Jus Corpus Law Journal

Open Access Law Journal – Copyright © 2025 – ISSN 2582-7820

Editor-in-Chief – Prof. (Dr.) Rhishikesh Dave; Publisher – Ayush Pandey

Right to Die with Dignity: Evolving Concept of Passive Euthanasia in India

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Received 15 April 2025; *Accepted* 16 May 2025; *Published* 20 May 2025

The article examines the evolving jurisprudence of the Supreme Court on passive euthanasia and Advance Medical Directives (AMD), tracing the legal trajectory from the initial recognition of right to die as a fundamental right in P. Rathinam, to be overturned in the Gian Kaur and eventually given a limited recognition of right to die with dignity. It summarises the delicate reasoning of the Court on how futile medical interventions in an unbeatable quest with death are an affront to life with dignity and an individual's right to consent or refuse medical procedures and interventions. Notably, it focuses on the Common Cause judgment and its recent clarification by simplifying the process of implementation of AMDs and passive euthanasia, aimed at reducing potential hurdles and improving accessibility. The article further delves into the dilemma concerning bodily autonomy, active and passive euthanasia, and their intersection with the Indian Penal Code, acknowledging the judicial restraints on the legalisation of active euthanasia and highlighting the need for a clear and robust legislative framework on the same in light of the potential misuse.

Keywords: *passive euthanasia, advance medical directives, article 21, common cause judgment.*

INTRODUCTION

The Supreme Court, in its recent ruling[1], while adjudicating on an application filed by the Indian Society of Critical Care Medicine seeking clarification of the judgment reported in Common Cause (A Registered Society) v Union of India and Anr[2], simplified the procedure for Advance Medical Directives (AMD). An AMD is a legal document recording the preferences of an adult individual stating the medical treatment they wish to receive or opt out of in case of terminal illness. The role of AMD only comes into play when the person is rendered incapable of taking an informed decision and communicating their wishes. A person at any time is free to change their decision as taken at an earlier point in time and is not bound by such AMD.

The AMD has assumed particular importance in contemporary healthcare in light of continuously evolving technology and medical advancements, making it possible to artificially prolong the natural span of life. While such artificial prolongation may offer a source of hope to the family of the patient, it is easy to overlook the wishes and suffering of the individual unable to communicate consent and forced to live as the body progressively breaks down leading to a slow and undignified death, which, in some cases may take years.

Furthermore, in the absence of any clear guidelines on AMDs and passive euthanasia, the doctors found themselves in a precarious position, reluctant to act even though it is ethically the right thing to do, for fear of being charged with culpable homicide. The apprehension stemmed from the complex intersection with various provisions of the Indian Penal Code 1860 ('IPC'), failing to distinguish and protect an act done in clear absence of mens rea and good faith in the best interests of the patient. This legal ambiguity called for urgent judicial intervention for clarity and guidelines to navigate end-of-life decisions.

COMMON CAUSE (A REGISTERED SOCIETY) V UNION OF INDIA AND ANR

The court in the present judgment, after extensively dealing with the concept of liberty and dignity, recognised the right to die with dignity as a fundamental right under Article 21,[3] the

[1] *Common Cause (A Registered Society) v Union of India and Anr* (2018) 5 SCC 1
[2] *Ibid*
[3] Constitution of India 1950, art 21

Constitution of India provided elaborate guidelines that need to be followed in cases of passive euthanasia in both cases where AMD exists and in its absence of the same.

Background of the Writ Petition:

The right to live includes the right not to live a forced life -

In P. Rathinam v Union of India & Anr[4] while deciding on the constitutional validity of Section 309[5] Indian Penal Code, 1860 ('IPC'), dealing with the offence of attempt to commit suicide, expanded the scope of Article 21[6] to recognise the right to die as the negative aspect of the right to live and hold Section 309 IPC as ultra vires of the Constitution.

The dictum in P. Rathinam[7] was overruled. Relying on the dictum as laid under P. Rathinam[8], the constitutionality of Section 306[9] dealing with the offence of abetment to suicide, was called into question in Gian Kaur v State of Punjab[10]. The court in the present case, while merely discussing Airedale N.H.S. Trust v Bland.[11]

Relating to passive euthanasia, stated that by no means a comparison can be drawn between the right of a person to die with dignity when life is ebbing out of them and a right to die an unnatural death curtailing the natural span of life, held, right to die goes against the principle of sanctity of life and cannot enjoy the protection under Article 21[12], henceforth decided Section 309[13] and 306 IPC to be constitutional.

