

IN THE SUPREME COURT OF INDIA
CRIMINAL ORIGINAL JURISDICTION
WRIT PETITION (CRIMINAL) NO. 115 OF 2009

Aruna Ramchandra Shanbaug .. Petitioner

-versus-

Union of India and others .. Respondents

JUDGMENT

Markandey Katju, J.

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

- Mirza Ghalib

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

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

3. It is stated in the writ petition that the petitioner Aruna Ramachandra Shanbaug was a staff Nurse working in King Edward Memorial Hospital, Parel, Mumbai. On the evening of 27th November, 1973 she was attacked by a sweeper in the hospital who wrapped a dog chain around her neck and yanked her back with it. He tried to rape her but finding that she was menstruating, he sodomized her. To immobilize her during this act he twisted the chain around her neck. The next day on 28th November, 1973 at 7.45 a.m. a cleaner found her lying on the floor with blood all over in an unconscious condition. It is alleged that due to strangulation by the dog chain the supply of oxygen to the brain stopped and the brain got damaged. It is alleged that the Neurologist in the Hospital found that she had plantars' extensor, which indicates damage to the cortex or some other part of the brain. She also had brain stem contusion injury with associated cervical cord injury. It is alleged at page 11 of the petition that 36 years have expired since the incident and now Aruna Ramachandra Shanbaug is about 60 years of age. She is featherweight, and her brittle bones could break if her hand or leg are awkwardly caught, even accidentally, under her lighter body. She has stopped menstruating and her skin is now like papier mache' stretched over a skeleton. She is prone to bed sores. Her wrists are twisted inwards. Her teeth had decayed causing her immense pain. She can only be given mashed food, on which she survives. It is alleged that Aruna Ramachandra Shanbaug is in a persistent vegetative state (p.v.s.) and virtually a dead person and has no state of awareness, and her brain is virtually dead. She can neither see, nor hear anything nor can she express herself or communicate, in any manner whatsoever. Mashed food is put in her mouth, she is not able to chew or taste any food. She is not even aware that food has been put in her mouth. She is not able to swallow any liquid food, which shows that the food goes down on its own and not because of any effort on her part. The process of digestion goes on in this way as the mashed food passes through her system. However, Aruna is virtually a skeleton. Her excreta and the urine is discharged on the bed itself. Once in a while she is cleaned up but in a short while again she goes back into the same sub-human condition. Judged by any parameter, Aruna cannot be said to be a living person and it is only on account of mashed food which is put into her mouth that there

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

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

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

6. Since there was some variance in the allegation in the writ petition and the counter affidavit of Dr. Pazare, we, by our order dated 24 January, 2011 appointed a team of three very distinguished doctors of Mumbai to examine Aruna Shanbaug thoroughly and submit a report about her physical and mental condition. These three doctors were :

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

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

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

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

"Report of Examination of Ms. Aruna Ramachandra Shanbaug"

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

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

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

I. Background

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

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

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

This report is based on:

1. The longitudinal case history and observations obtained from the Dean and the medical and nursing staff of K. E. M. Hospital,
2. Case records (including nursing records) since January 2010
3. Findings of the physical, neurological and mental status examinations performed by the panel.
4. Investigations performed during the course of this assessment (Blood tests, CT head, Electroencephalogram)

II. Medical history

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

It was learnt from the persons mentioned above that

1. Ms. Aruna Ramachandra Shanbaug was admitted in the hospital after she was assaulted and strangled by a sweeper of the hospital on November 27, 1973.
2. Though she survived, she never fully recovered from the trauma and brain damage resulting from the assault and strangulation.
3. Since last so many years she is in the same bed in the side-room of ward-4.
4. The hospital staff has provided her an excellent nursing care since then which included feeding her by mouth, bathing her and taking care of her toilet needs. The care was of such an exceptional nature that she has not developed a single bed-sore or fracture in spite of her bedridden state since 1973.
5. According to the history from them, though she is not very much aware of herself and her surrounding, she somehow recognizes the presence of people around her and expresses her like or dislike by making certain types of vocal sounds and by waving her hands in certain manners. She appears to be happy and smiles when she receives her favorite food items like fish and chicken soup. She accepts feed which she likes but may spit out food which she doesn't like. She was able to take oral feeds till 16th September 2010, when she developed a febrile illness, probably malaria. After that, her oral intake reduced and a feeding tube (Ryle's tube) was passed into her stomach via her nose. Since then she receives her major feeds by the Ryle's tube, and is only occasionally able to accept the oral liquids. Malaria has taken a toll in her physical condition but she is gradually recuperating from it.
6. Occasionally, when there are many people in the room she makes vocal sounds indicating distress. She calms down when people move out of her room. She also seems to enjoy the devotional songs and music which is played in her room and it has calming effect on her.
7. In an annual ritual, each and every batch of nursing students is introduced to Ms. Aruna Ramachandra Shanbaug, and is told that "She was one of us"; "She was a very nice and efficient staff nurse but due to the mishap she is in this bed-ridden state".
8. The entire nursing staff member and other staff members have a very compassionate attitude towards Ms. Aruna Ramachandra Shanbaug and they all very happily and willingly take care of her. They all are very proud of their achievement of taking such a good care of their bed-ridden colleague and feel very strongly that they want to continue to take care of her in the same manner till she succumbs naturally. They do not feel that Ms. Aruna Ramachandra Shanbaug is living a painful and miserable life.

