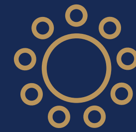
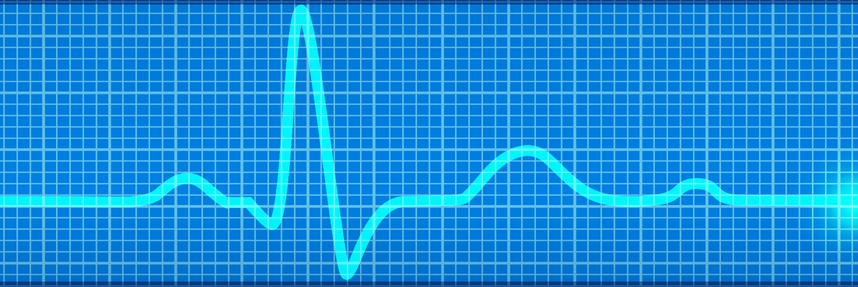


Shardul Amarchand Mangaldas

Advance Medical Directives



Advance Medical Directives: To die with dignity - the status of advance medical directives under Indian law

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Introduction

The decision of the Supreme Court of India ("**Supreme Court**") in the case of *Common Cause* v. *Union of India*[1] ("**Common Cause**") is the culmination of a fascinating evolution of jurisprudence: the relatively straightforward question of the constitutionality of the criminalization of attempted suicide, as discussed in *P. Rathinam* v. *Union of India*[2] ("**Rathinam**") made way for the nuanced analysis of a right to refuse life-prolonging medical treatment in *Aruna Ramachandra Shanbaug* v. *Union of India*[3] ("**Aruna Shanbaug**"). The *Aruna Shanbaug* case paved the way for predicating the validation of passive euthanasia and recognised the importance of Right to Life as provided in Article 21 of the Constitution of India.

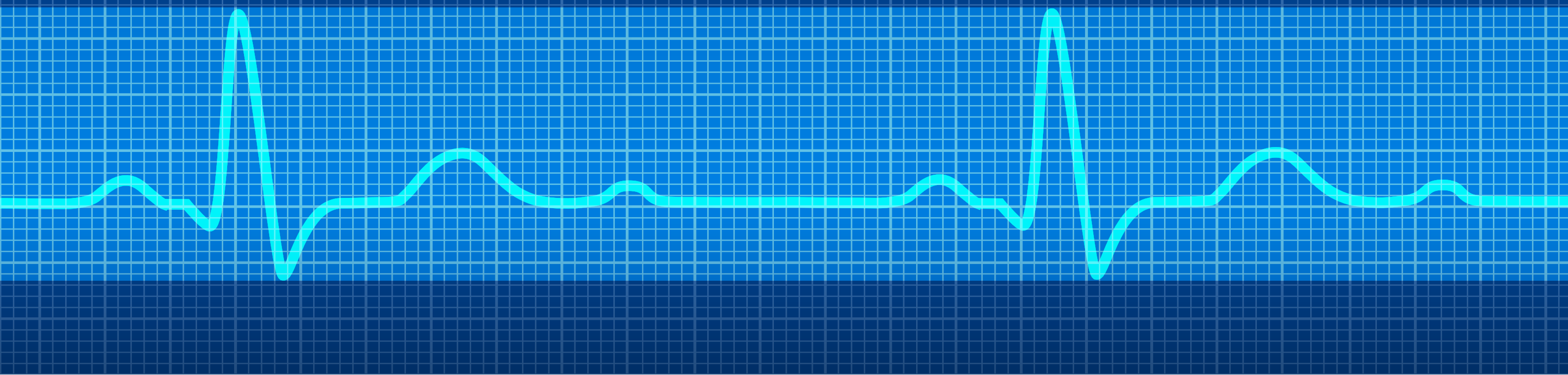
The contribution of *Common Cause* to the development of Indian law is two-fold: *firstly*, in advancing on the analysis provided in *Aruna Shanbaug*, the Supreme Court reiterated and strengthened the right of an individual suffering from a terminal illness with no hope of recovery to refuse (or allow the withdrawal of) life-extending medical treatment. *Secondly*, it provided a detailed framework for allowing individuals to regulate the manner in which they were to receive medical treatment and created a mechanism which would allow for the recognition of their wishes with regards to refusal to receive such treatment even in case of their being unable to provide direction in this regard at the time of such illness affecting them. It is this framework, enshrined in the form of 'advance medical directives' or 'living wills', which is to be evaluated in the course of this paper.

The position in law prior to Common Cause

The extent to which individuals were allowed to regulate the manner of their own deaths first drew significant attention as part of the case of *Rathinam*, which involved a two-judge bench of the Supreme Court looking at a challenge to the validity of Section 309 of the Indian Penal Code ("**IPC**") (which criminalised attempted suicide), in light of Articles 14 and 21 of the Constitution. The decision in *Rathinam* hinged, *inter alia*, on the construction of the fundamental rights provided in the Constitution. The Supreme Court placed reliance on the dual nature in which other fundamental rights were construed so as to analogously determine the extent of the operation of the Right to Life in Article 21.

