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Passive Euthanasia – A Relook

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11 August, 2012

Dear Minister Salman Khurshid ji,

By the D.O. letter No.17(9)/2011-LI-1251 dated 20.04.2011, addressed by the then Law Minister, the Law Commission has been asked "to give its considered report on the feasibility of making legislation on euthanasia, taking into account the earlier 196th Report of the Law Commission". This letter has been addressed in the aftermath of the judgment of the Supreme Court in *Aruna Ramachandra Shanbaug* (2011) 4 SCC 454. The Supreme Court laid down the law on the subject of passive euthanasia in relation to incompetent patients such as patients in Persistent Vegetative State or irreversible coma or of unsound mind and then observed at paragraph 124: "*Following the technique used in Vishakha's case (1997) 6 SCC 241, we are laying down the law in this connection which will continue to be the law until Parliament makes a law on the subject.*" The same observation was reiterated in paragraph 135 of the said judgment. The Supreme Court put its seal of approval on passive euthanasia, i.e., withdrawing life-sustaining measures subject to the safeguard that in respect of an incompetent patient, the permission of the High Court has to be obtained. The procedure to be followed by the High Court has been laid down. The High Court should seek the opinion of a Committee of three medical experts and also put on notice the close relations and in their absence, the next friend of the patient and the State. The role of the High Court has been described to be that of '*parens patriae*'.

2. The Law Commission is in agreement with the view expressed by the previous Law Commission and the Supreme Court that Passive euthanasia should be allowed subject to certain safeguards. It is felt that on humanitarian considerations and also for providing protection to the doctors who genuinely act in the best interests of terminally ill patients, the law proposed is considered necessary. As regards the safeguards, the Law Commission has substantially endorsed the views of the Supreme Court. However, in regard to preparation and composition of panel of medical experts, we have fallen in line with the suggestion made by the 17th Law Commission in 196th Report.

3. In the 196th Report, the 17th Law Commission while supporting passive euthanasia, i.e. withdrawal of life-supporting measures to dying patients (which is different from euthanasia and assisted suicide), drew up a Bill entitled "The Medical Treatment of Terminally-ill Patients (Protection of Patients and Medical Practitioners) Bill 2006". The safeguards to be observed by the attending doctors before withdrawing the life-support systems have been suggested by the Commission. As far as a competent patient is concerned, the Commission observed that he / she has a right to take the decision for withdrawing from continued medical treatment and the said decision is binding on the doctor and he cannot force life-support systems on an unwilling patient. The Supreme Court also made it clear that in India, if a person consciously and voluntarily refuses to take life saving medical treatment, it is not a crime. The discussion in Aruna's case centered round non-voluntary passive euthanasia which is applicable to a patient who is not in a position to decide for herself, i.e., if she is in coma or PVS and the like. Both the Supreme Court and the Law Commission (196th Report) relied on and extensively quoted the opinions of House of Lords in the case of *Airedale* in which the primacy was given to the 'best interests' test. We have given supplemental reasons in justification of passive euthanasia especially from the point of view of Article 21 of the Constitution.

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4. I may mention here that the main difference between the recommendations of the Law Commission (in 196th 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 recommendation, the attending medical practitioner will have to obtain the expert 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 relations, medical practitioner etc. to approach the High Court for an appropriate declaratory relief. 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 High Court's approval will be a condition precedent for stopping the life supporting measures.

5. Accordingly, changes have been made in the Medical Treatment of Terminally-ill Patients (Protection of Patients and Medical Practitioners) Bill drafted by the 17th Law Commission in the year 2006. The Bill has been recast as indicated in paras 13.1 to 13.7 of the Report. The summary of recommendations are at para 14. The revised draft Bill is at Annexure-1. The Commission considers it desirable to enact a law on the lines suggested by the Commission at the earliest so that the uncertainty may be removed and the procedure prescribed by the Supreme Court may be refined.

