2 SCC (Civ) 280 : (2011) 2 SCC (Cri) 294
10 *Gian Kaur* v. *State of Punjab*, (1996) 2 SCC 648 : 1996 SCC (Cri) 374
20 *Common Cause* v. *Union of India*, (2014) 5 SCC 338 : (2014) 2 SCC (Cri) 557

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is unconstitutional. It was argued that the constitutionality of Section 306 rested on the two-Judge Bench decision in *Rathinam*[6], where Section 309 (penalising the attempt to commit suicide) was held to be unconstitutional. While *Rathinam*[6] had rejected the challenge to the validity of Section 309 on the ground that it was arbitrary (and violated Article 14), the provision was held to be unconstitutional on the ground that it violated Article 21. The right to die was found to inhere in the right to life, as a result of which Section 309 was found to be invalid. The challenge in *Gian Kaur*[10] was premised on the decision in *Rathinam*[6]: abetment of suicide by another (it was urged) is merely assisting in the enforcement of the fundamental right under Article 21 and hence Section 306 (like Section 309) would violate Article 21.

364. The Constitution Bench in *Gian Kaur*[10] disapproved of the foundation of *Rathinam*[6], holding that it was flawed. The Constitution Bench held thus: (*Gian Kaur case*[10], SCC p. 660, para 22)

> "*22*. When a man commits suicide he has to undertake certain positive overt acts and the genesis of those acts cannot be traced to, or be included within the protection of the "right to life" under Article 21. The significant aspect of "sanctity of life" is also not to be overlooked. Article 21 is a provision guaranteeing protection of life and personal liberty and by no stretch of imagination can "extinction of life" be read to be included in "protection of life". Whatever may be the philosophy of permitting a person to extinguish his life by committing suicide, we find it difficult to construe Article 21 to include within it the "right to die" as a part of the fundamental right guaranteed therein. "Right to life" is a natural right embodied in Article 21 but suicide is an unnatural termination or extinction of life, and therefore, incompatible and inconsistent with the concept of "right to life". With respect and in all humility, we find no similarity in the nature of the other rights, such as the right to "freedom of speech", etc. to provide a comparable basis to hold that the "right to life" also includes the "right to die". With respect, the comparison is inapposite, for the reason indicated in the context of Article 21. The decisions relating to other fundamental rights wherein the absence of compulsion to exercise a right was held to be included within the exercise of that right, are not available to support the view taken in *P. Rathinam*[6] qua Article 21."

The Court further held that: (SCC p. 660, para 23)

> "*23*. To give meaning and content to the word "life" in Article 21, it has been construed as life with human dignity. Any aspect of life which makes it dignified may be read into it but not that which extinguishes it and is, therefore, inconsistent with the continued existence of life resulting in effacing the right itself. The "right to die", if any, is inherently inconsistent with the "right to life" as is "death" with "life"."

6 *P. Rathinam* v. *Union of India*, (1994) 3 SCC 394 : 1994 SCC (Cri) 740
10 *Gian Kaur* v. *State of Punjab*, (1996) 2 SCC 648 : 1996 SCC (Cri) 374

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365. *Gian Kaur*[10] holds that life within the meaning of Article 21 means a life of dignity. Extinguishment of life is (in that view) inconsistent with its continued existence. Hence, as a matter of textual construction, the right to life has been held not to include the right to die. In coming to that conclusion, it appears that *Gian Kaur*[10] emphasises two strands (which the present judgment will revisit at a later stage). The first strand is the sanctity of life, which Article 21 recognises. Extinction of life, would in this view, in the manner which *Rathinam*[6] allowed, violate the sanctity of life. The second strand that emerges from *Gian Kaur*[10] is that the right to life is a natural right. Suicide as an unnatural extinction of life is incompatible with it. The Court distinguishes the right to life under Article 21 from other rights which are guaranteed by Article 19 such as the freedom of speech and expression. While free speech may involve the absence of a compulsion to exercise the right (the right not to speak) this could not be said about the right to life. The Constitution Bench noticed the debate on euthanasia in the context of individuals in a permanent vegetative state. A scholarly article on the decision notes that the Constitution Bench "seemed amenable to an exception being made for euthanasia in cases of patients in a condition of PVS[148]. This view of the decision in *Gian Kaur*[10] does find support in the following observations of the Constitution Bench: (SCC p. 660, para 24)

> "*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."

However, in the paragraph which followed, the Constitution Bench distinguished between cases where a premature end to life may be permissible, when death is imminent, from the right to commit suicide: (SCC pp. 660-61, para 25)

> "*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"

10 *Gian Kaur* v. *State of Punjab*, (1996) 2 SCC 648 : 1996 SCC (Cri) 374
6 *P. Rathinam* v. *Union of India*, (1994) 3 SCC 394 : 1994 SCC (Cri) 740
148 Sushila Rao, "India and Euthanasia: The Poignant Case of Aruna Shanbaug", Oxford Medical Law Review, Vol. 19, Issue 4 (1-12-2011), at pp. 646-656.

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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."

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

366. This Court's holding in *Gian Kaur*[10] that the right to life does not include the right to die in the context of suicide may require to be revisited in future in view of domestic and international developments[149] pointing towards decriminalisation of suicide. In India, the Mental Health Care Act, 2017 has created a "presumption of severe stress in cases of attempt to commit suicide". Section 115(1) provides thus:

> "**115.** ***Presumption of severe stress in case of attempt to commit suicide.***—(1) Notwithstanding anything contained in Section 309 of the Indian Penal Code any person who attempts to commit suicide shall be presumed, unless proved otherwise, to have severe stress and shall not be tried and punished under the said Code."

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

10 *Gian Kaur* v. *State of Punjab*, (1996) 2 SCC 648 : 1996 SCC (Cri) 374

149 "Humanization and Decriminalization of Attempt to Suicide", Law Commission of India (Report No. 210, 2008); Rajeev Ranjan, et al, "(De-) Criminalization of Attempted Suicide in India: A Review", Industrial Psychiatry Journal (2014), Vol. 23, Issue 1, at pp. 4-9.

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367. It may also be argued that the right to life and the right to die are not two separate rights, but two sides of the same coin. The right to life is the right to decide whether one will *or will not* continue living.[150] If the right to life were only a right to decide to continue living and did not also include a right to decide not to continue living, then it would be a *duty* to live rather than a *right* to life. The emphasis on life as a right and not as a duty or obligation has also been expressed by several other legal scholars:

> "When, by electing euthanasia, the individual has expressly renounced his right to life, the State cannot reasonably assert an interest in protecting that right as a basis for overriding the individual's private decision to die. To hold otherwise makes little more sense than urging a prohibition against destroying or giving away one's private property simply because the Constitution protects property as well as life. Although the Constitution recognizes that human life is, to most persons, of inestimable value and protects against its taking without due process of law, *nothing in that document compels a person to continue living who does not desire to do so. Such an interpretation effectively converts a right into an obligation, a result the Constitution-Framers manifestly did not intend.*"[151] (emphasis supplied)

368. For the present case, we will leave the matter there, since neither side has asked for reconsideration of *Gian Kaur*[10], it being perhaps not quite required for the purposes of the reference.

369. At this stage, it is also necessary to note that the decision in *Gian Kaur*[10] contained a passing reference to the judgment of the House of Lords in *Airedale*[11] which dealt with the withdrawal of artificial measures for the continuance of life by a physician. In that context, it was held that a persistent vegetative state was of no benefit to the patient and hence, the principle of sanctity of life is not absolute. The Constitution Bench reproduced the following extracts from the decision in *Airedale*[11]: (*Gian Kaur case*[10], SCC p. 665, para 40)

> "*40.* ... '... But it is not lawful for a doctor to administer a drug to his patient to bring about his death, even though that course is prompted by a humanitarian desire to end his suffering, however great that suffering may be [see *R.* v. *Cox*[21], (unreported), 18-9-1992]. 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

150 D. Benatar, "Should There Be a Legal Right to Die?" *Current Oncology* (2010), Vol. 17, Issue 5, at pp. 2-3.

151 Richard Delgado, "Euthanasia Reconsidered—The Choice of Death as an Aspect of the Right of Privacy", Arizona Law Review (1975), Vol. 17, at p. 474.

10 *Gian Kaur* v. *State of Punjab*, (1996) 2 SCC 648 : 1996 SCC (Cri) 374

11 *Airedale N.H.S. Trust* v. *Bland*, 1993 AC 789 : (1993) 2 WLR 316 : (1993) 1 All ER 821 (CA & HL)

21 18-9-1992, Ognall, J. (unreported).

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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.*' (*Airedale case*[11], AC p. 865 E-G)" (emphasis in original)

Making emphasis as above, this Court held that it is in the realm of the legislature to enact a suitable law to provide adequate safeguards regarding euthanasia. The Constitution Bench noted that the desirability of bringing about such a change was considered (in *Airedale*[11]) to be a function of the legislature by enacting a law with safeguards, to prevent abuse.

D. *Aruna Shanbaug*[5]

370. Aruna Shanbaug was a nurse in a public hospital when she was sexually assaulted in 1973. During the incident, she was strangled by the attacker with a chain. The assault resulted in depriving the supply of oxygen to her brain. Over a period of thirty-seven years, she had not recovered from the trauma and damage to the brain. She was forsaken by family and was cared for over this period by the staff of the hospital. A petition under Article 32 was instituted before this Court. The petitioner had authored a book on her saga and instituted the proceedings claiming to be her "next friend". The direction which was sought was to stop feeding the patient and allow her to die a natural death. Aruna Shanbaug was examined by a team of doctors constituted by this Court who observed that while she was in a permanent vegetative state, she was clearly not in coma.

371. A two-Judge Bench of this Court held that *Gian Kaur*[10] did not lay down a final view on euthanasia: (*Aruna Shanbaug case*[5], SCC p. 487, para 21)

"*21*. We have carefully considered paras 24 and 25 in *Gian Kaur case*[10] and we are of the opinion that all that has been said therein is that the view in *Rathinam case*[6] that the right to life includes the right to die is not correct. We cannot construe *Gian Kaur case*[10] 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*[10] beyond what we have mentioned above."

11 *Airedale N.H.S. Trust* v. *Bland*, 1993 AC 789 : (1993) 2 WLR 316 : (1993) 1 All ER 821 (CA & HL)
5 *Aruna Ramachandra Shanbaug* v. *Union of India*, (2011) 4 SCC 454 : (2011) 2 SCC (Civ) 280 : (2011) 2 SCC (Cri) 294
10 *Gian Kaur* v. *State of Punjab*, (1996) 2 SCC 648 : 1996 SCC (Cri) 374
6 *P. Rathinam* v. *Union of India*, (1994) 3 SCC 394 : 1994 SCC (Cri) 740

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372. The decision in *Aruna Shanbaug*[5] distinguishes between active and passive euthanasia. "Active euthanasia" is defined as the administration of a lethal substance or force to kill a person, such as for instance, a lethal injection given to a person suffering from agony in a terminal state of cancer. "Passive euthanasia" is defined to mean the withholding or withdrawing of medical treatment necessary for continuance of life. This may consist of withholding antibiotics without which the patient may die or the removing of the patient from artificial heart/lung support. According to the Court, a comparative context of the position prevailing in other countries would indicate that: (SCC p. 491, para 39)

> "*39*. … The general legal position all over the world seems to be that while active euthanasia is illegal unless there is legislation permitting it, passive euthanasia is legal even without legislation provided certain conditions and safeguards are maintained."

"Voluntary euthanasia" envisages the consent of the patient being taken whereas "non-voluntary euthanasia" deals with a situation where the patient is in a condition where he or she is unable to give consent. The Court noted that a distinction is drawn between euthanasia and physician-assisted death in the form of a physician or third party who administers it. Physician-assisted suicide involves a situation where the patient carries out the procedure, though on the advice of the doctor. The Court in *Aruna Shanbaug*[5] distinguished between active and passive euthanasia: (SCC p. 492, para 43)

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

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

373. Active euthanasia, in the view of the Court, would be an offence under Section 302 or at least under Section 304 while physician-assisted suicide would be an offence under Section 306 of the Penal Code. The decision adverted to the judgment of the House of Lords in *Airedale*[11] and then observed that: (*Aruna Shanbaug case*[5], SCC p. 572, para 104)

> "*104*. It may be noted that in *Gian Kaur case*[4] although the Supreme Court has quoted with approval the view of the House of Lords in *Airedale case*[11], it has not clarified who can decide whether life support should be

5 *Aruna Ramachandra Shanbaug* v. *Union of India*, (2011) 4 SCC 454 : (2011) 2 SCC (Civ) 280 : (2011) 2 SCC (Cri) 294

11 *Airedale N.H.S. Trust* v. *Bland*, 1993 AC 789 : (1993) 2 WLR 316 : (1993) 1 All ER 821 (CA & HL)

4 *Cruzan* v. *Missouri Department of Health*, 1990 SCC OnLine US SC 123 : 111 L Ed 2d 224 : 110 S Ct 2841 : 497 US 261 (1990)

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discontinued in the case of an incompetent person e.g. a person in coma or PVS."

Explaining the concept of brain death, the Court held that passive euthanasia depends upon two circumstances: (SCC p. 517, para 117)

> "*117.* ... (*a*) When a person is only kept alive mechanically i.e. when not only consciousness is lost, but the person is only able to sustain involuntary functioning through advanced medical technology—such as the use of heart-lung machines, medical ventilators, etc.
>
> (*b*) When there is no plausible possibility of the person ever being able to come out of this stage. Medical "miracles" are not unknown, but if a person has been at a stage where his life is only sustained through medical technology, and there has been no significant alteration in the person's condition for a long period of time—at least a few years—then there can be a fair case made out for passive euthanasia."

374. Noting that there is no statutory provision regulating the procedure for withdrawing life support to a person in PVS or who is incompetent to take a decision, the Court ruled that passive euthanasia should be permitted in certain situations. Until Parliament decides on the matter, the modalities to regulate passive euthanasia would (according to the Court) be as follows: (*Aruna Shanbaug case*[5], SCC pp. 518-19, para 124)

> "*124.* ... (*i*) A decision has to be taken to discontinue life support either by the parents or the spouse or other close relatives, or in the absence of any of them, such a decision can be taken even by a person or a body of persons acting as a next friend. It can also be taken by the doctors attending the patient. However, the decision should be taken bona fide in the best interest of the patient.
>
> * * *
>
> (*ii*) Hence, even if a decision is taken by the near relatives or doctors or next friend to withdraw life support, such a decision requires approval from the High Court concerned as laid down in *Airedale case*[11]."

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

5 *Aruna Ramachandra Shanbaug* v. *Union of India*, (2011) 4 SCC 454 : (2011) 2 SCC (Civ) 280 : (2011) 2 SCC (Cri) 294

11 *Airedale N.H.S. Trust* v. *Bland*, 1993 AC 789 : (1993) 2 WLR 316 : (1993) 1 All ER 821 (CA & HL)

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her for long years which would be recognised. The doctors and nursing staff had evinced an intent to allow her to live in their care.

376. The decision in *Aruna Shanbaug*[5] has proceeded on the hypothesis that the Constitution Bench in *Gian Kaur*[10] had "quoted with approval" the decision of the House of Lords in *Airedale*[11]. This hypothesis is incorrect. There was only a passing reference to the decision of the House of Lords. In fact, *Gian Kaur*[10] prefaces its reference to *Airedale*[11] with the following observation: (*Gian Kaur case*[10], SCC p. 665, para 40)

> "*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."

The decision in *Gian Kaur*[10] referred to the distinction made in *Airedale*[11] between cases in which a physician decides not to provide or to continue to provide treatment which would prolong life and cases in which a physician decides to actively bring an end to the life of the patient by administering a lethal drug. The Court in *Airedale*[11] observed that actively causing the death of the patient could be made lawful only by legislation. It was this aspect which was emphasised by the judgment in *Gian Kaur*[10]. Hence, the position adopted in *Aruna Shanbaug*[5], that the Constitution Bench in *Gian Kaur*[10] quoted *Airedale*[11] with approval (as the basis of allowing passive euthanasia) is seriously problematic. In fact, the extract from *Airedale*[11] which was cited in *Gian Kaur*[10] indicates the emphasis placed on the need to bring in legislation to allow active euthanasia.

377. In an incisive analysis[152], Ratna Kapur argues that while focussing on euthanasia, discussions on *Aruna Shanbaug*[5] have ignored other considerations regarding gender, sexual assault, what constitutes "caring", the right to bodily integrity and workplace protection. A central issue is, according to Kapur, the "politics of caring", — who can care, has the capacity to care and who is less caring or less capable of caring. The Supreme Court did not accept Pinki Virani as the "next friend" but awarded guardianship to KEM Hospital staff on the ground that they had "an emotional bonding and attachment" to Aruna Shanbaug and were her "real family".

378. Kapur observes that an emotional bond is not a valid criterion for a "next friend" and the expression "real family" has dangerous implications for those who may not fall within the normative remit of that phrase though they have a relationship with the person concerned. She asks if the concept of "next friend" will cover only "biological familial ties" and "render all other

5 *Aruna Ramachandra Shanbaug* v. *Union of India*, (2011) 4 SCC 454 : (2011) 2 SCC (Civ) 280 : (2011) 2 SCC (Cri) 294

10 *Gian Kaur* v. *State of Punjab*, (1996) 2 SCC 648 : 1996 SCC (Cri) 374

11 *Airedale N.H.S. Trust* v. *Bland*, 1993 AC 789 : (1993) 2 WLR 316 : (1993) 1 All ER 821 (CA & HL)

152 Ratna Kapur, "The Spectre of Aruna Shanbaug", *The Wire* (18-5-2015) <https://thewire.in/2005/the-spectre-of-aruna-shanbaug/>.

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non-familial, non-marital, non-heterosexual relationships as ineligible?" She argues that decisions about life and death should "rest on the anvil of dignity, and dignity is not a family value, or linked to some essential gendered trait. It is a societal value and hence needs to be delinked from the traditional frameworks of family and gender stereotypes". Kapur expresses concerns about how the focus on "care" seemed to obscure a deeper and more important consideration regarding women's safety in the workplace. The attack on Aruna Shanbaug in KEM Hospital was indicative of how the workplace was unsafe for women, and yet the staff of the same Hospital were given her guardianship. This is especially concerning given the fact that the Dean of the Hospital at the time refused to allow a complaint of sodomy to go forward as he was more concerned about the reputation of the institution. Kapur laments the fact that Aruna's case was not used to bring out the reform that it should have—stating that it should

> "have been a leading case on women's rights where "caring" extended beyond the physical support for the individual who was harmed, to taking active steps to improve the working conditions for women, including addressing pervasive and systemic sex discrimination and sexism."

379. Lastly, Kapur compels us to think about the choices Aruna Shanbaug may have made:

> "Had Shanbaug not been reduced to a PVS, would she have chosen to remain in KEM for her treatment after the violent and brutal sexual assault that she experienced in her workplace? Or would she have chosen to be treated elsewhere? Would she have sued the Hospital for failing to provide her a safe working environment?"

Thus, Kapur questions the very basis of making the hospital the guardians by questioning why the hospital did not "care" when it mattered the most—when the case of sexual assault and sodomy should have been pursued by the hospital on behalf of its employee. By denying Aruna Shanbaug the right to bodily integrity in life and the right to self-determination in death, and by viewing her life from all lenses but from her own, ranging from the "carers", to the medical and legal profession and their views on euthanasia, she "became nothing more than a spectre in her own story".

380. *Aruna Shanbaug*[5] also presents another problem—one of inconsistency. *Gian Kaur*[10] is construed as laying down only that the right to life does not include the right to die and that the decision in *Rathinam*[6] was incorrect. In that context, it has been noticed that the Constitution Bench observed that the debate overseas even in physician-assisted termination of life is inconclusive. *Aruna Shanbaug*[5] finds, on the one hand, that "no final view was expressed" in *Gian Kaur*[10] beyond stating that the right to life does not include the right to die. Yet, on the other hand, having inferred the absence

5 *Aruna Ramachandra Shanbaug* v. *Union of India*, (2011) 4 SCC 454 : (2011) 2 SCC (Civ) 280 : (2011) 2 SCC (Cri) 294
10 *Gian Kaur* v. *State of Punjab*, (1996) 2 SCC 648 : 1996 SCC (Cri) 374
6 *P. Rathinam* v. *Union of India*, (1994) 3 SCC 394 : 1994 SCC (Cri) 740

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of a final view on euthanasia in *Gian Kaur*[10], that decision is subsequently construed as having allowed the termination of life by a premature extinction in the case of a "dying person who is terminally ill or in a permanent vegetative state". Both lines of reasoning cannot survive together.

381. The procedure which was followed by this Court in *Aruna Shanbaug*[5] of arranging for a screening of a CD submitted by the team of doctors pertaining to her examination in a live court proceeding open to the public has been criticised as being fundamentally violative of privacy. What transpired in the Court is set out in the following observations from the decision: (SCC p. 476, para 11)

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

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

382. *Aruna Shanbaug*[5] rests on the distinction between an act and an omission. The Court seems to accept that the withdrawal of life support or a decision not to provide artificial support to prolong life is an omission. In the view of the Court, an omission is what is "not done". On the other hand, what is actively done to end life is held to stand on a separate foundation. At this stage, it would be necessary to note that the validity of the distinction between what is passive and what is active has been the subject of a considerable degree of debate. This would be dealt with in a subsequent part of this judgment.

383. The issue before the Constitution Bench in *Gian Kaur*[10] related to the constitutionality of Section 306 of the Penal Code which penalises the abetment of suicide. The challenge proceeded on the foundation that penalising an attempt to commit suicide had been held to be unconstitutional since the right to live included the right to die. The Constitution Bench emphasised the value ascribed to the sanctity of life and came to the conclusion that the right to die does not emanate from the right to life under Article 21. Having held that the right to die is "inherently inconsistent" with the right to life "as is death with life", the Constitution Bench opined that the debate on euthanasia was "of no assistance to determine the scope of Article 21" and to decide whether the right to life includes the right to die. The Court noted that the right to life embodies the right to live with human dignity which postulates the existence of such a right "up to the end of natural life". This, the Court

10 *Gian Kaur* v. *State of Punjab*, (1996) 2 SCC 648 : 1996 SCC (Cri) 374

5 *Aruna Ramachandra Shanbaug* v. *Union of India*, (2011) 4 SCC 454 : (2011) 2 SCC (Civ) 280 : (2011) 2 SCC (Cri) 294

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observed, included the right to lead a dignified life up to the point of death and included a dignified procedure of death. Thus, in the context of the debate on euthanasia, the Constitution Bench was careful in observing that the right to a dignified life "*may include*" the right of an individual to die with dignity. A premature termination of life of a person facing imminent death in a terminal illness or in a permanent vegetative state was in the view of the Court a situation which "*may fall*" within the ambit of the right to die with dignity. The debate on physician-assisted termination of life was noted to be "*inconclusive*". The Court observed that the *argument* to support the termination of life in such cases to reduce the period of suffering during the process of "certain natural death" was not available to interpret Article 21 as embodying the right to curtail the natural span of life. These observations in *Gian Kaur*[10] would indicate that the Constitution Bench has not made a final or conclusive determination on euthanasia. Indeed, the scope of the controversy before the Court did not directly involve that question. *Aruna Shanbaug*[5] evidently proceeds on a construction of the decision in *Gian Kaur*[10] which does not emerge from it. *Aruna Shanbaug*[5] has inherent internal inconsistencies. Hence, the controversy which has been referred to the Constitution Bench would have to be resolved without regarding *Aruna Shanbaug*[5] as having laid down an authoritative principle of constitutional law.

E. *The distinction between the legality of active and passive euthanasia*

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

(*i*) involuntary euthanasia refers to the termination of life against the will of the person killed;

(*ii*) non-voluntary euthanasia refers to the termination of life without the consent or opposition of the person killed;

(*iii*) voluntary euthanasia refers to the termination of life at the request of the person killed;

(*iv*) active euthanasia refers to a positive contribution to the acceleration of death;

(*v*) passive euthanasia refers to the omission of steps which might otherwise sustain life.

What is relatively straightforward is that involuntary euthanasia is illegal and amounts to murder. However, the boundaries between active and passive

10 *Gian Kaur* v. *State of Punjab*, (1996) 2 SCC 648 : 1996 SCC (Cri) 374
5 *Aruna Ramachandra Shanbaug* v. *Union of India*, (2011) 4 SCC 454 : (2011) 2 SCC (Civ) 280 : (2011) 2 SCC (Cri) 294

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euthanasia are blurred since it is quite possible to argue that an omission amounts to a positive act.

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

386. The distinctions between active and passive euthanasia are based on the manner in which death is brought about. They closely relate (in the words of Hazel Biggs in a seminal work on the subject) to the understanding and consequences of the legal concepts of act and omission.[153]

387. As early as 1975, American philosopher and medical ethicist James Rachels offered a radical critique of a distinction that was widely accepted by medical ethicists at that time, that passive euthanasia or "letting die" was morally acceptable while active euthanasia or "killing" was not.[154] Even though his paper did not change the prevalence of this distinction at the time it was published, it paved the way by providing credibility for arguments to legalise assisted suicide in the 1990s. In what he calls the "Equivalence Thesis", Rachels states "there is no morally important difference between killing and letting die; if one is permissible (or objectionable), then so is the other and to the same degree".[155] He does not offer a view on whether the practice of euthanasia is acceptable or not. His central thesis is that both active and passive euthanasia are morally equivalent—either both are acceptable or both are not. Reichenbach for instance, asks: Supposing all else is equal, can a moral judgment about euthanasia be made on the basis of it being active or passive alone?[156]. The "Equivalence thesis" postulates that if a doctor lets a patient die (commonly understood as passive euthanasia) for humane reasons, he is in the same moral position as if he decided to kill the patient by giving a lethal injection (commonly understood as active euthanasia) for humane reasons.

153 Hazel Biggs, "Euthanasia, Death with Dignity and the Law" (Hart Publishing, 2001), at p. 12.

154 James Rachels, "Active and Passive Euthanasia", New England Journal of Medicine (9-1-1975), at pp. 78-80.

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

156 Bruce R. Reichenbach, "Euthanasia and the Active-Passive Distinction", *Bioethics* (January 1987), Vol. 1, at pp. 51-73.