Relying on previous judicial pronouncements, the Supreme Court provided that the right to freedom of speech carried within itself the right to abstain from speech. Therefore, the recognition of a right to do an act would contain within itself the corollary right of not being compelled to take such action. In *Rathinam*, the Supreme Court allowed for such a construction to be applied in the case of Article 21, and included the right not to live a forced life as a part of Article 21.

This pronouncement, however, was overruled by a Constitution bench of the Supreme Court in the 1996 case of *Gian Kaur* v. *State of Punjab*[4] ("**Gian Kaur**"). As part of an appeal against a conviction under Section 306 of the IPC (which criminalises abetment of suicide), the Supreme Court evaluated the reasoning employed in *Rathinam*. While it accepted the principle of a right to do



an act also encompassing the right not to do such an act, the Supreme Court rejected the proposition that the same would result in Article 21 carrying within itself a supposed 'right to die'.

The difference, the Supreme Court stated, was that the principle *Rathinam* hinged on was applicable only when the right under consideration was *to do an act*, and the corollary being included was the right *not to do an act*, i.e. the right to refrain from acting. However, a purported right to die would necessarily have to include the ability to *commit an overt act*, i.e. take a positive step to accomplish an end, which would distinguish it from the principle that *Rathinam* relied upon to reach its conclusion. Thus, the Supreme Court ruled Sections 306 and 309 of the IPC to be constitutional, and rejected the idea of a right to die being part of Article 21.

The next case in which the Supreme Court grappled with the question of allowing for a planned termination of life was *Aruna Shanbaug*. Considering a writ petition filed by Ms. Pinki Virani, the Supreme Court dealt with the question of allowing the cessation of feeding of Ms. Aruna Shanbaug, a the victim of an assault that had left her in a persistent vegetative state for thirty six years, with no potential of recovery of brain function or state of consciousness.

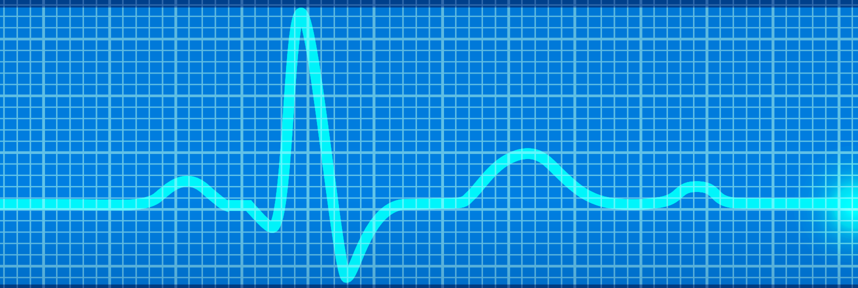
While the petition was not granted due to the Supreme Court electing to view the staff and administration of King Edward Memorial Hospital, Mumbai as her next best friend and accepting their submissions arguing for the continuation of Ms. Shanbaug's life, the case did include significant analysis regarding the various stages of physical and mental incapacity that might afflict individuals and when the same might allow for euthanasia to be granted to the individual concerned.

As part of the ruling, the Supreme Court also characterised the forms which euthanasia procedures could take. The most important of these was the differentiation of *active* and *passive* euthanasia, which hinges upon the degree of causation that can be attributed to the patient or practitioner.

The usage of lethal substances or forces to kill a person was categorized as active euthanasia. This would include methods such as injection of lethal substances into a patient suffering from a terminal disease. Herein, the practitioner would be taking an active step that caused the death, i.e. the death would result out of the intervening agent introduced by the practitioner, and not solely from the terminal illness of the patient.

Passive euthanasia, on the other hand, involves the withholding or withdrawal of medical treatment that was necessary for continuance of the patient's life. This would include the withholding of antibiotics, or removal from a ventilation system of a patient that was dependent on such a system for their survival. Unlike active euthanasia, the direct cause of death herein would continue to be the terminal illness: the role of the medical practitioner would be limited to non-intervention in a manner that allowed for the natural progression of the illness or infirmity.

The Supreme Court relied on the submissions of a panel of experts regarding the exact operative conditions that distinguished conditions such as brain death, coma, persistent vegetative state and minimally conscious state, and on the basis of the same, evaluated the prohibitions made in *Gian Kaur*. It found that while a right to die could not be read into Article 21, the same would not prevent individuals suffering from a terminal illness or permanent incapacity with no hope of recovery from electing not to continue with life-prolonging



treatment. This was construed as part of the distinction drawn in *Gian Kaur* between facing the natural conclusion of life in a dignified manner, in contrast with actively causing a forceful termination of the same.

Aruna Shanbaug also relied strongly on the opinion of the House of Lords in the United Kingdom case of *Airedale* v. *Bland*. In that case, the parents of a teenager that had suffered significant brain injury resulting in permanent and terminal incapacity had sought to withdraw life-prolonging treatment for their child.

The House of Lords, while going on to allow such a prayer, had noted that the principle of sanctity of life could not be held paramount in circumstances where the individual concerned was in a permanent vegetative state with no hope of recovery, and that the *best interests* of the patient might allow for the withdrawal of life prolonging treatment. *Airedale* had also indicated that other individuals seeking the same would be required to approach the courts for a case-by-case determination.

