Page 3653 - 3662 **DOI:** *https://doij.org/10.10000/IJLMH.1110220*

INTERNATIONAL JOURNAL OF LAW MANAGEMENT & HUMANITIES

[ISSN 2581-5369]

Volume 8 | Issue 3

2025

Understanding India's Draft Guidelines on Passive Euthanasia

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ABSTRACT

The suggested passive euthanasia guidelines released by the Indian Union Health Ministry are discussed in this article. The guidelines attempt to establish a systematic and morally justified system for withdrawing or withholding life-sustaining treatment (LST) in terminally ill patients. This system takes into account the right to die with dignity under Article 21 of the Constitution. Clinicians face a legal and moral dilemma in the care of patients at the end of life; these recommendations, prepared with the assistance of AIIMS specialists, are intended to assist. Among the conditions under which passive euthanasia may be warranted are brainstem death, treatment with no beneficial impact, and informed refusal by the patient or his representative, as covered in the suggestions.

The landmark Supreme Court ruling in Common Cause v. Union of India (2018), legalizing passive euthanasia and facilitating living wills, is the foundation upon which this is based. With ensuring due medical and ethical diligence, the norms simplify previously complicated processes, ushering in a truce between the sanctity of life and death's dignity. The essay continues on to discuss the financial and psychological burdens of unnecessary treatment, emphasizing ways in which humane withdrawal of treatment can reduce suffering and preserve a patient's autonomy.

Finally, we consider how the law is changing, from the judge-centered approach to a patient-centered approach, indicating a movement toward honoring patients' rights to decide for themselves regarding their end-of-life care. Finally, the standards proposed are a giant leap towards bringing medical practice in line with constitutional principles and ethical commitments to promote, within a firm legal framework, the humane care of terminally ill patients.

I. INTRODUCTION

The jurisprudential dimension of passive euthanasia lies at the confluence of legal norms and medical values, forming the cornerstone for its regulation and discourse. The core centre of this idea is the recognition of the "right to die with dignity," a principle that has been accorded legal sanctity by the Hon'ble Supreme Court of India in *Common Cause (A Regd. Society) v.*

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Union of India.[2] This landmark judgment, building upon the precedent set in *Aruna Ramachandra Shanbaug v. Union of India*[3], unequivocally acknowledged passive euthanasia as a facet of Article 21 of the Constitution, which guarantees the right to life and personal liberty. The Court held that the right to live with dignity includes the right to a dignified end, and in circumstances where medical treatment merely prolongs the process of dying without hope of recovery, the withdrawal of life-sustaining measures aligns with constitutional principles. This legal recognition harmonises the rights of terminally ill patients with the ethical obligations of the medical profession, creating a framework that upholds autonomy, compassion, and dignity at the end of life.

The Union Health Ministry has laid draft guidelines on the sensitive issue of withdrawing or withholding medical treatment for terminally ill patients. These guidelines, developed by experts from AIIMS, aim to fill a long-standing gap that has left healthcare professionals uncertain about their legal and ethical boundaries. They empower patients to make informed choices about life support and resuscitation. The draft also permits withdrawing supportive care, such as ventilation, dialysis, or ECMO, under specific conditions—when a patient has been declared brain dead, when advanced interventions are unlikely to help, and when the patient or their representative has provided an informed refusal of care.[4]

Dr Sushma Bhatnagar, a palliative care professor at AIIMS New Delhi, shared with Indian Express, "We've been doing this informally for years. Once a patient is determined to be terminal, we counsel them and their families about withdrawing care, ensuring they are comfortable and can spend their remaining time at home. However, there has never been a clear legal framework or guidelines for this process."[5]

II. EUTHANASIA

Euthanasia is the act of deliberately ending a person's life to eliminate pain or suffering. Ethicists differentiate between active and passive euthanasia. **Passive euthanasia** entails the deliberate decision to withhold or withdraw medical interventions, like life support, with the aim of permitting a person's natural death. **Active Euthanasia** is the intentional act of killing a terminally ill patient on voluntary request, by the direct intervention of a doctor, for the

[2] (2018) 5 SCC 1.
[3] (2011) 4 SCC 454.
[4] Govt comes up with new draft guidelines on passive euthanasia, Indian Express, https://indianexpress.com/article/cities/delhi/govt-comes-up-with-new-draft-guidelines-on-passive-euthanasia-9593697/ (Sep. 30, 2024).
[5] Govt comes up with new draft guidelines on passive euthanasia, Indian Express, https://indianexpress.com/article/cities/delhi/govt-comes-up-with-new-draft-guidelines-on-passive-euthanasia-9593697/ (Sep. 30, 2024).

