IN THE SUPREME COURT OF INDIA

CIVIL ORIGINAL WRIT JURISDICTION

IA NO OF 2014

IN

WRIT PETITION (CIVIL) NO 215 OF 2005

IN THE MATTER OF:

COMMON CAUSE (A Regd Society)

… Petitioner

Versus

UNION OF INDIA & ORS

… Respondents

AND

IN THE MATTER OF:

1. VIDHI CENTRE FOR LEGAL POLICY

… Applicants/Intervenors

ADVOCATE FOR THE APPLICANTS/INTERVENORS:

RAUF RAHIM

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1) VIDHI CENTRE FOR LEGAL POLICY
Through its Senior Resident Fellow
Mr Alok Prasanna Kumar
D-21, Lower Ground Floor,
Jangpura Extension,
New Delhi
Delhi 110048

… Applicants/Interveners

APPLICATION FOR INTERVENTION

To

THE HON'BLE CHIEF JUSTICE OF INDIA AND HIS COMPANION JUDGES OF THE SUPREME COURT OF INDIA

THE HUMBLE APPLICATION OF THE APPLICANT ABOVENAMED

MOST RESPECTFULLY SHOWETH:

1. That the present Writ Petition has been preferred by the Petitioner seeking, *inter alia* that this court be pleased to declare the "right to die with dignity" as a fundamental right arising from Article 21 and permit persons to execute an "advance directive" which can be presented to hospitals or medical care providers to stop treatment in a situation where the executor of such an advance directive is not in a position to express such desire.

2. That the Applicant herein is an independent legal policy advisory group whose mission is to achieve good governance in India by impacting legislative and regulatory design. The Applicant is a not for profit company limited by guarantee, registered under Section 25 of the Companies Act, 1956, having its registered office in K-40, Ground Floor, Hauz Khas, New Delhi 110016, and bearing Company Identity Number : U93000DL2013NPL256042.

3. That a Resolution dated 11.12.2014 was passed by the Board of Directors of the Applicant to file an intervention application in the present matter, in order to assist this Hon'ble Court in laying down the law and presenting the relevant materials before it, and authorising Mr Alok Prasanna Kumar, Senior Resident Fellow to act on its behalf for these purposes. (**Annexure A-1**)

4. That the Applicant has been assisting and advising Governments, Constitutional and other statutory bodies on legislative drafting, legal inputs and legal policy advice. (Concept note annexed as **Annexure A-2**)

5. The Applicant, along with the Centre for Study of Social Exclusion and Inclusive Policy, National Law School of India has assisted in drafting the Karnataka Prevention of Superstitious Practices Bill, 2013 and also the Karnataka Scheduled Castes and Scheduled Tribes Sub Plans Rules, 2014 for the Karnataka State Government. (**Annexure A-3**)

6. That Applicant has assisted the Law Commission of India in the preparation of the 244th Report of the Law Commission of India on Electoral Disqualifications. The said report was the basis for the order of this Hon'ble Court dated 10.03.2014 in *Public Interest Foundation v Union of India* (Writ Petition (civil) 536 of 2011). (**Annexure A-4**)

7. The Applicant and its research fellows have also assisted the Law Commission of India in its research and preparation of various reports, such as the 244th Report on Electoral Disqualifications; the 248th, 249th, 250th and 251st Reports on Obsolete Laws; and the 253rd Report on Commercial Division and Commercial Appellate Division of High Courts and Commercial Courts Bill. (**Annexure A-5**)

8. The Applicant was also engaged by the Fourteenth Finance Commission of India to provide legal inputs in the preparation of the Fourteenth Finance Commission Report on issues relating to professional tax, control of sub-national debt and the creation of an empowered Inter-State Council. (**Annexure A-6**)

9. The Applicant is also currently providing legal inputs and assistance to the T.K. Viswanathan Committee set up by the Ministry of Finance to examine India's bankruptcy laws and suggest reforms for making the system more effective. (**Annexure A-7**)

10. The Applicant is also currently preparing six reports for the Reserve Bank of India on various issues related to the banking sector and financial regulation. (**Annexure A-8**).

11. That Applicant is also currently undertaking independent research on the functioning and constitutionality of Tribunals assessing them on parameters of independence, efficiency and efficacy. Presently, the Applicant has published two reports on the functioning of the Telecom Disputes Settlement Appellate Tribunal and the Intellectual Property Appellate Board.

12. That the Applicant wishes to assist the Court with legal research and inputs on a matter of constitutional importance and having a bearing on the larger public interest.

13. That the Applicant humbly submits that:

a. the right to die with dignity and the right to refuse treatment has already been enshrined in the Constitution of India and has been recognised by this Hon'ble Court in prior judgments and is also an internationally recognised right of individuals.

b. The recognition of the legality of an "advance directive" is necessary for the enforcement of the right to die with dignity. It is necessary in order for the right to die with dignity to be given meaning and content to.It is also an aspect of the right to refuse treatment.

14. That in order for legally enforcing an advance directive, this Court may be pleased to issue certain directions on the following five aspects which are essential to ensure a functional regime for the enforcement of advance directives:

   a. Who will be competent to execute an advance directive?

   b. In what form will an advance directive have to be issued in order to be valid?

   c. Who is to ensure that an advance directive is properly obeyed?

   d. What legal consequences follow from the non-obedience to an advance directive?

   e. Can a doctor, for reasons of conscience or faith, refuse to execute an advance directive?

A. RIGHT TO DIE WITH DIGNITY AND THE RIGHT TO REFUSE TREATMENT IS A FUNDAMENTAL RIGHT

15. That the Applicant agrees that the Petitioner's contention that the right to die with dignity is a feature of the right of any individual to refuse treatment and is borne out by the judicial pronouncements of this Hon'ble Court and other Constitutional courts in different jurisdictions.

16. Furthermore, the right to refuse life-saving medical treatment is a well-recognised common law right enforced by courts around the world and has been recognized by Courts in Indian law as well. This, it is respectfully submitted, is a feature of the right to life protected under Article 21 of the Constitution of Indiaand cannot therefore be denied except through procedure established by law.