Therefore, *Aruna Shanbaug* conceptually validated the usage of passive euthanasia in case of terminal illness with no hope of recovery. In case of individuals who did not retain the capacity to consent to the same at the time such determination was to be made, the parents, spouse, close relatives, next friends or even attending doctors of the person were be allowed to make such a decision, subject to the approval of a High Court, which could in turn rely on the opinions of a panel of medical experts.

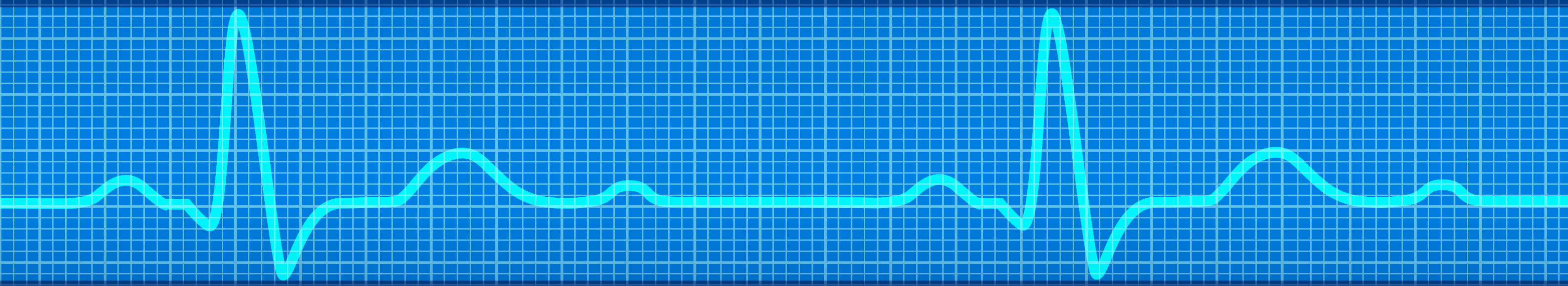
Common Cause: Need for Advance Medical Directives

The ruling in *Common Cause* was concerned both with evaluating the development of jurisprudence with regards to a right to cease life-prolonging treatment in case of a state of terminal illness or incapacitation with no hope of recovery and elaborating upon the manner in which individuals could record, authenticate and ask for recognition of their wishes regarding the medical treatment that could be given to them in case of such terminal illness or incapacity.

While the Supreme Court had recognised in *Aruna Shanbaug* the permissibility of withdrawal of life-prolonging medical treatment for patients that were unable to make an informed decision regarding the same, there still existed ambiguity with regards to the manner in which people could access such a course of action, as well as the manner in which medical practitioners could participate in such a process without fear of legal reprisal or liability. The Supreme Court sought to address concerns regarding abuse of such a right, as well as the determination of authenticity and verifiability of patients' wishes, by way of mandating judicial oversight of each case in which passive euthanasia was sought.

However, such a mechanism would have necessitated the expenditure of significant amounts of money, effort and time, given the modalities of the judicial process. This mechanism, while fair in its intent, had the potential to negatively affect the capacity and willingness of the people wishing to avail the right to die with dignity.

The failure of the Treatment of Terminally Ill Patients (Protection of Patients and Medical Practitioners) Bill of 2016 in Parliament, which would have provided a framework for individuals to *access* permissible passive euthanasia, further reinforced the need of guidance regarding how best to allow people to record and authenticate their wishes regarding withdrawal or withholding of medical treatment.



Common Cause, therefore, enshrines the usage of Advance Medical Directives ("**AMDs**") for recording and implementing the wishes of an individual regarding medical treatment. The emphasis placed on AMDs in the case is in recognition of these procedural concerns. The procedure mandated in *Common Cause* (for both patients with and without AMDs) provides greater security to the patient, practitioner and state: the ruling allows patients to access the right to die with dignity without relying on High Courts in each individual case, illustrates to practitioners how best to recognize and act upon such wishes, and provides safeguards to ensure the state's interest in protection of life and prevention of abuse was limited.

AMDs are written legal documents that record the wishes of individuals with regards to the provision of medical treatment in future instances of physical and mental incapacity and terminal illness. These authenticate and preserve the instructions which the individual wishes to see implemented in case of him or her being unable to communicate his wishes or lacking the mental capacity to understand the consequences of accepting or rejecting medical treatment at the time it would be warranted.

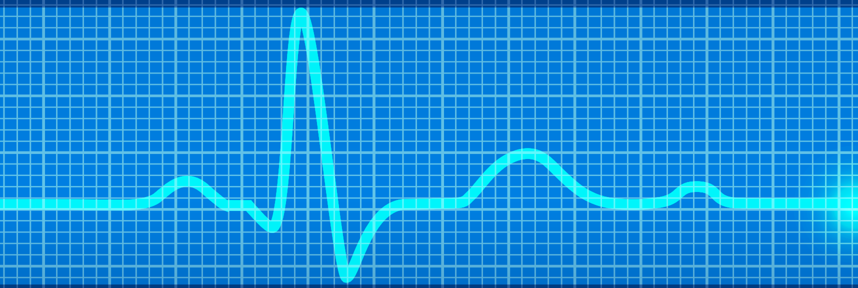
Such AMDs allow for individuals to potentially outline their wishes and direct medical practitioners to adhere to the same with regards to a wide variety of circumstances, and have been used in other jurisdictions for regulating everything from the provision of cardiopulmonary resuscitation to determining the extent of usage of artificial life-support systems. Such documents reduce the ambiguity that might otherwise be associated with gleaning the wishes of a currently incapacitated individual, as well as the concerns associated with relying entirely on a guardian or close relative to relay such information and act upon the individual's best interests.