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388. The correctness of this precept may be questioned by pointing out that there is a qualitative difference between a positive medical intervention (such as a lethal injection) which terminates life and a decision to not put a patient on artificial life support, which will not artificially prolong life. The former brings a premature extinction of life. The latter does not delay the end of life beyond its natural end point. But, if the decision to proceed with euthanasia is the right one based on compassion and the humanitarian impulse to reduce pain and suffering, then the method used is not in itself important. Moreover, it is argued that passive euthanasia often involves more suffering since simply withholding treatment means that the patient may take longer to die and thus suffer more. Passive euthanasia may become questionable where the withholding or withdrawal of medical intervention may lead to a condition of pain and suffering, often a lingering and cruel death. The avoidance of suffering, which is the object and purpose of euthanasia, may hence not be the result of passive euthanasia and the converse may result. Besides raising troubling moral questions—especially where it is non-voluntary, it questions the efficacy of passive euthanasia. Moreover, it raises a troubling issue of the validity of the active-passive divide.

389. The moral and legal validity of the active-passive distinction based on the exculpation of omissions has been criticised. One of the reasons for the exculpation of omissions is based on the idea that our duty not to harm people is generally stricter than our duty to help them.[157] James Rachels offers a compelling counter-argument to the argument that killing someone is a violation of our duty not to do harm, whereas letting someone die is merely a failure to help. He argues that our duty to help people is less stringent than the duty not to harm them only in cases where it would be very difficult to help them or require a great amount of effort or sacrifice. However, when we think of cases where it would be relatively simple to help someone and there would be no great personal sacrifice required, the morally justifiable response would be different. He provides a hypothetical example of a child drowning in a bathtub, anyone standing next to the tub would have a strict moral duty to help the child.[158] Due to the equation between the child and the person standing next to the bathtub (the proximity may be in terms of spatial distance or relationship) the "alleged asymmetry" between the duty to help and the duty not to do harm vanishes. A person standing next to the bathtub would have no defence to say that this was *merely* a failure to help and did not violate the duty to do no harm. In cases of euthanasia since the patient is close at hand and it is within the professional skills of the medical practitioner to keep him alive, the alleged asymmetry has little relevance. The distinction is rendered irrelevant even in light of the duty of care that doctors owe to their patients. Against the background of the duty to care, the moral and legal status of not saving a life due to failure to provide treatment, can be the same as actively taking that

157 James Rachels (Supra note 155), at pp. 101-20.
158 *Ibid.*

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life.[159] A doctor who knowingly allows a patient who could be saved to bleed to death might be accused of murder and medical negligence. The nature of the doctor-patient relationship which is founded on the doctor's duty of care towards the patient necessitates that omissions on the doctor's part will also be penalised. When doctors take off life support, they can foresee that death will be the outcome even though the timing of the death cannot be determined. Thus, what must be deemed to be morally and legally important must not be the emotionally appealing distinction between omission and commission but the justifiability or otherwise of the clinical outcome. Indeed, the distinction between omission and commission may be of little value in some healthcare settings.[160]

390. This distinction leads to the result that even though euthanasia is grounded in compassion and to relieve the patient of suffering, only certain types of deaths can be lawful. If active euthanasia amounts to "killing", the operation of criminal law can lead to medical practitioners being exposed to the indignity of criminal prosecutions and punishments.[161] While passive euthanasia can appear to save the dignity of medical practitioners, it is perhaps at the expense of the patient's dignity.[162]

391. A recent article by Rohini Shukla in the Indian Journal of Medical Ethics (2016) points out two major flaws in *Aruna Shanbaug*[5] regarding the distinction between active and passive euthanasia.[163] First, it fails to prioritise the interest of the patient and is preoccupied with the effect of euthanasia on everyone but the patient, and second, that it does not distinguish between the terms "withholding and withdrawing and uses them interchangeably". Throughout the above judgment, the words "withholding" and "withdrawing" are used interchangeably. However, the difference between the two is relevant to the distinction between what is "active" and "passive" as act and omission. Withholding life support implies that crucial medical intervention is restrained or is not provided—an act of omission on the part of the doctor. Withdrawing life support implies suspending medical intervention that was already in use to sustain the patient's life—an act of commission. If the basis of distinction between active and passive euthanasia is that in passive euthanasia the doctor only passively commits acts of omission, while in active euthanasia the doctor commits acts of commission then withdrawing medical treatment is an act of commission and therefore amounts to active euthanasia. In both these cases, the doctor is aware that his/her commissions or omissions will in all likelihood

159 Len Doyal and Lesley Doyal, "Why Active Euthanasia and Physician-Assisted Suicide should be Legalised if Death is in a Patient's Best Interest Then Death Constitutes a Moral Good", British Medical Journal (2001), at pp. 1079-80.

160 *Ibid.*

161 Hazel Biggs (Supra note 153), at p. 162.

162 *Ibid.*

5 *Aruna Ramachandra Shanbaug* v. *Union of India*, (2011) 4 SCC 454 : (2011) 2 SCC (Civ) 280 : (2011) 2 SCC (Cri) 294

163 Rohini Shukla, "Passive Euthanasia in India: A Critique", Indian Journal of Medical Ethics (Jan-Mar 2016), at pp. 35-38.

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lead to the patient's death. However, in passive euthanasia death may not be the only consequence and the suffering that passive euthanasia often entails such as suffocation to death or starvation till death, raises the question of whether passive euthanasia, in such circumstances, militates against the idea of death with dignity—the very basis of legalising euthanasia.[164] Shukla's criticism needs careful attention since it raises profound questions about the doctor-patient relationship and the efficacy of the distinction in the context of death with dignity. If the divide between active-passive is questioned, should both forms be disallowed or, in converse should both be allowed? More significantly, are both equally amenable to judicially manageable standards?

392. Even with *Aruna Shanbaug's*[5] starting position that passive euthanasia is permitted under Indian law until expressly prohibited, the Court did not traverse the vast Indian legal framework to determine whether there was a prohibition to this effect. Instead the Court made an analogy (perhaps incorrect) between a doctor conducting passive euthanasia and a person who watches a building burning: (*Aruna Shanbaug case*[5], SCC p. 492, para 43)

> "*43*. An important idea behind this distinction is that in "passive euthanasia", the doctors are not actively killing anyone; they are simply not saving him. While we usually applaud someone who saves another person's life, we do not normally condemn someone for failing to do so. If one rushes into a burning building and carries someone out to safety, he will probably be called a hero. But if one sees a burning building and people screaming for help, and he stands on the sidelines—whether out of fear for his own safety, or the belief that an inexperienced and ill-equipped person like himself would only get in the way of the professional fire-fighters, or whatever—if one does nothing, few would judge him for his inaction. One would surely not be prosecuted for homicide. (At least, not unless one started the fire in the first place.) … [T]here can be no debate about passive euthanasia: you cannot persecute someone for failing to save a life. Even if you think it would be good for people to do *X*, you cannot make it illegal for people to *not* do *X*, or everyone in the country who did not do *X* today would have to be arrested." (emphasis in original)

The example is inapposite because it begs the relationship between the person who is in distress and the individual whose position as a caregiver (actual or prospective) is being considered. The above example may suggest a distinct outcome if the bystander who is ill-equipped to enter a burning building is substituted by a fire-fighter on duty. Where there is a duty to care, the distinction between an act and an omission may have questionable relevance. Acts and omissions are not disjunctive or isolated events. Treatment of the human body involves a continuous association between the caregiver and receiver. The expert caregiver is involved in a continuous process where medical knowledge and the condition of the patient as well as the circumstances require the doctor

164 *Ibid.*

5 *Aruna Ramachandra Shanbaug* v. *Union of India*, (2011) 4 SCC 454 : (2011) 2 SCC (Civ) 280 : (2011) 2 SCC (Cri) 294

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to evaluate choices—choices on the nature and extent of medical intervention, the wisdom about a course of action and about what should or should not be done.

393. An erroneous premise in the judgment is that omissions are not illegal under Indian law.[165] Section 32 of the Penal Code, 1860 deals with *illegal* omissions and states that "In every part of this Code, except where a contrary intention appears from the context, words which refer to acts done, extend to illegal omissions." Whether and to what extent this omission would be illegal under Indian law will be discussed in a subsequent part of the judgment.

394. Since the judgment legalised passive euthanasia, withdrawing medical support was the only option in *Aruna Shanbaug*[5] and if this had been done, she would have in all likelihood suffocated to death. We must ponder over whether this could be the best possible death in consonance with the right to live with dignity (which extends to dignity when death approaches) and the extent to which it upholds the principle of prioritising the patient's autonomy and dignity over mere prolongation of life. Had the Court taken into account these consequences of passive euthanasia for the patient, it would be apparent that passive euthanasia is not a simple panacea for an individual faced with end of life suffering.

395. This brings us to the second and more crucial flaw, which was the unjustified emphasis on doctor's agency in administering different types of euthanasia which led to ignoring the patient's autonomy and suffering. Respecting patient autonomy and reducing suffering are fundamental ethical values ascribed to euthanasia. It is also the foremost principle of bioethics.[166] The effects of euthanasia on everyone (particularly her caregivers) were given greater importance than the patient's own wishes and caregiver: (*Aruna Shanbaug case*[5], SCC p. 488, para 23)

> "*23.* ... (*v*) In case hydration or food is withdrawn/withheld from Aruna Ramachandra Shanbaug, the efforts which have been put in by batches after batches of nurses of KEM Hospital for the last 37 years will be undermined.
>
> (*vi*) Besides causing a deep sense of resentment in the nursing staff as well as other well-wishers of Aruna Ramachandra Shanbaug in KEM Hospital including the management, such act/omissions will lead to disheartenment in them and large-scale disillusionment."

165 Aparna Chandra and Mrinal Satish, "Misadventures of the Supreme Court in *Aruna Shanbaug* v. *Union of India*", *Law and Other Things* (13-3-2011) <http://lawandotherthings.com/2011/03/misadventures-of-supreme-court-in-aruna/>.

5 *Aruna Ramachandra Shanbaug* v. *Union of India*, (2011) 4 SCC 454 : (2011) 2 SCC (Civ) 280 : (2011) 2 SCC (Cri) 294

166 Roop Gurusahani and Raj Kumar Mani, "India: Not a Country to Die in", Indian Journal of Medical Ethics (Jan-Mar 2016), at pp. 30-35.

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396. Aruna Shanbaug was in no position to communicate her wishes. But the above extract from the judgment relegates her caregiver to the background. The manner in which the constitutional dialogue is framed by the Court elevates the concerns of the caregiver on a high pedestal without focusing on the dignity and personhood of the individual in a permanent vegetative state. In doing so, the judgment subordinates the primary concern of bioethics and constitutional law, which is preserving the dignity of human life.

397. An article[167] in the Oxford Medical Law Review notes that there are strong grounds to believe that the active-passive distinction in *Aruna Shanbaug*[5] was not grounded so much in morality as in "reasons of policy".

398. Even while there are pertinent questions regarding the moral validity of the active-passive distinction, there appears to be a significant difference between active and passive euthanasia when viewed from the lens of the patient's consent. Consent gives an individual the ability to choose whether or not to accept the treatment that is offered. But consent does not confer on a patient the right to demand that a particular form of treatment be administered, even in the quest for death with dignity.[168] Voluntary passive euthanasia, where death results from selective non-treatment because consent is withheld, is therefore legally permissible while voluntary active euthanasia is prohibited. Moreover, passive euthanasia is conceived with a purpose of not prolonging the life of the patient by artificial medical intervention. Both in the case of a withdrawal of artificial support as well as in non-intervention, passive euthanasia allows for life to ebb away and to end in the natural course. In contrast, active euthanasia results in the consequence of shortening life by a positive act of medical intervention. It is perhaps this distinction which necessitates legislative authorisation for active euthanasia, as differentiated from the passive.

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

167 Sushila Rao (Supra note 148), at pp. 646-656.

5 *Aruna Ramachandra Shanbaug* v. *Union of India*, (2011) 4 SCC 454 : (2011) 2 SCC (Civ) 280 : (2011) 2 SCC (Cri) 294

168 Hazel Biggs (Supra note 153), at p. 30.

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F. ***Sanctity of life***

400. Diverse thinkers have debated and deliberated upon the value accorded to human life.[169] The "sanctity of life" principle has historically been the single most basic and normative concept in ethics and the law.[170] The phrase has emerged as a key principle in contemporary bioethics, especially in debates about end-of-life issues.[171]

401. The traditional and standard view is that life is invaluable.[172] It has persisted as an idea in various cultures through the centuries. A sacred value has been prioritised for human life. This "rhetoric of the value in human life"[173] has been highlighted in various traditions.[174] The protection of the right to life derives from "the idea that all human life is of equal value"—the idea being drawn from religion, philosophy and science.[175]

402. The principle or doctrine of the "sanctity of life", sometimes also referred to as the "inviolability of human life"[176], is based on "overarching moral considerations", the first of which has been stated as:

> "Human life is sacred, that is inviolable, so one should never aim to cause an innocent person's death by act or omission."[177]

403. Distinct from religious beliefs, the special value inherent in human life has been recognised in secular ideas of natural law — "man as an end in himself, and human investment in life".[178] Locke has been of the view that every human being "is bound to preserve himself, and not to quit his station wilfully".[179] In his book *Life's Dominion*, Ronald Dworkin explains the sanctity of human life thus:

> "The hallmark of the sacred as distinct from the incrementally valuable is that the sacred is intrinsically valuable because—and therefore only once

169 Elizabeth Wicks (Supra note 141), at p. 29.
170 Anne J. Davis, "Dilemmas in Practice: To Make Live or Let Die", The American Journal of Nursing (March 1981), Vol. 81, No. 3, at p. 582.
171 Heike Baranzke, " "Sanctity-of-Life"—A Bioethical Principle for a Right to Life?", *Ethic Theory Moral Practice* (2012), Vol. 15, Issue 3, at p. 295.
172 Elizabeth Wicks (Supra note 141), at p. 1.
173 *Ibid.*, at p. 240.
174 P.G. Lauren argues that it is "essential to recognise that the moral worth of each person is a belief that no single civilization, or people, or nation, or geographical area, or even century can claim as uniquely its own". *See* P.G. Lauren, *The Evolution of International Human Rights: Visions Seen* (University of Pennsylvania Press, 2003, 2nd Edn.), at p. 12, as quoted in Elizabeth Wicks (Supra note 141), at pp. 25-29.
175 Elizabeth Wicks (Supra note 141), at p. 47.
176 John Keown, *The Law and Ethics of Medicine: Essays on the Inviolability of Human Life* (Oxford University Press, 2012), at p. 3.
177 *Ibid.*
178 Elizabeth Wicks (Supra note 141), at pp. 34-35.
179 John Locke, *Two Treatises of Government* (ed. P. Laslett) (Cambridge University Press, 1988).

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—it exists. It is inviolable because of what it represents or embodies. It is not important that there be more people. But once a human life has begun, it is very important that it flourish and not be wasted."[180]

Life today, according to Dworkin, is not just created by the science of evolution but by past choices—by the investment that an individual, and others, have put into his or her life.[181]

404. Elizabeth Wicks in her book titled *The Right to Life and Conflicting Interests* (2010) has succinctly summarised the moral and ethical justifications for the sanctity of life thus:

> "The life of an individual human being matters morally not because that organism is sentient or rational (or free of pain, or values its own existence) but because it is a human life. This point is supported by the ethical and legal principle of equality which is well established in the field of human rights.... From an end of life perspective, this means that life ends only when the human organism dies. This cannot sensibly require the death of all of the body's cells but rather the death of the organism as a whole. In other words, life comes to an end when the integrative action between the organs of the body is irreversibly lost. It is the life of the organism which matters, not its living component parts, and thus it is the permanent destruction of that integrative organism which signifies the end of the organism's life."[182]

405. The value of human life has been emphasised by Finnis in the following words:

> "[H]uman bodily life is the life of a person and has the dignity of the person. Every human being is equal precisely in having that human life which is also humanity and personhood, and thus that dignity and intrinsic value. Human bodily life is not mere habitation, platform, or instrument for the human person or spirit. It is therefore not a merely instrumental good, but is an intrinsic and basic human good. Human life is indeed the concrete reality of the human person. In sustaining human bodily life, in however impaired a condition, one is sustaining the person whose life it is. In refusing to choose to violate it, one respects the person in the most fundamental and indispensable way. In the life of the person in an irreversible coma or irreversibly persistent vegetative state, the good of human life is really but very inadequately instantiated. Respect for persons and the goods intrinsic to their well-being requires that one make no choice to violate that good by terminating their life."[183]

180 Ronald Dworkin, *Life's Dominion: An Argument about Abortion and Euthanasia* (HarperCollins, 1993), at pp. 73-74.
181 Elizabeth Wicks (Supra note 141), at p. 32.
182 *Ibid.*, at pp. 16-17.
183 John Finnis, *Human Rights and Common Good* (Oxford University Press, 2011), at p. 221.

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406. In his book *The Law and Ethics of Medicine: Essays on the Inviolability of Human Life* (2012), John Keown has explained the principle of the sanctity or inviolability of human life and its continuing relevance to English law governing aspects of medical practice at the beginning and end of life. Keown has distinguished the principle from the other two "main competing approaches to the valuation of human life"[184]—"vitalism" on the one hand and a "qualitative" evaluation of human life on the other. The approach of "vitalism" assumes that "human life is the supreme good and one should do everything possible to preserve it". The core principle of this approach is "try to maintain the life of each patient at all costs".[185]

407. In the "quality of life" approach, Keown has argued that "there is nothing supremely or even inherently valuable about the life of a human being". The value of human life "resides in meeting a particular "quality" threshold", above which the dignity of life would be "worthwhile". Keown criticises this approach for its basis that since "certain lives are not worth living, it is right intentionally to terminate them, whether by act or omission".[186]

408. Keown sums up that the doctrine of the sanctity or inviolability of life holds that "we all share, by virtue of our common humanity, an ineliminable dignity"—this dignity grounds the "right to life".[187] The essence of the principle is that "it is wrong to try to extinguish life".[188] Intentional killing is prohibited by any act or omission. Keown thereby emphasises the sanctity and inviolability of life in the following words:

> "Human life is a *basic*, *intrinsic* good. … The dignity of human beings inheres because of the radical capacities, such as for understanding, rational choice, and free will, inherent in human nature. … All human beings possess the capacities inherent in their nature even though, because of infancy, disability, or senility, they may not yet, not now, or no longer have the ability to exercise them.
>
> The right not to be killed is enjoyed regardless of inability or disability. Our dignity does not depend on our having a particular intellectual ability or having it to a particular degree."[189] (emphasis in original)

409. The principle of the sanctity of life considers autonomy as a "valuable capacity, and part of human dignity"[190]. However, autonomy's contribution to dignity is "conditional, not absolute"[191]. The limitations of autonomy under the sanctity of life doctrine can be summarised as follows:

> "Exercising one's autonomy to destroy one's (or another's) life is always wrong because it is always disrespectful of human dignity. So: it is always wrong intentionally to assist/encourage a patient to commit suicide

184 John Keown (Supra note 176), at p. 4.
185 *Ibid.*
186 *Ibid.*, at p. 5.
187 *Ibid.*, at p. 6.
188 *Ibid.*
189 *Ibid.*, at pp. 5-6.
190 *Ibid.*, at p. 18.
191 *Ibid.*

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and, equally, there is no "right to commit suicide", let alone a right to be assisted to commit suicide, either by act or omission.

> The principle of "respect for autonomy" has in recent years become for many a core if not dominant principle of biomedical ethics and law. It is not, however, unproblematic. Its advocates often fail to agree on precisely what constitutes an "autonomous" choice or to offer any convincing account of why respect for someone else's choice as such should be regarded as a moral principle at all, let alone a core or dominant moral principle."[192]

John Keown, however, while distinguishing the principle of sanctity of life from vitalism, has also argued that though this principle "prohibits withholding or withdrawing treatment with intent to shorten life", but it also "permits withholding/withdrawing a life-prolonging treatment which is not worthwhile because it is futile or too burdensome". It does not require doctors to try to preserve life at all costs.[193] This consideration, despite all the assumptions and discussions about the sanctity of life, in a way, makes the doctrine an open-ended phenomenon.

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

> "If we accept that human life has some inherent value, is it solely to the individual who is enjoying that life or is there some broader state or societal benefit in that life? If life is of value only to the person living it, then this may elevate the importance of individual autonomy. It may even suggest that it is an individual's desire for respect for his or her own life that provides the inherent value in that life. On the other hand, it might be argued that the protection of human life is, at least partly, a matter of public interest. Whether it is to the State, or other members of society, or only an individual's own family and friends, there is an argument that a human life is a thing of value to others beyond the individual living that life… [I]f life is legally and ethically protected in deference to the individual's wish for respect for that life, the protection would logically cease when an autonomous choice is made to bring the life to an end. If, however, the life is protected, at least partly, due to the legitimate interest in that life enjoyed by the State or other (perhaps select) members of society, then the individual's autonomous choice to end his or her life is not necessarily the decisive factor in determining whether legal and ethical protection for that life should continue."[194]

411. The disagreement between "sanctity of life" and the "quality of life" is another conflict, which can be summarised as follows:

> "If we start with a sanctity of life position, this affirms the value of human life in a way that trumps even claims to self-determination. …

192 *Ibid.*
193 *Ibid.*, at p. 13.
194 Elizabeth Wicks (Supra note 141), at pp. 176-77.

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> [P]eople who suffer from terminal or degenerative illness ... who want to die must remain alive in great pain or discomfort until death comes "naturally" to them. Similarly, people who suffer from long-term disability or paralysis which grossly diminishes their capacities for life and who cannot take their own lives, are not permitted to die. In such circumstances, the argument for sanctity of life may seem somewhat sanctimonious to the person who is not allowed the assistance to end their own life. There have been cases in the media in recent years where the moral difficulty in insisting on the sanctity of life in such situations has been made clear. Though such cases will not disturb the position of she who beliefs fundamentally in the sanctity of life, they do lead others to accept that there may be exceptional cases where sanctity gives way to quality of life issues."[195]

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

G. *Nuances of the sanctity of life principle*

412. The sanctity of life has been central to the moral and ethical foundations of society for many centuries. Yet, it has been suggested that "across the range of opinions most people would seem to agree that life is valuable to some degree, but the extent to which any "value" is founded in intrinsic worth or instrumental opportunity is contentious".[196] Glanville Williams, a strong proponent of voluntary euthanasia, was of the view that "there was a human freedom to end one's life". According to him, "the law could not forbid conduct that, albeit undesirable, did not adversely affect the social order".[197] That view, as argued by Luis Kutner in his article "Euthanasia: Due Process for Death with Dignity; The Living Will"[198], was similar to that advanced by John Stuart Mill. Mill, in his classic work *On Liberty* stated:

> "Mankind are great gainers by suffering each other to live as seems good to themselves, than by compelling each to live as seems good to the rest."[199]

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

195 Alan Norrie (Supra note 140), at pp. 141-142.
196 Alexandra Mullock, End-of-Life Law and Assisted Dying in the 21st Century: Time for Cautious Revolution? (PhD Thesis, University of Manchester, 2011), at p. 24.
197 Luis Kutner, "Euthanasia: Due Process for Death with Dignity; The Living Will", Indiana Law Journal (Winter 1979), Vol. 54, Issue, 2, at p. 225.
198 *Ibid.*, at pp. 201-28.
199 *Ibid.*, at pp. 225-26.

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413. Though the sanctity principle prohibits "the deliberate destruction of human life, it does not demand that life should always be prolonged for as long as possible".[200] While providing for an intrinsic sacred value to life "irrespective of the person's capacity to enjoy life and notwithstanding that a person may feel their life to be a great burden", the principle holds that "life should not always be maintained at any and all cost".[201] Ethical proponents of the sanctity of life tend to agree that when "medical treatment, such as ventilation and probably also antibiotics, can do nothing to restore those in permanent vegetative state to a state of health and well-functioning, it is futile and need not be provided".[202] Rao has thus suggested that "the law's recognition that withdrawal of life-prolonging treatment is sometimes legitimate" is not generally an exception to the sanctity principle, but is actually "an embodiment of it".[203]

414. Philosopher and medical ethicist James Rachels has in a seminal work[204] titled *The End of Life: Euthanasia and Morality (Studies in Bioethics)* in the year 1986 propounded that we must embrace an idea of the sanctity of life which is firmly based in ethics (the idea of right and wrong) and not based in religion. The separation of religion from morality and ethics does not necessarily mean a rejection of religion, but that the doctrine of "sanctity of life" must be accepted or rejected on its merits, by religious and non-religious people alike. The value of life is not the value that it has for God or the value that it may have from any religious perspective. The truth of moral judgments and exercising reason to decide what is right and wrong does not depend on the truth of theological claims. The value of life is the value that it has for the human beings who are subjects of lives. Thus, the value of life must be understood from the perspective of the person who will be harmed by the loss, the subject of life. It is also important to understand the true meaning behind the moral rule against killing. The rationale behind such a law is to protect the interests of individuals who are the subject of lives. If the point of the rule against killing is the protection of lives, then we must acknowledge that in some cases killing does not involve the destruction of "life" in the sense that life is sought to be protected by law. For example, a person in an irreversible coma or suffering a serious terminal illness is alive in a strictly biological sense but is no longer able to live life in a way that may give meaning to this biological existence. The rule against killing protects individuals that have lives and not merely individuals who are alive. When an individual is alive only to the extent of being conscious

200 Sushila Rao, "The Moral Basis for a Right to Die", Economic & Political Weekly (30-4-2011), at p. 14.

201 Alexandra Mullock, End-of-Life Law and Assisted Dying in the 21st Century: Time for Cautious Revolution? (PhD Thesis, University of Manchester, 2011), at p. 25.

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

203 Sushila Rao (Supra note 200), at p. 14.

204 James Rachels, (Supra note 155).

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in the most rudimentary sense, the capacity to experience pleasure and pain (if any) does not necessarily have value if that is the only capacity one has. These sensations will not be endowed with any significance by the one experiencing them since they do not arise from any human activities or projects and they will not be connected with any coherent view of the world.

