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Euthanasia: Present Position in India

Despite having a long history in India, the subject of euthanasia has never been legally addressed. However, the Indian Judiciary's effort to bring the euthanasia debate to the limelight has been notable. We have often seen terminally sick patients, patients who are incapacitated owing to severe injuries, and patients who rely entirely on others in our daily lives. Such individuals are not in a dignified situation. A sensible person would believe that choosing death over an agonizing existence would be the best strategy. Physical and psychological deterioration occurs quickly, but relief from such suffering takes a long time. In these circumstances, euthanasia is justifiable. However, it is not an easy process for the administration or legislature. The misuse of euthanasia is the most concerning disadvantage of legalizing it.

There is currently no euthanasia statute in force in India. From the Maruti Shripati Dubal v. State of Maharashtra[281] in 1986 to the Common Cause (A Regd. Society) v. Union of India[282] in 2018, the Supreme Court's numerous judgments have governed how the law of the nation is applied. The discussion about euthanasia in India has risen steadily over the years. Numerous courts in India have also thought about various facets of the right to die. The constitutionality of laws making aiding and abetting suicide illegal was first a problem that the courts had to deal with. In subsequent years, the Apex court of the country addressed euthanasia-related concerns and its enforceability. Most recently, the Supreme Court has addressed the

[281] (1986) 88 BOMLR 589
[282] (2018) 5 SCC 1

idea of "advanced directives"[283] and has established rules for how they should be carried out and upheld.

4.1 Concept of Suicide in The Context of Euthanasia

Even though there are several ways to define suicide, most people agree with Durkheim's concept. According to Durkheim, “Suicide is applied to all cases of death resulting directly or indirectly from a positive or negative act of the victim himself, which he knows will produce this result.”[284] Suicide is an act condemned in the history of most of the countries. Suicide is an impulsive act done under severe emotional stress, whereas euthanasia is the consequence of a well-considered decision taken by an individual in full possession of his or her faculties. Suicide is a negative tendency where the sole purpose of the person is to destroy himself due to depression, failure in the examination, failure in love or any complicated issue. However, euthanasia is administered by a doctor, or by the person with the assistance of a medical personnel, as a last resort when all medical treatments fail to bring the patient back to normal. The opponents of euthanasia who equate suicide and euthanasia are correct in their opinion of opposing suicide, as whatever justification for suicide, it cannot be legalized; taking one’s life voluntarily for whatsoever reason is against human rights. However, in the case of euthanasia, the opponents probably have failed to understand the exceptional reason for taking away life in a terminal illness. In the rarest of rare cases, euthanasia should be allowed.[285]

4.1.1 The Indian Position on Suicide

Comparable to the UK, India's suicide law has seen similar evolution. Both suicide attempts and aiding or abetting another person's suicide were crimes under the Indian Penal Code. A violation of Section 306 of the Indian Penal Code, 1860, is considered an offence and punishable with a maximum of 10 years of imprisonment.[286] Additionally, attempting to commit suicide or doing any action that might lead to the

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[283] (2018) 5 SCC 1

[284] Emile Durkheim, *Suicide: A Study in Sociology*, (Routledge Publication, 2nd edn., 2002).

[285] Sharmila Ghuge, *Legalizing Euthanasia: A Pedagogue's Perspective* 1 (Himalaya Publishing House Pvt. Ltd, 1st edn., 2015).

[286] The Indian Penal Code, 1860 (Act 45 of 1860), s. 306

committing of suicide is a crime punishable by up to a year in imprisonment, according to Section 309 of the Indian Penal Code, 1860.[287]

In India, Sadanand Varde, the president of the Indian Society for the Right to Die with Dignity, introduced a bill (popularly known as the Varde Bill) in the Maharashtra assembly aiming to legalize mercy killing in 1984, but the bill was heavily criticized and was withdrawn, never to become law. The aforementioned Bill included a clause granting legal immunity from civil and criminal liability to all clinicians who remove artificial life-prolonging measures at the request of a terminally ill patient. The Bill was criticized on the grounds that such a law would be abused. Mr B.V. Patil also made an attempt in the Lok Sabha in 1985. Nevertheless, both attempts could not fructify.[288]

Section 309 of the Indian Penal Code, 1860, was criticized by the Delhi High Court in the 1985 case of State v. Sanjay Kumar Bhatia[289], which was the first time the issue of the right to die was brought before an Indian court. The court noted that the continuation of this section is an antiquated idea incompatible with our society. The court further stated that a person driven to such frustration and wanting to commit suicide should be taken to a psychiatric clinic rather than a jail where he would be surrounded by criminals. Euthanasia is a crime in India, according to Indian penal law. Any doctor who attempts to kill a patient will be punished with culpable homicide under Section 300 of the Indian Penal Code. Following this judgement, the Bombay High Court and the Andhra Pradesh High Court issued contradictory decisions in the instances of Maruti Sripati Dubal v. State of Maharashtra[290] and Chenna Jagdishwar v. State of Andhra Pradesh[291], respectively.

The case of Maruti Sripati Dubal v. State of Maharashtra[292] contested the constitutionality of section 309. The fact of the case was that the petitioner was a police constable attached to the Bombay city police force. He had been a constable for 19 years. He was injured in a car accident in 1981, suffering head trauma. Even though he recovered in a few months, he had a mental illness. In 1985, he attempted

[287] *Id.*, s. 309
[288] Bhawana Tiwari, Euthanasia, and Indian Criminal Law by Youth Forum,2014, Varde Bill, available at- https://youthforum.co/euthanasia-and-indian-criminal-law// (last visited on September 17,2022)
[289] (1986) 10 DRJ 31
[290] (1986) 88 BOMLR 589
[291] 1988 CrLJ 549
[292] (1986) 88 BOMLR 589

suicide by attempting self-immolation outside the office of the municipal commissioner. The petitioner was detained for attempting suicide in accordance with section 309 of the IPC. As a violation of Article 21 of the Indian Constitution, Section 309's validity was contested. Fundamental rights were argued to have both positive and negative aspects. For instance, freedom of speech and expression encompasses the right to remain silent[293], and freedom of association encompasses the right to refrain from joining any association[294]. Likewise, freedom of trade and occupation includes freedom not to trade[295]. According to the court, it follows logically that the right to life, as recognized by Article 21, will also encompass the right to die, at least in extenuating circumstances.[296] The court observed that when a person is a victim of unbearable physical ailments, decrepit physical condition disabling the person from taking routine chores, the loss of all senses, or extremely cruel or unbearable condition of life making it painful to live, should have a right to die. In this case, Justice Sawant noted that it is common for people suffering from unbearable agony to wish to pass away and that everyone should have the freedom to do so whenever they choose. The court ultimately determined that section 309 is ultra vires the Constitution and must be repealed since it violates Article 21.[297]

In P. Rathinam Nagabhushan Patnaik v. Union of India and another,[298] the decision in Maruti's case was upheld by the Supreme Court. On the grounds that it breaches Article 21 of the Indian Constitution, Section 309's constitutional validity was contested before the Supreme Court of India in this case. The petitioner had attempted to commit suicide. The issues before the court were whether section 309 was unconstitutional and whether the right to die was included under the right to life. The court ruled that section 309 of the IPC was invalid because it violated Article 21. Suicidal attempts are motivated by suffering, sorrow, and torment. If he succeeds, he dies, but if he fails, he is penalized. Hence it is a cruel and irrational provision to punish a person for his failure to commit suicide. The court also held that the right to life under Article 21 includes the right not to live a forced life or a right to die. The court referred to the decision of the Bombay High Court in Maruti Sripati Dubal v.