With regards and good wishes,

SD/-
(P.V. Reddi)

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PASSIVE EUTHANASIA – A RELOOK

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Passive Euthanasia - A relook

1. Introduction

1.1 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 17th Century by Francis Bacon to refer to an easy, painless and happy death for which it was the physician's duty and responsibility to alleviate the physical suffering of the body of the patient. The House of Lords Select Committee on 'Medical Ethics' in England defined Euthanasia as "a deliberate intervention undertaken with the express 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 is 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*¹. 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

¹ (2011) 4 SCC 454

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)². **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.g., 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's 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 so". 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*³, 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:

² *Ibid* at 481

³ *Airedale NHS Trust vs. Bland* (1993)1 All ER 821.

“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 196th Report

2.1 The Law Commission of India, in its 196th Report⁴, had in its opening remarks clarified in unmistakable terms that the Commission was not dealing with “euthanasia” or “assisted suicide” which are unlawful but the 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”.

2.2 The 17th 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

⁴ Medical Treatment to Terminally Ill Patients (Protection of Patients and Medical Practitioners).

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:

"A 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."

2.5 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 196th 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

the Patient (if conscious) and other close relatives. Then he shall wait for 15 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 law 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

4.1 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

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 196th 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 196th 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

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 196th 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 17th Law Commission and its features

5.1 We shall start our discussion by taking an overview of the Law Commission's 196th Report and the main features of legislation suggested by the Law Commission under the title - "**Medical Treatment to Terminally ill Patients (Protection of Patients and Medical Practitioners) Bill 2006**" (*vide Annexure - II*). At the risk of repetition, we may mention that the main difference between the recommendations of the Law Commission (in 196th 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 196th 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

is binding on the doctor, “provided that the decision of the patient is an ‘informed decision’ ”. ‘**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 the administration of medicine etc. and use of mechanical or artificial means such as ventilation, artificial nutrition and cardio resuscitation. The 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, (iii) the consequences of those forms of treatment, and (iv) the consequences of remaining untreated”.

5.3 At this juncture, we may mention that this terminology – ‘**informed decision**’ has been borrowed from the decided cases in England (UK) and

other countries. It broadly means that the lack of capacity to decide (in spite 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 196th Report. In Re: **MB (Medical Treatment)**⁵ – a Court of appeal decision rendered by Butler Sloss L.J., 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)⁶. 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**

⁵ 1997 (2) FLR 426

⁶ 1990 (2) AC 1

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 L.J. laid down *inter alia* the following propositions on the capacity of a woman to decide in the context of caesarian cases:

"A 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 to 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 a 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 L.J. The definition of 'informed decision' given in the 196th Report of Law Commission of India is almost on the same lines as what Butler Sloss L.J. 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 IPC) or 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

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*⁷ - a test reiterated in *Jacob Mathew's case*⁸ 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 8 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 VII, 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 582

⁸ (2006) 5 SCC 472

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 [(2011) 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 life 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 out 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. It 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-*

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)*⁹, 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 (1990) 3 All ER 930

extensively to *Cruzan's case*¹⁰ , 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 case*¹¹ , 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 e.g. 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 to inherit or otherwise grab property of the patient*".

¹⁰ 497 US 261

¹¹ (1996) 2 SCC 648

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 Vishaka¹² case, we are laying down the law in this connection which will continue to be the law until Parliament makes a law on the subject¹³:*

- (i) *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.

- (ii) *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.*

¹² Cause title & citation to be given

¹³ Underlining ours

In our opinion, this is even more necessary in our country as we cannot rule 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 to 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 it is 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 life 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*

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 etc. of the patient, and in their absence his/her next friend, and supply a 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 she/she been competent, or to act in the patient's best interest.

2. *Beneficence 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 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 Goff 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 I 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: *"It is 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*

should die. The question is whether it is 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 it is 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 it is not in his best interests to 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 patient's life. Common humanity requires otherwise, as do medical ethics and good medical practice accepted in this country and overseas. As I 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 to abbreviate the patient's 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*

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 17th 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.

