Page 964 - 974

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Cadaveric Organ Donation in India: A Critical Appraisal of the Legal Framework

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ABSTRACT

Cadaveric organs are among the least utilised in India in cases of brain death, leading to an acute shortage of organs that needs to be addressed. Although the statute on organ and tissue donation and transplantation was passed by Parliament in 1994 and amended in 2011, three decades on, the cadaveric donor rate has remained below one per million population (PMP). This study undertakes a jurisprudential and socio-legal examination of cadaveric organ and tissue donation in India. It traces the legislative history, sets out the procedure for brain-death certification, examines the consent framework, assesses the central government's institutional establishment of NOTTO, and probes the cultural, ethical and constitutional dimensions of the subject. It also throws light on the leading judicial decisions that have interpreted organ transplantation as an essential element of the fundamental rights under Article 21 of the Constitution of India. The article identifies the need for structural and organisational transformation, including an opt-out consent model, improvement in infrastructure and stronger inter-agency coordination, to reduce the gap between organ demand and supply.

Keywords: *cadaver organ donation, brain death, THOA 1994, THOTA 2011, NOTTO, Article 21, organ transplantation, consent, Indian legal framework*

I. INTRODUCTION: THE GIFT OF LIFE AND THE WEIGHT OF LAW

Cadaveric transplantation involves the donation of organs after death, by a stranger, to a person in need for therapeutic purposes. It saves human lives, and the humanitarian act is thereby preserved. Cadaveric or deceased organ donation involves the medical retrieval of usable organs from an individual who is brain dead or has died an unnatural death; certain organs can also be utilised where a person has died naturally, subject to age and the duration since death. It represents humanity at its highest. In India, out of 1.4 billion people, only about 1,100 cadaveric donations were recorded in 2023.[1] An estimated 500,000 people die every year for want of organs for transplantation: approximately 200,000 kidneys are needed each year, yet only about

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[1] NATIONAL ORGAN AND TISSUE TRANSPLANT ORGANISATION, ANNUAL REPORT 2023-24 (2024), https://notto.mohfw.gov.in/WriteReadData/Portal/News/858_1_Updated_NOTTO_ANNUAL_REPORT__08-05-24_.pdf.

 [ISSN 2581-5369]

10,000 transplants are carried out annually.[2] Many patients wait for the same single organ, and the national cadaveric organ donation registry carries a long waiting list.

The gap between potential donors and actual delivery is not only a medical problem; it also involves legal, organisational and cultural issues. India moved to regulate organ and tissue transplantation in 1994 by enacting the Transplantation of Human Organs Act (THOA),[3] which was subsequently amended in 2011[4] and further elaborated by rules in 2014,[5] and which forms the underpinning of India's organ donation jurisprudence. The difference between legal ambition and medical reality, however, remains gigantic. This paper attempts to highlight how the law is formulated, where it prospers, and where it continues to fail the hundreds of thousands of patients who place their hope in a system that too often disheartens them.

This study proceeds as follows. Part II traces the legislative history from pre-THOA confusion to the current statutory scheme. Part III examines the medical and legal architecture of brain-death certification. Part IV examines the consent framework and its contested limitations. Part V assesses the institutional ecosystem, including the National Organ and Tissue Transplant Organisation (NOTTO). Part VI addresses the constitutional and judicial dimensions, including the jurisprudence of Article 21 (right to life and personal liberty). The paper concludes with an assessment of unsettled challenges and a set of reform recommendations.

II. Legislative History: From Unregulated Trade to Statutory Structure

There was no governing legislation on organ transplantation in India before 1994. The practice evolved in the shadow of general medical negligence law and ethics, agreements between private parties, and the supervisory authority of state medical councils.

The absence of a specific framework created fertile ground for abuse. By the late 1980s, India had developed a notorious organ trade market, fuelled by financial desperation, unscrupulous middlemen and compliant private hospitals. The victims were typically impoverished individuals forced or deceived into selling their kidneys; the recipients were often wealthy medical tourists seeking to evade the restrictive laws in force in their home nations.[6]

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[2] Bedanta Sarma et al., *Cadaveric Organ Donation: Indian Perspective*, 11 INDIAN J. FORENSIC & COMMUNITY MED. 44 (2024).
[3] The Transplantation of Human Organs Act, No. 42 of 1994, INDIA CODE (1994).
[4] The Transplantation of Human Organs and Tissues (Amendment) Act, No. 16 of 2011, INDIA CODE (2011).
[5] The Transplantation of Human Organs and Tissues Rules, 2014, MINISTRY OF HEALTH & FAMILY WELFARE, Gov't of India (2014).
[6] Aradhana Yadav et al., *Development of Organ Transplantation in Light of Criminal and Constitutional Laws in India*, 18 INDIAN J. TRANSPLANTATION 274 (2024).

