

## ANALYSIS OF THE COMMON CAUSE JUDGMENT: WOULD LIVING WILLS BECOME A PRACTICAL REALITY?

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### **I Introduction**

### **II Foundational principles for advance directives**

### **III The procedure for execution and implementation**

### **IV shortcomings of the procedure laid down**

### **V Conclusion and suggestions**

### **I Introduction**

ON 9<sup>TH</sup> MARCH 2018, the Supreme Court of India in the case of *Common Cause (A regd. Society) v. Union of India*<sup>1</sup> (hereinafter referred to as the *Common Cause* judgement) not only upheld the legality of passive euthanasia but also laid down an elaborate procedure with respect to living wills in India, but, before dwelling into the details of this case it is important to briefly trace the history of the concept of euthanasia and living wills in India. One can say, that the debate on this aspect is somewhere rooted in the case of *P. Rathinam v. Union of India*<sup>2</sup> (hereinafter referred to as *P. Rathinamcase*) wherein the question of unconstitutionality of Section 309 of the Indian Penal Code arose and an analogy with freedom of speech and expression was made where it was held that the freedom of speech and expression includes freedom not to speak and a similar corollary was also drawn for the other fundamental rights as well, including for article 21 *i.e.*, right to life and it was held that “logically it must follow that the right to live would include the right not to live, *i.e.*, right to die or to terminate one’s life.”

Thereafter came the case of *Smt. Gian Kaur v. The state of Punjab*<sup>3</sup> (hereinafter referred to as the *Gian Kaur* case) wherein the Supreme Court dealt with the question of unconstitutionality of section 306 of the Indian Penal Code, 1860 and held that “suicide is an unnatural termination of life and, therefore, incompatible and inconsistent with the concept of right to

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<sup>1</sup> (2018) 5 SCC 1.

<sup>2</sup> (1994) 3 SCC 394.

<sup>3</sup> 1996 AIR 946.

life.” The court further held that the comparison between right to life and other rights is not apt because they differ greatly in nature and there is absolutely no similarity between them. But the court proceeded to clarify that right to die with dignity should not be equated with the right to die an unnatural death. The court further observed that:<sup>4</sup>

A question may arise, in the context of a dying man who is terminally ill or in a persistent vegetative state that he may be permitted to terminate it by a premature extinction of his life in those circumstances. This category of cases may fall within the ambit of the right to die with dignity as a part of right to live with dignity, when death due to termination of natural life is certain and imminent and the process of natural death has commenced. These are not cases of extinguishing life but only of accelerating conclusion of the process of natural death which has already commenced. The debate even in such cases to permit physician-assisted termination of life is inconclusive. It is sufficient to reiterate that the argument to support the view of permitting termination of life in such cases to reduce the period of suffering during the process of certain natural death is not available to interpret Article 21 to include therein the right to curtail the natural span of life.

Though the *Gian Kaur* case settled the controversy pertaining to suicide, yet the issue of euthanasia remained unsettled and ambiguous. The issue of euthanasia was for the first time as a subject matter in issue was dealt with in the case of *Aruna Shanbaug*<sup>5</sup> wherein the Supreme Court expressly allowed passive euthanasia and held that the constitution bench in *Gian Kaur* did not express any binding opinion with respect to passive euthanasia and reiterated its understanding of the above case as follows:<sup>6</sup>

It was held in *Gian Kaur* that there is no right to die under Article 21 of the Constitution and the right to life includes the right to live with human dignity but in the case of a dying person who is terminally ill or in permanent vegetative state, he may be allowed a premature extinction of his life and it would not amount to a crime.

After *Aruna Shanbaug* case came the *Common Cause* judgement which laid down the foundation of living wills in India. The case was a reference matter before the Constitution

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<sup>4</sup>*Id.* at para. 25.

<sup>5</sup>(2011) 4 SCC 454.

<sup>6</sup>*Id.* at para. 30.

