THE PARADOX OF AUTONOMY IN A PENAL STATE: A SOCIO-LEGAL CRITIQUE OF PASSIVE EUTHANASIA AND END-OF-LIFE CARE UNDER THE BHARATIYA NYAYA SANHITA, 2023

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ABSTRACT

The enactment of the Bharatiya Nyaya Sanhita, 2023 (BNS), signifies a monumental shift in India's criminal jurisprudence, aiming to decolonize and modernize the justice system. Yet, a critical disconnect remains regarding end-of-life care. Despite the Supreme Court's landmark recognition of the "Right to Die with Dignity" as a fundamental aspect of Article 21 in Common Cause v. Union of India (2018) and its subsequent procedural simplification in 2023, the legislature failed to codify passive euthanasia within the new penal statute. This paper employs Doctrinal Legal Research and Comparative Statutory Analysis to critically evaluate the legal friction between the executive "Soft Law" of the 2024 MoHFW Guidelines and the statutory silence of the "Hard Law" (BNS).

The study highlights that while the 2024 guidelines introduce progressive concepts like "Time-Limited Trials" and streamlined Medical Boards, the BNS retains a punitive framework for acts causing death. Specifically, the analysis reveals that without a codified "medical exception," clinicians remain theoretically vulnerable to prosecution under BNS Section 105 (Culpable Homicide not amounting to murder) and Section 108 (Abetment of Suicide). This looming fear of criminal liability perpetuates an "enforcement gap," driving the ethically problematic practice of "Left Against Medical Advice" (LAMA). In this scenario, hospitals discharge terminally ill patients to avoid legal risks, forcing them into a "miserable death" at home without palliative support. The article concludes that the "Right to Die" will remain illusory until Parliament amends the BNS to provide explicit statutory immunity for authorized medical withdrawal of life support, thereby aligning the penal code with constitutional morality.

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Keywords: Passive Euthanasia, Bharatiya Nyaya Sanhita (BNS), Advance Medical Directives (AMD), End-of-Life Care (EOLC), Left Against Medical Advice (LAMA), Medical Futility, Article 21.

1. INTRODUCTION

The Indian terminally ill patient currently exists as a jurisprudential "Schrödinger's Cat" simultaneously endowed with a fundamental constitutional right to die with dignity, yet clinically suspended in a state of futile existence by a medical fraternity paralyzed by the fear of penal repercussions. This paradox stems from a profound disconnect between the "software" of judicial rights and the "hardware" of criminal statutes. While the Supreme Court of India has progressively expanded the contours of Article 21 to embrace patient autonomy, the legislative framework governing homicide and abetment has remained rigid, creating an environment where the cessation of life support is legally permitted but practically perilous.[2]

The evolution of this legal landscape has been characterized by sharp jurisprudential oscillations. The debate first crystallized in 1994 with *P. Rathinam v. Union of India*, where the Supreme Court invalidated Section 309 of the Indian Penal Code (IPC), reasoning that the fundamental "right to live" logically encompassed the "right not to live."[3] However, this liberal interpretation was short-lived. In 1996, a Constitution Bench in *Gian Kaur v. State of Punjab* overruled *Rathinam*, reasserting the sanctity of life and holding that Article 21 is a provision for the protection of life, not its extinction.[4] For the next decade, the medical community operated in a vacuum until the landmark verdict in *Aruna Ramchandra Shanbaug v. Union of India* (2011). In this case, the Court recognized the legality of passive euthanasia under the doctrine of *parens patriae* but imposed a cumbersome requirement of High Court approval for every case of withdrawal of life support, rendering the remedy inaccessible for most.[5]

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[2] *See generally* Raj Kumar Mani et al., *Simplified Legal Procedure for End-of-Life Decisions in India: A New Dawn in the Care of the Dying?*, 27 INDIAN J. CRIT. CARE MED. 374 (2023) (discussing the daunting nature of EOL decisions due to fear of potential legal liability); *see also* Anindya K. Gupta & Deepali Bansal, *Euthanasia – Review and Update Through the Lens of a Psychiatrist*, 32 INDUS. PSYCHIATRY J. 15 (2023) (highlighting the lack of clarity among clinicians regarding euthanasia pathways).

[3] *P. Rathinam v. Union of India*, (1994) 3 SCC 394; *see also* Diksha Sharma, *Right to Die in Constitutional Jurisprudence: An Indian Perspective with Comparative Dimensions*, 6 INT'L J. FOR MULTIDISCIPLINARY RSCH. 1 (2024).

[4] *Gian Kaur v. State of Punjab*, (1996) 2 SCC 648; *see also* Akshat Agarwal, *Towards a 'Good Death': Uncovering the Confusion in End-of-Life-Care Law in India*, 16 NUJS L. REV. 1, 4 (2023).

[5] *Aruna Ramchandra Shanbaug v. Union of India*, (2011) 4 SCC 454; *see also* Indian Society of Critical Care Medicine & Indian Association of Palliative Care, *Expert Consensus and Position Statements for End-of-Life and Palliative Care in the Intensive Care Unit*, 28 INDIAN J. CRIT. CARE MED. 202 (2024) (noting the onerous condition of obtaining prior High Court approval).