Act and Omission

The decision in *Common Cause* reiterates and strengthens the distinction made between *active* and *passive* euthanasia that formed the crux of *Aruna Shanbaug*. Herein, a distinction is sought to be made between *causing the death* of the patient by way of a positive act (e.g. by injecting the patient with lethal medication such as sodium pentothal) on one hand, and *letting* the underlying illness result in the death of the patient by withdrawing or not introducing any medical treatment that would have acted in a manner so as to prolong the life of the patient.

In both *Aruna Shanbaug* and *Common Cause*, non-intervention in the form of withdrawal of life-prolonging treatment is concluded to not be violative of penal provisions in the IPC that prohibit the causing of death, or the aid and abetment of death by any means. As part of such analysis, *Common Cause* also provides that such non-intervention would not constitute an illegal omission under the IPC or associated penal statutes.

Common Cause also delved into the principle of patient autonomy, with particular emphasis on the recognition of the right of patients to refuse treatment so as to prevent unnecessary pain, trauma and indignity. Such a right was taken as another illustration of the manner in which causation of death ought to be interpreted, in that a patient refusing medical treatment was stated to *lack a specific intention to die*, and only allowed for the disease afflicting the patient to take its natural course. In such a scenario, the occurrence of death would be attributed to the progression of the underlying disease, and not any act initiated by the patient or the physician. It is this nuance that enables both *Aruna Shanbaug* and *Common Cause* to obviate the strictures laid down in *Gian*



Kaur, as the procedure enshrined herein is stated *not to be causing death*, but allowing for a dignified progression of the existing state of affairs without making positive interventions that might have deferred the expiration of the individual.

However, the Supreme Court also stepped beyond the realm of determining causation and into the question of the dignity inherent to the individual, and its protection under Article 21. Relying on the ruling in *K. S. Puttaswamy* v. *Union of India*,[5] the Supreme Court indicated that prolonging existence merely by way of artificial mechanisms would be deleterious to the dignity inherent to human existence, as it would be a life devoid of the capacity of self-assertion and choice that constitute meaningful existence.

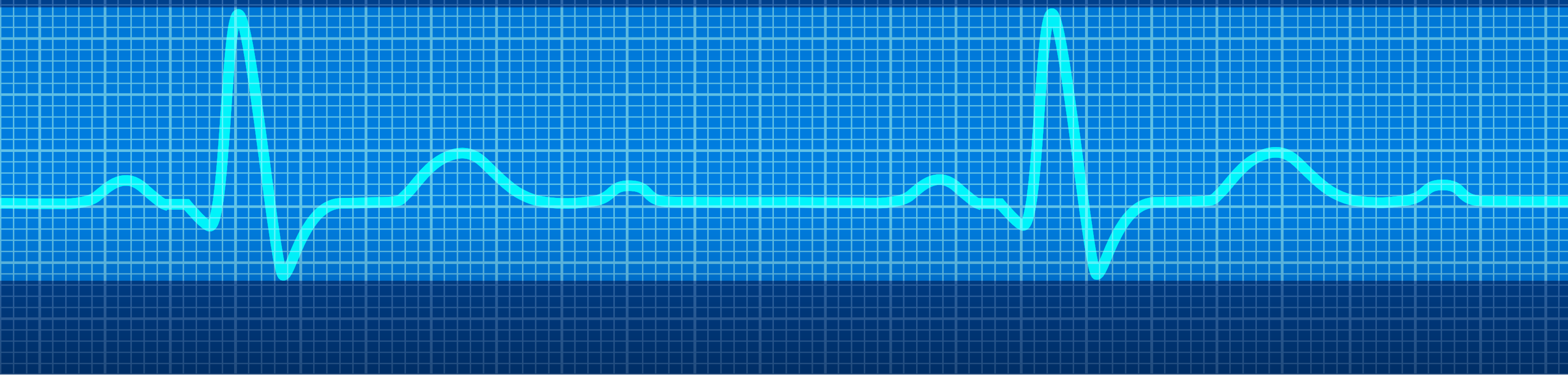
Common Cause also attempts to evaluate the validity of placing such extensive emphasis on the distinction between act and omission. Its analysis of the best interests of a patient and the value attached to maintaining patient autonomy or dignity exist independent of the act-omission dichotomy. It is important to note the attempt the Supreme Court makes to integrate the two lines of argument here, indicating in one instance that non-intervention as a form of passive euthanasia would be justifiable *only* if it could be stated to be in the best interests of the patient. For instance, as part of his concurring opinion, Justice Chandrachud notes that "*against the background of the duty to care, the moral and legal status of not saving a life due to failure to provide treatment, can be the same as actively taking that life. A doctor who knowingly allows a patient who could be saved to bleed to death might be accused of murder and medical negligence. The nature of the doctor-patient relationship which is founded on the doctor's duty of care towards the patient necessitates that omissions on the doctor's part will also be penalised. When doctors take off life support, they can foresee that death will be the outcome even though the timing of the death cannot be determined. Thus, what must be deemed to be morally and legally important must not be the emotionally appealing distinction between omission and commission but the justifiability or otherwise of the clinical outcome.*"