III. Examination

IIIa. Physical examination

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

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

She was afebrile, pulse rate was 80/min, regular, and good volume. Her blood pressure recorded on the nursing charts was normal. Respiratory rate was 15/min, regular, with no signs of respiratory distress or breathlessness. There was no pallor, cyanosis, clubbing or icterus. She was edentulous (no teeth).

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

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

A nasogastric feeding tube (Ryle's tube) was in situ. She was wearing diapers. Abdominal, respiratory and cardiovascular examination was unremarkable.

IIIb. Neurological Examination

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

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

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

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

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

IIIc. Mental Status Examination

1. Consciousness, General Appearance, Attitude and Behavior :

Ms. Aruna Ramachandra Shanbaug was resting quietly in her bed, apparently listening to the devotional music, when we entered the room. Though, her body built is lean, she appeared to be well nourished and there were no signs of malnourishment. She appeared neat and clean. She has developed contractures at both the wrist joints and knee joints and so lied curled up in the bed with minimum restricted physical movements.

She was conscious but appeared to be unaware of herself and her surroundings. As soon as she realized the presence of some people in her room, she started making repetitive vocal sounds and

moving her hands. This behavior subsided as we left the room. She did not have any involuntary movements. She did not demonstrate any catatonic, hostile or violent behavior.

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

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

2. Mood and affect :

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

3. Speech and thoughts :

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

4. Perception :

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

5. Orientation, memory and intellectual capacity :

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

6. Insight :

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

IV. Reports of Investigations

IVa. CT Scan Head (Plain)

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

IVb. EEG

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

IVc. Blood

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

V. Diagnostic impression

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

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

VI. Prognosis

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

VII. Appendix

VII a. Table 1. CLINICAL ASSESSMENT TO ESTABLISH UNAWARENESS

[TABLE OMITTED]

Conclusion:

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

VIIb. Table 2. Application of Criteria for Vegetative State

[TABLE OMITTED]

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

2. Wade DT, Johnston C. The permanent vegetative state: practical guidance on diagnosis and management. Brit Med J 1999; 319:841.4

3. Giacino JT, Ashwal S, Childs N, et al. The minimally conscious state : Definition and diagnostic criteria. Neurology 2002;58:349.353

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

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

"In the above case Dr. J.V. Divatia on 17.02.2011 handed over the report of the team of three doctors whom we had appointed by our order dated 24th January, 2011. He has also handed over a CD in this connection. Let the report as well as the CD form part of the record.

On mentioning, the case has been adjourned to be listed on 2nd March, 2011 at the request of learned Attorney General of India, Mr. T.R. Andhyarujina, learned Senior Advocate, whom we have appointed as amicus curiae in the case as well as Mr. Shekhar Naphade, learned Senior Advocate for the petitioner.

We request the doctors whom we had appointed viz., Dr. J.V. Divatia, Dr. Roop Gurshani and Dr. Nilesh Shah to appear before us on 2nd March, 2011 at 10.30 A.M. in the Court, since it is quite possible that we may like to ask them questions about the report which they have submitted, and in general about their views in connection with euthanasia.

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

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

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

The Dean of King Edward Memorial Hospital as well as Ms. Pinky Virani (who claims to be the next friend of the petitioner) are directed to intimate the brother(s)/sister(s) or other close relatives of

the petitioner that the case will be listed on 2nd March, 2011 in the Supreme Court and they can put forward their views before the Court, if they so desire. Learned counsel for the petitioner and the Registry of this Court shall communicate a copy of this Order forthwith to the Dean, KEM Hospital. The Dean, KEM Hospital is requested to file an affidavit stating his views regarding the prayer in this writ petition, and also the condition of the petitioner.

Copy of this Order shall be given forthwith to learned Attorney General of India, Mr. Shekhar Naphade and Mr. Andhyarujina, learned Senior Advocates. Let the matter be listed as the first item on 2nd March, 2011".