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purpose of the good of the patient. It is illegal in India.

III. PASSIVE EUTHANASIA: A GLOBAL PERSPECTIVE

Several laws and professional codes in different legal jurisdictions have addressed passive euthanasia, which is the deliberate withholding or withdrawal of therapy to prolong life when the patient is unable to recover. It is possible to apply the shared ethical standards and many procedural protections offered by five jurisdictions to the proposed recommendations in India.[6]

The Netherlands

Active and passive euthanasia are legal in the Netherlands under strict regulations since the 2002 Termination of Life on Request and Assisted Suicide Act.[7] The four pillars upon which passive euthanasia rests are as follows: (1) an informed, freely given request by the patient (or an advance directive in the event of a disabled patient); (2) the affirmation by two separate medical professionals that the pain is intolerable and not curable; (3) documentation of the patient's consent; and (4) the obligatory reporting of every case to regional review committees.[8] To ensure that the decision to remove life support is neither subjective or based on doctors' opinions alone, this model stresses openness, structured oversight, and clear criteria for "unbearable suffering."[9]

Belgium

The Euthanasia Act of 2002 legalized active euthanasia in Belgium, going beyond passive procedures and being closely regulated.[10] For any kind of terminal care, the following are essentials: (5) each case must be referred to a federal commission; (1) the patient must have the mental capacity to make an informed decision; (2) the patient must be in constant and unbearable physical or mental pain; (3) a second doctor must evaluate the patient (and a psychiatrist must be involved if the case is not terminal); (4) a written advance declaration must direct treatment; and (5) the patient must be in competent legal capacity.[11] In contrast to India's draft, which just covers the withdrawal of life support, Belgium's multi-disciplinary review approach provides a more holistic view on the integration of a wider range of experts,

[6] A. Ghosh, Euthanasia and the Right to Die with Dignity in India: A Jurisprudential Perspective, 4 *Indian J.L. & Hum. Behav.* 20 (2018).
[7] Termination of Life on Request and Assisted Suicide (Review Procedures) Act, 2002 (Neth.).
[8] Regional Euthanasia Review Committees, *Annual Report 2022*, https://www.euthanasiecommissie.nl.
[9] John Griffiths, Heleen Weyers & Maurice Adams, *Euthanasia and Law in Europe* (Hart Publ'g 2008).
[10] Belgian Act on Euthanasia of May 28, 2002, art. 3, Moniteur belge [M.B.] [Official Gazette of Belgium], June 22, 2002.
[11] S. Dierickx et al., Regulatory and Medical Aspects of Euthanasia in Belgium, 42 *J. Med. Ethics* 654 (2016).

as it incorporates mental-health examination.[12]

The Beaver State in the USA

The historic 1997 Death with Dignity Act, which authorizes physician-prescribed lethal medicines for adults, is only applied in one U.S. state, Oregon.[13] While the system does allow for an active process instead of a passive withdrawal, the procedures are just as stringent as the protection measures suggested by India: two verbal requests spaced fifteen days apart, one written request verified by two witnesses, and a third doctor's approval.[14] Similar to how the Indian draft mandated medical board certification before LST was removed, obligatory reporting to state agencies establishes accountability.[15]

The country "UK"

Passive euthanasia is legal in the UK according to the Mental Capacity Act of 2005 and common law, but active euthanasia is still illegal.[16] The legal system has upheld the right to refuse or discontinue treatment if it is determined to be harmful, too onerous, or otherwise not in the patient's best interest.[17] Decisions may be taken by court deputies or based on advance directives to refuse treatment (ADRTs) if the patient lacks ability.[18] The UK approach moves the emphasis from procedural steps to ethical judgment, in contrast to India's draft that specifies elaborate medical board procedures. Instead, physicians rely on generic "best interests" evaluation and, where needed, seek declaratory relief from courts.[19]

Japan

Since euthanasia is not legal in Japan, institutional standards and professional ethics control end-of-life care.[20] Doctors usually talk to patients' families and ethical boards before discontinuing therapy in terminal illness. Though they are not officially acknowledged, advance directives are certainly doable.[21] The significance of written rules in ensuring patient and practitioner safety and establishing legal clarity is highlighted by this informal,

