COMMON CAUSE V. UNION OF INDIA

[Writ Petition (Civil) No.13 of 2003]

FACTS

While proponents of euthanasia cite the right to self-determination and the futility of extending a life without meaning and dignity, opponents argue that palliative care should take first and that legalizing euthanasia would be a violation of the concept of life sanctity. As a result, most governments have sought to strike a balance between these perspectives by allowing only passive euthanasia, or the removal of life-sustaining measures, with appropriate protections for terminally sick or permanently vegetative individuals. Many nations, including the United Kingdom, Canada, the Netherlands, and others, allow passive euthanasia. In the case of Aruna Ramchandra Shanbaug v. Union of India, the Supreme Court of India supported the right to die with dignity and authorized passive euthanasia for those who are terminally ill or in a persistent vegetative condition, based on international precedent. However, the judgement remained unclear on how a person might exercise his or her right to bodily autonomy and communicate his or her desires about treatment withdrawal. The Supreme Court was given another chance to rule on the issue when the NGO ‘Common Cause' filed a writ case seeking rules for the execution and implementation of advance directives and attorney authorizations.

In the case of Justice K.S. Puttaswamy v. Union of India, the Supreme Court affirmed the right, citing its decision in which it examined the link between privacy, dignity, and autonomy, and based it on Article 21. Furthermore, in order to prevent family members or physicians from abusing these directions and authorizations, the Court has established specific instructions for their implementation and execution. This article examines the subject of euthanasia in light of the Supreme Court's decision and analyses the recommendations provided in the same.

ISSUES

The question of whether the right to die is part of the Article 21 guarantee was first addressed in P. Rathinam v. Union of India, a constitutional challenge against Section 309 of the Indian Penal Code, 1860 [“IPC”), which prohibits attempting to commit suicide. The Court concluded that because basic rights have both positive and negative meaning, the right to life would include the right to die, and so Section 309 of the IPC was unconstitutional, citing the case of Maruti Shripati Dubal v. State of Maharashtra. Following that, in Gian Kaur v. State of Punjab, a challenge to the legality of Section 306 of the IPC, i.e. aiding and abetting suicide, was filed. It was claimed here, based on P. Rathinam, that abetment to suicide could not be punished because the abettor was just aiding in the enforcement of a basic right. The Court overturned its decision in P. Rathinam, stating that all basic rights are not created equal, and hence the same test should not be applied to all of them. As a result, whereas Article 19 assurances contain a negative component, Article 21 cannot be construed in the same way.

Furthermore, even if Article 21 is construed in this way, suicide cannot be included since it always includes an overt act on the side of the individual committing suicide. As a result, an unnatural death could not be considered part of the right to life. The Court, however, used the House of Lords' decision in Airedale N.H.S. v. Anthony Bland to distinguish between the "right to die" and the "right to die with dignity." When a person is in a persistent vegetative state or is terminally sick, the natural process of dying has already begun, and death is unavoidable without the use of life support equipment.

RULE

Following that, in Shanbaug, the Court addressed the question of euthanasia for the first time. Aruna Shanbaug was working as a nurse at KEM Hospital in Mumbai when she was viciously raped and suffered injuries that left her in a vegetative condition. Despite the fact that she was cared for by hospital workers and nurses for an extended length of time, her health did not improve. Pinki Virani, a social activist, filed a writ petition on her behalf requesting authorization for Aruna Shanbaug's euthanasia, but it was determined that she lacked jurisdiction to do so since she could not be accorded the status of a close friend. However, the two-judge bench went on to decide on the matter, using Airedale 15 and other international precedent to hold that passive euthanasia for terminally ill patients or those in a persistent vegetative state is permissible if certain precautions are followed. Recognizing the patient's autonomy, the Court decided that if the patient is aware and capable of providing permission, his or her view must be sought; otherwise, the opinion of a close friend must be sought, who should make the same decision as the patient. The case would then be taken to the High Court, where a division bench would be needed to appoint three qualified doctors to examine the patient. It went on to say that these principles should be followed until Parliament passes legislation on the subject.

