PASSIVE EUTHANASIA IN INDIA: JUDICIAL DEVELOPMENTS, ETHICAL CONCERNS AND LEGISLATIVE CHALLENGES

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ABSTRACT

Passive euthanasia has emerged as one of the most debated issues in today's legal and medical world, involving complex intersections between constitutional law, medical ethics and human dignity. It basically refers to withdrawing or withholding medical treatment that is needed to sustain life, especially when the patient has a terminal illness or is in a permanent vegetative state. The laws on passive euthanasia in India have changed mostly through judicial interpretation and not legislative action. The Supreme Court, in its judgments in Aruna Shanbaug Case and Common Cause v. Union of India, respected passive euthanasia and established the concept of living will under Article 21 of the Constitution. There are important constitutional, ethical and procedural concerns raised on passive euthanasia. The right to life as provided in Article 21 also covers the right to die with dignity, especially when extended medical treatment only prolongs the suffering, as argued by the supporters. The opponents, however, emphasise the sanctity of life, risks of misuse and moral concerns about life support systems. This paper critically analyses the constitutional aspect of passive euthanasia in India, analyses landmark judgments and then critically examines the ethical arguments about the issue. It further analyses and compares India's position with other foreign jurisdictions to assess different approaches to end-of-life decisions. The paper suggests that while the recognition of the practice of passive euthanasia by judges in India is a positive development toward respecting patient autonomy and dignity, the country needs thorough legislative measures to make the process clear, avoid vulnerability and prevent misuse.

Keywords: Passive Euthanasia, Right to Die, Article 21, Living Will, Euthanasia Law.

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INTRODUCTION

As medical science has progressed, people are able to be kept alive longer by artificial means and life support systems. As medicine has developed, it has become possible to keep humans alive longer by using artificial and life-support systems. As these technological advances have helped to improve contemporary healthcare, they have also introduced challenging legal and ethical issues around the issue of continued life in situations where there is no medical chance of recovery. Euthanasia is one of the most controversial issues that has come out of this debate.

The word euthanasia comes from the Greek words 'eu' (good) and 'thanatos' (death), together signifying good death or mercy killing. Euthanasia normally means the deliberate killing of a living human being to end their suffering and/or pain. It can be generally divided into active euthanasia and passive euthanasia. Active euthanasia is the deliberate killing of a person by a doctor or another medical professional by means of a direct act, such as giving a lethal injection, while passive euthanasia is letting a patient die by withdrawing or withholding medical treatment or life support, which are necessary to keep the patient alive.[1]

The issue of euthanasia has now become very relevant to India because of the growing awareness of the rights of the patient and their right to die with dignity and patient autonomy. Issues of whether an individual has the right to refuse life-sustaining treatment and whether such refusal is within the scope of Article 21 of the Constitution have attracted a lot of constitutional debate. The judiciary has been at the centre of India's legal stance on passive euthanasia, with a series of landmark decisions.

The Aruna Shanbaug Case was the first in which the Supreme Court officially legalised passive euthanasia in India. The Court allowed withdrawal of life support under exceptional conditions and set out some procedural safeguards to guide the procedure. Later, in Common Cause v Union of India, the Supreme Court once again amplified the meaning of Article 21 by declaring living wills and advance medical directives as a reflection of individual autonomy and dignity.

Passive euthanasia still raises moral and procedural issues, although in light of these judicial developments. Legalisation of withdrawal of treatment can lead to vulnerability to coercion and family pressure, and may involve those seeking help in a health care system already facing

[1] R K Bangia, *Law of Torts* (Allahabad Law Agency 2019) 412.

infrastructure challenges, critics say. There is also a continuing debate in the public arena on the matter that is rooted in religious and moral concerns.

This paper aims to explore the constitutional aspect and moral implications of passive euthanasia in India. It examines the changing judicial interpretation of Article 21, examines important judgments and critically examines comparative legal approaches followed in other jurisdictions. The paper contends that although Article 21 does recognise the rights of the individual in terms of dignity and autonomy, the process of passive euthanasia has several serious ethical, medical and procedural concerns which need to be addressed to an extent via a comprehensive regulation of the process by legislation.

THE EUTHANASIA ISSUES: WHAT IS MEANT BY IT AND WHY IS ONE?

