COMMON CAUSE

A REGISTERED SOCIETY
AN ORGANISATION FOR VENTILATING COMMON PROBLEMS OF THE PEOPLE
COMMON CAUSE HOUSE, 5, Institutional Area,
Nelson Mandela Road, Vasant Kunj, New Delhi –110 070. Phone: 26131313
www.commoncauseindia.in; commoncauseindia@gmail.com; contact@commoncause.in

Department of Health and Family Welfare,
Ministry of Health and Family Welfare,
Government of India,
New Delhi

June 15, 2016

Subject: Comments on the draft Bill on Passive Euthanasia

Sir,

Common Cause wishes to put forth comments on the Medical Treatment of Terminally Ill Patients (Protection of Patients and Medical Practitioners) Bill, 2016, pursuant to the public notice issued by the Department of Health and Family Welfare on June 6, 2016.

As a litigant in *Common Cause Vs UOI* (WP (C) 215 of 2005), Common Cause has been involved in researching medical and ethical aspects of the issue and hence, the enclosed are our considered views. We believe that the Government has a good opportunity to take advantage of the arguments and proceedings of the case in order to draft a modern legislation suited to the realities of new advancements in medical sciences and the changing nature of medical ethics and patient rights globally.

Yours faithfully,

Vipul Mudgal,

Director and Chief Executive,

Common Cause

General Comments

1. The Bill fails to take into account the evolution of medical ethics and patient rights globally.

2. The Explanatory Note accompanying the Bill is generic in nature and does not give a clause-by-clause justification for various provisions to permit an objective assessment of their relevance to the object and purposes of the Bill.

Specific Comments

3. **Section 11: Advance Medical Directives as to medical treatment and Medical Power of Attorney to be void and not binding on medical practitioners:**

The Bill recognizes the capacity of a competent and terminally ill patient to determine what treatment is to be administered to her. Paradoxically, under Section 11, an individual in full control of her faculties is not allowed to do so in advance in the form of a written directive to her care givers and next of kin.

We submit that an absolute prohibition on such advanced directives under Section 11 runs contrary to the idea of patient competence endorsed by the instant Bill under Section 3. It can lead to an absurd conclusion where the competence of a terminally ill person with possibly impaired cognitive capacity is acknowledged, but a fully informed choice made by way of an advanced directive is completely disregarded.

The rejection of living wills, while endorsing passive euthanasia, is also incompatible with the idea of patient autonomy, as it allows others, but not the patient herself, to make decisions about her life and death. If the right to refuse, or discontinue, an extraordinary or intrusive medical treatment in the case of an incompetent and terminally ill patient can be granted to her physician and next of kin, why should it be denied to a person who while in full control of her faculties wishes to lay down in advance her preference for the medical treatment to be given or not given in the event of her incapacitation?

A living will gives effect to the rights of a terminally ill patients to privacy, autonomy and death with dignity. There would be many among the terminally ill who do not wish to be kept alive through artificial life support systems, but continue to suffer intrusive medical processes for want of legal recognition of 'living will', Indisputably, the primary duty of medical practitioners is to provide treatment and save life, but not in cases where the patient has already expressed her desire of not being subjected to any kind of extraordinary life prolonging treatment.

It is a common law right of people to refuse unwanted medical treatment and no one can force them to take any medical treatment which they do not desire to undergo or continue with. It is submitted that if a person is forcibly or against her express desire subjected to an intrusive life prolonging medical treatment, it would amount to an offence of assault or battery. Similarly, if a person is kept in hospital against her wish in the name of providing treatment, it would amount to an offence of illegal confinement.

The foundation of the aforesaid right has already been laid down by the Hon'ble Supreme Court in *Aruna Ramachandra Shanbaug vs. UOI & Ors.*, (2011) 4 SCC 454, where the Hon'ble Court has permitted "involuntary passive euthanasia", i.e. withdrawal of life support or stopping treatment or medication when there is no possible chance of recovery, even when the patient is not in a position to express her desire, but if such decision is taken by the next of kin. The aforesaid principle has also been recognized by the Hon'ble Supreme Court in the Constitution Bench judgment in *Gian Kaur vs. State of Punjab*, (1996) 2 SCC 648, wherein it was

held that although the 'Right to Life' under Article 21 does not include the 'Right to Die', the "right to live with dignity" includes the "right to die with dignity".

Various countries have already recognized the concept of 'Living Will'. The USA enacted the Patient Self-Determination Act in 1990. Australia followed with The Consent to Medical Treatment and Palliative Care Act in 1995. In Denmark, the concept of 'Living Will' is enshrined in Section 17 of the Law No. 482 of 1st July 1998 on Patients' Rights. Singapore and Canada also have their corresponding laws. In the USA, apart from the said Federal Law, as many as 48 States have enacted their own laws regarding Patients' Rights and Living Wills. The State of Indiana has also framed guidelines along with the forms of living will or advance directives under the Patient self Determination Act.

We would, therefore, urge that Section 11 be rewritten to legalize advance medical directives in the nature of a living will. When the executant of a living will is admitted to a hospital with a terminal illness, the care givers will have to abide by the patient's advance directive not to subject her to unwanted life support treatment in the event of her incapacitation.

In recognition of the fact that the executant may change her mind later on, and that the advances in medical science may throw up an acceptable course of treatment for an illness hitherto considered mortal, the statute may provide for periodical reaffirmation of the advance medical directive.