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[293] The Constitution of India, art 19(1)(a).
[294] *Id*., art.19(1)(b)
[295] *Id*., art.19(1)(g)
[296] The Constitution of India, art.21
[297] *Ibid.*
[298] (1994) 3 SCC 394

State of Maharashtra[299] that placed reliance on Rustom Cavasjee Cooper v. Union of India[300] , wherein it had been held that what is true of the Fundamental right and on the said premise, the Bombay High Court has opined that it cannot be seriously disputed that Fundamental rights have their positive as well as negative aspects. After citing an example, the court approved the view taken by the Bombay High Court. The court further ruled that no one could be forced to exercise their right to life in a way that would be harmful, disadvantageous, or against their will. Finally, the court found that the right not to live a life that is forced can be considered to follow in the footsteps of the right to life that Article 21 refers to.[301]

However, two years later, a five-judge Constitution Bench of the Supreme Court of India in the case of Gian Kaur v. State of Punjab,[302] disagreed with the decision laid out in the case of P. Rathinam Nagabhushan Patnaik v. Union of India and another[303] and disapproved the basis on which the earlier decisions were passed. Gian Kaur and her husband Harbans Singh were accused of encouraging their daughter-in-law Kulwant Singh to commit suicide in this case. According to section 306 of the IPC, the Trial court found the appellants guilty. The High Court upheld both defendants' convictions in an appeal. A special leave petition was granted by the Supreme Court. The appellants argued that because Section 309 of the IPC is invalid due to Article 21's inclusion of the right to die, anyone who aids another person in committing suicide is only contributing to the enforcement of the Fundamental Right under Article 21. As a result, Article 21 is also violated by Section 306 of the IPC, which criminalizes assisted suicide. The court had to decide if Article 21 of the Constitution's right to life also encompassed the right to die. The Court clarified that the right to life is a natural right for which constitutional protection is granted; however, suicide is the unnatural extinction of life and therefore is in direct contravention with the meaning and understanding of the right of life and, therefore, inconsistent with the Fundamental right to life[304] and hence is incompatible and inconsistent to be robed within the scope of Article 21. According to the court, any facet of life that gives life dignity may be read into Article 21 of the Constitution, but

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[299] (1986) 88 Bom LR 589
[300] 1970 SCR (3) 530
[301] *Rustom Cavasjee Cooper v. Union of India*, (1970) SCR (3) 530
[302] 1996 AIR 946, 1996 SCC (2) 648
[303] *Ibid.*
[304] *Gian Kaur v. State of Punjab*, (1996) 2 SCC 648

not those that terminate life.[305] Therefore the court stated that terminating life through suicide is in contravention of the principles of the sanctity of life and is against the natural right to life granted to all individuals by the Constitution. While the Court has stated that unnatural termination of life through suicide is not constitutionally protected, the Court distinguished between the cases of suicide and the cases of euthanasia. According to the Court, a fundamental component of the right to life protected by Article 21 of the Constitution is respect for an individual's dignity. The right to life includes the right to live with human dignity, and the court made it abundantly plain that this right extends until the end of a person's natural life. The court also examined the situation of a person who is terminally sick or in a chronic vegetative state and is approaching death. In such a situation, the person might be allowed to end his life prematurely under specified conditions. This category of cases may fall within the ambit of the right to die with dignity as a part of the right to live with dignity. In these situations, the natural death process has already started. The Court stated that this right to die with dignity during the natural end of life is not equivalent to the right to die against the course of nature and curtail one's life period by terminating it early. Though the Constitution Bench did not interpret the right to die to be a part of Article 21 of the Constitution of India, it did leave scope for interpreting cases where the process of natural death has already commenced and if the acceleration of such process would lead to a dignified death to be part of Article 21 of the Constitution. However, the court rejected unnatural termination of life and held that Section 309 of IPC was not violative of Article 21 of the Constitution. [306]

4.2 Judicial Approach Regarding the Right to Die in India

4.2.1 Distinction Between The 'Right to Die' And The 'Right to Die with Dignity'

In the case of Gian Kaur v. State of Punjab[307], which dealt with the constitutionality of Section 306 of the Indian Penal Code, which made aiding suicide a crime, the Supreme Court of India determined that these provisions are legally valid. However,

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[305] *Gian Kaur v. State of Punjab*, (1996) 2 SCC 648
[306] *Common Cause (A Registered Society) v. Union of India, (2018)* 5 SCC 1
[307] (1996) 2 SCC 648

while discussing this issue, the Supreme Court made a fine distinction between the 'right to die' and the 'right to die with dignity'.[308]

The Court stated that the term 'right to die' does not find validity under Article 21 of the Indian Constitution, as it would imply that every individual has an intricate right guaranteed by the Constitution to end their life. The Constitution of India, through Article 21, provides for the right to life, which by no stretch of the imagination can be understood as a right to terminate one's life at own will. However, the Constitution provides for a life with dignity, which means that an individual has a right to live the entire life in a dignified manner, including the last moments of life when life is ebbing out. In these moments, a dignified death could be covered under the constitutional scheme of the right to life. According to the Court, a request for a premature death would fall inside the scope of the right to die with dignity in the case of a person who is terminally ill or in a persistent vegetative state because natural death is inevitable and the termination of natural life has already started. Thus, the Court clarified that the right to die with dignity, i.e., a right to accelerate one's death when the natural process of death has already begun, could be within the constitutional provisions; however, the right to die, i.e., unnatural termination of one's life is beyond the ambit of Article 21 and is not guaranteed by the Constitution of India.[309]

The Supreme Court then discussed the views on euthanasia in common law nations and the stance taken by British courts in the historic case of Airedale NHS Trust v. Bland.[310] In this case, the House of Lords allowed passive euthanasia for terminally ill patients and initiated the development of jurisprudence on euthanasia. Though the Constitution Bench of the Supreme Court in Gian Kaur[311] discussed issues of euthanasia in brief, it opined that the desirability for bringing about change in the euthanasia law could be undertaken by the legislature. Hence, despite the Court mentioning the right to death with dignity and touching upon issues surrounding euthanasia, it did not lay down any law on how death with dignity could be achieved or the practice of euthanasia could be developed or regulated in India.

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[308] *Gian Kaur v. State of Punjab* (1996) 2 SCC 648.
[309] *Ibid.*
[310] (1993) 2 WLR 316 (United Kingdom)
[311] *Gian Kaur v. State of Punjab* (1996) 2 SCC 648

The constitutionality of Section 306 of the Indian Penal Code was contested in the case of Naresh Marotrao Sakhre v. Union of India[312]. The petition had no merits; hence it was dismissed. However, in this case, Justice Lodha clarified that suicide and euthanasia are distinct and separate. Regardless of the conditions, euthanasia or mercy killing is still homicide. Any type of unnatural life termination, including suicide attempts, abetment to suicide/assisted suicide, or euthanasia, is criminal, according to the above interpretations. Therefore, mercy killing is not suicide, and an attempt at mercy killing is not covered by Section 309 IPC.[313]

In a few instances, the High Courts have denied euthanasia petitions because there is insufficient legal protection for this contentious practice. The Writ Petition submitted by a citizen asking the government to establish a "Mahaprasthan Kendra" (Voluntary Death Clinic) to facilitate voluntary death, organ donation, and organ transplantation was denied by the Kerala High Court in C.A. Thomas Master v. Union of India[314]. The Gian Kaur case verdict was heavily cited by the High court in dismissing his petition. In 2001, B K Pillai[315] filed an appeal before the Kerala High Court for allowing euthanasia, but unfortunately, it was also rejected. Similarly, in 2005, Mohammad Yunus Ansari from Orissa[316] appealed to the President of India for the mercy death of his four children suffering from an incurable disease. He pleaded to the president that his children were suffering from an incurable disease and that he did not have enough money for their treatment. However, the appeal was rejected.

K. Venkatesh, a 25-year-old terminally ill patient, submitted a plea for euthanasia before the Andhra Pradesh High Court in 2004; however, a two-judge bench of the court dismissed the case.[317] Venkatesh was a 25 years old budding chess

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[312] 1996 (1) BomCR 92, 1995 Cr.LJ 96, 1994 (2) MLJ 1850

[313] 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.

[314] 2000 Cr. LJ 3729.

