

# TOWARDS A ‘GOOD DEATH’: UNCOVERING THE CONFUSION IN END-OF-LIFE-CARE LAW IN INDIA

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*Legal confusion in end-of-life care law has remained a key barrier before dying with dignity in India. The history of legal developments on end-of-life care, however, is not linear, and has been marked by continuities, shifts, and a lack of clarity. This article excavates the history of Indian end-of-life care law to demonstrate how and why confusion has plagued Indian law. It argues that the Supreme Court’s guidelines in its landmark decision in *Common Cause v. Union of India* were practically unimplementable since they conflated “passive euthanasia” with the “withholding and withdrawing of life sustaining treatment,” disregarded patient autonomy and did not account for a surrogate decision-making framework for patients who lack decision-making capacity. Recently, the Supreme Court modified the *Common Cause* guidelines to address some of their practical issues, yet these substantive concerns remain relevant for any future legislative intervention on end-of-life care.*

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## I. INTRODUCTION

The Indian Council of Medical Research (‘ICMR’) defines end-of-life care as “an approach to terminally ill patients that shifts the focus of care to symptom control, comfort, dignity, quality of life and quality of dying rather than treatments aimed at cure or prolongation of life”.<sup>1</sup> End-of-life care involves the withholding and withdrawing of life-sustaining treatment and shifting the focus of medical attention to palliative care. The ICMR further defines palliative care as “a holistic approach to treatment that improves the quality of life of patients and their families facing the problems associated with life threatening illness, through the prevention and relief of suffering”.<sup>2</sup> For patients who are terminally ill and for whom the risks of further medical treatment are higher than any perceived benefits, end-of-life care can be essential to dying with dignity. Unfortunately, India falls behind in providing end-of-life care. A 2021 study on the quality of death and dying ranked India 59th amongst a group of 81 countries in the quality and provision of end-of-life care.<sup>3</sup>

Since the extent of public health spending contributes to the capacity to deliver such services, the level of public health spending is an obvious and significant indicator of the quality of palliative care.<sup>4</sup> However, structural, and attitudinal barriers against shifting the focus of care from curative to comfort care at the end-of-life also contribute to its quality.<sup>5</sup> While India has historically had low public health spending,<sup>6</sup> it is also a particularly good example of a jurisdiction where legal confusion has been a barrier to high quality end-of-life care.<sup>7</sup>

With an already high non-communicable disease burden and cancer remaining a leading cause of death,<sup>8</sup> the experiences with the Covid-19 pandemic

<sup>1</sup> Indian Council of Medical Research, *Definition of Terms Used in Limitation of Treatment and Providing Palliative Care at End of Life*, March 12, 2018, available at [https://main.icmr.nic.in/sites/default/files/Books/Definition\\_of\\_terms\\_used\\_in\\_limitation\\_of\\_treatment\\_and\\_providing\\_palliative\\_care\\_at\\_end\\_of\\_life.pdf](https://main.icmr.nic.in/sites/default/files/Books/Definition_of_terms_used_in_limitation_of_treatment_and_providing_palliative_care_at_end_of_life.pdf) (Last visited on August 15, 2023).

<sup>2</sup> *Id.*

<sup>3</sup> Eric A. Finkelstein et al., *Cross Country Comparison of Expert Assessments of the Quality of Death and Dying 2021*, Vol. 63(4), *JOURNAL OF PAIN AND SYMPTOM MANAGEMENT* (2022).

<sup>4</sup> The Economist Intelligence Unit, *The 2015 Quality of Death Index*, October 29, 2015, available at <https://impact.economist.com/perspectives/sites/default/files/2015%20EIU%20Quality%20of%20Death%20Index%20Oct%2029%20FINAL.pdf> (Last visited on December 18, 2021).

<sup>5</sup> *Id.*

<sup>6</sup> *In 2018-19, India just Spent 1.5% of its GDP on Healthcare, India needs to Raise Public Health Spending to 2.5-3.5% of GDP*, *THE ECONOMIC TIMES*, October 21, 2021, available at <https://economictimes.indiatimes.com/industry/healthcare/biotech/healthcare/india-needs-to-raise-public-health-spending-to-2-5-3-5-of-gdp-report/articleshow/87188111.cms?from=mdr> (Last visited on December 18, 2021).

<sup>7</sup> RK Mani et al., *The Advance Directives and Foregoing of Life Support: Where do we Stand now?*, Vol. 22(3), *INDIAN JOURNAL OF CRITICAL CARE MEDICINE*, 135-137 (2018); Stanley C. Macaden et al., *End of Life Care Policy for the Dying: Consensus Position Statement of Indian Association of Palliative Care*, Vol. 20(3), *INDIAN JOURNAL OF PALLIATIVE CARE*, 171-181 (2014).

<sup>8</sup> Prashant Mathur et al., *Cancer Statistics, 2020: Report from National Cancer Registry Programme, India*, Vol. 6, *JCO GLOBAL ONCOLOGY*, 1063-1075 (2020).

have only reiterated the need for clear end-of-life care policies.<sup>9</sup> In the absence of legislative interventions, Indian law has remained confined to judicial guidelines in landmark Supreme Court decisions like *Aruna Shanbaug v. Union of India* ('Aruna'),<sup>10</sup> and *Common Cause v. Union of India* ('Common Cause') that have proven un-implementable in practice.<sup>11</sup> These guidelines were animated by concerns of misuse by "unscrupulous persons" who may connive with "unscrupulous doctors" to inherit their relatives' property.<sup>12</sup> They provided an extremely restrictive process with multiple tiers of official authorization before treatment could be withheld or withdrawn, and the focus of care could shift to palliative care. This restrictive and cumbersome process made these guidelines almost impossible to implement.

This article argues that a key reason behind the unimplementability of these guidelines was conceptual confusion in end-of-life care law. Moreover, this confusion is not linked to any one development but is visible throughout the trajectory of legal developments which have been marked by both continuities and shifts. This includes judicial pronouncements and law reform proposals. Therefore, end-of-life care law in India has conflated concepts such as 'passive euthanasia' and the 'withholding and withdrawing of life-sustaining treatment' disregarded patient autonomy and failed to account for a framework of surrogate decision-making. To show how this has happened, this article traces the historical evolution of the legal developments around end-of-life care law and policy in India. It goes back to early Supreme Court decisions on the right to die and looks at various Law Commission reports that contributed to legal arguments around the provision of end-of-life care.

This lack of clarity resulted in a flawed law and policy framework on end-of-life care, exemplified by the highly restrictive nature of the judicial guidelines. Recently, in response to a clarification application filed by the Indian Society of Critical Care Medicine, the Supreme Court modified its guidelines in *Common Cause* thereby simplifying the procedures and addressing concerns regarding unimplementability.<sup>13</sup> However, the court did not address the conceptual issues underlying substantive end-of-life care law India. It thus becomes even more important to address these conceptual issues since, considering the status of

<sup>9</sup> Seema Rao et al., *Covid-19 Palliative and End-of-Life Care Plan: Development and Audit of Outcomes*, Vol. 28(3), INDIAN JOURNAL OF PALLIATIVE CARE (2022); Akshat Agarwal, *Covid-19 and the Need for a Framework to Support End of Life Decision-Making*, VIDHI CENTRE FOR LEGAL POLICY BLOG, March 24, 2020, available at <https://vidhilegalpolicy.in/blog/covid-19-and-the-need-for-a-framework-to-support-end-of-life-decision-making/> (Last visited on December 18, 2021).

<sup>10</sup> *Aruna Ramchandra Shanbaug v. Union of India*, (2011) 4 SCC 454.

