IN THE SUPREME COURT OF INDIA

CIVIL ORIGINAL JURISDICTION

I.A. NO. _____ OF 2018

IN

WRIT PETITION (CIVIL) NO. 215 OF 2005

IN THE MATTER OF:

COMMON CAUSE (A REGD. SOCIETY) ...Petitioner

VERSUS

UNION OF INDIA ...Respondent

AND IN THE MATTER OF:

Indian Society of Critical Care Medicine
Unit 13 and 14, First Floor,
Hind Service Industries Premises Co-operative Society,
Near Chaitya Bhoomi,
Off Veer Savarkar Marg,
Dadar, Mumbai-400028 Applicant

APPLICATION FOR CLARIFICATION OF JUDGEMENT DATED 09-03-2018

To:

The Hon'ble Chief Justice of India and his companion Justices of the Supreme Court of India

The humble application of the Applicant above named

MOST RESPECTFULLY SHOWETH:-

1. That the Applicant herein was Intervenor No. 4 in the above mentioned Writ Petition (Civil) No. 215 of 2005.
2. That Writ Petition (Civil) No. 215 of 2005 (Common Cause (A Regd. Society) v Union of India) was filed seeking the grant of

legal recognition to advance medical directives, also known as living wills.

3. That this Hon'ble Court, in its judgement dated 09.03.2018, granted legal recognition to advance medical directives and laid down directions for their operation. This Hon'ble Court also laid down directions for the withholding or withdrawal of life-sustaining treatment from patients who have not made advance medical directives, but do not have the capacity to exercise their judgement or express their wishes.

4. The present Application is seeking a clarification of the judgement of this Hon'ble Court dated 09.03.2018, the relevant portion of which is extracted hereinbelow:-

"191. In our considered opinion, Advance Medical Directive would serve as a fruitful means to facilitate the fructification of the sacrosanct right to life with dignity. The said directive, we think, will dispel many a doubt at the relevant time of need during the course of treatment of the patient. That apart, it will strengthen the mind of the treating doctors as they will be in a position to ensure, after being satisfied, that they are acting in a lawful manner. We may hasten to add that Advance Medical Directive cannot operate in abstraction. There has to be safeguards. They need to be spelt out. We enumerate them as follows:-

(a) Who can execute the Advance Directive and how?

(i) The Advance Directive can be executed only by an adult who is of a sound and healthy state of mind and in a position

to communicate, relate and comprehend the purpose and consequences of executing the document.

(ii) It must be voluntarily executed and without any coercion or inducement or compulsion and after having full knowledge or information.

(iii) It should have characteristics of an informed consent given without any undue influence or constraint.

(iv) It shall be in writing clearly stating as to when medical treatment may be withdrawn or no specific medical treatment shall be given which will only have the effect of delaying the process of death that may otherwise cause him/her pain, anguish and suffering an further put him/her in a state of indignity.

(b) What should it contain?

(i) It should clearly indicate the decision relating to the circumstances in which withholding or withdrawal of medical treatment can be resorted to.

(ii) It should be in specific terms and the instructions must be absolutely clear and unambiguous.

(iii) It should mention that the executor may revoked the instructions/authority at any time.

(iv) It should disclose that the executor has understood the consequences of executing such a document.

(v) It should specify the name of a guardian or close relative who, in the event of the executor becoming incapable of taking decision at the relevant time, will be authorized to give

consent to refuse or withdraw medical treatment in a manner consistent with the Advance Directive.

(vi) In the event that there is more than one valid Advance Directive, none of which have been revoked, the most recently signed Advance Directive will be considered as the last expression of the patient's wishes and will be given effect to.

(c) How should it be recorded and preserved?

(i) The document should be signed by the executor in the presence of two attesting witnesses, preferably independent, and countersigned by the jurisdictional Judicial Magistrate of First Class (JMFC) so designated by the concerned District Judge.

(ii) The witnesses and the jurisdictional JMFC shall record their satisfaction that the document has been executed voluntarily and without any coercion or inducement or compulsion and with full understanding of all the relevant information and consequences.

(iii) The JMFC shall preserve one copy of the document in his office, in addition to keeping it in digital format.

(iv) The JMFC shall forward one copy of the document to the Registry of the jurisdictional District Court for being preserved. Additionally, the Registry of the District Judge shall retain the document in digital format.

(v) The JMFC shall cause to inform the immediate family members of the executor, if not present at the time of

execution, and make them aware about the execution of the document.

(vi) A copy shall be handed over to the competent officer of the local Government or the Municipal Corporation or Municipality or Panchayat, as the case may be. The aforesaid authorities shall nominate a competent official in that regard who shall be the custodian of the said document.

(vii) The JMFC shall cause to handover copy of the Advance Directive to the family physician, if any.

(d) When and by whom can it be given effect to?

(i) In the event the executor becomes terminally ill and is undergoing prolonged medical treatment with no hope of recovery and cure of the ailment, the treating physician, when made aware about the Advance Directive, shall ascertain the genuineness and authenticity thereof from the jurisdictional JMFC before acting upon the same.

(ii) The instructions in the document must be given due weight by the doctors. However, it should be given effect to only after being fully satisfied that the executor is terminally ill and is undergoing prolonged treatment or is surviving on life support and that the illness of the executor is incurable or there is no hope of him/her being cured.

(iii) If the physician treating the patient (executor of the document) is satisfied that the instructions given in the document need to be acted upon, he shall inform the executor or his guardian/close relative, as the case may be,

about the nature of illness, the availability of medical care and consequences of alternative forms of treatment and the consequences of remaining untreated. He must also ensure that he believes on reasonable grounds that the person in question 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.

(iv) The physician/hospital where the executor has been admitted for medical treatment shall then constitute a Medical Board consisting of the Head of the treating Department and at least three experts from the fields of general medicine, cardiology, neurology, nephrology, psychiatry or oncology with experience in critical care and with overall standing in the medical profession of at least twenty years who, in turn, shall visit the patient in the presence of his guardian/close relative and form an opinion whether to certify or not to certify carrying out the instructions of withdrawal or refusal of further medical treatment. This decision shall be regarded as a preliminary opinion.

(v) In the event the Hospital Medical Board certifies that the instructions contained in the Advance Directive ought to be carried out, the physician/hospital shall forthwith inform the jurisdictional Collector about the proposal. The jurisdictional Collector shall then immediately constitute a Medical Board comprising the Chief District Medical Officer of the concerned

district as the Chairman and three expert doctors from the fields of general medicine, cardiology, neurology, nephrology, psychiatry or oncology with experience in critical care and with overall standing in the medical profession of at least twenty years (who were not members of the previous Medical Board of the hospital). They shall jointly visit the hospital where the patient is admitted and if they concur with the initial decision of the Medical Board of the hospital, they may endorse the certificate to carry out the instructions given in the Advance Directive.