The deliberate and willful ending of someone's life, usually in the interest of relieving him from intolerable pain or suffering, is called euthanasia. The idea is as old as the ancient ages, but the legal and moral acceptance of the idea has changed according to different societies and cultures. The current concept of euthanasia is mostly directed at patients who are suffering from a 'terminal illness', 'irreversible coma', or 'permanent vegetative' state and have 'no reasonable chance of improvement'.[2]

The debates on euthanasia have surfaced clearly in the twentieth century, with the development of new medical technologies that have allowed the prolongation of life to be made possible. Although in past societies euthanasia has been considered a violation of moral norms, modern legal systems increasingly value the patient's autonomy and dignity in making decisions about the end of life.

There are various types of euthanasia. Active euthanasia is an act that is done to bring about death, e.g., by giving a lethal dose of a medicine to a patient. In most jurisdictions, this form is still prohibited, as it actually includes the taking of life, in India. Passive euthanasia, in contrast, is the withdrawal or withholding of medical treatment required to maintain life, such as ventilators, feeding tubes or resuscitative medical support.[3]

[2] K S Narayan Reddy and O P Murty, *The Essentials of Forensic Medicine and Toxicology* (34th edn, Jaypee Brothers 2017) 588.
[3] Ibid

Euthanasia could also be classified based on consent. Voluntary euthanasia is when someone who is competent and in control of their own mind requests that treatment be ended. The second form of euthanasia is non-voluntary, which occurs when the patient cannot give consent because of being unconscious or a lack of mental competency. Also called "involuntary euthanasia," it is killing a patient without his consent when he can make his own choices and is generally considered illegal and unethical.

There also needs to be a separation between euthanasia and physician-assisted suicide. In physician-assisted suicide, a physician supplies the means for ending one's life, but the actual act is carried out by the patient. In euthanasia, the act causing death is carried out either directly or indirectly by another person.[4]

In the international context, there is still a split on euthanasia among medical ethics organisations. The World Medical Association does not allow for active euthanasia, but does allow for withholding of extraordinary medical treatment under certain circumstances. Respect for bodily autonomy and self-determination plays a central role in the issue of the legality and morality of passive euthanasia, as evidenced by consent.[5]

Even in India, passive euthanasia has been getting acceptance from courts, as the concept of prolonging life without dignity has been understood as a violation of the Constitution. Yet the lack of a detailed statutory structure still leaves room for uncertainty about medical procedures, about patients' rights and the responsibility of institutions.

CONSTITUTIONAL AND LEGAL FRAMEWORK IN INDIA

Article 21 and Right to Die: Under Article 21 of the Indian Constitution, no one would be deprived of life or personal liberty unless in accordance with the procedure laid down by law. Judicial interpretation has added dignity, privacy and autonomy to the scope of Article 21. But the “right to die” has been a cause of debate since the “right to life” was introduced.

In P. Rathinam v. Union of India, the Supreme Court ruled that the right to life under Article 21 was an extension of the right not to live,[6] and that Section 309 of the Indian Penal Code was

[4] Poonam Pradhan Saxena, *Family Law Lectures: Family Law II* (LexisNexis 2015) 233.
[5] World Medical Association, ‘WMA Declaration on Euthanasia and Physician-Assisted Suicide’ (2019).
[6] P. Rathinam v. Union of India AIR 1994 SC 1844.

unconstitutional. The Court said that personal liberty and dignity had been infringed upon when someone was forced to live against their will.

But this was set aside in Gian Kaur vs. State of Punjab,[7] where a Constitution Bench ruled that the right to life did not encompass the right to die as Article 21 was concerned with life, not life's termination. However, the court had acknowledged that there is a difference between unnatural death and the right to be allowed to die with dignity at the end of one's life or when terminal illness is present. This observation was later to form the basis for the constitutionality of the recognition of passive euthanasia.

The judiciary has slowly been moving towards balancing dignity and autonomy with preservation of life in the evolution of Article 21. The concept of "dignity" protected under Article 21 is increasingly being recognised by the modern interpretation of the Constitution as one that would be compromised when a terminally ill patient is forced to suffer for an extended period.

Recognising Passive Euthanasia: The Aruna Shanbaug Case[8] 1973 is an example of the recognition of passive euthanasia in India, where Aruna Shanbaug, a nurse at KEM Hospital in Mumbai, was in a permanent vegetative state for more than four decades after being brutally assaulted sexually in 1973. A petition seeking permission for withdrawal of life support was filed before the Supreme Court.