Passive euthanasia has been made legally permissible. Thereafter, came the tragic case of Aruna Ramachandra Shanbaug v Union of India and Ors[14], wherein Aruna, a nurse at the King Edward Memorial Hospital ('KEM Hospital'), was brutally sexually assaulted and strangled by a dog chain by a hospital staff, leaving her in a persistent vegetative state for 36 years. Abandoned by her family following the barbaric act, she was left to the sole care of

[4] *P. Rathinam v Union of India & Anr* (1994) 3 SCC 394
[5] Indian Penal Code 1860, s 309
[6] Constitution of India 1950, art 21
[7] *P. Rathinam v Union of India & Anr* (1994) 3 SCC 394
[8] *Ibid*
[9] Indian Penal Code 1860, s 306
[10] *Gian Kaur v State of Punjab* (1996) 2 SCC 648
[11] *Airedale N.H.S. Trust v Bland* [1993] AC 789
[12] Constitution of India 1950, art 21
[13] Indian Penal Code 1860, s 309
[14] *Aruna Ramachandra Shanbaug v Union of India and Ors* (2011) 4 SCC 454

KEM Hospital staff, where the brutal assault occurred. Disturbed by Aruna's plight, activist and journalist Ms Pinki Virani filed a writ petition under Article 32[15], praying that the KEM Hospital be directed to stop feeding Aruna so that she to die peacefully.

The Hon'ble Court, while noting that even though no violation of any fundamental right is pleaded, and the right to die, not being explicitly recognised as a fundamental right, recognising the importance of the issues raised, decided to adjudicate the merits of the case. In the present case, the court dealt with the issue of involuntary passive euthanasia wherein the patient is not in a competent state to consent or withhold consent to treatment.

Discussing the ethical complexities present in such cases and taking into account the moral depravity that our society has descended to, held that all applications for withdrawing or withholding treatment need to be decided by the respective High Courts under Article 226[16] after taking into consideration the wishes of the next of kin, and further provided for the elaborate procedure to be followed by the High Courts while dealing with such applications.

The court was of the view that, though active euthanasia, wherein a lethal substance is administered by the physician to accelerate death, absent legislation, would be a crime under Section 306[17], passive euthanasia, involving the omission to provide life-sustaining treatment, stands on a different footing.

The Reference: The judgment in Aruna Shanbaug,[18] even though it recognised passive euthanasia, provided no mandate regarding living wills and advance directives. Hence, in 2005, a non-governmental organisation, Common Cause (India), filed a writ petition for the legal recognition of living wills and advance directives. The bench, while adjudicating on the matter, found an inconsistency in the judgment of Aruna Shanbaug.[19] Which had, for the first time, upheld the legality of withdrawing treatment to a terminally ill patient while wrongly interpreting and relying on the judgment in Gian Kaur.[20] Consequently, the matter was referred to a five-judge bench comprising Former Chief Justice of India Dipak Misra, Justice A.K. Sikri, Justice A.M. Khanwilkar, former Chief Justice of India D.Y. Chandrachud, and

[15] Constitution of India 1950, art 32
[16] Constitution of India 1950, art 226
[17] Indian Penal Code 1860, s 306
[18] *Aruna Shanbaug v Union of India* (2011) 4 SCC 454
[19] *Ibid*
[20] *Gian Kaur v State of Punjab* (1996) 2 SCC 648

Justice Ashok Bhushan for conclusive determination on the legality of passive euthanasia in the light of social, legal, medical and constitutional perspectives.

Analysis of the Judgment in Gian Kaur and Aruna Shanbaug: In Gian Kaur, the court, while discussing the ratio as laid down in Airedale[21] on the principle of sanctity of life, made a clear distinction between withdrawing of life-supporting treatment and abetting the commission of suicide by curtailing the natural span of life. However, given that the question of passive euthanasia was not open before this court for determination, no definite ruling was made on euthanasia, nor did it suggest that euthanasia can be made permissible only by legislation. More importantly, no independent expression or approval of the dictum in Airedale was given.

However, the judgment in Aruna Shanbaug was delivered based on the erroneous premise of the approval of the Airedale judgment in the Gian Kaur. It also suffers from internal inconsistencies since it has taken the view of Gian Kaur. It has been held that euthanasia can only be made legal by legislation, and then goes on to provide the procedure to be opted for the same.

