

Editorial

One Death, One Law: Why India Needs a Uniform Declaration of Death Framework

Death is a biological certainty, but its legal determination is a construct shaped by medicine, ethics, and law. Advances in critical care and life-support technologies have fundamentally altered how death is determined and diagnosed, particularly with the recognition, for the past 60 years, of brain-stem death as an irreversible form of biological death.

In India, however, the legal framework governing the determination and declaration of death remains fragmented. Three separate legislations—the Bharatiya Nyaya Sanhita (BNS), 2023; the Registration of Births and Deaths (RBD) Act, 1969 and the Transplantation of Human Organs and Tissues Act (THOTA), 1994—operate with differing definitions and standards.¹⁻³ This lack of uniformity has created persistent ambiguity for clinicians, families, hospital administrators, and the State.

India urgently requires a Uniform Declaration of Death Act (UDDA), similar to the UDDA, 1981, in the USA, to harmonise medical science with legal certainty and constitutional values.⁴

Fragmented definitions of death in Indian law

Under BNS, ‘death’ means the ‘death of a human being unless the contrary appears from the context’, and the RBD Act defines death as ‘the permanent disappearance of all evidence of life’.² This definition was never intended to establish medical criteria for death; rather, the legislative intent was administrative—registration and maintenance of vital statistics. However, this is the definition applied when a physician certifies death in India at either home or in a hospital. The act neither specifies cardio-pulmonary death nor recognises brain-stem death, nor does it empower registered medical practitioners (RMPs) to certify death based on neurological criteria.

In contrast, THOTA explicitly recognises brain-stem death. Section 2(d) of the Act defines brain-stem death as the permanent and irreversible cessation of all functions of the brain-stem, certified under a prescribed procedure, while Section 2(e) recognises death occurring either by brain-stem death or in the cardio-pulmonary sense.³ Thus, THOTA aligns with contemporary medical science but limits the declaration of brain-stem death to the context of organ donation to be undertaken in registered hospitals that undertake organ transplants or hospitals that are registered as non-transplant organ retrieval centres.

Medical reality of brain-stem death

The brain-stem is responsible for essential life-sustaining functions, including respiration, cardiovascular regulation, consciousness or wakefulness and reflex integration. Irreversible cessation of brain-stem function results in permanent apnoea, loss of brain-stem reflexes, absence of consciousness, and total dependence on artificial support systems.⁵

The concept of brain death was first described as *coma dépassé* in Paris in 1959.⁶ This was followed by the landmark Harvard Ad Hoc Committee report in 1968, which formally established neurological criteria for death.⁴ Since then, global medical consensus has recognized brain-stem death as biological death. Artificial ventilation may temporarily sustain organ perfusion but does not reverse death; it merely delays somatic disintegration of the body.⁵

Legal ambiguity and ethical conflict

The coexistence of the RBD Act and THOTA has produced a paradox. If consent for organ donation is obtained, a brain-stem dead individual is legally recognized as deceased under THOTA, and the hospital can proceed with organ donation.³ However, if consent is refused, the same individual may not be declared legally dead under the RBD Act.² This differential treatment of similarly situated persons is arbitrary and constitutionally suspect under Article 14, which states that— ‘the State shall not deny to any person equality before the law or the equal protection of the laws within the territory of India.’

Further, the absence of enabling provisions under the RBD Act prevents clinicians from lawfully withdrawing life support following brain-stem death outside the organ donation context. This results in prolonged mechanical ventilation of the dead, moral distress among healthcare professionals, false hope for families, misuse of scarce intensive care unit (ICU) resources, and potential financial exploitation by for-profit healthcare institutions.

Divergent State practices

In the absence of central legislative clarity, several states and institutions have attempted to address the issue through their own executive or administrative orders (Table 1).

The Kerala government order explicitly states that declaration of brain-stem death amounts to declaring a person dead—clinically and legally—and mandates discontinuation of cardio-respiratory support thereafter.^{7,8} Such recognition, however, remains inconsistent across the country.

Constitutional and human rights implications

Failure to uniformly recognise brain-stem death contravenes Article 21 of the Constitution, which guarantees the right to life and dignity. The Supreme Court of India has recognized the right to die with dignity as an intrinsic part of Article 21.⁹ Prolonged artificial support after death constitutes mistreatment of the dead and undermines human dignity.

Scarcity of ICU beds and ventilators further exacerbates injustice, as resources are occupied by brain-dead individuals while patients with potentially reversible illnesses are denied care. Families experience prolonged grief, emotional trauma, and financial hardship, while clinicians face ethical dilemmas and fear of criminal liability.

Lessons from the USA: The UDDA

The USA resolved similar ambiguities through the UDDA, 1981, adopted across all states.¹⁰⁻¹² The UDDA establishes a single, comprehensive standard. An individual is dead if they have sustained either (i) irreversible cessation of circulatory and respiratory functions, or (ii) irreversible cessation of all functions of the entire brain, including the brain stem. Determination must be made in accordance with accepted medical standards.

The UDDA decouples death determination from organ donation and provides clinicians with clear legal authority when acting in accordance with accepted medical standards.

The case for a uniform declaration of death act in India

India urgently requires legislative reform—either through amendment of the RBD Act or enactment of a standalone UDDA. Such legislation should:

1. Recognize both cardio-pulmonary and brain-stem death as legal death
2. Empower RMPs to certify death using accepted medical standards

TABLE 1. Variations in state-level recognition of brain-stem death in India

State or institution	Legal position on brain-stem death
Kerala	Brain-stem death recognized as legal death; withdrawal of life support mandated ⁷
Tamil Nadu	Institutional protocols permit declaration beyond organ donation
Gujarat	Administrative orders recognise brain-stem death ⁸
AIIMS, New Delhi	Institutional guidelines permit withdrawal after declaration
West Bengal	Continued ventilation requires explicit family consent
Other states	Discretionary, hospital-dependent practices

TABLE 2. Comparison of the Indian framework and the U.S. UDDA

Aspect	India (current)	USA (UDDA)
Single legal definition of death	No	Yes
Recognition of brain-stem death	Limited to THOTA	Universal
Applicability	Organ donation-specific	All clinical contexts
Physician authority	Restricted	Explicit
Legal protection	Unclear	Clearly defined

THOTA Transplantation of Human Organs and Tissues Act

3. Apply uniformly across all clinical contexts
4. Provide legal immunity for good-faith medical decisions
5. Safeguard patient dignity and family rights

Without such reform, death determination remains contingent on consent for organ donation—an ethically indefensible and constitutionally untenable position.

The absence of a uniform legal definition of death in India is no longer tenable in the era of advanced critical care. The current legislative silos create arbitrariness, violate constitutional guarantees under Articles 14 and 21, and impose avoidable suffering on families and clinicians alike. Comparative experience from jurisdictions such as the USA demonstrates that clarity is achievable without compromising ethical safeguards (Table 2). A UDDA is therefore not merely a legal reform but a constitutional, ethical, and medical imperative.

Conflicts of interest. None declared

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