415. It is instructive to analyse how the principle of the sanctity of life impacts upon views in regard to capital punishment. (This comparison, it needs to be clarified in the present judgment, is not to indicate an opinion on the constitutionality of the death penalty which is not in issue here.) Advocates of the sanctity of life would even allow capital punishment[205], implying that they do not oppose all killing of human beings. This suggests that "while they are anti-euthanasia, they are not uniformly pro-life"[206]. In a seminal article titled "The Song of Death: The Lyrics of Euthanasia"[207], Margaret A. Somerville has laid down four possible positions that persons could take:

> "(*i*) that they are against capital punishment and against euthanasia;
>
> (*ii*) that they agree with capital punishment, but are against euthanasia;
>
> (*iii*) that they agree with capital punishment and euthanasia; or
>
> (*iv*) that they are against capital punishment, but agree with euthanasia".[208]

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

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

205 Elizabeth Wicks (Supra note 141), at pp. 102-149.
206 Margaret A. Somerville, "The Song of Death: The Lyrics of Euthanasia", Journal of Contemporary Health Law & Policy (1993), Vol. 9, Issue 1, at p. 67.
207 *Ibid.*, at pp. 1-76.
208 *Ibid.*, at p. 67.

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whereas the fundamentalists and some conservatives agree that this is acceptable."[209]

The above explanation suggests that there are variations in intellectual opinion on the concept of sanctity of life. When it comes to taking of a person's life, various groups while agreeing in certain terms, may be "radically divergent in others".[210]

416. Contrary to the vitalism or the sanctity of life principle, some scholars and bioethicists have argued that "life is only valuable when it has a certain quality which enables the subject to derive enjoyment from their existence so that life is viewed as being, on balance, more beneficial than burdensome". It has been argued that the sanctity of life principle should be interpreted to protect lives in the biographical sense and not merely in a biological sense.[211] There is a difference in the fact of being alive and the experience of living. From the point of view of the living individual, there is no value in being alive except that it enables one to have a life.[212]

417. There is wide-ranging academic research suggestive of a nuanced approach to the sanctity principle. During the last four decades, "there has been a subtle change in the way" people perceive human life and that "the idea of quality of life has become more prevalent in recent times".[213] The moral premium, as Magnusson has remarked, is shifting "from longevity and onto quality of life"[214].

418. In his article titled the "Sanctity of Life or Quality of Life?"[215], Singer argued that the sanctity of life principle has been under erosion — the "philosophical foundations" of the principle being "knocked asunder".[216] "The first major blow" to the principle, Singer stressed, "was the spreading acceptance of abortion throughout the Western world". Late abortions diluted the defence of the "[alleged] universal sanctity of innocent human life".[217] Singer has further remarked:

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

209 *Ibid.*, at pp. 67-68.
210 *Ibid.*
211 James Rachels (Supra note 155), at p. 26.
212 *Ibid.*
213 Jessica Stern, Euthanasia and the Terminally Ill (2013), retrieved from Florida State University Libraries.
214 Roger S. Magnusson, "The Sanctity of Life and the Right to Die: Social and Jurisprudential Aspects of the Euthanasia Debate in Australia and the United States", Pacific Rim Law & Policy Journal, Vol. 6, No. I, at p. 40.
215 Peter Singer, "Sanctity of Life or Quality of Life", *Pediatrics* (1983), Vol. 72, Issue 1, at pp. 128-129.
216 *Ibid.*, at p. 129.
217 *Ibid.*, at p. 128.

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> One difference between humans and other animals that is relevant irrespective of any defect is that humans have families who can intelligently take part in decisions about their offspring. This does not affect the intrinsic value of human life, but it often should affect our treatment of humans who are incapable of expressing their own wishes about their future. Any such effect will not, however, always be in the direction of prolonging life…
>
> If we can put aside the obsolete and erroneous notion of the sanctity of all human life, we may start to look at human life as it really is: at the quality of life that each human being has or can achieve. Then it will be possible to approach these difficult questions of life and death with the ethical sensitivity that each case demands, rather than with the blindness to individual differences…"[218]

419. The quality of life approach has its basis in the way life is being lived. "An overriding concern", under this approach, "is the conditions under which people live rather than whether they live".[219] This does not mean that someone "who chooses to end their life through euthanasia" does not value their lives as much as others.[220] Breck in his article titled "Euthanasia and the Quality of Life Debate"[221] has stated that:

> "Ethicists of all moral and religious traditions recognize that medical decisions today inevitably involve quality of life considerations. Very few would be inclined to sustain limited physiological functioning in clearly hopeless cases, as with anencephaly or whole-brain death, simply because the technology exists to do so. That such a case is indeed hopeless, however, is a quality of life judgment: it weighs the relationship between the patient's condition and the treatment options and concludes that attempts to sustain biological existence would be unnecessarily burdensome or simply futile. Judgments made in light of "futility" or the "burden-benefit calculus" are necessarily based on evaluations of the "quality" of the patient's life. Such quality, however, must always be determined in light of the patient's own personal interests and well-being, and not on grounds of the burden imposed on other parties (the family, for example) or the medical care system with its economic considerations and limited resources."[222]

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

218 *Ibid.*, at p. 129.
219 "Sanctity of Life versus Quality of Life", *Los Angeles Times* (7-6-2015), <http://www.latimes.com/opinion/readersreact/la-le-0607-sunday-assisted-suicide-20150607- story.html>.
220 Jessica Stern, Euthanasia and the Terminally Ill (2013) <https://fsu.digital.flvc.org/islandora/object/fsu: 209909/datastream/PDF/view>.
221 John Breck, "Euthanasia and the Quality of Life Debate", *Christian Bioethics* (1995), Vol. 1, No. 3, at pp. 322-337.
222 *Ibid.*, at pp. 325-326.

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scrutiny. Medicine can better cope with its current and future ethical dilemmas by a case-by-case approach."[223]

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

> "[W]hile there are good moral reasons of either a direct (that human life should be generally valued as of intrinsic worth) or an indirect (that allowing exceptions would lead to a slippery slope) kind for supporting a sanctity of life view in the case of the terminally ill and ancillary cases, there are also good moral reasons for allowing exceptions to it. The latter stem from a quality of life view and, linked to that, the possibility of choosing the time and place of one's own death. The possibility of agency as a central element in what it means to be human is premised on the notion of human freedom, and freedom implies a number of different elements. These include a simple freedom to be left alone with one's life, as well as a positive freedom to become what we have it within ourselves to be. Such freedom then entails further conceptions of autonomy, emancipation, and flourishing, insofar as human life reflects the potentialities in human being. The ability to choose one's own death reflects many of these aspects of human freedom, from the simple sense that one should be left alone to do what one likes with one's life to the more complex sense that an autonomous life would include amongst its components control over one's death, and then on to the sense—that is surely there in the term "euthanasia" (a "good death")—that a flourishing life is one in which one is genuinely able to register the time to go. These are moral arguments placing choice and quality of life ahead of sanctity of life.... A good life means a good death too, and it is this kind of argument that leads one to think that a categorical prohibition on voluntary euthanasia ... is problematic."[224]

Life and natural death

421. The defenders of the sanctity principle place sacred value to human life from "conception to natural death".[225] The word "natural" implies that "the only acceptable death is one that occurs from natural causes". Life is only "sacred insofar as it ends by natural means"[226]. Medical advancements, however, have brought uncertainty about the definition of death — "what constitutes death, in particular a "natural" death". This uncertainty can be expressed through the following questions:

223 Michael A. Weingarten, "On the Sanctity of Life", British Journal of General Practice (April 2007), Vol. 57(537), at p. 333.

224 Alan Norrie (Supra note 140), at p. 143.

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

226 *Ibid.*, at p. 69.

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"If a person stays alive thanks to medical advances, is that really "natural"?…

When is the benefit of using technology and treatments to sustain life no longer worth the pain that comes along with it?"[227]

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

"[T]he process of dying is an inevitable consequence of life, the right to life necessarily implies the right to have nature take its course and to die a natural death. It also encompasses a right, unless the individual so wishes, not to have life artificially maintained by the provision of nourishment by abnormal artificial means which have no curative effect and which are intended merely to prolong life."[228]

423. Modern medicine has found ways to prolong life and to delay death. But, it does not imply that modern medicine "necessarily prolongs our living a full and robust life because in some cases it serves only to prolong mere biological existence during the act of dying". This may, in certain situations result in a mere "prolongation of a heartbeat that activates the husk of a mindless, degenerating body that sustains an unknowing and pitiable life—one without vitality, health or any opportunity for normal existence—an inevitable stage in the process of dying".[229] Prolonging life in a vegetative state by artificial means or allowing pain and suffering in a terminal state would lead to questioning the belief that any kind of life is so sanctified as to be preferred absolutely over death.[230]

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

"Today the advances of science are occurring every minute. Lasers are used to crush kidney stones; mechanical hearts are transplanted to prolong life; and organ transplants are being increasingly used, particularly livers and eyes and, now experimentally, legs. Microprocessor ventilators are used to maintain breathing in patients unable to breathe on their own; chemotherapy/radiology is being used to prolong the lives of cancer patients; long-term haemodialysis is being used for those who have non-functional kidneys; and cardiac pacemakers are being implanted in patients whose hearts are unable to beat normally. While society has supported research and development in medicine, the issues regarding the termination

227 *Ibid.*, at p. 68.
228 Sushila Rao (Supra note 200), at p. 15.
229 Arval A. Morris, "Voluntary Euthanasia", Washington Law Review (1970), Vol. 45, at p. 240.
230 *Ibid.*, at p. 243.

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of such treatment and, more importantly, the withholding of such treatment have not been fully addressed."[231]

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

> "As the sophistication of techniques for producing images of soft tissue increases, we will be able to determine with a high degree of certainty that some living, breathing human beings have suffered such severe brain damage that they will never regain consciousness. In these cases, with the hope of recovery gone, families and loved ones will usually understand that even if the human organism is still alive, the person they loved has ceased to exist. Hence, a decision to remove the feeding tube will be less controversial, for it will be a decision to end the life of a human body, but not of a person."[232]

426. Lady Justice Arden recently delivered a lecture in India on a topic dealing with the intersection of law and medicine titled "What does patient autonomy mean for courts?"[233]. The Judge explained that advancement in medical technology has contributed towards a growing importance of patient autonomy and an increasing social trend towards questioning clinical judgment, which is causing conflict among courts in the UK—particularly in end of life treatment decisions. To highlight this conflict, Judge Arden cites the example of baby Charlie Gard, a "caregiver case"[234] that engendered debate on medical ethics world over. Born in August 2016 in London, Charlie suffered from an extremely rare genetic condition known as MDDS, which causes progressive brain damage and muscle failure, usually leading to death in infancy. His parents wanted him to undergo experimental treatment known as nucleoside which was available in the USA and raised a large amount of money to enable him to travel there. However, the doctors at the hospital in London who were treating him did not think it was in his caregiver to have this treatment as instead they believed his caregiver demanded that his life-support be withdrawn as they considered the treatment to be futile. Due to the conflicting views between the parents and the doctors, the core issue to be decided i.e. whether it was in the best interest of the child to receive further treatment had to be answered by the Court. The case went through the judicial system—including the High Court, the Supreme Court, the ECHR and finally back to the High Court, which on the

231 Elizabeth M. Andal Sorrentino, "The Right to Die?", Journal of Health and Human Resources Administration (Spring, 1986), Vol. 8, No. 4, at pp. 361-373.

232 Peter Singer, "The Sanctity of Life", *Foreign Policy* (20-10-2009) <http://foreignpolicy.com/2009/10/20/the-sanctity-of-life/>.

233 Lady Justice Arden, Law of Medicine and the Individual: Current Issues, What does patient autonomy mean for the courts?, (Justice K.T. Desai Memorial Lecture 2017).

234 *Great Ormond Street Hospital* v. *Yates*, 2017 EWHC 1909 : (2017) 4 WLR 131 (Fam)

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basis of medical reports concluded that it was not in the child's caregiver to have further treatment and passed an order permitting the doctors to allow Charlie to die. In addition to the issue of caregiver, Lady Justice Arden also mentioned the issue of resources in such cases. In the present case, the parents were able to raise large amounts of financial resources required for the treatment of the child, but lack of resources could lead to difficulties in other cases where treatment is unaffordable in a public health system.

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

H. *Euthanasia and the Indian Constitution*

428. The sanctity of life principle appears in declarations on human rights as the "right to life".[235] Under the Indian Constitution, right to life has been provided under Article 21. In *Parmanand Katara* v. *Union of India*[236], it was pointed out: (SCC p. 293, para 7)

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

The sanctity of human life lies in its intrinsic value. It inheres in nature and is recognised by natural law. But human lives also have instrumental functions. Our lives enable us to fulfil our needs and aspirations. The intrinsic worth of life is not conditional on what it seeks to or is capable to achieve. Life is valuable because it *is*. The Indian Constitution protects the right to life as the supreme right, which is inalienable and inviolable even in times of Emergency.[237] It clearly recognises that every human being has the inherent right to life, which is protected by law, and that "No person shall be deprived of his life… except according to procedure established by law"[238]. It, thus, envisages only very limited circumstances where a person can be deprived of life.

429. According to Stefania Negri, the debate around euthanasia has "essentially developed within the framework of the universal rights to life and to human dignity"[239]. This leads us to the relationship between end-of-life decisions and human dignity under the Indian Constitution.

Dignity

430. Human dignity has been "considered the unique universal value that inspires the major common bioethical principles, and it is therefore considered

235 John Keown (Supra note 176), at p. 4.
236 (1989) 4 SCC 286 : 1989 SCC (Cri) 721 : AIR 1989 SC 2039
237 Article 359.
238 Article 21.
239 Stefania Negri, "Universal Human Rights and End-of-Life Care" in S. Negri et al. (eds.), Advance Care Decision Making in Germany and Italy: A Comparative, European and International Law Perspective, Springer (2013), at p. 18.

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the *noyau dur* of both international bio law and international human rights law"[240]. Ronald Dworkin observes that "the notion of a right to dignity has been used in many senses by moral and political philosophers".[241]

431. The first idea considers dignity as the foundation of human rights — "that dignity relates to the intrinsic value of persons (such that it is wrong to treat persons as mere things rather than as autonomous ends or agents)"[242]. According to this premise, every person, from conception to natural death, possesses inherent dignity:

> "The sanctity of life view is often accompanied by a set of claims about human dignity, namely, that human beings possess essential, underived, or intrinsic dignity. That is, they possess dignity, or excellence, in virtue of the kind of being they are; and this essential dignity can be used summarily to express why it is impermissible, for example, intentionally to kill human beings: to do so is to act against their dignity."[243]

The other interpretation of dignity is by the supporters of euthanasia.[244] For them, right to lead a healthy life also includes leaving the world in a peaceful and dignified manner. Living with dignity, in this view, means the right to live a meaningful life having certain quality. This interpretation endorses the "quality of life" proposition.

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

> "*To be meaningful in the end-of-life discourse, and hence to avoid being invoked as mere rhetoric, dignity should be considered as a substantive legal concept, at whose basic minimum core is the legal guarantee assuring the protection of every human being against degradation and humiliation.* Besides this, as international and national case law demonstrate, it can also play an important role as an interpretive principle, assisting Judges in the interpretation and application of other

240 *Ibid.*, at pp. 21-22.

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

242 Deryck Beyleveld and Roger Brownsword, "Human Dignity, Human Rights, and Human Genetics", Modern Law Review (1998), Vol. 61, at p. 666.

243 Christopher O. Tollefsen, "Capital Punishment, Sanctity of Life, and Human Dignity", *Public Discourse* (16-9-2011), <http://www.thepublic discourse.com/2011/09/3985/>.

244 Stefania Negri, "Ending Life and Death" in A. den Exter (eds.), European Health Law, MAKLU Press (2017), at p. 241.

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human rights, such as the right to life and the right to respect for private life, both crucial in the end-of-life debate."[245] (emphasis supplied)

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

433. Morris, in his article, "Voluntary Euthanasia", regards cruelty as a violation of human dignity:

> "All civilized men will agree that cruelty is an evil to be avoided. But few people acknowledge the cruelty of our present laws which require a man be kept alive against his will, while denying his pleas for merciful release after all the dignity, beauty, promise and meaning of life have vanished, and he can only linger for weeks or months in the last stages of agony, weakness and decay." In addition, the fact that many people, as they die, are fully conscious of their tragic state of deterioration greatly magnifies the cruelty inherent in forcing them to endure this loss of dignity against their will."[246]

He has further stated:

> "it is exceedingly cruel to compel the spouse and children of a dying man to witness the ever-worsening stages of his disease, and to watch the slow, agonising death of their loved one, degenerating before their eyes, being transformed from a vital and robust parent and spouse into a pathetic and humiliated creature, devoid of human dignity".[247]

434. Liberty and autonomy promote the cause of human dignity. Arguments about autonomy are often linked to human dignity.[248] Gostin evaluates the relationship between the dignity of dying with autonomy thus:

> "The dying process, after all, is the most intimate, private and fundamental of all parts of life. It is the voice that we, as humans, assert in influencing this autonomous part of our life. At the moment of our death, this right of autonomy ought not to be taken from us simply because we are dying. An autonomous person should not be required to have a good reason for the decision that he or she will make; that is the nature of autonomy. We do not judge for other competent human beings what may be in their best interest, but instead allow them to determine that for themselves. As such, an autonomous person does not need to have a good understanding or even good reasons. All they need is an understanding of what they are confronting. There is no reason to believe that when a person faces

245 *Ibid.*
246 Arval A. Morris (Supra note 229), at pp. 251-252.
247 *Ibid.*
248 Sebastian Muders, *Autonomy and the Value of Life as Elements of Human Dignity* (Oxford University Press, 2017).

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imminent death that they have less human understanding, or less ability to fathom what they will face, than other people. Of course, death is a mystery. But death is what we will all confront sooner or later, and we all may wish to assert our interests in how we may die."[249]

435. Sumner in his work titled "Dignity through Thick and Thin"[250] discusses the dignity associated with patients:

> "[P]atients associate dignity with concepts such as respect and esteem, presumably including self-respect and self-esteem, whereas they experience its opposite—indignity—as degrading, shameful, or embarrassing. … Abstractly speaking, a person's dignity seems to be a matter of assurance of her fully human status, both in her own eyes and in the eyes of others. Dignity is maintained when one can face others with pride and with confidence of being worthy of their respect; it is lost or impaired when being seen by others occasions feelings of shame, inferiority, or embarrassment. The element of degradation that is implicated in indignity seems a matter of feeling demoted or diminished from a higher standing to a lower, perhaps from the status of a fully functioning person to something lesser."[251]

While stating that dignity and indignity are "basically subjective notions"[252] depending upon how individual patients experience them, he has further stated:

> "One condition that patients report as degrading— as an indignity—is loss of control over the course of their own healthcare. Loss of autonomy matters in its own right, but it matters even more if it is the source for patients of shame and humiliation. This suggests that autonomy and well-being are themselves interconnected: Patients typically experience a loss of the former as a decline in the latter, as something that makes their dying process go worse for them by causing them feelings of indignity. Appeals to dignity thus flesh out what is at stake for patients in terms of their autonomy and well-being, but they do not introduce any factors that fall outside the limits of these values."[253]

436. An article titled "Euthanasia: A Social Science Perspective"[254] in the Economic & Political Weekly has suggested that the discourses on death with dignity "need to be situated within processes of living with dignity in everyday contexts".[255] The end of life must not be seen as "human disposal", but, as

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

250 L.W. Sumner, "Dignity Through Thick and Thin", in Sebastian Muders, *Human Dignity and Assisted Death* (Oxford University Press, 2017).

251 *Ibid.*, at p. 61.

252 *Ibid.*, at p. 64.

253 *Ibid.*, at p. 68.

254 Aneeta A. Minocha, Arima Mishra and Vivek R. Minocha, "Euthanasia: A Social Science Perspective", Economic & Political Weekly (3-12-2011), at pp. 25-28.

255 *Ibid.*, at p. 27.

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"the enhancement of human dignity by permitting each man's last act to be an exercise of his free choice between a tortured, hideous death and a painless, dignified one."[256]

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

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

439. From *Maneka Gandhi*[50] to *Puttaswamy*[58], dignity is the element which binds the constitutional quest for a meaningful existence. In *Francis Coralie Mullin* v. *State (UT of Delhi)*[62], this Court held that: (SCC p. 618, paras 7-8)

> "7. … the right to life enshrined in Article 21 cannot be restricted to mere animal existence. It means something much more than just physical survival. …
>
> 8. We think that the right to life includes the right to live with human dignity…."

Explaining the ambit of dignity, this Court further held that: (SCC p. 619, para 8)

> "8. … [A]ny form of torture or cruel, inhuman or degrading treatment would be offensive to human dignity and constitute an inroad into this right to live…. [T]here is implicit in Article 21 the right to protection against torture or cruel, inhuman or degrading treatment which is enunciated in

256 Arval A. Morris (Supra note 229), at p. 247.
50 *Maneka Gandhi* v. *Union of India*, (1978) 1 SCC 248
58 *K.S. Puttaswamy* v. *Union of India*, (2017) 10 SCC 1
62 (1981) 1 SCC 608 : 1981 SCC (Cri) 212

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Article 5 of the Universal Declaration of Human Rights and guaranteed by Article 7 of the International Covenant on Civil and Political Rights."

Dignity is the core value of life and personal liberty which infuses every stage of human existence. Dignity in the process of dying as well as dignity in death reflects a long yearning through the ages that the passage away from life should be bereft of suffering. These individual yearnings are enhanced by the experiences of sharing, observing and feeling with others: the loss of a parent, spouse, friend or an acquaintance to the cycle of life. Dignity in death has a sense of realism that permeates the right to life. It has a basic connect with the autonomy of the individual and the right to self-determination. Loss of control over the body and the mind are portents of the deprivation of liberty. As the end of life approaches, a loss of control over human faculties denudes life of its meaning. Terminal illness hastens the loss of faculties. Control over essential decisions about how an individual should be treated at the end of life is hence an essential attribute of the right to life. Corresponding to the right is a legitimate expectation that the State must protect it and provide a just legal order in which the right is not denied. In matters as fundamental as death and the process of dying, each individual is entitled to a reasonable expectation of the protection of his or her autonomy by a legal order founded on the rule of law. A constitutional expectation of providing dignity in death is protected by Article 21 and is enforceable against the State.

Privacy

440. The nine-Judge Bench decision of this Court in *K.S. Puttaswamy* v. *Union of India*[58] held privacy to be the constitutional core of human dignity. The right to privacy was held to be an intrinsic part of the right to life and liberty under Article 21 and protected under Part III of the Constitution. Each of the six decisions has a vital bearing on the issues in the present case. Excerpts from the judgment are reproduced below: (SCC pp. 413, 530, 544, 577, 611-12, 618 & 624, paras 127, 373, 392, 411, 482, 543, 583 & 609)

Justice D.Y. Chandrachud

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

Justice Chelameswar

"*373.* … 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 of privacy."

58 (2017) 10 SCC 1

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Justice S.A. Bobde

"*392*. … Privacy, with which we are here concerned, eminently qualifies as an inalienable natural right, intimately connected to two values whose protection is a matter of universal moral agreement: the innate dignity and autonomy of man.

* * *

411. … Both dignity and privacy are intimately intertwined and are natural conditions for the birth and death of individuals, and for many significant events in life between these events."

Justice R.F. Nariman

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

Justice A.M. Sapre

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

Justice S.K. Kaul

"*583*. A person-hood would be a protection of one's personality, individuality and dignity."

* * *

"*609*. Privacy, for example is nothing but a form of dignity, which itself is a subset of liberty."

441. The protective mantle of privacy covers certain decisions that fundamentally affect the human life cycle.[257] It protects the most personal and intimate decisions of individuals that affect their life and development.[258] Thus, choices and decisions on matters such as procreation, contraception and marriage have been held to be protected. While death is an inevitable end in the trajectory of the cycle of human life of individuals are often faced with choices and decisions relating to death. Decisions relating to death, like those relating to birth, sex, and marriage, are protected by the Constitution by virtue of the right of privacy. The right to privacy resides in the right to liberty and in the respect of autonomy.[259] The right to privacy protects autonomy in making decisions related to the intimate domain of death as well as bodily integrity. Few

257 Richard Delgado, "Euthanasia Reconsidered—The Choice of Death as an Aspect of the Right of Privacy", Arizona Law Review (1975), Vol. 17, at p. 474.

258 *Ibid.*

259 T.L. Beauchamp, "The Right to Privacy and the Right to Die", *Social Philosophy and Policy* (2000), Vol. 17, at p. 276.

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moments could be of as much importance as the intimate and private decisions that we are faced regarding death.[260] Continuing treatment against the wishes of a patient is not only a violation of the principle of informed consent, but also of bodily privacy and bodily integrity that have been recognised as a facet of privacy by this Court.

442. Just as people value having control over decisions during their lives such as where to live, which occupation to pursue, whom to marry, and whether to have children, so people value having control over whether to continue living when the quality of life deteriorates.[261]

443. In *Quinlan, In re*[26], the New Jersey Supreme Court dealt with a case of a patient, Karen Quinlan, who had suffered irreversible brain damage and was in a persistent vegetative state and had no prospect of recovery. The patient's father sought judicial authority to withdraw the life-sustaining mechanisms temporarily preserving his daughter's life, and his appointment as guardian of her person to that end. The father's lawyer contended that the patient was being forced to function against all natural impulses and that her right to make a private decision about her fate superseded the State's right to keep her alive. The New Jersey Supreme Court held that the patient had a right of privacy grounded in the US Constitution to terminate treatment and in a celebrated statement said that:

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

Since Karen Quinlan was not competent to assert her right to privacy, the Court held that Karen's right of privacy may be asserted on her behalf by her guardian due to the reason that Karen Quinlan did not have the capacity to assert her right to privacy indicating that the right of privacy is so fundamental that others, who had been intimately involved with the patient, should be able to exercise it in circumstances when the patient is unable to do so. However, subsequently scholars have argued that when euthanasia is founded in the right to privacy, only voluntary euthanasia can be permitted. The right to privacy can only be exerted by the patient and cannot be exercised vicariously.[262] The substituted judgment and caregiver criterion cannot be logically based on the right to privacy of the patient.[263]

444. In the landmark case of *Pretty* v. *United Kingdom*[32], the European Court of Human Rights analysed Article 8 of the European Convention on Human Rights (respect for private life). It held that the term "private life" is a

260 *Ibid.*
261 D. Benatar (Supra note 150).
26 355 A 2d 647 : 70 NJ 10 (NJ 1976), cert. denied sub nom *Garger* v. *New Jersey*, 429 US 922 (1976)
262 Peter J. Riga, "Privacy and the Right to Die", *The Catholic Lawyer* (2017) Vol. 26: No. 2, Article 2.
263 *Ibid.*
32 (2002) 35 EHRR 1 : 2002 ECHR 423

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broad term not susceptible to exhaustive definition and covers the physical and psychological integrity of a person. In relation to the withdrawing of treatment, it was held that the way in which an individual "chooses to pass the closing moments of her life is part of the act of living, and she has a right to ask that this too must be respected". The right to privacy protects even those choices that may be considered harmful for the individual exercising the choice:

> "The extent to which a State can use compulsory powers or the criminal law to protect people from the consequences of their chosen lifestyle has long been a topic of moral and jurisprudential discussion, the fact that the interference is often viewed as trespassing on the private and personal sphere adding to the vigour of the debate. However, even where the conduct poses a danger to health or, arguably, where it is of a life-threatening nature, the case law of the Convention institutions has regarded the State's imposition of compulsory or criminal measures as impinging on the private life of the applicant within the meaning of Article 8 § 1.... In the sphere of medical treatment, the refusal to accept a particular treatment might, inevitably, lead to a fatal outcome, yet the imposition of medical treatment, without the consent of a mentally competent adult patient, would interfere with a person's physical integrity."