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

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

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

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

Mumbai

February 26, 2011

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Introduction

This document is a supplement to the Report of Examination of Ms. Aruna Ramachandra Shanbaug, dated February 14, 2011. On perusal of the report, the Hon. Court observed that there were many technical terms which a non-medical man would find it difficult to understand, and requested us to submit a supplementary report in which the meaning of these technical terms in the report is also explained.

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

Terminology

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

Brain death

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

Explanation: This is the most severe form of brain damage. The patient is unconscious, completely unresponsive, has no reflex activity from centres in the brain, and has no breathing efforts on his own. However the heart is beating. This patient can only be maintained alive by advanced life

support (breathing machine or ventilator, drugs to maintain blood pressure, etc). These patients can be legally declared dead ('brain dead') to allow their organs to be taken for donation.

Aruna Shanbaug is clearly not brain dead.

Coma

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

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

Aruna Shanbaug is clearly not in Coma.

Vegetative State (VS)

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

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

Sleep-wake cycles with eyes closed, then open

Patient breathes on her own

Spontaneous blinking and roving eye movements

Produce sounds but no words

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

Grimacing to pain, changing facial expressions

Yawning; chewing jaw movements

Swallowing of her own spit

Nonpurposeful limb movements; arching of back

Reflex withdrawal from painful stimuli

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

Startles with a loud sound

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

Minimally Conscious State

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

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

. Following simple commands.

. Gestural or verbal yes/no responses (regardless of accuracy).

. Intelligible sounds

. Purposeful behavior, including movements or emotional behaviors (smiling, crying) that occur in relation to relevant environmental stimuli and are not due to reflexive activity.

Some examples of qualifying purposeful behavior include:

- appropriate smiling or crying in response to the linguistic or visual content of emotional but not to neutral topics or stimuli
- vocalizations or gestures that occur in direct response to the linguistic content of questions
- reaching for objects that demonstrates a clear relationship between object location and direction of reach
- touching or holding objects in a manner that accommodates the size and shape of the object
- pursuit eye movement or sustained fixation that occurs in direct response to moving or salient stimuli

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

Opinion

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

1. In a person who is in a permanent vegetative state (PVS), should withholding or withdrawal of life sustaining therapies (many authorities would include placement of an artificial feeding tube as a life sustaining intervention) be permissible or 'not unlawful' ?
2. If the patient has previously expressed a wish not to have life-sustaining treatments in case of futile care or a PVS, should his / her wishes be respected when the situation arises?
3. In case a person has not previously expressed such a wish, if his family or next of kin makes a request to withhold or withdraw futile life-sustaining treatments, should their wishes be respected?
4. Aruna Shanbaug has been abandoned by her family and is being looked after for the last 37 years by the staff of KEM Hospital. Who should take decisions on her behalf? Questions such as these come up at times in the course of medical practice. We realize that answers to these questions are difficult, and involve several ethical, legal and social issues. Our opinion is based on medical facts and on the principles of medical ethics. We hope that the Honourable Court will provide guidance and clarity in this matter.

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

1. Autonomy means the right to self-determination, where the informed patient has a right to choose the manner of his treatment. To be autonomous the patient should be competent to make decisions and choices. In the event that he is incompetent to make choices, his wishes expressed in advance in the form of a Living Will, OR the wishes of surrogates acting on his behalf ('substituted judgment') are to be respected.

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

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

In the present case under consideration

1. We have no indication of Aruna Shanbaug's views or wishes with respect to life-sustaining treatments for a permanent vegetative state.
2. Any decision regarding her treatment will have to be taken by a surrogate
3. The staff of the KEM hospital have looked after her for 37 years, after she was abandoned by her family. We believe that the Dean of the KEM Hospital (representing the staff of hospital) is an appropriate surrogate.

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

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

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

"She means a lot to KEM hospital. She is on liquid diet and loves listening to music. We have never subjected her to intravenous food or fed her via a tube. All these years, she hasn't had even one bed sore. When those looking after her do not have a problem, I don't understand why a third party who has nothing to do with her [Pinky Virani who has moved the apex court to seek euthanasia for Shanbaug] needs to worry," added Dr Oak, who, when he took over as dean of KEM hospital in 2008, visited her first to take her blessings. "I call on her whenever I get time. I am there whenever she has dysentery or any another problem. She is very much alive and we have faith in the judiciary," said Dr Oak."

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

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

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

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

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

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

12. The Hospital staff of KEM Hospital, Mumbai e.g. the doctors, sister-in-charge ward no. 4 KEM hospital Lenny Cornielo, Assistant Matron Urmila Chauhan and others have also issued statements that they were looking after Aruna Shanbaug and want her to live. "Aruna is the bond that unites us", the KEM Hospital staff has stated. One retired nurse, Tidi Makwana, who used to take care of Aruna while in service, has even offered to continue to take care of her without any salary and without charging any traveling expenses.