(vi) The board constituted by the Collector must beforehand ascertain the wishes of the executor if he is in a position to communicate and is capable of understanding the consequences of withdrawal of medical treatment. In the event the executor is incapable of taking decision or develops impaired decision making capacity, then the consent of the guardian nominated by the executor in the Advance Directive should be obtained regarding refusal or withdrawal of medical treatment to the executor to the extent of and consistent with the clear instructions given in the Advance Directive.

(vii) The Chairman of the Medical Board nominated by the Collector, that is, the Chief District Medical Officer, shall convey the decision of the Board to the jurisdictional JMFC before giving effect to the decision to withdraw the medical treatment administered to the executor. The JMFC shall visit

the patient at the earliest and, after examining all aspects, authorise the implementation of the decision of the Board.

(viii) It will be open to the executor to revoke the document at any stage before it is acted upon and implemented.

(e) What if permission is refused by the Medical Board?

(i) If permission to withdraw medical treatment is refused by the Medical Board, it would be open to the executor of the Advance Directive or his family members or even the treating doctor or the hospital staff to approach the High Court by way of writ petition under Article 226 of the Constitution. If such application is filed before the High Court, the Chief Justice of the said High Court shall constitute a Division Bench to decide upon grant of approval or to refuse the same. The High Court will be free to constitute an independent Committee, consisting of three doctors from the fields of general medicine, cardiology, neurology, nephrology, psychiatry or oncology with experience in critical care and with overall standing in the medical profession of at least twenty years.

(ii) The High Court shall hear the application expeditiously after affording opportunity to the State counsel. It would be open to the High Court to constitute Medical Board in terms of its order to examine the patient and submit report about the feasibility of acting upon the instructions contained in the Advance Directive.

(iii) Needless to say that the High Court shall render its decision at the earliest as such matters cannot brook any delay and it shall ascribe reasons specifically keeping in mind the principles of "best interests of the patient".

(f) Revocation or inapplicability of Advance Directive

(i) An individual may withdraw or alter the Advance Directive at any time when he/she has the capacity to do so and by following the same procedure as provided for recording of Advance Directive. Withdrawal or revocation of an Advance Directive must be in writing.

(ii) An Advance Directive shall not be applicable to the treatment in question if there are reasonable grounds for believing that circumstances exist which the person making the directive did not anticipate at the time of the Advance Directive and which would have affected his decision had he anticipated them.

(iii) If the Advance Directive is not clear and ambiguous, the concerned Medical Boards shall not give effect to the same an, in that event, the guidelines meant for patients without Advance Directive shall be made applicable.

(iv) Where the Hospital Medical Board takes a decision not to follow an Advance Directive while treating a person, then it shall make an application to the Medical Board constituted by the Collector for consideration and appropriate direction on the Advance Directive.

192. It is necessary to make it clear that there will be cases where there is no Advance Directive. The said class of persons cannot be alienated. In cases where there is no Advance Directive, the procedure and safeguards are to be same as applied to cases where Advance Directives are in existence and in addition there to, the following procedure shall be followed:-

(i) In cases where the patient is terminally ill and undergoing prolonged treatment in respect of ailment which is incurable or where there is no hope of being cured, the physician may inform the hospital which, in turn, shall constitute a Hospital Medical Board in the manner indicated earlier. The Hospital Medical Board shall discuss with the family physician and the family members and record the minutes of the discussion in writing. During the discussion, the family members shall be apprised of the pros and cons of withdrawal or refusal of further medical treatment to the patient and if they give consent in writing then the Hospital Medical Board may certify the course of action to be taken. Their decision will be regarded as a preliminary opinion.

(ii) In the event the Hospital Medical Board certifies the option of withdrawal or refusal of further medical treatment, the hospital shall immediately inform the jurisdictional Collector. The jurisdictional Collector shall then constitute a Medical Board comprising the Chief District Medical Officer as the Chairman and three experts from the fields of general

medicine, cardiology, neurology, nephrology, psychiatry or oncology with experience in critical care and with overall standing in the medical profession of at least twenty years. The Medical Board constituted by the Collector shall visit the hospital for physical examination of the patient and, after studying the medical papers, may concur with the opinion of the Hospital Medical Board. In that event, intimation shall be given by the Chairman of the Collector nominated Medical Board to the JMFC and the family members of the patient.

(iii) The JMFC shall visit the patient at the earliest and verify the medical reports, examine the condition of the patient, discuss with the family members of the patient and, if satisfied in all respects, may endorse the decision of the Collector nominated Medical Board to withdraw or refuse further medical treatment to the terminally ill patient.

(iv) There may be cases where the Board may not take a decision to the effect of withdrawing medical treatment of the patient on the Collector nominated Medical Board may not concur with the opinion of the hospital Medical Board. In such a situation, the nominee of the patient or the family member or the treating doctor or the hospital staff can seek permission from the High Court to withdraw life support by way of writ petition under Article 226 of the Constitution in which case the Chief Justice of the said High Court shall constitute a Division Bench which shall decide to grant approval or not. The High Court may constitute an independent Committee to

depute three doctors from the fields of general medicine, cardiology, neurology, nephrology, psychiatry or oncology with experience in critical care and with overall standing in the medical profession of at least twenty years after consulting the competent medical practitioners. It shall also afford an opportunity to the State counsel. The High Court in such cases shall render its decision at the earliest since such matters cannot brook any delay. Needless to say, the High Court shall ascribe reasons specifically keeping in mind the principle of "best interests of the patient"..

193. Having said this, we think it appropriate to cover a vital aspect to the effect the life support is withdrawn, the same shall also be intimated by the Magistrate to the High Court. It shall be kept in a digital format by the Registry of the High Court apart from keeping the hard copy which shall be destroyed after the expiry of three years from the death of the patient.

194. Our directions with regard to the Advance Directives and the safeguards as mentioned hereinabove shall remain in force till the Parliament makes legislation on this subject."