The Court further observed that:

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

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

445. Subsequently in *Haas* v. *Switzerland*[264], the European Court of Human Rights has further held that the right to decide in which way and at which time an individual's life should end, provided that he or she was in a position freely to form her own will and to act accordingly, was one of the aspects of the right to respect for private life within the meaning of Article 8 of the Convention.

446. The right to privacy as held by this Court mandates that we safeguard the integrity of individual choice in the intimate sphere of decisions relating to death, subject to the restrictions to the right to privacy, as laid down by us. However, since privacy is not an absolute right and is subject to restrictions, the restrictions must fulfil the requirements as laid down by this Court in *Puttaswamy*[58].

264 (2011) 53 EHRR 33, para 51.
58 *K.S. Puttaswamy* v. *Union of India*, (2017) 10 SCC 1

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

Socio-economic concerns

448. One of the limitations of contemporary debates on euthanasia is that they do not take into consideration "certain socio-economic concerns that must necessarily be factored into any discourse"[265]. This has been criticised as making the debate around ending life "incomplete" as well as "elitist".

449. In an article titled "Euthanasia: Cost Factor is a Worry"[266] Nagral (2011) seeks to construct a "critical linkage" between euthanasia and "the economic and social dimension" in the Indian context. Stating that many Indian doctors have been practising passive euthanasia silently and practically, Nagral contemplates the cost of treatment to be a critical factor in influencing the medical decision:

> "[O]ne of the reasons for 'passive' euthanasia is that the patient or his family could be running out of money. In some cases, this overlaps with the incurability of the disease. In others, it may not. Costly medication and intervention is often withdrawn as the first step of this passive euthanasia process. Sometimes patients are 'transferred' to smaller (read cheaper) institutions or even their homes, with the tacit understanding that this will hasten the inevitable. If a third party is funding the patient's treatment, chances are that the intervention and support will continue. Shocking and arbitrary as this may sound, this is the reality that needs flagging because it is relevant to the proposed legitimisation of passive euthanasia. In a system where out-of-pocket payment is the norm and healthcare costs are booming, there has to be a way of differentiating a plea made on genuine medical grounds from one that might be an attempt to avoid financial ruin."[267]

Rao (2011) has observed:

> "In the absence of adequate medical insurance, specialised treatments like ventilator support, kidney dialysis, and expensive lifesaving drugs administered in private hospitals can turn middle-class families into virtual paupers. Poorly equipped government hospitals simply do not have enough life-support machines compared to the number of patients who need them. … This also leads to the inevitable possibility of a comatose patient's family and relatives potentially exploiting the euthanasia law to benefit from a premature death, by way of inheritance, etc."[268]

265 Sushila Rao (Supra note 148), at p. 654.

266 S. Nagral, "Euthanasia: Cost Factor is a Worry", *The Times of India* (19-6-2011) <http://www.timesofindia.com/home/sunday/Euthanasia-cost-factor-is-a-worry/articleshow/7690155.cms>.

267 *Ibid*.

268 Sushila Rao (Supra note 148), at pp. 654-655.

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

> "This concerns the problem of the differential social impact that such a position would have on the poor and the well-to-do… Wealth, poverty, and class structure have a profound effect on the choices people make."[269]

The inadequacies of the range and reach of Indian healthcare may, it is observed, lead to a situation where euthanasia/active euthanasia may become "an instrument of cost containment"[270].

Restraints on judicial power

450. An earlier part of this judgment has dwelt on the criticism of the distinction between passive and active euthanasia, founded as it is on the act—omission divide. The criticism is that as a matter of substance, there is no valid distinguishing basis between active and passive euthanasia. The criticism takes one of two forms: either both should be recognised or neither should be allowed. The view that passive euthanasia involves an omission while active euthanasia involves a positive act is questioned on the ground that the withdrawal of artificial life support (as an incident of passive euthanasia) requires a positive act. While noticing this criticism, it is necessary to distinguish between active and passive euthanasia in terms of the underlying constitutional principles as well as in relation to the exercise of judicial power. Passive euthanasia —whether in the form of withholding or withdrawing treatment—has the effect of removing, or as the case may be, not providing supportive treatment. Its effect is to allow the individual to continue to exist until the end of the natural span of life. On the other hand, active euthanasia involves hastening of death: the lifespan of the individual is curtailed by a specific act designed to bring an end to life. Active euthanasia would on the state of the penal law as it stands constitute an offence. Hence, it is only Parliament which can in its legislative wisdom decide whether active euthanasia should be permitted. Passive euthanasia on the other hand would not implicate a criminal offence since the decision to withhold or withdraw artificial life support after taking into account the best interest of the patient would not constitute an illegal omission prohibited by law.

451. Moreover, it is necessary to make a distinction between active and passive euthanasia in terms of the incidents of judicial power. We may refer in this context to the felicitous words of Sales, L.J. speaking for the Queen's Bench Division in a recent decision delivered on 5-10-2017 in *R. (Conway)* v. *Secy. of State for Justice*[271]. Dealing with the plea that physician-assisted suicide should be accepted as a principle by the Court, the learned Judge observed thus: (WLR p. 352 C-G)

> "*109*. Parliament is the body composed of representatives of the community at large with what can be called a democratic mandate to make

269 Alan Norrie (Supra note 140), at p. 144.

270 S. Nagral, "Euthanasia: Cost Factor is a Worry", *The Times of India* (19-6-2011) <http://www.timesofindia.com/home/sunday/Euthanasia-cost-factor-is-a-worry/articleshow/7690155.cms>.

271 (2018) 2 WLR 322 : 2017 EWHC 2447 (Admin)

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the relevant assessment in a case where there is an important element of social policy and moral value-judgment involved with much to be said on both sides of the debate (paras 229 and 233). There is not a single, clear, uniquely rational solution which can be identified; the decision cannot fail to be influenced by the decision-makers' opinions about the moral case for assisted suicide, including in deciding what level of risk to others is acceptable and whether any safeguards are sufficiently robust; and it is not appropriate for professional Judges to impose their personal opinions on matters of this kind (paras 229-230 and 234). In Nicklinson's case in the Court of Appeal, Lord Judge CJ aptly referred to Parliament as representing 'the conscience of the nation' for decisions which raise "profoundly sensitive questions about the nature of our society, and its values and standards, on which passionate but contradictory opinions are held" (Court of Appeal, para 155). Parliament has made the relevant decision; opponents of Section 2 have thus far failed to persuade Parliament to change the law despite active consideration given to the issue, in particular in relation to the Falconer Bill which contained essentially the same proposals as Mr Conway now puts before the court; and the democratic process would be liable to be subverted if, on a question of moral and political judgment, opponents of the legislation could achieve through the courts what they could not achieve in Parliament (para 231), per Lord Sumption, referring to *R. (Countryside Alliance)* v. *Attorney General*[272], para 45 per Lord Bingham and *AXA General Insurance Ltd.* v. *HM Advocate*[273] para 49 per Lord Hope)."

Emphasising the limitations on the exercise of the judicial power, Sales, L.J. observed: (WLR p. 353 C-E, para 112)

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

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

272 2008 AC 719 : (2007) 3 WLR 922 (HL)
273 (2012) 1 AC 868 : (2011) 3 WLR 871 (SC)

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I. ***Penal provisions***

452. The legality of and constitutional protection which is afforded to passive euthanasia cannot be read in isolation from the provisions of the Penal Code. Physicians are apprehensive about their civil or criminal liability when called upon to decide whether to limit life-supporting treatment.[274] A decision on the constitutional question cannot be rendered without analysing the statutory context and the impact of penal provisions. The decision in *Aruna Shanbaug*[5] did not dwell on the provisions of the Penal Code (apart from Sections 306 and 309) which have a vital bearing on the issue of euthanasia. Undoubtedly, constitutional positions are not controlled by statutory provisions, because the Constitution rises above and controls legislative mandates. But, in the present reference where no statutory provision is called into question, it is necessary for the court to analyse the relationship between what the statute penalises and what the Constitution protects. The task of interpretation is to allow for their co-existence while interpreting the statute to give effect to constitutional principle. This is particularly so in an area such as the present where criminal law may bear a significant relationship to the fundamental constitutional principles of liberty, dignity and autonomy.

453. The first aspect which needs to be noticed is that our law of crimes deals with acts and omissions. Section 32 of the Penal Code places acts and omissions on the same plane. An *illegal* omission (unless a contrary intent appears in the Code) is proscribed when the act is unlawful. Section 32 states:

> "**32.** ***Words referring to acts include illegal omissions***.—In every part of this Code, except where a contrary intention appears from the context, words which refer to acts done extend also to illegal omissions."

The language of the statute which refers to acts applies, unless a contrary intent appears in the text, to omissions. The next aspect is about when an act or omission is illegal. Section 43 explains the concept of illegality. It provides thus:

> "**43.** ***"Illegal", "Legally bound to do"***.—The word "illegal" is applicable to everything which is an offence or which is prohibited by law, or which furnishes ground for a civil action; and a person is said to be "legally bound to do" whatever it is illegal in him to omit."

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

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

274 S. Balakrishnan and R.K. Mani, "The Constitutional and Legal Provisions in Indian Law for Limiting Life Support", Indian Journal of Critical Care Medicine (2005), Vol. 9, Issue 2, at p. 108.

5 *Aruna Ramachandra Shanbaug* v. *Union of India*, (2011) 4 SCC 454 : (2011) 2 SCC (Civ) 280 : (2011) 2 SCC (Cri) 294

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

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

> "**81.** ***Act likely to cause harm, but done without criminal intent, and to prevent other harm.***—Nothing is an offence merely by reason of its being done with the knowledge that it is likely to cause harm, if it be done without any criminal intention to cause harm, and in good faith for the purpose of preventing or avoiding other harm to person or property.
>
> *Explanation.*—It is a question of fact in such a case whether the harm to be prevented or avoided was of such a nature and so imminent as to justify or excuse the risk of doing the act with the knowledge that it was likely to cause harm."

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

456. Section 92 IPC states:

> "**92.** ***Act done in good faith for benefit of a person without consent.***—Nothing is an offence by reason of any harm which it may cause to a person for whose benefit it is done in good faith, even without that person's consent, if the circumstances are such that it is impossible for that person to signify consent, or if that person is incapable of giving consent, and has no guardian or other person in lawful charge of him from whom it is possible to obtain consent in time for the thing to be done with benefit: Provided—
>
> *Provisos.*—*First.*—That this exception shall not extend to the intentional causing of death, or the attempting to cause death;"

Section 92 protects an individual from a consequence which arises from the doing of an act for the benefit of another in good faith, though a harm is caused to the other. What was done is protected because it was done in good faith. Good faith is distinguished from an evil design. When a person does something to protect another from a harm or injury, the law protects what was done in good faith, treating the harm that may result as a consequence unintended by the doer of the act. This protection is afforded by the law even in the absence of consent when the circumstances are such that it is impossible for the person for whose benefit the act was done to consent to it. This may arise where the imminence of the apprehended danger makes it impossible to obtain consent. Another eventuality is where the individual is incapable of consenting (by being incapacitated in mind) and there is no person in the position of a guardian or person in lawful charge from whom consent can be obtained in time to perform the act for the benefit of that person. However, the first proviso to Section 92

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makes it clear that the exception does not extend to the *intentional* causing of death or attempt to cause death to the individual, howsoever it may be for the benefit of the other. Absence of intent to cause death is the crucial element in the protection extended by Section 92.

457. Section 107 deals with abetment. It provides thus:

> "**107.** ***Abetment of a thing***.—A person *abets* the doing of a thing, who—
>
> * * *
>
> *Thirdly*.—Intentionally *aids*, by any act or illegal omission, the doing of that thing." (emphasis supplied)

Abetment embodies a threefold requirement: first an intentional aiding, second the aiding of an act or illegal omission and third, that this must be toward the doing of that thing. Explanation 2 of this Section states:

> "*Explanation 2*.—Whoever, either prior to or at the time of the commission of an act, does anything in order to facilitate the commission of that act, and thereby facilitates the commission thereof, is said to *aid* the doing of that act." (emphasis supplied)

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

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

> "**299.** ***Culpable homicide***.—Whoever causes death by doing an act with the intention of causing death, or with the intention of causing such bodily injury as is likely to cause death, or with the knowledge that he is likely by such act to cause death, commits the offence of culpable homicide."

Section 300 states:

> "**300.** ***Murder***.—Except in the cases hereinafter excepted, culpable homicide is murder, if the act by which the death is caused is done with the intention of causing death, or—
>
> *Secondly*.—If it is done with the intention of causing such bodily injury as the offender knows to be likely to cause the death of the person to whom the harm is caused, or—
>
> *Thirdly*.—If it is done with the intention of causing bodily injury to any person and the bodily injury intended to be inflicted is sufficient in the ordinary course of nature to cause death, or—
>
> *Fourthly*.—If the person committing the act knows that it is so imminently dangerous that it must, in all probability, cause death, or such bodily injury as is likely to cause death, and commits such act without any excuse for incurring the risk of causing death or such injury as aforesaid."

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Active euthanasia involves an intention on the part of the doctor to cause the death of the patient. Such cases fall under the first clause of Section 300. Exception 5 to Section 300 states:

> "*Exception 5*.—Culpable homicide is not murder when the person whose death is caused, being above the age of eighteen years, suffers death or takes the risk of death with his own consent."

460. Section 304 provides:

> "**304.** ***Punishment for culpable homicide not amounting to murder***.—Whoever commits culpable homicide not amounting to murder, shall be punished with imprisonment for life, or imprisonment of either description for a term which may extend to ten years, and shall also be liable to fine, if the act by which the death is caused is done with the intention of causing death, or of causing such bodily injury as is likely to cause death;
>
> or with imprisonment of either description for a term which may extend to ten years, or with fine, or with both, if the act is done with the knowledge that it is likely to cause death, but without any intention to cause death, or to cause such bodily injury as is likely to cause death."

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

> "The doctrine (or principle) of double effect is often invoked to explain the permissibility of an action that causes a serious harm, such as the death of a human being, as a side-effect of promoting some good end. According to the principle of double effect, sometimes it is permissible to cause a harm as a side-effect (or "double effect") of bringing about a good result even though it would not be permissible to cause such a harm as a means to bringing about the same good end."[275]

It has been observed further:

> "A doctor who intends to hasten the death of a terminally-ill patient by injecting a large dose of morphine would act impermissibly because he intends to bring about the patient's death. However, a doctor who intended to relieve the patient's pain with that same dose and merely foresaw the hastening of the patient's death would act permissibly."[276]

462. A distinction arises between active and passive euthanasia from the provisions of the Penal Code. Active euthanasia involves an intention to cause the death of the patient. Mens rea requires a guilty mind; essentially an intent to cause harm or injury. Passive euthanasia does not embody an intent to cause death. A doctor may withhold life support to ensure that the life of a patient who is in the terminal stage of an incurable illness or in a permanent vegetative state, is not prolonged artificially. The decision to do so is not founded upon an intent

275 "Doctrine of Double Effect", *Stanford Encyclopedia of Philosophy* (28-7-2004) <https://plato.stanford.edu/entries/double-effect/>.
276 *Ibid*.

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to cause death but to allow the life of the patient to continue till and cease at the end of its natural term. Placing such a person on life support would have been an intervention in the natural process of death. A decision not to prolong life by artificial means does not carry an intention to cause death. The crucial element in Section 299 is provided by the expression "causes death". In a case involving passive euthanasia, the affliction of the patient is not brought about either by an act or omission of the doctor. There is neither an animus nor an intent to cause death. The creation of the condition of the patient is outside the volition of the doctor and has come about without a covert or overt act by the doctor. The decision to withhold medical intervention is not intended to cause death but to prevent pain, suffering and indignity to a human being who is in the end stage of a terminal illness or of a vegetative state with no reasonable prospect of cure. Placing a patient on artificial life support would, in such a situation, merely prolong the agony of the patient. Hence, a decision by the doctor based on what is in the best interest of the patient precludes an intent to cause death. Similarly, withdrawal of artificial life support is not motivated by an intent to cause death. What a withdrawal of life support does is not to artificially prolong life. The end of life is brought about by the inherent condition of the patient. Thus, both in a case of a withdrawal of life supporting intervention and withholding it, the law protects a bona fide assessment of a medical professional. There being no intent to cause death, the act does not constitute either culpable homicide or murder.

463. Moreover, the doctor does not inflict a bodily injury. The condition of a patient is on account of a factor independent of the doctor and is not an outcome of his or her actions. Death emanates from the pre-existing medical condition of the patient which enables life to chart a natural course to its inexorable end. The law protects a decision which has been made in good faith by a medical professional not to prolong the indignity of a life placed on artificial support in a situation where medical knowledge indicates a point of no return. Neither the act nor the omission is done with the knowledge that it is likely to cause death. This is for the reason that the likelihood of death is not occasioned by the act or omission but by the medical condition of the patient. When a doctor takes a considered decision in the case of a patient in a terminal stage of illness or in a permanently vegetative state, not to provide artificial life support, the law does not attribute to the doctor the knowledge that it is likely to cause death.

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

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on the knowledge that it is likely to cause death. An act done in pursuance of the duty of care owed by the doctor to a patient is not prohibited by law.

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

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

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

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

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

466.4. A doctor who withholds or withdraws medical treatment in the best interest of a patient, such as when a patient is in a permanent vegetative state

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or in a terminal state of an incurable illness, is not guilty under Section 299 because there is no intention to cause death or bodily injury which is likely to cause death. The act of withholding or withdrawing a life support system in the case of a competent patient who has refused medical treatment and, in the case of an incompetent person where the action is in the best interest of the patient would be protected by good faith protections available under Sections 76, 79, 81 or, as the case may be, by Section 88, even if it is construed that the doctor had knowledge of the likelihood of death; and

466.5. The decision of the doctor, who is under a duty at common law to obey the refusal of a competent patient to take medical treatment, would not constitute a culpable act of negligence under Section 304-A. When the doctor has taken such a decision to withhold or withdraw treatment in the best interest of the patient, the decision would not constitute an act of gross negligence punishable under Section 304-A.

467. Introducing a structural safeguard, in the form of a Medical Board of experts can be contemplated to further such an objective. The Transplantation of Human Organs and Tissues Act, 1994 provides for the constitution of Authorisation Committees under Section 9(4). Authorisation Committees are contemplated at the State and district levels and a hospital board.[277] Once the process of decision-making has been arrived at by fulfilling a mandated safeguard (the prior approval of a committee), the decision to withdraw life support should not constitute an illegal act or omission. The setting up of a broad-based board is precisely with a view to lend assurance that the duty of care owed by the doctor to the patient has been fulfilled. Once due safeguards have been fulfilled, the doctor is protected against the attribution of a culpable intent or knowledge. It will hence fall outside the definition of culpable homicide (Section 299), murder (Section 300) or causing death by a rash or negligent act (Section 304-A). The composition of this broad-based committee has been dealt with in the last segment of this judgment.

J. ***Advance Directives***

468. A patient, in a sound state of mind, possesses the ability to make decisions and choices and can legitimately refuse medical intervention. Cardozo, J. had this to say in a seminal statement of principle in the 1914 decision in *Schloendorff* v. *Society of New York Hospital*[278]:

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

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

> "… The attitude of the law is to recognise the inviolability of the human body. The patient's consent must be voluntary and informed. These notions

277 Rule 6-A, Transplantation of Human Organs and Tissues Act, 1995.
278 105 NE 92 at p. 93 (NY 1914)

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are buttressed by the constitutionally recognized right to privacy. Clearly, then, a patient may refuse treatment which would extend his life. Such a decision must rest with the patient."[279]

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

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

470. Recognition of the right to accept or refuse medical treatment is founded upon autonomy. The *Stanford Encyclopaedia of Philosophy*[280] postulates that there is "a rough consensus in medical ethics on the requirement of respect for patient autonomy". However, a patient may not always have the opportunity to grant or withhold consent to medical treatment. An unforeseen event may deprive the individual of the ability to indicate a desire to either receive or not to have medical treatment. An occasion necessitating treatment in sudden cases where a person suffers an accident, a stroke or coronary[281] episode may provide no time for reflection. In anticipation of such situations, "where an individual patient has no desire to be kept in a state of complete and indefinite vegetated animation with no possibility of recovering his mental and physical faculties, that individual, while still in control of all his/her faculties and his ability to express himself/herself"[282], could still retain the right to refuse medical treatment by way of "Advance Directives".

471. Broadly, there are two forms of Advance Directives:

(*i*) A *Living Will* which indicates a person's views and wishes regarding medical treatment.

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

279 Luis Kutner, "Due Process of Euthanasia: The Living Will, A Proposal", Indiana Law Journal (1969), Vol. 44, Issue 4, at p. 539.

280 "Advance Directives and Substitute Decision-Making", *Stanford Encyclopaedia of Philosophy* (24-3-2009) <https://plato.standford.edu/entries/advance-directives/>.

281 Luis Kutner (Supra note 279) at p. 551.

282 Luis Kutner (Supra note 197) at p. 226.

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Although there can be an overlap between these two forms of Advance Directives, the focus of a durable power is on who makes the decision while the focus of a living will is on what the decision should be. A "living will" has also been referred as "a declaration determining the termination of life", "testament permitting death", "declaration for bodily autonomy", "declaration for ending treatment", "body trust", or other similar reference.[283] Living wills are not a new entity and were first suggested by US attorney, Luis Kutner, in late 1960s.[284]

472. Advance Directives have evolved conceptually to deal with cases where a patient who subsequently faces a loss of the mental faculty to decide has left instructions, when he or she was possessed of decision-making capacity, on how future medical decisions should be made. The *Stanford Encyclopaedia*[285] explains the concept thus:

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

Hazel Biggs[286] explains the meaning of "living wills" and Advance Directives:

> "Usually a living will is thought of as a statement indicating a person's preferred treatment options at the end of life, but the term "living will" is also "sometimes used for Advance Directives which are concerned with other situations or which can be used to express a willingness to receive particular treatments". Some stipulate that specific treatments are acceptable while others are not, while others insist that all available appropriate medical resources should be utilised to maintain life. Living wills are not therefore exclusively associated with end-of-life decisions, although generally the purpose of a living will is to promote individual autonomy and choice for the patient; characteristics which have long been associated with euthanasia as a means of achieving death with dignity".

283 Luis Kutner (Supra note 279) at p. 551.
284 *Ibid.*
285 "Advance Directives and Substitute Decision-Making", *Stanford Encyclopaedia of Philosophy* (24-3-2009) <https://plato.standford.edu/entries/advance-directives/>.
286 Hazel Biggs (Supra note 153), at p. 115.

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James C. Turner[287] explains the concept of a living will thus:

> "The living will is a document by which a competent adult signifies a desire that if there ever comes a time when there is no reasonable expectation of his recovery from physical or mental disability that he be allowed to die rather than be kept alive by artificial means or heroic measures. What the typical living will does, in effect, is to sanction passive euthanasia, or, as it has been called, antidysthanasia.
>
> The living will is a document which directs one's physician to cease affirmative treatment under certain specified conditions. It can presumably apply to both the situation in which a person with a terminal disease lapses into the final stage of his illness and also the situation in which a victim of a serious accident deteriorates into a state of indefinite vegetated animation...."

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

> "... Founded upon respect for individual autonomy this is a right that operates through the law of consent to protect patients from unfettered medical paternalism. Common law holds that patients with the capacity to give consent are also competent to refuse or withhold consent, "even if a refusal may risk personal injury to health or even lead to premature death". Furthermore, a "refusal of treatment can take the form of a declaration of intent never to consent to that treatment in the future, or never to consent in some future circumstances". Accordingly, any consent or refusal of consent made by a competent adult patient can also be valid in respect of the same treatment at any time in the future."

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

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

287 James C. Turner, "Living Wills — Need for Legal Recognition", West Virginia Law Review (1976), Vol. 78, Issue 3, at p. 370.

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

477. Advance Directives are founded on the principle that an individual whose state of mind is not clouded by an affliction which prevents him or her from taking decisions is entitled to decide whether to accept or not accept medical intervention. If a decision can be made for the present, when the individual is in a sound state of mind, such a person should be allowed to decide the course of action which should be followed in the future if he or she were to be in a situation which affects the ability to take decisions. If a decision on whether or not to receive medical treatment is valid for the present such a decision must be equally valid when it is intended to operate in the future. Advance Directives are, in other words, grounded in a recognition by the law of the importance of consent as an essential attribute of personal liberty. It is the consensual nature of the act underlying the Advance Directive which imparts sanctity to it in future in the same manner as a decision in the present on whether or not to accept medical treatment.

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

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479. Conceptually, there is a second standard, which is the caregiver standard. This is founded on the principle of beneficence. The second standard seeks to apply an objective notion of a line of treatment which a reasonable individual would desire in the circumstances.