 [ISSN 2581-5369]

The THOA 1994 represented a legislative turning point. Enacted initially pursuant to resolutions of the States of Maharashtra, Himachal Pradesh and Goa, the Act applied by default to those states and to all Union Territories; in due course, other states adopted it.[7] The statute pursued three initial objectives: first, it prohibited commercial transactions in human organs and tissues, prescribing criminal penalties for abuses; second, it shaped a structured framework for both living-donor and cadaveric-donor transplantation; and third, and most meaningfully for present purposes, it recognised brain-stem death as a form of death under Indian law, thereby clearing the path for deceased-donor organ retrieval. The Act underwent momentous amendment through the Transplantation of Human Organs and Tissues (Amendment) Act, 2011 (THOTA).[8]

The amended Act expanded the definition of 'near relative' to include grandparents and grandchildren; introduced the concept of 'swap donation', permitting kidney exchanges between paired donors and recipients; mandated the registration of tissue banks; unified provisions for retrieval centres; and, critically, created the statutory basis for NOTTO. The rules were revised in 2014, and the national guidelines for organ allocation were updated in February 2023, when the upper age limit of 65 years for recipients registering on deceased-donor waiting lists was eliminated.[9]

A distinctive feature of the Act is its applicability. Health is a State subject under the Seventh Schedule to the Constitution, and THOA operates as a Central Act which requires state acceptance. While most Indian states have adopted it, Andhra Pradesh and Jammu and Kashmir historically maintained parallel frameworks.[10] This federal fragmentation has produced discrepancies in application standards, waiting-list norms and implementation mechanisms that continue to affect equitable organ distribution across the nation.

III. Brain Death: The Legal and Medical Threshold for Cadaver Donation

Brain-stem death means the irreversible cessation of brain-stem functions, and it is the *sine qua non* of cadaveric organ donation.[11] Only upon legal recognition of death can the organs of a patient on a ventilator be removed for transplantation; anything to the contrary would amount to homicide. Section 2(d) of THOA defines 'brain-stem death' as the stage at which all functions

[7] The Transplantation of Human Organs Act, *supra* note 3, pmbl. & sec. 1(2).
[8] The Transplantation of Human Organs and Tissues (Amendment) Act, *supra* note 4; Bharat Vallabhdas Shah, *Legal Aspects of Transplantation in India*, 12 INDIAN J. TRANSPLANTATION 169 (2018).
[9] MINISTRY OF HEALTH & FAMILY WELFARE, Gov't of India, *National Guidelines for Organ and Tissue Transplantation* (2023).
[10] Manjusha Yadla, *Legal Policies of Organ Transplantation in India: Basics and Beyond*, 30 SAUDI J. KIDNEY DISEASES & TRANSPLANTATION 943 (2019).
[11] EELCO F.M. WIJDICKS, BRAIN DEATH (2d ed. 2011).

 [ISSN 2581-5369]

of the brain-stem have permanently and irreversibly ceased.[12] To certify brain death, there must be a Board of Medical Experts consisting of four physicians: the medical officer in charge of the hospital, the registered medical practitioner treating the patient, a neurologist or neurosurgeon, and an independent registered medical practitioner nominated from a panel approved by the Appropriate Authority.[13] Two appraisals of brain-stem function, six hours apart, are mandatory, and both examinations must return identical results before death is declared. This two-step protocol, strictly followed to safeguard against premature or erroneous certification, results in delay that can compromise the viability of retrievable organs. Two of the four certifying physicians must not be involved in the transplant surgery; this is an important conflict-of-interest safeguard, as it prevents the certifying team from having a clinical stake in the declaration of the patient's death.