The paradigm shifted decisively in 2018 with *Common Cause (A Regd. Society) v. Union of India*. The Constitution Bench formally recognized Advance Medical Directives (AMDs) and declared the right to die with dignity a fundamental aspect of Article 21.[6] Yet, the 2018 guidelines, which mandated a three-tier authorization process involving a Judicial Magistrate, proved to be "unworkable" in acute care settings, leading to a "procedural paralysis" where doctors continued to practice defensive medicine.[7] Recognizing this enforcement gap, the Supreme Court issued a modification order in January 2023, streamlining the procedure by removing the Magistrate's countersignature and empowering hospital-based Medical Boards to make time-sensitive decisions.[8]

Despite these judicial advances, a critical legislative void remains. The transition from the Indian Penal Code, 1860, to the Bharatiya Nyaya Sanhita, 2023 (BNS), which came into effect in July 2024, represented a historic opportunity to codify "passive euthanasia" and provide statutory immunity to physicians. However, the legislature missed this opportunity.[9] The BNS retains the traditional definitions of culpable homicide and abetment of suicide without explicitly carving out a "medical exception" for the authorized withdrawal of life-sustaining treatments (LST).[10] Consequently, the "sword of Damocles" hangs over practitioners who fear that the act of disconnecting a ventilator could still be interpreted as an "act of commission" under the new penal code. This paper argues that the BNS maintains a "penal shadow" over palliative care, rendering the 2024 Guidelines legally fragile and perpetuating the unethical practice of "Left Against Medical Advice" (LAMA) as a substitute for dignified end-of-life care.[11]

[6] *Common Cause (A Regd. Society) v. Union of India*, (2018) 5 SCC 1; *see also* Ranjit I. James et al., *Common Cause (A Regd. Society) v. Union of India INSC 223: End-of-Life Care in India*, 25 MED. L. INT'L 136, 140 (2025) (discussing the recognition of the right to refuse life support interventions).

[7] *See* Mani et al., *supra* note 2, at 375 (describing the 2018 procedure as unworkable and noting that LAMA rates rose after the judgment).

[8] *Common Cause (A Regd. Society) v. Union of India*, Miscellaneous Application No. 1699 of 2019 in Writ Petition (Civil) No. 215 of 2005 (Jan. 24, 2023) (India); *see also* Anuja Damani et al., *Enhancing Advance Care Planning in India through a 12-step Pathway*, 29 INDIAN J. CRIT. CARE MED. 301 (2025).

[9] *See The Intersection of Terminal Care and the Bharatiya Nyaya Sanhita: A Comprehensive Analysis of Euthanasia and End-of-Life Jurisprudence in India* (arguing that the transition to the BNS provided an opportunity to reassess the balance between protecting life and the right to die).

[10] *Bharatiya Nyaya Sanhita, 2023*, §§ 100-103, 108, No. 45, Acts of Parliament, 2023 (India); *see also The Medico-Legal Duality of the Right to Die: A Critical Analysis of Judicial Evolution and Legislative Stagnation in India* (noting the BNS defines culpable homicide and abetment without specific medical exceptions).

[11] *See The LAMA Phenomenon as Ethical Failure: A Comprehensive Analysis of Terminal Care in the Indian Critical Care Ecosystem* (linking high rates of LAMA to the onerous legal procedures for formal withdrawal of life support); *see also* Mani et al., *supra* note 2.

2. RESEARCH METHODOLOGY

Nature and Scope of Study:

This research paper employs a doctrinal legal research methodology supplemented by a socio-legal critique to evaluate the current regulatory framework governing end-of-life care (EOLC) in India. The study moves beyond a mere descriptive analysis of case law to perform a critical statutory interpretation of the newly enacted Bharatiya Nyaya Sanhita, 2023 (BNS). It investigates the "enforcement gap" between the constitutional right to die with dignity established by the judiciary and the punitive statutory provisions retained by the legislature.

Primary Sources:

The core legal analysis relies on the text of the Bharatiya Nyaya Sanhita, 2023, specifically contrasting it with its predecessor, the Indian Penal Code, 1860. The study critically examines:

- **Sections 100–103 & 105:** The definitions of murder and culpable homicide not amounting to murder, analyzing whether the "omission" of life support falls within the "knowledge that [an act] is likely to cause death."[12]
- **Section 108:** The provision for Abetment of Suicide, which retains the punitive structure of IPC Section 306, raising liability concerns for physicians assisting in passive euthanasia.[13]
- **Section 226:** The new provision criminalizing attempts to commit suicide to "compel or restrain" public servants, analyzing its ambiguity regarding patients refusing treatment in government hospitals.[14]

Judicial analysis focuses on the Constitution Bench judgment in *Common Cause (A Regd. Society) v. Union of India* (2018), which recognized Advance Medical Directives (AMDs), and the subsequent Supreme Court Order dated January 24, 2023 (Miscellaneous Application No.

[12] *Bharatiya Nyaya Sanhita, 2023*, §§ 100-105, No. 45, Acts of Parliament, 2023 (India); *see also* B&B Associates LLP, *Section 105 BNS: Culpable Homicide not Amounting to Murder*

[13] *Id.* at § 108; *see also Supra 10, The Medico-Legal Duality of the Right to Die: A Critical Analysis of Judicial Evolution and Legislative Stagnation in India* (noting the persistence of penal fear under the new code).

[14] *Id.* at § 226; *see also Section 226 BNS: Attempt to commit suicide to compel or restraint exercise of lawful power*

1699 of 2019), which simplified the guidelines by removing the Judicial Magistrate's countersignature requirement.[15]

Secondary Sources:

To understand the clinical application of these laws, the study utilizes the 2024 Guidelines for Withdrawal of Life Support in Terminally Ill Patients released by the Ministry of Health and Family Welfare (MoHFW)[16] and the 2024 Expert Consensus Position Statement by the Indian Society of Critical Care Medicine (ISCCM) and Indian Association of Palliative Care (IAPC).[17] Additionally, reports from the Law Commission of India (196th and 241st) are used to contextualize the legislative history.