ANALYSIS

The Bench examines the idea of euthanasia.

An NGO, Common Cause, brought the issue of the right to die with dignity before the Supreme Court in a writ petition, asking for the legalization of "advance directives and attorney authorizations" to allow people who are terminally ill and/or in a permanent vegetative state to exercise their right to die with dignity. Dipak Misra C.J., A.M. Khanwilkar, D.Y. Chandrachud, A.K. Sikri, and Ashok Bhushan J.J. were referred the case from a three-judge bench to a five-judge panel. The right to die with dignity was derived by the bench from the privacy-autonomy-dignity matrix inside the Article 21 guarantee as elucidated by the nine-judge bench of the Apex Court in Puttaswamy. It maintained an individual's ability to provide "advance directives and attorney authorizations" if the patient is terminally ill or in a persistent vegetative state, allowing for the withdrawal of fruitless treatment or life support systems. In order to establish a balance between law and bioethics, the bench has also set rules to prevent any potential misuse of such directives, as well as the way in which such directives may be carried out.

All of the judges have thoroughly examined the moral, ethical, and jurisprudential concerns surrounding euthanasia and advance directives in order to provide a foundation for the right to carry out such directives and attorney authorizations. For example, Dipak Misra C.J.'s opinion for

himself and Khanwilkar J. begins with a philosophical discussion on the worth of life and the futility of a life devoid of significance and dignity. He has quoted a number of authors, poets, and philosophers, including Epicurus, Hemingway, and Tennyson, who have argued that death is not an adversary, and that a dignified death, rather than an undignified extension of life, is a reason for celebration. He has also considered the cultural implications of this problem, such as the shame that may be attached to doctors who withdraw life support and the potential for exploitation of such a provision by unscrupulous relatives, emphasizing the necessity of careful design of an advance directive's statute. Similarly, Sikri J. derived the right to die with dignity from Article 21 using Gandhian ideals, religious precepts on human dignity, international mechanisms, and Mill's concept of individual autonomy.

The subject of euthanasia has been explored by Chandrachud J. in the context of the interplay between science, medicine, ethics, and the constitutional values of individual dignity and autonomy. He has emphasized the need of evaluating this right not just from an individual standpoint, but also from institutional, governmental, and social viewpoints, all with a forward-looking orientation. Bhushan J. has taken a similar approach, tracing the origins of the best interest standard, which is used by medical practitioners, back to the Hippocratic Oath and Plato's works, as well as discussing diverse religion beliefs on life and death. In addition, all members of the bench have reviewed the Apex Court's precedents from P.Rathinam to Shanbaug in order to defend the right to die with dignity. To give an example, Misra C.J. has stated that the Supreme Court has distinguished between the "right to die" and "the right to die with dignity" in prior decisions. While the former could not be regarded a component of Article 21's protection of life and personal liberty, the latter may be drawn from it in a restricted way, namely as passive euthanasia for terminally sick and/or people in a persistent vegetative condition. The justices have relied on the Puttaswamy decision, which laid the groundwork for this right by articulating the connection between the principles of dignity, privacy, and human autonomy. They have emphasised on the ideas of worth and quality of life, which have been established in our jurisprudence via numerous Apex Court rulings ranging from Maneka to Puttaswamy.

In the case of Justice K.S. Puttaswamy v. Union of India, the Supreme Court affirmed the right, citing its decision in which it examined the link between privacy, dignity, and autonomy, and based it on Article 21. Furthermore, in order to prevent family members or physicians from abusing these directions and authorizations, the Court has established specific instructions for their implementation and execution. This article examines the subject of euthanasia in light of the Supreme Court's decision and analyses the recommendations provided in the same. The right to die with dignity, as stated in Article 21, has been anchored by Misra C.J. He has put out specific processes and precautions with respect to advance directives and attorney authorisations, which have been agreed upon and supplemented by other justices on the bench, considering it a matter of constitutional interpretation and therefore a responsibility of the Court. Only an adult of sound mind, capable of communicating, relating, and comprehending the implications of executing the document may freely execute such a document after having full knowledge and information, according to the rules. The statement must clearly represent informed consent and plainly state when medical treatment may be stopped or no more treatment offered for the purpose of extending life. It should also include a provision allowing the executor to revoke the advance directive, as

well as the name of a guardian who will consent to deny or withdraw treatment in line with the advance directive. When there are several advance directives, the most recent one will take effect; however, the rules do not address instances when the directive is unclear.