[12] Raphael Cohen-Almagor, Euthanasia in Belgium and the Netherlands: On a Slippery Slope, 23 *Notre Dame J.L. Ethics & Pub. Pol'y* 403 (2009).
[13] Or. Health Auth., *Oregon Death with Dignity Act Annual Report* (2023), https://www.oregon.gov/oha.
[14] Or. Rev. Stat. §§ 127.800–127.995 (2021).
[15] Margaret P. Battin et al., Legal Physician-Assisted Dying in Oregon and the Netherlands, 33 *J. Med. Ethics* 591 (2007).
[16] Mental Capacity Act 2005, c. 9 (UK).
[17] Airedale NHS Trust v. Bland [1993] AC 789 (HL).
[18] Br. Med. Ass'n, *End-of-Life Care and Physician-Assisted Dying: Ethics Guidance* (2020).
[19] Richard Huxtable, *Euthanasia, Ethics and the Law: From Conflict to Compromise* (Routledge 2014).
[20] Akira Akabayashi, Brian T. Slingsby & Ichiro Kai, Perspectives on End-of-Life Decision Making in Japan, 6 *J. Palliat. Med.* 439 (2003).
[21] Atsushi Asai, Shunichi Fukuhara & Bernard Lo, Attitudes of Japanese and Japanese-American Physicians, 14 *J. Gen. Intern. Med.* 161 (1999).

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consensus-based system, which mimics the original passive euthanasia practice in India.[22]

Suggestions and Conflicting Opinions on India

All around the globe, passive euthanasia models strike a balance between respecting autonomy and preventing abuse.[23] The proposed guidelines in India align with this attitude since they make the right to die the basis for turning off life support, demand consent from the patient or surrogate, and have professional medical boards assess the case. In contrast to European models that rely on psychiatric evaluations or centralized review committees, India's plan is based on medical tribunals supervised by the Supreme Court and procedural adherence.[24] India might strengthen enforceability by forming regional monitoring committees, bringing in mental health specialists, improving reporting procedures, and training medical practitioners on a large scale.[25] This would make sure that the draft takes into account the specifics of local healthcare systems while also adhering to international standards.[26]

IV. CONDITIONS ON PASSIVE EUTHANASIA

The draft guidelines lay out certain essential requirements and circumstances when passive euthanasia may come to the rescue of patients.

The draft guidelines permit passive euthanasia under a strong basis and rare conditions to ensure that the right to life with dignity is respected without violating the sanctity of life. The decision to withdraw life-sustaining treatment (LST) must comply with the following conditions:

- **It applies to:** Many patients in the ICU are terminally ill and not expected to benefit from life-sustaining treatments (LST).
- What are LSTs? LSTs include mechanical ventilation, vasopressors, dialysis, surgical procedures, transfusions, parenteral nutrition, and extracorporeal membrane oxygenation (EMCO). This list is not exhaustive but merely illustrative.
- **When:** In such circumstances, LST is non – beneficial and increase avoidable burdens and suffering to patients such circumstances, LST is non – beneficial and increase

[22] Masayuki Kawai, Consensus-Based End-of-Life Care in Japan: Ethical and Legal Perspectives, 13 *Asian Bioethics Rev.* 67 (2021).
[23] S.B. Math & S.K. Chaturvedi, Euthanasia in India: General Opinions and Legal Aspects, 136 *Indian J. Med. Res.* 899 (2012).
[24] Common Cause v. Union of India, (2018) 5 S.C.C. 1 (India).
[25] Supreme Court of India, Modified Guidelines on Advance Medical Directives and Passive Euthanasia (2023).
[26] Ruchi Khosla, Aligning End-of-Life Practices in India with Global Standards, 56(42) *Econ. & Pol. Wkly.* 35 (2021).

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avoidable burdens and suffering to patients and, therefore, are considered excessive and inappropriate.

Additionally, they increase emotional stress and economic hardship for the family and moral distress for professional caregivers.

- **Rationale:** Withdrawal of LST in such patients is regarded as a standard of ICU care worldwide and upheld by jurisdictions.

The conditions could be listed as:

1. The individual has been declared to have had a brainstem death
2. There is medical prognostication and a considered opinion that the patient's disease condition is advanced and not likely to benefit from aggressive therapeutic interventions,
3. A patient/surrogate documented informed refusal, following prognostic awareness, to continue life support.
4. Compliance with procedures prescribed by the Supreme Court.

Brain stem death is when a person no longer has any brain stem functions and has permanently lost the potential for consciousness and the capacity to breathe. When this happens, a ventilator keeps the person's heart beating and oxygen circulating through the bloodstream. A person is confirmed as being dead when their brain stem function is permanently lost.