17. It is therefore respectfully submitted that the right to refuse life-saving treatment, even if it is likely to result in death flows naturally from both the right to die with dignity and the right to refuse treatment.

18. That at present there is no legislation or any statutory provision which expressly permits a patient to exercise the right to refuse life-saving treatment.

19. While Regulation 6.7 of the Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002, provides for the removal of life support system from a patient who has suffered "brain death" after such a finding has been made by a team of doctors, it does not provide for any avenue for the patient herself to express her wishes as indicated prior.

20. Likewise, while Regulation 7.16 of the Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002, provides that doctors shall not perform surgeries without the consent of the patient or if the patient cannot give consent, whoever is capable of giving consent on behalf of the patient, it does not provide for a situation where the treatment of any sort may be withdrawn on the express wishes of the patient.

21. Further, these Regulations do not vest a right on the person receiving the treatment not to be treated against her express wishes and also does not provide a remedy in law to enforce the right to die with dignity.

22. That the right to die with dignity and the right to refuse treatment have been established in Indian law and in foreign jurisdictions as discussed hereinbelow.

a. INDIAN COURTS

23. In *Gian Kaur v. State of Punjab* (1996) 2 SCC 648 (para 23), a Constitution Bench of this Hon'ble Court held that "To give meaning and content to the word 'life' in Article 21, it has been construed as life with human dignity." Further, this Hon'ble Court held

> "…. The 'right to life' including the right to live with human dignity would mean the existence of such a right up to the end of natural life. … In other words, this may include the right of a dying man to also die with dignity when his life is ebbing out. But the "right to die" with dignity at the end of life is not to be confused or equated with the "right to die" an unnatural death curtailing the natural span of life" (para 24).

24. From the above it is clear that this Hon'ble Court in *Gian Kaur* held that "right to life" includes the "right to die with dignity". In fact, there is no controversy on this aspect. Vide order dated 25.02.2014 passed in the present case [reported in (2014) 5 SCC 338 (para 16)], a three-judge Bench of this Hon'ble Court stated that *Gian Kaur* held that the "right to live with dignity" under Article 21 will be inclusive of the "right to die with dignity".

25. Vide the said order dated 25.2.2014, this Hon'ble Court noted that *Aruna Ramachandra Shanbaug v. Union of India* (2011) 4 SCC 454 (*"Aruna Shanbaug")* had rendered certain inconsistent opinions.This Hon'ble Court, vide order dated 25.02.2014 had held that *Aruna Shanbaug* had upheld the validity of passive euthanasia on the "wrong

premise" that the judgment of the Constitution Bench in *Gian Kaur* had permitted the same.

26. Considering the important question of law involved, this Hon'ble Court referred the matter to a Constitution Bench.

27. It is respectfully submitted that the order dated 25.02.2014 is incorrect in so far as it states that the judgment in *Aruna Shanbaug* was inconsistent in any manner with the judgment in *Gian Kaur*.

28. It is respectfully submitted that granting the reliefs sought in the present writ petition by the petitioner do not require any finding on whether passive euthanasia is permissible in Indian law or not and but is a simple recognition of the right of an individual to choose the treatment they wish to receive and an individual's right to die with dignity.

29. In that regard, it is submitted that *Aruna Shanbaug* was a case pertaining to non-voluntary passive euthanasia. In para 67 of the said judgment, this Hon'ble Court held that:

> "The present is a case where we have to consider non-voluntary passive euthanasia i.e. whether to allow a person to die who is not in a position to give his / her consent."

30. The present case pertains to execution of "advance directives" by a person at a time when she is in a position to make a conscious decision as regards receiving medical treatment if she were to be incapacitated at a future point in time. It is therefore submitted that *Aruna Shanbaug* has limited application to the present case, since it dealt with non-voluntary passive form of euthanasia, although some of the principles laid down therein are relevant to be noted hereinbelow.

31. This Hon'ble Court upheld the 'best interest' principle in *Aruna Shanbaug* and held (in paras 85 and 86) that the decision of close relatives carries weight, but is not decisive, to decide what is the patient's best interest when she is in a permanent vegetative state. Ultimately, it is for the Court to decide, as *parens patriae*, as to what is the patient's best interest.

32. The Applicant submits that the right to die with dignity also gives effect to two of the cardinal principles of medical ethics namely, patient autonomy and beneficence which have been discussed by this Hon'ble Court in *Aruna Shanbaug* (para 12, page 482) as follows:

> "1. Autonomy means the right to self-determination, where the informed patient has a right to choose the manner of his treatment. To be autonomous, the patient should be competent to make decisions and choices. In the event that he is incompetent to make choices, his wishes expressed in advance in the form of a living will, OR the wishes of surrogates acting on his behalf (substituted judgment) are to be respected.
>
> 2. The surrogate is expected to represent what the patient may have decided had he/she been competent, or to act in the patient's best interest. It is expected that a surrogate acting in the patient's best interest follows a course of action because it is best for the patient, and is not influenced by personal convictions, motives or other considerations.
>
> 3. Beneficence is acting in what is (or judged to be) in the patient's best interest. Acting in the patient's best interest means following a course of action that is best for the patient, and is not influenced by personal convictions, motives or other considerations. In some cases, the doctor's expanded goals may include allowing the natural dying process (neither hastening nor delaying death, but 'letting nature take its course'), thus avoiding or reducing the sufferings of the patient and his family, and providing emotional support. This is not to be confused with euthanasia, which involves the doctor's deliberate and intentional act through administering a lethal injection to end the life of the patient."

33. In light of the above, it is submitted that advance directives are a method to give effect to the cardinal principles of 'patient autonomy' and 'best interest of the patient'. Patient autonomy would require respecting the individual's choices and bodily integrity. Further, a voluntary choice made by an adult when she is not in an incapacitated state necessarily has to be taken into account in determining her 'best interest'.

34. It is respectfully submitted that the two principles are not necessarily in any conflict. An advance directive is the expression of the patient's will and must be followed by the doctors treating such patient since it upholds not just the patient's autonomy but also ensures that the patient's wishes are taken into account while taking a decision in her "best interests".