A noteworthy gap in the Indian legal framework on organ donation is its silence on ancillary confirmatory tests. Recourse to supplementary investigations, such as four-vessel cerebral angiography and transcranial Doppler ultrasound, where clinical brain-stem testing is inconclusive or cannot be performed, has been proposed by the World Brain Death Project, an international consensus document.[14,15] THOA and the rules framed under it contain no guidelines on such tests, creating uncertainty for clinicians handling unusual cases. The resulting legal void has been identified as a material barrier to effective brain-stem-death certification.[16]

The definition of death under the Registration of Births and Deaths Act, 1969 differs from brain-stem death under THOA, and the 1969 Act has never been amended to incorporate neurological principles.[17]

This bifurcation has real-world consequences: a patient certified as brain dead under THOA is simultaneously alive under the 1969 Act for all other legal purposes, including inheritance and insurance. The delinking of brain-stem death from the general law of death creates confusion for families, generates medico-legal ambiguity in contested cases, and complicates the practical

[12] The Transplantation of Human Organs Act, *supra* note 3, sec. 2(d).
[13] *Id.* sec. 3(6); The Transplantation of Human Organs and Tissues Rules, 2014, *supra* note 5, Form 10.
[14] David M. Greer et al., *Determination of Brain Death/Death by Neurologic Criteria: The World Brain Death Project*, 324 JAMA 1078 (2020).
[15] Eelco F.M. Wijdicks et al., *Evidence-Based Guideline Update: Determining Brain Death in Adults*, 74 NEUROLOGY 1911 (2010).
[16] D. Choudhary et al., *Challenges in Brain-Death Certification in India*, 70 NEUROLOGY INDIA 1162 (2022).
[17] The Registration of Births and Deaths Act, No. 18 of 1969, INDIA CODE (1969).

 [ISSN 2581-5369]

administration of intensive care units, where maintaining a ventilated, brain-dead patient occupies a bed; the donation of that patient's organs could save another life.[18,19]

IV. The Consent Framework: Autonomy, Family, and the Limits of Law

India has adopted an opt-in consent model for deceased organ donation. An individual may, during his or her lifetime, sign a donor card or similar instrument expressly consenting to posthumous organ and tissue donation. However, no such pledge, wish or consent is legally binding on the family after the death of the individual, even where the deceased had signed such an instrument. A few countries, such as France and Spain, follow a presumed-consent or soft opt-out model.[20,21]

The ethical architecture of Indian healthcare is deeply rooted in the family's pre-eminent role in consent, as a matter of cultural accommodation. The obligations of the next of kin, grief and communal belief are all negotiated alongside organ donation; the individual's own wish is rarely determinative. Families' decisions are overwhelmingly shaped by religious beliefs about the soul's post-mortem journey, fears of physical disfigurement, apprehensions about the authenticity of brain death, and cynicism towards the healthcare system. Qualitative research among Indian transplant coordinators has borne this out.[22] In most cases, families who have not discussed donation in advance are approached by transplant coordinators amid the acute grief of an ICU setting, a deeply disadvantaged context for nuanced decision-making.

The recognition of the living will under Article 21 by the Supreme Court of India in *Common Cause v. Union of India*[23] opened a possible path for strengthening individual autonomy in organ donation decisions.

An appropriately executed advance directive that lays down organ donation preferences carries statutory weight; however, it remains subsidiary to practical family dynamics in the absence of

[18] Sunil Shroff & Sumana Navin, *"Brain Death" and "Circulatory Death": Need for a Uniform Definition of Death in India*, 3 Indian J. Med. Ethics 321 (2018).
[19] Palepu B.N. Gopal, *Death, Brain Death, and Organ Donation: A Work in Progress*, 24 Indian J. Critical Care Med. 748 (2020).
[20] World Health Organization, *Guiding Principles on Human Cell, Tissue and Organ Transplantation*, WHA Res. 63.22 (2010).
[21] Preetha Vijayalakshmi & Yashfeen M., *Consent for Organ Donation in India: Factors, Challenges, and Opportunities - A Review*, 1 J. Indian Physician Assocs. art. 3 (2024).
[22] Britzer Paul Vincent, Gurch Randhawa & Erica Cook, *A Qualitative Study Exploring Barriers and Facilitators in Deceased Organ Donation Process Among Transplant Coordinators in India*, 14 Scientific Reports 28591 (2024), https://doi.org/10.1038/s41598-024-80290-9.
[23] *Common Cause (A Regd. Society) v. Union of India*, (2018) 5 SCC 1 (India).

a hard legal mandate. A critical gap also remains in the absence of a centralised, legally enforceable donor registry that the hospital which is to consult the donor's family can rely upon.