<sup>11</sup> *Common Cause v. Union of India*, (2018) 5 SCC 1; Ambika Pandit, *Why Registering a 'Living will' is an Arduous Task Despite SC Guidelines*, THE TIMES OF INDIA, February 23, 2021, available at <https://timesofindia.indiatimes.com/india/why-registering-a-living-will-is-an-arduous-task-despite-sc-guidelines/articleshow/81144053.cms> (Last visited on December 18, 2021).

<sup>12</sup> *Aruna Ramachandra Shanbaug v. Union of India*, (2011) 4 SCC 454, ¶125.

<sup>13</sup> Indian Society of Critical Care Medicine (Applicant) in *Common Cause v. Union of India*, 2023 SCC OnLine SC 99.

judicially declared law and the high degree of deference that the Indian Parliament generally accords it, existing judicial decisions are likely to inform any future legislative activity.<sup>14</sup> Moreover, substantive law will still guide future judicial decisions on any disputes that may arise out of the implementation of these revised guidelines.

Part II traces early developments in Indian law on the right to die and Law Commission proposals for the withholding and withdrawing of life-sustaining treatment. Part III analyses the Supreme Court's key decisions in *Aruna* and *Common Cause* that recognized a constitutional right to die with dignity and upheld the legality of passive euthanasia. The article briefly details the judicial guidelines in *Common Cause* and explains why they have proven to be unimplementable. It also discusses the Supreme Court's recent modification of its earlier *Common Cause* guidelines. Part II looks at legal development pre-*Aruna* while Part III focuses on developments post-*Aruna* due to the decision's significance in bringing questions of end-of-life care to broader public attention. Part IV demonstrates how various conceptual confusions riddle existing end-of-life care law, which have contributed to the highly restrictive nature of the judicial guidelines. Part V, concludes the discussion by emphasizing that any future legislative intervention must account for these substantive concerns.

## II. PRE-ARUNA - RATHINAM, GIAN KAUR AND THE FIRST LAW COMMISSION REPORT

### A. RATHINAM AND GIAN KAUR

The earliest Supreme Court decision on the right to die was *P. Rathinam v. Union of India* ('*Rathinam*') in 1994,<sup>15</sup> where a division bench of the Court dealt with the constitutionality of §309 of the Indian Penal Code, 1860 ('*IPC*') that criminalized attempts to commit suicide.<sup>16</sup> The court held that Article 21 of the Constitution of India,<sup>17</sup> which recognizes the right to life and personal liberty, included the right not to live a forced life since a positive declaration of the right to live would logically include the right not to live, which is a right to die.<sup>18</sup> Consequently, the criminalization of attempted suicide was held to be unconstitutional.<sup>19</sup> The court also reasoned that such an attempt had no impact on the society or the State. Therefore, there was no state interest in restricting an individual's personal liberty through criminalization.<sup>20</sup>

<sup>14</sup> For an example of a comprehensive legislative proposal addressing end-of-care law in India, see Dhvani Mehta et al., *End of Life Care in India: A Model Legal Framework 2.0*, VIDHI CENTRE FOR LEGAL POLICY, February 4, 2021, available at [https://vidhilegalpolicy.in/wp-content/uploads/2021/02/Model-End-of-Life-Care-Bill\\_Version-2.0.pdf](https://vidhilegalpolicy.in/wp-content/uploads/2021/02/Model-End-of-Life-Care-Bill_Version-2.0.pdf) (Last visited on August 17, 2023).

<sup>15</sup> *P. Rathinam v. Union of India*, (1994) 3 SCC 394.

<sup>16</sup> Indian Penal Code, 1860, §309.

<sup>17</sup> The Constitution of India, 1950, Art. 21.

<sup>18</sup> *P. Rathinam v. Union of India*, (1994) 3 SCC 394, ¶¶33, ¶35.

<sup>19</sup> *Id.*, ¶35.

<sup>20</sup> *Id.*, ¶¶109-110.

Within two years, however, a constitution bench,<sup>21</sup> of the Supreme Court in *Gian Kaur v. State of Punjab*<sup>22</sup> ('Gian Kaur') overruled the decision in Rathinam. Gian Kaur dealt with the constitutionality of §306 of the IPC,<sup>23</sup> which criminalized the abetment of suicide. The petitioners had argued that since Rathinam had decriminalized suicide, abetments should be decriminalized as well, as the abettors were only assisting the realization of a constitutional right. The court rejected this argument and overruled Rathinam's reasoning. It held that the right to life could not contain a right to die since the extinction of life was inconsistent with the very idea of life and dignity under Article 21.<sup>24</sup> The court rejected analogies with other fundamental rights such as the freedom of speech which had been interpreted as containing a negative element.<sup>25</sup> In doing so the court emphasized that the right to life was a natural right and death was the unnatural termination of life and therefore a right to take one's own life could never be part of Article 21.<sup>26</sup>

The court, however, did observe that the right to human dignity under Article 21 meant the "existence of such a right up to the end of natural life".<sup>27</sup> Further clarifying, the court observed that this could include the "right of a dying man to also die with dignity when his life is ebbing out".<sup>28</sup> Illustrating such a right, the court alluded to a patient who is terminally ill or in a persistent vegetative state where the "process of natural death has commenced".<sup>29</sup> It, however, specifically pointed out that questions of physician-assisted suicide in such instances were "inconclusive", and such a conception could not include the right to terminate one's life.<sup>30</sup>

In a separate part of the judgment, where the court was specifically discussing abetment as an offense distinct from attempted suicide, the court referred to the British House of Lord's decision in *Airedale NHS Trust v. Bland* ('Bland').<sup>31</sup> Bland dealt with the question of withdrawing nutrition from a person in a persistent vegetative state and had held that in such instances, the State's interest in the sanctity of life was not absolute. The House of Lords had made a distinction between a physician's decision to not provide care to prolong life and the administration of a lethal injection to end life. Stressing on this distinction, the Indian Supreme Court reasoned that since such causation was relevant in the

<sup>21</sup> India's Supreme Court is a polyvocal court which sits and hears cases in various benches. According to the rules of precedent, a judicial ruling can only be overruled by a bench of a higher bench strength.

<sup>22</sup> *Gian Kaur v. State of Punjab*, (1996) 2 SCC 648.

<sup>23</sup> The Indian Penal Code, 1860, §306.

<sup>24</sup> *Gian Kaur v. State of Punjab*, (1996) 2 SCC 648, ¶¶22-23.

<sup>25</sup> *Id.*

<sup>26</sup> *Id.*

<sup>27</sup> *Id.*, ¶24.

<sup>28</sup> *Id.*

<sup>29</sup> *Id.*, ¶25.

<sup>30</sup> *Id.*, ¶¶24-25.

<sup>31</sup> *Airedale NHS Trust v. Bland*, (1993) 1 All ER 821 (HL) (United Kingdom House of Lords).

physician-assisted suicide context,<sup>32</sup> there was no reason why it would not be relevant in talking about abetment.<sup>33</sup> In other words, abetment, which concerned causing someone's suicide was more akin to the administration of a lethal injection, and therefore was different from attempting suicide. Thus, the reasons available to challenge the latter were not available to challenge the former.

It is important to note that this reference to Bland was in the context of abetment and was limited to illustrating the broader point about causation and was not an approval of Bland's reasoning. In fact, the court's discussion of the right to die with dignity and Bland occur in entirely different parts of the judgment and are not used to substantiate the conclusions arrived at in these parts. These observations about Bland while a matter-of-course in *Gian Kaur* become matters of controversy in later decisions.

Post *Gian Kaur* the question of suicide criminalization remained controversial, but was finally settled by Mental Healthcare Act, 2017 which stipulated that persons attempting suicide would not be prosecuted under §309 of the IPC.<sup>34</sup> Paradoxically, thus while *Gian Kaur*, which was primarily concerned with the criminalization of suicide and its abetment, as the article will go on to show, proved to be much more significant for its observations on the right to die with dignity.