35. It is submitted that while *Aruna Shanbaug* expressly held (in para 124) that passive euthanasia should be permitted in our country, it noted the following in respect of voluntary and non-voluntary forms of passive euthanasia:

> "67. As already stated above, euthanasia can be both(sic) voluntary or non-voluntary. In voluntary passive euthanasia a person who is capable of deciding for himself decides that he would prefer to die (which may be for various reasons e.g. that he is in great pain or that the money being spent on his treatment should instead be given to his family who are in greater need, etc.), and for this purpose he consciously and of his own free will refuses to take life-saving medicines. In India, if a person consciously and voluntarily refuses to take life-saving medical treatment it is not a crime. […] Non-voluntary passive euthanasia implies that the person is not in a position to decide for himself e.g. if he is in coma or PVS. The present is a case where we have to consider non-voluntary passive euthanasia i.e. whether to allow a person to die who is not in a position to give his/her consent." (emphasis supplied)

36. It is submitted that from the above, it is clear that as per the ratio laid down in *Aruna Shanbaug*, the right to refuse life-saving treatment is already permitted. Therefore, advance directives, which operate when the patient is not in a position to give consent to withdraw treatment therefore only facilitatesthis voluntary passive form of euthanasia. It thus ought to berecognised and given effect to in Indian law.

37. It is also respectfully submitted that the order of this Hon'ble Courtdated 25.02.2014 in the present writ petition, in so far as it holds that there is a "conflict" between the judgment of this Hon'ble Court in *Gian Kaur* and the judgment of this Hon'ble Court in *Aruna Shanbaug* is incorrect for the reasons discussed above.

38. It is respectfully submitted that the observations of this Hon'ble Court in *Gian Kaur*, relating to the right to die with dignity being a facet of the right to life under Article 21, was made in the limited context of the question of the legality of suicide (voluntary ending of one's life) but did not relate to the withdrawal of treatment of an incapacitated person.

39. It is respectfully submitted that the observation of this Hon'ble Court in paragraph 24 of *Gian Kaur* correctly states the law relating to the legal recognition of the right to die with dignity.

40. In *Aruna Shanbaug*, this Hon'ble Court has correctly inferred the principle from *Gian Kaur* to mean that active euthanasia is not permitted but passive euthanasia may be permitted in limited circumstances.

41. It is our respectful submission therefore, that reading the judgments of this Hon'ble Court in *Gian Kaur* and *Aruna Shanbaug* together, there is no constitutional bar to the legal recognition of advance directives and such recognition in fact proceeds from the well-recognised right to refuse treatment and the right to die with dignity.

b. FOREIGN CASE LAW

i. US Case law

42. The Supreme Court of the United States in *Cruzan* v. *Director, Mo. Dept. of Health*, 497 U. S. 261 (1990) has held that the right to refuse medical treatment (even life-saving medical treatment) is an aspect of the Fifth Amendment of the Constitution of the United States of America (the "Due Process Clause").

43. However, in the case of *Cruzan*, the Supreme Court found that on the facts, the clear wishes of the patient had not been established and therefore, could not direct removal of treatment on that basis. Here, the US Supreme Court has not accepted the principle of "substituted judgment" of the family.

44. The principle, in US law, was established as far back as in in 1914 in the case of *Schloendorff vs. Societyof New York Hospitals* (1914) 211 NY 123 (126) where it was held:

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

ii. <u>UK Case law</u>

45. In the United Kingdom, the landmark case of *Airedale NHS Trust v Bland* [1993] AC 789 has held that there is a distinction between withdrawing life-saving treatment and the administration of drugs to end a patient's life, holding that the former was valid and permissible in law, whereas the latter was not.

46. As summarized by Lord Bingham MR, the law in England was succinctly stated as follows:

> "There are certain important principles relevant to this issue which both parties accept. (1) A profound respect for the sanctity of human life is embedded in our law and our moral philosophy, as it is in that of most civilised societies in the East and the West. That is why murder (next only to treason) has always been treated here as the most grave and heinous of crimes. (2) It is a civil wrong, and may be a crime, to

impose medical treatment on a conscious adult of sound mind without his or her consent: *In re F. (Mental Patient: Sterilisation) [1990] 2 A.C. 1*. (3) A medical practitioner must comply with clear instructions given by an adult of sound mind as to the treatment to be given or not given in certain circumstances, whether those instructions are rational or irrational: *Sidaway v. Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital [1985] A.C. 871*, 904-905; *In re T. (Adult: Refusal of Treatment) [1993] Fam. 95*. This principle applies even if, by the time the specified circumstances obtain, the patient is unconscious or no longer of sound mind. (4) Where an adult patient is mentally incapable of giving his consent, no one (including the court) can give consent on his behalf. ”

47. However, it must also be pointed out that the House of Lords has drawn the distinction between withdrawing treatment and actively assisting a person taking her life much more precisely in the case of Regina (Pretty) v Director of Public Prosecutions [2002] 1 AC 80 where it was held that right to life guaranteed under the European Convention on Human Rights did not protect a guarantee against prosecution for assisted suicide.

48. It is thus submitted, that the case law in the UK as well has accepted the proposition that the right to refuse treatment, even when such refusal can lead to death, is an alienable right of the patient and when expressed, must be followed by the physician in charge of her treatment.

iii. <u>Ireland Case law</u>

49. In *Re A Ward of the Court*, [1996] 2 I.R. 79 the Supreme Court of Ireland upheld the order of the High Court of Ireland which had directed, on a petition made by the family of a woman who was in a persistent vegetative state, to remove the feeding tube which was keeping her alive and allow her to die naturally. Here, the Ireland Supreme Court has applied the test of “best interests” of the patient, based on the contention of the patient’s family that it was not in her best interests to be kept alive solely by way of a feeding

tube. Given however, that this was a case where the patient was unable to express her own wishes, the Court accepted the "substituted judgment" of the family as regards what her wishes were likely to be.

iv. Canadian Case Law

50. In *Couture-Jacquet v. Montreal Children's Hospital* (1986) 28 D.L.R. (4th) 22 the Quebec Court of Appeal directed that chemotherapy treatment being given to a child by a hospital must be stopped since the mother and grandmother had not consented to the same, and the hospital had not discharged the burden of proof to show that the consent was being withheld contrary to the interests of the minor patient.