[315] Editorial, "Legal sanction to end life sought," *The times of India,* Jun 10, 2003, available at- https://timesofindia.indiatimes.com/city/thiruvananthapuram/legal-sanction-to-end-life sought/article show/15937.cms// (last visited September 18, 2022)

[316] Sandeep Mishra, "We want to die, kids write to Prez," May 18, 2005, available at- https://timesofindia.indiatimes.com/india/we-want-to-die-kids-write-to-prez/articleshow/1114689.cms// (last visited on Sep.17,2022)

[317] Editorial, "Venkatesh is gone, but his struggle lives" *The times of India*, Dec 18, 2004, available at https://timesofindia.indiatimes.com/india/venkatesh-is-gone-but-his-struggle-lives/articleshow/963064.cms// (last visited on September 18, 2022)

player. He was attacked by muscular dystrophy at age 10, which led to the slow decay of muscles and was incurable. He was on life support system at a hospital in Hyderabad. He could not speak, but he was conscious and could understand what was being said. His muscles from the neck to the legs had stopped working, and he had developed a serious chest infection. The life support system was assisting his respiration. The doctors had medically pronounced that his days were numbered. He sought the court's permission to end his life peacefully so that his organs could be donated to someone needy before his organs were infected. The Honorable High Court rejected the petition.[318]

The Karnataka High Court denied a retired teacher from Davangere, who was 71 years old, permission to end her life in the case of H.B. Karibasamma v. Union of India.[319] Since 2003, Karibasamma, who claimed to have a slipped disc and have been bedridden for 10 to 11 years, had written to local officials, as well as the President and Prime Minister, requesting authorization for euthanasia. In 2010, Karibasamma said she was only receiving a monthly pension of Rs. 8968, which was insufficient to cover her medical costs. Her suffering was tremendous, and doctors had decided against surgery due to her advanced age. The plea of H.B. Karibasamma was dismissed by Justice Ajith Gunjal based on the findings of neurosurgery and psychiatric specialists from NIMHANS. According to the reports, Karibasamma was free from any pain or serious illness. She could stand up pain-free because her spine was in normal condition. She was also free of any mental illnesses. "Since she is elderly and fears she would become disabled in future due to her multiple ailments and has no family support, she could be provided psychiatric counselling", the report suggested, noting that Karibasamma refused to undergo further investigation and medication.

In Chandrakant Narayanrao Tandale v. the State of Maharashtra (2020)[320], the petitioner was an 81 years old person suffering from degenerative disease of the spine along with prolapsed discs at multiple levels causing unbearable pain. The patient was not fit to undergo surgery and the ongoing treatment was not able to provide adequate relief from pain. The petitioner, therefore, requested active euthanasia by a qualified

[318] Kavita Rai, "Need of law relating to Euthanasia" 1(4), *Bharati Law Review*, 160-161, (2013).
[319] (2012) SCC OnLine Kar 9051

[320] Chandrakant Narayanrao Tandale v. the State of Maharashtra, writ petition no. 5613 of 2020.

medical practitioner so that he could get relief from pain and could donate his body to a medical college. His petition was rejected as active euthanasia has not been legalized in India.

4.2.2 Attempts to bring in legislation on Euthanasia

In 2007, C K Chandrappan,[321] a member of Parliament from Trichur, Kerala, introduced a bill in the Lok Sabha, titled "The Euthanasia (Permission and regulation) Bill", to make provisions for the compassionate, humane, and painless death of those who have become completely and permanently disabled and/or bedridden as a result of an incurable disease or for any other reason, or for matters related thereto. According to the bill, euthanasia is described as causing a gentle, painless, and easy death in cases where an individual has an incurable and painful disease that renders them completely and permanently disabled, bedridden, unable to carry out daily activities without constant and regular assistance, or who has become completely and permanently disabled for any other reason. According to the statement of objects and reasons, euthanasia is required in certain situations because the patient has a right to put an end to his suffering in a way that is respectable and dignified because there is no chance of recovery. Additionally, it states that adequate checks and balances must exist in order to prevent the misuse of euthanasia before it is legalized. The bill was an excellent move in the right direction, but it was rejected. In 2009 also, a draft bill was put forth in the Kerala legislative assembly for the legalization of euthanasia, but all such attempts were unsuccessful.[322]

4.3 Reports by The Law Commission of India

4.3.1 The 42nd Report of the Law Commission

The Fifth Law Commission presided over by Mr. K.V.K. Sundaram, produced the 42nd Law Commission Report in 1971. In its report on the Indian Penal Code of 1860, the Commission discussed Section 306 of the IPC in light of the opinions of Ancient and British legislators on the matter. This was followed by a proposal to repeal Section 309 and replace it with new penal provisions to punish those who incite someone to take the drastic action of ending their life. The panel claimed that Manu's

[321] Kuljeet Kaur, Divya Sharma, "Jurisprudential Aspects of Euthanasia: With Special Reference to India" 1(3), *International journal of law and legal jurisprudence studies*,1-14, (2014).
[322] *Ibid.*

code and several commentaries on it supported the validity of suicide in situations where the person was ill and lived in appalling circumstances. A Brahmin who had his body destroyed was held in high esteem and was thought to have left earthly joys, grief, and pain behind. The report described the view of British writers to decriminalize the act of attempted suicide. The Law Commission, therefore, advocated for the abolition of the severe and unfair provision. It was suggested adding a new clause that would punish people with up to three years in prison and a fine for coercing a family member to commit suicide through repeated acts of cruelty.[323]

4.3.2 The 156th Report of the Law Commission

The Law Commission's 156th report, which was released in 1997, supported the penalty for suicide attempts and advised against decriminalizing suicide attempts. Using the legal reasoning provided by the Hon'ble Supreme Court in the Gian Kaur case, it is claimed that article 21 cannot be read or expanded to include the "right to die." This report stressed the fact that the Supreme Court only upheld this section's constitutional legality after carefully considering all pertinent legal considerations. By mentioning the problems of drug trafficking and terrorism, this paper furthered its point. The commission believed that a terrorist or drug trafficker who failed to kill himself or his intended victims should still be held accountable under section 306 for posing a threat to public safety.[324]

4.3.3 The 196th report of the Law Commission

The Law Commission of India, in March 2006, for the first time, looked into the issue of euthanasia and assisted suicide. The Law Commission of India examined the legal status of euthanasia in India and other nations across the world in its 196th report, Medical Treatment of Terminally Ill Patients (Protection of Patients and Medical Practitioners).[325]The Law Commission advised several reforms to the current legal framework governing euthanasia in India, including the Medical Treatment of Terminally Ill Patients (Protection of Patients and Medical Practitioners) Bill, 2006.[326] The proposed Bill allowed for patients, parents, relatives, next friends or doctors to

[323] Law Commission of India, "42nd Report on Indian Penal Code" (June 1971).
[324] Law Commission of India, "156th Report of the Indian Penal Code" (Aug,1997).
[325] The Law Commission of India, "196th report on Medical Treatment to Terminally Ill Patients (Protection of Patients and Medical Practitioners)" (March, 2006).
[326]*Ibid.*

move a Division Bench of the High Court for withdrawal of life support and allowing euthanasia in cases where the patient had no chance of recovery. The Bill stated that "time is of the essence," and hence, the High Court should provide its decision within 30 days. The proposed Bill also provided that in cases where High Court allows euthanasia, the doctors or family of the patient would not be held liable for suicide or abetment of suicide.[327]However, the Government of India did not accept the proposed Bill, and the Law Commission was asked to relook into the issue.

4.3.4 The 210th Report of the Law Commission

The Law Commission of India examined the clauses of the Penal Code that make attempts at suicide and aiding in suicide illegal in its 210th Report on Humanization and Decriminalization of Attempt to Suicide published in 2008.[328]The Law Commission opined that Government should repeal the archaic law contained in section 309 of the Indian Penal Code and should decriminalize an attempt to suicide. However, these changes were not accepted for a very long time, until the Mental Healthcare Act, 2017[329] was passed that decriminalized attempt to commit suicide.