## B. FIRST LAW COMMISSION REPORT

With regard to developments on end-of-life care law, after *Gian Kaur* the next major milestone was the Law Commission of India's 196<sup>th</sup> Report on the medical treatment of terminally ill patients published in 2006.<sup>35</sup> This report recommended legislation legally recognizing the withholding and withdrawing of life-sustaining treatment. The project was undertaken at the request of the Indian Society of Critical Care Medicine, a professional organization of medical doctors with a long history of advocating forend-of-life issues.<sup>36</sup> The report recommended that while euthanasia or physician-assisted suicide was illegal as per the decision in *Gian Kaur*, there was a global consensus that withholding and withdrawing of treatment from terminally ill patients should be permissible.<sup>37</sup> In making this recommendation it relied on *Gian Kaur*'s discussion on the right to die with dignity.

<sup>32</sup> It appears that in referring to "physician assisted suicide" the court had a broader notion of withholding and withdrawing life-sustaining treatment in mind. This is yet another illustration of the use of confusing terminology in Indian decisions on end-of-life care.

<sup>33</sup> *Gian Kaur v. State of Punjab*, (1996) 2 SCC 648, ¶43.

<sup>34</sup> Mental Healthcare Act, 2017, §115; Although, the Law Commission of India as far back as 2008 had recommended the decriminalisation of attempted suicide and had instead suggested instead treating such attempts as a mental health issue, see Law Commission of India, *Humanization and Decriminalization of Attempt to Suicide*, Report No. 210 (October 2008).

<sup>35</sup> Law Commission of India, *Medical Treatment of Terminally Ill Patients (Protection of Patients and Medical Practitioners)*, Report No. 196 (March 2006).

<sup>36</sup> Mani et al., *supra* note 7.

<sup>37</sup> *Supra* note 35, 390-408.

The report interpreted Gian Kaur as approving Bland for the propositions that the state's interest in the sanctity of life was not absolute and that in certain situations life-sustaining treatment could be withdrawn when the patient was close to death and there was no scope for recovery.<sup>38</sup> As this article just showed, Gian Kaur had only speculated about the right to die with dignity and its reference to Bland was only in passing and for a completely different proposition about abetment and causation. In interpreting Gian Kaur as approving Bland the Law Commission thus misread Gian Kaur. This misreading would have a long life going forward.

In discussing other aspects of end-of-life care law and policy the Report did not use the terminology of 'passive euthanasia' but only referred to the withholding and withdrawing of treatment from terminally ill patients. It centred the patient and observed that competent patients capable of making an informed decision could refuse life-sustaining treatment in accordance with their common law right to refuse treatment.<sup>39</sup> Not respecting such patient's refusal would have amounted to battery. In the case of incompetent patients or competent patients who were incapable of making an informed decision, the report recommended that the doctor could make a decision to withhold and withdraw treatment from the patient if it was in the best interests of the patient.<sup>40</sup> 'Best interests' was defined as including not just medical but also "ethical, social, moral, emotional and other welfare considerations."<sup>41</sup> To avoid misuse, the Report recommended several safeguards such as further approval of the doctor's decision by a three-member medical expert panel, record keeping of all withholding and withdrawing decisions with a public authority, and relaying of information to a conscious patient and their relatives along with an option to judicially review the medical decision to ensure that it was lawful.<sup>42</sup>

The Report's vision was firmly rooted in the doctor-patient relationship. It viewed withholding and withdrawing decisions for all incompetent patients as decisions taken by doctors in the best interests of the patient. It is this vision that informed the Report's analysis of whether the actions of the doctors amounted to criminal offences. The Report observed that the doctor's actions were not indicative of the intent to cause death but only showed that the doctor had knowledge that their actions may result in death.<sup>43</sup> Since such knowledge could potentially be

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<sup>38</sup> *Id.*, 336-337.

<sup>39</sup> Similar to other common law jurisdictions, Indian law recognizes a common law right to refuse treatment, *see* Samira Kohli v. Dr Prabha Manchanda, (2008) 2 SCC 1; For the common law position, *see* The Rt Hon Lady Justice Arden DBE, *Law of Medicine and the Individual: Current Issues What does Patient Autonomy mean for the Courts?* at JUSTICE KT DESAI MEMORIAL LECTURE 2017, COURTS AND TRIBUNALS JUDICIARY, December 8, 2017, available at <https://www.judiciary.uk/wp-content/uploads/2017/12/arden-lj-medicine-and-the-law-oct-2017.pdf> (Last visited on September 26, 2023).

<sup>40</sup> *Supra* note 35, 390-408.

<sup>41</sup> *Id.*, 405.

<sup>42</sup> *Id.*, 390-408.

<sup>43</sup> *Id.*, 379-392.

criminalized, these actions would be legally deemed ‘lawful’ when such decisions to withhold and withdraw treatment were in the patient’s best interests.<sup>44</sup>

The Government, however, did not take any action on the Law Commission’s recommendations. These early developments are notable for two reasons. *First*, even though Gian Kaur was not directly concerned with euthanasia or even with withholding and withdrawing, the Law Commission concluded otherwise by misreading Gian Kaur as approving the House of Lord’s decision in Bland. As the article showed, Gian Kaur’s reliance on Bland was in passing and for the completely unrelated proposition about causation and abetment. It did not rely on Bland for its reasoning on the right to die with dignity. The Law Commission, however, proceeded to misread Gian Kaur as recognizing withholding and withdrawing decisions. *Second*, in recommending the legalization of decision to withhold and withdraw treatment from terminally ill patients the Law Commission’s vision was firmly rooted in the context of the doctor-patient relationship. Thus, it viewed such decisions as primarily medical decisions taken by doctors in healthcare settings in the best interests of the patient. The idea of individual autonomy or past wishes did not play any significant role in the Law Commission’s framing of these issues. Rather, the Law Commission was primarily concerned with protecting the patients’ and doctors’ interests in healthcare settings.

### III. ARUNA, SECOND LAW COMMISSION REPORT AND COMMON CAUSE

#### A. ARUNA AND THE SECOND LAW COMMISSION REPORT

In 2011, the Supreme Court delivered its decision in Aruna. The tragic facts of this case captured public imagination and brought debates about euthanasia to the mainstream. In 1973, when Aruna Shanbaug was a nurse at Bombay’s KEM hospital another staff member violently sodomized her. The incident caused neurological injuries that left her in a permanent vegetative state. For close to 38 years, she was lovingly cared for by the nursing staff and doctors of the KEM hospital. Her own relatives were absent from her life. The petition was filed by a social activist acting as her next friend who sought orders from the court to direct the hospital to stop feeding her and let her die. The KEM hospital opposed this and cited the excellent care it had given her over the years. The deep bond between Aruna and the hospital staff established due to decades of caring clearly informed the hospital’s position.<sup>45</sup>

In an opinion by Katju J., the Supreme Court articulated the issues before it as being one of “passive euthanasia”. It, therefore, conflated the withholding and withdrawing of life-sustaining treatment with passive euthanasia. This

<sup>44</sup> *Id.*, 394-395.

<sup>45</sup> The Dean of KEM Hospital submitted an affidavit before the Supreme Court opposing euthanasia. See *Aruna Ramachandra Shanbaug v. Union of India*, (2011) 4 SCC 454, ¶¶13-14.



marked a shift from the approach of the first Law Commission report which had not used the term 'passive euthanasia'. However, like the Law Commission, the Court interpreted Gian Kaur as approving the decision in Bland and therefore concluded that passive euthanasia in the case of terminally ill patients was legal in India.<sup>46</sup> Aruna thus perpetuated Gian Kaur's misreading of Bland thus giving a very long life to a legal misinterpretation. Moreover, the court went beyond the recommendations of the first Law Commission report and building on Gian Kaur, it explicitly recognized passive euthanasia in Indian law. In reaching this conclusion Katju J., also discussed why a doctor's decision to withhold and withdraw treatment was an omission and was therefore different from a positive action like the administration of a lethal injection which was otherwise illegal.<sup>47</sup> The legal recognition of passive euthanasia in Aruna thus ultimately traced back its legal authority to the first Law Commission Report's mistaken interpretation of Gian Kaur's approval of Bland.