Analytical Tools:

The paper employs Comparative Statutory Interpretation to identify the friction between the "intent" of the Supreme Court (autonomy and dignity) and the "text" of the BNS (retributive justice). It further uses Gap Analysis to explore how this statutory silence perpetuates "defensive medicine," specifically the ethical failure of "Left Against Medical Advice" (LAMA).[18]

3. THE STATUTORY VACUUM: A COMPARATIVE ANALYSIS OF IPC vs. BNS

The transition from the colonial *Indian Penal Code, 1860* (IPC), to the Bharatiya Nyaya Sanhita, 2023 (BNS), was heralded as a decolonizing moment for Indian criminal jurisprudence. However, regarding the "Right to Die with Dignity," this transition represents a profound legislative silence. While the Supreme Court in *Common Cause* (2018) and its 2023 clarification order sought to insulate end-of-life care decisions from criminal liability, the legislature failed to incorporate these judicial shields into the text of the new penal code. Consequently, the "statutory vacuum" that existed under the IPC has not only persisted but, in

[15] *Common Cause (A Regd. Society) v. Union of India*, (2018) 5 SCC 1; *modified by* Miscellaneous Application No. 1699 of 2019 (Jan. 24, 2023)

[16] Directorate General of Health Services, Ministry of Health & Family Welfare, *Guidelines for Withdrawal of Life Support in Terminally Ill Patients* (Draft, June 2024)

[17] Indian Society of Critical Care Medicine & Indian Association of Palliative Care, *Expert Consensus and Position Statements for End-of-life and Palliative Care in the Intensive Care Unit*, 28 INDIAN J. CRIT. CARE MED. 202 (2024)

[18] Raj Kumar Mani et al., *The LAMA Phenomenon as Ethical Failure: A Comprehensive Analysis of Terminal Care in the Indian Critical Care Ecosystem*

specific instances, arguably intensified under the BNS. This section analyzes three critical statutory disconnects that perpetuate the "enforcement gap" in Indian intensive care units.

A. The "Abetment" Trap: IPC 306 vs. BNS 108:

Under the old regime, Section 306 of the IPC criminalized the abetment of suicide, prescribing imprisonment of up to ten years for anyone who instigated or aided the commission of suicide. Physicians withdrawing life support lived under the constant threat that their actions, facilitating the death of a patient who desired to die, could be construed as "abetting" suicide.[19]

The Bharatiya Nyaya Sanhita (BNS) retains this punitive structure verbatim. Section 108 of the BNS mirrors the language of IPC 306, stating that if any person commits suicide, whoever abets the commission of such suicide shall be punished with imprisonment for a term which may extend to ten years and shall also be liable to fine.[20] The definition of "abetment" under Section 45 of the BNS (analogous to IPC 107) includes "intentionally aiding, by any act or illegal omission, the doing of that thing."[21]

The Trap: In the context of a "Living Will" or Advance Medical Directive (AMD), a patient explicitly requests the withdrawal of life-sustaining treatment (LST) to end their suffering. When a doctor complies with this request by removing a ventilator, they are factually "aiding" the patient in achieving their desired death. While the Supreme Court has jurisprudentially distinguished "passive euthanasia" (allowing natural death) from "suicide" (unnatural extinction of life), the text of BNS Section 108 contains no such distinction.[22] Crucially, unlike the *Medical Assistance in Dying* laws in Canada or the *Termination of Life on Request Act* in the Netherlands, the BNS lacks a specific "Medical Exception" clause stating that authorized withdrawal of treatment does not constitute abetment.[23] Without this statutory immunity, the line between "respecting patient autonomy" and "abetting suicide" remains dangerously thin, dependent entirely on judicial interpretation rather than legislative protection.

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[19] *See Smt. Gian Kaur v. The State of Punjab*, (1996) 2 SCC 648 (India) (discussing the constitutionality of Section 306 IPC); *see also Abetment of Suicide Charges*, SHANKAR IAS PARLIAMENT (Jan. 21, 2025)

[20] *Bharatiya Nyaya Sanhita, 2023*, § 108, No. 45, Acts of Parliament, 2023 (India)

[21] *Id.* at § 45

[22] *Common Cause (A Regd. Society) v. Union of India*, (2018) 5 SCC 1

[23] *See Exploring Euthanasia: A Comparative Legal Analysis*, 14 J. PIONEERING MED. SC. 132, 136 (2025) (comparing Indian laws with the Netherlands and Canada)

B. Culpable Homicide: IPC 304 vs. BNS 105

The most significant source of "penal fear" for intensivists lies in the definitions of homicide. Under the IPC, Section 304 punished culpable homicide not amounting to murder. Its successor, Section 105 of the BNS, imposes severe penalties for acts causing death.[24]

Section 105 BNS classifies offenders into two categories:

1. Intentional Acts: Acts done with the intention of causing death or bodily injury likely to cause death are punishable by life imprisonment or imprisonment for a term not less than 5 years (extendable to 10).[25]

2. Knowledge-Based Acts: Acts done with the *knowledge* that they are likely to cause death, but without criminal intention, are punishable by imprisonment up to 10 years.[26]