The deliberation over opt-in versus opt-out is not simply procedural but philosophical. In an opt-out system, consent is presumed unless an individual has openly expressed and registered an objection. This raises serious concerns about individual sovereignty, informed consent and the relationship between the state and bodily integrity. In a country as diverse as India, where a Dalit Christian in Nagaland, a Muslim weaver in Varanasi and a Jain trader in Ahmedabad may hold conflicting views on post-mortem bodily intervention, a blanket assumption of consent risks profound cultural estrangement.[24] The 'soft opt-out' system followed in Wales and Spain, which retains a family consultation requirement but shifts the default presumption, may represent a constitutionally and culturally defensible middle path.

V. Institutional Architecture: NOTTO, ROTTO, SOTTO and the Allocation Ecosystem

The institutional machinery for organ procurement and allocation in India is organised on a three-tier pyramidal model. At the apex sits NOTTO, recognised under THOTA 2011 and operationalised in 2014 under the Directorate General of Health Services, Ministry of Health and Family Welfare. NOTTO serves as the apex coordinating centre for all-India activities relating to organ and tissue procurement, allocation, distribution and national registry management. It issues policy guidelines and protocols, compiles registry data from states and regions, monitors transplantation activity, coordinates inter-state organ allocation, and promotes awareness of deceased donation.

Below NOTTO operate the Regional Organ and Tissue Transplant Organisations (ROTTOs), which coordinate organ procurement and allocation within assigned geographic regions, while the State Organ and Tissue Transplant Organisations (SOTTOs) function at the state level as the nodal coordinating bodies interfacing with individual transplant hospitals. A key empirical marker of NOTTO's institutional impact is the doubling of the deceased organ donation rate from 0.27 per million population in 2013, before NOTTO's full operationalisation, to 0.65 per million in 2018; total organ transplants grew from 4,990 to 10,340 in the same period, placing India as the second largest transplantation nation globally after the USA.[25]

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[24] Shibu Sasidharan et al., *At the Crossroads of Culture and Medicine: Navigating Brain Death and Organ Donation Ethics in Contemporary India*, 26 Developing World Bioethics 5 (2026), https://doi.org/10.1111/dewb.12490.

[25] Vasanthi Ramesh, *Why NOTTO? The National Organ and Tissue Transplant Organisation and Why It Is Crucial to Regulate Organ Donation and Transplantation in India*, 52 Transplantation Proceedings 2930 (2020).

 [ISSN 2581-5369]

Despite this development, significant structural deficiencies remain. First, deceased donation is largely confined to urban areas and is most prevalent in the southern states. According to 2023 data, the majority of cadaveric donations were recorded in Telangana, Karnataka, Tamil Nadu, Maharashtra and Gujarat, while states such as Bihar, Jharkhand and the north-eastern states collectively contributed almost nothing.[26] Large numbers of brain-dead potential donors who die in road accidents in smaller cities, rural areas and district hospitals are never identified or approached, in the absence of adequately equipped retrieval centres.

Second, there is an acute shortage of trained transplant coordinators, the dedicated professionals who link the medical, legal and family-counselling dimensions of deceased donation.[27] The gap is being filled by nurses or social workers who are neither trained nor qualified for the role, and who receive little institutional support. An advisory issued by NOTTO in 2024 called for the creation of permanent transplant coordinator posts in every transplant centre and hospital, meeting a long-overdue demand for professional support to the donation ecosystem.

Third, the organ allocation rules which determine who will receive a donated organ, based on medical urgency, compatibility, waiting time and geographical proximity, remain incoherently applied across the states. The 2023 national guidelines endeavoured to introduce greater consistency by abolishing the age ceiling and standardising allocation norms, but enforcement mechanisms remain weak.[28] A further NOTTO advisory, introducing additional allocation points for women patients and priority for donor family members on transplant waiting lists, represents a creditable equity initiative, though the fidelity of its implementation across states remains to be assessed.

VI. Constitutional and Judicial Dimensions

Under Article 21 of the Constitution of India, the judiciary has gradually interpreted organ transplantation as an expression of the fundamental right to life and personal liberty. The jurisprudential foundation was laid in *Maneka Gandhi v. Union of India*,[29] which held that the right to life encompasses the right to live with human dignity, paving the way for the recognition of health as a fundamental right. The expansive interpretation of Article 21 continued with *Parmanand Katara v. Union of India*[30] and *Paschim Banga Khet Mazdoor Samiti v. State of West Bengal*,[31] which declared that the refusal of emergency medical treatment constitutes a

[26] National Organ and Tissue Transplant Organisation, *supra* note 1.
[27] Vincent et al., *supra* note 22.
[28] Ministry of Health & Family Welfare, *supra* note 9.
[29] *Maneka Gandhi v. Union of India*, (1978) 1 SCC 248 (India).
[30] *Parmanand Katara v. Union of India*, (1989) 4 SCC 286 (India).
[31] *Paschim Banga Khet Mazdoor Samiti v. State of West Bengal*, (1996) 4 SCC 37 (India).