Bench of the Supreme Court. The reference was made because the three-judge bench opined that there was some faulty interpretation which formed the basis of the *Aruna Shanbaug* case and there was need of clarification regarding the same. The three-judge bench did not frame any questions for the Constitution Bench in light of the fact that the issue needed to be dealt with in broader context of social, legal, medical and constitutional perspectives. The Constitution Bench reproduced its understanding of the *Gian Kaur* judgement in the following terms:<sup>7</sup>

In our understanding of the judgment in Gian Kaur, we do not find that it has decried euthanasia as a concept. On the contrary, it gives an indication that in such situations, it is the acceleration of the process of dying which may constitute a part of right to life with dignity so that the period of suffering is reduced. We are absolutely conscious that a judgment is not to be construed as a statute but our effort is to understand what has been really expressed in Gian Kaur. Be it clarified, it is understood and appreciated that there is a distinction between a positive or overt act to put an end to life by the person living his life and termination of life so that an individual does not remain in a vegetative state or, for that matter, when the death is certain because of terminal illness and he remains alive with the artificially assisted medical system. It is also not the ratio of the authority in Gian Kaur that euthanasia has to be introduced only by a legislation...Therefore, it can be held without any hesitation that Gian Kaur has neither given any definite opinion with regard to euthanasia nor has it stated that the same can be conceived of only by a legislation.

Post *Aruna Shanbaug* verdict, the law commission published the 241<sup>st</sup> report in 2012 on Passive Euthanasia, the report rightly recognises the concepts of individual autonomy and the need for euthanasia in certain cases,<sup>8</sup> but it vaguely like the 196<sup>th</sup> Law commission report in 2006 on Medical Treatment to Terminally Ill Patients (Protection of Patients and Medical Practitioners) recommended against the enforcement of living wills on the ground that they involve complex questions and are not suitable in the current Indian scenario.<sup>9</sup>

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<sup>7</sup>Supra note 5 at para. 42.

<sup>8</sup> Law Commission of India, “241<sup>st</sup> Report on Passive Euthanasia” (August 2012).

<sup>9</sup> Law Commission of India, “196<sup>th</sup> Report on Medical Treatment to Terminally Ill Patients (Protection of Patients and Medical Practitioners)” (Mar. 2006).

## **II Foundational principles for advance directives**

As has been discussed above, living wills derive their legitimacy in India by way of the *Common Cause* judgement. The principles that form the foundation of the judgement and the concept of advance directives are those of patient autonomy, right of self-determination and the concept of human dignity as has been enshrined in article 21 of the Constitution.

The judges while elaborating on the foundational principles took assistance from writings of various jurists and authors. For instance, the Supreme Court referred to writings of Hazel Biggs at various juncture. Hazel Biggs<sup>10</sup> has enunciated that the core principles of advance directives are patient autonomy and consent in the following terms:

...Founded upon respect for individual autonomy this is a right that operates through the law of consent to protect patients from unfettered medical paternalism. Common law holds that patients with the capacity to give consent are also competent to refuse or withhold consent, even if a refusal may risk personal injury to health or even lead to premature death. Furthermore, a refusal of treatment can take the form of a declaration of intent never to consent to that treatment in the future, or never to consent in some future circumstances. Accordingly, any consent or refusal of consent made by a competent adult patient can also be valid in respect of the same treatment at any time in the future.

Professor Glanville Williams writes, “Some doctors seem to fail to realize that if an adult patient has positively forbidden particular treatment, they act illegally if they administer it, and could be...prosecuted for assault.”<sup>11</sup> Further, Justice Cardozo in the landmark case of *Schloendorff v. Society of New York Hospital*<sup>12</sup> held that “every human being of adult years and sound mind has a right to determine what shall be done with his own body.”

The Supreme Court also took note of Kennedy’s<sup>13</sup> opinion that paternalism practised by medical practitioners undermines the very valuable human right of right to self-determination. The medical decisions are invariably made for a person instead of by him, there is no problem with the same as long as the patient voluntarily desired the decision to be

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<sup>10</sup>Hazel Biggs, *Euthanasia, Death with Dignity and the Law* 102 (Hart Publishing, Oxford, 2001).

<sup>11</sup>Glanville Williams, “Euthanasia” 41 *Medico-Legal Journal* 24 (1972).

<sup>12</sup> 211 N.Y. 125.

<sup>13</sup> Ian Kennedy, “Legal Effect Of Request By Terminally Ill And Aged Not To Receive Further Treatment” 73 *Criminal Law review* 217 (1976).

made by the doctors for him. In cases wherein a patient wishes to not undergo a certain treatment, then his decision should be respected and medical paternalism should not be practiced.