A copy of the judgement dated 09.03.2018 is marked and attached as **Annexure-A-1**. Pages (47 to 356)

5. The present Applicant is seeking the following modifications/clarifications in the directions laid down by this Hon'ble Court ("present directions"):

(a)That an advance medical directive be permitted to be executed before a Notary, as an alternative to its execution before a Judicial Magistrate of the First Class;

(b)That an advance medical directive comes into operation only when its executor is incapable of exercising her judgement or expressing her wishes;

(c)That the decision regarding the withholding or withdrawal of life-sustaining treatment be permitted to be taken by the treating team of the patient comprising three senior doctors, after communicating with and taking into account the wishes of her family and/or next friend or guardian;

(d)that the prior approval of the Medical Board constituted by the Collector, as well as of the Judicial Magistrate of the First Class not be required for the implementation of a decision to withhold or withdraw life-sustaining treatment, so long as all such decisions are reviewed post-facto by a Clinical Ethics Committee;

(e)that the withdrawal of life-sustaining treatment from a person who has suffered brain-stem death be permitted, irrespective of whether such person or her family had consented to the donation of their organs.

6. These clarifications/modifications are necessary to remove the uncertainty regarding the withholding or withdrawal of life-sustaining treatment that currently prevails throughout the medical community in India. They are also necessary to ensure that the processes for the withholding or withdrawal of life-

sustaining treatment are workable and give effect to the basis of this Hon'ble Court's judgement i.e. the right to refuse life-sustaining treatment and to die with dignity. The scope and rationale for each of these modifications/clarifications is explained below in detail:

Execution of an Advance Medical Directive

7. This Hon'ble Court, in Paragraph 191(c)(i), of the present directions, has stated that an advance medical directive is to be executed in the presence of two attesting witnesses, preferably independent, and countersigned by a Judicial Magistrate of the First Class. This is an onerous requirement that is likely to discourage ordinary citizens from executing advance medical directives, thereby preventing them from exercising their rights to autonomy, dignity and privacy, affirmed by this Hon'ble Court.

8. This Applicant has received a letter dated 9 April 2019 from a Mr Mayur Amritlal Mehta, aged 66 years, resident of Dadar, Mumbai, which explains the difficulties faced by such citizens in executing advance medical directives before a Judicial Magistrate. Mr Mehta approached the Bhoiwada Metropolitan Magistrate's Court in Mumbai on 5 April 2019 with the advance medical directives of his sister, Dr Lopa Amritlal Mehta, aged 74 years and his mother-in-law, Mrs Ramila Mahesh Bhatt, aged 84 years. His letter notes that the requirement to approach a Judicial Magistrate to have their advance medical directives executed

was a discouraging factor for elderly persons like his sister and mother-in-law. He writes that:

> *"Neither my mother-in-law nor my sister has experience interacting with the judicial system and have been hesitant about approaching a magistrate to execute their advance directives. Additionally, my mother-in-law had a brief bout of illness last year which left her weak and unable to undertake the journey to the nearest metropolitan magistrate's court."*

Mr Mehta's letter also states that he was unable to have his sister and mother-in-law's directives executed before the Metropolitan Magistrate. He could not meet the Magistrate who was busy with urgent bail applications. Instead, he met the Additional Registrar, Ms R R Siddiqui, who discussed the execution of the directives with the Magistrate. She informed Mr Mehta that the Magistrate had said that it would not be possible to have the directives executed because no circulars, orders or directions had been issued to the court authorising the Magistrate to witness the execution. A copy of Mr Mehta's letter, addressed to the Applicant, documenting his inability to have the advance medical directives executed in accordance with this Hon'ble Court's judgment and pointing out the difficulties faced by elderly citizens in visiting the Metropolitan Magistrate's court is annexed and marked hereto as **Annexure A-2.** Pages (357 to 369)

9. The authenticity of an advance medical directive can also be established by swearing and attesting to it before a Notary.

Section 8(1)(a) of the Notaries Act, 1952, states that a notary may "verify, authenticate, certify or attest the execution of any instrument." This would include an advance medical directive.

10. There are several documents that may be sworn to and attested either before a Judicial Magistrate of the First Class or a Notary.

(a) Under section 139 of the Code of Civil Procedure, 1908, any affidavit under the Code may be administered by any Court or Magistrate or any notary appointed under the Notaries Act, 1952.

(b) Under section 297 of the Code of Criminal Procedure, 1973, affidavits that are to be used before any court under the Code may be sworn or affirmed before any Judge or Judicial or Executive Magistrate or any notary appointed under the Notaries Act, 1952.

(c) Under Rule 4A of the Conduct of Election Rules, under the Representation of the People Act, 1951, a candidate, while delivering the nomination paper to the returning officer, must also deliver an affidavit sworn by the candidate before a Magistrate of the first class or a Notary. Similarly, under Rule 94A of the same rules, an affidavit to be filed with an election petition must be sworn before a magistrate of the first class or a notary.

11. These examples demonstrate that it is a well-established practice for documents to be sworn to or attested either before a magistrate or a notary. Under section 85 of the Indian Evidence

Act, 1972, the evidentiary value of a power of attorney, whether executed before a magistrate or a notary, is the same. The provision states that:

"The Court shall presume that every document purporting to be a power-of-attorney, and to have been executed before, and authenticated by, a Notary Public, or any court, Judge, Magistrate, Indian Consul or Vice-Consul, or representative of the Central Government, was so executed and authenticated."

An advance medical directive is a healthcare power-of-attorney, where the person executing the document appoints another to make decisions regarding the withholding or withdrawal of life-sustaining treatment on her behalf, when such person is not in a position to do so herself. According to section 85 of the Indian Evidence Act, the Court would presume that a healthcare power-of-attorney was executed and authenticated as claimed, whether it was executed and authenticated before a Magistrate or a Notary Public.

12. In countries that recognise the legal validity of advance medical directives, it is a sufficient requirement for the directive to be notarised, rather than sworn to and attested before a judicial officer. Extracts of the relevant provisions from countries, such as the United Kingdom, the State of Victoria in Australia, Ireland and Germany, related to the execution of advance medical directives, are annexed and marked hereto as **Annexure A-3,** Pages (370 to 373) **A-4,** Pages (374 to 377) **A-5 and A-6** Pages (382 to 384) respectively

13. The Indian Association of Palliative Care, which has over 25 years experience in palliative care and comprises doctors, nurses, counselors and volunteers, has also issued a statement that the requirement that an advance medical directive be countersigned by a Judicial Magistrate of the First Class is onerous, and that a notary's confirmation of an advance medical directive should suffice. A copy of the statement of the Indian Association of Palliative Care is annexed and marked hereto as **Annexure A-7.** Pages 385 to 386)

14. It is humbly submitted that permitting advance medical directives to be attested only before a Judicial Magistrate of the First Class will cause considerable hardship to ordinary citizens, who will find it difficult to locate and obtain access to a Judicial Magistrate. This will discourage persons from executing advance medical directives, effectively preventing them from exercising their fundamental right to autonomy. This Hon'ble Court, in its judgment dated 09.03.2018, held that (pg 190):

> "(xi) A failure to legally recognize advance medical directives may amount to non-facilitation of the right to smoothen the dying process and the right to live with dignity."