In Aruna's case, however, the Court refused to withdraw the petitioner's plea because the medical staff at the hospital were not in favour of euthanasia. The judgment, however, is of historical value because for the first time the Supreme Court officially acknowledged the possibility of passive euthanasia under certain conditions. The Court determined that withdrawal of life support would be allowed upon the approval of the relevant High Court and based on expert medical opinion.

The decision set out procedures to ensure that life support is not withdrawn without a medical board and judicial review. The Court did make a distinction between euthanasia passive and euthanasia active, but it also took into account that in some cases the treatment continues artificially, without a therapeutic effect, but only to extend the duration of suffering.

[7] Gian Kaur v. State of Punjab (1996) 2 SCC 648.
[8] Aruna Shanbaug Case (2011) 4 SCC 454.

This judgment marked a major milestone in Indian constitutional law as it recognised the dignity and compassionate care as a part of the end-of-life choices.

Living Will and Advance Directives: Passive euthanasia was further broadened in Common Cause v Union of India,[9] where the Supreme Court held that an advance medical directive and a living will are legal. This upholds a person's right to refuse life-sustaining treatment in the future in medical circumstances. A living will helps someone to make their wishes known beforehand if they are not able to make them later. The Court recognised that the right to die with dignity is a part of Article 21 and the autonomy over one's body is represented by the freedom to refuse extraordinary medical treatment. In order to safeguard against misuse, the Court imposed strict procedural protections. This included the execution of the living will before witnesses, and multiple reviews by a medical board and a Judicial Magistrate before withdrawal of treatment. While these measures were meant to prevent harm to those who were vulnerable, it was pointed out that the process was very complex and not very manageable. The Supreme Court in 2023 gave certain procedural conditions to help advance directives become easier and more convenient in healthcare institutions.[10]

Judicial Implementation of Passive Euthanasia: Harish Rana v. Union of India[11] also marked a further evolution of the legal position on passive euthanasia in India, and was one of the most important post-Common Cause judgments on end-of-life care. This was a case of a patient who had been in a PVS for over thirteen years with no chance of recovery. The petitioner requested the Supreme Court to let him withdraw his life support systems and medical care because they could not restore consciousness and dignity.

As it decided the case, the Supreme Court extensively used the principles established in the Common Cause case, and reiterated that the “right to die with dignity” is part of the right to life guaranteed under Article 21 of the Constitution. The Court explained that passive euthanasia does not involve a deliberate act to end life but only the withdrawal of extraordinary means of life-sustaining when they no longer have any therapeutic value. The court stated that an individual's human dignity and personal autonomy could be infringed if they were forced to be permanently reliant on artificial medical assistance even though their medical condition was irreversible.

[9] Common Cause v. Union of India (2018) 5 SCC 1.
[10] *Common Cause v Union of India* (2023) SCC OnLine SC 373.
[11] *Harish Rana v Union of India* 2026 SCC OnLine SC 358.

The Court also noted that the matter of withdrawal of treatment must be based on expert medical opinion, informed consent and procedural safeguards for abuse of the right. The Court emphasised the need for palliative care and for humane treatment, and reiterated that the intent of passive euthanasia is not to end the patient's life too early, but to permit a natural death in cases when there is no hope of recovery. The judgment further pointed out the difficulties in practice that stem from the lack of a general law on passive euthanasia in India and suggested that the Parliament needs to frame a comprehensive legislation regarding end-of-life decisions.

The importance of the case of Harish Rana is that it has brought to the fore the principles identified in Aruna Shanbaug and Common Cause and implemented them in practice. It illustrated the ongoing process of the judiciary to strike a balance between constitutional morality, medical ethics and patient dignity with appropriate protection from abuse.

RELEVANT STATUTORY PROVISIONS

India does not have extensive laws to govern euthanasia now. But some of the provisions of the statute indirectly regulate related matters. Section 309 of the IPC used to make attempted suicide a crime, and Section 306[12] (recently amended) makes abetment of suicide a crime. Active euthanasia is still not legal, as the Mental Healthcare Act, 2017,[13] has effectively rendered Section 309 redundant, and as intentional killing can lead to criminal liability under the IPC, there remains a gap in the law.