The concept of advance medical directives arose primarily across jurisdictions to deal with conundrum that doctors and the families faced when a patient whose life was in question was unable to express his/her desires at such a crucial time. Since the principle of patient autonomy is of utmost importance, the supporters of advance medical directives believe in accomplishing the will of the patient by devising methods via which the patient in question can communicate his desires and wishes before he reaches a stage of incompetency. Also, it is debated that non-recognition of advance medical directives would amount to non-facilitation of a smoothed dying process, which may be violative of article 21 of the Indian Constitution and the concept of dignity that has been enshrined therein. The Supreme Court in the *Common Cause* judgment after having considered various other judgments laid down the following essential elements of dignity with respect to death with dignity:

- a) Encompasses self-determination;
- b) Maintains/ability to make autonomous choices;
- c) Self-control *i.e.*, same control as one exercised all throughout his life;
- d) Law of consent;
- e) Dignity should not be compromised by a prolonged process leading to dependency and incapacitation.
- f) Respecting the intrinsic value of human life;
- g) Avoidance of dependency;
- h) Indefinite continuation of futile physical life is qualified as undignified;
- i) Dignity commands emphatic respect;
- j) Serenity and powerfulness must prevail and must have other positive qualities and emotions.
- k) Observer's Dignity aspect; if a person possessed of dignity at the end of life, then it may even bring peace and a sense of tranquillity to the observers and loved ones;

There are numerous advantages<sup>14</sup> of living will, the most important one being that it implements the principle of patient autonomy, it also discharges the loved ones of excruciatingly difficult and painful decisions. Advance directive if reviewed periodically can be a great tool to facilitate patient's right of self-determination. Also, a lot of people view living wills with scepticism, but a living will does not provide for anything illegal and works strictly within the framework of the law.

Just because an advance directive provides for various advantages does not in any way mean that it does not have its share of short-comings,<sup>15</sup> a person in a healthy state today may be in no condition to predict how or what he would want when he is in a debilitating situation, his refusal for treatment may be based on what he assumes and not what might be his actual state of mind at that point. Then with advances in science what seems like a path of no return today may actually end up being a very treatable condition in the future. A person's wishes may change before he revokes or reviews his living will.

Even though advance directives have their shortcomings, but the Supreme Court in the *Common Cause* judgment highlighted that advantages of advance directives outweigh those as advance directives are symbolic of patient autonomy and right of self-determination. To give effect to these core principles human dignity and right of self-determination in case of patients the court laid down an elaborate procedure for execution and implementation of advance medical directives.

### **III The procedure for execution and implementation**

As per the *Common Cause* judgment, advance medical directives in India can be effectuated under three cases, *i.e.*, when a person is suffering from a terminal condition; when a person is in a persistently unconscious condition; and when the person is suffering from an end-stage condition. Now, there may be circumstances wherein such a valid advance medical directive exists, and there may be circumstances where such a directive does not exist and the patient has reached a stage wherein he is incompetent or has lost the capacity to exercise judgment and decide for himself. The guidelines cover both the situations and the procedure is quite similar in both the cases, barring a few necessary changes.

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<sup>14</sup> Alec Samuels, "The Advance Directive (or Living Will)" 36 *Medicine Science and Law Journal* 2 (1996).

<sup>15</sup> *Id.* at 5.

## **Procedure for execution of the advance directive**

Advance directives in India can be executed only by a competent adult, who is of sound mind and has complete understanding of the directive. Further, the directive should be absolutely voluntary and free from any form of coercion or undue influence even in the slightest possible manner. The advance directive should also specify the name of a person who will be the authorised agent of the executor and will be responsible for medical decision in case the executor becomes incapable or incompetent of the same.

Supreme Court in the *Common Cause*<sup>16</sup> judgement laid down the following procedure for execution of the advance directives:

- i. The executor is required to sign the advance directive in presence of two, preferably independent, attesting witnesses.
- ii. The advance directive shall then be countersigned by the jurisdictional Judicial Magistrate of First Class (hereinafter referred to as the JMFC).
- iii. The jurisdictional JMFC and both the witnesses shall then record their satisfaction regarding the fact of voluntary execution and absence of any form of coercion or inducement or compulsion and that the document was executed with complete understanding of all the relevant information and consequences.
- iv. There shall be multiple copies of the advance directive including a digital copy and each of the hardcopy of the document will be kept in custody of JMFC, the registry of the jurisdictional District Court and with the competent officer of the local Government or the Municipal Corporation or Municipality or Panchayat for being preserved.
- v. Additionally, the JMFC shall also have the immediate family members of the executor informed regarding the advance directive and a copy will also be entrusted to the family physician.