 [ISSN 2581-5369]

breach of Article 21. On this reasoning, bureaucratic delay and administrative obstructionism in the processing of transplant authorisations amount to a constitutional violation. In *Uvais Muhammed K.C. v. State of Kerala*,[32] the Kerala High Court quashed orders of the Authorisation Committee that had repeatedly forbidden an altruistic kidney donation without acceptable explanation, directing the committee to grant approval within a week under threat of deemed authorisation.

The financial disparity between donor and recipient alone cannot be a ground for rejecting an application for non-relative donation, and the Supreme Court in *Association of Medical Superspeciality Aspirants & Residents v. Union of India*[33] recognised the right to health as part of the fundamental rights under Article 21. In *Aruna Ramachandra Shanbaug v. Union of India*,[34] the Supreme Court's directions, though primarily concerned with passive euthanasia, tacitly strengthened the legal framework for brain-stem-death certification under THOA by endorsing the procedures for ascertaining brain death as a precondition for cadaveric organ donation. The High Court of Bombay has further held, in consonance with this jurisprudence, that a patient's need for an organ transplant is directly a facet of the right to life guaranteed under Article 21, imposing a corresponding state obligation to ensure that the transplantation system functions efficiently, transparently and equitably.[35]

Recently, the Supreme Court has called for a uniform organ transplantation policy across the nation, emphasising that patients with comparable medical conditions should not face fundamentally different outcomes based purely on the state in which they reside.[36] The Court grounded this directive in Article 14 (equality before law) read with Article 21, holding that the discrepancies in waiting-list management, priority criteria and allocation protocols across states are constitutionally suspect. This developing jurisprudence places significant pressure on the Union Government to draft a comprehensive national policy that sets minimum uniform standards, establishes transparent digital registries and provides for regular independent audits. The Authorisation Committee system, intended as a safeguard against commercial dealings but in practice often a bottleneck, deserves particular judicial and legislative attention.[37] High Courts across the country have consistently found that committees deny applications without

[32] *Uvais Muhammed K.C. v. State of Kerala*, 2025:KER:195, W.P.(C) No. 45300 of 2024 (Ker. H.C.) (India).
[33] *Association of Medical Superspeciality Aspirants & Residents v. Union of India*, (2019) 8 SCC 607 (India).
[34] *Aruna Ramachandra Shanbaug v. Union of India*, (2011) 4 SCC 454 (India).
[35] *Harshad Rohidas Bhoite v. State of Maharashtra*, 2025 SCC OnLine Bom 1706 (India).
[36] *Indian Society of Organ Transplantation v. Union of India*, 2025 INSC 1361 (India).
[37] Anushka Pandey, *From Brain Death to Bureaucratic Delay: A Critical Appraisal of India's Organ Transplant Regime*, LIVELAW (Jan. 27, 2026), https://www.livelaw.in/lawschoolcolumn/organ-transplantation-bureaucratic-delay-520698.

adequate reasoning, apply inconsistent criteria, and fail to balance the prevention of organ trading against the facilitation of genuine altruistic donations. A more structured, judicially reviewable authorisation process, with compulsory written reasoning, time-bound disposal and a designated appellate mechanism, would both protect against exploitation and respect the fundamental rights of patients in dire medical need.

VII. Challenges and the Path Forward

Cadaveric organ donation in India is characterised by an incongruity: a legal framework that is comparatively sophisticated in its formal structure, and a practical reality that remains deeply inadequate. The challenges fall into three clusters: legal, institutional and socio-cultural.

A. Legal and Regulatory Challenges

The non-binding character of the deceased donor's consent, which the family may override, structurally undermines personal autonomy. The divergence between brain-stem death under THOA and the general law of death under the Registration of Births and Deaths Act, 1969 generates persistent medico-legal ambiguity.[38] The absence of guidelines on ancillary tests for certification in complex cases limits clinical confidence and organ recovery.[39] Federal fragmentation has produced inequitable stages of adoption and implementation of THOA across the states.

