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GOVERNMENT OF INDIA  
  
LAW  
COMMISSION  
OF  
  
INDIA  
  
Passive Euthanasia — A Relook  
  
Report No.241  
  
AUGUST 2012  
  
  
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‘ren fe ae at  
Chairman  
  
By the DO. letter No.17(9)/2011-1-1251 dated 20.04.2011, addresed by the then Law  
‘Baking legston on sstnaaasl, wisn ints sctouat the sation 10etn fuper the Law  
Commission This lever nas been addzeseed in the aftermath ofthe fudement ste Supre=  
(Cour n Arune Ramachandra Shanbaug2011) 4 SCC 454) The Supreme Court ld own the  
la on the subject of passive euthanasia in relation to incompetent patents such as patents it  
‘Bereistane Vopratve Stes cr sraoribin soma oroftnasund mind and then cbonod  
futearaph 124: Follwong the technique used m Vishabha's case (1997) 6 SCC 24), we gre  
[yg down the aw tis connecton which wt continue fo be the fount Parament makes  
aw on the subject” The same sbservanen was guested in paragragh 135 of the ead  
Jolement The Supreme Court put is sel of approval on passe euthanasia, Le. witdraing  
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ermision of the High Court has t ke obtained, The procedure to be followed by the High  
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‘edicl experts and also put on notice the close relations and in ther sbrence, the neat fiend  
tthe ptient ad the Sate. The role cf the High Court has been described to be that of parens  
perce  
  
2. The Law Commission is in agreement with the view expressed ty the previous Law  
Commiceen and the Supreme Court that Passive suthanaria thould be allowed eubject to  
‘ertin saleguarde, ie ie hit that on humanitarian contderstions and also for proving  
rote a te Soctce who gemma tia tha ast itcreste terminal pent, ht  
law proposed is considered necessary” As regards the safeguards. the Lav Commission hs  
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Componton of panel of medical expart, we have fallen in line wth the suggroun made Ey the  
ra Law Commun in 196th Repor  
  
Le, withdrawal of ie supporting measures to ving paientatwhich is ilerent from euthanasia  
‘ed cited suse) deer up Bal ered “Te Med Tes of Terma lt Paces  
(Protecon of Paints nd Medical Practitioners) Bill 2006” The safemuard to be observed by  
{he attending doctors before mithdraweng the Kie-supportsjaema have been sugested Ly the  
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fatint. The Supreme Court also made it clear that ia India. @ a person consciously and  
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[Aruna coe centered round non ohuntary passe euthansain which in apptcae to paint  
‘wno a notin a muon to ates tor erwe re she sin cot or rv a te ie eth CE  
Supreme Court and the Law Commission (196th Report) relied on aad extanstly qucted the  
opinions of House of Lorde in the care of Airedale in which the primacy ws given co the est  
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declacatry calief before che High Cours whereas the Supreme Court mace mandatory to get  
Clearance from the [Ligh Court to give effect to the decision to withdraw life support to an  
Sacompctont paticet, Ine opinion of the Cosumitice of Lpersa shoud be obtained Gy the Hish  
Court, a5 per che Supreme Cour's judgment whereas according to the Law Commiscicn’s  
recommentation, the attending med:cal practtioner wl have to oztain the expert opinioe from.  
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tuestireat so ‘suca patient. In such an evect, it would be open to sie lations, medeal  
practitioner ete. to sprroach the Tigh Court for en appropriate declaratory relist. The present  
Yaw Comoisaica fools that it 19 alee and deouabl to fodow the procedur laud down Gy the  
‘Supreane Coust in Anona’s ace ve that the High Courts approval wil bea condition precedent  
for stopping the fe supporting measures.  
  
5. Accordingly, changes have been made in the Medical Treatment of Terminally  
Patients (Protection of Patients acd Medical Tracttioners) Dil drafted ty the 17:2 Law  
Commission in the your 20Ub. Iho bil haa Geer. recast aa snckcated in paras 1.1 t= 15./ of te  
‘Report. Ihe curmary of recoramendations are a: para 1¢. Ihe seviced draft ill i at Annexire-  
I. The Commission considers 1 dasirable to enact a law on che lnes euggerted by the  
Commission at :oe eariest so that the uncertainty may be removed and the procedie  
prescribed bythe Supreme Court may be efired.  
  
‘With regards and cod wishes,  
  
(ov. Reda  
‘Si Salman Khussnia, 16.  
Fone Ureon Mins rar Taw ara Taste  
  
Shaate Ehime  
  
New Del,  
  
  
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Commission.  
  
  
  
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Passive Euthanasia  
  
Arelook  
  
1. Introduction  
  
4.1 The word ‘Euthanasia’ is a derivative from the Greek words ‘eu’ and  
‘thanotos’ which literally mean “good death”. It is otherwise described as mercy  
killing. The death of a terminally ill patient is accelerated through active or  
passive means in order to relieve such patient of pain or suffering. It appears  
that the word was used in the 17% Century by Francis Bacon to refer to an  
easy, painless and happy death for which it was the physician's duty and  
  
responsit  
House of Lords Select Committee on ‘Medical Ethics’ in England defined  
Euthanasia as “a deliberate intervention undertaken with the express  
  
¥y to alleviate the physical suffering of the body of the patient. The  
  
intention of ending a life to relieve intractable suffering’. The European  
‘Association of Palliative Care (EPAC) Ethics Task Force, in a discussion on  
Euthanasia in 2003, clarified that “medicalised killing of a person without the  
person's consent, whether non-voluntary (where the person in unable to  
consent) or involuntary (against the person's will) is not euthanasia: it is a  
murder. Hence, euthanasia can be voluntary only”  
  
1.2 We are here concerned with passive euthanasia as distinct from ‘active  
euthanasia’. The distinction has been highlighted in the decision of the  
Supreme Court of India in Aruna Ramachandra Shanbaug vs. Union of India’  
Active euthanasia involves taking specific steps such as injecting the patient  
with a lethal substance e.g. Sodium Pentothal which causes the person to go  
in deep sleep in a few seconds and the person dies painlessly in sleep, thus it  
amounts to killing a person by a positive act in order to end suffering of a  
person in a state of terminal illness. It is considered to be a crime all over the  
world (irrespective of the will of the patient) except where permitted by  
legislation, as observed earlier by Supreme Court. In India too, active  
  
(2011) 4 S00 454  
  
  
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euthanasia is illegal and a crime under Section 302 or 304 of the IPC.  
Physician assisted suicide is a crime under Section 306 IPC (abetment to  
suicide)’. Passive euthanasia, otherwise known as ‘negative euthanasia’,  
however, stands on a different footing. It involves withholding of medical  
treatment or withholding life support system for continuance of life e.9.,  
withholding of antibiotic where without doing it, the patient is likely to die or  
removing the heart-lung machine from a patient in coma. Passive euthanasia  
is legal even without legislation provided certain conditions and safeguards are  
maintained (vide para 39 of SCC in Aruna’s case). The core point of distinction  
between active and passive euthanasia as noted by Supreme Court is that in  
active euthanasia, something is done to end the patient's life while in passive  
euthanasia, something is not done that would have preserved the patient’ life.  
To quote the words of learned Judge in Aruna's case, in passive euthanasia,  
‘the doctors are not actively killing anyone; they are simply not saving him’  
The Court graphically said “while we usually applaud someone who saves  
another person's life, we do not normally condemn someone for failing to do  
0". The Supreme Court pointed out that according to the proponents of  
Euthanasia, while we can debate whether active euthanasia should be legal,  
there cannot be any doubt about passive euthanasia as “you cannot prosecute  
‘someone for failing to save a life". The Supreme Court then repelled the view  
that the distinction is valid and in doing so, relied on the landmark English  
decision of House of Lords in Airedale case®, which will be referred to in detail  
later.  
  
1.3 Passive euthanasia is further classified as voluntary and non-voluntary.  
Voluntary euthanasia is where the consent is taken from the patient. In non-  
voluntary euthanasia, the consent is unavailable on account of the condition  
of the patient for example, when he is in coma. The Supreme Court then  
observed  
  
\* fbid at 481  
5 Airedale NHS Trust ve. Bland (1993)1 All ER 821  
  
2  
  
  
Page 7:  
‘while there is no legal difficulty in the case of the former, the latter poses  
several problems, which we shall address”. The Supreme Court was concerned  
with a case of non-voluntary passive euthanasia because the patient was in  
coma.  
  
2. Law Commission's 196" Report  
  
24 The Law Commission of India, in its 196 Report, had in its opening  
remarks clarified in unmistakable terms that the Commission was not dealing  
with “euthanasi  
‘Commission was dealing with a different matter, i.e, “withholding life-support  
measures to patients terminally ill and universally in all countries, such  
withdrawal is treated as lawful’. Time and again, it was pointed out by the  
Commission that withdrawal of life support to patients is very much different  
from euthanasia and assisted suicide, a distinction which has been sharply  
focused in Aruna's case as well. Aruna’s case (supra) preferred to use the  
compendious expression - “passive euthanasia’.  
  
or “assisted suicide” which are unlawful but the  
  
22 The 17" Law Commission of India took up the subject for consideration  
at the instance of Indian Society of Critical Care Medicine, Mumbai which  
held a Seminar attended by medical and legal experts. It was inaugurated by  
the then Union Law Minister. The Law Commission studied a vast literature on  
the subject before the preparation of report.  
  
2.3. In the introductory chapter, the Law Commission also clarified:  
  
“In this Report, we are of the view that ‘Euthanasia’ and ‘Assisted  
Suicide’ must continue to be offences under our law. The scope of the  
inquiry is, therefore, confined to examining the various legal concepts  
applicable to ‘withdrawal of life support measures’ and to suggest the  
manner and circumstances in which the medical profession could take  
decisions for withdrawal of life support if it was in the ‘best interests’ of  
the patient. Further, question arises as to in what circumstances a patient  
  
“ Medical Treatment to Terminally Ill Patients (Protection of Patients and Medical  
Practitioners)  
  
  
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can refuse to take treatment and ask for withdrawal or withholding of life  
support measure, if it is an informed decision."  
  
2.4 The following pertinent observations made by the then Chairman of the  
Law Commission in the forwarding letter dated 28 August 2006 addressed to  
the Hon'ble Minister are extracted below:  
  
hundred years ago, when medicine and medical technology had not  
invented the artificial methods of keeping a terminally ill patient alive by  
‘medical treatment, including by means of ventilators and artificial feeding,  
such patients were meeting their death on account of natural causes.  
Today, it is accepted, a terminally ill person has a common law right to  
refuse modern medical procedures and allow nature to take its own  
course, as was done in good old times. It is well-settled law in all  
countries that a terminally ill patient who is conscious and is competent,  
can take an ‘informed decision’ to die a natural death and direct that he  
or she be not given medical treatment which may merely prolong life.  
There are currently a large number of such patients who have reached a  
stage in their illness when according to well-informed body of medical  
opinion, there are no chances of recovery. But modern medicine and  
technology may yet enable such patients to prolong life to no purpose and  
during such prolongation, patients could go through extreme pain and  
suffering. Several such patients prefer palliative care for reducing pain  
and suffering and do not want medical treatment which will merely  
prolong life or postpone death.”  
  
25 As stated in Airdale’s case by Lord Goff: “It is of course the development  
of modern medical technology, and in particular the development of life-support  
systems, which has rendered such as the present so much more relevant than in  
the past”, That observation made in 1993 in the case of a PVS patient applies  
with greater force to the present day medical scenario.  
  
3. Passive Euthanasia ~ How the Law Commission & Supreme Court viewed it  
  
3.1. Passive Euthanasia has been advocated by the Law Commission of India  
in the 196 Report both in the case of competent patients and incompetent  
patients who are terminally ill, In the case of incompetent patients, the  
attending medical practitioner should obtain the opinion of three medical  
experts whose names are on the approved panel and thereafter he shall inform  
  
4  
  
  
Page 9:  
the Patient (if conscious) and other close relatives. Then he shall wait for 18  
days before withholding or withdrawing medical treatment including  
discontinuance of life supporting systems. This 15 days’ time was  
contemplated with a view to enable the patient (if conscious) or relatives or  
guardian to move an original petition in the High Court seeking declaratory  
relief that the proposed act or omission by the medical practitioner /hospital  
in respect of withholding medical treatments is lawful or unlawful. High Court  
will then give a final declaration which shall be binding on all concerned and  
will have the effect of protecting the doctor or hospital from any civil or  
criminal liability. The Supreme Court in Aruna's case has put its seal of  
approval on (non-voluntary) passive euthanasia subject to the safeguards laid  
down in the judgment. In the arena of safeguards, the Supreme Court  
adopted an approach different from that adopted by the Law Commission. The  
Supreme Court ruled in Aruna’s case that in the case of incompetent patients,  
specific permission of the High Court has to be obtained by the close relatives  
‘or next friend or the doctor / hospital staff attending on the patient. On such  
application being filed, the High Court should seek the opinion of a Committee  
of three experts selected from a panel prepared by it after consultation with  
medical authorities. On the basis of the report and after taking into account  
the wishes of the relations or next friend, the High Court should give its  
verdict. At paragraph 135, it was declared: “the above procedure should be  
followed all over India until Parliament makes legislation on this. subject.”  
Earlier at para 124 also, the learned Judges stated “we are laying down the  
Jaw in this connection which will continue to be the law until parliament makes  
a law on the subject.”  
  
4, The question broadly and our approach  
  
4.4 The question now is whether parliament should enact a law on the  
subject permitting passive euthanasia in the case of terminally ill patients ~  
both competent to express the desire and incompetent to express the wish or  
to take an informed decision. If so, what should be the modalities of  
  
5  
  
  
Page 10:  
legislation? This is exactly the reason why the Government of India speaking  
through the Minister for Law and Justice has referred the matter to the Law  
Commission of India. In the letter dated 20 April 2011 addressed by the  
Hon'ble Minister, after referring to the observations made by the Supreme  
Court in Aruna’s case, has requested the Commission “to give its considered  
report on the feasibility of making legislation on euthanasia taking into account  
the earlier 196” Report of the Law Commission.”  
  