51. In *Nancy B. v. Hôtel-Dieu de Québec*(1992) 86 D.L.R. (4th) 385, the Quebec Superior Court, on an application made by a patient who wished for respiratory support treatment to be stopped, directed her doctors to do the same on the basis of Article 19.1 of the Civil Code of Lower Canada which expressly stated that "No person may be made to undergo care of any nature, whether for examination, specimen taking, removal of tissue, treatment or any other act, except with his consent."

c. REPORT OF THE LAW COMMISSION OF INDIA

52. The 196th Report of the Law Commission of India, published in March 2006, deals with 'Medical Treatment to Terminally Ill Patients (Protection of Patients and Medical Practitioners)'. In August 2012, in the aftermath of this Hon'ble Court's judgment rendered in *Aruna Shanbaug,* the Law Commission of India came out with the 241st Report titled 'Passive Euthanasia – A Relook'. On the principle of Advance Directives, the latter Report adopts the stand taken by the former Report and is therefore not discussed separately hereunder.

53. Chapter VII of the 196th Report deals with 'Legal Principles applicable in India and position under Indian Penal Code, 1860'. Some of the principles proposed for application in India (at p.296) include the following:

- Adult patients' right of self-determination and right to refuse treatment is binding on doctors if it is based on informed decision process.
- Giving invasive medical treatment contrary to a patient's will amounts to battering or in some cases may amount to murder.
- Advance directives (living wills) and powers of attorney in favour of surrogates to be invalid.
- State's interest in protecting life and principle of sanctity of life are not absolute.
- Refusal to obtain medical treatment does not amount to 'attempt to commit suicide' and withholding or withdrawing medical treatment by a doctor does not amount to 'abetment of suicide'.
- Competent and incompetent patients, 'informed decision' and 'best interests' of the patients, consultation with a body of three experts before treatment is withheld or withdrawn. (**Annexure A-8)**

54. It is submitted that, for reasons discussed below, all the above-mentioned principles, barring the one on declaring Advance Directives as invalid (which has not been decided by this Hon'ble Court so far), are completely in accordance with the law laid down by this Hon'ble Court and reflect the well-established principles of law in this regard. The principles have been enumerated after lengthy discussion of the relevant case law and the same are not being repeated here for the sake of brevity.

55. Explaining the principle of an adult patient's right of self-determination, the 196th Report states the following: (at p.308)

> "It is, however, settled that if a competent adult patient wants life support systems not to be withheld or withdrawn, that decision is binding on the doctors. However, if a patient suggests a particular form of medical treatment be administered to him which the doctors think is not appropriate, then the doctors, if they do not follow the directive of the patient, they are not guilty of any offence or wrong. If a competent patient wants life support system to be

> withheld or withdrawn, it is binding on the doctors unless they come to the conclusion that the patient's decision is not an 'informed decision'. In such cases, the doctor has to take a decision in the 'best interests' of the patient."

Further, the Report states: (at p.309)

> "If the patient is incompetent and it is a fit case where, in the best interests of the patient, the life support system would be discontinued, if it is not discontinued, it may amount to battery. It was so observed in Airedale.
>
> It is a well settled principle at common law that a patient has a right to accept medical treatment or refuse it. This is called the principle of self-determination."

After discussing several case-law on this aspect, the Report concludes: (at pp.316-317)

> "Summarizing the position, while patient's right to refuse or consent to medical treatment is fundamental and is binding on the doctors however rational or irrational it may be, but the said principle applies only where the patient is competent i.e. able to balance the advantages and disadvantages and mentally in a position to take a decision and is able to take an 'informed decision'. If he is not competent or not mentally in a position to take an informed decision, his refusal or consent is not binding on the doctors and if they take a decision which is in the best interests of the patient, it is lawful. A patient cannot also compel a doctor to give him a particular line of treatment for it is for the doctors what treatment is necessary in the best interests of the patient. These aspects are proposed to be brought into proposed Bill."

56. It should logically follow from the above that an advance directive, which is the expression of a person's choice, made at a time when her faculties are properly functioning and the person is of a sound mind, ought to be relevant, and binding, subject to certain conditions being fulfilled, since it is an expression of her right of self-determination. What remains to be determined is whether such a choice would qualify as an 'informed decision'. If it qualifies as 'informed decision', then it would be binding on the doctors; and if not, then the doctors would have to decide based on the 'best interest' of the patient.

57. The 196th Report defines 'informed decision' as under: (at p.349)

> "An 'informed decision' is a decision taken by a competent patient, i.e. an adult who has capacity to take a decision as to his or her medical treatment after understanding the gravity or otherwise of his disease, the availability or otherwise of alternative medicine or technology to cure his disease, the consequences of those forms of treatment and the consequences of remaining untreated."

58. It is submitted that since an Advance Directive could be written at a time when a person is healthy and is unaware of the medical condition that he may, in future, suffer from, the choice made in the Advance Directive may or may not be an 'informed decision'. It is submitted that if the choice does not qualify as an informed decision, the 'best interest' of the patient ought to be considered.

59. Noting that the question of 'best interest' has to be decided by a doctor in the case of (a) incompetent patients and (b) in the case of competent patients who are unable to take an informed decision, the 196th Report states as under: (at p.350)

> "It is true, as stated in Lord Goff in Airedale 1993 (1) All ER 821 (HL), that on the principle of self-determination, if an adult patient of sound mind refuses, however, unreasonably, to consent to treatment or care by which his life could be prolonged, the doctors responsible for his care must give effect to his wishes, even though they do not consider it to be in the best interests of the patient, to do so. To this extent, the principle of sanctity of life must yield to the principle of self-determination. Such refusal by a patient may also be by way of an advance directive. (emphasis supplied)"

60. After discussing case law which have held that "best interests" include not only medical interests but also emotional, ethical, social and welfare considerations, the 196th Report summarises its conclusion on the aspect as under: (at p.359)

> "The best interests are not confined to medical interests but encompass ethical, social, emotional and welfare considerations. There cannot be any single test of what is in the best interests of an incompetent patient but it must depend upon a variety of considerations depending upon the facts of the case. Where a patient is not competent, it is lawful for doctors to take a decision to give, withhold or withdraw medical treatment if they consider that to be the appropriate action to be taken in the best interests of the patient."