While such analysis seems to act equally as a justification for passive *and* active euthanasia, it should not be taken to be indicative of the possibility of active euthanasia being legalised by way of judicial pronouncement. Given the emphasis placed within the judgment on navigating the distinction drawn between acts and omissions in criminal law, such recognition of active euthanasia would, in all probability, require legislative intervention.

Requirements and Procedure for Implementing Advance Medical Directive IN INDIA

Framework: *Common Cause*, in addition to enshrining the right to die with dignity, also provides an elaborate framework for authenticating and implementing the wishes of people with regards to the provision of medical treatment, which has been described below. The judgement does note, however, that the framework provided herein would only be for interim usage, until the promulgation of a law by the legislature, akin to the guidelines provided by the Supreme Court in *Vishaka* v. *State of Rajasthan*.[6]

Eligibility for executing an AMD: AMDs can be executed by adults of sound mind who are capable of understanding and communicating the purpose and consequences of executing them. Such execution must be voluntary and with informed



consent, and without any coercion, inducement, undue influence or constraint.

Contents of an AMD: The AMD must be in writing, in specific terms, with clear and unambiguous instructions, and should contain the following details:

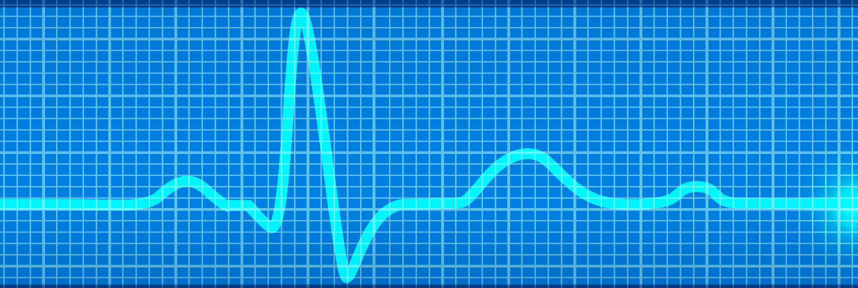
- A statement regarding the circumstances in which medical treatment may be withheld or withdrawn if the treatment under consideration is only life-prolonging and may otherwise cause the person concerned pain, suffering or indignity.
- The name of a guardian or close relative who will be authorised to give consent to refuse or withdraw medical treatment in a manner consistent with the AMD.
- A statement declaring that the executor has understood the consequences of executing an AMD, and that the AMD might be revoked at any point of time.

Manner of recording: The AMD is to be executed in the presence of two attesting witnesses, which should preferably be independent witnesses, and countersigned by the jurisdictional Judicial Magistrate of First Class ("**JMFC**"). The execution will also require recording the satisfaction of the witnesses and JMFC about the authenticity of the document, and that the execution was voluntary, without any coercion, inducement or compulsion, and with full knowledge of the consequences. In case of the immediate family members of the executor not being present at the time, the JMFC will inform them of the execution of the AMD.

Preservation of AMD: The JMFC will be required to preserve both a physical and a digital copy of the AMD in his or her office, and shall also provide a copy of the document to the family physician of the executor (if any), and the Registry of the jurisdictional District Court (which shall also retain a digital copy of the AMD). The competent officer of the appropriate local government entity, municipal corporation, municipality or panchayat will also be provided a copy, all of which will nominate an official to act as custodian of AMDs.

Procedure of implementation: The AMD will assume importance in case of the executor becoming terminally ill with no hope of recovery and cure of the ailment, and is undergoing prolonged medical treatment. It can be revoked by the executor at any time before implementation of the directions provided therein.

- The treating physician will be informed of the existence of the AMD and shall verify the authenticity of the same from the JMFC.
- If the treating physician believes the aforementioned criterion (i.e. the illness is terminal, with no hope of cure etc.) are met, he shall inform the guardian or close relative of the nature of illness, available medical care, alternative treatments and the consequences of non-treatment, and ensure he has grounds for reasonably believing the same have been understood properly and mulled over.
- In case the guardian or close relative determines that withdrawal or refusal of medical treatment is to be undertaken, the treating physician or the hospital where the individual is undergoing treatment shall form a medical board ("**Hospital Medical Board**"). This will 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 with overall standing in the medical profession of at least twenty years.
- The Hospital Medical Board shall visit the patient in the presence of the guardian or close relative and provide a preliminary opinion choosing or refusing to certify the instructions of the guardian or close relative.