B. Institutional Challenges

A notable failure of the Indian organ donation network is the under-identification of potential brain-dead donors in smaller hospitals and the trauma centres of district hospitals; rural hospitals go largely unnoticed. The shortage of trained transplant coordinators weakens the family approach and consent process. The concentration of retrieval and transplant infrastructure away from rural areas creates geographical imbalance in both donation and access. Inconsistent application by the State SOTTOs of the national organ allocation protocols undermines the principle of equitable distribution.

C. Socio-Cultural Challenges

Indian society labours under persistent misunderstandings about organ donation, including fears of bodily disfigurement, concerns for the integrity of the soul post mortem, and

[38] Pulkit Athavle & K.S. Uplabdh Gopal, *Consent Without Capacity: Structural Hurdles in India's Organ Donation Ecosystem*, Observer Research Foundation Special Report No. 296 (2026), https://www.orfonline.org/research/consent-without-capacity-structural-hurdles-in-india-s-organ-donation-ecosystem.

[39] Choudhary et al., *supra* note 16.

 [ISSN 2581-5369]

misapprehension of the definition and reality of brain death.[40] Decisions are taken by family members according to their own cultural frames, which frequently override registered donor preferences in the absence of properly coordinated conversations within families before death. Consent rates are further depressed by public distrust of the healthcare system, aggravated by occasional transplant scandals and perceptions of unequal allocation of organs. These challenges call for evidence-based transformation.

First, India should seriously consider moving from a hard opt-in to a soft opt-out consent model, under which consent to cadaveric organ donation is presumed unless an individual has registered a clear objection, while the family retains a meaningful consultation right. This model has already been implemented in Wales and Spain, with positive results; it expands the pool of potential organ donors while protecting cultural sensitivity.[41] Its implementation would require legislative amendment of THOTA and a continuous public awareness campaign.

Second, the formal recognition of brain-stem death as a legal definition of death requires amendment of the Registration of Births and Deaths Act, 1969, eradicating the current bifurcation and resolving the medico-legal vacuum it creates.

Third, the rules on confirmatory tests for brain-stem-death certification need to be amended in line with international consensus protocols.

Fourth, a mandatory national digital donor registry should be created, consultable at the time of admission to hospital, enabling real-time verification of donor preferences and ensuring that registered wishes inform, even if they do not bind, family negotiations.

Fifth, infrastructure decentralisation is essential: every district hospital and government medical college should have an organ retrieval centre, with emergency responders and ICU teams trained to identify probable donors.

Sixth, transplant coordinators must be professionalised, with the creation of a dedicated cadre, standardised training curricula and statutory recognition of the role.

Finally, a programme of continued religious and community outreach, illustrating the recognised support for organ donation within the Hindu, Muslim, Christian, Sikh and Jain religious traditions, can progressively erode the myths that suppress family consent rates.

[40] Sarma et al., *supra* note 2.
[41] Vijayalakshmi & Yashfeen M., *supra* note 21.

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VIII. CONCLUSION

Cadaveric organ donation engages medicine, law, ethics and the deepest human instincts about death. The Transplantation of Human Organs Act, 1994 and its amendment in 2011 signify an honest and evolving effort to balance the necessities of organ availability, donor protection and the prohibition of commercial exploitation.

Meaningful legal evolution has occurred: India's progressive constitutional jurisprudence recognises health as part of the fundamental right to life and personal liberty under Article 21; brain-stem death has been legally recognised; NOTTO has been created; and swap organ donation has been introduced. Yet the law has not kept pace with the necessity of transplantation. The estimated 500,000 Indians who die each year awaiting transplants are not victims of legislation; they are victims of execution failure, institutional weakness, cultural resistance and political inertia.

There are many brain-dead patients, potential donors who die in district hospitals or rural health care centres, whose families are never approached by a trained counsellor and for whom no retrieval team is available. Owing to this systemic failure, the wishes of registered donors who chose to donate their organs after death are overridden by their uninformed family members. That is not a medical disaster but a failure of law and institutions. The conviction that every cadaveric organ should be utilised in the humane service of life is one that transcends the boundaries of jurisprudence; it speaks to something ancient and universal: the instinct to give, to leave something of oneself in the world, to ensure that one's ending is another's beginning, life after life. The task before Indian law, medicine and society is to build the institutional, legal and cultural infrastructure that makes this desire actionable for every willing citizen. That is not simply a policy challenge; it is a moral responsibility towards humanity and the nation.

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