61. It is submitted that if 'best interests' are to include a wide array of considerations such as ethical, social, emotional, etc., then it is all the more imperative that an adult patient's wishes and beliefs, expressed by an "Advance Directive", be taken into consideration, while deciding what decision would be in her 'best interest'.

62. However, the 196th Report concluded that "Advance Directives" and Medical Powers of Attorney could be declared void.

63. After noting that in several countries it is permissible for a competent adult to execute an Advance Directive as to whether he or she should or should not be given medical treatment when he or she is terminally ill and not in a position to take a medical decision, the 196th Report discusses several case laws from various countries and concludes as under: (at p.327)

> "In our view, if an Advance Directive can also be oral, it can create serious problems of proof and may also lead to serious abuse.
>
> Coming to Advance Directives in writing, we have seen the legal position. It must be proved that the Advance Directive was based upon informed consent of the patient, with knowledge of state of his or her illness and of the medicines or medical technology available. This again requires oral evidence to be adduced. Then again, due to change in circumstances or on account of delay or developments in medicine / technology which have improved and which give scope for living longer without pain or suffering, the earlier Directive may have been rendered inapplicable or invalid on account of latter circumstances. There may also be oral evidence of withdrawal of a written or oral directive. This can also create serious problems of proof.
>
> In our view, there is not only scope for contentious and complex issues of fact and law being raised in every case relating to oral or written Advance Directives, but in a country where there is considerable illiteracy and lack of knowledge of developments in medicine and technology, there is scope for Advance Directives being based on wrong assumptions or requiring proof that they were, as a fact, made or that they continue to be applicable and valid or have not been withdrawn and there is large scope for abuse and litigation. A lot of evidence will be oral and may be conflicting. Doctor's consequential actions can give rise to any amount of litigation.

> In our view, as a matter of public policy in India, Advance Directives oral or written are controversial and can lead to mischief and should be made legally ineffective, overriding the common law right."

64. For the same reasons, the Report rejects Medical Powers of Attorney as well.

65. It is submitted that the Hon'ble Law Commission's conclusion as indicated above is flawed and should be rejected by this Court for the reasons discussed in the following paragraphs.

66. That having recognised that an Advance Directive is an exercise of the 'inherent right of self – determination', the Report ought not to have rejected the concept of Advance Directives on the presumption that it can create problems of proof and can also be abused. By doing so, the 196th Report has placed common problems of potential abuse and litigation on a higher pedestal than the right of self-determination of an individual.

67. In effect, the Law Commission has denied the right of an individual entirely on the mere possibility of abuse and difficulty in proving by way of evidence, particularly in oral advance directives.

68. It is respectfully submitted that provision of any legal or fundamental right involves a certain degree of risk as to its abuse. However, that cannot come in the way of individuals being guaranteed the right itself.

69. Potential problems of large scale litigation and abuse of rights can be addressed by provision of safeguards in the law. For instance, oral Advance Directives can be declared void or need not be recognized in law unless proved satisfactorily. Furthermore, written Advance Directives could be made enforceable only if sworn to before two competent witnesses, who will be required to testify as regards its validity.

70. It is thus submitted that the 196th Report of the Law Commission, in so far as it concludes that Advance Directives are features of the right to self-determination and autonomy of any person has correctly appreciated the position of law. However, its summary dismissal of the need for legal

recognition of the same in India is not borne out by sufficient facts or reasoning and this part of the recommendation must be rejected.

B. ADVANCE DIRECTIVE LEGISLATIONS IN FOREIGN JURISDICTIONS

71. Advance directives are recognised in a number of countries around the world and the legal regimes of a few countries are being discussed here to identify the issues that need to be addressed in any legal regime where advance directives are legally recognised and enforced.

United Kingdom

72. In the United Kingdom, the relevant legislation is the Mental Capacity Act, 2005 (hereinafter "the UK Act"). (**Annexure A-9**)

73. Under Section 24 of the UK Act, a person who is above 18 years of age has the capacity to execute an advance directive. Section 2 of the Act explains who is considered to lack capacity, and states that "a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain".

74. Under Section 25 of the UK Act, an advance decision does not have to be in writing, unless it is a decision to refuse life-sustaining treatment. With respect to decisions to refuse life-sustaining treatment, the advance decision has to be in writing, signed by the patient or someone on his behalf, and signed by a witness. It also has to include a written statement by the patient that the advance decision is to apply to the specific treatment even if the patient's life is at risk.

75. Section 4(9) of the UK Act defined "Life-sustaining treatment" as treatment that, in the view of the person providing health care to the person concerned, is necessary to sustain their life.

76. Advance directions are not required to be registered in the UK and Section 26(4) of the Act provides that the court can make a declaration as to whether the advance decision exists, is valid, and applicable to a treatment.

77. Under Section 26 of the UK Act, if a person has made an advance decision which is valid and applicable to the treatment, the decision has effect at the time when the question arises whether the treatment should be continued. Further, if a person is satisfied that an advance decision exists and is applicable to the treatment, he shall incur liability for non-obedience to the advance decision.

78. Failure to respect a valid advance directive could give rise to legal actions in trespass to the person (a civil wrong, for which financial compensation might be awarded) and/or assault or battery (criminal wrongs, subject to penalties like imprisonment).

Netherlands

79. Chapter 7 of the Dutch Civil Code ("the Dutch Code") governs advance directives and their enforcement. (**Annexure A-10)**

80. According to Article 7:450 of the Dutch Code, a patient aged sixteen or over, when he or she is still capable of reasonable assessment is competent to execute an advance directive.

81. Such advance directive, under Article 7:450 of the Dutch Code, should be in written form, dated and signed in order to be valid.

82. While the Dutch Code does not give any specific mode of enforcement of an advance directive, it is enforceable as any other legally valid document under Dutch law.

83. Under the Dutch Code, care providers are legally bound by the advance directive but they may deviate from it if there are "good reasons" for so doing.