4.2 Before proceeding further, we must acknowledge the fact that the Law  
Commission before formulating its recommendations in its 196 Report, has  
made an exhaustive study, considered the pros and cons of the issue and  
recorded its conclusions which were put in legislative framework. Five years  
later, the Supreme Court of India in Aruna’s case has rendered a landmark  
judgment approving passive euthanasia subject to certain safeguards and  
conditions envisaged in the judgment. There was an elaborate reference to the  
legal position obtaining in other countries, the best medical practices and the  
law laid down in series of authoritative pronouncements in UK and USA. Both  
the Supreme Court and Law Commission felt sufficient justification for  
allowing passive euthanasia in principle, falling in line with most of the  
countries in the world. The Supreme Court as well as the Commission  
considered it to be no crime and found no objection from legal or constitutional  
point of view.  
  
4.3. Unless there are compelling reasons - and we find none, for differing  
with the view taken by the apex Court and the Law Commission, the views  
deserve respect. At the same time, we had a fresh look of the entire matter and  
have reached the conclusion that a legislation on the subject is desirable.  
Such legislation while approving the passive euthanasia should introduce  
safeguards to be followed in the case of such patients who are not in a position  
to express their desire or give consent (incompetent patients). As regards the  
procedure and safeguards to be adopted, the Commission is inclined to follow  
substantially the opinion of the Supreme Court in preference to the Law  
Commission's view. We have, however, suggested certain variations in so far  
  
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Page 11:  
‘as the preparation and composition of panel of medical experts to be  
nominated by the High Courts. Many other provisions proposed by the Law  
Commission in its 196 Report have been usefully adopted. A revised draft  
Bill has been prepared by the present Commission which is enclosed to  
this report. We shall elaborate our views and changes proposed at the  
appropriate juncture.  
  
5. The Bill proposed by 17" Law Commission and its features  
  
5.1 We shall start our discussion by taking an overview of the Law  
Commission's 196! Report and the main features of legislation suggested by  
the Law Commission under the title - “Medical Treatment to Terminally il  
Patients (Protection of Patients and Medical Practitioners) Bill 2006" (vide  
Annexure - I). At the risk of repetition, we may mention that the main  
difference between the recommendations of the Law Commission (in 196"  
Report) and the law laid down by the Supreme Court (pro tempore) lies in the  
fact that the Law Commission suggested enactment of an enabling provision  
for seeking declaratory relief before the High Court whereas the Supreme  
Court made it mandatory to get clearance from the High Court to give effect to  
the decision to withdraw life support to an incompetent patient. The opinion  
of the Committee of experts should be obtained by the High Court, as per the  
Supreme Court's judgment whereas according to the Law Commission's  
recommendations, the attending medical practitioner will have to obtain the  
experts’ opinion from an approved panel of medical experts before taking a  
decision to withdraw/withhold medical treatment to such patient. In such an  
event, it would be open to the patient, relations, etc. to approach the High  
Court for an appropriate declaratory relief.  
  
5.2 The 196!” Report of the Law Commission stated the fundamental  
principle that a terminally ill but competent patient has a right to refuse  
treatment including discontinuance of life sustaining measures and the same  
  
  
Page 12:  
is binding on the doctor, “provided that the decision of the patient is an  
". ‘Patient! has been defined as a person suffering from  
terminal illness. “Terminal illness” has also been defined under Section 2  
(m). The definition of a ‘competent patient’ has to be understood by the  
definition of ‘incompetent patient’. ‘Incompetent patient’ means a patient  
who is a minor or a person of unsound mind or a patient who is unable to  
weigh, understand or retain the relevant information about his or her medical  
treatment or unable to make an ‘informed decision’ because of impairment of  
or a disturbance in the functioning of the mind or brain or a person who is  
unable to communicate the informed decision regarding medical treatment  
through speech, sign or language or any other mode (vide Section 2(d) of the  
Bill, 2006). “Medical Treatment” has been defined in Section 2(i) as treatment  
intended to sustain, restore or replace vital functions which, when applied to a  
patient suffering from terminal illness, would serve only to prolong the process  
of dying and includes life sustaining treatment by way of surgical operation or  
  
informed decision’  
  
the administration of medicine etc. and use of mechanical or artificial means  
such as ventilation, arti  
expressions “best interests" and “informed decision” have also been defined in  
the proposed Bill. “Best Interests", according to Section 2(b), includes the  
best interests of both on incompetent patient and competent patient who has  
not taken an informed decision and it ought not to be limited to medical  
interests of the patient but includes ethical, social, emotional and other  
welfare considerations. The term ‘informed decision’ means, as per Section 2  
(e) “the decision as to continuance or withholding or withdrawing medical  
treatment taken by a patient who is competent and who is, or has been  
informed about - (i) the nature of his or her illness, (ii) any alternative form of  
treatment that may be available, (ii) the consequences of those forms of  
treatment, and (iv) the consequences of remaining untreated”  
  
ial nutrition and cardio resuscitation. The  
  
5.3. At this juncture, we may mention that this terminology - ‘informed  
decision’ has been borrowed from the decided cases in England (UK) and  
  
8  
  
  
Page 13:  
other countries. It broadly means that the lack of capacity to decide (inspite of  
consciousness of the patient) has precluded him from taking ‘informed  
decision’. though the patient might be conscious. The said definition of  
informed decision’ can be best understood by reference to one or two  
illustrative cases cited by the Commission in the 196” Report. In Re: MB  
(Medical Treatment)’ - a Court of appeal decision rendered by Butler Sloss  
LuJ., had this to say after considering the facts of that case:  
  
On the facts, the evidence of the obstetrician and the consultant  
psychiatrist established that the patient could not bring herself to undergo  
the caesarian section she desired because a panic-fear of needles  
dominated everything and, at the critical point she was not capable of  
‘making a decision at all, On that basis, it was clear that she was at the  
  
time suffering from an impairment of her mental functioning which  
disabled her and was temporarily incompetent. (emphasis supplied)  
  
Furthermore, since the mother (pregnant lady) and father wanted the child  
to be born alive and the mother (the pregnant lady) was in favour of the  
operation, subject only to her needle phobia, and was likely to suffer long  
term damage if the child was born handicapped or dead, it must follow  
that medical intervention was in the patient's best interests, with the use  
of force if necessary for it to be carried out. In these circumstances, the  
judge was right in granting the declaration.  
  
5.4 On the question of capacity to decide, the Court of Appeal quoted Lord  
Donaldson in the case of Re: T (An Adult) (Refusal of Medical Treatment) ~ a  
1992 decision on the same point:- “The right to decide one's own fate  
presupposes a capacity to do so. Every adult is presumed to have that  
capacity, but it is a presumption which can be rebutted. This is not a question  
of the degree of intelligence or education of the adult concerned. However, a  
‘small minority of the population lack the necessary mental capacity due to  
mental illness or retarded development (see, for example Re F (Mental Patient)  
{Sterilization)®. This is a permanent or at least a long term state. Others who  
would normally have that capacity may be deprived of it or have it  
reduced by reason of temporary factors, such as unconsciousness or  
  
© 1997 (2) FLA 426  
© 1990 (2) AC 1  
  
  
Page 14:  
confusion or other effects of shock, severe fatigue, pain or drugs used in  
their treatment.”  
  
5.5 In another case which is also a case of caesarian operation - Rockdale  
Healthcare Trust cited by Butler Sloss L.J., it was found that the patient was  
not capable of weighing up information that she was given as she was “in the  
throes of labour with all that is involved in terms of pain and emotional  
stress"  
  
5.6 Butler Sloss LJ. laid down inter alia the following propositions on the  
capacity of a woman to decide in the context of caesarian cases:  
  
person lacks capacity if some impairment or disturbance of mental  
functioning renders the person unable to make a decision whether to  
consent to or refuse treatment. That inability to make a decision will occur  
when (a) the patient is unable to comprehend and retain the information  
which is material to the decision, especially as to the likely consequences  
of having or not having the treatment in question; (b) the patient is unable  
1 use the information and weigh it in the balance as part of the process of  
arriving at the decision. If, as Thorpe J observed in Re C (above), a  
compulsive disorder or phobia from which the patient suffers stifles belief  
in the information presented to her, then the decision may not be @ true  
one.”  
  
5.7 The Consultation Paper of the Law Commission of U.K. has adopted a  
similar approach in dealing with the subject of “Mental Capacity" and this has  
been referred to by Butler Sloss LJ. The definition of ‘informed decision’  
given in the 196% Report of Law Commission of India is almost on the same  
lines as what Butler Sloss LJ. said and the Law Commission of U.K. suggested  
in 1995.  
  
5.8 The Law Commission of India clarified that where a competent patient  
takes an ‘informed decision’ to allow nature to have its course, the patient is,  
under common law, not guilty of attempt to commit suicide (u/s 309 IPC) nor  
is the doctor who omits to give treatment, guilty of abetting suicide (u/s 306  
1PC) oF of culpable homicide (u/s 299 read with Section 304 of IPC)  
  
5.9 As far as (i) incompetent patients as defined above and (ii) competent  
patients who have not taken ‘informed decision’, a doctor can take a decision  
  
10  
  
  
Page 15:  
to withhold or withdraw ‘medical treatment’ if that is in the ‘best interests’ of  
the patient and is based on the opinion of a body of three medical experts. The  
‘best interest’ test, stated by the Law Commission, is based on the test laid  
down in Bolam's case” - a test reiterated in Jacob Mathews case® by the  
Supreme Court. The procedure for the constitution of the body of experts has  
been set out in detail. The Director General of Health Services in relation to  
Union territories and the Directors of Medical Services in the States should  
prepare that panel and notify the same. The requirement of maintaining a  
register by the doctor attending on the patient has been laid down in Section &  
of the proposed Bill. The register shall contain all the relevant details  
regarding the patient and the treatment being given to the patient, and should  
also contain the opinion of the doctor as to whether the patient is competent or  
incompetent, the views of the experts and what is in the best interests of the  
incompetent patient. The medical practitioner shall then inform the patient (if  
he is conscious) and the parents or other close relatives or next friend who can  
approach the High Court by filing a Original Petition which shall be heard by a  
Division Bench of the High Court (vide Section 12 of the said Bill). Certain  
procedural aspects relating to the hearing and disposal of the OP have been  
laid down. If no order of the High Court has been received within the period of  
15 days, it is permissible for the medical practitioner to withhold or withdraw  
further treatment pursuant to the decision he has already taken in the best  
interests of the patient. However, he can continue to extend palliative care to  
the patient. The Medical Council of India has been enjoined to issue the  
guidelines from time to time for the guidance of medical practitioners in the  
matter of withholding or withdrawing the medical treatment to competent or  
incompetent patients suffering from terminal illness (vide Section 14). The  
Law Commission, for the reasons stated in Chapter Vil, under the heading  
‘Whether advance directives (living will) should be allowed legal sanctity in our  
country”, was not in favour of recognizing the advance medical directive even if  
7 (1957) 1 WLR S82  
  
= (2006) 5 SCC 472  
  
"  
  
  
Page 16:  
it is in writing. The Commission observed that as a matter of public policy,  
such directive should be made legally ineffective overriding the common law  
right. Accordingly, Section 4 was introduced in the Bill.  
  
6 Supreme Courts’ decision in Aruna’s case (2011)  
  
6.1 The case of Aruna Ramachandra Shanbaug (201 1) 4 SCC 454) is the first  
case in India which deliberated at length on ‘euthanasia’. The Supreme Court,  
while making it clear that passive euthanasia is permissible in our country as  
in other countries, proceeded to lay down the safeguards and guidelines to be  
observed in the case of a terminally ill patient who is not in a position to  
signify consent on account of physical or mental predicaments such as  
irreversible coma and unsound mind. It was held that a close relation or a  
‘surrogate’ cannot take a decision to discontinue or withdraw artificial lite  
sustaining measures and that the High Court's approval has to be sought to  
adopt such a course. The High Court in its turn will have to obtain the  
opinion of three medical experts. In that case, Aruna Shanbaug was in  
Persistent Vegetative State (PVS for short) for more than three decades and the  
Court found that there was a little possibility of coming out of PVS. However,  
the Court pointed out that she was not dead. She was abandoned by her  
family and was being looked after by staff of KEM Hospital in which she  
worked earlier as staff nurse. The Court started the discussion by pointing  
cout the distinction between active and passive euthanasia and observed that  
“the general legal position all over the world seems to be that while active  
euthanasia is illegal unless there is legislation permitting it, passive euthanasia  
is legal even without legislation provided certain conditions and safeguards are  
maintained”. The distinctive feature of PVS, it was pointed out, is that brain  
stem remains active and functioning while the cortex. has lost its function and  
‘activity. The Supreme Court addressed the question when a person can be  
said to be dead.{t was answered by saying that “one is dead when one’s brain  
is dead”. Brain death is different from PVS. Reference was made to American  
Uniform Definition of Death, 1980. Then it was concluded: “Hence, a present-  
  
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Page 17:  
day understanding of death as the irreversible end of life must imply total brain  
failure such that neither breathing nor circulation is possible any more”.  
  
