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From Gian Kaur to Living Wills: The Changing Landscape of Euthanasia Law in India.

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Abstract

The law of euthanasia in India has moved from the language of criminal prohibition to the language of constitutional dignity. This paper argues that Indian law has not recognized a free-standing "right to die"; instead, it has gradually constitutionalized a limited right to die with dignity at the end of natural life through refusal or withdrawal of futile treatment and through advance medical directives or living wills. The doctrinal path runs from P. Rathinam to Gian Kaur, where the Supreme Court rejected a general right to die but preserved the idea that dignity extends to the point of natural death; through Aruna Ramachandra Shanbaug, where passive euthanasia was cautiously admitted under court supervision; and finally to Common Cause (2018), where passive euthanasia and living wills were grounded in Article 21 values of dignity, liberty, privacy, and self-determination. The 2023 modification of Common Cause made the living-will regime substantially more workable, but the 2026 Harish Rana judgment demonstrates that implementation remains fragile, legislation is still absent, and palliative care, hospital governance, and anti-coercion safeguards remain underdeveloped. The paper concludes that India has moved from prohibition to guarded autonomy, but not yet to a coherent statutory end-of-life regime.

Keywords*: euthanasia, passive euthanasia, living will, advance medical directive, Article 21, end-of-life care, India.*

1: Introduction

Few questions in Indian constitutional law are as morally charged and conceptually confused as euthanasia. For a long time, the debate was framed through the offences of attempt to suicide and abetment of suicide. That frame, however, is too narrow for present law. The modern issue is not whether the Constitution creates a general liberty to end one's life at will, but whether a person at the threshold of irreversible decline may refuse burdensome, non-beneficial medical treatment, and whether that choice may be expressed in advance through a living will.[1]

This paper argues that the Indian position has evolved in a precise and limited way. It rejects a broad "right to die," but it accepts a constitutionally protected right to die with dignity in circumstances of terminal illness, permanent incapacity, or medical futility. Yet that advance remains incomplete. The current regime is still largely judge-made, unevenly implemented, and vulnerable to institutional delay, family pressure, and socio-economic inequality. The absence of a comprehensive statute means that the jurisprudence is normatively ambitious but administratively fragile.[2]

I. Conceptual Clarifications

Any serious discussion of euthanasia must begin with terminology. In *Aruna Ramachandra Shanbaug v. Union of India*, the Supreme Court described active euthanasia as the use of lethal substances or direct force to end life, while passive euthanasia referred to withholding or withdrawing treatment necessary to prolong life. The 2026 Supreme Court reiterated that only the latter is legally permissible in India and emphasized that conceptual imprecision can expose doctors to grave legal risk.[3]

Even so, the phrase "passive euthanasia" is not entirely satisfactory. Much recent medical-legal writing prefers the expression foregoing life-sustaining treatment because the real issue is often not an intention to kill, but a decision not to continue ventilation, artificial nutrition, hydration, dialysis, vasopressors, or resuscitative care that no longer benefits the patient. That distinction matters. Indian law seeks to authorize omission in the patient's best interests, not affirmative medical killing.[4]

A second distinction must also be maintained: physician-assisted suicide is conceptually different from both active and passive euthanasia. Indian case law has consistently treated active euthanasia and assisted suicide as unlawful, even while

[1] *P. Rathinam v. Union of India*, (1994) 3 SCC 394.

[2] *Gian Kaur v. State of Punjab*, (1996) 2 SCC 648.

[3] *Aruna Ramachandra Shanbaug v. Union of India*, (2011) 4 SCC 454.

[4] *Harish Rana v. Union of India*, 2026 INSC 222.

gradually permitting withdrawal or withholding of treatment under carefully structured safeguards.[5]

II. From *P. Rathinam* to *Gian Kaur*

The doctrinal starting point is *P. Rathinam v. Union of India*, where a two-judge Bench briefly treated the right to life under Article 21 as including a right not to live and struck at section 309 of the Indian Penal Code.[6] That position did not survive. In *Gian Kaur v. State of Punjab*, a Constitution Bench overruled *P. Rathinam* and held that Article 21 does **not** include a general right to die.