4.3.5 The 241st Report of the Law Commission

In 2012, the Law Commission was asked to relook into the position of euthanasia and revise its earlier reports. The Law Commission, through its 241st Report on Passive Euthanasia– A Relook, again suggested that passive euthanasia should be allowed after the High Court grants permission for it, and the High Court is bound to take the opinion of medical experts before passing any decision.[330] The Law Commission's view concurs with the Supreme Court of India's ruling in the matter of Aruna Ramchandra Shanbaug v. Union of India.**[331]** The Law Commission's recommendations, meanwhile, were not followed up on. After years of debate and legal battles, a draft bill acts as a light of hope to the proponents of euthanasia and the terminally ill patients

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[327] The Law Commission of India, "196th report on Medical Treatment to Terminally Ill Patients (Protection of Patients and Medical Practitioners)" (March, 2006).
[328] The Law Commission of India, "210th report on Humanization and Decriminalization of Attempt to Suicide" (October, 2008)
[329] The Mental Healthcare Act, 2017 (Act 10 of 2017)
[330] The Law Commission of India, 241st report on Passive Euthanasia – A Relook" (August 2012)
[331] (2011) 4 SCC 454

4.4 The Mental Health Care Act, 2017

Similar to how the UK's Suicide Act decriminalized suicide attempts, India's Mental Health Care Act acknowledged that those who attempt suicide were not criminals but needed assistance from the state and society.[332] Though the efforts to decriminalize suicide have been rampant in India, the law for the same was passed only in the year 2017, almost 57 years after suicide was decriminalized in the United Kingdom, the country from where we initially borrowed these criminal principles. Despite the penal provisions criminalizing attempt to suicide still exist under Section 309 of the Indian Penal Code, Section 115(1) of the Mental Health Care Act, 2017 states that notwithstanding the contents of Section 309, if an individual attempts to commit suicide, it shall be presumed that the individual is undergoing stress unless proved otherwise. The clause further clarifies that such an individual shall not be punished for penal law violations.[333] This provision attempts to provide a progressive view of the law on suicide in India and humanizes it by recognizing that an individual who attempts to commit suicide is not an offender in the eyes of the law but is a victim of some form of stress and pressure. The law ensures that for such individuals, who are victims of stress, the state authorities provide them with the requisite help, not criminal sanctions. The state authorities are required by Section 115(2) of the Mental Health Care Act to give care, treatment, and rehabilitation to anyone who has attempted suicide. The law also casts a duty on the state authorities to reduce recurrences of suicide attempts.[334] Thus, this law ensures that even though the Constitution Bench of the Supreme Court in the case of Gian Kaur[335] had recognized the constitutional validity of the penal provisions criminalizing attempt to commit suicide, the penal provisions do not apply when a person attempts suicide.

4.5 New Perspective in Indian History: Aruna's Case

The Aruna Ramchandra Shanbaug v. Union of India & Ors[336]case is a landmark case where a revolution was brought in the medical world by allowing Passive Euthanasia with some restrictive guidelines. A Division Bench composed of Honorable Justice

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[332] Suresh Bada Math, Vinay Basavaraju, et. al., "Mental Healthcare Act 2017 – Aspiration to Action" 61(10), *Indian Journal of Psychiatry*,660-666, (2019).
[333] The Mental Health Care Act, 2017 (Act 10 of 2017), s. 115(1)
[334] *Id.,* s. 115(2)
[335] *Gian Kaur v State of Punjab* (1996) 2 SCC 648
[336] (2011) 4 SCC 454

Markandey Katju and Honorable Justice Gyan Sudha Misra wrote and delivered this 141-page judgment. Our judicial system has explored the topic of euthanasia in great detail, carefully examining different contentious areas and considering remedies so that no unfair benefit is gained. The Supreme Court has explicitly stated and ordered that passive euthanasia is permitted under the condition that doctors may withdraw life support when doing so is in the patient's best interest if they act in accordance with an expert medical opinion that has been appointed by the Apex Court and on the court's approval. The Parens Patriae principle, which means "parent of the nation" in Latin and refers to a situation in which the Court may step in and act as a guardian, was used to make the decision that the Court would ultimately decide what was in the patient's best interests.[337] According to Article 226 of the Constitution, which gives courts the authority to give directions to anybody, the Apex Court's authority to permit passive euthanasia has been extended to High Courts as well. The case of Aruna Shanbaug may be the most important one in terms of the right to die in India. This case sparked discussions on a range of legal, social, and policy issues, including euthanasia, workplace harassment, and the right to choose one's own end of life. The Indian Supreme Court went into great length into the idea of euthanasia as well as the concepts of patient autonomy and self-determination. Considering that the Supreme Court addressed and clarified several significant ideas, a thorough analysis of this judgement is offered.

Aruna Shanbaug, a nurse working at the King Edward Memorial Hospital, Mumbai, was a victim of sexual assault on the night of 27 November 1973. She was assaulted by one Sohanlal Bhartha Walmiki, a sanitary worker at the same hospital. As a result of the assault, she suffered serious injuries which resulted in brain damage, brain stem contusion injury, cervical cord injury, and cortical blindness. Although her life could be saved, she went into a persistent vegetative state.[338]

4.5.1 The procedure followed by the court

The Supreme Court appointed a medical team on January 24, 2011, to assess Aruna's condition and provide a report. Videographic evidence was also displayed at the Court, showing Aruna’s day-to-day activities. The Court saw the hospital as Aruna's

[337] *Common Cause (A Registered Society) v. Union of India, (2018)* 5 SCC 1
[338] Malavika Karlekar, "Review: Ten Minutes to Hell" *Outlook India* (24 May2015).

next friend[339] because of the loving care the KEM hospital staff provided for Aruna over many years and their bond with Aruna. Aruna's unusual condition and how she has managed to survive for the past 37 years were scrutinized from several angles by the court. According to the court, Aruna had movements and was aware of her surroundings; therefore, it was impossible to say that she was entirely brain-dead. Although she would spend the rest of her life in a persistent vegetative state, and there was little chance that she would escape, the court found that her cortex and brainstem were "clearly alive."[340] The videographic evidence convinced the court that Aruna could not be considered dead since she was making sounds, blinking, eating, and licking food particles with her tongue.[341]

Pinki Virani's plea for Shanbaug's euthanasia was denied by the court, which noted that in this situation, Aruna's "next friend" would be the KEM hospital staff since they were eager to continue caring for her and because they had an emotional bond with her. As Aruna was not brain dead, and the hospital staff who had been caring for her had not voiced any objections, the Court came to the judgement that the request to discontinue feeding Aruna could not be taken into consideration. The hospital would be upset if Aruna were to pass away, the Court further stated.[342]

4.5.2 Analysis of the precedent

The Court then examined how euthanasia laws have evolved worldwide and frequently cited the House of Lords' judgment in the case of Airedale,[343] which was the first instance in English legal history where a patient's life-saving medical procedures could be discontinued and the patient allowed to pass away. In Aruna's case,[344] the Supreme Court noted that following the House of Lords' judgement in the case of Airedale, the law is well-established throughout the United Kingdom that doctors may refuse to perform life-saving procedures on a patient who is terminally ill and unable to give or refuse consent if doing so is in the patient's best interests.[345] The

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[339] Next friend is defined as any person who takes decision on behalf of an incompetent or a minor person, generally, this position is taken up by a family member or a relative, but can be anybody as in the case of Aruna Shanbaug; See also Legal Information Institute, 'Definition – Next Friend', available at-https://www.law.cornell.edu/wex/next_friend (last visited on September 18,2022)
[340] *Aruna Ramachandra Shanbaug v Union of India* (2011) 4 SCC 454.
[341] *Ibid.*
[342] *Ibid.*
[343] *Airedale NHS Trust v. Anthony Bland* [1993] 1 AER 821 (United Kingdom)
[344] *Aruna Ramachandra Shanbaug v. Union of India* (2011) 4 SCC 454
[345] *Ibid.*

Court then emphasized the need for legislation to control this type of activity in India and cited the earlier decision in Gian Kaur,[346] which had referred to the decision in Airedale from the United Kingdom.

4.5.3 The decision by the division bench

On March 7, 2011, the Supreme Court's division bench approved the practice of passive euthanasia in the Aruna case. The Court stated that there is a high risk of the law being abused and that it is possible for uncouth doctors or family members to kill a patient for personal gains even though the patient was not afflicted with a terminal illness and has a good chance of surviving. Active euthanasia, including the use of fatal chemicals, was still viewed as unlawful. As a result, only passive euthanasia was approved, and strict guidelines were established for its implementation Shanbaug was diagnosed with pneumonia a few days before her demise. She was transferred to the clinic's therapeutic emergency unit and given a ventilator. She passed away early on May 18, 2015.[347]

4.5.4 Critical Analysis of The Aruna Shanbaug Decision

The Supreme Court's Division Bench outlined the legislation on passive euthanasia and the procedure to be followed in such circumstances as in the case of Aruna. However, the judgement has been criticized as being based on faulty interpretation of previous judgements and breaching the patient's privacy.