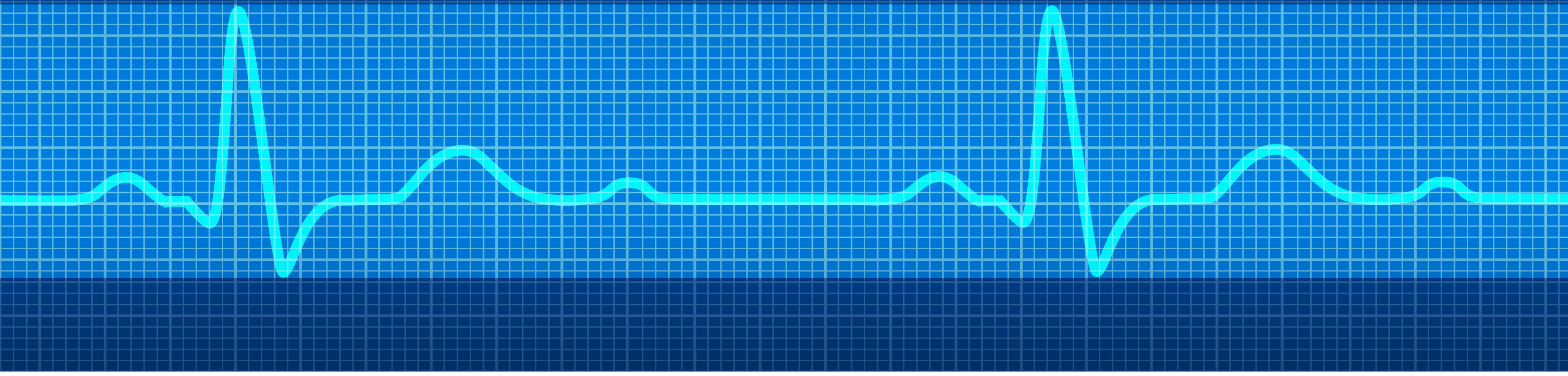


- In case of the Hospital Medical Board certifying the instructions of the guardian or close relative, the concerned physician or hospital shall inform the jurisdictional Collector of the same. In case of the Hospital Medical Board not approving the direction in the AMD, it shall sent in an application to the Collector Medical Board for consideration of and appropriate direction on the concerned AMD.
- The Collector will form another medical board ("**Collector Medical Board**") comprising of 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).
- The Collector Medical Board shall jointly visit the patient, and in case of agreement with the opinion of the Hospital Medical Board, shall endorse the certificate for carrying out the instructions given in the AMD.
- The Collector Medical Board must ascertain the wishes of the individual (if he or she can communicate and retains the capacity to understand the consequences of withdrawing medical treatment and make a decision regarding the same), or conversely the guardian nominated by the individual in the AMD, and obtain consent for withdrawal of treatment in accordance with the AMD.
- The Chairman of the Collector Medical Board will inform the JMFC of the decision of the Board. The JMFC will visit the patient, and after an examination of all aspects, shall authorise the implementation of the decision.
- The JMFC shall intimate the High Court if life support is withdrawn, Such intimation shall be digitally stored by the Registry of the High Court, along with a physical copy of the same which shall be destroyed after three years of the death of the individual.

Recourse to the Courts: If the Collector Medical Board refuses permission to withdraw medical treatment, the High Court may be approached by way of a writ petition under Article 226 by the individual concerned, his family members, the treating doctor or the hospital staff. *Common Cause* has also laid down guidelines in this regard:

- A Division Bench shall permit or refuse implementation of the AMD, and may utilise 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.
- The High Court would also have the ability to constitute a medical board to examine the patient and submit report about the feasibility of acting upon the instructions contained in the AMD.
- The High Court would be required to provide a decision at the earliest, with such ruling providing reasons keeping in mind the principle of acting in accordance with the best interests of the patient.

Revocation or Inapplicability of AMD: In case of there existing multiple unrevoked AMDs for an individual, the most recently signed AMD will supersede all previous AMDs. Withdrawal or alteration of an AMD may be done by utilising the same procedure provided for recording an AMD. The AMD may be held inapplicable in case of (i) in case of there being reasonable grounds to believe that the extant circumstances were not anticipated or foreseen by the executor of the AMD and that knowledge of such circumstances would have affected his decision; or (ii) in case of the AMD not being clear and unambiguous.



Advance Medical Directives in other jurisdictions

The United Kingdom

The United Kingdom recognizes advance medical directives under Sections 24 to 26 of the Mental Capacity Act, 2005 ("**Mental Capacity Act**"). The statutory provisions recognise the creation of an advance directive (contrasted with advance *statements*, which help inform medical practitioners of religious or personal concerns that need to be addressed during treatment), which allow for adults with the mental capacity to provide instructions for future medical treatment. Herein, the directive needs to be witnessed by one person and modifications or withdrawal of advance directives is allowed to be made in a non-written manner, except for decisions regarding life-sustaining treatment, the withdrawal of which would risk the life of the concerned individual. Any modification of such serious nature would require the witnessing and execution of a written directive.