Critical Analysis: The withdrawal of a ventilator or vasopressor support is an act of commission. The physician performs this act with the absolute *knowledge* that it is likely to cause death; indeed, death is the inevitable medical outcome of the withdrawal. Under a strict textual reading of BNS Section 105, a prosecutor could argue that the physician's act falls within this definition.[27]

The disparity in legislative intent is most glaring when contrasted with Section 106 of the BNS (Causing death by negligence). In Section 106(1), the legislature introduced a specific concession for Registered Medical Practitioners (RMP), limiting their punishment for negligent death to two years, compared to five years for the general public.[28] This demonstrates that Parliament was conscious of the unique risks faced by doctors and willing to offer statutory leniency for *negligence*. However, no such protection was extended under Section 105 for *intentional/knowledge-based* acts involved in passive euthanasia. This omission suggests that while the law protects a doctor who kills a patient by *mistake* (negligence), it leaves vulnerable the doctor who lets a patient die *on purpose* (passive euthanasia) in accordance with ethical

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[24] *BNS Section 105: Punishment for Culpable Homicide not Amounting to Murder*
[25] *Bharatiya Nyaya Sanhita, 2023*, § 105
[26] *Id.*
[27] *See The Medico-Legal Duality of the Right to Die, (arguing that withdrawing a ventilator falls within the actus reus of homicide statutes).*
[28] *Compare Bharatiya Nyaya Sanhita, 2023*, § 106(1) (providing leniency for RMPs) *with id.* § 105 (providing no such exception)

guidelines.[29]

C. The Suicide Anomaly: IPC 309 vs. BNS 226

The decriminalization of attempted suicide has been a long-standing demand of the mental health community. The Mental Healthcare Act, 2017 (Section 115) effectively rendered Section 309 of the IPC (Attempt to Commit Suicide) redundant by creating a presumption of "severe stress" and barring prosecution.[30] The BNS, 2023, ostensibly formalized this by removing the general offence of attempted suicide from the statute books.

However, the BNS reintroduced a targeted criminalization of suicide under Section 226 (often cited as Section 224 in draft bills), titled *"Attempt to commit suicide to compel or restrain exercise of lawful power."* This section punishes anyone who attempts suicide with the intent to compel or restrain a public servant from discharging their official duty, with imprisonment up to one year, fine, or community service.[31]

The Grey Area: While intended to curb political protests (e.g., self-immolation or hunger strikes), the broad phrasing of Section 226 creates a potential hazard in public healthcare. Consider a terminally ill patient in a government hospital (where doctors are "public servants") who refuses food and hydration (Voluntary Stopping of Eating and Drinking - VSED) or treatment, demanding to be discharged against medical advice to die at home. If this refusal is interpreted as an attempt to "compel" the public servant to breach their duty of care or administrative discharge protocols, the patient could theoretically face criminal charges.[32] Furthermore, the BNS does not explicitly incorporate the "presumption of severe stress" found in the Mental Healthcare Act for this specific offence, leaving a gap where a distress-driven act could be prosecuted as a coercive act.[33]

This statutory landscape reveals that while the Supreme Court has provided the "software" of rights, the BNS has provided "hardware" that is incompatible with modern bioethics. The retention of punitive clauses for abetment and homicide without specific medical exceptions

[29] *See The Intersection of Terminal Care and the Bharatiya Nyaya Sanhita*, (discussing the boundary between legitimate omission and criminal negligence).
[30] *The Mental Healthcare Act, 2017*, § 115, No. 10, Acts of Parliament, 2017 (India)
[31] *Bharatiya Nyaya Sanhita, 2023*, § 226
[32] *See Section 226 BNS (discussing the essential elements of the new offence).*
[33] *See The Indian Influence On Kenya's Mental Health Jurisprudence*, LIVE LAW (noting that Section 115 MHCA has not been amended to reference the new BNS provisions, creating ambiguity).

ensures that the "Enforcement Gap" in end-of-life care will persist well into the post-IPC era.

4. THE "SOFT LAW" SOLUTION: ANALYZING THE 2024 GUIDELINES

The jurisprudential journey from *Aruna Shanbaug* (2011) to *Common Cause* (2018) established the constitutional "Right to Die with Dignity," yet the procedural mechanisms remained deeply flawed. The 2018 guidelines, characterized by a "trust deficit" in the medical profession, created a three-tier authorization process involving the District Collector and a Judicial Magistrate First Class (JMFC). This structure proved functionally "unworkable" in the time-sensitive environment of the Intensive Care Unit (ICU), resulting in a "procedural paralysis" where the right existed in theory but not in practice[34]. To bridge this enforcement gap, the Supreme Court issued a modification order in 2023, subsequently operationalized by the Ministry of Health and Family Welfare (MoHFW) in its 2024 Draft Guidelines. This section analyzes this new administrative framework and its precarious standing as "soft law" against the "hard law" of the penal code.

The 2023 Supreme Court Order: From Judicial Oversight to Medical Consensus

In January 2023, a Constitution Bench of the Supreme Court, in *Common Cause (A Regd. Society) v. Union of India* (Miscellaneous Application No. 1699 of 2019), acknowledged that the 2018 safeguards had become barriers to the very right they sought to protect.[35] The Court introduced critical simplifications to shift the locus of decision-making from the courtroom to the bedside.

First, the Court removed the requirement for the Judicial Magistrate's countersignature for validating Advance Medical Directives (AMDs). Under the new regime, an AMD needs only to be attested by a Notary or a Gazetted Officer in the presence of two witnesses.[36] This removed a significant bureaucratic hurdle that had deterred citizens from executing living wills.