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

14. It is thus obvious that the KEM hospital staff has developed an emotional bonding and attachment to Aruna Shanbaug, and in a sense they are her real family today. Ms. Pinki Virani who claims to be the next friend of Aruna Shanbaug and has filed this petition on her behalf is not a relative of Aruna Shanbaug nor can she claim to have such close emotional bonding with her as the KEM hospital staff. Hence, we are treating the KEM hospital staff as the next friend of Aruna Shanbaug and we decline to recognize Ms. Pinki Virani as her next friend. No doubt Ms. Pinki Virani has written a book about Aruna Shanbaug and has visited her a few times, and we have great

respect for her for the social causes she has espoused, but she cannot claim to have the extent of attachment or bonding with Aruna which the KEM hospital staff, which has been looking after her for years, claims to have.

SUBMISSIONS OF LEARNED COUNSEL FOR THE PARTIES

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

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

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

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

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

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

"(24) Protagonism of euthanasia on the view that existence in persistent vegetative state (PVS) is not a benefit to the patient of a terminal illness being unrelated to the principle of 'sanctity of life' or the right to live with dignity' is of no assistance to determine the scope of Article 21 for deciding whether the guarantee of right to life' therein includes the right to die'. The right to life' including the right to live with human dignity would mean the existence of such a right upto the end of natural life. This also includes the right to a dignified life upto the point of death including a dignified procedure of death. In other words, this may include the right of a dying man to also die with dignity when his life is ebbing out. But the 'right to die' with dignity at the end of life is not to be confused or equated with the right to die' an unnatural death curtailing the natural span of life.

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

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

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

20. Mr. Naphade, learned senior counsel submitted that Ms. Pinky Virani is the next friend of Aruna as she has written a book on her life called 'Aruna's story' and has been following Aruna's case from 1980 and has done whatever possible and within her means to help Aruna. Mr. Naphade has also invited our attention to the report of the Law Commission of India, 2006 on 'Medical Treatment to Terminally Ill Patients'. We have perused the said report carefully.

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

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

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

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

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

(v) In case hydration or food is withdrawn/withheld from Aruna Ramchandra Shanbaug, the efforts which have been put in by batches after batches of nurses of KEM Hospital for the last 37 years will be undermined.

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

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

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

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

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

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

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

25. If the doctor acts on such consent there is no question of the patient committing suicide or of the doctor having aided or abetted him in doing so. It is simply that the patient, as he is entitled to

do, declines to consent to treatment which might or would have the effect of prolonging his life and the doctor has in accordance with his duties complied with the patient's wishes.

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

27. Absent any indication from a patient who is incompetent the test which is adopted by Courts is what is in the best interest of the patient whose life is artificially prolonged by such life support. This is not a question whether it is in the best interest of the patient that he should die. The question is whether it is in the best interest of the patient that his life should be prolonged by the continuance of the life support treatment. This opinion must be formed by a responsible and competent body of medical persons in charge of the patient.

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

29. In such a situation, generally the wishes of the patient's immediate family will be given due weight, though their views cannot be determinative of the carrying on of treatment as they cannot dictate to responsible and competent doctors what is in the best interest of the patient. However, experience shows that in most cases the opinions of the doctors and the immediate relatives coincide.

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

31. Mr. Andhyarujina submitted that the decision to withdraw the life support is taken in the best interests of the patient by a body of medical persons. It is not the function of the Court to evaluate the situation and form an opinion on its own. In England for historical reasons the *parens patriae* jurisdiction over adult mentally incompetent persons was abolished by statute and the Court has no power now to give its consent. In this situation, the Court only gives a declaration that the proposed omission by doctors is not unlawful.

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

33. Mr. Andhyarujina submitted that the withdrawal of nutrition by stopping essential food by means of nasogastric tube is not the same as unplugging a ventilator which artificially breathes air into the lungs of a patient incapable of breathing resulting in instant death. In case of discontinuance of artificial feeding the patient will as a result starve to death with all the sufferings and pain and distress associated with such starving. This is a very relevant consideration in a PVS patient like Aruna who is not totally unconscious and has sensory conditions of pain etc. unlike Antony Bland in *Airedale vs. Director MHD* (1993) 2 WLR 316 who was totally unconscious. Would the doctor be able to avoid such pain or distress by use of sedatives etc.? In such a condition would it not be more appropriate to continue with the nasogastric feeding but not take any other active steps to combat any other illness which she may contract and which may lead to her death?