Acknowledging that competent patients could refuse treatment and having concluded that Indian law permitted passive euthanasia, the key question that the court framed for itself was "who can decide whether life support should be discontinued in the case of an incompetent person".<sup>48</sup> This marked another shift from the approach of the first Law Commission report, which primarily saw such decisions in the context of a doctor-patient relationship. This is clearly visible in the guidelines the court issued to operationalize passive euthanasia in future cases, which are animated by concerns of misuse.<sup>49</sup> The court's use of terms such as "unscrupulous" in describing both doctors and relatives shows a marked distrust of both.<sup>50</sup>

In its guidelines, the court required that a decision to discontinue life-sustaining treatment should be taken by a surrogate such as a spouse or parents or any person acting as a next friend, including doctors.<sup>51</sup> Such a decision should be *bona fide* and in best interests. Furthermore, before being implemented the jurisdictional High Court should approve such a decision.<sup>52</sup> The High Court should appoint a panel of three medical experts to give their inputs and hear any other interested parties, including relatives or doctors.<sup>53</sup> However, the High Court should take the ultimate decision to withhold and withdraw treatment in the best interests of the patient. In Aruna, the court considered the hospital staff as the

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<sup>46</sup> *Id.*, ¶104.

<sup>47</sup> *Id.*, ¶78.

<sup>48</sup> *Id.*, ¶104.

<sup>49</sup> In Indian law, the court has often issued judicial guidelines to operationalize its decision. The court views this power as part of its constitutional power to lay down the law of the land, see *Vishakha v. State of Rajasthan*, (1976) 6 SCC 241.

<sup>50</sup> *Aruna Ramachandra Shanbaug v. Union of India*, (2011) 4 SCC 454, ¶125.

<sup>51</sup> *Id.*, ¶124.

<sup>52</sup> *Id.*

<sup>53</sup> *Id.*, ¶134.

surrogate decision-makers due to their long standing bond with her and deferred to their wishes against the discontinuation of life-sustaining nutrition.<sup>54</sup>

Thus, even though the court's decision did not lead to any actual withholding and withdrawing, it led to much public debate on passive euthanasia.<sup>55</sup> Soon after, the Law Commission of India published a second report taking a relook at the issue of passive euthanasia.<sup>56</sup> This second report was, however, unremarkable since it unequivocally endorsed the views of the Supreme Court in Aruna. Cumulatively, Aruna and the second Law Commission Report thus marked a complete shift from the approach of the first Law Commission Report. In line with Aruna, the Law Commission now suggested a new draft bill that required a doctor's decision to withhold and withdraw treatment followed by judicial approval. No legislative action was taken on this report either.

However, both the first and the second Law Commission reports were unanimous in rejecting the use of advance directives in end-of-life decision-making.<sup>57</sup> Their reasoning for doing so was also similar. They argued that introducing such an instrument in the Indian context would lead to unnecessary litigation about the instrument's veracity and implementation, and therefore doing so was not advisable. This refusal to recognize advance directives led to several petitions being filed before the Supreme Court asking for the legalization of such directives. These petitions culminated in the Supreme Court delivering another decision in Common Cause in 2018.

## B. COMMON CAUSE AND ITS AFTERMATH

Delivered by a five-judge bench, Common Cause again marked a radical shift in debates on end-of-life care due to its explicit focus on rights-based arguments. Common Cause was delivered by a bench of higher strength due to the need to reconsider Aruna's holding that passive euthanasia was legal in India, which was based on the mistaken view that Gian Kaur had approved Bland.<sup>58</sup> As

<sup>54</sup> This approach of the court has been criticized because it decentred Aruna's rights and privileged the views of the staff at KEM Hospital, see Ratna Kapur, *The Spectre of Aruna Shanbaug*, THE WIRE, May 18, 2015, available at <https://thewire.in/law/the-spectre-of-aruna-shanbaug> (Last visited on December 18, 2021).

<sup>55</sup> *The Aruna Shanbaug Case which Changed Euthanasia Laws in India*, THE ECONOMIC TIMES, March 9, 2018, available at <https://economictimes.indiatimes.com/news/politics-and-nation/the-aruna-shanbaug-case-which-changed-euthanasia-laws-in-india/a-landmark-verdict/slide-show/63231071.cms> (Last visited on December 18, 2021); Kavitha Iyer, *Legacy of Aruna Shanbaug Explained: Debate on Right to Die, Accountability for Life Lost*, THE INDIAN EXPRESS, October 26, 2021, available at <https://indianexpress.com/article/explained/legacy-of-aruna-shanbaug-explained-debate-on-right-to-die-accountability-for-life-lost/n> (Last visited on December 18, 2021); *Aruna Shanbaug Died a Natural Death Four Years after the Decision in 2015, Aruna Shanbaug: Brain-damaged India Nurse Dies 42 years after Rape*, BBC NEWS, March 18, 2015, available at <https://www.bbc.com/news/world-asia-india-32776897> (Last visited on December 18, 2021).

<sup>56</sup> Law Commission of India, *Passive Euthanasia – A Relook*, Report No. 241 (August 2012).

<sup>57</sup> *Id.*, 41; *Supra* note 35, 390-408.

<sup>58</sup> Common Cause v. Union of India, (2018) 5 SCC 1, ¶39 (per Misra CJI).

this article showed, this reading of Gian Kaur can be traced further back to the views of the first Law Commission report.

The decision comprised four concurring judicial opinions which makes it hard to identify common strands in reasoning.<sup>59</sup> However, all the judges were unanimous that Aruna's reading of Gian Kaur as approving Bland was flawed, and the issue of passive euthanasia had to be considered afresh. They arrived at this conclusion for the same reasons identified in this article, that Gian Kaur had discussed Bland in the context of abetment and causation and this discussion had no relevance for questions of the right to die with dignity.

The Supreme Court in Common Cause held that the right to die with dignity was a fundamental right which had to be explicitly recognized as part of Article 21's guarantee of life and personal liberty. Further, the court held that concepts of autonomy and dignity inherent in Article 21 necessitated the recognition of (i) a terminally ill patient's right to refuse treatment, (ii) passive euthanasia, which the court interpreted as the withholding and withdrawing of treatment to accelerate the process of death when death is inevitable, and, (iii) advance directives to express future wishes regarding passive euthanasia upon the loss of competence.

The court relied on concepts of both patient autonomy, which respects self-determination and the ability to take one's medical decisions, and dignity, which accounts for judgments about the quality of life at the end of life, as a theoretical basis for its reasoning. In recognizing advance directives, the court considered it necessary to account for the past wishes of formerly competent patients to respect their autonomy and dignity fully. However, it did not consider such autonomy interests absolute and felt that they should be balanced with medical judgments in the best interests of the patient.<sup>60</sup> This understanding of autonomy interests had significant implications for how the court designed its eventual guidelines which enforce several checks on the patient's exercise of autonomy.

With regard to permitting passive euthanasia for patients who are not competent to make medical decisions, the notion of medical futility informed the judges' reasoning. For instance, both Misra's CJI,<sup>61</sup> and Chandrachud's J.,<sup>62</sup> opinions stress how passive euthanasia, by removing unnecessary medical treatment, leads to death in the natural course. In fact, Chandrachud J., viewed passive euthanasia as an extension of the principle of sanctity of life since extending life when medical treatment was futile would not further the sanctity of life.<sup>63</sup> He also reasoned that since passive euthanasia did not require the intent to cause death, it

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<sup>59</sup> The four opinions are authored by Misra CJI., (joined by Khanwilkar J.), Chandrachud J., Sikri J., and Bhushan J.

