Volume 8, January 2020 ISSN 2581-5504

"Dying With Dignity" – The Promises and Problems of Common Cause, A Registered Society Vs Union of India"

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1.Introduction:

In 2018, in Common Cause, a Registered Society vs UoI[1] (in short, referred to as Common Cause) a 5 judges Bench of the Supreme Court of India legalized 'passive euthanasia' subject strictly, to the procedure laid down in guidelines of the court. It also recognized the concept of Advance Directives. The judgment is hailed as one which celebrates 'personal autonomy' of the individual. However on a closer evaluation, it looks like a mixed bag of promises and problems, especially with respect to individual autonomy. This paper seeks to critically comment on the commendable and the condemnable aspects of this judgment.

2.The achievements of Common Cause:

Common Cause marks a major victory for the champions of 'death with dignity' claims. Through a detailed analysis of the complex issue of euthanasia, the court uses its interpretive tool to read 'right to die with dignity' as a facet of the 'right to live with dignity' under Article 21. In holding this, the court gave an elaborate consideration to the intertwined cobweb of emotional, moral, religious and psychological aspects, apart from evaluating the legal position on this point in other jurisdictions of the world[2]. The case unleashes a completely new dimension of human **dignity.** It also depicts the humaneness of the law that is concerned about the quality of life, of death and of dying.

The judgment has been especially hailed as path-breaking for, by recognizing Advance Directives/Living wills for the very first time in India, it indeed celebrates **personal autonomy**. It enables a person to express his categorical wish in advance, of what must be done to him, if ever he slips into a 'Persistent Vegitative State' (PVS) in future. Thus the autonomy of the person can be respected and given effect to, even if, at any future unfortunate moment, the person becomes incapable of expressing any wish. Recognition of Advance Directives also eases the complications for the care-takers/relatives of the patient by relieving them of any attendant guilt in taking the decision to withdraw life-support. Hence to that extent, the judgment is commendable indeed.

[1] Common Cause, A Registered Society vs UoI and Another (2018) 5 SCC 1.
[2] Id at 54-59,103.

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3. The Discontents of Common Cause:

Firstly, as a general comment, it may be observed that this judgment looks like a compilation of four exhaustive essays on euthanasia, loaded in intense philosophical ideas about life and death. Notwithstanding that there is no dissent, yet four separate ornately worded opinions have been penned. Such lengthy judgments, it is respectfully submitted, can be avoided, thereby enabling a reader to get to the important aspects thereof with greater ease.

3A. Preliminary Objections:

The Court has issued guidelines[3] relating to Advance Directives and the procedure that must be followed before an Advance Directive can be given effect to.

Before indulging into a substantive review of the guidelines on merits, one is compelled to ask a more preliminary question about the propriety of the court to devise a procedure for deprivation of life through the strategy of judicial guidelines. When Article 21 proclaims that "No person shall be deprived of his life and personal liberty except according to **procedure established by law**"(emphasis supplied), one has to remember that Article 21 is addressed to the legislature and not to the judiciary. In matters of deprivation of life (which is precisely in issue here) the law and the procedure must be prescribed by the democratic legislature and not by the non-democratic judiciary. Hence I argue that if passive euthanasia has to be legalized, the appropriate institution that must be engaged in laying down the procedure therefor is the legislature alone. Though the court does express the anxiety and hope that legislature will engage itself sooner in the task of enacting the necessary law, yet until such a law is enacted the court says that its guidelines shall be the binding law. Vishakha's[4] case is a grim reminder that the day when the legislature will deliver the law may not dawn sooner[5].

Secondly, the court has followed the Vishakha precedent in filling the legislative vacuum through its guidelines. However even on this count, such an application of the Vishakha precedent (towards laying down guidelines) seems incorrect. In Vishakha, apart from the specific violation of fundamental rights under Articles 14 & 21, there was also an obligation under CEDAW, to which India was a signatory. Such an obligation was not there in the present case. Hence the court should have ideally confined itself to declaring whether right to die is a part of right to life, leaving the subsequent task of specifying the procedure for ending life in the hands of the legislature. Secondly, in Vishakha, when the court laid down guidelines against sexual harassment of women, by doing so, it added something more to the quality of life. In that sense, Vishakha was a life-enriching judgment. However, arguably, Common Cause is a verdict about

[3] Id.at 129-134
[4] Vishakha vs State of Rajasthan AIR 1997 SC 3011.
[5] The Sexual Harassment of Women at Workplace (Prevention, Prohibition and Redressal Act) was passed in 2013 while the Vishakha judgment was of 1997.

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'deprivation of life'. Can the life-enriching jurisprudence of the court apply *mutatis-mutandis* to cases of life deprivation as well? These questions invite us to ponder over the propriety of the court to step into the shoes of the legislature for prescription of a procedure for deprivation of life.