Yet *Gian Kaur* was not purely restrictive. Its enduring importance lies in its nuance. The Court reasoned that the right to live with dignity extends to the end of natural life and may include a dignified process of death when life is already ebbing out. What the Court rejected was not dignity in dying, but the claim that Article 21 protects an unnatural curtailment of life. That single distinction later became the bridge between criminal prohibition and constitutional protection in end-of-life cases.

Later statutory developments show that Indian law itself moved away from an undifferentiated penal approach to self-destructive conduct. Section 115 of the Mental Healthcare Act, 2017 presumes severe stress in cases of attempted suicide and ordinarily bars trial and punishment. The Bharatiya Nyaya Sanhita, 2023 expressly carries forward only a narrow offence of attempting suicide to compel or restrain the exercise of lawful power under section 226. Euthanasia remains doctrinally distinct from suicide law, but the broader legal atmosphere has clearly shifted from punishment toward care, vulnerability, and dignity.[7]

III. *Aruna Shanbaug*, Law Commission Reform, and the Search for Procedure

Aruna Ramachandra Shanbaug v. Union of India marked the first major judicial opening in Indian euthanasia law. Faced with an incapacitated patient in a long-term non-responsive condition, the Supreme Court drew a sharp line between active and passive euthanasia. It held that active euthanasia remained illegal and would amount to homicide liability, while passive euthanasia could, in principle, be permitted in India until Parliament enacted legislation on the subject.

Because the patient could not decide for herself, the Court vested the final decision in the High Court under Article 226, acting as parens patriae. That move was humane in intention but institutionally conservative: bedside end-of-life decisions were effectively made dependent on constitutional litigation.

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

[6] Supra 2

[7] The Mental Healthcare Act, 2017 (Act 10 of 2017), s. 115.

Between *Aruna* and *Common Cause*, the debate moved through the Law Commission and Parliament. Report No. 196, titled *Medical Treatment to Terminally Ill Patients (Protection of Patients and Medical Practitioners)*, and Report No. 241, titled *Passive Euthanasia – A Relook*, both sought to distinguish terminal end-of-life decisions from ordinary suicide.[8] The *Medical Treatment of Terminally-ill Patients (Protection of Patients and Medical Practitioners) Bill, 2016* went further: it defined an "advance medical directive" or living will, recognized the right of a competent patient to seek withholding or withdrawal of treatment, and required palliative care even when treatment was forgone. Yet no comprehensive central statute emerged. The judiciary was thus left to govern an increasingly important field through interim constitutional techniques.[9]

In practice, *Aruna*'s High Court-centric procedure proved difficult to operationalise. Subsequent medical commentary argued that the judgment, though morally significant, reduced physician confidence because few hospitals could realistically route urgent end-of-life decisions through a constitutional court process.[10]

IV. *Common Cause* (2018): Constitutionalising Death with Dignity

The decisive transformation came in *Common Cause (A Regd. Society) v. Union of India*. As the Supreme Court later summarized, the 2018 Constitution Bench held across four concurring opinions that the right to live with dignity under Article 21 inherently includes the right to die with dignity, and that both passive euthanasia and advance medical directives are legal and permissible because they are rooted in liberty, dignity, and individual privacy.

The doctrinal significance of *Common Cause* lies in what it did not do. It did not legalize active euthanasia. Nor did it resurrect a generalized constitutional right to die. Instead, it transformed the patient's right to refuse non-beneficial treatment into an enforceable aspect of bodily integrity and self-determination. Put differently, *Common Cause* converted *Gian Kaur*'s narrow dignity-at-the-end-of-life observation into a concrete legal entitlement.

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[8] Law Commission of India, "196th Report on Medical Treatment to Terminally Ill Patients (Protection of Patients and Medical Practitioners)" (2006).

[9] The Medical Treatment of Terminally-ill Patients (Protection of Patients and Medical Practitioners) Bill, 2016, Bill No. XXVII of 2016.

