REPORTABLE

ITEM NO.1A COURT NO.6 SECTION X

S U P R E M E C O U R T O F I N D I A
RECORD OF PROCEEDINGS

WRIT PETITION (CRL.) NO(s). 115 OF 2009

ARUNA RAMCHANDRA SHANBAUG Petitioner(s)

VERSUS

UNION OF INDIA & ORS. Respondent(s)
[HEARD BY HON'BLE MARKANDEY KATJU AND GYAN SUDHA MISRA, JJ.)

Date: 07/03/2011 This Writ Petition was called on for Judgment today.

Amicus Curiae Mr. G.E. Vahanvati, Attorney General(Not present)
Mr. Chinmoy P. Sharma, Adv.
Dr. Aaray Lingaiah, Adv.
Mr. Nishanth Patil, Adv.
Mr. Anoopam Prasad, Adv.
Ms. Naila Jung, Adv.
Mr. Rohit Sharma, Adv.
Mr. D.D.Kamat, Adv.
Mr. D.S.Mahra, Adv.

Amicus Curiae Mr. T.R. Andhyarujina, Sr. Adv.
Mr. Soumik Ghosal, Adv.

For Petitioner(s) Mr. Shekhar Naphade, Sr. Adv.
Ms. Shubhangi Tuli, Adv.
Ms. Divya Jain, Adv.
Mr. Vimal Chandra S. Dave,Adv.

For Respondent(s) Ms. Sunaina Dutta, Adv.
Mrs.Suchitra Atul Chitale,Adv.

Ms. Asha Gopalan Nair, Adv.

Hon'ble Mr. Justice Markandey Katju pronounced the judgment of the Bench comprising His Lordship and Hon'ble Mrs. Justice Gyan Sudha Misra.

For the reasons given in the reportable judgment which is placed on the file, the writ petition is dismissed.

(Parveen Kr.Chawla)
Court Master

(Indu Satija)
Court Master

REPORTABLE

IN THE SUPREME COURT OF INDIA

CRIMINAL ORIGINAL JURISDICTION

WRIT PETITION (CRIMINAL) NO. 115 OF 2009

Aruna Ramchandra Shanbaug .. Petitioner

-versus-

Union of India and others .. Respondents

J U D G M E N T

Markandey Katju, J.

"Marte hain aarzoo mein marne ki
Maut aati hai par nahin aati"

-- MIRZA GHALIB

1. Heard Mr. Shekhar Naphade, learned senior counsel for the petitioner, learned Attorney General for India for the Union of India Mr. Vahanvati, Mr. T. R. Andhyarujina, learned Senior Counsel, whom we had appointed as *amicus curiae,* Mr. Pallav Sisodia, learned senior counsel for the Dean, KEM Hospital, Mumbai, and Mr. Chinmay Khaldkar, learned counsel

for the State of Maharashtra.

2. Euthanasia is one of the most perplexing issues which the courts and legislatures all over the world are facing today. This Court, in this case, is facing the same issue, and we feel like a ship in an uncharted sea, seeking some guidance by the light thrown by the legislations and judicial pronouncements of foreign countries, as well as the submissions of learned counsels before us. The case before us is a writ petition under Article 32 of the Constitution, and has been filed on behalf of the petitioner Aruna Ramachandra Shanbaug by one Ms. Pinki Virani of Mumbai, claiming to be a next friend.

3. It is stated in the writ petition that the petitioner Aruna Ramachandra Shanbaug was a staff Nurse working in King Edward Memorial Hospital, Parel, Mumbai. On the evening of 27th November, 1973 she was attacked by a sweeper in the hospital who wrapped a dog chain around her neck and yanked her

back with it. He tried to rape her but finding that she was menstruating, he sodomized her. To immobilize her during this act he twisted the chain around her neck. The next day on 28th November, 1973 at 7.45 a.m. a cleaner found her lying on the floor with blood all over in an unconscious condition. It is alleged that due to strangulation by the dog chain the supply of oxygen to the brain stopped and the brain got damaged. It is alleged that the Neurologist in the Hospital found that she had plantars' extensor, which indicates damage to the cortex or some other part of the brain. She also had brain stem contusion injury with associated cervical cord injury. It is alleged at page 11 of the petition that 36 years have expired since the incident and now Aruna Ramachandra Shanbaug is about 60 years of age. She is featherweight, and her brittle bones could break if her hand or leg are awkwardly caught, even accidentally, under her lighter body. She has stopped menstruating and her skin is now like papier mache' stretched over a skeleton. She is prone to bed sores. Her wrists are

twisted inwards. Her teeth had decayed causing her immense pain. She can only be given mashed food, on which she survives. It is alleged that Aruna Ramachandra Shanbaug is in a persistent negetative state (p.v.s.) and virtually a dead person and has no state of awareness, and her brain is virtually dead. She can neither see, nor hear anything nor can she express herself or communicate, in any manner whatsoever. Mashed food is put in her mouth, she is not able to chew or taste any food. She is not even aware that food has been put in her mouth. She is not able to swallow any liquid food, which shows that the food goes down on its own and not because of any effort on her part. The process of digestion goes on in this way as the mashed food passes through her system. However, Aruna is virtually a skeleton. Her excreta and the urine is discharged on the bed itself. Once in a while she is cleaned up but in a short while again she goes back into the same sub-human condition. Judged by any parameter, Aruna cannot be said to be a living person and it is only on account of mashed food which is put into her

mouth that there is a facade of life which is totally devoid of any human element. It is alleged that there is not the slightest possibility of any improvement in her condition and her body lies on the bed in the KEM Hospital, Mumbai like a dead animal, and this has been the position for the last 36 years. The prayer of the petitioner is that the respondents be directed to stop feeding Aruna, and let her die peacefully.

4. We could have dismissed this petition on the short ground that under Article 32 of the Constitution of India (unlike Article 226) the petitioner has to prove violation of a fundamental right, and it has been held by the Constitution Bench decision of this Court in **Gian Kaur vs. State of Punjab**, 1996(2) SCC 648 (vide paragraphs 22 and 23) that the right to life guaranteed by Article 21 of the Constitution does not include the right to die. Hence the petitioner has not shown violation of any of her fundamental rights. However, in view of the importance of the issues involved we decided

to go deeper into the merits of the case.

5. Notice had been issued by this Court on 16.12.2009 to all the respondents in this petition. A counter affidavit was earlier filed on behalf of the respondent nos.3 and 4, the Mumbai Municipal Corporation and the Dean, KEM Hospital by Dr. Amar Ramaji Pazare, Professor and Head in the said hospital, stating in paragraph 6 that Aruna accepts the food in normal course and responds by facial expressions. She responds to commands intermittently by making sounds. She makes sounds when she has to pass stool and urine which the nursing staff identifies and attends to by leading her to the toilet. Thus, there was some variance between the allegations in the writ petition and the counter affidavit of Dr. Pazare.

6. Since there was some variance in the allegation in the writ petition and the counter affidavit of Dr. Pazare, we, by our order dated 24 January, 2011 appointed a team of three very distinguished doctors

of Mumbai to examine Aruna Shanbaug thoroughly and submit a report about her physical and mental condition. These three doctors were :

(1) Dr. J. V. Divatia, Professor and Head, Department of Anesthesia, Critical Care and Pain at Tata Memorial Hospital, Mumbai;

(2) Dr. Roop Gursahani, Consultant Neurologist at P.D.Hinduja, Mumbai; and

(3) Dr. Nilesh Shah, Professor and Head, Department of Psychiatry at Lokmanya Tilak Municipal Corporation Medical College and General Hospital.

7. In pursuance of our order dated 24th January, 2011, the team of three doctors above mentioned examined Aruna Shanbuag in KEM Hospital and has submitted us the following report:

" **Report of Examination of Ms. Aruna Ramachandra Shanbaug**
Jointly prepared and signed by

1. Dr. J.V. Divatia
(Professor and Head, Department of Anesthesia, Critical Care and Pain, at Tata Memorial Hospital, Mumbai)

2. Dr. Roop Gursahani
(Consultant Neurologist at P.D. Hinduja Hospital, Mumbai)

3. Dr. Nilesh Shah

(Professor and Head, Department of Psychiatry at Lokmanya Tilak Municipal Corporation Medical College and General Hospital).

I. Background

As per the request of Hon. Justice Katju and Hon. Justice Mishra of the Supreme Court of India, Ms. Aruna Ramachandra Shanbaug, a 60-year-old female patient was examined on 28th January 2011, morning and 3rd February 2011, in the side-room of ward-4, of the K. E. M. Hospital by the team of 3 doctors viz. Dr. J.V. Divatia (Professor and Head, Department of Anesthesia, Critical Care and Pain at Tata Memorial Hospital, Mumbai), Dr. Roop Gursahani (Consultant Neurologist at P.D. Hinduja Hospital, Mumbai) and Dr. Nilesh Shah (Professor and Head, Department of Psychiatry at Lokmanya Tilak Municipal Corporation Medical College and General Hospital).

This committee was set up because the Court found some variance between the allegations in the writ petition filed by Ms. Pinki Virani on behalf of Aruna Ramchandras Shanbaug and the counter affidavit of Dr. Pazare. This team of three doctors was appointed to examine Aruna Ramachandra Shanbaug thoroughly and give a report to the Court about her physical and mental condition

It was felt by the team of doctors appointed by the Supreme Court that longitudinal case history and observations of last 37 years along with findings of examination will give a better, clear and comprehensive picture of the patient's condition.

This report is based on:

1. The longitudinal case history and observations obtained from the Dean and the medical and nursing staff of K. E. M. Hospital,

2. Case records (including nursing records) since January 2010

3. Findings of the physical, neurological and mental status examinations performed by the panel.

4. Investigations performed during the course of this assessment (Blood tests, CT head, Electroencephalogram)

II. Medical history

Medical history of Ms. Aruna Ramachandra Shanbaug was obtained from the Dean, the Principal of the School of Nursing and the medical and nursing staff of ward-4 who has been looking after her.

It was learnt from the persons mentioned above that

1. Ms. Aruna Ramachandra Shanbaug was admitted in the hospital after she was assaulted and strangulated by a sweeper of the hospital on November 27, 1973.

2. Though she survived, she never fully recovered from the trauma and brain damage resulting from the assault and strangulation.

3. Since last so many years she is in the same bed in the side-room of ward-4.

4. The hospital staff has provided her an excellent nursing care since then which included feeding her by mouth, bathing her and taking care of her toilet needs. The care was of such an exceptional nature that she has not developed a single bed-sore or fracture in spite of her bed-ridden state since 1973.

5. According to the history from them, though she is not very much aware of herself and her surrounding, she somehow recognizes the presence of people around her and expresses her like or dislike by making certain types of vocal sounds and by waving her hands in certain manners. She appears to be happy and smiles when she receives her favorite food items like fish and chicken soup. She accepts feed which she likes but may spit out food which she

doesn't like. She was able to take oral feeds till 16th September 2010, when she developed a febrile illness, probably malaria. After that, her oral intake reduced and a feeding tube (Ryle's tube) was passed into her stomach via her nose. Since then she receives her major feeds by the Ryle's tube, and is only occasionally able to accept the oral liquids. Malaria has taken a toll in her physical condition but she is gradually recuperating from it.

6. Occasionally, when there are many people in the room she makes vocal sounds indicating distress. She calms down when people move out of her room. She also seems to enjoy the devotional songs and music which is played in her room and it has calming effect on her.

7. In an annual ritual, each and every batch of nursing students is introduced to Ms. Aruna Ramachandra Shanbaug, and is told that "She was one of us"; "She was a very nice and efficient staff nurse but due to the mishap she is in this bed-ridden state".

8. The entire nursing staff member and other staff members have a very compassionate attitude towards Ms. Aruna Ramachandra Shanbaug and they all very happily and willingly take care of her. They all are very proud of their achievement of taking such a good care of their bed-ridden colleague and feel very strongly that they want to continue to take care of her in the same manner till she succumbs naturally. They do not feel that Ms. Aruna Ramachandra Shanbaug is living a painful and miserable life.

III. Examination

IIIa. Physical examination

She was conscious, unable to co-operate and appeared to be unaware of her surroundings.

Her body was lean and thin. She appeared neat and clean and lay curled up in the bed with movements of the left hand and made sounds, especially when many people were present in the room.

She was afebrile, pulse rate was 80/min, regular, and good volume. Her blood pressure recorded on the nursing charts was normal. Respiratory rate was 15/min, regular, with no signs of respiratory distress or breathlessness.

There was no pallor, cyanosis, clubbing or icterus. She was edentulous (no teeth).

Skin appeared to be generally in good condition, there were no bed sores, bruises or evidence of old healed bed sores. There were no skin signs suggestive of nutritional deficiency or dehydration.

Her wrists had developed severe contractures, and were fixed in acute flexion. Both knees had also developed contractures (right more than left).

A nasogastric feeding tube (Ryle‟s tube) was in situ. She was wearing diapers.

Abdominal, respiratory and cardiovascular examination was unremarkable.

IIIb. Neurological Examination

When examined she was conscious with eyes open wakefulness but without any apparent awareness (see Table 1 for detailed assessment of awareness). From the above examination, she has evidence of intact auditory, visual, somatic and motor primary neural pathways. However no definitive evidence for awareness of auditory, visual, somatic and motor stimuli was observed during our examinations.

There was no coherent response to verbal commands or to calling her name. She did not turn her head to the direction of sounds or voices. When roused she made non-specific unintelligible sounds (“uhhh, ahhh”) loudly and continuously but was generally silent when undisturbed.

Menace reflex (blinking in response to hand movements in front of eyes) was present in both eyes and hemifields but brisker and more consistent on the left. Pupillary reaction was normal bilaterally. Fundi could not be seen since she closed her eyes tightly when this was attempted. At rest she seemed to maintain preferential gaze to the left but otherwise gaze was random and undirected (roving) though largely conjugate. Facial movements were symmetric. Gag reflex (movement of the palate in response to insertion of a tongue depressor in the throat) was present and she does not pool saliva. She could swallow both teaspoonfuls of water as well as a small quantity of mashed banana. She licked though not very completely sugar smeared on her lips, suggesting some tongue control.

She had flexion contractures of all limbs and seemed to be incapable of turning in bed spontaneously. There was what appeared to be minimal voluntary movement with the left upper limb (touching her wrist to the eye for instance, perhaps as an attempt to rub it). When examined/disturbed, she seemed to curl up even further in her flexed foetal position. Sensory examination was not possible but she did seem to find passive movement painful in all four limbs and moaned continuously during the examination. Deep tendon reflexes were difficult to elicit elsewhere but were present at the ankles. Plantars were withdrawal/extensor.

Thus neurologically she appears to be in a state of intact consciousness without awareness of self/environment. No cognitive or communication abilities could be discerned. Visual function if present is severely limited. Motor function is grossly impaired with quadriparesis.

IIIc. Mental Status Examination

1. **Consciousness, General Appearance, Attitude and Behavior** :

Ms. Aruna Ramachandra Shanbaug was resting quietly in her bed, apparently listening to the devotional music, when we entered the room. Though, her body built

is lean, she appeared to be well nourished and there were no signs of malnourishment. She appeared neat and clean. She has developed contractures at both the wrist joints and knee joints and so lied curled up in the bed with minimum restricted physical movements.

She was conscious but appeared to be unaware of herself and her surroundings. As soon as she realized the presence of some people in her room, she started making repetitive vocal sounds and moving her hands. This behavior subsided as we left the room. She did not have any involuntary movements. She did not demonstrate any catatonic, hostile or violent behavior.

Her eyes were wide open and from her behavior it appeared that she could see and hear us, as when one loudly called her name, she stopped making vocal sounds and hand movements for a while. She was unable to maintain sustained eye-to eye contact but when the hand was suddenly taken near her eyes, she was able to blink well.

When an attempt was made to feed her by mouth, she accepted a spoonful of water, some sugar and mashed banana. She also licked the sugar and banana paste sticking on her upper lips and swallowed it. Thus, at times she could cooperate when fed.

2. **Mood and affect** :

It was difficult to assess her mood as she was unable to communicate or express her feelings. She appeared to calm down when she was touched or caressed gently. She did not cry or laugh or expressed any other emotions verbally or non-verbally during the examination period. When not disturbed and observed quietly from a distance, she did not appear to be in severe pain or misery. Only when many people enter her room, she appears to get a bit disturbed about it.

3. **Speech and thoughts** :

She could make repeated vocal sounds but she could not utter or repeat any comprehensible words or follow and respond to any of the simple commands (such as "show me your tongue"). The only way she expressed herself was by making some sounds. She appeared to have minimal language comprehension or expression.

4. **Perception** :

She did not appear to be having any perceptual abnormality like hallucinations or illusions from her behavior.

5. **Orientation, memory and intellectual capacity** :

Formal assessment of orientation in time, place and person, memory of immediate, recent and remote events and her intellectual capacity could not be carried out.

6. **Insight** :

As she does not appear to be fully aware of herself and her surroundings, she is unlikely to have any insight into her illness.

IV. Reports of Investigations

IVa. CT Scan Head (Plain)

This is contaminated by movement artefacts. It shows generalized prominence of supratentorial sulci and ventricles suggestive of generalized cerebral atrophy. Brainstem and cerebellum seem normal. Ischemic foci are seen in left centrum semi-ovale and right external capsule. In addition a small left parieto-occipital cortical lesion is also seen and is probably ischemic.

IVb. EEG

The dominant feature is a moderately rhythmic alpha frequency at 8-10 Hz and 20-70 microvolts which is widely distributed and is equally prominent both anteriorly and posteriorly. It is not responsive to eye-opening as seen on the video. Beta at 18-25 Hz is also seen diffusely but more prominently anteriorly. No focal or paroxysmal abnormalities were noted

IVc. Blood

Reports of the hemoglobin, white cell count, liver function tests, renal function tests, electrolytes, thyroid function, Vitamin B12 and 1,25 dihydroxy Vit D3 levels are unremarkable. (Detailed report from KEM hospital attached.)

V. Diagnostic impression

1) From the longitudinal case history and examination it appears that Ms. Aruna Ramachandra Shanbaug has developed non-progressive but irreversible brain damage secondary to hypoxic-ischemic brain injury consistent with the known effects of strangulation. Most authorities consider a period exceeding 4 weeks in this condition, especially when due to hypoxic-ischemic injury as confirming irreversibility. In Ms. Aruna's case, this period has been as long as 37 years, making her perhaps the longest survivor in this situation.

2) She meets most of the criteria for being in a permanent vegetative state (PVS). PVS is defined as a clinical condition of unawareness (Table 1) of self and environment in which the patient breathes spontaneously, has a stable circulation and shows cycles of eye closure and opening which may simulate sleep and waking (Table 2). While she has evidence of intact auditory, visual, somatic and motor primary neural pathways, no definitive evidence for awareness of auditory, visual, somatic and motor stimuli was observed during our examinations.

VI. Prognosis

Her dementia has not progressed and has remained stable for last many years and it is likely to remain same over next many years. At present there is no treatment available for the brain damage she has sustained.

VII. Appendix

VII a. Table 1. CLINICAL ASSESSMENT TO ESTABLISH UNAWARENESS (Wade DT, Johnston C. British Med Journal 1999; 319:841-844)

DOMAIN OBSERVED	STIMULUS	RESPONSE
AUDITORY AWARENESS	Sudden loud noise (*clap*)	Startle present, ceases other movements
	Meaningful noise (*rattled steel tumbler and spoon, film songs of 1970s*)	Non-specific head and body movements
	Spoken commands (*"close your eyes", "lift left hand" in English, Marathi and Konkani*)	Unable to obey commands. No specific or reproducible response
VISUAL AWARENESS	Bright light to eyes	Pupillary responses present
	Large moving object in front of eyes (*bright red torch rattle*)	Tracking movements: present but inconsistent and poorly reproducible
	Visual threat (*fingers suddenly moved toward eyes*)	Blinks, but more consistent on left than right
	Written command (*English, Marathi: close your eyes*)	No response
SOMATIC AWARENESS	Painful stimuli to limbs (*light prick with sharp end of tendon hammer*)	Withdrawal, maximal in left upper limb
	Painful stimuli to face	Distress but no co-ordinated response to remove stimulus
	Routine sensory stimuli during care (*changing position, bed and feeding*)	Generalized non specific response presence but no coordinated attempt to assist in process
MOTOR OUTPUT	Spontaneous	Non-specific undirected activities. Goal directed – lifting left hand to left side of face, apparently to rub her left eye.
	Responsive	Non-specific undirected without any goal directed activities.

Conclusion:

From the above examination, she has evidence of intact auditory, visual, somatic and motor primary neural pathways. However no definitive evidence for awareness of auditory, visual, somatic and motor stimuli was observed during our examinations.

VIIb. Table 2. Application of Criteria for Vegetative State

(Bernat JL. Neurology clinical Practice 2010; 75 (suppl 1): S33-S38)

Criteria	**Examination findings : whether she meets Criteria (Yes /No / Probably)**
Unaware of self and environment	Yes, Unaware
No interaction with others	Yes, no interaction
No sustained, reproducible or purposeful voluntary behavioural response to visual, auditory, tactile or noxious stimuli	Yes, no sustained, reproducible or purposeful behavioural response, but : 1. Resisted examination of fundus 2. Licked sugar off lips
No language comprehension or expression	Yes, no comprehension
No blink to visual threat	Blinks, but more consistent on left than right

Present sleep wake cycles	Yes (according to nurses)
Preserved autonomic and hypothalamic function	Yes
Preserved cranial nerve reflexes	Yes
Bowel and bladder incontinence	Yes

VIII. References

1. Multi-Society Task Force on PVS. Medical aspects of the persistent vegetative state. N Engl J Med 1994; 330: 1499-508

2. Wade DT, Johnston C. The permanent vegetative state: practical guidance on diagnosis and management. Brit Med J 1999; 319:841–4

3. Giacino JT, Ashwal S, Childs N, et al. The minimally conscious state : Definition and diagnostic criteria. Neurology 2002;58:349–353

4. Bernat JL. Current controversies in states of chronic unconsciousness. Neurology 2010;75;S33"

8. On 18th February, 2011, we then passed the following order :

> "In the above case Dr. J.V. Divatia on 17.02.2011 handed over the report of the team of three doctors whom we had appointed by our order dated 24th January, 2011. He has also handed over a CD in this connection. Let the report as well as the CD form part of the record.
>
> On mentioning, the case has been adjourned to be listed on 2nd March, 2011 at the request of learned Attorney General of India, Mr. T.R. Andhyarujina, learned Senior Advocate, whom we have appointed as amicus curiae in the case as well as Mr. Shekhar Naphade, learned Senior Advocate for the petitioner.
>
> We request the doctors whom we had appointed viz., Dr. J.V. Divatia, Dr. Roop Gurshani and Dr. Nilesh Shah to appear before us on 2nd March, 2011 at 10.30 A.M. in the Court, since it is quite possible that we may like to ask them questions about the

report which they have submitted, and in general about their views in connection with euthanasia.

On perusal of the report of the committee of doctors to us we have noted that there are many technical terms which have been used therein which a non-medical man would find it difficult to understand. We, therefore, request the doctors to submit a supplementary report by the next date of hearing (by e-mailing copy of the same two days before the next date of hearing) in which the meaning of these technical terms in the report is also explained.

The Central Government is directed to arrange for the air travel expenses of all the three doctors as well as their stay in a suitable accommodation at Delhi and also to provide them necessary conveyance and other facilities they require, so that they can appear before us on 02.03.2011.

An honorarium may also be given to the doctors, if they so desire, which may be arranged mutually with the learned Attorney General.

The Dean of King Edward Memorial Hospital as well as Ms. Pinky Virani (who claims to be the next friend of the petitioner) are directed to intimate the brother(s)/sister(s) or other close relatives of the petitioner that the case will be listed on 2nd March, 2011 in the Supreme Court and they can put forward their views before the Court, if they so desire. Learned counsel for the petitioner and the Registry of this Court shall communicate a copy of this Order forthwith to the Dean, KEM Hospital. The Dean, KEM Hospital is requested to file an affidavit stating his

views regarding the prayer in this writ petition, and also the condition of the petitioner.

Copy of this Order shall be given forthwith to learned Attorney General of India, Mr. Shekhar Naphade and Mr. Andhyarujina, learned Senior Advocates.

Let the matter be listed as the first item on 2nd March, 2011".

9. On 2.3.2011, the matter was listed again before us and we first saw the screening of the CD submitted by the team of doctors along with their report. We had arranged for the screening of the CD in the Courtroom, so that all present in Court could see the condition of Aruna Shanbaug. For doing so, we have relied on the precedent of the Nuremburg trials in which a screening was done in the Courtroom of some of the Nazi atrocities during the Second World War. We have heard learned counsel for the parties in great detail. The three doctors nominated by us are also present in Court. As requested by us, the doctors team submitted a supplementary report before us which states :

Jointly prepared and signed by

1. Dr. J.V. Divatia
(Professor and Head, Department of Anesthesia, Critical Care and Pain, at Tata Memorial Hospital, Mumbai)

2. Dr. Roop Gursahani
(Consultant Neurologist at P.D. Hinduja Hospital, Mumbai)

3. Dr. Nilesh Shah
(Professor and Head, Department of Psychiatry at Lokmanya Tilak Municipal Corporation Medical College and General Hospital).

Mumbai
February 26, 2011

INDEX

Introduction

This document is a supplement to the Report of Examination of Ms. Aruna Ramachandra Shanbaug, dated February 14, 2011.

On perusal of the report, the Hon. Court observed that there were many technical terms which a non-medical man would find it difficult to understand, and requested us to submit a supplementary report in which the meaning of these technical terms in the report is also explained.

We have therefore prepared this Supplement to include a glossary of technical terms used in the earlier Report, and also to clarify some of the terminology related to brain damage. Finally, we have given our opinion in the case of Aruna Shanbaug.

Terminology

The words coma, brain death and vegetative state are often used in common language to describe severe brain damage. However, in medical terminology, these terms have specific meaning and significance.

Brain death

A state of prolonged irreversible cessation of all brain activity, including lower brain stem function with the complete absence of voluntary movements, responses to stimuli, brain stem reflexes, and spontaneous respirations.

Explanation: This is the most severe form of brain damage. The patient is unconscious, completely unresponsive, has no reflex activity from centres in the brain, and has no breathing efforts on his own. However the heart is beating. This patient can only be maintained alive by advanced life support (breathing machine or ventilator, drugs to maintain blood pressure, etc). These patients can be legally declared dead (‘brain dead’) to allow their organs to be taken for donation.

Aruna Shanbaug is clearly not brain dead.

Coma

Patients in coma have complete failure of the arousal system with no spontaneous eye opening and are unable to be awakened by application of vigorous sensory stimulation.

Explanation: These patients are unconscious. They cannot be awakened even by application of a painful stimulus. They have normal heart beat and breathing, and do not require advanced life support to preserve life.

Aruna Shanbaug is clearly not in Coma.

Vegetative State (VS)

The complete absence of behavioral evidence for self or environmental awareness. There is preserved capacity for spontaneous or stimulus-induced arousal, evidenced by sleep–wake cycles. .i.e. patients are awake, but have no awareness.

Explanation: Patients appear awake. They have normal heart beat and breathing, and do not require advanced life support to preserve life. They cannot produce a purposeful, co-ordinated, voluntary response in a sustained manner, although they may have primitive reflexive responses to light, sound, touch or pain. They cannot understand, communicate, speak, or have emotions. They are unaware of self and environment and have no interaction with others. They cannot voluntarily control passing of urine or stools. They sleep and awaken. As the centres in the brain controlling the heart and breathing are intact, there is no threat to life, and patients can survive for many years with expert nursing care. The following behaviours may be seen in the vegetative state :

Sleep-wake cycles with eyes closed, then open

Patient breathes on her own

Spontaneous blinking and roving eye movements

Produce sounds but no words

Brief, unsustained visual pursuit (following an object with her eyes)

Grimacing to pain, changing facial expressions

Yawning; chewing jaw movements

Swallowing of her own spit

Nonpurposeful limb movements; arching of back

Reflex withdrawal from painful stimuli

Brief movements of head or eyes toward sound or movement without apparent localization or fixation

Startles with a loud sound

Almost all of these features consistent with the diagnosis of permanent vegetative state were present during the medical examination of Aruna Shanbaug.

Minimally Conscious State

Some patients with severe alteration in consciousness have neurologic findings that do not meet criteria for VS. These patients demonstrate some behavioral evidence of conscious awareness but remain unable to reproduce this behavior consistently. This condition is referred to here as the minimally conscious state (MCS). MCS is distinguished from VS by the partial preservation of conscious awareness.

To make the diagnosis of MCS, limited but clearly discernible evidence of self or environmental awareness must be demonstrated on a reproducible or sustained basis by one or more of the following behaviors:

• Following simple commands.
• Gestural or verbal yes/no responses (regardless of accuracy).
• Intelligible sounds
• Purposeful behavior, including movements or emotional behaviors (smiling, crying) that occur in relation to relevant environmental stimuli and are not due to reflexive activity. Some examples of qualifying purposeful behavior include:

– appropriate smiling or crying in response to the linguistic

or visual content of emotional but not to neutral topics or stimuli

– vocalizations or gestures that occur in direct response to the linguistic content of questions

– reaching for objects that demonstrates a clear relationship between object location and direction of reach

– touching or holding objects in a manner that accommodates the size and shape of the object

– pursuit eye movement or sustained fixation that occurs in direct response to moving or salient stimuli

None of the above behaviours suggestive of a Minimally Conscious State were observed during the examination of Aruna Shanbaug.

GLOSSARY OF TECHNICAL TERMS USED IN THE MAIN REPORT

(In Alphabetical order) Term in text	**Meaning**
Affect	Feeling conveyed though expressions and behavior
Afebrile	No fever
Auditory	Related to hearing
Bedsore	A painful wound on the body caused by having to lie in bed for a long time
Bilaterally	On both sides (right and left)
Bruise	An injury or mark where the skin has not been broken but is darker in colour, often as a result of being hit by something
Catatonic	Describes someone who is stiff and not moving or reacting, as if dead
Cerebral atrophy	Shrinking of the globe (cortex) of the brain
Clubbing	Bulging or prominence of the nailbed, making base of the nails look thick. This is often due to longstanding infection inside the lungs.
Cognitive	Related to ability to understand and process information in the brain
Conjugate	Synchronised movement (of the eyeball)

Conscious	Awake with eyes open. By itself the term conscious does not convey any information about awareness of self and surroundings, or the ability to understand, communicate, have emotions, etc.
Contractures	Muscles or tendons that have become shortened and taut over a period of time. This causes deformity and restriction of movements.
CT Scan	A specialized X-ray test where images of the brain (or other part of the body) are obtained in cross-section at different levels. This allows clear visualization of different parts of the brain
Cyanosis	Bluish discoloration of the nails, lips or skin. It may be due to low levels of oxygen in the blood
Deep tendon reflexes	Reflex response of the fleshy part of certain muscles when its tendon is hit lightly with an examination hammer
Dementia	Disorder in which there is a cognitive defect, i.e. the patient is unable to understand and process information in the brain
Electroencephalography, (EEG)	Recording of the electrical activity of the brain
Febrile illness	Illness with fever
Fracture	A crack or a break in bones
Fundi	Plural of fundus. Fundus of the eye is the interior surface of the eye, opposite the lens. It is examined with an instrument called the ophthalmoscope
Gag reflex	Movement of the palate in response to insertion of a tongue depressor in the throat
Hallucinations	Perception in the absence of stimuli. (e.g. hearing voices which are not there or which are inaudible to others)
Hemifields	Right or left part of the field of vision
Hypoxic	Related to reduced oxygen levels in the blood
Icterus	Yellowish discoloration of the skin and eyeballs. This is commonly known as jaundice, and may be caused by liver disease
Illusions	Misperception of stimuli (seeing a rope as a snake)
Immediate memory	Memory of events which have occurred just a few minutes ago

Insight	Person's understanding of his or her own illness
Intellectual capacity	Ability to solve problems. The ability to learn, understand and make judgments or have opinions that are based on reason
Involuntary movements	Automatic movements over which patient has no control
Ischemic	Related to restriction or cutting off of the blood flow to any part of the body
Malnourishment	Weak and in bad health because of having too little food or too little of the types of food necessary for good health
Menace reflex	Blinking in response to hand movements in front of eyes
Mood	The way one feels at a particular time
Motor	Related to movement
Movement artefacts	Disturbance in the image seen in the CT scan due to patient movement
Oral feed	Food given through mouth
Orientation	Awareness about the time, place and person
Pallor	Pale appearance of the skin. Usually this is due to a low red blood cell count or low haemoglobin level in the blood.
Passive movement	Movement of a limb or part of the body done by the doctor without any effort by the patient
Perception	Sensory experiences (such as seeing, hearing etc.)
Perceptual abnormalities	Abnormal sensory experiences, e.g, seeing things that do not exist, hearing sounds when there are none
Plantars	Reflex response of the toes when a sharp painful stimulus is applied to the sole of the foot. The normal response is curling downwards of the toes.
Plantars were withdrawal/extensor	When a painful stimulus was applied to the sole of the foot the toes spread out and there was reflex movement of the leg (withdrawal) or upward curling of the great toe and other toes (extensor). This is an abnormal response indicating damage in the pathway in the brain or to the area in the brain controlling function of the legs.
Primary neural pathways	Course of the nerves from a part of the body to the area in the brain responsible for the function of that part
Pupillary reaction	The pupillary light reflex controls the diameter of the pupil, in response to the intensity of light. Greater intensity light

causes the pupil to become smaller (allowing less light in), whereas

Opinion

In our view, the issues in this case (and other similar cases) are:

1. In a person who is in a permanent vegetative state (PVS), should withholding or withdrawal of life sustaining therapies (many authorities would include placement of an artificial feeding tube as a life sustaining intervention) be permissible or 'not unlawful' ?

2. If the patient has previously expressed a wish not to have life-sustaining treatments in case of futile care or a PVS, should his / her wishes be respected when the situation arises?

3. In case a person has not previously expressed such a wish, if his family or next of kin makes a request to withhold or withdraw futile life-sustaining treatments, should their wishes be respected?

4. Aruna Shanbaug has been abandoned by her family and is being looked after for the last 37 years by the staff of KEM Hospital. Who should take decisions on her behalf?

Questions such as these come up at times in the course of medical practice. We realize that answers to these questions are difficult, and involve several ethical, legal and social issues. Our opinion is based on medical facts and on the principles of medical ethics. We hope that the Honourable Court will provide guidance and clarity in this matter.

Two of the cardinal principles of medical ethics are Patient Autonomy and Beneficiance.

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 decisions and choices. In the event that he is incompetent to make choices, his wishes expressed in advance in the form of a Living Will, OR the wishes of surrogates acting on his behalf ('substituted judgment') are to be respected.

The surrogate is expected to represent what the patient may have decided had he / she been competent, or to act in the patient's best interest. It is expected that a surrogate acting in the patient's best interest follows a course of action because it is best for the patient, and is not influenced by personal convictions, motives or other considerations.

2. Beneficence is acting in what is (or judged to be) in 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. In some cases, the doctor's expanded goals may include allowing the natural dying process (neither hastening nor delaying death, but 'letting nature take its course'), thus avoiding or reducing the sufferings of the patient and his family, and providing emotional support. This is not to be confused with euthanasia, which involves the doctor's deliberate and intentional act through administering a lethal injection to end the life of the patient.

In the present case under consideration

1. We have no indication of Aruna Shanbaug's views or wishes with respect to life-sustaining treatments for a permanent vegetative state.

2. Any decision regarding her treatment will have to be taken by a surrogate

3. The staff of the KEM hospital have looked after her for 37 years, after she was abandoned by her family. We believe that the Dean of the KEM Hospital (representing the staff of hospital) is an appropriate surrogate.

4. If the doctors treating Aruna Shanbaug and the Dean of the KEM Hospital, together acting in the best interest of the patient, feel that life sustaining treatments should continue, their decision should be respected.

5. If the doctors treating Aruna Shanbaug and the Dean of the KEM Hospital, together acting in the best interest of the patient, feel that withholding or withdrawing life-sustaining treatments is the appropriate course of action, they should be allowed to do so, and their actions should not be considered unlawful.

10. To complete the narration of facts and before we come to the legal issues involved, we may mention that Dr. Sanjay Oak, Dean KEM Hospital Mumbai has issued a statement on 24.1.2011 opposing euthanasia for the petitioner :-

> "She means a lot to KEM hospital. She is on liquid diet and loves listening to music. We have never subjected her to intravenous food or fed her via a tube. All these years, she hasn't had even one bedsore. When those looking after her do not have a problem, I don't understand why a third party who has nothing to do with her [Pinky Virani who has moved the apex court to seek euthanasia for Shanbaug] needs to worry," added Dr Oak, who, when he took over as dean of KEM hospital in 2008, visited her

first to take her blessings. “I call on her whenever I get time. I am there whenever she has dysentery or any another problem. She is very much alive and we have faith in the judiciary,” said Dr Oak.”

11. Dr. Sanjay Oak has subsequently filed an affidavit in this Court which states :

“a) Smt. Aruna Ramchandra Shanbaug has been admitted in a single room in Ward No.4 which is a ward of general internal medicine patients and she has been there for last 37 years. She is looked after entirely by doctors, nurses and para-medical staff of KEM Hospital. She has been our staff nurse and the unfortunate tragic incidence has happened with her in KEM Hospital and I must put on record that the entire medical, administrative, nursing and para-medical staff is extremely attached to her and consider her as one of us. Her relatives and a gentleman (her fiancee) used to visit her in the initial period of her illness but subsequently she has been left to the care of KEM staff. I visit her frequently and my last visit to her was on 22nd February, 2011. I give my observations as a Clinician about Smt. Aruna Shanbaug as under :

b) It would be incorrect to say that Smt. Aruna Shanbaug is an appropriate case for Coma. It appears that for a crucial, critical period her brain was deprived of Oxygen supply and this has resulted in her present state similar to that of Cerebral Palsy in the newborn child. It is a condition where brain looses it’s co-ordinatory, sensory as well as motor functions and this includes loss of speech

and perception. This has resulted into a state which in a layman's words **"Aruna lives in her own world for last 37 years"**. She is lying in a bed in a single room for 33 years. She has not been able to stand or walk, nor have we attempted to do that of late because we fear that she is fragile and would break her bones if she falls. Her extremities and fingers have developed contractures and subsequent to non-use; there is wasting of her body muscles. Her eyes are open and she blinks frequently; however, these movements are not pertaining to a specific purpose or as a response to a question. At times she is quiet and at times she shouts or shrieks. However, I must say that her shouts and shrieks are completely oblivious to anybody's presence in her room. It is not true that she shouts after seeing a man. I do not think Aruna can distinguish between a man and a woman, nor can she even distinguish between ordinate and inordinate object. We play devotional songs rendered by Sadguru Wamanrao Pai continuously in her room and she lies down on her bed listening to them. She expresses her displeasure by grimaces and shouts if the tape recorder is switched off. All these years she was never fed by tube and whenever a nurse used to take food to her lips, she used to swallow it. It is only since September 2010 she developed Malaria and her oral intake dropped. In order to take care of her calorie make need, nurses cadre resorted to naso-gastric tube feed and now she is used to NG feeding. However, if small morsels are held near her lips, Aruna accepts them gladly. It appears that she relishes fish and occasionally smiles when she is given non-vegetarian food. However, I am honest in admitting that her smiles are not purposeful and it would be improper to interpret them as a

signal of gratification. I must put on record that in the world history of medicine there would not be another single case where such a person is cared and nurtured in bed for 33 long years and has not developed a single bed sore. This speaks of volumes of excellence of nursing care that KEM Nursing staff has given to her.

c) This care is given not as a part of duty but as a part of feeling of oneness. With every new batch of entrants, the student nurses are introduced to her and they are told that she was one of us and she continues to be one of us and then they whole-heartedly take care of Aruna. In my opinion, this one is finest example of love, professionalism, dedication and commitment to one of our professional colleagues who is ailing and cannot support herself. Not once, in this long sojourn of 33 years, anybody has thought of putting an end to her so called vegetative existence. There have been several Deans and Doctors of KEM Hospital who have cared her in succession. Right from illustrious Dr. C.K. Deshpande in whose tenure the incidence happened in 1973, Dr. G.B. Parulkar, Dr. Smt. Pragna M. Pai, Dr. R.J. Shirahatti, Dr. Smt. N.A. Kshirsagar, Dr. M.E. Yeolekar and now myself Dr. Sanjay N. Oak, all of us have visited her room time and again and have cared for her and seen her through her ups and downs. The very idea of withholding food or putting her to sleep by active medication (mercy killing) is extremely difficult for anybody working in Seth GSMC & KEM Hospital to accept and I sincerely make a plea to the Learned Counsel and Hon’ble Judges of Supreme Court of India that this should not be allowed. Aruna has probably crossed 60 years of life and would one day meet her

> natural end. The Doctors, Nurses and staff of KEM, are determined to take care of her till her last breath by natural process.
>
> d) I do not think it is proper on my part to make a comment on the entire case. However, as a clinical surgeon for last 3 decades and as an administrator of the hospitals for last 7 years and as a student of legal system of India (as I hold "Bachelor of Law" degree from Mumbai University), I feel that entire society has not matured enough to accept the execution of an Act of Euthanasia or Mercy Killing. I fear that this may get misused and our monitoring and deterring mechanisms may fail to prevent those unfortunate incidences. To me any mature society is best judged by it's capacity and commitment to take care of it's "invalid" ones. They are the children of Lesser God and in fact, developing nation as we are, we should move in a positive manner of taking care of several unfortunate ones who have deficiencies, disabilities and deformities."

12. The Hospital staff of KEM Hospital, Mumbai e.g. the doctors, sister-in-charge ward no. 4 KEM hospital Lenny Cornielo, Assistant Matron Urmila Chauhan and others have also issued statements that they were looking after Aruna Shanbaug and want her to live. "Aruna is the bond that unites us", the KEM Hospital staff has stated. One retired nurse, Tidi Makwana, who used to take care of Aruna while in

service, has even offered to continue to take care of her without any salary and without charging any traveling expenses.

13. We have referred to these statements because it is evident that the KEM Hospital staff right from the Dean, including the present Dean Dr. Sanjay Oak and down to the staff nurses and para-medical staff have been looking after Aruna for 38 years day and night. What they have done is simply marvelous. They feed Aruna, wash her, bathe her, cut her nails, and generally take care of her, and they have been doing this not on a few occasions but day and night, year after year. The whole country must learn the meaning of dedication and sacrifice from the KEM hospital staff. In 38 years Aruna has not developed one bed sore.

14. It is thus obvious that the KEM hospital staff has developed an emotional bonding and attachment to Aruna Shanbaug, and in a sense they are her real family today. Ms. Pinki Virani who claims to be the

next friend of Aruna Shanbaug and has filed this petition on her behalf is not a relative of Aruna Shanbaug nor can she claim to have such close emotional bonding with her as the KEM hospital staff. Hence, we are treating the KEM hospital staff as the next friend of Aruna Shanbaug and we decline to recognize Ms. Pinki Virani as her next friend. No doubt Ms. Pinki Virani has written a book about Aruna Shanbaug and has visited her a few times, and we have great respect for her for the social causes she has espoused, but she cannot claim to have the extent of attachment or bonding with Aruna which the KEM hospital staff, which has been looking after her for years, claims to have.

SUBMISSIONS OF LEARNED COUNSEL FOR THE PARTIES

15. Mr. Shekhar Naphade, learned senior counsel for the petitioner has relied on the decision of this Court in **Vikram Deo Singh Tomar vs. State of Bihar** 1988 (Supp) SCC 734 (vide para 2) where it was observed by this Court :

> "We live in an age when this Court has demonstrated, while interpreting Article 21 of the Constitution, that every person is entitled to a quality of life consistent with his human personality. The right to live with human dignity is the fundamental right of every Indian citizen".

16. He has also relied on the decision of this Court in **P. Rathinam vs. Union of India and another** (1994) 3 SCC 394 in which a two-Judge bench of this Court quoted with approval a passage from an article by Dr. M. Indira and Dr. Alka Dhal in which it was mentioned :

> "Life is not mere living but living in health. Health is not the absence of illness but a glowing vitality".

17. The decision in **Rathinam's** case (supra) was, however, overruled by a Constitution Bench decision of this Court in **Gian Kaur vs. State of Punjab** (1996) 2 SCC 648.

18. Mr. Naphade, however, has invited our attention to paras 24 & 25 of the aforesaid decision in which

it was observed :

> "(24) Protagonism of euthanasia on the view that existence in persistent vegetative state (PVS) is not a benefit to the patient of a terminal illness being unrelated to the principle of 'sanctity of life' or the right to live with dignity' is of no assistance to determine the scope of Article 21 for deciding whether the guarantee of right to life' therein includes the right to die'. The right to life' including the right to live with human dignity would mean the existence of such a right upto the end of natural life. This also includes the right to a dignified life upto the point of death including a dignified procedure of death. In other words, this may include the right of a dying man to also die with dignity when his life is ebbing out. But the 'right to die' with dignity at the end of life is not to be confused or equated with the right to die' an unnatural death curtailing the natural span of life.
>
> (25) A question may arise, in the context of a dying man, who is, terminally ill or in a persistent vegetative state that he may be permitted to terminate it by a premature extinction of his life in those circumstances. This category of cases may fall within the ambit of the 'right to die' with dignity as a part of right to live with dignity, when death due to termination of natural life is certain and imminent and the process of natural death has commenced. These are not cases of extinguishing life but only of accelerating conclusion of the process of natural death which has already commenced. The debate even in such cases to permit physician assisted termination of life is inconclusive. It is sufficient to reiterate that the argument to support the view of permitting termination of life in such cases to reduce the period of suffering during the process of certain natural death is not available to interpret Article 21 to include therein the right to curtail the natural span of life".

He has particularly emphasized paragraph 25 of the said judgment in support of his submission that Aruna Shanbaug should be allowed to die.

19. We have carefully considered paragraphs 24 and 25 in **Gian Kaur's** case (supra) and we are of the opinion that all that has been said therein is that the view in **Rathinam's** case (supra) that the right to life includes the right to die is not correct. We cannot construe **Gian Kaur's** case (supra) to mean anything beyond that. In fact, it has been specifically mentioned in paragraph 25 of the aforesaid decision that "the debate even in such cases to permit physician assisted termination of life is inconclusive". Thus it is obvious that no final view was expressed in the decision in **Gian Kaur's** case beyond what we have mentioned above.

20. Mr. Naphade, learned senior counsel submitted that Ms. Pinky Virani is the next friend of Aruna as

she has written a book on her life called '**Aruna's story**' and has been following Aruna's case from 1980 and has done whatever possible and within her means to help Aruna. Mr. Naphade has also invited our attention to the report of the Law Commission of India, 2006 on '**Medical Treatment to Terminally Ill Patients**'. We have perused the said report carefully.

21. Learned Attorney General appearing for the Union of India after inviting our attention to the relevant case law submitted as under :

(i) Aruna Ramchandra Shanbaug has the right to live in her present state.

(ii) The state that Aruna Ramchandra Shanbaug is presently in does not justify terminating her life by withdrawing hydration/food/medical support.

(iii) The aforesaid acts or series of acts and/or such omissions will be cruel, inhuman and intolerable.

(iv) Withdrawing/withholding of hydration/food/medical support to a patient is unknown to Indian law and is contrary to law.

(v) In case hydration or food is

withdrawn/withheld from Aruna Ramchandra Shanbaug, the efforts which have been put in by batches after batches of nurses of KEM Hospital for the last 37 years will be undermined.

(vi) Besides causing a deep sense of resentment in the nursing staff as well as other well wishers of Aruna Ramchandra Shanbaug in KEM Hospital including the management, such acts/omissions will lead to disheartenment in them and large scale disillusionment.

(vii) In any event, these acts/omissions cannot be permitted at the instance of Ms. Pinky Virani who desires to be the next friend of Aruna Ramchandra Shanbaug without any locus.

Learned Attorney General stated that the report of the Law Commission of India on euthanasia has not been accepted by the Government of India. He further submitted that Indian society is emotional and care-oriented. We do not send our parents to old age homes, as it happens in the West. He stated that there was a great danger in permitting euthanasia that the relatives of a person may conspire with doctors and get him killed to inherit his property. He further submitted that tomorrow there may be a cure to a medical state perceived as

incurable today.

22. Mr. T. R. Andhyarujina, learned senior counsel whom we had appointed as Amicus Curiae, in his erudite submissions explained to us the law on the point. He submitted that in general in common law it is the right of every individual to have the control of his own person free from all restraints or interferences of others. Every human being of adult years and sound mind has a right to determine what shall be done with his own body. In the case of medical treatment, for example, a surgeon who performs an operation without the patient's consent commits assault or battery.

23. It follows as a corollary that the patient possesses the right not to consent i.e. to refuse treatment. (In the United States this right is reinforced by a Constitutional right of privacy). This is known as the principle of self-determination or informed consent.

24. Mr. Andhyarujina submitted that the principle of self-determination applies when a patient of sound mind requires that life support should be discontinued. The same principle applies where a patient's consent has been expressed at an earlier date before he became unconscious or otherwise incapable of communicating it as by a 'living will' or by giving written authority to doctors in anticipation of his incompetent situation.

Mr. Andhyarujina differed from the view of the learned Attorney General in that while the latter opposed even passive euthanasia, Mr. Andhyarujina was in favour of passive euthanasia provided the decision to discontinue life support was taken by responsible medical practitioners.

25. If the doctor acts on such consent there is no question of the patient committing suicide or of the doctor having aided or abetted him in doing so. It is simply that the patient, as he is entitled to do, declines to consent to treatment which might or would have the effect of prolonging his life and the

doctor has in accordance with his duties complied with the patient’s wishes.

26. The troublesome question is what happens when the patient is in no condition to be able to say whether or not he consents to discontinuance of the treatment and has also given no prior indication of his wishes with regard to it as in the case of Aruna. In such a situation the patient being incompetent to express his self-determination the approach adopted in some of the American cases is of “substituted judgment” or the judgment of a surrogate. This involves a detailed inquiry into the patient’s views and preferences. The surrogate decision maker has to gather from material facts as far as possible the decision which the incompetent patient would have made if he was competent. However, such a test is not favoured in English law in relation to incompetent adults.

27. Absent any indication from a patient who is incompetent the test which is adopted by Courts is

what is in the best interest of the patient whose life is artificially prolonged by such life support. This is not a question whether it is in the best interest of the patient that he should die. The question is whether it is in the best interest of the patient that his life should be prolonged by the continuance of the life support treatment. This opinion must be formed by a responsible and competent body of medical persons in charge of the patient.

28. The withdrawal of life support by the doctors is in law considered as an omission and not a positive step to terminate the life. The latter would be euthanasia, a criminal offence under the present law in UK, USA and India.

29. In such a situation, generally the wishes of the patient's immediate family will be given due weight, though their views cannot be determinative of the carrying on of treatment as they cannot dictate to responsible and competent doctors what is in the

best interest of the patient. However, experience shows that in most cases the opinions of the doctors and the immediate relatives coincide.

30. Whilst this Court has held that there is no right to die (suicide) under Article 21 of the Constitution and attempt to suicide is a crime vide Section 309 IPC, the Court has held that the right to life includes the right to live with human dignity, and in the case of a dying person who is terminally ill or in a permanent vegetative state he may be permitted to terminate it by a premature extinction of his life in these circumstances and it is not a crime vide **Gian Kaur's** case (supra).

31. Mr. Andhyarujina submitted that the decision to withdraw the life support is taken in the best interests of the patient by a body of medical persons. It is not the function of the Court to evaluate the situation and form an opinion on its own. In England for historical reasons the parens patriae jurisdiction over adult mentally

incompetent persons was abolished by statute and the Court has no power now to give its consent. In this situation, the Court only gives a declaration that the proposed omission by doctors is not unlawful.

32. In U.K., the Mental Capacity Act, 2005 now makes provision relating to persons who lack capacity and to determine what is in their best interests and the power to make declaration by a special Court of Protection as to the lawfulness of any act done in relation to a patient.

33. Mr. Andhyarujina submitted that the withdrawal of nutrition by stopping essential food by means of nasogastric tube is not the same as unplugging a ventilator which artificially breathes air into the lungs of a patient incapable of breathing resulting in instant death. In case of discontinuance of artificial feeding the patient will as a result starve to death with all the sufferings and pain and distress associated with such starving. This is a very relevant consideration in a PVS patient like

Aruna who is not totally unconscious and has sensory conditions of pain etc. unlike Antony Bland in **Airedale vs. Director MHD** (1993) 2 WLR 316 who was totally unconscious. Would the doctor be able to avoid such pain or distress by use of sedatives etc.? In such a condition would it not be more appropriate to continue with the nasogastric feeding but not take any other active steps to combat any other illness which she may contract and which may lead to her death?

34. Mr. Andhyarujina further submitted that in a situation like that of Aruna, it is also necessary to recognize the deep agony of nurses of the hospital who have with deep care looked after her for over 37 years and who may not appreciate the withdrawal of the life support. It may be necessary that their views should be considered by the Court in some appropriate way.

35. Mr. Andhyarujina, in the course of his submission stated that some Courts in USA have

observed that the view of a surrogate may be taken to be the view of the incompetent patient for deciding whether to withdraw the life support, though the House of Lords in **Airedale's** case has not accepted this. He submitted that relatives of Aruna do not seem to have cared for her and it is only the nursing staff and medical attendants of KEM hospital who have looked after her for 37 years. He has also submitted that though the humanistic intention of Ms. Pinky Virani cannot be doubted, it is the opinion of the attending doctors and nursing staff which is more relevant in this case as they have looked after her for so many years.

36. Mr. Pallav Shishodia, learned senior counsel for the Dean, KEM hospital, Mumbai submitted that Ms. Pinky Virani has no *locus standi* in the matter and it is only the KEM hospital staff which could have filed such a writ petition.

37. We have also heard learned counsel for the State of Maharashtra, Mr. Chinmoy Khaldkar and other

assisting counsel whose names have been mentioned in this judgment. They have been of great assistance to us as we are deciding a very sensitive and delicate issue which while requiring a humanistic approach, also requires great case and caution to prevent misuse. We were informed that not only the learned counsel who argued the case before us, but also the assistants (whose names have been mentioned in the judgment) have done research on the subject for several weeks, and indeed this has made our task easier in deciding this case. They therefore deserve our compliment and thanks.

Legal Issues : Active and Passive Euthanasia

38. Coming now to the legal issues in this case, it may be noted that euthanasia is of two types : active and passive. Active euthanasia entails the use of lethal substances or forces to kill a person e.g. a lethal injection given to a person with terminal cancer who is in terrible agony. Passive euthanasia entails withholding of medical treatment

for continuance of life, e.g. withholding of antibiotics where without giving it a patient is likely to die, or removing the heart lung machine, from a patient in coma.

39. 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.

40. A further categorization of euthanasia is between voluntary euthanasia and non voluntary euthanasia. Voluntary euthanasia is where the consent is taken from the patient, whereas non voluntary euthanasia is where the consent is unavailable e.g. when the patient is in coma, or is otherwise unable to give consent. While there is no legal difficulty in the case of the former, the latter poses several problems, which we shall address.

ACTIVE EUTHANASIA

41. As already stated above active euthanasia is a crime all over the world except where permitted by legislation. In India active euthanasia is illegal and a crime under section 302 or at least section 304 IPC. Physician assisted suicide is a crime under section 306 IPC (abetment to suicide).

42. Active euthanasia is taking specific steps to cause the patient's death, such as injecting the patient with some lethal substance, e.g. sodium pentothal which causes a person deep sleep in a few seconds, and the person instantaneously and painlessly dies in this deep sleep.

43. A distinction is sometimes drawn between euthanasia and physician assisted dying, the difference being in who administers the lethal medication. In euthanasia, a physician or third party administers it, while in physician assisted

suicide it is the patient himself who does it, though on the advice of the doctor. In many countries/States the latter is legal while the former is not.

44. The difference between "active" and "passive" euthanasia 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.

45. An important idea behind this distinction is that in "passive euthanasia" the doctors are not actively killing anyone; they are simply not saving him. While we usually applaud someone who saves another person's life, we do not normally condemn someone for failing to do so. If one rushes into a burning building and carries someone out to safety, he will probably be called a hero. But if one sees a burning building and people screaming for help, and he stands on the sidelines -- whether out of fear for his own safety, or the belief that an

inexperienced and ill-equipped person like himself would only get in the way of the professional firefighters, or whatever -- if one does nothing, few would judge him for his inaction. One would surely not be prosecuted for homicide. (At least, not unless one started the fire in the first place.)

46. Thus, proponents of euthanasia say that while we can debate whether active euthanasia should be legal, there can be no debate about passive euthanasia: You cannot prosecute someone for failing to save a life. Even if you think it would be good for people to do X, you cannot make it illegal for people to *not* do X, or everyone in the country who did not do X today would have to be arrested.

47. Some persons are of the view that the distinction is not valid. They give the example of the old joke about the child who says to his teacher, "Do you think it's right to punish someone for something that he didn't do?" "Why, of course not," the teacher replies. "Good," the child says,

"because I didn't do my homework."

48. In fact we have many laws that penalize people for what they did not do. A person cannot simply decide not to pay his income taxes, or not bother to send his/her children to school (where the law requires sending them), or not to obey a policeman's order to put down one’s gun.

49. However, we are of the opinion that the distinction is valid, as has been explained in some details by Lord Goff in **Airedale’s** case (infra) which we shall presently discuss.

LEGISLATION IN SOME COUNTRIES RELATING TO EUTHANASIA OR PHYSICIAN ASSISTED DEATH

50. Although in the present case we are dealing with a case related to passive euthanasia, it would be of some interest to note the legislations in certain countries permitting active euthanasia. These are given below.

Netherlands:

Euthanasia in the Netherlands is regulated by the "Termination of Life on Request and Assisted Suicide (Review Procedures) Act", 2002. It states that euthanasia and physician-assisted suicide are not punishable if the attending physician acts in accordance with the criteria of due care. These criteria concern the patient's request, the patient's suffering (unbearable and hopeless), the information provided to the patient, the presence of reasonable alternatives, consultation of another physician and the applied method of ending life. To demonstrate their compliance, the Act requires physicians to report euthanasia to a review committee.

The legal debate concerning euthanasia in the Netherlands took off with the "Postma case" in 1973, concerning a physician who had facilitated the death of her mother following repeated explicit requests for euthanasia. While the physician was convicted, the court's judgment set out criteria when a doctor would not be

required to keep a patient alive contrary to his will. This set of criteria was formalized in the course of a number of court cases during the 1980s.

Termination of Life on Request and Assisted Suicide (Review Procedures) Act took effect on April 1, 2002. It legalizes euthanasia and physician assisted suicide in very specific cases, under very specific circumstances. The law was proposed by Els Borst, the minister of Health. The procedures codified in the law had been a convention of the Dutch medical community for over twenty years.

The law allows a medical review board to suspend prosecution of doctors who performed euthanasia when each of the following conditions is fulfilled:

- the patient's suffering is unbearable with no prospect of improvement
- the patient's request for euthanasia must be voluntary and persist over time (the request

cannot be granted when under the influence of others, psychological illness, or drugs)

- the patient must be fully aware of his/her condition, prospects and options
- there must be consultation with at least one other independent doctor who needs to confirm the conditions mentioned above
- the death must be carried out in a medically appropriate fashion by the doctor or patient, in which case the doctor must be present
- the patient is at least 12 years old (patients between 12 and 16 years of age require the consent of their parents)

The doctor must also report the cause of death to the municipal coroner in accordance with the relevant provisions of the Burial and Cremation Act. A regional review committee assesses whether a case of termination of life on request or assisted suicide complies with the due care criteria. Depending on its findings, the case will either be closed or, if the conditions are

not met, brought to the attention of the Public Prosecutor. Finally, the legislation offers an explicit recognition of the validity of a written declaration of the will of the patient regarding euthanasia (a "euthanasia directive"). Such declarations can be used when a patient is in a coma or otherwise unable to state if they wish to be euthanized.

Euthanasia remains a criminal offense in cases not meeting the law's specific conditions, with the exception of several situations that are not subject to the restrictions of the law at all, because they are considered normal medical practice. These are :

- stopping or not starting a medically useless (futile) treatment
- stopping or not starting a treatment at the patient's request
- speeding up death as a side-effect of treatment necessary for alleviating serious suffering

Euthanasia of children under the age of 12

remains technically illegal; however, Dr. Eduard Verhagen has documented several cases and, together with colleagues and prosecutors, has developed a protocol to be followed in those cases. Prosecutors will refrain from pressing charges if this Groningen Protocol is followed.

Switzerland:

Switzerland has an unusual position on assisted suicide: it is legally permitted and can be performed by non-physicians. However, euthanasia is illegal, the difference between assisted suicide and euthanasia being that while in the former the patient administers the lethal injection himself, in the latter a doctor or some other person administers it.

Article 115 of the Swiss penal code, which came into effect in 1942 (having been approved in 1937), considers assisting suicide a crime if, and only if, the motive is selfish. The code does not give physicians a special status in

assisting suicide; although, they are most likely to have access to suitable drugs. Ethical guidelines have cautioned physicians against prescribing deadly drugs.

Switzerland seems to be the only country in which the law limits the circumstances in which assisted suicide is a crime, thereby decriminalising it in other cases, without requiring the involvement of a physician. Consequently, non-physicians have participated in assisted suicide. However, legally, active euthanasia e.g. administering a lethal injection by a doctor or some other person to a patient is illegal in Switzerland (unlike in Holland where it is legal under certain conditions).

The Swiss law is unique because (1) the recipient need not be a Swiss national, and (2) a physician need not be involved. Many persons from other countries, especially Germany, go to Switzerland to undergo euthanasia.

Belgium:

Belgium became the second country in Europe after Netherlands to legalize the practice of euthanasia in September 2002.

The Belgian law sets out conditions under which suicide can be practised without giving doctors a licence to kill.

Patients wishing to end their own lives must be conscious when the demand is made and repeat their request for euthanasia. They have to be under "constant and unbearable physical or psychological pain" resulting from an accident or incurable illness.

The law gives patients the right to receive ongoing treatment with painkillers -- the authorities have to pay to ensure that poor or isolated patients do not ask to die because they do not have money for such treatment.

Unlike the Dutch legislation, minors cannot seek assistance to die.

In the case of someone who is not in the terminal stages of illness, a third medical opinion must be sought.

Every mercy killing case will have to be filed at a special commission to decide if the doctors in charge are following the regulations.

U.K., Spain, Austria, Italy, Germany, France, etc.

In none of these countries is euthanasia or physician assisted death legal. In January 2011 the French Senate defeated by a 170-142 vote a bill seeking to legalize euthanasia. In England, in May 2006 a bill allowing physician assisted suicide, was blocked, and never became law.

United States of America:

Active Euthanasia is illegal in all states in U.S.A., but physician assisted dying is legal in

the states of Oregon, Washington and Montana. As already pointed out above, the difference between euthanasia and physician assisted suicide lies in who administers the lethal medication. In the former, the physician or someone else administers it, while in the latter the patient himself does so, though on the advice of the doctor.

Oregon:

Oregon was the first state in U.S.A. to legalize physician assisted death.

The Oregon legislature enacted the Oregon Death with Dignity Act, in 1997. Under the Death With Dignity Act, a person who sought physician-assisted suicide would have to meet certain criteria:

- He must be an Oregon resident, at least 18 years old, and must have decision making capacity.
- The person must be terminally ill, having six months or less to live.

- The person must make one written and two oral requests for medication to end his/her life, the written one substantially in the form provided in the Act, signed, dated, witnessed by two persons in the presence of the patient who attest that the person is capable, acting voluntarily and not being coerced to sign the request. There are stringent qualifications as to who may act as a witness.
- The patient’s decision must be an ‘informed’ one, and the attending physician is obligated to provide the patient with information about the diagnosis, prognosis, potential risks, and probable consequences of taking the prescribed medication, and alternatives, including, but not limited to comfort care, hospice care and pain control. Another physician must confirm the diagnosis, the patient’s decision making capacity, and voluntariness of the patient’s decisions.
- Counselling has to be provided if the patient is

suffering from depression or a mental disorder which may impact his judgment.

- There has to be a waiting period of 15 days, next of kin have to be notified, and State authorities have to be informed.
- The patient can rescind his decision at any time

In response to concerns that patients with depression may seek to end their lives, the 1999 amendment provides that the attending physician must determine that the patient does not have ‘depression causing impaired judgment’ before prescribing the medication.

Under the law, a person who met all requirements could receive a prescription of a barbiturate that would be sufficient to cause death. However, the lethal injection must be administered by the patient himself, and physicians are prohibited from administering it.

The landmark case to declare that the practice of euthanasia by doctors to help their patients shall not be taken into cognizance was **Gonzalez**

vs Oregon decided in 2006.

After the Oregon Law was enacted about 200 persons have had euthanasia in Oregon.

Washington:

Washington was the second state in U.S.A. which allowed the practice of physician assisted death in the year 2008 by passing the Washington Death with Dignity Act, 2008.

Montana:

Montana was the third state (after Oregon and Washington) in U.S.A. to legalize physician assisted deaths, but this was done by the State judiciary and not the legislature. On December 31, 2009, the Montana Supreme Court delivered its verdict in the case of ***Baxter v. Montana*** permitting physicians to prescribe lethal indication. The court held that there was "nothing in Montana Supreme Court precedent or Montana statutes indicating that physician aid

in dying is against public policy.”

Other States in U.S.A.:

In no other State in U.S.A. is euthanasia or physician assisted death legal. Michigan banned euthanasia and assisted suicide in 1993, after Dr. Kevorkian (who became known as ‘doctor death’) began encouraging and assisting in suicides. He was convicted in 1999 for an assisted suicide displayed on television, his medical licence cancelled, and he spent 8 years in jail.

In 1999 the State of Texas enacted the Texas Futile Care Law which entitles Texas hospitals and doctors, in some situations, to withdraw life support measures, such as mechanical respiration, from terminally ill patient when such treatment is considered futile and inappropriate. However, Texas has not legalized euthanasia or physician assisted death. In California, though 75 of people support

physician assisted death, the issue is highly controversial in the State legislature. Forty States in USA have enacted laws which explicitly make it a crime to provide another with the means of taking his or her life.

In 1977 California legalized living wills, and other States soon followed suit. A living will (also known as advance directive or advance decision) is an instruction given by an individual while conscious specifying what action should be taken in the event he/she is unable to make a decision due to illness or incapacity, and appoints a person to take such decisions on his/her behalf. It may include a directive to withdraw life support on certain eventualities.

Canada:

In Canada, physician assisted suicide is illegal vide Section 241(b) of the Criminal Code of

Canada.

The leading decision of the Canadian Supreme Court in this connection is ***Sue Rodriguez v. British Columbia (Attorney General),*** (1993) 3 SCR 519. Rodriguez, a woman of 43, was diagnosed with Amyotrophic Lateral Sclerosis (ALS), and requested the Canadian Supreme Court to allow someone to aid her in ending her life. Her condition was deteriorating rapidly, and the doctors told her that she would soon lose the ability to swallow, speak, walk, and move her body without assistance. Thereafter she would lose her capacity to breathe without a respirator, to eat without a gastrotomy, and would eventually be confined to bed. Her life expectancy was 2 to 14 months.

The Canadian Supreme Court was deeply divided. By a 5 to 4 majority her plea was rejected. Justice Sopinka, speaking for the majority (which included Justices La Forest, Gonthier, Iacobucci and Major) observed :

> "Sanctity of life has been understood historically as excluding freedom of choice in the self infliction of death, and certainly in the involvement of others in carrying out that choice. At the very least, no new consensus has emerged in society opposing the right of the State to regulate the involvement of others in exercising power over individuals ending their lives."

The minority, consisting of Chief Justice Lamer and Justices L'Heureux-Dube, Cory and McLachlin, dissented.

PASSIVE EUTHANASIA

51. Passive euthanasia is usually defined as withdrawing medical treatment with a deliberate intention of causing the patient's death. For example, if a patient requires kidney dialysis to survive, not giving dialysis although the machine is available, is passive euthanasia. Similarly, if a patient is in coma or on a heart lung machine, withdrawing of the machine will ordinarily result in passive euthanasia. Similarly not giving life saving medicines like antibiotics in certain

situations may result in passive euthanasia. Denying food to a person in coma or PVS may also amount to passive euthanasia.

52. As already stated above, euthanasia can be both voluntary or non voluntary. In voluntary passive euthanasia a person who is capable of deciding for himself decides that he would prefer to die (which may be for various reasons e.g., that he is in great pain or that the money being spent on his treatment should instead be given to his family who are in greater need, etc.), and for this purpose he consciously and of his own free will refuses to take life saving medicines. In India, if a person consciously and voluntarily refuses to take life saving medical treatment it is not a crime. Whether not taking food consciously and voluntarily with the aim of ending one's life is a crime under section 309 IPC (attempt to commit suicide) is a question which need not be decided in this case.

53. Non voluntary passive euthanasia implies that

the person is not in a position to decide for himself e.g., if he is in coma or PVS. The present is a case where we have to consider non voluntary passive euthanasia i.e. whether to allow a person to die who is not in a position to give his/her consent.

54. There is a plethora of case law on the subject of the Courts all over the world relating to both active and passive euthanasia. It is not necessary to refer in detail to all the decisions of the Courts in the world on the subject of euthanasia or physically assisted dead (p.a.d.) but we think it appropriate to refer in detail to certain landmark decisions, which have laid down the law on the subject.

THE AIREDALE CASE : (**Airedale NHS Trust v. Bland (1993) All E.R. 82) (H.L.)**

55. In the **Airedale** case decided by the House of Lords in the U.K., the facts were that one Anthony Bland aged about 17 went to the Hillsborough Ground

on 15th April 1989 to support the Liverpool Football Club. In the course of the disaster which occurred on that day, his lungs were crushed and punctured and the supply to his brain was interrupted. As a result, he suffered catastrophic and irreversible damage to the higher centres of the brain. For three years, he was in a condition known as ‘persistent vegetative state (PVS). This state arises from the destruction of the cerebral cortex on account of prolonged deprivation of oxygen, and the cerebral cortex of Anthony had resolved into a watery mass. The cortex is that part of the brain which is the seat of cognitive function and sensory capacity. Anthony Bland could not see, hear or feel anything. He could not communicate in any way. His consciousness, which is an essential feature of an individual personality, had departed forever. However, his brain-stem, which controls the reflective functions of the body, in particular the heart beat, breathing and digestion, continued to operate. He was in persistent vegetative state (PVS) which is a recognized medical condition quite

distinct from other conditions sometimes known as "irreversible coma", "the Guillain-Barre syndrome", "the locked-in syndrome" and "brain death".

56. The distinguishing characteristic of PVS is that the brain stem remains alive and functioning while the cortex has lost its function and activity. Thus the PVS patient continues to breathe unaided and his digestion continues to function. But although his eyes are open, he cannot see. He cannot hear. Although capable of reflex movement, particularly in response to painful stimuli, the patient is uncapable of voluntary movement and can feel no pain. He cannot taste or smell. He cannot speak or communicate in any way. He has no cognitive function and thus can feel no emotion, whether pleasure or distress. The absence of cerebral function is not a matter of surmise; it can be scientifically demonstrated. The space which the brain should occupy is full of watery fluid.

57. In order to maintain Mr. Bland in his condition,

feeding and hydration were achieved by artificial means of a nasogastric tube while the excretory functions were regulated by a catheter and enemas. According to eminent medical opinion, there was no prospect whatsoever that he would ever make a recovery from his condition, but there was every likelihood that he would maintain this state of existence for many years to come provided the artificial means of medical care was continued.

58. In this state of affairs the medical men in charge of Anthony Bland case took the view, which was supported by his parents, that no useful purpose would be served by continuing medical care, and that artificial feeding and other measures aimed at prolonging his existence should be stopped. Since however, there was a doubt as to whether this course might constitute a criminal offence, the hospital authorities sought a declaration from the British High Court to resolve these doubts.

59. The declaration was granted by the Family

Division of the High Court on 19.11.1992 and that judgment was affirmed by the Court of Appeal on 9.12.1992. A further appeal was made to the House of Lords which then decided the case.

60. The broad issued raised before the House of Lords in the **Airedale** case (supra) was "In what circumstances, if ever, can those having a duty to feed an invalid lawfully stop doing so?" In fact this is precisely the question raised in the present case of Aruna Shanbaug before us.

61. In **Airedale's** case (supra), Lord Keith of Kinkel, noted that it was unlawful to administer treatment to an adult who is conscious and of sound mind, without his consent. Such a person is completely at liberty to decline to undergo treatment, even if the result of his doing so will be that he will die. This extends to the situation where the person in anticipation of his entering into a condition such as PVS, gives clear instructions that in such an event he is not to be

given medical care, including artificial feeding, designed to keep him alive.

62. It was held that if a person, due to accident or some other cause becomes unconscious and is thus not able to give or withhold consent to medical treatment, in that situation it is lawful for medical men to apply such treatment as in their informed opinion is in the best interests of the unconscious patient. That is what happened in the case of Anthony Bland when he was first dealt with by the emergency services and later taken to hospital.

63. When the incident happened the first imperative was to prevent Anthony from dying, as he would certainly have done in the absence of the steps that were taken. For a time, no doubt, there was some hope that he might recover sufficiently for him to be able to live a life that had some meaning. Some patients who have suffered damage to the cerebral cortex have, indeed, made a complete recovery. It

all depends on the degree of damage. But sound medical opinion takes the view that if a P.V.S. patient shows no signs of recovery after six months, or at most a year, then there is no prospect whatever of any recovery.

64. There are techniques available which make it possible to ascertain the state of the cerebral cortex, and in **Anthony Bland's** case these indicated that, it had degenerated into a mass of watery fluid. In this situation the question before the House of Lords was whether the doctors could withdraw medical treatment or feeding Anthony Bland thus allowing him to die.

65. It was held by Lord Keith that a medical practitioner is under no duty to continue to treat such a patient where a large body of informed and responsible medical opinion is to the effect that no benefit at all would be conferred by continuance of the treatment. Existence in a vegetative state with no prospect of recovery is by that opinion regarded

as not being of benefit to the patient.

66. Given that existence in the persistent vegetative state is of no benefit to the patient, the House of Lords then considered whether the principle of the sanctity of life which is the concern of the State (and the Judiciary is one of the arms of the State) required the Court to hold that medical treatment to Bland could not be discontinued.

67. Lord Keith observed that the principle of sanctity of life is not an absolute one. For instance, it does not compel the medical practitioner on pain of criminal sanction to treat a patient, who will die, if he does not, according to the express wish of the patient. It does not authorize forcible feeding of prisoners on hunger strike. It does not compel the temporary keeping alive of patients who are terminally ill where to do so would merely prolong their suffering. On the other hand, it forbids the taking of active measures

to cut short the life of a terminally-ill patient (unless there is legislation which permits it).

68. Lord Keith observed that although the decision whether or not the continued treatment and cure of a PVS patient confers any benefit on him is essentially one for the medical practitioners in charge of his case to decide, as a matter of routine the hospital/medical practitioner should apply to the Family Division of the High Court for endorsing or reversing the said decision. This is in the interest of the protection of the patient, protection of the doctors, and for the reassurance of the patient's family and the public.

69. In **Airdale's** case (Supra) another Judge on the Bench, Lord Goff of Chievely observed:-

> "The central issue in the present case has been aptly stated by the Master of the Rolls to be whether artificial feeding and antibiotic drugs may lawfully be withheld from an insensate patient with no hope of recovery when it is known that if that is done the patient will shortly thereafter die. The Court of Appeal, like the President, answered this question generally in the affirmative, and (in

the declarations made or approved by them) specifically also in the affirmative in relation to Anthony Bland . I find myself to be in agreement with the conclusions so reached by all the judges below, substantially for the reasons given by them. But the matter is of such importance that I propose to express my reasons in my own words.

I start with the simple fact that, in law, Anthony is still alive. It is true that his condition is such that it can be described as a living death; but he is nevertheless still alive. This is because, as a result of developments in modern medical technology, doctors no longer associate death exclusively with breathing and heart beat, and it has come to be accepted that death occurs when the brain, and in particular the brain stem, has been destroyed (see Professor Ian Kennedy's Paper entitled "Switching off Life Support Machines: The Legal Implications" reprinted in Treat Me Right, Essays in Medical Law and Ethics, (1988)), especially at pp. 351-2, and the material there cited). There has been no dispute on this point in the present case, and it is unnecessary for me to consider it further. The evidence is that Anthony's brain stem is still alive and functioning and it follows that, in the present state of medical science, he is still alive and should be so regarded as a matter of law.

It is on this basis that I turn to the applicable principles of law. Here, the fundamental principle is the principle of the sanctity of human life – a

principle long recognized not only in our own society but also in most, if not all, civilized societies throughout the modern world, as is indeed evidenced by its recognition both in article 2 of the European Convention of Human Rights, and in article 6 of the International Covenant of Civil and Political Rights.

But this principle, fundamental though it is, is not absolute. Indeed there are circumstances in which it is lawful to take another man's life, for example by a lawful act of self-defence, or (in the days when capital punishment was acceptable in our society) by lawful execution. We are not however concerned with cases such as these. We are concerned with circumstances in which it may be lawful to withhold from a patient medical treatment or care by means of which his life may be prolonged. But here too there is no absolute rule that the patient's life must be prolonged by such treatment or care, if available, regardless of the circumstances.

First, it is established that the principle of self-determination requires that respect must be given to the wishes of the patient, so that if an adult patient of sound mind refuses, however unreasonably, to consent to treatment or care by which his life would or might be prolonged, the doctors responsible for his care must give effect to his wishes, even though they do not consider it to be in his best interests to do so (see Schloendorff v . Society of New York Hospital 105 N.E. 92, 93, per Cardozo

J. (1914); S. v . McC. (Orse S.) and M (D.S. Intervene); W v . W [1972] A.C. 24, 43, per Lord Reid; and Sidaway v . Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital [1985] AC 871, 882, per Lord Scarman). To this extent, the principle of the sanctity of human life must yield to the principle of self- determination (see Court of Appeal Transcript in the present case, at p. 38F per Hoffmann L.J.), and, for present purposes perhaps more important, the doctor's duty to act in the best interests of his patient must likewise be qualified. On this basis, it has been held that a patient of sound mind may, if properly informed, require that life support should be discontinued: see **Nancy B. v. Hotel Dieu de Quebec** (1992) 86 D.L.R. (4th) 385. Moreover the same principle applies where the patient's refusal to give his consent has been expressed at an earlier date, before he became unconscious or otherwise incapable of communicating it; though in such circumstances especial care may be necessary to ensure that the prior refusal of consent is still properly to be regarded as applicable in the circumstances which have subsequently occurred (see, e.g. In re T. (Adult: Refusal of treatment) [1992] 3 W.L.R. 782). 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.

But in many cases not only may the patient be in no condition to be able to say whether or not he consents to the relevant treatment or care, but also he may have given no prior indication of his wishes with regard to it. In the case of a child who is a ward of court, the court itself will decide whether medical treatment should be provided in the child's best interests, taking into account medical opinion. But the court cannot give its consent on behalf of an adult patient who is incapable of himself deciding whether or not to consent to treatment. I am of the opinion that <u>there is nevertheless no absolute obligation upon the doctor who has the patient in his care to prolong his life, regardless of the circumstances</u>. Indeed, it would be most startling, and could lead to the most adverse and cruel effects upon the patient, if any such absolute rule were held to exist. 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. The point was put forcibly in the judgment of the Supreme Judicial Court of Massachusetts in **Superintendent of Belchertown State School v. Saikewicz** (1977) 370 N.E. 2d. 417, 428, as follows:

"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."

I must however stress, at this point, that the law draws a crucial distinction between cases in which a doctor decides not to provide, or to continue to provide, for his patient treatment or care which could or might prolong his life, and those in which he decides, for example by administering a lethal drug, actively to bring his patient's life to an end. As I have already indicated, the former may be lawful, either because the doctor is giving effect to his patient's wishes by withholding the treatment or care, or even in certain circumstances in which (on principles which I shall describe) the patient is incapacitated from stating whether or not he gives his consent. But it is not lawful for a doctor to administer a drug to his patient to bring about his death, even though that course is prompted by a humanitarian desire to end his suffering, however great that suffering may be: see **Reg. v. Cox** (Unreported), Ognall J., Winchester Crown Court, 18 September 1992. So to act is to cross the Rubicon which runs between on the one hand the care of the living patient and on the other hand euthanasia - actively causing his death to avoid or to end his suffering. Euthanasia is not lawful at common law. It is of course well known that there are many responsible members of our society who

believe that euthanasia should be made lawful; but that result could, I believe, only be achieved by legislation which expresses the democratic will that so fundamental a change should be made in our law, and can, if enacted, ensure that such legalised killing can only be carried out subject to appropriate supervision and control. It is true that the drawing of this distinction may lead to a charge of hypocrisy; because it can be asked why, if the doctor, by discontinuing treatment, is entitled in consequence to let his patient die, it should not be lawful to put him out of his misery straight away, in a more humane manner, by a lethal injection, rather than let him linger on in pain until he dies. But the law does not feel able to authorize euthanasia, even in circumstances such as these; for once euthanasia is recognized as lawful in these circumstances, it is difficult to see any logical basis for excluding it in others.

At the heart of this distinction lies a theoretical question. Why is it that the doctor who gives his patient a lethal injection which kills him commits an unlawful act and indeed is guilty of murder, whereas a doctor who, by discontinuing life support, allows his patient to die, may not act unlawfully - and will not do so, if he commits no breach of duty to his patient? Professor Glanville Williams has suggested (see his Textbook of Criminal Law, 2nd ed., p. 282) that the reason is that what the doctor does when he switches off a life support machine 'is in substance not an act but

an omission to struggle, and that 'the omission is not a breach of duty by the doctor because he is not obliged to continue in a hopeless case'.

I agree that the doctor's conduct in discontinuing life support can properly be categorized as an omission. It is true that it may be difficult to describe what the doctor actually does as an omission, for example where he takes some positive step to bring the life support to an end. But discontinuation of life support is, for present purposes, no different from not initiating life support in the first place. In each case, the doctor is simply allowing his patient to die in the sense that he is desisting from taking a step which might, in certain circumstances, prevent his patient from dying as a result of his pre-existing condition; and as a matter of general principle an omission such as this will not be unlawful unless it constitutes a breach of duty to the patient. I also agree that the doctor's conduct is to be differentiated from that of, for example, an interloper who maliciously switches off a life support machine because, although the interloper may perform exactly the same act as the doctor who discontinues life support, his doing so constitutes interference with the life-prolonging treatment then being administered by the doctor. Accordingly, whereas the doctor, in discontinuing life support, is simply allowing his patient to die of his pre-existing condition, the interloper is actively intervening to stop the doctor from prolonging the patient's life, and such conduct cannot possibly be

categorised as an omission.

The distinction appears, therefore, to be useful in the present context in that it can be invoked to explain how discontinuance of life support can be differentiated from ending a patient's life by a lethal injection. But in the end the reason for that difference is that, whereas the law considers that discontinuance of life support may be consistent with the doctor's duty to care for his patient, it does not, for reasons of policy, consider that it forms any part of his duty to give his patient a lethal injection to put him out of his agony.

I return to the patient who, because for example he is of unsound mind or has been rendered unconscious by accident or by illness, is incapable of stating whether or not he consents to treatment or care. In such circumstances, it is now established that a doctor may lawfully treat such a patient if he acts in his best interests, and indeed that, if the patient is already in his care, he is under a duty so to treat him: see In re F [1990] 2 AC 1, in which the legal principles governing treatment in such circumstances were stated by this House. For my part I can see no reason why, as a matter of principle, a decision by a doctor whether or not to initiate, or to continue to provide, treatment or care which could or might have the effect of prolonging such a patient's life, should not be governed by the same fundamental principle. Of course, in the great majority of cases, the best interests of the patient are

likely to require that treatment of this kind, if available, should be given to a patient. But this may not always be so. To take a simple example given by Thomas J. in Re J.H.L. (Unreported) (High Court of New Zealand) 13 August 1992, at p. 35), to whose judgment in that case I wish to pay tribute, it cannot be right that a doctor, who has under his care a patient suffering painfully from terminal cancer, should be under an absolute obligation to perform upon him major surgery to abate another condition which, if unabated, would or might shorten his life still further. 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. Such a decision may properly be made as part of the care of the living patient, in his best interests; and, on this basis, the treatment will be

lawful. Moreover, where the doctor's treatment of his patient is lawful, the patient's death will be regarded in law as exclusively caused by the injury or disease to which his condition is attributable.

It is of course the development of modern medical technology, and in particular the development of life support systems, which has rendered cases such as the present so much more relevant than in the past. 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 <u>whether he should be kept on it indefinitely</u>. 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. 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 <u>treatment</u> may, and <u>indeed ultimately</u>

should, be discontinued where it is no longer in his best interests to provide it. 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.

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. For example, in the case of a life support system, it is sometimes asked: Should a doctor be entitled to switch it off, or to pull the plug? And then it is asked: Can it be in the best interests of the patient that a doctor should be able to switch the life support system off, when this will inevitably result in the patient's death? Such an approach has rightly been criticised as misleading, for example by Professor Ian Kennedy (in his paper in Treat Me Right, Essays in Medical Law and Ethics (1988), and by Thomas J. in Re J.H.L. at pp. 21- 22. This is because 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.
>
> 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 the 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.
>
> (emphasis supplied)

70. In a Discussion Paper on Treatment of Patients in Persistent Vegetative State issued in September 1992 by the Medical Ethics Committee of the British Medical Association certain safeguards were mentioned which

should be observed before constituting life support for such patients:-

> “(1) Every effort should be made at rehabilitation for at least six months after the injury; (2) The diagnosis of irreversible PVS should not be considered confirmed until at least twelve months after the injury, with the effect that any decision to withhold life prolonging treatment will be delayed for that period; (3) The diagnosis should be agreed by two other independent doctors; and (4) Generally, the wishes of the patient's immediate family will be given great weight.”

71. Lord Goff observed that discontinuance of artificial feeding in such cases is not equivalent to cutting a mountaineer’s rope, or severing the air pipe of a deep sea diver. The true question is not whether the doctor should take a course in which he will actively kill his patient, but rather whether he should continue to provide his patient with medical treatment or care which, if continued, will prolong his life.

72. Lord Browne-Wilkinson was of the view that removing the nasogastric tube in the case of Anthony Bland cannot be regarded as a positive act causing the death. The tube itself, without the food being

supplied through it, does nothing. Its non removal itself does not cause the death since by itself, it does not sustain life. Hence removal of the tube would not constitute the actus reus of murder, since such an act would not cause the death.

73. Lord Mustill observed:-

> "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."

74. Thus all the Judges of the House of Lords in the **Airedale** case (supra) were agreed that Anthony Bland

should be allowed to die.

75. Airedale (1993) decided by the House of Lords has been followed in a number of cases in U.K., and the law is now fairly well settled that in the case of incompetent patients, if the doctors act on the basis of informed medical opinion, and withdraw the artificial life support system if it is in the patient's best interest, the said act cannot be regarded as a crime.

76. The question, however, remains as to who is to decide what is the patient's best interest where he is in a persistent vegetative state (PVS)? Most decisions have held that the decision of the parents, spouse, or other close relative, should carry weight if it is an informed one, <u>but it is not decisive</u> (several of these decisions have been referred to in Chapter IV of the 196th Report of the Law Commission of India on Medical Treatment to Terminally ill Patients).

77. It is ultimately for the Court to decide, as parens patriae, as to what is is in the best interest of the patient, though the wishes of close relatives and next friend, and opinion of medical practitioners should be given due weight in coming to its decision. As stated by Balcombe, J. in **In Re J** (A Minor Wardship : Medical Treatment) 1990(3) All E.R. 930, the Court as representative of the Sovereign as parens patriae will adopt the same standard which a reasonable and responsible parent would do.

78. The parens patriae (father of the country) jurisdiction was the jurisdiction of the Crown, which, as stated in Airedale, could be traced to the 13th Century. This principle laid down that as the Sovereign it was the duty of the King to protect the person and property of those who were unable to protect themselves. The Court, as a wing of the State, has inherited the parens patriae jurisdiction which formerly belonged to the King.

U.S. decisions

79. The two most significant cases of the U.S. Supreme Court that addressed the issue whether there was a federal constitutional right to assisted suicide arose from challenges to State laws banning physician assisted suicide brought by terminally ill patients and their physicians. These were **Washington vs. Glucksberg** 521 U.S. 702 (1997) and **Vacco vs. Quill** 521 U.S. 793 (1997).

80. In **Glucksberg's** case, the U.S. Supreme Court held that the asserted right to assistance in committing suicide is not a fundamental liberty interest protected by the Due Process Clause of the Fourteenth Amendment. The Court observed :

> "The decision to commit suicide with the assistance of another may be just as personal and profound as the decision to refuse unwanted medical treatment, but it has never enjoyed similar legal protection. Indeed the two acts are widely and reasonably regarded as quite distinct."

81. The Court went on to conclude that the Washington statute being challenged was rationally

related to five legitimate government interest : protection of life, prevention of suicide, protection of ethical integrity of the medical profession, protection of vulnerable groups, and protection against the "slippery slope" towards euthanasia. The Court then noted that perhaps the individual States were more suited to resolving or at least addressing the myriad concerns raised by both proponents and opponents of physician assisted suicide. The Court observed :

> "Throughout the Nation, Americans are engaged in an earnest and profound debate about the morality, legality and practicality of physician assisted suicide. Our holding permits this debate to continue, as it should in a democratic society."

82. In **Vacco's** case (supra) the U.S. Supreme Court again recognized the distinction between refusing life saving medical treatment and giving lethal medication. The Court disagreed with the view of the Second Circuit Federal Court that ending or refusing lifesaving medical treatment is nothing more nor less than assisted suicide. The Court held that "the distinction between letting a patient die and making that patient die is important, logical,

rational, and well established". The Court held that the State of New York could validly ban the latter.

83. In **Cruzan** v. **Director, MDH**, 497 U.S. 261(1990) decided by the U.S. Supreme Court the majority opinion was delivered by the Chief Justice Rehnquist.

84. In that case, the petitioner Nancy Cruzan sustained injuries in an automobile accident and lay in a Missouri State hospital in what has been referred to as a persistent vegetative state (PVS), a condition in which a person exhibits motor reflexes but evinces no indication of significant cognitive function. The state of Missouri was bearing the cost of her care. Her parents and co-guardians applied to the Court for permission to withdraw her artificial feeding and hydration equipment and allow her to die. While the trial Court granted the prayer, the State Supreme Court of Missouri reversed, holding that under a statute in the State of Missouri it was necessary to prove by

clear and convincing evidence that the incompetent person had wanted, while competent, withdrawal of life support treatment in such an eventuality. The only evidence led on that point was the alleged statement of Nancy Cruzan to a housemate about a year before the accident that she did not want life as a ‘vegetable’. The State Supreme Court was of the view that this did not amount to saying that medical treatment or nutrition or hydration should be withdrawn.

85. Chief Justice Rehnquist delivering the opinion of the Court (in which Justices White, O'Connor, Scalia, and Kennedy, joined) in his judgment first noted the facts:-

> “On the night of January 11, 1983, Nancy Cruzan lost control of her car as she traveled down Elm Road in Jasper County, Missouri. The vehicle overturned, and Cruzan was discovered lying face down in a ditch without detectable respiratory or cardiac function. Paramedics were able to restore her breathing and heartbeat at the accident site, and she was transported to a hospital in an unconscious state. An attending

neurosurgeon diagnosed her as having sustained probable cerebral contusions compounded by significant anoxia (lack of oxygen). The Missouri trial court in this case found that permanent brain damage generally results after 6 minutes in an anoxic state; it was estimated that Cruzan was deprived of oxygen from 12 to 14 minutes. She remained in a coma for approximately three weeks, and then progressed to an unconscious state in which she was able to orally ingest some nutrition. In order to ease feeding and further the recovery, surgeons implanted a gastrostomy feeding and hydration tube in Cruzan with the consent of her then husband. Subsequent rehabilitative efforts proved unavailing. She now lies in a Missouri state hospital in what is commonly referred to as a persistent vegetative state: generally, a condition in which a person exhibits motor reflexes but evinces no indications of significant cognitive function. 1 The State of Missouri is bearing the cost of her care. [497 U.S. 261, 267]

After it had become apparent that Nancy Cruzan had virtually no chance of regaining her mental faculties, her parents asked hospital employees to terminate the artificial nutrition and hydration procedures. All agree that such a [497 U.S. 261, 268] removal would cause her death. The employees refused to honor the request without court approval. The parents then sought and received authorization from the state trial court for termination."

86. While the trial Court allowed the petition the State Supreme Court of Missouri reversed. The US Supreme Court by majority affirmed the verdict of the State Supreme Court

87. Chief Justice Rehnquist noted that in law even touching of one person by another without consent and without legal justification was a battery, and hence illegal. The notion of bodily integrity has been embodied in the requirement that informed consent is generally required for medical treatment. As observed by Justice Cardozo, while on the Court of Appeals of New York “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.” vide **Schloendorff vs. Society of New York Hospital**, 211 N.Y. 125, 129-30, 105 N.E. 92, 93 (1914). Thus the informed consent doctrine has become firmly entrenched in American Tort Law. The logical corollary of the doctrine of informed

consent is that the patient generally possesses the right not to consent, that is to refuse treatment.

88. The question, however, arises in cases where the patient is unable to decide whether the treatment should continue or not e.g. if he is in coma or PVS. Who is to give consent to terminate the treatment in such a case? The learned Chief Justice referred to a large number of decisions of Courts in U.S.A. in this connection, often taking diverse approaches.

89. **In re Quinlan** 70 N.J.10, 355 A. 2d 647, Karen Quinlan suffered severe brain damage as a result of anoxia, and entered into PVS. Her father sought judicial approval to disconnect her respirator. The New Jersey Supreme Court granted the prayer, holding that Karen had a right of privacy grounded in the U.S. Constitution to terminate treatment. The Court concluded that the way Karen's right to privacy could be exercised would be to allow her guardian and family to decide whether she would exercise it in the circumstances.

90. **In re Conroy** 98 NJ 321, 486 A.2d 1209 (1985), however, the New Jersey Supreme Court, in a case of an 84 year old incompetent nursing home resident who had suffered irreversible mental and physical ailments, contrary to its decision in Quinlan's case, decided to base its decision on the common law right to self determination and informed consent. This right can be exercised by a surrogate decision maker when there was a clear evidence that the incompetent person would have exercised it. Where such evidence was lacking the Court held that an individual's right could still be invoked in certain circumstances under objective 'best interest' standards. Where no trustworthy evidence existed that the individual would have wanted to terminate treatment, and a person's suffering would make the administration of life sustaining treatment inhumane, a pure objective standard could be used to terminate the treatment. If none of these conditions obtained, it was best to err in favour of preserving life.

91. What is important to note in **Cruzan's** case (supra) is that there was a statute of the State of Missouri, unlike in **Airedale's** case (where there was none), which required clear and convincing evidence that while the patient was competent she had desired that if she becomes incompetent and in a PVS her life support should be withdrawn.

92. In **Cruzan's** case (supra) the learned Chief Justice observed :

> "Not all incompetent patients will have loved ones available to serve as surrogate decision makers. And even where family members are present, there will be, of course, some unfortunate situations in which family members will not act to protect a patient. A State is entitled to guard against potential abuses in such situations."

93. The learned Chief Justice further observed :

> "An erroneous decision not to terminate results in maintenance of the status quo; the possibility of subsequent developments such as advancements in medical science, the discovery of new evidence regarding the

> patient's intent, changes in the law, or simply the unexpected death of the patient despite the administration of life-sustaining treatment, at least create the potential that a wrong decision will eventually be corrected or its impact mitigated. An erroneous decision to withdraw life-sustaining treatment, however, is not susceptible of correction."

94. No doubt Mr. Justice Brennan (with whom Justices Marshall and Blackmun joined) wrote a powerful dissenting opinion, but it is not necessary for us to go into the question whether the view of the learned Chief Justice or that of Justice Brennan, is correct.

95. It may be clarified that foreign decisions have only persuasive value in our country, and are not binding authorities on our Courts. Hence we can even prefer to follow the minority view, rather than the majority view, of a foreign decision, or follow an overruled foreign decision.

96. **Cruzan's** case (supra) can be distinguished on

the simple ground that there was a statute in the State of Missouri, whereas there was none in the **Airedale's** case nor in the present case before us. We are, therefore, of the opinion that the **Airedale's** case (supra) is more apposite as a precedent for us. No doubt foreign decisions are not binding on us, but they certainly have persuasive value.

LAW IN INDIA

97. In India abetment of suicide (Section 306 Indian Penal Code) and attempt to suicide (Section 309 of Indian Penal Code) are both criminal offences. This is in contrast to many countries such as USA where attempt to suicide is not a crime.

98. The Constitution Bench of the Indian Supreme Court in **Gian Kaur vs. State of Punjab**, 1996(2) SCC 648 held that both euthanasia and assisted suicide are not lawful in India. That decision overruled the earlier two Judge Bench decision of the Supreme Court in **P. Rathinam vs. Union of**

India, 1994(3) SCC 394. The Court held that the right to life under Article 21 of the Constitution does not include the right to die (vide para 33). In **Gian Kaur's** case (supra) the Supreme Court approved of the decision of the House of Lords in **Airedale's** case (supra), and observed that euthanasia could be made lawful only by legislation.

99. Sections 306 and 309 IPC read as under :

> "**306. Abetment of suicide** -If any person commits suicide, whoever abets the commission of such suicide, shall be punished with imprisonment of either description for a term which may extend to ten years, and shall also be liable to fine.
>
> **309. Attempt to commit suicide** - Whoever attempts to commit suicide and does any act towards the commission of such offence, shall be punished with simple imprisonment for a term which may extend to one year or with fine, or with both."

100. We are of the opinion that although Section 309 Indian Penal Code (attempt to commit suicide) has been held to be constitutionally valid in **Gian**

Kaur's case (supra), the time has come when it should be deleted by Parliament as it has become anachronistic. A person attempts suicide in a depression, and hence he needs help, rather than punishment. We therefore recommend to Parliament to consider the feasibility of deleting Section 309 from the Indian Penal Code.

101. It may be noted that in **Gian Kaur's** case (supra) although the Supreme Court has quoted with approval the view of the House of Lords in **Airedale's** case (supra), 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.

102. This is an extremely important question in India

because of the unfortunate low level of ethical standards to which our society has descended, its raw and widespread commercialization, and the rampant corruption, and hence, the Court has to be very cautious that unscrupulous persons who wish to inherit the property of someone may not get him eliminated by some crooked method.

103. Also, since medical science is advancing fast, doctors must not declare a patient to be a hopeless case unless there appears to be no reasonable possibility of any improvement by some newly discovered medical method in the near future. In this connection we may refer to a recent news item which we have come across on the internet of an Arkansas man Terry Wallis, who was 19 years of age and newly married with a baby daughter when in 1984 his truck plunged through a guard rail, falling 25 feet. He went into coma in the crash in 1984, but after 24 years he has regained consciousness. This was perhaps because his brain spontaneously rewired itself by growing tiny new nerve connections to

replace the ones sheared apart in the car crash. Probably the nerve fibers from Terry Wallis' cells were severed but the cells themselves remained intact, unlike Terri Schiavo, whose brain cells had died (see Terri Schiavo's case on Google).

104. However, we make it clear that it is experts like medical practitioners who can decide whether there is any reasonable possibility of a new medical discovery which could enable such a patient to revive in the near future.

WHEN CAN A PERSON IS SAID TO BE DEAD

105. It is alleged in the writ petition filed by Ms. Pinky Virani (claiming to be the next friend of Aruna Shanbaug) that in fact Aruna Shanbaug is already dead and hence by not feeding her body any more we shall not be killing her. The question hence arises as to when a person can be said to be dead ?

106. A person's most important organ is his/her

brain. This organ cannot be replaced. Other body parts can be replaced e.g. if a person’s hand or leg is amputed, he can get an artificial limb. Similarly, we can transplant a kidney, a heart or a liver when the original one has failed. However, we cannot transplant a brain. If someone else’s brain is transplanted into one’s body, then in fact, it will be that other person living in one’s body. The entire mind, including one’s personality, cognition, memory, capacity of receiving signals from the five senses and capacity of giving commands to the other parts of the body, etc. are the functions of the brain. Hence one is one’s brain. It follows that one is dead when one’s brain is dead.

107. As is well-known, the brain cells normally do not multiply after the early years of childhood (except in the region called hippocampus), unlike other cells like skin cells, which are regularly dying and being replaced by new cells produced by multiplying of the old cells. This is probably because brain cells are too highly specialized to

multiply. Hence if the brain cells die, they usually cannot be replaced (though sometimes one part of the brain can take over the function of another part in certain situations where the other part has been irreversibly damaged).

108. Brain cells require regular supply of oxygen which comes through the red cells in the blood. If oxygen supply is cut off for more than six minutes, the brain cells die and this condition is known as anoxia. Hence, if the brain is dead a person is said to be dead.

BRAIN DEATH

109. The term ‘brain death’ has developed various meanings. While initially, death could be defined as a cessation of breathing, or, more scientifically, a cessation of heart-beat, recent medical advances have made such definitions obsolete. In order to understand the nature and scope of brain death, it is worthwhile to look at how death was understood.

Historically, as the oft-quoted definition in Black's Law Dictionary suggests, death was: "*The cessation of life; the ceasing to exist; defined by physicians as a total stoppage of the circulation of the blood, and a cessation of the animal and vital functions consequent thereon, such as respiration, pulsation, etc.*".[1] This definition saw its echo in numerous other texts and legal case law. This includes many American precedents- such as ***Schmidt v. Pierce***, 344 S.W.2d 120, 133 (Mo. 1961) ("Black's Law Dictionary, 4th Ed., defines death as 'the cessation of life; the ceasing to exist ...."'); and ***Sanger v. Butler***, 101 S.W. 459, 462 (Tex. Civ. App. 1907) ("The Encyclopaedic Dictionary, among others, gives the following definitions of [death]: 'The state of being dead; the act or state of dying; the state or condition of the dead.' The Century Dictionary defines death as 'cessation of life; that state of a being, animal or vegetable, in which there is a total and permanent

1 Black's Law Dictionary 488 (4th ed., rev. 1968).

cessation of all the vital functions."').[2]

110. This understanding of death emerged from a cardiopulmonary perspective. In such cases, the brain was usually irrelevant -- being understood that the cessation of circulation would automatically lead to the death of brain cells, which require a great deal of blood to survive.

111. The invention of the ventilator and the defibrillator in the 1920s altered this understanding, it being now possible that the cessation of respiration and circulation, though critical, would no longer be irreversible[3]. 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. The question of the length of time that may determine such death is significant, especially considering a significant

2 Goldsmith, Jason, *Wanted! Dead and/or Alive: Choosing Amongst the Many Not-so-Uniform Definitions of Death,* 61 U. Miami L. Rev. 871. (2007).

3 Samantha Weyrauch, *Acceptance of Whole Brain Death Criteria for Determination of Death: A Comparative Analysis of the United States and Japan,* 17 UCLA Pac. Basin L.J. 91, 96. (1999).

increase in organ donations across jurisdictions over the last few years.

112. Brain death, may thus, be defined as “the irreversible cessation of all functions of the entire brain, including the brain stem”.[4] It is important to understand that this definition goes beyond acknowledging consciousness **--** a person who is incapable of ever regaining consciousness will not be considered to be brain dead as long as parts of the brain e.g. brain stem that regulate involuntary activity (such as response to light, respiration, heartbeat etc.) still continue to function. Likewise, if consciousness, albeit severely limited, is present, then a person will be considered to be alive even if he has suffered brain stem death, wherein breathing and heartbeat can no longer be regulated and must be mechanically determined. Hence, the international standard for brain death is usually considered to include “whole-

4 Section 1, Universal Determination of Death Act, (The United States Legislation)

brain death”, i.e., a situation where the higher brain (i.e. the part of the brain that regulates consciousness and thought), the cerebellum or mid-brain, and the brain-stem have all ceased to demonstrate any electrical activity whatsoever for a significant amount of time. To say, in most cases, that only the death of the higher brain would be a criteria for ‘brain death’ may have certain serious consequences **--** for example, a foetus, technically under this definition, would not be considered to be alive at all. Similarly, as per this, different definitions of death would apply to human and non-human organisms.

113. Brain death, thus, is different from a persistent vegetative state, where the brain stem continues to work, and so some degree of reactions may occur, though the possibility of regaining consciousness is relatively remote. Even when a person is incapable of any response, but is able to sustain respiration and circulation, he cannot be said to be dead. The mere mechanical act of

breathing, thus, would enable him or her to be “alive”.

114. The first attempt to define death in this manner came about in 1968, as a result of a Harvard Committee constituted for the purpose.[5] This definition, widely criticized for trying to maximize organ donations, considered death to be a situation wherein *“individuals who had sustained traumatic brain injury that caused them to be in an irreversible coma, and had lost the ability to breathe spontaneously”*[6], would be considered dead. This criticism led to the Presidents’ Committee, set up for the purpose, in 1981, defining death more vaguely as the point *“where the body’s physiological system ceases to contribute a uniform whole*”.

This definition of whole brain death, however, is not without its critics. Some argue that the brain is not always responsible for all bodily

5 Ad Hoc Comm. of the Harvard Med. Sch. to Examine the Definition of Brain Death, *A Definition of Irreversible Coma*, 205 JAMA 337, 337-40 (1968).

6 Seema K. Shah, Franklin Miller, *Can We Handle The Truth? Legal Fictions in the Determination of Death.* 36 Am. J.L. & Med. 540 (2010).

functioning- digestion, growth, and some degree of movement (regulated by the spinal cord) may not require any electrical activity in the brain. In order to combat this argument, and further explain what brain death could include, the President's Committee on Bio-ethics in the United States of America in 2008 came up with a new definition of brain death, according to which a person was considered to be brain dead when he could no longer perform the fundamental human work of an organism. These are:

"(1) "openness to the world, that is receptivity to stimuli and signals from the surrounding environment,"
(2) "the ability to act upon the world to obtain selectively what it needs.
and (3) "the basic felt need that drives the organism to act ... to obtain what it needs."[7]

115. When this situation is reached, it is possible to assume that the person is dead, even though he or she, through mechanical stimulation, may be able to breathe, his or her heart might be able to beat, and

7 Ibid.

he or she may be able to take some form of nourishment. It is important, thus, that it be medically proved that a situation where any human functioning would be impossible should have been reached for there to be a declaration of brain death--situations where a person is in a persistent vegetative state but can support breathing, cardiac functions, and digestion *without* any mechanical aid are necessarily those that will not come within the ambit of brain death.

116. In legal terms, the question of death would naturally assume significance as death has a set of *legal* consequences as well. As per the definition in the American Uniform Definition of Death Act, 1980. an individual who "*sustain[s] . . . irreversible cessation of all functions of the entire brain, including the brain stem, is dead*." This stage, thus, is reached at a situation where not only consciousness, but every other aspect of life regulated from the brain can no longer be so regulated.

117. In the case of ‘euthanasia’, however, the situation is slightly different. In these cases, it is believed, that a determination of when it would be right or fair to disallow resuscitation of a person who is incapable of expressing his or her consent to a termination of his or her life depends on two circumstances:

a. when a person is only kept alive mechanically, i.e. when not only consciousness is lost, but the person is only able to sustain involuntary functioning through advanced medical technology--such as the use of heart-lung machines, medical ventilators etc.
b. when there is no plausible possibility of the person ever being able to come out of this stage. Medical “miracles” are not unknown, but if a person has been at a stage where his life is only sustained through medical technology, and there has been no significant alteration in the person’s condition for a long period of time—at least a few years--then there can be a fair case made out for passive

euthanasia.

To extend this further, especially when a person is incapable of being able to give any consent, would amount to committing judicial murder.

118. In this connection we may refer to the Transplantation of Human Organs Act, 1994 enacted by the Indian Parliament. Section 2(d) of the Act states :

> "brain-stem death" means the stage at which all functions of the brain-stem have permanently and irreversibly ceased and is so certified under sub-section (6) of section 3:"

119. Section 3(6) of the said Act states:

"(6) Where any human organ is to be removed from the body of a person in the event of his brain-stem death, no such removal shall be undertaken unless such death is certified, in such form and in such manner and on satisfaction of such conditions and requirements as may be prescribed, by a Board of medical experts consisting of the following,

namely:-

(i) the registered medical practitioner, in charge of the hospital in which brain-stem death has occurred;

(ii) an independent registered medical practitioner, being a specialist, to be nominated by the registered medical practitioner specified in clause (i), from the panel of names approved by the Appropriate Authority;

(iii) a neurologist or a neurosurgeon to be nominated by the registered medical practitioner specified in clause (i), from the panel of names approved by the Appropriate Authority; and

(iv) the registered medical practitioner treating the person whose brain-stem death has occurred".

120. Although the above Act was only for the purpose of regulation of transplantation of human organs it throws some light on the meaning of brain death.

121. From the above angle, it cannot be said that Aruna Shanbaug is dead. Even from the report of Committee of Doctors which we have quoted above it appears that she has some brain activity, though

very little.

122. She recognizes that persons are around her and expresses her like or dislike by making some vocal sound and waving her hand by certain movements. She smiles if she receives her favourite food, fish and chicken soup. She breathes normally and does not require a heart lung machine or intravenous tube for feeding. Her pulse rate and respiratory rate and blood pressure are normal. She was able to blink well and could see her doctors who examined her. When an attempt was made to feed her through mouth she accepted a spoonful of water, some sugar and mashed banana. She also licked the sugar and banana paste sticking on her upper lips and swallowed it. She would get disturbed when many people entered her room, but she appeared to calm down when she was touched or caressed gently.

123. Aruna Shanbaug meets most of the criteria for being in a permanent vegetative state which has resulted for 37 years. However, her dementia has

not progressed and has remained stable for many years.

124. From the above examination by the team of doctors, it cannot be said that Aruna Shanbaug is dead. Whatever the condition of her cortex, her brain stem is certainly alive. She does not need a heart--lung machine. She breathes on her own without the help of a respirator. She digests food, and her body performs other involuntary function without any help. From the CD (which we had screened in the courtroom on 2.3.2011 in the presence of counsels and others) it appears that she can certainly not be called dead. She was making some sounds, blinking, eating food put in her mouth, and even licking with her tongue morsels on her mouth.

125. However, there appears little possibility of her coming out of PVS in which she is in. In all probability, she will continue to be in the state in which she is in till her death. The question now is

whether her life support system (which is done by feeding her) should be withdrawn, and at whose instance?

WITHDRAWAL OF LIFE SUPPORT OF A PATIENT IN PERMANENT VEGETATIVE STATE (PVS)

126. 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 **Vishakha's** case (supra), we are laying down the law in this connection which will continue to be the law until Parliament makes a law on the subject.

(i) A decision has to be taken to discontinue life support either by the parents or the spouse or other close

relatives, 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. Pinky Virani who has only visited her on few occasions and written a book on her. Hence it is for the KEM hospital staff to take that decision. The KEM hospital staff have clearly

expressed their wish that Aruna Shanbaug should be allowed to live.

Mr. Pallav Shisodia, learned senior counsel, appearing for the Dean, KEM Hospital, Mumbai, submitted that Ms. Pinky Virani has no locus standi in this case. In our opinion it is not necessary for us to go into this question since we are of the opinion that it is the KEM Hospital staff who is really the next friend of Aruna Shanbaug.

We do not mean to decry or disparage what Ms. Pinky Virani has done. Rather, we wish to express our appreciation of the splendid social spirit she has shown. We have seen on the internet that she has been espousing many social causes, and we hold her in high esteem. All that we wish to say is that however much her interest in Aruna Shanbaug may be it cannot match the

involvement of the KEM hospital staff who have been taking care of Aruna day and night for 38 years.

However, assuming that the KEM hospital staff at some future time changes its mind, in our opinion in such a situation the 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's** case (supra).

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.

127. 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 the property of the patient. Considering the low ethical levels prevailing in our society today and the rampant commercialization and corruption, 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. There are doctors and doctors. While many doctors are upright, there are others who can do anything for money (see George Bernard Shaw's play 'The Doctors Dilemma'). The commercialization of our society has crossed all limits. Hence we have to guard against the potential of misuse (see Robin Cook's novel 'Coma'). 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 the Lord Keith in **Airedale's** case (supra) 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, relative 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 a well known principle of law.

DOCTRINE OF PARENS PATRIAE

128. The doctrine of Parens Patriae (father of the country) had originated in British law as early as the 13th century. It implies that the King is the father of the country and is under obligation to look after the interest of those who are unable to

look after themselves. The idea behind Parens Patriae is that if a citizen is in need of someone who can act as a parent who can make decisions and take some other action, sometimes the State is best qualified to take on this role.

129. In the Constitution Bench decision of this Court in **Charan Lal Sahu vs. Union of India** (1990) 1 SCC 613 (vide paras 35 and 36), the doctrine has been explained in some details as follows :

> "In the "*Words and Phrases*" Permanent Edition, Vol. 33 at page 99, it is stated that parens patriae is the inherent power and authority of a legislature to provide protection to the person and property of persons *non sui juris*, such as minor, insane, and incompetent persons, but the words parens patriae meaning thereby 'the father of the country', were applied originally to the King and are used to designate the State referring to its sovereign power of guardianship over persons under disability. Parens patriae jurisdiction, it has been explained, is the right of the sovereign and imposes a duty on the sovereign, in public interest, to protect persons under disability who have no rightful protector. The connotation of the term parens patriae differs from country to country, for instance, in England it is the King, in

> America it is the people, etc. The government is within its duty to protect and to control persons under disability".

The duty of the King in feudal times to act as parens patriae (father of the country) has been taken over in modern times by the State.

130. In **Heller vs. DOE** (509) US 312 Mr. Justice Kennedy speaking for the U.S. Supreme Court observed :

> "the State has a legitimate interest under its parens patriae powers in providing care to its citizens who are unable to care for themselves".

131. In **State of Kerala** vs. **N.M. Thomas**, 1976(1) SCR 906 (at page 951) Mr. Justice Mathew observed :

> " The Court also is 'state' within the meaning of Article 12 (of the Constitution).".

132. In our opinion, in the case of an incompetent person who is unable to take a decision whether to withdraw life support or not, it is the Court alone,

as parens patriae, which ultimately must take this decision, though, no doubt, the views of the near relatives, next friend and doctors must be given due weight.

UNDER WHICH PROVISION OF THE LAW CAN THE COURT GRANT APPROVAL FOR WITHDRAWING LIFE SUPPORT TO AN INCOMPETENT PERSON

133. In our opinion, it is the High Court under Article 226 of the Constitution which can grant approval for withdrawal of life support to such an incompetent person. Article 226(1) of the Constitution states :

> "Notwithstanding anything in article 32, every High Court shall have power, throughout the territories in relation to which it exercises jurisdiction, to issue to any person or authority, including in appropriate cases, any Government, within those territories directions, orders or writs, including writs in the nature of *habeas corpus*, *mandamus,* prohibition, *quo warranto* and *certiorari,* or any of them, for the enforcement of any of the rights conferred by Part III and for any other purpose".

134. A bare perusal of the above provisions shows

that the High Court under Article 226 of the Constitution is not only entitled to issue writs, but is also entitled to issue directions or orders.

135. In **Dwarka Nath** vs. **ITO** AIR 1966 SC 81(vide paragraph 4) this Court observed :

> "This article is couched in comprehensive phraseology and it ex facie confers a wide power on the High Courts to reach injustice wherever it is found. The Constitution designedly used a wide language in describing the nature of the power, the purpose for which and the person or authority against whom it can be exercised. It can issue writs in the nature of prerogative writs as understood in England; but the scope of those writs also is widened by the use of the expression "nature", for the said expression does not equate the writs that can be issued in India with those in England, but only draws an analogy from them. That apart, High Courts can also issue directions, orders or writs other than the prerogative writs. It enables the High Courts to mould the reliefs to meet the peculiar and complicated requirements of this country. Any attempt to equate the scope of the power of the High Court under Art. 226 of the Constitution with that of the English Courts to issue prerogative writs is to introduce the unnecessary procedural restrictions grown over the years in a comparatively small country like England with a

> unitary form of Government to a vast country like India functioning under a federal structure."

136. The above decision has been followed by this Court in **Shri Anadi Mukta Sadguru vs. V. R. Rudani** AIR 1989 SC 1607 (vide para 18).

137. No doubt, the ordinary practice in our High Courts since the time of framing of the Constitution in 1950 is that petitions filed under Article 226 of the Constitution pray for a writ of the kind referred to in the provision. However, from the very language of the Article 226, and as explained by the above decisions, a petition can also be made to the High Court under Article 226 of the Constitution praying for an order or direction, and not for any writ. Hence, in our opinion, Article 226 gives abundant power to the High Court to pass suitable orders on the application filed by the near relatives or next friend or the doctors/hospital staff praying for permission to withdraw the life support to an incompetent person of the kind above

mentioned.

PROCEDURE TO BE ADOPTED BY THE HIGH COURT WHEN SUCH AN APPLICATION IS FILED

138. 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.

139. 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.

140. 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.

141. The High Court should give its decision speedily at the earliest, since delay in the matter may result in causing great mental agony to the relatives and persons close to the patient.

142. The High Court should give its decision assigning specific reasons in accordance with the

principle of ‘best interest of the patient’ laid down by the House of Lords in **Airedale’s** case (supra). The views of the near relatives and committee of doctors should be given due weight by the High Court before pronouncing a final verdict which shall not be summary in nature.

143. With these observations, this petition is dismissed.

144. Before parting with the case, we would like to express our gratitude to Mr. Shekhar Naphade, learned senior counsel for the petitioner, assisted by Ms. Shubhangi Tuli, Ms. Divya Jain and Mr. Vimal Chandra S. Dave, advocates, the learned Attorney General for India Mr. G. E. Vahanvati, assisted by Mr. Chinmoy P. Sharma, advocate, Mr. T. R. Andhyarujina, learned Senior Counsel, whom we had appointed as amicus curiae assisted by Mr. Soumik Ghoshal, advocate, Mr. Pallav Shishodia, learned senior counsel, assisted by Ms. Sunaina Dutta and Mrs. Suchitra Atul Chitale, advocates for the KEM

Hospital, Mumbai and Mr. Chinmoy Khaldkar, counsel for the State of Maharashtra, assisted by Mr. Sanjay V. Kharde and Ms. Asha Gopalan Nair, advocates, who were of great assistance to us. We wish to express our appreciation of Mr. Manav Kapur, Advocate, who is Law-Clerk-cum-Research Assistant of one of us (Katju, J.) as well as Ms. Neha Purohit, Advocate, who is Law-Clerk-cum-Research Assistant of Hon'ble Justice Gyan Sudha Mishra. We also wish to mention the names of Mr. Nithyaesh Nataraj and Mr. Vaibhav Rangarajan, final year law students in the School of Excellence, Dr. B.R. Ambedkar Law University, Chennai, who were the interns of one of us (Katju, J.) and who were of great help in doing research in this case.

145. We wish to commend the team of doctors of Mumbai who helped us viz. Dr. J. V. Divatia, Professor and Head, Department of Anesthesia, Critical Care and Pain at Tata Memorial Hospital, Mumbai; Dr. Roop Gursahani, Consultant Neurologist at P.D. Hinduja, Mumbai; and Dr. Nilesh Shah, Professor and Head,

Department of Psychiatry at Lokmanya Tilak Municipal Corporation Medical College and General Hospital. They did an excellent job.

146. We also wish to express our appreciation of Ms. Pinki Virani who filed this petition. Although we have dismissed the petition for the reasons given above, we regard her as a public spirited person who filed the petition for a cause she bona fide regarded as correct and ethical. We hold her in high esteem.

147. We also commend the entire staff of KEM Hospital, Mumbai (including the retired staff) for their noble spirit and outstanding, exemplary and unprecedented dedication in taking care of Aruna for so many long years. Every Indian is proud of them.

…….……J.
(Markandey Katju)

…….J.
(Gyan Sudha Misra)

New Delhi:
March 07, 2011