Switzerland

84. As with Netherlands, Switzerland does not have a special law dealing with advance directives but governs the same in accordance with certain provisions of the Swiss Civil Code. (**Annexure A-11)**

85. According to Article 370 of the Swiss Civil Code, a person who is capable of judgement is competent to execute an advance directive. Article 16 provides that "a person is capable of judgement within the meaning of the law if he or she does not lack the capacity to act rationally by virtue of being under age or because of a mental disability, mental disorder, intoxication or similar circumstances".

86. Under Article 371, in order to be legally recognised, advance directives must be in writing, and signed and dated.

87. In order to enforce such advance directive, under Article 373 of the Code, "any person closely related to the patient can contact the adult protection authority in writing and claim that the patient decree is not being complied with; the interests of the patient are being endangered or no longer safeguarded; or that the patient decree is not based on the patient's free will".

88. The adult protection authority is empower under Article 368 of the Swiss Civil Code to take the "required measures" if the interest of the person are endangered or no longer protected in the context of an advance directive executed by such a person.

89. Under Article 372 of the Code the doctor shall comply with the patient decree unless it violatesstatutory regulations or there is reasonable doubt that it is based on the patient's free will or still corresponds to his or her presumed will.

Australia

90. Australia does not have a national law relating to advance directives but each State and Territory has its own legislation. The Applicant wishes to place for this Court's consideration the Western Australia Guardianship and Administration Act, 1990 ("the WA Act") and the South Australia Advance Directives Act, 2013 ("the SA Act") for its perusal. (**Annexure A-12 and Annexure A-13** respectively)

Western Australia

91. Under Section 110P of the WA Act, a person who is 18 years age and has full legal capacity is entitled to execute an advance directive.

92. Section 110Q of the WA Act provides that an advance directive has to be written substantially in the form prescribed by the regulations. The advance directive must be signed by the person or another person in his presence and on his directions, in the presence of two witnesses. Further, the two witnesses should sign the directive in the presence of the person and each other. The witnesses must not be parties to the agreement, be at least 18 years of age and have full legal capacity and at least one of them must be a person authorised to witness legal documents under the Oaths, Affidavits and Statutory Declarations Act, 2005. The person is encouraged to seek medical and legal advice while making the advance directive but failure to comply with such requirement does not affect the legality of the advance directive.

93. Under the WA Act, specifically Sections 110V, 110W, 110X, 110Y, and 110Z, a person who has a "proper interest" in the matter, in the view of the State Administrative Tribunal, can apply to it for a declaration with respect to the validity of an advance direction, or a treatment specified within it. It can also declare that the maker of an advance health directive is unable to make reasonable judgments in respect of the treatment specified in the directive. It can interpret the terms of the directive, give directions to give effect to it or revoke a treatment decision in the advance directive.

94. Under Section 110S of the WA Act, when applicable, the decisions in the advance directive are taken as if they are made at the time of the treatment, and as if the maker had full legal capacity. However, the Act does not specify the consequences of not obeying the advance decision.

South Australia

95. As per Section 11 of the SA Act, a competent adult if she understands what an advance care directive is and its consequences would be competent to execute an advance directive. The SA Act only defines impaired decision making capacity but does not define "competent" adult per se.

96. As per Section 11 of the SA Act and Regulation 7 of the Advance Care Directives Regulations, 2014, the advance directive must be made by a person in the form prescribed by the SA Act and it must be witnessed and certified by a 'suitable witness' as prescribed in the SA Act.

97. Sections 47 and 48 of the SA Act provide for a Public Advocate as an authority who can provide preliminary assistance, including mediation and declarations, with respect to issues relating to advance care directives upon application by an eligible person (i.e. the maker of the directive, a health care professional or any other person who satisfies the Public Advocate that he has proper interest in this matter) or on his own initiative (Sections 43- 45 of the Act). Subsequently, on reference by the Public Advocate or by an application by an eligible person, the Guardianship Board may make any decisions or give directives or advice as it feels necessary or desirable in the circumstances of the case. In doing so, the Board shall try to give effect to the wishes of the maker of the advance directive as far as is reasonably practicable.

98. Section 19 of the SA Act provides that a provision of an advance care directive which comprises of a refusal of a particular health care (whether express or implied) is the only binding provision. Further, if a decision has been made by the Guardianship Board in relation to an advance directive, the person who fails to comply with such direction of the Guardianship Board

would be guilty of an offence with a maximum penalty of $20000 or imprisonment for 6 months.

99. Section 12 of the SA Act also provides that an advance care directive cannot make provisions that are unlawful; require an unlawful act to be committed such as euthanasia; require a health practitioner to violate his professional code of conduct; or refuse a mandatory medical treatment.

100. Further, under Sections 36 and 37 of the Act, a health practitioner can refuse to comply with a provision of an advance care directive on conscientious grounds or can refuse a particular health care specified in the directions if it is consistent with relevant professional standards or does not reflect current standards of healthcare in the State.

United States of America

101. The petitioners have already discussed the law of the Federal Government in the United States of America along with certain State legislation and the Applicant does not wish to replicate the same. However, the laws of the State of Pennsylvania and the State of Washington are discussed by way of reference. (**Annexure A-14 and Annexure A-15** respectively)

State of Pennsylvania

102. In the State of Pennsylvania the Advance Directive for Health Care Act, Act 24 of 1992 (“the Pennsylvania Act”) provides the legal regime for the enforcement of advance directives.

103. According to Section 5404(a) of the Act, any individual, who is 18 years or older or who has graduated from high school or has married, and is of sound mind is competent to execute an advance directive.

104. The advance declaration must be signed by the declarant, or by another on behalf of and at the direction of the declarant, and must be

witnessed by two other individuals, each of whom should be at least 18 years old. Further, there is a model form for the advance declaration provided, but it does not need to be in the model form.

105. While the Pennsylvania Act does not provide for any specific means of enforcement of advance directives, the same may be enforced as a legal document through a regular civil suit in a court of competent civil jurisdiction.

106. The Pennsylvania Act states that once the declaration is operative, "the attending physician and other health care providers shall act in accordance with its provisions or comply with the transfer provisions" (Section 5405 of the Act).