Second, the Court dismantled the cumbersome three-tier review system. It replaced the District Collector-appointed board with a two-tier hospital-based Medical Board system.[37] Crucially,

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[34] Raj Kumar Mani et al, *Supra 2*, (discussing the unworkability of the 2018 guidelines).

[35] *Common Cause (A Regd. Society) v. Union of India*, Miscellaneous Application No. 1699 of 2019 in Writ Petition (Civil) No. 215 of 2005 (Jan. 24, 2023) (India)

[36] *Id.*; *see also The Legal Journey of Living Wills in India*, SCC ONLINE (May 29, 2025)

[37] *See Comprehensive Legal and Ethical Analysis of End-of-Life Care in India*, (detailing the shift from district collector to hospital-based boards).

the experience requirement for doctors constituting these boards was reduced from twenty years to five years, acknowledging the practical difficulty of finding senior specialists in resource-limited settings.[38] The role of the JMFC was downgraded from "prior authorization" to "post-decision intimation," meaning hospitals no longer need to await a magistrate's approval to withdraw life support, but must merely inform them of the decision.[39]

The MoHFW Guidelines (2024): Operationalizing the Right

Following the Supreme Court's directive, the Ministry of Health and Family Welfare (MoHFW) released the "Guidelines for Withdrawal of Life Support in Terminally Ill Patients" in 2024 to standardize clinical protocols across India.[40] These guidelines provide granular definitions and timelines absent in the broad strokes of the judicial order.

1. **Definition of Terminal Illness:** The guidelines define "terminal illness" as an irreversible or incurable condition from which death is inevitable in the foreseeable future.[41] Significantly, the guidelines address the grey area of neuro-critical care by explicitly including cases of "severe devastating traumatic brain injury" that show no recovery after 72 hours.[42] This inclusion is vital for intensivists who previously faced legal ambiguity when managing brain-injured patients who did not meet the strict criteria for brain-stem death under the *Transplantation of Human Organs Act, 1994* (THOA), but had no meaningful chance of recovery.[43]

2. **The 48-Hour Pathway:** To prevent "procedural paralysis," the guidelines mandate a strict timeline.

   - **Primary Medical Board (PMB):** Constituted by the hospital, comprising the treating physician and two subject experts with at least five years of experience. They assess the "appropriateness" of continuing life support.[44]

[38] *See Supreme Court Review 2023: Right to Life*, SUPREME COURT OBSERVER (Dec. 29, 2023) (noting the reduction in experience criteria).
[39] *See* Mani et al., *supra* note 2, (explaining the shift from authorization to intimation).
[40] Ministry of Health & Family Welfare, *Guidelines for Withdrawal of Life Support in Terminally Ill Patients* (Draft, 2024)
[41] *Id.* at Definition of Terminal Illness.
[42] *See Government unveils draft rules to take terminally ill off life support*, TIMES OF INDIA (Sep. 29, 2024)
[43] *See Organ Donation after Circulatory Determination of Death in India*, (discussing the limitations of THOA in non-brain-dead contexts).
[44] MoHFW Guidelines, *supra* note 40, at Constitution of Medical Boards.

- **Secondary Medical Board (SMB):** If the PMB recommends withdrawal, the hospital must constitute an SMB. This board includes one Registered Medical Practitioner (RMP) nominated by the District Chief Medical Officer (CMO) and two other subject experts. The SMB must validate the decision.[45] The Supreme Court and MoHFW guidelines direct the SMB to provide its opinion preferably within 48 hours of the referral.[46] This time-bound mechanism is designed to prevent the indefinite prolongation of patient suffering and the emotional/financial exhaustion of families.

3. **Active vs. Passive Distinction:** The guidelines explicitly clarify the boundary of the law. They reiterate that Active Euthanasia (the administration of lethal substances to end life) remains illegal in India.[47] The framework applies strictly to Foregoing Life Support Treatments (FLST), defined as Withholding (not starting) or Withdrawing (stopping) interventions like mechanical ventilation, vasopressors, or dialysis when they are non-beneficial.[48]

The Conflict: Soft Law Jurisprudence vs. Hard Law Statutes

While the 2024 Guidelines represent a progressive leap in bioethics, they function legally as "Soft Law" executive instructions and judicial guidelines that lack the statutory immunity of a parliamentary act ("Hard Law").[49] This creates a precarious "Enforcement Gap" when viewed against the *Bharatiya Nyaya Sanhita, 2023* (BNS).

The "Act of Commission" Paradox:

From a clinical perspective, withdrawing a ventilator is an ethical cessation of futile care. However, from a strict criminal law perspective, the physical act of turning off a switch or extubating a patient is an "act of commission". Under Section 100 (Culpable Homicide) and Section 103 (Murder) of the BNS, liability attaches to acts done with the "knowledge" that they are likely to cause death.[50] A doctor withdrawing life support possesses this knowledge with

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[45] *Id. see also Guidelines For The Withdrawal Of Life Support In Terminally Ill Patients, PWONLYIAS*
[46] *See The Medico-Legal Duality of the Right to Die*, (highlighting the mandatory 48-hour timeframe).
[47] MoHFW Guidelines, *supra* note 40.
[48] *See* Indian Society of Critical Care Medicine & Indian Association of Palliative Care, *Expert Consensus and Position Statements*, 28 INDIAN J. CRIT. CARE MED. 202 (2024)
[49] *See The Intersection of Terminal Care and the Bharatiya Nyaya Sanhita*, (arguing that guidelines are "Soft Law" lacking the protective weight of a parliamentary act).
[50] *Bharatiya Nyaya Sanhita, 2023*, §§ 100, 103, No. 45, Acts of Parliament, 2023 (India)

certainty.