After the above requirements have been complied with, the advance directive will be said to have been duly executed. It is pertinent to note that the same procedure is required to be followed in case of revocation of the advance directive. The Supreme Court has further laid down the procedure for the implementation of the advance directives which involves a long tedious process.

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<sup>16</sup>Supra note 1 at para. 191-192.

## **Procedure for implementation of the advance directive**

After the advance directive is properly executed, a situation may arise wherein the enforcement of the advance directive is needed. In such a situation the Supreme Court laid down the following guidelines for execution:

- i. The treating physician shall ascertain the genuineness and authenticity of the advance directive with the jurisdictional JMFC.
- ii. The physician shall thereafter apprise the guardian/ close relative or the executor, depending on the circumstances, about the nature and gravity of illness, forms of treatment available and the consequences of not seeking medical treatment, among other things. The doctor has an additional responsibility of ensuring that on reasonable grounds he believes that the executor or the guardian as the case may be fully understands the information provided and has deliberated over the various options that were provided and has come to a well-founded opinion that all of the options, withdrawal or refusal of medical treatment remains the best option.
- iii. After a decision regarding withdrawal or refusal of treatment has been made by the patient or his guardian, a Medical Board will be assembled by the hospital comprising of the Head of the treating Department and three other experts from particular specialities. All these experts should mandatorily have experience in critical care and experience of at least twenty years. The board shall visit the patient while his guardian/close relative are also present and thereupon deliberate on whether to certify or not to certify enforcement of withdrawal or refusal of further medical treatment. This decision of the Board shall be referred to as a preliminary opinion.
- iv. After the preliminary opinion, the jurisdictional Collector shall be informed regarding the proposal of withdrawing of treatment. The collector thereafter will constitute another Medical Board comprising the Chief District Medical Officer of the district as the Chairman and three other expert doctors from the specialities specified in the judgement with practice of over 20 years. The doctors of this board should not have been members of the Medical Board assembled by the hospital. This medical board constituted under the supervision of the jurisdictional collector shall then, depending on their opinion endorse the certificate to carry out the directions given in the living will.
- v. Before effectuating the advance directive, the Chairman of the Medical Board formulated by the Collector shall have to mandatorily communicate the decision to

the jurisdictional JMFC. Thereafter, the JMFC then shall also visit the patient and examine all relevant aspects, and after being satisfied he may authorise the implementation of the decision.

In cases where there is no advance directive, 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.

In case 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 jurisdictional collector for consideration and appropriate action on the advance directive.

Further, if permission to withdraw medical treatment is refused by the Medical Board constituted by the jurisdictional collector, 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.

#### **IV Shortcomings of the procedure laid down**

The procedure laid down with respect to the execution and implementation of the advance directives is rather detailed and the crux of the same has been discussed above. The need for such an elaborate procedure can be understood in light of growing corrupt minds and malpractices in the society. To check the same, it is required that the attesting witnesses should be ‘preferably’ independent, but there is room for interpretation and unscrupulous relatives may still become witnesses. The requirement for independent witnesses should be mandatory.

With respect to revocation, the advance directive can be revoked by the executor at any stage before it is acted upon and implemented. It is mandatory that the withdrawal or revocation of an advance directive must be in writing and the same procedure as provided for recording of advance directive shall be followed for revocation as well. This seems to be a rather illogical mechanism when it comes to revocation, the procedure is too cumbersome and a person who wishes to revoke the same should be allowed to do it in a rather simple manner by communicating his desire to the JFMC or the treating physician. There can be situations a

persons desires to revoke the same but owing to ill health is unable to carry out the procedure, and before he is able to fulfil the formalities he passes into an unconscious state wherein as per his original advance directive he desired withdrawal of life support. Hence, the procedure for revocation should be rather simple in order to avoid errors of grave character. Other than that, there should also be a mandatory renewal clause with respect to advance directives as a person can go through a complete shift in ideology.