[10] Raj Kumar Mani, Srinagesh Simha and Roopkumar Gursahani, "Simplified Legal Procedure for End-of-life Decisions in India: A New Dawn in the Care of the Dying?" 27 *Indian Journal of Critical Care Medicine* 374 (2023).

The judgment also recognized the living will or advance medical directive as a mechanism through which anticipatory autonomy could survive future incapacity. This was a significant jurisprudential step. It meant that the Constitution no longer protected only contemporaneous refusal of treatment by a competent patient; it also protected advance instructions given for a time when the patient could no longer speak for himself or herself.

At the same time, the 2018 framework remained procedurally dense. The living-will process involved multiple attestations and authorities; decision-making for incapacitated patients was surrounded by formalities that made real-world use rare. Critics thus welcomed *Common Cause* for its rights-based reasoning while doubting whether a right so difficult to invoke could truly become part of ordinary clinical practice.[11]

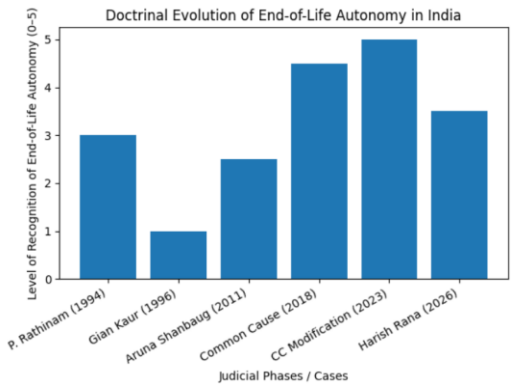

Fig. 1: Doctrinal Evolution of End-of-Life Autonomy in Indian Euthanasia Jurisprudence

As illustrated in Fig. 1, the evolution of euthanasia jurisprudence in India reflects a non-linear trajectory-from limited recognition in *P. Rathinam*, to doctrinal restriction in *Gian Kaur*, followed by gradual expansion culminating in *Common Cause*. However, the slight decline in *Harish Rana* indicates that implementation challenges continue to affect the practical realization of end-of-life autonomy.

V. Living Wills After the 2023 Modification

In 2023, the Supreme Court acknowledged these implementation difficulties and modified the *Common Cause* guidelines so that they would remain workable for both patients and medical practitioners.[12]

After modification, an advance medical directive must be signed by the executor in the presence of two attesting witnesses and attested before a notary or gazetted officer. The witnesses and the notary or gazetted officer must record satisfaction that the document was executed voluntarily, without coercion, and with full understanding of its consequences. Copies may be given to the nominated decision-maker, the family physician, and the local authority, and the Court now expressly contemplates incorporation of the directive into digital health records.

[11] Ibid

[12] *Common Cause v. Union of India*, 2023 SCC OnLine SC 99.

The procedure for patients without an advance medical directive was also simplified. A Primary Medical Board must consult the family physician, if any, and the patient's next of kin, next friend, or guardian; if written consent is given, the Board may certify the proposed course of action, preferably within forty-eight hours. A Secondary Medical Board then independently examines the patient and the medical papers. If it concurs, the hospital needs only to intimate the JMFC and the family, rather than seek prior judicial approval. The Boards now require relevant subject experts with at least five years' experience, a marked relaxation from the older, more onerous structure.[13]

The change is not trivial. It indicates a jurisprudential shift from a model of formal recognition without access to a model of guarded usability. The Court implicitly accepted that a constitutional right existing only on paper is not enough; the procedure itself must be clinically usable.

VI. *Harish Rana*, the 2024 Draft Guidelines, and the Unfinished Regime

The 2026 decision in *Harish Rana v. Union of India* exposed the gap between doctrine and implementation. The Court recorded that, across much of the country, the medical-board mechanism had not been effectively operationalized, Chief Medical Officers had failed to nominate practitioners for Secondary Medical Boards, and Judicial Magistrates were often unaware of the intimation process under *Common Cause*. It therefore directed High Courts to ensure that JMFCs receive such intimation and required CMOs across the country to prepare and maintain panels of eligible practitioners for secondary boards.