Two attesting witnesses, preferably independent, are necessary, and the document must be countersigned by a Judicial Magistrate of First Class (hence, JMFC), who is intended to record satisfaction as to the executor's voluntariness and informed consent. To avoid future manipulation, a physical and digital copy of the document must be maintained with the JMFC, and another physical and digital copy must be retained with the Registry of the jurisdictional District Court. A copy must also be kept by the local authority, such as the municipality or panchayat, depending on the situation. If family members are uninformed, they must be notified, and if there is a family physician, he must also be notified. Only when the patient is terminally ill and after confirming the document's authenticity with the JMFC may the document be put into effect at the doctor's request. The hospital authorities are obligated to intervene if the doctor has a conscientious or religious objection.

The doctor must notify the hospital authorities of who would establish a medical board consisting of the director of the treatment department and three specialists from diverse fields such as medicine, cardiology, nephrology, and others with critical care expertise and overall status in the profession. In the presence of the nominated guardian, the board will visit the patient and confirm whether or not the directions in the document can be carried out. If the preliminary opinion is positive, it will be forwarded to the jurisdictional Collector, who will form a new medical board consisting of the Chief District Medical Officer as chairman and three expert doctors from various fields such as cardiology, oncology, medicine, and so on, all of whom have at least 20 years of experience, except those who were members of the previous medical board.

If the medical board refuses to provide authorization, the executor, family, or even the doctor may file a writ petition under Article 226 with the High Court, and the Chief Justice of the said Court will be compelled to convene a division bench to hear the matter. The High Court may appoint an independent medical board with the same credentials as those listed above, and it would be required to rule quickly in the best interests of the patient. Furthermore, there is no requirement to carry out unclear orders. As a result, the Court has issued detailed rules that will apply until Parliament passes legislation on the topic.

Given the experience of countries such as the Netherlands, where advance instructions have been authorized for a long time, it is necessary to ensure that these rules are followed to the letter. The Court, in my opinion, should have ordered the formation of an independent committee comprised of judicial and medical professionals to supervise the application of these recommendations in all cases. After all, given India's shortage of resources and low level of healthcare, there is a strong possibility that these instructions and authorizations would be abused. Furthermore, the instructions give no advice as to whether a person's "consent" may be considered informed. Before a person exercises his or her right to execute advance directives, I believe the Hon'ble Court might have mandated psychiatric examination and counselling by medical professionals. Furthermore, they do not provide a method for revoking such directives, which might lead to disagreements over whether or not the patient has withdrawn the advance directives. In an ideal world, a similar

mechanism for revocation of such directives would have been established. Furthermore, by allowing the treating physician to approach the hospital authorities for the formation of a medical board in the absence of any directives or authorizations from a terminally ill patient with the informed consent of family members, the Court has opened an avenue for the abuse of this right. Although the Court's procedure would be followed in this situation as well, taking such action in the absence of such directions would constitute a violation of the individual's right to autonomy.

CONCLUSION

This decision demonstrates the use of the proportionality doctrine, in which the Court weighed two aspects of the same right, namely the right to life under Article 21. While the right to life provides a compelling State interest in safeguarding human life, it also ensures that individuals have the liberty to make decisions about their own bodies.

The Court has conducted a careful examination of the sociological, intellectual, ethical, and economic elements of this matter. It has made an exemption to the sanctity of life concept in instances when a person's life has lost all value and extension is no longer in his best interests. Comparative jurisprudence has also aided the Court in this endeavor, with members of the bench conducting an extensive review of international jurisprudence. The Court, citing the Visakha54 decision, has not only confirmed the right to die with dignity and to make advance instructions, but has also offered extensive guidance on the subject.