This Hon'ble Court has therefore held that the legal recognition of advance medical directives is a part of the fundamental right to dignity under the Constitution. In ***Maneka Gandhi v Union of India*** *(1978) 1 SCC 248* (para 80), this Hon'ble Court has stated

that the test to determine whether an activity is part of a fundamental right is to determine whether it is an integral part of the fundamental right or of the same basic nature and character as the right. In this instance, the right to execute advance medical directives is an integral part of the right to have advance medical directives legally recognised. The guarantee of this right will not be meaningful or effective if the only authority before which such directives can be executed is a Judicial Magistrate of the First Class. The requirement to execute an advance medical directive before a Judicial Magistrate has been imposed as a measure to assist medical practitioners in identifying an authentic directive. Since this purpose can be served equally by allowing its execution before a Notary, it is humbly submitted that this option be permitted as a valid alternative to the execution of an advance medical directive before a Judicial Magistrate.

Trigger for Implementation of Advance Medical Directives

15. This Hon'ble Court, in the present directions has laid down the obligations of a physician treating a patient who has executed an advance medical directive. This Hon'ble Court has stated that (para 191(d)(iii)):

> "If the physician treating the patient (executor of the document) is satisfied that the document need to be acted upon, he shall inform the executor or his guardian/close relative, as the case may be, about the nature of illness, the availability of medical care and consequences of alternative forms of treatment and the consequences of remaining untreated. He must also ensure that the person

in question 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."

16. The above directions contradict the commonly accepted understanding of advance medical directives the world over, as well as this Hon'ble Court's own definition of such a directive, which recognise that advance directives are to be implemented only when the person who has executed them is herself incapable of exercising her judgement or expressing her wishes. At para 178, this Hon'ble Court stated that:

> "Advance Directives for health care go by various names in different countries though the objective by and large is the same, that is, to specify an individual's health care decisions and to identify persons who will take those decisions for the said individual in the event he is unable to communicate his wishes to the doctor."

At para 179, this Hon'ble Court cited the definition of an advance medical directive in Black's Law Dictionary as

> "a legal document explaining one's wishes about medical treatment if one becomes incompetent or unable to communicate."

At para 180, this Hon'ble Court referred to a medical power of attorney, a specific type of advance medical directive. It defined this as:

> "a document which allows an individual (principal) to appoint a trusted person (agent) to take health care decisions when the principal is not able to take such decision."

17. It is abundantly clear from this Hon'ble Court's own pronouncements that an advance medical directive is a document that is to be used only when a person executing such a directive is unable to take a decision herself regarding her own medical treatment or is unable to communicate her wishes regarding such treatment. A physician can be satisfied that an advance medical directive needs to be acted upon only when the executor is incapable of making a decision or communicating her wishes. This is the very basis of an advance medical directive and the fundamental reason for its execution.

18. It follows that when the executor is incapable of making a decision or communicating her wishes, there can be no question of the physician informing the executor of the nature of the illness, availability of medical care, consequences of alternative forms of treatment and consequences of remaining untreated. There can also be no question of ensuring that the executor has understood the information provided, thought over the options, and reached the conclusion that the withdrawal or refusal of medical treatment is the best choice. However, this is what is contemplated by the directions of this Hon'ble Court in the present directions, at para 191(d)(iii).

19. Similarly, this Hon'ble Court, at para 191(d)(vi) of the present directions, while stating when an advance medical directive can be given effect to, states that:

> "The Board constituted by the Collector must beforehand ascertain the wishes of the executor if he is in a position to

communicate and is capable of understanding the consequences of withdrawal of medical treatment."

20. Again, there can be no question of ascertaining the wishes of the executor to determine whether or not an advance medical directive should be given effect. An advance medical directive can only be given effect when the executor cannot express his/her/their wishes.

21. Therefore, it is humbly submitted that this inconsistency in the present directions be removed by clarifying that an advance medical directive can be given effect to only when the executor of the directive is incapable of taking a decision regarding her medical treatment or of expressing her wishes regarding such treatment. Para 191 (d)(iii) of the present guidelines should be modified to read as follows:

> "If the physician treating the patient (executor of the document) is satisfied that the instructions given in the document need to be acted upon, he shall inform the guardian/close relative of the patient, as the case may be, about the nature of illness, the availability of medical care and consequences of alternative forms of treatment and the consequences of remaining untreated. He must also ensure that he believes on reasonable grounds that the guardian/close relative of 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."

Decision to Withhold or Withdraw Life-Sustaining Treatment to be taken by the Patient's Treating Team in consultation with the Patient's Family and/or Guardian or Next Friend

22. In para 191(d)(iv) of the present directions, this Hon'ble Court has imposed an obligation on the physician/hospital where the executor of an advance medical directive has been admitted to constitute a Medical Board to provide a preliminary opinion whether or not the instructions to withhold or withdraw life-sustaining treatment in the advance medical directive should be given effect to. This Medical Board is to consist of the Head of the treating Department and at least three experts from the fields of general medicine, cardiology, neurology, nephrology, psychiatry or oncology with experience in critical care and an overall standing of at least twenty years in the medical profession. The same obligation has also been imposed in para 192 (i), where the patient has not executed an advance medical directive.

23. It is humbly submitted that the requirement to constitute a Hospital Medical Board to make decisions about the withholding or withdrawal of life-sustaining treatment is contrary to existing treatment guidelines and protocols recommended by medical professionals that recommend that such decisions should be taken by the patient's treating team. A joint position statement of the Applicant herein, the Indian Society of Critical Care Medicine and the Indian Association of Palliative Care on an end-of-life care policy, published in 2014, states, at pg. 78, that

> *"Many healthcare professionals are usually involved in the care of acutely ill patients including the intensivist, the primary care team and the specialists to whom the patient may have been referred. The doctor under whose care the patient is admitted assumes primary care for the patient. In closed units, this doctor is the intensivist but more not often than not units in India are semi-open, semi-closed, or open in which case the primary physician is from the respective specialty. Each specialist is likely to have differing opinion about futility and about when to start EOLD [end-of-life-decision-making]. The intensivist often has to assume the role of coordinator and communicate with all stakeholders in order to arrive at a consensus. This is a painstaking and arduous process. It is a good plan to schedule a meeting among all significant caregivers and establish a consensus before starting EOLD with the family."* [emphasis supplied]