If 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*¹⁴ 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

¹⁴ supra, note 11

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 his ordinary senses and prudence could have done or failed to do the thing which was attributed to the accused doctor.

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 196th 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 (4th 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 Das¹⁵, various view points have been discussed and vast literature on the subject including end – of – life care has

¹⁵ an LLM student at Symbiosis Law School, Pune, who has been guided by Dr. Shashikala Gurupur, Director of Law School & Member(P.T.) of Law Commission; sayandas@symlaw.ac.in

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 considerations¹⁶. 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 euthanasia should be legalized.

¹⁶ See p. 482 of SCC in *Aruna Shaunbaug's case, supra*.

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 quoted¹⁷:

“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 210th 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 42nd 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.”

¹⁷ V. R. Jaydevan, *“Right of the Alive [who] but has no Life at all – Crossing the Rubicon from Suicide to Active Euthanasia”* (2011) 53 JILI 437 at 471.

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 euthanasia, would logically get strengthened. There would then be no Section in any penal statute to regard it as a crime. However, we need not go 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 196th 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

¹⁸ Development in Law – Medical Technology and the Law (1993) 103 HLR 1519 at 1651-25.

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 euthanasia – 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 196th report) would furnish an answer to the above question in clearest terms to the effect that legally and constitutionally, the patient (competent) has a 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

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 Cardozo¹⁹, "*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 Goff 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 196th 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

¹⁹ In 211 NY 125, (1914)

(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, i.e., 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. 21? 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 L.J. in *Airdale case*²⁰, 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".

²⁰ supra, note 3

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 Belhcetown State School vs. Saikewicz*²¹ pertinently observed:

“To 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 no condition to indicate, if that was his wish, that he did not consent to it”*.

11.9 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

²¹ 370 NE 2d 417 (1977)

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.21.

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. Illinois*²² 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

²² (1877) 94 US 113 at 142

Supreme Court in *Maneka Gandhi's case*²³ 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 I.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.g., 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 196th 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*

²³ AIR 1978 SC 597

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 enjoined 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

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 pain-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 Schemes extending palliative care to terminally ill patients undergoing grave suffering and pain.** The palliative care seems to be a neglected area at 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

13.1 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

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 2nd 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'.
- (ii) 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.

- (iii) Sub-sections (3) 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.

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 not quite appropriate. After clause (c) of Sub-section (1), the words "*as to 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

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 opinion of three expert medical practitioners whose names are found in the panel prepared under Section 4 or 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 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

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 196th 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 196th 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 17th 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

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 196th 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

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 196th 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 it is 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 - I**.

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 17th Law Commission of India and as held by the Supreme Court in *Aruna*

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 invasive medical treatment by way of artificial 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 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 196th 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 17th Law Commission. Advance medical directive given by the patient before his illness is not valid.

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 17th Law Commission in the 196th 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. Reddi]
Chairman

[Justice (Retd.) Shiv Kumar Sharma]
Member

[Amarjit Singh]
Member

New Delhi
11 August 2012

**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) It extends 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

(ii) 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 and other welfare considerations.

(c) ‘competent patient’ means a patient who is not an incompetent patient.

(d) ‘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;

- (ii) retain that information;
 - (iii) use or weigh that information as part of the process of making his 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.
- (e) '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,
 - (iii) the consequences of those forms of treatment, and
 - (iv) the consequences of remaining untreated.
- (f) 'Medical Council of India' means the Medical Council of India constituted under the Indian Medical Council Act, 1956 (102 of 1956).
- (g) '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.
- (h) '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.
- (i) '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

- (ii) use of mechanical or artificial means such as ventilation, artificial nutrition and hydration and cardiopulmonary resuscitation.
- (j) '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.
- (l) 'Patient' means a patient who is suffering from terminal illness.
- (m) 'terminal illness' means –
 - (i) 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
 - (ii) which has caused a persistent and irreversible vegetative condition under which no meaningful existence of life is possible for the 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 himself.
- (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,

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

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 be 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

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.