3B. Analysis on Merits:

Turning the register of analysis now to the merits of the guidelines issued by the court, one needs to understand the entire procedure prescribed for giving effect to an Advance Directive. The judgment stipulates a four-stage mandatory procedure before the desire of the patient for withdrawal of treatment/life support can be given effect to.

First, the treating physician will have to be made aware of an Advance Directive made by the patient who then, will ascertain the genuineness thereof from the jurisdictional JMFC and will fully satisfy himself that the executor is indeed terminally ill and cannot be cured through medical treatment. On being satisfied, the physician is duty bound to explain all possibilities to the executor of the Advance Directive if he is competent and conscious, or to his guardian/close relative in case the executor is not conscious. This will include information about the nature of illness, the medical treatments available, the consequences of the treatment as well as the consequences of remaining untreated. After making sure that it is fully understood and that they have thought over all the available options, and yet believe firmly that withdrawal of treatment/life support is the best thing to do, then comes the second level of safeguard/procedure.

The treating physician or the hospital where such a patient is admitted will constitute a Medical Board. This Medical Board will comprise of the Head of the treating department and atleast three experts from the fields of general medicine, cardiology, neurology, nephrology, psychiatry or oncology with experience in critical care and a standing practice of twenty years. The doctors nominated on the Board will visit the patient in the presence of the guardian/close relatives of the patient in order to be satisfied that it is, from all points of view, a fit case for withdrawal of treatment/life-support. The opinion of this Board will be a 'preliminary opinion'. If this medical board records its opinion that the instructions given in the Advance Directive can be given effect to, then, the third stage in the procedure sets in.

The treating physician or the hospital concerned is 'forthwith' required to inform the jurisdictional Collector about their opinion. The Collector will then constitute another Medical Board comprising of the Chief District Medical Officer (Chairman) and three other expert doctors from any of fields and experience as above. The Collector's Medical board cannot however have any doctor from the Hospital's Board. The guidelines mandate that the doctors in this medical board should firstly satisfy themselves about the genuine wishes of the executor of the Advance Directive and make sure that it is an informed decision, or in case the executor is incapacitated then they must obtain the consent of the guardians/close relatives of the patient

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with regard to withdrawal of medical treatment/life support. After ensuring this, the doctors on the Collector's medical board will jointly examine the patient. On such examination, if they agree with the preliminary opinion, they may endorse a certificate for permitting the hospital to give effect to the instructions in the Advance Directive. This permission will be granted only 'to the extent of and consistent with the clear instructions given in the Advance Directive'. Once this endorsement is made by the Collector's Medical Board, now sets in the fourth step in the process.

The Chairperson of the said board must convey their decision of withdrawal to the jurisdictional JMFC before giving effect to their decision. On such intimation, the JMFC will personally visit the patient "at the earliest" and examine all aspects with regard to the observance of the entire procedure and genuineness of the informed decision of the executor and only then authorise the implementation of the decision taken by the Board.

This is the minimum mandatory procedure that must be complied with before one can give effect to the 'autonomous choice' of the patient about how he must be dealt with at the terminal stage of his life. Now the following aspects deserve attention:

3B(i). Burdensome and Time Consuming Procedure:

What is self-evident is that the procedure is too onerous and time-consuming to enable a person to reap the benefits of an informed and autonomous choice which he has already made. It is important to remember that in all such cases we are dealing with patients who are in the last stages of life and the central idea is to ease the process of dying. But the judgment does not give any specific time-limit within which the whole procedure must be completed. Hospitals with smaller set-ups are often unlikely to have doctors with the requisite experience from the required field of expertise. In such cases they will be required to involve services of such doctors from outside. Will an outside doctor agree to be a part of such a Board? Will he find the time from his own busy schedule (given the fact that all doctors on the Board will be senior ones from specialized fields) to render an opinion? How much time will the hospital and the jurisdictional Collector take to constitute the respective Boards given all these difficulties? All courts in India are already over-burdened with huge pendency and backlog. Given this fact, when will the JMFC find time to personally visit the patient? The bureaucratic inertia in India does not paint a happy picture to generate confidence that these matters will be attended with the required urgency 'to ease the process of death'. It is most likely that the person at the terminal stage of his life will even otherwise exit from the world without his wish being fulfilled, while these procedures are pending or will be languishing in hospital bed subjecting himself to a treatment he has never wanted to undergo. In both cases, the person's autonomy is allowed to evaporate in thin air. Thus the autonomy is likely to die before the patient dies.