34. Mr. Andhyarujina further submitted that in a situation like that of Aruna, it is also necessary to recognize the deep agony of nurses of the hospital who have with deep care looked after her for

over 37 years and who may not appreciate the withdrawal of the life support. It may be necessary that their views should be considered by the Court in some appropriate way.

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

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

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

Legal Issues : Active and Passive Euthanasia

38. Coming now to the legal issues in this case, it may be noted that euthanasia is of two types : active and passive. Active euthanasia entails the use of lethal substances or forces to kill a person e.g. a lethal injection given to a person with terminal cancer who is in terrible agony. Passive euthanasia entails withholding of medical treatment for continuance of life, e.g. withholding of antibiotics where without giving it a patient is likely to die, or removing the heart lung machine, from a patient in coma.

39. The general legal position all over the world seems to be that while active euthanasia is illegal unless there is legislation permitting it, passive euthanasia is legal even without legislation provided certain conditions and safeguards are maintained.

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

ACTIVE EUTHANASIA

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

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

43. A distinction is sometimes drawn between euthanasia and physician assisted dying, the difference being in who administers the lethal medication. In euthanasia, a physician or third party administers it, while in physician assisted suicide it is the patient himself who does it, though on the advice of the doctor. In many countries/States the latter is legal while the former is not.

44. The difference between "active" and "passive" euthanasia is that in active euthanasia, something is done to end the patient's life while in passive euthanasia, something is not done that would have preserved the patient's life.

45. An important idea behind this distinction is that in "passive euthanasia" the doctors are not actively killing anyone; they are simply not saving him. While we usually applaud someone who saves another person's life, we do not normally condemn someone for failing to do so. If one rushes into a burning building and carries someone out to safety, he will probably be called a hero. But if one sees a burning building and people screaming for help, and he stands on the sidelines -- whether out of fear for his own safety, or the belief that an inexperienced and ill-equipped person like himself would only get in the way of the professional firefighters, or whatever -- if one does nothing, few would judge him for his inaction. One would surely not be prosecuted for homicide. (At least, not unless one started the fire in the first place.)

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

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

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

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

LEGISLATION IN SOME COUNTRIES RELATING TO EUTHANASIA OR PHYSICIAN ASSISTED DEATH

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

Netherlands:

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

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Switzerland:

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

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

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

Belgium:

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

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

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

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

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

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

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

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

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

United States of America:

Active Euthanasia is illegal in all states in U.S.A., but physician assisted dying is legal in the states of Oregon, Washington and Montana. As already pointed out above, the difference between euthanasia and physician assisted suicide lies in who administers the lethal medication. In the former, the physician or someone else administers it, while in the latter the patient himself does so, though on the advice of the doctor.

Canada:

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

PASSIVE EUTHANASIA

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

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

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

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

appropriate to refer in detail to certain landmark decisions, which have laid down the law on the subject.

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

LAW IN INDIA

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

98. The Constitution Bench of the Indian Supreme Court in *Gian Kaur vs. State of Punjab*, 1996(2) SCC 648 held that both euthanasia and assisted suicide are not lawful in India. That decision overruled the earlier two Judge Bench decision of the Supreme Court in *P. Rathinam vs. Union of India*, 1994(3) SCC 394. The Court held that the right to life under Article 21 of the Constitution does not include the right to die (vide para 33).

In *Gian Kaur's* case (supra) the Supreme Court approved of the decision of the House of Lords in *Airedale's* case (supra), and observed that euthanasia could be made lawful only by legislation.

99. Sections 306 and 309 IPC read as under :

"306. Abetment of suicide -If any person commits suicide, whoever abets the commission of such suicide, shall be punished with imprisonment of either description for a term which may extend to ten years, and shall also be liable to fine.

309. Attempt to commit suicide - Whoever attempts to commit suicide and does any act towards the commission of such offence, shall be punished with simple imprisonment for a term which may extend to one year or with fine, or with both."

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

101. It may be noted that in *Gian Kaur's* case (supra) although the Supreme Court has quoted with approval the view of the House of Lords in *Airedale's* case (supra), it has not clarified who can decide whether life support should be discontinued in the case of an incompetent person e.g. a person in coma or PVS. This vexed question has been arising often in India because there are a large number of cases where persons go into coma (due to an accident or some other reason) or for some other reason are unable to give consent, and then the question arises as to who should give consent for withdrawal of life support.