6.2 After referring extensively to the opinions expressed in Airedale case, the  
Supreme Court stated that the law in U.K. is fairly well-settled that in the case  
of incompetent patient, if the doctors act on the basis of informed medical  
opinion and withdraw the artificial life support system, the said act cannot be  
regarded as a crime. The question was then posed as to who is to decide what  
the patient's best interest is where he or she is in a Persistent Vegetative State  
(PVS). It was then answered by holding that although the wishes of the  
parents, spouse or other close relatives and the opinion of the attending  
doctors should carry due weight, it is not decisive and it is ultimately for the  
Court to decide as parens patriae as to what is in the best interest of the  
patient. The High Court has been entrusted with this responsibility, following  
what Lord Keith said in Airdale case. The Supreme Court referred to the dicta  
in the Court of appeal decision in J. (A minor} (Wardship: medical treatment),  
that the Court as a representative of sovereign as parens patriae will adopt the  
same standard which a reasonable and responsible parent would do. The  
same is the standard for a ‘surrogate’ as well. But, there is no decision-  
making role to a ‘surrogate’ or anyone else except the High Court, as per the  
decision in Aruna’s case.  
  
6.3 Referring to the U.S. decisions and in particular the observations of  
Cardozo J., the Supreme Court pointed out that the informed consent  
doctrine has become firmly entrenched in American Tort Law (vide para 93 of  
SCC). The logical corollary of the doctrine of informed consent is that the  
patient generally possesses the right not to consent i.e., to refuse treatment’.  
The court relied on the observation of Rehnquist C.J. that “the notion of bodily  
integrity has been embodied in the requirement that informed consent is  
generally required for medical treatment’. The Supreme Court referred  
  
9 (1980) 3 Al  
  
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Page 18:  
extensively to Cruzan’s case'® , wherein the U.S. Supreme Court affirmed the  
view of the State Supreme Court that the permission to withdraw artificial  
feeding and hydration equipment to Nancy Cruzan who was in a PVS state  
ought not to be allowed. It was observed that there was a powerful dissenting  
opinion by Brennan J. with whom two Judges concurred. The Supreme Court  
then highlighted the fact that in Cruzan case, there was a statute of the State  
of Missouri unlike in Airedale case (where there was none), which required  
clear and convincing evidence that while the patient was competent, had  
desired that if she becomes incompetent and enters into a PVS, her life  
support system should be withdrawn. There was no such evidence in that  
case. It was in that background, in Cruzan’s case, the Court's permission was  
refused.  
  
6.4 Coming to Indian law on the subject, it was pointed out that in Gian  
Kaur’s caset" , the Supreme Court approvingly referred to the view taken by  
House of Lords in Airedale case on the point that Euthanasia can be made  
lawful only by legislation. Then it was observed: “It may be noted that in Gian  
Kaur case although the Supreme Court has quoted with approval the view of  
House of Lords in Airedale case, it has not clarified who can decide whether life  
support should be discontinued in the case of an incompetent person eg. a  
person in coma or PVS. This vexed question has been arising often in India  
because there are a large number of cases where persons go into coma (due to  
an accident or some other reason) or for some other reason are unable to give  
consent, and then the question arises as to who should give consent for  
withdrawal of life support”. Then, it was observed: “in our opinion, if we leave it  
solely to the patient's relatives or to the doctors or next friend to decide whether  
to withdraw the life support of an incompetent person, there is always a risk in  
our country that this may be misused by some unscrupulous persons who wish  
10 inherit or otherwise grab property of the patient’  
  
‘© 497 US 261  
(1996) 2 SCc 648  
  
14  
  
  
Page 19:  
6.5 Proceeding to discuss the question whether life support system (which is  
done by feeding her) should be withdrawn and at whose instance, the Supreme  
Court laid down the law with prefacing observations at paragraph 124 as  
follows: “There is no statutory provision in our country as to the legal procedure  
for withdrawing life support to a person in PVS or who is otherwise incompetent  
to take a decision in this connection. We agree with Mr. Andhyarujina that  
passive Euthanasia should be permitted in our country in certain situations, and  
we disagree with the learned Attorney General that it should never be permitted.  
Hence, following the technique used in Vishaka'? case, we are laying down the  
Jaw in this connection which will continue to be the law until Parliament makes  
a law on the subject”  
  
() A decision has to be taken to discontinue life support either by the  
  
parent or the spouse or other close relative or in the absence of any of  
them, such a decision can be taken even by a person or a body of  
persons acting as a next friend. It can also be taken by the doctors  
attending the patient. However, the decision should be taken bona fide  
in the best interest of the patient.  
In the present case, we have already noted that Aruna Shanbaug's  
parents are dead and other close relatives are not interested in her  
ever since she had the unfortunate assault on her. As already noted  
above, it is the KEM Hospital staff, who have been amazingly caring  
for her day and night for so many long years, who really are her next  
friends, and not Ms. Pinki Virani who has only visited her on few  
‘occasions and written a book on her. Hence, it is for KEM Hospital  
staff to take that decision. KEM Hospital staff have clearly expressed  
their wish that Aruna Shanbaug should be allowed to live.  
  
However, assuming that the KEM Hospital staff at some future time  
changes its’ mind, in our opinion, in such a situation, KEM Hospital  
would have to apply to the Bombay High Court for approval of the  
decision to withdraw life support.  
  
(i) Hence, even if a decision is taken by the near relatives or doctors or  
next friend to withdraw life support, such a decision requires approval  
from the High Court concerned as laid down in Airedale case.  
  
\* Cause title & citation tobe given  
+ Underlining ours  
  
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Page 20:  
In our opinion, this is even more necessary in our country as we cannot  
tule out the possibility of mischief being done by relatives or others for  
inheriting the property of the patient”.  
  
In our opinion, if we leave solely to the patient's relatives or to the  
doctors or next friend to decide whether to withdraw the life support of  
an incompetent person, there is always a risk in our country that this  
may be misused by some unscrupulous person who wish fo inherit or  
otherwise grab the property of the patient.  
  
“We cannot rule out the possibility that unscrupulous persons with the  
help of some unscrupulous doctors may fabricate material to show that  
itis a terminal case with no chance of recovery. In our opinion, while  
giving great weight to the wishes of the parents, spouse, or other close  
relatives or next friend of the incompetent patient and also giving due  
weight to the opinion of the attending doctors, we cannot leave it  
entirely to their discretion whether to discontinue the lift support or not.  
We agree with the decision of Lord Keith in Airedale case that the  
approval of the High Court should be taken in this connection. This is  
in the interest of the protection of the patient, protection of the doctors,  
relatives and next friend, and for reassurance of the patient's family as  
well as the public. This is also in consonance with the doctrine of  
parens patriae which is well-known principle of law”. (see p. 520 of  
SCC}  
  
6.6 Then Supreme Court explained the doctrine of ‘Parens Patriae’.  
‘The Supreme Court then observed that Article 226 of the Constitution  
gives ample powers to the High Court to pass suitable orders on the  
application filed by the near relatives or next friend or the doctors/hospital  
staff seeking permission to withdraw the life support to an incompetent  
patient,  
6.7 The procedure to be adopted by the High Court has been laid down in  
paragraph 134 (p. 522)as follows: “When such an application is filed, the Chief  
Justice of the High Court should forthwith constitute a Bench of at least two  
Judges who should decide to grant approval or not. Before doing so the Bench  
should seek the opinion of a committee of three reputed doctors to be nominated  
by the Bench after consulting such medical authorities/medical practitioners as  
it may deem fit. Preferably one of the three doctors should be a neurologist, one  
should be a psychiatrist, and the third a physician. For this purpose a panel of  
  
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doctors in every city may be prepared by the High Court in consultation with the  
State Government/Union Territory and their fees for this purpose may be fixed.  
The committee of three doctors nominated by the Bench should carefully  
examine the patient and also consult the record of the patient as well as taking  
the views of the hospital staff and submit its report to the High Court Bench.  
Simultaneously with appointing the committee of doctors, the High Court Bench  
shall also issue notice to the State and close relatives e.g. parents, spouse,  
brothers ‘sisters ete. of the patient, and in their absence his/her next friend, and  
supply @ copy of the report of the doctor's committee to them as soon as it is  
available. After hearing them, the High Court bench should give its verdict.  
  
The above procedure should be followed all over India until Parliament  
‘makes legislation on this subject.”  
  
7. Medical ethics and duty of the doctor  
  
7.1 What is the duty of the doctor? Is he bound to take patient's consent for  
starting or continuing the treatment including surgery or artificial ventilation  
etc? How is he expected to act where a patient is not in a position to express  
his will or take an informed decision? ‘These are the primary questions which  
come up for discussion and these issues were addressed in Airedale and  
Aruna.  
  
7.2 In this context, two cardinal principles of medical ethics are stated to be  
patient autonomy and beneficence (vide P. 482 of SCC in Aruna’s case}  
  
1. “Autonomy means the right to self-determination, where the informed  
patient has a right to choose the manner of his treatment. To be  
autonomous, the patient should be competent to make decision and  
Choices. In the event that he is incompetent to make choices, his wishes  
expressed in advance in the form of a living will, OR the wishes of  
surrogates acting on his behalf (substituted judgment) are to be  
respected.  
  
The surrogate is expected to represent what the patient may have decided  
had he/she been competent, or to act in the patient's best interest.  
  
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Page 22:  
2. Beneticence is acting in what (or judged to be) in the patient’s best  
interest. Acting in the patient's best interest means following a course of  
action that is best for the patient, and is not in influenced by personal  
convictions, motives or other considerations...”  
  
7.3 Both the Supreme Court as well as the Law Commission relied on the  
  
opinion of House of Lords on these aspects. The contours of controversy has  
  
been put in the following words by Lord Gott in Airedale case ~ “Even so, where  
  
(for example) a patient is brought into hospital in such a condition that, without  
  
the benefit of a life support system, he will not continue to live, the decision has  
  
to be made whether or not to give him that benefit, if available. That decision can  
only be made in the best interests of the patient. No doubt, his best interests will  
ordinarily require that he should be placed on a life support system as soon as  
  
necessary, if only to make an accurate assessment of his condition and a  
  
prognosis for the future. But if he neither recovers sufficiently to be taken off it  
  
nor dies, the question will ultimately arise whether he should be kept on it  
indefinitely. As I see it, that question (assuming the continued availability of the  
system) can only be answered by reference to the best interests of the  
patient himself, having regard to established medical practice. ...... The  
question which lies at the heart of the present case is, as | see it, whether on  
that principle the doctors responsible for the treatment and care of Anthony  
  
Bland can justifiably discontinue the process of artificial feeding upon which the  
  
prolongation of his life depends”. That question was dealt with in the following  
  
words: “itis crucial for the understanding of this question that the question itself  
should be correctly formulated. The question is not whether the doctor should  
take a course which will kill his patient, or even take a course which has the  
effect of accelerating his death. The question is whether the doctor should or  
should not continue to provide his patient with medical treatment or care which,  
if continued, will prolong his patient's life. The question is sometimes put in  
striking or emotional terms, which can be misleading”. To stay clear of such  
misconception, the right question to be asked and answered was stated as =~  
The question is not whether it is in the best interests of the patient that he  
  
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Page 23:  
should die. The question is whether itis in the best interests of the patient that  
his life should be prolonged by the continuance of this form of medical treatment  
or care.” Then, it was observed:- “The correct formulation of the question is of  
particular importance in a case such as the present, where the patient is totally  
unconscious and where there is no hope whatsoever of any amelioration of his  
condition. In circumstances such as these, it may be difficult to say that itis in  
his best interests that treatment should be ended. But if the question is asked,  
as in my opinion it should be, whether it is in his best interests that treatment  
Which has the effect of artificially prolonging his life should be continued, that  
question can sensibly be answered to the effect that itis not in his best interests  
t0 do so."  
  
The following words of Lord Goff touching on the duty and obligation of a  
doctor towards a terminally ill incompetent patient are quite apposite:  
  
“The doctor who is caring for such a patient cannot, in my opinion, be  
under an absolute obligation to prolong his life by any means available to  
him, regardless of the quality of the patients life. Common humanity  
requires otherwise, as do medical ethics and good medical practice  
accepted in this country and overseas. As | see it, the doctor's decision  
Whether or not to take any such step must (subject to his patient's ability  
to give or withhold his consent) be made in the best interests of the  
patient. It is this principle too which, in my opinion, underlies the  
established rule that a doctor may, when caring for a patient who is, for  
example, dying of cancer, lawfully administer painkilling drugs despite  
the fact that he knows that an incidental effect of that application will be  
10 abbreviate the patients life.”  
  
7.4 Lord Goff then made a pertinent observation that discontinuance of  
artificial feeding in such case (PVS and the like) is not equivalent to cutting a  
mountaineer’s rope or severing the air pipe of a deep sea diver. In the same  
case, Lord Brown Wilkinson having said that the doctor cannot owe to the  
patient any duty to maintain his life where that life can only be sustained by  
intrusive medical care to which the patient will not consent, further clarified  
the legal position thus : “If there comes a stage where the responsible doctor  
comes to the reasonable conclusion (which accords with the views of a  
  
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Page 24:  
responsible body of medical opinion), that further continuance of an intrusive life  
support system is not in the “best interests” of the patient, he can no longer  
lawfully continue that life support system; to do so would constitute the crime of  
battery and the tort of trespass to the person. Therefore, he cannot be in breach  
of any duty to maintain the patient's life. Therefore, he is not guilty of murder  
by omission”.  
  
7.5 These passages have been approvingly quoted by learned Judges of the  
Supreme Court in Aruna’s case.  
  
7.6 The observations of Lord Mustill in Airedale’s case which were quoted by  
Supreme Court are also relevant - “Threaded through the technical arguments  
addressed to the House were the strands of a much wider position, that it is in  
the best interests of the community at large that Anthony Bland's life should  
now end. The doctors have done all they can. Nothing will be gained by going on  
and much will be lost. The distress of the family will get steadily worse. The  
strain on the devotion of a medical staff charged with the care of a patient  
whose condition will never improve, who may live for years and who does not  
even recognize that he is being cared for, will continue to mount. The large  
resources of skill, labour and money now being devoted to Anthony Bland might  
in the opinion of many be more fruitfully employed in improving the condition of  
other patients, who if treated may have useful, healthy and enjoyable lives for  
years to come”.  
  