***4.5.4.1 The judgment is based on the wrong premise of Gian Kaur's Case*.** The decision of Lord Goff of Chieveley in the Airedale case,[348] which noted that euthanasia could only be made legal by legislation, was cited by the Constitution Bench in the Gian Kaur case.[349] As a result, in Paragraph 101, the Bench stated that they agreed with the Constitution Bench's conclusion in Gian Kaur, which stated that euthanasia could only be legalized by legislation. Although this Court endorsed the stance held in Airedale, the Bench contradicts itself in Para. 101 by stating in Para. 104 that it has not been made clear who can determine whether life support should be withdrawn in the case of an incompetent patient, such as a patient in a coma or PVS.

[346] *Gian Kaur v. State of Punjab* (1996) 2 SCC 648
[347] *Aruna Ramachandra Shanbaug v. Union of India* (2011) 4 SCC 454
[348] *Airedale NHS Trust v. Anthony Bland* [1993] 1 ALL ER 821 (United Kingdom)
[349]*Ibid.*

The issue of whether life support should be withdrawn in the case of an incompetent individual, such as a person in a coma or PVS, arises when it is initially regarded to hold that euthanasia could only be allowed by legislation.

Secondly, the Supreme Court's Constitution Bench did not decide on the issue of euthanasia in the previous Gian Kaur case; instead, it only made a reference to it. The Division Bench in Aruna correctly understood the previous Gian Kaur decision and noted that it simply made a passing reference to the subject of euthanasia. However, the Division Bench in Aruna erroneously concluded that the Constitution Bench in Gian Kaur had approved the ratio set forth in Airedale when making the critical determination regarding the constitutionality of euthanasia in India. The Constitution Bench in Gian Kaur merely cited a few passages from the House of Lords' decision in Airedale without giving it its approval or disapproval. However, it is inaccurate to claim that the Airedale case's ratio was adopted by the Constitution Bench presided over by Gian Kaur. As a result, the legal basis for the judgement in Aruna's case is incorrect, and it was based on an inaccurate interpretation of an earlier judgement.

4.5.4.2 Jurisdiction and non-formation of a constitutional bench. In this case, a writ petition was filed in accordance with Article 32 of the Indian Constitution. The petition, in this case, did not allege any violation of fundamental rights, and the court correctly stated this right away, saying that "the Court would have immediately dismissed the petition on the ground that there is no violation of fundamental rights, but given the issues involved the Court decided to go deeper into the merits of the case." Here, the Court made it clear that it lacked the authority to take the petition under consideration. However, the Court disregarded the law while making its own decisions. In this judgement, the Court itself noted that the High Court is given broad authority under Article 226 in certain situations but casually disregarded it. Accepting the Bombay High Court's jurisdiction instead would have been appropriate.

4.5.4.3 The procedure was a breach of the right to privacy. In this case, the court appointed a team of doctors to assess Ms Aruna's physical and mental health. The physicians presented a CD containing a video of Aruna's mental and physical condition along with their reports, and the CD was screened in front of the whole courtroom so that everyone in attendance could view Aruna's condition. Although it is

not specified in the petition whether the CD included the entire medical examination, it is presumed that it did not. Nevertheless, the screening of a film describing the physical and mental status of a patient who is in a persistent vegetative state is unquestionably a breach of her basic right to privacy and dignity. In this case, the Court neglected to defend the citizen's right in favour of treating a person as an inanimate object of study during the legal procedure. If this standard is applied in the instances to follow, it will be a flagrant breach of the patient's fundamental rights in light of the fact that this case serves as a turning point in the debate. In addition, the Court relied on the Nuremberg trials' precedent, which allowed for the screening of Nazi atrocities in open court. This analogy of a patient in a PVS condition to the trial of Nazi war criminals was considered by Justice Chandrachud to be extremely frightening and unsettling in the lawsuit that followed. Therefore, the Division Bench decision in the matter of Aruna was tainted by contentious and callous conclusions reached by the Court without carefully considering and comprehending all the relevant nuances and subtleties.

4.5.4.4 The phrase "Living Will & Attorney authorization" is not included in the judgment. The decision makes no recommendations about living wills or attorney authorization, which allow patients to make an informed decision to terminate their lives by expressing their choices in advance through the use of a document termed a "living will" if they experience a condition that makes it impossible for them to communicate their wishes. The essential two of the four pleas in the Common Cause petition, which was filed by the Common Cause organization in 2005, are One of its requests was that Article 21 of the Indian Constitution's provision of the right to live with dignity be expanded to include the "right to die with dignity" as a fundamental right. The other request was for the recognition of living wills and "attorney authorization," but in Aruna's opinion, there is not a single line about them in the Constitution.

4.6 Common Cause Vs Union of India

Common Cause (A Regd. Society) v. Union of India and Ors[350] is another noteworthy judgment. The right to die with dignity was first raised in 2002 by Common Cause, a registered society. In 2005, the Common Cause society petitioned the Supreme Court

[350] (2018) 5 SCC 1

under Article 32, requesting that the right to a dignified death be recognized as a fundamental right under Article 21 and that patients who are terminally ill be allowed to make living wills. The court subsequently formed an expert committee consisting of attorneys, physicians, and scientists to decide on the specifics of living will execution. The case was then referred to a larger panel for resolution on February 25, 2014, by a three-judge Supreme Court panel made up of the then-Chief Justice P. Sathasiavn, Justice Ranjan Gogoi, and Justice Shiva Kirti Singh in light of the court rulings in Aruna Shanbaug v. Union of India (2011) and Gian Kaur v. State of Punjab (1996).[351] In this case, the basis for the argument was Aruna Shanbaug v. Union of India.[352] They argued that if the decision to stop receiving medical treatment can be made by the patient's family members, then why not allow the patient to write down and declare in advance whether he wants to receive or refuse medical treatment in the event that he becomes incapable of doing so in the future. The court, in this case, pointed out the discrepancies in Aruna Shanbaug's decision and declared that relying on it would be risky since it was founded on the incorrect premise. A Constitution Bench has to be constituted to re-examine the situation because of the errors in the Aruna judgement. The Court stated that because there is a significant legal issue at stake in this case, it would be appropriate to form a constitutional bench to make the decision.

Finally, on March 9, 2018, the five-judge Constitution Bench of the Supreme Court of India, which was chaired by Chief Justice of India Dipak Mishra and included Justices A.K. Sikri, A.M. Khanwilkar, D.Y. Chandrachud, and Ashok Bhushan, pronounced its decision.[353] This judgement granted, for the first time in India, legal recognition to “advanced medical directives” or “living wills”, which are decisions made in advance on withholding life-saving treatment under certain conditions, which should be respected by the treating doctors and the hospital. Furthermore, it alludes to Article 21 of the Indian Constitution[354], which defends the right to life, and broadly interprets it to encompass the "right to die with dignity," affirming the legal legitimacy of the "right to passive euthanasia".

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[351] (1996) 2 SCC 648
[352] (2011) 4 SCC 454
[353] Prachi Bhardwaj, “Passive Euthanasia is permissible; Human beings have a fundamental right to die with dignity: Supreme Court” March 9, 2018, available at-
https://www.scconline.com/blog/post/2018/03/09/breaking-passive-euthanasia-permissible-human-beings-fundamental-right-die-dignity-supreme-court// (last visited on September 18,2022)
[354] The Constitution of India, art 21.