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

103. Also, since medical science is advancing fast, doctors must not declare a patient to be a hopeless case unless there appears to be no reasonable possibility of any improvement by some newly discovered medical method in the near future. In this connection we may refer to a recent news item which we have come across on the internet of an Arkansas man Terry Wallis, who was

19 years of age and newly married with a baby daughter when in 1984 his truck plunged through a guard rail, falling 25 feet. He went into coma in the crash in 1984, but after 24 years he has regained consciousness. This was perhaps because his brain spontaneously rewired itself by growing tiny new nerve connections to replace the ones sheared apart in the car crash. Probably the nerve fibers from Terry Wallis' cells were severed but the cells themselves remained intact, unlike Terri Schiavo, whose brain cells had died (see Terri Schiavo's case on Google). 104. However, we make it clear that it is experts like medical practitioners who can decide whether there is any reasonable possibility of a new medical discovery which could enable such a patient to revive in the near future.

WHEN CAN A PERSON IS SAID TO BE DEAD

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

106. A person's most important organ is his/her brain. This organ cannot be replaced. Other body parts can be replaced e.g. if a person's hand or leg is amputated, he can get an artificial limb.

Similarly, we can transplant a kidney, a heart or a liver when the original one has failed. However, we cannot transplant a brain. If someone else's brain is transplanted into one's body, then in fact, it will be that other person living in one's body. The entire mind, including one's personality, cognition, memory, capacity of receiving signals from the five senses and capacity of giving commands to the other parts of the body, etc. are the functions of the brain. Hence one is one's brain. It follows that one is dead when one's brain is dead.

107. As is well-known, the brain cells normally do not multiply after the early years of childhood (except in the region called hippocampus), unlike other cells like skin cells, which are regularly dying and being replaced by new cells produced by multiplying of the old cells. This is probably because brain cells are too highly specialized to multiply. Hence if the brain cells die, they usually cannot be replaced (though sometimes one part of the brain can take over the function of another part in certain situations where the other part has been irreversibly damaged).

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

BRAIN DEATH

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

Historically, as the oft-quoted definition in Black's Law Dictionary suggests, death was:

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

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

112. Brain death, may thus, be defined as "the irreversible cessation of all functions of the entire brain, including the brain stem". 4 It is important to understand that this definition goes beyond acknowledging consciousness -- a person who is incapable of ever regaining consciousness will not

be considered to be brain dead as long as parts of the brain e.g. brain stem that regulate involuntary activity (such as response to light, respiration, heartbeat etc.) still continue to function. Likewise, if consciousness, albeit severely limited, is present, then a person will be considered to be alive even if he has suffered brain stem death, wherein breathing and heartbeat can no longer be regulated and must be mechanically determined. Hence, the international standard for brain death is usually considered to include "whole- brain death", i.e., a situation where the higher brain (i.e. the part of the brain that regulates consciousness and thought), the cerebellum or midbrain, and the brain-stem have all ceased to demonstrate any electrical activity whatsoever for a significant amount of time. To say, in most cases, that only the death of the higher brain would be a criteria for 'brain death' may have certain serious consequences -- for example, a foetus, technically under this definition, would not be considered to be alive at all. Similarly, as per this, different definitions of death would apply to human and nonhuman organisms.

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

115. When this situation is reached, it is possible to assume that the person is dead, even though he or she, through mechanical stimulation, may be able to breathe, his or her heart might be able to beat, and he or she may be able to take some form of nourishment. It is important, thus, that it be medically proved that a situation where any human functioning would be impossible should have been reached for there to be a declaration of brain death--situations where a person is in a persistent vegetative state but can support breathing, cardiac functions, and digestion without any mechanical aid are necessarily those that will not come within the ambit of brain death.

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

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

a. when a person is only kept alive mechanically, i.e. when not only consciousness is lost, but the person is only able to sustain involuntary functioning through advanced medical technology--such as the use of heart-lung machines, medical ventilators etc.

b. when there is no plausible possibility of the person ever being able to come out of this stage. Medical "miracles" are not unknown, but if a person has been at a stage where his life is only sustained through medical technology, and there has been no significant alteration in the person's condition for a long period of time at least a few years--then there can be a fair case made out for passive euthanasia.

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

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

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

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

"(6) Where any human organ is to be removed from the body of a person in the event of his brainstem death, no such removal shall be undertaken unless such death is certified, in such form

and in such manner and on satisfaction of such conditions and requirements as may be prescribed, by a Board of medical experts consisting of the following, namely:-

- (i) the registered medical practitioner, in charge of the hospital in which brain-stem death has occurred;
- (ii) an independent registered medical practitioner, being a specialist, to be nominated by the registered medical practitioner specified in clause (i), from the panel of names approved by the Appropriate Authority;
- (iii) a neurologist or a neurosurgeon to be nominated by the registered medical practitioner specified in clause (i), from the panel of names approved by the Appropriate Authority; and
- (iv) the registered medical practitioner treating the person whose brainstem death has occurred".