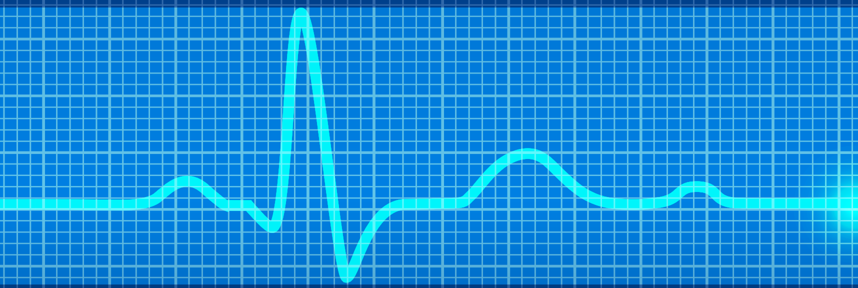
Furthermore, the Mental Capacity Act also allows for the vesting of a lasting power of attorney in a donee for making decisions regarding the personal welfare of the individual concerned. Such power can also extend to providing consent or refusal of life-sustaining treatment if a provision delegating power to that effect has been incorporated as part of the power of attorney. Read in conjunction with decisions in cases such as *Airedale*, the United Kingdom as a well-established framework for regulating the withdrawal or withholding of medical treatment if the individual concerned consents to it, and in case of the individual lacking capacity to do so, such decision is deemed to be in his or her best interests.

In Australia, advance health directives are regulated by way of state legislation. In Queensland, for instance, the validity of advance health directives is enshrined in Section 35 of the Powers of Attorney Act, 1998 ("**Powers of Attorney Act**") read with the provisions of the Guardianship and Administration Act, 2000. Under the Powers of Attorney Act, instructions forming part of advance health directives are that entail withholding of life-prolonging measures are inapplicable unless the individual concerned has an incurable or irreversible illness that is expected to cause death within one year, or the individual is in a permanently unconscious or persistent vegetative state, or the individual has an illness or injury that necessitates the continued application of life-sustaining measures to prolong the individual's life, or if the individual has no prospect of regaining capacity for determining health matters. Furthermore, directions to withhold or withdraw artificial nutrition or hydration would only be implemented if consistent with good medical practice. Section 103 of the Powers of Attorney Act also allows the concerned medical practitioner to operate in contravention of a medical directive if the same is uncertain, inconsistent with good medical practice, or in case circumstances including advances in medical science have changed significantly enough to render the directive inappropriate.

United States of America

In the United States of America, advance directives work on a federal basis, with state laws operating in conjunction with the Patient Self-Determination Act, 1990 ("**PSDA**"). The PSDA defines an "advance directive" as a "*written instruction, such as an Individual Instruction or Power of Attorney for Health Care, recognized under State law and relating to the provision of health care when the individual is incapacitated*", and allows for such a directive to regulate provision of medical treatment

1 This list does not include India's IIAs which have been terminated recently and are in their sunset period.



as part of its recognition of the right of the patient to accept or refuse medical treatment.

While all US states have enacted legislation to allow for and create a framework implementing advance directives, there are often localised variations in practice that illustrate the varying ways in which such systems can function. Many US states, for instance, allow for the appointment of a healthcare proxy that has the ability to make decisions in case the concerned patient does not retain the ability to do the same. Judicial pronouncements and statutory provisions have placed significant emphasis on giving effect to the wishes of individuals as stated in their advance directives.

In order to aid such determination, the U.S. Advance Care Plan Registry acts as a database of advance directives, with hospitals being required to enquire about any existing advance directives and store any received files in their own medical files.

Furthermore, there have also been provisions made to account for people who wish to be given all life-sustaining treatment, so as to ensure that there exists an active, authenticated statement that ensures such treatment is not withdrawn in case of any ambiguity in determining the wishes of the concerned individual at the time the treatment becomes necessary. This has taken the form of variants of living wills called 'Will to Live'.

Germany

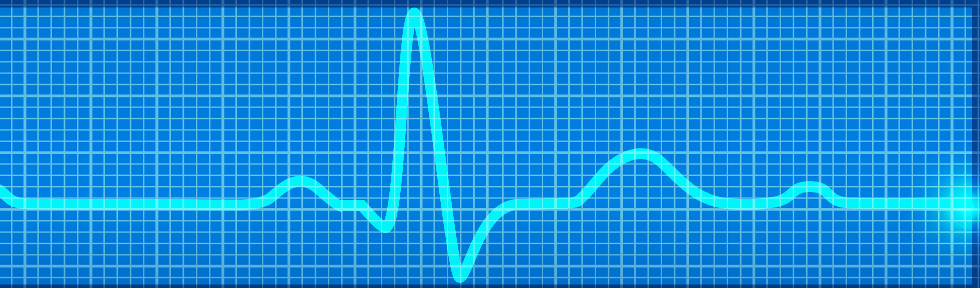
In Germany, consolidating the various judicial pronouncements made in this regard, the law on advance medical directives has been statutorily incorporated and brought into effect from September 1, 2009. Under Provision 1901a.1 of the Bürgerliches Gesetzbuch ("**BGB**"), the German Civil Code, an advance directive made by an individual having the mental capacity to make such declaration accounting for the eventuality of future mental incapacity is legally valid and binding.