<sup>60</sup> Common Cause v. Union of India, (2018) 5 SCC 1, ¶120 (per Chandrachud J.).

<sup>61</sup> *Id.*, ¶¶159-160 (per Misra CJI.).

<sup>62</sup> *Id.*, ¶60 (per Chandrachud J.).

<sup>63</sup> *Id.*, ¶¶60,63 (per Chandrachud J.).

would not constitute a criminal offense. Rather such an act to withhold and withdraw treatment was in the best interests of the patient and hence was in furtherance of a physician's duty of care.<sup>64</sup> The focus on medical futility and the inevitability of death shows that the court understood best interests as a purely medical decision.

Like Aruna, pending the enactment of a law by Parliament, the judges in Common Cause too issued guidelines.<sup>65</sup> Mainly authored by Misra CJI., all the other judges concurred with him. While Common Cause did not use language similar to Aruna in expressing its unease with the implementation of passive euthanasia, the tone set by Aruna clearly informs its guidelines, which lay down an equally, if not more, restrictive procedure.

Unlike Aruna, the court's guidelines revolve around the presence or absence of advance directives. They also create an elaborate set of conditions for the execution of advance directives that require attestation by two witnesses and countersigning by a judicial magistrate of the first class.<sup>66</sup> The magistrate is required to preserve a copy and further share copies with the District Court, relatives of the executor, the local government, and a family physician, if available.<sup>67</sup> The process of giving effect to the advance directive only kicks in if the patient was terminally ill or was undergoing treatment for an incurable illness with no hope for recovery.<sup>68</sup> The physician was required to ascertain if an advance directive exists and then discuss withholding and withdrawing with the patient and their relatives.<sup>69</sup>

The implementation of the directive required three-levels of authorization, *first*, by a three-member medical board at the hospital, and *second*, by a district-level committee of medical experts, and *third*, by the Judicial Magistrate.<sup>70</sup> In case of disagreement at any stage, the parties could approach the jurisdictional High Court.<sup>71</sup> For persons with no advance directives, if the health conditions are satisfied, the physician may initiate a virtually similar process involving authorization at three levels.<sup>72</sup>

Needless to say, these guidelines were incredibly arduous and did not account for the realities or resource constraints of real-life critical care settings in India.<sup>73</sup> Based on information available in the public domain, they have never been

<sup>64</sup> *Id.*, ¶98 (per Chandrachud J.).

<sup>65</sup> *Id.*, ¶191 (per Misra CJI).

<sup>66</sup> *Id.*, ¶191(c) (i) (per Misra CJI).

<sup>67</sup> *Id.*, ¶191(c) (per Misra CJI).

<sup>68</sup> *Id.*, ¶191(d) (i) (per Misra CJI).

<sup>69</sup> *Id.*, ¶191(d) (iii) (per Misra CJI).

<sup>70</sup> *Id.*, ¶191(d) (iv)-(vii) (per Misra CJI).

<sup>71</sup> *Id.*, ¶191(e) (per Misra CJI).

<sup>72</sup> *Id.*, ¶192 (per Misra CJI).

<sup>73</sup> Mani et al, *supra* note 7. The guidelines have been criticized for introducing needless bureaucratic procedures which are impossible to implement due to the time-sensitive nature of end of life decision-making, *see* Clarification application filed by the Indian Society of Critical Care Medicine, available on file with the author.

fully implemented in India.<sup>74</sup> Due to the impossibility of following the Supreme Court's mandated procedure, hospitals and professional associations came up with their own processes and internal guidelines to give effect to the withholding and withdrawing of life-sustaining treatment.<sup>75</sup> Even getting the advance directive attested by the judicial magistrate was an incredibly complicated process, with very few people having managed to get their advance directives executed.<sup>76</sup> In instances where magistrates were approached, they often expressed ignorance about the procedure in Common Cause or cited the absence of any instructions for countersigning such directives.<sup>77</sup> In one instance, where an elderly couple sought to get their advance directives executed it took them more than nine months to do it.<sup>78</sup>

Recently, the Indian Society of Critical Care Medicine filed an application before the Supreme Court seeking a clarification of the Common Cause guidelines.<sup>79</sup> They sought a modification of the earlier guidelines citing concerns such as the time-sensitive nature of end-of-life decisions which made following such a protracted process virtually impossible to follow in practice.<sup>80</sup> Consequently, based on inputs from the petitioners and the central government, a constitution bench of the Supreme Court issued revised guidelines.<sup>81</sup> These revised procedures address many of the problems with the earlier Common Cause guidelines. For instance, for the execution of advance directives they do away with

<sup>74</sup> There appears to be one instance where the High Court of Madras constituted a committee to look into a potential case of withholding/withdrawing, see *R. Thirumeni v. Union of India*, 2018 SCC OnLine Mad 3303; However, the judicial order indicates that the patient's medical situation improved soon after; Interestingly, over the years several petitions unsuccessfully seeking active euthanasia have been filed before Indian High Courts, see *HB Karibasamma v. Union of India*, 2012 SCC OnLine Kar 9051; *Mukta Mehra v. State of Uttarakhand*, 2014 SCC OnLine Utt 414; *Chandrakant v. State of Maharashtra*, 2020 SCC OnLine Bom 10188.

<sup>75</sup> AIMS, New Delhi, *Guidelines for End of Life Care*, February 24, 2021, available at <http://www.palliativecare.in/wp-content/uploads/2021/03/Final-Guidelines-for-End-of-Life-Care-Policy-at-AIIMS-New-Delhi-2021.pdf> (Last visited on December 18, 2021); Palliative Medicine and Supportive Care Department, Kasturba Hospital, Manipal, *Before Life Ends, Understand and Evaluate the Choice of Medical Treatment Offered Methodised Action Plan for Limitation of Life-Sustaining Treatment and End of Life*, 2010, available at <http://vishnudutas.com/wp-content/uploads/2020/03/Blue-Maple-1-End-of-Life-CarePolicy-Document-of-Manipal-Hospitals-1.pdf> (Last visited on December 18, 2021); Sydney Morss & John F P Bridges, *Improving End-of-Life Care and Decision-Making, Information Guide to Facilitate Execution of End-of-Life Decisions*, Vol. 30(8), JOURNAL OF GENERAL INTERNAL MEDICINE(2019); Sushma Bhatnagar et al, *Institutional End-of-Life Care Policy for Inpatients at a Tertiary Care Center in India: A Way Forward to Provide a System for a Dignified Death*, Vol. 155(2), INDIAN JOURNAL OF MEDICAL RESEARCH, 232-242 (2022).

<sup>76</sup> Pandit, *supra* note 11.

<sup>77</sup> Clarification application filed by the Indian Society of Critical Care Medicine, available on file with the author.

<sup>78</sup> *Chandigarh: Retired Prof Couple Execute Living will, Say 'Want to Die with Dignity'*, THE INDIAN EXPRESS, December 21, 2019 available at <https://indianexpress.com/article/cities/chandigarh/chandigarh-retired-prof-couple-execute-living-will-say-want-to-die-with-dignity-6177839/> (Last visited on December 18, 2021).

<sup>79</sup> *Common Cause v. Union of India*, (2018) 5 SCC 1.