The laws for medical ethics also affect euthanasia practices. Doctors are required to save lives and uphold professional honour as per the Indian Medical Council regulation. But there are moral questions of continued treatment when there is no therapeutic benefit, and it only adds to suffering. There is no specific legislation, so there is ambiguity about what constitutes institutional liability, consent standards, and how to implement the consent process. Thus, the judiciary has remained the most important regulating entity for passive euthanasia in India.[14]

ETHICAL AND MORAL DIMENSIONS

Passive euthanasia raises complex ethical issues, for it involves direct issues of the value of human life, of individual autonomy and medical responsibility. There are strong arguments

[12] Indian Penal Code 1860, ss 306 and 309
[13] Mental Healthcare Act 2017, s 115.
[14] Ministry of Health and Family Welfare, ‘Guidelines on End of Life Care’ (Government of India, 2023).

both for and against that come from both the supporters and the opponents, on both moral and religious grounds, as well as constitutional and healthcare ethics.

The principle of dignity and autonomy is the most important one for proponents of passive euthanasia. They believe that each person has the right to make the choice about how to treat him or her when life is no longer worth living or living is too painful. An extended life at the cost of irreversible suffering can be seen as a disrespect of the patient and his/her personal liberty. The supporters argue that it is a fundamental part of the constitutional morality that the right to die with dignity naturally flows from Article 21, which guarantees the dignity of life.

Another argument has to do with the alleviation of intolerable suffering. At the end of life, patients may have a lot of pain, emotional distress, and may be totally dependent on medical devices. Passive euthanasia can be given to these people so that they do not suffer unnecessarily for long if they are not expected to improve. The families can also be subjected to long-term treatment without any improvement, and they can suffer from enormous emotional and financial strains.

But opponents are strongly condemning passive euthanasia based on moral and religious reasons. The idea of the sanctity of life and the fact that human beings do not have the right to willfully destroy life are held by many religions. Some say that legalising euthanasia undermines the sanctity of life and that it can eventually become accepted as a treatment for ills.

Socio-economic inequalities in India and the poor health care system are also a concern regarding the use of these. Elderly People, disabled people or those who are economically dependent can be subtly coerced by relatives not wanting to be held responsible for their care. In addition, there are risks of abuse when dealing with disputes concerning inheritance or poor medical care.

Medical uncertainty is another ethical dilemma. The prognosis for terminal illness is not always right, and sometimes those who are considered to be 'dead' come back to life. This results in the arguments against allowing withdrawal of life support that we should be saving lives that might otherwise have a meaningful life.

The implementation of passive euthanasia also brings up ethical dilemmas for doctors. There are two traditional duties that doctors have – to preserve life and, at the same time, to minimise

suffering and respect patient autonomy. These demands present internal psychological and professional dilemmas in health care practice. So, the moral issue of passive euthanasia continues to be a subject of major controversy between the maintenance of life and the protection of dignity. All systems of law governing euthanasia require balancing these competing values appropriately, with effective procedural protections and institutional controls.

A COMPARATIVE ANALYSIS OF FOREIGN JURISDICTIONS

There are various strategies for legalising euthanasia and decisions about death in different countries. A comparative analysis is used to illustrate the tension between patient autonomy and protection from misuse in the law.

Under the Termination of Life on Request and Assisted Suicide Act, 2002,[15] euthanasia is legally allowed in the Netherlands, one of the first countries to do so. Active euthanasia and physician-assisted suicide are legal under certain conditions. The patient should suffer from intolerable pain and suffering with no chance of relief, and the request should be of their own free will and well thought out. Independent medical consultations and reporting are in place to help prevent abuse.

Likewise, euthanasia was legalised in Belgium in 2002. In Belgium, euthanasia is legal for adults if they are in a state of "unbearable physical or psychological suffering" due to irretrievable illness. Compliance with the procedure is supervised by judicial and medical supervision. Belgium subsequently widened its euthanisation law to include minors in specific cases, thus creating a more generalised system.

Medical Assistance in Dying (MAID) is now legal in Canada, as a result of the Supreme Court's ruling in Carter v. Canada (2015).[16] Under Canadian law, eligible adults are those who have serious and incurable medical conditions who can request medical assistance in dying. Implementation is controlled by strict consent requirements and medical evaluation procedures.

The United States takes a relatively piecemeal approach since there are state-by-state variations in euthanasia legislation. The practice of active euthanasia is still prohibited in the country, but

[15] *Termination of Life on Request and Assisted Suicide (Review Procedures) Act* (Netherlands, 2002)
[16] *Carter v Canada (Attorney General)* 2015 SCC 5, [2015] 1 SCR 331.

some States like Oregon and Washington allow physician-assisted suicide as part of their 'Death with Dignity' laws. These laws state that one must have a terminal diagnosis, make repeated requests and wait for a period of time before they can receive assistance.