Unlike the *Transplantation of Human Organs Act* (THOA), which provides statutory protection for disconnecting ventilators from brain-dead patients, the BNS contains no specific "Medical Exception" clause for passive euthanasia in terminally ill (but legally alive) patients.[51] The 2024 Guidelines attempt to shield doctors by citing the Supreme Court's interpretation that such withdrawal is an "omission" to struggle rather than an act of killing.[52] However, without a specific amendment to the BNS (specifically to Section 108: Abetment of Suicide), doctors theoretically remain vulnerable to prosecution if a dissatisfied relative alleges that the withdrawal "abetted" the patient's death.[53]

Thus, while the 2024 guidelines provide a clinical roadmap, they act as a fragile shield. The medical practitioner is left relying on the "good faith" defence and judicial precedent, rather than statutory immunity, ensuring that the fear of litigation and the consequent practice of defensive medicine continue to loom over the Intensive Care Unit.

5. THE ENFORCEMENT GAP: "LAMA" AS ETHICAL FAILURE

While the Supreme Court of India has jurisprudentially validated the "Right to Die with Dignity," the operational reality in Indian intensive care units (ICUs) reveals a starkly different picture. The procedural complexities of the 2018 *Common Cause* guidelines and the residual bureaucratic hurdles of the 2023 modification have inadvertently incentivized a practice that bioethicists describe as a systemic failure: the "Left Against Medical Advice" (LAMA) or "Discharge Against Medical Advice" (DAMA) phenomenon. In the absence of statutory immunity under the *Bharatiya Nyaya Sanhita* (BNS), LAMA has emerged as a "procedural loophole," a defensive mechanism used by risk-averse physicians to facilitate the exit of terminally ill patients from the hospital without triggering the scrutiny of Medical Boards or the police.[54]

The "LAMA" Loophole: Bypassing the Law

LAMA is legally defined as a patient's decision to leave a healthcare facility before the treating

[51] *See The Medico-Legal Duality of the Right to Die.*
[52] *Aruna Ramchandra Shanbaug v. Union of India*, (2011) 4 SCC 454, (classifying withdrawal as an omission).
[53] *See Euthanasia: Exploring Criminal Liability and Individual Autonomy*, VIRTUOSITY LEGAL (Oct. 8, 2025) (discussing the persisting shadow of criminal liability under BNS).
[54] *See* Raj Kumar Mani et al., *The LAMA Phenomenon as Ethical Failure: A Comprehensive Analysis of Terminal Care in the Indian Critical Care Ecosystem*

physician recommends discharge. In standard practice, this signifies a rejection of medical advice. However, in the context of End-of-Life Care (EOLC), LAMA has been co-opted as a proxy for the withdrawal of life support.[55]

When a family cannot sustain the emotional or financial burden of futile ICU care, and the hospital finds the formal "Medical Board" process too cumbersome or legally risky, LAMA becomes the path of least resistance. By signing a LAMA declaration, the family "voluntarily" takes the patient home, absolving the hospital and the physician of legal liability for the patient's subsequent death.[56] This practice allows the medical establishment to bypass the documentation, board constitution, and time-bound protocols mandated by the Supreme Court, effectively privatizing the "act of commission" (withdrawing support) to the family outside the hospital gates.

Data Point: The INDICAPS II Findings:

The prevalence of this practice is supported by empirical data. The *Indian Intensive Care Case Mix and Practice Patterns Study* (INDICAPS II), published in 2021, analyzed data from 4,669 patients across 120 ICUs. The study revealed that "Terminal Discharges" (discharges initiated with the understanding that the patient will die shortly) accounted for 32.5% of all non-survivors in Indian ICUs.[57] This represents a significant increase from previous years, suggesting that despite the legalization of passive euthanasia, clinicians prefer the informality of LAMA over the formal legal pathway. In contrast to Western nations, where limiting life-sustaining treatment (LST) occurs in ~90% of ICU deaths via formal withholding/withdrawing, the Indian ecosystem relies heavily on this unregulated exit strategy.[58]

Ethical Analysis: The Violation of Non-Maleficence

The most profound critique of the LAMA phenomenon is its violation of the bioethical principle of Non-Maleficence (Primum non nocere or "do no harm"). When a terminally ill

[55] *See* Darshan Rajatadri Rangaswamy et al., *Legal Aspects of Discharge Against Medical Advice in India*, 16 J. S. INDIA MEDICO-LEGAL ASSN. 107 (2024)

[56] *See* Ram E. Rajagopalan & Farhad Kapadia, *The ISCCM/IAPC Position Statement: Ending the Sisyphean Struggle to Practice Ethical End-of-life Care in India*, 28 INDIAN J. CRIT. CARE MED. 189 (2024) (describing LAMA as a "revolting act" promoted by the legal void)

[57] *See* Jigeeshu V. Divatia et al., *Intensive Care in India in 2018–2019: The Second Indian Intensive Care Case Mix and Practice Patterns Study (INDICAPS-II)*, 25 INDIAN J. CRIT. CARE MED. 1093 (2021)

[58] *See* Raj Kumar Mani, *INDICAPS II: A Bird's Eye View of the Indian Intensive Care Landscape*, 25 INDIAN J. CRIT. CARE MED. 1087 (2021)

patient is discharged LAMA, they are effectively abandoned by the medical system at their most vulnerable moment.