7.7 The negative effects of compelling a doctor to continue the treatment to a  
PVS patient till the end have thus been forcibly portrayed.  
  
8 Analysis by 17% Law Commission  
  
8.1. The Law Commission summarized Airedale’s case as follows:-  
  
“The above judgment of the House of Lords in Airedale lays down a  
crucial principle of law when it says that withholding or withdrawal of life  
support to a dying patient merely amounts to allowing the patient to die a  
natural death and that where death in the normal course is certain,  
withholding or withdrawal of life support is not an offence.  
  
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Page 25:  
Wf a patient capable of giving informed consent refuses to give  
consent or has, in advance, refused such consent, the doctor cannot  
administer life support systems to continue his life even if the doctor  
thinks that it is in the patient's interest to administer such system. The  
patient's right of self-determination is absolute. But the duty of a doctor to  
save life of a patient is not absolute. He can desist from prolonging life by  
artificial means if it is in the best interests of the patient. Such an  
‘omission is not an offence. The doctor or the hospital may seek a  
declaration from the Court that such withholding, which is proposed, will  
be lawful.”  
  
8.2 The Law Commission brought out two important aspects concerning  
passive euthanasia. First, the observations in Gian Kaur vs. State of Punjab"  
which is a Constitution Bench decision. In that case the Supreme Court  
upheld the constitutional validity of both Section 306 and 309 of Indian Penal  
Code whereunder the abetment to suicide and attempt to suicide are made  
punishable. In the context of Section 306, the Supreme Court touched upon  
the subject of withdrawal of life support. Airedale's case was also cited in that  
judgment. The Supreme Court reiterated the proposition that euthanasia can  
only be legalized by enacting a suitable law. However, the distinction pointed  
out in Airedale between euthanasia which can be legalized by legislation and  
withdrawal of life support which is permissible in certain circumstances was  
recognized by the Supreme Court in Gian Kaur's case. Another significant  
observation made in the same case while dealing with Article 21 of the  
Constitution is the following:- “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’. That is how the Law Commission  
drew support from the dictum of the Supreme Court in Gian Kaur's case.  
  
8.3 Another approach of the Law Commission is from the stand point of the  
‘General Exceptions" contained in Indian Penal Code. Some of these  
provisions were relied upon to demonstrate that the doctor acting on the basis,  
of a desire expressed by the patient suffering from terminal illness or acting in  
  
supra, note 11  
a  
  
  
Page 26:  
the best interest of a patient in coma or PVS state etc. shall not be deemed to  
have committed a crime. After discussing the various ‘exceptions’, the Law  
Commission concluded as follows: “in our view Section 76 - 79 are more  
appropriate than Section 88 and there is no offence under Section 299 read  
with Section 304 of IPC", Section 76 says that “nothing is an offence which is  
done by a person who is, or who by reason of a mistake of fact and not by  
reason of mistake of law in good faith believes himself to be, bound by law to  
do it", Section 79 enacts the exception as follows: “nothing is an offence  
which is done by any person who is justified by law or by reason of mistake of  
fact, and not by reason of mistake of law, in good faith believes himself to be  
justified by law in doing it  
  
8.4 Section 76, it was clarified, was attracted to a case of withholding or  
withdrawal of medical treatment at the instance of a competent patient who  
decides not to have the treatment. Section 79, it was stated, applies to the  
doctor's action in the case of both competent and incompetent patients. Then,  
it was observed  
  
in our view where a medical practitioner is under a duty at  
‘common law to obey refusal of a patient who is an adult and who is competent,  
to take medical treatment, he cannot be accused of gross negligence resulting in  
the death of a person within the above parameters.” Likewise, it was pointed  
out that in the case of an incompetent patient or a patient who is not in a  
position to take informed decision, if the doctor decides to withhold or  
withdraw the treatment in the best interests of patient, based upon the  
opinion of experts then such withholding or withdrawal cannot be said to be a  
grossly negligent act. Section 304-A of I.P.C. will not therefore be attracted  
  
8.5 The Law Commission relied on the decision of Supreme Court in Jacob  
Mathew’s case in which it was pointed out in the context of gross negligence  
under 304-A, that it must be established that no medical professional in  
  
ordinary senses and prudence could have done or failed to do the thing  
which was attributed to the accused doctor.  
  
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Page 27:  
8.6 At the same time, the Commission, by way of abundant caution,  
‘suggested the introduction of a Section (Section 11) in the proposed Bill to the  
effect that the act or omission by the doctor in such situations is lawful. On  
the point of criminal liability, the Law Commission also referred to the holding  
in Airedale (UK) and Cruzan (US) that the omission of the doctor in giving or  
continuing the medical treatment did not amount to an offence. In this  
context, we may mention here that there is a criticism of the ‘act’ and  
‘omission’ approach adopted in Airdale’s case in holding that no criminal  
offence is committed by the doctor by withdrawing the artificial life-prolonging  
treatment. The omission involved therein, it was pointed out, did not amount  
to an offence. Irrespective of this approach, the Law Commission, in its 196%  
Report, reached the conclusion that no substantive offence is made out and in  
any case the ‘general exceptions’ in IPC excluded the criminal liability of the  
doctors.  
  
8.7 Coming to civil liability in torts, the Law Commission after referring to  
Jacob Mathew and Bolam relied on the proposition stated in Halsbury’s of  
England (4% Edition, Volume 30, para 35) that if the doctor had acted in  
accordance with the practice accepted as proper by a responsible body of  
medical men skilled in that particular art, even though a body of adverse  
opinion also existed among medical men, he is not guilty of negligence.  
  
9. \_Legalizing euthanasia — the perspectives and views  
  
9.1 The question of recognizing and legalizing euthanasia is being debated  
all over the world. The views pro and contra rest on philosophical, moral,  
ethical and legal perspectives. Different views have emerged, some of them  
being extreme. In a comprehensive Dissertation on “Legislative Passive  
Euthanasia” presented by Mr. Sayan Das'\*, various view points have been  
discussed and vast literature on the subject including end - of - life care has  
  
\*© an LLM student at Symbosis Law School, Pune, who has beon guided by Dr. Shashikala  
‘Gurupur, Director of Law School & Member{P.T.) of Law Commission; sayandas@symlawac.in  
  
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been referred to. We are of the view that rational and humanitarian outlook  
should have primacy in such a complex matter. Now, passive euthanasia in  
the sense in which it has been described at the beginning of this report both in  
the case of competent and incompetent patients is being allowed in most of the  
countries, subject to the doctor acting in the best interests of the patient who  
is not in a position to express the will. The broad principles of medical ethics  
which shall be observed by the doctor in taking the decision are the patient's  
autonomy (or the right to self determination) and beneficence, which means  
following a course of action that is best for the patient uninfluenced by  
personal convictions, motives or other considerations"®. In Airedale’s case,  
Lord Keith observed that the hospital / medical practitioner should apply to  
the Family Division of High Court for endorsing or reversing the decision taken  
by the medical practitioners in charge to discontinue the treatment of a PVS  
patient. Such a course should be taken till a body of experience and practice  
has been developed, as pointed out by Lord Keith in Airedale’s case. The  
course suggested by Lord Keith has been approved by our Supreme Court in  
Aruna’s case and this salutary safeguard has been implanted in our legal  
system now. As far as active euthanasia is concerned, lot of debate is still  
going on and there are “many responsible members of our society who believe  
that euthanasia should be made lawful, but as the laws now stand, euthanasia  
(other than passive euthanasia) is a crime in common law and it can only be  
made lawful by means of legislation”, as observed in Airedale’s case and  
reiterated by Law Commission (196th report). In India too, many from the legal  
and medical profession and academia have expressed the view that euthanasi  
should be legalized.  
  
% See p. 482 of SCC in Aruna Shaunbaug's case, supra  
24  
  
  
Page 29:  
9.2 V.R. Jayadevan pleads for ushering in an era of active euthanasia. The  
  
following pertinent observations made by him on the subject of legalizing active  
  
euthanasia may usefully be quoted”  
“The trend of the decisions of both the US and English courts reveals that  
the common law systems continue to proscribe active euthanasia as an  
offence. At the same time, many realize that active euthanasia is gaining  
relevance in the modern world. The objections to legalizing active  
euthanasia are based on religious principles, professional and ethical  
aspects and the fear of misuse. But, it cannot be forgotten that it was by  
overruling similar objections that abortion was legalized and later raised  
as an ingredient of the right to privacy. It is submitted that just like  
abortion, the modern societies demand the right to assisted suicide.”  
  
He has cited many authorities in support of his view point.  
9.3 Passive euthanasia, subject to the observance of certain restrictions and  
safeguards, has been endorsed and recognized by the Supreme Court in the  
latest case of Aruna Shanbaug and in Gian Kaur's case also, there is sufficient  
indication of its legality and propriety. The verdict in Airedale’s case has given  
‘a quietus to this controversy not only in U.K., but also in other countries  
where the ratio of the Judgment has been followed.  
9.4 It is relevant to mention in this context that the Law Commission of  
India in a more recent report, i.e. in 210% Report has recommended the repeal  
of Section 309 of Indian Penal Code so that the attempt to commit suicide  
could be decriminalized. As long back as 1971, the Law Commission in its 42°  
report pleaded for obliterating Section 309 from the Statute Book. The moral  
and philosophical aspects were also considered in detail. In Aruna Shanbaug  
too, case the Supreme Court made a categorical observation:  
  
“We are of the opinion that although Section 309 of the IPC has been held  
  
to be constitutionally valid in the Gian Kaur case, the time has come  
  
where it should be deleted by Parliament as it has become anachronistic.  
  
A person attempts suicide in depression and hence he needs help rather  
than punishment.”  
  
© V. B. Jaydevan, “Right ofthe Alive [who] but has no Life at all - Crossing the Rubicon from  
Suicide to Active Euthanasia” (2011) 82 JILL 437 at 47%  
  
25  
  
  
Page 30:  
9.5 The Supreme Court recommended to the parliament to consider the  
feasibility of deleting Section 309 from the Penal Code. If Parliament in its  
wisdom gives effect to this recommendation, the case for legalizing euthanasia,  
even active euthanasi  
  
would logically get strengthened. There would then be  
no Section in any penal statute to regard it as a crime. However, we need not  
g0 thus far in the case of passive euthanasia. It is not a crime and there is no  
constitutional taboo. Rational and humane considerations fully justify the  
endorsement of passive euthanasia. Moral or philosophical notions and  
attitude towards passive euthanasia may vary but it can be safely said that the  
preponderance of view is that such considerations do not come in the way of  
relieving the dying man of his intractable suffering, lingering pain, anguish  
and misery. The principle of sanctity to human life which is an integral part of  
Art. 21, the right to self determination on a matter of life and death which is  
also an offshoot of Art. 21, the right to privacy which is another facet of Art. 21  
and incidentally the duty of doctor in critical situations - all these  
considerations which may seem to clash with each other if a disintegrated  
view of Art.21 is taken - do arise. A fair balance has to be struck and a  
holistic approach has to be taken. That is what has been done by the Law  
Commission of India in its 196" Report and the Supreme Court of India in the  
very recent case of Aruna Shanbaug. The landmark decision of House of Lords  
in Airedale’s case has charted out the course to recognize and legalise passive  
euthanasia even in the case of incompetent patient. In Airdale, as seen earlier,  
the principle of best interests of the patient was pressed into service to uphold  
passive euthanasia in relation to incompetent patients and this in turn opened  
the doors for judicial determination for granting approval. “The best interest  
calculus generally involves an open-ended consideration of factors relating to the  
treatment decision, including the patient's current condition, degree of pain, loss  
of dignity, prognosis, and the risks, side effects, and benefits of each  
treatment.18"  
  
'® Development in Law ~ Medical Technology and the Law (1983) 103 HLR 1519 at 1651-25,  
26  
  
  
Page 31:  
10. Whether legislation necessary?  
  
10.1. The path breaking judgment in Aruna Ramachandra and the directives,  
given therein has become the law of the land. The Law Commission of India  
too made a fervent plea for legal recognition to be given to passive euthanasia  
subject to certain safeguards. The crucial and serious question now is, should  
we recommend to the Government to tread a different path and neutralize the  
effect of the decision in Aruna’s case and to suggest a course contrary to the  
law and practices in most of the countries of the world? As we said earlier,  
there is no compelling reasons for this Law Commission to do so. Our earnest  
effort at the present juncture, is only to reinforce the reasoning adopted by the  
Supreme Court and the previous Law Commission. On taking stock of the  
pros and cons, this Commission would like to restate the propriety and of  
legality of passive euthanasia rather than putting the clock back in the  
medico-legal history of this country.  
  
11. \_ Passive euthana:  
  
Issues discussed.  
  
11.1. At the risk of repetition, we shall first deal with the case of a competent  
patient who is terribly suffering from terminal illness of grave nature. What is  
the doctor's duty and does the content of the right in Art. 21 preclude the  
doctor and the patient from facilitating passive euthanasia?  
  