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

> "The Substituted Judgment standard:
>
> The surrogate's task is to reconstruct what the patient himself would have wanted, in the circumstances at hand, if the patient had decision-making capacity. Substantive Advance Directives are here thought of as a helpful mechanism for aiding the application of Substituted Judgment. The moral principle underlying this legal standard is the principle of respect for autonomy, supplemented by the idea that when a patient is not currently capable of making a decision for himself, we can nonetheless respect his autonomy by following or reconstructing, as best we can, the autonomous decision he would have made if he were able. In a subset of cases, a substituted judgment can implement an actual earlier decision of the patient, made in anticipation of the current circumstances; this is known as precedent autonomy.
>
> The Caregiver standard:
>
> The surrogate is to decide based on what, in general, would be good for the patient. The moral principle underlying this standard is the principle of beneficence. This legal standard has traditionally assumed a quite generic view of interests, asking what a "reasonable" person would want under the circumstances and focusing on general goods such as freedom from pain, comfort, restoration and/or development of the patient's physical and mental capacities. This is because the Caregiver standard has mainly been employed when there is little or no information about the patient's specific values and preferences. However, the concept of caregiver is simply the concept of what is best for the person. There is no reason why, in principle, the Caregiver judgment could not be as nuanced and individual as the best theory of well-being dictates."

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

481. The *Encyclopaedia* explains that the "orthodox view" contained the following ordering of priorities:

> "1. Honour a substantive Advance Directive, as an aid to Substituted Judgment, whenever such directive is available.
>
> 2. Absent an Advance Directive, apply the Substituted Judgment standard based on available information about the patient's past decisions and values.

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3. If you cannot apply the Substituted Judgment standard — either because the patient has never been competent or because information about the patient's former wishes and values is unavailable — use the Caregiver standard."

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

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

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

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

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

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

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issues. Advance Directives may hence conceivably raise ethical issues of the extent to which the perception of the individual who executes it must prevail in priority to the best interest of the patient.

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

487. In a society such as ours where family ties have an important place in social existence, Advance Directives also provide a sense of solace to the family. Decisions such as whether to withhold or withdraw artificial life saving treatment are difficult for families to take. Advance Directives provide moral authority for the family of the patient that the decision which has been taken to withdraw or withhold artificial life support is in accord with the stated desire of the patient expressed earlier. But the ethical concerns which have been referred to earlier may warrant a nuanced application of the principle. The circumstances which have been adverted to earlier indicate that the decision on whether to withhold or withdraw medical treatment should be left to a competent body comprising of, but not restricted to medical professionals. Assigning a supervisory role to such a body is also necessary in order to protect against the possibility of abuse and the dangers surrounding the misuse of an Advance Directive. One cannot be unmindful of prevailing social reality in the country. Hence, it is necessary to ensure that an Advance Directive is not utilised as a subterfuge to fulfil unlawful or unethical purposes such as facilitating a succession to property.

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

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

489. In 1995, the British Medical Association (BMA) published a report on advance statements about medical treatment with the intention to reflect "good clinical practice in encouraging dialogue about individuals' wishes concerning their future treatment".[288] The report theoretically discussed six different types of advance statements[289]:

(*i*) A requesting statement reflecting an individual's aspirations and preferences

(*ii*) A statement of general beliefs and aspects of life that the individual values

(*iii*) A statement naming a proxy

(*iv*) A directive giving clear instructions refusing some or all treatment(s)

(*v*) A statement specifying a degree of irreversible deterioration after which no life-sustaining treatment should be given

(*vi*) A combination of the above

490. A decade later, the Mental Capacity Act (MCA), 2005 was enacted, which came into force in October 2007. The statute "enabled individuals to write an Advance Directive or appoint a lasting power of attorney to make their views on healthcare known should they lose capacity"[290]. The Act enshrined in statute law the right of an adult with capacity to make an Advance Directive to refuse specific treatment at a point in the future when they lack capacity.

491. Before turning to MCA, it is of importance to state the position of the common law before the enactment of the legislation. English Law has recognised the entitlement of an individual possessed of the ability to take decisions to refuse medical treatment[291]. The law has had to confront problems in applying this standard in difficult, practical situations. For instance, in a judgment in *B. (Adult: Refusal of Medical Treatment), In re*[292], a patient who was suffering from tetraplegia declined to consent to artificial ventilation. Though the patient was found initially to suffer from depression and to lack

288 A.S. Kessel and J. Meran, "Advance Directives in the UK: Legal, Ethical, and Practical Considerations for Doctors", British Journal of General Practice (1998), at p. 1263.

289 *Ibid.*

290 "Are Advance Directives legally binding or simply the starting point for discussion on patients' best interests?", BMJ (28-11-2009), Vol. 339, p. 1231

291 *T. (Adult: Refusal of Treatment), In re*, (1942) 4 All ER 649; *C. (Adult: Refusal of Treatment), In re*, (1994) 1 WLR 290 : (1994) 1 All ER 819 and *St. George's Healthcare N.H.S. Trust* v. *S.*, 1999 Fam 26 : (1998) 3 WLR 936 (CA)

292 (2002) 2 All ER 449

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decision-making capacity, subsequent evaluation found that she was mentally competent. For a period of nine months, the hospital refused to respect the wishes of the patient not to place her on artificial ventilation, necessitating judicial intervention. When the case travelled to court, the President of the Family Division, Dame Butler-Sloss emphasised that "the right of the patient to demand cessation of treatment must prevail "over the natural desire of the medical and nursing professions to try to keep her alive". The Judge recognised the serious danger of "a benevolent paternalism which does not embrace recognition of the personal autonomy of the severely disabled patient".

492. Commenting on the above decision, Elizabeth Wicks in her recently published book titled *The State and The Body — Legal Regulation of Bodily Autonomy*[293] observes that:

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

493. In *AK (Adult Patient) (Medical Treatment: Consent), In re*[294] Hughes, J. (as he then was) in the High Court of Justice, reviewed the authorities, and summarised the common law position thus:

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

494. In *HE* v. *A Hospital N.H.S. Trust*[295], Munby, J. of the High Court of Justice (Family Division) considered an "Advance Medical Directive/Release" signed by a young woman, which sought to refuse the transfusion of blood or primary blood components in absolute and irrevocable terms. The Court had to

293 Elizabeth Wicks, The State and the Body: Legal Regulation of Bodily Autonomy, Hart Publishing (2016).
294 (2001) 1 FLR 129
295 (2003) 2 FLR 408

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decide whether the Advance Directive was valid and applicable. It was noted that:

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

The Court then analysed the specific aspects of the law governing Advance Directives:

> "1. There are no formal requirements for a valid Advance Directive. An Advance Directive need not be either in or evidenced by writing. An Advance Directive may be oral or in writing.
>
> 2. There are no formal requirements for the revocation of an Advance Directive. An Advance Directive, whether oral or in writing, may be revoked either orally or in writing. A written Advance Directive or an Advance Directive executed under seal can be revoked orally.
>
> 3. An Advance Directive is inherently revocable. Any condition in an Advance Directive purporting to make it irrevocable, any even self-imposed fetter on a patient's ability to revoke an Advance Directive, and any provision in an Advance Directive purporting to impose formal or other conditions upon its revocation, is contrary to public policy and void. So, a stipulation in an Advance Directive, even if in writing, that it shall be binding unless and until revoked in writing is void as being contrary to public policy.
>
> 4. The existence and continuing validity and applicability of an Advance Directive is a question of fact. Whether an Advance Directive has been revoked or has for some other reason ceased to be operative is a question of fact.
>
> 5. The burden of proof is on those who seek to establish the existence and continuing validity and applicability of an Advance Directive.
>
> 6. Where life is at stake the evidence must be scrutinised with especial care. Clear and convincing proof is required. The continuing validity and applicability of the Advance Directive must be clearly established by convincing and inherently reliable evidence.
>
> 7. If there is doubt that doubt falls to be resolved in favour of the preservation of life."

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495. The common law has been "refined" by passage of the MCA, 2005, which makes statutory provision for advance decisions to refuse treatment.[296] The Mental Capacity Act has certain underlying principles[297], which can be stated as follows:

(*i*) A person must be assumed to have capacity unless it is established that she lacks capacity.

(*ii*) A person is not to be treated as unable to make a decision unless all practicable steps to help her to do so have been taken without success.

(*iii*) A person is not to be treated as unable to make a decision merely because she makes an unwise decision.

(*iv*) An act done, or decision made, under the Act for or on behalf of a person who lacks capacity must be done, or made, in her caregiver.

(*v*) Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

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

497. The law in UK empowers the court of protection to make a declaration as to whether an advance decision— (*a*) exists; (*b*) is valid; (*c*) is applicable to a treatment.[298] Moreover, a person will not incur any liability for the consequences of withholding or withdrawing a treatment from an individual, if she at the material time, reasonably beliefs that a valid advance decision applicable to the treatment, made by that individual, exists.[299]

498. Until the implementation of the Mental Capacity Act, 2005 in October 2007, nobody was able legally to make medical decisions on behalf of another adult in England and Wales. The Act imposes duties on the person who has to make a determination as to what is in an individual's caregiver. All the relevant circumstances must be taken into consideration, which are as follows[300]:

498.1. Considering whether it is likely that the person will at some time have capacity in relation to the matter in question, and if it appears likely that he or she will, when that is likely to be;

296 Alexander Ruck Keene, "Advance Decisions: Getting it Right?" <http://www.39essex.com/docs/articles/advance_decisions_paper_ark_december_2012.pdf>.
297 Section 1, Mental Capacity Act, 2005.
298 Section 26(4), Mental Capacity Act, 2005.
299 Section 26(3), Mental Capacity Act, 2005.
300 Section 4, Mental Capacity Act, 2005.

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498.2. Permitting and encouraging, so far as reasonably practicable, the person to participate, or to improve the ability to participate, as fully as possible in any act done for and any decision affecting the person;

498.3. Where the determination relates to life-sustaining treatment he or she must not, in considering whether the treatment is in the caregiver of the person concerned, be motivated by a desire to bring about death;

498.4. Considering so far as is reasonably ascertainable, the person's past and present wishes and feelings (and, in particular, any relevant written statement made when he or she had capacity); the beliefs and values that would be likely to influence the decision if the person had capacity; and the other factors that he or she would be likely to consider if able to do so; and

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

499. Even after the enforcement of the Mental Capacity Act, 2005, there have been examples of life-sustaining treatment being continued despite the desire of the patient to the contrary. In *M. (Adult Patient), In re*[301], a patient who was in a minimally conscious state had previously expressed a desire against artificial intervention. An application was made to withdraw artificial nutrition and hydration. The application was refused by the Judge on the basis that her life had some benefit, in spite of the wishes of the family and the previously expressed desire of the patient when she was competent that she would not like to continue living in such a condition. The Judge took the view that the wishes of the patient were not binding and did not carry substantial weight, not being formally recorded so as to constitute an advance decision under the Mental Capacity Act, 2005. Adverting to this decision, Wicks notes that despite the emphasis in the Act of 2005, on the previously expressed desires of the patient, "these are just one relevant factor and may well not be regarded as the crucial one if they point towards death rather than continued life"[302].

500. Yet, a subsequent decision of the UK Supreme Court in *Aintree University Hospitals NHS Foundation Trust* v. *James*[303] "does signify greater acceptance of the centrality of the dying person's choices"[304]. But decided cases show the "medical evidence relating to the benefits of continued existence remains an influential consideration"[305]. The result has been a greater emphasis in providing palliative care towards the end of life. The palliative care approach gives priority to providing dignity to a dying patient over an approach which only seeks to prolong life:

301 (2012) 1 WLR 1653 : 2011 EWHC 2443 (Fam)
302 Elizabeth Wicks (Supra note 293), at p. 69.
303 2013 UK SC 67
304 Elizabeth Wicks (Supra note 293), at p. 69.
305 *Ibid*.

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"A civilised society really ought to be able to respect the dignity and autonomy of the dying in a way that both gives value to their lives and dignity to their death. The withdrawal of medical treatment from a dying patient can, in some circumstances, be justified; the withdrawal of basic care and compassion cannot."[306]

501. The Mental Health Care Act, 2017, which was assented to by the President of India on 7-4-2017, enacts specific provisions for recognising and enforcing Advance Directives for persons with mental illness. The expression "mental illness" is defined by Section 2(*s*) thus:

"**2.** (*s*) "**mental illness**" means a substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgment, behaviour, capacity to recognise reality or ability to meet the ordinary demands of life, mental conditions associated with the abuse of alcohol and drugs, but does not include mental retardation which is a condition of arrested or incomplete development of mind of a person, specially characterised by subnormality of intelligence."

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

(*i*) The manner in which he or she wishes or does not wish to be cared for and treated for a mental illness; and

(*ii*) The person he or she appoints as a nominated representative[307].

An Advance Directive is to be invoked only when the person who made it ceases to have the capacity to make mental healthcare treatment decisions. It remains effective until the maker regains the capacity to do so[308].

502. The Central Mental Health Authority constituted under the Act is empowered to make regulations governing the making of Advance Directives[309].

503. The Mental Health Review Board constituted under the Act has to maintain an online register of all Advance Directives and to make them available to a mental health professional when required[310].

504. Advance Directives are capable of being revoked, amended or modified by the maker at any time[311]. The Act specifies that an Advance Directive will not apply to emergency treatment[312] administered to the maker. Otherwise, a duty has been cast upon every medical officer in charge of a mental health establishment and a psychiatrist in charge of treatment to propose or

306 Elizabeth Wicks (Supra note 293), at p. 71.
307 Section 5(1), Mental Health Care Act, 2017 (India).
308 Section 5(3), Mental Health Care Act, 2017 (India).
309 Section 6, Mental Health Care Act, 2017 (India).
310 Section 7, Mental Health Care Act, 2017 (India).
311 Section 8(1), Mental Health Care Act, 2017 (India).
312 Section 9, Mental Health Care Act, 2017 (India).

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give treatment to a person with a mental illness, in accordance with a valid Advance Directive, subject to Section 11[313]. Section 11 elucidates a procedure which is to be followed where a mental health professional, relative or caregiver does not desire to follow the Advance Directive. In such a case, an application has to be made to the Board to review, alter, cancel or modify the Advance Directive. In deciding whether to allow such an application the Board must consider whether:

(*i*) The Advance Directive is truly voluntary and made without force, undue influence or coercion;

(*ii*) The Advance Directive should apply in circumstances which are materially different;

(*iii*) The maker had made a sufficiently well-informed decision;

(*iv*) The maker possessed the capacity to make decisions relating to mental healthcare or treatment at the time when it was made; and

(*v*) The directive is contrary to law or to constitutional provisions[314].

A duty has been cast to provide access to the Advance Directive to a medical practitioner or mental health professional, as the case may be[315]. In the case of a minor, an Advance Directive can be made by a legal guardian[316]. The Act has specifically granted protection to medical practitioners and to mental health professionals against being held liable for unforeseen consequences upon following an Advance Directive[317].

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

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

313 Section 10, Mental Health Care Act, 2017 (India).
314 Section 11(2), Mental Health Care Act, 2017 (India).
315 Section 11(3), Mental Health Care Act, 2017 (India).
316 Section 11(4), Mental Health Care Act, 2017 (India).
317 Section 13(1), Mental Health Care Act, 2017 (India).

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507. A comparative analysis of Advance Directives in various jurisdictions indicates some common components. They include the patient's views and wishes regarding: (*i*) Cardio-pulmonary resuscitation (CPR) — treatment that attempts to start breathing and blood flow in people who have stopped breathing or whose heart has stopped beating; (*ii*) Breathing tubes; (*iii*) Feeding/ hydration; (*iv*) Dialysis; (*v*) Pain killers; (*vi*) Antibiotics; (*vii*) Directions for organ donation; and (*viii*) Appointment of proxy/healthcare agent/surrogate, etc.

508. Legal recognition of Advance Directives is founded upon the belief that an individual's right to have a dignified life must be respected. In *Vishaka* v. *State of Rajasthan*[69], the Court, in the absence of enacted law against sexual harassment at workplaces, had laid down the guidelines and norms for due observance at all workplaces or other institutions, until a legislation is enacted for the purpose. Certain precepts can be deduced from the existing global framework on Advance Directives. These include the following:

508.1. Advance Directives reflect the right of an adult with capacity to make a decision to refuse specific treatment at a point in the future when they lack capacity. A person can be said to lack capacity when "in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain"[318]. He/she must be deemed to have capacity to make decisions regarding his treatment if such person has ability to— (*a*) understand the information that is relevant to take a decision on the treatment or admission or personal assistance; or (*b*) appreciate any reasonably foreseeable consequence of a decision or lack of decision on the treatment or admission or personal assistance; or (*c*) communicate such decision by means of speech, expression, gesture or any other means.[319]

508.2. For a legally valid advance decision to refuse treatment, an Advance Directive must fulfil a basic criteria[320], which should include that—a directive must be made by a person after he has reached 18 years of age[321]; the person must be mentally competent when the directive is made; the directive must specify—in medical or layman's terms—the treatment refused; and, it can specify the circumstances in which the refusal is to apply.

508.3. At any time before reaching the comatose state, an individual can revoke the directive. In other words, an individual may withdraw or alter an advance decision at any time when he/she has capacity to do so. Such withdrawal (including a partial withdrawal) need not be in writing. A directive must be revoked if the statements or actions subsequent to the written document indicate contrary consent.[322]

69 (1997) 6 SCC 241 : 1997 SCC (Cri) 932
318 Section 2, Mental Capacity Act, 2005 (UK).
319 Section 4, Mental Health Care Act, 2017 (India).
320 Section 24, Mental Capacity Act, 2005 (UK).
321 A parent acting on behalf of his child cannot make such a declaration.
322 Luis Kutner (Supra note 197), at p. 228.

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508.4. An advance decision will not be applicable to the treatment in question if — (*a*) at the material time, the person, who made it, did not have the capacity to give or refuse consent to it[323]; (*b*) the treatment is not the treatment specified in the advance decision[324]; (*c*) any circumstances specified in the advance decision are absent[325]; or (*d*) there are reasonable grounds for believing that circumstances exist which the person making the directive did not anticipate at the time of the advance decision and which would have affected his decision had he anticipated them.[326]

508.5. If a person intends specifically to refuse life-sustaining procedures[327], he/she must — clearly indicate that it is to apply even if life is at risk and death will predictably result; put the decision in writing; and, ensure it is signed and witnessed.

508.6. 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.

508.7. A person will not incur any liability for the consequences of withholding or withdrawing a treatment from an individual, if he, at the material time, reasonably beliefs that a valid advance decision applicable to the treatment, made by that individual, exists.[328]

508.8. An Advance Directive must clearly contain the following:

(*a*) full details of its maker, including date of birth, home address and any distinguishing features;

(*b*) the name and address of a general practitioner and whether they have a copy;

(*c*) a statement that the document should be used if the maker lacks capacity to make treatment decisions;

(*d*) a clear statement of the decision, the treatment to be refused and the circumstances in which the decision will apply;

(*e*) the date the document was written (or reviewed); and,

(*f*) the person's signature and the signature of a witness.[329]

509. Advance Directives also have limitations. Individuals may not fully understand treatment options or recognise the consequences of certain choices in the future. Sometimes, people change their minds after expressing Advance Directives and forget to inform others. Another issue with Advance Directives is that vague statements can make it difficult to understand the course of action

323 Section 25(3), Mental Capacity Act, 2005 (UK).
324 Section 25(4)(*a*), Mental Capacity Act, 2005 (UK).
325 Section 25(4)(*b*), Mental Capacity Act, 2005 (UK).
326 Section 25(4)(*c*), Mental Capacity Act, 2005 (UK).
327 Sections 25(5) and (6), Mental Capacity Act, 2005 (UK).
328 Section 26(3), Mental Capacity Act, 2005 (UK).
329 Alexander Ruck Keene, "Advance Decisions: Getting it Right?" <http://www.39essex.com/docs/articles/advance_decisions_paper_ark_december_2012.pdf>.

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when a situation arises. For example, general statements rejecting "heroic treatments" are vague and do not indicate whether you want a particular treatment for a specific situation (such as antibiotics for pneumonia after a severe stroke). On the other hand, very specific directives for future care may not be useful when situations change in unexpected ways. New medical therapies may also have become available since an Advance Directive was given. Thus, Advance Directives should be reviewed and revised regularly if feelings about certain issues change, so that current wishes and decisions are always legally documented.

510. An important facet which a regime of advanced care directives must factor in, is the existence of variables which affect the process. These include, in our society, institutional aspects such as the paucity of access to publicly funded medicare, declining standards of professional ethics and the inadequacy of institutional responses to the lack of professional accountability in the medical profession.

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

> "A good starting point in understanding this landscape is a realization that law and regulation are but one slice of the universe of variables that profoundly affect the experience of dying....
>
> ... other key variables include institutional innovation, the role of financing systems, professional and public education and professional standards and guidelines. All these operate in a larger framework that is defined by family, workplace, community life and spirituality. Thus, the isolation of law and regulation as a strategy for behaviour change requires a sense of humility in establishing expectations, lest we overstate the influence of law in the human experience of dying...."[330]

512. There are variables which "profoundly affect the experience of dying" even in a developed society. They provide a sobering reflection of the gulf which separates the needs of patients and the availability of services to the poor, in a society like ours with large impoverished strata. Patient autonomy may mean little to the impoverished citizen. For marginalised groups in urban and rural India, even basic medical care is a distant reality. Advance Directives postulate the availability of medical care. For, it is on the hypothesis of such care being available that the right to choose or refuse treatment is based. The stark reality in our society is that medical facilities are woefully inadequate. Primary medical care is a luxury in many places. Public hospitals are overwhelmed by the gap between the demand for medical care and its supply. Advance Directives may have little significance to large segments of Indian society which are denied access to basic care. Advance Directives also require an

330 "Advance Directives and Advance Care Planning: Legal and Policy Issues", US Department of Health and Human Services (October 2007) <https://aspe.hhs.gov/system/files/pdf/75366/adacplpi.pdf> at p. 1.

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awareness of rights. The stark reality is that the average Indian is deprived of even basic medical facilities in an environment where absence of rudimentary care is the norm. Moreover, absolute notions of patient autonomy need to be evaluated in the context of the Indian social structure where bonds of family, religion and caste predominate. The immediate family and in many situations, the larger unit of the extended family are caregivers. In the absence of a social security net, universal medical coverage and compulsory insurance, it is the family to which a patient turns to in distress. Families become the caregivers, willingly or as a result of social conditioning, especially in the absence of resources and alternative institutional facilities. The views of the family which are drawn by close bonds of kinship have to be factored into the process. At the other end of the spectrum, rising costs of medical care in the urban areas threaten to ruin the finances of a family when a member is struck by a serious illness. To them, Advance Directives may provide a measure of assurance when a crucial decision as to whether to prolong artificial support in an irreversible medical situation is to be taken. The fact that the patient had expressed a desire in the form of an Advance Directive obviates a sense of moral guilt on the part of the caregivers, when the family accepts the doctors' wisdom to withdraw or withhold artificial support. Another important variable which a regime of Advance Directives must bear in mind is the danger of misuse. The regime of Advance Directives which is intended to secure patient autonomy must contain safeguards against the greed of avaricious relatives colluding with willing medical professionals. The safeguards must be robust to obviate the dangers. The complexities of culture and of the social strata adverted to above only emphasise the wide diversity that prevails within the country. Our solution must take into account the diversity across the country. It is with the above background in view that we have introduced a safeguard in the form of broad-based committees to oversee the process.

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

K. *Conclusion*

514. The Court is above all, engaged in the task of expounding the Constitution. In doing so, we have been confronted with the enormous task of finding substance and balance in the relationship between life, morality and the experience of dying. The reason which has impelled the Court to recognise passive euthanasia and Advance Directives is that both bear a close association to the human urge to live with dignity. Age brings isolation. Physical and mental debility bring a loss of self-worth. Pain and suffering are accompanied by a sense of being helpless. The loss of control is compounded when medical intervention takes over life. Human values are then lost to technology. More significant than the affliction of ageing and disease is the fear of our human persona being lost in the anonymity of an intensive care ward. It is hence necessary for this Court to recognise that our dignity as citizens continues to be

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safeguarded by the Constitution even when life is seemingly lost and questions about our own mortality confront us in the twilight of existence.

515. The sanctity of human life is the arterial vein which animates the values, spirit and cellular structure of the Constitution. The Constitution recognises the value of life as its indestructible component. The survival of the sanctity principle is founded upon the guarantees of dignity, autonomy and liberty;

516. The right to a dignified existence, the liberty to make decisions and choices and the autonomy of the individual are central to the quest to live a meaningful life. Liberty, dignity and autonomy are essential to the pursuit of happiness and to find meaning in human existence;

517. The entitlement of each individual to a dignified existence necessitates constitutional recognition of the principle that an individual possessed of a free and competent mental state is entitled to decide whether or not to accept medical treatment. The right of such an individual to refuse medical treatment is unconditional. Neither the law nor the Constitution compel an individual who is competent and able to take decisions, to disclose the reasons for refusing medical treatment nor is such a refusal subject to the supervisory control of an outside entity;

518. Constitutional recognition of the dignity of existence as an inseparable element of the right to life necessarily means that dignity attaches throughout the life of the individual. Every individual has a constitutionally protected expectation that the dignity which attaches to life must subsist even in the culminating phase of human existence. Dignity of life must encompass dignity in the stages of living which lead up to the end of life. Dignity in the process of dying is as much a part of the right to life under Article 21. To deprive an individual of dignity towards the end of life is to deprive the individual of a meaningful existence. Hence, the Constitution protects the legitimate expectation of every person to lead a life of dignity until death occurs;

519. The constitutionally recognised right to life is subject to the procedure established by law. The procedure for regulation or deprivation must, it is well-settled, be fair, just and reasonable. Criminal law imposes restraints and penal exactions which regulate the deprivation of life, or as the case may be, personal liberty. The intentional taking away of the life of another is made culpable by the Penal Code. Active euthanasia falls within the express prohibitions of the law and is unlawful;

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

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

522. In *Gian Kaur*[10], the Constitution Bench held, while affirming the constitutional validity of Section 306 of the Penal Code (abetment of suicide), that the right to life does not include the right to die. *Gian Kaur*[10] does not conclusively rule on the validity of passive euthanasia. The two-Judge Bench decision in *Aruna Shanbaug*[5] proceeds on an incorrect perception of *Gian Kaur*[10]. Moreover, *Aruna Shanbaug*[5] has proceeded on the basis of the act-omission distinction which suffers from incongruities of a jurisprudential nature. *Aruna Shanbaug*[5] has also not dwelt on the intersection between criminal law and passive euthanasia, beyond adverting to Sections 306 and 309 of the Penal Code. *Aruna Shanbaug*[5] has subordinated the interest of the patient to the interest of others including the treating doctors and supporting caregivers. The underlying basis of the decision in *Aruna Shanbaug*[5] is flawed. Hence, it has become necessary for this Court in the present reference to revisit the issues raised and to independently arrive at a conclusion based on the constitutional position;

523. While upholding the legality of passive euthanasia (voluntary and non-voluntary) and in recognising the importance of Advance Directives, the present judgment draws sustenance from the constitutional values of liberty, dignity, autonomy and privacy. In order to lend assurance to a decision taken by the treating doctor in good faith, this judgment has mandated the setting up of committees to exercise a supervisory role and function. Besides lending assurance to the decision of the treating doctors, the setting up of such committees and the processing of a proposed decision through the committee will protect the ultimate decision that is taken from an imputation of a lack of bona fides; and

524. The directions in regard to the regime of Advance Directives have been issued in exercise of the power conferred by Article 142 of the Constitution and shall continue to hold the field until a suitable legislation is enacted by Parliament to govern the area.