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

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

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

123. Aruna Shanbaug meets most of the criteria for being in a permanent vegetative state which has resulted for 37 years. However, her dementia has not progressed and has remained stable for many years.

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

125. However, there appears little possibility of her coming out of PVS in which she is in. In all probability, she will continue to be in the state in which she is in till her death. The question now is whether her life support system (which is done by feeding her) should be withdrawn, and at whose instance?

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

126. There is no statutory provision in our country as to the legal procedure for withdrawing life support to a person in PVS or who is otherwise incompetent to take a decision in this connection. We agree with Mr. Andhyarujina that passive euthanasia should be permitted in our country in certain situations, and we disagree with the learned Attorney General that it should never be permitted. Hence, following the technique used in Vishakha's case (supra), we are laying down the law in this connection which will continue to be the law until Parliament makes a law on the subject.

- (i) A decision has to be taken to discontinue life support either by the parents or the spouse or other close relatives, or in the absence of any of them, such a decision can be taken even by a person or a body of persons acting as a next friend. It can also be taken by the doctors attending the patient. However, the decision should be taken bona fide in the best interest of the patient.

In the present case, we have already noted that Aruna Shanbaug's parents are dead and other close relatives are not interested in her ever since she had the unfortunate assault on her. As already noted above, it is the KEM hospital staff, who have been amazingly caring for her day and night for so many long years, who really are her next friends, and not Ms. Pinky Virani who has only visited her on few occasions and written a book on her. Hence it is for the KEM hospital staff to take that decision. The KEM hospital staff have clearly expressed their wish that Aruna Shanbaug should be allowed to live.

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

We do not mean to decry or disparage what Ms. Pinky Virani has done. Rather, we wish to express our appreciation of the splendid social spirit she has shown. We have seen on the internet that she has been espousing many social causes, and we hold her in high esteem. All that we wish to say is that however much her interest in Aruna Shanbaug may be it cannot match the involvement of the KEM hospital staff who have been taking care of Aruna day and night for 38 years.

However, assuming that the KEM hospital staff at some future time changes its mind, in our opinion in such a situation the KEM hospital would have to apply to the Bombay High Court for approval of the decision to withdraw life support.

(ii) Hence, even if a decision is taken by the near relatives or doctors or next friend to withdraw life support, such a decision requires approval from the High Court concerned as laid down in Airedale's case (supra).

In our opinion, this is even more necessary in our country as we cannot rule out the possibility of mischief being done by relatives or others for inheriting the property of the patient.

127. In our opinion, if we leave it solely to the patient's relatives or to the doctors or next friend to decide whether to withdraw the life support of an incompetent person there is always a risk in our country that this may be misused by some unscrupulous persons who wish to inherit or otherwise grab the property of the patient. Considering the low ethical levels prevailing in our society today and the rampant commercialization and corruption, we cannot rule out the possibility that unscrupulous persons with the help of some unscrupulous doctors may fabricate material to show that it is a terminal case with no chance of recovery. There are doctors and doctors. While many doctors are upright, there are others who can do anything for money (see George Bernard Shaw's play 'The Doctors Dilemma'). The commercialization of our society has crossed all limits. Hence we have to guard against the potential of misuse (see Robin Cook's novel 'Coma'). In our opinion, while giving great weight to the wishes of the parents, spouse, or other close relatives or next friend of the incompetent patient and also giving due weight to the opinion of the attending doctors, we cannot leave it entirely to their discretion whether to discontinue the life support or not. We agree with the decision of the Lord Keith in Airedale's case (supra) that the approval of the High Court should be taken in this connection. This is in the interest of the protection of the patient, protection of the doctors, relative and next friend, and for reassurance of the patient's family as well as the public. This is also in consonance with the doctrine of *parens patriae* which is a well known principle of law.

132. In our opinion, in the case of an incompetent person who is unable to take a decision whether to withdraw life support or not, it is the Court alone, as *parens patriae*, which ultimately must take this decision, though, no doubt, the views of the near relatives, next friend and doctors must be given due weight.

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

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

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

134. A bare perusal of the above provisions shows that the High Court under Article 226 of the Constitution is not only entitled to issue writs, but is also entitled to issue directions or orders.

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

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

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

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

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

138. When such an application is filed the Chief Justice of the High Court should forthwith constitute a Bench of at least two Judges who should decide to grant approval or not. Before doing so the Bench should seek the opinion of a committee of three reputed doctors to be nominated by the Bench after consulting such medical authorities/medical practitioners as it may deem fit. Preferably one of the three doctors should be a neurologist, one should be a psychiatrist, and the third a physician. For this purpose a panel of doctors in every city may be prepared by the High Court in consultation with the State Government/Union Territory and their fees for this purpose may be fixed.