More importantly, the Court said in unmistakable terms that the prolonged absence of a comprehensive end-of-life statute had forced the judiciary to fill a legislative vacuum. It stressed that the *Common Cause* guidelines were only an interim safeguard and urged the Union Government to enact a coherent statutory framework. The message was clear: Indian euthanasia law has been constitutionalized, but it has not yet been fully legislated.

Administrative action has begun, but incompletely. The Ministry of Health and Family Welfare's 2024 draft *Guidelines for Withdrawal of Life Support in Terminally Ill Patients* define withdrawal, withholding, DNAR, best interests, surrogate decision-making, and transition to palliative care. They propose hospital oversight through clinical ethics committees and expressly state that active euthanasia is illegal in India. Yet the 2026 Supreme Court noted that no fruitful conclusion had been reached even on these draft guidelines. The Indian position is

[13] Supta 10

therefore advanced in principle, but unfinished in administration.

VII. A Critical Appraisal

The changing landscape of euthanasia law in India can be described as a shift from sanctity-of-life absolutism toward guarded autonomy. Indian law no longer treats the dying body merely as an object that must be medically preserved at all costs. Article 21 has been read to protect dignity, privacy, bodily integrity, and anticipatory choice at the end of life. Yet the autonomy recognized is carefully cabined: active euthanasia remains unlawful, patient wishes must be verified, surrogates are consulted in structured ways, and medical boards remain central to legitimacy.

That transformation is normatively defensible. A constitutional order committed to dignity cannot insist upon mere biological persistence where treatment has become futile, burdensome, or disconnected from any meaningful prospect of recovery. The right protected by Indian law is therefore better understood not as a right to choose death in the abstract, but as a right to refuse a forced prolongation of dying.

But serious weaknesses remain. First, the regime is still overwhelmingly judge-made. Second, implementation depends on hospital capacity, timely CMO action, physician training, and awareness among magistrates-conditions that are deeply uneven across India. Third, end-of-life decisions in a highly unequal society cannot be insulated from economic desperation, lack of insurance, and family exhaustion. The 2026 Court itself warned that, in the absence of legislation, financial distress and socio-economic vulnerability may blur the line between a genuine best-interest determination and one driven by economic compulsion.[14]

A further weakness is the under-integration of palliative care. Commentators have long argued that a legal right to die with dignity is hollow unless the State and hospitals also guarantee comfort, pain relief, communication support, and compassionate end-of-life care. The 2026 Supreme Court's statement that the right to die with dignity is inseparable from the right to receive quality palliative and end-of-life care is therefore one of the most important developments in the recent jurisprudence. It shifts the debate from mere permission to withdraw treatment toward a positive duty to manage the dying process humanely.

The next stage of reform should therefore be legislative and institutional rather than purely interpretive. India needs a dedicated end-of-life care statute with clear definitions; a reliable recording and retrieval mechanism for living wills; mandatory hospital protocols for Primary and Secondary Medical Boards; anti-coercion safeguards; periodic audit; and explicit integration of palliative care and ethics consultation. The

[14] Ibid

goal should not be to expand Indian law into active euthanasia, but to make the existing right to refuse futile treatment real, safe, and evenly accessible.[15]

Conclusion

From *Gian Kaur* to living wills, Indian law has travelled a considerable distance. What began as a constitutional rejection of a generalized right to die has matured into a limited but meaningful right to die with dignity at the end of natural life through passive euthanasia and advance medical directives. Yet the journey is incomplete. The courts have largely answered the first-order question of principle, but the second-order questions of implementation, equity, hospital preparedness, palliative care, and legislative certainty remain unresolved. The true test of the new landscape will be whether dignity in dying becomes a practical reality beyond a handful of informed hospitals, families, and courtrooms.

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[15] Ministry of Health and Family Welfare, "Guidelines for Withdrawal of Life Support in Terminally Ill Patients" (Draft, 2024).