11.2. The discussion in the foregoing paras and the weighty opinions of the  
Judges of highest courts as well as the considered views of Law Commission  
(in 196% report) would furnish an answer to the above question in clearest  
terms to the effect that legally and constitutionally, the patient (competent) has  
4 right to refuse medical treatment resulting in temporary prolongation of life.  
‘The patient's life is at the brink of extinction. There is no slightest hope of  
recovery. The patient undergoing terrible suffering and worst mental agony  
does not want his life to be prolonged by artificial means. She/he would not  
like to spend for his treatment which is practically worthless. She/he cares for  
his bodily integrity rather than bodily suffering. She/he would not like to live  
  
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Page 32:  
like a ‘cabbage’ in an intensive care unit for some days or months till the  
inevitable death occurs. He would like to have the right of privacy protected  
which implies protection from interference and bodily invasion. As observed in  
Gian Kaur’s case, the natural process of his death has already commenced  
and he would like to die with peace and dignity. No law can inhibit him from  
opting such course. This is not a situation comparable to suicide, keeping  
aside the view point in favour of decriminalizing the attempt to suicide. The  
doctor or relatives cannot compel him to have invasive medical treatment by  
artificial means or treatment. If there is forced medical intervention on his  
body, according to the decisions cited supra (especially the remarks of Lord  
Brown Wilkinson in Airdale’s case), the doctor / surgeon is guilty of ‘assault’  
or ‘battery’. In the words of Justice Cardozo!®, “every human being of adult  
years and sound mind has a right to determine what shall be done with his own  
body and a surgeon who performs an operation without his patient’s consent  
commits an assault for which he is liable in damages.” Lord Gott in Airedale’s  
case places the right to self determination on a high pedestal. He observed  
that “in the circumstances such as this, the principle of sanctity of human life  
must yield to the principle of self determination and the doctor's duty to act in  
the best interests of the patient must likewise be qualified by the wish of the  
patient.” The following observations of Lord Goff deserve particular notice:  
  
“I wish to add that, in cases of this kind, there is no question of the  
patient having committed suicide, nor therefore of the doctor having aided  
or abetted him in doing so. It is simply that the patient has, as he is  
entitled to do, declined to consent to treatment which might or would have  
the effect of prolonging his life, and the doctor has, in accordance with his  
duty, complied with his patient's wishes.”  
  
11.3. As noticed earlier, the line of thinking is the same in Gian Kaur - which  
  
aspect has been highlighted by Law Commission (in 196" report)  
  
11.4 To accede to the choice and volition of a competent patient in a state of  
  
terminal illness, far from being invasive of the fundamental right under Art.21  
  
in 211 NY 125, (1914)  
28  
  
  
Page 33:  
(built on the premise that sanctity of life cannot be jeopardized), will be more  
conducive to the promotion of that right. This would be so, whether we  
‘approach ‘life’, and its definition or meaning from the natural law perspective  
or a rationalist or a positive law angle. While life cannot be extinguished or its  
attributes decimated or taken away, provisions of canvas of choice, when life's  
elements have ebbed away cannot be critiqued. Even in respect of incompetent  
patient, as pointed out earlier by reference to the various passages in the  
weighty pronouncements in our country, U.K., and U.S.A., the violation of  
‘Art.21 does not really arise when the decision to withdraw the life support  
measures is taken in the best interest of the incompetent patient, especially  
when the evaluation of best interests is left to a high judicial body, ie., the  
High Court. For instance, in case of dysfunctional bodily organs, or  
decapacitated limbs, decisions are taken to transplant or amputate in the best  
interests of the patient. Again, abortion laws, or Medical Termination of  
Pregnancy Laws, are similar instances of best interest concept.  
  
11.5 In Cruzan’s case (497 US 261), the US Supreme Court observed that the  
due process clause undoubtedly protected “the interests of a person in life as  
well as an interest in refusing life sustaining medical treatment.”  
  
11.6 What is the proper approach to the case of an incompetent patient,  
such as a patient who may be in a PVS or irreversible coma? Should  
(involuntary) passive euthanasia be allowed in his case? Will the  
discontinuance of life-prolonging treatment by artificial measures result in  
violation of Art. 217 Here again, we cannot adopt an abstract or disintegrated  
view of Art.21 and record the conclusion that the withdrawal of life-sustaining  
systems would automatically amount to violation of Art.21. As stated by  
Hoffman LJ. in Airdale case, the ‘sanctity of life’ and ‘respect for life! should  
not be carried “to the point at which it has become almost empty of any real  
content and when it involves the sacrifice of other important values such as  
human dignity and freedom of choice".  
  
® supra, note 3  
  
29  
  
  
Page 34:  
11.7 The fact that he is helpless, unconscious and uncommunicative - should  
it come in the way of withdrawing life-support systems if it is considered to be  
in his best interests and a rational person in his position, would most  
probably have opted for withdrawal? As the patient is not in a position to  
exercise the right of self-determination, should artificial life-support be thrust  
on him throughout the span of his short life? Should he be in a worse position  
because he cannot express, communicate or take informed decision? In this,  
context, we may quote what the Supreme Judicial Court of Massachusetts in  
Supdt. of Belhcertown State Schoo! vs. Saikewicz"' pertinently observed:  
  
fo presume that the incompetent person must always be subjected to  
what many rational and intelligent persons may decline is to downgrade  
the status of the incompetent person by placing a lesser value on his  
intrinsic human worth and vitality.”  
11.8 This statement was quoted by Lord Goff approvingly in Airedale case  
(vide pg 502 of SCC in Aruna’s case). Before referring to that passage, Lord  
Goff observed: “It is scarcely consistent with the primacy given to the principle of  
self-determination in those cases in which the patient of sound mind has  
declined to give his consent, that the law should provide no means of enabling  
treatment to be withheld in appropriate circumstances where the patient is in  
1no condition to indicate, if that was his wish, that he did not consent to it’  
41.9 It would be unjust and inhumane to thrust on him the invasive  
treatment of infructuous nature knowing fully well that the end is near and  
certain. He shall not be placed on a worse footing than a patient who can  
exercise his volition and express his wish to die peacefully and with dignity.  
Had he been alive, what he would have in all probability decided as a rational  
human being? Would it be in his best interests that he should be allowed to  
die in natural course? These decisions have to be taken by the High Court as  
parens patriae and this will be a statutory safeguard against arbitrary or  
uninformed decisions. In this context, the words of Lord Goff in Airedale are  
  
2 370 NE 24 417 (1977)  
30  
  
  
Page 35:  
pertinent: “Indeed if the justification for treating a patient who lacks the  
capacity to consent lies in the fact that the treatment is provided in his best  
interests, it must follow that the treatment may, and indeed ultimately should be  
discontinued where it is no longer in the best interests to provide it’. The right  
question to be asked, according to the learned Law Lord, “is not whether it is in  
the best interest of the patient that he should die. The question is whether it is in  
the best interests of the patient that his life should be prolonged by continuing  
this form of medical treatment and care".  
  
11.10 Compassionate medical care towards a terminally ill patient does not  
necessarily mean artificially prolonging the life which has started sinking and  
which cannot, by any objective standards, be maintained for long. Life support  
intervention far from helping to mitigate the suffering would rather add to the  
agony of a prolonged dying process. The Commission is of the view that on a  
reasonable interpretation, Article 21 does not forbid resorting to passive  
euthanasia even in the case of an incompetent patient provided that it is  
considered to be in his best interests, on a holistic appraisal. The doctors’ duty  
to make assessment and the High Courts’ duty to take stock of the entire  
situation are directed towards the evaluation of best interest which does not  
really clash with the right to life content under Art.24  
  
11.11 Article 21 of the Constitution of India injuncts against deprivation of  
life or personal liberty except according to procedure established by law. By  
the term ‘Life’, “something more is meant than mere animal existence”. “The  
inhibition against its deprivation extends to all those limits and faculties by  
which life is enjoyed”, as observed by Field, J of the Supreme Court of US in  
‘Munn v. llinois® and this observation has been quoted by the Constitution  
Bench of the Supreme Court in Kharak Singh v. State of Uttar Pradesh (1963).  
The expression ‘procedure established by law’, has been interpreted by the  
  
2% (1877) 94 US 113 at 142  
31  
  
  
Page 36:  
Supreme Court in Maneka Gandhi's case® to mean right and just and fair  
procedure and not any sort of procedure. The scope of Article 21 which was  
initially confined to arbitrary deprivation of life and personal liberty, was  
extended to positive rights to enable an individual to live the life with dignity  
In Gian Kaur's case supra, the Constitution Bench of Supreme Court while  
upholding the validity of Section 309 of 1.P.C. laid down the proposition that  
the right to life does not include the “right to die”. In this respect, it was  
pointed out that the analogy of the nature of rights in Article 19 of the  
Constitution e.9., freedom of speech includes the freedom not to speak, cannot  
be applied to the right under Article 21. The Court held that the right to  
death, if any, is inherently inconsistent with the right to life. The Court  
however emphasized that right to life under Article 21 would include the right  
to live with human dignity upto the end of natural life which includes within  
its ambit a dignified procedure of death. In other words, the right to die with  
dignity is subsumed within the right to life. It was further clarified that the  
right to die with dignity at the end of life is not to be confused or equated with  
right to die an unnatural death curtailing the natural span of life. As already  
noticed, there are significant observations of the Supreme Court in Gian Kaur  
case while considering the aspect of withdrawal of life support systems to a  
patient in PVS which were stressed in the 196" report of Commission. Such a  
step in a situation in which the patient is beyond recovery and when the  
process of natural death has already commenced, was placed on a different  
footing than suicide, while considering the impact of Art. 21. At this juncture,  
we may quote the pertinent observations of Constitution Bench in Gian Kaur’s  
case: “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  
  
AIR 1978 SC 697  
32  
  
  
Page 37:  
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.  
  
11.12 Post Maneka Gandhi (1978), law can deal with life and liberty of a  
person by or under a fair, just and reasonable procedure. By a series of  
judgments of the Supreme Court, life has been construed at the material and  
physical level to include various components, understood to be essential for a  
dignified and wholesome existence. The International Human Rights  
Documents identify and enumerate several entitlements which are  
acknowledged to be integral to a free and meaningful existence. These  
entitlements are now considered to be indisputable elements of life and liberty.  
While the State or any other body is injuncted from denuding or depriving a  
person of all or any attributes of life possessed by him, the situation would be  
different when a person is disabled from the usual enjoyment of any of the  
attributes of life by a conscious exercise of choices or volition. The State or  
medical practitioner would not be accused of taking away the life when the law  
merely provides assistance to the patient to allow his life devoid of essential  
attributes to wane by withdrawal of medical care and procedures. At any rate,  
the fairness and reasonableness of the procedure to be followed and the  
cautions to be exercised by the medical personnel and the High Court will  
negate a challenge to law based on violation of Art.21. It must be noted that  
the State would not be depriving life by sanctioning the proposed legislation  
but, as stated already, the proposed law would operate at a stage when a  
person has no life to be protected or to be preserved and has become an empty  
vessel devoid of volitional capacity and wholesome attributes of life in the  
physical as well as philosophical sense. In these circumstances, the State  
cannot be said to be taking away anything, for there may exist nothing to be  
taken away which the person concerned may decide to retain as necessary or  
relevant for one's existence. What the State is forbidden from doing is  
interfering with the autonomy of a person when the autonomy makes sense.  
However, when the patient is not in a position to make sense of his autonomy  
  
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and is not in a position to wish death or prefer the life bereft of its basic and  
essential attributes, the intervention by the judicial organ of the State to  
sanction passive euthanasia cannot be said to be hostile to the concept of  
sanctity of life of the patient concerned. The constitutional concern to prevent  
external invasions of human autonomy will not conflict with constitutional  
concern to aid benignly human autonomy in its frailest condition.  
  
12. Palliative Care  
  
12.1. Palliative care to the terminally ill patients beyond the stage of recovery  
is an allied aspect which needs to be taken care of by the Governments.  
Making palliative care affordable and free for the needy people, training of  
doctors and medical students in pain-treatment and palliative care are the  
needs of the day. The medical profession apart from giving effect to passive  
euthanasia where necessary must ensure that the dying patient receives  
proper care in a peaceful environment inside or outside the hospital. There  
are reports that the hospitals find it difficult to procure morphine and other  
pin-relieving drugs which are regulated under the Narcotics Drugs and  
Psychotropic Substances Act. The stumbling blocks in the way of palliative  
care have to be removed, if necessary, by changing the rules dealing with  
narcotic drugs. There is every need for the Governments to frame  
patients undergoing  
grave suffering and pain. The palliative care seems to be a neglected area at  
  
‘Schemes extending palliative care to terminally i  
  
present. This situation should not continue for long. It is needless to state  
that patients who are economically handicapped or those belonging to weaker  
sections of the society should come up for special focus in any such Scheme.  
13. Changes now proposed in the draft Bill  
  
18.1 In Section 2{d) — (definition of ‘incompetent patient) the words “below the  
‘age of 16 years” are now added.  
  
13.2. Two changes are proposed to be made to Section 3. One is to treat the  
informed decision taken by a patient above 16 years (but below 18 years) at  
  
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par with the decision taken by a competent patient subject to the condition  
that in such a case, the major spouse and one of the parents or major son or  
daughter of such patient has given consent for discontinuance of treatment.  
Having regard to the level of understanding and capacity of the present  
generation youngsters, it is considered appropriate to introduce this provision,  
subject to the additional safeguard of consent of spouse and parents so that  
such patients need not have to experience the torments of suffering for a  
longer period.  
  
13.3. Secondly, a 2» proviso is added to Section 3 to make it obligatory on the  
part of the doctor to inform the spouse or close relation of the patient  
regarding the decision taken or request made by the competent patient and to  
desist from discontinuance of treatment for a period of three days thereafter.  
This time gap may be necessary for facilitating further deliberations among the  
patient and relations.  
  
13.4. Section 7 (renumbered as Section 4)  
  
(i) Omit the words ‘section 6" and substitute ‘this Act’  
  
Sub-section (2) of Section 7 (renumbered Section 4) shall be recast as  
  
follows:-  
  
The panel referred to in Sub-section 7 shall include experienced medical  
experts in various branches such as medicine, surgery, critical care  
medicine or any other speciality as decided by the said authority.  
  
(ill) Sub-sections (a) and (4) of Section 7 (renumbered Section 4) may be  
  
omitted as this provision is either unnecessary or may unduly fetter the  
freedom of choice conferred on the high medical authority of the Centre  
or the State.  
  