<sup>80</sup> *Id.*

<sup>81</sup> *Indian Society of Critical Care Medicine (Applicant) in Common Cause v. Union of India*, 2023 SCC OnLine SC 99.

requirement of countersigning by the jurisdictional judicial magistrate, but only require attestation before a notary or gazetted government officer.<sup>82</sup> Additionally, the requirement to preserve copies with lower judiciary has been done away with and the directive only has to be preserved by the local municipal authorities.<sup>83</sup> Moreover, instead of three levels of authorization, withholding and withdrawing decisions now only require two levels of authorization, first, by a primary medical board comprising doctors in the hospital and a secondary medical board comprising at least one external doctor nominated by the Chief Medical Officer of the district.<sup>84</sup> The Judicial Magistrate First Class only needs to be informed before any withholding and withdrawing decisions are implemented.<sup>85</sup> In cases of disputes or disagreements between the medical boards, relatives or the patient, if the patient has capacity, the parties can approach the jurisdictional High Court.<sup>86</sup>

These revised guidelines are a welcome move and address many of the practical problems with the earlier Common Cause guidelines. What the Supreme Court's order, however, does not do, is address questions of substantive law or address what the conceptual basis for these revised guidelines is. Consequently, the critique of the earlier guidelines still remains relevant due to their link to substantive law which despite these procedural revisions continues to be operative. Since the Supreme Court's order does not go into questions of substantive end-of-life care law and policy, it has two concrete implications for future developments on end-of-life care law. *First*, any future legislative activity will look at earlier substantive end-of-life care law as laid down in judicial decisions like Aruna and Common Cause. *Second*, as and when disputes under the revised guidelines arise courts will necessarily have to deal with the conceptual assumptions of end-of-life care law to resolve such disputes.

Common Cause marked a complete shift from the approach of the first Law Commission report and Aruna. It did so in three ways. *First*, it explicitly introduced rights-based language and viewed both passive euthanasia and the execution of advance directives as part of the right to die with dignity. This provided a much stronger legal basis for end-of-life care in India. *Second*, rather than focusing on the patient or substituted decision-making for withholding and withdrawing, its guidelines were primarily concerned with the procedural aspects of executing advance directives and implementing the withholding and withdrawing decision. *Third*, it appeared to have struck a middle path between merely requiring medical authorization and necessitating judicial approval by involving district-level administration and the lower judiciary in the process. The revised guidelines perhaps make this middle path less cumbersome by only requiring approvals by the primary and secondary medical boards.

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<sup>82</sup> *Id.*, at 7-16.

<sup>83</sup> *Id.*

<sup>84</sup> *Id.*

<sup>85</sup> *Id.*

<sup>86</sup> *Id.*

Aruna and Common Cause have been watershed in moving forward the conversation on end-of-life care law and policy in India, however, as the next Part shows both decisions have fallen short in providing the necessary conceptual clarity.

#### IV. LACK OF CLARITY IN INDIAN END-OF-LIFE CARE LAW

The historical trajectories in Parts II and III help in understanding how far issues of end-of-life care law and policy in India have come and how each stage has been characterized by both continuities and shifts. I will now show that despite these major developments, the law is characterized by a lack of conceptual clarity. The unenforceability of the Common Cause guidelines was a key consequence of this confusion. I identify three major reasons:

##### A. CONFLATING 'PASSIVE EUTHANASIA' WITH THE 'WITHHOLDING AND WITHDRAWING OF LIFE-SUSTAINING TREATMENT'

While the first Law Commission report did not use the term 'passive euthanasia' and only referred to the 'withholding and withdrawing of life-sustaining treatment', since Aruna, the two have been conflated. As Ian Brassington has argued, both Aruna and Common Cause show a lack of clarity in how they understand passive euthanasia, with judges often relying on conflicting definitions.<sup>87</sup>

Gerrard and Wilkinson argue that the definition of 'passive euthanasia' in bioethics is usually understood to have three elements: (i) there is the withdrawal and withholding of life-sustaining treatment, (ii) such withholding or withdrawing is done with the intention of causing or hastening the patient's death and (iii) this is done because dying is considered to be in the best interests of the patient.<sup>88</sup> Passive euthanasia is understood to be in best interests when the current quality of the person's life is considered to be worse than death.<sup>89</sup> These factors distinguish passive euthanasia from the various other situations which may lead to the withholding and withdrawing of life-sustaining treatment. Gerrard and Wilkinson argue that such situations could include medical futility, the cost-ineffectiveness of treatment, excessively burdensome or harmful nature of treatment, or the patient's autonomous refusal to receive treatment.<sup>90</sup> In all these cases either there is both the absence of an intention to cause death, and the doctor's actions are motivated by a reason other than a mere quality-of-life determination i.e., best interests.

<sup>87</sup> Ian Brassington, *How not to Talk About Passive Euthanasia: A Lesson From India*, Vol. 6(1), INDIAN J. MED ETHICS (2021).

<sup>88</sup> E. Gerrard & S. Wilkinson, *Passive Euthanasia*, Vol. 31(2), J. MED ETHICS, (2005).

<sup>89</sup> *Id.*

<sup>90</sup> *Id.*

The first Law Commission Report more or less adhered to this broader understanding of withholding and withdrawing, which is consistent with the fact that the report did not use the term ‘passive euthanasia.’ Like arguments made by Gerrard and Wilkinson, the report explicitly notes the difference between the two terms as being the absence of an intention to cause death.<sup>91</sup> Moreover, the report takes a broader view of best interests as not only including medical but also including “ethical, social, moral, emotional and welfare considerations”<sup>92</sup> The report therefore appears to understand withholding and withdrawing in the broadest sense rather than restricting its approach to just questions of passive euthanasia.

With Aruna, this distinction collapses as both Aruna and Common Cause conflate withholding and withdrawing with passive euthanasia. As Brassington has shown, at different points of the opinions, the judges seem to both include the intention to cause death as well as the absence of such intention in their analysis.<sup>93</sup> Consequently, while medical futility, the fact that further medical treatment is non-beneficial and would only prolong death when death is otherwise inevitable, seems to play an important role in the court’s reasoning in legalizing passive euthanasia, its guidelines seem to show a heightened concern with misuse by scheming doctors and relatives. This is demonstrated by the cumbersome procedures that the guidelines lay down which are ostensibly meant to act as checks against unscrupulous uses of end-of-life procedures. It is worth questioning why such stringent procedures are necessitated when the court has already limited end-of-life decisions to situations in which death is inevitable and where medical actions are not motivated by an intention to cause death? After all, is it ethical for doctors to continue to provide treatment which does not benefit their patients?

The first Law Commission Report only recommended approval of the physician’s decision by a medical board of three experts. Aruna required judicial approval. By the time Common Cause was pronounced, three levels of approval had become necessary. The revised Common Cause guidelines now require two levels of authorization. The more tiers of scrutiny, the more time-consuming the process becomes, and the implementation of such procedures requires greater investment of resources. Existing medical literature shows that end-of-life care decisions in critical care settings need to be time efficient to be effective.<sup>94</sup> Moreover, in the Indian healthcare context where public health capacity and personnel shortages are a perennial issue implementing more resource-intensive end-of-life interventions is bound to be difficult and is especially likely to exclude the marginalized who may not have access to resource-rich healthcare facilities.<sup>95</sup>

<sup>91</sup> *Supra* note 35, 304.

<sup>92</sup> *Id.*, 5.

<sup>93</sup> Brassington, *supra* note 87.

<sup>94</sup> Statement issued by the Indian Society of Critical Care Medicine dated 21 August 2018, available on file with the author; for studies on the average length of patient stay in critical care settings, see JV Divatia et al., *Intensive Care in India: The Indian Intensive Care Case Mix and Practice Patterns Study*, Vol. 20(4), *INDIAN J. CRIT CARE MED.*, 216-225 (2016).

<sup>95</sup> Problems in Indian healthcare are plentiful and include the lack of human resources as well as cost-effective healthcare services, see Kasthuri A., *Challenges to Healthcare in India - The Five A’s*, Vol. 43(3), *INDIAN J COMMUNITY MED.*(2018).