The Court in Common Cause,[22] citing an article by Rohini Shukla,[23] further criticised the judgment in Aruna Shanbaug.[24] On the differentiation between active and passive euthanasia based on the flawed 'act or omission dichotomy by the doctor. The Court pointed out that throughout the judgment, the words 'withhold' and withdraw' have been used interchangeably. This approach is problematic since the distinction between 'withholding of treatment, which implies restraint of treatment, is an omission on the part of the doctor and 'withdrawing of treatment, which entails the suspending of medical intervention that was already in use, is a positive act, has been blurred.

The Court cited an article published in the Indian Journal of Medical Ethics has further highlighted how passive euthanasia entails suffocation to death or starvation to death, and in such cases might militate against death with dignity- the very basis of legalising euthanasia.

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[21] *Airedale v Bland* [1993] AC 789
[22] *Common Cause v Union of India* (2018) 5 SCC 1
[23] Rohini Shukla, 'Passive euthanasia in India: a critique' (2015) 1(1) Indian Journal of Medical Ethics <https://doi.org/10.20529/IJME.2016.008> accessed 23 March 2025
[24] *Aruna Shanbaug v Union of India* (2011) 4 SCC 454

Active-Passive Difference, Intersection with IPC and Judicial Restraints –

The meeting point between bio-ethics and law does not lie on a straight course. The Court observed that both in the case of withdrawal of artificial support as well as in non-intervention, passive euthanasia allows for life to ebb away and to end in the natural course. In contrast, active euthanasia results in the consequence of shortening life by a positive act of medical intervention. It is this distinction which necessitates legislative authorisation for active euthanasia, as differentiated from the passive. This Court further remarked that the fact that active euthanasia is an illegal act (pending legislation) stops the medical practitioners from performing it, even though it is the compassionate thing to do, thereby prolonging the suffering of the patient.

The judgment in Aruna Shanbaug[25] states that passive euthanasia is legal unless expressly prohibited by law. This, however, appears contrary to Section 32[26], which deals with illegal omissions and states that, in every part of this Code, except where a contrary intention appears from the context, words which refer to acts done, extend to illegal omissions.

Illegal omissions, in this context, could refer to the failure to provide necessary life-sustaining treatment. Therefore, the omission of treatment, which is passive euthanasia, could be seen as an illegal act under the IPC.

A doctor has a moral and legal duty to care, and in case of failure to provide treatment, can be accused of culpable homicide and medical negligence. The act of passive euthanasia by withdrawing or withholding treatment is only permissible to the extent that it is voluntary and done keeping in view the best interest of the patient and with the express consent of the patient, or in cases of incompetence, in line with the established legal and medical protocols.

The court states that even though pertinent questions regarding active-passive euthanasia remain, the distinction can be drawn when seen from the lens of the patient's consent. Consent gives an individual the ability to choose whether or not to accept the treatment, allowing them to refuse interventions that prolong suffering. This framework seeks to respect patient autonomy within the confines of allowing a natural death. However, it is vital to understand that even though consent confers the right to refuse treatment, no such right is

[25] *Ibid*
[26] Indian Penal Code 1860, s 32

conferred on the patient to demand a particular form of treatment, particularly one that accelerates the process of death, even under the guise of death with dignity. Held- Active euthanasia would, on the state of the penal law as it stands, constitute an offence. Hence, it is only Parliament which can, in its legislative wisdom, decide whether active euthanasia should be permitted.

The court observed that even though both active and passive euthanasia is an act in good faith to reduce the suffering of the patient, the distinction between both lies as follows: Passive euthanasia is not based on the intent to cause death but to let life take its natural course and ensure that the life of the patient is not prolonged artificially. Section 299[27] penalises the causing of death by act or omission. However, it is observed that the cause of death by withdrawal of treatment is not due to an act or omission on the part of the doctor, but as a result of the inherent condition of the patient. When a doctor takes a considered decision in the case of a patient in a terminal stage of illness or a permanently vegetative state, not to provide artificial life support, the law does not attribute to the doctor the knowledge that it is likely to cause death. On the contrary, active euthanasia is performed to cause death by a positive act of the doctor, and as such is impermissible under Indian law unless made permissible by an act of the legislature.