107. Under Section 5409, the physician or health care provider must make reasonable efforts to assist in the transfer of the patient to another physician or health care provider if they cannot comply with his declaration. However, if the transfer is not possible, Section 5409 also provides that the "provision of life-sustaining treatment to the patient shall not subject a health care provider to criminal or civil liability or administrative sanction for failure to carry out the provisions of a declaration".

108. The Pennsylvania Act also specifically provides that it is not "intended to condone, authorize or approve mercy killing, euthanasia or aided suicide or to permit any affirmative or deliberate act or omission to end lifeother than as provided" under Section 5402(b) of the Act. Further, the Act states that if a doctor is unwilling to follow the directive, he must promptly advise the patient (Section 5404(d) of the Act).

109. Further, Section 5409 provides that if the attending physician or other health care provider cannot in good conscience comply with a declaration, or if the policies of the health care provider preclude compliance with a declaration, the patient must be informed about it. Further, they will make reasonable efforts to assist in the transfer of the patient to another physician or health care provider who would follow the declaration.

State of Washington

110. In the State of Washington, under the Revised Code of Washington, specifically RCW 70.122.030, any adult is competent to execute an advance directive.

111. As per RCW 70.122.030, a model form has been provided, which can be amended and additional specific directions incorporated. Further, the directive should be signed by the declarer in the presence of two witnesses not related to the declarer by blood or marriage and who would not be entitled to any portion of the estate of the declarer upon declarer's decease under any will of the declarer or codicil thereto then existing or, at the time of the directive, by operation of law then existing. In addition, the witness should not be the attending physician, an employee of the attending physician or a health facility in which the declarer is a patient. The witness should also not be any person who has a claim against any portion of the estate of the declarer upon declarer's decease at the time of the execution of the directive.

112. RCW 70.122.060 provides that a directive is conclusively presumed to be the directions of the patient regarding the withholding or withdrawal of life-sustaining treatment. However, it also states that a medical professional who acts in good faith with the directive or in accordance with a written plan made by them in relation to such directive shall not be criminally or civilly liable for failing to effectuate the directive of the qualified patient.

113. The consequences of not obeying the advance directives in other cases could potentially give rise to civil or criminal liability and amount to unprofessional conduct.

114. Under RCW 70.122.060, no medical professional can be required by law or contract to participate in the withholding or withdrawal of life-sustaining treatment if he has objections in doing so. Further, it is specified that such person would not be discriminated against in employment or professional privileges because of the person's participation or refusal to participate in the withholding or withdrawal of life-sustaining treatment.

RCW 70.122.110 expressly states that euthanasia, lethal injection or mercy killing is not condoned or authorised under the provisions related to advance directives.

115. From a survey of the legal regimes described above, it is submitted that the legal regimes discussed above have different approaches to the issue of advance directives.

116. All of the above discussed legal regimes indicate specific policy choices having been made by the concerned Governments,as to how, and in what manner,advance directives should be regulated and enforced.

117. It is respectfully submitted that at the very least, each of these legal regimes address the following questions, namely:

a. Who will be competent to execute an advance directive?

b. In what form will an advance directive have to be issued in order to be valid?

c. Who is to ensure that an advance directive is properly obeyed?

d. What legal consequences follow from the non-obedience to an advance directive?

e. In what circumstances can a doctor refuse to enforce an advance directive?

118. In the subsequent paragraphs, it is our respectful submission as to what the legal regime surrounding the legality and enforcement of advance directives should be in India.

C. LEGAL REGIME FOR THE ENFORCEMENT OF ADVANCE DIRECTIVES IN INDIA

119. At present, there is no legislation promulgated either by the Parliament or by a State Government on the topic of advance directives and their regulation. The only law relating to the stopping of treatment of a terminally ill person is Regulation 6.7 of the Indian Medical Council Regulations.

120. "Advance directives" as a subject matter is not mentioned in the Seventh Schedule of the Constitution of India but given the contours of the legislations examined above and the present limited legal regime, it is respectfully submitted that the subject matter of advance directives would fall within the purview of Entry 26 of List III relating to "legal, medical and other professions" as in pith and substance, it relates to the obligations of the doctor and the hospital towards a patient. This Hon'ble Court has observed in *A.S. Krishna v State of Madras* [AIR 1957 SC 297] that "[…] if a statute is found in substance to relate to a topic within the competence of the legislature, it should be held to be *intra vires,* even though it might incidentally trench on topics not within its legislative competence."

121. The pith and substance of a law relating to advance directiveswould be primarily dealing with the medical profession, it is therefore respectfully submitted that the Parliament will have the power to legislate upon the topic of advance directives as it falls within Entry 26 of List III relating to "legal, medical and other professions".

122. It is respectfully submitted that althoughthe legalisation and regulation of advance directives can be carried out through a law made by Parliament or any other competent legislature, thishowever does not detract from the power of this Hon'ble Court to hold and declare in exercise of its powers under Article 32 that advance directives will be valid and enforceable in a court of law. This Hon'ble Court has observed in the case of *State of West Bengal v. Committee for Protection of Democratic Rights* (2010) 3 SCC 571that the power conferred on this Hon'ble Court in clause (2) of Article 32"[…] is not confined to issuing the high prerogative writs specified in the said clause but includes within its ambit the power to issue any directions or

orders or writs which may be appropriate for enforcement of the fundamental rights".

123. It is therefore respectfully submitted that this Court is empowered, under Article 32, to direct that Advance Directives, executed in a legal manner, shall be valid and recognized in a court of law, and binding upon physicians who are required to act upon the same in terminating treatment of patients.

124. It is therefore respectfully submitted that following on from the best international practices described above, any legal regime which recognises the sanctity and validity of advance directives must address the following five issues, namely:

a. Who will be competent to execute an advance directive?

b. In what form will an advance directive have to be issued in order to be valid?

c. Who is to ensure that an advance directive is properly obeyed?

d. What legal consequences follow from the non-obedience to an advance directive?

e. Can a doctor, for reasons of conscience or faith, refuse to execute an advance directive?

125. The last question has been particularly framed in the context of the Constitution of India, specifically Article 25 which permits the freedom to practice one's religion and does not permit the State to compel a person to act contrary to her genuinely held religious beliefs.