It is difficult to not link these heightening tiers of scrutiny with the court's increasing conflation of passive euthanasia and withholding and withdrawing of life-sustaining treatment. Passive euthanasia explicitly involves an intention to cause death which is what has worried the courts and has made them enforce several tiers of scrutiny. In contrast, an approach to withholding and withdrawing which was visible in the First Law Commission Report focused on the necessity of such procedures based on an assessment of the patient's medical condition.<sup>96</sup> Therefore, apart from creating uncertainty in the law,<sup>97</sup> the lack of conceptual clarity in these decisions led to the formulation of end-of-life care procedures, as was the case in *Common Cause*, that were impractical to implement in practice.

It is noteworthy that medical professional organizations in India have primarily called for recognizing medical futility and the dying process as leading to withholding and withdrawing instead of asking for legalizing passive euthanasia.<sup>98</sup> This distinction is important since in this framing withholding and withdrawing proceeds from medical assessment that further medical intervention is likely to be non-beneficial, so continuing medical treatment is not in the best interests of the patient. This distance between the medical and judicial framing may also explain why doctors continue to view the confused state of the law as a major barrier to end-of-life decision-making.<sup>99</sup>

## B. DISREGARDING PATIENT AUTONOMY

Instead of determining the patient's competence and deferring to patient autonomy, the guidelines in *Common Cause* appeared to treat advance directives as the starting point of end-of-life care procedures. In contrast, both the first Law Commission Report and *Aruna* stressed that the procedures they envisaged were only applicable in the case of an incompetent patient who is otherwise not competent to make a decision. This stress on decision-making capacity of patients is based on the need to respect patient autonomy. Interestingly, even the judges in *Common Cause* stressed a competent patient's right to refuse treatment as being both a common law as well as a constitutional right.<sup>100</sup> Bhushan J., in his opinion, particularly characterized the issues facing the court as being one of withholding and withdrawing of life-sustaining treatment from terminally ill, incompetent patients.<sup>101</sup> However, puzzlingly, Misra's CJI guidelines do not account for such a refusal by a competent patient and instead, paradoxically require that the physician

<sup>96</sup> See *supra* Part II on "Pre-Aruna - Rathinam, Gian Kaur and the First Law Commission Report".

<sup>97</sup> Brassington, *supra* note 87.

<sup>98</sup> Sheila Myatra et al., *End-of-Life Care Policy: An Integrated Care Plan for the Dying: A Joint Position Statement of the Indian Society of Critical Care Medicine (ISCCM) and the Indian Association of Palliative Care (IAPC)*, Vol. 18(9), INDIAN J. CRIT CARE MED, 615-635 (2014); However, bio ethicists such as Ian Brassington have argued that the definition of passive of euthanasia is preferable over a broader understanding of withdrawing/withholding, see Ian Brassington, *What passive euthanasia is*, Vol. 21, BMC MEDICAL ETHICS (2020).

<sup>99</sup> See Mehta, *supra* note 14.

<sup>100</sup> *Common Cause v. Union of India*, (2018) 5 SCC 1, ¶¶128-129 (per Sikri J.).

<sup>101</sup> *Id.*, ¶83 (per Bhushan J.).

discuss the advance directive with the patient and ensure that the patient “understands the information provided, has cogitated over the options and has come to a firm view that the option of withdrawal or refusal of medical treatment is the best choice”.<sup>102</sup> Such a requirement goes against the common understanding of advance directives, which are only meant to indicate past wishes when the person has lost the competence to make decisions.<sup>103</sup> If the person possesses the competence to decide, then paying regard to past wishes is ethically meaningless since wishes regarding life-sustaining treatment can be expressed in the present.

In fact, the revised Common Cause guidelines now require the treating physician to only consider the advance directive if the patient “does not have decision-making capacity”.<sup>104</sup> This re-establishes the primacy of patient autonomy in the end-of-life care process. However, since the Supreme Court’s order issuing the revised guidelines does not go into questions of substantive law, it is important to re-emphasize the significance and implications of patient autonomy in the end-of-life care context.

There are three distinct implications of patient autonomy. *First*, given the common law right to refuse treatment,<sup>105</sup> and Common Cause’s emphasis on a similar constitutional right, under Indian law patients have the unequivocal right to refuse medical treatment.<sup>106</sup> This can be at any stage of illness and not just terminal illness. In short, patients cannot be compelled to receive medical treatment. *Second*, if physicians think that further medical treatment is futile and the patient has the decision-making capacity to make decisions, then physicians can initiate end-of-life care conversations with the patient. In such cases, however, any end-of-life care measures such as the withholding and withdrawing of treatment would depend on the consent of the competent patient. If the patient does not consent then such procedures cannot be implemented. However, physicians are generally not obliged to continue to provide medical treatment that they may consider futile or ethically questionable.<sup>107</sup> *Third*, advance directives represent past wishes or previous expressions of patient autonomy that only become operational when doctors determine that end-of-life care procedures are necessary such as in case of

<sup>102</sup> *Id.*, ¶191 (per Misra CJI).

<sup>103</sup> Agnieszka Jaworska, *Advance Directives and Substitute Decision-Making in Edward N. Zalta (ed.), THE STANFORD ENCYCLOPEDIA OF PHILOSOPHY* (2017 Ed.), available at <https://plato.stanford.edu/archives/sum2017/entries/advance-directives/> (Last visited on December 18, 2021).

<sup>104</sup> Indian Society of Critical Care Medicine (Applicant) in *Common Cause v. Union of India*, 2023 SCC OnLine SC 99, ¶8.

<sup>105</sup> See *supra* Part III. A on “Aruna and the Second Law Commission Report”.

<sup>106</sup> *Id.*

<sup>107</sup> This is a general consensus amongst bioethicists, see Sandeep Jauhar, “Can Doctors Refuse to Treat a Patient?” *THE NEW YORK TIMES*, May 13, 2019, available at <https://www.nytimes.com/2019/05/13/opinion/can-doctors-refuse-patients.html> (Last visited on August 15, 2023); See *The Code of Medical Ethics Regulations, 2002, Regulation 2.1.1*; *The Code of Medical Ethics Regulations, 2002 in India envisages such a situation when the patient’s illness is not within the physician’s range of experiences.*

terminal illness *and* when the patient does not have the decision-making capacity to express their autonomous wishes in the present.<sup>108</sup>

The guidelines in Common Cause conflated these implications of patient autonomy thereby creating conceptual confusion.

### C. FAILING TO ACCOUNT FOR A FRAMEWORK OF SURROGATE DECISION-MAKING FOR PATIENTS WHO LACK CAPACITY

At the heart of issues around end-of-life care for patients who lack decision-making capacity are questions of how decisions for persons with impaired capacity should be taken.<sup>109</sup> Indian law on end-of-life care, especially the guidelines in Common Cause, demonstrated a lack of clarity about decision-making issues. Buchanan and Brock, in their work, have created one of the most comprehensive frameworks to understand how decision-making for persons with impaired capacity or substituted decision-making works.<sup>110</sup> They identify four key sets of principles:<sup>111</sup>

Ethical Value Principles – These refer to the overall values that inform a framework of substituted decision-making. They identify self-determination, concern for individual well-being, and distributive justice as three ethical principles.<sup>112</sup> Self-determination refers to autonomy, well-being to objective interests, and distributive justice to balancing individual and societal interests.<sup>113</sup>

Guidance Principles – refer to the principles which provide the basis for making decisions on behalf of the person with impaired capacity.<sup>114</sup> Buchanan and Brock identify three standards: best interests, substituted judgment, and advance directives. Best interests seek to maximize individual well-being from an objective perspective, and in medical ethics are indicative of the moral principle of beneficence.<sup>115</sup> Substituted judgment tries to replicate the individual's decision and is therefore based on their supposed wishes and preference.<sup>116</sup> Advance direc-

<sup>108</sup> See generally Jaworska *supra* note 103.