525. I agree with the directions proposed in the judgment of the learned Chief Justice. The reference shall stand disposed of in the above terms.

10 *Gian Kaur* v. *State of Punjab*, (1996) 2 SCC 648 : 1996 SCC (Cri) 374
5 *Aruna Ramachandra Shanbaug* v. *Union of India*, (2011) 4 SCC 454 : (2011) 2 SCC (Civ) 280 : (2011) 2 SCC (Cri) 294

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ASHOK BHUSHAN, J. (*concurring*)— I had the advantage of going through the draft judgment of the Hon'ble the Chief Justice. Though, broadly I subscribe to the views expressed by Hon'ble the Chief Justice on various principles and facets as expressed in the judgment, but looking to the great importance of issues involved, I have penned my reasons for my views expressed. However, I am in full agreement with the directions and safeguards as enumerated by the Hon'ble the Chief Justice in paras 198 to 201 of the judgment with regard to Advance Medical Directives. I also had the benefit of going through the erudite opinion of Dr D.Y. Chandrachud, J., which expresses almost the same views which are reflected in my judgment.

527. This Constitution Bench has been constituted on a reference made by a three-Judge Bench vide its order dated 25-2-2014[20]. The writ petition filed in public interest prayed for essentially following two reliefs:

> (*a*) declare "right to die with dignity" as a fundamental right within the fold of right to live with dignity guaranteed under Article 21 of the Constitution of India;
>
> (*b*) issue direction to the respondent, to adopt suitable procedures, in consultation with the State Governments where necessary, to ensure that persons of deteriorated health or terminally ill should be able to execute a document titled "MY LIVING WILL & ATTORNEY AUTHORISATION" which can be presented to hospital for appropriate action in event of the executant being admitted to the hospital with serious illness which may threaten termination of life of the executant or in the alternative, issue appropriate guidelines to this effect;"

528. The petitioner in support of the writ petition has placed reliance on the Constitution Bench judgment in *Gian Kaur* v. *State of Punjab*[10], as well as two-Judge Bench judgment in *Aruna Ramachandra Shanbaug* v. *Union of India*[5]. The petitioner's case is that this Court in the above two judgments has although disapproved active euthanasia but has granted its approval to passive euthanasia. The three-Judge Bench after referring to paras 24 and 25 of the Constitution Bench judgment observed that the Constitution Bench did not express any binding view on the subject of euthanasia rather reiterated that the legislature would be the appropriate authority to bring the change. Three-Judge Bench further observed that view of two-Judge Bench in *Aruna Ramachandra Shanbaug*[5] that the Constitution Bench in *Gian Kaur*[10] has approved the judgment of House of Lords in *Airedale N.H.S. Trust* v. *Bland*[11] is not correct and further opinion expressed by the two-Judge Bench judgment in paras 101 and 104 is inconsistent. In the above view of the matter the three-Judge Bench made the reference to the Constitution Bench. It is useful to extract

20 *Common Cause* v. *Union of India*, (2014) 5 SCC 338 : (2014) 2 SCC (Cri) 557
10 (1996) 2 SCC 648 : 1996 SCC (Cri) 374
5 (2011) 4 SCC 454 : (2011) 2 SCC (Civ) 280 : (2011) 2 SCC (Cri) 294
11 1993 AC 789 : (1993) 2 WLR 316 : (1993) 1 All ER 821 (CA & HL)

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paras 17 and 18 of the referring order which is to the following effect: (*Common Cause case*[20], SCC p. 345)

> "*17*. In view of the inconsistent opinions rendered in *Aruna Shanbaug*[5] and also considering the important question of law involved which needs to be reflected in the light of social, legal, medical and constitutional perspective, it becomes extremely important to have a clear enunciation of law. Thus, in our cogent opinion, the question of law 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."

529. We have heard Shri Prashant Bhushan, learned counsel appearing for the petitioner. Shri P.S. Narasimha, learned Additional Solicitor General appearing for the Union of India. Shri Arvind Datar, learned Senior Counsel for Vidhi Centre for Legal Policy, Shri Sanjay R. Hegde, learned Senior Counsel for Indian Society of Critical Care Medicine, Mr Devansh A. Mohta, learned counsel for Society for Right to Die with Dignity and Mr Praveen Khattar, learned counsel for Delhi Medical Council. We have also been assisted by Dr R.R. Kishore, Member of the Bar who has joined the Bar after carrying on the profession of doctor for more than 40 years.

A. *Petitioner's case*

530. The petitioner is a registered society which is engaged in taking of the common problems of the people. The petitioner vide this public interest litigation brings to the notice of this Court the serious problem of violation of fundamental right to life, liberty, privacy and the right to die with dignity of the people of this country, guaranteed to them under Article 21 of the Constitution of India. It is submitted that the citizens who are suffering from chronic diseases and/or are at the end of their natural lifespan and are likely to go into a state of terminal illness or permanent vegetative state are deprived of their rights to refuse cruel and unwanted medical treatment, like feeding through hydration tubes, being kept on ventilator and other life supporting machines in order to artificially prolong their natural lifespan. This sometimes leads to extension of pain and agony both physical and mental which they desperately seek to end by making an informed choice and clearly expressing their wishes in advance, (called a living will) in the event of they going into a state when it will not be possible for them to express their wishes.

20 *Common Cause* v. *Union of India*, (2014) 5 SCC 338 : (2014) 2 SCC (Cri) 557
5 *Aruna Ramachandra Shanbaug* v. *Union of India*, (2011) 4 SCC 454 : (2011) 2 SCC (Civ) 280 : (2011) 2 SCC (Cri) 294

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

B. ***Man & Medicine***

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

533. In Western World "Hippocrates" is regarded as "father of western medicine". Hippocratic period dates from 460 BC. *Corpus Hippocraticum* comprises of not only general medical prescription, description of diseases, diagnosis, dietary recommendations but also opinion of professional ethics of a physician. Thus, those who practised medicine from ancient time were ordained to follow some ethical principles. For those who follow medical profession "Hippocratic Oath" was always treated to be Oath to which every medical professional was held to be bound. It is useful to refer to original Hippocratic Oath (as translated into English):

> "I swear by Apollo, the healer, Asclepius, Hygieia, and Panacea, and I take to witness all the Gods, all the Goddesses, to keep according to my ability and my judgment, the following Oath and agreement:
>
> To consider dear to me, as my parents, him who taught me this art; to live in common with him and, if necessary, to share my goods with him; To look upon his children as my own brothers, to teach them this art.
>
> I will prescribe regimens for the good of my patients according to my ability and my judgment and never do harm to anyone.
>
> I will not give a lethal drug to anyone if I am asked, nor will I advise such a plan; and similarly I will not give a woman a pessary to cause an abortion.
>
> But I will preserve the purity of my life and my arts.
>
> I will not cut for stone, even for patients in whom the disease is manifest; I will leave this operation to be performed by practitioners, specialists in this art.

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> In every house where I come I will enter only for the good of my patients, keeping myself far from all intentional ill-doing and all seduction and especially from the pleasures of love with women or with men, be they free or slaves.
>
> All that may come to my knowledge in the exercise of my profession or in daily commerce with men, which ought not to be spread abroad, I will keep secret and will never reveal.
>
> If I keep this Oath faithfully, may I enjoy my life and practise my art, respected by all men and in all times; but if I swerve from it or violate it, may the reverse be my lot."

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

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

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

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

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

537. From what has been noted above, it is apparent that although on one hand *medical* professional has to take Hippocratic Oath that he shall treat his patient according to his ability and judgment and never do harm to anyone. Further, he will not give any lethal drug to anyone even he is asked for, on the other hand, Plato held that those who has sickly constitution and intemperate habits should not be helped by medicine. Thus, the cleavage in views regarding ethics of a medical professional as well as not supporting medical treatment for those who are thoroughly diseased is found from ancient time in Greek thoughts itself.

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

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

C. *Concept of life & death*

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

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

541. The death was never feared in ancient Indian culture and mythology. Death was treated sometimes a means to obtain liberation, that is, "moksha". Every life is a gift of God and sacred and it has to be protected at all cost. No person is bestowed with the right to end his or her life. However, an individual's act of discarding mortal body may be permissible under certain circumstances. In ancient Indian religion, sanctity was attached to a Yogi (a person who has mastered the art of regulating his involuntary physical and mental functions, at will) can discard his/her mortal coil (body) through the process of higher spiritual practices called "yoga". Such state was known as "Samadhi". But there was no concept in ancient India/mythology of putting an end to life of another human being which was always regarded as crime and against "dharma".

542. The Vedic Rules also forbid suicide whereas according to ancient Hindu culture, a man in his fourth stage i.e. Vanaprastha could go into the forest sustaining only on water and air, end his body. A Brahmin also could have got rid of his body by drowning oneself in a river, precipitating oneself from a mount, burning oneself or starving oneself to death; or by one of those modes of practising austerities, mentioned above. The Laws of Manu as contained in *Sacred Books of the East*, edited by Max Muller, Vol. 25 Chapter VI Verses 31 and 32 refers to above. The book also refers to views of various commentators on Verses 31 and 32. It is useful to extract Verses 31 and 32 and Note of the author on aforesaid verses containing the views of different commentators which are to the following effect:

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

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

.....

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

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

543. The Hindu scriptures also say that life and death is the gift of God and no human being has right to take away the said gift. Suicide is disapproved in Hindu way of life and it is believed that those who commit suicide did not attain moksha or salvation from the cycle of life and death.

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

545. Christianity also disapproves taking of one's life. *Bible* says that human being is a temple of God and the spirit of God dwelleth in the body and no man can defile the temple. Reference is made to Chapter 3 Verses 16 and 17 of I CORINTHIANS, which is as below:

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

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

546. Pope John Paul II in, *The Gospel of Life*, denouncing euthanasia writes:

"Laws which authorise and promote euthanasia are therefore radically opposed not only to the good of the individual but also to the common good; as such they are completely lacking in authentic juridical validity. Disregarded for the right to life, precisely because it leads to the killing of the person whom society exists to serve, is what most directly conflicts

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with the possibility of achieving the common good. Consequently, a civil law authorising euthanasia ceases by that very fact to be a true, morally binding civil law."

547. The tenets of Jainism also talk about the practice of religiously nominated self-build death called "Sallkhana", meaning "fast up to death".

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

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

550. The petitioner in the writ petition has categorically clarified that the petitioner is neither challenging the provisions of IPC by which "attempt to suicide" is made a penal offence nor praying for right to die be declared as fundamental right under Article 21. It is useful to refer to Para 7 of the writ petition, in which petitioner pleads the following:

> "It is submitted at the outset that the petitioner in the instant petition is neither challenging Section 309 of the Indian Penal Code, vide which attempt to suicide is a penal offence nor is asking right to die per se as a fundamental right under Article 21 (as the issue is squarely covered by the Constitution Bench judgment of this Hon'ble Court in *Gian Kaur* v. *State of Punjab*[10]). The endeavour of the petitioner in the instant petition is to seek guidelines from this Hon'ble Court whereby the people who are diagnosed of suffering from terminal diseases or ailments can execute Living Will or give directives in advance or otherwise to his/her attorney/executor to act in a specific manner in the event he/she goes into persistent vegetative state or coma owing to that illness or due to some other reason."

D. ***The relevant provisions of IPC***

551. The Penal Code, 1860, is a general penal code defining various acts which are offence and providing for punishment thereof. Chapter XVI deals with "offences affecting the human body". The provisions of the Penal Code which are relevant in the present context are Section 306 and Section 309. Section 306 relates to abetment of suicide. It provides—

> "**306.** ***Abetment of suicide***.—If any person commits suicide, whoever abets the commission of such suicide, shall be punished with imprisonment of either description for a term which may extend to ten years, and shall also be liable to fine."

Another provision which is relevant is Section 309 i.e. attempt to commit suicide. The provision states, whoever attempts to commit suicide and does any act towards the commission of such offence, shall be punished with simple imprisonment for a term which may extend to one year (or with fine, or with both). The issues which have come up for consideration in the present case have to be dealt with keeping in view the above provisions of the Penal Code which declares certain acts to be offence.

10 (1996) 2 SCC 648 : 1996 SCC (Cri) 374

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E. ***Legislation in reference to euthanasia***

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

> "**6.** ***Unethical Acts***.—A physician shall not aid or abet or commit any of the following acts which shall be construed as unethical—
>
> * * *
>
> **6.7.** ***Euthanasia***.—Practising euthanasia shall constitute unethical conduct. However, on specific occasion, the question of withdrawing supporting devices to sustain cardio-pulmonary function even after brain death, shall be decided only by a team of doctors and not merely by the treating physician alone. A team of doctors shall declare withdrawal of support system. Such team shall consist of the doctor in charge of the patient, Chief Medical Officer/Medical Officer in charge of the hospital and a doctor nominated by the in charge of the hospital from the hospital staff or in accordance with the provisions of the Transplantation of Human Organs Act, 1994."

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

554. Chapter 8 of the Report contains summary of recommendations. It is not necessary to reproduce all the recommendations. It is sufficient to refer to Paras 1 and 2 of the recommendations:

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

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

(1) There is need to have a law to *protect patients* who are terminally ill, when they take decisions to refuse medical treatment, including artificial nutrition and hydration, so that they may not be considered guilty of the offence of "attempt to commit suicide" under Section 309 of the Indian Penal Code, 1860.

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

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

555. The 196th Report was again revised by the Law Commission of India in 241st Report dated August 2012. The 2006 draft Bill was redrafted by the Law Commission which was Annexure 1 to the Report. The above Bill however could not fructify into a law. The Ministry of Health and Family Welfare had published another draft Bill, namely, the Medical Treatment of Terminally-Ill Patients (Protection of Patients and Medical Practitioners) Bill, 2016, as a Private Member Bill which was introduced in Rajya Sabha on 5-8-2016, which is still pending.

556. From the above, it is clear that only statutory provision on euthanasia is Regulation 6.7 of the 2002 Regulations as referred to above. The Regulations prohibit practising euthanasia and declare that practising euthanasia constitutes unethical conduct on behalf of the medical practitioner. The Regulation however carves an exception that on specific occasion, the question of withdrawing supporting devices to sustain cardio-pulmonary function even after brain death, shall be decided only by a team of doctors and not merely by the treating physician alone. The Regulation further provides that the team of doctors shall declare withdrawal of support system.

557. The withdrawal of medical treatment of terminally ill persons is a complex ethical, moral and social issue with which many countries have wrestled with their attempt to introduce a legal framework for end of life

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decision-making. In absence of a comprehensive legal framework on the subject the issue has to be dealt with great caution.

F. *Two important judgments of this Court on the subject*

558. The first important judgment delivered by the Constitution Bench of this Court touching the subject is the judgment of the Constitution Bench in *Gian Kaur* v. *State of Punjab*[10]. In the above case, the appellants were convicted under Section 306 and awarded sentence for abetment of commission of suicide by one Kulwant Kaur. The conviction was maintained by the High Court against which the appeal was filed as special leave in this Court. One of the grounds for assailing the conviction before this Court was that Section 306 IPC is unconstitutional. The reliance was placed on two-Judge Bench decision of this Court in *P. Rathinam* v. *Union of India*[6], wherein Section 309 IPC was held to be unconstitutional as violative of Article 21 of the Constitution.

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

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

561. The second judgment which needs to be noted in detail is the two-Judge Bench judgment of this Court in *Aruna Ramachandra Shanbaug* v. *Union of India*[5]. The writ petition under Article 32 on behalf of Aruna Ramachandra Shanbaug was filed by one Ms Pinky Virani claiming to be best friend. Aruna Ramachandra Shanbaug was staff nurse working in King Edward Memorial (KEM) Hospital, Parel, Mumbai. On 27-11-1973, she was attacked by a sweeper of the hospital who wrapped a dog chain around her neck and yanked her back with it. While sodomising her, he twisted the chain around her neck, as a result supply of oxygen to the brain stopped and the brain got damaged. On the next day she was found in unconscious condition. From the date of above incident she continued to be in persistent vegetative state (PVS) having no state of awareness, she was bedridden, unable to express herself, unable to think, hear and see anything or communicate in any manner. In writ petition under Article 32 it was prayed that the hospital where she is laying for last 36 years be directed to stop feeding and let her die peacefully. In the above case, two-Judge Bench considered all aspects of euthanasia, the Court examined both active and passive euthanasia.

10 (1996) 2 SCC 648 : 1996 SCC (Cri) 374
6 (1994) 3 SCC 394 : 1994 SCC (Cri) 740
5 (2011) 4 SCC 454 : (2011) 2 SCC (Civ) 280 : (2011) 2 SCC (Cri) 294

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562. Dealing with active and passive euthanasia and further voluntary and involuntary euthanasia, following was laid down in paras 39 and 40: (*Aruna Ramachandra case*[5], SCC p. 491)

> "*39*. Coming now to the legal issues in this case, it may be noted that euthanasia is of two types: active and passive. Active euthanasia entails the use of lethal substances or forces to kill a person e.g. a lethal injection given to a person with terminal cancer who is in terrible agony. Passive euthanasia entails withholding of medical treatment for continuance of life e.g. withholding of antibiotics where without giving it a patient is likely to die, or removing the heart-lung machine, from a patient in coma. The general legal position all over the world seems to be that while active euthanasia is illegal unless there is legislation permitting it, passive euthanasia is legal even without legislation provided certain conditions and safeguards are maintained.
>
> *40*. A further categorisation of euthanasia is between voluntary euthanasia and non-voluntary euthanasia. Voluntary euthanasia is where the consent is taken from the patient, whereas non-voluntary euthanasia is where the consent is unavailable e.g. when the patient is in coma, or is otherwise unable to give consent. While there is no legal difficulty in the case of the former, the latter poses several problems, which we shall address."

563. The Court held that in India, active euthanasia is illegal and crime. In para 41, following was held: (*Aruna Ramachandra case*[5], SCC p. 491)

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

564. The Court noticed various judgments of different countries in the above context. The two-Judge Bench also referred to the Constitution Bench judgment in *Gian Kaur* v. *State of Punjab*[10]. In paras 101 and 104, following has been laid down: (*Aruna Ramachandra case*[5], SCC pp. 512-13)

> "*101*. The Constitution Bench of the Supreme Court in *Gian Kaur* v. *State of Punjab*[10] held that both euthanasia and assisted suicide are not lawful in India. That decision overruled the earlier two-Judge Bench

5 *Aruna Ramachandra Shanbaug* v. *Union of India*, (2011) 4 SCC 454 : (2011) 2 SCC (Civ) 280 : (2011) 2 SCC (Cri) 294

10 (1996) 2 SCC 648 : 1996 SCC (Cri) 374

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decision of the Supreme Court in *P. Rathinam* v. *Union of India*[6]. 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*[10] the Supreme Court approved of the decision of the House of Lords in *Airedale case*[11] and observed that euthanasia could be made lawful only by legislation.

* * *

104. It may be noted that in *Gian Kaur case*[10] although the Supreme Court has quoted with approval the view of the House of Lords in *Airedale case*[11], 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."

565. The two-Judge Bench noticed that there is no statutory provision in this country as to the legal procedure to withdraw life support to a person in persistent vegetative state (PVS) or who is otherwise incompetent to take the decision in this connection. The Court, however, issued certain directions which were to continue to be the law until Parliament makes a law on this subject. In para 124, following has been laid down: (*Aruna Ramachandra case*[5], SCC pp. 518-19)

"*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*[69], we are laying down the law in this connection which will continue to be the law until Parliament makes a law on the subject:

6 (1994) 3 SCC 394 : 1994 SCC (Cri) 740
10 *Gian Kaur* v. *State of Punjab*, (1996) 2 SCC 648 : 1996 SCC (Cri) 374
11 *Airedale N.H.S. Trust* v. *Bland*, 1993 AC 789 : (1993) 2 WLR 316 : (1993) 1 All ER 821 (CA & HL)
5 *Aruna Ramachandra Shanbaug* v. *Union of India*, (2011) 4 SCC 454 : (2011) 2 SCC (Civ) 280 : (2011) 2 SCC (Cri) 294
69 *Vishaka* v. *State of Rajasthan*, (1997) 6 SCC 241 : 1997 SCC (Cri) 932

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(*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*[11].

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."

11 *Airedale N.H.S. Trust* v. *Bland*, 1993 AC 789 : (1993) 2 WLR 316 : (1993) 1 All ER 821 (CA & HL)

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G. ***Law on subject in other countries***

566. The debate on euthanasia had gathered momentum in last 100 years. The laws of different countries express thoughts of people based on different culture, philosophy and social conditions. Assisted suicide was always treated as an offence in most of the countries. Physician-assisted suicide is also not accepted in most of the countries except in few where it gain ground in last century. In several countries including different States of the USA, European countries and United Kingdom, various legislations have come into existence codifying different provisions pertaining to physician-assisted suicide. The right to not commence or withdraw medical treatment in case of terminally ill or PSV patients, Advance Medical Directives have also been made part of different legislations in different countries.

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

United Kingdom

568. Euthanasia is criminal offence in the United Kingdom. According to Section 2(1) of the Suicide Act, 1961, a person assisting an individual, who wish to die commits an offence. The provision states that it is an offence to aid, abet, counsel or procure the suicide of another or an attempt by another to commit suicide, however, it is not a crime if it is by their own hands. There has been large parliamentary opposition to the current United Kingdom law concerning assisted suicide but there has been no fundamental change in the law so far. In 1997, the Doctor Assisted Dying Bill as well as in 2000, the Medical Treatment (Prevention of Euthanasia) Bill were not approved.

569. The most celebrated judgment of the House of Lords is *Airedale N.H.S. Trust* v. *Bland*[11]. Anthony David Bland was injured on 15-4-1989 at the Hillsborough football ground in which his lungs were crushed and punctured, the supply of oxygen to the brain was interrupted. As a result, he sustained catastrophic and irreversible damage to the higher centres of the brain, which had left him in a condition known as a persistent vegetative state (PVS). Medical opinion was unanimous that there was no hope of improvement in his condition or recovery. At no time before the disaster had the patient indicated his wishes if he should find himself in such a condition. Bland's father sought declarations that hospital authorities may discontinue all his life-sustaining

11 1993 AC 789 : (1993) 2 WLR 316 : (1993) 1 All ER 821 (CA & HL)

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treatment and medical support measures and further lawfully discontinue and thereafter need not furnish medical treatment to the patient except for the sole purpose of enabling the patient to end his life and die peacefully with the greatest dignity and the least of pain, suffering and distress.

570. The lower court granted the declarations sought for. The Court of Appeal upheld the order. The Official Solicitor filed an appeal before the House of Lords. Lord Goff held that it is not lawful for a doctor to administer a drug to his patient to bring about his death, even though that course is prompted by a humanitarian desire to end his suffering. Such act is actively causing death i.e. euthanasia which is not lawful. It was further held that a case in which doctor decides not to provide or continue to provide treatment or care, it may be lawful. Following was stated by Lord Goff: (*Airedale case*[11], AC pp. 367 E-H, 368 A, F-H & 369 B-C)

> "First, it is established that the principle of self-determination requires that respect must be given to the wishes of the patient, so that if an adult patient of sound mind refuses, however unreasonably, to consent to treatment or care by which his life would or might be prolonged, the doctors responsible for his care must give effect to his wishes even though they do not consider it to be in his best interests to do so … To this extent, the principle of the sanctity of human life must yield to the principle of self-determination (*see* ante, pp. 826H-827A, per Hoffmann, L.J.), and, for present purposes perhaps more important, the doctor's duty to act in the best interests of his patient must likewise be qualified. On this basis, it has been held that a patient of sound mind may, if properly informed, require that life support should be discontinued: see *Nancy B.* v. *Hotel Dieu de Quebec*[132]. 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*[133]. 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.
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> * * *
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> I must however stress, at this point, that the law draws a crucial distinction between cases in which a doctor decides not to provide, or to continue to provide, for his patient treatment or care which could or

11 *Airedale N.H.S. Trust* v. *Bland*, 1993 AC 789 : (1993) 2 WLR 316 : (1993) 1 All ER 821 (CA & HL)

132 (1992) 86 DLR (4th) 385 (Que SC)

133 1993 Fam 95 : (1992) 3 WLR 782 : (1992) 4 All ER 649 (CA)

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might prolong his life, and those in which he decides, for example by administering a lethal drug, actively to bring his patient's life to an end. As I have already indicated, the former may be lawful, either because the doctor is giving effect to his patient's wishes by withholding the treatment or care, or even in certain circumstances in which (on principles which I shall describe) the patient is incapacitated from stating whether or not he gives his consent. But it is not lawful for a doctor to administer a drug to his patient to bring about his death, even though that course is prompted by a humanitarian desire to end his suffering, however great that suffering may be: see *R.* v. *Cox*[21] (unreported), 18-9-1992. So to act is to cross the Rubicon which runs between on the one hand the care of the living patient and on the other hand euthanasia—actively causing his death to avoid or to end his suffering. Euthanasia is not lawful at common law. It is of course well known that there are many responsible members of our society who believe that euthanasia should be made lawful; but that result could, I believe, only be achieved by legislation which expresses the democratic will that so fundamental a change should be made in our law, and can, if enacted, ensure that such legalised killing can only be carried out subject to appropriate supervision and control.