Of note is the order of precedence established in the BGB with regards to the implementation of patients' wishes. While Provision 1901a.3 of the BGB mandates compliance with such directive in any decision concerning medical treatment irrespective of the stage or degree of illness or degradation, the authority of making decisions in this regard may also be delegated by way of a lasting power of attorney or to a healthcare proxy appointed by the judiciary. Such authorised person is required to act in accordance with the will of the concerned patient.

Furthermore, in the absence of either such mechanism, the law places reliance on the treatment preferences or the patient's presumed will, as determined by way of concrete evidence (including prior oral statements or expressed values) to reach the appropriate course of action. It is only in the absence of such evidence and the situation being regarded as an emergency that a medical professional would be given the authority to make a decision in accordance with the presumed best interests of the patient.

Conclusion

The Supreme Court, in *Common Cause*, acted upon the basis it had built in *Aruna Shanbaug* to reiterate and strengthen the legal validity of passive euthanasia. The unique element it brought to Indian jurisprudence was the recognition of a procedural framework which would allow individuals to access it in a systematised manner, along with the recognition of AMDs as an important facet of the rights enshrined under Article 21.



In reducing the scope of the ruling in *Gian Kaur*, the judgement allowed India to join other jurisdictions of the world in granting some degree of recognition to the ability of individuals to regulate their manner of death. More importantly, in replacing the solely judiciary-centric framework created in *Aruna Shanbaug*, the Supreme Court has allowed for a far greater number of people to potentially access this ability, and determine the extent to which they shall be subjected to medical treatments for the sole purpose of extending what might be existence only in name, where all the attendant capacities that characterise human life have otherwise ceased to exist. The provision of a more comprehensive framework for people who create AMDs, as well as people who do not, allays concerns regarding abuse while allowing for a greater degree of access to the right to die with dignity.

The emphasis on recognizing the dignity inherent to meaningful human existence and the pre-eminence of the best interest of the concerned patient, as displayed in *Common Cause*, will form the bulwark of greater recognition of rights relating to autonomy over oneself. However, the questions of active euthanasia and assisted suicide seemingly still remain wholly subject to legislative intervention in the future, given the thicket of currently existing laws that would have to be navigated for incorporating the same by way of judicial pronouncement.

However, the most significant impact of *Common Cause* is the positive change it brings about for people who wish to die with dignity: the enshrining of such a right, along with a procedural framework that both regulates and validates the exercise of the right, allows people to think about and account for the end of their lives, and plan for the treatment they would prefer to receive in such circumstances.

Common Cause states the fact that its framework is intended only as a placeholder for a more elaborate set of provisions promulgated by the legislature, and it is hoped that such legislation will be made on the same lines as *Common Cause*, allowing for greater public certainty and utilisation.

1 Common Cause (A Regd. Society) v. Union of India, AIR 2018 SC 1665.
2 P. Rathinam v. Union of India, (1994) 3 SCC 394.
3 Aruna Ramachandra Shanbaug v. Union of India, (2011) 4 SCC 454.
4 Gian Kaur v. State of Punjab, (1996) 2 SCC 648.
5 K.S. Puttaswamy v. Union of India, (2017) 10 SCC 1.
6 Vishaka v. State of Rajasthan, AIR 1997 SC 3011.

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Shardul Amarchand Mangaldas, founded on a century of legal achievement, is one of India's leading full service law firms. Our mission is to enable business by providing solutions as trusted advisors through excellence, responsiveness, innovation, and collaboration.

We are one of India's most well recognised firms, and are known globally for our integrated approach. With approximately 600 lawyers including over 110 partners, we provide exceptional services across practice areas which include General Corporate, Merger & Acquisition, Private Equity, Banking & Finance, Insolvency & Bankruptcy, Competition Law, Dispute Resolution, Projects & Project Finance, Capital Markets, Tax, Intellectual Property and Venture Capital. We are at the forefront of global and Indian M&A and private equity transactions, cutting edge high risk litigation and advice on strategically important matters across a spectrum of practices and industries for our multi-jurisdictional clients.

We have a pan India presence, with offices in seven cities across India - New Delhi, Mumbai, Gurugram, Bengaluru, Chennai, Ahmedabad and Kolkata.

'Outstanding'
provider of legal services in 2019 for Banking and finance, Capital markets, Competition/antitrust, Construction, Corporate and M&A, Dispute Resolution, Energy, Infrastructure, Insurance, Private Equity and Regulatory

asialaw PROFILES

Ranked #1
in both deal count and value, Mergermarket annual India league table 2018

'Tier 1'
in 2019 for Antitrust and Competition, Banking & Finance, Capital Markets, Corporate / M&A, Dispute Resolution, Insurance, Projects and Energy, Real Estate & Construction, TMT and White Collar Crime

The LEGAL 500

'Tier 1'
in 2019 for Banking & Finance, Capital Markets, M&A, Private Equity, Project Finance, Project Development: Infrastructure, Oil & Gas and Transport

IFLR 1000

Country Firm of the Year, India 2019

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'Band 1' in 2019 for
Banking & Finance
Capital Markets
Competition/Antitrust
Corporate/M&A
Dispute Resolution
Fintech
Private Equity
Projects, Infrastructure & Energy
White Collar Crime

National Law Firm of the year, 2017, India

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