10. Confidentiality for purposes of section 9. – The Division Bench of the 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 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.

**The Medical Treatment of Terminally ill Patients
(Protection of Patients and Medical Practitioners) Bill, 2006**

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 Fifty Seventh 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, 2006.

(2) It extends to the whole of India except the State of Jammu and 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
 - (ii) 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 and other welfare considerations.
- (c) 'competent patient' means a patient who is not an incompetent patient.
- (d) 'incompetent patient' means a patient who is a minor 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;
 - (ii) retain that information;
 - (iii) use or weigh that information as part of the process of making his 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.

- (e) '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,
 - (iii) the consequences of those forms of treatment, and
 - (iv) the consequences of remaining untreated.

- (f) 'Medical Council of India' means the Medical Council of India constituted under the Indian Medical Council Act, 1956 (102 of 1956).

- (g) '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.

- (h) 'medical power-of-attorney' means a document executed by a person delegating to another person (called a surrogate), the authority to take 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.

- (i) '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 of 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
 - (ii) use of mechanical or artificial means such as ventilation, artificial nutrition and hydration and cardiopulmonary resuscitation.
- (j) '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.
- (l) 'Patient' means a patient who is suffering from terminal illness.
- (m) 'terminal illness' means
- (i) 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

(ii) which has caused a persistent and irreversible vegetative condition under which no meaningful existence of life is possible for the patient.

3. Refusal of medical treatment by a competent patient and its binding nature on medical practitioners:

- (1) Every competent patient has a right to take a decision
 - (i) for withholding or withdrawing of medical treatment to himself or herself and to allow nature to take its own course, or
 - (ii) for starting or continuing medical treatment to himself or herself.
- (2) 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.

4. Advance Medical Directives as to medical treatment and Medical Power of Attorney to be void and not binding on medical practitioner:

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 any medical practitioner.

5. Withholding or withdrawing of medical treatment by medical practitioner in relation to a competent patient who has not taken an informed decision and in relation to an incompetent patient:

(1) Subject to compliance of the provisions of section 6, a medical practitioner may take a decision to withhold or withdraw medical treatment

(a) from a competent patient who has not taken an informed decision, or

(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 withdrawn, and

(b) consult the parents or relatives (if any) of the patient but shall not be bound by their views.

6. Expert medical opinion to be obtained by medical practitioner for purposes of section 5:

(1) No decision to withhold or withdraw medical treatment in respect of patients referred to in section 5 shall be taken by any

medical practitioner unless such medical practitioner has consulted and obtained the opinion in writing of three medical practitioners selected by him from the panel of medical experts referred to in section 7, who are experts in relation to the illness of the patient and unless the majority opinion of the experts is in favour of withholding or withdrawing the medical treatment.

(2) Where there is difference in the opinion of the three medical experts, the majority opinion shall prevail.

7. Authority to prepare panel of medical experts for purposes of section 6:

(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 section 6.

(2) The panels referred to in subsection (1) shall include medical experts in various branches of medicine, surgery and critical care medicine.

(3) The medical experts referred to in subsection (1) shall be experts with not less than twenty years experience.

(4) While empanelling medical experts on the panels, the authorities mentioned in subsection (1) shall keep in mind the reputation of the expert and shall exclude from the panel, experts against whom disciplinary proceedings are pending with the State Medical Council concerned or the Medical Council of India and those experts who have been found guilty of professional misconduct.