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3B(ii). Considerations of Cost:

The judgment also does not comment on whether any fees will have to be paid to such doctors nominated on the Board. For, if no fees need be paid, then doctors may not agree to give an opinion as they will have neither time nor interest for thankless jobs. On the other hand, if fees have to be paid to these doctors then, who bears that expense? If it must be borne by the patient/the family members of the patient then they bear an additional cost for giving effect to their autonomous decision. They are already incurring the expenditure for the hospital bed, treatment if any, apart from the fees of the treating physician. But now they will be required to incur additional expenses for the fees of eight other doctors on the two medical boards taken together! Is there some minimum fees for the JMFC's visit that will be required to be paid in court? Nothing of this has been clarified in the judgment. What this only means is that autonomy will come with a huge cost.

Also, especially in corporate hospitals wherein health care is a business for profit, one cannot negate the possibility that the Hospital Medical Board might advise continuation of life-support not because it is perceived as necessary to revive the patient back to meaningful life, but simply for the handsome monetary gains pouring from the use of hospital/ICU bed, ventilator or other support system etc.. In such an eventuality, the Board might not agree for withdrawal and then the patient/relatives will be required to approach the High Court for permission to act upon the Advance Directive. The High Court might think it fit to appoint yet another Medical Board of its own, which means more doctors and more expenditure. Such a tedious procedure for preventing abuse is most likely to result in corruption.

3B(iii). De-personalization in the Process:

A person is entitled to choose a doctor/physician of his choice for getting himself treated. This choice could depend on a variety of factors like for example, the doctor's competence, or the doctor being personally known to him, etc. to name just a few. When a physician/doctor treats a patient for many years, knowingly or unknowingly, a bond develops between the two. Infact a person continues to go to a particular doctor only because he begins to repose some trust and faith in that doctor. However when it comes to the Medical Board, either the one appointed by the Hospital or the Collector, it is most likely that the doctors appointed on such Boards will not even be known to the patient/his relatives, leave alone being ones of his choice. And such doctors then will be tendering an opinion that has a bearing on the patient's intimate choice about his life/death. This, in my opinion, brings about a painful de-personalization (or more precisely, pluri-personalization) in the entire process.

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3B(iv). Emotionally Burdensome Procedure:

In case the opinions of the two medical Boards and the treating physician do not concur, then the guidelines stipulate that the patient/relatives may approach the High Court under Article 226 of the Constitution of India, seeking permission to act upon the wish expressed in the Advance Directive. When the patient is living the last days of his life, ailing and suffering, he as well as his relatives are under considerable stress. If in the midst of this, they are required to pay visits to the courts and lawyer's chambers, then this could rather operate as intimidating factors in the way of giving effect to the genuine wishes/desires of the patient. Thus again the autonomy of the patient will have to be compromised at the cost of the cumbersome procedures.

4. Conclusion:

This paper reflects on the positive and negative aspects of the judgment in Common Cause. It raises a preliminary objection against the court's initiative to prescribe a procedure for ending life through the strategy of guidelines. I argue that the judiciary cannot arrogate to itself a power which must reside in the hands of the democratic and representative legislature, especially in view of the fact that it is a matter regarding the end of life. Even otherwise, Article 21 is directed to the legislature and not to the judiciary. But if one were to travel beyond these preliminary objections and undertake an analysis of the judgment on merits, then the judgment is a mixed bag.

The decision in Common Cause is indeed commendable in so far as it recognized the 'right to die with dignity' as an aspect of the 'right to live with dignity' under Article 21. It holds in its womb a promise and hope that a person will now no longer be compelled to undergo degrading and torturous medical treatment against his will. The person can, in advance, determine how he should be treated if and when, on a later occasion, he enters into the persistent vegetative state. Thus unnecessary medical interventions can be avoided and that too without generating any guilt in the minds of close relatives and family members. In giving a place to death with dignity within the compass of Article 21, the judgment marks a great leap forward in enriching Constitutional jurisprudence in India. It re-defines dignity by extending it beyond the realms of life on the temporal plane and attaches it to death and the dying process as well. Also, by recognizing the concept of Advance Directive, the court gives a premium to the personal autonomy of the individual.

However while the judgment does celebrate autonomy at the theoretical level, from the practical standpoint, it looks like being a complete farce of autonomy. The procedure for withdrawing life-support or medical treatment, whether with or without Advance Directives is shrouded in a maze of time consuming technicalities. Though these technicalities seem to have been weaved in for ensuring that there is no abuse, yet the procedure itself could result in frustrating the very autonomy it is meant to uphold. Thus it is like throwing the baby with the bath-water. Instead

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simpler and friendlier procedures could be incentives for more number of people to write Advance Directives for making their last days as consistent with their ideas about dignified exit, as possible.

This paper ends in the hope that whenever the legislature takes upon itself the task of framing a law on this point, it must give due regard to these practical difficulties and ease out the unwanted, avoidable burdens of lengthy and costly procedures. That would be the most appropriate tribute to the 'autonomy-dignity' duo.