Right to Die with Dignity is part of Article 21 -

In a further dynamic manner, the right to life with dignity has to include the smoothing of the process of dying. In the present matter of Common Cause, the Court is deciding on the scope of Article 21[28] to include passive euthanasia, first considering the concept of liberty. Liberty, the court remarked, is what impels an individual to change, as life welcomes the change and movement. That life does not intend to live sans liberty, as that would, in all possibility, be a meaningless existence. The court cited many cases to denote that life does not mean mere animal existence and continued drudgery through life, and in essence, it is individual liberty and freedom that make life meaningful and worth living. Further quoting J. Cohen[29], on how interpretation is inescapably a kind of legislation, held that the Court shall

[27] Indian Penal Code 1860, s 299
[28] *Ibid*
[29] Dickerson and F. Reed, *The Interpretation and Application of Statutes* (Little, Brown 1975)

have power within itself to provide for guidelines on passive euthanasia, for it comes within the sweep of Article 21[30].

In K.S. Puttaswamy and another v Union of India and Ors[31], when talking about liberty and dignity, the court observed- Dignity is the core which unites the fundamental rights..…. It is only when life can be enjoyed with dignity that liberty can be of true substance. A distinction was made between the right to die and the right to die with dignity. The Court observed that a person who is terminally ill, though having the will to live, may at the same time wish to be free from any life-supporting medical procedures and treatment. That such a right, the Court held, stands on a different pedestal to suicide, physician-assisted suicide or even euthanasia.

Reference was made to a judgment in Francis Coralie Mullin v The Administrator, Union Territory of Delhi.[32] To state that the prolongation of life by artificial means while the patient waits for his inevitable death mars the pristine concept of life, corrodes the essence of dignity and erodes the fact of eventual choice, which is pivotal to privacy.

The Court on self-determination and bodily autonomy, observed that a person who is terminally ill or on life support shall have the choice to consent or refuse to a medical treatment by which his/her life might or would be prolonged, and such choice of the patient shall be respected keeping in mind his best interests. The Court further asserted that a dying man who is in a persistent vegetative state can make a choice of premature extinction of his life, and such a choice is a facet of Article 21[33] and shall need no legislative backing, for this is his natural human right. However, it was observed how the family members and the doctors of a patient in medical futility and unable to consent, remain in a constant state of hesitation for reasons of social stigma and the duty under the Hippocratic oath, which provides that a patient shall be treated till their last respectively. The doctors further face the fear of allegations of criminal culpability or medical negligence.

Keeping in view the same, the court noted that this right, even though fundamental to human dignity and liberty, cannot be made absolute and shall be subject to regulatory measures to

[30] Constitution of India 1950, art 21
[31] *K.S. Putt swamy and Anr v Union of India and Ors* (2017) 10 SCC 1
[32] *Francis Coralie Mullin v The Administrator* (1981) 1 SCC 608
[33] Constitution of India 1950, art 21

be prescribed by a suitable legislation which, however, must be in the form of reasonable restrictions and interest of the general public. And in the absence of such legislation, the Court provided temporary guidelines in respect to the same to remain in effect until elaborate guidelines are enacted by the legislature. The guidelines passed were to provide certainty to doctors that they are acting lawfully and also provide for adequate safeguards, taking into account the abuse of process by unscrupulous persons who wish to inherit the property of the dying person.

Guidelines for the Execution and Implementation of AMD -

An advance directive to be executed by an adult person in a healthy state of mind stating his/ her preferences as to the medical treatment they wish to receive. The AMD so executed needs to be signed in the presence of two witnesses and countersigned by the Judicial Magistrate of First Class ('JMFC') so designated by the concerned District Judge. The document is to be handed over to the local government, which shall act as the custodian of the same. In case the executor of the document becomes terminally ill, the treating physician is to ascertain the genuineness of the document from the jurisdictional JMFC before acting on the same.

The implementation of an AMD was envisaged to be done in case of medical futility by constituting two separate Medical Boards. The first Board to be constituted by the Hospital and the other by the Jurisdictional Collector. Both the Boards shall take their decision after visiting the patient. In case both the Boards give their decision in favour of passive euthanasia, a report is to be sent to the JMFC, who shall visit the patient and authorise the carrying out of the Advance Directive.

In case of absence of AMD, the same aforesaid procedure is to be followed if permission to withdraw medical treatment is refused by the Medical Board, it would be open to the guardian or family members of the AMD executor, or even the treating doctor or the Hospital staff, to approach the High Court under Article 226[34] For a decision on the same.