(iv) The following provision to be added as sub-section (3) to Section 4 (old  
Section 7}  
The Director General of Health Services may consult the Directors of  
Medical Services or the equivalent rank officers in regard to the  
composition of panel in order to ensure uniformity, as far as practicable.  
  
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Page 40:  
In sub-section (5) of Section 7 (renumbered sub-section (4) of new Section  
4), the reference to ‘official Gazette’ to be omitted as it does not serve any  
useful purpose.  
  
13.5 Section 8 (renumbered Section 5) to be recast as follows:- The words ‘in  
  
a register’ occurring in sub-Section (1) of Section 8 may be omitted as they are  
  
ot quite appropriate. After clause (c) of Sub-section (1), the words “as fo the  
  
expert advice received ....”to be omitted. In view of the changes now suggested  
in the light of Supreme Court judgment, the said expression becomes  
irrelevant because the expert opinion has to be obtained by the High Court. In  
their place, the words ‘and the name of spouse or other close relation found to  
be with patient regularly’ to be substituted in the last para of Sub-section (1) of  
  
Section 8 (renumbered Section 5). In Sub-section 2) of Section 8 (new Section  
  
5), instead of the word ‘decision’ the words “need or otherwise” has to be  
  
substituted. Sub-sections (3) to (6) of Section 8 (new Section 5) are to be  
  
omitted as they are irrelevant in view of the main change suggested.  
  
13.6 In Section 11 (renumbered Section 8), clause (b) to be omitted and in  
  
the existing proviso occurring after sub-clause (ii) of Section 11 (new Section  
  
8), the words “Sections 5 & 6’ to be omitted and only Section 8 to be retained.  
  
‘The words “notwithstanding anything in any other law” has also been added to  
  
the closing sentence of Section 11 [after clause (ii. This is by way of  
  
abundant caution.  
  
13.7 The most crucial change is with reference to Section 12. Section 12  
  
(renumbered as Section 9) to be substituted as follows:-  
  
‘Section 9 : Permission to be obtained from the High Court and the  
procedure  
  
(1) Any near relative, next friend, legal guardian of patient, the  
medical practitioner or the para-medical staff generally attending on the  
patient or the management of the hospital where the patient has been  
receiving treatment or any other person with the leave of Court, may  
apply to the High Court for granting permission for withholding or  
  
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withdrawing medical treatment of an incompetent patient or a  
competent patient who has not taken informed decision.  
(2) Such application shall be treated as Original Petition and the  
Chief Justice of High Court shall assign the same to a Division Bench  
without any loss of time and the same shall be disposed of by the High  
Court as far as practicable within a month,  
  
provided that a letter addressed to the Registrar-General or  
Judicial Registrar of High Court by any of the persons above mentioned  
containing all the material particulars seeking the permission under  
‘sub-section (1) shall be placed before the Chief Justice without delay and  
the letter shall be treated as original petition.  
(3) The Division bench of the High Court may, wherever it deems it  
necessary, appoint an amicus curiae to assist the Court and where a  
patient is unrepresented, direct legal aid to be provided to such patient,  
4) The High Court shall take necessary steps to obtain the expert  
medical opit  
found in the panel prepared under Section 4 or any other expert medical  
  
ion of three expert medical practitioners whose names are  
  
practitioner if considered necessary and issue appropriate directions for  
the payment to be made towards the remuneration of the experts.  
(5) The High Court shall, having due regard to the report of panel of  
experts and the wishes of close relations or legal guardian or in their  
absence such other persons whom the High Court deems fit to put on  
notice and on consideration of the best interests of the patient, pass  
orders granting or refusing permission or granting permission subject to  
any conditions.  
(6) The medical practitioner or the hospital management or staff who  
in accordance with the order of High Court, withholds or withdraws  
medical treatment to the patient concerned shall, notwithstanding any  
other law in force, be absolved of any criminal or civil liability.  
  
13.8. The present Law Commission feels that it is safer and desirable to follow  
  
the procedure laid down by the Supreme Court in Aruna’s case so that the  
  
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Page 42:  
High Court's approval will be a condition precedent for stopping the life-  
supporting measures. The question of obtaining the opinion of panel of  
experts will arise only when the High Court's approval is sought by the close  
relations, next friend or attending doctor/hospital. The Supreme Court,  
following the dicta in Airedale and other cases, considered it appropriate to  
confer the parens patriae jurisdiction on the High Court. The Law  
Commission, (in its 196! Report) also drew support from the English cases  
decided by the highest courts in U.K. to provide for an enabling provision  
seeking declaratory relief in the High Court after the medical practitioner  
informs the relatives about the proposed discontinuance of life-sustaining  
treatment to the terminally ill patient based on the expert medical advice he  
obtained. The present Commission is inclined to lean in favour of the view  
taken by the Supreme Court as it will allay the apprehensions expressed by  
the Court (vide para 125 of SCC). Further, when the right to life dimension  
has to be addressed, it is desirable that the High Court undertakes the  
responsibility of weighing the pros and cons on the basis of expert medical  
advice, etc. and take an appropriate decision. In fact, one of the Members of  
the Commission, Shri Amarjit Singh, has also expressed the apprehension that  
having regard to the socio-economic conditions in our country, the greedy  
relations who are interested in the wealth of the critically ill patient may stoop  
to malpractices with a nefarious design to hasten the process of death. The  
manipulations that could possibly be made by the greedy relations with the  
help of accommodative doctors has also been adverted to by the Id. Judges of  
the Supreme Court in Aruna’s case. Keeping all these factors in view, we have  
deviated from the recommendation in the 196 Report, to this extent.  
  
13.9 There is a view point that the approach to the High Court may involve  
cost and the decision will get unnecessarily delayed. Instead of that, the  
procedure suggested by the 17% Law Commission would be a better  
alternative. Though this point of view is not without force, on weighing the  
pros and cons, the Commission prefers the course adopted by the Supreme  
  
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Page 43:  
Court in Aurna's case. At this stage, it cannot be assumed that the  
proceedings in the High Court will get delayed. Having regard to the time limit,  
prescribed and even otherwise in view of the nature of the case and its  
sensitivity, the High Court will certainly give top priority to such matters. As  
far as the cost is concerned, legal aid is available to women, disabled persons,  
SCs and STs and those in low income groups under the provisions of Legal  
Services Authorities Act. Further, the High Court is enabled to act on the  
basis of a letter and the Court can also appoint amicus curiae to assist the  
Court in the absence of any advocate for the petitioner. When the court is  
exercising parens patriae jurisdiction, as said by the Supreme Court, the  
stakeholders will not suffer any handicap in terms of legal assistance as the  
Court will ensure the same. The experience will tell us if the procedure now  
envisaged is working alright and needs any change. What all the Commission  
would like to say at this stage is that it is worth trying.  
  
13.10 However, we would like to enter a caveat in regard to the  
methodology suggested by the Supreme Court as regards the selection of the  
panel of experts. The Commission is of the view that the High Court should not  
be burdened with the task of preparation of panels of medical experts from  
time to time. The better and more expedient course would be as suggested by  
the Law Commission in its 196! Report. The panel shall be prepared by the  
highest medical body of the Centre or the State. Further, the composition of  
such expert panel, i.e., which specialists are to be included in the panel or  
whether there should be more than one combination is best left to the Director  
General or Director of Medical Services who are expert officials. Therefore, it is  
better that the Director General / Director of Medical Services decides on the  
composition of panel and prepare a list of experts from different fields. The  
High Court will nominate the experts as per the panel prepared by the said  
authorities subject to the residual discretion to nominate any other expert in  
addition to or in the place of any expert.  
  
13.11 Secondly, the Hon'ble Supreme Court discussed at length the  
plenitude of jurisdiction of the High Courts under Article 226 of the  
  
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Page 44:  
Constitution to pass appropriate orders in the matter of dealing with cases of  
this nature. In the English cases cited in the judgment of Supreme Court as  
well as the Law Commission's earlier Reports, it is observed that the person  
concerned can approach the Family Division of the High Court for a  
declaratory relief. While a Writ Petition under Art.226 can be entertained by  
the High Courts by virtue of the judgment in Aruna’s Case till a legislation is  
made, it would be more appropriate to provide for a special remedy under the  
original jurisdiction of the High Court. As suggested in the 196 Report, it is  
desirable to specifically provide for an Original Petition to cover this category of  
cases. Incidentally, it will dispel plausible arguments on the maintainability of  
Writ Petition against private bodies or persons. Of course whether itis original  
petition or Art. 226 petition, the approach will be the same. As specific  
jurisdiction is being invested with the High Court by a specific provision, the  
High Court will exercise jurisdiction under that special provision of the Act  
rather than proceeding under Art. 226. At the same time, we have suggested  
the insertion of a provision under which even a letter addressed to the  
Registrar of the High Court can be taken cognizance of.  
  
13.12 The Commission is of the view that a letter addressed to the  
Registrar General of High Court containing all the material particulars filed by  
those desirous of seeking the High Court's approval for the proposed  
withdrawal of life support to an incompetent patient, shall be treated as  
Original Petition without insisting on formalities. The said letter shall be  
placed before the Hon'ble Chief Justice and acted upon.  
  
13.13 Accordingly, the changes in Medical Treatment of Terminally ill  
Patients (Protection of Patients and Medical Practitioners) Bill, 2006 are  
proposed by the present Law Commission in this report and the Bill, as  
modified and recast, is at Annexure ~ 1  
  
14, Summary of Recommendations  
  
14.1 Passive euthanasia, which is allowed in many countries, shall have legal  
recognition in our country too subject to certain safeguards, as suggested by  
the 17" Law Commission of India and as held by the Supreme Court in Aruna  
  
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Page 45:  
Ramachandra’s case (2011) 4 SCC 454)]. It is not objectionable from legal  
and constitutional point of view.  
  
14.2 A competent adult patient has the right to insist that there should be no  
ial life sustaining measures /  
treatment and such decision is binding on the doctors / hospital attending on  
such patient provided that the doctor is satisfied that the patient has taken an  
informed decision’ based on free exercise of his or her will. The same rule will  
  
invasive medical treatment by way of arti  
  
apply to a minor above 16 years of age who has expressed his or her wish not  
to have such treatment provided the consent has been given by the major  
‘spouse and one of the parents of such minor patient.  
  
14.3 As regards an incompetent patient such as a person in irreversible coma  
or in Persistent Vegetative State and a competent patient who has not taken  
‘an ‘informed decision’, the doctor's or relatives’ decision to withhold or  
withdraw the medical treatment is not final. The relatives, next friend, or the  
doctors concerned / hospital management shall get the clearance from the  
High Court for withdrawing or withholding the life sustaining treatment.  
  
In this respect, the recommendations of Law Commission in 196 report  
is somewhat different. The Law Commission proposed an enabling provision  
to move the High Court.  
  
14.4 The High Court shall take a decision after obtaining the opinion of a  
panel of three medical experts and after ascertaining the wishes of the relatives,  
of the patient. The High Court, as parens patriae will take an appropriate  
decision having regard to the best interests of the patient.  
14.5 Provisions are introduced for protection of medical practitioners and  
others who act according to the wishes of the competent patient or the order of  
the High Court from criminal or civil action. Further, a competent patient  
(who is terminally ill) refusing medical treatment shall not be deemed to be  
guilty of any offence under any law.  
14.6 The procedure for preparation of panels has been set out broadly in  
conformity with the recommendations of 17" Law Commission. Advance  
medical directive given by the patient before his illness is not valid.  
  
at  
  
  
Page 46:  
14.7 Notwithstanding that medical treatment has been withheld or withdrawn  
in accordance with the provisions referred to above, palliative care can be  
extended to the competent and incompetent patients.  
  
‘The Governments have to devise schemes for palliative care at affordable  
cost to terminally ill patients undergoing intractable suffering.  
14.8. The Medical Council of India is required issue guidelines in the matter of  
withholding or withdrawing of medical treatment to competent or incompetent  
patients suffering from terminal illness.  
14.9 Accordingly, the Medical Treatment of Terminally ill Patients (Protection  
of Patients and Medical Practitioners) Bill, 2006, drafted by the 17 Law  
Commission in the 196% Report has been modified and the revised Bill is  
practically an amalgam of the earlier recommendations of the Law Commission  
and the views / directions of the Supreme Court in Aruna Ramachandra case.  
The revised Bill is at Annexure I.  
  