According to society, the right to live with dignity and the right to die with dignity go hand in hand. The patient is dragged out of an untreatable state in which he is experiencing excruciating anguish, hence passive euthanasia should be made lawful. There are four prayers in the Common Cause plea: The "right to die with dignity" was advocated for as a subset of the "right to live with dignity" guaranteed by Article 21 of the Indian Constitution, as well as the acceptance of "living wills" and "attorney authorization". The court's decision overturned the Gian Kaur v. State of Punjab precedent and recognized the right to a dignified death as a fundamental right guaranteed by Article 21. Even more, the court provided instructions on how to effectively implement a living will. It is safe to say that the Common Cause judgement has responded favourably to the Common Cause petition and is being praised as a "landmark" judgment. This judgement is undoubtedly quite revolutionary and significant. The Court held that the right to life and liberty guaranteed by Article 21 of the Constitution is futile unless it encompasses individual dignity. The right to live with dignity as a component of the rights to life and liberty has been added to the ambit of Article 21 over time by the Supreme Court.[355]

The court ruled on March 9th, 2018, following a lengthy hearing that, as the prior case of Gian Kaur v. State of Punjab had shown, the right to live with dignity also encompasses the right to die with dignity.[356] When the process of natural death has already begun due to a terminal disease or if a person is in PVS and there is no chance of recovery, it was acknowledged in Gian Kaur that accelerating the process of death in order to shorten the duration of suffering would constitute the right to die with dignity.[357] The Constitution Bench, relying on the earlier judgement, concluded that there is no reason for contention in holding that the fundamental right to life includes within it the right to smoothen the process of death in cases of people who are suffered from a terminal illness or in a state of PVS with no chance of recovery.[358] Advance medical directives must be legally recognized to ensure a painless death. The Court ruled that the right to a dignified death for a patient in a PVS or who is terminally ill and has no chance of recovery is likewise a part of the right to a

[355] *Common Cause (A Registered Society) v. Union of India,* (2018) 5 SCC 1
[356] (1996) 2 SCC 648
[357] *Ibid.*
[358] *Common Cause (A Registered Society) v. Union of India,* (2018) 5 SCC 1

dignified life. Failure to legally recognize advance medical directives may tantamount to a denial of the right to a dignified death and the right to a peaceful death.[359]

The Court acknowledged that although doctors are responsible for preserving patients and administering all necessary treatment, patients' autonomy must take priority. In situations where patients have stated a desire not to receive any treatment, this request should be honoured.[360] The Court also highlighted that passive euthanasia, which involves withdrawing treatments that would artificially prolong life or life support measures, has been recognized legally in many countries worldwide via legislation or judicial decisions. The Law Commission of India acknowledged the necessity for a law legalizing passive euthanasia following the Supreme Court's decision in the case of Aruna, but the legislature has not yet passed any such legislation.[361] The Court also ruled that while it is crucial to place the values of the sanctity of life on a higher pedestal, in cases of terminally ill patients or patients in PVS where there is little possibility of recovery, the patient's advance directives and the right to self-determination will be given priority.[362]

The patient should be permitted to exercise bodily autonomy over their body and make choices that save them from the unbearable suffering and anguish brought on by a terminal illness. Consequently, the Court established certain guidelines that must be observed while acknowledging the necessity to prioritize patients' rights to select the type of treatment they wish to receive (or decline).

4.6.1 Guidelines for the Implementation of Advance Directives/Passive euthanasia

The Court, in the exercise of powers granted under Article 142 of the Constitution[363] and as per the law settled in the case of Vishaka v. State of Rajasthan,[364] laid down

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[359] *Common Cause (A Registered Society) v. Union of India,* (2018) 5 SCC 1
[360] *Ibid.*
[361] *Aruna Ramachandra Shanbaug v. Union of India* (2011) 4 SCC 454
[362] *Common Cause (A Registered Society) v. Union of India,* (2018) 5 SCC 1
[363] The Constitution of India, 1950, Art. 142, states:
1. The Supreme Court in the exercise of its jurisdiction may pass such decree or make such order as is necessary for doing complete justice in any cause or matter pending before it, and any decree so passed or orders so made shall be enforceable throughout the territory of India in such manner as may be prescribed by or under any law made by Parliament and, until provision in that behalf is so made, in such manner as the President may by order prescribe;
2. Subject to the provisions of any law made in this behalf by Parliament, the Supreme Court shall, as respects the whole of the territory of India, have all and every power to make any order for the purpose

guidelines that have to be followed in cases where an advance directive given by the patient is to be implemented. The Court also laid down certain guidelines to be followed in cases where an advance directive is not provided. These guidelines remain in force until the time law on this subject is framed by the legislature. A summary of the guidelines that the Court has laid down is as under:

a. An adult of sound mind, without any influence or coercion, who is able to understand the consequences of his / her decision and has complete information about the decision can execute an advance directive.

b. The advance directive should expressly say when medical treatment may be discontinued or that medical treatment shall not be prolonged to indefinitely extend life artificially, causing pain, suffering, and further indignity.

c. If the executor of the advance directive becomes incapacitated, the advance directive should state the name of a guardian or a close family who would be in charge of granting or refusing consent.

d. The advance directive must be signed by two witnesses and countersigned by the jurisdictional Judicial Magistrate First Class, who will then keep a copy and send a copy to the District Court Registry, the local government, or municipal authorities, and, if applicable, the family physician.

e. In the case where a patient is undergoing treatment for a terminal disease, the patient or the relative of the patient shall inform the treating physician of the advance directive. The physician shall verify the authenticity of this document from the JMFC.

f. The treating physician shall form an independent opinion on implementing the directions mentioned in the advance directive and shall determine if the patient's condition is terminal with no hope of recovery.

g. If the treating physician is satisfied that the condition is such that advance directives can be implemented, then a Medical Board of doctors shall be formed,

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of securing the attendance of any person, the discovery or production of any documents, or the investigation or punishment of any contempt of itself.

[364] *Vishaka & Ors v. State of Rajasthan and Ors,* AIR 1997 SC 3011

which shall form a preliminary opinion if the instructions of withdrawal of treatment or withholding of medical procedure shall be implemented.

h. If the Hospital Medical Board is in favour of implementing the advance directive, then they should inform the Collector about this, and the Collector shall then constitute a District Medical Board, which shall again examine the patient and determine if the condition of the patient is such that, the life-supporting medical procedures can be withheld and advance directives can be implemented.

i. The JMFC will be informed of the Medical Board's decision and will visit the patient before deciding whether to approve or disapprove its implementation.

j. When a treating physician believes that a patient has a fatal illness with no chance of recovery and no advance directive has been executed, they may notify the hospital, which will then set up a medical board as previously mentioned. If the hospital medical board certifies withdrawal of treatment, then the district medical board shall be constituted. If the district medical board certifies withdrawal of treatment, then JMFC shall be informed.

k. The JMFC shall then visit the patient, verify all the documents, discuss the decision with the family members, and, if satisfied, endorse the decision made by the medical board.

l. It is possible for the executor of the advance directive, his family, the treating physician, or the hospital staff to approach the High Court via a writ petition under Article 226 of the Constitution in cases where the permission to implement the advance directive has been denied and the Medical Board has not granted permission to withdraw medical treatment. The Division Bench of the High Court will then review all the evidence and make a decision.[365]

4.6.2 Critical Analysis of Common Cause Judgment

The notion of a dynamic and living constitution, wherein the articles of the Constitution are interpreted and reinterpreted in accordance with the changing times and changes in society, is reinstated by the Constitution Bench's decision in the Common Cause case. The Court makes it clear that the interpretation of the

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[365] *Common Cause (A Registered Society) v. Union of India,* (2018) 5 SCC 1

Constitution, particularly regarding fundamental rights, must be dynamic in character. Only via a non-static interpretation will the Constitution's provisions be able to accomplish their genuine and authentic purposes. When the Supreme Court gave an expansive interpretation of Article 21 of the Indian Constitution, it also explicitly acknowledged the patient's right to facilitate their own death when there is no possibility of recovery. In this situation, for the first time, the Supreme Court gave advance medical directives legal acceptance and permitted their implementation. The Court also stressed the need for amendments to the existing draft law that did not recognize advance medical directives, the legality of passive euthanasia, and the necessity to include a fair, just, and reasonable approach to facilitate end-of-life decisions.