Thus, medical professionals recommend that decisions about end-of-life care be taken by significant caregivers. This means doctors who are part of the patient's treating team, not by a group of other experts, as laid down in the present directions in paras 192 (d)(iv) and 192(i). The rationale for this is that end-of-life care is seen as a shared decision-making process between the patient, the family and his/her/their caregivers. This involves repeated discussions and communications that are open, honest and consistent. To achieve this, it is essential that caregivers are able to build a rapport with their patients and families. A Medical Board comprising experts will not be able to build a rapport in the same way as doctors who form part of the patient's treating team. Such a Medical Board is also unlikely to have the same information as the patient's treating team about the values and

wishes of the patient and her family. This is because they will not have had the same opportunity as the patient's treating team to get to know them and her family. A copy of the joint position statement of the Indian Society of Critical Care Medicine and the Indian Association of Palliative Care recommending that decisions about end of life care are taken by the significant caregivers of the patient is annexed and marked hereto as **Annexure A-8.** Pages (387 to 408)

24. A consensus position statement of the Indian Association of Palliative Care on an end of life care policy for the dying, published in 2014, in the Indian Journal of Palliative Care, also recommends that decisions about the withholding or withdrawal of life-sustaining treatment be taken by the patient's treating team. At pg. 173, this statement notes that

> *End of life decision-making is a complex process but is vital for good EOLC [end of life care]. The decision-makers should always be the primary care givers, in consultation with the palliative care team. Primary care givers are the ones who have longer patient/family contact and therapeutic bonding, which could facilitate better communication and decision-making.* [emphasis supplied]

The Hospital Medical Board to be constituted in accordance with the present guidelines will comprise experts who will not be the primary caregivers of the patient. These experts will not have the opportunity for sustained contact and bonding with the patient and her family that is recommended by medical professionals that specialise in end of life care. A copy of the consensus

position statement of the Indian Association of Palliative Care, recommending that decision-makers for end of life care should always be the primary caregivers is annexed and marked hereto as **Annexure A-9.** Pages (५०९ to ५१९)

25. The Applicant herein, the Indian Society for Critical Care Medicine, has also published Guidelines for limiting life-prolonging interventions and providing palliative care towards the end of life in Indian Intensive care units. These guidelines state that

> *The overall responsibility for the decision rests with the attending physician/intensivist of the patient, who must ensure that all members of the caregiver team,including the medical and nursing staff represent the same approach to the care of the patient.* [emphasis supplied]

The guidelines also emphasise the importance of early and effective communication about end of life decision-making between patients, his/her/their families and doctors. Such communication requires 'frequent and consistent information provided by a single contact physician, preferably an intensivist.' If a Hospital Medical Board, comprising medical experts that are not a part of the patient's treating team, were to be entrusted with the decision to withhold or withdraw life-sustaining treatment, as laid down in the present guidelines, there would be a break in the frequent and consistent information-sharing between the patient, her family and the treating doctors, as recommended in the guidelines published by the Applicant. A copy of these guidelines, affirming that the overall responsibility for the withholding or withdrawing of life-sustaining treatment lies with

the attending physician is annexed and marked hereto as **Annexure A-10**. Pages (420 to 434)

The need for the involvement of the patient's caregiving team in decision-making processes relating to end of life care has also been reiterated by the Indian Academy of Paediatrics in a Consensus Statement. A copy of this statement (Mishra S, Mukhopadhyay K, Tiwari S, Bangal R, Yadav B, Sachdeva A and Kumar V. End-of-life care: Consensus Statement by Indian Academy of Paediatrics. *Indian Paediatrics* (2017):54,851-859 is annexed hereto and marked as **Annexure A-11.** Pages (435 to 443

26. The participation of the patient's caregiving team also reflects the professional consensus of critical care physicians worldwide. A study on the Consensus for Worldwide End-of-Life Practice for Patients in Intensive Care Units, published in the American Journal of Respiratory and Critical Care Medicine in 2014, based on the responses of 3,049 participants from 32 countries, also recorded consensus that end of life care decisions are to be taken through communication between the patient, his family and the patient's health care team. A copy of this study (Sprung CL, Trough RD, Curtis JR, Joint GM, Barras M, Michelson A, Brie gel J, Kesecioglu J, Efferen L, De Robertis E, Bulpa P, Metnitz P, Patil N, Hawryluck L, Manthous C, Moreno R, Leonard S, Hill NS, Wennberg E, McDermid RC, Mikstacki A, Mularski RA, Hartog CS, Avidan A. Seeking worldwide professional consensus on the principles of end-of-life care for the critically ill: the WELPICUS study. Am J Respir Crit Care Med. 2014; 190(8):855–

66.doi:10.1164/rccm.201403-0593CC) is annexed and marked hereto as **Annexure A-12.** Pages (444 to 455)

This confirms the position adopted by the jury of the 5th International Consensus Conference in Critical Care at Belgium in 2003, where it was recognised that the ultimately responsibility for a patient's medical care vested in the attending clinician and that decisions about the withholding or withdrawal of life-sustaining treatment ought to involve communication between the caregiving team and the patient and his family. A copy of the statement made at this International Consensus Conference (Carlet J, Thijs LG, Antonelli M, Cassell J, Cox P, Hill N, et al . Challenges in end-of-life care in the ICU: Statement of the 5th International Consensus Conference in Critical Care:Brussels, Belgium, April 2003. *Intensive Care Medicine* 2004;30: 770-84) is annexed and marked hereto as **Annexure A-13.** (456-478)

27. The statements in Annexures A-8, A-9 and A-10, A-11, A-12 and A-13 demonstrate that Indian and global professional medical opinion recommends that decisions about the withholding or withdrawal of life-sustaining treatment be taken through a shared decision-making process between the patient, her family and her doctors. Trust is an important component of this and can only be built when doctors have had the opportunity to build a rapport with patients and their families. Only doctors that are the primary or significant caregivers of the patient or part of the treating team will have this opportunity. It is therefore, humbly submitted that the present directions at paragraphs 192(d)(iv) and 192(i) be

modified to allow the decision regarding the withholding or withdrawal of life-sustaining treatment to be taken by three senior doctors of the patient's treating team after communicating with and taking into account the wishes of the patient's family and/or next friend or guardian.