Justice (Retd.) P. V. Reda]  
Chairman  
  
Justice (Retd.) Shiv Kumar Sharma] [Amarjit Singh]  
‘Member ‘Member  
  
New Delhi  
11 August 2012  
  
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Annexure -  
[Reler para 13.13 ofthe report)  
  
‘THE MEDICAL TREATMENT OF TERMINALLY-ILL PATIENTS  
(PROTECTION OF PATIENTS AND MEDICAL PRACTITIONERS) BILL  
A Bill to provide for the protection of patients and medical practitioners  
from liability in the context of withholding or withdrawing medical treatment  
including life support systems from patients who are terminally-ill.  
BE it enacted in the Sixty Second Year of the Republic of India as  
follows:-  
1. Short title, extent and commencement. - (1) This Act may be called the  
Medical Treatment of Terminally-ill Patients (Protection of Patients and Medical  
Practitioners) Act.  
2) Itextends to the whole of India except the State of Jammu & Kashmir.  
(3) It shall come into force on such date as the Central Government may, by  
notification in the Official Gazette, appoint.  
2. Definitions. - Unless, the context otherwise requires ~  
(a) ‘advance medical directive’ (called living will) means a directive given by  
  
‘a person that he or she, as the case may be, shall or shall not be given medical  
treatment in future when he or she becomes terminally ill.  
(b) ‘best interests’ include the best interests of a patient  
(i) who is an incompetent patient, or  
(i) who is @ competent patient but who has not taken an informed  
decision, and  
are not limited to medical interests of the patient but include ethical,  
social, moral, emotional and other welfare considerations.  
(c) ‘competent patient’ means a patient who is not an incompetent patient.  
(@) ‘incompetent patient’ means a patient who is a minor below the age of 16  
years or person of unsound mind or a patient who is unable to ~  
(i) understand the information relevant to an informed decision  
about his or her medical treatment;  
  
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Page 48:  
(@)  
  
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(hy  
  
“  
  
retain that information;  
)) use or weigh that information as part of the process of making his  
  
‘i  
or her informed decision;  
(iv) make an informed decision because of impairment of or a  
disturbance in the functioning of his or her mind or brain; or  
(v) communicate his or her informed decision (whether by speech,  
sign, language or any other mode) as to medical treatment.  
informed decision’ means the decision as to continuance or withholding  
or withdrawing medical treatment taken by a patient who is competent  
and who is, or has been informed about :~  
(i) the nature of his or her illness,  
(ii) any alternative form of treatment that may be available,  
(ili) the consequences of those forms of treatment, and  
(iv) the consequences of remaining untreated,  
‘Medical Council of India’ means the Medical Council of India constituted  
under the Indian Medical Council Act, 1956 (102 of 1956).  
‘medical practitioner’ means a medical practitioner who possesses any  
recognized medical qualification as defined in clause (h) of section 2 of  
the Indian Medical Council Act, 1956 (102 of 1956) and who is enrolled  
on a State Medical Register as defined in clause (k) of that section.  
‘medical power-of-attorney’ means a document of decisions in future as  
to medical treatment which has to be given or not to be given to him or  
her if he or she becomes terminally ill and becomes an incompetent  
patient.  
‘medical treatment’ means treatment intended to sustain, restore or  
replace vital functions which, when applied to a patient suffering from  
terminal illness, would serve only to prolong the process to dying and  
includes ~  
(i) life-sustaining treatment by way of surgical operation or the  
administration of medicine or the carrying out of any other medical  
procedure and  
  
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Page 49:  
(ii) use of mechanical or artificial means such as ventilation, artificial  
  
nutrition and hydration and cardiopulmonary resuscitation.  
  
() ‘minor’ means a person who, under the provisions of an Indian Majority  
Act, 1875 (4 of 1875) is to be deemed not to have attained majority.  
  
(k) ‘palliative care’ includes ~  
(i) the provision of reasonable medical and nursing procedures for  
the relief of physical pain, suffering, discomfort or emotional and  
psycho-social suffering,  
(ii) the reasonable provision for food and water.  
  
() ‘Patient’ means a patient who is suffering from terminal illness.  
  
(m) ‘terminal illness’ means -  
() such illness, injury or degeneration of physical or mental  
condition which is causing extreme pain and suffering to the patients  
‘and which, according to reasonable medical opinion, will inevitably  
cause the untimely death of the patient concerned, or  
‘i  
condition under which no meaningful existence of life is possible for the  
  
which has caused a persistent and irreversible vegetative  
  
patient,  
3. Refusal of medical treatment by a competent patient and its  
binding nature on medical practitioners. - (1) Every competent patient  
including minor aged above 16 years has a right to take a decision and  
express the desire to the medical practitioner attending on her or him:-  
  
(i) for withholding or withdrawing of medical treatment to herself or  
  
himself and to allow nature to take its own course, or  
  
(ii) for starting or continuing medical treatment to herself or himselt.  
(2) When a patient referred to in sub-section (1) communicates her or his  
  
decision to the medical practitioner, such decision is binding on the  
  
medical practitioner,  
  
Provided that the medical practitioner is satisfied that the patient  
is a competent patient and that the patient has taken an informed  
decision based upon a free exercise of her or his free will and,  
  
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Page 50:  
Provided further that in the case of minor above 16 years of age,  
the consent has also been given by the major spouse and the parents.  
  
(3) Before proceeding further to give effect to the decision of the competent  
patient, the medical practitioner shall inform the spouse, parent or  
major son or daughter of the patient or in their absence any relative or  
other person regularly visiting the patient at the hospital about the need  
or otherwise of withholding or withdrawing treatment from the patient  
and shall desist from giving effect to the decision for a period of three  
days following the intimation given to the said patient's relations.  
  
4, Authority to prepare panel of medical experts. (1) The Director-General  
  
of Health Services, Central Government and the Director of Medical Services  
  
(or officer holding equivalent post) in each State shall, prepare a panel of  
  
medical experts for purposes of this Act and more than one panel may be  
  
notified to serve the needs of different areas.  
  
(2) The panels referred to in sub-section(1) shall include experienced  
  
medical experts in various branches such as medicine, surgery, critical care  
  
medicine or any other specialty as decided by the said authority  
  
(3) The Director General of Health Services may consult the Directors of  
  
Medical Services or the equivalent rank officers in regard to the composition of  
  
panel in order to ensure uniformity, as far as practicable.  
  
(4) The panels prepared under sub-section (1) shall be published in the  
respective websites of the said authorities and the panels may be reviewed and  
modified by the authorities specified in sub-section (1) from time to time and  
such modifications shall also be published on the websites, as the case may  
be.  
  
5. Medical Practitioner to maintain record and inform patient, parent etc.  
The medical practitioner attending on the patient shall maintain a record  
containing personal details of the patient such as age and full address, the  
nature of illness and the treatment being given and the names of spouse,  
parent or major son or daughter, the request or decision if any communicated  
  
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Page 51:  
by the patient and his opinion whether it would be in the best interest of the  
patient to withdraw or withhold the treatment. The medical practitioner shall  
inform the patient if conscious and the spouse, parent or major son or  
daughter of the patient or in their absence the persons regularly visiting the  
patient at the hospital about the need or otherwise of withholding or  
withdrawing treatment from the patient.  
6. Palliative care for competent and incompetent patients. - Even though  
medical treatment has been withheld or withdrawn by the medical practitioner  
in the case of competent patients and incompetent patients in accordance with  
the foregoing provisions, such medical practitioner is not debarred from  
administering palliative care.  
7. Protection of competent patients from criminal action in certain  
circumstances. - Where a competent patient refuses medical treatment in  
circumstances mentioned in section 3, notwithstanding anything contained in  
the Indian Penal Code (45 of 1860), such a patient shall be deemed to be not  
guilty of any offence under that Code or under any other law for the time being  
in force.  
8. Protection of medical practitioners and other acting under their  
direction, in relation to competent and incompetent patients. - Where a  
medical practitioner or any other person acting under the direction of medical  
practitioner withholds or withdraws medical treatment in respect of a  
competent patient on the basis of the desire expressed by the patient which on  
the assessment of a medical practitioner is in her or his best interest, then,  
notwithstanding anything contained in any other law, such action of the  
medical practitioner or those acting under his direction and of the hospital  
concerned shall deemed to be lawful provided that the medical practitioner has  
complied with the requirements of Section 3 and 5.  
9. Permission to be obtained from High Court and the procedure. - (1) Any  
near relative, next friend, legal guardian of patient, the medical practitioner or  
para-medical staff generally attending on the patient or the management of the  
hospital where the patient has been receiving treatment or any other person  
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Page 52:  
obtaining the leave of court, may apply to the High Court having territorial  
jurisdiction for granting permission for withholding or withdrawing medical  
treatment of an incompetent patient or a competent patient who has not taken  
informed decision  
  
(2) Such application shall be treated as original petition and the Chief  
Justice of High Court shall assign the same to a Division Bench without any  
loss of time and the same shall be disposed of by the High Court as far as  
practicable within a month,  
  
Provided that a letter addressed to the Registrar-General or Judicial  
Registrar of the High Court by any of the persons above mentioned containing  
all the material particulars seeking the permission under sub-section (1) shall  
be placed before the Chief Justice without delay and the letter shall be treated  
as original petition.  
  
(3) The Division Bench of the High Court may, if deemed necessary, appoint  
an amicus curiae to assist the Court and where a patient is unrepresented,  
direct legal aid to be provided to such patient.  
(4) The High Court shall take necessary steps to obtain the expert medical  
opinion of three medical practitioners drawn from the panel prepared under  
Section 4 and any other expert medical practitioner if considered necessary  
and issue appropriate directions for the payment to be made towards the  
remuneration of the experts.  
(5) The High Court shall, having due regard to the report of panel of experts  
and the wishes of close relations, namely, spouse, parents, major children or  
in their absence such other persons whom the High Court deems fit to put on  
notice and on consideration of the best interests of the patient, pass orders  
granting or refusing permission or granting permission subject to any  
conditions.  
(6) The medical practitioner or the hospital management or staff who in  
accordance with the order of High Court, withholds or withdraws medical  
treatment to the patient concerned shall, notwithstanding any other law in  
force, be absolved of any criminal or civil liability  
  
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10. Confidentiality for purposes of section 9. - The Di  
High Court may, whenever a petition under Section 9 is filed, direct that the  
identity of the patient and of his or her parents or spouse, the identity of the  
medical practitioner and hospitals, the identity of the medical experts referred  
to in Section 4, or of other experts or witnesses consulted by the Court or who  
have given evidence in the Court, shall, during the pendency of the petition,  
and after its disposal, be kept confidential and shall be referred only by the  
English alphabets.  
  
11. Advance Medical Directives as to medical treatment and Medical  
Powe-of-Attorney to be void and not binding on medical practitioners. -  
Every advance medical directive (called living will) or medical power-of-attorney  
executed by a person shall be void and of no effect and shall not be binding on  
  
ion Bench of the  
  
any medical practitioner.  
12. Medical Council of India to issue Guidelines. - (1) Consistent with the  
provisions of this Act, the Medical Council of India may prepare and issue  
guidelines, from time to time for the guidance of medical practitioners in the  
matter of withholding or withdrawing of medical treatment to competent or  
incompetent patients suffering from terminal illness.  
  
(2) The Medical Council of India may review and modify the guidelines from  
time to time.  
  
(3) The guidelines and modifications thereto, if any, shall be published on  
the website and a press release may be issued to that effect.  
  
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Page 54:  
Annexure - Il  
{Peter para 5.1 of the report)  
  
‘The Medical Treatment of Terminally ill Patients  
  
(Protection of Patients and Medical Pra:  
  
fioners) Bill, 2006  
  
A Bill to provide for the protection of patients and medi  
  
practitioners fom liability ia dhe context of withholding or withdawing  
medical treatment including life support systems fiom patients who are  
(cruinally ill  
  
Be it enacted in the Fifty Seventh Year of the Republic of India as follows:  
  
1. Short title, extent and commencement: (1) This Act may be called the  
  
‘Medical Iveatment of Yecminally ill Patients (Protection of Patients anc  
‘Medics! Pretitioners) Act, 2006.  
  
(2) It extends to the whole of India except the State of Jammu anc  
Kashunir.  
  
(3) It shall come into foree on such date as the Central Govermmen  
may, by notification in the Official Gazette, appoint.  
  
2. Definitions: unless ihe context otherwise requires,  
  
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Page 55:  
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(a) ‘advance medical directive’ (called living will) means a directive  
given by a person that he of she, as the case may be, shall or shall not b=  
aiven medical weatment in furure when he or she becomes terminally ill  
  
(b) “best nterests" include the best mterests of a patient  
(@ who is en incompetent patient, or  
(di) who is a competent patient but who has not taken an informed  
decision, and  
are not limited to medical interests of the patient but include ethical,  
  
social, moral, emotional aud oiler welfare considerations  
  
competent patient” smems a patient! who is nol an incompetent  
  
patient,  
  
(‘incompetent patient” means # patient who is = minor or person of  
ansound mind or @ patient who is nnable to  
  
understand the information relevant to an informed decision  
  
about his or her medical treatment;  
retein that information;  
use or weizh that information as part of the process of making  
  
his or er informed decision:  
  
(iv) make an informed decision because of impairment of or a  
  
disturbance in the fimetioning of his or her mind er brain: or  
(%) — communicare his oF her informed decision (whether by speech,  
sign, language or any other mode) as to medical treatment  
  
  
Page 56:  
(e)  
  
(g)  
  
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‘informed decision’ means the decision as to continuance or  
withholding or withdrawing medicel treatment taken by a patient who.  
is competent and who is, or hes been informed about  
  
(the neture of his or her illness,  
  
Gi) any altemative form of treatment thet may be available,  
  
ii) the consequences of those forms of treatment, and  
  
(iv) the consequences of remaining untreated.  
  
“Medical Council of India’ means the Medical Council of India  
‘constituted under the Indian Medical Council Act, 1956 (102 of  
1956).  
  
‘medical practitioner’ means a medical practitioner who possesses  
any recognized medical qualification as defined in clause (h) of  
section 2 of the Indian Medical Council Act, 1956 (102 of 1946) and  
who is enrolled on a State Medical Register as defined in clause (k) of  
that section.  
  
“medical power-of-attorney” means 2 document executed by a person  
delegating to another person (called a siurogate), the authority to take  
decisions in fi  
  
ure as to medical treatment which has to be given or  
not to be given to him or her if he or she becomes terminally ill and  
  
becomes an incompetent patient  
  
‘medical treatment’ means ‘reatment intended to sustain, restore or  
  
replace vital functions which, when applied to a patient suffering  
  
  
Page 57:  
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from terminal illness, would serve only to prolong the process of  
dying and includes  
  
(life-sustaining treatment by way of surgical operation or the  
administration of medicine or the carrying out of any other medical  
procedure and  
  
(ii) use of mechanical or artificial means such as ventilation,  
artificial nutrition and hydration and cardiopulmonary resuscitation,  
  
() ‘minor’ means a person who, under the provisions of an Indian  
Majority Act, 1875 (4 of 1875) is to be deemed not to have attained  
  
majority.  
  
(&) ‘palliative care” includes  
(i) the provision of reasonable medical and nursing procedures for  
the relief of physical pain, suffering, discomfort or emotional and  
psycho-social suffering.  
ii) the reasonable provision for food and water.  
  