4.6.2.1 The Active and Passive Euthanasia Definition Crisis. The CC judgement differentiated between active and passive euthanasia from the point of view of the jurisdiction of the Supreme Court of India to legislate from the bench. The constitutional bench left the idea of active euthanasia to be considered by the Parliament and only commented upon the legal validity of passive euthanasia. However, this distinction defeated the purpose of providing a dignified death to a person. The idea of dying with dignity in particular circumstances has to be based on reducing human suffering and maximizing individual autonomy. The moral necessity of euthanasia is based on these two ideas. The CC judgement is criticized for differentiating active and passive euthanasia for two reasons: One, passive euthanasia does not always result in a painless death without suffering. In many instances, patients who had their ventilators turned off and their life-supporting medications withdrawn would choke to death, wait until their bodies decomposed, or starve to death, resulting in a painful death and negating the very point of dying with dignity. Therefore, passive euthanasia might result in instances when death does not happen in a compassionate manner and instead enhances the patient's suffering and misery during their final moments. Two, the Supreme Court has not even thought about the possibility that an active euthanasia procedure may genuinely result in a painless and dignified death. If medical professionals could actively intervene to speed death in circumstances where a patient is in agony and has little chance of recovery, rather than letting nature take its course and waiting for death to happen, the wait time and, subsequently, the length of suffering and pain may be decreased. This might be done

through a regulated system that would ensure the use of such a procedure is kept to a minimum and restricted to situations when passive euthanasia would result in more misery and anguish.[366]

4.6.2.2 The Complexity of the Procedure. The lengthy and complicated procedures outlined for implementing an advance directive and even the complicated process of executing passive euthanasia provide another difficult feature of the Constitution Bench decision. Prolonging the issue by involving JMFC in preservation and execution seems unnecessary. The issue will only be prolonged by the medical board's and committee's case-by-case procedures. There is a need for a permanent body that handles this subject entirely and precisely. According to the guidelines made by the Constitution Bench, up to 7-8 members the patient's family, the treating physician, the hospital board, the medical board, the JMFC, and the High Court—are involved in the decision-making process. This might undoubtedly lead to the complete failure of the goal of making time-effective judgments to lessen pain and suffering since the time required at any level of the process could cause it to freeze and render the entire procedure useless.[367] The purpose of the entire decision is also undermined since the high number of participants compromises the patient's autonomy and privacy as well as the privacy of their family members and doctor. More participants would mean more viewpoints and personal biases, making it less likely that the patient's true wishes would be understood.[368] With so many people engaged in the decision-making process, there is concern that personal views influenced by religion, faith, culture, etc., may play a role in deciding whether the patient should be allowed to live or not. For instance, if one of the people involved in the decision-making states that a member of the hospital board is from a conservative religious family that only accepts natural death as a final outcome, this person's judgement is likely to be affected by family beliefs rather than the patient's actual condition. Individual biases are prevalent in every human decision-making process, but the Supreme Court's procedure involves

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[366] Sunita Vs Bandewar, Leni Chaudhuri et. al., "The Supreme Court of India on Euthanasia: Too Little, Too Late" 3(2), *Indian Journal of Medical Ethics*,91-94, (2018).
[367] Nivedita Saksena,. Living wills are now Legally binding but might be still hard to Implement', (13 March 2018),available at- https://scroll.in/pulse/871790/living-wills-are-now-legally-binding-but-might-be-still-hard-to-implement// (last visited on July 28 ,2022)
[368] Sunita Vs Bandewar, Leni Chaudhuri et. al., "The Supreme Court of India on Euthanasia: Too Little, Too Late" 3(2), *Indian Journal of Medical Ethics*,91-94, (2018).

a large number of participants, increasing the likelihood that one person's biases may determine whether the patient lives or dies.

4.6.2.3 Beyond the reach of the Common people. The Supreme Court seems to have not considered the fact that the vast majority of Indians lack access to even the most basic medical treatment. A substantial number of individuals in India are obliged to accept an undignified death because they lack the resources to receive essential medical care. These people cannot access healthcare for various reasons, including societal pressure, immobility, a lack of economic resources, a lack of infrastructural facilities, etc. Due to the lack of access to medical facilities, many euthanasia situations go unsupervised without medical guidance.[369] The Constitution Bench has failed to understand that many individuals would not be able to follow the lengthy procedure set forth by the Court because they would not be able to access hospitals or other medical care facilities due to a lack of access to healthcare. Only a few people who may be able to get care in such circumstances when a patient is in a persistent vegetative state or the last stage of an incurable illness would thus effectively be able to access the Constitution Bench's decision.[370]

It is also important to note that Justice Sikri writes in a separate judgement that there is an economic justification for euthanasia because the poor cannot afford medical care, there are few medical care facilities, and there are many patients, rather than highlighting the responsibility of the state to ensure that all people have access to healthcare. This is because the poor cannot afford medical care; there are few medical care facilities and many patients. In other words, euthanasia, or letting the patients die, is acceptable since there are many patients and few hospitals and physicians, so if some patients pass away, it will free up the medical professionals to treat the remaining patients. If euthanasia is regarded or addressed from the perspective of economic principles, he contends, it may also be justifiable. He brings up two inquiries: First, due to widespread poverty, when the majority of people cannot afford health care, should they be compelled to spend more than they can afford on medical care, forcing them to sell their homes, belongings, and other assets that could be a source of income? Second, should patients who have no prospect of recovery receive

[369] Sunita Vs Bandewar, Leni Chaudhuri et. al., “The Supreme Court of India on Euthanasia: Too Little, Too Late” 3(2), *Indian Journal of Medical Ethics*,91-94, (2018).
[370]*Ibid.*

the majority of the attention from the few accessible medical facilities when there are few medical facilities available?[371] So, in Justice Sikri's opinion, considering the economic implications of euthanasia would increase society's overall gain. This decision has drawn criticism for appearing to be unaware of the state's obligation to provide health care for all of its citizens and for appearing to be predicated on the idea that individuals who cannot afford treatment must suffer their misery and should be allowed to pass away.[372] Last but not least, the verdict failed to contextualize the "right to die" discussion by considering the existing disparities in access to healthcare and the overall structure of the Indian healthcare system. Except for the government's most recent announcement of the Ayushman Bharat- Pradhan Mantri Jan Arogya Yojna (AB-PMJAY) plan, Indian residents do not currently have access to universal health care.[373] What is extremely concerning about Justice Sikri's opinion is that neither he nor any other judge from the CC even mentions the state's moral duty to respect citizens' rights to healthcare by implementing strong regulations like universal health coverage. Without this, using economic arguments to support euthanasia implies that those who cannot afford the requisite comprehensive treatment are fewer human beings and must endure agony and painful death. This stance effectively frees the state from all of its general responsibilities to its citizens, which is a risky course for our country to take. It undermines the fundamental principles underlying the Constitution.[374]

In India, the legal status of the right to die has changed over time. The Law Commission of India has occasionally emphasized the necessity for the government to draught legislation governing how a person may end his life. In its report from 2012, the Law Commission expressed the opinion that passive euthanasia should be permitted after being approved by the High Court and a group of medical professionals.[375] However, the Law Commission's suggestions were not included in the statutes, and the parliament left it up to the courts to make the final decision.

[371] *Common Cause (A Registered Society) v. Union of India,* (2018) 5 SCC 1
[372] *Ibid.*
[373] *Ibid.*
[374] *Ibid.*
[375] The Law Commission of India, "196th report, on Medical Treatment to Terminally Ill Patients (Protection of Patients and Medical Practitioners)" (March, 2006)

The Supreme Court first stated in the Gian Kaur case[376] that although the right to die does not have any mention in the Indian Constitution, the right to die with dignity in situations where death is impending is a fundamental right and would be guaranteed by the right to life. The Court, however, did not establish any legislation or guidelines to carry out this right, leaving it to the legislature to draught the proper legislation and guidelines to control the right to die.

In the case of Aruna,[377] the Supreme Court had the opportunity to address the concerns of the right to die once again. The Supreme Court revisited the question in this case but only legalized passive euthanasia; the idea of living wills or advance directives was not recognized. However, the Court's approval of passive euthanasia in the Aruna case was based on an incorrect interpretation of Gian Kaur's decision.

In the Common Cause case, the five-judge Supreme Court Constitution Bench had the chance to address the topic of the right to die once more.[378] The Supreme Court ruled that dying with dignity is a part of the fundamental right to live in dignity. The court further held that while it is vital to uphold the idea that life is sacred, it is also possible to take steps to ensure that someone dies with dignity when they have a terminal illness and no chance of recovery. The right to self-determination and advance directives must be honoured in such circumstances.[379] The Supreme Court reversed its previous stance and now permits both the idea of advanced directives and their implementation, in addition to legalizing passive euthanasia. The court has devised a process to be followed in cases where there are no prior directives if the medical professional treating the patient thinks the patient has a slim prospect of recovering.