The guidelines that follow after the advance directive has been executed for the purposes of enforcing the advance medical directive are simply too cumbersome and cannot be implemented in real life, especially in the current Indian scenario. It is understandable that the court aimed at preventing the misuse by unscrupulous family members and unethical doctors but such an elaborate procedure might just end up making sure that the provision is not used at all. The procedure has mandatorily three stages of decision-making boards and authorities before the living will can be enforced, this is absolutely impractical given the situation of the patient and his well-wishers. The process is lengthy beyond explanation especially considering the timeline they are operating against. Constitution of boards in the hospital, formulation of another medical board by the jurisdictional magistrate and asking the already overburdened JFMC to visit and analyse the matter before the living will is implemented, might seem very good on paper and as a scheme to check nefarious practices, but what good is a scheme if it cannot be implemented.

The practical significance of living wills is greatly dependent upon the efficient legal enforcement and circumventing unnecessary technicalities that might result in the inadequate execution of the document.<sup>17</sup> One should formulate guidelines which are practicable and can be adhered to, what is the point of permitting something and then making a cumbersome procedure which is simply not employable.

Though one can say that this procedure seems more approachable than the procedure as was laid down in the *Aruna Shanbaug* case wherein it was directed that the doctors would have to approach the high court before implementing a decision of withholding or withdrawal of life-sustaining treatment. But the current procedure in fact might end up being as difficult, if not more, considering the Indian system. The Indian medical system is overwhelmed with increasing number of patients; the doctors are overloaded with work, especially in the

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<sup>17</sup> Parks H. Wilson, "The Living Will - Death with Dignity or Mechanical Vitality" 10 *Cumberland Law Review* 163 (1979).

government department; the unimaginable slow process of the bureaucratic process which will be done by the Boards; etc.

These guidelines are yet to be implemented, based on interviews with collectors and judicial magistrates one can observe that no medical boards have been constituted by the collectors in their respective jurisdictions and the judicial magistrates are absolutely oblivious to their responsibilities under the said guidelines. The problem that arises now is that in *Aruna Shanbaug* case the court laid down a seemingly inaccessible procedure for implementation and in *Common Cause* case the court laid down a relatively more accessible process, but due to absence of mechanism to facilitate the guideline one feels that the process in *Aruna Shanbaug* case was rather more accessible.

In the backdrop of an ever changing medical and legal world, the Living Will may not be the perfect instrument to carry out the will of the patient, there are various drawbacks of a living will, it is often condition specific; it may become obsolete in reference to advancements in medical science; the instructions given may be too specific or broad; Issues of consent and execution; etc, but misuse or complexity of issues involved cannot be held to be a valid ground for rejecting advance directive, as was opined by the Law Commission of India in its 196<sup>th</sup> report<sup>18</sup> and 241<sup>st</sup> report.<sup>19</sup> Instead, attempt can be made to provide safeguards for exercise of such advance directive.

India ranks 67 out of 80 countries on the Quality of Death Index,<sup>20</sup> with such a poor ranking India cannot further afford to compromise on its end of life care because of shortcomings in the legal framework.

## V Conclusion and suggestions

In the 21<sup>st</sup> century due to unimaginable advancement in the field on medical science, it is possible for a human to stay alive with the help of machines for months or even years. Under these circumstances it is important to give the patient a right to refuse treatment. It is important to understand that by refusing treatment a patient is not committing suicide but is

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<sup>18</sup>*Supra* note 9.

<sup>19</sup>*Supra* note 8.

<sup>20</sup> The Economist Intelligence Unit, “The 2015 Quality of Death Index: Ranking palliative care across the world” (2015), available at: <https://eiuperspectives.economist.com/sites/default/files/2015%20EIU%20Quality%20of%20Death%20Index%20Oct%2029%20FINAL.pdf> (last visited on Nov. 10, 2019).

only following the natural course of nature that would have existed had such fancy advancements not taken place. One needs to keep in mind that though these medicines and equipment prolong life but they deteriorate the quality often to a great extent. Hence, a person should have the right to refuse treatment and have a choice to determine the quality of his life and should not be forced to live by being hooked up to machines.

The primary purpose of living wills as advance medical directives is to ensure the right of self-determination and patient autonomy of a person who is unfortunately in such a position that he cannot actively decide for himself at that point in time and there is no hope for his health condition to improve.