(5) The panels prepared under subsection (1) shall be published in the Official Gazette of the Central Government or the Official Gazette of the State, as the case may be, and on the respective websites of the said authorities and the panels may be reviewed and modified by the authorities specified in subsection (1) from 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 panel for selection of experts will be the panel for the State or Union Territory 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 etc:

(1) The medical practitioner who is bound to follow the decision of a competent patient given under section 3 or who takes a decision under 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 continuance of medical treatment;

(c) the best interests of an incompetent patient or of a competent patient who has not taken an informed decision, require medical treatment to be withheld or withdrawn; and

shall maintain record of age, sex, address and other particulars of the patient and as to the expert advice received by him under section 6

- from the three experts selected by him out of the panel referred to in section 7.
- (2) Before withholding or withdrawing medical treatment under sec 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 such treatment in the patient's best interests.
 - (3) 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 from the High within that period, he may proceed with the withholding or withdrawing of the medical treatment.
 - (4) A photocopy of the pages in the register with regard to each such patient shall be lodged immediately, as a matter of information, on the same date, with the Director General of Health Services or the Director of Medical Services of the Union Territory or State, as the case 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 media.
 - (5) 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

said authorities and shall keep the information confidential and shall not reveal the same to the public or the media.

- (6) The said Authorities may make Rules for the purposes of sections 7 and 8 and publish the said Rules in the appropriate Gazette or on their websites.

9. 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 provisions of sections 3, 5 and 6, such medical practitioner is not debarred from administering palliative care.

10. 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.

11. Protection of medical practitioners and others acting under their direction, in relation to competent and incompetent patients:

Where a medical practitioner or any other person acting under the direction of the medical practitioner withholds or withdraws medical treatment,

(a) in respect of a competent patient, on the basis of the informed decision of such patient communicated to the medical practitioner for such withholding or withdrawal, or

(b) (i) in respect of a competent patient who has not taken an informed decision, or

(ii) in respect of an incompetent patient,

and the medical practitioner takes a decision in the best interests of the patient for withholding or withdrawal of such treatment,

such action of the medical practitioner or those acting under his direction, and of the hospital concerned, shall be deemed to be lawful, provided only 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:

(1) Any patient or his or her parents or his or her relatives or next friend may move an original petition before a Division Bench of the High Court seeking 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 from a patient is lawful or unlawful and seeking such interim or final directions from the said Court as they may deem fit.

Explanation: 'High Court' in this section and section 13 means the High Court within whose territorial jurisdiction the treatment is being given or is proposed or proposed to be withheld or withdrawn.

- (2) Any medical practitioner or a hospital may move an original petition before a Division Bench of the High Court 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 treatment from a patient is lawful and seek such interim or final directions from the said Court as he or it may deem fit.
- (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 patients.
- (4) The Division Bench of the High Court shall dispose of such petitions in the light of the provisions of this Act, after hearing the patient if he or she is competent or hearing his or her parents or relatives or next friend or guardian-ad-litem, the medical practitioners or the hospital authorities treating the patient and the amicus curiae, if any, and after receiving, wherever necessary or appropriate, such further evidence of witnesses including expert medical practitioners.
- (5) Such original petitions shall be disposed of expeditiously and, at any rate, within a period of thirty days from the date of filing of the original petition.

- (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:

- (1)(i) 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)..

- (ii) 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.
- (iii) 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 electronic 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.
- (iv) Any person or body acting in violation of the provisions of sub clause (iii) 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 (i) to (iv), when the declarations or directions given by the High Court have to be communicated to the patient, parents, medical practitioner, hospital or

experts concerned, it shall be permissible to refer to the true identity of the patient, persons or hospital and such communications shall be made in sealed 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 particular patient.

(vi) The High Court may make Rules of Procedure for the implementation of provisions of section 12 and this section.

(2) No person or body including media shall, in cases which have not gone to the High Court under subsection (1), publish the names of the patients or other information which may disclose the identity of the patient, relatives, doctor, hospital or experts and if these provisions are violated, may be proceeded against by way of a civil or criminal action in accordance with law.

14. Medical Council of India to issue Guidelines:

(1) Consistent with the provisions of this Act, the Medical Council of India shall 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) 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

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 from time to time.

(4) The guidelines and modifications thereto, if any, shall be published in the Official Gazette of India and on its website.

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