While this decision by the Supreme Court's Constitutional Bench did clarify some of the earlier-declared ambiguous concepts, it failed to address the many complex issues pertaining to the right to die. The Court seems to have accepted the validity of advance directives and did not consider the fact that they are subject to error due to changing circumstances and medical developments between the time of execution and the time of implementation, which might render the entire idea of

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[376] *Gian Kaur v. State of Punjab* (1996) 2 SCC 648
[377] *Aruna Ramachandra Shanbaug v. Union of India* (2011) 4 SCC 454
[378] *Ibid.*
[379] *Ibid.*

advance directives meaningless. Furthermore, when establishing the guidelines for executing advance directives, the Court did not take into account how difficult it would be for a layperson to follow the procedure and how long it would take to approach the executive and judicial authorities. Additionally, even while the Supreme Court's present stance permits passive euthanasia and advance directives, it does not justify why active euthanasia might not be utilized to terminate the lives of individuals suffering from a terminal illness.[380]

4.6.3 Modifications of the Common Cause Judgement

The Indian Society of Critical Care Medicine (ISCCM) filed an application seeking clarification of the Common Cause judgement.[381] The application raised the issue of operational difficulties faced by the common citizens in making advanced directives like getting it countersigned by a JMFC. The court passed an order modifying paragraphs 198 to 199 of the earlier judgement. These modifications are summarized as under.

a) Names of multiple guardians or close relatives can be specified instead of a single guardian or relative for taking decisions when the executor is no longer capable of taking decisions. (Para 198.2.5)
b) The document should be attested before a notary or gazette officer instead of being countersigned by a JMFC. (Para 198.3.1)
c) As the JMFC is no longer involved in the process of making the advance directive, there is no need for him/her to preserve one copy and forward one copy to the registry of the jurisdictional District Court. These provisions are therefore deleted. (Paras 198.3.3 and 198.3.4)
d) The executor has to inform and deliver a copy of the document to the persons specified in the document. Earlier the JMFC was tasked with informing the family members. The executor has to submit a copy of the document to the local government or municipal corporation or municipality or panchayat, and these authorities shall then nominate an official to act as a custodian of the document. The executor can incorporate the document in their digital health records. (Para 198.3.5 and 198.3.6)

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[380] Sunita Vs Bandewar, Leni Chaudhuri et. al., "The Supreme Court of India on Euthanasia: Too Little, Too Late" 3(2), *Indian Journal of Medical Ethics*,91-94, (2018).
[381] (2011) 4 SCC 454

e) If the executor develops an incurable illness and loses the decision-making ability, and the treating physician is made aware of the advance directive, he should verify the authenticity of such directives from the digital health records or the custodian of the document (as mentioned in para 198.3.6). (Para 198.4.1)
f) If the treating physician has to inform the persons mentioned in the document regarding the nature of the illness, available treatment options and the consequences of not getting treated. (198.4.3)
g) The hospital, where the executor is admitted, has to constitute a "primary medical board". The earlier judgement had specified the fields of medicine from which the members of the medical board were to be chosen. There was also a requirement for the members to have at least 20 years of experience in their respective fields. Now it has been modified to constitute the board with the treating physician with at least two other subject experts of the concerned speciality with at least five years of experience. The primary medical board has to then visit the patient in the presence of his guardian or close relative and give their opinion preferably within 48 hours of the case being referred to the board. The board has to opine whether to certify or not to certify the instructions provided in the advance directive to withhold or withdraw treatment. (Para 198.4.4)
h) If the Primary Medical Board certifies to carry out the instructions given in the advance directive, the hospital shall constitute a Secondary Medical board immediately. This secondary board should consist of one registered medical practitioner nominated by the Chief Medical Officer of the district and at least two subject experts with at least 5 years of experience in the concerned specialty, who were not part of the primary medical board. According to the earlier judgement, the hospital had to inform the decision of the medical board of the hospital to the jurisdictional collector. The Collector had to constitute a medical board which had to have members from specified specialities with at least 20 years of experience. The secondary board shall then visit the patient and certify whether they concur with the opinion of the primary medical board, preferably within 48 hours of the case being referred to it. (Para 18.4.5)
i) If the executor is in a position to communicate his or her decisions, the secondary board must ascertain his wishes to withhold or withdraw treatment,

before coming to a conclusion. If the executor is not capable of taking decisions or communicating his or her decisions, the secondary board has to obtain the consent of the person of persons nominated by the executor in the advance directive. (Para 198.4.6)

j) The treating hospital has to communicate the decisions of the primary and secondary medical boards as well as the consent of the persons named in the advance directive to the jurisdictional JMFC, before giving withdrawing treatment. Previously, this task was entrusted to the Chief Medical Officer of the District. (Para 198.4.7)

k) If the secondary medical board refuses the permission to withdraw treatment, the persons named in the advance directive or the treating doctor or the hospital staff can file a writ petition under article 226 of the Constitution in the jurisdictional High Court. The Chief Justice of the High Court shall then constitute a division bench to hear the matter and is also free to constitute a committee of doctors to assist in the matter, consisting of three doctors with at least 20 years of experience from the fields of general medicine, cardiology, neurology, nephrology, psychiatry, or oncology. (Para 198.5.1)

l) If the primary medical board decides not to follow the advance directive, the persons named in the directive can apply to the hospital to refer the case to the secondary board. (Para 198.6.4)

m) In cases where there are no advance directives, and the patient is suffering from an incurable terminal illness, the treating doctor may inform the hospital to constitute a primary medical board. The primary board has to discuss the patient's condition and the pros and cons of withdrawing or withholding further treatment with the family physician, if any, and the patient's next of kin/next friend/guardian. The minutes of the discussion have to be recorded in writing and the consent of the next of kin/ next friend/ guardian has to be taken in writing. The preliminary opinion of the primary medical board on the further course of action has to be given preferably within 48 hours of the case being referred to it. (Para 199.1)

If the Primary Medical Board certifies the option of withdrawing or withholding further treatment, the hospital shall then constitute a Secondary Medical Board. If the secondary board, after examining the patient physically

and studying the medical papers concurs with the recommendation of the primary board, intimation shall be given by the hospital to the Jurisdictional JMFC and the next of kin/ next friend/ guardian of the patient, preferably within 48 hours of the case being referred to it. (Para 199.2)

If the primary board decides not to withdraw or withhold treatment, or if the secondary board does not concur with the primary board's recommendation of withdrawing or withholding treatment, the nominee of the patient or the family member or the treating doctor or the hospital staff can file a writ petition under Article 226 of the Constitution in the jurisdictional High Court to seek permission to withdraw or withhold treatment. The Chief Justice of the High Court shall then constitute a division bench to hear the matter and may constitute a committee of doctors as mentioned in Para 198.5.1. The Court shall also afford an opportunity to the State Counsel and shall render its decision at the earliest. (Para 199.4) Para 199.3, which required the JMFC to visit the patient to verify the medical reports, examine the condition of the patient and hold discussions with the family members of the patient, has been deleted.

These modified provisions of this judgement are definite improvements compared to the original provisions. Yet, a few lacunae remain in the provisions.

a) A time limit of 48 hours has been set for the medical boards to give their recommendations. However, the judgment uses the phrase '*preferably* within 48 hours' which leaves room for delay. Instead, the judgement should have mentioned that the board '*must* form an opinion within 48 hours of the case being referred to it'.
b) The provision to inform the decision of withdrawing or withholding treatment to the JMFC even in cases where there is concurrence of opinion between the primary and secondary boards and the persons nominated by the patient have given their consent seems unnecessary. This is only going to introduce one more procedural step and delay in executing the decision. The judiciary should be involved when there are conflicted opinions.
c) The provision of 'hospital staff' being allowed to approach the high court seems inappropriate. The decision to withdraw treatment may seem

> incompatible with someone's moral, ethical, or religious beliefs. But that should not take precedence over the patient's wish to refuse futile treatment, especially when such wishes have been specifically documented in an advance directive. The more the number of people allowed to take decisions on the patient's behalf, the more the likelihood of their own values and beliefs taking precedence over those of the patient.

It is sincerely proposed that there is an urgent need for legislation regulating every element of the right to die with dignity. The CC judgement is a comprehensive text that supports its different points of contention with references to various recent and up-to-date multidisciplinary scholarly literature from the fields of law, philosophy, and ethics. The idea of dignity, which is, strangely, at the heart of the arguments for and against the right to die, is one of the judgment's most prominent and recurrent topics. It is remarkable that the judgment also discusses the compassionate and humanitarian attitude. Nonetheless, the procedure laid out in the judgement for implementing advanced directives is too lengthy and nebulous for an ordinary citizen to navigate through. Moreover, the purpose of upholding the right to a dignified death cannot be achieved in its entirety unless both active and passive euthanasia is legalized, albeit with adequate safeguards.