Prior Approval of Medical Board Constituted by the Collector and Presence of the Judicial Magistrate of the First Class not to be required for the withholding or withdrawal of life-sustaining treatment

28. In Para 191(d)(v) of the present guidelines, this Hon'ble Court has laid down the procedure that should follow the preliminary opinion of the Hospital Medical Board certifying the withholding or withdrawal of life-sustaining treatment. In such a case, the physician/hospital must inform the jurisdictional Collector, who must then constitute another Medical Board comprising the Chief District Medical officer and three expert doctors who were not members of the Hospital Medical Board. This second Board must jointly visit the hospital where the patient is and decide whether or not to endorse the decision of the Hospital Medical Board. In Para 191(d)(vii) of the present guidelines, this Hon'ble Court has stated that if the second Board also certifies that life-sustaining treatment should be withheld or withdrawn, this decision must be conveyed to the Judicial Magistrate of the First Class. The Magistrate must visit the patient and finally authorise the implementation of the decision to withhold or withdraw life-sustaining treatment.

29. It is humbly submitted that the procedure laid down in the present guidelines is not practically capable of implementation. This is because such a procedure is likely to be lengthy and unsuited to intensive care settings where decisions about the withholding or withdrawal of life-sustaining treatment must usually be taken within a few hours or a couple of weeks, at the very most. Implementing the procedure laid down in the present guidelines runs the risk of forcing the patient to submit to treatment that she might explicitly not have desired, thereby violating her right to bodily autonomy, as well as of increasing the costs of hospitalisation.

30. The Applicant herein, the Indian Society of Critical Care Medicine, is an association of around 10,000 medical professionals who have specialised in the care of critically-ill patients, and who have considerable experience working in intensive care settings in India and have overlapping, multiple specialities in anaesthesiology, internal medicine, pulmonology, surgery, paediatrics and neonatology. The Society was set up in 1993 to establish benchmarks and best practices in critical care, to promote awareness and research and to provide continuing education and research to physicians and nurses. The Applicant issued a statement on 21.08.2018 in response to the present guidelines. A copy of this statement of the Indian Society of Critical Care Medicine is annexed and marked hereto as **Annexure A-14**. Pages (५७१ to ५७३). This statement, while referring to the present guidelines notes that:

...the difficulties inherent in this procedure are obvious and will make the judgment ineffectual in practice. While it does away with a procedure involving the High Court prescribed in the Aruna Shanbaug judgment, it has replaced it with another potentially lengthy procedure. Death and dying in hospitals are common and disproportionate interventions too are commonplace. Too have a procedure that involves too many persons and procedure would be cumbersome. Safeguards if too heavy may actually defeat the main purpose-that of caring appropriately for the dying and their families.

To detail the problems:

1. *This decision-making is largely required for serious or critically-ill patients who are often admitted to ICUs. This decision-making worldwide takes place within a few hours to usually a maximum of 2 weeks. Because the SC recommended process will be very lengthy to implement, it is unlikely to be usable for most patients in ICUs except for those in the persistent vegetative state which is an exceptional situation.'*

This statement of the applicant, pointing out the time within which decisions are usually required to be taken in intensive care settings is affirmed by the studies listed below that have measured the average length of stay of patients in intensive care units in tertiary hospitals in India, as well as the time within which decisions related to the end of life care are taken.

(i) Aditi Agrawal, Mahendra Bhauraoji Gandhe, Swapnali Gandhe, Nikhil Agrawal, 'Study of length of stay and average cost of treatment in Medicine Intensive Care Unit at tertiary care center' (2017) 4 Journal of Health Research and Reviews in Developing Countries: This study, conducted at a tertiary care hospital in Mumbai, found that the average stay of a patient in an

intensive care unit was 4 days. A copy of this study of length of stay and average cost of treatment in Medicine intensive care Unit at tertiary care centre is annexed and marked hereto as **Annexure A-15**. Pages (474 to 479)

(ii) Divatia JV, Amin PR, Ramakrishnan N, et al. Intensive Care in India: The Indian Intensive Care Case Mix and Practice Patterns Study. *Indian J Crit Care Med*. 2016; 20(4): 216-25: This study found that the median length of stay of patients in an intensive care unit was 6 days. A copy of Intensive care in India The Indian intensive care case mix and practice patterns study this study is annexed and marked hereto as **Annexure A-16**. Pages (480 to 501)

(iii) Mani RK, Mandal AK, Bal S, Javeri Y, Kumar R, Nama DK et al End-of-life decisions in an Indian intensive care unit. Intensive Care Med (2009) 35:1713–1719: This retrospective, observational study of consecutive patients admitted to a 12-bed, closed surgical medical intensive care unit observed that 53% of decisions relating to the withholding or withdrawal of life-sustaining treatment were taken in the first week of admitting patients to the intensive care unit. A copy of this study end-of-live deisions in a Indian intensive care unit is annexed and marked hereto as **Annexure A-17**. Pages (502 to 508)

31. The three-tier process laid down in the present directions, involving the Hospital Medical Board, the Medical Board constituted by the Collector and finally the Judicial Magistrate of

the First Class, will not be capable of implementation within the time in which patients, their families and their treating doctors are typically required to make a decision regarding the withholding or withdrawal of life-sustaining treatment. Another reason for this is the sheer number of patients in Indian intensive care units, for a significant proportion of whom a decision about withholding or withdrawing life-sustaining treatment will have to be taken. The scientific study in Annexure A-16 analysed the data of 4038 patients from 120 intensive care units in India over four separate days, 1495 or 37 per cent of such patients received mechanical ventilation, which is a form of life-sustaining treatment. It would be physically impossible for Medical Boards constituted by the Collector and Judicial Magistrates of the First Class to be physically present to verify the withdrawal of ventilation in each of these 1495 cases over 4 days, even if it were assumed that a separate Medical Board and a separate Judicial Magistrate were assigned to each of the 120 intensive care units. In another study of intensive care units in four major public hospitals in Mumbai, limitation of life-sustaining treatment occurred in nearly 34 per cent of the deaths of patients admitted to such units, providing further confirmation of the vast number of decisions that would have to be taken by Medical Boards and Judicial Magistrates under the present directions. A copy of this study (Kapadia F, Singh M, Divatia J, Vaidyanathan P, Udwadia FE, Raisinghaney SJ, Limaye HS, Karnad DR (2005) Limitation and withdrawal of intensive therapy at end of life: practices in intensive care units

in Mumbai, India. Crit Care Med 33:1272–1275) is annexed and marked hereto as **Annexure A-18.** Pages (509 to 512)

32. The unworkability of the present directions is also compounded by the fact that Judicial Magistrates of the First Class already have a considerable workload, being empowered to try offences under a wide range of Central and State legislation. According to figures released by this Hon'ble Court, as of 30.06.2018, there were 19957168 criminal cases pending in district and subordinate courts across India, a significant portion of which are likely to be before Judicial Magistrates of the First Class. Since Judicial Magistrates are already overburdened, it will not be possible for them to perform an additional time-consuming task that requires them to physically visit hospitals and satisfy themselves about the withholding or withdrawal of life-sustaining treatment.