The situation in India is quite different, as only passive euthanasia is recognised as a judicial act, while active euthanasia is not legal. The Indian courts have pointed to the need for procedural safeguards and judicial supervision, because of concerns about misuse and socio-economic vulnerability. India does not have comprehensive legislation to govern end-of-life decisions as in the Netherlands or Belgium. The comparative analysis shows the importance of strict safeguards, informed consent and institutional review for jurisdictions that allow for euthanasia. This can be a learning point for India in shaping its own legislation in sync with the constitutional values and realities of healthcare.

CHALLENGES IN IMPLEMENTATION

Although passive euthanasia has been recognised by the courts in India, there remain several issues that make it difficult to put into practice. Lack of public knowledge about living wills and advance directives is one of the problems. Few people know they have the legal authority to refuse extraordinary medical care in some instances. As a result, advance directives are not actually carried out.

Healthcare facilities in India are also insufficient, causing serious concern. Ethics committees and trained professionals to help with the implementation of judicial guidelines are not always available at rural hospitals and smaller medical institutions. In addition to this, quality medical care is not equally available, which makes it even more difficult to make end-of-life decisions.

One other difficulty is the potential for coercion and family pressure. Relatives may have an indirect influence on vulnerable patients, such as elderly people. It is difficult to determine if there has been true consent.

A lack of broad-based legislation is a major hurdle. Hospitals and doctors must rely on judicial decisions to a large extent for this legal regulation, but this may not be sufficient to give them the clarity they need for procedures. There is a reluctance by the medical profession to end treatment because of the threat of criminal liability or professional repercussions.

Additionally, confusion over medical standards and documentation processes in implementation. Irreversible conditions and/or permanent vegetative state are determined by expert evaluation, and opinions are often quite divergent.

Such struggles reveal that there is a need for judicial recognition beyond that. To ensure the fair and transparent operation of passive euthanasia, institution-based frameworks, public education and statutory regulation are required in India.

SUGGESTIONS AND RECOMMENDATIONS

There should be a proper law in India relating to passive euthanasia and further the medical directives. A detailed statutory framework would help to minimise ambiguity, make clear institutional responsibilities and give doctors, patients and families greater legal certainty.

Procedural rules should be set out as to how living wills are carried out, how medical boards are constituted and what constitutes an irreversible condition or terminal illness. The use of simplified procedures would enhance the implementation in practice, but would not compromise the protection from misuse.

The hospitals should have independent medical ethics committees that consist of medical experts, legal professionals and mental health specialists to make decisions on euthanasia objectively. Such committees might help minimise arbitrary decision-making and adherence to ethical standards.

In complex or controversial cases, judges should retain authority over the dispute, especially if there is disagreement in the family or issues of coercion. But, there should not be too many formalities in the routine medical decisions.

There is also a need for public awareness campaigns to provide education on living wills, patient autonomy, end-of-life rights, etc. Ethical and legal aspects of passive euthanasia should be properly trained to medical practitioners.

Any future legislation should continue to have strong safeguards as integral parts of the bill. Coercion, consent under duress and the abuse of the euthanasia process should be punishable by strict measures. Autonomy and accountability must be balanced to make sure humane and ethical implementation in the socio-economic context of the Indian scenario.

CONCLUSION

Passive euthanasia is among the most complex topics in constitutional law and medical ethics, as it involves the relationship between life, dignity and autonomy. The Indian judiciary has been instrumental in recognising passive euthanasia in some of its landmark cases, including the Aruna Shanbaug Case and Common Cause v. Union of India. These judgments broadened the concept of Article 21 to accommodate the right to refuse extraordinary medical intervention but also recognised that dignity goes far beyond simply living.

At the same time, passive euthanasia raises serious ethical, procedural and institutional concerns. Coercion, poor health care systems and a lack of comprehensive laws remain threats to effective implementation. Case law can leave medical practice uncertain and inconsistent if it is the only method of regulation. Case law can be an uncertain and inconsistent way of regulation, while guidelines from the judiciary offer a more short-term solution.

Finally, the constitutional debate must consider a balance between two principles – the preservation of life and respect for human dignity. A humane legal system should have the power to safeguard the innocent from harm and honour the will of the afflicted in situations where pain is irreversible.

Passive euthanasia is a phenomenon in India where the judiciary successfully tries to harmonise the values of human dignity, medical ethics, and constitutional morality, but with legislation, there is a need for clarity to ensure consistent implementation and a humane approach.