126. Keeping in mind the judgements of the Supreme Court of India and foreign courts, the 196th Report of the Law Commission of India and foreign legislation that deal with the Advance Directives, we submit that this Hon'ble Court should address these issues as follows.

127. In relation to competence, it is humbly submitted that only an adult person, above the age of eighteen years and of sound mind at the time in

which such living is executed should be deemed to be competent to execute an advance directive. This should include persons who may suffer from mental disabilities provided they are of sound mind at the time of executing an advance directive, keeping in mind India's obligations under Article 12 of the UN Convention on the Rights of Persons with Disabilities, which requires the State to recognise that persons with disabilities enjoy equal legal capacity as others.

128. Addressing the concerns of the Law Commission as indicated in the 196th Report, it is respectfully submitted that only written advance directivesthat have been executed properly with the notarised signature of the person executing the advance directive, in the presence of two adult witnesses shall be valid and enforceable in the eyes of the law. Further, such advance directives may be in a format prescribed that requires a reaffirmation that the person executing such directive has made an informed decision.

129. With reference to the content of the advance directive, the Applicant submits that recognising only those advance directives relating to stoppage of life-saving treatment when the person executing the advance directive is no longer capable of making the decisionshould be adopted, since this is a clear and limited formulation of the concept. Therefore, only those advance directives which relate to stoppage of life support treatment when the creator of the advance directive is no longer in a position to make such a decision forherself should be recognised in law. The assessment that the creator of the advance directive is no longer capable of making the decision is a medical one, which would be decided in accordance with the relevant medical professional regulations.Life support treatment, for this purpose should be restricted to only such treatment that in the absence of which a person's life would terminate.

130. The primary responsibility of ensuring obedience to the wishes of the person who has executed an advance directive should be on the medical institution where the person is receiving such treatment. The procedure adopted to take a decision on whether or not the person is incapable of

making an informed decisionshould be taken in accordance with the existing procedure provided for by the Medical Council of India in Regulation 6.7 of the Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002. Once such a finding is made, and if there is an advance directive to the effect that treatment must be withdrawn, the hospital in question must be bound by the wishes of the person receiving treatment.

131. If any hospital refuses to recognise the validity of an advance directive produced by the relatives or the "next friend" of the person receiving treatment, such relatives or "next friend" would be empowered to approach the jurisdictional High Court seeking a writ of mandamus against the concerned hospital to perform its public duty as prescribed in the Indian Medical Council's regulations including taking into account the advance directive. The High Court can examine whether the advance directive has been properly executed, is still valid (i.e. whether or not the circumstances have fundamentally changed since its execution, making it invalid) and/or applicable to the particular circumstances or treatment,before directing the enforcement of the same by the Hospital.

132. No hospital or doctor should be made liable in any court of law, in either civil or criminal proceedings for having obeyed a validly executed advance directive and having followed the procedure laid down in the Indian Medical Council's Regulations.

133. On the issue of conscientious objection on the grounds of religion, since Article 25 protects an individual's right to follow their religion and lead their lives according to religious dictates subject to certain restrictions as held by this Hon'ble Court in *Bijoe Immanuel v State of Kerala* (1986) 3 SCC 615, it would not be constitutional to compel a doctor to go against her religious beliefs to withdraw treatment to a patient. However, this will not detract from the obligation of the hospital since, unlike educational institutions, hospitals do not enjoy any specific rights available to religious minorities in respect of treatment of individuals.

134. In summary, it is respectfully submitted that:

a. An advance directive is an expression of the right to refuse treatment and the right to die with dignity, which are both aspects of Article 21 of the Constitution of India.

b. There is no conflict between the judgments of this Hon'ble Court in *Gian Kaur* and *Aruna Shanbaug* in that they are consistent in upholding the right to refuse treatment and the right to die with dignity being aspects of the right to life and liberty under Article 21 of the Constitution of India.

c. The possibility of abuse of advance directives, as expressed in the 196th Report of the Law Commission of India, may be adequately addressed through procedural safeguards indicated in the directions of this Hon'ble Court in recognising the legal validity of advance directives.

d. The directions to recognise the legal validity of advance directives are:

    i. Only written advance directives indicating when treatment should be stopped shall be declared to be valid and binding in law and shall be enforceable against the physicians and hospital responsible for treating the patient who has executed such advance directive.

    ii. Only adults of sound mind, including adults with mental disabilities when they are of sound mind, should be permitted to execute an advance directive.

    iii. An advance directive will be binding upon the physician and hospital treating the patient without the need for a specific order from the court and no criminal, civil or professional liability will upon such physician or hospital for having properly followed an advance directive to withdraw treatment from a patient.

    iv. Where a physician or the hospital refuses to obey an advance directive, the relatives or the "next friends" of the patient shall

be entitled to move the jurisdictional High Court under Article 226 seeking enforcement of the advance directive.

v. No physician can be compelled to deny treatment contrary to his or her religious beliefs. However, this will not apply to the hospital and a hospital may be directed to fulfil the mandate of the advance directive.

135. That the Applicant therefore wishes to assist the Court on the above aspects outlined in this application and for this reason, may be permitted to intervene and place the relevant material before this Hon'ble Court for its consideration on this vital issue relating to the constitutional fundamental rights of all citizens.

136. That the Applicant has no pecuniary, proprietary or business interest in the subject matter of the present case and only seeks to assist this Hon'ble Court in laying down the law on this particular subject matter.

PRAYER

In view of the submissions made above, it is most respectfully prayed that this Hon'ble Court may be pleased to:

A) Allow the Applicant to intervene in the Writ Petition (Civil) No. 215 of 2005 and be pleased to array the Applicant Society as a party respondent in Writ Petition (Civil) No. 215 of 2005;

B) That this Hon'ble Court permit the Applicant to file the material for the kind consideration of the Hon'ble Court at the appropriate time; and

C) Pass any order (s) deemed fit and proper in the facts and circumstances of the case.

AND FOR THIS ACT OF KINDNESS THE APPLICANT HEREIN SHALL HUMBLY EVERY PRAY.

Place: New Delhi

Dated:

Drafted by:

AlokPrasanna Kumar, Advocate

Shubhangi Bhadada, Advocate

Manasi Kumar, Advocate

Filed by: