IN THE HIGH COURT OF DELHI AT NEW DELHI

No. 2387 – 2399 /DHC/Gaz.IB/G-2/SC-Judgment/2026 Dated: 27 .04.2026

From :

The Registrar General,
High Court of Delhi,
New Delhi.

To

1. The Principal District & Sessions Judge (HQ), Tis Hazari Courts Complex, Delhi.
2. The Principal District & Sessions Judge (South), Saket Courts Complex, New Delhi
3. The Principal District & Sessions Judge (South-East), Saket Courts complex, Delhi.
4. The Principal District & Sessions Judge (North-West), Rohini Courts Complex, Delhi.
5. The Principal District & Sessions Judge (East), Karkardooma Courts Complex, Delhi.
6. The Principal District & Sessions Judge (North-East), Karkardooma Courts Complex, Delhi.
7. The Principal District & Sessions Judge (West), Tis Hazari Courts Complex, Delhi.
8. The Principal District & Sessions Judge (North), Rohini Courts Complex, Delhi.
9. The Principal District & Sessions Judge-cum-Special Judge (PC Act) (CBI), RACC, New Delhi.
10. The Principal District & Sessions Judge (New Delhi), Patiala House Courts Complex, New Delhi.
11. The Principal District & Sessions Judge (Shahdara), Karkardooma Courts Complex, Delhi.
12. The Principal District & Sessions Judge (South-West), Dwarka Courts Complex, New Delhi.
13. The Principal Judge (HQ), Family Courts, Dwarka, New Delhi.

Sub : **Request for circulation of two separate but concurring judgments dated 11.03.2026 passed by the Hon'ble Supreme Court of India in M.A. No. 2238 of 2025 in SLP (Civil) No. 18225 of 2024 titled "Harish Rana vs. Union of India & Ors."**

Sir/ Madam,

I am directed to request you to kindly download two separate but concurring judgments dated 11.03.2026 passed by the Hon'ble Supreme Court of India in M.A. No. 2238 of 2025 in SLP (Civil) No. 18225 of 2024 titled "Harish Rana vs. Union of India & Ors" from the official website of Supreme Court of India i.e. **supremecourtofindia.nic.in** and circulate the same amongst all the Judicial Officers working under your respective control for information and necessary compliance.

Yours faithfully,

27/04/2

(Sunil Singh Negi)
Deputy Registrar (Gazette-IB)
For Registrar General.

OFFICE OF THE PRINCIPAL DISTRICT & SESSIONS JUDGE: ROHINI COURTS, DELHI

No. 17768-17849 Genl.I/F.3-A/N-W&N/RC/2026 Dated 29/04/2026

Copy alongwith its enclosures **(through electronic mode)**, forwarded for information & necessary action/compliance, to :-

1. All Ld. Judicial Officers posted at **N/W & North District**, Rohini Courts, Delhi.
2. Dealing Official, Computer Branch, Rohini Courts for uploading the same on WEBSITE **(on e-mail of Ld. Judicial Officers also)**
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29/4/26

(RAJANI RANGA)
Officer In-Charge, General Branch-I
North-West & North District
Rohini Court Complex, Delhi.

2026 INSC 222

REPORTABLE

IN THE SUPREME COURT OF INDIA

EXTRA-ORDINARY APPELLATE JURISDICTION

MISCELLANEOUS APPLICATION NO. 2238 OF 2025

IN

SPECIAL LEAVE PETITION (CIVIL) NO. 18225 OF 2024

HARISH RANA **...APPLICANT**

VERSUS

UNION OF INDIA & ORS. **...RESPONDENTS**

J U D G M E N T

J.B. PARDIWALA, J.:

For the convenience of exposition, this judgment is divided into the following parts:

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"*God asks no man whether*
he will accept life.
That is not the choice.
You must take it.
The only choice is how."

1. The above words of Henry Ward Beecher assume great significance in the present case, more particularly when the courts are asked to give their decision on the question whether an individual can choose to accept life by preferring to die. The famous Shakespearean dilemma of "*to be or not to be*", which had so far remained as a literary quote, is now being used for judicial interpretation to canvass the liberty to die.

2. The present Miscellaneous Application ("**MA**") has been filed by a mentally and physically incapacitated applicant, namely, Harish Rana, through his parents, in the captioned SLP that came to be disposed of by this Court *vide* order dated 08.11.2024. By way of the said order, this Court resolved the matter between the parties by ensuring that adequate care and necessary treatment are provided to the applicant, including but not limited to the provision of home care, at the expense of the respondents.

3. The captioned SLP had arisen from the order dated 02.07.2024 passed by the High Court of Delhi in Writ Petition (C) No. 4927 of 2024, whereby the High Court had dismissed the writ petition on the ground that the applicant was not being kept alive mechanically and that he was able to sustain himself without any extra or external medical aid. In the High Court's opinion, such a condition did not require any judicial intervention. Aggrieved by the said

order, the applicant, through his parents, preferred the captioned SLP.

4. While disposing of the captioned SLP, this Court had granted liberty to the applicant to move this Court through his parents for obtaining any further directions should it become necessary to do so. Accordingly, owing to the applicant's continued vegetative existence, which violates his right to live with dignity as enshrined under Article 21 of the Constitution of India, the parents have moved this Court once again *vide* the present MA *inter alia* seeking: (i) constitution and referral of the applicant's case to the primary medical board; and (ii) declaration that the provision of Clinically Assisted Nutrition and Hydration (hereinafter referred to as "**CANH**") which is currently being administered to him through a Percutaneous Endoscopic Gastrostomy tube (hereinafter referred to as "**PEG tube**") is *"medical treatment"*.

5. Further, the parents have also prayed that the suitability of continuation of CANH be assessed in accordance with the ruling of the five- judge Constitution Bench of this Court in ***Common Cause v. Union of India***, reported in **(2018) 5 SCC 1** (hereinafter referred to as "**Common Cause 2018**") and the guidelines ascribed therein, which were later modified to some extent by ***Common Cause v. Union of India***, reported in **(2023) 14 SCC 131** (hereinafter referred to as "**Common Cause 2023**"). For ease of reference, the guidelines regarding withdrawal and withholding of medical treatment where no Advance Medical Directive ("**AMD**") exist, as laid down in **Common Cause 2018** (*supra*) and modified in **Common**

Cause 2023 (*supra*), will be hereinafter referred to as "**Common Cause Guidelines**"

(A). FACTUAL MATRIX

6. The applicant, presently aged 32 years, was once a young man of 20 years with a promising future, pursuing a B.Tech degree at Punjab University, when he met with a tragic and life-altering accident. On the fateful evening of 20.08.2013, at around 6 p.m., the applicant is stated to have fallen from the fourth floor of his paying guest accommodation, as a result of which he sustained a diffuse axonal injury. He was initially rushed to the Garhwal local hospital, but within a few hours, he had to be shifted to the Postgraduate Institute of Medical Education & Research, Chandigarh ("**PGI, Chandigarh**") due to the severity of his medical condition. From 21.08.2013 to 27.08.2013, he remained admitted at the PGI, Chandigarh, where he was administered treatment in the form of conservative management, including AED, analgesics, ventilating support, antibiotics, tracheostomy, and feeding through a Ryle's tube (nasogastric tube). Although he was discharged from PGI, Chandigarh, on 27.08.2013, yet unfortunately, his condition remained far from recovery.

7. Following his discharge, his fragile health condition necessitated frequent hospital admissions and regular medical treatments for his head injury, seizures, pneumonia and bedsores at the Jai Prakash Narayan Trauma Centre, All India Institute of Medical Sciences, New Delhi ("**AIIMS**"). In the year 2013, the mode of administering

CANH to the petitioner came to be switched from Ryle's Tube/nasogastric tube to a surgically placed PEG tube, which now requires replacement at a hospital every two months.

8. Ever since the incident, the applicant has been on tracheostomy, urinary catheter and CANH administered through the PEG tube. The applicant's medical records also indicate that he had a history of seizures in the year 2014, for which he was put on medication. The last seizure occurred in the year 2016, and since then, he has been receiving anti-seizure drugs for its prevention.

9. Medical reports of the applicant indicate that he exhibits no evidence of awareness of his environment and is incapable of interacting with others. He also does not indicate by any facial gesture, grunting, or body movement if he is hungry, has soiled himself or is in any other discomfort. The family of the applicant have also conveyed that they have not noted any significant benefit from any of the several treatments, including hyperbaric oxygen therapy, that were tried over the span of the last 13 years. The applicant's neurological condition has remained static with no improvement. He is unable to express his needs and has been dependent on all activities of self-care.

10. He has sleep-wake cycles and sleeps through the night. His eyes open with normal blinks but with no purposeful movement or as a response to auditory, verbal, tactile or painful stimulus. The applicant has remained bedridden ever since the incident, due to which he has often suffered terribly from painful bedsores, despite receiving the most attentive nursing care from his mother. Although

the applicant has largely been cared for at home, yet his susceptible condition has time and again necessitated hospitalisation for infections. His most recent hospitalisation had been in May 2025, at the District Hospital Ghaziabad, for the treatment of coughing and bedsores. The week-long hospitalisation also involved another tracheostomy.

11. Furthermore, the disability certificate dated 21.11.2014 issued by the Janakpuri Super Speciality Hospital Society (Autonomous Institute), Government of NCT of Delhi, which has been annexed with the present MA, certified the applicant's condition as having a head injury with diffuse axonal injury with vegetative stage, quadriplegia and 100% permanent physical disability in relation to the whole body. The relevant extract from the said disability certificate is as follows:

> *"This is to certify that Harish Rana, Age 21 years, Sex Male, S/o Shri Ashok Rana, Resident of Block-D-House No. 309-A, Street No. 55A, Mahavir Enclave, NEW DELHI-110059, Registration No-0026879 is a case of Head Injury with Diffuse Axonal Injury with Vegetative Stage, Quadriplegic. He is Physically disabled and has 100% [Hundred percent] disability in relation to his whole body and is Permanent in nature."*

12. Another disability certificate dated 13.04.2016, issued by Dr. Ram Manohar Lohia Hospital, New Delhi, Government of India, certified that the applicant is in a Persistent Vegetative State (hereinafter referred to as "**PVS**") with complete sensorimotor dysfunction, and 100% permanent physical impairment. The relevant extract from the said disability certificate is as follows:

> *"This is to certify that I have carefully examined Mr. Harish Rana, S/o Mr. Ashok Rana, 24Y/M, r/o- D-309/A, Gali No. 55A, Mahavir Enclave III, Delhi-110059, photograph is affixed above, and am satisfied that he is a case of PERSISTENT VEGETATION STAGE WITH COMPLETE SENSORIMOTOR DYSFUNCTION, HIS PERMANENT PHYSICAL IMPAIRMENT IS 100% (HUNDRED PERCENT). His extent of physical impairment/disability has been evaluated as per guidelines F. No. A13021/2010-MS/MH-II-Directorate General of Health Services (Medical Hospital Section-II), Nirman Bhawan, New Delhi dated 18.06.2010 and is shown against the relevant disability in the table below […]"*

13. In the aforementioned circumstances, when the present MA came before this Court, *vide* order dated 26.11.2025, we directed the constitution of a primary medical board of doctors in accordance with the Common Cause Guidelines. The primary medical board was directed to submit its report ascertaining whether life-sustaining treatment ought to be withdrawn or withheld in the present case.

14. Pursuant to the above, the Chief Medical Officer, Ghaziabad, U.P., constituted the primary medical board which visited the residence of the applicant for the purpose of evaluating his health condition. The primary medical board comprised of Dr. Sachin Garg, Neurologist, Dr. Amit Srivastava, Plastic Surgeon, Dr. Ankit Kumar, Anaesthesiologist and Dr. Akhil Prakash, Neurosurgeon. The primary medical board examined the applicant and addressed a letter to the Principal, LLRM Medical College, Meerut, UP. The contents of the letter read thus:

> *"This is to say that after consulting with CMO Ghaziabad we have visited residential place of Mr. Harish Rana S/O Mr. Ashok Rana R/O- AM-1314, Raj Empire, Rajnagar Extension, Ghaziabad for evaluation of his health condition. The team included a neurosurgeon, a neurologist, a plastic surgeon and a critical care expert. Attendants Mr. Ashish Rana (brother) and Ms. Bhawna Rana (sister) were present during evaluation. Harish Rana suffered injuries about 13yrs back since that time he is under medical care under many centers. At present Patient was lying in bed with tracheostomy tube for respiration and gastrostomy for feeding. Patient was opening eyes spontaneously. His breathing was spontaneous with treacheostomy tube. He was emasciated and contactures were present in both lower limb and upper limb at shoulder, elbow, wrist, fingers, knee, ankle and toes. His pupils were normal in size but sluggish in reaction with no movement restriction. No facial asymmetry present. Gag reflex present. He was having spasticity all over both upper limb and lower limb with deep tendon exaggerated at bicep, triceps, supinator, knee, ankle. Sensory and cerebellar examination could not be accurately assessed due to his state. He had intact brainstem function but due to his vegetative state he requires external support for his feeding, bladder bowel and back. He needs constant physiotherapy and tracheostomy tube care. The chances of his recovery from this state is negligible."*

15. Following the primary medical board's report, *vide* order dated 11.12.2025, we directed the AIIMS, New Delhi, to constitute a secondary medical board, in accordance with the Common Cause Guidelines, for the purpose of further examination and evaluation of the applicant's condition.

16. Pursuant to the same, the AIIMS constituted a secondary medical board comprising Dr. Vimi Rewari, Professor, Dept. of Anaesthesia

as the Chairperson; Dr. Pratap Saran, Professor & Head, Dept. of Psychiatry; Dr. Deepti Vibha, Professor, Dept. of Neurology; Dr. Deepak Kumar Gupta, Professor, Dept. of Neuro Surgery; Dr. Sheetal Singh, Assoc. Professor, Dept. of Hospital Administration; Dr. Swati Kedia Gupta, Asst. Professor, Dept. of Psychiatry; and Dr. Poonam, Dept. of Hospital Administration (Member Secretary) as members. The secondary medical board issued its report dated 17.12.2025, *inter alia* consisting of the medical history, the general examination, the neurological examination, other observations made, as well as the diagnostic criteria that were applied. The said report further included a table indicating the clinical assessment of the patient's awareness, and a table indicating the patient's assessment when the diagnostic criteria of PVS are applied. The said report of the secondary medical board concludes with the following observation:

> "*Based on the history and examination findings, the medical board is of the following opinion:*
>
> *a. Mr. Harish Rana has non-progressive, irreversible brain damage following severe traumatic brain injury with diffuse axonal injury. He fulfills the criteria of permanent vegetative state (PVS) and has been in this state for the past 13 years.*
>
> *b. The continued administration of clinically assisted nutrition and hydration is required for the sustenance of his survival. However, it may not aid in improving his medical condition or repairing his underlying brain damage."*

17. Thereafter, *vide* order dated 18.12.2025, we requested the learned counsel for the applicant and the learned Additional Solicitor

General (ASG) appearing for the respondents to jointly speak to the parents and other family members of the applicant and to submit a report in that regard. Pursuant to the same, a Joint Report came to be filed *inter alia* stating that the learned counsels had interacted with the family of the applicant. During the discussion, the family spoke to the learned counsels about the nature of the applicant's life before the incident. They informed that the applicant was the eldest child who was extremely energetic and physically active. Further, they shared that the applicant was deeply interested in gymming and playing football. The applicant's brother fondly remembered that the applicant used to play football and video games with him. The brother also stated that after years of exhaustive efforts, the family and the doctors have reached to the decision with great difficulty and on firm belief that the continuation of medical treatment no longer serves any meaningful purpose and only prolongs the agony of the applicant.

18. In the aforesaid discussion, the parents stated that they have been taking care of the applicant for more than 13 years and that they, along with doctors, have done everything within their human capacity to alleviate the condition of the applicant during this period. However, they believe there has been no improvement in his condition. Both parents are worried as to who would take care of the applicant if anything were to happen to either of them due to their old age. According to the parents, brother, and sister, the applicant has no voice of his own, he has not been able to speak, hear or see, or recognise anyone or eat on his own or respond to touch or affection for the past 13 years, and he is entirely dependent

on artificial support. The applicant's sister is of the opinion that the decision is being taken by the family solely in furtherance of the applicant's dignity and best interests.

19. Following the in-person meeting dated 07.01.2026, another meeting was conducted by the learned ASG, through video conferencing on 08.01.2026. The said meeting was attended by the learned ASG herself, along with the representatives of the Ministry of Health and Family Welfare ("**MoHFW**"), and the doctors who were part of the secondary medical board, namely Professor Deepti Vibha, Professor Nishkarsh Gupta, and other concerned officials. During the course of the meeting, the following points were deliberated upon:

> *"Present Medical Status of the Petitioner as per Clinical Findings*
> *(i) The petitioner has been in an irreversible permanent vegetative state for the last 13 years;*
> *(ii) There is no chance of improvement or repair of the medical condition, rendering continued treatment futile;*
> *(iii) There exists a clear, unquivocal and well-considered view of the parents of the petitioner, who are also the primary caregivers, arrived at after informed interaction and deliberation."*

20. Thereafter, in pursuance of our Order dated 18.12.2025, the father, the mother and the younger brother of the petitioner were present before us in the committee room of this Court. All three made a fervent appeal before us to take necessary steps to ensure that the applicant does not suffer any more. They tried to convey to us that the medical treatment imparted over a period of almost 13 years be discontinued and nature be allowed to take its own course. According to them, if the medical treatment is not making any

difference, then there is no point in continuing with such medical treatment and making the applicant suffer for no good reason. They believe that the applicant is immensely suffering and should thus be relieved of all further pain and suffering. We acknowledge that they may not be aware of the legal nuances involved in this litigation. However, they were very clear that in view of the two reports filed by the primary medical board and the secondary medical board, respectively, there is no sign, or rather no hope, for the applicant to recover.

21. During this interaction before us on 13.01.2025, the learned ASG submitted that she had a talk with the team of doctors, i.e., the members of the primary medical board as well as the members of the secondary medical board. The doctors are of the opinion that the medical treatment of the applicant should be discontinued as its continuation is not in the best interest of the applicant, and that in the given circumstances, nature should be allowed to take its own course. The doctors are also of the opinion that the petitioner would remain in this PVS for years to come, with the PEG tubes inserted all over his body. However, he would never be able to recover and live a normal life.

22. In such circumstances referred to above, the learned counsel appearing for the parties made their final submissions before us on 15.01.2025. The same are delineated in detail in the next section.

(B). SUBMISSIONS ON BEHALF OF THE APPLICANT

23. Ms. Rashmi Nandakumar, assisted by Ms. Dhvani Mehta, Ms. Shivani Mody, Ms. Anindita Mitra & Ms. Yashmita Pandey, the learned counsels appearing on behalf of the applicant made the following submissions:

(a) That the present matter concerns the application of the guidelines laid down by this Court in ***Common Cause 2018*** *(supra)*, on the withdrawal or withholding of medical treatment. The judgment in ***Common Cause 2018*** *(supra)* or in ***Common Cause 2023*** *(supra)* respectively, does not contemplate routine or initial adjudication by constitutional courts in such matters. On the contrary, the mechanism for withdrawal or withholding of medical treatment in cases where no AMD exists is predicated on the hospital in which the patient is undergoing treatment, which is required to constitute a primary medical board, followed by a secondary medical board. She submitted that judicial intervention by the High Court under Article 226 of the Constitution of India is envisaged only at a later stage, i.e., when there is a disagreement between the primary medical board and the secondary medical board and that the High Court was intended to play a limited, supervisory role, stepping in only when the medical decision-making process reaches an impasse. Ordinarily, therefore, courts are not required to adjudicate in the determination of whether medical treatment ought to be withdrawn or withheld. However, in

the present case, owing to the absence of an institutional mechanism to trigger the process for a patient who was being provided long-term home-based care, the applicant's family was left with no alternative but to approach the High Court of Delhi under Article 226 of the Constitution of India in Writ Petition (Civil) No. 4927 of 2024, seeking a determination regarding the continuation of the medical treatment which the applicant was undergoing, in accordance with the Common Cause Guidelines. The High Court of Delhi had declined the applicant's prayer seeking to obtain an opinion from the medical boards regarding the withdrawal of the PEG tube on the ground that the applicant was not being kept alive mechanically and that he was able to sustain himself without any extra external aid and that such condition did not allow the High Court to intervene and grant the relief prayed for.

(b) After the Delhi High Court dismissed the writ petition, the applicant filed the captioned SLP, which in turn was disposed of with the direction to the respondent no. 1 in conjunction with the Government of Uttar Pradesh, to provide home-based care to the applicant, but with the liberty to the parents to move this Court in the future should it become necessary for further directions.

(c) Owing to further deterioration in the applicant's condition, including hospitalisation in May 2025, and the need for a fresh tracheostomy, the present MA was filed. The learned

counsel submitted that with this Court's orders dated 26.11.2025 and 11.12.2025 respectively, whereby the primary medical board and secondary medical board were directed to be constituted, the medical decision-making framework as envisaged under the Common Cause Guidelines was effectively restored.

(d) On the issue regarding the withdrawal or withholding of medical treatment, the learned counsel submitted that the PEG tube through which the applicant receives artificial nutrition and hydration is a form of mechanical life-support. The learned counsel submitted that the appropriate medical term for such forms of support providing artificial nutrition and hydration is CANH, and the same has been widely recognised, both medically and legally, as a form of life-sustaining 'treatment'.

(e) The learned counsel further submitted that this Court in ***Common Cause 2018*** *(supra)*, has already recognised that feeding tubes constitute a form of life support. She quoted the following extracts from the concurring opinions authored by Sikri J., and D.Y. Chandrachud, J. respectively, to substantiate her contention:

> ***A.K. Sikri, J.***
>
> "*219. Passive euthanasia occurs when medical practitioners do not provide life-sustaining treatment (i.e. treatment necessary to keep a patient alive) or remove patients from life-sustaining treatment. This could include*

discontinuing treatment. This could include discontinuing life-support machines or feeding tubes or not carrying out life-saving operations or providing life-extending drugs."

D.Y. Chandrachud, J.

"359. Individuals who suffer from chronic disease or approach the end of the span of natural life often lapse into terminal illness or a permanent vegetative state. When a medical emergency leads to hospitalization, individuals in that condition are sometimes deprived of their right to refuse unwanted medical treatment such as feeding through hydration tubes or being kept on a ventilator and other life support equipment. Life is prolonged artificially resulting in human suffering."

(f) Most pertinently, the learned counsel went on to submit that the question that must be considered by this Court is not whether it is in the best interest of the patient to die, but whether it is in their best interest to prolong life-support artificially through the continued provision of CANH.

(g) Furthermore, the learned counsel submitted that there exists a long line of cases in the United Kingdom wherein it has been held that the continued provision of CANH to persons in PVS or other irreversible conditions would not be in their best interests, given the irreversibility and incurability of the condition, the futile and burdensome nature of CANH, the wishes of the caregivers of such persons, and the court's assessment of what such persons would themselves have wished had they possessed decision-making

capacity. The learned counsel placed reliance on the following cases:

(i) ***Airdale NHS Trust v. Bland***, reported in **(1993) All ER 821,**

(ii) ***County Durham and Darlington NHS Foundation Trust v PP and Ors***, reported in **[2014] EWCOP 9;**

(iii) ***M v. Mrs. N and Ors.***, reported in **2015 EWCOP 76**;

(iv) ***Cumbria NHS Clinical Commissioning Group v. Miss S,*** reported in **[2016] EWCOP 32 (Fam)**;

(v) ***NHS Windsor And Maidenhead Clinical Commissioning Group v. SP***, reported in **[2018] EWCOP 11**;

(vi) ***Hillingdon Hospitals NHS Foundation Trust v. IN & Ors,*** reported in **[2023] EWCOP 32**; and,

(vii) ***NHS South East London Integrated Care Board v. JP (by his litigation friend, the Official Solicitor), The Royal Hospital for Neuro-disability, TP, VP, OP*** reported in **[2025] EWCOP 4 (T3)**.

(h) The learned counsel also submitted that this Court in ***Common Cause 2018*** *(supra)* has recognised that doctors owe a duty of care to also determine whether certain kinds of medical treatments are warranted and are in the patient's best interests. This is drawn from the common law principle that any medical treatment constitutes a trespass to the person, and it therefore, must always be justified.

(i) The learned counsel also submitted that this Court in ***Common Cause 2018*** *(supra)* firmly established the link between the right to dignity, the freedom from continuing in an undignified state like the one that the applicant is in and the removal of medical intervention that only artificially extends life and prolongs suffering.

(j) Lastly, the learned counsel raised certain serious concerns relating to the implementation of the guidelines as laid down in ***Common Cause*** *(supra)*. She submitted that the guidelines have not been translated into on-ground action and that there is a considerable amount of legal uncertainty amongst medical professionals and hospitals regarding their obligations. As a result, harmful practices like routinely obtaining signatures on "Discharge against Medical Advice" forms, where patients are sent home without appropriate palliative and comfort care, get encouraged. In light of this concern, the learned counsel urged that appropriate steps be directed to be taken by the respective Governments of the States and the Union Territories, in order to dispel the confusion faced by medical practitioners. In this regard, the learned counsel also put forth a suggestion that the following measures can be taken by the concerned government to implement the Common Cause Guidelines more effectively:

(i) The nomination of competent officials in local government as 'custodians' of AMD.

(ii) Issuing directions to hospitals to constitute primary and secondary medical boards or to establish clear-cut mechanisms for their constitution.

(iii) Issuing directions to the Chief Medical Officers (CMO) of each district to nominate or create a process for the nomination of registered medical practitioners to secondary medical boards.

24. In light of the aforesaid, the learned counsel prayed that the present Miscellaneous Application be allowed and the reliefs prayed for, be granted.

(C). SUBMISSIONS ON BEHALF OF THE UNION OF INDIA

25. Ms. Aishwarya Bhati, the learned ASG, assisted by Ms. Shivika Mehra and Ms. Shreya Jain, the learned counsels, appearing on behalf of the respondents, submitted as follows:

(a) On the issue of the permissibility of passive euthanasia, the learned ASG submitted that passive euthanasia, in law and in medical ethics, refers to the withdrawal or withholding of medical treatment, where such treatment no longer serves any therapeutic purpose and merely prolongs the dying process. She submitted that this Court in ***Common Cause 2018*** *(supra)* recognised that where continued medical treatment is futile and serves no purpose except prolonging an irreversible condition, the withdrawal or withholding of such treatment would be constitutionally permissible.

(b) As regards the question whether CANH administered through medical devices constituted 'medical treatment', the learned ASG submitted that this Court in ***Common Cause 2018*** *(supra)*, by approving the principle laid down by the House of Lords in ***Airdale*** *(supra)*, has recognised that CANH administered through medical devices indeed constitutes medical treatment and cannot be categorised as mere basic care.

(c) On the aspect of legal justification for the withdrawal of artificial feeding, the learned ASG submitted that this Court in ***Common Cause 2018*** *(supra)* draws a clear and constitutionally significant distinction between an unlawful positive act causing death and the lawful withdrawal of futile medical treatment. She submitted that this Court in ***Common Cause 2018*** *(supra)* held that the removal of artificial feeding mechanisms does not amount to causing death. Rather, it constitutes cessation of an artificial medical intervention, allowing death to ensue due to the underlying irreversible condition of the patient. This, she submitted, was based on this Court's reasoning that the withdrawal of a nasogastric tube does not itself cause death, as the tube has no life-sustaining function independent of the medical regime it facilitates. Rather, upon such withdrawal or withholding, the patient ultimately succumbs to the natural consequences of the underlying fatal condition, and not to any positive act of the physician. Thus, in this backdrop, the

withdrawal or withholding of CANH would amount to an act of omission, falling within the permissible contours of passive euthanasia as recognised in ***Common Cause 2018*** *(supra)*.

(d) The learned ASG further highlighted that upon perusal of the reports of the primary medical board, the secondary medical board, and the subsequent deliberations dated 08.01.2025, respectively, it clearly emerges that the clinical assessment of the applicant has been done by applying established diagnostic criteria. What has emerged from the same is that the applicant is in an irreversible PVS. Furthermore, the medical opinion certifies that there is no hope of improvement of the applicant's neurological condition and that continuation of treatment constitutes medical futility.

(e) It was further submitted that the parents and the siblings who are the caregivers of the applicant, for the past 13 years, have exhibited a clear, categoric, and well-considered decision to allow the applicant a humane and kind passing away and thereby further his dignity.

(f) Thus, in view of the medical opinion and the settled constitutional position, the learned ASG submitted that this Court may consider permitting the withdrawal or withholding of CANH being provided to the applicant through the PEG tube.

(g) In the last, the learned ASG with a view to further the best interests of the applicant, prayed that appropriate arrangements for palliative care at home or at a choice of hospital indicated by the applicant's family, be permitted to be provided by the government to ensure dignity, humane support and comfort to the applicant in the course of implementation of the decision to withdraw the CANH.

(D). CORE CONCEPTS UNDERLYING THE DECISION IN COMMON CAUSE 2018

26. A detailed perusal of the facts makes it evident that this case revolves around one central issue: whether, when and on what legal basis can medical treatment be withdrawn or withheld? In addressing this issue, we are not writing on a clean slate. The definitive word on this subject lies in the decision rendered by a five-judge Constitution Bench of this Court in ***Common Cause 2018*** *(supra).* As the aforesaid decision forms the essential foundation upon which our current decision must rest, we deem it not only important but absolutely necessary to begin by discussing the principles laid down and the line of reasoning adopted therein.

27. The decision in ***Common Cause 2018*** *(supra)* arose from the reference by a three-judge bench of this Court which sought to *inter-alia* resolve certain inconsistencies which existed in earlier judicial pronouncements and provide some clarity on the "right to die with dignity" and other concomitant issues, such as euthanasia.

28. The primary contentions of the petitioners in ***Common Cause 2018*** *(supra)* were two-fold: **(i)** declaration to the effect that the "right to die with dignity" forms an integral part of the "right to live with dignity" guaranteed under Article 21 of the Constitution of India, and **(ii)** legal recognition of Living Wills/AMD/Attorney Authorisation through which individuals could specify their wish to forgo medical treatment in the future, or authorize an attorney to make such decisions on their behalf should they lose the capacity to do so. While examining these contentions, this Court found it necessary to discuss the concepts of both active and passive euthanasia and determine their permissibility within our constitutional framework.

29. Succinctly put, this Court in ***Common Cause 2018*** *(supra),* across the four concurring opinions, held the following: **(i)** the "right to live with dignity" under Article 21 of the Constitution of India inherently includes the "right to die with dignity" and **(ii)** passive euthanasia and AMD are both legal and permissible under the framework of Article 21, being rooted in the constitutional values of liberty, dignity, and individual privacy.

30. Dipak Misra, CJ., (as he then was), in his leading opinion, prescribed a detailed set of guidelines governing the execution and enforcement of AMDs. Furthermore, he laid down the mandatory procedure for deciding whether the medical treatment of an incompetent patient must be terminated, covering both scenarios in which an AMD existed and in which it was absent. These guidelines and the prescribed procedure received the concurrence

of the other members of the Constitution Bench, who affirmed them through their respective opinions. It was directed that these guidelines would remain in force as the law of the land until the Parliament enacts a specific legislation on the subject. We note that, as of the date of this judgment, no such legislation has been brought into the field.

31. We must further observe that in the year 2023, an MA was moved before this Court in ***Common Cause 2018*** *(supra)* seeking certain clarifications on the judgment, specifically regarding the challenges encountered in the practical implementation of the guidelines as laid down therein. Recognising the procedural difficulties faced by patients and medical practitioners alike, this Court modified and streamlined the guidelines to ensure that they remain workable. Throughout this judgment, we have taken care to refer to these updated and modified guidelines, wherever applicable.

32. We shall now delve deeper into certain substantive aspects that need to be duly addressed in any discussion surrounding euthanasia. While analyzing and demystifying the reasoning adopted in ***Common Cause 2018*** *(supra)* as regards several legal issues which have arisen in the matter before us, we wish to weave in some of our own views to the existing discourse as well. Our analysis will focus on the following core areas: (i) the conceptual distinction between active and passive euthanasia; (ii) the constitutional basis for permitting passive euthanasia under Article 21 of the Constitution of India; (iii) the impermissibility of active euthanasia under Article 21 of the Constitution of India; (iv) the

permissibility of AMDs and (v) the procedure used to determine whether medical treatment ought to be withdrawn or withheld.

I. The Essential Distinction: Active and Passive Euthanasia

33. As D.Y. Chandrachud, J., has observed in his concurring opinion in ***Common Cause 2018*** *(supra),* the discourse on euthanasia is rendered complex by the problems of the uncertain and shifting descriptions of key concepts. Therefore, he noted that in examining the legality of euthanasia, clarity on terminology is of absolute essence. This is more so now, where there is a clear ruling to the effect that only passive euthanasia is permissible. The legality of a medical professional's action often depends entirely on which side of this conceptual line their action falls. If our understanding of active and passive euthanasia is imprecise, it would breed a precarious environment and, consequently, render any decision-making ambiguous. More critically, such confusion leaves medical practitioners in constant danger of unwittingly violating the law, or conversely, withholding necessary care out of an unfounded fear of legal reprisal. We, therefore, find it imperative to delineate the boundaries between active and passive euthanasia with absolute clarity.

34. At this juncture, it is essential to examine the meaning attributed to the terms active and passive euthanasia in ***Common Cause 2018*** *(supra)* in each of the four concurring opinions. The relevant extracts are reproduced below:

Dipak Misra, CJ.,

"178. It is to be borne in mind that passive euthanasia fundamentally connotes absence of any overt act either by the patient or by the doctors [...]

xxx xxx xxx

202.6. In active euthanasia, a specific overt act is done to end the patient's life whereas in passive euthanasia, something is not done which is necessary for preserving a patient's life...."

Dr. A.K. Sikri, J.,

"219. Contrary to the above, in legal parlance, euthanasia has since come to be recognised as of two distinct types: the first is active euthanasia, where death is caused by the administration of a lethal injection or drugs. Active euthanasia also includes physician-assisted suicide, where the injection or drugs are supplied by the physician, but the act of administration is undertaken by the patient himself […] Passive euthanasia occurs when medical practitioners do not provide life-sustaining treatment (i.e. treatment necessary to keep a patient alive) or remove patients from life-sustaining treatment. This could include disconnecting life support machines or feeding tubes or not carrying out life-saving operations or providing life-extending drugs...."

Dr. D.Y. Chandrachud, J.,

"384 […]
(iv) active euthanasia refers to a positive contribution to the acceleration of death;
(v) passive euthanasia refers to the omission of steps which might otherwise sustain life […]
385. The expression "passive" has been used to denote the withdrawal or withholding of medical treatment […]"

Ashok Bhushan, J.,

> *"602...Euthanasia, as noted above, as the meaning of the word suggest is an act which leads to a good death. Some positive act is necessary to characterise the action as euthanasia [...]*
>
> *603. Withdrawal of medical assistance or withdrawal of medical devices which artificially prolong the life cannot be regarded as an act to achieve a good death [...]"*
>
> (Emphasis Supplied)

35. On a close examination of the excerpts above, it is apparent that while the descriptions of the terms active and passive euthanasia vary at a granular level across the four concurring opinions, they converge on a single, broader understanding. The Constitution Bench consistently characterises 'Active Euthanasia' as involving a positive or overt act, such as the administration of a lethal injection or drugs, which serves to either cause death or directly accelerate it. In contrast, 'Passive Euthanasia' is defined by the absence of such an overt act. It is characterised by an omission (a decision not to intervene) and primarily encompasses the withdrawal or withholding of medical treatments that would otherwise sustain and/or preserve life.

36. At first blush, it would appear that the primary distinction between active and passive euthanasia rests solely on the binary of "acts" versus "omissions". Such an understanding is only natural. Indeed, in the preceding paragraph, we ourselves have used phrases like "positive or overt acts" to describe active euthanasia, while characterising passive euthanasia through terms such as "omission", "absence of an overt act", or "decision not to intervene".

However, we must caution that a distinction between the two based on the simplistic dichotomy of "act" versus "omission" would be problematic.

37. While passive euthanasia is defined by the withdrawal or withholding of medical treatment, the physical process of withdrawing such treatment, *for instance*, switching off a ventilator or removing a feeding tube, requires a positive, physical movement. If we were to apply the simplistic act versus omission test, such necessary steps could be misconstrued as active measures, i.e., acts. This would potentially place them outside the legal protections afforded to passive euthanasia. This dilemma had also been brought forth in the concurring opinion of D.Y. Chandrachud, J., in ***Common Cause 2018*** *(supra).*

38. The complexity of this issue is further compounded by the extensive academic discourse regarding the precise meaning to be attributed to the terms "acts" and "omissions". We need not delve into this debate here, as doing so would only further obscure the jurisprudence surrounding active and passive euthanasia. For our present purposes, it is sufficient to observe that while the distinction between the two forms of euthanasia is partially rooted in the conventional understanding of acts and omissions, that the binary alone does not complete the legal picture.

39. It is clear that a more nuanced approach is required in order to understand the difference between active and passive euthanasia, one that allows for the difference on the basis of act and omission

to exist broadly, but one that also provides more grounding on other facets. What would these other facets include? A closer look at some of the observations made in ***Common Cause 2018*** *(supra)* would provide additional guidance. The relevant extracts are reproduced below:

> ***Dipak Misra, CJ.,***
>
> *"49. While scrutinising the distinction between active and passive euthanasia, the paramount aspect is "foreseeing the hastening of death". The said view has been propagated in several decisions all over the world. The Supreme Court of Canada, in Rodriguez v. Attorney General of Canada, drew the distinction between these two forms of euthanasia on the basis of intention. Echoing a similar view, the Supreme Court of the United States affirmed the said distinction on the basis of "intention" in Vacco wherein Rehnquist, C.J. observed that the said distinction coheres with the fundamental legal principles of causation and intention. In case when the death of a patient occurs due to removal of life-supporting measures, the patient dies due to an underlying fatal disease without any intervening act on the part of the doctor or medical practitioner, whereas in the cases coming within the purview of active euthanasia, for example, when the patient ingests lethal medication, he is killed by that medication.*
>
> *xxx xxx xxx*
>
> *202.5. There is an inherent difference between active euthanasia and passive euthanasia as the former entails a positive affirmative act, while the latter relates to withdrawal of life-support measures or withholding of medical treatment meant for artificially prolonging life."*
>
> ***Dr. A.K. Sikri, J.,***
>
> *"219. [...] Passive euthanasia occurs when medical practitioners do not provide life-sustaining treatment (i.e.*

treatment necessary to keep a patient alive) or remove patients from life-sustaining treatment. This could include disconnecting life support machines or feeding tubes or not carrying out life-saving operations or providing life-extending drugs. In such cases, the omission by the medical practitioner is not treated as the cause of death; instead, the patient is understood to have died because of his underlying condition."

Dr. D.Y. Chandrachud, J.,

"388. The correctness of this precept may be questioned by pointing out that there is a qualitative difference between a positive medical intervention (such as a lethal injection) which terminates life and a decision to not put a patient on artificial life support, which will not artificially prolong life. The former brings a premature extinction of life. The latter does not delay the end of life beyond its natural end point […]

xxx xxx xxx

398. […] Moreover, passive euthanasia is conceived with a purpose of not prolonging the life of the patient by artificial medical intervention. Both in the case of a withdrawal of artificial support as well as in non-intervention, passive euthanasia allows for life to ebb away and to end in the natural course. In contrast, active euthanasia results in the consequence of shortening life by a positive act of medical intervention […]

xxx xxx xxx

450. […] necessary to distinguish between active and passive euthanasia in terms of the underlying constitutional principles as well as in relation to the exercise of judicial power. Passive euthanasia—whether in the form of withholding or withdrawing treatment—has the effect of removing, or as the case may be, not providing supportive treatment. Its effect is to allow the individual to continue to exist until the end of the natural span of life. On the other hand, active euthanasia involves

hastening of death : the lifespan of the individual is curtailed by a specific act designed to bring an end to life [...]"

Ashok Bhushan, J.,

606. Withdrawal of life-saving devices, leads to natural death which is arrested for the time being due to above device and the act of withdrawal put the life on the natural track. Decision to withdraw life-saving devices is not an act to cause good death of the person rather, decision to withdraw or not to initiate life-supporting measures is a decision when treatment becomes futile and unnecessary...."

(Emphasis Supplied)

40. A deeper analysis of the above extracts from ***Common Cause 2018*** *(supra)* reveals that, according to the Constitution Bench, the true distinction between active and passive euthanasia lies not merely in the nature of the conduct, i.e., acts or omissions, but also in the source of the harm that leads to death. Active euthanasia is characterised as *causing death* because it introduces a new, external agency of harm, such as a lethal injection, that was not previously present. In such cases, death is not the result of the patient's underlying illness, but of an intervention that sets a new chain of events in motion. It is for this reason that active euthanasia is understood as an intervention that disrupts the natural path towards death.

41. Conversely, passive euthanasia is understood as *allowing death to occur*. By withdrawing or withholding life support, the physician is not creating a new risk of death. Rather, they are choosing to allow

the underlying fatal condition to take its natural course by no longer continuing the medical interventions that were artificially prolonging life. In this sense, the doctor simply allows the original harm-causing event to run its natural course, returning the patient to their natural path towards death. The undeniable fact remains that the patient's affliction, i.e., the underlying medical condition, is not caused by any act or omission of the doctor. Rather, the underlying condition is due to factors independent of the doctor or their actions.

42. Having said so, one must also remain vigilant and qualify the aforesaid reasoning, i.e., that it is the original affliction of the patient which is allowed to resume its control over the patient, with a sufficient condition. The sufficient condition being that there must be no violation of the duty of care that a doctor would otherwise, in all circumstances, owe to the patient. In other words, the surrendering of any medical effort must not be at loggerheads with the duty of care which joists all medical action. A more detailed perspective of the passive euthanasia dilemma from a "duty of care" lens and when the withdrawal or withholding of medical intervention would be in consonance with the duty of care expected of doctors, has been provided in the later paragraphs of our discussion. We have simply alluded to the same in our current discussion on the broad conceptual distinction between active and passive euthanasia, to aid better context-setting.

43. Coming back to the focal point of our discussion herein, when viewed through the lens of "*causing death*" versus "*allowing death*

to occur", the traditional distinction between acts and omissions also begins to acquire significance. While admittedly the physical withdrawal of treatment involves a willed bodily movement, conventionally viewed as an 'act', the consequence of that movement is simply the termination of life-saving medical treatment. If the focus is shifted from the nature of the conduct to the ultimate effect of the conduct, the same course of action could be correctly characterised as an omission. Even when "*allowing death to occur*" is initiated by a physician's physical action, it remains an omission in the eyes of the law because the essence of the conduct is a decision not to do something, i.e., 'omission to treat' or 'omission to ventilate'. Thus, at a broader level, passive euthanasia is defined by this refusal to impede the natural progress of death.

44. The aforesaid discussion also finds support in the reasoning given by both, the Court of Appeals and the House of Lords respectively in ***Airedale*** *(supra)*. Butler-Sloss L.J., Hoffmann L.J., Lord Goff, and Lord Browne-Wilkinson, respectively, drew a distinction between active and passive euthanasia on similar grounds. It is important to note, however, that the House of Lords did not explicitly frame the issue as a choice between active and passive euthanasia. For their Lordships, the term 'euthanasia' was reserved exclusively for 'Active Euthanasia'. What all the four concurring opinions in ***Common Cause 2018*** *(supra)* categorised as passive euthanasia was referred to by the House of Lords simply as the withholding or withdrawal of medical treatment. The relevant extracts are reproduced below:

Butler-Sloss L.J. (in the Court of Appeal)

"The position of Dr. Cox is different (Reg. v. Cox , 18 September 1992, Ognall J.). He injected a lethal dose which was designed to cause death and was an external and intrusive act committed by an outsider and was not in accordance with his duty of care as a doctor. The effect of the cessation of artificial feeding is to place the patient in the position he would have been in before the nasogastric tube was inserted. Without the tube he would have died from his medical condition and with it he has been artificially kept alive despite that condition until now. Whether this is an act or omission carries the matter no further. The distinction between Mr. Bland's doctors and Dr. Cox is between an act or omission which allows causes already present in the body to operate and the introduction of an external agency of death."

Hoffmann L.J. (in the Court of Appeal)

"On the other hand, we recognise that, one way or another, life must come to an end. We do not impose on outsiders an unqualified duty to do everything possible to prolong life as long as possible. I think that the principle of inviolability explains why, although we accept that in certain cases it is right to allow a person to die (and the debate so far has been over whether this is such a case) we hold without qualification that no one may introduce an external agency with the intention of causing death. I do not think that the distinction turns upon whether what is done is an act or omission. This leads to barren arguments over whether the withdrawal of equipment from the body is a positive act or an omission to keep it in place. The distinction is between an act or omission which allows an existing cause to operate and the introduction of an external agency of death."

Lord Goff

"I agree that the doctor's conduct in discontinuing life support can properly be categorised 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"

Lord Browne-Wilkinson

"The positive act of removing the nasogastric tube presents more difficulty. It is undoubtedly a positive act, similar to switching off a ventilator in the case of a patient whose life is being sustained by artificial ventilation. But in my judgment in neither case should the act be classified as positive, since to do so would be to introduce intolerably fine distinctions. If, instead of removing the nasogastric tube, it was left in place but no further nutrients were provided for the tube to convey to the patient's stomach, that would not be an act of commission. Again, as has been pointed out (Skegg, Law, Ethics and Medicine (1984), p.169 et seq.) if the switching off of a ventilator were to be classified as a positive act, exactly the same result can be achieved by installing a time-clock which requires to be reset every 12 hours: the failure to reset the machine could not be classified as a

> *positive act. In my judgment, essentially what is being done is to omit to feed or to ventilate: the removal of the nasogastric tube or the switching off of a ventilator are merely incidents of that omission: see Glanville Williams, Textbook of Criminal Law , p.282; Skegg , pp.169 et seq."*
>
> (Emphasis Supplied)

45. In summation, the essential distinction between active and passive euthanasia transcends the simplistic binary of acts and omissions. Active euthanasia is characterised as "*causing death*" because it introduces an external, intrusive agency, such as a lethal injection, an intervention that disrupts the natural path towards death. Conversely, passive euthanasia is understood as "*allowing death to occur*" or "*letting die*". By withdrawing or withholding medical treatment that was otherwise prolonging life, the physician allows the original harm causing event to run its natural course, returning the patient to their natural path toward death. When viewed through this lens, the role of acts and omissions also becomes clear. While the physical withdrawal of treatment may involve an 'act', its effect is an omission, i.e., omission to treat. By shifting the focus from the muscle movement to the conduct's ultimate effect, there is a recognition that such interventions are, in substance, omissions.

II. Permissibility of Passive Euthanasia under Article 21 of the Constitution of India

46. Our preceding analysis establishes that the Constitution Bench in ***Common Cause 2018*** *(supra)* envisaged passive euthanasia as being synonymous with the withdrawal or withholding of medical

treatment. For the Constitution Bench, these two concepts are functionally identical, i.e., withdrawing and withholding medical treatment constitute the very essence of passive euthanasia. To comprehend the legal logic that renders such conduct permissible under Article 21 of the Constitution of India, while simultaneously holding that active euthanasia is not permissible, it is essential to examine how the Court interpreted the fundamental concepts of life, dignity, privacy and autonomy. It is through the intricate interlinking of these core constitutional values that the Bench established the "right to die with dignity" and the permissibility of passive euthanasia under the framework of Article 21 of the Constitution of India.

(a) The unifying and omnipresent force of 'dignity' in the discourse on 'right to die with dignity'

47. Article 21 of the Constitution of India mandates that no person shall be deprived of their life or personal liberty except according to the procedure established by law. In interpreting this guarantee, this Court in ***Common Cause 2018*** *(supra)* unequivocally held that "life" cannot be reduced to mere animal existence or a state of continued drudgery. Instead, it was observed that the expression "life" has a much wider meaning, with the non-negotiable element of "dignity" being at its very core. Dignity is viewed as the unifying force of all fundamental rights, as these rights collectively seek to secure for every individual a dignified existence. In acting as this unifying force, dignity acts as the normative basis for the fundamental rights enshrined in the Constitution of India, and as

an essential interpretative principle for determining the true scope and reach of those rights.

48. Despite its central importance, dignity remains a malleable concept, difficult to define and perhaps best left undefined. This inherent conceptual flexibility allows proponents of varying, and often contradicting, legal perspectives to invoke dignity as the primary justification for their respective positions. D.Y. Chandrachud, J., and A.K. Sikri, J., in their respective concurring opinions, acknowledge that this conceptual tension also arises in the debate over euthanasia and the right to die with dignity.

49. On one side are the proponents of a rather strict "Sanctity of Life" principle, who argue that because every individual possesses dignity by the mere virtue of their existence, life must be preserved at all times. From this perspective, any intentional ending of life is viewed as an act against that person's inherent dignity. This sanctity of life principle forms the very core of the Article 21 framework. It is rooted in the understanding that the preservation of life is of paramount importance and that the intrinsic worth of life is not conditional upon what it seeks to or is capable of achieving. Rather, life is valuable simply because it is. Under the Constitution, this right to life is protected as a supreme right, inalienable and inviolable even during an Emergency, envisaging only the most limited and strictly defined circumstances where a person may be deprived of it [See ***Parmanand Katara v. Union of India***, reported in **(1989) 4 SCC 286**].

50. Conversely, the concept of dignity is also invoked to support the "Quality of Life" proposition. For those who hold this view, the constitutional guarantee of a dignified life extends beyond mere biological persistence to include the right to leave the world in a peaceful and dignified manner. Under this interpretation, living with dignity is seen as the right to a meaningful existence characterised by certain essential qualities.

51. Acknowledging this profound jurisprudential conflict, D.Y. Chandrachud, J., in his concurring opinion, probed the very essence of these competing values. While accepting that the preservation of life is fundamentally rooted in the recognition of human dignity, he raised critical inquiries regarding the point at which this dignity might be compromised by the realities of terminal suffering. He questioned whether the progressive loss of bodily and mental functions, coupled with the imminence of death, does not itself erode the dignity that the law seeks to protect. This led him to the following pivotal questions: What constitutes the core of life that the law is bound to protect? Does a severely diminished quality of life, cast in the shadow of impending death, impact the value of that life to such an extent that it reduces the protection traditionally offered by the sanctity of life doctrine? And ultimately, are there constitutional limits to the principle of sanctity itself?

52. It was in the pursuit of answers to these questions and dilemmas that the Constitution Bench, across all four opinions, arrived at a seminal conclusion. The Bench unequivocally held that the 'right to

live with dignity' under Article 21 extends beyond the preservation of life to encompass the 'right to die with dignity'.

53. In his opinion, Dipak Misra, CJ., anchored the right to die with dignity on the observations of the Constitution Bench in ***Gian Kaur v. State of Punjab***, reported in **(1996) 2 SCC 648**. He reasoned that the fundamental right to life under Article 21 is not merely a guarantee of biological survival but a right to live with dignity. Crucially, this entitlement does not cease as life nears its end. Rather, it extends to the very terminus of existence. Consequently, it was held that the "right to live with dignity" inherently embraces the right to dignity until the moment of death, including a right to have a dignified process of death. To fully comprehend the weight of this reasoning, it is apposite that we look closely at the specific context in which ***Gian Kaur*** *(supra)* held that the 'right to live with dignity' could encompass a 'right to die with dignity'.

54. The Constitution Bench in ***Gian Kaur*** *(supra)* held that the right to life under Article 21 of the Constitution of India does not include the right to die in its absolute sense. In coming to the conclusion, the Court in ***Gian Kaur*** *(supra)* emphasized on two strands: **(i)** that the extinction of life or the extinguishment of life would violate the sanctity of life, and consequently be in teeth with Article 21 itself, which recognizes the said sanctity of life, and **(ii)** that the right to life is a natural right and suicide as an unnatural extinction of life is incompatible with it. Further, while dealing with the issue therein, the Court took note of the debate on euthanasia in the context of individuals in PVS and observed that: **(i)** the right to live

with human dignity would mean the existence of such a right up to the end of natural life and may include the right of a dying man to a die with dignity when his life is ebbing out; and **(ii)** in such cases, premature termination of life would not amount to extinguishing life but only constitute accelerating the conclusion of the process of natural death which has already commenced. However, this Court sounded a clear note of caution that such cases should not be equated with the right to die an unnatural death i.e., one that curtails the natural span of life. The relevant observations made by this Court in ***Gian Kaur*** *(supra)* are reproduced as follows:

> *"22. When a man commits suicide he has to undertake certain positive overt acts and the genesis of those acts cannot be traced to, or be included within the protection of the "right to life" under Article 21. The significant aspect of "sanctity of life" is also not to be overlooked. Article 21 is a provision guaranteeing protection of life and personal liberty and by no stretch of imagination can "extinction of life" be read to be included in "protection of life". Whatever may be the philosophy of permitting a person to extinguish his life by committing suicide, we find it difficult to construe Article 21 to include within it the "right to die" as a part of the fundamental right guaranteed therein. "Right to life" is a natural right embodied in Article 21 but suicide is an unnatural termination or extinction of life, and therefore, incompatible and inconsistent with the concept of "right to life [...]"*
>
> *23. To give meaning and content to the word "life" in Article 21, it has been construed as life with human dignity. Any aspect of life which makes it dignified may be read into it but not that which extinguishes it and is, therefore, inconsistent with the continued existence of life resulting in effacing the right itself. The "right to die", if any, is inherently inconsistent with the "right to life" as is "death" with "life".*

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 up to the end of natural life. This also includes the right to a dignified life up to 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."

(Emphasis Supplied)

55. Building upon this fine distinction between 'extinguishing life' and merely 'accelerating the conclusion of the natural process of death'

as expounded in ***Gian Kaur*** *(supra),* Dipak Misra, CJ., in his opinion in ***Common Cause 2018*** *(supra),* proceeded to hold that passive euthanasia falls firmly within the ambit of Article 21 of the Constitution of India. He reasoned that the withdrawal or withholding of medical treatment of a person in PVS would not be considered as suicide or abetment of suicide but rather as an acceleration of the process of natural death, which has already commenced.

56. We must, however, hasten to clarify that the use of the words "acceleration of the process of natural death" in the aforesaid context must not again be confused and pitted against any debate on active euthanasia. The word "accelerate" has essentially been used to connote the phenomenon of "allowing natural death to occur" which is central to passive euthanasia. The same clarification inheres in the use of the phrase "premature extinction of life" which has been used in ***Common Cause 2018*** *(supra).* On a cursory reading, these phrases may appear to blur the lines with active euthanasia, which is also described as an act that "hastens death". However, the use of these expressions must be understood in their appropriate context. In active euthanasia, the acceleration curtails the natural lifespan. In contrast, the acceleration referred to in passive euthanasia is only relative to the artificially prolonged existence sustained by medical technology. *For instance*, when a ventilator is withdrawn, death is 'accelerated' only in the sense that the patient dies sooner than they would have if the machine had remained and not been withdrawn. However, viewed in light of the underlying ailment, this withdrawal is not an acceleration but

rather the removal of an artificial barrier, allowing the natural trajectory of life to resume and reach its inevitable conclusion.

57. Having clarified the same, what then follows is that the opinion of Dipak Misra, CJ., roots the withdrawal and withholding of medical treatment as a mode and mechanism that furthers the dying person's dignity. The relevant observations made in his opinion are reproduced as follows:

> *"164. In Gian Kaur, the Constitution Bench indicates acceleration of the conclusion of the process of death which has commenced and this indication, as observed by us, allows room for expansion. In the said case, the Court was primarily concerned with the question of constitutional validity of Sections 306 and 309 IPC. The Court was conscious of the fact that the debate on euthanasia was not relevant for deciding the question under consideration. The Court, however, in no uncertain terms expounded that the word "life" in Article 21 has been construed as life with human dignity and it takes within its ambit the "right to die with dignity" being part of the "right to live with dignity". Further, the "right to live with human dignity" would mean existence of such a right up to the end of natural life which would include the right to live a dignified life up to the point of death including the dignified procedure of death. While adverting to the situation of a dying man who is terminally ill or in a persistent vegetative state where he may be permitted to terminate it by a premature extinction of his life, the Court observed that the said category of cases may fall within the ambit of "right to die with dignity" as part of the right to live with dignity when death due to the termination of natural life is certain and imminent and the process of natural death has commenced, for these are not cases of extinguishing life but only of accelerating the conclusion of the process of natural death which has already commenced. […]*

165. In the context of the issue under consideration, we must make it clear that as part of the right to die with dignity in case of a dying man who is terminally ill or in a persistent vegetative state, only passive euthanasia would come within the ambit of Article 21 and not the one which would fall within the description of active euthanasia in which positive steps are taken either by the treating physician or some other person. That is because the right to die with dignity is an intrinsic facet of Article 21. The concept that has been touched deserves to be concretised, the thought has to be realised. It has to be viewed from various angles, namely, legal permissibility, social and ethical ethos and medical values.

166. The purpose of saying so is only to highlight that the law must take cognizance of the changing society and march in consonance with the developing concepts. The need of the present has to be served with the interpretative process of law. However, it is to be seen how much strength and sanction can be drawn from the Constitution to consummate the changing ideology and convert it into a reality. The immediate needs are required to be addressed through the process of interpretation by the Court unless the same totally falls outside the constitutional framework or the constitutional interpretation fails to recognise such dynamism. The Constitution Bench in Gian Kaur, as stated earlier, distinguishes attempt to suicide and abetment of suicide from acceleration of the process of natural death which has commenced. […]

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202.1. A careful and precise perusal of the judgment in Gian Kaur case reflects the right of a dying man to die with dignity when life is ebbing out, and in the case of a terminally-ill patient or a person in PVS, where there is no hope of recovery, accelerating the process of death for reducing the period of suffering constitutes a right to live with dignity."

(Emphasis Supplied)

(b) Viewing the "right to die with dignity" through the prism of self-determination, individual autonomy and privacy.

58. The Constitution Bench in ***Common Cause 2018*** *(supra)* has charted out the "right to die with dignity" in the context of passive euthanasia by also interlinking key facets of the right to life that have already been cemented in Article 21 jurisprudence, i.e., through a combined interpretation of the right to self-determination, individual autonomy and privacy.

59. Dipak Misra, CJ., builds this reasoning by opining that, when the treatment is administered only as a procrastinating effort, the patient would be condemned to a continuum of pain and suffering which would violate the preserved concepts of bodily autonomy and right to privacy. He further pinpoints that, especially in relation to health and medical care decisions, a person's exercise of self-determination and autonomy would involve the exercise of their right to decide whether and to what extent they are willing to subject themselves to medical procedures and treatments. In exercising such a freedom in decision-making, one may choose to opt out of any treatment which is not in consonance with their own individual aspirations and values. This is precisely how adults with the capacity to consent manifest their right to self-determination in the medical context. The relevant observations in the opinion of Dipak Misra, CJ., which evince the same are reproduced thus:

"166. […] The concept is based on non-prolongation of life where there is no cure for the state the patient is in and he, under no circumstances, would have liked to have such a degrading state. The words "no cure" have to be understood to convey that the patient remains in the same state of pain and suffering or the dying process is delayed by means of taking recourse to modern medical technology. It is a state where the treating physicians and the family members know fully well that the treatment is administered only to procrastinate the continuum of breath of the individual and the patient is not even aware that he is breathing. Life is measured by artificial heartbeats and the patient has to go through this undignified state which is imposed on him. The dignity of life is denied to him as there is no other choice but to suffer an avoidable protracted treatment thereby thus indubitably casting a cloud and creating a dent in his right to live with dignity and face death with dignity, which is a preserved concept of bodily autonomy and right to privacy. In such a stage, he has no old memories or any future hopes but he is in a state of misery which nobody ever desires to have. […]

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169. In the context of health and medical care decisions, a person's exercise of self-determination and autonomy involves the exercise of his right to decide whether and to what extent he/she is willing to submit himself/herself to medical procedures and treatments, choosing amongst the available alternative treatments or, for that matter, opting for no treatment at all which, as per his or her own understanding, is in consonance with his or her own individual aspirations and values.

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174. Thus, enquiring into Common Law and statutory rights of terminally ill persons in other jurisdictions would indicate that all adults with the capacity to consent have the Common Law right to refuse medical treatment and the right of self-determination."

(Emphasis Supplied)

60. A.K. Sikri, J., in his concurring opinion, begins by noting that the "personal autonomy" of an individual, as a part of human dignity, can be pressed into service in the context of euthanasia. He combines this with other facets of human dignity namely self-expression and the right to self-determination, to buttress that the choice to receive or not receive treatment must be made available to patients. By weaving these multiple facets together, A.K. Sikri, J., took the view that dignity envisions within itself a quality of life consistent with the ability to exercise self-determined and autonomous choices. However, this comes with the obvious caveat that such a freedom in decision-making would not include the intentional curtailment or extinguishment of the natural span of one's life. The relevant observations are reproduced as follows:

> *"305. In the context of euthanasia, "personal autonomy" of an individual, as a part of human dignity, can be pressed into service. In National Legal Services Authority v. Union of India, this Court observed : (SCC p. 491, para 75)*
>
> > *"75. Article 21, as already indicated, guarantees the protection of "personal autonomy" of an individual. In Anuj Garg v. Hotel Assn. of India, this Court held that personal autonomy includes both the negative right of not to be subject to interference by others and the positive right of individuals to make decisions about their life, to express themselves and to choose which activities to take part in. Self-determination of gender is an integral part of personal autonomy and self-expression and falls within the realm of personal liberty guaranteed under Article 21 of the Constitution of India."*

306. In addition to personal autonomy, other facets of human dignity, namely, "self-expression" and "right to determine" also support the argument that it is the choice of the patient to receive or not to receive treatment.

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308. Dignity is, thus, the core value of life and dying in dignity stands recognised in Gian Kaur . It becomes a part of right of self-determination.

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310. Taking into consideration the conceptual aspects of dignity and the manner in which it has been judicially adopted by various judgments, the following elements of dignity can be highlighted (in the context of death with dignity):
310.1. Encompasses self-determination; implies a quality of life consistent with the ability to exercise self-determined choices;
310.2. Maintains/ability to make autonomous choices; high regard for individual autonomy that is pivotal to the perceived quality of a person's life;
310.3.Self-control (retain a similar kind of control over dying as one has exercised during life—a way of achieving death with dignity);
310.4. Law of consent : The ability to choose—orchestrate the timing of their own death; […]
310.9. Dignity commands emphatic respect:
310.9.1. Reason and emotion are both significant in treatment decisions, especially at the end of life where compassion is a natural response to appeals made on the basis of stifled self-determination; […]
310.11.2. Dignity clearly does play a valuable role in contextualising people's perceptions of death and dying, especially as it appears to embody a spirit of self-determination that advocates of voluntary euthanasia crave.

> *311. Once we examine the matter in the aforesaid perspective, the inevitable conclusion would be that passive euthanasia and death with dignity are inextricably linked, which can be summed up with the following pointers:*
> *311.1. The opportunity to die unencumbered by the intrusion of medical technology and before experiencing loss of independence and control, appears to many to extend the promise of a dignified death. When medical technology intervenes to prolong dying like this it does not do so unobtrusively;*
> *311.2. Today many patients insist on more than just a right to healthcare in general. They seek a right to choose specific types of treatment, able to retain control throughout the entire span of their lives and to exercise autonomy in all medical decisions concerning their welfare and treatment;*
> *311.3. A dreadful, painful death on a rational but incapacitated terminally-ill patient are an affront to human dignity."*
>
> (Emphasis Supplied)

61. D.Y. Chandrachud, J., in his concurring opinion, further expanded this jurisprudential horizon by situating the right to die with dignity at the intersection of dignity, privacy, autonomy and liberty. Dignity, he held, must infuse every stage of human existence, including the closing chapters of one's life. Crucially, D.Y. Chandrachud, J., brought the "protective mantle of privacy" to the forefront, ruling that decisions regarding death are as intimate and protected as decisions regarding birth, marriage, or procreation. Further, he unequivocally recognised that a competent individual possesses an unconditional right to refuse medical treatment, a choice that requires no justification to the State and is not subject to the supervisory control of any outside entity. The relevant

observations made by D.Y. Chandrachud, J., are reproduced as follows:

> "*434. Liberty and autonomy promote the cause of human dignity. Arguments about autonomy are often linked to human dignity. Gostin evaluates the relationship between the dignity of dying with autonomy thus:*
>
> > *"The dying process, after all, is the most intimate, private and fundamental of all parts of life. It is the voice that we, as humans, assert in influencing this autonomous part of our life. At the moment of our death, this right of autonomy ought not to be taken from us simply because we are dying. An autonomous person should not be required to have a good reason for the decision that he or she will make; that is the nature of autonomy. We do not judge for other competent human beings what may be in their best interest, but instead allow them to determine that for themselves. As such, an autonomous person does not need to have a good understanding or even good reasons. All they need is an understanding of what they are confronting. There is no reason to believe that when a person faces imminent death that they have less human understanding, or less ability to fathom what they will face, than other people. Of course, death is a mystery. But death is what we will all confront sooner or later, and we all may wish to assert our interests in how we may die."*
>
> *xxx xxx xxx*
>
> *436. An article titled "Euthanasia : A Social Science Perspective" in the Economic & Political Weekly has suggested that the discourses on death with dignity "need to be situated within processes of living with dignity in everyday contexts". The end of life must not be seen as "human disposal", but, as "the enhancement of human dignity by permitting each man's last act to be an exercise of his free choice between a tortured, hideous death and a painless, dignified one."*

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438. Human dignity is an essential element of a meaningful existence. A life of dignity comprehends all stages of living including the final stage which leads to the end of life. Liberty and autonomy are essential attributes of a life of substance. It is liberty which enables an individual to decide upon those matters which are central to the pursuit of a meaningful existence. The expectation that the individual should not be deprived of his or her dignity in the final stage of life gives expression to the central expectation of a fading life : control over pain and suffering and the ability to determine the treatment which the individual should receive. When society assures to each individual a protection against being subjected to degrading treatment in the process of dying, it seeks to assure basic human dignity. Dignity ensures the sanctity of life. The recognition afforded to the autonomy of the individual in matters relating to end-of-life decisions is ultimately a step towards ensuring that life does not despair of dignity as it ebbs away.

439. From Maneka Gandhi to Puttaswamy, dignity is the element which binds the constitutional quest for a meaningful existence. […] Dignity in death has a sense of realism that permeates the right to life. It has a basic connect with the autonomy of the individual and the right to self-determination. Loss of control over the body and the mind are portents of the deprivation of liberty. As the end of life approaches, a loss of control over human faculties denudes life of its meaning. Terminal illness hastens the loss of faculties. Control over essential decisions about how an individual should be treated at the end of life is hence an essential attribute of the right to life. Corresponding to the right is a legitimate expectation that the State must protect it and provide a just legal order in which the right is not denied. In matters as fundamental as death and the process of dying, each individual is entitled to a reasonable expectation of the protection of his or her autonomy by a legal order founded on the rule of law. A constitutional expectation of

providing dignity in death is protected by Article 21 and is enforceable against the State.

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440. The nine-Judge Bench decision of this Court in K.S. Puttaswamy v. Union of India held privacy to be the constitutional core of human dignity. The right to privacy was held to be an intrinsic part of the right to life and liberty under Article 21 and protected under Part III of the Constitution [...]

441. The protective mantle of privacy covers certain decisions that fundamentally affect the human life cycle. It protects the most personal and intimate decisions of individuals that affect their life and development. Thus, choices and decisions on matters such as procreation, contraception and marriage have been held to be protected. While death is an inevitable end in the trajectory of the cycle of human life of individuals are often faced with choices and decisions relating to death. Decisions relating to death, like those relating to birth, sex, and marriage, are protected by the Constitution by virtue of the right of privacy. The right to privacy resides in the right to liberty and in the respect of autonomy. The right to privacy protects autonomy in making decisions related to the intimate domain of death as well as bodily integrity. Few moments could be of as much importance as the intimate and private decisions that we are faced regarding death. Continuing treatment against the wishes of a patient is not only a violation of the principle of informed consent, but also of bodily privacy and bodily integrity that have been recognised as a facet of privacy by this Court.

442. Just as people value having control over decisions during their lives such as where to live, which occupation to pursue, whom to marry, and whether to have children, so people value having control over whether to continue living when the quality of life deteriorates.

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> *517. The entitlement of each individual to a dignified existence necessitates constitutional recognition of the principle that an individual possessed of a free and competent mental state is entitled to decide whether or not to accept medical treatment. The right of such an individual to refuse medical treatment is unconditional.* ***Neither the law nor the Constitution compel an individual who is competent and able to take decisions, to disclose the reasons for refusing medical treatment nor is such a refusal subject to the supervisory control of an outside entity;"***
>
> (Emphasis Supplied)

62. On a holistic reading of the above extracted paragraphs across the various concurring opinions in ***Common Cause 2018*** *(supra),* a clear basis for allowing passive euthanasia in cases involving competent patients is made out (otherwise commonly referred to as voluntary passive euthanasia). For individuals who have the capacity to make decisions, the justification rests on the convergence of two legal principles: **(i)** the common law right to refuse medical treatment **(ii)** the constitutional guarantees of dignity, liberty, privacy and self-determination. In this framework, withdrawing or withholding treatment is not just a medical decision but a fundamental exercise of the patient's right to choose, rooted in one's rights to dignity, autonomy, liberty, and self-determination. For a competent individual, this choice is absolute and free from the State's or any external entity's supervisory control. Such a person is under no legal obligation to provide reasons for refusing medical treatment. Their autonomy is paramount, and their decision to reject treatment is a protected expression of their dignity which even trumps traditional notions regarding the Sanctity of

Life. Hoffmann L.JJ pithily captures this point in the Court of Appeals decision of ***Airedale*** *(supra)* in the following manner:

> *"A conflict between the principles of the sanctity of life and the individual's right of self-determination may therefore require a painful compromise to be made. In the case of the person who refuses an operation without which he will certainly die, one or other principle must be sacrificed. We may adopt a paternalist view, deny that his autonomy can be allowed to prevail in so extreme a case, and uphold the sanctity of life. Sometimes this looks an attractive solution, but it can have disturbing implications. Do we insist upon patients accepting life-saving treatment which is contrary to their strongly held religious beliefs? Should one force-feed prisoners on hunger strike? English law is, as one would expect, paternalist towards minors. But it upholds the autonomy of adults. A person of full age may refuse treatment for any reason or no reason at all, even if it appears certain that the result will be his death."*

63. Where then does this jurisprudence place incompetent patients, i.e., those who, due to their condition, lack the capacity to make decisions for themselves? A careful reading of ***Common Cause 2018*** *(supra)* clarifies that the permission for passive euthanasia, i.e., withholding or withdrawing of medical treatment, is not the exclusive preserve of the competent. It extends to incompetent patients as well, including those patients who may not have appointed proxies or executed AMD. However, some careful attention must be paid to how the constitutional basis for cases involving non-voluntary passive euthanasia, or in simple terms, for incompetent patients, has been charted out.

(c) Recognising non-voluntary passive euthanasia within the framework of Article 21

64. On a bare overview, it may seem as though the Constitution Bench in ***Common Cause 2018*** *(supra)* has rooted its constitutional permissibility of voluntary and non-voluntary passive euthanasia respectively, on identical foundations. In other words, the rooting of the right to refuse medical treatment in the combined guarantees of dignity, liberty, privacy, self-determination, individual autonomy and freedom from bodily invasion, could appear to have been echoed for both, competent and incompetent patients alike. However, such a reading would give way to criticisms which point out that the specific constitutional protections of the right to privacy, self-determination and individual autonomy would only be available for 'voluntary' passive euthanasia and be unavailable for non-voluntary passive euthanasia. According to them, this would be so, since, privacy, self-determination or individual autonomy form part of those bouquet of rights which can be exerted or exercised in pursuance of something 'by the patient alone' and not vicariously. Hence, in a case where the patient is in PVS, since there is no exercise of choice on his part, it may not entirely be appropriate to strictly tether the permissibility of passive euthanasia to the values of privacy or individual autonomy.

65. D.Y. Chandrachud, J., briefly alludes to this criticism[1] which seems to have gained some momentum in the aftermath of the decision of

[1] Peter J. Riga, "Privacy and the Right to Die", *The Catholic Lawyer* (2017) Vol. 26: No. 2, Article 2

the New Jersey Supreme Court in ***In re Quinlan***, reported in **70 N. J. 10**. Therein, the Court while holding that the incompetent patient's right to make a private decision supersedes the State's interest in preserving life, also reasoned that since the patient herself was not competent to assert her right to privacy, it may be asserted by her parents who would qualify as persons who had been intimately involved in the patient's life.

66. Viewed from the perspective of autonomy as well, such criticisms may assume the forefront. In a very literal sense, autonomy means 'self-government'. People are autonomous to the extent to which they are able to control their own choices by the exercise of their own faculties, free from any arbitrary or otherwise unjustified interference.[2] Capacity is, therefore, often described as the gatekeeper and agent for autonomy. The exercise of the right to self-determination and autonomy may, again, be so intimate to the specific individual or patient that it may never come to be appropriately exercised by another on the patient's behalf.

67. However, this is not to say that autonomy must always be viewed from this angle. We would be remiss not to acknowledge that, on the other side of the spectrum, there are views propounding that in situations where the patient themselves are unable to make a decision, autonomy morphs into 'relational autonomy' – it transforms from being an individualistic concept to a relational one.[3] Autonomy is relational owing to the fact that a person's

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[2] Mirko Bagaric, Euthanasia: Patient Autonomy versus the Public Good, 18 *University of Tasmania Law Review* 149 (1999).
[3] Jonathan Herring, *Relational Autonomy and Family Law,* 11 (Springer, New York, 2014).

decision-making is shaped by their environment and relationships, and therefore, family members or the next of kin can fill in when autonomy in its traditional understanding becomes vulnerable on account of the unconscious state of the patient.

68. Having duly acknowledged such perspectives on the right to privacy and self-determination and its rather complex relationship with non-voluntary passive euthanasia, we are nevertheless of the view that they don't muddy the waters insofar as the constitutional recognition of the right to die with dignity, through the withdrawal or withholding of medical treatment for incompetent patients, is concerned. This is because its permissibility can be fastened upon the standalone basis of dignity and bodily integrity as well, one that may not necessarily closely intersect with the elements of privacy, autonomy and self-determination.

(i) <u>'Dignity' as the standalone basis for the recognition of non-voluntary passive euthanasia.</u>

69. Dignity is the most sacred possession of a human being. Its possession can neither be said to lose its sanctity in the process of death nor when death occurs. Across the four concurring opinions in ***Common Cause 2018*** *(supra)*, there is an absolute convergence on the view that the process of death must not be characterised with a continuum of cruel, degrading and inhuman treatment, especially when medical intervention is conferring no benefit to the patient and only exacerbating pain and suffering. This would go against the assurance of basic human dignity to all.

70. Temporarily keeping alive a terminally ill patient who is brain dead or in PVS, solely because doctors are able to leverage the technological advancements in medicine, and compelling such patients to endure a slow, agonising death, cannot fully be compatible with the constitutional ideal of dignity. There would arise a point of precipice where such prolonged medical treatment would stand as an affront to basic human dignity. Ascertaining when such a point of precipice has arisen for an unconscious/incompetent patient, i.e., where any further continuation of medical treatment comes with a serious risk of infringing dignity, is undoubtedly a complex task. This Court recognized the complicated nature of such decision-making and accordingly provided clear guidance for the same in ***Common Cause 2018*** *(supra).*

71. The exercise of the right to die with dignity in the form of passive euthanasia for competent and incompetent patients, i.e., for voluntary and non-voluntary passive euthanasia, respectively, differs significantly. Unlike competent patients, whose right to refuse treatment is unencumbered and absolute, the path for incompetent patients is far more restricted and arduous. It is hedged by strict procedural safeguards and, crucially, can only be initiated if specific threshold conditions are met. Once these threshold conditions are met, it could be said that the point of precipice, as referred to above, has been reached. Drawing from the opinions of Dipak Misra, CJI., and A.K. Sikri, J., this Court in ***Common Cause 2018*** *(supra)* established that passive euthanasia

for incompetent patients can only be entertained when the following three prerequisites/medical parameters are satisfied:

a) The patient must be diagnosed to be suffering from a medical ailment and be classified as either terminally ill, in a PVS, or like conditions;

b) The patient must be undergoing prolonged medical treatment with respect to the said ailment, indicating that the intervention has ceased to be temporary; and

c) The ailment must be irreversible, meaning:
   i. the condition is incurable; or
   ii. there is no hope of the patient being cured.

72. When the aforesaid threshold conditions/medical parameters are met, any medical intervention would prove to be futile and not afford any benefit to the patient. In such a situation, merely prolonging an inevitable death comes with the heavy cost of pain and suffering, which directly impacts the right to die with dignity. For incompetent patients who cannot directly express their wishes, it is at this stage that constitutional morality, underscored by dignity, must take over. This direct relationship between the prolonged administration of futile and invasive treatment that does not confer any benefit or which is *sans* any purpose to the patient, and the infringement of dignity, comes across from the opinions of Dipak Misra, CJI., Sikri, J., and Chandrachud, J., respectively, in ***Common Cause 2018*** *(supra)* as follows:

(i). Dipak Misra, CJ., while discussing social morality, medical ethicality and the State interest under the constitutional backdrop, emphasised that withdrawal of treatment in an 'irreversible' situation or when life is ebbing out, must not give way to social morality or the doctor's dilemma about their Hippocratic Oath. "When prolongation is done *sans* purpose", the aforesaid considerations must not assume the forefront, but rather, it is the sustenance of dignity and self-respect of an individual, which is inherent in Article 21, that needs protection. Moreover, passive euthanasia, in such cases, essentially involves the prevention of unnecessary intrusion into the physical frame of a person in order to enable a smooth exit from life, one that is without pain, suffering and most importantly, indignity. The relevant observations are reproduced as thus:

> *"M. Social morality, medical ethicality and State interest*
>
> *176. Having dwelt upon the issue of self-determination, we may presently delve into three aspects, namely, social morality, medical ethicality and the State interest. The aforesaid concepts have to be addressed in the constitutional backdrop. We may clearly note that the society at large may feel that a patient should be treated till he breathes his last breath and the treating physicians may feel that they are bound by their Hippocratic oath which requires them to provide treatment and save life and not to put an end to life by not treating the patient. The members of the family may remain in a constant state of hesitation being apprehensive of many a social factor which include immediate claim of inheritance, social stigma and, sometimes, the individual guilt. The Hippocratic oath taken by a doctor may make him feel that there has been a failure on his part and sometimes*

also make him feel scared of various laws. There can be allegations against him for negligence or criminal culpability.

177. In this regard, two aspects are to be borne in mind. First, withdrawal of treatment in an irreversible situation is different from not treating or attending to a patient and second, once passive euthanasia is recognised in law regard being had to the right to die with dignity when life is ebbing out and when the prolongation is done sans purpose, neither the social morality nor the doctors' dilemma or fear will have any place. It is because the sustenance of dignity and self-respect of an individual is inhered in the right of an individual pertaining to life and liberty and there is necessity for this protection. And once the said right comes within the shelter of Article 21 of the Constitution, the social perception and the apprehension of the physician or treating doctor regarding facing litigation should be treated as secondary because the primacy of the right of an individual in this regard has to be kept on a high pedestal.

178. It is to be borne in mind that passive euthanasia fundamentally connotes absence of any overt act either by the patient or by the doctors. It also does not involve any kind of overt act on the part of the family members. It is avoidance of unnecessary intrusion in the physical frame of a person, for the inaction is meant for smooth exit from life. It is paramount for an individual to protect his dignity as an inseparable part of the right to life which engulfs the dignified process of dying sans pain, sans suffering and, most importantly, sans indignity.

179. There are philosophers, thinkers and also scientists who feel that life is not confined to the physical frame and biological characteristics. But there is no denial of the fact that life in its connotative expanse intends to search for its meaning and find the solution of the riddle of existence for which some lean on atheism and some vouchsafe for faith and yet some stand by the ideas of an agnostic. However, the legal fulcrum has to be how Article 21 of the Constitution is understood. If a man is allowed to or, for

that matter, forced to undergo pain, suffering and state of indignity because of unwarranted medical support, the meaning of dignity is lost and the search for meaning of life is in vain."

(Emphasis Supplied)

(ii). A.K. Sikri, J., while discussing the "morality of euthanasia" underscored that euthanasia is one such issue where law cannot be divorced from morality. Viewed from this lens, he proposes that the "sanctity of life" principle might not strictly require that life be preserved "at all costs". The principle only requires that there should not be a deliberate destruction of human life. Therefore, when a certain brink is reached, withdrawal of life-prolonging treatment might very well be in consonance with the preservation of the sanctity of life in its fullest form. He opines that the right to life with dignity subsumes within itself the right to die a natural death and therefore, would permit the withdrawal of prolonged treatment which has no curative effect. The relevant observations are reproduced as thus:

"263. Influenced primarily by the aforesaid considerations, I deem it relevant to indulge into discussion on morality.

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266. The moral dilemma is that it projects both the sides—protracted as well as intractable. On the one hand, it is argued by those who are the proponents of a liberal view that a right to life must include a concomitant right to choose when the life becomes unbearable and not so worth living, when such a stage comes and the sufferer feels that that the life has become useless, he should have right to die. Opponents, on the other hand, project

"Sanctity of Life" (SOL) as the most important factor and argue that this "SOL" principle is violated by self-styled angles of death. Protagonists on "SOL" principle believe that life should be preserved at all costs and the least which is expected is that there should not be a deliberate destruction of human life, though it does not demand that life should always be prolonged as long as possible.

267. It might therefore be argued, as Emily Jackson (2008) cogently does, that the law's recognition that withdrawal of life-prolonging treatment is sometimes legitimate is not so much an exception to the SOL principle, as an embodiment of it.

268. In the most secular judicial interpretation of the SOL doctrine yet, Denman, J. of UKHL explicated thus:

> *"in respect a person's death, we are also respecting their life — giving it sanctity…A view that life must be preserved at all costs does not sanctify life.,..to care for the dying, to love and cherish them, and to free them from suffering rather than simply to postpone death is to have fundamental respect for the sanctity of life and its end."*

269. Hence, as the process of dying is an inevitable consequence of life, the right to life necessarily implies the right to have nature take its course and to die a natural death. It also encompasses a right, unless the individual so wishes, not to have life artificially maintained by the provision of nourishment by abnormal artificial means which have no curative effect and which are intended merely to prolong life.

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310. Taking into consideration the conceptual aspects of dignity and the manner in which it has been judicially adopted by various judgments, the following elements of dignity can be highlighted (in the context of death with dignity): […]

> *310.5. Dignity may be compromised if the dying process is prolonged and involves becoming incapacitated and dependent;*
> *310.6. Respect for human dignity means respecting the intrinsic value of human life;*
> *310.7. Avoidance of dependency;*
> *310.8. Indefinite continuation of futile physical life is regarded as undignified;[...]*
>
> *311. Once we examine the matter in the aforesaid perspective, the inevitable conclusion would be that passive euthanasia and death with dignity are inextricably linked, which can be summed up with the following pointers:[…]*
> *311.3. A dreadful, painful death on a rational but incapacitated terminally-ill patient are an affront to human dignity."*
>
> (Emphasis Supplied)

(iii). D.Y. Chandrachud, J., also echoes the view taken by A.K. Sikri, J., insofar as the interpretation of the "Sanctity of Life" principle is concerned, and elaborates that the said principle does not require that life always be prolonged for as long as possible. He also dissuades the adoption of an absolutist interpretation of Sanctity of Life and states that a dignified existence is the cornerstone that sanctifies life. When medical treatment can do nothing to restore those in a PVS to a state of health, it would largely be futile. The growth of modern medicine has found innovative ways to delay death and prolong mere biological existence during the act of dying. However, in his opinion, when the same medical knowledge indicates a point of no return, endlessly continuing artificial medical support would only protract indignity. The relevant observations are thus:

"413. Though the sanctity principle prohibits "the deliberate destruction of human life, it does not demand that life should always be prolonged for as long as possible". While providing for an intrinsic sacred value to life "irrespective of the person's capacity to enjoy life and notwithstanding that a person may feel their life to be a great burden", the principle holds that "life should not always be maintained at any and all cost". Ethical proponents of the sanctity of life tend to agree that when "medical treatment, such as ventilation and probably also antibiotics, can do nothing to restore those in permanent vegetative state to a state of health and well-functioning, it is futile and need not be provided". Rao has thus suggested that "the law's recognition that withdrawal of life-prolonging treatment is sometimes legitimate" is not generally an exception to the sanctity principle, but is actually "an embodiment of it".

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423. Modern medicine has found ways to prolong life and to delay death. But, it does not imply that modern medicine "necessarily prolongs our living a full and robust life because in some cases it serves only to prolong mere biological existence during the act of dying". This may, in certain situations result in a mere "prolongation of a heartbeat that activates the husk of a mindless, degenerating body that sustains an unknowing and pitiable life—one without vitality, health or any opportunity for normal existence—an inevitable stage in the process of dying". Prolonging life in a vegetative state by artificial means or allowing pain and suffering in a terminal state would lead to questioning the belief that any kind of life is so sanctified as to be preferred absolutely over death.

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437. Under our Constitution, the inherent value which sanctifies life is the dignity of existence. Recognising human dignity is intrinsic to preserving the sanctity of life. Life is truly sanctified when it is lived with dignity. There

> *exists a close relationship between dignity and the quality of life. For, it is only when life can be lived with a true sense of quality that the dignity of human existence is fully realised. Hence, there should be no antagonism between the sanctity of human life on the one hand and the dignity and quality of life on the other hand. Quality of life ensures dignity of living and dignity is but a process in realising the sanctity of life."*
>
> (Emphasis Supplied)

73. When the degree of bodily invasion progressively increases, and the prognosis for recovery progressively decreases, there arises a certain point when the State's absolute interest in preserving life must become subservient to the dignity of the said individual, though he is unconscious or incompetent. The State's interest must not be allowed to overpower the dignity which must be equally assured to all individuals in the process of life and in the process of death. To obviate any confusion, we must clarify that there is no real conflict between the patient's right to dignity and the State's interest from the get-go when the patient is subjected to medical treatment. This is because it is initially administered with a view to confer some benefit to the patient and to secure or safeguard his right to life with dignity. It is only post the fulfilment of the aforesaid threshold prerequisites/medical parameters that this conflict becomes apparent, particularly with reference to unconscious or incompetent patients who are unable to exercise any choice in the matter. That the vigour of the State interest is diluted in such a situation has also been expounded by Dipak Misra, CJ., in his opinion as follows:

> "*O. Submissions of Intervenor (Society for the Right to Die with Dignity)*
>
> *182. […] It is his submission that in the modern State, the State interest should not overweigh the individual interest in the sphere of a desire to die a peaceful death which basically conveys refusal of treatment when the condition of the individual suffering from a disease is irreversible. The freedom of choice in this sphere, as Mr Mohta would put it, serves the cause of humanitarian approach which is not the process to put an end to life by taking a positive action but to allow a dying patient to die peaceably instead of prolonging the process of dying without purpose that creates a dent in his dignity*
>
> *183. The aforesaid argument, we have no hesitation to say, has force. It is so because it is in accord with the constitutional precept and fosters the cherished value of dignity of an individual. It saves a helpless person from uncalled for and unnecessary treatment when he is considered as merely a creature whose breath is felt or measured because of advanced medical technology. His "being" exclusively rests on the mercy of the technology which can prolong the condition for some period. The said prolongation is definitely not in his interest. On the contrary, it tantamounts to destruction of his dignity which is the core value of life. In our considered opinion, in such a situation, an individual interest has to be given priority over the State interest."*
>
> (Emphasis Supplied)

74. In the aforesaid excerpt, it may seem as though the view that State interest must not outweigh individual interest, is specific to a context wherein the individual himself has expressed his desire to die a peaceful death through the refusal of further invasive treatment when the condition is irreversible. However, that would be a rather restrictive outlook that ignores the depth of what was sought to be conveyed by Dipak Misra, CJ. We say so because

whether the affliction of the patient is reversible or not would be a hurdle for a conscious patient who has expressed a desire to withdraw or withhold medical treatment. Competent individuals have an unconditional right to refuse medical treatment, and this has been particularly emphasised in the opinion of D.Y. Chandrachud, J., as we had already previously stated. It is under such circumstances that we are of the view that the aforesaid inverse relationship between state interest and withdrawal of withholding of medical treatment must necessarily be understood in the context of incompetent patients as well.

75. A sceptic might further argue that, because incompetent patients are themselves unable to convey their decision on whether medical treatment must be continued or withheld/withdrawn, a 'choice' is being made for them by external individuals who have thought it fit to calculate the subjective worth of the patient's life. However, such an argument would itself be built on shaky foundation as it conveniently ignores the reality that the commencement of any medical intervention already begins with a 'choice'. More often than not, this initial 'choice' to intervene commences with validation i.e., through the informed consent expressed by the patient himself. If the 'choice' to 'treat', by any chance, is not set in motion with such consent, it begins with necessity – the necessity to restore the patient to health that combines itself with the Hippocratic Oath that doctors always bind themselves to.

76. However, a crucial question that then arises is, how long can we keep such medical intervention ongoing? Especially when the

grounding of the medical intervention in necessity slowly begins to fade away, owing to it being *sans* any purpose? Even if the consent to intervene was initially expressed by the patient himself, the issue still remains complex because one cannot endlessly assume continuous consent despite the circumstances of the patient undergoing myriad changes during the period of unconsciousness. Assuming the existence of such a continuous and endless consent would be problematic for several obvious reasons.

77. In such circumstances, continuing medical treatment or withholding/withdrawing the same would both necessarily include a 'choice'. Any averment that only its discontinuation would involve a moral, legal and ethical dilemma and its continuation would not, is seriously misplaced. This aspect has been very pithily captured by the following observations made by Hoffmann L.J. in the Court of Appeals decision of ***Airedale*** *(supra)*:

> "*Does this mean that people who have not expressed their wishes in advance and are now incapable of expression must lose all right to have treatment discontinued and that those caring for them are in every case under a corresponding duty to keep them alive as long as medical science will allow? Counsel for the Official Solicitor said that this was so. If they have not chosen, the court has no right to choose on their behalf. I think that the fallacy in this argument is that choice cannot be avoided. To continue treatment is as much a choice as to discontinue it. Why is it not an act of choice to decide to continue to invade the privacy of Anthony Bland's body with tubes, catheters, probes and injections? If on account of his unconsciousness he is obliged to submit to such treatment, one cannot say that it is because the court is refusing to choose on his behalf. One way or the other, a choice is being made. It is only if one thinks it natural and*

> *normal to want treatment that continuing to provide it seems not so much a choice as a given state of affairs. And of course in most cases this would be true. In a case in which it was being said that a person should not be given treatment which would avoid death and restore him to full health, one would want to know that this was his personal choice and that it had been expressed very clearly indeed.*
>
> *But Anthony Bland's is not a normal case. The continuation of artificial sustenance and medical treatment will keep him alive but will not restore him to having a life in any sense at all […]*
>
> *xxx xxx xxx*
>
> *In my view the choice which the law makes must reassure people that the courts do have full respect for life, but that they do not pursue the principle to the point at which it has become almost empty of any real content and when it involves the sacrifice of other important values such as human dignity and freedom of choice. I think that such reassurance can be provided by a decision, properly explained, to allow Anthony Bland to die. It does not involve, as counsel for the Official Solicitor suggested, a decision that he may die because the court thinks that his "life is not worth living."*
>
> (Emphasis Supplied)

78. Hoffmann L.J. was addressing a dilemma that preoccupied the minds of this Court in ***Common Cause 2018*** *(supra)* as well – when patients have not expressed their wishes in advance, either expressly through their informed consent during the commencement of the medical intervention or by executing an AMD, and have been subsequently rendered unconscious, whether they must always succumb to the choice of continuing treatment rather than the choice of bringing it to a halt? This was answered

with an emphatic 'No', by highlighting that one cannot escape the reality of the fact that there resides a choice in every action or omission that is made in relation to the patient, and that the same is true also as regards the unending continuation of medical treatment. Therefore, when we are confronted with the truth that both continuation and withdrawal of treatment are based on a 'choice', the duty of the court and the doctors alike, must be to ensure that the scales tilt in favour of safeguarding the full respect for life and its avowed values of human dignity.

(ii) <u>Unconscious or incompetent patients and their right to bodily integrity.</u>

79. This 'choice' which has preoccupied our aforesaid discussion can be looked at in relation to the concept of bodily integrity as well. Before proceeding any further, it has to be clarified that bodily integrity and bodily autonomy have a notable yet nuanced conceptual difference. It may not be appropriate for us to equate them to mean one and the same, under all circumstances. We understand 'bodily integrity' as a right that exists with a separate identity. It serves as one of the foundational bases upon which the idea of 'bodily autonomy' rests. In other words, it is because one enjoys the right to bodily integrity (amongst other personal rights), that they are able to exercise the right to bodily autonomy. Now, why is it important for us to highlight any distinction that may exist between them? Once it is established that the right to bodily integrity is neither a mere sub-set of autonomy nor its mirror

reflection, we may be able to strongly cement that its strength is not diluted for unconscious or incompetent patients.

80. The most common definition of bodily integrity is the "*right to be free from physical interference*"[4]. Jonathan Herring argues that the right to bodily integrity provides for the exclusive use and control over our own bodies on the basis that our bodies are the "site" and "location" of where our subjectivity engages with the world.[5] Therefore, the right carries with it, the concomitant right to exclude all others from the body. If there existed no right to bodily integrity and no right to exclude, then any right to either invite or deny would lose its value.[6] Bodily autonomy, on the other hand, protects a person's capacity to make his or her own decisions in relation to his or her body. Therefore, when there is an infringement upon the bodily integrity of another, the same would amount to a disrespect that is broader than the disrespect for the person's capacity to live life according to their own reasons, motivations and terms. Bodily integrity reflects a focus on the welfare, well-being and respect for one's personhood rather than a myopic focus on his rational decision-making capacity. Such a right carries with it strict duties of non-interference against an open set of persons and makes any infringement actionable.

81. We also wish to elucidate the existence of the aforesaid conceptual difference between bodily autonomy and bodily integrity through

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[4] D. Feldman, *Civil Liberties and Human Rights in England and Wales,* 2nd ed. (Oxford, 2002), 241.
[5] Jonathan Herring and Jesse Wall, *The Nature and Significance of the Right to Bodily Integrity,* 76(3) Cambridge Law Journal 577, 2017
[6] *Ibid* at 581.

certain observations made by A.K. Sikri, J. and Ashok Bhushan J., respectively. The relevant observations are reproduced as follows:

A.K. Sikri, J.,

"315. I had indicated at the earlier stage that Hippocratic Oath, coupled with ethical norms of medical profession, stand in the way of euthanasia. It brings about a situation of dilemma insofar as medical practitioner is concerned. On the one hand his duty is to save the life of a person till he is alive, even when the patient is terminally ill and there are no chances of revival. On the other hand, the concept of dignity and right to bodily integrity, which recognises legal right of autonomy and choice to the patient (or even to his relations in certain circumstances, particularly when the patient is unconscious or incapacitated to take a decision) may lead to exercising his right of euthanasia.

316. Dignity implies, apart from a right to life enjoyment of right to be free of physical interference. At common law, any physical interference with a person is, prima facie, tortious. If it interferes with freedom of movement, it may constitute a false imprisonment. If it involves physical touching, it may constitute a battery. If it puts a person in fear of violence, it may amount to an assault. For any of these wrongs, the victim may be able to obtain damages.

317. When it comes to medical treatment, even there the general common law principle is that any medical treatment constitutes a trespass to the person which must be justified, by reference either to the patient's consent or to the necessity of saving life in circumstances where the patient is unable to decide whether or not to consent

Ashok Bhushan, J.,

"611. The rights of bodily integrity and self-determination are the rights which belong to every human being. When an adult person having mental capacity to take a decision

> *can exercise his right not to take treatment or withdraw from treatment, the above right cannot be negated for a person who is not able to take an informed decision due to terminal illness or being in a persistent vegetative state (PVS). The question is who is competent to take decision in case of terminally ill or PVS patient, who is not able to take decision. In case of a person who is suffering from a disease and is taking medical treatment, there are three stakeholders; the person himself, his family members and doctor treating the patient. The American Courts give recognition to opinion of "surrogate" where person is incompetent to take a decision. No person can take decision regarding life of another unless he is entitled to take such decision authorised under any law. The English Courts have applied the "best interests" test in case of an incompetent person. The best interests of the patient have to be found out not by doctor treating the patient alone but a team of doctors specifically nominated by the State Authority. […]"*
>
> (Emphasis Supplied)

82. *Firstly,* A.K. Sikri, J., identifies that it is the concept of dignity and the right to bodily integrity, which in turn recognises the legal right of autonomy and choice afforded to the patient. Therefore, he aptly places the right to bodily integrity at a core and higher conceptual standing instead of viewing it as a subset of autonomy. Recognising this hierarchical relationship, he then alludes to the idea that, despite unconscious or incapacitated patients being unable to exercise their choice, they may still secure their right to bodily integrity through their relations/kin. This reinforces the broader normative basis that we have assigned to bodily integrity – one that is not necessarily to be conflated with bodily autonomy or the individual's choice. He echoes that everyone enjoys the right to be free from physical interference and that in common law, any infringement is tortious.

83. *Secondly,* Ashok Bhushan, J., while stating that the rights of bodily integrity and self-determination belong to every human being, also does not commingle the two. He carries forward the same idea propounded by A.K. Sikri, J., that the option not to take treatment or withdraw from treatment, which would thereby secure bodily integrity, cannot be made unavailable for a patient who is in a PVS state. It is in this regard that he identifies three key stakeholders in the process – the patient himself, his family members and the doctor treating the patient. Therefore, when a patient is incompetent, it would be the remaining stakeholders who would be assigned the responsibility to safeguard the bodily integrity of the patient from a well-being point of view.

84. It is to ensure that the other stakeholders conscientiously safeguard the dignity and right to bodily integrity of the patient that the "best interest" standard has been jurisprudentially developed, especially to answer legal issues surrounding non-voluntary passive euthanasia. This doctrine or standard would bind both the remaining stakeholders as identified by Ashok Bhushan, J., i.e., the family/kin and the treating doctors, respectively. This is precisely why they both play a key role in the procedure laid down by ***Common Cause 2018*** *(supra)* in the process of determining whether the medical treatment must be withheld or withdrawn. We have briefly contextualised the 'best interest' doctrine here but have deemed it appropriate to discuss the same separately under another section to afford the doctrine the detailed discussion that it deserves.

(iii) <u>'Authorized omission' in consonance with the duty of care of doctors</u>

85. Despite the constitutional permissibility of passive euthanasia under Article 21, the fear of criminal liability creates a hurdle in its rightful exercise and implementation. The looming threat that a doctor could be charged with a crime for withdrawing life support creates a chilling effect. Physicians, wary of prosecution, may hesitate to withhold futile treatment, even when continuing it prolongs the patient's suffering and indignity. Such an environment risks relegating the rights and dignity of incompetent patients to the background in favour of legal wariness. This Court in ***Common Cause 2018*** *(supra),* while addressing this issue, explicitly ruled that when treatment is withdrawn or withheld in strict adherence to the prescribed procedural safeguards, no criminal liability could be attached to the physician. While this Court explored various legal justifications for this immunity, including the lack of intent and causation, we are of the considered opinion that the most robust defence lies in the absence of an '<u>illegal</u> omission', as once the same is established, the doctor cannot be held liable, rendering further inquiries into intent or causation unnecessary. The observation made by Dipak Misra, CJ., that such a withdrawal or withholding either comes within the protection of informed consent (in cases of voluntary passive euthanasia) or "authorised omission" (in cases of non-voluntary passive euthanasia) respectively, and hence, no criminal liability can be attached, captures this perfectly. The same is reproduced thus:

> *"166. […] The authorities, we have noted from other jurisdictions, have observed the distinctions between the administration of lethal injection or certain medicines to cause painless death and non-administration of certain treatment which can prolong the life in cases where the process of dying that has commenced is not reversible or withdrawal of the treatment that has been given to the patient because of the absolute absence of possibility of saving the life. To explicate, the first part relates to an overt act whereas the second one would come within the sphere of informed consent and authorised omission. The omission of such a nature will not invite any criminal liability if such action is guided by certain safeguards."*
>
> (Emphasis Supplied)

86. It is true that under the Indian penal law, the definition of an 'act' encompasses illegal omissions. Further, it is fairly well established that the fiduciary relationship between a doctor and a patient generally imposes a duty of care on the doctor to preserve life. Consequently, a failure to treat would, in normal circumstances, constitute a breach of this duty, thereby inviting liability. However, this duty does not translate into a mandate to artificially prolong life *ad infinitum* or to avert death at all costs. It is recognised that 'to be is to die' and that death is the inevitable conclusion of existence. In such circumstances, it would be legally and logically unreasonable to impose upon doctors a duty to perpetually prevent the unpreventable. Therefore, the scope of this duty of care shifts shape when a patient meets the threshold conditions/medical parameters previously discussed, i.e., when they are terminally ill or in a PVS, undergoing prolonged medical treatment with no hope of cure. In such scenarios, where continued intervention ceases to

be 'treatment' and becomes merely a mechanism for prolonging physical life, causing harm to the patient's dignity, the duty to avert death ceases to exist. Simply put, in such cases, if the doctor withdraws or withholds treatment in accordance with the prescribed procedure, then such omission to treat will not constitute a breach of their duty of care. It, in fact, becomes the truest manifestation of the duty of care. Consequently, the act of withdrawing or withholding medical treatment, in such scenarios, will not be held to be an 'illegal omission'.

87. D.Y. Chandrachud. J., in his concurring opinion in ***Common Cause 2018*** *(supra),* stated that the treatment of the human body involves a "continuous association" between the caregiver and the receiver. He further stated that the expert caregiver is involved in a continuous process where medical knowledge, the condition of the patient, and the relevant circumstances, require them to constantly evaluate choices, i.e., choices on the nature and extent of medical intervention, the wisdom regarding a course of action, and about what should or should not be done. This perspective was also expressed by Sir Thomas in ***Airedale*** *(supra),* wherein he held that what is involved is not just medical treatment, but medical treatment in accordance with the doctor's best judgment as to what is in the patient's best interests. Dr. Atul Gawande, in his acclaimed book, *Being Mortal,* brings to the fore this point in a beautiful manner*:*

> *"If to be human is to be limited, then the role of caring professions and institutions—from surgeons to nursing homes—ought to be aiding people in their struggle with*

> *those limits. Sometimes we can offer a cure, sometimes only a salve, sometimes not even that. But whatever we can offer, our interventions, and the risks and sacrifices they entail, are justified only if they serve the large aims of a person's life. When we forget that, the suffering we inflict can be barbaric. When we remember it, the good we do can be breathtaking."*

88. Thus, when a doctor, on the basis of the best interests of their patient and in accordance with the procedural safeguards prescribed under ***Common Cause 2018*** *(supra),* withholds or withdraws medical treatment, it can very well be termed as a step taken in furtherance of their duty of care, not in contradiction to it. In fact, the procedural safeguards prescribed in ***Common Cause 2018*** *(supra),* especially the establishment of two independent medical boards, were intended to ensure that any act taken in accordance with that procedure would best take care of two things simultaneously – ensure that patient interests are kept at the forefront and also that the doctors are not exposed to any liability.

89. It could be argued that, in essence, withdrawing support places the patient back into the "zone of danger" from which they were initially rescued. Does this not constitute a breach of the duty of care? By exposing the patient to the potential pain and agony associated with the removal of life support, such as a ventilator or feeding tube, are we not contradicting the very principles of dignity that support passive euthanasia in the first place? To answer this, it is important to understand passive euthanasia as a termination of a 'rescue operation' and not as the 'abandonment' of a patient. As noted above, the duty of care does not cease. It merely shifts from curative

treatment to palliative care. In cases where medical treatment is withdrawn or withheld, the doctor's duty entails providing robust palliative care (as discussed in further detail in the later parts of this judgment) and ensuring that the act of withdrawal does not result in a situation in which the patient's dignity is further compromised.

III. Impermissibility of Active Euthanasia under Article 21 of the Constitution of India

90. One of the many aspects that have been highlighted by us in the preceding paragraphs is the concurrence in the opinions of A.K. Sikri, J., and Chandrachud, J., that the right to a dignified death cannot be said to be at loggerheads with the conception of sanctity of life. If one accepts the nuanced interpretation where the quality of life breathes meaning into the sanctity of life, a natural corollary might suggest that active euthanasia should also be permissible. Indeed, in their respective opinions, both A.K. Sikri, J., and Chandrachud, J., have themselves acknowledged the existence of a body of scholarship arguing that, on moral grounds, the distinction between active and passive euthanasia is tenuous, and that, if any difference exists, it is purely a matter of policy. However, the Court noted that its role was not to test the touchstone of morality, but to apply the yardstick of constitutional principles inherent in Article 21. Consequently, while the moral divide between the two may be blurred for philosophers, for the Bench in ***Common Cause 2018*** *(supra),* the constitutional divide remained clear.

91. To understand the basis for the constitutional divide between active and passive euthanasia, it is apposite to look at the observations made by this Court in ***Common Cause 2018*** *(supra),* which are as follows:

> ***Dipak Misra, CJ.,***
>
> *"165. In the context of the issue under consideration, we must make it clear that as part of the right to die with dignity in case of a dying man who is terminally ill or in a persistent vegetative state, only passive euthanasia would come within the ambit of Article 21 and not the one which would fall within the description of active euthanasia in which positive steps are taken either by the treating physician or some other person. That is because the right to die with dignity is an intrinsic facet of Article 21 [...]"*
>
> ***Dr. A.K. Sikri, J.,***
>
> *"220. [...] Thus, insofar as active euthanasia is concerned, this has to be treated as legally impermissible, at least for the time being. It is more so, as there is absence of any statutory law permitting active euthanasia. If at all, legal provisions in the form of Sections 306 and 307 IPC, etc. point towards its criminality."*
>
> ***Dr. D.Y. Chandrachud, J.,***
>
> *"398. [...] Voluntary passive euthanasia, where death results from selective non-treatment because consent is withheld, is therefore legally permissible while voluntary active euthanasia is prohibited. Moreover, passive euthanasia is conceived with a purpose of not prolonging the life of the patient by artificial medical intervention. Both in the case of a withdrawal of artificial support as well as in non-intervention, passive euthanasia allows for life to ebb away and to end in the natural course. In*

contrast, active euthanasia results in the consequence of shortening life by a positive act of medical intervention. It is perhaps this distinction which necessitates legislative authorisation for active euthanasia, as differentiated from the passive.

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450. […] While noticing this criticism, it is necessary to distinguish between active and passive euthanasia in terms of the underlying constitutional principles as well as in relation to the exercise of judicial power. Passive euthanasia—whether in the form of withholding or withdrawing treatment—has the effect of removing, or as the case may be, not providing supportive treatment. Its effect is to allow the individual to continue to exist until the end of the natural span of life. On the other hand, active euthanasia involves hastening of death: the lifespan of the individual is curtailed by a specific act designed to bring an end to life. Active euthanasia would on the state of the penal law as it stands constitute an offence. Hence, it is only Parliament which can in its legislative wisdom decide whether active euthanasia should be permitted. Passive euthanasia on the other hand would not implicate a criminal offence since the decision to withhold or withdraw artificial life support after taking into account the best interest of the patient would not constitute an illegal omission prohibited by law.

451. Moreover, it is necessary to make a distinction between active and passive euthanasia in terms of the incidents of judicial power […]

> *"[…] Parliament was and is entitled to decide that the clarity of such a moral position could only be achieved by means of such a rule. Although views about this vary in society, we think that the legitimacy of Parliament deciding to maintain such a clear line that people should not seek to intervene to hasten the death of a human is not open to serious doubt. Parliament is entitled to make the assessment that it should protect*

moral standards in society by issuing clear and unambiguous laws which reflect and embody such standards."

In taking the view which has been taken in the present judgment, the Court has been conscious of the need to preserve to Parliament, the area which properly belongs to its legislative authority. Our view must hence be informed by the impact of existing legislation on the field of debate in the present case."

Ashok Bhushan, J.,

"606. Withdrawal of life-saving devices, leads to natural death which is arrested for the time being due to above device and the act of withdrawal put the life on the natural track. Decision to withdraw life-saving devices is not an act to cause good death of the person rather, decision to withdraw or not to initiate life-supporting measures is a decision when treatment becomes futile and unnecessary. Practice of euthanasia in this country is prohibited and for medical practitioners it is already ordained to be unethical conduct [...]"

(Emphasis Supplied)

92. A close scrutiny of the above-quoted paragraphs reveals that the Court's distinction between active and passive euthanasia in ***Common Cause*** *(supra)* was based on the constitutional principles underlying Article 21. This Court reasoned that active euthanasia involves a positive, overt act which is designed to curtail the natural lifespan and extinguish life. Under the mandate of Article 21, no person can be deprived of their life except in accordance with a procedure established by law. Consequently, for active euthanasia to be legally permissible, there must be an explicit legislative enactment authorizing such deprivation. The Bench noted the

absence of such a statute and observed that active euthanasia in such circumstances would constitute a penal offence under the existing laws of our country. Further, this Court held that it is Parliament's call to decide whether active euthanasia should be allowed, as it is the proper forum to address such fundamentally contentious moral issues, and the Court cannot usurp powers properly belonging to the legislature. In stark contrast to active euthanasia, the legal permissibility of passive euthanasia rests on a fundamentally different premise.

IV. Establishing the Permissibility of Advanced Medical Directives

93. Beyond establishing the constitutional permissibility of passive euthanasia, this Court in ***Common Cause 2018*** *(supra)* also validated the legal status of AMDs. This Court held that these instruments are not void or legally unenforceable but are, in fact, a permissible exercise of rights under the Constitution of India. However, before delving into the Court's rationale for establishing their validity, it is essential to clarify what the Bench understood by the term 'Advanced Medical Directive' or 'Advanced Directive'. A review of the concurring opinions reveal convergence on the view that an AMD is a mechanism that effectively bridges the gap between present competence and future incapacity. It is characterised as a document executed by a person while they are still in possession of their mental faculties and decision-making capacity, specifying their instructions regarding medical treatment or appointment of a trusted surrogate to make medical decisions on their behalf, upon the occurrence of a specific future event, and

them being unable to communicate their wishes. The relevant observations made by this Court are as follows:

Dipak Misra, CJ.

"185. Advance Directives for healthcare go by various names in different countries though the objective by and large is the same, that is, to specify an individual's healthcare decisions and to identify persons who will take those decisions for the said individual in the event he is unable to communicate his wishes to the doctor.

186. Black's Law Dictionary defines an Advance Medical Directive as, "a legal document explaining one's wishes about medical treatment if one becomes incompetent or unable to communicate". A living will, on the other hand, is a document prescribing a person's wishes regarding the medical treatment the person would want if he was unable to share his wishes with the healthcare provider.

187. Another type of Advance Medical Directive is medical power of attorney. It is a document which allows an individual (principal) to appoint a trusted person (agent) to take healthcare decisions when the principal is not able to take such decisions. The agent appointed to deal with such issues can interpret the principal's decisions based on their mutual knowledge and understanding.

Dr. A.K. Sikri, J.

"335. Advance Directives are instruments through which persons express their wishes at a prior point in time, when they are capable of making an informed decision, regarding their medical treatment in the future, when they are not in a position to make an informed decision, by reason of being unconscious or in a PVS or in a coma. A medical power of attorney is an instrument through which persons nominate representatives to make decisions regarding their medical treatment at a point in

time when the persons executing the instrument are unable to make informed decisions themselves [...]"

Dr. D.Y. Chandrachud, J.

"471. Broadly, there are two forms of Advance Directives:
(i) A Living Will which indicates a person's views and wishes regarding medical treatment.
(ii) A Durable Power of Attorney for Health Care or healthcare proxy which authorises a surrogate decision-maker to make medical care decisions for the patient in the event she or he is incapacitated.
Although there can be an overlap between these two forms of Advance Directives, the focus of a durable power is on who makes the decision while the focus of a living will is on what the decision should be. A "living will" has also been referred as "a declaration determining the termination of life", "testament permitting death", "declaration for bodily autonomy", "declaration for ending treatment", "body trust", or other similar reference. Living wills are not a new entity and were first suggested by US attorney, Luis Kutner, in late 1960s.

472. Advance Directives have evolved conceptually to deal with cases where a patient who subsequently faces a loss of the mental faculty to decide has left instructions, when he or she was possessed of decision-making capacity, on how future medical decisions should be made. [...]"

(Emphasis Supplied)

94. In ***Common Cause 2018*** *(supra),* this Court held that AMDs are legal and valid instruments, as they facilitate the exercise of the right to die with dignity, specifically for patients who have lost their decision-making capacity. The reasoning was that if a competent patient has the right to make decisions regarding medical treatment, then, as a natural corollary, even incompetent patients should be entitled to the same right. However, due to their lack of

decision-making capacity, a precarious situation may arise. It is this very gap that AMDs seek to bridge.

95. In effect, an AMD is an instrument that allows a decision regarding medical treatment to be made in advance, on the notion that if the situation prescribed therein arises at a later time when the patient is incompetent, the decision will be enforced. The justification is that if competent patients have the right to refuse treatment now, they would also have the right to refuse treatment that might be imposed on them even in the future. In other words, if a decision on whether or not to receive medical treatment is valid for the present, such a decision must be equally valid when it is intended to operate in the future. Thus, the notions of patient autonomy and consent played an instrumental role in the Court's recognition of AMDs as valid under the law. In fact, the Constitution Bench was unequivocal in stating that, in cases where there is a valid AMD, the right of self-determination, rooted in autonomy and consent, trumps notions of sanctity of life. The relevant observations made by the Court in this regard are as follows:

> ***Dipak Misra, CJ.***
>
> *"198. In our considered opinion, <u>Advance Medical Directive would serve as a fruitful means to facilitate the fructification of the sacrosanct right to life with dignity.</u> The said directive, we think, will dispel many a doubt at the relevant time of need during the course of treatment of the patient. That apart, it will strengthen the mind of the treating doctors as they will be in a position to ensure, after being satisfied, that they are acting in a lawful manner […]*
>
> *xxx xxx xxx*

202.11. A failure to legally recognise Advance Medical Directives may amount to non-facilitation of the right to smoothen the dying process and the right to live with dignity.[…]

202.12. Though the sanctity of life has to be kept on the high pedestal yet in cases of terminally ill persons or PVS patients where there is no hope for revival, priority shall be given to the Advance Directive and the right of self-determination."

Dr. A.K. Sikri, J.

333. I am also of the view that such an advance authority is akin to well-recognised common law right to refuse medical treatment.

Dr. D.Y. Chandrachud, J.

"473. The principles of patient autonomy and consent are the foundation of Advance Medical Directives. A competent and consenting adult is entitled to refuse medical treatment. By the same postulate, a decision by a competent adult will be valid in respect of medical treatment in future. […]

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476. The reason for recognising an Advance Directive is based on individual autonomy. As an autonomous person, every individual has a constitutionally recognised right to refuse medical treatment. The right not to accept medical treatment is essential to liberty. Medical treatment cannot be thrust upon an individual, however, it may have been conceived in the interest of the individual. The reasons which may lead a person in a sound state of mind to refuse medical treatment are inscrutable. Those decisions are not subject to scrutiny and have to be respected by the law as an essential attribute of the right of the individual to have control over the body. The State cannot compel an unwilling individual

to receive medical treatment. While an individual cannot compel a medical professional to provide a particular treatment (this being in the realm of professional medical judgment), it is equally true that the individual cannot be compelled to undergo medical intervention. The principle of sanctity of life thus recognises the fundamental liberty of every person to control his or her body and as its incident, to decline medical treatment. The ability to take such a decision is an essential element of the privacy of the being. Privacy also ensures that a decision as personal as whether or not to accept medical treatment lies exclusively with the individual as an autonomous being. The reasons which impel an individual to do so are part of the privacy of the individual. The mental processes which lead to decision-making are equally part of the constitutionally protected right to privacy.

477. Advance Directives are founded on the principle that an individual whose state of mind is not clouded by an affliction which prevents him or her from taking decisions is entitled to decide whether to accept or not accept medical intervention. If a decision can be made for the present, when the individual is in a sound state of mind, such a person should be allowed to decide the course of action which should be followed in the future if he or she were to be in a situation which affects the ability to take decisions. If a decision on whether or not to receive medical treatment is valid for the present such a decision must be equally valid when it is intended to operate in the future. Advance Directives are, in other words, grounded in a recognition by the law of the importance of consent as an essential attribute of personal liberty. It is the consensual nature of the act underlying the Advance Directive which imparts sanctity to it in future in the same manner as a decision in the present on whether or not to accept medical treatment.

Ashok Bhushan, J.

"617. […] The foundation for seeking direction regarding Advance Medical Directive is extension of the right to

refuse medical treatment and the right to die with dignity. When a competent patient has right to take a decision regarding medical treatment, with regard to medical procedure entailing right to die with dignity, the said right cannot be denied to those patients, who have become incompetent to take an informed decision at the relevant time. The concept of Advance Medical Directive has gained ground to give effect to the rights of those patients, who at a particular time are not able to take an informed decision."

(Emphasis Supplied)

96. While recognising AMDs as valid legal instruments, the Constitution Bench was cognisant that their enforcement could give rise to misuse. Chandrachud, J., in his concurring opinion, went a step further, acknowledging the limitations of such AMDs and the challenges that may arise in implementing them. It is in this context that he made the following observations:

"485. Human experience suggests that there is a chasm of imponderables which divide the present from the future. Such a divide may have a bearing on whether and if so, the extent to which an Advance Directive should bind in the future. As stated above, the sanctity of an Advance Directive is founded upon the expression of the will of an individual who is in a sound state of mind when the directive is executed. Underlying the consensual character of the declaration is the notion of the consent being informed. Undoubtedly, the reasons which have weighed with an individual in executing the Advance Directive cannot be scrutinised (in the absence of situations such as fraud or coercion which implicate the very basis of the consent). However, an individual who expresses the desire not to be subjected to a particular line of treatment in the future, should she or he be ailing in the future, does so on an assessment of treatment options available when the directive is executed. For instance, a decision not to accept chemotherapy in the

event that the individual is detected with cancer in the future, is based on today's perception of the trauma that may be suffered by the patient through that treatment. Advances in medical knowledge between the date of the execution of the document and an uncertain future date when the individual may possibly confront treatment for the disease may have led to a re-evaluation by the person of the basis on which a desire was expressed several years earlier. Another fundamental issue is whether the individual can by means of an Advance Directive compel the withholding of basic care such as hydration and nourishment in the future. Protecting the individual from pain and suffering as well as the indignity of debility may similarly raise important issues. Advance Directives may hence conceivably raise ethical issues of the extent to which the perception of the individual who executes it must prevail in priority to the best interest of the patient.

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509. Advance Directives also have limitations. Individuals may not fully understand treatment options or recognise the consequences of certain choices in the future. Sometimes, people change their minds after expressing Advance Directives and forget to inform others. Another issue with Advance Directives is that vague statements can make it difficult to understand the course of action when a situation arises. For example, general statements rejecting "heroic treatments" are vague and do not indicate whether you want a particular treatment for a specific situation (such as antibiotics for pneumonia after a severe stroke). On the other hand, very specific directives for future care may not be useful when situations change in unexpected ways. New medical therapies may also have become available since an Advance Directive was given. Thus, Advance Directives should be reviewed and revised regularly if feelings about certain issues change, so that current wishes and decisions are always legally documented."

(Emphasis Supplied)

97. Well aware of such challenges in their implementation and the potential for misuse, ***Common Cause 2018*** *(supra)* noted that recognition of AMDs cannot be withheld solely because, in their implementation, they might create a potential for misuse or raise certain ethical or legal challenges. It is to alleviate such concerns of misuse that the Bench found it fit to lay down broad principles to govern and provide a just basis for the execution and enforcement of such AMDs. Dipak Misra, CJ., in his leading opinion, laid down guidelines that would govern aspects such as: **(i)** who can execute an AMD, **(ii)** what such a directive should contain, **(iii)** how it should be recorded and preserved, and lastly, **(iv)** when and by whom it can be given effect to. Acknowledging and directly addressing the challenge of enforcing AMDs due to the chasm that divides the past and present, the following guideline was also incorporated:

> *"198.6.2. An Advance Directive shall not be applicable to the treatment in question if there are reasonable grounds for believing that circumstances exist which the person making the directive did not anticipate at the time of the Advance Directive and which would have affected his decision had he anticipated them."*

98. In addition to the guidelines on execution and enforcement of an AMD, Dipak Misra, CJ., also laid down guidelines regarding the procedure to be followed for undertaking passive euthanasia in those scenarios where no AMD exists. Therefore, when dealing with an AMD and passive euthanasia (with or without an AMD), the guidelines as laid down by this Court in ***Common Cause 2018***

(supra) and later modified in ***Common Cause 2023*** *(supra)* constitute the governing law of the land.

99. On the issue of who can execute an AMD, this Court in ***Common Cause 2018*** *(supra)* laid down the following guidelines:

a) *The Advance Directive can be executed only by an adult who is of a sound and healthy state of mind and in a position to communicate, relate and comprehend the purpose and consequences of executing the document.*[7]
b) *It must be voluntarily executed and without any coercion or inducement or compulsion and after having full knowledge or information.*[8]
c) *It should have characteristics of an informed consent given without any undue influence or constraint.*[9]
d) *It shall be in writing clearly stating as to when medical treatment may be withdrawn or no specific medical treatment shall be given which will only have the effect of delaying the process of death that may otherwise cause him/her pain, anguish and suffering and further put him/her in a state of indignity.*[10]

100. On the issue of what an AMD should contain, this Court in ***Common Cause 2018*** *(supra)* laid down the following guidelines:

[7] Para 198.1.1 of Common Cause 2018.
[8] Para 198.1.2 of Common Cause 2018.
[9] Para 198.1.3 of Common Cause 2018.
[10] Para 198.1.4 of Common Cause 2018.

a) *It should clearly indicate the decision relating to the circumstances in which withholding or withdrawal of medical treatment can be resorted to.*[11]

b) *It should be in specific terms and the instructions must be absolutely clear and unambiguous.*[12]

c) *It should mention that the executor may revoke the instructions/authority at any time.*[13]

d) *It should disclose that the executor has understood the consequences of executing such a document.*[14]

e) *It should specify the name of a guardian(s) or close relative(s) who, in the event of the executor becoming incapable of taking decision at the relevant time, will be authorised to give consent to refuse or withdraw medical treatment in a manner consistent with the Advance Directive.*[15]

f) *In the event that there is more than one valid Advance Directive, none of which have been revoked, the most recently signed Advance Directive will be considered as the last expression of the patient's wishes and will be given effect to.*[16]

101. On the issue of how an AMD should be recorded and preserved, this Court in ***Common Cause 2018*** *(supra)* laid down the following guidelines:

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[11] Para 198.2.1 of Common Cause 2018.
[12] Para 198.2.2 of Common Cause 2018.
[13] Para 198.2.3 of Common Cause 2018
[14] Para 198.2.4 of Common Cause 2018.
[15] Para 198.2.5 of Common Cause 2018, as modified by Common Cause 2023.
[16] Para 198.2.6 of Common Cause 2018.

a) *The document should be signed by the executor in the presence of two attesting witnesses, preferably independent, and attested before a notary or gazetted officer.*[17]

b) *The witnesses and the notary or gazetted officer shall record their satisfaction that the document has been executed voluntarily and without any coercion or inducement or compulsion and with full understanding of all the relevant information and consequences.*[18]

c) *The executor shall inform, and hand over a copy of the Advance Directive to the person or persons named in para 57(e) as well as to the family physician, if any.*[19]

d) *A copy shall be handed over to the competent officer of the local Government or the Municipal Corporation or Municipality or Panchayat, as the case may be. The aforesaid authorities shall nominate a competent official in that regard who shall be the custodian of the said document. The executor may also choose to incorporate their Advance Directive as a part of the digital health records, if any.*[20]

102. On the issue of withdrawal, revocation and inapplicability of an AMD, this Court in ***Common Cause 2018*** *(supra)* laid down the following guidelines:

a) *An individual may withdraw or alter the Advance Directive at any time when he/she has the capacity to do so and by following*

[17] Para 198.3.1 of Common Cause 2018, as modified by Common Cause 2023.
[18] Para 198.3.2 of Common Cause 2018, as modified by Common Cause 2023.
[19] Para 198.3.5 of Common Cause 2018, as modified by Common Cause 2023.
[20] Para 198.3.6 of Common Cause 2018, as modified by Common Cause 2023.

the same procedure as provided for recording of Advance Directive. Withdrawal or revocation of an Advance Directive must be in writing.[21]

b) *It will be open to the executor to revoke the document at any stage before it is acted upon and implemented.*[22]

c) *An Advance Directive shall not be applicable to the treatment in question if there are reasonable grounds for believing that circumstances exist which the person making the directive did not anticipate at the time of the Advance Directive and which would have affected his decision had he anticipated them.*[23]

d) *If the Advance Directive is not clear and ambiguous, the Medical Boards concerned shall not give effect to the same and, in that event, the guidelines meant for patients without Advance Directive shall be made applicable.*[24]

103. The step-wise procedure to undertake passive euthanasia as laid down in ***Common Cause 2018*** *(supra)*, both in situations where an AMD exists and where there is no such AMD, is discussed in the next sub-section.

V. Procedural Framework for Passive Euthanasia

104. On a close reading of this Court's decision in ***Common Cause 2018*** *(supra)*, it appears to us that this Court declared the law on withholding or withdrawing medical treatment by categorising

[21] Para 198.6.1 of Common Cause 2018.
[22] Para 198.4.8 of Common Cause 2018.
[23] Para 198.6.2 of Common Cause 2018.
[24] Para 198.6.3 of Common Cause 2018.

patients into three distinct categories. The applicability of the procedure depends on the patient's category. The three categories are as follows:

a) Where the patient is competent and capable of making an informed decision regarding their medical treatment.
b) Where the patient is incompetent and incapable of taking an informed decision, but has executed a valid AMD in accordance with the safeguards laid down above.
c) Where the patient is incompetent and has not executed an AMD, or the same is invalid or inapplicable.

105. For competent patients, withdrawal or withholding of medical treatment is rooted in their right to refuse medical treatment, which is part of the right to live with dignity, combined with personal autonomy and self-determination. As noted above, this right to refuse medical treatment for competent patients is unencumbered, and the right of self-determination in such situations trumps the interest in the sanctity of life. Thus, any patient, regardless of the medical condition they are suffering from, has the right to refuse treatment. In situations where a competent patient, aware of the consequences, refuses medical treatment, the treating physician is bound by that informed decision and must withdraw or withhold medical treatment to give effect to it. In such cases, the withdrawal or withholding of medical treatment would be fairly uncontroversial and authorised, as it is supported by the patient's explicit and informed consent at the time of the withdrawal or withholding. In

our opinion, if a patient is competent, it would eliminate the need to refer to or consider any existing AMD.

106. When dealing with incompetent patients, the circumstances are more knotty. It could be argued that an AMD represents express consent from the patient and, consequently, that its enforcement should be as unencumbered as the right to refuse treatment. However, it is important to recognise the qualitative difference between explicit consent given at the very time of withdrawal or withholding, and consent derived from a past directive. Relying on a past decision is admittedly fraught with complexities. The patient's knowledge at the time may have been limited, or circumstances may have effectively changed. Essentially, there is no absolute equivalence between the past and the present. Events may have occurred that could have altered the patient's decision, but their current incompetence prevents us from accurately ascertaining this. Due to these uncertainties, the unrestrained enforcement of an AMD was not permitted, and a strict procedure was put in place.

107. The most important restriction, however, appears to be that an AMD can also only be enforced in situations where the executor is in a condition so as to fulfil the three prerequisites/medical parameters that we have culled out above, when discussing passive euthanasia for incompetent patients. Thus, following this Court's ruling in ***Common Cause 2018*** *(supra)*, passive euthanasia for incompetent patients, regardless of whether an AMD exists or not, is permitted only if the following conditions are met:

a) The patient must be diagnosed to be suffering from a medical ailment and be classified as either terminally ill, in a PVS, or like conditions.

b) The patient must be undergoing prolonged medical treatment with respect to the said ailment, indicating that the intervention has ceased to be temporary.

c) The ailment must be irreversible, meaning:
   i. the condition is incurable; or
   ii. there is absolutely no hope of the patient being cured.

108. To reiterate, an AMD which conveys the refusal of treatment cannot be enforced unless all the aforementioned conditions are satisfied. This applies even where the directive is explicit. *For instance*, consider a patient whose directive specifically states that no treatment should be administered in the event of a heart attack. If this patient is admitted with a heart attack, that instruction cannot be given effect to. The same is because the patient's condition does not meet the requisite threshold conditions as aforesaid (e.g., terminally ill in PVS, prolonged medical treatment etc.) and therefore, the directive remains unenforceable despite its specific wording. In effect, the decision in ***Common Cause 2018*** *(supra)* limited the enforceability of AMDs to rare and extreme cases, precluding their application in general medical circumstances, thereby, differentiating us from certain other jurisdictions.

109. With that being said, on the procedure to be followed to undertake passive euthanasia in those cases where an AMD exists, this Court in ***Common Cause 2018*** *(supra)* laid down the following guidelines:

a) *In the event the executor becomes terminally ill and is undergoing prolonged medical treatment with no hope of recovery and cure of the ailment, and does not have decision-making capacity, the treating physician, when made aware about the Advance Directive, shall ascertain the genuineness and authenticity thereof with reference to the existing digital health records of the patient, if any or from the custodian of the document referred to in para 58(d).*[25] *The instructions in the document must be given due weight by the doctors. However, it should be given effect to only after being fully satisfied that the executor is terminally ill and is undergoing prolonged treatment or is surviving on life support and that the illness of the executor is incurable or there is no hope of him/her being cured.*[26]

b) *If the physician treating the patient (executor of the document) is satisfied that the instructions given in the document need to be acted upon, he shall inform the person or persons named in the Advance Directive, as the case may be, about the nature of illness, the availability of medical care and consequences of alternative forms of treatment and the consequences of remaining untreated. He must also ensure that he believes on reasonable grounds that the person in question understands the information provided, has cogitated over the options and has*

[25] Para 198.4.1 of Common Cause 2018, as modified by Common Cause 2023.
[26] Para 198.4.2 of Common Cause 2018.

come to a firm view that the option of withdrawal or refusal of medical treatment is the best choice.[27]

c) *The hospital where the executor has been admitted for medical treatment shall then constitute a Primary Medical Board consisting of the treating physician and at least two subject experts of the specialty concerned with at least five years' experience, who, in turn, shall visit the patient in the presence of his guardian/close relative and form an opinion preferably within 48 hours of the case being referred to it whether to certify or not to certify carrying out the instructions of withdrawal or refusal of further medical treatment. This decision shall be regarded as a preliminary opinion.*[28]

d) *In the event the Primary Medical Board certifies that the instructions contained in the Advance Directive ought to be carried out, the hospital shall then immediately constitute a Secondary Medical Board comprising one registered medical practitioner nominated by the Chief Medical Officer of the district and at least two subject experts with at least five years' experience of the specialty concerned who were not part of the Primary Medical Board. They shall visit the hospital where the patient is admitted and if they concur with the initial decision of the Primary Medical Board of the hospital, they may endorse the certificate to carry out the instructions given in the Advance Directive. The Secondary Medical Board shall provide its opinion preferably within 48 hours of the case being referred to it.*[29]

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[27] Para 198.4.3 of Common Cause 2018, as modified by Common Cause 2023.
[28] Para 198.4.4 of Common Cause 2018, as modified by Common Cause 2023.
[29] Para 198.4.5 of Common Cause 2018, as modified by Common Cause 2023.

e) The Secondary Board must beforehand ascertain the wishes of the executor if he is in a position to communicate and is capable of understanding the consequences of withdrawal of medical treatment. In the event the executor is incapable of taking decision or develops impaired decision-making capacity, then the consent of the person or persons nominated by the executor in the Advance Directive should be obtained regarding refusal or withdrawal of medical treatment to the executor to the extent of and consistent with the clear instructions given in the Advance Directive.[30]

f) The hospital where the patient is admitted, shall convey the decision of the Primary and Secondary Medical Boards and the consent of the person or persons named in the Advance Directive to the jurisdictional JMFC before giving effect to the decision to withdraw the medical treatment administered to the executor.[31]

g) If permission to withdraw medical treatment is refused by the Secondary Medical Board, it would be open to the person or persons named in the Advance Directive or even the treating doctor or the hospital staff to approach the High Court by way of writ petition under Article 226 of the Constitution. If such application is filed before the High Court, the Chief Justice of the said High Court shall constitute a Division Bench to decide upon grant of approval or to refuse the same. The High Court will be free to constitute an independent committee consisting of three doctors from the fields of general medicine, cardiology,

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[30] Para 198.4.6 of Common Cause 2018, as modified by Common Cause 2023.
[31] Para 198.4.7 of Common Cause 2018, as modified by Common Cause 2023.

neurology, nephrology, psychiatry or oncology with experience in critical care and with overall standing in the medical profession of at least twenty years.[32]

h) *The High Court shall hear the application expeditiously after affording opportunity to the State counsel. It would be open to the High Court to constitute Medical Board in terms of its order to examine the patient and submit report about the feasibility of acting upon the instructions contained in the advanced directive.*[33] *Needless to say that the High Court shall render its decision at the earliest as such matters cannot brook any delay and it shall ascribe reasons specifically keeping in mind the principles of "best interests of the patient".*[34]

i) *Where the Primary Medical Board takes a decision not to follow an Advance Directive while treating a person, the person or persons named in the Advance Directive may request the hospital to refer the case to the Secondary Medical Board for consideration and appropriate direction on the Advance Directive.*[35]

110. As discussed above, the Court also noted that there would be many scenarios in which no AMDs would exist, or where the directive would become inapplicable for various reasons. For undertaking passive euthanasia in such scenarios, the Bench in ***Common Cause 2018*** *(supra)* held that the procedure and safeguards are largely to be the same as applied to cases where an AMD is in

[32] Para 198.5.1 of Common Cause 2018, as modified by Common Cause 2023.
[33] Para 198.5.2 of Common Cause 2018.
[34] Para 198.5.3 of Common Cause 2018.
[35] Para 198.6.4 of Common Cause 2018, as modified by Common Cause 2023.

existence; in addition thereto, the following procedure shall be followed:

a) *In cases where the patient is terminally ill and undergoing prolonged treatment in respect of ailment which is incurable or where there is no hope of being cured, the physician may inform the hospital, which, in turn, shall constitute a Primary Medical Board in the manner indicated earlier. The Primary Medical Board shall discuss with the family physician, if any, and the patient's next of kin/next friend/guardian and record the minutes of the discussion in writing. During the discussion, the patient's next of kin/next friend/guardian shall be apprised of the pros and cons of withdrawal or refusal of further medical treatment to the patient and if they give consent in writing, then the Primary Medical Board may certify the course of action to be taken preferably within 48 hours of the case being referred to it. Their decision will be regarded as a preliminary opinion.*[36]

b) *In the event the Primary Medical Board certifies the option of withdrawal or refusal of further medical treatment, the hospital shall then constitute a Secondary Medical Board comprising in the manner indicated hereinbefore. The Secondary Medical Board shall visit the hospital for physical examination of the patient and, after studying the medical papers, may concur with the opinion of the Primary Medical Board. In that event, intimation shall be given by the hospital to the JMFC and the*

[36] Para 199.1 of Common Cause 2018, as modified by Common Cause 2023.

next of kin/ next friend/ guardian of the patient preferably within 48 hours of the case being referred to it.[37]

c) *There may be cases where the Primary Medical Board may not take a decision to the effect of withdrawing medical treatment of the patient or the Secondary Medical Board may not concur with the opinion of the Primary Medical Board. In such a situation, the nominee of the patient or the family member or the treating doctor or the hospital staff can seek permission from the High Court to withdraw life support by way of writ petition under Article 226 of the Constitution in which case the Chief Justice of the said High Court shall constitute a Division Bench which shall decide to grant approval or not. The High Court may constitute an independent committee to depute three doctors from the fields of general medicine, cardiology, neurology, nephrology, psychiatry or oncology with experience in critical care and with overall standing in the medical profession of at least twenty years after consulting the competent medical practitioners. It shall also afford an opportunity to the State counsel. The High Court in such cases shall render its decision at the earliest since such matters cannot brook any delay. Needless to say, the High Court shall ascribe reasons specifically keeping in mind the principle of "best interests of the patient".*[38]

111. Before addressing the substantive issues, a clarification regarding nomenclature is essential. The ruling of this Court in ***Common Cause 2018*** *(supra)* permitted passive euthanasia while prohibiting

[37] Para 199.2 of Common Cause 2018, as modified by Common Cause 2023.
[38] Para 199.4 of Common Cause 2018, as modified by Common Cause 2023.

active euthanasia. It is also abundantly clear that, for the Court in ***Common Cause 2018*** *(supra),* the term 'passive euthanasia' was equated or synonymised with the withholding or withdrawal of medical treatment. However, there seems to be a general consensus on the fact that 'passive euthanasia' is an obsolete and a rather, confusing term. We are also of the view that imprecise terminology unnecessarily obscures the legal position. Therefore, to ensure clarity in this judgment, we will henceforth adopt the following definitions/phrases:

a) 'Euthanasia' will refer strictly to active euthanasia, which remains impermissible.
b) 'Withdrawing or Withholding of Medical Treatment' will replace the term 'passive euthanasia'.

It is imperative to state that this change is merely a matter of terminology, not of substance. Accordingly, the withholding or withdrawing of medical treatment remains strictly governed by the guidelines and procedural safeguards established for 'passive euthanasia' in ***Common Cause 2018*** *(supra).*

112. While the preceding discussion has dwelt at length on the constitutional basis and procedural mechanics of withholding or withdrawing medical treatment, we must not lose sight of another substantive aspect we briefly broached in this section. The Constitution Bench in ***Common Cause 2018*** *(supra)* was unequivocal in holding that such withdrawal or withholding is permissible only when it serves the 'best interests' of the patient.

This principle serves as the bedrock of the entire legal framework. Consequently, any decision to withdraw or withhold medical treatment must withstand scrutiny on two primary grounds: first, the intervention in question must qualify as 'medical treatment', and secondly, its withdrawal must strictly be in the patient's best interests.

(E). ISSUES FOR DETERMINATION

113. Having heard the learned counsel appearing for the parties, having gone through the materials on record and having exhaustively examined the reasoning adopted in ***Common Cause 2018*** *(supra)*, the following questions fall for our consideration:

(1) Whether the administration of CANH is to be regarded as *"medical treatment"*?

(2) What is the meaning, scope, and contours of the principle of *"best interest of the patient"* in determining whether medical treatment should be withdrawn or withheld?

(3) Whether it is in the best interest of the applicant that his life be prolonged by continuation of medical treatment?

(4) What are the further steps to be undertaken in the event that a decision to withdraw or withhold medical treatment is arrived at?

(F). ANALYSIS

(1) WHETHER THE ADMINISTRATION OF CANH IS TO BE REGARDED AS "MEDICAL TREATMENT"?

114. The present medical condition of the applicant necessitates the determination of an issue that is central to the further course of action which is to be adopted. In the present matter, the applicant has sustained non-progressive, irreversible brain damage having suffered a severe traumatic brain injury with diffuse axonal injury at the time of the fateful incident. Following his discharge from the hospital in the immediate aftermath of the incident, his fragile health condition has necessitated frequent hospital admissions for the treatment of his head injury, seizures, pneumonia and bedsores. However, his medical condition has been such that it did not warrant continuous hospitalisation all the time and, therefore, he has largely been maintained at home, albeit with a tracheostomy tube, urinary catheter, and PEG tube *in situ*. He retains intact brainstem function and breathes spontaneously with the tracheostomy tube in place. Nonetheless, due to his PVS condition, his survival is dependent upon the continued administration of CANH.

115. The pertinent question before us is whether the applicant's medical treatment can be withdrawn or withheld. Since the applicant is being sustained through the provision of CANH, through a PEG tube, it is essential for us to first determine whether the administration of CANH constitutes 'medical treatment' and would

therefore be amenable to being lawfully withheld or withdrawn. In other words, it is only in the event that CANH is recognised as a medical treatment, as opposed to being regarded as basic primary care that the withholding or withdrawal of such treatment would be permissible. In order to analyse this issue, we have delved into some landmark cases across developed common law jurisdictions, including briefly revisiting those cases already referred to in our preceding discussion, to answer the limited question whether CANH is a form of "medical treatment" and therefore, is amenable to the same principles governing the withholding or withdrawal of any other form of medical treatment.

116. Before proceeding any further, we must begin by clarifying that by the term CANH, we refer to all forms of enteral nutrition and parenteral nutrition which are administered upon clinical indication, which is not inclusive of oral feeding, by cup, spoon, or any other method of delivering food or nutritional supplements into the patient's mouth. In order to ascertain the status of CANH as a "medical treatment", it is crucial that the scope of the term CANH, as it is currently understood, be explained in some detail. CANH can be primarily categorised into two broad categories: enteral nutrition and parenteral nutrition.

(a) Enteral nutrition, also known as "tube feeding", is a method of providing nutrition directly into the gastrointestinal (GI) tract through an enteral access device (feeding tube) that is passed either through the nose, mouth or directly through the

abdominal wall, up to the stomach or small intestine.[39] Enteral nutrition is a special liquid food mixture containing all the nutrients required to meet the nutritional needs, such as protein, carbohydrates, fats, vitamins, minerals, etc. of the patient. The formula can include ready-to-feed liquids, formulas made from a powder or a concentrate, or blenderized food, but the suitability of the feed type would vary on a case to case basis, as per the clinical judgment of the medical practitioner.[40] The enteral access device/feeding tubes can be of various types such as:

(i). Tubes placed through the nose into the stomach (nasogastric) or the small intestine (nasoduodenal/nasojejunal), called nasoenteral tubes.

(ii). Tubes placed through the mouth into the stomach (orogastric) or the small intestine (oroduodenal/orojejunal), called oroenteral tubes.

(iii). Tubes surgically placed directly through the skin into the stomach (gastrostomy) or small intestine (jejunostomy), for e.g. Percutaneous Endoscopic Gastrostomy (PEG) tube, Percutaneous Endoscopic Jejunostomy (PEJ) tube, etc.[41]

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[39] ASPEN (American Society for Parental and Enteral Nutrition), *What is Enteral Nutrition?*, available at: https://nutritioncare.org/about/what-we-do/nutrition-support/what-is-enteral-nutrition/ (last visited on: 05.02.2026)

[40] *Ibid*.

[41] Bedfordshire Hospitals, NHS Foundation Trust, *Having a PEG Tube Inserted,* available at: https://www.bedfordshirehospitals.nhs.uk/patient-information-leaflets/having-a-peg-tube-inserted/, (Last visited on : 10.02.2026); Cambridge University Hospitals, NHS Foundation Trust, *Direct (Surgically*

(b) Parenteral nutrition is a method for patients to receive nutrition other than through the gastrointestinal (GI) tract, and may comprise a unique sterile intravenous (IV) solution administered directly into the bloodstream via a catheter inserted into a vein. [42]

117. There is no gainsaying that the prescription and administration of CANH involves careful consideration of a multitude of clinical factors, ranging from installation of the CANH device (placed surgically or otherwise), precise assessment of the patient's nutritional requirements, the underlying clinical condition of the patient, gastrointestinal tolerance, potential metabolic instability, and an assessment of the anticipated duration of CANH support, amongst others. [43] Some complications that are associated with CANH include the risk of aspiration pneumonia, peritonitis, and wound/stoma site infection. [44] Administration of CANH also requires periodic medical review of its indications, route of administration, risks, benefits and therapeutic goals. Even where enteral nutrition is administered by caregivers in a home setting, the process remains strictly governed by medical protocols,

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placed) Jejunostomy tube- information for parents/carers, available at: https://www.cuh.nhs.uk/patient-information/direct-surgically-placed-jejunostomy-tube-information-for-parentscarers/ , (Last visited on: 10.02.2026)

[42] *Ibid.*

[43] National Collaborating Centre for Acute Care at The Royal College of Surgeons of England, *Nutrition Support for Adults Oral Nutrition Support, Enteral Tube Feeding and Parenteral Nutrition: Methods, Evidence & Guidance, 2006,* (Last updated: July 2017), available at: https://www.nice.org.uk/guidance/cg32/evidence/full-guideline-194889853, (Last visited on: 06.02.2026)

[44] Royal Berkshire NHS Foundation Trust, *Percutaneous Endoscopic Gastrostomy (PEG) tube- what is it?*, (Last updated : February 2025), available at: https://www.royalberkshire.nhs.uk/media/ji4ptjfd/peg-tube-what-is-it_feb25.pdf, (Last visited on: 10.02.2026)

requiring the prescribing clinician to specify the nutritional formulation, dosage, rate and method of delivery.[45] For example, feeding pumps are used to regulate the flow of feed delivered over a specific period of time. The enteral nutrition administration may be through the use of an electronic feeding pump or by bolus feeding using a syringe. This may include 'continuous gravity feeding' that is manually controlled with a feeding bag and a roller clamp to help control the rate; and 'intermittent gravity feeding' where liquid feeds are delivered over a certain duration or, 'bolus feeding' where a specific volume of feeding is infused *via* bag or a syringe rapidly over several minutes[46]. Pump assisted feeding utilizes an electric pump device to more precisely control the rate of delivery in patients who are at a higher risk of inadvertently getting formula in their lungs, sensitive to volume, have delayed gastric emptying or are being fed into the small intestine.[47] Regular flushing of feeding tubes, preventing and controlling of infections and monitoring for complications are integral components of CANH protocols.[48] The

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[45] North Tees and Hartlepool, NHS Foundation Trust, *Percutaneous Endoscopic Gastrostomy (PEG) : A Patient leaflet for those having a PEG feeding tube inserted*, (Last updated : 09.05.2025) available at: https://www.nth.nhs.uk/resources/percutaneous-endoscopic-gastrostomy-peg/, (last visited on 10.02.2026); Kent Community Health, NHS Foundation Trust, *Care of a PEG feeding tube*, (Last updated: on 05.02.2024), available at: https://www.kentcht.nhs.uk/leaflet/care-of-a-peg-feeding-tube/, (Last visited on 10.02.2026);

[46] American College of Gastroenterology, *Enteral and Parenteral Nutrition*, available at: https://gi.org/topics/enteral-and-parenteral-nutrition/, (Last visited on 05.02.2026)

[47] *Ibid.*

[48] *Ibid.*; Tees, Esk and Wear Valleys, NHS Foundation Trust, *Enteral Feeding (PEG) Procedure (Adults): Ref CLIN-0077-v3*, available at https://www.tewv.nhs.uk/wp-content/uploads/2021/12/Enteral-feeding-PEG-procedure-adults.pdf , (Last updated on: 08.04.2021), (Last visited on 10.02.2026); Milton Keynes University Hospital, NHS Foundation Trust, *Adult Enteral Tube Feeding Guidelines for Clients in their own Homes or Care Homes*, (Last updated on August, 2016), available at https://www.mkuh.nhs.uk/wp-content/uploads/2019/01/Adult-Enteral-Tube-Feeding-Guidelines-for-adults-in-their-own-homes-or-carehomes.pdf, (Last visited on 10.02.2026); The Leeds Teaching Hospitals NHS Trust, *Jejunostomy feeding tube care advice- information for patients*, available at: https://www.leedsth.nhs.uk/patients/resources/jejunostomy-feeding-tube-care-advice/, (Last visited on 10.02.2026)

CANH protocols require that enteral feeding tubes be flushed with water before and after medication or feeding, or at certain hourly intervals during continuous feeding, to prevent clogging and ensure adequate hydration.[49] The protocols further mandate that, in the event a CANH device gets dislodged, the reinsertion of the CANH shall be undertaken only under appropriate medical supervision so as to obviate the high risk of peritonitis and aspiration, which are potentially fatal complications.[50] For example, if a PEG tube becomes partially dislodged and such dislodgement goes unnoticed, the specialised liquid nutrition, fluids, or medication administered through it may leak into the abdominal cavity, leading to peritonitis, which is a severe infection that may be life-threatening. Similarly, if a nasogastric or orogastric tube gets misplaced, it risks introducing fluids or medication into the respiratory tract or pleura, which could be fatal. Therefore, medical guidance has to be sought for reinsertion, to prevent such adverse consequences.[51]

118. The aforesaid clinical and procedural characteristics of CANH indicate, without an iota of doubt, that CANH cannot be regarded as a mere means of basic sustenance or primary care, but should

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[49] *Ibid*.

[50] North Tees and Hartlepool, NHS Foundation Trust, *Percutaneous Endoscopic Gastrostomy (PEG) : A Patient leaflet for those having a PEG feeding tube inserted*, (Last updated : 09.05.2025) available at: https://www.nth.nhs.uk/resources/percutaneous-endoscopic-gastrostomy-peg/, (last visited on 10.02.2026); Kent Community Health, NHS Foundation Trust, *Care of a PEG feeding tube*, (Last updated: on 05.02.2024), available at: https://www.kentcht.nhs.uk/leaflet/care-of-a-peg-feeding-tube/, (Last visited on 10.02.2026); NHS England, *Patient safety alert: Nasogastrict tube misplacement: continuing risk of death and severe harm*, (Last updated on 14.02.2022), available at: https://www.england.nhs.uk/publication/patient-safety-alert-nasogastric-tube-misplacement-continuing-risk-of-death-and-severe-harm/, (Last visited on 11.02.2026)

[51] Sandwell and West Birbingham Hospitals NHS Trust, *Nasogastric tube feeding : Information and advice for patients (2012)*, available at: https://www.swbh.nhs.uk/wp-content/uploads/2012/07/Nasogastric-tube-feeding-ML4763.pdf, (Last visited on 11.02.2026).

be recognised as a technologically mediated medical intervention that is prescribed, supervised and periodically reviewed by trained healthcare professionals in accordance with established medical standards.

119. We are in respectful agreement with Schreiber J.'s erudite reasoning in ***In re Conroy***, reported in **98 N.J. 321**, wherein, although he acknowledged the emotional symbolism of food and the innate emotions which are invoked when it comes to feeding and nourishment, yet he went on to hold that CANH methods are significantly different from bottle feeding or spoon feeding when judged on medical parameters. He observed that artificial feeding mechanisms such as nasogastric tubes, gastrostomies and intravenous infusions are significantly different from bottle or spoon feeding as they are medical procedures with inherent risks and possible side effects, administered by skilled health care providers to compensate for impaired physical functioning. Drawing an analogy between artificial feeding by means of a nasogastric tube or intravenous infusion and artificial breathing by means of a respirator, Schreiber J. elaborated on how these medical procedures that ensure nutrition and hydration involve the risks and burdens of serious complications and could sometimes be seriously distressing to the patient. The pertinent observations made by Schreiber J. read thus:

> "*Certainly, feeding has an emotional significance. As infants we could breathe without assistance, but we were dependent on others for our lifeline of nourishment. Even more, feeding is an expression of nurturing and*

caring, certainly for infants and children, and in many cases for adults as well.

Once one enters the realm of complex, high technology medical care, it is hard to shed the 'emotional symbolism' of food. However, artificial feedings such as nasogastric tubes, gastrostomies, and intravenous infusions are significantly different from bottle feeding or spoon feeding - they are medical procedures with inherent risks and possible side effects, instituted by skilled health care providers to compensate for impaired physical functioning. Analytically, artificial feeding by means of a nasogastric tube or intravenous infusion can be seen as equivalent to artificial breathing by means of a respirator. Both prolong life through mechanical means when the body is no longer able to perform a vital bodily function on its own.

Furthermore, while nasogastric feeding and other medical procedures to ensure nutrition and hydration are usually well tolerated, they are not free from risks or burdens; they have complications that are sometimes serious and distressing to the patient."

(Emphasis Supplied)

120. Drawing upon this analogy between CANH and artificial respiratory support given by Schreiber J., we may refer to one another crucial observation made by the High Court of Auckland, New Zealand in ***Auckland Area Health Board v. Attorney-General*** reported in **(1992) 8 CRNZ 634** regarding the role played by such artificial life sustaining systems and why their medical function or purpose should be given due regard when considering their administration. In ***Auckland Area Health Board*** *(supra)*, while considering the permissibility of withholding artificial respiratory support, Thomas J. observed that a life support system may by itself not prevent or

cure the underlying life-threatening condition but may nonetheless serve a therapeutic or medical function by enabling the patient to survive long enough for recovery. In such a case, the intervention only alleviates the effect(s) of the illness while nature or other medical treatments address the underlying condition. In that sense, unless the life support system serves further medical function or therapeutic purpose, it would not be unlawful to discontinue it if such discontinuance is in accordance with good medical practice. Thomas J. goes on to observe that:

> "*To require the administration of a life support system when such a system has no further medical function or purpose and serves only to defer the death of the patient is to confound the purpose of medicine. In such circumstances, the continuation of the artificial ventilation may be lawful, but that does not make it unlawful to discontinue it if the discontinuance accords with good medical practice.*"

This reasoning adopted in ***Auckland Area Health Board*** *(supra)* applies with equal force to CANH. Thus, like artificial ventilatory support, CANH also serves a therapeutic or medical function and must therefore be assessed under the same legal framework applicable to other life-sustaining medical interventions.

121. Furthermore, in ***Airedale*** *(supra)*, Lord Keith rejected the argument that artificial feeding by nasogastric tube was indistinguishable from normal feeding, the latter of which did not amount to medical treatment. He emphatically acknowledged that there is a distinction between CANH and normal feeding, as the administration of nourishment by artificial means involves the application of a medical

technique. Driving home this point, Lord Keith succinctly observed that it is incorrect to direct exclusive attention to the fact that nourishment is being provided. Rather, regard should be had for the whole regime of medical treatment that keeps the patient alive, including that of artificial feeding, which involves the application of medical technique. In observing thus, Lord Keith places CANH on the same pedestal as other forms of medical treatment, *vis-à-vis* which the medical practitioners are under no greater duty to administer it if such medical treatment would not confer any benefit to the patient. We consider it important to quote Lord Keith's observations in ***Airedale*** *(supra)*, which are as follows:

> *"[…] It was argued for the guardian ad litem, by analogy with that case, that here the doctors in charge of Anthony Bland had a continuing duty to feed him by means of the nasogastric tube and that if they failed to carry out that duty they were guilty of manslaughter, if not murder. This was coupled with the argument that feeding by means of the nasogastric tube was not medical treatment at all, but simply feeding indistinguishable from feeding by normal means. As regards this latter argument, I am of the opinion that regard should be had to the whole regime, including the artificial feeding, which at present keeps Anthony Bland alive. That regime amounts to medical treatment and care, and it is incorrect to direct attention exclusively to the fact that nourishment is being provided. In any event, the administration of nourishment by the means adopted involves the application of a medical technique. But it is, of course, true that in general it would not be lawful for a medical practitioner who assumed responsibility for the care of an unconscious patient simply to give up treatment in circumstances where continuance of it would confer some benefit on the patient. On the other hand 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. Existence in a vegetative state with no prospect of recovery is by that opinion regarded as not being a benefit, and that, if not unarguably correct, at least forms a proper basis for the decision to discontinue treatment and care: Bolam v. Friern Hospital Management Committee [1957] 1 W.L.R. 582"

(Emphasis Supplied)

122. The aforementioned observation made by Lord Keith regarding consideration of the whole regime of medical treatment, including artificial feeding, when read with Lord Lowry's observation ***Airedale*** *(supra)*, makes it all the more poignant. Taking a comprehensive view of CANH, Lord Lowry observed that an artificial feeding regime is inevitably associated with the continuous use of catheters and enemas and the constant combating of potentially deadly infection(s). He observes thus:

"*4. Although entirely satisfied with your Lordships' consensus, I ought finally to touch on the real point in the case. The strength of the Official Solicitor's argument lies in its simplicity. In answer to the respondent's reliance on accepted medical opinion that feeding (nutrition and hydration), particularly by sophisticated artificial methods, is part of the life-supporting medical treatment, he says that the duty to feed a helpless person, such as a baby or an unconscious patient, is something different, an elementary duty to keep the patient alive which exists independently of all questions of treatment and which the person in charge cannot omit to perform: to omit deliberately to perform this duty in the knowledge that the omission will lead to the death of the helpless one, and indeed with the intention, as in the present case, of conducing to that death, will render those in charge guilty of murder. One of the respondent's counter- arguments, albeit not conclusive, is based on the overwhelming*

> *verdict of informed medical opinion worldwide, with particular reference to the common law jurisdictions, where the relevant law generally corresponds closely with our own, that therapy and life-supporting care, including sophisticated methods of artificial feeding, are components of medical treatment and cannot be separated as the Official Solicitor contends. In this connection it may also be emphasised that an artificial feeding regime is inevitably associated with the continuous use of catheters and enemas and the sedulous avoidance and combatting of potentially deadly infection. I consider that the court, when intent on reaching a decision according to law, ought to give weight to informed medical opinion both on the point now under discussion and also on the question of what is in the best interests of a patient and I reject the idea, which is implicit in the appellant's argument, that informed medical opinion in these respects is merely a disguise for a philosophy which, if accepted, would legalise euthanasia."*
>
> (Emphasis Supplied)

123. At this juncture, it is pertinent to refer to the observation regarding 'feeding tubes' made by Sikri, J. in Common Cause 2018 (supra), which reads thus:

> "*219. Passive euthanasia occurs when medical practitioners do not provide life-sustaining treatment (i.e. treatment necessary to keep a patient alive) or remove patients from life-sustaining treatment. This could include discontinuing treatment. This could include discontinuing life-support machines or feeding tubes or not carrying out life-saving operations or providing life-extending drugs.*"
>
> (Emphasis Supplied)

124. A similar view has been echoed by D.Y. Chandrachud, J., in ***Common Cause 2018*** *(supra),* in his reference to feeding through hydration tubes as an example of medical treatment which an

individual might be subjected to in an emergency, but with regard to which one should have the right of refusal if such artificial prolongation results in human suffering. D.Y. Chandrachud, J., in ***Common Cause 2018*** *(supra)* observes thus:

> "*359. Individuals who suffer from chronic disease or approach the end of the span of natural life often lapse into terminal illness or a permanent vegetative state. When a medical emergency leads to hospitalisation, individuals in that condition are sometimes deprived of their right to refuse unwanted medical treatment such as feeding through hydration tubes or being kept on a ventilator and other life support equipment. Life is prolonged artificially resulting in human suffering […]*"

125. To acknowledge that the very survival of the patient in a PVS condition is resting on an invasive form of artificial support made possible by medical science and technology, yet deny such intervention the status of a 'medical treatment' in respect of which doctors could exercise their clinical judgment, would stretch the concept of basic or primary care to an extent that it becomes illogical. Thus, it is crucial that CANH be regarded as medical treatment, forming an integral part of a patient's medical management, and be subject to the same ethical, legal, and clinical principles that govern the initiation, continuation, withholding, or withdrawal of other life-sustaining medical interventions. To deny it recognition as a medical treatment would reduce the patient to being a passive subject of medical technology, while simultaneously depriving doctors of the agency necessary to responsibly assess the therapeutic value of such intervention in the discharge of their duty of care.

126. However, another significant aspect that needs to be addressed is whether CANH that is administered at home can still be regarded as a medical treatment. We hereby clarify that merely because routine feeding in the form of CANH can be administered at home, by an informed lay person, it cannot be relegated to a non-medical status. We find the reasoning given by Morris J., in ***Re BWV; Ex parte Gardner***, reported in **2003 VSC 173**, to be most apt in addressing this point. Therein it was recognised by the Supreme Court of Victoria, Australia, that artificial nutrition and hydration involves protocols, skills and care which draw from and depend upon medical knowledge. In his opinion, Morris J., clearly reasons out why the use of PEG for artificial nutrition and hydration is unquestionably a medical procedure. He explains how artificial nutrition and hydration will inevitably require the careful choice of materials and preparation methods, close consideration of dosage rates, measures to prevent infection, and regular cleaning of conduits. These measures cannot be regarded as common knowledge. Rather, they draw from and depend upon medical knowledge. More pertinently, he observes, that although artificial nutrition and hydration, via a PEG, can be performed at home by an informed lay person, it remains a medical procedure because such administration of nutrition and hydration must necessarily be performed under regular medical and nursing supervision, involving skills and protocols which the lay person would need to specifically obtain by drawing upon medical knowledge. Morris J.'s observations read as follows:

> *"76. It is not necessary to explore all the circumstances which might be said to constitute a medical procedure: because, unquestionably in my judgment, the use of a PEG for artificial nutrition and hydration, or for that matter any form of artificial feeding, is a "medical" procedure. Artificial nutrition and hydration involves protocols, skills and care which draw from, and depend upon, medical knowledge. Artificial nutrition and hydration will inevitably require careful choice of and preparation of materials to be introduced into the body, close consideration to dosage rates, measures to prevent infection and regular cleaning of conduits. These are not matters of common knowledge. In this regard, I particularly rely upon the evidence given to the Court by Dr Woodward, Professor Ashby and Professor Horne.*
>
> 77. *In my opinion, the claim that artificial nutrition and hydration via a PEG, can be performed in the home by an informed lay person does not mean that this procedure is not a medical procedure. Quite apart from the fact that the evidence is that such artificial nutrition and hydration must necessarily be performed under regular medical and nursing supervision, such a procedure involves skills and protocols which the lay person would need to specifically obtain by drawing upon medical knowledge."*
>
> (Emphasis Supplied)

127. The recognition accorded to CANH as a 'medical treatment' is of particular importance as it enables doctors acting in good faith and with due medical propriety to undertake such treatment and be able to take further decisions regarding its discontinuation, in the same manner as any other decision the doctor is duty-bound to make concerning the appropriateness of continuing a medical intervention. In other words, recognising CANH as a medical treatment brings decisions regarding its administration, refusal, withholding or withdrawal squarely within the realm of clinical

judgment, thereby making physicians duty-bound to evaluate whether it is in the best interest of the patient to continue such treatment, or whether it has lost its therapeutic purpose and has become futile, thereby outweighing its intended benefits. It cannot be said that a patient should be made a passive subject of medical technology without allowing the doctors to engage in clinical decision-making regarding such technological intervention.

128. We are therefore of the considered view that CANH constitutes 'medical treatment' and must be governed by the same legal principles applicable to the withholding or withdrawal of other forms of life-sustaining medical interventions, subject, of course, to the safeguards and procedural requirements laid down by this Court in ***Common Cause 2018*** *(supra)*.

129. In the present matter before us, the applicant is sustained through the administration of nutrition and hydration in medically prescribed quantities of certain prescribed feed, *via* a surgically installed PEG tube. We have already explained how the continuation of such CANH requires an ongoing clinical decision-making process, through routine medical supervision, periodic evaluation, and emergency medical management in case of infection or dislodgment of the CANH device. Consequently, it is beyond question that administration of CANH in this case is to be considered as medical treatment. Further, as we have already explained hereinabove, the fact that the applicant is administered CANH at home does not displace the status of such CANH as being considered as a medical treatment.

130. Therefore, in line with our considered view that CANH constitutes medical treatment, it is permissible for the primary medical board and secondary medical board to exercise their clinical judgment with regard to the continuation or withdrawal or withholding of CANH, like any other form of medical treatment, in accordance with the guidelines as laid down in ***Common Cause*** *(supra)*. In other words, the primary and secondary medical boards are at liberty to exercise their independent clinical judgment on the question of continuation or withdrawal of CANH, as they would in respect of any other form of medical treatment.

(2) WHAT IS THE MEANING, SCOPE, AND CONTOURS OF THE PRINCIPLE OF *"BEST INTEREST OF THE PATIENT"* IN DETERMINING WHETHER MEDICAL TREATMENT SHOULD BE WITHDRAWN OR WITHHELD?

131. As discussed above, a five-judge Constitution Bench of this Court in ***Common Cause 2018*** *(supra)* had *inter alia* laid out certain guidelines for the withdrawal or withholding of medical treatment. According to the ***Common Cause 2018*** *(supra)*, when following these step-by-step guidelines and determining whether a particular medical treatment is to be withdrawn or withheld, the doctors and the courts have to keep in mind the principle of *"best interest of the patient"*.

132. While referring to this principle, Dipak Misra, CJ., in his opinion, referred to the decision of the House of Lords in ***Airedale*** *(supra)* wherein it was settled that the life sustaining treatment can be

withdrawn in the case of a competent patient, if he consents to it and in the case of an incompetent patient, if it is in his best interest to do so. Similarly, A.K. Sikri, J., in his opinion, was of the same view that the decision of a doctor to withdraw or withhold medical treatment must be based on what is in the best interest of the patient. Additionally, D.Y. Chandrachud, J., also expressed in clear and categorical terms, that the decision of a treating doctor to withdraw or withhold medical treatment is legally protected, so long as such decision is taken *bona fide*, in faithful discharge of professional duty, and in the best interests of the patient. Lastly, Ashok Bhushan, J., while concurring with the aforesaid views, also observed that in cases involving incompetent patients who are incapable of taking an informed decision, the governing principle shall be the *"best interests of the patient"*, and the determination in that regard must rest with competent medical experts. The relevant observations are as under:

> ***Dipak Misra, CJ.***
>
> *"192. […] In general, as per the settled law vide the decision in Airedale, life-sustaining treatment including artificial nutrition and hydration can be withdrawn if the patient consents to it and in case of incompetent patients,* ***if it is in their best interest to do so****."*
>
> ***A.K. Sikri, J.***
>
> *"462 […] Placing a patient on artificial life support would, in such a situation, merely prolong the agony of the patient. Hence, a decision by the doctor based on* ***what is in the best interest of the patient*** *precludes an intent to cause death […].*

D.Y. Chandrachud, J.

"521. The decision by a treating doctor to withhold or withdraw medical intervention in the case of a patient in the terminal stage of illness or in a persistently vegetative state or the like where artificial intervention will merely prolong the suffering and agony of the patient is protected by the law. Where the doctor has acted in such a case in the ***best interest of the patient*** *and in bona fide discharge of the duty of care, the law will protect the reasonable exercise of a professional decision."*

Ashok Bhushan, J.

*"629.9. We are also of the opinion that in cases of incompetent patients who are unable to take an informed decision, "****the best interests principle" be applied and such decision be taken by specified competent medical experts*** *and be implemented after providing a cooling period to enable aggrieved person to approach the court of law."*

(Emphasis Supplied)

133. Furthermore, according to Para. 198.5.3 (cases where an AMD is present) and Para. 199.4 (cases where an AMD is absent) of the guidelines as laid down in ***Common Cause*** *(supra)*, respectively, it is also obligatory upon the court dealing with the question of withdrawal or withholding of medical treatment to ascribe reasons for the same, while specifically keeping in mind the principle of best interest of the patient. At Para. 202.14 of the guidelines as laid down in ***Common Cause*** *(supra)*, this Court also laid down that when withdrawing or withholding medical treatment is considered medically appropriate as a part of the patient's palliative care, then the patient's best interests must take priority over the interests of

the State to preserve life. The relevant excerpts from the guidelines as laid down in ***Common Cause*** *(supra)* are as follows:

> *"198.5.3. Needless to say that the High Court shall render its decision at the earliest as such matters cannot brook any delay and it shall ascribe reasons specifically keeping in mind the principles of "best interests of the patient".*
>
> *xxx xxx xxx*
>
> *199.4. […] Needless to say, the High Court shall ascribe High Court shall ascribe reasons specifically reasons specifically keeping in mind the keeping principle of "best interests of the patient".*
>
> *xxx xxx xxx*
>
> *202.14. When passive euthanasia as a situational palliative measure becomes applicable, the best interest of the patient shall override the State interest.*
>
> (Emphasis Supplied)

134. From the foregoing discussion, it emerges that the application of the principle of the *"best interests of the patient"* possesses an intrinsic and qualified significance in determining whether medical treatment should be withdrawn or withheld. However, at this stage, a pertinent question arises as to the precise content, contours, and scope of this principle, and the manner in which it is to be applied to the facts and circumstances of each individual case. We are, therefore, of the considered view that it is imperative, at the threshold, to elucidate the meaning and ambit of the principle of best interests, which receives paramount consideration in contemplating the withdrawal or withholding of medical

intervention. We intend to undertake this exercise by examining a series of decisions rendered by courts across various jurisdictions, wherein the principle of best interests has been expounded, particularly in the context of issues relating to the withdrawal or withholding of medical treatment. We shall also advert, albeit briefly, to the meaning and scope of this principle as evidenced in the recommendations given by the Law Commission of India in its 196th Report titled *"Medical Treatment to Terminally Ill Patients (Protection of Patients and Medical Practitioners)"* and in its 241st Report titled *"Passive Euthanasia – A Relook"*, and, finally, to the exposition of this Court in ***Common Cause 2018*** *(supra)*.

(a) <u>Best interest of the patient in United States of America (USA)</u>

135. The earliest authority in the USA relevant for our discourse is of ***In re Eichner on behalf of Fox***, reported in **73 A.D.2d 431**. In this case, the Supreme Court of New York was concerned with the case of Brother Joseph Charles Fox, an 83-year-old Catholic monk who suffered a cardiac arrest during routine hernia surgery, resulting in severe and irreversible brain damage and leaving him in a PVS. He was sustained solely by artificial ventilation and had no prospect of recovery. Father Philip K. Eichner, a close associate and religious superior, applied before the court seeking a declaration of the patient's incompetence and authorisation to withdraw the respirator, relying on the patient's previously expressed wishes not to be kept alive by extraordinary means. The trial court permitted withdrawal of the respirator. The District Attorney preferred an appeal. During the pendency of the appeal, the patient died

naturally; however, the court proceeded to determine the matter, observing that similar issues were capable of recurring. The Supreme Court of New York ultimately affirmed the decision of the trial court, holding that withdrawal of extraordinary life-sustaining treatment was permissible, subject to strict procedural safeguards and clear medical confirmation. The court observed that the law confers jurisdiction upon the court to act in relation to an incompetent person only in furtherance of his best interests and in exercise of its protective jurisdiction.

136. The court then addressed the question of the patient's wishes and recognised that, in many cases, a specific prior statement of intent may not be available. In such circumstances, the court held that an alternative mechanism is required to safeguard the patient's right to refuse treatment. The court approved the use of the substituted judgment standard in such circumstances and recognised that such an approach had received judicial acceptance in the USA. The court further observed that substituted judgment is intended to give effect to the patient's own wishes and autonomy and is best undertaken by persons who knew the patient closely. The court further emphasised that the substituted judgment must proceed on the basis that it reflects the patient's own choice, i.e., what the patient would have wanted if he had capacity. The relevant observations are as under:

> *"The legal component concerns the mechanism by which the patient's intentions are ascertained, if possible, and his best interests safeguarded.*

*But the question does not end there for we recognize that a specific statement of intent by the patient will occur only in a minority of cases. Another mechanism is required if the comatose patient's [**548] right to refuse extraordinary life-prolonging medical treatment is to be safeguarded. Both Quinlan and Saikewicz faced the problem, although in different contexts: in Quinlan the 21-year-old Karen, in the full flower of her [***89] health, had no reason to contemplate the possibility of death and therefore no reason to make known her wishes; in Saikewicz, the 67-year-old retardate had an I.Q. of 10, and a mental age of less than three, and hence was incapable of intelligently expressing his wishes […] Both courts, however, elected a similar procedural mechanism: a "substitute" or proxy judgment by the patient's guardian in the best interests of the incompetent patient. This was no great departure from the norm since "[courts] in the exercise of their parens patriae responsibility to protect those under disability have sometimes implemented medical decisions and authorized their carrying out under the doctrine of 'substituted judgment […] The Quinlan court held that the "only practical way to prevent destruction of the right is to permit the [***90] guardian and family of Karen to render their best judgment * * * as to whether she would exercise it in these circumstances". Similarly, the guardian ad litem in Saikewicz was required to make a substitute judgment based on the "incompetent person's actual interests and preferences […] We believe that this is essentially a sound approach, borne of the exigencies of the circumstances. We look particularly to a close family relative, a spouse, parent, child, brother, sister or grandchild -- in Brother Fox's case, a member of his religious family -- as an appropriate person to initiate, as committee of the incompetent, the process of reaching such a decision. Such an individual who has known and loved the patient personally, presumably for years, can best determine what that patient would have wanted under the circumstances. It is a decision we trust that will derive from a deep and abiding respect for the patient as an individual. But more important, [***91] we believe that it must be based on the assumption that the patient would have wanted it that way. This approach seeks*

to fulfill what would be deemed to be the dying patient's own wishes, and reaffirms notions of self-determination.

We note that the doctrine of substitute judgment is not unknown in this jurisdiction in incompetency proceedings."

(Emphasis Supplied)

137. In ***Barber v Superior Court***, reported in **147 Cal App 3d 1006**, the patient had suffered a cardiac arrest resulting in severe brain damage and leaving him in a deep and irreversible vegetative state with virtually no prospect of regaining cognitive or motor function. He was sustained on life-support systems, including a respirator and intravenous nutrition and hydration. After being informed of the prognosis, the patient's wife and children requested withdrawal of all life-sustaining treatment, consistent with the patient's previously expressed wishes not to be kept alive artificially. The treating physicians thereafter withdrew the respirator and subsequently, the CANH. The patient, thereafter, died while receiving palliative care. In consequence, the doctors were charged with murder and conspiracy to commit murder, which they challenged before the Court of Appeal of California by seeking a writ of prohibition. The court held that the doctors' omission to continue treatment did not constitute an unlawful failure to perform a legal duty when the patient had virtually no prospect of recovering cognitive function.

138. In holding so, the court emphasised that medical decision-making in such cases must be rationally approached by examining whether the proposed treatment is proportionate or disproportionate, having

regard to the benefits and burdens associated with such treatment. The court recognised that treatment may still be regarded as proportionate, even if painful or intrusive, where there exists a reasonable prospect of cure or significant improvement in the patient's condition. The court further recognised that the patient's interests and desires constitute central components of the decision-making process. However, in cases where the possibility of full recovery is virtually non-existent, and the patient is incapable of expressing his wishes, the focus of the inquiry must shift to the medical prognosis, particularly the reasonable possibility of return to cognitive and sapient life, as distinct from mere continuation of biological existence in a vegetative state. The court recognised that where the patient's choice cannot be ascertained, the surrogate must act in the patient's best interests, assessed by factors such as relief from suffering, preservation or restoration of functioning, and the quality and extent of life sustained. The surrogate may also consider the impact of the decision on those closest to the patient. The relevant observations are as under:

> *"[…] A more rational approach involves the determination of whether the proposed [*1019] treatment is proportionate or disproportionate in terms of the benefits to be gained versus the burdens caused.*
>
> *Under this approach, proportionate treatment is that which, in the view of the patient, has at least a reasonable chance of providing [***22] benefits to the patient, which benefits outweigh the burdens attendant to the treatment. Thus, even if a proposed course of treatment might be extremely painful or intrusive, it would still be proportionate treatment if the prognosis was for complete cure or significant improvement in the patient's condition […]*

xxx xxx xxx

Of course the patient's interests and desires are the key ingredients of the decision-making process. When dealing with patients for whom the possibility of full recovery is virtually nonexistent, and who are incapable of expressing their desires, there is also something of a consensus on the standard to be applied.

The focal point of decision should be the prognosis as to the reasonable possibility of return to cognitive and sapient life, as distinguished from the forced continuance of that biological vegetative existence.

Prolongation of life [...] does not mean a mere suspension of the act of dying, but contemplates, at the very least, a remission of symptoms enabling a return towards a normal, functioning, integrated existence.

*If it is not possible to ascertain the choice the patient would have made, the surrogate ought to be guided in his decision by the patient's best interests. Under this standard, such factors as the relief of suffering, the preservation or restoration of functioning and the quality as well as the extent of life sustained may be considered. Finally, since most people are concerned about the well-being [***27] of their loved ones, the surrogate may take into account the impact of the decision on those people closest to the patient."*

(Emphasis Supplied)

139. Further, in ***In re Conroy*** *(supra)*, the Supreme Court of New Jersey considered the case of Claire C. Conroy, an incompetent, bedridden nursing-home resident suffering from severe and irreversible physical and mental impairments, including advanced dementia, gangrene, ulcers, and inability to swallow. She was not terminally ill, comatose, or in a vegetative state, but was being sustained

through a nasogastric feeding tube, which constituted her sole source of nutrition and hydration. Her nephew and legal guardian sought judicial authorisation to withdraw the feeding tube, contending that continued artificial feeding merely prolonged her suffering and was inconsistent with what she would have wanted. The trial court permitted withdrawal of the feeding tube. However, the Appellate Division reversed, holding that withdrawal of nourishment would amount to killing. During the pendency of the appeal, the patient died naturally, yet the Supreme Court of New Jersey proceeded to determine the matter in view of its public importance.

140. The court held that a patient's best interests may be assessed through structured objective standards. Under the *limited-objective test*, life-sustaining treatment may be withdrawn where there is some trustworthy evidence of the patient's prior wishes to refuse such treatment and where the burdens of continued life with treatment clearly outweigh its benefits, including unavoidable and continuing pain and suffering. In the absence of any trustworthy evidence of prior wishes, the court recognised that withdrawal may still be permissible under a *pure-objective test*, where the net burdens of continued treatment clearly and markedly outweigh the benefits and the patient's suffering renders continuation inhumane. The court, however, clarified that even under such objective standards, treatment must not be withdrawn where the patient had previously expressed a clear wish to be kept alive despite suffering. The relevant observations are as under:

"[…] We therefore hold that life-sustaining treatment may also be withheld or withdrawn from a patient in Claire Conroy's situation if either of two "best interests" tests-- a limited-objective or a pure-objective test – is satisfied.

Under the limited-objective test, life-sustaining treatment may be withheld or withdrawn from a patient in Claire Conroy's situation when there is some trustworthy evidence that the patient would have refused the treatment, and the decision-maker is satisfied that it is clear that the burdens of the patient's continued life with the treatment outweigh the benefits of that life for him. By this we mean that the patient is suffering, and will continue to suffer throughout the expected duration of his life, unavoidable pain, and that the net burdens of his prolonged life (the pain and suffering of his life with the treatment less the amount and duration of pain that the patient would likely experience if the treatment were withdrawn) markedly outweigh any physical pleasure, emotional enjoyment, or intellectual satisfaction that the patient may still be able to derive from life. This limited-objective standard permits the termination of treatment for a patient who had not unequivocally expressed his desires before becoming incompetent, when it is clear that the treatment in question would merely prolong the patient's suffering.

This limited-objective test also requires some trustworthy evidence that the patient would have wanted the treatment terminated. This evidence could take any one or more of the various forms appropriate to prove the patient's intent under the subjective test. Evidence that, taken as a whole, would be too vague, casual, or remote to constitute the clear proof of the patient's subjective intent that is necessary to satisfy the subjective test -- for example, informally expressed reactions to other people's medical conditions and treatment -- might be sufficient to satisfy this prong of the limited-objective test.

In the absence of trustworthy evidence, or indeed any evidence at all, that the patient would have declined the treatment, life-sustaining treatment may still be withheld or

> *withdrawn from a formerly competent person like Claire Conroy if a third, pure-objective test is satisfied. Under that test, as under the limited-objective test, the net burdens of the patient's life with the treatment should clearly and markedly outweigh the benefits that the patient derives from life. Further, the recurring, unavoidable and severe pain of the patient's life with the treatment should be such that the effect of administering life-sustaining treatment would be inhumane. Subjective evidence that the patient would not have wanted the treatment is not necessary under this pure-objective standard. Nevertheless, even in the context of severe pain, life-sustaining treatment should not be withdrawn from an incompetent patient who had previously expressed a wish to be kept alive in spite of any pain that he might experience."*
>
> (Emphasis Supplied)

141. In ***Rasmussen v. Fleming***, reported in **154 Ariz. 207**, the Supreme Court of Arizona was seized with a case involving a 64-year-old patient named Mildred Rasmussen who was admitted to a nursing home and later suffered multiple strokes, leading to severe, irreversible brain damage and a chronic vegetative state. She was incapable of caring for herself, was largely non-responsive, and had no realistic prospects of recovery, according to medical experts.

142. The Supreme Court of Arizona expressed the view that in cases involving surrogate medical decision-making, two distinct standards have been developed by courts, namely, substituted judgment and best interests. Under the substituted judgment standard, the guardian is required to attempt to reach the decision that the incapacitated person would have made if he or she had the capacity to choose, and this standard is most appropriately applied where the patient, while competent, has manifested his or her

intentions concerning medical treatment. However, the court clarified that where the evidentiary record is barren of any reliable indication of the patient's prior wishes, the substituted judgment standard provides little or no meaningful guidance and must therefore give way to the best interests standard. In such circumstances, the surrogate decision-maker is required to determine what course of medical treatment would best serve the patient's interests, assessed by reference to objective considerations. The relevant observations are as under:

> *"We conclude that Rasmussen's right to refuse medical treatment still existed despite her incompetency and her failure to articulate her medical treatment desires prior to becoming incompetent. Because she was incapable of exercising that right, however, we must determine who could exercise that right for her.*
>
> *WHO CAN* EXERCISE *AN INCOMPETENT'S RIGHT TO REFUSE MEDICAL TREATMENT*
>
> *The court of appeals held that either a family member or a guardian could exercise Rasmussen's right to refuse medical treatment [...] The guardian ad litem contends that the guardian should not have unbridled discretion to decide whether to refuse* any *or all medical treatment. We agree. Courts have developed two standards to guide surrogate decision making: "substituted judgment" and "best interests." Under the substituted judgment standard, the guardian "attempt[s] to reach the [***36] decision that the incapacitated person would make if he or she were able to choose." [...] This standard best guides a guardian's decision-making when a patient has manifested his or her intent while competent. [***37] Unfortunately, the record in this [*222] [**689] case is barren of any evidence that Rasmussen expressed her medical desires in any form prior to becoming incompetent. Where no reliable evidence of a patient's intent exists, as here, the substituted judgment*

> *standard provides little, if any, guidance to the surrogate decisionmaker and should be abandoned in favour of the "best interests" standard [...] Under the best interests standard, the surrogate decisionmaker assesses what medical treatment would be in the patient's best interests as determined by such objective criteria as relief from suffering, preservation or restoration of functioning, and quality and extent of sustained life."*
>
> (Emphasis Supplied)

143. Later, in the landmark decision of ***Cruzan v Director, Missouri Department of Health***, reported in **497 U.S. 261**, the Supreme Court of the USA considered the case of Nancy Cruzan, a 25-year-old woman who had suffered severe brain damage due to oxygen deprivation following a motor vehicle accident, leaving her in a PVS with no realistic prospect of regaining cognitive function. She was sustained by CANH through a feeding tube, though she could breathe without mechanical assistance. Nancy's parents, acting as her guardians, sought withdrawal of the feeding tube, relying upon her prior informal statements indicating that she would not wish to live in a "vegetable-like" condition. The hospital declined to withdraw life-sustaining treatment without judicial authorisation. The Missouri Supreme Court denied permission, holding that there was no clear and convincing evidence of Nancy's wishes to refuse life-sustaining treatment.

144. The matter reached the Supreme Court of the United States to decide whether the Federal Constitution required the State of Missouri to permit withdrawal of CANH in such circumstances. A majority of the court, speaking through Chief Justice Rehnquist

and four concurring judges, upheld the decision of the Missouri Supreme Court. While recognising that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment, the court held that an incompetent person cannot exercise such a choice directly, and that any decision in that regard must be made through a surrogate, subject to procedural safeguards designed to reflect, as nearly as possible, the patient's own wishes expressed while competent. The court further held that the Constitution does not prohibit a State from requiring that an incompetent patient's wishes regarding withdrawal of life-sustaining treatment be established by clear and convincing evidence. It observed that close family members, though often acting in good faith, cannot automatically be presumed to represent the patient's own views, and that the State may therefore insist on a heightened evidentiary standard. Applying this standard, the court held that the evidence relied upon by Nancy Cruzan's parents did not satisfy the clear and convincing threshold and accordingly affirmed the decision to continue CANH. The relevant observations of the majority opinion are as under:

> *"The difficulty with petitioners' claim [****35] is that in a sense it begs the question: An incompetent person is not able to make an informed and voluntary choice to exercise a hypothetical right to refuse treatment or any other right. Such a "right" must be exercised for her, if at all, by some sort of surrogate. Here, Missouri has in effect recognised that under certain circumstances a surrogate may act for the patient in electing to have hydration and nutrition withdrawn in such a way as to cause death, but it has established a procedural safeguard to assure that the action of the surrogate conforms as best it may to the wishes expressed by the patient while competent. Missouri requires*

that evidence of the incompetent's wishes as to the withdrawal of treatment be proved by clear and convincing evidence. The question, then, is whether the United States Constitution forbids the establishment of this procedural requirement by the State. We hold that it does not.

xxx xxx xxx

*No doubt is engendered by [****47] anything in this record but that Nancy Cruzan's mother and father are loving and caring parents. If the State were required by the United States Constitution to repose a right of "substituted judgment" with anyone, the Cruzans would surely qualify. But we do not think the Due Process Clause requires the State to repose judgment on these matters with anyone but the patient herself. Close family members may have a strong feeling -- a feeling not at all ignoble or unworthy, but not entirely disinterested, [**2856] either -- that they do not wish to witness the continuation of the life of a loved one which they regard as hopeless, meaningless, and even degrading. But there is no automatic assurance that the view of close family members will necessarily be the same as the patient's would have been had she been confronted with the prospect of her situation while competent. All of the reasons previously discussed for allowing Missouri to require clear and convincing evidence of the patient's wishes lead us to conclude that the State may [*287] choose to defer only to those wishes, rather than confide the decision to close family members."*

(Emphasis Supplied)

145. However, Justice Brennan and Justice Stevens dissented from the above opinion. Justice Brennan's dissent was concurred by 2 other judges, and Justice Stevens delivered a separate dissent.

146. Justice Brennan, in his dissent, was of the view that the majority had erred in permitting the State's abstract interest in the preservation of life to override the concrete and individual best

interests of Nancy Cruzan. According to him, the Missouri Supreme Court adverted to no evidence supporting its decision, but nevertheless concluded that there was no clear and convincing, inherently reliable evidence establishing that Nancy would have wished to avoid further treatment. In doing so, the court, in Justice Brennan's view, failed to consider relevant and material evidence, including statements made by Nancy to family members and a close friend, as well as the testimony of her mother and sister, who were certain that Nancy would have wished to discontinue CANH. He noted that this omission occurred despite the court's own finding that Nancy's family was loving and acted without any improper or malignant motive. Justice Brennan further observed that the Missouri Supreme Court failed to give due consideration to the conclusions of the guardian ad litem appointed by the trial court, who had found clear and convincing evidence that Nancy would have wished to discontinue medical treatment and that such discontinuation was in her best interests. According to Justice Brennan, such an approach imposed an unduly rigid and unrealistic evidentiary burden, inconsistent with the realities of medical decision-making and personal autonomy. The relevant observations from Justice Brennan's dissenting opinion are as follows:

> *"[…] The court adverted to no evidence supporting its decision, but held that no clear and convincing, inherently reliable evidence had been presented to show that Nancy would want to avoid further treatment. In doing so, the court failed to consider statements Nancy had made to family members and a close friend. The [***270] court also failed to consider testimony [*322] from Nancy's mother*

> *and sister that they were certain that Nancy would want to discontinue artificial nutrition and hydration, even after the court found that Nancy's family was loving and without malignant motive. The court also failed to consider the conclusions of the guardian ad litem, appointed by the trial court, that there was clear and convincing evidence that Nancy would want to [*323] discontinue medical treatment and that this was in her best interests. The court did not specifically define what kind of evidence it would consider [**2875] clear and convincing, but its general discussion suggests that only a living will or equivalently formal directive from the patient when competent would meet this standard."*
>
> (Emphasis Supplied)

147. Justice Stevens, in his dissent, was of the further view that the majority had impermissibly allowed the State's undifferentiated interest in preserving life to overwhelm Nancy Cruzan's individual best interests, which, according to undisputed findings at trial, would have been served by permitting her guardians to exercise her constitutional right to discontinue medical treatment. He found it ironic that the court reached this conclusion despite endorsing propositions which, in his view, should have led to the opposite result. In his opinion, the Constitution required the State to care for Nancy Cruzan's life in a manner that accords appropriate respect to her own best interests.

148. Justice Stevens emphasised that this case was the first in which the apex court of USA was called upon to consider whether, and in what manner, the Constitution protects the liberty of seriously ill patients to be free from medical treatment. He cautioned against resolving the issue in the abstract and stressed that the court's responsibility was to address the problem as illuminated by the

specific facts before it. In this regard, he highlighted that clear and convincing evidence established that Nancy Cruzan was permanently unconscious, incapable of swallowing food or water, and would never recover any cognitive function, with irreversible and progressive cerebral cortical atrophy. Recovery and consciousness were impossible, and the highest level of function that could be hoped for was a reflexive response to painful stimuli. Justice Stevens further noted that the trial judge had examined the potential impact of withdrawing treatment on third parties and had found that Nancy's parents were motivated neither by economic considerations nor by any improper purpose, and that granting their request would neither harm innocent third parties nor violate ethical medical standards. He further observed that the guardian ad litem, despite appealing the trial court's order as a matter of duty, did not disagree with its conclusion and expressly endorsed the finding that it was in Nancy Cruzan's best interests to have tube feeding discontinued. According to Justice Stevens, this critical conclusion was undisputed by the parties and ought to have been dispositive. He questioned how, in such circumstances, where continued treatment served no interest of the patient and where the good faith of the family was not in doubt, the state could legitimately insist upon continued medical treatment, particularly when the Missouri Supreme Court had largely ignored the trial court's findings regarding Nancy Cruzan's interests. The relevant observations from Justice Brennan's dissenting opinion are as follows:

> *"The Court would make an exception here. It permits the State's abstract, undifferentiated interest in the*

preservation of life to overwhelm the best interests of Nancy Beth Cruzan, interests which would, according to an undisputed finding, be served by allowing her guardians to exercise her constitutional right to discontinue medical treatment. Ironically, the Court reaches this conclusion despite endorsing three significant propositions which should save it from any such dilemma.

I would so hold: In my view, the Constitution requires the State to care for Nancy Cruzan's life in a way that gives appropriate respect to her own best interests.

This case is the first in which we consider whether, and how, the Constitution protects the liberty of seriously ill patients to be free from life-sustaining medical treatment. So put, the question is both general and profound. We need not, however, resolve the question in the abstract. Our responsibility as judges both enables and compels us to treat the problem as it is illuminated by the facts of the controversy before us.

*[*332] The most important of those facts are these: "Clear and convincing evidence" established that Nancy Cruzan is "oblivious to her environment except for reflexive responses to sound and perhaps to painful stimuli"; that "she has no cognitive or reflexive ability to swallow food or water"; that "she will never recover" these abilities; and that her "cerebral cortical atrophy is irreversible, permanent, progressive and [***276] ongoing." App. to Pet. for Cert. A94-A95. Recovery and consciousness are impossible; the highest cognitive brain function [****125] that can be hoped for is a grimace in "recognition of ordinarily painful stimuli" or an "apparent response to sound." Id., at A95.*

*[****126] [**2880] After thus evaluating Nancy Cruzan's medical condition, the trial judge next examined how the interests of third parties would be affected if Nancy's parents were allowed to withdraw the gastrostomy tube that had been implanted in [*333] their daughter. His findings make it clear that the parents' request had no economic motivation, and that granting their request would*

> *neither adversely affect any innocent third parties nor breach the ethical standards of the medical profession. [...]*
>
> *Because he believed he had a duty to do so, the independent guardian ad litem appealed the trial court's order to the Missouri Supreme Court. In that appeal, however, the guardian advised the court that he did not disagree with the trial court's decision. Specifically, he endorsed the critical finding [****129] that "it was in Nancy Cruzan's best interests to have the tube feeding discontinued."*
>
> *That important conclusion thus was not disputed by the litigants. One might reasonably suppose that it would be dispositive: If Nancy Cruzan has no interest in continued treatment, and if she has a liberty interest in being free from unwanted treatment, and if the cessation of treatment would have no [**2881] adverse impact on third parties, and if no reason exists to doubt the good faith of Nancy's parents, then what possible basis could the State have for insisting upon continued medical treatment? Yet, instead of questioning or endorsing the trial court's [****130] conclusions about Nancy Cruzan's interests, the State Supreme Court largely ignored them."*
>
> (Emphasis Supplied)

149. From above, it is our view that the real divergence in ***Cruzan*** *(supra)* lay not in the recognition of a patient's liberty to refuse medical treatment, but in whether the State of Missouri could have constitutionally insisted upon a rigid and formal application of the *"clear and convincing evidence"* standard, even where the patient's best interests were undisputed and her wishes could be reasonably inferred through substituted judgment.

150. Thereafter, in ***In re Guardianship of Jane Doe***, reported in **411 Mass. 512**, the Supreme Court of Massachusetts considered the

case of Jane Doe, a 33-year-old woman suffering from Canavan's disease, who was also in a PVS, with no prospect of improvement. The medical evidence established that she had suffered a total loss of cerebral functioning, had no awareness of herself or her surroundings, and was incapable of experiencing cognitive responses to stimuli, hunger, or thirst. For nearly a decade, she had been sustained through CANH administered *via* a nasoduodenal tube. In such circumstances, a petition was brought before the Probate and Family Court by Doe's permanent guardian seeking authorisation for the withdrawal of the feeding tube. The Probate Court judge applied the doctrine of substituted judgment and recognised substituted judgment as a legal fiction in cases involving incompetent persons, through which liberty interests of the patient may nonetheless be vindicated. While applying the substituted judgment standard, the judge concluded that, if Doe had been competent, he would have chosen to discontinue CANH, and accordingly allowed the petition. On appeal, the Supreme Court of Massachusetts affirmed the decision of the judge, reiterating that although best interests considerations are relevant to substituted judgment analysis, yet they are relevant only to the extent that the individual herself would have considered them in deciding whether to accept or refuse continued treatment, if he were to be competent. The relevant observations are as under:

> *"Lack of a prior expressed intention regarding medical treatment does not bar use of the doctrine of substituted judgment [...] We recognize that in situations in which there is an attempt to use substituted judgment for a never-competent person, it is a legal fiction. It is the legal mechanism by which society (at least in Massachusetts)*

*attempts to vindicate liberty interests, albeit through a legal fiction. We are also aware that therefore "the substituted judgment [doctrine] is difficult to apply." That difficulty, however, "provides inadequate justification for denying its benefits" [...] "While it may ... be necessary to rely to a greater degree on objective criteria [in the case of a never-competent person] ... the effort to bring the substituted judgment into step with [***15] the values and desires of the affected individual must not, and need not, be abandoned".*

Some of these objective criteria are the same as those considered in the "best interests of the ward" test. "[T]he best interests analysis, like that of the substituted judgment doctrine, requires a court to focus on the various factors unique to the situation of the individual for whom it must act." [...] while ward's best interests are relevant to substituted judgment determination, "they are relevant only to the extent that the individual, if competent, would weigh them in deciding whether to accept treatment"."

(Emphasis Supplied)

151. In the case of ***In re Guardianship of L.W.***, reported in **167 Wis. 2d 53**, the Supreme Court of Wisconsin examined whether life-sustaining medical treatment, including artificial nutrition and hydration, could be withdrawn from an incompetent patient in a PVS, and whether such a decision could lawfully be taken by a guardian. In this case, L.W., a 79-year-old man with a long history of severe schizophrenia who had been admitted to the hospital for decades and may never be competent, suffered a cardiac arrest and thereafter entered a chronic PVS. His physicians advised that, absent his improvement, withdrawal of life-sustaining treatment would be considered. The guardian sought declaratory guidance as to whether he could consent to such withdrawal without prior court approval. Although L.W. died naturally while the matter was

pending, the court addressed the issues owing to their public importance. The court held that an incompetent individual in a PVS possesses a constitutionally protected right to refuse unwanted medical treatment, including CANH, and that a guardian may exercise that right on the ward's behalf where withdrawal is in the ward's best interests. The court clarified that, where a patient's wishes can be clearly ascertained, it is in the patient's best interests to honour those wishes, however, where there is little or no reliable evidence of past wishes (as in the case of a never-competent or long-incompetent patient) the substituted judgment standard would be inapplicable, and the decision must instead be governed exclusively by the best interests principle. In applying that principle, the guardian must begin from a presumption in favour of the continuation of life, but may rebut that presumption through a good faith assessment of objective factors viewed from the patient's standpoint, including prognosis, life expectancy, prospects of recovery, the burdens and benefits of continued treatment, and the degree of humiliation, dependence, and loss of dignity likely to result from the patient's condition and its treatment. The court gave ample caution that in such circumstances the guardian must not substitute his own assessment of the beliefs, values, and wishes of the patient's life. The relevant observations are as under:

> "*We conclude that an incompetent individual in a persistent vegetative state has a constitutionally protected right to refuse unwanted medical treatment, including artificial nutrition and hydration, that a court-appointed guardian may consent to withdrawal of such treatment where it is in the "best interests" of the ward to do so, and that the guardian does not need the prior authority of the court,*

although that decision may be reviewed by the court at the instance of parties in interest. We stress that this opinion is limited in scope to persons in a persistent vegetative state.

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*Certainly the patient's wishes, as far as they can be discerned, are an appropriate consideration for the guardian. If the wishes are clear, it is invariable as a matter of law, both common and statutory, that it is in the best interests of the patient to have those wishes honored, for the patient has made the pre-choice of what he or she considers to be the best interests under the *80 circumstances that arise […]*

xxx xxx xxx

We also hold that in a case such as this one where there can be no reliable ascertainment of the incompetent's wishes, only the best interests standard can be applied. We are fully in accord with the circuit court's conclusion in this respect. In the circumstances of this proceeding the guardian.

xxx xxx xxx

In making the best interests determination, the guardian must begin with a presumption that continued life is in the best interests of the ward. Whether that presumption may be overcome depends upon a good faith assessment by the guardian of several objective factors.

Objective factors the guardian may consider include:

The degree of humiliation, dependence, and loss of dignity probably resulting from the condition and treatment; the life expectancy and prognosis for recovery with and without treatment; the various treatment options; and the risks, side effects, and benefits of each of those options.

xxx xxx xxx

> *In determining whether to withdraw or withhold medical treatment from patient in persistent vegetative state, guardian must assess objective factors from standpoint of patient, and should not substitute his or her own view of "quality of life" of ward; guardian's determination of what is in ward's best interests necessarily involves assessment of value that continuation of life has for ward, but should not involve value others find in continuation of ward's life, and guardian should not engage in subjective quality of life determination on behalf of ward. U.S.C.A. Const. Amend. 14; W.S.A. Const. Art. 1, § 1; W.S.A. 154.01 et seq."*
>
> (Emphasis Supplied)

152. From the above, it appears that courts in the USA have approached decisions relating to withdrawal of life-sustaining treatment through a structured interaction between the substituted judgment standard and the best interests principle, rather than treating them as isolated or competing tests.

153. Where evidence exists of the patient's prior wishes, values, or convictions, the courts in the USA have preferred the substituted judgment standard as the primary mode of decision-making. This is evident in ***In re Eichner*** *(supra)*, where the court emphasised that the role of the surrogate is to determine what the patient would have decided if he had been competent, based on prior expressions and deeply held beliefs, while simultaneously grounding that inquiry in the objective threshold of medical findings of irreversibility, absence of cognitive function, and lack of therapeutic purpose i.e., medically what is in best interest. Similarly, in ***Barber*** *(supra)*, the court acknowledged the prior expressions of the patient's wishes and then evaluated continued treatment through a

proportionality analysis, holding that treatment which merely prolongs biological existence without any reasonable prospect of recovery does not serve the patient's interests and imposes no legal duty on physicians to continue it.

154. At the same time, the courts have repeatedly acknowledged that substituted judgment cannot operate meaningfully in the absence of reliable evidence of the patient's intentions. In such circumstances, the substituted judgment standard yields to a best interests determination grounded in objective criteria. This transition is clearly articulated in ***Rasmussen*** *(supra)*, where the court held that substituted judgment is appropriate only where the patient has expressed his wishes while competent, and that where the record is barren of such evidence, decisions must be guided solely by the patient's best interests, assessed through factors such as relief from suffering, recovery of cognitive functioning, and the quality and extent of life sustained. A similar approach is reflected in ***In re Conroy*** *(supra)*, where the court developed best interests tests to govern cases involving incompetent patients whose wishes could not be clearly established, permitting withdrawal of treatment where the burdens of continued life with treatment clearly outweigh its benefits and continuation would be inhumane.

155. The decision of the Supreme Court of the USA in ***Cruzan*** *(supra),* introduces an important point of divergence. While the majority upheld the State's requirement of clear and convincing evidence of the patient's wishes before permitting withdrawal of life-sustaining treatment, the dissenting opinions, particularly those of Justice

Brennan and Justice Stevens, placed greater emphasis on the patient's best interests and the factual findings of the trial court. The dissent criticised the elevation of the State's abstract interest in preserving life over the individual patient's interests, especially where the medical evidence established permanent unconsciousness, irreversibility, and the absence of any benefit to the patient from continued treatment. The dissent further noted that the trial court had already found, on clear and convincing evidence, that withdrawal of treatment was in the patient's best interests, that the family acted in good faith, and that no third-party interests were adversely affected. We resonate with the observations made in the dissenting opinions, more particularly, the primacy that they have accorded to the patient's welfare and dignity, rather than endorsing very strict procedural evidentiary thresholds that serve to defeat substantively just outcomes in cases where continued treatment serves no purpose for the patient.

156. Subsequent State court decisions reflect both strands of ***Cruzan*** *(supra)*. In ***Guardianship of Jane Doe*** *(supra)*, the Supreme Court of Massachusetts reaffirmed the continued applicability of substituted judgment even for incompetent patients, recognising it as a legal fiction but one necessary to vindicate liberty interests, while permitting reliance on objective criteria where subjective intent cannot be reconstructed. Conversely, in ***In the Matter of Guardianship of L.W.*** *(supra)*, the Supreme Court of Wisconsin drew a clearer line between substituted judgment and best interests, holding that where the patient's wishes cannot be reliably ascertained, only the best interests standard may be applied,

beginning with a presumption in favour of life but allowing that presumption to be rebutted through a good-faith, patient-centred assessment of prognosis, dignity, and the burdens of treatment, without importing subjective quality-of-life judgments of others.

(b) <u>Best interest of the patient in United Kingdom (UK)</u>

157. In one of the first cases of its kind in the United Kingdom, the House of Lords in ***In re F. (Mental Patient: Sterilisation)***, reported in **(1990) 2 AC 1**, was seized with an issue involving a patient F, suffering from a severe mental disability, with the verbal capacity of a two-year old and the mental capacity of a child aged about four-five years. F resided as a voluntary patient in a mental hospital where she formed a sexual relationship with a male patient, P. Although F had the physical capacity to conceive, she was incapable of understanding the causal link between intercourse and pregnancy, nor could she cope with the psychiatric consequences of pregnancy and childbirth. Medical evidence established that standard reversible contraceptives were medically contraindicated or impracticable for her. Consequently, her mother and doctors sought a declaration that the sterilisation of F by tubal occlusion would not be unlawful, despite F's inability to consent to the procedure. In this backdrop, the House of Lords had held that it would be lawful to sterilise a mental patient who was incapable of giving consent to the procedure on the ground that sterilisation would be in the patient's best interests. The House of Lords further observed that the duty of a doctor towards a patient who lacks mental capacity to express his own wishes and has not expressed

at any time when he had such capacity, is to give or withhold treatment according to what appears to be in the best interests of the patient. The House of Lords observed that an operation or a medical treatment will be said to be in the best interests of the patient only if it is carried out in order either to save their lives, or to ensure improvement or prevent deterioration in the patient's health. The relevant observation is as follows:

> *"At common law, a doctor cannot lawfully operate on adult patients of sound mind, or give them any other treatment involving the application of physical force however small ("other treatment"), without their consent. If a doctor were to operate on such patients, or give them other treatment, without their consent, he would commit the actionable tort of trespass to the person. There are, however, cases where adult patients cannot give or refuse their consent to an operation or other treatment. One case is where, as a result of an accident or otherwise, an adult patient is unconscious and an operation or other treatment cannot be safely delayed until he or she recovers consciousness. Another case is where a patient, though adult, is not by reason of mental disability, able to understand the nature or purpose of an operation or other treatment. The common law would be seriously defective if it failed to provide a solution to the problem created by such inability to consent. In my opinion, however, the common law does not so fail. In my opinion, the solution to the problem that the common law provides is that a doctor can lawfully operate on, or give other treatment to, adult patients who are incapable, for one reason or another, of consenting to his doing so, provided that the operation or other treatment concerned is in the best interests of such patients. The operation or other treatment will be in their best interests if, but only if, it is carried out in order either to save their lives, or to ensure improvement or prevent deterioration in their F physical or mental health."*

(Emphasis Supplied)

158. In another pivotal ruling in the case of ***Airedale*** *(supra)*, the House of Lords was seized of a matter involving a patient, Anthony Bland, who was 17 years old and had sustained irreversible damage to the brain, which had left him in a PVS, without cognitive function, and loss of sight and hearing. He was artificially fed by CANH *via* a nasogastric tube. After three years with no hope of recovery, his doctors and family felt that no fruitful purpose would be served by continuing the medical treatment. Therefore, they sought a declaration from the court that it would be lawful to withdraw CANH and associated medical treatment. While holding that it would be in good medical practice and in the best interest of the patient, the House of Lords permitted discontinuation of medical treatment, including the CANH.

159. While doing so, Lord Keith observed that the existence in a vegetative state with no prospect of recovery is regarded as not being beneficial and forms a proper basis for the decision to discontinue medical treatment. Lord Keith was also of the view that the decision whether the continued treatment confers any benefit on a PVS patient is essentially a decision for the doctor in charge. The relevant observations of Lord Keith are as under:

> *"[…] But it is, of course, true that in general it would not be lawful for a medical practitioner who assumed responsibility for the care of an unconscious patient simply to give up treatment in circumstances where continuance of it would confer some benefit on the patient. On the other hand, 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. Existence in a vegetative state with no prospect of recovery is, by that opinion, regarded as not being a benefit, and that, if not unarguably correct, at least forms a proper basis for the decision to discontinue treatment and care [...]"*
>
> (Emphasis Supplied)

160. In addition to this, Lord Goff, while emphasising the principle of the best interest of the patient, referred to ***In re F. (Mental Patient: Sterilisation)*** *(supra)* and observed that a decision by a doctor whether or not to initiate or to continue to provide treatment should also be governed by the same fundamental principle of the patient's best interest. According to Lord Goff, in cases involving the patient being incompetent to consent to the discontinuation of medical treatment where there is no hope for his recovery, and prolongation of medical treatment is serving no therapeutic purposes, the question is not whether it is in the best interests of the patient that he should die, rather the correct question for consideration is "*whether it is in the best interests of the patient that his life should be prolonged by the continuance of such form of medical treatment or care*". Further, Lord Goff also observed that medical treatment is neither appropriate nor requisite "*simply to prolong a patient's life, when such treatment has no therapeutic purpose of any kind, as where it is futile because the patient is unconscious and there is no prospect of any improvement in his condition*". Thereafter, the Lord Goff observed that regard should also be had to the invasive character of the treatment and to the "*indignity*" to which a patient is subjected by prolonging his life by artificial means, which, in turn, causes considerable distress to his family. In such cases, Lord

Goff said that it is the futility of the treatment which justifies its termination and in such circumstances, a doctor is not required to initiate or to continue life-prolonging treatment or care, keeping in mind the best interests of the patient. The relevant observations of Lord Goff are as follows:

> *"[…] 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. (Mental Patient: Sterilisation) [1990] 2 A.C. 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 […]*
>
> *xxx xxx xxx*
>
> *[…] Indeed, if the justification for treating a patient who lacks the capacity to consent lies in the fact that the treatment is provided in his best interests, it must follow that the treatment may, and indeed ultimately should, be discontinued where it is no longer in his best interests to provide it. […] The question is not whether the doctor should take a course that 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 […] 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.

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[…] 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 his best interests no longer require that it should be.

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[…] Here, the condition of the patient, who is totally unconscious and in whose condition there is no prospect of any improvement, is such that life-prolonging treatment is properly regarded as being, in medical terms, useless […] But for my part, I cannot see that medical treatment is appropriate or requisite simply to prolong a patient's life, when such treatment has no therapeutic purpose of any kind, as where it is futile because the patient is unconscious and there is no prospect of any improvement in his condition. It is reasonable also that account should be taken of the invasiveness of the treatment and of the indignity to which, as the present case shows, a person has to be subjected if his life is prolonged by artificial means […] But in the end, in a case such as the present, it is the futility of the treatment that justifies its termination. I do not consider that, in circumstances such as these, a doctor is required to initiate or to continue life-prolonging treatment or care in the best interests of his patient […]"

(Emphasis Supplied)

161. In a similar trend, Lord Mustill observed that it was in the best interest of the community at large that Anthony Bland's life should end. The doctors had done all they could have done. It was a lose-lose situation as nothing would be gained by continuing Bland's treatment. Lord Lowry also observed that in reaching a decision according to law, one ought to give weight to informed medical opinion both on the point whether to continue the artificial feeding regime of a patient in PVS and also on the question of what is in the best interests of a patient. The relevant observations of Lord Mustill and Lord Lowry are as follows:

> *"[…] Threaded through the technical arguments addressed to the House were the strands of a much wider position, that <u>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 recognise that he is being cared for, will continue to mount</u> […]*
>
> *xxx xxx xxx*
>
> *[…] <u>I consider that the court, when intent on reaching a decision according to law, ought to give weight to informed medical opinion both on the point now under discussion and also on the question of what is in the best interests of a patient</u> and I reject the idea, which is implicit in the appellant's argument, that informed medical opinion in these respects is merely a disguise for a philosophy which, if accepted, would legalise euthanasia."*
>
> (Emphasis Supplied)

162. Lastly, Lord Browne-Wilkinson, in concurrence with the above views, expressed the view that if there comes a stage where a responsible doctor reaches a reasonable conclusion, which accords with the views of a responsible body of medical opinion, that further continuance of an intrusive life support system is not in the best interests of the patient, the doctor can no longer lawfully continue that life support system as to do so would constitute the crime of battery and the tort of trespass. According to him, unless the doctor has reached the affirmative conclusion that it is in the patient's best interest to continue the invasive care, such care must cease. The relevant observations of Lord Browne-Wilkinson are as under:

> *"[…] In my judgment it must follow from this that if there comes a stage where the responsible doctor comes to the reasonable conclusion (which accords with the views of a responsible body of medical opinion) that further continuance of an intrusive life support system is not in the best interests of the patient, he can no longer lawfully continue that life support system: to do so would constitute the crime of battery and the tort of trespass to the person. Therefore, he cannot be in breach of any duty to maintain the patient's life. Therefore, he is not guilty of murder by omission."*
>
> (Emphasis Supplied)

163. Thus, from the collective reasoning and concurring opinions expressed by the House of Lords in ***Airedale*** *(supra)*, it becomes manifest that the determination of what constitutes the "best interests of the patient" must be guided by an objective evaluation of the medical realities attending each individual case. Central to this evaluation is the question of whether it is in the best interests of the patient that his life should be prolonged by the continuation

of medical treatment, which, in the given facts and circumstances, may have ceased to serve any therapeutic purpose and has instead become medically futile. In this context, as per ***Airedale*** *(supra),* the principle of best interests does not mandate the preservation of life at all costs or by every available artificial means, irrespective of the quality of life and the invasiveness of the medical intervention. Rather, the focus must remain on whether the continuation of such treatment confers any real benefit upon the patient. Where a responsible body of informed medical opinion concludes that the *patient's condition is irreversible*, that *there exists no reasonable hope of recovery*, and that continued treatment merely sustains biological existence without consciousness or cognitive function, *causing indignity to the life of the patient*, such existence cannot, in law or medical ethics, be regarded as constituting a *benefit* to the patient.

164. What further emerges is that the correct formulation of the enquiry is not whether it is in the best interests of the patient that he should die, but whether it is in his best interests that his life should be artificially prolonged through the continuation of medical treatment which has become non-beneficial, non-therapeutic, or futile. Where the answer to this enquiry, based on sound medical judgment and ethical considerations, is in the negative, the withdrawal or withholding of such treatment must accord with the principle of best interests.

165. At this juncture, for the purposes of our discussion ahead, it is also noteworthy to mention that Lord Goff in ***Airedale*** *(supra)* had also

drawn a tangent upon the scope and application of *the "substituted judgment"* standard while determining the *"best interest of the patient"*. According to Lord Goff, American courts had adopted the substituted judgment standard, where, in a case in which the patient is incapacitated from expressing any view on the question whether life-prolonging medical treatment should be withheld in the relevant circumstances, the determination is anchored on what decision the patient himself would have made had he been able to do so. This came to be known as the substituted judgment standard, and it generally involves a detailed patient-centric consideration of his views and wishes. However, Lord Goff was of the view that any such American standard did not form part of the English law in relation to incompetent adults and in decisions relating to withdrawal or withholding of their medical treatment. The relevant observation is as under:

> *"I wish however, to refer at this stage to the approach adopted in most American courts, under which the court seeks, in a case in which the patient is incapacitated from expressing any view on the question whether life-prolonging treatment should be withheld in the relevant circumstances, to determine what decision the patient himself would have made had he been able to do so. This is called the substituted judgment test, and it generally involves a detailed inquiry into the patient's views and preferences"*

(Emphasis Supplied

166. Later, in the case of ***Re A (Male Sterilisation)***, reported in **[2000] 1 FLR 549 560 F-H**, the Court of Appeal developed the use of a *"balance sheet approach"* in determining the best interest of an incompetent person. According to this approach, a judge who is

tasked with the responsibility to make an evaluation of what is in the best interest of the patient who lacks capacity should draw up a balance sheet. In such a balance sheet, the first entry should be of any factor or factors of actual benefit. On the other side, a judge or a decision-maker should write any counter-balancing disadvantages to the patient. Then he should enter on each side the potential gains and losses for each instance. At the end of that exercise, the judge or the decision-maker should be better placed to strike a balance between the sum of certain and possible gains against the sum of the certain and possible losses. The account that has relatively significant credit will be the concluding factor in deciding what is in the best interest of the patient. The relevant observation is as under:

> *"Pending the enactment of a checklist or other statutory direction it seems to me that the first instance judge with the responsibility to make an evaluation of the best interests of a claimant lacking capacity should draw up a balance sheet. The first entry should be of any factor or factors of actual benefit. In the present case the instance would be the acquisition of foolproof contraception. Then on the other sheet the judge should write any counterbalancing disbenefits to the applicant. An obvious instance in this case would be the apprehension, the risk and the discomfort inherent in the operation. Then the judge should enter on each sheet the potential gains and losses in each instance making some estimate of the extent of the possibility that the gain or loss might accrue. At the end of that exercise the judge should be better placed to strike a balance between the sum of the certain and possible gains against the sum of the certain and possible losses. Obviously, only if the account is in relatively significant credit will the judge conclude that the application is likely to advance the best interests of the claimant."*
>
> (Emphasis Supplied)

167. In drawing up this balance sheet, the court is not concerned solely with medical issues, but also takes into account wider factors concerning the patient. Therefore, in ***Re A (Male Sterilisation)*** *(supra)*, the Court of Appeal had observed that the best interests of the patient are not limited to best medical interests. In fact, the best interests of the patient should encompass medical, emotional and any other welfare issues as well. The relevant observation is as under:

> *"In re MB (Medical Treatment) [1997] 2 FLR 426 I said at page 439:*
> *"Best interests are not limited to best medical interests."*
>
> *In my judgement best interests encompasses medical, emotional and all other welfare issues."*
>
> (Emphasis Supplied)

168. Further, in ***Re S (Adult Patient: Sterilisation)***, reported in **[2001] Fam 15**, the Court of Appeal was of the view that in determining what is in the best interest, the judge must have regard to welfare as an important consideration, which means the determination should embrace issues far wider than the medical ones. The relevant observation is as under:

> *"in deciding what is best interest [...] the judge must have regard to [...] welfare as the paramount consideration. That embraces issues far wider than the medical. Indeed, it would be undesirable and probably impossible to set bounds to what is relevant to a welfare determination."*
>
> (Emphasis Supplied)

169. In furtherance of the above, in the case of ***Portsmouth NHS Trust v Wyatt***, reported in **[2005] 1 FLR 21**, Lord Hedly, while relying on ***Re A (Male Sterilisation)*** *(supra)* and ***Re S (Adult Patient: Sterilisation)*** *(supra)* respectively, added that the infinite variety of the human condition never ceases to surprise and it is that fact that defeats any attempt to be more precise in a defining the contours of the best interests of the patient principle.

170. Even so more, Lord Phillips in the case of ***R (Burke) v GMC (Official Solicitor and others intervening)***, reported in **[2005] EWCA Civ 1003**, added that it is not possible to attempt to define what is in the best interest of a patient by any *single test*.

171. At this juncture, it is pertinent to mention that post the landmark ruling of ***Airedale*** *(supra)* and other cases as referred to above, the Parliament of the UK found it necessary to introduce an exclusive legislation in this respect.

172. Therefore, the Parliament of the UK introduced the Mental Capacity Act, 2005 ("**MCA**") *inter alia,* with an objective to provide a comprehensive statutory regime for making decisions about mentally incapacitated adults. This Act was supported by a Code of Practice as well. The basic principles to be applied under the MCA are set out in Section 1 and include, under Section 1(4), the cardinal principle that *"an act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests"*. The steps to be taken to determine what is in a

person's best interests are set out in Section 4, which provides *inter alia* the determinants to be considered under the "Best Interest" principle. Section 4 of this Act states that:

> *"(1) In determining for the purposes of this Act what is in a person's best interests, the person making the determination must not make it merely on the basis of (a) the person's age or appearance or (b) a condition of his, or an aspect of his behaviour, which might lead others to make unjustified assumptions about what might be in his best interests.*
>
> *(2) The person making the determination must consider all the relevant circumstances and, in particular, take the following steps.*
>
> *(3) He must consider (a) whether it is likely that the person will at some time have the capacity in relation to the matter in question, and (b) if it appears likely that he will, when that is likely to be.*
>
> *(4) He must, so far as reasonably practicable, permit and encourage the person to participate, or improve his ability to participate, as fully as possible in any act done for him and any decision affecting him.*
>
> *(5) Where the determination relates to life-sustaining treatment, he must not, in considering whether the treatment is in the best interests of the person concerned, be motivated by a desire to bring about his death.*
>
> *(6) He must consider, so far as is reasonably ascertainable, (a) the person's past and present wishes and feelings (and, in particular, any relevant written statement made by him when he had capacity); (b) the beliefs and values that would be likely to influence his decision if he had capacity, and (c) the other factors that he would be likely to consider if he were able to do so.*
>
> *(7) He must take into account, if it is practicable and appropriate to consult them, the views of (a) anyone named*

by the person as someone to be consulted on the matter in question or on matters of that kind; (b) anyone engaged in caring for the person or interested in his welfare; (c) any donee of a lasting power of attorney granted by the person, and (d) any deputy appointed by the court

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(11) "Relevant circumstances" are those - (a) of which the person making the determination is aware, and (b) which it would be reasonable to regard as relevant."

(Emphasis Supplied)

173. In a nutshell, the MCA did not provide a straight-jacketed one size fit for all standard in determining what is in the best interest. Instead, it delineated a set of guiding considerations, upon due evaluation of which the best interests of the patient are to be ascertained. The most notable addition to the position of law in the UK was Section 4(6) of MCA, wherein due consideration was given to the wishes, feelings, beliefs, and values of the patient while determining his best interest. The person or body making such a determination has been defined as a decision-maker.

174. The noticeable determinants under the MCA are as follows: (i) the determination must not rest merely upon the patient's age, appearance, or any medical condition or behavioural aspect that might give rise to unjustified assumptions; (ii) the decision-maker must consider all the relevant circumstances of which he is aware, and which would be reasonable to be regarded as relevant; (iii) due regard must be had to the likelihood of the patient regaining decision-making capacity and, if so, the probable timeframe thereof;

(iv) where the determination concerns life-sustaining treatment, the decision-maker must not be influenced by any desire to bring about the patient's death; (v) so far as reasonably ascertainable, consideration must be accorded to the patient's past and present wishes and feelings, including any relevant written statements made when the patient possessed capacity; (vi) equal regard must be had to the beliefs, values, and other factors that would likely have guided the patient's decision had he been competent to decide; and (vii), where practicable and appropriate, the views of those among others who are engaged in the care of the patient or otherwise interested in his welfare, must also be taken into account.

175. Moreover, the MCA is supported by a Code of Practice. Section 5 of this Code of Practice gives specific guidance as to how to work out someone's best interests when making decisions about life-sustaining treatment. Section 5.7 of the Code of Practice states that when working out what is in the best interests of the person who lacks capacity to make a decision or act for themselves, decision-makers must take into account all relevant factors that would be reasonable to consider, not just those that they think are important. The decision-makers must not act or make a decision based on what they would want to do if they were the person who lacked capacity. Further, Section 5.19 of the Code of Practice states that the relevant circumstances will, of course, vary from case to case. *For instance*, when making a decision about major medical treatment, a doctor would need to consider the clinical needs of the patient, the potential benefits and burdens of the treatment on the

person's health and life expectancy and any other factor relevant to making a professional judgement.

176. In particular, Section 5.31 of the Code of Practice provides that all reasonable steps which are in the person's best interests should be taken to prolong their life. However, *"there will be a limited number of cases where treatment is futile, overly burdensome to the patient or where there is no prospect of recovery. In circumstances such as these, it may be that an assessment of best interests leads to the conclusion that it would be in the best interests of the patient to withdraw or withhold life-sustaining treatment, even if this may result in the person's death"*. The decision maker must not be motivated by a desire to bring about the person's death for whatever reason, even if this is from a sense of compassion. Section 5.33 of the Code of Practice states that the requirement that a doctor must not be motivated by a desire to bring about the patient's death cannot be interpreted to mean that doctors are under an obligation to provide, or to continue to provide, a treatment where that treatment is not in the best interests of the person. Section 5.38 of the Code of Practice states that even if a patient cannot make the decision due to his incapacity, "*his wishes and feelings, beliefs and values should be taken fully into account, whether expressed in the past or now. But his wishes and feelings, beliefs and values will not necessarily be the deciding factor in working out their best interests*". Any such assessment must consider past and current wishes and feelings, beliefs and values alongside all other factors, but the final decision must be based entirely on what is in the person's best interests. The relevant portions of these provisions are as under:

"5.7 When working out what is in the best interests of the person who lacks capacity to make a decision or act for themselves, decision-makers must take into account all relevant factors that it would be reasonable to consider, not just those that they think are important. They must not act or make a decision based on what they would want to do if they were the person who lacked capacity.

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5.19 The relevant circumstances will of course vary from case to case. For example, when making a decision about major medical treatment, a doctor would need to consider the clinical needs of the patient, the potential benefits and burdens of the treatment on the person's health and life expectancy and any other factors relevant to making a professional judgement […]

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5.31 All reasonable steps which are in the person's best interests should be taken to prolong their life. There will be a limited number of cases where treatment is futile, overly burdensome to the patient or where there is no prospect of recovery. In circumstances such as these, it may be that an assessment of best interests leads to the conclusion that it would be in the best interests of the patient to withdraw or withhold life-sustaining treatment, even if this may result in the person's death. The decision-maker must make a decision based on the best interests of the person who lacks capacity. They must not be motivated by a desire to bring about the person's death for whatever reason, even if this is from a sense of compassion. Healthcare and social care staff should also refer to relevant professional guidance when making decisions regarding life-sustaining treatment.

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5.33 Importantly, section 4(5) cannot be interpreted to mean that doctors are under an obligation to provide, or to continue

to provide, life-sustaining treatment where that treatment is not in the best interests of the person, even where the person's death is foreseen [...]

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5.38 In setting out the requirements for working out a person's 'best interests', section 4 of the Act puts the person who lacks capacity at the centre of the decision to be made. Even if they cannot make the decision, their wishes and feelings, beliefs and values should be taken fully into account – whether expressed in the past or now. But their wishes and feelings, beliefs and values will not necessarily be the deciding factor in working out their best interests. Any such assessment must consider past and current wishes and feelings, beliefs and values alongside all other factors, but the final decision must be based entirely on what is in the person's best interests."

(Emphasis Supplied)

177. Upon the introduction of the MCA, the Court of Protection in the case of ***W v. M***, reported in **[2011] EWHC 2443 (Fam)**, was called upon to consider a matter involving a patient, named 'M', who was diagnosed with a state of mind called Minimally Conscious State (MCS). In such a state, a patient is not in PVS. Rather, in MCS, a patient is considered to be above the vegetative state and is aware to some extent of herself and her environment, but does not have full consciousness. The issue before the court was whether it is in M's best interests that all life-sustaining treatment, including CANH, is withdrawn and withheld and, secondly, if it is in M's best interests to continue life-sustaining treatment, including CANH, then what future management would be in her best interests. In such circumstances, Justice Baker was of the opinion that the reasoning adopted in ***Airedale*** *(supra)* more particularly that a

balance sheet approach need not be undertaken in cases involving PVS patients, cannot directly be imported to cases involving MCS patients. On this basis, the Court of Protection adopted the balance sheet approach to the MCS patient in weighing the benefits of withdrawal of CANH against the disadvantages of continuing with the same. On the aspect of the substituted judgment standard, the court also observed that M's past and present wishes and feelings, so far as reasonably ascertainable, had to be given significant weight when deciding whether CANH should be withdrawn or not. The relevant observations of the Court of Protection are as under:

> *"4. Any decision made under the Mental Capacity Act for a person who lacks capacity must be made in her best interests. The law requires the court to identify those factors which are relevant to the person's best interests and carry out a balancing exercise weighing up the factors on each side of the issue. This approach is well established in cases involving medical treatment. This is, however, the first time in this country that a court has been asked to authorise the withdrawal of artificial nutrition and hydration from a patient in a minimally conscious state.*
>
> *xxx xxx xxx*
>
> *"81. It is important to note that, while any decision maker, including a judge, is under an obligation to consider P's wishes and feelings, and the beliefs, values and other factors that he would have taken into account if he had capacity, the decision must be based on P's best interests and not on what P would have decided if he had capacity. Like Lewison J (as he then was) in Re P (Statutory Wills) [2009] EWHC 163 (Ch) [2010] Ch 33, I agree with the observation in the explanatory notes to the original Mental Capacity Bill (which in turn echoed the observation of Lord Goff in the Bland case cited above) that "best interests is not a test of 'substituted judgement' (what the person would*

have wanted), but rather it requires a determination to be made by applying an objective test as to what would be in the person's best interests." This is confirmed by the Code of Practice at paragraph 5.38:"

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99. On behalf of the Official Solicitor, Miss Harry Thomas and Miss Apps argue that the balance sheet approach should not be adopted in cases where the patient is otherwise clinically stable. They argue that the balance sheet analysis cannot apply in such circumstances as it can never be in P's best interests to withhold or withdraw life-sustaining treatment. They submit that the House of Lords in Bland specifically rejected the weighing up the benefits and disadvantages of treatment in PVS cases and that the balance sheet approach has been confined in other cases to circumstances where the patient is very seriously ill or is at the end of their life […]

100. This submission is opposed not only by the Applicant but also by the Primary Care Trust. On behalf of the PCT, Miss Dolan submits that the balance sheet approach is to be applied in all cases save for those involving PVS. She submits that a clear reading of the speeches in Bland demonstrates that the House envisaged that weighing up the patient's best interests should be conducted in every case save where the patient was in a PVS where the futility of treatment means that treatment had no benefit at all […]

101. Miss Dolan submits that, whilst it is clear that the benefit of preserving of life will always weigh extremely heavily in the balance, it cannot be assumed that there will always be no relevant dis-benefit to weigh against it. Even in a clinically stable patient there must be room for any relevant psychological and emotional aspects of their position to be taken into account as part of the balancing exercise. She further argues that the fact that the balance is most likely to come down in favour of preserving life in a MCS patient whose only medical treatment need is for ANH is not grounds for saying that a balance between factors in support of and against providing such treatment need not be

struck in such cases. To do away with the balancing exercise and balance sheet would be to disregard the requirement of s.4(2) MCA that consideration be given to "all of the relevant circumstances" and would also disregard s.4(6) MCA which requires consideration of those matters of import to P or that P would be likely to consider if he could do so, when coming to any best interests decision […]

102. On this point I am wholly unpersuaded by the Official Solicitor's argument and fully accept the submissions advanced by Miss Dolan on behalf of the PCT. There is, in my judgment, no rationale for extending the approach adopted by the House of Lords in Bland to non-VS cases. Lord Goff specifically distinguished between cases in which, having regard to all the circumstances, it may not be in the patient's best interests to continue treatment and cases in which a patient was permanently insensate and thus unable to benefit at all from the treatment. Crucially Lord Goff observed: "In both classes of case, the decision whether or not to withhold treatment must be made in the best interests of the patient. In the first class, however, the decision has to be made by weighing the relevant considerations" […]

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223. The second factor requires more extensive analysis. As set out above, s.4(6) of the MCA requires the court to consider, so far as reasonably ascertainable, M's past and present wishes and feelings. Even though M made no formal advance decision as to medical treatment, it is said on behalf of the Applicant that she expressed wishes and feelings about the matter which should be give significant weight when deciding whether ANH should now be withdrawn. Indeed, Mr Sachdeva and Miss Butler-Cole on behalf of the Applicant, say that this factor should be given decisive weight and place M's wishes and feelings at the forefront of their argument. M's family feel strongly that she would have rejected her current treatment, and the rationale for this application is fundamentally based on M's perceived wishes and feelings. They submit that those who oppose this application fail to give appropriate respect to M's wishes

and feelings about the right to choose her life and the manner of her death.

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245. As set out above, it is the Official Solicitor's submission that the balance sheet approach is inappropriate in respect of a patient in a MCS who is clinically stable. For the reasons set out above, I do not accept this argument.

246. I adopt the balance sheet approach proposed by Thorpe LJ in Re: A Male Sterilisation (supra) and applied in subsequent cases. In my judgment, that process is best expressed in this case by a comparison of the advantages of withdrawing ANH against the advantages of continuing with the treatment."

(Emphasis Supplied)

178. Following the ruling of ***W v. M*** *(supra)*, the UK Supreme Court in the case of ***Aintree University Hospitals NHS Foundation Trust v James***, reported in **[2013] UKSC 67**, was concerned with a patient who had a very limited level of awareness and lacked the capacity to make a decision concerning his medical treatment. The applicant trust had applied to the court seeking the withdrawal of medical treatment as it was in the patient's best interest. The unanimous view of the clinical team was that it would not be in the patient's best interests to receive these treatments, should his condition deteriorate to the extent that he needed them. The family did not agree with the withdrawal of treatment. They felt that every time the patient had an infection, he had pulled through. According to the family, although he would never regain his previous quality of life, yet he found great enjoyment in seeing his family and close friends.

179. In such circumstances, the trial judge approached the question of best interests by adopting a patient-centred evaluation, wherein medical considerations were treated as only one component of the inquiry. He held that the concept of *"futility"* must be understood as treatment being ineffective or of no benefit to the patient, rather than treatment being incapable of curing the underlying disease. He further held that *"recovery"* does not signify restoration to full health, but rather the resumption of a quality of life which the patient himself would regard as worthwhile. The judge emphasised that the burdens of treatment must be weighed against the benefits of continued existence and that due weight must be accorded to the patient's family life, emotional welfare, and dignity. Here, the reference to a patient's family life does not entail an assessment of the lives, interests, or emotional needs of the family members themselves, rather, it requires consideration of the life of the patient as lived in and through his or her relationship with the family, and the value that such family life holds for the patient in assessing what constitutes his or her best interests.

180. The Court of Appeal, however, adopted a materially different approach. Sir Alan Ward held that futility must be assessed against the therapeutic goal sought to be achieved, namely, whether the treatment had a real prospect of curing or at least palliating the life-threatening illness. He further held that recovery must be understood as the restoration of such a state of good health as would avert the impending prospect of death. Sir Alan Ward of the Court of Appeal further held that while best interests encompassed more than medical factors, the patient's wishes must yield to

medical imperatives where treatment was futile, overly burdensome, and incapable of restoring health. Arden LJ of the Court of Appeal, while reaching the same result, applied a different reasoning, holding that in the case of uncertainty regarding the patient's wishes, the court should proceed on the basis of what a reasonable person would choose.

181. Due to contrary views taken by both the trial judge and the Court of Appeal, the UK Supreme Court undertook a detailed review of the legal principles governing best interests and disagreed with several propositions advanced by the Court of Appeal while also substantially endorsing the approach of the trial judge. First, the Supreme Court rejected the Court of Appeal's formulation that the futility of a treatment can be considered only if it has a real prospect of curing or palliating the disease. The court held that such a formulation sets the bar too high and is inconsistent with the view flowing from ***Airedale*** *(supra)*, clarifying that futility must be understood in the sense of treatment being useless or pointless, i.e., conferring no benefit at all upon the patient. Secondly, the Supreme Court rejected the Court of Appeal's formulation of *recovery* as restoration to such good health as would avert death. The Court held that, particularly in cases involving incurable illness or permanent disability, recovery cannot realistically be equated with restoration of good health, and that the correct inquiry is whether treatment would enable the patient to resume a quality of life which he would himself regard as worthwhile. Thirdly, the Supreme Court rejected the objective reasonable person standard adopted by Arden LJ, holding that the best interests inquiry must focus on the

particular patient's own wishes, beliefs, and values, rather than on what a hypothetical reasonable person would choose. The relevant observation is as under:

> *"43. It follows that I respectfully disagree with the statements of principle in the Court of Appeal where they differ from those of the judge. Thus it is setting the goal too high to say that treatment is futile unless it has 'a real prospect of curing or at least palliating the life-threatening disease or illness from which the patient is suffering' [...] Given its genesis in Bland, this seems the more likely meaning to be attributed to the word as used in the Code of Practice. A treatment may bring some benefit to the patient even though it has no effect on the underlying disease or disability.*
>
> *44. I also respectfully disagree with the statement that 'no prospect of recovery' means 'no prospect of recovering such a state of good health as will avert the looming prospect of death if the life-sustaining treatment is given'. [...] It was accepted in Burke (as it had been earlier) that where the patient is close to death, the object may properly be to make his dying as comfortable and as dignified as possible, rather than to take invasive steps to prolong his life for a short while (see paras 62-63). But where a patient is suffering from an incurable illness, disease or disability, it is not very helpful to talk of recovering a state of "good health". The patient's life may still be very well worth living. Resuming a quality of life which the patient would regard as worthwhile is more readily applicable.*
>
> *"45. Finally, insofar as Sir Alan Ward and Arden LJ were suggesting that the test of the patient's wishes and feelings was an objective one, what the reasonable patient would think, again I respectfully disagree [...] insofar as it is possible to ascertain the patient's wishes and feelings, his beliefs and values [...] it is those which should be taken into account."*
>
> (Emphasis Supplied)

182. In addition to the foregoing, the UK Supreme Court observed that the advantage of the best interests standard lies in its focus upon the patient as an individual, rather than upon the conduct of the doctor, and in its requirement to take into account the totality of circumstances, *both medical and non-medical*. The Court further held that the best interests inquiry must incorporate *a strong element of substituted judgment*, by giving due regard to the patient's past and present wishes and feelings, as well as to the considerations which the patient himself would have taken into account had he possessed decision-making capacity. The UK Supreme Court further stated that in considering the best interests of a particular patient at a particular time, decision-makers must look at his welfare in the widest sense, not just medical but social and psychological; they must consider the nature of the medical treatment in question, what it involves and its prospects of success; they must consider what the outcome of that treatment for the patient is likely to be; they must try and put themselves in the place of the individual patient and ask what his attitude to the treatment is or would be likely to be; and they must consult others who are looking after him or interested in his welfare, in particular for their view of what his attitude would be. The relevant observation is as under:

> *"24. […] The advantage of a best interests test was that it focused upon the patient as an individual, rather than the conduct of the doctor, and took all the circumstances, both medical and non-medical, into account (paras 3.26, 3.27). But the best interests test should also contain "a strong element of 'substituted judgment'" (para 3.25), taking into account both the past and present wishes and feelings of*

patient as an individual, and also the factors which he would consider if able to do so (para 3.28). This might include "altruistic sentiments and concern for others" (para 3.31). The Act has helpfully added a reference to the beliefs and values which would be likely to influence his decision if he had capacity. Both provide for consultation with carers and others interested in the patient's welfare as to what would be in his best interests and in particular, what his own views would have been. This is, as the Explanatory Notes to the Bill made clear, still a "best interests" rather than a "substituted judgment" test, but one which accepts that the preferences of the person concerned are an important component in deciding where his best interests lie [...]

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39. The most that can be said, therefore, is that in considering the best interests of this particular patient at this particular time, decision-makers must look at his welfare in the widest sense, not just medical but social and psychological; they must consider the nature of the medical treatment in question, what it involves and its prospects of success; they must consider what the outcome of that treatment for the patient is likely to be; they must try and put themselves in the place of the individual patient and ask what his attitude to the treatment is or would be likely to be; and they must consult others who are looking after him or interested in his welfare, in particular for their view of what his attitude would be."

(Emphasis Supplied)

183. In short, the decision of the UK Supreme Court in ***Aintree*** *(supra)* clarifies that the governing standard in cases of medical decision-making for incapacitated patients is that of the patient's best interests. While substituted judgment forms an integral component of this inquiry, it does not supplant the best interests test, but instead informs it by incorporating the patient's past and present wishes, feelings, beliefs, and values. This means that though the

substituted judgment standard is a component of the best interest principle, it is the latter that would still remain as a governing test. With respect to futility, the court further held that medical futility is to be understood not in terms of the inability of treatment to cure the underlying disease but in the absence of any benefit being conferred to the patient. Likewise, recovery does not connote restoration to full health or avoidance of death but rather the resumption of a quality of life which the patient himself would regard as worthwhile.

184. In another case, ***M v. Mrs. N*** *(supra)*, the patient, a 68-year-old woman was diagnosed as being in an MCS. Her condition was profoundly impaired, both physically and cognitively, as a consequence of the progressive degenerative nature of the disease. Her family sought a declaration permitting the withdrawal of CANH. While determining the patient's best interests, the court held that where the wishes, views, and feelings of the patient can be ascertained with reasonable confidence, they must invariably be accorded great respect. At the same time, the court observed that such wishes, views, and feelings would rarely, if ever, be exclusively determinative of a patient's best interests. The court emphasised that the assessment of best interests involves an intensely complex and fact-sensitive exercise, in which numerous factors fall to be considered, including the nature of the proposed treatment, its degree of intrusiveness, and, most importantly, the likely outcome of such treatment for the individual patient. Within this multifaceted matrix, the weight to be attached to the patient's wishes may vary from case to case. A broader evaluative exercise

may, therefore, require consideration of the patient's past conduct and life choices, insofar as they illuminate the strength and content of her views on the contemplated treatment. In the facts of the case, all medical experts concurred that, if CANH were withdrawn pursuant to a structured palliative care plan, the patient would not experience pain or distress. Upon an overall assessment of the material on record, the court was satisfied that there existed no realistic prospect of the patient attaining a life that she would regard as meaningful, worthwhile, or dignified, and consequently held that it was lawful and in her best interests to permit the withdrawal of CANH. The relevant observations are as under:

> *"28. I have given both these passages very considerable thought. I draw from them only this: where the wishes, views and feelings of P can be ascertained with reasonable confidence, they are always to be afforded great respect. That said, they will rarely, if ever, be determinative of P's 'best interest's'. Respecting individual autonomy does not always require P's wishes to be afforded predominant weight. Sometimes it will be right to do so, sometimes it will not. The factors that fall to be considered in this intensely complex process are infinitely variable e.g. the nature of the contemplated treatment, how intrusive such treatment might be and crucially what the outcome of that treatment maybe for the individual patient. Into that complex matrix the appropriate weight to be given to P's wishes will vary. What must be stressed is the obligation imposed by statute to inquire into these matters and for the decision maker fully to consider them. Finally, I would observe that an assessment of P's wishes, views and attitudes are not to be confined within the narrow parameters of what P may have said. Strong feelings are often expressed non-verbally, sometimes in contradistinction to what is actually said. Evaluating the wider canvass may involve deriving an understanding of P's views from what he may have done in the past in*

circumstances which may cast light on the strength of his views on the contemplated treatment […]

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30. It is clear, therefore, that the framework of the Act and the scheme of the Code of Practice place great emphasis on the importance of personal autonomy and the obligation to be alert to direct or indirect discrimination against those who lack capacity. Decisions taken in the 'best interests' of an incapacitous individual must factor in the recognition that respect for an individual's past and present (where relevant) wishes and identifiable codes and beliefs by which he has lived are a crucial part of promoting best interests. To subvert these to a substitution of an objective evaluation, i.e. to superimpose what the Court thinks best, may result in indirect discrimination. The central objective is to avoid a paternalistic approach and to ensure that the incapacitous achieve equality with the capacitous."

(Emphasis Supplied)

185. Further, in ***Lindsey Briggs v. Paul Briggs and Ors.***, reported in **[2016] EWCOP 53**, the patient, Mr. Paul Briggs, a 43-year-old police officer, was diagnosed as being in an MCS. The treating doctors had advised continuation of CANH. Although no formal AMD had been executed, the patient's family contended that, on the basis of the his repeated informal statements, it was evident that he would have preferred discontinuation of CANH. Upon considering the principle of the best interests of the patient, the Court of Protection permitted the withdrawal of CANH. At the threshold, the court was of the *prima facie* view that the balance sheet approach could be applied to the case, since the patient was in MCS. The court held that the life of Mr. Briggs continued to possess some benefit and value, and in such circumstances, the default position

is founded upon the sanctity of life where life retains value. However, the court held that the ultimate determination of best interests required a careful weighing of all relevant and determinative factors, chief among them being an assessment of what Mr. Briggs would have wanted and considered to be in his own best interests.

186. Relying upon ***Aintree*** *(supra)*, the court reiterated that the best interests principle is not a substituted judgment test, though it does incorporate elements thereof. It affirmed that the best interests test must be applied holistically and that such holistic application is directed towards doing for the patient what he would have done for himself had he possessed full capacity. The court evaluated the evidence adduced by the patient's family, who consistently stated that Mr. Briggs would not have consented to the continuation of CANH had he retained capacity and that he would have regarded his condition as intolerable and one which he would not have wished to endure. While permitting the discontinuation of CANH, the court, however, reiterated that a conclusion as to what the patient would have done is not, in itself, decisive. The governing test remains that of best interests, which requires the decision-maker to undertake a careful weighing and balancing exercise among a range of divergent and competing considerations. The relevant observations are as follows:

> *"44. The test is now a statutory test and the factors in s. 4 of the MCA are not given any priority. Of key importance in this case is s. 4(6) and so the weight to be given (with my*

emphasis on parts of the language) so far as is reasonably ascertainable to:
i) Mr Briggs' past and present wishes and feelings (and, in particular, any relevant written statement made by him when he had capacity),
ii) Mr Briggs' beliefs and values that would be likely to influence his decision if he had capacity, and
iii) the other factors that Mr Briggs would be likely to consider if he were able to do so.

45. Before any of these matters can be taken into account they must be "reasonably ascertainable" and the influence of Mr Briggs' beliefs and values is to be assessed on the premise that he had capacity now and, in my view, the influence of the other factors he would be likely to consider is assessed if he were able to do so now, and so on the same basis.

46. The sub-section clearly introduces a number of "what if" issues and assessments. An obvious problem set by s. 4(6) is how the decision maker is to determine the existence of, and then the weight to be given to, the past and present matters it refers to at a time when P cannot (or cannot clearly) communicate and explain either:
i) what he or she used to wish and feel and how they would have applied their beliefs, values and other factors they thought were relevant,
ii) what he or she now wishes and feels or how they would now take their past beliefs and values and other relevant factors into account if they were able to do so.

47. As to the past a decision maker can gather and consider evidence of what the relevant person has said and done when he or she had capacity and was able to make their own decisions.

48. A court can if necessary make binding findings of fact and it carries out the weighing exercise required by the MCA with the benefit of hearing evidence that is tested and argument. As a consequence, it is likely to be in a better position to determine the existence of, and the weight to be given to, the matters set out in s. 4(6) of the MCA that are

based on the past when P had capacity than, for example, treating doctors are. So, if P's family are asserting that they favour a different conclusion to that reached by the medical team, it is likely that in many cases to be reasonable if not inevitable for doctors to give great and probably determinative weight to medical and ethical issues in their exercise of the MCA best interests test pending the resolution of the existence of the matters in s. 4(6) and the weight to be given to them by a court.

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100. Mr Briggs' wife is sure that her husband and the father of their young child would not consent to his CANH treatment being continued and made it clear that she is pursuing this painful litigation to try to achieve the result for her husband that she is sure he would have wanted and chosen if he was able to do so. All his close family support that position.

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108. Mr Briggs' experience of witnessing death and the consequences of serious accidents informs and probably explains the number of conversations, views and discussions reported in the evidence before me about death and injury. The one closest to home relates to his mother-in-law and her refusal of PEG feeding and nutrition when she was terminally ill with cancer. His wife reports that he fully supported her and her mother in this decision and told her that he would never want a feeding tube. This provides a clear indication that Mr Briggs did not consider it was sensible to prolong life at all costs and thought it was right that the suffering of his mother-in-law was not prolonged. Indeed his wife reports that he used to ask why there was not something legal that could be done to end her mother's suffering […]

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111. Members of the family told me that in their view Mr Briggs would regard his present situation as horrible and

one that he would not wish to continue. Included within the reasons given are that a life in which he did not have the ability to communicate with his wife and child is not one that he would be willing to have […]

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129. I have concluded that as I am sure that if Mr Briggs had been sitting in my chair and heard all the evidence and argument he would, in exercise of his right of self-determination, not have consented to further CANH treatment that his best interests are best promoted by the court not giving that consent on his behalf."

(Emphasis Supplied)

187. In the case of ***In re M (Incapacitated Person: Withdrawal of Treatment)***, reported in **[2018] 1 WLR 465**, the Court of Protection was seized of the case of M, whose condition had deteriorated to an MCS. M's mother and litigation friend, supported by her immediate family, treating clinicians, and an independent external specialist, approached the court seeking a declaration that it was no longer in M's best interests to continue CANH. The court emphasised that the fundamental starting point in such cases is a strong presumption in favour of the preservation of life, grounded in the sanctity of life principle. However, the court clarified that this presumption is not absolute, and that there are circumstances in which it may be displaced, particularly where continuation of treatment would no longer serve the patient's overall welfare. Applying the statutory framework underlying the MCA, the court was satisfied, on the basis of comprehensive medical evidence and the consistent views of the family, that it was no longer in M's best interests for her life to be artificially prolonged by CANH. The court accepted that the

clinicians and family had arrived at their respective positions after the most careful reflection, placing M at the centre of their concern, and having concluded that she would not have wished to continue living in her present state, nor to endure the inevitable further decline attendant upon her terminal condition. The court further observed that the concurrence of medical and familial views reflected a considered and collaborative decision-making process, thereby lending credibility to the conclusion reached. Accordingly, the court granted the declaration sought, holding that CANH should be discontinued and replaced by appropriate palliative care, to be implemented in a planned and structured manner after consultation between family members and medical professionals. The relevant observation is as follows:

> *"26. In this case, the evidence satisfied me that it was no longer in M's interests for her life to be artificially continued by CANH. I accepted the evidence of the family and the clinicians. They had reached their positions after the most careful thought, placing M at the centre of their concern, and concluding that she would not have wanted to go on living like as she was, nor endure the inevitable continued decline in her terminal condition. I therefore decided that CANH should be discontinued and replaced by palliative care after a meeting of family members and professionals had agreed on a suitable timetable.*
>
> *27 […] I also noted that the medical opinion on M's overall best interests was to some degree influenced by (and might, in the end, be said to have been tipped by) the views of her family. There is nothing wrong with that. For obvious reasons, it is not found in many of the reported cases, which often portray doctors and families in opposite camps, but those cases are surely unrepresentative of the much greater number where a common position is reached through people listening to each other. Just as family members will*

> *naturally pay regard to the views of carers and doctors, particularly on the medical aspects of the situation, so doctors will naturally listen to the views of the family about their relative's wider best interests."*
>
> (Emphasis Supplied)

188. Even in the recent case of ***An NHS Trust and others v. Y (Intensive Care Society and others intervening)***, reported in **[2019] A.C. 978**, the UK Supreme Court construed and affirmed the observations as more particularly discussed above.

189. From a cumulative reading of the decisions of the Court of Appeals, House of Lords and the UK Supreme Court respectively, together with the statutory framework of the MCA and the Code of Practice framed thereunder, it appears to us that the principle of the best interests of the patient constitutes the governing standard for decision-making concerning the withdrawal or withholding of medical treatment of persons lacking capacity in the UK. The said principle appears to be neither a narrow test nor a rigid, straight-jacketed formula, but a holistic evaluative assessment requiring due consideration of all relevant circumstances bearing upon the patient's welfare in the widest sense. This is evident from the observation of Lord Hedley in ***Portsmouth*** *(supra)* wherein he had observed that *"the infinite variety of the human condition never ceases to surprise, and it is that fact that defeats any attempt to be more precise in a definition of best interests"*. Similarly, in ***R (Burke)*** *(supra)*, Lord Phillips reiterated that *"it is not possible to attempt to define what is in the best interests of a patient by a single test"*,

affirming that the doctrine resists any rigid formulation and must operate through a holistic assessment of all relevant circumstances.

190. At the foundational level, the best interests inquiry is anchored in a strong presumption in favour of the preservation of life, reflecting the sanctity of life. However, as consistently emphasised in ***Airedale*** *(supra)* and reaffirmed in ***Aintree*** *(supra)*, this presumption is not absolute and may be displaced where continuation of medical treatment ceases to serve any therapeutic purpose, i.e., becomes futile, merely prolongs the suffering without the hope of recovery or causes indignity to the life of the patient. In such circumstances, the preservation of biological existence alone does not constitute a determinative good, and the legal inquiry must shift towards an assessment of whether continued treatment truly advances the patient's overall welfare.

191. The position of law in the UK further clarifies that the formulation of the legal question itself is of decisive importance in cases concerning withdrawal or withholding of life-sustaining treatment. As held in ***Airedale*** *(supra)* and later followed by the UK Supreme Court in ***Aintree*** *(supra)* and in other cases, as more particularly discussed above, the inquiry must not be whether it is in the patient's best interests that he should die, nor whether the proposed course would hasten or cause death. Rather, the correct question should be *whether it is in the patient's best interests that life should be prolonged by the continuance of the particular medical treatment in question.*

192. In cases involving patients in a PVS, the House of Lords in ***Airedale*** *(supra)* held that existence devoid of consciousness, cognition, or awareness of the external world cannot be regarded as conferring any benefit upon the patient. Where medical opinion establishes that such a condition is irreversible or that no hope of recovery exists, and that treatment merely sustains biological life without therapeutic benefit, the medical treatment may be characterised as *futile*. In such circumstances, the continuation of life-sustaining treatment does not involve any meaningful weighing of competing considerations, since no benefit exists to be balanced against the burdens of treatment. Consequently, once futility is established, withdrawal of life-sustaining treatment stands fully justified within the framework of best interests. A distinction is, however, drawn between patients in a PVS and those in an MCS. As discussed in ***W v. M*** *(supra)* and subsequently applied in ***Lindsey Briggs*** *(supra)*, where some degree of awareness, responsiveness, or experiential capacity subsists, life continues to retain some value. In such cases, treatment cannot be presumed to be futile *ab initio*, and in such cases, the determination of best interests would necessarily require a balancing exercise to be undertaken. In a nutshell, this balance sheet approach involves weighing the potential benefits of continued treatment against its burdens, including physical suffering, invasiveness, indignity, psychological distress, the impact upon the patient's lived experience, etc.

193. However, we do not agree with the observation that for a PVS patient, the continuation of life-sustaining treatment does not involve any meaningful weighing of competing considerations under

the balance sheet approach on the mere ground of having no benefits to be balanced against the burdens of treatment. In our considered view, post recognition of the substituted judgment standard in MCA, the balance sheet approach can be drawn even in the case of a PVS patient, since the wishes, feelings, beliefs, or values of the patient, if ascertainable, would be a relevant entry in the balance sheet. It is our view that ***Airedale*** *(supra),* while endorsing the non-application of the balance sheet approach to PVS patients, had not yet recognised the application of the substituted judgment standard in the UK jurisprudence. Thus, ***Airedale*** *(supra),* in the absence of such a recognition, limited itself to saying that since there are of no benefits accruing whatsoever in cases involving a patient with PVS, there is no need to go into the balancing exercise. However, we are of the view that if there are any wishes, feelings, beliefs, or values of a PVS patient that are reasonably ascertainable, then the same shall also be weighed by drawing a balance sheet despite the patient being in a PVS.

194. Another central consideration within the best interests framework in the UK is the presence of terminal illness and the absence of any realistic prospect of recovery. As explained in ***Aintree*** *(supra)* and later affirmed in ***M v Mrs. N*** *(supra)*, *recovery* does not signify restoration to full physical health, but rather the resumption of a quality of life which the patient would himself regard as worthwhile. Where medical evidence establishes that such a quality of life cannot be achieved and that continued treatment merely prolongs the dying process, the patient's best interests may lie in the withdrawal of life-sustaining treatments.

195. The courts in the UK have further recognised that the burdensome and intrusive nature of medical treatment, the *indignity* inherent in artificial prolongation of life, and prolongation of physical and psychological suffering constitute a significant factor within the best interests principle. Treatment that subjects a patient to invasive interventions, loss of bodily integrity, and prolonged distress, without corresponding therapeutic gain, cannot ordinarily be justified as advancing the patient's welfare. Thus, dignity and experiential quality of life are treated as intrinsic components of the best interests standard.

196. Another component of the best interests principle is the patient's own wishes, feelings, beliefs, and values, as statutorily mandated under Section 4(6) of MCA and elaborated in cases above. These factors are to be considered so far as reasonably ascertainable and must be accorded great respect. However, the courts have consistently clarified that such wishes, whether past or present, are not determinative in themselves. While they constitute a strong element and an often weighty component of the inquiry, they do not displace the overarching obligation to act in the patient's best interests, which requires a holistic evaluation of all relevant circumstances. The reason that the substituted judgment standard does not override the best interest principle in the UK is that while applying the substituted judgment standard, the family of the patient makes reasonable endeavours to ascertain what the patient would have wanted had he possessed the capacity, but such an endeavour at its heart is a surmise at best and cannot in itself be a

determinative factor to decide withdrawal or withholding of medical treatment. Therefore, other relevant factors are also to be looked at under the best interest principle. As explained in ***Aintree*** *(supra)* and later followed in ***Lindsey Briggs*** *(supra)*, *the best interests principle incorporates a strong element of the substituted judgment standard*, requiring the decision maker to place himself, so far as possible, in the position of the patient and to consider what the patient would have wanted if he had capacity. This enables the doctors and the court to do for the patient what he would have done for himself. However, substituted judgment does not operate autonomously or in an overriding manner. The ultimate inquiry remains what course of action would serve the patient's best interest, even where that conclusion diverges from a reconstructed preference of the patient.

(c) Best interest of the patient in Ireland

197. In ***In the matter of a Ward of Court (No. 2)***, reported in **[1996] 2 IR 79**, the Supreme Court of Ireland was concerned with a case involving a 22-year-old woman who had suffered three cardiac arrests, resulting in profound anoxic brain damage. For more than two decades thereafter, she remained in a near PVS, being spastic, incontinent, bedridden, incapable of speech or meaningful communication, and possessing only the most minimal cognitive capacity. She was initially sustained by nasogastric feeding and subsequently by a PEG tube. An application was made to the High Court seeking authorisation for the withdrawal of CANH. The High Court granted the application, holding that such withdrawal was

lawful and in the patient's best interests. Lynch J. found that although the patient did not strictly satisfy the clinical definition of a PVS, yet she was very nearly so, that any cognitive capacity she retained was negligible, and that there was no prospect of improvement in her condition. Applying the best interests principle, Lynch J. framed the inquiry as whether it was in the patient's best interests that her life should be prolonged by the continuation of artificial means of nourishment, and held that the court was entitled, as part of that inquiry, to take into account what the ward's own wishes would likely have been had she been able to express them i.e., substituted judgment. Thus, the Supreme Court of Ireland acknowledged the existence of the substituted judgment standard as a component of best interests in its jurisdiction. On a consideration of the evidence, the withdrawal of CANH was authorised and declared lawful. On appeal, the Supreme Court affirmed the High Court's decision, endorsing the application of the best interests test and the conclusion that continued artificial nourishment served no meaningful benefit to the patient. The relevant observations are as under:

> *"I take the view that the proper and most satisfactory test to be applied by the Court in this case is the best interests test, i.e., whether it is in the best interests of the ward that her life, such as it is at present, should be prolonged by the continuation of the abnormal artificial means of nourishment, [...]*
>
> *I am of opinion that it is or it is not in the best interests of the ward that her life should be prolonged by the continuance of the abnormal artificial means of nourishment, whether by nasogastric or gastrostomy tube. Whilst the best interests of the ward is the acid test, I think that I can take into account*

> *what would be her own wishes if she could be granted a momentary lucid and articulate period in which to express them and if, despite what I have already said, I can form a view on the matter. I think that it is highly probable, and I find the evidence of the family on this aspect of the case to be clear and convincing, that the ward would choose to refuse the continuance of the present regime to which she is subjected involving abnormal artificial feeding and total nursing care with all the indignities inherent in such care and would instead choose the withdrawal of such abnormal artificial feeding resulting in an immediate reduction of bodily functions and their attendant indignities and a peaceful death in accordance with nature within two weeks or so."*
>
> (Emphasis Supplied)

198. From the above, it is clear that the Supreme Court of Ireland also rightly framed the question as proposed in ***Airedale*** *(supra)* i.e., whether it was in the patient's best interests that her life should be prolonged by the continuation of artificial means of nourishment. The court also took into account what the ward's own wishes would likely have been had she been able to express them under the substituted judgment standard. Further, the court also undertook a balancing exercise by weighing the benefits of sustaining life by artificial feeding with the burdens attendant upon such treatment and concluded that the burdens far outweighed the benefits in the case.

(d) Best interest of the patient in Italy

199. The position of law in Italy on the withdrawal of CANH was authoritatively articulated by the Supreme Court of Cassation in the case of ***Eluana Englaro***, reported in **Case No. 21748 of 2007**.

For the first time in Italy, the court had addressed the legality of discontinuing CANH in a patient with PVS. The facts of the case were such that the patient, a young woman, had lapsed into a PVS following a road accident and had remained in that condition for over fifteen years, being kept alive solely through CANH administered *via* a nasogastric tube. Her guardian sought authorisation for its withdrawal. The Court of Appeal of Milan initially rejected the request, holding that, in the case of an incapacitated patient, the right to life must unconditionally prevail over the right to self-determination, and that the patient's best interests are objectively served by the preservation of life, save where a living will exists. Aggrieved thereby, the guardian preferred an appeal before the Supreme Court of Cassation. In allowing the appeal, the Supreme Court expounded on the contours of the best interests principle, holding that in consenting to or dissenting from medical treatment on behalf of an incapacitated person, the guardian decision maker is subject to a two-fold constraint: first, that he must act exclusively in the interests of the incapacitated person; and second, that in determining such interest, he must decide neither *"in the place of"* nor *"for"* the incapacitated person, but rather *"with"* her. According to the court, this necessitated a reconstruction of the presumed will of the patient, who had been an adult prior to losing consciousness, by reference to her previously expressed wishes, or, in their absence, by inference from her personality, lifestyle, inclinations, and her fundamental ethical, religious, cultural, and philosophical convictions.

200. The court further held that where a patient has remained for a prolonged period in a PVS, marked by a complete and irreversible incapacity to relate to the external world, and is sustained solely by artificial nutrition and hydration, the judge may authorise the withdrawal of such treatment, upon an application by the guardian and after due consideration, only upon the satisfaction of two cumulative conditions. First, that the vegetative state is, on the basis of a rigorous and internationally accepted clinical assessment, irreversible, and that there exists no medical foundation whatsoever to assume even the minimal possibility of recovery of consciousness or perception of the external environment. Second, that the application genuinely reflects the patient's own will, established on the basis of clear, univocal, and convincing evidence, drawn either from her prior declarations or from her personality, lifestyle, and deeply held convictions, corresponding to her conception of human dignity prior to the onset of unconsciousness. The relevant observations are as under:

> *"7.3 [...] In the opinion of the bench, the highly personal character of the right to health of the incapacitated person requires that the reference to the institution of legal representation does not transfer to the guardian, who is invested with a function of private law, an unconditional power to provide for the health of the person in a state of total and permanent unconsciousness. <u>In consenting to medical treatment or in dissenting from the prosecution of the same upon the incapacitated person, the representation of the guardian is subjected to a two-fold order of constraints: he must, above all, act in the exclusive interest of the incapacitated person; and, in search of the best interest, must decide not "in the place" of the incapacitated person nor "for" the incapacitated, but "with" the incapacitated person: therefore, reconstructing the</u>*

presumed will of the unconscious patient, who was already adult before falling into such a state, taking into account the wishes expressed by him before the loss of consciousness, or inferring that will from his personality, from his lifestyle, from his inclinations, from his basic values and of his ethical, religious, cultural and philosophical convictions.

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10. Having absorbed the examination of the question of constitutional legitimacy, the appeals are granted, according to the reasoning and within the limits indicated in it. From there ensues the cassation of the challenged decree and the remand of the case to a different Section of the Court of Appeals of Milan. Said Court will rule conforming itself to the following principle of law: Where the sick person lingers for very many years (in the case, more than fifteen) in a permanent vegetative state, with consequent radical incapacity of relating to the external world, and is kept artificially alive by means of a nasogastric tube that provides to her nutrition and hydration, upon request of the guardian who represents her, and in the debate with the guardian ad litem, the judge may authorize the deactivation of such a health defense (except the application of the measures suggested by science and medical practice in the interest of the patient), only in the presence of the following presuppositions: (a) when the condition of the vegetative state is, on the basis of a rigorous clinical judgment, irreversible and there isn't any medical foundation whatsoever, according to scientific standards recognized at the international level, allowing the assumption of the minimum possibility, even if faint, of the recovery of consciousness and of returning to a perception of the external world; and (b) on the condition that such an appeal is truly expressive, on the grounds of clear, univocal and convincing elements of proof, of the voice of the patient herself, drawn from her previous declarations or from her personality, from her lifestyle and from her convictions, corresponding to her way of conceiving, before falling into a state of unconsciousness, of the very idea of dignity of the person. Where one or the other presupposition does not exist, the judge must deny the authorization, with

unconditional prevalence having then to be given to the right to life, independently of the degree of health, autonomy and capacity to understand and to express the will of the interested subject and from the perception, that others are able to have, of the quality of life itself."

(Emphasis Supplied)

(e) Best interest of the patient in Australia

201. The position of law in Australia on this issue was considered by the Supreme Court of Victoria in ***Re BWV*** *(supra)*. In this case, the patient was a 68-year-old woman suffering from a progressive and fatal form of dementia, who was being kept alive through CANH administered *via* a PEG tube. Medical reports confirmed that there was no prospect of recovery or improvement in her condition. The public advocate, appointed as the patient's guardian, approached the Supreme Court of Victoria seeking a determination as to whether the PEG tube feeding constituted medical treatment that could lawfully be discontinued. The evidence of three medical practitioners, who had examined the patient, was unanimous in concluding that the provision of nutrition and hydration through the PEG tube was futile, and that it had no prospect whatsoever of improving the patient's condition, and that, in accordance with good medical practice and principles of palliative care, the PEG tube ought to be removed. The patient's family also shared the view that continued provision of nutrition and hydration was unwarranted and unreasonable in the best interest of the patient. The court, while holding that CANH administered through a PEG tube constituted medical treatment, permitted its withdrawal, observing

that where death has become inevitable, the patient's best interests are better served by treatment directed towards relief and comfort, rather than by futile attempts to cure. The relevant observations are as under:

> *"80. Various explanations are given of the nature of palliative care. The report quotes various submissions, including a submission from Right to Life Victoria, which emphasises that when death has become inevitable, treatment should be adjusted, since the patient's best interest would then be served by treatment that emphasised relief, rather than futile attempts to cure.*
>
> *81. I find that the administration of artificial nutrition and hydration, via a PEG, cannot be regarded as palliative care, where that expression is used in its natural sense. Such a procedure is, in essence, a procedure to sustain life; it is not a procedure to manage the dying process, so that it results in as little pain and suffering as possible."*

(Emphasis Supplied)

202. Thereafter, in ***Messiha v South East Health***, reported in **[2004] NSWSC 1061**, the Supreme Court of New South Wales was seized of a case concerning a 75-year-old patient who had suffered a cardiac arrest resulting in severe hypoxic brain damage, leaving him in a deep coma with no realistic prospect of neurological recovery. The treating doctors concluded that any further medical treatment had become futile and proposed the withdrawal of mechanical ventilation and artificial nutrition so as to permit the patient to die naturally. The patient's family opposed this course, contending that he had exhibited certain signs of life, such as opening his eyes, and sought an injunction compelling the hospital to continue treatment.

The court dismissed the family's application and authorised the withdrawal of treatment. The court observed that, in applications of this nature, the paramount consideration is the health, welfare, and best interests of the patient. The court further clarified that such an approach does not entail any value judgment on the intrinsic worth of the patient's life in his existing condition, nor does it disregard the family's sincerely held hopes and beliefs. Rather, it reflects a recognition of the reality that, where the court is satisfied that treatment decisions are being taken in the welfare and best interests of the patient, such determinations primarily fall within the domain of professional medical expertise. On the facts, the court was satisfied that the continuation of medical treatment, including CANH, would serve no purpose beyond prolonging life for a brief period and would be futile, burdensome, and intrusive upon the patient. The relevant observations are as under:

> *"25. I appreciate that the Court on such an application as the present is concerned with the best interest of the health and welfare of the patient: Northridge at [22] and it is not bound to give effect to the medical opinion, even where, as here, it is unanimous. However, it seems to me that it would be an unusual case where the Court would act against what is unanimously held by medical experts as an appropriate treatment regime for the patient in order to preserve the life of a terminally ill patient in a deep coma where there is no real prospect of recovery to any significant degree. This is not to make any value judgment of the life of the patient in his present situation or to disregard the wishes of the family and the beliefs that they genuinely hold for his recovery. But it is simply an acceptance of the fact that the treatment of the patient, where, as here, the Court is satisfied that decision as to the appropriate treatment is being made in the welfare and interest of the patient, is principally a matter for*

the expertise of professional medical practitioners: Northridge at [24].

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28. Apart from extending the patient's life for some relatively brief period, the current treatment is futile. I believe that it is also burdensome and will be intrusive to a degree. I am not satisfied that this Court's jurisdiction has been enlivened by the evidence before me from the family members. The Court is in no better position to make a determination of future treatment than are those who are principally under the duty to make such a decision. The withdrawal of treatment may put his life in jeopardy but only to the extent of bringing forward what I believe to be the inevitable in the short term. I am not satisfied that the withdrawal of his present treatment is not in the patient's best interest and welfare."

(Emphasis Supplied)

203. Subsequently, the Supreme Court of the Australian Capital Territory, in ***Australian Capital Territory v. JT***, reported **in [2009] ACTSC 105**, was seized of a case concerning a 69-year-old man suffering from long-standing paranoid schizophrenia. The patient believed that prolonged fasting would bring him closer to God and consequently refused all nourishment. The medical evidence established that the patient lacked the capacity to provide informed consent and that his expressed wishes were the product of delusional and irrational thought arising directly from his severe mental illness. In such circumstances, the government sought a declaration that it would be lawful for medical staff to desist from forcibly feeding the patient, a process that would require physical restraint and sedation. The court observed that the approach to his care could be no different from that adopted in cases involving

unconscious patients or helpless infants, since even his apparent wish for death was premised upon irrational assumptions. Unlike other cases where the wishes of the patient played an important role in determining the best interest, the patient in this case was not suffering from any terminal illness, and the medical opinion was that his deteriorating condition was caused solely by self-imposed starvation. According to the court, the CANH would, therefore, provide a tangible benefit by preserving his life. The patient's guardian did not oppose the medical recommendations but acknowledged that the patient's stated wishes were fundamentally compromised by his mental illness. In these circumstances, the court was required to determine whether it would be lawful to withhold nutrition and hydration, save for the provision of palliative care. Higgins, CJ., after careful consideration, declined to grant the declaration sought. The court held that the withdrawal of nutrition and hydration would be unlawful, primarily on the ground that the treatment was effective in sustaining the patient's life and that he was not otherwise dying from any irreversible underlying physical condition. Accordingly, the court held that the patient's best interests lay in the continuation of nutrition and hydration, even if this necessitated restraint and sedation. The relevant observations are as under:

> *"18. The truth is that JT lacks the capacity for informed consent and his 'wishes' are the product of delusional and irrational thought in turn the product of his severe mental illness. The approach to his care can be no less than would be the case if he lacked consciousness or was a helpless infant. Indeed, even his apparent acceptance of death is*

premised on the irrational view that God will preserve him from such a consequence.

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21. Ms Anita Phillips, Public Advocate, has the role of guardian of JT under a guardianship order. She does not oppose any course recommended by JT's physicians. She does not wish to propose that he be forcibly nourished to sustain his life. Her conclusion, however, that it accords with his wishes, must be qualified by the obvious conclusion that those wishes are irrational and based on a delusional set of assumptions arising from his mental illness.

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33. In the present case the provision of nutrition and hydration will provide a benefit, in the sense that life will be maintained, albeit, that it will to an extent derogate from the patient's dignity.

(Emphasis Supplied)

204. From the above, it appears that Australian courts have construed the determination of whether medical treatment ought to be continued or withdrawn as one governed primarily by an assessment of the patient's best interests, grounded in clinical medical assessment, rather than by a determinative factor under the substituted judgment standard. In ***Re BWV*** *(supra)*, the Supreme Court of Victoria treated CANH as medical treatment and held that where death has become inevitable, and treatment serves no therapeutic purpose, the patient's best interests are no longer advanced by sustaining biological life through artificial means. A similar approach is evident in ***Messiha*** *(supra)*, where the court reiterated that the paramount consideration is the health, welfare, and best interests of the patient. Importantly, the court clarified that authorising withdrawal of treatment in such circumstances

does not involve a value judgment on the worth of the patient's life, nor a rejection of the family's sincerely held beliefs, but rather an acceptance that decisions concerning futile treatment lie principally within the expertise of medical practitioners, provided they are taken in good faith and in the patient's welfare. The decision in the ***Australian Capital Territory*** *(supra)* further clarifies the Australian position by delineating the limits of the patient's wishes in the best interests inquiry. Unlike cases involving terminal illness or irreversible injury, the court held that where treatment is effective in sustaining life, and the patient is not otherwise dying from an irreversible condition, such treatment cannot be characterised as futile. The court expressly declined to give effect to the patient's stated wishes, as they were found to be the product of delusional and irrational beliefs arising from severe mental illness.

(f) <u>Best interest of the patient in New Zealand</u>

205. The position of law in New Zealand on this issue was considered by the High Court of New Zealand in ***Auckland Area Health Board*** *(supra)*. The case concerned a 59-year-old patient suffering from an extreme form of Guillain-Barré Syndrome, resulting in total paralysis and complete inability to communicate, who was being kept alive solely by artificial ventilation. The medical consensus was that there existed no prospect of recovery and that continued ventilation of the patient served no therapeutic purpose. The court held that a doctor acting in good faith and in accordance with good medical practice is under no legal duty to administer life support when, in his or her clinical judgment, such treatment is contrary to

the patient's best interests. Emphasising that modern medical science is intended to benefit life and health, and not to prolong biological existence devoid of therapeutic purpose, the court observed that to compel continuation of life support in such circumstances would be to confound the very purpose of medicine. The court further recognised that no rigid rule can govern the infinite variety of clinical situations, and that decisions of this nature must rest upon a bona fide assessment of the patient's best interests, informed by prevailing medical standards, specialist consultation, ethical oversight, and concurrence of the patient's family or guardian. While noting the conceptual proximity between the best interests principle and the substituted judgment standard, as developed in the UK and USA, Thomas J. suggested that the two approaches are closely interlinked to each other, though he refrained from conclusively delineating their precise doctrinal relationship. The relevant observations are as under:

> *"[…] Two distinct approaches have been identified in the exercise of this jurisdiction; the "substituted judgment" approach […] I suspect that the two tests are inextricably linked. But I do not need to take the issue further because of the way in which the hearing developed […]*
>
> *xxx xxx xxx*
>
> *In my view, doctors have a lawful excuse to discontinue ventilation when there is no medical justification for continuing that form of medical assistance. To require the administration of a life support system when such a system has no further medical function or purpose and serves only to defer the death of the patient is to confound the purpose of medicine. In such circumstances, the continuation of the artificial ventilation may be lawful, but that does not make*

it unlawful to discontinue it if the discontinuance accords with good medical practice.

A phrase such as "good medical practice" may not have the precision of meaning that the medical profession or the public would desire. But that imprecision is inherent in the problem itself. There can be no single or fixed rule as to exactly when a doctor may withhold a life support system which would cover the infinite variety of factual situations arising in practice. Consequently, the criterion can only be a general phrase such as "good medical practice".

Nor is it imperative that the phrase "good medical practice" be accepted in any exclusive or dogmatic sense. It has been selected because it already enjoys some currency. But any description such as "sound medical practice" or "proper medical standards and procedures" would serve equally well. What is important is its perceived content. Clearly, it must begin with a bona fide decision on the part of the attending doctors as to what, in their judgment, is in the best interests of the patient. Equally, it must encompass the prevailing medical standards, practices, procedures, and traditions which command general approval within the medical profession. All relevant tests would need to be carried out […]

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[…] The point, for present purposes is, as I apprehend it, that a doctor acting in good faith and in accordance with good medical practice is not under a duty to render life support necessary to prolong life if that is, in his or her judgment, contrary to the best interests of the patient.

(Emphasis Supplied)

206. Thereafter, the High Court of New Zealand, in ***In Re G***, reported in **[1997] 2 NZLR 201**, while relying upon the observation of Thomas J. in ***Auckland Area Health Board*** *(supra)* and ***A Ward of Court*** *(supra)*, was of the opinion that in such cases the adoption of the

best interest principle is proper, but weightage should also be given to the likely wishes of the patient and to the view of the patient's family and carers, as the substituted judgment standard is closely interlinked with the best interest principle. The relevant observation is as under:

> *"In the extract from p 242 of Thomas J's judgment in the Auckland Area Health Board case quoted above, discussing the parens patriae jurisdiction, that learned Judge noted that two distinct approaches have been identified: the "substituted judgment" approach and the "best interests" approach. He commented that he suspected the two tests were inextricably linked.*
>
> *Bearing this in mind, and having regard to the reasoning of Hamilton CJ in the Ward of Court case (supra) at p 411, I think that the proper course for me is to adopt the "best interests" test but to give weight to the likely wishes of the patient and to the views of the patient's family and carers.*
>
> (Emphasis Supplied)

207. From the above, it appears that courts in New Zealand have consistently construed the best interests of the patient as the governing standard in cases involving withdrawal or withholding of medical treatment, with that standard being rooted primarily in medical futility, good medical practice, and the intrinsic purpose of medicine. At the same time, the courts have acknowledged the conceptual proximity between best interests and substituted judgment, without elevating substituted judgment into an independent or controlling test.

(g) <u>Best interest of the patient in European Union (EU)</u>

208. In the year 2015, the European Court of Human Rights ("**ECHR**"), in ***Lambert v France***, reported in **(2016) 62 EHRR 2**, considered the issue of withdrawal of CANH. The case concerned a patient who had sustained severe head injuries resulting in tetraplegia and complete dependence, accompanied by irreversible brain damage. He was being maintained on CANH through a gastric tube. He was diagnosed with a chronic vegetative state. The treatment was considered futile and disproportionate, serving no purpose other than the artificial prolongation of life. The decision-making process involved consultation with the patient's wife and, subsequently, with his parents, half-brother, and sister. While the patient's wife supported the decision, his parents, half-brother, and sister opposed the withdrawal of CANH. In light of these circumstances, the *Conseil d'État* was of the view that withdrawal of CANH must be permitted. The *Conseil d'État* observed that where a patient is unable to express his wishes due to incapacity, it is for the treating doctor, acting within a collective decision-making process involving relevant healthcare professionals, to take a clinical decision guided by the patient's best interests. In doing so, the doctor must take into account all relevant elements, including consultation with family members, close friends, any designated person of trust, and any previously expressed wishes of the patient. The *Conseil d'État* further observed that withdrawal of treatment is subject to additional conditions, including the presence of serious and irreversible medical consequences, the absence of any continuing benefit to the patient, medical futility, and, where required, a

sufficiently prolonged observation phase and review of the patient's condition. The relevant observations are as under:

> *"64. Other persons involved in the decision-making process may include the patient's legal representative or a person granted a power of attorney, family members and close friends, and the carers. The Guide stresses that doctors have a vital, not to say primary, role because of their ability to appraise the patient's situation from a medical viewpoint. Where patients are not, or are no longer, able to express their wishes, doctors are the people who, in the context of the collective decision-making process, having involved all the health-care professionals concerned, will take the clinical decision guided by the best interests of the patient. To this end, they will have taken note of all the relevant elements (consultation of family members, close friends, the person of trust, and so on) and taken into account any previously expressed wishes. In some systems the decision is taken by a third party, but in all cases doctors are the ones to ensure that the decision-making process is properly conducted.*
>
> *xxx xxx xxx*
>
> *76. In addition to the requirement to seek the patient's consent, the withdrawal of treatment is also subject to other conditions. Depending on the country, the patient must be dying or be suffering from a condition with serious and irreversible medical consequences, the treatment must no longer be in the patient's best interests, it must be futile, or withdrawal must be preceded by an observation phase of sufficient duration and by a review of the patient's condition."*
>
> (Emphasis Supplied)

(h) Best interest of the patient in India

209. It is often suggested, in a rigid and oversimplified manner, that courts in the USA proceed primarily on the subjective standard of substituted judgment, whereas courts in the UK apply an objective standard under the rubric of the best interests of the patient. In our considered view, such a binary characterisation emerges only when these tests are examined at the surface. A closer, multi-jurisdictional reading of the authorities we discussed above shows that neither standard operates in isolation or in absolute terms. In the USA, substituted judgment is not applied as a free-standing exercise of personal preference. It is invariably conditioned by objective medical findings, considerations of the futility of treatment, proportionality of treatment, dignity of the patient, and the patient's present welfare. Where the patient's wishes cannot be reliably ascertained, courts explicitly abandon substituted judgment in favour of a best interests analysis. Conversely, in the UK, while best interests remains the governing test, it is neither purely objective nor indifferent to the patient's individuality, but incorporates a strong subjective element through a consideration of the patient's past and present wishes, values, beliefs, and conception of dignity.

210. A similar convergence is evident in other jurisdictions as well. In Italy, the best interests inquiry is structured through a dual threshold: (i) a clinical determination of irreversible vegetative state and medical futility, (ii) coupled with a faithful reconstruction of the patient's presumed will, grounded in clear and convincing evidence of values and conception of dignity. In Australia and New Zealand, courts have consistently treated best interests as the controlling

standard, yet it is required to be informed by good medical practice, futility, proportionality, and the likely wishes of the patient, without elevating the substituted judgment standard into an autonomous rule. In the EU, the emphasis has been placed on a procedurally robust, collective decision-making process guided by medical proportionality, absence of unreasonable obstinacy, and respect for human dignity, with prior wishes operating as an important but not decisive consideration.

211. When examined in this manner, the two approaches, i.e., the best interest principle and the substituted judgment standard, cease to conform to a stark day and night distinction. Instead, they converge at twilight where subjective autonomy and objective welfare intersect, each informing and tempering the other, in order to reach a decision that accords with what is overall in the best interest of the patient in the facts and circumstances. It is worth mentioning here that though the substituted judgment standard in the USA may be heavily rooted in privacy and personal choice of the patient, it is our endeavour, keeping in mind the vision of the Constitution Bench in ***Common Cause 2018*** *(supra),* to further this substituted judgment standard from the lens of dignity.

212. At this juncture, it becomes imperative for us to also refer to ***Common Cause 2018*** *(supra)* to weave a comprehensive thread of consensus upon the meaning and scope of the best interest principle. However, before delving into that exercise, we must reiterate that a competent person has the right to refuse medical treatment within their right to self-determination under Article 21

of the Constitution of India. It is also clear that the autonomy of a competent person in refusing to take or continue a medical treatment needs to be respected. This means that until the patient is competent and is in a position to exercise his right to refuse medical treatment, he may do so. However, it is only when the patient becomes incompetent and is unable to make an informed decision for himself that the need to construe the best interest principle comes into play, because in such circumstances, the decision to withdraw or withhold medical treatment needs to be built upon the determination of whether it is in the best interest of the patient.

213. Having said that, a reading of the guidelines as set out in ***Common Cause*** *(supra)*, particularly with respect to cases where there is an AMD, shows that the treating physician triggers the process under Para. 198.4.1 of the guidelines for withdrawal or withholding of medical treatment upon the fulfilment of five broad conditions in his opinion. They are: (i) the Executor becomes terminally ill, (ii) is undergoing prolonged medical treatment, (iii) with no hope of recovery, (iv) no cure of ailment, and (v) the patient does not have decision-making capacity i.e., the patient is incompetent.

214. With respect to cases where there is no AMD, the treating physician triggers the process under Para 199.1 of the guidelines for withdrawal or withholding of medical treatment upon the fulfilment of three broad conditions in his opinion: (i) the Patient is terminally ill, (ii) is undergoing prolonged treatment in respect of an ailment which is, (iii) incurable or where there is no hope of being cured.

However, unlike Para 198.4.1 of the guidelines, Para 199.1 does not explicitly set forth the fifth condition, i.e., that the patient does not have decision-making capacity. This is because the incompetence of the patient is implied in Para 199.1 of the guidelines. Had the patient been competent to make an informed decision, he would have exercised his right to refuse medical treatment, but it is only when he is not in a position to exercise that right and where no AMD exists in this regard that the treating physician, and patient's next of kin/next friend/guardian, followed by the primary medical board and secondary medical board, undertake this task on behalf of the patient. This is also clear from Para 199 of the guidelines, which states that there will be cases where there is no existing AMD and in such cases, the procedure and safeguards are required to be the same as in cases where there is an existing AMD.

215. Once these threshold conditions/medical parameters are fulfilled, and the treating physician informs the hospital to constitute a primary medical board, the primary medical board gets constituted by the hospital, which after taking a medical prognosis of the patient and discussing the pros and cons of the withdrawal or refusal of further medical treatment with the patient's next of kin/next friend/guardian, and taking consent of the patient's next of kin/next friend/guardian in writing, renders its opinion by either certifying the withdrawal or refusal of further medical treatment or opposing the option of withdrawal or refusal of further medical treatment. In the event that the primary medical board certifies the withdrawal or refusal of medical treatment, the secondary medical board is constituted by the hospital, which, after taking a medical

prognosis of the patient and studying the medical papers, either concurs with or opposes the opinion of the primary medical board for withdrawal or refusal of further medical treatment. In the event, either at the primary board stage or at secondary board stage, the primary medical board in the former or secondary medical board in the latter opposes the withdrawal or refusal of medical treatment, then the nominee of the patient or family member of the patient i.e., the patient's next of kin/next friend/guardian or treating physician or hospital staff may knock the doors of High Court under Article 226 of the Constitution of India.

216. During this entire exercise as described above, at every stage, the need to adhere to the best interest principle while determining whether withdrawal or withholding of medical treatment must be proceeded with, is of paramount importance, for all the stakeholders including the medical boards, the patient's next of kin/next friend/guardian, and the courts (if involved).

217. The discussion above provides clarity as to when the best interest principle ought to be applied and who should consider it. The next concomitant question that arises is much more fundamental – why do we have to adopt the best interest principle when determining whether treatment ought to be withheld or withdrawn? The answer lies somewhere between the realms of a doctor's continuing duty to provide treatment and the lawful discharge of that duty once the threshold conditions/medical parameters are satisfied. In this context, the decision of a doctor to withdraw or withhold medical treatment on the basis of the best interests of the patient is not one

directed towards causing death, but towards relieving pain, suffering, and indignity in circumstances where continued treatment no longer serves any therapeutic purpose. A doctor's duty to provide treatment obliges until the provision of treatment is capable of conferring some therapeutic benefit upon the patient. Where, however, the patient is in the terminal stage of illness or in a vegetative state with no reasonable prospect of recovery, and the continuation of treatment merely prolongs biological existence without any therapeutic benefit, that duty no longer mandates continuing with life-sustaining treatment. In determining whether or not such a stage has been reached, the best interests of the patient must be the driving force.

218. Now having understood when and why the best interest principle comes into play, we shall attempt to explain what the best interest principle entails on a holistic reading of the Constitution Bench decision in ***Common Cause 2018*** *(supra)*.

219. As consistently recognised in ***Cruzan*** *(supra)*, ***Re A (Male Sterilisation)*** *(supra)*, ***Aintree*** *(supra)* and many other cases as above-mentioned, the best interest principle consists of both medical and non-medical considerations. In fact, the Law Commission of India, in its 196th Report titled *"Medical Treatment to Terminally Ill Patients (Protection of Patients and Medical Practitioners)"* as well as in its 241st Report titled *"Passive Euthanasia - A relook"* was also of the view that the best interest principle must not only include the medical interest of the patient

but also certain non-medical considerations such as ethical, social, moral, emotional, and other welfare considerations.

220. A similar approach can also be gauged from this court's decision in ***Common Cause 2018*** *(supra)* wherein it was noted that the application of the best interest principle entails taking into account both medical and non-medical considerations. We shall now discuss below the aspects that, as per ***Common Cause 2018*** *(supra)*, form part of such medical and non-medical considerations.

(i) <u>Medical considerations under the best interest principle</u>

221. ***Common Cause 2018*** *(supra)* places great significance on factors such as the futility of treatment, no hope of recovery or cure, and the indignity of the patient, all of which forms a part of medical considerations.

222. On the aspect of *<u>futility</u>*, Para 198.4.1 of the guidelines uses the phrase *"no cure of ailment"*, and Para 199.1 of the guidelines uses the phrase *"incurable"*. In addition to this, Ashok Bhushan, J., in his opinion, also supported the view that the decision to withdraw or withhold medical treatment is not the act of causing a good death, but rather it is a decision one takes when treatment becomes futile. Further, Dipak Misra, CJ., also supports the idea that the words *"no cure"* have to be understood to convey that the patient remains in the same state of pain and suffering and only the dying process is delayed by means of taking recourse to modern medical technology. However, we must also reflect upon what the UK

Supreme Court in ***Aintree*** *(supra)* had observed i.e., that the concept of futility must not be understood on the mere basis of the treatment being incapable of curing the underlying disease of the patient, rather futility must be understood as the treatment being ineffective on the patient or of no benefit to the patient or useless in that particular case of the patient. Thus, futility must be understood by the doctors in the sense of the treatment being useless or pointless on an individual case to case basis, i.e., conferring no benefit at all upon the patient in question. However, this futility must only be conclusive when all possible means to cure the ailment have been exhausted, and the particular medical treatment has become so prolonged so as to render it futile. This means that there must be an aspect of prolongation which is attached to futility. This also necessarily means that calling a condition incurable at the threshold without attaching the aspect of prolongation of medical treatment to it, or in other terms, without exploring all possible means to cure the condition, cannot be considered sufficient for allowing the withdrawal or withholding of medical treatment.

223. On the aspect of *recovery*, Para 198.4.1 of the guidelines uses the phrase *"no hope of recovery",* and Para 199.1 of the guidelines uses the phrase *"no hope of being cured"*. In this context, ***Aintree*** *(supra)* observes that the concept of recovery does not signify restoration to full health, but rather the resumption of a quality of life which the patient himself would regard as worthwhile. This emphasises that the burdens of treatment must be weighed against the benefits of

continued existence and that due weight must be accorded to other non-medical considerations as well.

224. The dimension of dignity occupies a significant place in the constitutional reasoning of ***Common Cause 2018*** *(supra)*. On the aspect of *indignity*, Dipak Misra, CJ., was of the view that if a man is allowed to or, for that matter, forced to undergo pain, suffering and a state of indignity because of unwarranted medical support, the meaning of dignity is lost, and the search for the meaning of life is in vain. Similarly, D.Y. Chandrachud, J., in his opinion, was of the view that the decision to withhold medical treatment is not intended to cause death but to prevent pain, suffering and indignity to a human being who is in the end stage of a terminal illness or of a vegetative state with no reasonable prospect of cure. He also observes that the law must protect a decision which has been made in good faith by a medical professional not to prolong the indignity of a life placed on artificial support in a situation where medical knowledge indicates a point of no return. He was of the further opinion that the court has a duty to interpret Article 21 of the Constitution of India in a further dynamic manner in such a manner that the right to life with dignity must include the smoothening of the process of dying when the person is in a vegetative state or is living exclusively by the administration of artificial aid that prolongs life by arresting the dignified and inevitable process of dying. In a similar fashion, A.K. Sikri, J., also observed that the indefinite continuation of futile physical life is regarded as undignified.

(ii) <u>Non-medical considerations under the best interest principle</u>

225. At this juncture, it is also pertinent to note that, as per Para 199.2 of the Common Cause Guidelines, the primary medical board is required to discuss with the patient's next of kin/next friend/guardian, the pros and cons of withdrawal or withholding and also obtain their consent in writing before certifying or opposing such withdrawal or withholding. It is in this process of obtaining consent that the non-medical considerations, alongside the relevant medical considerations as described above, form the basis for determining whether or not medical treatment should be withdrawn or withheld.

226. It is also pertinent to mention that this Court in ***Common Cause 2018*** *(supra)* had looked into the observations made in ***Aruna Shanbaug*** *(supra)*, wherein it was held that the autonomy of the patient means his right to self-determination and that, therefore, a competent patient, equipped with informed decision-making, has the right to choose the manner of his treatment. In the event that he is incompetent to make such choices, his wishes expressed in advance, in the form of a living will, or the wishes of the surrogates acting on his behalf under the substituted judgment standard, are to be respected. In such a case, the surrogate is expected to represent what the patient may have decided had he/she been competent. This court was of the further view that a surrogate acting in the patient's best interest must follow a particular course of action because it is the best course of action for the patient, and

must not be influenced by their personal convictions, motives or other considerations.

227. Under the guidelines, with respect to cases where there exists no AMD, though the process generally commences with the treating physician evaluating the threshold conditions/medical parameters of Para 199.1 and informing the hospital to constitute the primary medical board, there comes a point where, without obtaining the consent of the patient's next of kin/next friend/guardian, the primary medical board may not be able to move ahead and certify or oppose their opinion. This requirement of obtaining the consent of the patient's next of kin/next friend/guardian in writing before the primary medical board has the opportunity to certify or oppose the withdrawal or refusal of medical treatment comes with an inherent objective to save the derailment of the entire exercise that lies ahead. The objective of taking such consent is to allow the patient's next of kin/next friend/guardian to bring forth the non-medical considerations after being informed of the medical considerations put forth by the primary medical board.

228. At this moment, it is important to adhere to two notes of caution: first, while giving their consent, the patient's next of kin/next friend/guardian should not simply base their consent solely on non-medical considerations. Rather, they must weigh and take into account both medical and non-medical considerations before reaching a decision. Secondly, it has to be ensured that the patient's next of kin/next friend/guardian evaluates such medical and non-medical considerations by factoring in not their personal wishes,

feelings, beliefs, values, etc., but the wishes, feelings, beliefs, values, and other circumstances that the patient would have evaluated for himself if he had capacity to do so. Here, the patient's next of kin/next friend/guardian does not go into the enquiry from a caregiver's standard, as to what a reasonable person in such circumstances would have done. Rather, they must portray, as far as ascertainable, the beliefs and values of the patient that would have been likely to influence his decision if he had capacity. Thus, the patient's next of kin/next friend/guardian must keep this exercise as a patient-centric exercise, not a parent-centric one. This is essentially how the substituted judgment standard must be construed as factoring into the Indian position.

229. Moreover, the courts in various jurisdictions, as more particularly discussed above, have considered the substituted judgment standard to be an element of the best interest of the patient principle and have always endeavoured to strike a balance between the two, on a case to case basis. We agree that such a balancing between the two standards/principles must exist in our jurisdiction as well. On the substituted judgment standard, D.Y. Chandrachud, J., in his opinion, had observed that it seeks to determine what the individual would have decided. He also acknowledged that there is an evident tension between these two standards. What an individual would decide as an autonomous entity is a matter of subjective perception. What is in the best interest of the patient is an objective standard. Thus, D.Y Chandrachud, J., was of the view that a balance between the application of the substituted judgment

standard and the best interest principle is necessary as a matter of public interest. The relevant observation is as under:

> *"486. The substituted judgment standard basically seeks to determine what the individual would have decided. This gives primacy to the autonomy of the individual. On the other hand, as seen earlier, the best interest standard is based on the principle of beneficence. There is an evident tension between these two standards. What an individual would decide as an autonomous entity is a matter of subjective perception. What is in the best interest of the patient is an objective standard: objective, with the limitation that even experts differ […]*
>
> *xxx xxx xxx*
>
> *488. The view which this judgment puts forth is that the recognition of Advance Directives as part of a regime of constitutional jurisprudence is an essential attribute of the right to life and personal liberty under Article 21. That right comprehends dignity as its essential foundation. Quality of life is integral to dignity. As an essential aspect of dignity and the preservation of autonomy of choice and decision-making, each individual must have the right on whether or not to accept medical intervention. Such a choice expressed at a point in time when the individual is in a sound and competent state of mind should have sanctity in the future if the individual were to cease to have the mental capability to take decisions and make choices. Yet, a balance between the application of the substituted judgment standard and the best interest standard is necessary as a matter of public interest. This can be achieved by allowing a supervisory role to an expert body with whom shall rest oversight in regard to whether a patient in the terminal stage of an illness or in a permanent vegetative state should be withheld or withdrawn from artificial life support."*
>
> (Emphasis Supplied)

(i) <u>Application of the best interest principle</u>

230. From the above discussion, it is evident that this Court in ***Common Cause 2018*** *(supra)* has unequivocally held that when deciding whether medical treatment ought to be withdrawn or withheld, both medical as well as non-medical considerations ought to be given due weightage and be considered as a part of the governing principle of best interest.

231. Thus, we are of the view that the patient's next of kin/next friend/guardian, the medical boards, or the courts (if involved), while determining what constitutes the best interests of the patient, are required to undertake a holistic assessment of all relevant circumstances, both medical and non-medical, including but not limited to, the patient's wishes, feelings, beliefs, values, and any other factor that would be likely to influence the patient's decision, or which the patient himself would have taken into account, had he retained the capacity to decide. While saying so, we understand that athough the substituted judgment standard would be a component of the best interest principle, yet it is the latter that would still remain as a governing test to decide the questions concerning withdrawal or withholding of medical treatment.

232. Once the relevant medical and non-medical considerations are discernible, the next step would be to undertake a weighing exercise of both these considerations as per the balance sheet approach. This approach was developed in the case of ***Re A (Male Sterilisation)***, by following the opinions of the law lords in

Airedale *(supra),* which was later adopted in ***W v. M*** *(supra)*, ***Aintree*** *(supra)*, ***Lindsey Briggs*** *(supra),* and so on. This balance sheet approach involves weighing the potential benefits of continued treatment against its burdens, including physical suffering, invasiveness, indignity, psychological distress, wishes and welfare of the patient, the impact upon the patient's lived experience and family life, and similar considerations. For the sake of reiteration, the reference to a patient's family life does not entail an assessment of the lives, interests, or emotional needs of the family members themselves, rather, it requires a consideration of the life of the patient as lived in and through his or her relationship with the family, and the value that such family life holds for the patient.

233. As discussed earlier, the best interest principle cannot be defined by a single, straight-jacketed test that would fit across all facts and circumstances. Therefore, we have endeavoured to cull out the contours of this principle as far as possible from across the jurisdictions as examined above. From our discussion, we are of the opinion that the principle of *"best interest of the patient"* may include, but not be limited to, the following considerations:

1. While deciding upon the withdrawal or withholding of medical treatment, the correct question should be whether it is in the patient's best interests that life should be prolonged by the continuance of the particular medical treatment in question.

2. While answering such a question, the best interest principle cannot be construed in a narrow, rigid, straight-jacketed single test. The determination of the same requires due evaluation of all relevant circumstances and considerations, both medical and non-medical.

3. At the foundational level, the best interests inquiry is anchored in a strong presumption in favour of preserving life, reflecting the sanctity of life. This presumption is not absolute and may be displaced where continuation of medical treatment ceases to serve any therapeutic purpose, i.e., becomes futile, merely prolongs the suffering without the hope of recovery or causes indignity to the life of the patient.

4. The assessment of best interests must, therefore, necessarily encompass an evaluation of the futility of treatment, the absence of therapeutic purpose, the invasive and burdensome nature of continued medical intervention, and the indignity attendant upon artificially prolonging life in a state devoid of awareness, autonomy, or human interaction.

5. Further, while considering the best interests of the patient, decision-makers such as the patient's next of kin/next friend/guardian, the treating physician, the members of the medical boards, or the courts (if involved), as the case may be, must look at the patient's welfare in the widest sense, not just medical but also social and psychological.

6. Decision-makers must try to put themselves in the place of the individual patient and ask what his wishes and attitude to the treatment is or would be likely to be; and they must consult others who are looking after him or interested in his welfare, in particular for their view of what the patient would have wanted.

7. The best interests principle shall incorporate a strong element of the substituted judgment standard, requiring the decision-maker to place himself, so far as possible, in the position of the patient and to consider in a patient-centric manner what that patient would have wanted if he had capacity to do so. However, substituted judgment would not operate as an autonomous or overriding standard. The ultimate inquiry remains what course of action serves the patient's best interest.

8. The decision-makers, after identifying and collating necessary and ascertainable considerations, both medical or non-medical, must engage in the balance sheet exercise, which would involve weighing the potential benefits of continued treatment against its burdens, including physical suffering, invasiveness, indignity, psychological distress, wishes and welfare of the patient, the impact upon the patient's lived experience and family life, and other like considerations.

(3) WHETHER IT IS IN THE BEST INTEREST OF THE APPLICANT THAT HIS LIFE BE PROLONGED BY CONTINUATION OF MEDICAL TREATMENT?

234. Now, adverting to the facts of the present case, the medical history of the applicant shows that due to a severe traumatic brain injury (diffuse axonal injury), he slipped into a PVS.

235. Further, the opinion of the primary medical board reported the following conditions:

(a) The applicant has been bedridden in a vegetative state for the last 13 years;
(b) He requires external aid for his feeding, bladder, bowel and back;
(c) He has recurring bed sores and infections;
(d) He is emaciated and contractures are present in both lower and upper limbs;
(e) He has spasticity all over the body;
(f) The prospects of the patient's recovery from this state are negligible.

236. The opinion of the secondary medical board reported the following conditions:

(a) He is bedbound and cachexic with evident muscle wasting; He maintains a generalized flexed posture;
(b) His body is lean with a tracheostomy tube, urinary catheter and PEG in situ;
(c) He is afebrile to touch;

(d) Pulse rate of 90/minute, regular and normovolemic. Blood pressure was noted at 130/80 mm Hg and respiratory rate at 16/minute;

(e) Shows no signs of respiratory distress;

(f) Although the skin is normal, there was a healing bed sore over the lower back;

(g) He has contractures in both upper and lower limbs;

(h) His eyes were open with normal blinks with no purposeful movement or response to auditory, verbal, tactile, or painful stimulus;

(i) The pupils were bilaterally normal and reacting. There were no eye tracking movement to light or auditory stimuli;

(j) There were flexion contractures of all limbs and attempts for passive movement did not elicit any facial grimace or voluntary resistance;

(k) Spontaneous, but non-purposive eye opening;

(l) No vocalization (or attempt thereof, since the patient is tracheostomised);

(m) No auditory awareness as reflected by no response to sudden noise or meaningful noise stimuli;

(n) Pupils reacting to bright light indicates intact anterior visual pathway, but no eye tracking to moving object or response to visual threat indicates that the primary visual pathway may be affected;

(o) No spontaneous or responsive response to stimuli, indicates higher level moto pathways affected;

(p) Fulfils the diagnostic criteria of PVS;

(q) He has non-progressive, irreversible brain damage, and he has been in PVS for the last 13 years;

(r) The continued administration of CANH is required for the sustenance of his survival. However, the same may not aid in improving his condition or repairing his underlying brain damage.

237. The patient's next of kins/next friends/guardians, after being informed of medical considerations by the doctors, have stated the following:

(a) The applicant was extremely energetic, physically active, and deeply interested in gymming and playing football;

(b) They have done everything with the hope that their son may recover but there has been no improvement in his condition;

(c) Their son no longer has a voice of his own and therefore, they feel it is their moral responsibility to speak for him in his best interest;

(d) Their decision to initiate the process under Common Cause Guidelines has been taken not out of despair or pressure but after prolonged thought, years of care, and acceptance that in medical consensus, there is hope of recovery of their son;

(e) That continuing the medical treatment no longer serves any meaningful purpose for the applicant and only prolongs his agony, which is causing an undignified life for the applicant;

(f) The applicant has bed sores, and his position has to be changed every two hours;

(g) That in such circumstances a decision has to be taken in the best interest and dignity of the applicant.

238. Further, the patient's next of kin/next friend/guardian, the primary medical board and the secondary medical board after considering medical as well as non-medical considerations as mentioned above are of the opinion that the medical treatment should be discontinued as the continuation of the same is not in the best interest of the applicant, and that, in the given circumstances, nature should be allowed to take its own course. They are also of the opinion that the applicant would remain in PVS for years to come, with the tubes inserted all over his body. However, he would never be able to recover from such a condition.

239. The medical considerations in the present case admit of no ambiguity. The treatment being administered to the applicant has become prolonged, futile, and offers no hope of recovery. The applicant has remained in a PVS for over 13 years, with irreversible and non-progressive brain damage, and the continuation of CANH serves only to sustain biological existence without any prospect of cognitive recovery or improvement in condition. While there is no material on record evidencing any prior expressed wishes of the applicant, the non-medical considerations placed before us, such as the applicant's life prior to the injury, where he was physically active, energetic, and deeply engaged in activities such as gymming and football, provide a relevant lens through which his likely values and preferences may be assessed. In conjunction with the unanimous medical opinion and the considered stand of the

applicant's next of kin/next friend/guardian, who have cared for him for years and have taken this decision after prolonged reflection, we acknowledge that had the applicant been competent today, he would not have chosen to continue CANH in these circumstances. The conclusion reached by the medical boards that withdrawal of CANH is in the applicant's best interests is, therefore, both medically sound and consistent with a patient-centric assessment of dignity, values, and welfare.

240. However, in order to obviate any confusion, we wish to emphatically clarify that our discussion demonstrating how the best interest principle applies to the facts of the present matter should not be misconstrued to mean that a court must always be the final arbiter of what is in the best interest of the patient according to the guidelines as laid down in ***Common Cause*** *(supra)*. In the present matter, the decision to withdraw or withhold medical treatment to the applicant could have been put into effect immediately upon the submission of the secondary medical board's opinion, since the same was in concurrence with the opinion of the primary medical board. Both the primary medical board and the secondary medical board have unequivocally certified that the withdrawal of CANH from the applicant would be in his best interest. In other words, we would like to reiterate that if both the primary medical board and secondary medical board certify the withdrawal or withholding of medical treatment, there is no further requirement for any court intervention, except in the very limited circumstances as explained in our detailed discussion hereinabove.

241. Given that this is the first case that has reached this Court wherein the Common Cause Guidelines are being applied in their full measure, we considered it necessary, in the larger public interest, to explain and clarify certain legal and procedural aspects that arise in the application of these guidelines. Such an exposition, in our view, was required not solely for the resolution of the present case but to provide some guidance to treating physicians, medical boards, families, and courts in similar cases that could arise in the future.

(4) WHAT ARE THE FURTHER STEPS TO BE UNDERTAKEN IN THE EVENT THAT A DECISION TO WITHDRAW OR WITHHOLD MEDICAL TREATMENT IS ARRIVED AT?

242. In the aforesaid discussion, we have addressed when, how and in what manner the decision to withdraw or withhold a medical treatment, including CANH, could be arrived at. However, there is a crucial need to address the stage that follows any decision to withdraw or withhold medical treatment as well. As the decision to withdraw or withhold a medical treatment is made keeping the best interests of the patient in mind, we deem it necessary to underscore that the same must be carried out in a manner that is humane and reflects a responsible and sensitive extension of the doctors' duty of care towards their patient. The resultant effect of the withdrawal or withholding of medical treatment must not be the abandonment of the patient. Due focus must be given to the comfort of the patient through pain and symptom management. It is in this regard that the branch of medical science known as Palliative Medicine,

including End of Life Care ("**EOL Care**"), becomes significant in governing protocols regarding the withdrawal or withholding of a medical treatment, in which the goals of medical treatment shift from cure to care.

243. It is essential to understand that the withholding of withdrawal of a medical treatment is not a single, abrupt act. Once the decision has been taken to withdraw or withhold a medical treatment in accordance with the law, the obligation of medically caring for the patient does not stop. In other words, the withdrawal or withholding of a medical treatment is not the termination of the doctor-patient relationship altogether, but merely a purposeful reorientation of medical goals. The withdrawal or withholding of a medical treatment cannot result in a vacuum of care or medical supervision. The process of withdrawal or withholding of a medical treatment necessarily entails a structured, step-wise process, anchored in a clearly articulated withdrawal plan as part of an appropriate palliative and EOL care framework. The importance of such a plan lies in ensuring that the decision to withdraw or withhold a medical treatment, which has been taken in the best interests of the patient, gets translated into clinical practice in a manner that minimises pain, distress, and affords him maximum dignity.

244. In this context, we express our strong disapproval of the practice of "discharge against medical advice" (also known as "leaving against medical advice" or "discharge at own risk") that is routinely misused in cases where the medical treatment of a patient stands discontinued. Such a course of action, when resorted to in

substitution of a structured palliative and EOL care plan, risks amounting to an abdication of the doctor's responsibility and undermines the very rationale of treatment limitation being founded on the patient's best interest. The choice to withdraw or withhold a medical treatment cannot amount to a forfeiture of the patient's right to a medically supervised care. We would like to clarify that it is not always mandatory that palliative and EOL care is provided in a hospital or any other institutional setting. It is permissible that the palliative care is given at home or at any place of choice of the patient or his/her family, as long as a palliative and EOL care plan has been prescribed at the time of discharge, so that the patient is not deprived of structured medical support in the most vulnerable phase of life.

245. As emphasised by the Court of Protection, United Kingdom, in ***Hillingdon Hospitals*** *(supra)*, the withdrawal of CANH must be carried out strictly in accordance with a step-by-step withdrawal plan, so that the burdens of a medical treatment are not merely discontinued in principle, but are meted out in practice. The same principle applies with equal force to the withdrawal of all forms of medical treatment and medical devices, i.e. such withdrawal or withholding can only be undertaken pursuant to a carefully calibrated palliative and EOL care plan. The following extract from the observations of Poole J., in ***Hillingdon Hospitals*** *(supra)*, underscores that the law does not merely permit the withdrawal of a medical treatment, but mandates that it be carried out through a plan that balances the cessation of burdensome interventions with the assurance that the patient will not be subjected to further

avoidable pain or distress, and will continue to receive palliative and EOL care for as long as life continues:

> "*42. I have sought to step back and to consider IN's best interests in the widest sense. In doing so I conclude that it is not in his best interests to continue to receive CANH. Accordingly, the withdrawal of CANH in accordance with the step by step withdrawal of care plan is in his best interests and is lawful. Putting it plainly, he has no prospect of recovery and the provision of CANH will only prolong his burdens and give him no benefit. Even though his life expectancy with continued CANH is relatively short, for so long as he is given CANH, his burdens are continued.*
>
> *43. The current plan is to leave IN's tracheostomy in situ. Although that may have the effect of prolonging his life by some days, I do think it is in his best interests to keep the tracheostomy in place – IN's values are such that he would not have wanted his family or staff to witness his struggling for breath for a period that might last for a week or more were the tracheostomy removed. That is what I believe would have been in accordance with his values as relayed to the court by his family. Whilst he will continue to suffer the burdens of his condition and interventions including the tracheostomy for as long as he is alive, he will receive palliative care and so the Court can be as sure as it is possible to be, that IN will not experience pain or distress whilst the plan is implemented. On balance I consider that the plan to maintain his tracheostomy is in his best interests."*
>
> (Emphasis Supplied)

246. Having thus emphasised that the withdrawal or withholding of medical treatment must be effected through a structured and humane process, accompanied by a palliative and EOL care plan, it becomes necessary to examine the contours of palliative care as

recognised within the Indian medical and regulatory framework. Such an examination is essential not only to demonstrate that the obligation to provide palliative and EOL care is grounded in established medical ethics and policy, but also to ensure that the transition from curative treatment to pain-relieving symptom management care is informed by nationally accepted standards and guidance. It is in this context that reference to the guidance issued by expert medical bodies in India assumes significance.

247. The Indian Council of Medical Research (ICMR) document titled "*Definition of terms used in limitation of treatment and providing palliative care at end of life*" ("**ICMR Palliative & EOL Care Primer**"), published under the authority of the Secretary, Department of Health Research (DHR), MoHFW, Government of India provides a cursory guidance on the duty of a health care provider to mitigate suffering and improve the quality of life throughout one's life, including the dying phase.[52] Although the Palliative & EOL Care Primer is a document that predates this Court's decision in ***Common Cause 2018*** *(supra)*, the primary discussion in the document is not in conflict with it, and we find it apposite to refer to the same. It pragmatically addresses how the inevitability of death must be recognised as a natural culmination of life, and that in this phase, curative intent would have to give way

[52] Indian Council of Medical Research, *Definition of Terms used in Limitation of Treatment and Providing Palliative Care at End of Life*, published in March, 2018, available at: https://www.icmr.gov.in/icmrobject/custom_data/pdf/downloadable-books/Definition_of_terms_used_in_limitation_of_treatment_and_providing_palliative_care_at_end_of_life.pdf, (Last accessed on 06.02.2026)

to pain relief and symptom management, so as to improve the patient's quality of life for the remaining duration of his life.

248. The ICMR Palliative & EOL Care Primer defines the term 'Palliative Care' as "*a holistic approach to treatment that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering.*" Palliative care affirms life by supporting the patient and the family's goals for the future, as well as their hopes for peace and dignity throughout the course of illness, the dying process, and death. It creates an environment in which the needs of the patients and their families are comprehensively assessed, so that the physical, psychological, social, practical, and spiritual needs of patients and their families are endeavoured to be met, and the patient is afforded the maximum dignity possible. Endeavours in palliative care must ensure that the medical palliative care team collaborates with professional and informal caregivers to ensure coordination, communication, and continuity of palliative care across hospital and home settings. The ICMR Palliative and EOL Care Document defines 'End of Life Care' as 'an approach to a terminally ill patient that shifts the focus of care to symptom control, comfort, dignity, quality of life and quality of dying rather than treatments aimed at cure or prolongation of life."

249. According to the Operational Guidelines, 2017 ("**Palliative Care Operational Guidelines 2017")** issued under the National Programme for Palliative Care, by the Directorate General of Health Sciences (DGHS), MoHFW, Government of India, '*Palliative Care is*

an approach that improves the quality of life of patients and families who face life-threatening illness by providing pain and symptom relief, spiritual and psychosocial support from diagnosis to end of life and bereavement." The Palliative Care Operational Guidelines 2017 identify the goals of palliative care as providing relief from pain and other distressing symptoms, but it does not intend to hasten or postpone death. The Palliative Care Operational Guidelines 2017 stresses the ethical responsibility of the health system and the health care professionals respectively, to alleviate pain and suffering, whether physical, psychological or spiritual, irrespective of whether the disease or condition can be cured. It states that palliative care integrates the psychological and spiritual aspects of patient care and offers a support system to help the patients' families cope during the patients' illness and their own bereavement through spiritual support and bereavement counselling.

250. The position statement by the Indian Society of Critical Care Medicine and the Indian Association of Palliative Care, published in February, 2024 ("**ISCCM & IAPC Position Statement"**), identifies that in India, barriers to EOL Care include a lack of attention to the needs of the dying, reluctance to discuss anticipated death or make ethically challenging decisions, physician and organizational concerns over the legality of withdrawal or withholding of a medical treatment, families' inability to pay and lack of integration of palliative care and Intensive Care Units (ICUs).[53] It would be

[53] Raj K Mani, Sushma Bhatnagar, et. al., *Indian Society of Critical Care Medicine and Indian Association of Palliative Care Expert Consensus and Position Statements for End-of-life and Palliative Care in the Intensive Care Unit,* published on 29.02.2024, available at: https://www.ijccm.org/doi/pdf/10.5005/jp-journals-10071-24661, (Last visited on 05.02.2026)

incorrect to suggest that palliative care is limited to only ICUs. As the National Program for Palliative Care under the National Health Mission of the MoHFW notes that, effective palliative care requires a broad multidisciplinary approach that includes the family and makes use of available community resources, and can be provided in tertiary care facilities, in community health centres and even in patients' homes. However, when it comes to implementation of decisions regarding withdrawal or withholding of a medical treatment, there should be a palliative care plan in place. As the ISCCM & IAPC Position Statement notes, a stepwise approach to the same must be taken depending on the goals of care.

251. We find that the Guidelines for End of Life Care issued by AIIMS, New Delhi ("**AIIMS Guidelines**") in March 2020, can provide some guidance to doctors in navigating the documentation required during the palliative and EOL care phase of treatment.[54] The AIIMS Guidelines provide that there should be a guidance and care plan for the dying, which should be explained to the patient before initiation of the EOL care. Moreover, a crucial step in the guidelines is the continuous assessment of the daily supportive plan. The continuous assessment of the daily supportive care plan takes into account the assessment of physical symptoms (such as pain, agitation, nausea, vomiting, dyspnoea, ability to swallow, continence, catheterization, consciousness, respiratory tract secretions, etc. and others). The AIIMS guidelines also provide that

[54] All India Institute of Medical Sciences, New Delhi, *Guidelines for End of Life Care*, Last updated on: 24.02.2021, available at: https://www.aiims.edu/images/pdf/notice/Final_EOLC%20Final%20AIIMS%20(1).pdf, (last visited on: 05.02.2026)

while conducting such EOL care, a team review of the daily supportive care plan must be undertaken if there is an improvement in the consciousness level, functional ability, oral intake, mobility, or ability to perform self-care or if concerns have been expressed regarding the management plan from either the person, carer or team. Even otherwise, the AIIMS guidelines mandate that the supportive care plan must be reviewed daily by a doctor trained in EOL care. The outcomes of the assessment must also be documented on a daily basis, along with explanations/comments where relevant. The last step of the AIIMS guidelines requires feedback from the doctor, nursing staff, primary caregiver and the family, in the form of a simple questionnaire on whether the prognosis was informed, whether the symptoms anticipated in the last few days/hours were informed, whether the change of goals of treatment from cure to care were explained and whether it was a 'good and peaceful death'. We believe these documents provide necessary guidance on palliative and EOL care, ensuring that the patient receives medical supervision even at a stage when medical treatment is to be withdrawn or withheld.

252. One another aspect that we would wish to clarify is that it is legally permissible for hospitals to admit patients who are currently undergoing medical treatments at a home setting, but where a 'best interest' assessment of their ongoing medical treatments is sought. In such circumstances, the medical practitioners and healthcare institutions ought not to feel constrained or hesitant to admit such patients, since such admission would, in turn, enable an institutionalized process to ensure that the decisions relating to the

continuation, withholding, or withdrawal of medical treatment are taken in compliance with the procedural safeguards recognized in law. Upon the admission of such a patient, the treating physician is authorised, and indeed expected, to initiate the structured process of medical evaluation as per the guidelines as laid down in ***Common Cause*** *(supra)* to determine whether the continuation of any ongoing medical treatment serves the best interests of the patient. It would further the goal of ensuring the patient's right to dignity and a legitimate re-determination of the goals of medical treatment, and would allow the patient to receive the relief of palliative care and EOL care, whenever necessary, in accordance with the law.

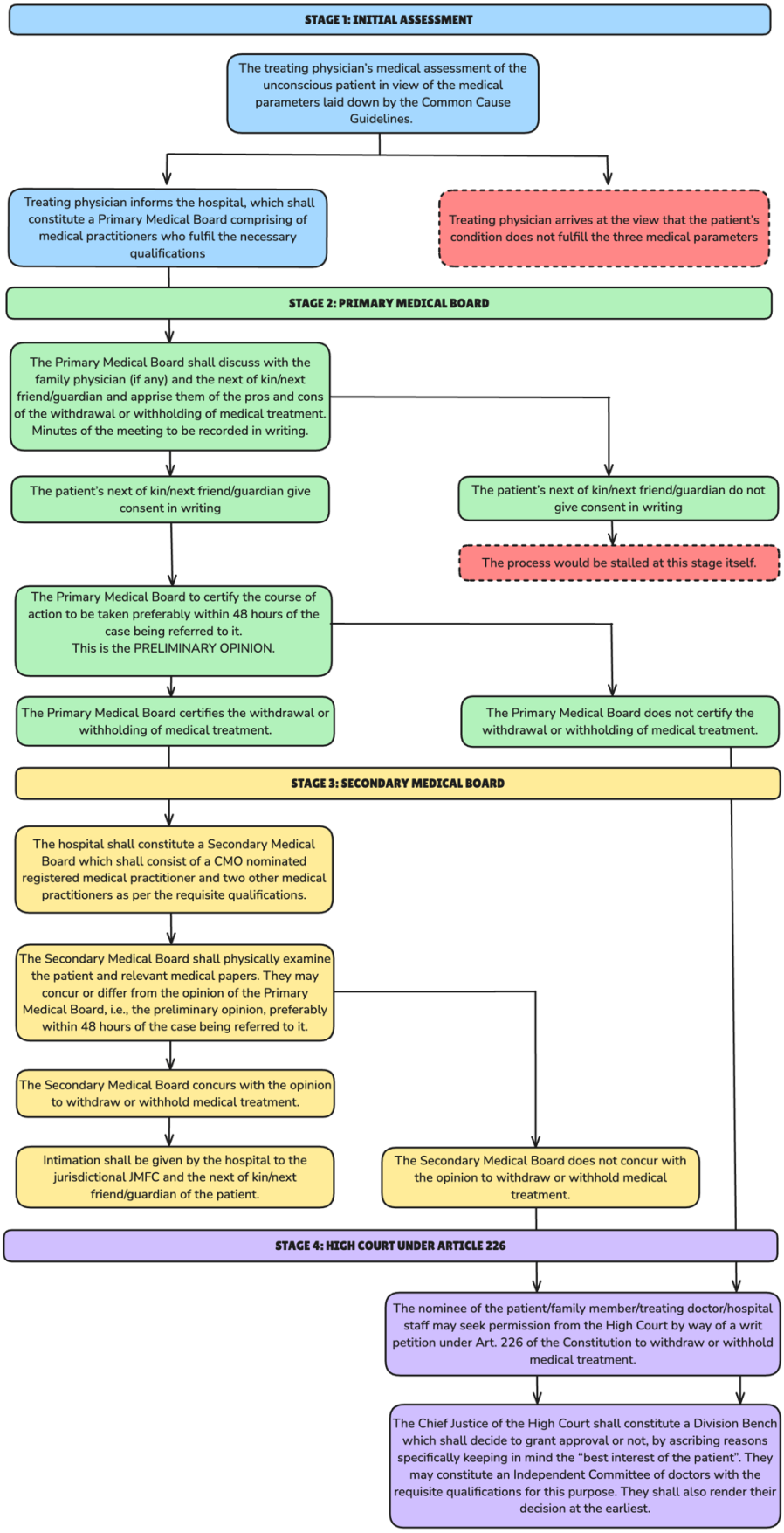
253. In the present matter before us, the primary medical board and the secondary medical board, in due accordance with the Common Cause guidelines, have certified that the withdrawal or withholding of medical treatment is in the best interest of the applicant. For the implementation of the same, it has to be ensured that there is a step-by-step withdrawal or withholding of CANH through a clearly articulated and medically supervised palliative and EOL care plan that will be directed towards the alleviation of pain and distress, management of symptoms, and preservation of the applicant's dignity. In view of the facts and circumstances of the present matter, it is necessary that the respondent no. 2/AIIMS grant admission to the applicant in its Palliative Care department so that the withdrawal or withholding of the applicant's medical treatment can be given effect to. The palliative and EOL care plan must be robust and specifically tailored to manage symptoms without

causing any discomfort to the applicant, ensuring that his dignity is preserved to the highest degree.

254. Furthermore, we are of the opinion that two other aspects are required to be addressed at this stage: (i) streamlining of the Common Cause Guidelines; and (ii) the need for a subject-specific legislation. These aspects are explained in detail in the following sections.

(5) STREAMLINING AND CONTEXTUALISING THE COMMON CAUSE GUIDELINES

255. This litigation presents the first substantive application of the Common Cause Guidelines. At the same time, it starkly illustrates the practical complexities, difficulties, and dilemmas encountered by all stakeholders in their implementation, most acutely by the patient's next of kin/next friend/guardian and by treating physicians or medical practitioners. Even when the threshold conditions/medical parameters, as more particularly discussed above, are fulfilled, the initiation of the process contemplated under the Common Cause Guidelines remains fraught with hesitation and apprehension amongst doctors. In paragraph 110 of our judgment, we have already reproduced the procedure envisaged by the Common Cause Guidelines in a scenario where no AMD exists. To avoid further repetition, we have concisely illustrated the same hereinbelow:


STAGE 1: INITIAL ASSESSMENT
The treating physician's medical assessment of the unconscious patient in view of the medical parameters laid down by the Common Cause Guidelines.
Treating physician informs the hospital, which shall constitute a Primary Medical Board comprising of medical practitioners who fulfil the necessary qualifications
Treating physician arrives at the view that the patient's condition does not fulfill the three medical parameters
STAGE 2: PRIMARY MEDICAL BOARD
The Primary Medical Board shall discuss with the family physician (if any) and the next of kin/next friend/guardian and apprise them of the pros and cons of the withdrawal or withholding of medical treatment. Minutes of the meeting to be recorded in writing.
The patient's next of kin/next friend/guardian give consent in writing
The patient's next of kin/next friend/guardian do not give consent in writing
The process would be stalled at this stage itself.
The Primary Medical Board to certify the course of action to be taken preferably within 48 hours of the case being referred to it.
This is the PRELIMINARY OPINION.
The Primary Medical Board certifies the withdrawal or withholding of medical treatment.
The Primary Medical Board does not certify the withdrawal or withholding of medical treatment.
STAGE 3: SECONDARY MEDICAL BOARD
The hospital shall constitute a Secondary Medical Board which shall consist of a CMO nominated registered medical practitioner and two other medical practitioners as per the requisite qualifications.
The Secondary Medical Board shall physically examine the patient and relevant medical papers. They may concur or differ from the opinion of the Primary Medical Board, i.e., the preliminary opinion, preferably within 48 hours of the case being referred to it.
The Secondary Medical Board concurs with the opinion to withdraw or withhold medical treatment.
Intimation shall be given by the hospital to the jurisdictional JMFC and the next of kin/next friend/guardian of the patient.
The Secondary Medical Board does not concur with the opinion to withdraw or withhold medical treatment.
STAGE 4: HIGH COURT UNDER ARTICLE 226
The nominee of the patient/family member/treating doctor/hospital staff may seek permission from the High Court by way of a writ petition under Art. 226 of the Constitution to withdraw or withhold medical treatment.
The Chief Justice of the High Court shall constitute a Division Bench which shall decide to grant approval or not, by ascribing reasons specifically keeping in mind the "best interest of the patient". They may constitute an Independent Committee of doctors with the requisite qualifications for this purpose. They shall also render their decision at the earliest.

256. A bare reading of Para 199.1 of the Common Cause Guidelines clearly indicates that the treating physician, upon being satisfied that the threshold conditions/medical parameters are fulfilled, sets the process into motion by informing the hospital to constitute the primary medical board. The treating physician has been entrusted with this responsibility as he is best positioned to know, assess, and evaluate the antecedents and present health condition of the patient at the threshold stage. It is for this reason that the treating physician is also required to be a member of the primary medical board along with at least two subject experts of the concerned speciality, each having a minimum of five years' experience.

I. Safeguarding Checkpoints that remove any hesitation amongst doctors

257. The practical difficulties in implementing the Common Cause Guidelines, more particularly, the potential hesitation of doctor(s) to initiate and carry forward the process, could not be said to have escaped the attention of the Constitution Bench in ***Common Cause 2018*** *(supra).* It is for this reason that they have inserted some safeguarding checkpoints, which exist at each stage of the implementation process.

258. At the very first stage, it is required that (i) the pros and cons of withdrawal or withholding of medical treatment be discussed by the primary medical board with the patient's next of kin/next friend/guardian and that (ii) their consent in writing is obtained prior to certifying or opposing such withdrawal or withholding.

259. At the second stage, in the event of the primary medical board opposes the withdrawal or withholding of medical treatment, even after receiving such consent in writing, (i) the nominee of the patient, or the family member and/or the patient's next of kin/next friend/guardian, or treating physician, or the hospital staff would have the option to approach the High Court under Article 226 of the Constitution. Conversely, in the event the primary medical board certifies the withdrawal or withholding of medical treatment after receiving the written consent of the patient's next of kin/next friend/guardian, (ii) the constitution of a secondary medical board consisting of one registered medical practitioner nominated by the Chief Medical Officer of the district (hereinafter referred to as "**CMO**") and at least two subject experts of the concerned speciality, each having a minimum of five years' experience, is triggered. Here, it is ensured that no member of the primary medical board forms part of the secondary medical board. The inclusion of a registered medical practitioner nominated by the CMO in the secondary medical board also serves to infuse some neutrality into the decision-making process.

260. At the third final stage, in the event that the secondary medical board does not concur with the opinion of the primary medical board, (i) the patient's next of kin/next friend/guardian, the treating physician, or the hospital staff again have the option to approach the High Court under Article 226 of the Constitution of India. Where the secondary medical board concurs with the decision to withdraw or withhold medical treatment, an additional

safeguard comes into operation, in the form of a (ii) '*Reconsideration period'*, which we shall discuss below under a separate heading.

261. In short, all that we are trying to convey is that these safeguards have been designed keeping in mind the various permutations and combinations of circumstances that may arise in decisions concerning withdrawal or withholding of medical treatment. Doctors must, therefore, not conduct themselves with hesitation, fear, or dilemma in initiating such a process. Each step and stage involves sufficient consultation, neutrality and oversight. It is not just the decision of the treating physician that is individually crystallised into the final decision. The process is collaborative and multi-tiered. Therefore, where the medical and factual circumstances of the patient clearly warrant consideration of withdrawal or withholding of medical treatment in the patient's best interests, the process must commence without any delay.

II. Role of the patient's next of kin/next friend/guardian

262. As illustrated above, once the primary medical board is constituted, the patient's next kin/next friend/guardian remains an integral part of the envisaged procedure. Upon its constitution, the primary medical board would have to visit the patient in the presence of the patient's next of kin/next friend/guardian. The board would also have to holistically and comprehensively identify, as far as practicable, the caregivers of the patient who may be considered as the patient's next of kin/next friend/guardian. They must apprise the patient's next of kin/next friend/guardian of the pros and cons of withdrawal or withholding of medical treatment and record the

minutes of their discussion in writing. A crucial step that follows is the necessity for the primary medical board to obtain the *consent* of such patient's next of kin/next friend/guardian before certifying or opposing the withdrawal or withholding of medical treatment. Thus, without the consent of the patient's next of kin/next friend/guardian in writing, the process would come to a stall and would eventually collapse.

263. The patient's next of kin/next friend/guardian and primary medical board must also make sure that such consent in writing embodies the notion of what the patient would have wanted had he possessed decision-making capacity and not what the patient's next of kin/next friend/guardian would want in their personal opinion, motive or conviction. They must ensure that the exercise of determining what is in the best interest of the patient is done in a patient-centric manner and not in a parent-centric manner.

264. Obtaining such consent is also critical for the reason that any further step which is undertaken in pursuance of the procedure envisaged is not fraught with allegations that the patient's next of kin/next friend/guardian was not duly consulted. Moreover, it also prevents the potential derailment of the entire process due to any undue retraction of consent already given by the patient's next of kin/next friend/guardian.

III. <u>Bridging the procedural gap for patients who are undertaking medical treatment in a home-setting</u>

265. In a lot of cases such as the present one, there might be patients who are undertaking prolonged medical treatment in a home-setting. The guidelines as laid down in ***Common Cause*** *(supra)* must not be read in a pedantic manner that unreasonably excludes such patients from taking recourse to the procedure that it has delineated for the withdrawal or withholding of medical treatment. However, if some careful attention is paid to the guidelines as laid down in ***Common Cause*** *(supra)*, it can be seen that the duty to constitute the primary medical board is fastened on the *hospital* in which the patient is admitted.

266. Therefore, we clarify that, in such a scenario, the next of kin/next friend/guardian of the patient who is undertaking medical treatment predominantly in a home setting would have the option to admit the patient in any hospital of their choice. It would then be the mandatory duty of this hospital and the primary treating physician therein to perform the responsibilities laid down under the guidelines as laid down in ***Common Cause*** *(supra)*. In cases where it is not feasible for the patient's next of kin/next friend/guardian to facilitate such an institutionalised admission, they may choose to approach any hospital for the limited purpose of designating a primary treating physician, who would then fully apprise himself of the patient's medical condition and initiate the process.

267. In both scenarios, we would strongly urge that the medical practitioners and the hospitals, respectively, do not hesitate to cater to the needs of such patients. Any such behaviour would further

defeat the very right to die with dignity which ***Common Cause 2018*** *(supra)* has set out to secure.

IV. Nomination of registered medical practitioner by CMO

268. Para 199.2 of the guidelines provides that in the event the primary medical board certifies the option of withdrawal or withholding of further medical treatment, the hospital shall then constitute a secondary medical board. The details of the composition of the secondary medical board is given under Para 198.4.5 of the guidelines, which states that the secondary medical board shall be comprised of one registered medical practitioner nominated by the CMO.

269. We have been apprised that this requirement of nomination of a registered medical practitioner by the CMO infuses extensive delay in the process of constitution of the secondary medical board owing directly to the failure of the CMOs of various districts to timely make such nominations. Expediency is one of the cornerstones of the procedure envisaged by the guidelines as laid down in ***Common Cause*** *(supra)* because the absence of same would prolong the suffering and indignity of the patient, thereby directly infringing the rights of the patient guaranteed under Article 21 of the Constitution of India.

270. It is for this reason that this Court, in ***Common Cause 2023*** *(supra)* modified the original guidelines by incorporating a requirement that both the primary medical board and the secondary medical board

certify the further course of action, *"preferably within a period of 48 hours"* from the referral of the case to them. This Court further envisioned that upon the primary medical board certifying the withdrawal or withholding of medical treatment, the hospital would *"immediately"* proceed to constitute the secondary medical board.

271. We wish to clarify one other aspect. Any interpretation that permits the hospital to retain discretion over the choice of the CMO-nominated practitioner would defeat the very object underlying the introduction of an external and neutral layer of scrutiny, which this Court had consciously embedded into the decision-making process governing withdrawal or withholding of medical treatment. This would strictly imply that the authority to nominate one registered medical practitioner vests exclusively with the CMO, while the role of the hospital would be to perform the administrative act of forming the secondary medical board in accordance with such nomination. This, however, does not curtail the hospital's discretion in placing the remaining members of the secondary medical board, as contemplated under the guidelines as laid down in ***Common Cause*** *(supra)*.

272. Accordingly, we are of the view that the CMOs of all concerned districts across the country must prepare and maintain a panel consisting of registered medical practitioners possessing qualifications in accordance with the guidelines as laid down in ***Common Cause*** *(supra)*, for the purpose of nomination to the secondary medical board. Upon receipt of a request from a hospital seeking nomination of one registered medical practitioner for the

constitution of the secondary medical board, the CMO also shall, preferably within a period of 48 hours from the receipt of the request, nominate one such practitioner from the said panel on a case to case basis. The panel so prepared must also be periodically reviewed and updated by the CMO at intervals not exceeding twelve months, so as to ensure availability, suitability, and continued compliance with the requirements under the guidelines as laid down in ***Common Cause*** *(supra)*.

V. Reconsideration Period

273. We have already noted that the role of the patient's next of kin/next friend/guardian has been given due importance in the envisaged procedure. A duty is placed upon the primary medical board to also reasonably ensure that all the caregivers are identified and their concurrence is secured before it certifies the withdrawal or withholding of medical treatment. However, we cannot discount the possibility of any third person claiming to be the patient's next of kin/next friend/guardian assailing the legitimacy of the whole process once it has been completed, alleging that they were not consulted with. We are cognisant that this would occur in the rarest of rare occasions.

274. Moreover, there may also arise situations wherein one of the persons forming the group of the patient's next of kin/next friend/guardian revisits their initial consent due to some validly changed or pressing circumstances. It would not be possible for us to exhaustively outline what reasons could underlie such a change

of stance. However, we are sure that there must be something cogent that reveals that the retraction of consent is grounded on what the patient would have wanted for himself and not merely reflect the altered morals/motivations of the patient's next of kin/next friend/guardian. Having said so, some recourse must exist to address scenarios like these as well. It is keeping such outliers in mind that that Ashok Bhushan, J., in his opinion, observed that in cases of incompetent patients who are unable to take an informed decision, the decision to withdraw or withhold medical treatment should be taken by competent medical experts applying the principle of best interest and should be implemented only after providing a period of 30 days (hereinafter referred to as the "**Reconsideration Period**"), so as to enable an aggrieved person to approach a court of law. The relevant observation is as follows:

> *"629.9. We are also of the opinion that in cases of incompetent patients who are unable to take an informed decision, "the best interests principle" be applied and such decision be taken by specified competent medical experts and be implemented after providing a cooling period to enable aggrieved person to approach the court of law.*
>
> *xxx xxx xxx*
>
> *612. Various learned counsel appearing before us have submitted that seeking declaration from the High Court in cases where medical treatment is needed to be withdrawn is time taking and does not advance the object nor is in the interest of terminally-ill patient. It is submitted that to keep check on such decisions, the State should constitute competent authorities consisting of predominantly experienced medical practitioners whose decision may be followed by all concerned with a rider that after taking of decision by competent body a cooling period should be provided to enable anyone aggrieved from the decision to*

> *approach a court of law. We also are of the opinion that in cases of incompetent patients who are unable to take an informed decision, it is in the best interests of the patient that the decision be taken by the competent medical experts and that such decision be implemented after providing a cooling period at least of one month to enable aggrieved person to approach the court of law […]"*
>
> (Emphasis Supplied)

275. We resonate with the above view delivered by Ashok Bhushan, J. However, it must be strictly borne in mind that in such cases, the aggrieved person shall be sufficiently required to establish his or her locus. The court must also tread with caution and not be quick to upend the entire process that has already been culminated, especially a process wherein due and careful attention to the best interest of the patient was paid.

VI. Court Intervention

276. The Constitution Bench in ***Common Cause 2023*** *(supra)* had modified the guidelines with a view to ensuring minimal judicial intervention in the process. Under the Common Cause Guidelines, there are two circumstances in which court intervention has been envisaged. *First*, in cases where the primary medical board opposes the withdrawal or withholding of medical treatment and *secondly*, in cases where the secondary medical board does not concur with the opinion of the primary medical board to withdraw or withhold medical treatment. In such circumstances, Para 199.4 of the guidelines provides that the nominee of the patient, the family

member, the treating physician, or the hospital staff may approach the High Court under Article 226 of the Constitution of India.

277. While the provision permitting recourse to the High Court under Article 226 of the Constitution of India under limited circumstances has been retained and extended to provide an overarching safeguard, the guidelines nevertheless envision that, in the ordinary course, court intervention shall be minimal, and that the process contemplated under the guidelines be initiated by the treating physician only and medical boards are to be constituted by the hospitals only.

278. However, in cases where the treating physician himself or the hospital, upon receiving information from the treating physician, fails to initiate the process or constitute the respective medical boards contemplated under the guidelines (as has happened in the present case), despite the patient having fulfilled the requisite threshold conditions/medical parameters, the patient's next of kin/next friend/guardian cannot be left remediless. In such circumstances, the patient's next of kin/next friend/guardian may also have the opportunity to approach the High Court under Article 226 of the Constitution of India seeking appropriate directions to be made to the treating physician and/or the hospital to directly constitute the primary medical board, who may then act in accordance with the Common Cause Guidelines.

(6) LEGISLATIVE INACTION AND THE NEED FOR LEGISLATION

279. There are moments when legislative inaction speaks more loudly than legislative action, and the absence of regulation with regard to the issue at hand presents one such instance. Despite the profound constitutional, ethical, and medical dimensions involved, the field continues to remain largely unregulated by legislation in India. Due to this legislative vacuum, this Court has, from time to time, been constrained to step in and frame guidelines, not as a matter of institutional preference, but as a matter of constitutional necessity, in order to safeguard the sanctity of fundamental rights, more particularly the right to life with dignity. We underscore that judicial intervention in this domain has never been intended to supplant legislative wisdom, but only to operate as a temporary constitutional bridge until Parliament discharges its role.

280. On more than one occasion, this Court has expressly invited legislative attention to the issue and urged Parliament to consider enacting a comprehensive legislation addressing the practice of euthanasia and/or the withdrawal or withholding of medical treatment. It is pertinent to mention that although two Law Commission Reports[55] have examined the subject in depth, and several private members' bills [56] have been introduced in Parliament, yet these have not generated sustained legislative deliberation. It is, therefore, necessary to advert to these efforts, to

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[55] Law Commission of India, 196th Report titled "*Medical Treatment to Terminally Ill Patients (Protection of Patients and Medical Practitioners"* submitted in year 2006; Law Commission of India, 241st report titled *'Passive Euthanasia – A Relook'* submitted in year 2012.

[56] Shri Uttam Rao Dhikale, *"Introduction of The Euthanasia (Regulation) Bill, 2002"* in Lok Sabha on 21.02.2002; Shri C. K. Chandrappan, *"Introduction of The Euthanasia (Permission and Regulation) Bill, 2007"* in Lok Sabha on 24.07.2007; Shri Bhartruhari Mahtab, *"Introduction of The Euthanasia (Regulation) Bill, 2014"* in Lok Sabha on 12.12.2014 and reintroduced on 26.07.2019.

demonstrate both the extent of engagement already undertaken and the need for further legislative rigour on the subject.

I. The 196th Law Commission Report

281. After undertaking an exhaustive survey of comparative jurisprudence across various countries, the Law Commission had concluded that a terminally ill patient's decision to discontinue medical treatment does not attract criminal liability and that such withdrawal ought to be permissible when it accords with the patient's best interests. Through this 196th Report, the Law Commission specifically traced the legislative competence of the Parliament to enact a law on the subject under Entry 26 of List III of the Seventh Schedule to the Constitution of India. To facilitate concrete action, the Law Commission also appended a draft bill to its report for the consideration of the Union Government.

II. The decision of Aruna Shanbaug

282. Five years later, this Court in ***Aruna Shanbaug*** *(supra)* was confronted with the same issues and was forced to deal with them in an acute legislative vacuum. This Court drew guidance from comparative jurisprudence and foreign legal frameworks and laid down guidelines permitting the withdrawal or withholding of medical treatment in cases of patients with terminal illness undergoing prolonged and futile treatment, causing indignity to the life of the patient. At the same time, the Court, being conscious of its limits, expressly clarified that the guidelines framed therein were

intended as an interim arrangement to bridge the legislative vacuum, and not as a substitute for legislation made by Parliament. The responsibility was ultimately left with the Parliament to exercise its legislative wisdom and enact a comprehensive statutory framework.

III. The 241st Law Commission Report

283. In the wake of the guidelines enunciated by this Court in ***Aruna Shanbaug*** *(supra)*, the Law Commission undertook a relook of the subject matter. In its 241st report, the Law Commission, found no reason to differ from the view taken by this Court or by the earlier Law Commission Report of 2006. However, a revised bill was appended to the 241st Report, incorporating certain variations with respect to the preparation and composition of the panel of medical experts. No concrete subsequent action was taken, and the recommendations mentioned therein failed to be converted into a tangible statutory framework.

284. Further, a question was put by a member of the Rajya Sabha seeking information from the MoHFW regarding the steps taken by the Government pursuant to the guidelines laid down in ***Aruna Shanbaug*** *(supra)* to enact a comprehensive law on end-of-life care. In reply to the aforesaid question, the Minister of Health and Family Welfare stated that since the Constitutional Bench of this Court has already laid down the guidelines, the same should be followed and treated as law. The Minister stated that *"at present, there is no*

proposal to enact a legislation on this subject and the judgment of the Hon'ble Supreme Court is binding on all".

285. Nevertheless, in 2016, the MoHFW published a draft bill, namely, the *Medical Treatment of Terminally-Ill Patients (Protection of Patients and Medical Practitioners Bill, 2016,* inviting public comments. However, following the consultative stage, no further steps were taken. The bill was neither finalised nor introduced for deliberation before the Parliament.

IV. The decision of Common Cause 2018

286. In ***Common Cause 2018*** (*supra*), this Court formulated fresh guidelines on this issue by exercising its powers under Article 142 of the Constitution of India. However, the need to lay down such guidelines arose solely because there was no law in place. It is in this context that Dipak Misra, CJ., clarified that the Court was not seeking to supplant the legislature, but was merely enabling the exercise of the recognised rights until legislation regarding the same was enacted. Further, in his concluding remarks, A.K. Sikri, J., expressed a *"pious hope"* that the legislature would intervene and enact an appropriate law to establish a coherent and comprehensive regulatory framework governing the subject.

287. In our view, this *"pious hope"* has now become an imminent necessity as nearly eight years have passed since the decision of this Court in ***Common Cause 2018*** *(supra)*, yet the legislative void remains.

V. Draft Guidelines of 2024

288. Post ***Common Cause 2023*** *(supra)*, the Directorate General of Health Services, MoHFW, released Draft Guidelines (namely Guidelines for Withdrawal of Life Support in Terminally Ill Patients, 2024) for public consultation in June 2024. However, no fruitful conclusion has been reached to date, even on these guidelines.

289. It must be emphasised that the cumulative effect of prolonged legislative inaction is leaving citizens, particularly those situated at the most vulnerable threshold of life, exposed to serious and systemic risk. In the absence of a clear and comprehensive legislation, end-of-life decisions stand imperilled by the possibility that considerations wholly extraneous to medical science or the patient's autonomy, most notably financial distress, lack of insurance coverage, or socio-economic vulnerability, may imperceptibly shape outcomes. Such a vacuum creates the danger that decisions ostensibly grounded in compassion or clinical futility may, in reality, be driven by the inability of families to sustain prolonged and expensive medical intervention, thereby blurring the line between a genuine best-interest determination and an act compelled by economic exhaustion.

290. It is required to be understood that guidelines framed by constitutional courts are intended only to bridge a temporary legislative vacuum arising out of imminent necessity. They are not designed to operate as a permanent substitute for legislative

enactment. It must be reiterated that the directions issued by this Court were never envisaged as a self-contained or exhaustive code. The responsibility for enacting a comprehensive, coherent, and enduring statutory framework continues to rest exclusively within Parliament's legislative domain. It must be emphasised that any guidelines this Court formulates are bound to be limited in their scope and efficacy. A legislative exercise is inherently more robust as it necessarily involves the engagement of a multitude of stakeholders from various fields, allowing for a broader range of issues to be considered, anticipated, and thereby addressed.

291. Therefore, we urge the Union Government to consider enacting a comprehensive legislation on the subject in line with the vision of the Bench in ***Common Cause*** *(supra)*. Such legislation would provide clarity, coherence, and certainty in matters that are deeply practical and emotionally sensitive.

(G). CONCLUSION

I. Summary of our discussion

292. A conspectus of our entire discussion is as follows:

(a) Understanding Common Cause 2018

293. The Constitution Bench in ***Common Cause 2018*** (*supra*) characterised active euthanasia as a positive overt act, such as the administration of a lethal injection, designed to directly cause or

accelerate death. In contrast, passive euthanasia was defined by the absence of such an act, primarily encompassing the withdrawal or withholding of medical treatment(s) that serve to sustain life. However, reliance cannot be placed solely on the binary of 'acts' and 'omissions' to distinguish the two.

(a) A more robust distinction between active and passive euthanasia lies in the source of the harm. Active euthanasia introduces a new, external agency of harm that disrupts the natural trajectory of life, effectively "*causing death*". Passive euthanasia, on the other hand, merely involves the withdrawal or withholding of medical treatment that sustained life and thus, can be effectively characterised as "*allowing death to occur*" on account of the underlying fatal condition and permitting the trajectory of life to resume its natural course.

(b) When viewed through this broader lens of "causing death" versus "*allowing death to occur*", the role of acts and omissions becomes more intelligible. While the physical mechanics of withdrawing life support may technically involve an 'act', its legal and substantive effect is that of an omission, i.e., an omission to treat. Thus, even when a physical action is required to stop a machine, the essence of the conduct remains an omission to continue life-prolonging measures.

294. This Court in ***Common Cause 2018*** (*supra*) unequivocally held that the withdrawing or withholding of medical treatment is constitutionally permissible under Article 21 of the Constitution of

India, provided it is exercised in the best interests of the patient. The rationale of this Court in arriving at this conclusion can be summarised as follows:

(a) The fundamental right to live with dignity envisages and encompasses dignity until death, including a dignified dying process. Consequently, the right to live with dignity under Article 21 includes a right to die with dignity. This Court reasoned that the withdrawal or withholding of medical treatment merely allows the natural path of life to run its inevitable course and therefore cannot be termed as the extinguishment of life or an unnatural termination of life. Consequently, the same was held not to fall foul of Article 21.

(b) For competent patients, this permissibility is clearly rooted in the common law and constitutional right to refuse medical treatment. This refusal is a manifestation of dignity intersecting with privacy, autonomy, and self-determination. Crucially, for a competent individual, this right to refuse medical treatment is unencumbered, i.e., they possess the absolute authority to reject treatment when it is the outcome of informed decision-making. This choice requires no justification to the State and is not subject to the supervisory control of any outside entity.

(c) This Court recognised that the withdrawal or withholding of medical treatment is equally permissible for incompetent patients, though the legal basis may slightly shift. Here, it is

rooted on the standalone basis of dignity and also dignity viewed through the lens of bodily integrity. Subjecting a patient to treatment that is futile, which only artificially prolongs the dying process and the accompanying pain, is an affront to their dignity and bodily integrity. Consent to treatment cannot be presumed to continue forever when the intervention yields no result. However, unlike the unencumbered right of competent patients to refuse treatment, this exercise for incompetent patients is conditional and can only occur when specific threshold conditions/medical parameters, as discussed above, are met.

(d) Withdrawal or withholding of medical treatment, when carried out in the patient's best interests, does not constitute a breach of the doctor's duty of care. The medical duty to care does not include an obligation to continue treatment *ad infinitum*. In fact, when the best interests of the patient dictate such withdrawal or withholding, such action is taken in furtherance and is a manifestation of the doctor's duty of care.

295. Further, this Court in ***Common Cause 2018*** (*supra*) held that since active euthanasia involves a positive act designed to extinguish life, it falls foul of Article 21 of the Constitution of India, which prohibits deprivation of life except according to a procedure established by law. Consequently, in the absence of an explicit legislative enactment authorising such an act, active euthanasia remains a penal offence under our existing laws. This Court has firmly held

that the prerogative to validate such a practice lies exclusively with the Parliament.

296. This Court in ***Common Cause 2018*** (*supra*) held that AMDs are legally valid documents. AMDs serve as instruments that enable individuals to exercise the right to self-determination and autonomy even when they have lost the capacity to communicate. However, this Court was conscious of the potential for abuse and thus, restricted the enforcement of AMDs to strictly those scenarios in which the specific threshold conditions/medical parameters were met and in accordance with the procedural safeguards laid down therein.

297. In giving effect to the recognition of the right to die with dignity, this Court also laid down a detailed procedure which is to be followed for the withdrawal or withholding of medical treatment for incompetent patients, both in scenarios where an AMD exists and where it is absent.

298. On a cumulative reading of ***Common Cause 2018*** *(supra)*, any decision to withdraw or withhold medical treatment must withstand scrutiny on two primary grounds: first, the intervention in question must qualify as *"medical treatment"*, and second, its withdrawal must strictly be in the patient's *"best interests"*. Consequently, the inquiry in the present matter also broadly revolved around two inquiries: (i) whether the CANH being administered to the applicant can be termed as 'medical treatment'; and (ii) whether withdrawing or withholding of such medical treatment would be in the applicant's best interest.

(b) CANH is a medical treatment

299. In the present matter before us, the applicant has sustained non-progressive, irreversible brain damage having suffered severe traumatic brain injury with diffuse axonal injury at the time of the fateful incident. Following his discharge from the hospital in the immediate aftermath of the incident, his fragile health condition necessitated frequent hospital admissions for the treatment of his head injury, seizures, pneumonia and bedsores. However, his medical condition has been such that it did not warrant continuous hospitalisation all the time and, therefore, he has largely been cared for at home, albeit with a tracheostomy tube, urinary catheter, and PEG tube *in situ*. He retains intact brainstem function and breathes spontaneously with the tracheostomy tube in place. Nonetheless, due to his PVS condition, his survival is dependent upon the continued administration of CANH. Since the applicant is being sustained through the provision of CANH, through a PEG tube, it is only in the event that CANH is recognised as a medical treatment, as opposed to being regarded as basic primary care, that the withdrawal or withholding of such treatment would be permissible and amenable to the same principles governing the withdrawal or withholding of any other form of medical treatment.

300. The prescription and administration of CANH involves careful consideration of a multitude of clinical factors, ranging from installation of the CANH device (placed surgically or otherwise), precise assessment of the patient's nutritional requirements, the

underlying clinical condition of the patient, gastrointestinal tolerance, potential metabolic instability, assessment of the anticipated duration of CANH support, and the potential risks of complications that are associated with CANH such as the risk of aspiration pneumonia, peritonitis, wound/stoma site infection. Administration of CANH also requires a periodic medical review of its indications, route of administration, risks, benefits and therapeutic goals.

301. The clinical and procedural characteristics of CANH, therefore, indicate, without an iota of doubt, that CANH cannot be regarded as a mere means of basic sustenance or primary care, but should be recognised as a technologically mediated medical intervention that is prescribed, supervised and periodically reviewed by trained healthcare professionals in accordance with established medical standards.

302. When comparing CANH with normal feeding, it is incorrect to direct exclusive attention to the fact that nourishment is being provided. Rather, regard should be had for the whole regime of artificial feeding, which involves the use of catheters and enemas and the constant combating of potentially deadly infection(s).

303. Merely because routine feeding in the form of CANH can be administered at home, by an informed lay person, it cannot be relegated to a non-medical status. CANH, even when administered at home, remains a medical procedure because such administration of nutrition and hydration must necessarily be performed under regular medical and nursing supervision, involving skills and

protocols which the lay person would need to specifically obtain by drawing upon medical knowledge.

304. In the present matter before us, the applicant is sustained through the CANH in medically prescribed quantities of certain prescribed feed, *via* a surgically installed PEG tube. The continuation of such CANH requires an ongoing clinical decision-making process, through routine medical supervision, periodic evaluation, and emergency medical management in case of infection or dislodgment of the CANH device. Consequently, it is beyond question that administration of CANH in this case is to be considered as medical treatment. Further, as we have already explained hereinabove, the fact that the applicant is administered CANH at home does not displace the status of such CANH as being considered as a medical treatment.

305. Therefore, in line with our considered view that CANH constitutes medical treatment, it is permissible for the primary medical board and secondary medical board to exercise their clinical judgment with regard to the continuation or withdrawal or withholding of the CANH, like any other form of medical treatment, in accordance with the guidelines as laid down in ***Common Cause*** *(supra)*.

(c) <u>Best Interest Principle</u>

306. In addition to the above, it is also abundantly clear that decisions concerning the withdrawal or withholding of medical treatment, in cases of incompetent patients, are required to be taken in accordance with the best interest principle. We have endeavoured

to explain when the "*best interest of the patient*" principle comes into application; who applies it; why it is applied; and what the contours of the best interest principle are. We have attempted to answer these questions by undertaking an exhaustive examination of (i) a series of decisions across various jurisdictions, (ii) the deliberations of the Law Commission under its 196th and 241st Reports, and (iii) the concurring opinions of the Constitution Bench of this Court in ***Common Cause 2018*** *(supra)*. Our analysis addresses the above four questions in the following manner:

When does the best interest of the patient principle come into play?

307. The best interest principle comes into play when the withdrawal or withholding of medical treatment is contemplated for an incompetent patient who is unable to make an informed decision for himself.

Who applies the best interest principle?

308. During the entire process as envisaged under the guidelines as laid down in ***Common Cause*** *(supra)*, there is a need to adhere to the best interest principle at every stage while determining whether withdrawal or withholding of medical treatment must be undertaken, by all stakeholders and decision-makers, including the medical boards, the patient's next of kin/next friend/guardian, and the courts (if involved).

Why is the best interest of the patient principle applied?

309. The answer to this question lies somewhere between the realms of a doctor's continuing duty to provide treatment and the lawful

discharge of that duty, once the threshold conditions/medical parameters under the guidelines as laid down in ***Common Cause*** *(supra)* are satisfied. In this context, a doctor's duty to continue treatment to a patient obliges until such treatment is capable of conferring some therapeutic benefit upon the patient. However, where the patient is diagnosed with a terminal illness or is in PVS, with no hope of recovery, and the continuation of treatment merely prolongs his biological existence without any therapeutic benefit, that duty no longer mandates continuing with the medical treatment. In determining whether or not such a stage has been reached, the best interests principle is to be applied.

What are the contours of the best interest principle?

310. Our analysis shows that the correct inquiry is not whether it is in the best interests of the patient that he should die, but rather whether it is in the best interests of the patient that his life should be prolonged by the continuance of such forms of medical treatment.

311. While answering this inquiry, the best interest principle cannot be construed as a narrow, rigid, formulaic and straight-jacketed single test. A true and holistic application of this principle would require the evaluation of all relevant circumstances and considerations, both medical and non-medical.

312. Further, at an initial and foundational level, the best interest of any patient would be anchored upon a strong presumption in favour of preserving his life. However, this presumption is not absolute, and

the same may be displaced where both medical and non-medical considerations warrant the discontinuation of a particular medical treatment.

313. The medical considerations may entail a determination of whether a particular treatment has ceased to serve any therapeutic purpose, i.e., becomes futile, merely prolongs the suffering without the hope of recovery or causes indignity to the life of the patient.

314. The non-medical considerations may entail a determination of what the patient would have wanted for himself had he possessed the decision making capacity. In this context, decision-makers must try to put themselves in the place of the individual patient and ask what his wishes and attitude to the treatment are or would be likely to be. They must not factor in their own wishes, feelings, beliefs, values etc.; and they must consult others who are looking after him or are interested in his well-being, in particular for their view of what the patient would have wanted. It is to be borne in mind that this does not entail the application of the caregiver's standard which is centred on what a reasonable person would do in such circumstances. Rather, it involves the application of the substituted judgment standard wherein the determination is based upon what decision the patient himself would have made had he possessed the competence to do so.

315. The best interests principle must incorporate a strong element of the non-medical considerations under the substituted judgment standard as aforesaid, requiring the decision-maker to consider, in

a patient-centric manner, what that patient would have wanted if he possessed the requisite capacity. However, this substituted judgment standard would not operate autonomously or in an overriding manner. The ultimate governing test or question would, nevertheless, be - what course of action serves the patient's best interest.

316. Lastly, after ascertaining both medical and non-medical considerations, the decision-makers must draw a balance sheet which would involve weighing the potential benefits of continued treatment against its burdens. The decision-makers must make entries of medical and non-medical considerations on such a balance sheet.

317. In facts of the present case, the patient's next of kin/next friend/guardian, the primary medical board and the secondary medical board respectively, after considering the medical as well as non-medical considerations, have reached the opinion that the CANH being administered to the applicant, should be discontinued as the continuation of the same is not in his best interests. In the given circumstances, they are of the view that nature should be allowed to take its own course.

318. In the present matter, the decision to withdraw or withhold medical treatment of the applicant could have been put into effect automatically upon the submission of the secondary medical board's opinion, since it was in concurrence with the primary medical board's opinion. Both the primary medical board and the

secondary medical board have unequivocally certified that the withdrawal of CANH from the applicant would be in his best interest. In other words, we would like to reiterate that if both the primary medical board and secondary medical board certify the withdrawal or withholding of medical treatment, there is no further requirement for Court intervention. However, given that this is the first case that has reached this Court wherein the Common Cause Guidelines are being applied in their full measure, we deemed it necessary to further delve and expound on issues relating to the legal framework surrounding the withdrawal and withholding of medical treatment.

(d) Palliative and EOL Care

319. Once a decision to withdraw or withhold medical treatment is taken in accordance with the guidelines as laid down in ***Common Cause*** *(supra)*, its implementation must be humane and reflective of a responsible and sensitive discharge of the doctor's continuing duty of care towards the patient. The withdrawal or withholding of treatment must not, in effect or execution, result in the abandonment of the patient. Rather, it must signify a transition from curative intervention to a carefully structured and medically supervised palliative and EOL care plan, directed towards the alleviation of pain and distress, management of symptoms, and preservation of the patient's dignity. The palliative and EOL care plan must ensure that a decision taken in the patient's best interests is translated into clinical practice in a manner that minimises suffering and upholds dignity.

320. In this regard, we strongly disapprove of the routine practice of "discharge against medical advice" (also known as "leaving against medical advice" or "discharge at own risk") which is misused in situations where medical treatment stands discontinued. Resorting to such a course of action in substitution of a structured palliative and end-of-life care plan, risks amounting to an abdication of medical responsibility and undermines the very rationale of treatment limitation, which is founded upon the patient's best interests. The choice to withdraw or withhold treatment does not entail a forfeiture of the patient's right to medically supervised care.

321. We deem it necessary to further clarify that it is legally permissible for hospitals to admit patients who are undergoing treatment in home settings, where a reassessment of the patient's best interests is sought. Healthcare institutions and practitioners ought not to hesitate in admitting such patients, as institutional admission facilitates compliance with the procedural safeguards recognised in law. Upon admission, the treating physician is authorised to initiate the structured evaluative process to determine whether the continuation, withholding, or withdrawal of treatment serves the patient's best interests. Such an approach furthers the patient's right to dignity, enables a legitimate re-determination of treatment goals, and ensures access to appropriate palliative and end-of-life care, in accordance with law.

(e) Streamlining of the Common Cause Guidelines

322. Further, in view of the practical uncertainty, difficulties, and dilemmas faced by all stakeholders, we have endeavoured to explain and streamline the Common Cause Guidelines so that the constitutional principles recognised by this Court in ***Common Cause 2018*** *(supra)* are translated into a workable, humane, and practically secure process. In essence, we have clarified that:

(i) The Constitution Bench consciously embedded multiple safeguarding checkpoints in the Guidelines to address the hesitation and apprehension amongst doctors in initiating the envisaged process;

(ii) The role of the patient's next of kin/next friend/guardian remains integral, as their written consent embodies, as far as possible, the patient's own wishes had he possessed decision-making capacity, without which consent the process may be stalled;

(iii) Where medical care is predominantly provided at home, the patient's next of kin/next friend/guardian may admit the patient to a hospital of their choice, or alternatively approach a hospital for the limited purpose of designating a primary treating physician, who shall thereafter initiate the process in accordance with the Common Cause Guidelines;

(iv) To prevent administrative delays in constituting the secondary medical board, CMOs of all concerned districts would be required to maintain a panel of qualified registered medical practitioners and nominate one, preferably within 48 hours of a hospital's request, on a case to case basis;

(v) Where the treating physician or hospital fails to commence the process despite satisfaction of the threshold conditions/medical parameters, the patient's next of kin/next friend/guardian may seek appropriate directions from the High Court under Article 226 of the Constitution of India; and

(vi) Once both the medical boards have concurred in their decision to withdraw or withhold medical treatment, such decision shall be implemented only after a reconsideration period of 30 days, during which an aggrieved person may approach the appropriate court of law, subject to establishing locus, for the purpose of challenging the concurring opinions of the medical boards. It is to be borne in mind that courts must exercise restraint and due caution in unsettling the process that has already culminated after a due and careful consideration of the patient's best interests.

(f) Need for a comprehensive statutory framework

323. The prolonged absence of a comprehensive legislation on end-of-life care has compelled this Court, time and again, to step in to fill the vacuum, out of constitutional necessity rather than institutional choice. While the guidelines as laid down in ***Common Cause*** *(supra)* have served as an important interim safeguard to protect the right to live and die with dignity, they were never intended to operate as a permanent substitute for legislation. Therefore, we urge the Union Government to consider enacting a comprehensive legislation on the subject in consonance with the vision of the Constitution Bench in ***Common Cause 2018*** *(supra)*. Such a legislation would provide

more clarity, coherence, and certainty to these pertinent, practical and emotionally charged issues.

II. **The Final Order**

324. In the facts and circumstances of the present case, we record our satisfaction that the twin legal requirements for the withdrawal and withholding of medical treatment have been unequivocally met. First, it is established that the CANH currently being administered to the applicant constitutes *"medical treatment"*. Secondly, it has been conclusively determined that the continued administration of the same is no longer in the *"best interests"* of the applicant. In light of the unanimous consensus arrived at by the parents/next of kin and the constituted medical boards respectively, we are of the opinion that the medical treatment ought not to be prolonged any further.

325. The right to die with dignity is inseparable from the right to receive quality palliative and EOL care. It is imperative to ensure that the withdrawal process is not marred by pain, agony, or suffering. Therefore, we deem it necessary to issue certain directions to the respondent no. 2/AIIMS as regards the further steps to be undertaken for giving effect to the withdrawal or withholding of the applicant's medical treatment.

326. Further, as discussed above, the nomination of a registered medical practitioner by the CMO may also cause administrative delays in the process of constitution of the secondary medical board, largely

owing to the failure of the CMOs to make such nominations in a timely manner. Therefore, we are also of the opinion that certain directions are required to be made to the CMOs of all concerned districts across the country for the purpose of maintaining a panel of registered medical practitioners.

327. For the reasons stated hereinabove and in the concurring opinion, we hereby dispose of the present MA with the following directions:

(a) The medical treatment, including CANH, being administered to the applicant shall be withdrawn and/or withheld.

(b) In the peculiar facts and circumstances of the present matter, the reconsideration period of 30 days stands waived, as all stakeholders are unanimous in their opinion that the medical treatment being administered to the applicant be withdrawn and/or withheld.

(c) The respondent no. 2/AIIMS shall grant admission to the applicant in its Palliative Care department so that the withdrawal and/or withholding of the applicant's medical treatment, including CANH, can be given effect to. For this purpose, respondent no. 2/AIIMS shall provide all necessary facilities for shifting the applicant from his residence to the said Palliative Care department.

(d) The respondent no. 2/AIIMS shall ensure that such withdrawal and/or withholding is carried out through a robust palliative

and EOL care plan, which is specifically tailored to manage symptoms without causing any discomfort to the applicant, and ensuring that his dignity is preserved to the highest degree.

(e) The High Courts of all States shall issue appropriate directions to all Judicial Magistrates of First Class (JMFC) within their jurisdiction to receive intimation from the hospital, in accordance with the guidelines as laid down in ***Common Cause*** *(supra)*, in the event the primary medical board and secondary medical board are unanimous in their decision to withdraw and/or withhold the medical treatment of any patient.

(f) The respondent no.1/Union of India in coordination with the respective Secretaries of Health & Family Welfare of all States/UTs, shall ensure that the CMOs of all concerned districts across the country, forthwith prepare and maintain a panel consisting of registered medical practitioners possessing qualifications in accordance with the guidelines as laid down in ***Common Cause*** *(supra)*, for the purpose of nomination to the secondary medical board. The panel so prepared shall be periodically reviewed and updated by the CMOs at regular intervals not exceeding twelve months, so as to ensure availability, suitability, and continued compliance with the requirements under the guidelines as laid down in ***Common Cause*** *(supra)*. It shall be the duty of the Secretaries of Health & Family Welfare of each State/UT to make sure that such periodic review and updation at regular intervals is undertaken

by the CMOs of all districts falling within their respective State/UT.

328. The Registry shall notify this matter once again before this very bench after a period of 1 month for the purpose of reporting compliance with the directions (a) to (e) as above-mentioned.

329. For the purpose of reporting compliance with direction (f) as above-mentioned, the Registry shall notify this matter once again before this very bench sometime in August 2026.

330. Throughout the adjudication of this matter, we have been gripped by profound sadness. The issues in this matter have once again brought to the fore the fragility and transient nature of the life we live, and how swiftly the tide can turn for the worse. For the past thirteen years, the applicant has lived a life defined by pain and suffering. A suffering made all the more cruel by the fact that, unlike most of us, he was stripped of the ability to even give voice to his anguish. However, while this case highlights how unforgiving life can be, it is easy to lose sight of another vital fact. We note with immense respect that the applicant's parents and siblings have stood as unyielding pillars of support. They have exhausted every effort to care for him and continue to do so with unwavering dedication. We can only place on record our deepest appreciation for their boundless love, endurance, and kindness in the face of such adversity.

331. Among the manifold truths about human existence that this case reveals, the most enduring is the resilience of love. In our considered opinion, the greatest tragedy in life is not death, but abandonment. Despite the catastrophic tragedy that struck the applicant, his family never left his side. He has been cared for, protected, and cherished at every moment. To us, this unwavering vigil is a testament to the true meaning of love. To love someone is to care for them not just in times of joy, but in their saddest and darkest hours. It is to care for them even when the horizon is devoid of hope. It is to stand by them as they prepare to cross the threshold into the beyond. Ultimately, to love is nothing but to care deeply, softly, and endlessly.

332. Our decision today does not neatly fit within logic and reason alone. It sits in a space between love, loss, medicine and mercy. This decision is not about choosing death, but is rather one of not artificially prolonging life. It is the decision to withdraw life-sustaining treatment when that treatment no longer heals, restores, or meaningfully improves life. It is allowing nature to take its course when medicine can only delay the inevitable because survival is not always the same as living.

333. To Harish's family, we want to acknowledge the deep emotional weight this decision carries. This decision can feel like an act of surrender, but we believe it is, in truth, an act of profound compassion and courage. You are not giving up on your son. You are allowing him to leave with dignity. It reflects the depth of your selfless love and devotion towards him.

334. We direct the Registry to send one copy each of our judgments to all the High Courts.

..... J.

(J.B. Pardiwala)

..... J.

(K.V. Viswanathan)

New Delhi;

11th March, 2026.

REPORTABLE

IN THE SUPREME COURT OF INDIA
EXTRAORDINARY APPELLATE JURISDICTION

MISCELLANEOUS APPLICATION NO. 2238 of 2025

IN

SPECIAL LEAVE PETITION (C) NO. 18225 of 2024

Harish Rana … Petitioner/ Applicant

Versus

Union of India & Ors. … Respondents

J U D G M E N T

K. V. Viswanathan, J.

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"The best interest of the patient is the only interest to be considered." ***Dr. William J.Mayo***

1. I have had the benefit of reading the erudite judgment of my esteemed Brother J.B. Pardiwala, J. While concurring with the said judgment, considering the importance of the issue involved, I am penning my thoughts and views independently.

BRIEF FACTS: -

2. A and N, deponents to this Application are parents of the petitioner-Harish Rana ('Harish' for short). Harish was pursuing his B.Tech from Punjab University when he, unfortunately, fell down from the fourth floor of his paying guest accommodation on 20.08.2013. He is in a permanent vegetative state and has been suffering from quadriplegia for the last more than 12 years. In these proceedings, primarily the relief prayed for, as set out in the application read with the written submissions, is as follows: -

> "It is respectfully prayed that in view of the settled legal position laid down by this Hon'ble Court in *Common Cause v. Union of India* (2018) as modified in 2023, the

> unanimous medical opinion of both the Primary and Secondary Medical Boards confirming the Petitioner's irreversible permanent vegetative state, the absence of any benefit from the continued provision of clinically assisted nutrition and hydration, and the considered, consistent and voluntary wishes of the Petitioner's parents and siblings acting in his best interest, this Hon'ble Court may be pleased to permit the withdrawal of clinically assisted nutrition and hydration to the Petitioner, in accordance with an appropriate palliative care protocol and under medical supervision at the Institute of Human Behaviour and Allied Sciences (IHBAS), New Delhi, (Govt. of NCT of Delhi)."

Certain other reliefs consequential to the direction in ***Common Cause vs. Union of India***[1] have also been sought.

3. After the unfortunate fall, Harish was treated at the Postgraduate Institute of Medical Education and Research, Chandigarh, from 21st to 27th August, 2013, where he was managed conservatively, provided respiratory support and underwent a tracheostomy (a surgically created hole through the front of the neck and into the windpipe, through which a tube is placed to provide a direct airway to the windpipe). He was advised feeding through a Ryle's tube (nasogastric tube). Later, he received treatment at the Jai Prakash

[1] (2023) 14 SCC 131

Narayan Trauma Centre at the All India Institute of Medical Sciences, New Delhi, as well as at the Dr. Ram Manohar Lohia Hospital, New Delhi and Safdarjung Hospital, New Delhi between 2014 and 2017. For better nutrition, a Percutaneous Endoscopic Gastrostomy tube (for short the "PEG tube") was also inserted.

4. It is undisputed that the petitioner suffered diffuse axonal injury resulting in quadriplegia and is in a permanent vegetative state with 100% permanent disability with complete sensorimotor dysfunction. The Application states that Harish's condition is irreversible and incurable.

5. Harish has been entirely bedridden for the past over 12 years and has undergone numerous hospitalizations including the last one being in May, 2025. He is unable to carry out any bodily functions on his own, is catheterized and diapered.

6. Harish is artificially fed through a PEG tube, which is being replaced at a hospital every two months. He suffers from bedsores which bleed occasionally. Harish's hands

make reflexive thrashing movements and, hence, his hands have to be bound so that the PEG tube is not involuntarily removed. He receives multiple medications, including anti-seizure drugs, on a regular basis. Harish has no awareness of his surroundings.

WRIT PETITION BEFORE THE HIGH COURT: -

7. On 03.04.2024, on behalf of Harish, a Writ Petition was filed before the High Court of Delhi, in substance, seeking a direction to constitute a Medical Board to examine whether life support/life-sustaining treatment in the form of PEG tube could be withdrawn. The prayer was based on the judgment of ***Common Cause*** (*supra*), as modified by the judgment of this Court dated 24.01.2023 in Miscellaneous Application No.1699 of 2019 in W.P (C) No. 215 of 2005.

8. On 02.07.2024, a learned Single Judge of the High Court declined to refer Harish to the Medical Board holding that the petitioner is not being kept alive mechanically and is able to sustain himself without any extra external aid. The High

Court held that active euthanasia was legally impermissible and as such the High Court observed that no directions could be given.

PROCEEDINGS BEFORE THIS COURT ON SPECIAL LEAVE: -

9. Aggrieved, a Special Leave Petition was filed before this Court. At that stage, this Court, by an order of 20.08.2024, requested the Union of India to explore alternative solutions to provide adequate care to the petitioner. A Status Report was filed. Taking on record the Status Report, this Court disposed of the Special Leave Petition on 08.11.2024 in the following terms:-

> "1. A petition under Article 226 of the Constitution was instituted before the Delhi High Court seeking a direction to constitute a Medical Board to examine the health condition of the petitioner who is in a permanent vegetative state and to facilitate the administration of passive euthanasia. The petitioner is stated to suffer from 100% disability with Quadriplegia.
>
> 2. On 20 August 2024, while issuing notice to the Union of India, this Court had requested Ms Aishwarya Bhati, Additional Solicitor General to explore alternative solutions for providing adequate care to the petitioner.

3. A status report has been submitted before this Court by the Under Secretary to the Government of India in the Ministry of Health and Family Welfare. Anneuxre R-3 of the status report contains a report of the Central Government in the matter. The solutions which have been provided in the report are in the following terms:

> "Consequent upon all the efforts made by the Central Government in compliance with the instructions given by the Hon'ble Supreme Court of India on 20 August, 2024, the following viable solutions have emerged for consideration of the Hon'ble Supreme Court of India:
>
> (i) Home care of Shri Harish Rana with assistance from the Government of Uttar Pradesh as under:
>
> a. Regular Physiotherapist's visit
> b. Regular Dietician's visit
> c. Medical Officer on call
> d. Nursing care provision at home
> e. Availability of all required medicines and consumables free of cost.
>
> (ii) If home care is not feasible, shifting of Shri Harish Rana to District Hospital, Noida, Sector-39 for ensuring availability of proper medical care considering his health condition.
>
> (iii) Support from NGOs, if deemed fit, may also be considered."

4. Mr Manish Jain, counsel appearing on behalf of the petitioner, who is represented by his mother in these proceedings, states that the matter has been resolved satisfactorily and both the parents are agreeable to accepting the course as suggested in the above extracts.

5. The Special Leave Petition is accordingly disposed of taking the arrangement on the record. **However, liberty is granted to either of the parents of the petitioner to move the Court in future should it become necessary to obtain further directions**."

EVENTS SUBSEQUENT TO THIS COURT'S ORDER OF 08.11.2024: -

10. Pursuant to the order of this Court dated 08.11.2024, Harish was under home care with assistance. Harish was hospitalized from 17.05.2025 to 24.05.2025 at the District Hospital, Ghaziabad for treatment of coughing and bedsores. During the said period, another tracheostomy was performed. The Application avers that at that point considerable distress was caused to the deponent-parents and it was clear that it was futile to prolong medical intervention. The present Application, for the relief set out above, was filed on 21.10.2025, pursuant to the liberty given in the order dated 08.11.2024.

11. It is averred in the Application that ***Common Cause*** (*supra*) recognizes that life-sustaining treatment can be withdrawn in circumstances where there is no hope of cure or recovery. It is averred that the High Court of Delhi erred in holding that Harish is able to sustain himself without any external aid. It is submitted that Harish requires Clinically

Assisted Nutrition and Hydration (for short "CANH") in the form of a PEG tube, which constitutes external aid. It is averred that Harish is in a permanent vegetative state, which is irreversible and incurable, and is receiving life-sustaining treatment through the PEG tube. It was prayed that determination must be made in accordance with the ***Common Cause*** (*supra*) guidelines to decide whether the continued provision of CANH is in the petitioner's best interest. It is stated in the Application that Harish's continued existence in his present state is a violation of his fundamental right to dignity, protected under Article 21 of the Constitution of India.

12. It is made clear that the Application does not pray assisted dying, namely "active euthanasia". The scope of the Application was confined to seeking a referral to the Primary Medical Board in accordance with the procedure laid down in ***Common Cause*** (*supra*). It was averred that the purpose of such referral was to obtain an expert medical opinion on the advisability of continuing CANH, which constitutes a form

of life sustaining treatment. It was stated that such a determination was imperative to safeguard the dignity of the petitioner, which is an integral facet of the right to life under Article 21 of the Constitution of India. It was submitted in the Application that Harish receives artificial nutrition and hydration through a PEG tube and that a PEG tube is a form of a mechanical life support – CANH. It is averred in the application that it is widely recognized, both medically and legally, as a form of life-sustaining treatment. It is also submitted that in ***Common Cause*** (*supra*), the Constitution Bench has recognized that feeding tubes constitute a form of life support.

13. Reference was made to the 241st Report of the Law Commission of India on passive euthanasia which recognized artificial feeding as a means of life support. Reference was also made to the guidance for decision making on CANH issued by the Royal College of Physicians in the United Kingdom to reinforce the submission.

14. It is submitted that the High Court erred in reading the ***Common Cause*** (*supra*) to hold that withdrawal of life sustaining treatment applied only to terminally ill patients. Reference was made to ***Common Cause*** (*supra*) to contend that the principle in ***Common Cause*** (*supra*) applies to individuals, like Harish, who are in a permanent vegetative state. Reference was made to the guidelines in ***Common Cause*** (*supra*), as modified in 2023, and the procedure laid down for withholding and withdrawal of life-sustaining treatment. Grievance was made that Primary and Secondary Medical Boards in accordance with ***Common Cause*** (*supra*) guidelines have not been implemented across most States. The requirement to nominate a medical practitioner to the Secondary Medical Boards by the Chief Medical Officer has not been complied with. It is averred that the ***Common Cause*** (*supra*) guidelines required hospitals to intimate the Judicial Magistrate of the First Class regarding the withholding and withdrawal of the life-sustaining treatment but the Judicial Magistrates are not aware since no directions

have been received from the respective High Courts. It is in this background that primarily a prayer for referring the petitioner for a Primary Medical Board was made.

SALIENT FEATURES OF COMMON CAUSE (2018) 5 SCC 1 :-

15. In ***Common Cause*** (*supra*), the Constitution Bench dealt with two categories of cases – i) cases where an advance medical directive is left by the patient; and ii) cases where there is no advance directive.

16. Admittedly, the case of Harish is a case where there is no advance directive. It will be useful to extract the modified guidelines laid down in ***Common Cause*** (*supra*) with regard to the category of cases where there is no advance directive:-

Cases where there is No Advance Directive	
Para 199.1	In cases where the patient is terminally ill and undergoing prolonged treatment in respect of ailment which is incurable or where there is no hope of being cured, the physician may inform the hospital, which, in turn, shall constitute a *Primary* Medical Board in the manner indicated earlier. The *Primary* Medical Board shall discuss with the family physician, *if any*, and the *patient's next of kin/next friend/guardian* and record the

	minutes of the discussion in writing. During the discussion, the *patient's next of kin/next friend/guardian* shall be apprised of the pros and cons of withdrawal or refusal of further medical treatment to the patient and if they give consent in writing, then the *Primary* Medical Board may certify the course of action to be taken *preferably within 48 hours of the case being referred to it.* Their decision will be regarded as a preliminary opinion.
Para 199.2	In the event the Primary Medical Board certifies the option of withdrawal or refusal of further medical treatment, the hospital shall then constitute a Secondary Medical Board comprising in the manner indicated hereinbefore. The Secondary Medical Board shall visit the hospital for physical examination of the patient and, after studying the medical papers, may concur with the opinion of the Primary Medical Board. In that event, intimation shall be given by the hospital to the JMFC and the next of kin/next friend/guardian of the patient preferably within 48 hours of the case being referred to it.

CONSTITUENTS OF THE PRIMARY MEDICAL BOARD AND SECONDARY MEDICAL BOARD: -

17. It is essential to set out the constituents of the Primary and Secondary Medical Board. Para 198.4.4 and 198.4.5 of the ***Common Cause*** (*supra*), as modified, read as under:-

Para 198.4.4	The hospital where the executor has been admitted for medical treatment shall then constitute a *Primary* Medical Board consisting of the treating *physician and at least two subject experts of the specialty concerned with at least five years' experience,* who, in turn, shall visit the patient in the presence of his guardian/close relative and form an opinion *preferably within 48 hours of the case being referred to it* whether to certify or not to certify carrying out the instructions of withdrawal or refusal of further medical treatment. This decision shall be regarded as a preliminary opinion.
Para 198.4.5	In the event the *Primary* Medical Board certifies that the instructions contained in the Advance Directive ought to be carried out, the hospital shall then immediately constitute a *Secondary* Medical Board comprising *one registered medical practitioner nominated by the Chief Medical Officer of the district and at least two subject experts with at least five years' experience of the specialty concerned who were not part of the Primary Medical Board*. They shall visit the hospital where the patient is admitted and if they concur with the initial decision of the *Primary* Medical Board of the hospital, they may endorse the certificate to carry out the instructions given in the Advance Directive. *The Secondary Medical Board shall provide its opinion preferably within 48 hours of the case being referred to it.*

18. The case of Harish had certain peculiarities. As set out earlier, since 2013 when Harish had the fall from the fourth floor, he has been treated at several hospitals. He was first

treated at Postgraduate Institute of Medical Education and Research, Chandigarh and then at the All India Institute of Medical Sciences, Dr. Ram Manohar Lohia Hospital and Safdarjung Hospital, all at New Delhi, between 2014 and 2017. Apart from this, the petitioner over the past 12 years has indisputably undergone numerous hospitalisations and the last one was in May, 2025.

19. Pursuant to the Status Report of the Union of India and the order of this Court dated 08.11.2024, Harish was under home care. Between 17.05.2025 to 24.05.2025, the petitioner was hospitalized at District Hospital, Ghaziabad for palliative care, and treatment for cough and bedsores. Thereafter, under the suggestions made in the Status Report, the homecare of the petitioner continued. A perusal of the Status Report and the suggestions indicate that the homecare offered to the petitioner which the petitioner accepted with support of physiotherapist, dietician, medical officer on call, nursing care at home and supply of all medicines, virtually treated the home as an extension of the hospital.

CONSTITUTION OF THE PRIMARY AND SECONDARY MEDICAL BOARD: -

20. It was in this scenario that when the matter came up, by order dated 26.11.2025, after recording the fact that Harish's condition has gone from bad to worse and that he is in a persistent vegetative state suffering from 100% disability with quadriplegia and not responding to any treatment and is being artificially kept alive, this Court directed the constitution of a Primary Medical Board of doctors in terms of ***Common Cause*** (*supra*), to give a report as to whether the life sustaining treatment can be withdrawn. Pursuant to this order, the Primary Medical Board submitted the following report:-

> "This is to say that after consulting with CMO Ghaziabad we have visited residential place of Mr. Harish Rana S/O Mr. A R/O- AM-1314, Raj Empire, Rajnagar Extention, Ghaziabad for evaluation of his health condition. The team included a neuro surgeon, a neurologist, a plastic surgeon and a critical care expert. Attendants Mr. AR (brother) and Ms. BR (sister) were present during evaluation. Harish Rana suffered injuries about 13yrs back since that time he is under medical care under many centers. At present Patient was lying in bed with tracheostomy tube for respiration and gastrostomy for feeding. Patient was

opening eyes spontaneously. His breathing was spontaneous with treacheostomy tube. He was emasciated and contractures were present in both lower limb and upper limb at shoulder, elbow, wrist, fingers, knee, ankle and toes. His pupils were normal in size but sluggish in reaction with no movement restriction. No facial asymmetry present. Gag reflex present. He was having spasticity all over both upper limb and lower limb with deep tendon exaggerated at bicep, triceps, supinator, knee, ankle. Sensory and cerebellar examination could not be accurately assessed due to his state. He had intact brainstem function **but due to his vegetative state he requires external support for his feeding, bladder bowel and back. He needs constant physiotherapy and tracheostomy tube care. The chances of his recovery from this state is negligible.**

Sd/-	Sd/-	Sd/-	Sd/-
Neurologist	Plastic Surgeon	Anaesthesiologist	Neuro Surgeon"

[Emphasis supplied]

21. When the matter came up for hearing on 11.12.2025, after noticing report of the Primary Medical Board, this Court in accordance with the judgment in ***Common Cause*** (*supra*), directed that a Secondary Medical Board be constituted for the purpose of examination of Harish. In this regard, a request was made to the Director, All India Institute of Medical Sciences, New Delhi, to constitute a Secondary

Medical Board, as referred to above, and report by 17.12.2025.

22. At the hearing on 18.12.2025, after directing the report of the Secondary Medical Board which had arrived since then to be given to the counsel for the parties, this Court expressed a desire that the counsel for the parties speak to the parents and other family members of Harish and give a report. This Court also recorded that the Court would like to speak to the parents personally.

23. In the Secondary Medical Report, the following conclusions were recorded:-

> "Based on the history and examination findings, the medical board is of the following opinion: -
>
> **"a. Mr. Harish Rana has non-progressive, irreversible brain damage following severe traumatic brain injury with diffuse axonal injury. He fulfills the criteria of permanent vegetative state (PVS) and has been in this state for the past 13 years.**
>
> **b. The continued administration of clinically assisted nutrition and hydration is required for the sustenance of his survival. However, it may not aid in improving his medical condition or repairing his underlying brain damage."**
>
> [Emphasis supplied]

24. Pursuant to the order dated 18.12.2025, Ms. Aishwarya Bhati, learned Additional Solicitor General, Ms. Rashmi Nandakumar, learned counsel for Harish, met with the parents, brother, sister and brother-in-law of Harish. They submitted a Report. The relevant parts of the Report which are comprehensive is set out hereinbelow: -

> "3. At the beginning of our interaction, we requested the parents to share their thoughts, wishes, and concerns in their own words. Mr. A, the father of Mr. Harish Rana, told us that the family has been caring for their son continuously for more than thirteen years and that they have done everything within their human capacity during this period. He said that their son no longer has a voice of his own, and therefore they feel it is their moral responsibility to speak for him. He also expressed gratitude that their concerns have been heard by this Hon'ble Court.
>
> 4. He told us that his son:
>
> - Cannot speak, hear, see, recognise anyone, or eat on his own;
> - Is entirely dependent on artificial life support, including a feeding tube.
>
> 5. He shared his deep worry that both parents are now ageing, and asked, with visible concern, who would take care of Mr. Harish if anything were to happen to either of them. Mr. A expressed that their family's earnest request is that the feeding tube / life sustaining medical support may be withdrawn under proper medical supervision.

6. Mr. A also shared that while the Government authorities have extended assistance over the years, the family has continuously faced practical difficulties in day-to-day medical care, availability of skilled personnel, and emergency medical support, despite their best efforts.

7. Mrs. N, the mother of Mr. Harish Rana, told us that they have tried everything within their means for the last many years in the hope that their son may recover, but there has been no improvement. She stated that her son has not responded to touch or affection for the past 13 years.

8. She expressed that watching her son in this condition day and night has become extremely painful, and that his continued existence in the present condition causes him suffering which they are unable to alleviate. **She was clear in telling us that the decision being expressed is not out of despair or pressure, but after prolonged thought, years of care, and acceptance that there is no medical hope of recovery of their son.**

9. Upon being specifically asked whether she would feel regret or emotional distress if her son were to pass away, she replied that the greater distress is watching him suffer continuously in his present state, and that she believes the family has done everything possible.

Views of the Siblings of Mr. Harish Rana

10. The brother of Mr. Harish Rana - Mr. AR, told us that the family has given more than their full capacity over the last 13 years, emotionally, physically and financially. He shared that after exhaustive efforts and consultations, the family has reached this decision with great difficulty, believing that continued medical intervention no longer

serves any meaningful purpose for his brother and only prolongs his agony.

11. Ms. BP, the sister of Mr. Harish Rana, told us that at the time of the incident they were children, and today she herself is a mother. **She shared that the family has lived through years of hardship and that the decision being taken is, in their belief, in the dignity and best interests of their brother.**

Observations

15. It is humbly submitted that throughout the interaction:

- The parents and family members appeared fully conscious, coherent, and consistent in their statements;
- Their views were expressed calmly, repeatedly, and without any sign of coercion, confusion, or external pressure;
- The decision articulated by them appears to be the result of long contemplation over many years, and not a momentary or impulsive reaction."

[Emphasis supplied]

25. Further, as has been set out in the written submissions of Ms. Aishwarya Bhati, learned Additional Solicitor General, a video conference was conducted on 08.01.2026 and the meeting apart from the learned ASG was attended by representatives of the Ministry of Health and Family Welfare, the doctors who constituted the Secondary Medical Board

Prof. (Dr.) DV, Prof. (Dr.) NG, along with the concerned officials. During the course of the meeting, the following points were deliberated upon:-

> "**(a) <u>Present Medical Status of the Petitioner as per Clinical Findings</u>**
>
> (i) The petitioner has been in an **irreversible permanent vegetative** state for the last 13 years;
>
> (ii) There is no chance of improvement or repair of the medical condition, rendering continued treatment futile;
>
> (iii) There exists a clear, unequivocal and well-considered view of the parents of the petitioner, who are also the primary caregivers, arrived at after informed interaction and deliberation."

26. In the order dated 13.01.2026, after interacting with the parents and younger brother of Harish, the following observations were recorded :-

> "6. All the three, i.e., the father, mother and younger brother, in one voice and with lot of pain in their hearts, made a fervent appeal before us to take necessary steps to ensure that Harish does not suffer any more. What they tried to convey, in their own way, was that the medical treatment imparted over a period of almost 12 years be discontinued and nature be allowed to take its own course. According to them if the medical treatment is not making any difference, then there is no point in continuing with such medical treatment and making Harish suffer for no good reason.

7. They believe that Harish is suffering like anything, and he should be relieved of all further pain and suffering.

8. They may not be aware of the legal nuances involved in this litigation. However, they are very clear that in view of the two reports filed by the Primary Board and the Secondary Board, respectively, there is no sign, or rather no hope, for Harish to recover.

9. Ms. Bhati submitted that she had a talk with the team of doctors, i.e., the members of the Primary Board as well as the members of the Secondary Board, and the doctors are of the opinion that the medical treatment should be discontinued as the continuation of the same is not in the best interest of Harish Rana, and that in the given circumstances, nature should be allowed to take its own course. The doctors are also of the opinion that Harish would remain in this permanent vegetative state (PVS) for years to come, with the tubes inserted all over his body. However, he would never be able to recover and live a normal life.

10. In such circumstances, referred to above, we should now hear the matter further in the Court. We request the learned counsel appearing for both parties to assist us on all issues.

11. Post the matter on Thursday, i.e., 15.1.2026, as the first item on the Board."

QUESTION FOR CONSIDERATION:

27. In view of the unanimous opinion of the Primary and Secondary Medical Boards confirming Harish's irreversible

permanent vegetative state; the absence of any benefit from continued provision of CANH and keeping in mind the non-medical considerations and after consultations with the family members, what are the consequential directions that deserve to be made? In answering this question, several incidental questions do arise which have been discussed in the course of the judgment.

28. Heard Ms. Rashmi Nandakumar and Ms. Dhvani Mehta, ably assisted by Ms. Shivani Mody, Ms. Anindita Mitra, Ms. Yashmita Pandey, Mr. Manish Jain, Mr. Vikash Kumar Verma and Mr. Jugal Kishore Gupta, learned counsels for the petitioner. Ms. Rashmi Nandakumar and her team, while reiterating the averments in the application, have very ably presented the case for the petitioner and filed detailed written submissions covering all aspects and have referred to a large number of judgments, including judgments from other countries.

29. Equally, Ms. Aishwarya Bhati, learned Additional Solicitor General, conducted the case in a non-adversarial

manner keeping in line with the highest traditions of the office of the Additional Solicitor General. She was ably assisted by Ms. Sushma Verma, Ms. Shreya Jain, Ms. Shivika Mehra, Mr. B.L. Narasamma Shivani, Mr. Arun Kanwa, Mr. Sudarshan Lamba and Mr. Amrish Kumar, learned counsels for the respondent.

ANALYSIS AND CONCLUSION:

Difference between "Active and Passive Euthanasia"

30. ***Common Cause*** (*supra*) has clearly set out that active euthanasia also known as "positive euthanasia" or "aggressive euthanasia" is a type of euthanasia that entails the positive act causing intentional death of a person by direct intervention. The present case is not of this category.

31. Passive euthanasia also known as "negative euthanasia" or "non-aggressive euthanasia" entails withdrawing of life support measures or withholding of medical treatment for continuance of life. ***Common Cause*** (*supra*) relying on

Vacco vs. Quill[2] observed that when the death of a patient occurs due to removal of life-supporting measures, the patient dies due to an underlying fatal disease without any intervening act on the part of the doctor or medical practitioner.

32. Active euthanasia would be illegal unless there is valid legislation permitting it. [Dipak Misra, CJ in ***Common Cause*** (*supra*)]

33. Further, in ***Common Cause*** (*supra*), it was set out relying on ***Smt. Gian Kaur vs. State of Punjab***[3] that the word "life" under Article 21 has to be construed as "life with human dignity" and that it takes within its ambit the "right to die with dignity" being part of the "right to live with dignity". It was also observed that the "right to live with human dignity" would mean existence of such a right up to the end of natural life which would include the right to live a dignified life up to the point of death including the dignified

[2] 138 L.Ed. 2d 834
[3] (1996) 2 SCC 648

procedure of death. This Court in ***Common Cause*** (*supra*) observed that the sequitur of this exposition was that there was little doubt that a dying man who is terminally ill or in a persistent vegetative state can make a choice to accelerate the process of natural death as being a facet of Article 21 of the Constitution of India. This Court further observed that if that choice is guaranteed as being part of Article 21, there was no necessity of any legislation for effectuating that fundamental right which was his natural human right.

34. Further, this Court in ***Common Cause*** (*supra*), reinforcing the aspect of dignity as an inseparable part of the right to life which engulfs the dignified process of dying, observed as follows:-

> "**178.** It is to be borne in mind that passive euthanasia fundamentally connotes absence of any overt act either by the patient or by the doctors. It also does not involve any kind of overt act on the part of the family members. It is avoidance of unnecessary intrusion in the physical frame of a person, for the inaction is meant for smooth exit from life. It is paramount for an individual to protect his dignity as an inseparable part of the right to life which engulfs the

dignified process of dying sans pain, sans suffering and, most importantly, sans indignity."

ADVANCE DIRECTIVE AND CASES WITH NO ADVANCE DIRECTIVE:-

35. This Court in ***Common Cause*** (*supra*) dealt with cases where patients had made an advance medical directive and cases where there was no advance medical directive. The present is a case where there is no advance medical directive. Elaborate procedures were laid down, the essential parts of which have been tabulated in the earlier part of this judgment. Para 198-199 of ***Common Cause*** (*supra*) which are crucial are set out herein below: -

> "**198.** In our considered opinion, Advance Medical Directive would serve as a fruitful means to facilitate the fructification of the sacrosanct right to life with dignity. The said directive, we think, will dispel many a doubt at the relevant time of need during the course of treatment of the patient. That apart, it will strengthen the mind of the treating doctors as they will be in a position to ensure, after being satisfied, that they are acting in a lawful manner. We may hasten to add that Advance Medical Directive cannot operate in abstraction. There has to be safeguards… …"

Safeguards and directions with regard to 1) Who can execute the Advance Directive and how? 2) What should it contain? 3) Manner of recording and preservation; 4) Persons who can give effect to? 5) Position when permission is refused by the Medical Board; and 6) When Revocable and inapplicable were all provided for.

> **"199. It is necessary to make it clear that there will be cases where there is no Advance Directive. The said class of persons cannot be alienated. In cases where there is no Advance Directive, the procedure and safeguards are to be same as applied to cases where Advance Directives are in existence and in addition there to, the following procedure shall be followed..."**
>
> [Emphasis supplied]

The procedure set out has already been extracted hereinabove.

ESSENTIAL PREREQUISITES FOR CONSTITUTION OF THE PRIMARY MEDICAL BOARD AND CONSEQUENTLY THE SECONDARY MEDICAL BOARD:-

36. The High Court, while dismissing the writ petition, clearly erred in holding that Harish was not terminally ill and hence his case was not covered by the four corners of the ***Common Cause (supra)*** judgment. Harish has been in a vegetative state for the last more than 12 years and clinically assisted nutrition and hydration is required for the

sustenance of his survival. Even the said life support/life-sustaining treatment would not aid in improving his medical condition. This aspect now stands confirmed by the opinion of both the Medical Boards.

37. Even though the case of Harish is a case of no advance medical directive, however, while considering the correctness of the High Court finding about the necessity of the patient being terminally ill, it will be useful to refer to the relevant paragraphs from ***Common Cause (supra)*** which is said in the context of persons with advance medical directive. Para 198.4.2 and 201.10 of ***Common Cause (supra)*** read as under:-

> ***"198.4.2.*** The instructions in the document must be given due weight by the doctors. However, it should be given effect to only after being fully satisfied that the executor is **terminally ill and is undergoing prolonged treatment or is surviving on life support and that the illness of the executor is incurable or there is no hope of him/her being cured.**
>
> **202.10.** It has to be stated without any trace of doubt that the right to live with dignity also includes the smoothening of the process of dying in case of a **terminally-ill patient or a person in PVS with no hope of recovery."**
>
> [Emphasis supplied]

38. Ms. Rashmi Nandakumar learned Counsel also drew our attention to Para 197 where this Court observed as under: -

> "**197.** .... The directions and guidelines to be given in this judgment would be comprehensive and would also cover the situation dealt with in Aruna Shanbaug case."

39. Learned Counsel contended that ***Aruna Ramachandra Shanbaug*** v. ***Union of India***[4], did not concern a terminally ill person but an individual in a permanent vegetative state which is the same condition Harish is in. The direction in ***Aruna Ramachandra Shanbaug (supra)*** in not granting relief to discontinue life support was not on the ground that Aruna Ramachandra Shanbaug was not terminally ill. In fact, a reading of para 17 read with para 124 of the judgment reveals that this Court considered KEM Hospital staff as the next friend and not Ms. P, who had moved the petition. According to the learned counsel, but for the issue of locus standi, ***Aruna Shanbaug (supra)*** was a case where the patient was in a permanent vegetative state, and would have

[4] (2011) 4 SCC 454

qualified the pre-requisites for constitution of Medical Boards.

40. Hence, the conclusion in para 199.1 and 199.2 of ***Common Cause (supra)*** read in the entire context of the judgment in ***Common Cause (supra)*** would indicate that for constitution of Primary Medical Board and consequently Secondary Medical Board, the patient need not necessarily be terminally ill. If the patient is in a permanent vegetative state or in any other like condition and is undergoing prolonged treatment in respect of ailment which is incurable or where there is no hope of being cured, the essential pre-requisites would be satisfied.

41. On reference to the Primary Medical Board, the Primary Medical Board shall discuss with the family physician, if any, and the patient's next of kin/ next friend/guardian and record the minutes of the discussion in writing. During the discussion, patient's next of kin/ next friend/guardian shall be apprised of the – i) pros and cons of <u>withdrawal or refusal of further medical treatment</u> to the patient and, ii) if they give

consent in writing, the Primary Medical Board may certify the course of action to be taken preferably within 48 hours of the case being referred to it.

42. ***Common Cause*** (*supra*) read with the modification order dated 24.01.2023, further holds that in the event the Primary Medical Board certifies the option of withdrawal or refusal of further medical treatment, the hospital shall then constitute a Secondary Medical Board. The Secondary Medical Board should visit the hospital for physical examination of the patient and after studying the medical papers may concur with the opinion of the Primary Medical Board. In that event, intimation shall be given by the hospital to the Judicial Magistrate First Class and the next of kin/ next friend/guard of the patient preferably within 48 hours of case being referred to it. In the case of Harish, the Primary and the Secondary Medical Board have concurred with each other.

43. Separate procedure has been set out where the Primary Medical Board does not take a decision to the effect of

withdrawing of medical treatment. That aspect does not arise herein.

44. The High Court erred in rejecting the case of Harish on the ground that he was not terminally ill without considering the alternative criterion, which he clearly fulfilled.

Clinically Assisted Nutrition and Hydration (CANH) – Does it qualify as medical treatment?

45. ***Common Cause (supra)*** has put this issue beyond any controversy. Justice Sikri J. in his opinion while elucidating on the aspect of passive Euthanasia had the following to observe.

> **"219. .....Passive euthanasia occurs when medical practitioners do not provide life-sustaining treatment (i.e. treatment necessary to keep a patient alive) or remove patients from life-sustaining treatment. This could include disconnecting life support machines or feeding tubes or not carrying out lifesaving operations or providing life-extending drugs.** In such cases, that omission by the medical practitioner is not treated as the cause of death; instead, the patient is understood to have died because of is underlying condition."
>
> [Emphasis supplied]

46. Equally, Justice D. Y. Chandrachud (as the learned Chief Justice then was), in his concurring opinion, observed as under.

> "**359.** Individuals who suffer from chronic disease or approach the end of the span of natural life often lapse into terminal illness or a permanent vegetative state. When a medical emergency leads to hospitalisation, individuals in that condition are sometimes deprived of their right to refuse **unwanted medical treatment such as feeding through hydration tubes or being kept** on a ventilator and other life support equipment. Life is prolonged artificially resulting in human suffering. The petition is founded on the right of each individual to make an informed choice. Documenting a wish in advance, not to be subjected to artificial means of prolonging life, should the individual not be in a position later to comprehend or decline treatment, is a manifestation of individual choice and autonomy. The process of ageing is marked by a sense of helplessness. Human faculties decline as we grow older. Social aspects of ageing, such as the loss of friendships and associations combine with the personal and intimate to enhance a sense of isolation. The boundaries and even the limits of constitutional law will be tested as the needs of the ageing and their concerns confront issues of ethics, morality and of dignity in death."
>
> [Emphasis supplied]

47. The above two passages make it abundantly clear that administration of feeding tubes constitute medical treatment. The case of Harish falls within the contours of ***Common***

Cause (supra) judgment. The issue is well settled here. This is also the position in other jurisdictions.

48. In ***Airedale NHS Trust*** v. ***Bland***[5], a judgment of the House of Lords, Lord Keith of Kinkel observed in this regard as under: -

> "… … As regards this latter argument, I am of opinion that regard should be had to the whole regime, including the artificial feeding, which at present keeps Anthony Bland alive. That regime amounts to medical treatment and care, and it is incorrect to direct attention exclusively to the fact that nourishment is being provided. **In any event, the administration of nourishment by the means adopted involves the application of a medical technique. But it is, of course, true that in general it would not be lawful for a medical practitioner who assumed responsibility for the care of an unconscious patient simply to give up treatment in circumstances where continuance of it would confer some benefit on the patient**. On the other hand 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. Existence in a vegetative stage with no prospect of recovery is by that opinion regarded as not being a benefit, and that, if not unarguably correct, at least forms a proper basis for the decision to discontinue treatment and care: *Bolam* v. *Friern Hospital Management Committee* [1957] 1 W.L.R. 582."

In the same judgment, Lord Goff of Chieveley, observed:

> "… … Anthony is not merely incapable of feeding himself. He is incapable of swallowing, and therefore of eating or drinking in the normal sense of those words. There is

[5] 1993 AC 799

> overwhelming evidence that, in the medical profession, artificial feeding is regarded as a form of medical treatment; and even if it is not strictly medical treatment, it must form part of the medical care of the patient. Indeed, the function of artificial feeding in the case of Anthony, by means of a nasogastric tube, is to provide a form of life support analogous to that provided by a ventilator which artificially breathes air in and out of the lungs of a patient incapable of breathing normally, thereby enabling oxygen to reach the bloodstream. The same principles must apply in either case when the question is asked whether the doctor in charge may lawfully discontinue the life-sustaining treatment or care; and if in either case the treatment is futile in the sense I have described, it can properly be concluded that it is no longer in the best interests of the patient to continue it. … "

49. Hence, there is no iota of doubt that the case of Harish is covered by the four corners of ***Common Cause (supra)*** since clinically assisted nutrition and hydration will constitute medical treatment.

BEST INTEREST OF THE PATIENT - SCOPE: -

50. Dealing as we are with a case of individual for whom withdrawal or refusal of medical treatment is under consideration, it is implicit that all those involved in the decision-making process act in the "best interest of the patient". This phrase in the context of passive euthanasia was highlighted in ***Common Cause (supra)*** while discussing the

241st report of the Law Commission of India on passive euthanasia. The Law Commission report referred to opinion of Lord Keith in ***Airedale NHS Trust (supra).***

51. Adverting to the report, Chief Justice Dipak Misra, in ***Common Cause (supra),*** observed as under.

> 129. The Report rightly points out that a rational and humanitarian outlook should have primacy in such a complex matter. Recognising that passive euthanasia, both in the case of competent and incompetent patients, is being allowed in most of the countries subject to the doctor **acting in the best interests of the patient, the Report summarised the broad principles of medical ethics which shall be observed by the doctor in taking the decision.** The said principles as obtained in the Report are the patient's autonomy (or the right to self-determination) and beneficence which means following a course of action that is best for the patient uninfluenced by personal convictions, motives or other considerations. **The Report also refers to the observations made by Lord Keith in Airedale case providing for a course to safeguard the patient's best interest.** As per the said course, which has also been approved by this Court, the hospital/medical practitioner should apply to the Family Division of the High Court for endorsing or reversing the decision taken by the medical practitioners in charge to discontinue the treatment of a PVS patient. With respect to the ongoing debates on "legalising euthanasia", the Report reiterates the observations made in Airedale that euthanasia (other than passive euthanasia) can be legalised by means of legislation only.
>
> [Emphasis supplied]

52. Hence, it is very clear that the fulcrum on which the decision of the Primary Medical Board and the Secondary Medical Board as well as the other functionaries wherever they are involved would be that, all decisions in this regard are to be taken keeping in mind "the best interests of the patient".

53. However, in considering as to what factors would constitute "best interest", courts have in the process of deciding individual cases laid down certain essential factors, while cautioning that no single factor can be determinative.

54. Lord Goff in ***Airedale NHS Trust (supra)*** while determining as to what the right question to ask would be in this scenario observed as under: -

> "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 interest 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 interest that treatment which has the effect of artificially prolonging his life should be continued,** that question

can sensibly be answered to the effect that his best interest no longer required that it should be."

[Emphasis supplied]

55. In ***Aintree University Hospitals NHS Foundation Trust*** v. ***James***[6], Lady Hale J. observed as under: -

> **"39. The most that can be said, therefore, is that in considering the best interests of this particular patient at this particular time, decision-makers must look at his welfare in the widest sense, not just medical but social and psychological; they must consider the nature of the medical treatment in question, what it involves and its prospects of success; they must consider what the outcome of that treatment for the patient is likely to be; they must try and put themselves in the place of the individual patient and ask what his attitude to the treatment is or would be likely to be; and they must consult others who are looking after him or interested in his welfare, in particular for their view of what his attitude would be."**

56. In ***NHS Windsor and Maidenhead Clinical Commissioning Group*** v. ***SP***[7], Lord Justice Williams of the Court of Protection quoting with approval the judgment In Re A (A Child) 2016 EWCA 759 of the Court of Appeal [which, in turn, relied on ***NHS Trust*** vs. ***MB and Others***, [2006] EWHC 507 (Fam)] said: -

[6] 2013 UKSC 67
[7] 2018 EWCOP 11

"In considering the balancing exercise to be conducted:

> "1. The decision must be objective; not what the judge might make for him or herself, for themselves or a child;
>
> 2. Best interest considerations cannot be mathematically weighed and include all considerations, which include (non-exhaustively), medical, emotional, sensory (pleasure, pain and suffering) and instinctive (the human instinct to survive) considerations;
>
> 3. There is considerable weight or a strong presumption for the prolongation of life but it is not absolute;
>
> 4. ....account must be taken of the pain and suffering and quality of life, and the pain and suffering involved in proposed treatment against a recognition that even very severely handicapped people find a quality of life rewarding.
>
> 5. Cases are all fact specific."

33. Therefore, a host of matters must all go into the balance when the judge seeks to arrive at his objective assessment of whether this treatment is in this patient's best interests. In particular I must consider the values and beliefs of SP as well as any views she expressed when she had capacity that shed light on the likely choice she would make if she were able to and what she would have considered relevant or important. Where those views can be ascertained with sufficient certainty they should carry great weight and usually should be followed; as they would be for a person with capacity who did express such views."

57. In ***NHS South East London Integrated Care Board*** v. ***JP***[8]

the Court of Protection in para 11 and 15 observed as under:-

[8] [2025] EWCOP 4 (T3)

> "11. Both Professor Turner-Stokes and Dr Hanrahan have concluded that clinically-assisted nutrition and hydration (CANH) is a 'futile' treatment for JP. This requires to be understood. CANH will preserve JP in his present condition. With CANH and good nursing care, Dr Hanrahan is of the view that JP's actuarial life expectancy could be between 5 and 10 years. However, CANH will not reverse his profound brain injury, nor restore him beyond his presently disordered consciousness, which has persisted for 9 years. It will most decidedly not restore him either to the person he was or to the life he enjoyed, with such vigour, prior to his brain injury. Alongside this, it is necessary to balance the obvious burdens of continuing treatment, which include the difficulty in managing his PEG and tracheostomy site. JP requires 24/7 care to keep him stable which is burdensome for him. In addition, JP requires care for the ongoing challenges of his cardiac condition and any acquired infection.
>
> 15. In resolving a 'best interests' decision, the judge must always consider the broader evidential canvas and the imperative to determine, to the extent that it may be possible, what the protected party (P) would want for themselves. JP did not make any advanced decision, and so it is his family who must be the conduit by which his views are understood and articulated in the courtroom."

58. A survey of the precedents on "Best Interest of the patient" lead to the irresistible conclusion that the test is fact specific and will depend on the facts and circumstances of each case. A holistic assessment of all relevant circumstances should be undertaken since no single factor can be

determinative. Without being exhaustive some of the factors which would play a role are :

i) There is a strong presumption in favour of preservation of life grounded in the sanctity of life principle.

ii) The presumption in favour of life can be displaced when continuation of treatment would no longer serve the patient's overall welfare.

iii) A careful weighing and balancing among a range of different and competing considerations have to be undertaken.

iv) The starting point of the enquiry should not be whether it will be in the best interest of the patient that the treatment should be ended, but the question should be whether it is in the best interest if the treatment that has the effect of artificially prolonging the life be continued.

v) Whether at all any benefit would accrue by the continuance of the treatment to the patient.

vi) Whether the continuation of treatment serves any therapeutic purpose;

vii) The indignity the patient is subjected to by prolongation of the treatment.

viii) Futility of the treatment;

ix) The opinion of the responsible body of the medical experts who have arrived at a reasonable conclusion.

x) The consideration of the medical and non-medical aspects like emotional and welfare issues.

xi) Consultation with the family members of the patient.

It is reiterated that the above factors are illustrative and are in no manner bound to be exhaustive.

59. In ***Portsmouth NHS Trust*** v. ***Wyatt and Wyatt, Southampton NHS Trust Intervening,***[9] Hedley J. pertinently pointed out as under:

> **"… … The infinite variety of the human condition never ceases to surprise and it is that fact that defeats any attempt to be more precise in a definition of best interests. That said, helpful attempts have been made**

[9] [2004] EWHC 2247 (Fam)

to tease out this concept but they always have to be viewed as no more than attempts at illumination."

(Emphasis supplied)

APPLICATION TO THE FACTS OF THE PRESENT CASE: -

60. I) The Primary Medical Report and the Secondary Medical Report are unanimous that: -

a) Harish is in a vegetative state and has been in that situation for the last more than 12 years.

b) He requires external support for his feeding, bladder, bowel and back.

c) The continued administration of CANH is required for sustenance and survival, though it may not aid in improving his medical condition or repairing his underlying damage.

d) He fulfils all the parameters for permanent vegetative state.

II) The general examination from the Secondary Medical Board as well as the parameters for permanent vegetative state are as under:-

"**General examination:**
He is bedbound and cachexic with evident muscle wasting. He maintains a generalized flexed posture. His body is lean with a tracheostomy tube, urinary catheter and PEG in situ.

He was afebrile to touch, pulse rate of 90/minute, regular and normovolemic. His blood pressure shown in the monitor was 130/80 mm Hg and his respiratory rate was 16/minute. There were no signs of respiratory distress. On general examination, there was mild pallor, no jaundice, and nails and teeth were normal.

Although the skin was normal, there was a healing bed sore over the lower back. In addition, there were contractures in both upper and lower limbs.

Neurological examination:
His eyes were open with normal blinks with no purposeful movement or response to auditory, verbal, tactile or painful stimulus (supraorbital pressure).

The pupils were bilaterally normal and reacting. There were no eye tracking movements to light or auditory stimuli.

There were flexion contractures of all limbs and attempts for passive movement did not elicit any facial grimace or voluntary resistance.

To summarize, there was spontaneous, but non-purposive eye opening, no vocalization (or attempt thereof, since the patient was tracheostomized), and flexion of limbs on stimulus.

No visual, cognitive or communication abilities could be ascertained. His deep tendon reflexes were elicitable. Sensory and cerebellar functions could not be examined.

Other observations made and diagnostic criteria that were applied:

There were secretions from the tracheotomy tube requiring periodic suctioning.

The patient did not show any evidence of contact with the surroundings, and while his family members were called to the meeting room, he remained in the same state.

Table 2: Diagnostic criteria of Permanent Vegetative State

1. Exhibits no evidence of awareness of themselves or their environment; they are incapable of interacting with others.	Yes
2. Exhibits no evidence of sustained, reproducible, purposeful, or voluntary behavioral response to visual, auditory, tactile, or noxious stimuli.	Yes
3. Exhibits no evidence of language comprehension or expression.	Yes
4. Exhibits intermittent wakefulness manifested by the presence of sleep-wake cycles.	Yes
5. Have sufficiently preserved autonomic functions of the hypothalamus and brain stem that enable them to survive given medical and nursing care.	Yes
6. Exhibit bowel and bladder incontinence.	Yes
7. Have some preserved cranial nerve reflexes (pupillary, oculocephalic, corneal, vestibulo-ocular, gag) and spinal reflexes.	Yes

III) As is clear from the joint report filed by the learned counsel and also the Court's interaction with the parents and siblings, the parents and siblings firmly believe that the medical treatment is not making any difference and

that there was no point in continuing with such treatment and making Harish suffer for no good reason.

IV) The treatment is, according to the medical board, offering no benefit to Harish.

V) It serves no therapeutic purpose.

VI) Harish is subjected to a lot of indignity.

VII) The futility of the treatment, the medical, emotional and welfare aspects all point to only one direction, namely, withdrawal of medical treatment.

VIII) There is no benefit much less continuing benefit from the treatment.

61. All the above factors cumulatively lead to the sole irresistible conclusion that it will not be in Harish's best interest to continue with the treatment and artificially prolong his life.

CONCLUSION: -

62. In view of what has been held hereinabove, a direction ought to be issued that in view of the concurrence of the Primary Medical Board and the Secondary Medical Board,

the consequences provided in ***Common Cause*** (*supra*) should operate.

63. The Miscellaneous Application is allowed in terms of the directions contained in the judgment authored by my esteemed brother J.B.Pardiwala, J.

POSTSCRIPT: -

64. Now that the legal aspect of the matter is concluded, a mention needs to be made of the love and affection by which the parents and the siblings have nursed Harish for the last more than 12 years. Harish has been in a vegetative state but the parents and siblings have left no stone unturned in ensuring best treatment for Harish. It is only when the matter reached a point of no return, that to relieve Harish from what he is undergoing they have resorted to this legal course of action. One can only imagine the agony they would have undergone during this period. As the ancient *Subhashita* (eloquent saying) in Sanskrit goes –

चिता चिंता द्वयोर्मध्ये,

Chita Chinta Dwayoormadhya,

चिंता तत्र गरीयसी ।

Chinta Tatra Gariyasi.

चिता दहति निर्जीवं,

Chita Dahati Nirjivam,

चिंता दहति सजीवकम् ।।

Chinta Dahati Sajeevakam

"Between the funeral fire and the mental worry,
it is the mental worry which is more devastating.
While the funeral fire burns only the dead body,
the mental worry burns the living one."

65. On the implementation of this order, it is not as if their agony will be entirely wiped off. However, the distress that they experience due to what Harish is undergoing will at least be over. **Though the judgment is not based on this aspect and has proceeded on the applicable legal principles by keeping the best interest of Harish, it will be very naive to ignore this harsh reality**.

……J.
[**K. V. VISWANATHAN**]

New Delhi;
11th March, 2026