The "Miserable Death":

Formal withdrawal of life support, as envisioned by the ISCCM/IAPC guidelines, mandates "Terminal Palliative Sedation," the administration of opioids and sedatives to ensure the patient does not suffer air hunger (dyspnea) or agitation when the ventilator is removed.[59] In a LAMA discharge, however, the patient is removed from the ventilator and sent home or into an ambulance without professional palliative support. The ISCCM Position Statement (2024) explicitly condemns this, noting that such patients often succumb to a "miserable death," struggling for breath in an ambulance or at home, while the family watches in helpless agony.[60] By facilitating LAMA to avoid legal paperwork, the physician acts in self-interest (defensive medicine) rather than the patient's best interest (beneficence), converting a potentially "good death" into a traumatic event.

Economic Coercion: "Passive Euthanasia by Poverty"

The rhetoric of "patient autonomy" often used to justify LAMA masks a darker socio-economic reality. In a country where out-of-pocket expenditure accounts for the majority of healthcare spending, LAMA is frequently not a medical choice but a financial compulsion.

Studies indicate that a lack of health insurance and low family income are independent risk factors for LAMA.[61] Families often opt for terminal discharge not because they wish to exercise their "Right to Die," but because they have exhausted their funds and can no longer afford the daily cost of an ICU bed. This has been termed "passive euthanasia by poverty."[62] The *Common Cause* judgment assumes a level of autonomy where choices are made based on dignity and values; LAMA reveals a system where choices are dictated by resource rationing. The new penal code (BNS) fails to address this; by keeping the "sword of Damocles" (criminal liability)

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[59] *See* Indian Society of Critical Care Medicine & Indian Association of Palliative Care, *Expert Consensus and Position Statements for End-of-life and Palliative Care in the Intensive Care Unit*, 28 INDIAN J. CRIT. CARE MED. 202 (2024)

[60] *See* Sheila Nainan Myatra et al., *End-of-life care policy: An integrated care plan for the dying*, 18 INDIAN J. CRIT. CARE MED. 615 (2014)

[61] *See* P. Mahanta, *Factors affecting leave against medical advice from the emergency department*, 33 NATL. MED. J. INDIA 1 (2020)

[62] *See Report of the Lancet Commission on the Value of Death: bringing death back into life*, 399 LANCET 837 (2022) (noting that LAMA is often done in the setting of inability to pay).

hanging over doctors, it discourages formal, ethical, and charitable withdrawal of care, thereby forcing the poor into the unregulated and undignified exit of LAMA.

6. SUGGESTIONS & THE WAY FORWARD

The current medico-legal framework governing End-of-Life Care (EOLC) in India is characterized by a "judicial monarchy" where the Supreme Court has had to legislate from the bench due to parliamentary inaction.[63] While the 2023 constitutional bench judgment significantly streamlined the procedural hurdles, reliance on judicial guidelines under Article 142 is inherently precarious; guidelines can be modified by future benches and lack the permanence and specific definition of a statute. To bridge the "enforcement gap" and transition from a "right in theory" to a "right in practice," the following legislative and technological reforms are imperative.

1. Legislative Necessity: Reviving the 2016 Draft Bill

Judicial guidelines function as "soft law"; they provide a pathway but do not inherently immunize practitioners from the "hard law" of the penal code. The Law Commission of India, in its 196th (2006) and 241st (2012) Reports, explicitly recommended a comprehensive parliamentary act to regulate the withdrawal of life support.[64] The Medical Treatment of Terminally-Ill Patients (Protection of Patients and Medical Practitioners) Bill, 2016, was a progressive step in this direction, distinguishing between competent and incompetent patients and recognizing Advance Medical Directives (AMDs). However, this Bill was never enacted.[65] Parliament must urgently revisit and pass a similar legislation. A dedicated statute would standardize definitions of "terminal illness" and "medical futility" across all states, replacing the current patchwork of hospital-specific policies with a uniform national standard.[66]

2. Specific Amendments to the Bharatiya Nyaya Sanhita (BNS)

The most critical barrier to ethical EOLC is the "Sword of Damocles" hanging over physicians

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[63] *See Legislation for End-of-Life Care in India: Reflections on 5 Years of the End-of-Life Care in India Taskforce Journey*, 25 INDIAN J. PALLIAT. CARE 25 (2025)

[64] Law Commission of India, *196th Report on Medical Treatment to Terminally Ill Patients* (2006); *see also Common Cause (A Regd. Society) v. Union of India*, (2018) 5 SCC 1

[65] *See The Right to Die with Dignity: A Human Right or A Legal Dilemma?*, THE SOCIETY FOR CONSTITUTIONAL LAW DISCUSSION (Oct. 6, 2025)

[66] *See The Medico-Legal Duality of the Right to Die: A Critical Analysis of Judicial Evolution and Legislative Stagnation in India*

in the form of criminal liability. Under the Bharatiya Nyaya Sanhita, 2023, the withdrawal of life support (an act of commission) technically satisfies the *actus reus* of Section 105 (Culpable Homicide not amounting to murder) or Section 108 (Abetment of Suicide), as the doctor acts with the "knowledge" that death will ensue.[67] To resolve this, a specific "Medical Exception Clause" must be inserted into the BNS. Just as Section 106(1) of the BNS provides specific leniency for medical negligence, a proviso should be added to Section 105 stating:

> *"Nothing in this section shall apply to the withholding or withdrawing of life-sustaining treatment by a Registered Medical Practitioner (RMP), provided such act is performed in accordance with the guidelines laid down by the Supreme Court or the Ministry of Health and Family Welfare."* This statutory immunity is the only mechanism that will effectively end the practice of defensive medicine and the unethical "LAMA" discharges.[68]

3. Digital Integration: The Ayushman Bharat Solution

A major practical hurdle is the retrieval of an Advance Directive during a medical emergency. A paper document locked in a cupboard or a municipal office is useless during the "golden hour" of critical care.[69] To make autonomy actionable, the execution of Living Wills must be integrated into the Ayushman Bharat Digital Mission (ABDM). The Supreme Court's 2023 order already hints at digital health records; this must be formalized so that an AMD is linked to the patient's ABHA (Ayushman Bharat Health Account) ID.[70] This would allow treating intensivists to instantly verify a patient's EOLC preferences via a centralized, secure database, eliminating bureaucratic delays and ensuring that the patient's voice is heard even in their silence.

7. CONCLUSION

The jurisprudential journey from *Aruna Shanbaug* to *Common Cause* (2023) marks a seismic shift in Indian bioethics, elevating the "Right to Die with Dignity" from a theoretical concept to a fundamental right under Article 21 of the Constitution.[71] However, this study concludes

[67] *Bharatiya Nyaya Sanhita, 2023*, §§ 105, 108, No. 45, Acts of Parliament, 2023 (India)
[68] *See The LAMA Phenomenon as Ethical Failure*, *supra* note 66.
[69] *See Analysis of the Common Cause Judgment: Would living wills become a practical reality?*, ILI LAW REVIEW 270, 279 (2019)
[70] *See The Intersection of Terminal Care and the Bharatiya Nyaya Sanhita*, *supra* note 66
[71] *Common Cause (A Regd. Society) v. Union of India*, (2018) 5 SCC 1; See also Ranjit I. James et al., *Common Cause (A Regd. Society) v. Union of India INSC 223: End-of-Life Care in India*, 25 MED. L. INT'L 136 (2025)

that the right currently exists in a precarious "twilight zone" constitutionally recognized by the Judiciary but effectively criminalized by the strict text of the new *Bharatiya Nyaya Sanhita, 2023* (BNS).[72] While the Supreme Court has provided the "software" of autonomy through the 2023 guidelines, the Legislature has failed to upgrade the "hardware" of the penal code to run it.[73]

The transition from the IPC to the BNS was a missed opportunity to codify a specific "medical exception" for the withdrawal of life support.[74] As this paper has demonstrated, the BNS modernizes various offenses yet retains the traditional definitions of culpable homicide (Section 105) and abetment of suicide (Section 108), leaving physicians theoretically vulnerable to prosecution for "acts of commission" involving the removal of life support.[75] This statutory silence creates a "chilling effect," forcing risk-averse hospitals to prioritize legal safety over patient dignity.[76] Consequently, the sophisticated 2024 MoHFW guidelines remain legally fragile "soft law" when pitted against the "hard law" of the penal statutes.[77]

Until Parliament enacts a comprehensive law similar to the draft *Medical Treatment of Terminally Ill Patients Bill, 2016,* granting explicit statutory immunity to doctors acting under Medical Board advice, the "enforcement gap" will persist.[78] Without this legislative shield, the unethical practice of "Left Against Medical Advice" (LAMA) will continue to serve as a tragic proxy for euthanasia.[79] In this scenario, the constitutional promise of a dignified exit is hollowed out by economic coercion and defensive medicine, condemning thousands of Indian citizens to a "miserable death" at home, devoid of palliative care and abandoned by the very system sworn to protect them.[80]

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[72] *The Intersection of Terminal Care and the Bharatiya Nyaya Sanhita: A Comprehensive Analysis of Euthanasia and End-of-Life Jurisprudence in India*
[73] *The Medico-Legal Duality of the Right to Die: A Critical Analysis of Judicial Evolution and Legislative Stagnation in India*
[74] *See The Intersection of Terminal Care and the Bharatiya Nyaya Sanhita*, *supra* note 72, (noting the BNS missed the opportunity to codify passive euthanasia).
[75] *Bharatiya Nyaya Sanhita, 2023*, §§ 105, 108, No. 45, Acts of Parliament, 2023 (India); See also, *See Euthanasia: Exploring Criminal Liability and Individual Autonomy*, VIRTUOSITY LEGAL (Oct. 8, 2025) (discussing the persisting shadow of criminal liability under BNS).
[76] *Supra 2*, Raj Kumar Mani et al.
[77] *See The Medico-Legal Duality of the Right to Die*, *supra* note 73; See also, Ministry of Health & Family Welfare, *Guidelines for Withdrawal of Life Support in Terminally Ill Patients* (Draft, 2024)
[78] Law Commission of India, *196th Report on Medical Treatment to Terminally Ill Patients* (2006); *See The Right to Die with Dignity: A Human Right or A Legal Dilemma?*, THE SOCIETY FOR CONSTITUTIONAL LAW DISCUSSION (Oct. 6, 2025) (highlighting the absence of a legislative framework).
[79] Raj Kumar Mani et al., *The LAMA Phenomenon as Ethical Failure: A Comprehensive Analysis of Terminal Care in the Indian Critical Care Ecosystem*
[80] *See Report of the Lancet Commission on the Value of Death: bringing death back into life*, 399 LANCET 837 (2022) (noting LAMA condemns patients to death with no symptom control).