Medically, the brain stem is the lower part of the brain that's connected to the spinal cord (part of the central nervous system in the spinal column). The brain stem is responsible for regulating most of the body's automatic functions that are essential for life. Brain death can occur when the blood and/or oxygen supply to the brain is stopped.

In 2018, the Supreme Court recognised the right to die with dignity as a fundamental right and prescribed guidelines for terminally ill patients to enforce the right. In 2023, the Supreme Court modified the guidelines to make the right to die with dignity more accessible.[27]

V. SUPREME COURT TIMELINE AND GUIDELINES

In 2002, Common Cause, a registered society, had written to the Ministries of Law & Justice, Health & Family Welfare, and Company Affairs, as well as State Governments, on the issue

[27] Euthanasia and the Right to Die with Dignity, Common Cause v Union of India, Supreme Court Observer, https://www.scobserver.in/cases/common-cause-euthanasia-and-the-right-to-die-with-dignity-case-background

of the right to die with dignity.

In 2005, Common Cause approached the Supreme Court under Article 32, praying for the declaration that the right to die with dignity is a fundamental right under Article 21. It also prayed the Court to issue directions to the Union Government to allow terminally ill patients to execute 'living wills' for appropriate action in the event that they are admitted to hospitals. As an alternative, Common Cause sought guidelines from the Court on this issue and the appointment of an expert committee comprising lawyers, doctors, and social scientists to determine the aspect of executing living wills.

Common Cause argued that terminally ill persons or those suffering from chronic diseases must not be subjected to cruel treatment. Denying them the right to die in a dignified manner extends their suffering. It prayed the Court to secure the right to die with dignity by allowing such persons to make an informed choice through a living will.

On February 25th 2014, a three-Judge Bench of the Supreme Court comprising the then P. Sathasivan CJI, Ranjan Gogoi and Shiva Kirti Singh JJ had referred the matter to a larger bench, to settle the issue in light of inconsistent opinions in Aruna Ramchandra Shanbaug v Union Of India (2011) and Gian Kaur v State of Punjab (1996).

On March 9th 2018, a five-judge Bench comprising Dipak Misra CJI, A K Sikri, A. M. Khanvilkar, D Y Chandrachud and Ashok Bhushan JJ held that the right to die with dignity is a fundamental right. An individual's right to execute advance medical directives is an assertion of the right to bodily integrity and self-determination and does not depend on any recognition or legislation by a State.

On March 8th 2018, the Supreme Court delivered two concurring opinions:

- **Majority opinion** authored by Dipak Misra CJI on behalf of himself and AM Khanwilkar J
- **Concurring opinion** authored by DY Chandrachud J.

On July 19th, 2019, the Indian Society for Critical Care filed a miscellaneous application requesting a 5-judge Constitution Bench to modify some of the guidelines prescribed in the 2018 Judgment. They claim that the procedure for terminally ill patients to exercise their right to die is extremely cumbersome and requires streamlining. The case is being heard by a 5-Judge Constitution Bench led by Justice K.M. Joseph.

1. The Supreme Court introduced the biggest change to the 2018 Judgement with the removal of the Judicial Magistrate's oversight. AMD is required to be signed in the presence

of two witnesses but can be attested before a notary or a Gazetted Officer—instead of a Judicial Magistrate First Class —who can confirm that the document was executed voluntarily. This decision to remove the Judicial Magistrate from the process also reduces the administrative burden placed on them. The requirements for the Judicial Magistrate to keep a copy of the document and forward it to the District Court Registry, family members and family physician were deleted. The duty to inform the family is instead given to the 'executor' of the AMD—the patients themselves.

2. The 2018 Judgement requires the treating physician to determine if the AMD is genuine and if there is any hope of the patient being cured before they suggest withdrawing treatment. The hospital must then form a medical board comprising the head of the treatment department and at least three experts with over 20 years of experience in general medicine, cardiology, nephrology, neurology, oncology or psychiatry, with an added experience in critical care.

If the medical board certifies that the instructions in the AMD should be carried out, the District Collector is charged with creating a second medical board, which will include the Chief Medical Officer of the district. The same experience requirements will apply to the three new doctors selected for the second medical board. After visiting the patient, this medical board will decide if they agree with the decision of the hospital's medical board.