[34] Constitution of India 1950, art 226

Issues with the Previous Guidelines -

The Court, in its present judgment, notes how the provision of an AMD to be counter-signed by JMFC has led to the very object of this Court issuing directions impaired, if not completely defeated. The guidelines were conceived to be temporary, to be followed until the legislature enacted suitable legislation. In such a case, the authorities and those keen on registering a 'living will' were both struggling in the absence of standard procedures at the central or state level to implement the SC guidelines.

As reported by the Times of India[35], a retired professor of anatomy based in Mumbai in her 70s, Dr Lopa Mehta drafted her living will, an advance directive on end-of-life treatment, in 2019. But I was unable to get it registered despite the guidelines that are part of the Supreme Court's 2018[36] Landmark judgment on passive euthanasia and living will.

The execution of an AMD before JMFC and further a three-tier approval process for its implementation turned out to be a tedious and arduous process. As a result, as reported by the Times of India,[37] very few people were successful in its execution.

The guidelines further failed to provide for any timeline for the decision by the two Medical Boards and the final decision by the JMFC. Keeping in view the sensitivity of the matter, the failure to provide any timeline may result in prolonging the suffering of the patient, which goes contrary to the object of providing such guidelines in the first place.

NEW GUIDELINES

In the new guidelines, the requirement of counter-signing of AMD by the JMFC is no longer required, and only needs to be attested before a notary or a Gazette Officer. The AMD then need to be handed over to the local government, which shall act as the custodian of the same. It can also be made part of digital health records, if any, and in case of the executor becoming

[35] Lata Mishra and Sunil Baghel, 'Why Choosing Dignified Death Should Be Made Simpler' *Times of India* (30 December 2022) <https://timesofindia.indiatimes.com/india/why-choosing-dignified-death-should-be-made-simpler/articleshow/90062984.cms> accessed 23 March 2025

[36] *Common Cause v Union of India* (2018) 5 SCC 1

[37] Ambika Pandit, 'Why registering a 'living will' is an arduous task despite SC guidelines' *Times of India* (23 February 2021) <https://timesofindia.indiatimes.com/india/why-registering-a-living-will-is-an-arduous-task-despite-sc-guidelines/articleshow/81144053.cms> accessed 23 March 2025

terminally ill, the genuineness has to be ascertained from the custodian of the document or the digital health records.

AMDs are to be implemented in case of medical futility, as determined by two separate Medical Boards to be constituted by the treating Hospital. Both the Medical Board are required to give their opinion preferably within 48 hours of reference. Upon approval, the decision of the Medical Boards and the consent of the executor of the AMD must be conveyed to the JMFC before implementation.

In case the Primary Medical Board refuses to carry out the AMD, the person named in the AMD can approach the Hospital for the constitution of a Secondary Medical Board. If the Secondary Medical Board refuses permission to withdraw treatment, the next of kin, the treating doctor or the Hospital staff can approach the respective High Court under Article 226 for a decision.

In the absence of AMD, in case the patient is terminally ill, the treating physician shall inform the Hospital, which shall, in turn, constitute a Primary Medical Board. The Board, after considering the best interest of the patient and obtaining written consent of the family, shall make a decision preferably within 48 hours of reference.

If the Primary Medical Board certifies the withdrawal of treatment, a Secondary Medical Board shall be constituted by the Hospital. In case of concurrence of opinion, intimation shall be sent to JMFC and family members. However, in case the Primary or the Secondary Medical Board decides not to withdraw treatment, a family member, the treating physician, or the Hospital staff may petition the respective High Court under Article 226 for a decision on the same.

CONCLUSION

The Hon'ble Supreme Court, through this judgment, has meticulously dealt with the issue of bodily autonomy, dignity and simplified the procedure of execution and implementation of living wills. However, the concerns remain regarding the potential conflict between bodily autonomy and the best interest of the patient, giving rise to significant ethical challenges. Situations may arise where, despite the patient's condition aligning with the AMD criteria, the Board's medical decision might differ.

In such cases, should the Board's medical decision be allowed to override the legally executed AMD?

While significant safeguards for review of the decision in case of refusal have been provided, the fundamental question persists: shouldn't bodily autonomy be given the paramount significance, given that any treatment without consent amounts to assault or should the best interest of the patient prevail?

Any legislation on euthanasia will have the formidable challenge of balancing the above dichotomy of bodily autonomy and best interests of the patient while also taking into account the potential misuse, including coercion of vulnerable populations and undue influence from family members, necessitating the need for robust safeguards and ethical frameworks. Furthermore, the importance of readily available palliative care cannot be understated and should be considered alongside any legislative action.