(1) “Patient” means a patient who is suffering from terminal illness  
  
(mm) ‘terminal illness’ means  
(such illness, injury or degeneration of physical or mental  
condition which is causing extreme pain and suffering to the patients  
and which, according to reasonable medical opinion, will inevitably  
cause the untimely death of the patient concerned, or  
  
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Page 58:  
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3)  
  
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Gi) which has caused a persistent and imeversible vegetative  
condition under which no meaningful existence of life is possible for  
  
the patient.  
  
Refusal of medical teatment by a competent patient and its binding  
nature on medical practitioners:  
  
Every competent patient has aright to take a decision  
( for withholding or withdrawing of medical treatment to himself or  
herself and to allow nature to take its own course, ot  
Gi) for starting or continuing medical treatment to himself or herself  
When a patient referred to in subsection (1) communicates his or her  
decision to the medical practitioner, such decision is binding on the  
medical practitioner  
  
Provided that the medical practitioner is satisfied that the  
patient is a competent patient and that the patient has taken an  
informed decision based upon a free exercise of his or her free will  
  
Advance Medical Directives as to medical treatment and Medical  
wer of Attorney to be void and not bind dical practit  
  
Every advance medical directive (called living will) or medical  
  
power-of-attomey executed by a person shall be void and of no effect and  
  
shall not be binding on any medical practitioner.  
  
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Page 59:  
withdraw:  
  
ractitioner in relation to a competent patient who has not taken an  
  
(Q) Subject to compliance of the provisions of section 6, a medical  
practitioner may take a decision to withhold or withdraw medical  
treatment  
  
(a) fiom a competent patient who has not taken an informed  
decision, o  
  
(b) from an incompetent patient  
  
provided that the medical practitioner is of the opinion that the  
  
medical treatment has to be withheld or withdrawn in the best  
  
interests of the patient.  
(2) The medical practitioner shall, while taking a decision under  
subsection (1),  
  
(a)adhere to such guidelines as might have been issued by the  
Medical Council of India under section 14 in relation to the  
circumstances under which medical treatment to a patient in  
respect of the particular illness could be withheld or  
withdrawm, and  
  
(b)consult the parents or relatives (if any) of the patient but  
  
shall not be bound by their views.  
  
urposes of section 5:  
  
(2) No decision to withhold or withdraw medical treatment in  
  
respect of patients referred to in section 5 shall be taken by any  
  
  
Page 60:  
medical practitioner inless such medical practitioner has consulted  
and obtained the opinion in writing of thrae medical praettionses  
selected by him fiom the panel of medical experts referred to in  
section 7, who are experts in relation to the illness of the patient and  
uuiless the musjorty opinion of the experts is iu favour of withholding  
or withdrawing the medical treatment.  
  
2) Whee Whee is difereuce in the upiniow of the duce medivel  
‘experts, the majority opinion shall prevail  
  
Authority to prepare panel of medical experts for purposes of section  
6  
  
(1) The Director Generel of Health Services, Central Government  
and the Director of Medical Services (or officer holdimg equivalent  
  
post) in each State shall, prepare 2 panel of medical experts for  
purposes oF scetion 6  
  
(2) The panels referred (o ins subsection (1) shall include medical  
experts in varions branches of medicine, surgery and critica! care  
medicine,  
  
(3) The medical experts refered to in subscetion (1) shall. be  
experts with not less nan (wenly years experience.  
  
(4) While emponetting medical experts on the panels, the  
authorities mentioned in subsection (1) stall keep im vind the  
repmtation of the expert and shall exchicle from the panel, experts  
against whom disciplinary proceedings are pending with the State  
Medical Conneil concemed or the Medical Council of India end those  
  
experts who have bea found guilty of professional misconduct,  
  
  
Page 61:  
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(5) The panels prepared under subsection (1) shall be published in  
the Official Gazette of the Central Govenaneut or the OMfcial Gazette  
of the State, as the case may be, and on the respective websites of the  
said euthoritics and the panels may be reviewed and modified by the  
authorities specified in subsection (1) ftom time to time and such  
‘modifications shall also be published in the Gazettes as aforesaid, or  
on the websites, as the case may be.  
  
(6) The relevant pane! for selection of experts will be the panel for  
the State or Union Yerritory in which the medical treatment is being  
given or is proposed or is proposed to be withheld or withdrawn,  
  
8. Medical Practitioner to maintain register and inform patient, parents  
ste:  
  
(1) The medical practitioner who is bound to follow the decision of a  
compeleut patient given under section 3 or who kes a decision umuder  
section 5, shall maintain a record in a register as to why he is satisfied that  
(a) the patient is competent or incompetent:  
(b) the competent patient has or has not taken an informed decision  
about withholding or withdrawing or starting or coutinmmee of  
medical treatment:  
(©) the best interests of an incompetent paticnt or of a competent  
patient who has not taken an informed decision, require medical  
ureaunent ty be withheld or withdrawu: aud  
shall uiaintain record of age, sex, address and other perticulars of the  
patient and as to the expert advice received by him under section 6  
  
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Page 62:  
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from the three experts selected by him out of the panel referred to in  
section 7.  
  
Before withholding or withdrawing medical treatment under see 5,  
the medical practitioner shall inform in writing the patient (if he is  
conscious), his parents or other relatives or guardian about the  
decision to withhold or withdraw stich treatment in the patient's best  
interests  
  
‘Where the patient, parents or relatives stated in subsection (2) inform  
‘the medical practitioner of their intention to move the High Court  
under sec 14, the medical practitioner shall postpone such  
withholding or withdrawal by fifteen days and if no orders are  
received fiom the High within that period, he may proceed with the  
  
withholding or withdrawing of the medical teatuueut,  
  
A photocopy of the pages in the register with regard to each such  
paticnt shall be lodged immediately, as a matter of information, on the  
same date, with the Durector General of Health Services of the  
Director of Medical Services of the Union Territory or State, as the  
‘ease may be, in which the medical treatment is being given or is  
proposed or is proposed to be withheld or withdrawn and  
acknowledgement obtained and the contents of the register shall be  
kept confidential by the medical practitioner and not revealed to the  
public or medi,  
  
The authorities referred to in subsection (2) shall on receipt of such,  
  
photo copies, maintain the said photocopies in a register in the offices of the  
  
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Page 63:  
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said authorities and shall keep the information confidential and shall not  
reveal the seame (o the public or the media,  
  
(©) The said Authorities may make Rules for the purposes of sections 7  
aud 8 and publish the suid Rules an Uke appropriate Gazelie or ou their  
  
websites,  
  
Even though medical treatment has been withheld or withdrawn by  
the medical practitioner in the case of competent patients and incompetent  
patients in accordance with the provisions of sections 3, $ end 6, such  
  
medical practitioner is not deberred from administering pelliative care  
  
10, Protection of competent patients trom criminal action in certain  
carcumstances:  
  
Where a competent patient refuses auedicel eaameut in  
Cincwustances mentioned in section 3, notwithstanding euything contained  
in the Indien Penal Code (45 of 1860), such a paticut shall be deemed to be  
hot guilty of any offence under that Code or under any other law for the  
time being in force.  
  
| practitioners and others acting under their  
dizection. in relation to competent and incompetent patients:  
  
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430  
  
Where a medical practitioner or any other person acting under the  
éircetion of the medical practitioner withholds or withdraws medical  
‘veatment,  
  
(a) in respect of a competent patient, on the basis of the informed  
decision of such patient conumunicated to the medical practitioner  
for such withholding or withdrawal, or  
  
(0) G@ in respect of a competent patient who has not taken an  
informed decision, ot  
(i) im respect of an incompetent patieul,  
  
and the medical practitioner takes a decision in the hest interests of  
  
the pationt for withholding or withdrawal of such treatment,  
  
such action of the medical practitioner or those acting under his direction,  
aud of the hospital coucermed, shall be deemed (o be lawful, provided ouly  
Where the medical practitioner has complied with the of sections 5, 6 and 8  
  
12. Enabling provision for seeking declaratory relief before a Division  
  
Bench of the High Court:  
  
(2) Any patient or iis or her parents or his or Ler relatives or ext  
friend may move an original petition before a Division Bench  
of the Tigh Court sccking a declaration that any act or  
‘omission or proposed act or omission by the medical  
practitioner or a hospital in respect of withholding or  
withdrawing medical treatment fiom a patient is lawful ot  
unlawiul and secking such mtcrim or final directions from the  
  
said Court es they may deem fit.  
  
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(2)  
  
co)  
  
(6)  
  
4a  
  
Explanation: “High Court’ in this section and section 13 means  
the High Court within whose temitorial jurisdiction te  
treatment is being given or is proposed or proposed to be  
withheld or withdrawn.  
  
Any snedical practitioner or a hospital may move an original  
petition before # Division Beuch of the High Count seeking a  
declaration that any act or omission or proposed act or  
omission by the medical practitioner or the hospital in respect  
of withholding or withdrawing medical weament fiom a  
patient is lawful and seek such interim or final directions from  
the said Court as he or it may deem fit.  
  
The Division Bench of the High Court may. wherever it deems  
it necessary, appoint an amicus curiae to assist te Court and  
where a patient is umrepresented, direct legal aid 1 be provided  
to such patients.  
  
The Division Beach of the High Court shall dispose of such  
  
petitions in the  
the patient if he or she is competent or hearing his or her  
parents or relatives or next fiend or guardian-ad-litem, the  
  
ight Of the provisions of this Act, after Learing  
  
medical practitioners or he hospital authorities ueating we  
patient and the amicus curiae, if any, and after receiving.  
Wherever necessary or appropriate, such further evidence of  
witnesses including expert medical practitioners.  
  
Such original petitions shall be disposed of expeditionsly and,  
al any rate, within a period of thitty days frour the date of filing  
of the original petition.  
  
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432  
  
(6) Where the High Court is of the view that interim or final  
directions have to be passed and implemented urgently, it may  
pass such operational orders initially and follow up the same by  
giving its reasons therefor, soon thereafter.  
  
(7) Any declarations or final directions given by the Division  
Bench of the High Court in a petition filed under subsection (1)  
or (2) shall be binding in all other actions civil or criminal  
against the medical practitioner or the hospital, in relation to  
the said act or omission of the medical practitioner or the  
hospital, in relation to the said patient.  
  
(8) Recourse to the High Court for a declaratory relief and for  
directions under this section is not a condition precedent for  
withholding or withdrawing medical treatment if such  
withdrawal or withholding is done in accordance with the  
provisions of this Act.  
  
13. Confidentiality for purposes of sections 12 and 13:  
  
(Gi) The Division Bench of the High Court shall, whenever a petition  
under section 12 is filed, direct that the identity of the patient and of  
his or her parents, the identity of the medical practitioner and  
hospitals, the identity of the medical experts, referred to in section 6.  
or of other experts or witnesses consulted by the Court or who have  
given evidence in the Court, shall, during the pendency of the  
petition, and after its disposal, be kept confidential and shall be  
referred only by the English alphabets as stated in clause (ii)  
  
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Gi)\_\_As soon as the original petition is filed, the Division Bench of the  
High Court shall make an order choosing English alphabets for  
identifying the patient, parents, doctors, hospitals or experts or other  
witnesses referred to in sub clause (i) or other persons connected with  
the medical treatment and shall direct that in the further proceedings  
of the Court or in any publications in the law reports or in the print or  
electronic media or audio-visual media, during and after disposal of  
the petition, those alphabets alone shall be used to refer to the  
particular patient, person or hospital and that the identity of the  
patient, person or hospital shall not be disclosed and the High Court  
may, where necessary, hold all or any part of the hearing in camera.  
  
(ii) It shall not be lawful for any person or body to refer to the identity of  
the patient, person or hospital or other particulars or matters referred  
to in sub clause (i) and (ii) in any law-report or publication in the  
print or clectronic or audio-visual media, and the alphabets  
designated by the Division Bench of the High Court under subsection  
(2) alone shall be referred to while publishing the proceedings of the  
Court, during the pendency of the petition and after its disposal.  
  
Civ) \_ Any person or body acting in violation of the provisions of sub clause  
ii) may be held liable for contempt of Court for violation of the  
orders of Court under sub clause (ii) and be dealt with accordingly.  
  
(v) Notwithstanding the provision of clauses (ji) to (iv), when the  
declarations or directions given by the High Court have to be  
communicated to the patient, parents, medical practitioner, hospital or  
  
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experts coucerned, it shall be pennissible to refer to the ue ideut  
  
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of the paticat, persons or hospital and such communications shall be  
made in secled covers to be delivered to these addresses so that the  
declarations or directions made by the High Court are understood and  
implemented as being with reference to the porticular patient,  
  
‘The High Court may make Rules of Procedure for the implementation  
  
of provisions of section 12 and this section.  
  
No person or body including media shall. in cases which have not  
  
h Court under subsection (1). publish the names of the  
  
patients or other information which mey disclose the identity of the patient,  
relatives, doctor, hospital or experts and if these provisions are violated,  
nay be proceeded against by way of a civil or criminal action in accordance  
with law.  
  
14,  
  
‘Medical Council of India to isste Guidelines:  
  
} Consistent with the provisions of this Act, the Medical Council  
of India sholl prepare anc issue guidelines, from time to time for the  
guidance of medical practitioners in the matter of withholding or  
withdrawing of medical teatment to competent or incompetent  
patients suffering from terminal illness,  
  
(2) While preparing such guidelines, the Medical Council of India  
may consult medical experts or bodies consisting of medical  
practitioners who have expertise in relation to withholding or  
  
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withdrawing medical treatment to patients or experts or bodies having  
  
experience in critical care medicine,  
  
(3) The Medical Council of India may review and modify the  
guidelines Grom tine to time  
  
(4) The guidelines and modifications thereto, if any. shell be  
  
Published in the Official Gazette of India and on ils website.  
  
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