33. A long drawn-out end of life decision-making process is not desirable given the costs of hospitalisation in India. The statement issued by the Applicant herein and set out in Annexure A-14 notes that in the time that will be taken to implement the decision-making process laid down in the present directions, hospital costs in the order of tens of thousands of rupees will be incurred. The Consensus Position Statement of the Indian Association of Palliative Care in Annexure A-9 cites a study conducted at a tertiary hospital in India which demonstrates that high hospital costs may force patients to leave against medical

advice. Other studies, listed below, also provide evidence of the impact of high costs in intensive care units in India on economically vulnerable sections of society:

(i) Peter JV, Thomas K, Jayaseelan L, Yadav B, Sudarsan TI, Christina J, Revathi A, Sudarsanam, TD. Cost of Intensive Care in India. International Journal of Technology Assessment in Health Care (2016) 32:4, 241-245: This study evaluating the cost and extent of financial subsidy required for patients admitted to an intensive care unit in India concluded that the family's contribution to expenses exceeded their willingness to pay, but a substantial subsidy of 33 per cent was still required to meet the costs of their care. The study recommended urgent alternate financing strategies for the poor and the optimal use of resources in intensive care settings. A copy of this study cost of intensive care in India is annexed and marked hereto as **Annexure A-19**. Pages (513 to 517)

(ii) Kulkarni, AP, Divatia, J. A prospective audit of costs of intensive care in cancer patients in India. Indian Journal of Critical Care Medicine (2013) 17:5, 292-297: This study of an Indian cancer hospital concluded that although the costs of intensive care in India were lower than in Western settings, the daily cost of intensive care in India was approximately 100 times the per capita income of an average Indian, thereby placing a much greater burden on them. A copy of this study a prospective audit of costs of intensive care in cancer patients in India is

annexed and marked hereto as **Annexure A-20.** Pages (518 to 529)

These studies demonstrate that a long decision-making process will increase hospital costs, prompting patients and their families to forego appropriate end of life care, thereby depriving them of the very protection that the present directions are intended to guarantee. This Hon'ble Court, in its judgment dated 09.03.2018 affirmed a patient's rights to autonomy, dignity and privacy, including the right to refuse life-sustaining medical treatment. The longer a patient is required to submit to such treatment because of a lengthy approval process, the more likely are these rights to be diluted, thereby defeating the spirit of the judgment of this Hon'ble Court.

34. In light of the practical impossibility of implementing the present directions, it is humbly submitted that the decision to withhold or withdraw life-sustaining treatment should be taken by three senior doctors of the patient's treating team, following consultations with the patient's family members and/or guardians or next friends. The prior approval of the second Medical Board constituted by the Collector or the Judicial Magistrate of the First Class should not be mandatory for the implementation of a decision to withhold or withdraw life-sustaining treatment.

35. In order to ensure appropriate safeguards, it is submitted that decisions to withhold or withdraw life-sustaining treatment should be submitted to a post-facto review, as recommended by medical

professionals. The Consensus Position Statement of the Indian Association of Palliative Care in Annexure A-9 recommends that a multi-disciplinary team should review the end of life care provided to understand gaps in the process and recommend any changes. A similar review process for end of life decisions is recommended in the Joint Position Statement of the Applicant herein, the Indian Society of Critical Care Medicine and the Indian Association of Palliative Care, set out in Annexure A-8 as well as in the statement made at the 5th International Consensus Conference in Critical Care, set out in Annexure A-13.

36. It is submitted that the review of decisions to withhold or withdraw life-sustaining treatment could follow the process suggested by the Applicant in its statement in Annexure A-14. The statement recommends that:

> *Each facility that operates an ICU must constitute a standing Clinical Ethics Committee (CEC) or must have access to a standing jurisdictional CEC which may be constituted by the District Collector or Chief Medical Officer. This committee will have adequate representation from outside the hospital/facility including legal experts, patient advocates/NGOs, etc. All cases where WH/WD-LST [withholding or withdrawing of life-sustaining treatment] is carried out must mandatorily be audited post-facto by the concerned committee and their recommendations will be binding on the hospital/facility/local administration within pre-specified time limits. This committee will also be involved from the beginning if there is a lack of consensus between surrogates and the treating team.*

37. Therefore, it is submitted that, instead of the Medical Board to be constituted by the Collector, as laid down in the present guidelines, a Clinical Ethics Committee be constituted. This

Committee could be constituted, either at the hospital, if the hospital has a sufficiently large number of patients in intensive care units, or at the district level, where the Committee may be accessed by other health care institutions. Instead of requiring the prior approval of the Medical Board constituted by the Collector, and of the Judicial Magistrate of the First Class, it is submitted that such a Clinical Ethics Committee be required to conduct a post-facto review of decisions to withhold or withdraw life-sustaining treatment, and make recommendations to improve the end of life decision-making process. This will allow end of life care decisions to be implemented in a timely manner, without submitting the patient to unnecessary medical interventions and hospital costs, while also ensuring sufficient checks against the abuse of the process. A post-facto review of this nature will also be in accordance with care and treatment guidelines recommended by medical professionals around the world.

Withdrawal of life-sustaining treatment in the case of brain-stem death independent of consent for organ donation

38. In India, there are different definitions of death under different laws. Section 2(b) of the Registration of Births and Deaths Act, 1969, defines death as the 'permanent disappearance of all evidence of life at any time after live-birth has taken place.' Section 2(e) of the Transplantation of Human Organs and Tissues Act, 1994 defines a deceased person as a 'person in whom permanent disappearance of all evidence of life occurs, by

reason of brain-stem death or in a cardio-pulmonary sense, at any time after live birth has taken place.' While the earlier law defines death in terms of the cessation of cardiac and respiratory functions, the later one explicitly recognises brain-stem death as a form of death. Therefore, under the Transplantation of Human Organs and Tissues Act, 1994, even if a person's cardiac and respiratory functions are being performed artificially, for example, through extracorporeal membrane oxygenation or left ventricular assist devices, such a person would be considered deceased by reason of brain-stem death. Brain-stem death is defined in section 2(d) of this law as the 'stage at which all functions of the brain stem have permanently and irreversibly ceased and is so certified under sub-section (6) of section 3.' Under sub-section (6) of section 3, brain-stem death is to be certified by a Board of medical experts.