* * *

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

571. Lord Browne-Wilkinson in his judgment noticed the following questions raised in the matter: (*Airedale case*[11], AC p. 380 B-C)

"(1) lawfully discontinue all life-sustaining treatment and medical support measures designed to keep (Mr Bland) alive in his existing persistent vegetative state including the termination of ventilation, nutrition and hydration by artificial means; and (2) lawfully discontinue and thereafter need not furnish medical treatment to (Mr Bland) except for the sole purpose of enabling (Mr Bland) to end his life and die peacefully with the greatest dignity and the least of pain, suffering and distress."

Answering the questions following was held: (AC p. 386 F-H)

"Anthony Bland has been irreversibly brain damaged; the most distinguished medical opinion is unanimous that there is no prospect at all that the condition will change for the better. He is not aware of anything. If artificial feeding is continued, he will feel nothing; if artificial feeding is discontinued and he dies, he will feel nothing. Whether he lives or dies he will feel no pain or distress. All the purely physical considerations indicate

21 18-9-1992, Ognall, J. (unreported).
11 *Airedale N.H.S. Trust* v. *Bland*, 1993 AC 789 : (1993) 2 WLR 316 : (1993) 1 All ER 821 (CA & HL)

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that it is pointless to continue life support. Only if the doctors responsible for his care held the view that, though he is aware of nothing, there is some benefit to him in staying alive, would there be anything to indicate that it is for his benefit to continue the invasive medical care.

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

572. Another judgment which needs to be noticed is *B. (Adult: Refusal of Medical Treatment), In re*[134]. The claimant, Ms *B* has sought declaration from the High Court that the invasive treatment which is currently being given by the respondent by way of artificial ventilation is an unlawful trespass. The main issue raised in the case was as to whether Ms *B* has the capacity to make her own decision about her treatment in hospital. Ms *B*, aged 43 years, had suffered a devastating illness which has caused her to become tetraplegic and whose expressed wish was not to be kept artificially alive by the use of a ventilator. The High Court in the above context examined several earlier cases on the principle of autonomy. Paras 16 to 22 are to the following effect: (*B. case*[134], All ER pp. 455*e-j* & 456*f*)

"*16*. In 1972 Lord Reid in *S.* v. *McC*[130] said, at AC p. 43: (WLR p. 374 C-D)

> '... English law goes to great lengths to protect a person of full age and capacity from interference with his personal liberty. We have too often seen freedom disappear in other countries not only by coups d'état but by gradual erosion: and often it is the first step that counts. So it would be unwise to make even minor concessions.'

17. F. (Mental Patient: Sterilisation), In re[24], Lord Goff of Chieveley said: (AC p. 72 E)

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

18. Lord Donaldson of Lymington, M.R. said *T. (Adult: Refusal of Treatment), In re*[133] Fam, at p. 113D:

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

134 (2002) 2 All ER 449
130 *S.* v. *McC. (Orse. S.) and M. (D.S. Intervener)*, 1972 AC 24 : (1970) 3 WLR 366 (HL)
24 (1990) 2 AC 1 : (1989) 2 WLR 1025 : (1989) 2 All ER 545 (HL)
133 1993 Fam 95 : (1992) 3 WLR 782 : (1992) 4 All ER 649 (CA)

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19. T. (Adult: Refusal of Treatment), In re[133], I cited Robins, J.A. in *Malette* v. *Shulman*[45] DLR at p. 336, and said: (AC pp. 116 H & 117 A-B)

> "… 'The right to determine what shall be done with one's own body is a fundamental right in our society. The concepts inherent in this right are the bedrock upon which the principles of self-determination and individual autonomy are based. Free individual choice in matters affecting this right should, in my opinion, be accorded very high priority.' (*Malette case*[45])"

20. MB (Medical Treatment), In re[47] FLR, I said at p. 432:

> 'A mentally competent patient has an absolute right to refuse to consent to medical treatment for any reason, rational or irrational, or for no reason at all, even where that decision may lead to his or her own death',

[referring to *Sidaway* v. *Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital*[131] AC, per Lord Templeman at 904-905; and to Lord Donaldson, M.R. in *T. (Adult: Refusal of Treatment), In re*[133] (*see* above)].

21. This approach is identical with the jurisprudence in other parts of the world. In *Cruzan* v. *Missouri Department of Health*[4], the United States Supreme Court stated that:

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

(*b*) *The sanctity of life*

22. Society and the medical profession in particular are concerned with the equally fundamental principle of the sanctity of life. The interface between the two principles of autonomy and sanctity of life is of great concern to the treating clinicians in the present case. Lord Keith of Kinkel in *Airedale N.H.S. Trust* v. *Bland*[11], said at p. 859:

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

133 1993 Fam 95 : (1992) 3 WLR 782 : (1992) 4 All ER 649 (CA)
45 (1990) 67 DLR (4th) 321 : 72 OR (2d) 417 (CA)
47 1997 EWCA Civ 3093 : (1997) 2 FLR 426
131 1985 AC 871 : (1985) 2 WLR 480 : (1985) 1 All ER 643 (HL)
4 1990 SCC OnLine US SC 123 : 111 L Ed 2d 224 : 110 S Ct 2841 : 497 US 261 (1990)
11 1993 AC 789 : (1993) 2 WLR 316 : (1993) 1 All ER 821 (CA & HL)

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573. The judgment of the House of Lords in *R. (Pretty)* v. *Director of Public Prosecutions*[29], also needs to be referred to. The claimant, who suffered from a progressive and degenerative terminal illness, faced the imminent prospect of a distressing and humiliating death. She was mentally alert and wished to control the time and manner of her dying but her physical disabilities prevented her from taking her life unaided. She wished her husband to help her and he was willing to do so provided that in the event of his giving such assistance he would not be prosecuted under Section 2(1) of the Suicide Act, 1961. The claimant accordingly requested the Director of Public Prosecutions to undertake that he would not consent to such a prosecution under Section 2(4). On his refusal to give that undertaking the claimant, in reliance on the rights guaranteed by the European Convention for the Protection of Human Rights and Fundamental Freedoms as Schedule to the Human Rights Act, 1998, sought relief by way of judicial review.

574. The Divisional Court of the Queen's Bench Division concluded that the Director has no power to give an undertaking and dismissed the claim. The House of Lords again reiterated the distinction between the cessation of life-saving or life-prolonging treatment on the one hand and the taking of action intended solely to terminate life on the other. In para 9 of the judgment following was held: [*R. (Pretty) case*[29], QB pp. 813 E-H, & 814 A-B]

> "*9*. In the Convention field the authority of domestic decisions is necessarily limited and, as already noted, Mrs Pretty bases her case on the Convention. But it is worthy of note that her argument is inconsistent with two principles deeply embedded in English law. The first is a distinction between the taking of one's own life by one's own act and the taking of life through the intervention or with the help of a third party. The former has been permissible since suicide ceased to be a crime in 1961. The latter has continued to be proscribed. The distinction was very clearly expressed by Hoffmann, L.J. in *Airedale N.H.S. Trust* v. *Bland*[11]: (AC p. 355 H & 356 A-B)
>
> > '… No one in this case is suggesting that Anthony Bland should be given a lethal injection. But there is concern about ceasing to supply food as against, for example, ceasing to treat an infection with antibiotics. Is there any real distinction? In order to come to terms with our intuitive feelings about whether there is a distinction, I must start by considering why most of us would be appalled if he was given a lethal injection. It is, I think, connected with our view that the sanctity of life entails its inviolability by an outsider. Subject to exceptions like self-defence, human life is inviolate even if the person in question has consented to its violation. That is why although suicide is not a crime, assisting someone to commit suicide is. It follows that, even if we think Anthony Bland would have consented, we would not be entitled to end his life by a lethal injection.'

29 (2002) 1 AC 800 : (2001) 3 WLR 1598 : (2002) 1 All ER 1 : 2001 UKHL 61 (HL)
11 1993 AC 789 : (1993) 2 WLR 316 : (1993) 1 All ER 821 (CA & HL)

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The second distinction is between the cessation of life-saving or life-prolonging treatment on the one hand and the taking of action lacking medical, therapeutic or palliative justification but intended solely to terminate life on the other. This distinction provided the rationale of the decisions in *Bland*[11]. It was very succinctly expressed in the Court of Appeal in *J. (A Minor) (Wardship: Medical Treatment), In re*[15], in which Lord Donaldson of Lymington, M.R. said: (Fam p. 46 C-D)

> '... What doctors and the court have to decide is whether, in the best interests of the child patient, a particular decision as to medical treatment should be taken which as a side-effect will render death more or less likely. This is not a matter of semantics. It is fundamental. At the other end of the age spectrum, the use of drugs to reduce pain will often be fully justified, notwithstanding that this will hasten the moment of death. What can never be justified is the use of drugs or surgical procedures with the primary purpose of doing so.' "

United States of America

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

576. Cardozo, J., about a century ago in *Schloendorff* v. *Society of New York Hospital*[42], while in Court of Appeal had recognised the right of self-determination by every adult human being. Following was held:

> "Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages. *Pratt* v. *Davis*[331], *Mohr* v. *Williams*[332]. This is true, except in cases of emergency where the patient is unconscious, and where it is necessary to operate before consent can be obtained."

577. The Supreme Court of the United States of America in *Cruzan* v. *Missouri Department of Health*[4], had occasion to consider a case of patient who was in persistent vegetative state, her guardian brought a declaratory judgment seeking judicial sanction to terminate artificial hydration and nutrition of patient. The Supreme Court recognised right possessed by every individual to have control over own person. Following was held by Rehnquist, C.J.: (SCC OnLine US SC paras 6-7)

> "*6*. At common law, even the touching of one person by another without consent and without legal justification was a battery. See *W. Keeton, D. Dobbs, R. Keeton, & D. Owen, Prosser and Keeton on Law of Torts,*

11 *Airedale N.H.S. Trust* v. *Bland*, 1993 AC 789 : (1993) 2 WLR 316 : (1993) 1 All ER 821 (CA & HL)
15 1991 Fam 33 (CA) : (1991) 2 WLR 140 : (1990) 3 All ER 930
42 105 NE 92 : 211 NY 125 (1914)
331 224 Ill 300 : 79 NE 562 (1906)
332 95 Minn 261 : 104 NW 12 (1905)
4 1990 SCC OnLine US SC 123 : 111 L Ed 2d 224 : 110 S Ct 2841 : 497 US 261 (1990)

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Section 9, pp. 39-42 (5th Edn. 1984). Before the turn of the century, this Court observed that—

> 'a [n]o right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law.'

Union Pacific Rly. Co. v. *Botsford*[333], SCC OnLine US SC : US p. 251 : S.Ct. p. 1001. This notion of bodily integrity has been embodied in b the requirement that informed consent is generally required for medical treatment. Cardozo, J., while on the Court of Appeals of New York, aptly described this doctrine:

> 'Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an c assault, for which he is liable in damages,'

Schloendorff v. *Society of New York Hospital*[42], NY pp. 129-130, NE p. 93. The informed consent doctrine has become firmly entrenched in American tort law. See *Keeton, Dobbs, Keeton, & Owen, supra, Section 32, pp. 189-192; F. Rozovsky, Consent to Treatment*, A Practical Guide 1-98 d (2d Edn. 1990).

7. 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."

578. Referring to certain earlier cases following was held: (*Cruzan case*[4], SCC OnLine US SC para 12) e

"*12.* Reasoning that the right of self-determination should not be lost merely because an individual is unable to sense a violation of it, the Court held that incompetent individuals retain a right to refuse treatment. It also held that such a right could be exercised by a surrogate decision-maker using a "subjective" standard when there was clear evidence that f the incompetent person would have exercised it. Where such evidence was lacking, the court held that an individual's right could still be invoked in certain circumstances under objective "best interest" standards. *Conroy, In re*[23], NJ at pp. 361-68 : A 2d at pp. 1229-33. Thus, if some trustworthy evidence existed that the individual would have wanted to terminate treatment, but not enough to clearly establish a person's wishes g for purposes of the subjective standard, and the burden of a prolonged life from the experience of pain and suffering markedly outweighed its

333 1891 SCC OnLine US SC 217 : 35 L Ed 734 : 11 S Ct 1000 : 141 US 250 (1891)
42 105 NE 92 : 211 NY 125 (1914)
4 *Cruzan* v. *Missouri Department of Health*, 1990 SCC OnLine US SC 123 : 111 L Ed 2d 224 : 110 S Ct 2841 : 497 US 261 (1990) h
23 98 NJ 321 : 486 A 2d 1209 (NJ 1985)

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satisfactions, treatment could be terminated under a "limited-objective" standard. Where no trustworthy evidence existed, and a person's suffering would make the administration of life-sustaining treatment inhumane, a "pure-objective" standard could be used to terminate treatment. If none of these conditions obtained, the Court held it was best to err in favour of preserving life. Id., NJ at pp. 364-68 : A 2d at pp. 1231-33."

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

579. All different aspects of euthanasia were again considered by the United States Supreme Court in *Washington* v. *Glucksberg*[16]. A Washington State Statute enacted in 1975 provided that a person was guilty of the felony of promoting a suicide attempt when the person knowingly caused or aided another person to attempt suicide. An action was brought in the United States District Court for the Western District of Washington by several plaintiffs, among whom were (*1*) physicians who occasionally treated terminally ill, suffering patients, and (*2*) individuals who were then in the terminal phases of serious and painful illness. The plaintiffs, asserting the existence of a liberty interest protected by the Federal Constitution's Fourteenth Amendment which extended to a personal choice by a mentally competent, terminally ill adult to commit physician-assisted suicide, sought a declaratory judgment that the Washington Statute was unconstitutional on its face. The District Court, granting motions for summary judgment by the physicians and the individuals, ruled that the Statute was unconstitutional because it placed an undue burden on the exercise of the asserted liberty interest (*Compassion in Dying* v. *Washington*[13]). On appeal, the United States Court of Appeals for the Ninth Circuit, expressed the view that (*1*) the Constitution encompassed a due process liberty interest in controlling the time and manner of one's death; and (*2*) the Washington Statute was unconstitutional as applied to terminally ill, competent adults who wished to hasten their deaths with medication prescribed by their physicians (*Compassion in Dying* v. *Washington*[334]).

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

16 1997 SCC OnLine US SC 79 : 138 L Ed 2d 772 : 521 US 702 (1997)
13 850 F Supp 1454 (WD Wash 1994)
334 79 F 3d 790 (1996)

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

581. The US Supreme Court held that the Washington Statute did not violate the Due Process Clause. Rehnquist, C.J. while delivering the opinion of the Court upheld the State's ban on assisted suicide to the following effect: (*Washington case*[16], SCC OnLine US SC)

> "… In almost every State—indeed, in almost every western democracy —it is a crime to assist a suicide. The States' assisted-suicide bans are long-standing expressions of the States' commitment to the protection and preservation of all human life. *Cruzan*[4], at p. 280 ("The States—indeed, all civilized nations—demonstrate their commitment to life by treating homicide as a serious crime. Moreover, the majority of States in this country have laws imposing criminal penalties on one who assists another to commit suicide"); see *Stanford* v. *Kentucky*[335], US p. 373 ('[T]he primary and most reliable indication of [a national] consensus is … the pattern of enacted laws'). Indeed, opposition to and condemnation of suicide—and, therefore, of assisting suicide—are consistent and enduring themes of our philosophical, legal, and cultural heritages."

582. Another judgment of the US Supreme Court which needs to be noted is *Vacco* v. *Quill*[17]. New York State law as in effect in 1994 provided that a person who intentionally caused or aided another person to attempt or commit suicide was guilty of felony; but under other statutes, a competent person could refuse even life-saving medical treatment. The plaintiff sought declaratory relief and injunctive against the enforcement of criminal law asserting that such law is violative of statutes of the Federal Constitution's Fourteenth Amendment.

583. Rehnquist, C.J. in his opinion again upheld distinction between assisted suicide and withdrawing of life sustaining treatment. Following was laid down: (*Washington case*[16], SCC OnLine US SC)

> "[1d] The Court of Appeals, however, concluded that some terminally ill people—those who are on life support systems—are treated differently from those who are not, in that the former may "hasten death" by ending treatment, but the latter may not "hasten death" through physician-assisted suicide. *Quill* v. *Vacco*[34] F 3d, at p. 729. This conclusion depends on the submission that ending or refusing life-saving medical treatment "is nothing more nor less than assisted suicide." *Ibid.* Unlike

16 *Washington* v. *Glucksberg*, 1997 SCC OnLine US SC 79 : 138 L Ed 2d 772 : 521 US 702 (1997)
4 *Cruzan* v. *Missouri Department of Health*, 1990 SCC OnLine US SC 123 : 111 L Ed 2d 224 : 110 S Ct 2841 : 497 US 261 (1990)
335 1989 SCC OnLine US SC 151 : 106 L Ed 2d 306 : 109 S Ct 2969 : 492 US 361 (1989)
17 1997 SCC OnLine US SC 80 : 138 L Ed 2d 834 : 521 US 793 (1997)
34 80 F 3d 716 (2d Cir 1996)

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the Court of Appeals, we think the distinction between assisting suicide and withdrawing life-sustaining treatment, a distinction widely recognised and endorsed in the medical profession and in our legal traditions, is both important and logical; it is certainly rational. …

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

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

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

Canada

585. Section 241(*b*) of the Criminal Code provides that everyone who aids or abets a person in committing suicide commits an indictable offence. In *Rodriguez* v. *British Columbia (Attorney General)*[22], the Supreme Court of Canada has considered the issue of assisted suicide. A 42 year old lady who was suffering from an incurable illness applied before the Supreme Court of British Columbia for an order that Section 241(*b*) which prohibits giving assistance to commit suicide, be declared invalid. The application was dismissed and the matter was taken to the Supreme Court of Canada which held that prohibition of Section 241(*b*) which fulfils the Government's objective of protecting the vulnerable, is grounded in the State interest in protecting life and reflects the policy of the State that human life should not be depreciated by allowing life to be taken.

Switzerland

586. In Switzerland the assisted suicide is allowed only for altruistic reasons. A person is guilty and deserved to be sentenced for imprisonment on assisted suicide when he incites someone to commit suicide for selfish reasons.

Netherlands

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

31. The request must be made entirely of the patient's own free will.
32. The patient must have a long-lasting desire for death.

22 1993 SCC OnLine Can SC 97 : (1993) 3 SCR 519 : 85 CCC 3d 15

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33. The patient must be experiencing unbearable suffering.

34. There must be no reasonable alternatives to relative suffering other than euthanasia.

35. The euthanasia or assisted suicide must be reported to the coroner.

588. The above discussion clearly indicates that predominant thought as on date prevailing in other part of the world is that assisted suicide is a crime. No one is permitted to assist another person to commit suicide by injecting a lethal drug or by other means. In India, Section 306 of the Indian Penal Code specifically makes it an offence. The Constitution Bench of this Court in *Gian Kaur*[10] has already upheld the constitutional validity of Section 306, thus, the law of the land as existing today is that no one is permitted to cause death of another person including a physician by administering any lethal drug even if the objective is to relive the patient from pain and suffering.

H. *Ratio of Gian Kaur* v. *State of Punjab*[10]

589. In *Gian Kaur case*[10], the constitutional validity of Section 306 of the Penal Code, 1860 was challenged. The appellant had placed reliance on two-Judge Bench judgment of this Court in *P. Rathinam* v. *Union of India*[6], wherein this Court declared Section 309 IPC to be unconstitutional as violative of Article 21 of the Constitution. It was contended that Section 309 having already been declared as unconstitutional, any person abetting the commission of suicide by another is merely assisting in the enforcement of the fundamental right under Article 21 and, therefore, Section 306 IPC penalising assisted suicide is equally violative of Article 21. The Court proceeded to consider the constitutional validity of Section 306 on the above submission. In para 17 of the judgment, this Court had made observation that reference to euthanasia cases tends to befog the real issue. Following are the relevant observations made in para 17: (*Gian Kaur case*[10], SCC p. 658)

> "*17.* … Any further reference to the global debate on the desirability of retaining a penal provision to punish attempted suicide is unnecessary for the purpose of this decision. Undue emphasis on that aspect and particularly the reference to euthanasia cases tends to befog the real issue of the constitutionality of the provision and the crux of the matter which is determinative of the issue."

The Constitution Bench held that Article 21 does not include right to die. Para 22 of the judgment contains the ratio in following words: (SCC p. 660)

> "*22.* … Whatever may be the philosophy of permitting a person to extinguish his life by committing suicide, we find it difficult to construe Article 21 to include within it the "right to die" as a part of the fundamental right guaranteed therein. "Right to life" is a natural right embodied in Article 21 but suicide is an unnatural termination or extinction of life and, therefore, incompatible and inconsistent with the concept of "right to life"."

10 *Gian Kaur* v. *State of Punjab*, (1996) 2 SCC 648 : 1996 SCC (Cri) 374
6 (1994) 3 SCC 394 : 1994 SCC (Cri) 740

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Although, right to die was held not to be a fundamental right enshrined under Article 21 but it was laid down that the right to life includes right to live with human dignity i.e. right of a dying man to also die with dignity when his life is ebbing out. Following pertinent observations have been made in para 24: (SCC p. 660)

> "*24.* ... The "right to life" including the right to live with human dignity would mean the existence of such a right up to the end of natural life. This also includes the right to a dignified life up to the point of death including a dignified procedure of death. In other words, this may include the right of a dying man to also die with dignity when his life is ebbing out. But the "right to die" with dignity at the end of life is not to be confused or equated with the "right to die" an unnatural death curtailing the natural span of life."

590. The Constitution Bench, however, noticed the distinction between a dying man, who is terminally ill or in a persistent vegetative state, when process of natural death has commenced, from one where life is extinguished. The Court, however, held that permitting termination of life to such cases to reduce the period of suffering during the process of certain natural death is not available to interpret Article 21 to include therein the right to curtail the natural span of life. Para 25 of the judgment is to the following effect: (*Gian Kaur case*[10], SCC pp. 660-61)

> "*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."

591. The Constitution Bench in above paragraphs has observed that termination of life in case of those who are terminally ill or in a persistent vegetative state, may fall within the ambit of "right to die" with dignity as a part of right to live with dignity when death due to termination of natural life is certain and imminent and process of natural death has commenced. But even in those cases, physician-assisted termination of life cannot be included in right guaranteed under Article 21. One more pertinent observation can be noticed from para 33, wherein this Court held that: (*Gian Kaur case*[10], SCC p. 663)

10 *Gian Kaur* v. *State of Punjab*, (1996) 2 SCC 648 : 1996 SCC (Cri) 374

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

592. The distinction between cases where physician decides not to provide or to discontinue to provide for treatment or care, which could or might prolong his life and those in which he decides to administer a lethal drug, was noticed while referring to the judgment of the House of Lords in *Airedale case*[11]. In *Airedale case*[11], it was held that it is not lawful for a doctor to administer a drug to his patient to bring about his death. Euthanasia is not lawful at common law and euthanasia can be made lawful only by legislation. It is further relevant to notice that in para 40, this Court had observed that it is not necessary to deal with physician-assisted suicide or euthanasia cases. Para 40, is as follows: (*Gian Kaur case*[10], SCC p. 666)

"*40. Airedale N.H.S. Trust* v. *Bland*[11] was a case relating to withdrawal of artificial measures for continuance of life by a physician. Even though it is not necessary to deal with physician-assisted suicide or euthanasia cases, a brief reference to this decision cited at the Bar may be made. In the context of existence in the persistent vegetative state of no benefit to the patient, the principle of sanctity of life, which is the concern of the State, was stated to be not an absolute one. In such cases also, the existing crucial distinction between cases in which a physician decides not to provide, or to continue to provide, for his patient, treatment or care which could or might prolong his life, and those in which he decides, for example, by administering a lethal drug, actively to bring his patient's life to an end, was indicated and it was then stated as under: (AC p. 865 E-G : All ER p. 867 : WLR p. 368 G-H)

'… But it is not lawful for a doctor to administer a drug to his patient to bring about his death, even though that course is prompted by a humanitarian desire to end his suffering, however great that suffering may be: [see *R.* v. *Cox*[21], (18-9-1992, unreported)] per Ognall, J. in the Crown Court at Winchester. So to act is to cross the Rubicon which runs between on the one hand the care of the living patient and on the other hand euthanasia — actively causing his death to avoid or to end his suffering. Euthanasia is not lawful at common law. It is of course well known that there are many responsible members of our society who believe that euthanasia should be made lawful; but that result could, I believe, only be achieved by legislation which expresses the democratic will that so fundamental a change should be made in

11 *Airedale N.H.S. Trust* v. *Bland*, 1993 AC 789 : (1993) 2 WLR 316 : (1993) 1 All ER 821 (CA & HL)
10 *Gian Kaur* v. *State of Punjab*, (1996) 2 SCC 648 : 1996 SCC (Cri) 374
21 18-9-1992, Ognall, J. (unreported).

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

593. A conjoint reading of observations in paras 25, 33 and 40 indicates that although for a person terminally ill or in PSV state, whose process of natural death has commenced, termination of life may fall in the ambit of right to die with dignity but in those cases also there is no right of actively terminating life by a physician. The clear opinion has thus been expressed that euthanasia is not lawful. But at the same time, the Constitution Bench has noticed the distinction between the cases in which a physician decides not to provide or to continue to provide for his patient's treatment or care which could or might prolong his life and those in which physician decides actively to bring life to an end. The *ratio* of the judgment is contained in paras 22 and 24, which is to the following effect: (*Gian Kaur case*[10], SCC p. 660)

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

* * *

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

594. We have noticed above that in para 17, this Court had observed that reference to euthanasia cases tends to befog the real issue and further in SCC p. 665, para 40, it was observed that "even though it is not necessary to deal with physician-assisted suicide or euthanasia cases"; the Constitution Bench has neither considered the concept of euthanasia nor has laid down any ratio approving euthanasia.

595. At best, the Constitution Bench noted a difference between cases in which physician decides not to provide or to continue to provide for medical treatment or care and those cases where he decides to administer a lethal drug activity to bring his patient's life to an end. The judgment of the House of Lords in *Airedale case*[11] was referred to and noted in the above context. The *Airedale case*[11] was cited on behalf of the appellant in support of the contention that in said case the withdrawal of life saving treatment was held not to be unlawful.