The ISCC could not convince the Bench to remove the requirement of a second medical board. However, the Bench introduced certain streamlining measures. Doctors only require five years of experience to be a part of the re-christened 'Primary' and 'Secondary' medical boards. The ISCC claimed that finding doctors with over 20 years of experience is incredibly difficult in most areas of the country.

The Secondary board will no longer include the Chief Medical Officer. Instead, the Chief medical officer will nominate a member to take their place. The minimum number of board members has been reduced to three for both boards. Both boards were instructed to arrive at a decision 'preferably within 48 hours'.

Economical and Emotional Points of View

Passive euthanasia acknowledges the vitality and intensity of the emotional and financial burden that futile LST imposes on families and also on the patient apprehending his end. The implementation must address the following:

- **Minimizing Economic Hardship:** Recognizing that prolonged ICU care without hope of recovery can lead to severe financial strain to families of the patient.

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- **Reducing Emotional Distress:** Offering palliative care options to ensure that the patient passes with dignity, minimising suffering for both the patient and their loved ones.

VI. THE 'WITHDRAWAL'

The title of the draft guidelines is – ***'Guidelines for withdrawal of life support in terminally ill patients'.*** It is notable that the draft also explains the meaning of withdrawal. Withdrawal is a considered decision in the best interests of a patient not to start a life-supporting measure in a terminally ill patient that is unlikely to benefit the patient and is likely to harm in terms of suffering and loss of dignity. This withdrawal is very pertinent and significant at this point as this is the deciding of the patient's life and death.

A considered decision in the best interests of a patient: the phrase categorically refers to a well-thought-out, deliberate decision made by the medical team, necessarily in consultation with the patient (if that is possible) or his or her family. The decision is based on the strong foundation of what is most beneficial for the patient in their current state, considering factors like the patient's quality of life, medical prognosis, and personal preferences. In the case of passive euthanasia, the decision is made after careful consideration of whether continuing medical interventions would truly benefit the patient or simply prolong the suffering of the patient in the most practical and real sense. This consideration needs to be keen and very fine because it is the question of life and death, the most vital and fundamental right guaranteed under Art. 21. The process, once performed or stopped, is irreversible, and its impact is of the highest connotation.

To not start a life-supporting measure in a terminally ill patient: This part speaks to the decision not to initiate life-supporting treatments, such as mechanical ventilation, artificial nutrition or dialysis, for a terminally ill patient. Terminally ill patients are the ones who have a condition that is incurable and expected to lead to death within a relatively short period. The decision not to start life-supporting measures showcases an understanding that in such cases, the patient's death is imminent, and further medical intervention would not alter this outcome but could lead to prolonged suffering of the patient. It could be understood as an extension in the sense of time without any actual increase of grant of 'life' in the living.

That is unlikely to benefit the patient: This part emphasises that life-support measures, in this context, offer no significant chance of improving the patient's health or medical condition or extending life in an actual and meaningful way. It's merely a prolongation or lengthening of the time and process, delaying death or postponing the last day of the patient. Provided and

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noting the fact of the terminal nature of the illness, measures like these turn out to be futile and hardly offer any substantial improvement in the quality of life, health, or bodily conditions of the patients. It does not extend the patient's existence in any appreciable way, rendering no meaning to life.

It is likely to cause harm in terms of suffering and loss of dignity. Here, the focus is on the potential negative effects of life-sustaining measures. Prolonged artificial interventions may cause physical pain, discomfort, or psychological distress, which diminishes the patient's dignity; for terminally ill patients, who may be facing inevitable death, maintaining dignity and minimising suffering becomes paramount. The Hon'ble Supreme Court, upholding the spirit of Art.21, laid that the right to life includes the right to live with dignity, and it also includes the right to die with dignity. Life-support measures could lead to a prolonged, undignified existence, where the patient's suffering is exacerbated without any hope of recovery or meaningful improvement.

In the aspect of passive euthanasia, the decision not to start life-supporting measures aligns with the ethical principles and moral basis of allowing death to occur naturally when it is certain that further medical and scientific intervention would only extend the time period and suffering and diminish the patient's dignity. There would be life, but that would be meaningless, devoid of actual living in it. Passive euthanasia, unlike active euthanasia, involves the withdrawal or withholding of life-sustaining treatments, allowing the terminally ill patient to die in a more humane and dignified manner, free from unnecessary pain or indignity. This decision must be based on the grounds of compassion and the recognition of the fact that the most ethical choice may not always be the prolongation of life at all costs but rather a relief of suffering to the human body and the securing of the patient's dignity in their final days.

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 [ISSN 2581-5369]