139. The committee of three doctors nominated by the Bench should carefully examine the patient and also consult the record of the patient as well as taking the views of the hospital staff and submit its report to the High Court Bench.

140. Simultaneously with appointing the committee of doctors, the High Court Bench shall also issue notice to the State and close relatives e.g. parents, spouse, brothers/sisters etc. of the patient, and in their absence his/her next friend, and supply a copy of the report of the doctor's committee to them

as soon as it is available. After hearing them, the High Court bench should give its verdict. The above procedure should be followed all over India until Parliament makes legislation on this subject.

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

142.The High Court should give its decision assigning specific reasons in accordance with the principle of 'best interest of the patient' laid down by the House of Lords in Airedale's case (supra). The views of the near relatives and committee of doctors should be given due weight by the High Court before pronouncing a final verdict which shall not be summary in nature.

143.With these observations, this petition is dismissed.

MERCY KILLING (EUTHANASIA)
THE ARUNA SHANBAUG VERDICT
BY
SUPREME COURT OF INDIA 07.03.2011

Today's update class is about one untouched legal issue-mercy killing or euthanasia. Euthanasia is one of the most perplexing issues which the courts and legislatures all over the world are facing today. In India the law is silent about euthanasia making it the most delicate issue. Euthanasia is the practice of helping severely-ill people die. Euthanasia is carried out at the request of terminally ill patients or their relatives who have otherwise no chance of recovery whatsoever. Euthanasia is thus, ending the prolonged painstaking misery and suffering of a patient who is otherwise left to the mercy of nature when it comes to natural death.

One such case is that of Aruna Ramchandra Shanbaug- a once vibrating youthful nurse at the KEM Hospital, Mumbai before a tragic incident that took place on that fateful day on November 27, 1973 at the KEM Hospital basement took the sheen off her life and reduced her in permanent vegetative state (PVS) completely bed ridden since the last 37 years. A writ petition before the Apex Court was filed by a noted writer and social activist Ms. Pinki Virani pleading the court to sanction mercy killing so as to let her die peacefully without waiting for the nature to take its course.

On the evening of November 27, 1973 she was attacked by the hospital sweeper Sohanlal Valimiki who strangled her with a dog chain around her neck so severely that it cut off the oxygen supply to her brain resulting in irreversible cortex damage to her brain. Since then she had been living a life of a dead animal.

Emotionally moved by her sub human condition, Ms. Virani, who used to visit her occasionally in the hospital and reportedly also writing a book on her, filed a writ petition before the Supreme Court to consider giving euthanasia to her. Thus, the most delicate issue in Indian medico history came before a two member bench of honorable Mr. Justice Markenday Katju and Gyan Sudha Mishra.

In the words of the Hon'ble judges: " we feel like a ship in an uncharted sea, seeking some guidance by the light thrown by the legislations and judicial pronouncements of foreign countries, as well as the submissions of learned counsels before us." Such was the delicacy and difficulty of deciding the issue.

The verdict was a unique one- the first of its kind in India's medico legal history and has been pronounced by the honorable judges after thorough deliberations and enquiries and

also lays down parameters for permitting passive euthanasia in certain cases albeit utmost caution. The judgment also lays down procedures to be followed by the High Courts while entertaining petitions of this sort until a law on the subject is made by the Indian Parliament. Thus, the judgment is a must read for everyone.

In her petition, Ms. Virani explained Aruna's critical condition to drive home the point that she has been reduced to a virtually dead person with no chance of recovery. She narrated at length to the Court that her teeth have decayed, wrists were twisted, she has no awareness of her surroundings, she could neither properly listen nor see and that her brain has been damaged severely beyond repair. Judging from any parameter, Aruna cannot be said to be a living person.

The senior counsel for the petitioner relied on the decision of the Apex Court in the case of *Vikram Deo Singh Vs State of Bihar* 1988 (supp.) SCC 734 wherein it was observed:

"We live in an age when this court has demonstrated, while interpreting Article 21 of the Constitution that every person is entitled to a quality of life consistent with his human personality. The right to live with human dignity is the fundamental right of every citizen." Relying on another case, he argued: life is not mere living but living in health. Health is not the absence of illness but a glowing vitality.

There were two counter affidavits to the petition filed by Dr. Sanjay Oak, dean of KEM Hospital and Dr. Pazare, Professor at KEM hospital in which both of them strongly opposed the admission of petition. Dr. Oak was particularly overwhelmed and emotional, he said: "Aruna means a lot to KEM hospital.