39. When a person has been certified dead (whether by virtue of brain-stem death or otherwise), it follows that they may be withdrawn from a ventilator. Ventilating a dead person is contrary to ethical medical practice. In June, 2018, the Delhi State Consumer Redressal Commission imposed a fine of 5 lakh rupees on a hospital for ventilating a person who had been certified brain dead. It found that there was no medical justification for this and awarded compensation to the patient's parents for mental agony and emotional suffering. A copy of the news article reporting this case (Aamir Khan, 'Hospital kept brain

dead boy alive, fined Rs 5L, *The Times of India* 24 June 2018) is annexed and marked hereto as **Annexure A-21**. Pages (53 to 53)

40. However, because brain-stem death has been defined only under the Transplantation of Human Organs and Tissues Act, 1994, it has created confusion among medical practitioners who are of the opinion that a patient may be certified brain-stem dead and taken off a ventilator only if the family/guardian of the patient consent to the donation of her organs. An article reporting this anomalous practice by medical professionals in India (Sunil Shroff, Sumana Navin, "Brain death" and "circulatory death": Need for a uniform definition of death in India") was published in the Indian Journal of Medical Ethics in September 2018. This article describes the prevailing confusion regarding the link between brain-stem death certification and organ donation as follows:

> *Many doctors are also of the opinion that consent is required to withdraw ventilation from a person certified brain dead. False and misleading stories in the media of a person making a "miraculous recovery" from coma or a "dead person coming alive" may have led to these doctors taking a defensive stand. The public has difficulty in understanding and accepting that brain death is, in fact, death, since the heart is still beating and the body is warm to the touch with occasional spinal reflexes. This can make a doctor reluctant to withdraw ventilation. There are situations in which the family of a brain-dead person demands continuation of the ventilator, hoping for a "miracle", and becomes belligerent if doctors advise turning it off. Hospitals, in such situations, have often yielded to the*

wishes of relatives. Continuing the ventilation of a brain dead patient also prevents care of another critical patient when ICU beds are full, and to ethical dilemmas among clinicians.

A copy of the article in the Indian Journal of Medical Ethics, pointing out the legal uncertainty regarding the link between brain-stem death is annexed and marked hereto as **Annexure A-22.** Pages (530 to 531)

41. The present directions laid down by this Hon'ble Court, govern the withholding or withdrawal of life-sustaining treatment for persons who are terminally-ill or surviving on life-support. A person who has suffered brain-stem death, but has not been taken off a ventilator could be said to be 'surviving' on life-support, thereby falling within the ambit of the present directions. The present directions do not make the withholding or withdrawal of life-sustaining treatment contingent upon the consent of the patient or her family to the donation of her organs under the Transplantation of Human Organs and Tissues Act, 1994. Given the prevailing uncertainty among the medical profession regarding the removal of brain-stem dead persons from ventilators, it is humbly submitted that this Hon'ble Court clarify that life-sustaining treatment may be withdrawn from persons who have suffered brain-stem death, irrespective of their consent for organ donation. Such cases should continue to be governed by the Transplantation of Human Organs and Tissues Act, 1994,

under section 3(6) of which a process for the certification of brain-stem death has already been provided.

42. The lack of legal clarity regarding end of life care decision-making can have an adverse impact on patients by preventing doctors from acting in their best interests. The Consensus Position Statement of the Indian Association of Palliative Care, in Annexure A-9 notes that:

> *Due to the lack of legal protection, Indian physicians practise defensive medicine, resulting in many inappropriate interventions being done. This ultimately results in holistic suffering instead of holistic care for the dying person and the family.*

The study in Annexure A-16, which found a high proportion of terminal discharges from the intensive care units of 4 hospitals in India concluded that its findings suggested that:

> *End-of-life-care in Indian ICUs may be suboptimal and is probably related to the unresolved legal status of withholding and withdrawal of life-sustaining treatments in critically ill patients in India.*

43. Although this Hon'ble Court has settled this legal uncertainty in its judgement, granting legal backing to advance medical directives as well as the withholding or withdrawal of life-sustaining treatment, there remains considerable confusion among medical professionals regarding the implementation of the present directions. At a public discussion held at the Seth Gordhandas Sunderdas Medical College, King Edward VIII Memorial Hospital, Mumbai on 10.03.2018, experts expressed

their concerns regarding the workability of the present directions. Copies of news reports in the Times of India (Swati Deshpande, 'Experts Hail SC verdict, but fear implementation is unworkable', 11 March 2018) and the Hindustan Times (Aayushi Pratap, 'Passive euthanasia: Here's why Mumbai experts feel implementing living will is a challenge' 10 March 2018), writing about these concerns are annexed and marked hereto as **Annexures A-23** Pages (535 to536) **and A-24.** Pages (537 to 541)

'44. A 2015 study by the Economist Intelligence Unit and commissioned by the Lien Foundation on a Quality of Death Index that ranks palliative care across the world places India at the 67th position out of the 80 countries surveyed. It is at the 59th position in the quality of care category and 74th in the affordability of care category. A copy of this study is marked and annexed hereto as **Annexure A-25.** Pages (542 to 612) This demonstrates that India has not been able to protect the right of persons to die with dignity. The judgement of this Hon'ble Court on 09.03.2018 is an important step towards addressing this. It is humbly submitted that the modifications/clarifications prayed for in this application are essential to ensure that the spirit of the judgement of this Hon'ble Court is appropriately implemented, that medical professionals are able to act in the best interests of their patients while making decisions regarding the withholding or withdrawal of life-sustaining treatments, and

that all persons are able to exercise, without hindrance, their rights to autonomy, privacy and a dignified death.

PRAYER

In light of the above legal and factual submissions, it is therefore prayed that this Hon'ble Court may be pleased to clarify or modify its judgement dated 09.03.2018 such that:

(i) an advance medical directive be permitted to be executed before a Notary, as an alternative to its execution before a Judicial Magistrate of the First Class;

(ii) an advance medical directive comes into operation only when its executor is incapable of exercising her judgement or expressing her wishes;

(iii) the decision regarding the withholding or withdrawal of life-sustaining treatment be permitted to be taken by the treating team of the patient comprising three senior doctors, after communicating with and taking into account the wishes of her family and/or next friend or guardian;

(iv) the prior approval of the Medical Board constituted by the Collector, as well as of the Judicial Magistrate of the First Class not be required for the implementation of a decision to withhold or withdraw life-sustaining treatment, so long as all such decisions are reviewed post-facto by a Clinical Ethics Committee;

(v) the withdrawal of life-sustaining treatment from a person who has suffered brain-stem death be permitted, irrespective of

whether such person or her family had consented to the donation of their organs;

(vi) and pass such further and other orders as this Hon'ble Court may deem fit and proper.

Filed by:

Drawn by:

Rashmi Nandakumar
Advocate for the Applicant

Place: Delhi
Date:08.07.2019