<sup>109</sup> See generally, Akshat Agarwal & Kim D'Souza, *Decision-Making for Persons with Impaired Capacity: A Background Paper*, VIDHI CENTER FOR LEGAL POLICY, March 19, 2021, available at <https://vidhilegalpolicy.in/wp-content/uploads/2021/03/Decision-Making-for-Persons-with-Impaired-Capacity-Full.pdf> (Last visited on September 26, 2023).

<sup>110</sup> See generally, ALLEN E. BUCHANAN & DAN W. BROCK, *DECIDING FOR OTHERS: THE ETHICS OF SURROGATE DECISIONMAKING* (Cambridge University Press, 1989).

<sup>111</sup> Allen E. Buchanan & Dan W. Brock, *Deciding for Others*, Vol. 64, *THE MILBANK QUARTERLY*, 17-94, 49 (1986).

<sup>112</sup> *Id.*

<sup>113</sup> *Id.*

<sup>114</sup> *Id.*

<sup>115</sup> Jonathan F. Will, *A Brief History and Theoretical Perspective on Patient Autonomy and Medical Decision Making*, Vol. 139(6), *CHEST*, 1491-1497 (2011).

<sup>116</sup> Buchanan & Brock, *supra* note 111.

tives are legal instruments through which individuals may indicate their wishes for future decisions, including the appointment of surrogate decision-makers.<sup>117</sup>

Authority Principles – refer to those who possess the authority to decide on behalf of the person who lacks capacity.<sup>118</sup>

Intervention Principles – refer to situations when public authorities like courts intervene in decisions made on behalf of persons who lack capacity because such decisions affect their important interests.<sup>119</sup>

While the content of individual principles may vary the four broad heads provide a useful framework for understanding the various elements of a legal and policy framework for substituted decision-making. In *Common Cause*, while the overall ethical principles of both respect for autonomy and objective well-being (articulated as dignity) are clear, the court appears to either conflate the remaining principles or fails to identify them, which leads to conceptual confusion.

For instance, the court’s starting point for the operationalization of its guidelines seemed to require that the patient either be terminally ill or be undergoing prolonged treatment without hope of cure or recovery. The physician was then required to follow the advance directive (if one existed) and inform the patient and their relatives about the withholding and withdrawing. Therefore, it appeared that the physician was deciding according to the advance directive. However, immediately after, the guidelines also stressed that the physician should ensure that the patient or relative has come to the “firm view that the option of withdrawal or refusal of medical treatment is the best choice”.<sup>120</sup> Leaving aside the fact the patient may not be able to take this decision since they are likely to lack decision-making capacity at this point, the language also shows the conflation of two guidance principles, advance directives which seek to secure autonomy and some understanding of best interests based on more objective considerations.

While the guidelines stipulate that advance directives can name a surrogate who can consent to withholding and withdrawing,<sup>121</sup> the surrogate’s role in the overall procedure remains unclear. For instance, is the physician taking the first decision to withhold and withdraw, or is the physician initiating an end-of-life conversation where the surrogate is ultimately vested with the authority of taking the final decision? In contrast, as this article discussed Aruna was specifically concerned with the question of who takes such a decision for an incompetent person.<sup>122</sup> It is of course, likely that the decision may be a result of rounds of shared decision-making between the physician and the surrogate; however, the guidelines

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<sup>117</sup> *Id.*

<sup>118</sup> *Id.*

<sup>119</sup> *Id.*

<sup>120</sup> *Common Cause v. Union of India*, (2018) 5 SCC 1, ¶191(d)(iii) (per Misra CJ).

<sup>121</sup> *Id.*, ¶191(b)(v) (per Misra CJ).

<sup>122</sup> *See supra* Part III.A on “Aruna and the Second Law Commission Report”.

do not clarify this. This position remains unchanged in the revised Common Cause guidelines.<sup>123</sup>

Moreover, under the original Common Cause guidelines the initial decision had to be certified by three different authorities, the hospital-level medical board, the district-level medical board, and the judicial magistrate. Under the revised Common Cause guidelines, the decision must be certified two authorities, a primary medical board and a secondary medical board constituted by the hospital. The secondary medical board should have at least one doctor nominated by the Chief Medical Officer of the District.<sup>124</sup> In both sets of guidelines, it is unclear what precisely these authorities are certifying. One kind of certification could be that they agree that the advance directive should be followed, which would entail certifying the validity of the directive itself. Another kind of determination could be a decision that the withholding and withdrawing of treatment is in the best interests of the patient. A third kind could be the certification of the patient's initial medical condition. The guidelines, however, do not specify any of this.

Since these tiers of authorization are also applicable when there is no advance directive, it appears that their decisions are likely based on objective considerations. If this is so, then one necessarily has to question the precise relevance of the advance directives which individuals have gone through pains to execute. One could imagine that these tiers of authorization represent interventions to protect important interests. The original Common Cause guidelines required authorizations by a board of three medical experts and a judicial magistrate. It is unclear if these authorities would have protected similar interests. The revised Common Cause now require authorization by two medical boards and only require the final decision to be conveyed to judicial magistrate first class.<sup>125</sup> However, the precise interests these boards are protecting still remains unclear.

Compared to the first Law Commission report and Aruna, thus, while Common Cause shifts attention to past autonomous wishes, the results remain far from clear. Rather, it is likely that requiring multiple authorities to weigh in may eventually crowd out the original wishes of the patient since views expressed in the advance directive are never unequivocally implemented.

## V. CONCLUSION

Continuities, shifts and a lack of clarity have marked the evolution of end-of-life care law in India. While the first Law Commission report focused on withholding and withdrawing life-sustaining treatment in the broadest sense, the approach since Aruna has been to focus on passive euthanasia and recognizing medical futility as the starting point of withholding and withdrawing. The decision

<sup>123</sup> Common Cause v. Union of India, 2023 SCC OnLine SC 99,¶9.

<sup>124</sup> *Id.*, ¶10.

<sup>125</sup> *Id.*, ¶11.

in Common Cause shifts the focus to a rights-based understanding of individual autonomy, including past autonomy and dignity. Still, notions of medical futility continued to play a significant role in the court's reasoning and guidelines.

While the recently issued revised Common Cause guidelines remove some of the practical barriers such as doing away with the need to get the advance directive counter-signed by the judicial magistrate and reducing the tiers of authorization from three to two they do not clarify issues of substantive law. Therefore, despite these shifts and continuities, end-of-life care law and policy in India has been plagued by a lack of clarity.

The erstwhile Common Cause guidelines exemplified this lack of conceptual clarity. The article highlighted three major issues with the substantive law of end-of-life care in India. *First*, the law has tended to conflate "passive euthanasia" with the "withholding and withdrawing of treatment" which has informed the design of judicial guidelines. *Second*, the law has disregarded and not given complete effect to patient's autonomous choices and past wishes. *Third*, the current law lacks a developed theory of surrogate decision-making and does not clearly identify who is making which decisions and based on what standards.

In critiquing the law, the article acknowledges that issues of withholding and withdrawing of life-sustaining treatment and decision-making for persons with impaired capacity are complex and raise difficult issues of ethics, law, and policy. However, it is important to strive for conceptual clarity, or the resulting frameworks exacerbate existing problems. The Common Cause guidelines were a case in point where well-intentioned law led to the creation of a highly cumbersome procedure that was extremely difficult to implement in practice and did not account for the realities of Indian critical care settings. The revised Common Cause guidelines are a step in the right direction but do not clarify issues of substantive law.

Conceptual clarity in end-of-life care law would ultimately require legislative interventions. Unfortunately, neither the Parliament nor state legislatures have showed any willingness to enact such a law. This article's three interventions with regard to the need to make a clear distinction between passive euthanasia and withholding and withdrawing decisions, giving effect to patient autonomy and articulating a coherent theory of surrogate decision-making should however be the pillars of any future legislative intervention.

A clear and consistent legal framework can improve the quality of end-of-life care in India and by prioritizing dignity in dying ensure a 'good death'.