10 *Gian Kaur* v. *State of Punjab*, (1996) 2 SCC 648 : 1996 SCC (Cri) 374

11 *Airedale N.H.S. Trust* v. *Bland*, 1993 AC 789 : (1993) 2 WLR 316 : (1993) 1 All ER 821 (CA & HL)

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

I. *Concept of euthanasia*

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

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

598. *Oxford English Dictionary* defines "euthanasia":

> "*Euthanasia*.—The painless killing of a patient suffering from an incurable and painful disease or in an irreversible coma."

The definition of the word "euthanasia" as given by the World Health Organisation may be noticed which defines it as:

> "*Euthanasia*.—A deliberate act undertaken by one person with the intention of either painlessly putting to death or failing to prevent death from natural causes in cases of terminal illness or irreversible coma of another person."

599. In ancient Greek society, euthanasia as "good death" was associated with the drinking of "Hemlock". Drinking of Hemlock had become common not only in cases of incurable diseases but also by those individuals who faced other difficult problems or old age. In ancient times, in Greece freedom to live was recognised principle, which permitted the sick and desperates to terminate their lives by themselves or by taking outside help. In last few centuries, euthanasia increasingly came to connote specific measures taken by physicians to hasten the death. The primary meaning, as has now been ascribed to the word is compassionate murder. In the last century, the thought has gained acceptance that euthanasia is to be distinguished from withdrawal of life saving treatments which may also result in death. Withdrawing medical treatment in a way hasten the death in case of terminal illness or persistent vegetative state (PVS) but is not to be treated as compassionate murder. Advancement in the medical science on account of which life can be prolonged by artificial devices are the developments of only last century. Lord Browne-Wilkinson, J., in *Airedale N.H.S. Trust* v. *Bland*[11] WLR at p. 389 observed: (AC p. 878 D-F)

> "… Death in the traditional sense was beyond human control. Apart from cases of unlawful homicide, death occurred automatically in the course of nature when the natural functions of the body failed to sustain the lungs and the heart.
>
> Recent developments in medical science have fundamentally affected these previous certainties. In medicine, the cessation of breathing or of

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heartbeat is no longer death. By the use of a ventilator, lungs which in the unaided course of nature would have stopped breathing can be made to breathe, thereby sustaining the heartbeat. Those, like Anthony Bland, who would previously have died through inability to swallow food can be kept alive by artificial feeding. This has led the medical profession to redefine death in terms of brain stem death i.e. the death of that part of the brain without which the body cannot function at all without assistance. In some cases it is now apparently possible, with the use of the ventilator, to sustain a beating heart even though the brain stem, and therefore in medical terms the patient, is dead; "the ventilated corpse"."

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

(*1*) Sanctity of life,

(*2*) Right of self-determination,

(*3*) Dignity of the individual human being.

601. The sanctity of life is one thought which is philosophically, religiously and mythologically accepted by the large number of population of the world practising different faiths and religions. Sanctity of life entails its inviolability by an outsider. Sanctity of life is the concern of State.

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

J. *Withdrawal of life saving devices*

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

"The title to this Report immediately suggests to one that we are dealing with 'Euthanasia' or 'Assisted Suicide'. But we make it clear at the

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outset that Euthanasia and Assisted Suicide continue to be unlawful and we are dealing with a different matter 'Withholding Life-support Measures' to patients terminally ill and, universally, in all countries, such withdrawal is treated as 'lawful'."

604. The Law Commission of India was of the opinion that withdrawing life supporting measures of patient terminally ill is a concept, different from euthanasia. The opinion of Cardozo, J., rendered more than hundred years ago that every human being of adult years and sound mind has a right to determine what shall be done with his own body, is now universally accepted principle. The judgment of the US Supreme Court and House of Lords, as noticed above, also reiterate the above principle.

605. Recently, in a nine-Judge judgment in *K.S. Puttaswamy* v. *Union of India*[58], J. Chelameswar, J. elaborating the concept of right to life as enshrined in Article 21 under the Constitution of India has observed: (SCC p. 530, para 373)

> "*373*. … 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 of privacy."

606. Withdrawal of life-saving devices, leads to natural death which is arrested for the time being due to above device and the act of withdrawal put the life on the natural track. Decision to withdraw life-saving devices is not an act to cause good death of the person rather, decision to withdraw or not to initiate life-supporting measures is a decision when treatment becomes futile and unnecessary. Practice of euthanasia in this country is prohibited and for medical practitioners it is already ordained to be unethical conduct. The question as to what should be the measures to be taken while taking a decision to withdraw life-saving measures or life-saving devices is another question which we shall consider a little later.

607. The two-Judge Bench in *Aruna Ramachandra Shanbaug* v. *Union of India*[5] has held that withdrawal of live-saving measures is a passive euthanasia which is permissible in India. A critically ill patient who is mentally competent to take a decision, decides not to take support of life prolonging measures, and respecting his wisdom if he is not put on such devices like ventilator, etc. it is not at all euthanasia. Large number of persons in advance age of life decide not to take medical treatment and embrace death in its natural way, can their death be termed as euthanasia. Answer is, obviously "No". The decision not to take life saving medical treatment by a patient, who is competent to express his opinion cannot be termed as euthanasia, but a decision to withdraw life saving treatment by a patient who is competent to take decision as well as with regard to a patient who is not competent to take decision can be termed as passive euthanasia. On the strength of the precedents in this country and weight of precedents of other countries as noted above, such action of withdrawing life saving device is legal.

58 (2017) 10 SCC 1
5 (2011) 4 SCC 454 : (2011) 2 SCC (Civ) 280 : (2011) 2 SCC (Cri) 294

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Thus, such acts, which are commonly expressed as passive euthanasia is lawful and legally permissible in this country.

608. We remind ourselves that this Court is not a legislative body nor is entitled or competent to act as a moral or ethical arbiter. The task of this Court is not to weigh or evaluate or reflect different beliefs and views or give effect to its own but to ascertain and build the law of land as it is now understood by all. Message which need to be sent to vulnerable and disadvantaged people should not, however, obliviously to encourage them to seek death but should assure them of care and support in life.

609. We thus are of the considered opinion that the act of withdrawal from live-saving devices is an independent right which can lawfully be exercised by informed decision.

K. ***Decision for withdrawal of life saving treatment in case of a person who is incompetent to take an informed decision***

610. One related aspect which needs to be considered is that is case of those patients who are incompetent to decide due to their mental state or due to the fact that they are in permanent persistent vegetative state or due to some other reasons unable to communicate their desire. When the right of an adult person who expresses his view regarding medical treatment can be regarded as right flowing from Article 21 of the Constitution of India, the right of patient who is incompetent to express his view cannot be outside the fold of Article 21 of the Constitution of India. It is another issue, as to how, the decision in cases of mentally incompetent patients regarding withdrawal of life saving measures, is to be taken.

611. The rights of bodily integrity and self-determination are the rights which belong to every human being. When an adult person having mental capacity to take a decision can exercise his right not to take treatment or withdraw from treatment, the above right cannot be negated for a person who is not able to take an informed decision due to terminal illness or being in a persistent vegetative state (PVS). The question is who is competent to take decision in case of terminally ill or PVS patient, who is not able to take decision. In case of a person who is suffering from a disease and is taking medical treatment, there are three stakeholders; the person himself, his family members and doctor treating the patient. The American Courts give recognition to opinion of "surrogate" where person is incompetent to take a decision. No person can take decision regarding life of another unless he is entitled to take such decision authorised under any law. The English Courts have applied the "best interests" test in case of an incompetent person. The best interests of the patient have to be found out not by doctor treating the patient alone but a team of doctors specifically nominated by the State Authority. In *Aruna Shanbaug*[5], two-Judge Bench of this Court has opined that in such cases relying on doctrine of "*parens patriae*" (father of the country), it is the court alone which is entitled

5 *Aruna Ramachandra Shanbaug* v. *Union of India*, (2011) 4 SCC 454 : (2011) 2 SCC (Civ) 280 : (2011) 2 SCC (Cri) 294

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to take a decision whether to withdraw treatment for incompetent terminally ill or PVS patient. In paras 130 and 131 following has been held: (SCC p. 521)

> "*130*. In our opinion, in the case of an incompetent person who is unable to take a decision whether to withdraw life support or not, it is the Court alone, as parens patriae, which ultimately must take this decision, though, no doubt, the views of the near relatives, next friend and doctors must be given due weight.
>
> ***Under which provision of law can the Court grant approval for withdrawing life support to an incompetent person***
>
> *131*. In our opinion, it is the High Court under Article 226 of the Constitution which can grant approval for withdrawal of life support to such an incompetent person. Article 226(1) of the Constitution states:
>
> > '**226.** ***Power of High Courts to issue certain writs***.—(1) Notwithstanding anything in Article 32, every High Court shall have power, throughout the territories in relation to which it exercises jurisdiction, to issue to any person or authority, including in appropriate cases, any Government, within those territories directions, orders or writs, including writs in the nature of *habeas corpus*, *mandamus*, *prohibition*, *quo warranto* and *certiorari*, or any of them, for the enforcement of any of the rights conferred by Part III and for any other purpose.'
>
> A bare perusal of the above provisions shows that the High Court under Article 226 of the Constitution is not only entitled to issue writs, *but is also entitled to issue directions or orders*." (emphasis in original)

612. Various learned counsel appearing before us have submitted that seeking declaration from the High Court in cases where medical treatment is needed to be withdrawn is time taking and does not advance the object nor is in the interest of terminally-ill patient. It is submitted that to keep check on such decisions, the State should constitute competent authorities consisting of predominantly experienced medical practitioners whose decision may be followed by all concerned with a rider that after taking of decision by competent body a cooling period should be provided to enable anyone aggrieved from the decision to approach a court of law. We also are of the opinion that in cases of incompetent patients who are unable to take an informed decision, it is in the best interests of the patient that the decision be taken by the competent medical experts and that such decision be implemented after providing a cooling period at least of one month to enable aggrieved person to approach the court of law. The best interest of the patient as determined by medical experts shall meet the ends of justice. The medical team by taking decision shall also take into consideration the opinion of the blood relations of the patient and other relevant facts and circumstances.

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L. *Advance Medical Directive*

613. The petitioner by the writ petition has also sought a direction to the respondent to adopt suitable procedures to ensure that persons of deteriorated health or terminally ill should be able to execute a document titled "MY LIVING WILL & ATTORNEY AUTHORISATION". The petitioner submits that it is an important personal decision of the patient to use or not to use the life sustaining treatment in case of terminal illness and stage of persistent vegetative state. The petitioner pleads that the petitioner's endeavour is only to seek a "choice" for the people which is not available at present and they are left to the mercy of doctors who to save themselves from any penal consequences half-heartedly, despite knowing that the death is inevitable continue administering the treatment which the person might not have wanted to continue with. A person will be free to issue Advance Directives both in a positive and negative manner, meaning thereby that a person is not necessarily required to issue directive that the life sustaining treatment should not be given to him in the event of he or she going into persistent vegetative state or in an irreversible state. The person can also issue directives as to all the possible treatment which should be given to him when he is not able to express his/her wishes on medical treatment. The petitioner also refers to and rely on various legislations in different countries, which recognise the concept of Advance Medical Directive. The petitioner pleads that in India also law in the nature "Patient Autonomy & Self-determination Act" should be enacted. The petitioner has also along with his writ petition has annexed a draft titling it "Patient's Self-determination Act".

614. The concept of Advance Medical Directive is also called living will is of recent origin, which gained recognition in latter part of 20th century. The Advance Medical Directive has been recognised first by the Statute in United States of America when in the year 1976, State of California passed "Natural Death Act". It is claimed that 48 States out of 50 in the United States of America have enacted their own laws regarding patient's rights and Advance Medical Directives. Advance Medical Directive is a mechanism through which individual autonomy can be safeguarded in order to provide dignity in dying. As noted above, the Constitution Bench of this Court in *Gian Kaur*[10] has laid down that right to die with dignity is enshrined in Article 21 of the Constitution.

615. It is to be noticed that Advance Medical Directives are not exclusively associated with end-of-life decisions. However, it is vital to ensure that form of an Advance Medical Directive reflects the needs of its author and is sufficiently authoritative and practical to enable its provisions to be upheld. In most of the western countries Advance Medical Directives have taken a legalistic form incorporating a formal declaration to be signed by competent witnesses. The laws also make provisions for updating confirmation of its applicability and revocation. Protecting the individual autonomy is obviously the primary purpose of an Advance Medical Directive. The right to decide one's own fate

10 *Gian Kaur* v. *State of Punjab*, (1996) 2 SCC 648 : 1996 SCC (Cri) 374

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presupposes a capacity to do so. The answer as to when a particular Advance Medical Directive becomes operative usually depends upon an assent of when its author is no longer competent to participate in medical decision-making.

616. *Black's Law Dictionary* defines the Advance Medical Directive as "a legal document explaining one's wishes about medical treatment if one becomes incompetent or unable to communicate". An Advance Medical Directive is an individual's advance exercise of his autonomy on the subject of extent of medical intervention that he wishes to allow upon his own body at a future date, when he may not be in a position to specify his wishes. The purpose and object of Advance Medical Directive is to express the choice of a person regarding medical treatment in an event when he loses capacity to take a decision. Use and operation of Advance Medical Directive is to confine only to a case when person becomes incapacitated to take an informed decision regarding his medical treatment. So long as an individual can take an informed decision regarding his medical treatment, there is no occasion to look into Advance Medical Directives. A person has unfettered right to change or cancel his Advance Medical Directives looking to the need of time and advancement in medical science. Hence, a person cannot be tied up or bound by his instructions given at an earlier point of time.

617. The concept of Advance Medical Directive originated largely as a response to development in medicines. Many people living depending on machines cause great financial distress to the family with the cost of long-term medical treatment. Advance Medical Directive was developed as a means to restrict the kinds of medical intervention in event when one becomes incapacitated. The foundation for seeking direction regarding Advance Medical Directive is extension of the right to refuse medical treatment and the right to die with dignity. When a competent patient has right to take a decision regarding medical treatment, with regard to medical procedure entailing right to die with dignity, the said right cannot be denied to those patients, who have become incompetent to take an informed decision at the relevant time. The concept of Advance Medical Directive has gained ground to give effect to the rights of those patients, who at a particular time are not able to take an informed decision.

618. Another concept which has been accepted in several countries is recognition of instrument through which a person nominates a representative to make decision regarding their medical treatment at a point of time when the person executing the instrument is unable to make an informed decision. This is called attorney authorisation leading to medical treatment. In this country, there is no legislation governing such Advance Medical Directives. It is, however, relevant to note a recent legislation passed by Parliament, namely, "the Mental Health Care Act, 2017", where as per Section 5 every person, who is not a minor has a right to make an Advance Directive in writing regarding treatment to his mental illness in the way a person wishes to be treated for mental illness. The

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person wishes not to be treated for mental illness and nomination of individual and individual's as his/her representative. Section 5 is to the following effect:

"**5.** ***Advance Directive***.—(1) Every person, who is not a minor, shall have a right to make an Advance Directive in writing, specifying any or all of the following, namely—

(*a*) the way the person wishes to be cared for and treated for a mental illness;

(*b*) the way the person wishes not to be cared for and treated for a mental illness;

(*c*) the individual or individuals, in order of precedence, he wants to appoint as his nominated representative as provided under Section 14.

(2) An Advance Directive under sub-section (1) may be made by a person irrespective of his past mental illness or treatment for the same.

(3) An Advance Directive made under sub-section (1), shall be invoked only when such person ceases to have capacity to make mental healthcare or treatment decisions and shall remain effective until such person regains capacity to make mental healthcare or treatment decisions.

(4) Any decision made by a person while he has the capacity to make mental healthcare and treatment decisions shall override any previously written Advance Directive by such person.

(5) Any Advance Directive made contrary to any law for the time being in force shall be ab initio void."

619. Section 6 of the Act provides that an Advance Directive shall be made in the manner as has been prescribed by the Regulations made by the Central Authority. In the draft Medical Healthcare Regulations published by the Ministry of Health and Family Welfare, a form is prescribed in which Advance Directive may be made. Other aspects of medical directive have also been dealt with by the draft Regulations. Thus, in our country, recognition of Advance Directives regarding medical treatment has started to be recognised and are in place relating to specified field and purpose. Another legislation which also recognises some kind of Advance Directive relating to a person's body is Section 3 of the Transplantation of Human Organs and Tissues Act, 1994. Section 3 sub-sections (1) and (2) which are relevant for the present purpose are as follows:

"**3.** ***Authority for removal of human organs or tissues or both***.—(1) Any donor may, in such manner and subject to such conditions as may be prescribed, authorise the removal, before his death, of any human organ or tissue or both of his body for therapeutic purposes.

(2) If any donor had, in writing and in the presence of two or more witnesses (at least one of whom is a near relative of such person), unequivocally authorised at any time before his death, the removal of any human organ or tissue or both of his body, after his death, for therapeutic purposes, the person lawfully in possession of the dead body of the donor shall,

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unless he has any reason to believe that the donor had subsequently revoked the authority aforesaid, grant to a registered medical practitioner all reasonable facilities for the removal, for therapeutic purposes, of that human organ or tissue or both from the dead body of the donor."

620. The Rules have been framed under Section 24 of the Transplantation of Human Organs and Tissues Act, 1994, namely, Transplantation of Human Organs and Tissues Rules, 2014 where form of authorisation for organ or tissue pledging is Form 7, which provides that an authorisation by donor in presence of two witnesses which is also required to be registered by Organ Donor Registry.

621. The statutory recognition of the abovementioned authorisation in two statutes is clear indication of acceptance of the concept of Advance Medical Directive in this country.

622. The learned counsel for the petitioner as well as for the intervenors and the Additional Solicitor General of India has expressed concern regarding manner and procedure of execution of Advance Medical Directive. It is submitted that unless proper safeguards are not laid down, those who are vulnerable, infirm and aged may be adversely affected and efforts by those related to a person to expedite death of a person for gaining different benefits, cannot be ruled out. We have been referred to various legislations in different countries, which provide a detailed procedure of execution of Advance Medical Directive, competence of witnesses, mode and manner of execution, authority to register and keep such Advance Medical Directive.

623. Shri Arvind Datar, learned Senior Counsel has in his written submissions referred to certain aspects, which may be kept in mind while formulating guidelines for Advance Medical Directive, which are as follows:

623.1. 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.

623.2. 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 eye of the law. The form should require a reaffirmation that the person executing such directive has made an informed decision. Only those Advance Directives relating to the withdrawal or withholding of life-sustaining treatment should be granted legal validity. The determination that the executor of the Advance Directive is no longer capable of making the decision should be made in accordance with relevant medical professional regulations or standard treatment guidelines, as also the determination that the executor's life would terminate in the absence of life-sustaining treatment. The constitution of a panel of experts may also be considered to make this determination. The use of expert

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committees or ethics committees in other jurisdictions is discussed at Para 28 of these written submissions.

623.3. Primary responsibility for ensuring compliance with the Advance Directive should be on the medical institution where the person is receiving such treatment.

623.4. If a hospital refuses to recognise the validity of an Advance Directive, the relatives or next friend may approach the jurisdictional High Court seeking a writ of mandamus against the hospital concerned to execute the directive. The High Court may examine whether the directive has been properly executed, whether it is still valid (Le, whether or not circumstances have fundamentally changed since its execution, making it invalid) and/or applicable to the particular circumstances or treatment.

623.5. No hospital or doctor should be made liable in civil or criminal proceedings for having obeyed a validly executed Advance Directive.

623.6. 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.

624. The right to self-determination and bodily integrity has been recognised by this Court as noted above. The right to execute an Advance Medical Directive is nothing but a step towards protection of the aforesaid right by an individual, in event he becomes incompetent to take an informed decision, in particular stage of life. It has to be recognised by all including the States that a person has right to execute an Advance Medical Directive to be utilised to know his decision regarding manner and extent of medical treatment given to his body, in case he is incapacitated to take an informed decision. Such right by an individual does not depend on any recognition or legislation by a State and we are of the considered opinion that such rights can be exercised by an individual in recognition and in affirmation of his right of bodily integrity and self-determination which are duly protected under Article 21 of the Constitution. The procedure and manner of such expression of such right is a question which needs to be addressed to protect the vulnerable, infirm and old from any misuse. It is the duty of the State to protect its subjects specially those who are infirm, old and need medical care. The duty of doctor to extend medical care to the patients, who come to them in no manner diminishes in any manner by recognition of concept that an individual is entitled to execute an Advance Medical Directive. The physicians and medical practitioners treating a person, who is incompetent to express an informed decision have to act in a manner so as to give effect to the express wishes of an individual.

625. The concept of Advance Medical Directive has gained ground throughout the world. Different countries have framed necessary legislation in this regard. Reference of few of such legislations shall give idea of such statutory scheme formulated by different countries to achieve the object. The

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Republic of Singapore has passed an enactment, namely, Advance Medical Directive Act (16 of 1996). Section 3 sub-section (1) of the Act empowers a person who is not mentally disordered and attained the age of 21 years to make an Advance Directive in the prescribed form.

626. Other provisions of the statute deal with duty of witness, registration of directives, objections, revocation of directive, panel of specialists, certification of terminal illness, duty of medical practitioner and other related provisions. The Belgian Act on Euthanasia, 2002 also contains provisions regarding Advance Directive in Section 4. Swiss Civil Code, 1907 in Articles 362 and 365 provide for advance care directive, its execution and termination. The Mental Capacity Act, 2005 (England) also contemplates for an Advance Directive. The statute further provides that an Advance Directive is applicable in life sustaining treatment only. When the decision taken in writing, signed by the patient or by another person in patient's presence on his direction. Pennsylvania Act 169 of 2006 also contains provisions with regard to execution of Advance Medical Directive and other related provisions, its revocation, etc.

627. In our country, there is yet no legislation pertaining to Advance Medical Directive. It is, however, relevant to note that Ministry of Health and Family Welfare vide its Order dated 6-5-2016 uploaded the Law Commission's 241st Report and solicited opinions, comments on the same. An explanatory note has also been uploaded by the Ministry of Health and Family Welfare where in Para 6 following was stated:

> "Living Will has been defined as 'A document in which person states his/her desire to have or not to have extraordinary life prolonging measures used when recovery is not possible from his/her terminal condition.'
>
> However, as per Para 11 of the said Bill the Advance Medical Directive (Living Will) or medical power of attorney executed by the person shall be void and of no effect and shall not be binding on any medical practitioner."

Although in Clause 11 of the draft Bill, it was contemplated that Advance Medical Directives are not binding on medical practitioner but the process of legislation had not reached at any final stage. The directions and safeguards which have been enumerated by the Hon'ble Chief Justice in his judgment shall be sufficient to safeguard the interests of the patients, doctors and society till the appropriate legislation is framed and enforced.

628. We thus conclude that a person with competent medical facility is entitled to execute an Advance Medical Directive subject to various safeguards as noted above.

M. *Conclusions*

629. From the above discussions, we arrive on following conclusions:

629.1. The Constitution Bench in *Gian Kaur case*[10] held that the "right to life: including right to live with human dignity" would mean the existence of such right up to the end of natural life, which also includes the right to a dignified life up to the point of death including a dignified procedure of death.

10 *Gian Kaur* v. *State of Punjab*, (1996) 2 SCC 648 : 1996 SCC (Cri) 374

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The above right was held to be part of fundamental right enshrined under Article 21 of the Constitution which we also reiterate.

629.2. We agree with the observation made in the reference order of the three-Judge Bench to the effect that the Constitution Bench in *Gian Kaur case*[10] did not express any binding view on the subject of euthanasia. We hold that no binding view was expressed by the Constitution Bench on the subject of euthanasia.

629.3. The Constitution Bench, however, noted a distinction between cases in which physician decides not to provide or continue to provide for treatment and care, which could or might prolong his life and those in which he decides to administer a lethal drug even though with object of relieving the patient from pain and suffering. The latter was held not to be covered under any right flowing from Article 21.

629.4. Thus, the law of the land as existing today is that no one is permitted to cause death of another person including a physician by administering any lethal drug even if the objective is to relieve the patient from pain and suffering.

629.5. An adult human being of conscious mind is fully entitled to refuse medical treatment or to decide not to take medical treatment and may decide to embrace the death in natural way.

629.6. Euthanasia as the meaning of word suggests is an act which leads to a good death. Some positive act is necessary to characterise the action as euthanasia. Euthanasia is also commonly called "assisted suicide" due to the above reasons.

629.7. We are thus of the opinion that the right not to take a life saving treatment by a person, who is competent to take an informed decision is not covered by the concept of euthanasia as it is commonly understood but a decision to withdraw life saving treatment by a patient who is competent to take decision as well as with regard to a patient who is not competent to take decision can be termed as passive euthanasia, which is lawful and legally permissible in this country.

629.8. The right of patient who is incompetent to express his view cannot be outside the fold of Article 21 of the Constitution of India.

629.9. We are also of the opinion that in cases of incompetent patients who are unable to take an informed decision, "the best interests principle" be applied and such decision be taken by specified competent medical experts and be implemented after providing a cooling period to enable aggrieved person to approach the court of law.

629.10. An Advance Medical Directive is an individual's advance exercise of his autonomy on the subject of extent of medical intervention that he wishes to allow upon his own body at a future date, when he may not be in a position to specify his wishes. The purpose and object of Advance Medical Directive is

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to express the choice of a person regarding medical treatment in an event when he loses capacity to take a decision. The right to execute an Advance Medical Directive is nothing but a step towards protection of the aforesaid right by an individual.

629.11. Right of execution of an Advance Medical Directive by an individual does not depend on any recognition or legislation by a State and we are of the considered opinion that such rights can be exercised by an individual in recognition and in affirmation of his right of bodily integrity and self-determination.

630. In view of our conclusions as noted above the writ petition is *allowed* in the following manner:

630.1. The right to die with dignity as fundamental right has already been declared by the Constitution Bench judgment of this Court in *Gian Kaur case*[10] which we reiterate.

630.2. We declare that an adult human being having mental capacity to take an informed decision has right to refuse medical treatment including withdrawal from life saving devices.

630.3. A person of competent mental faculty is entitled to execute an Advance Medical Directive in accordance with safeguards as referred to above.

631. Before we conclude, we acknowledge our indebtedness to all the learned advocates who have rendered valuable assistance with great industry and ability which made it possible for us to resolve issues of seminal public importance. We record our fullest appreciation for the assistance rendered by each and every counsel in this case.

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10 *Gian Kaur* v. *State of Punjab*, (1996) 2 SCC 648 : 1996 SCC (Cri) 374