It is important to assess the International treaties to which India is a signatory, International Covenant on Civil and Political Rights (hereinafter referred to as ICCPR) provides for some important obligations with respect to voluntary euthanasia. Right to life under article 6(1) of the ICCPR provides that, "Every human being has the inherent right to life. This right shall be protected by law. No one shall be arbitrarily deprived of his life." It is important to take note of the fact that how ICCPR provide that a person cannot be arbitrarily deprived of a right to life, the stand of United Nations Human Rights Committee (hereinafter referred to as UNHRC) with respect to euthanasia helps us understand that it as long as sufficient safeguards are provided the legislations pertaining to euthanasia are not inherently void. The same was expressed by UNHRC in 2002 when a legislation was introduced by Netherlands legalising Euthanasia:

where a State party seeks to relax legal protection with respect to an act deliberately intended to put an end to human life, the Committee believes that the Covenant obliges it to apply the most rigorous scrutiny to determine whether the State party's obligations to ensure the right to life are being complied with (articles 2 and 6 of the Covenant).

Now, having analysed the provisions in Indian law and other international covenants it is important to understand that though providing for passive euthanasia maybe a progressive step, but by making such a cumbersome procedure would amount to negating the guidelines laid down by the Supreme Court in the *Common Cause* judgement. Some of the suggestions that can be taken into consideration for making the law more accessible are as follows:

- i. The guidelines provide that the witnesses required for attesting the will should ‘preferably’ be independent. It is suggested that the witnesses should mandatorily be independent to avoid any chances of coercion or conflict of interest in future.
- ii. At the time of execution of the will, the court has laid down a cumbersome three stage process for scanning the correctness and need for enforcement of the will by various authorities and Medical Boards, though the court made this provision with utmost good intentions to prevent any form of abuse, but it failed to consider the plight of the patient and his family that would be left in uncertainty.
- iii. The court in making the three-stage process also failed to take into consideration that the pace at which things would work would be really slow because the doctors and magistrates are overwhelmed with work already, and putting additional work of bureaucratic nature on them would make matters worse.
- iv. It is sufficient to have a rather simple process, wherein confirmation is needed from the treating physician after he has authenticated the validity of the living will and a review board can confirm or deny permission. Providing three stages in such a sensitive matter is like negating the right in totality.
- v. In many states of Australia doctors have a say in implementing the living will on grounds that there has been a change in circumstances or he is of the opinion that the patient did not want the will to be enforced. Similar provision need to be incorporated in the guidelines as well, though it may add a lot of subjectivity to the law but since it is a matter of life and death certain amount of subjectivity may be permissible.
- vi. Another very problematic provision in the guidelines is that the same procedure needs to be adopted for revocation that is required for execution of the advance directive. It is suggested that revocation should be allowed to be a mere simple oral revocation as well. It is highly possible that a person made his living will at a point of time when he was health, but gradually he became excruciatingly sick and instead of giving up on his life wants to hold onto it. In such a case he may not be able to carry out the revocation process due to his ill health, but his will would have changed. Hence, it is submitted though the strenuous process may be desirable for execution of the document, but the same process for revocation may be counter-intuitive.
- vii. A person goes through various changes in his ideologies throughout his life, it may happen over years or months, and a law which affects the life and death of a person should take into consideration these frailties of the human mind. Therefore, keeping in mind such a nature of the human thought process it is submitted that a living will

should be made mandatorily renewable after a reasonable period of time such as three to five years.

- viii. It is also suggested that since advance directives are such decisive documents, a database of the same should be made or instead of making a database the document should be linked to his identity cards so that in case of an emergency the health care providers are aware of whether the person has an advance directive or not.
- ix. The general population of the country is unaware of this provision. Not only the general population but even the jurisdictional magistrates and judicial magistrates, who have such a nuanced role in the whole process are also not aware of their duties. It is imperative to create awareness amongst the masses as well as the authorities regarding the said guidelines.

It is also submitted, that though in *Aruna Shanbaug* case the court provided that in case a doctor seeks to conduct passive euthanasia, he must approach the respective high court of his state. The Supreme Court in *Common Cause* intended to ease this process because of its non-feasibility by formulating the guidelines, but by analysing the guidelines one can say that the process is still as non-feasible as before. After having analysed the guidelines one can say that though the Supreme Court intended well, but the guidelines are not feasible in such adverse scenarios. The fear of abuse is so predominantly visible in the guidelines that they are not implementable in the current Indian set up.